Annex 2: Study Area 1 Methodology

Annex 2: Methodology for Study Area 1

Study Area 1 (SA1) is led by Macro International Inc. (Macro) and a team of partners with global presence and expertise in public health; organization development; and qualitative and quantitative research. Partner organizations include the Johns Hopkins Bloomberg School of Public Health (JHBSPH); Development Finance International (DFI); Axios International Inc.; the CORE Group; and the Indian Institute for Health Management Research (IIHMR). Detailed descriptions of the methodology for both SAs 1 and 2 can be found in the Inception Report Summary. This document is available on the Five-Year Evaluation website, at the following web address:

http://www.theglobalfund.org/en/files/about/terg/announcements/Global_Fund_5YE.pdf

Study Area 1 Methodology

Study Area 1 assessed the organizational effectiveness and efficiency of the Global Fund, including how the Global Fund has respected its founding principles and whether it did so with operational effectiveness and efficiency. Explicitly out of this mandate is a questioning of the founding principles themselves through an examination of the Global Fund's business model. SA 1 comprised: (i) a study of Board governance; (ii) an organizational development (OD) assessment of the Global Fund secretariat; (iii) a review of the proposal development process and the technical review panel (TRP); (iv) an examination of procurement, supply management, financial management issues; and (v) a study of private sector resource mobilization. These last two components bridge both SA1 and SA2 activities (see SA2 methodology for information on the completed CPAs).

Benchmarks were explored to assess how the Global Fund compares to other organizations, but this analysis proved challenging for a number of reasons: 1) the Global Fund was conceived and has functioned as a different type of development institution from traditional multi-lateral or bi-lateral donors, and is therefore difficult to compare directly in terms of performance; 2) where comparable processes were identified, the specific metrics used often differ between the Global Fund and other institutions, so direct comparisons are, in most cases, not possible. While the benchmarks presented in this report are intended to provide some frame of reference for how the Global Fund is performing in key areas, each of these examples presented should be considered in the context of these limitations.

- **(i) Board Governance Study**

  During the inception phase, an initial paper was prepared to outline the conceptual framework and analytical approach for the internal governance study. Discussions were held with the Board during The Global Fund Board Retreat on April 24, 2007 comprising: (i) discussions with 5-6 individual delegations; and (ii) small group discussion among Board members regarding priority governance issues to be addressed during the evaluation. The SA1 team conducted an analysis of Board documents and decision points, as well as assessments prepared by the Secretariat. Finally, as shown in the table below, individual interviews were conducted with 18 Board Members, Alternates, and Focal Points from 16 delegations from July 17 – August 3.

Board Member Interviews

Constituency	Interview Respondent
Canada (Germany)	Mr. Ernest Loevinsohn
Communities	Dr. Francoise Ndayishimiye
Eastern Mediterranean Region (Jordan)	Dr. Ali Mohammed As'ad
EC	Mr. Enrico Mollica
France (Spain)	Amb. Louis Charles Viossat
France (Spain)	Mr. Serge Tomasi
Indonesia	Dr. Broto Wasisto
Japan	Mr. Toshiaki Kobayashi
LAC	Mrs. Carol Jacobs
LAC	Dr. Jorge Saavedra
NGO developed country	Mrs. Asia Russell
NGO developing country	Ms. Elisabeth Mataka
Norway (Point 7)	Dr. Sigrün Mogedal
Private Foundations	Dr. Todd Sommers
Private Sector	Mr. Rajat Gupta
UK (Australia)	Dr. Carole Presern
United States	Amb. Jimmy Kolker
United States	Mr. William Steiger

- **(ii) Organizational Development Study**

The OD Assessment examined the key functions of the Global Fund's four major processes (i.e., Resource Mobilization Process, Grant Approval Process, Grant Renewal Process, and the Board/Secretariat Relationship Process). It also reviewed the organization from the perspective of leadership; strategic planning; customer focus; workforce focus; process management; and measurement, analysis and knowledge management. In addition to the document review (see below), the Staff Surveys from 2003-2007 were reviewed and analyzed.

In June, 2007, the OD team conducted interviews and focus groups with 56 Secretariat staff members, representing 20% of its 283 current employees. An additional 33 Secretariat staff participated in pre-assessment meetings to aid in the identification of key organizational issues, potential interviewees, key processes for review and analysis, and to provide a historical perspective of their units. A total of 89 Secretariat staff representing 31% of all employees participated in assessment activities.

OD Assessment Interviews by Unit & Level

Unit	Executive Director	PEP	Operations	External Relations	Business Services	Legal	Finance	Totals
Senior Mgrs.	2	2	1	1	1	1	2	10
Mgrs.	2	4	15	3	6	0	0	30
Other Staff	1	8	17	4	13	2	4	49
Totals	5	14	33	8	20	3	6	89

- **(iii) Grant Approval and TRP Processes**

TRP records and documentation were reviewed for Rounds 3-6 for four major issues: pre-screening and eligibility; TRP recommendations on alignment with national health sector strategies; clarifications of category 2 proposals, particularly rejected proposals; and post-TRP appeals for category 3 proposals. Interviews were conducted with 7 TRP members, including the present TRP chair. Secretariat staff who support the TRP were also interviewed.

TRP Members Interviewed

TRP Members
Dr. Nemora Barcellos
Dr. Thomas Burkot
Dr. Malcolm Clark
Dr. Josef DeCosas
Dr. Peter Godfrey-Faussett
Dr. Antonio Pio
Dr. Stephanie Simmonds

- **(iv) Private Sector Resource Mobilization**

Private Sector Resource Mobilization has both in-country and Secretariat-level components. At the Global Fund Secretariat, the Evaluation team conducted interviews with staff in the External Relations, Finance, and the Co-Investment Manager. The team also met with the staff at the Geneva office of the Global Business Coalition against HIV/AIDS, as well as attended the conference organized by The Global Fund in Dakar in June 2007. Interviews and discussions were held with suppliers and potential private sector partners at the headquarters and regional levels.

Team members are also conducting of a study of private sector resource mobilization in conjunction with the Country Partnership Assessments (CPAs) in Tanzania and Malawi. As part of the CPAs, specialist are interviewing CCM representatives, Primary Recipients, and

partner organizations, as well as companies and private sector business associations engaged with HIV/AIDS, TB, and malaria resource mobilization.[139]

- **(v) Procurement and Supply Management**

Procurement and Supply Management also has in-country and Secretariat level components. At the Global Fund Secretariat, the Evaluation team conducted interviews with the Procurement Unit, Cluster leaders and former Team Leaders. In addition, interviews and discussions were held with former Global Fund staff, partner organizations, procurement agents and supplier companies. In conjunction with the CPAs, team members are conducting interviews with LFAs, PRs, SRs, Med Stores and other in-country partners in all 16 CPA countries. [140]

- **(vi) Cross-cutting SA1 evaluation tasks**

SA 1 conducted a thorough document review in concert with SA2. As specifically relevant to this report it focused on:

- Review of previous TERG-mandated Five Year Evaluation studies. [141]
- General review of expert reports, studies, opinion pieces, evaluation reports and Global Fund and independent studies, by thematic areas (i.e., Resource Mobilization, Procurement among others).
- Review of Board and Committee reports; TRP reports; etc.
- In addition, the Evaluation had access and examined for additional information the internal TERG and to the Secretariat SharePoint areas.

The list of references cited and consulted is provided in this report.

Finally, throughout the OD assessment period and beyond, the Evaluation team compiled the statistical annex (see Annex 1) from the different types of data provided by the Secretariat, as a reference and a basis for analyses.

List of Persons Met at the Global Fund Secretariat, in addition to OD Assessment Activities

Structure/Unit	Persons Met
Secretariat	
Executive Director Office	Michel Kazatchkine
	David Salinas
	Mark Grabowski
	Helen Evans

[139] The private sector resource mobilization study is ongoing through Study Area 2's CPAs.
[140] The study of Procurement and Supply Management is ongoing through the Study Area 2 CPAs.
[141] (These documents and relevant summaries are available on http://www.theglobalfund.org/en/about/terg/five_year_evaluation/)

Structure/Unit	Persons Met
Business Services	Ines Garcia-Thoumi
Administrative Services	Jean-Claude Crepy
Human Resources	Ann Duke
Information Systems	Doumit Abisaleh
	Steven Crockett
	Frederic Plain
	Bruno Larmounier
	Lapalu Lokumarambage
	Andrew Ritchie
Contracts	Orion Yeandel
Procurement & Supply Policies and Management	Sophie Logez
	Luca LiBassi
	Steen Stottrup
External Relations	Christoph Benn
Board & Donor Relations	Dianne Stewart
	Luke Aspinall
Global Partnerships	Khaya Matsha
	Edwige Fortier
Private Sector Partnerships	Rajesh Anandan
Communications	Jon Lidden
Online Communications	Pierre Conille
	Robert Bourgoing
Performance Evaluation & Policy	Bernhard Schwartländer
	Daniel Low-Beer
Strategic Information	John Cutler
	Ryuichi Komatsu
	Ronald Tran-Ba-Huy
M&E Services and Systems	Annette Reinisch
	Nathalie le Guillouzic-Zorzi
Evaluation Quality and Learning	Serge Xueref
	Mary Bendig
	Cedric Mahe
	Eline Korenromp
	Alex Lang
	Fortunate Mendlula
Operations	Nosa Orobaton
	Wolfgang Munar
Operational policy	Paula Hacopian
Operational Partnerships & Country Support	Duncan Earle
Operational Partnerships	Kirsi Viisainen
	Sarah Churchill
	Crystel Terzis
CCM	David Winters
Co-Investment	Olivier Vilaca

Structure/Unit	Persons Met
Portfolio Services & Projects	Samual Boateng
	Ruwan De Mel
Financial Advisory Services	David Powell
	David Curry
Proposal Advisory Services	Karmen Bennett
LFA Management	Katherine Ryan
Grant Renewals	Patricia Kuo
	Bintou Touré
Fund Portfolio Management	
Latin America & the Caribbean	Lelio Marmora
	Bertha Ormeno
	Matias Gomez
South Asia	J. Scott Morey
	Taufiqur Rahman
East Asia & the Pacific	Elmar Vinh-Thomas
	Oren Ginzburg
	Enkhjin Hatagin Bavuu
Middle East & North Africa	Hind Othman
West /Central Africa	Cyrille Dubois
	Wilfred Thalmas
	Mark Willis
	Mabingue Ngom
	Marguerite-Marie Samba-Maliavo
Southern Africa	Amal Medani
	Edward Greene
	Tatjana Peterson
East Africa & Indian Ocean	Victor Bampoe
	Linden Morrison
E. Europe/Central Asia	Valery Chernyavskiy
	Urban Weber
Finance	Barry Green
	Ian Carter
	David Ball
	Eric Godfrey
	Julia van Riel-Jameson
	Mark Troger
Legal	Bart Migone
	Tamima Boutel
	Tal Sagorsky
Other	

Structure/Unit	Persons Met
OIG	Ken Langford
Technical Evaluation Reference Group (TERG)	Rolfe Korte
	Rose Léké
Chair of Replenishment Committee	Sven Sandstrom
WHO	Francisco Cardenas
Global Business Coalition	Barbara Bulc

Annex 3: Principles of the Global Fund

Annex 3

The Principles of the Global Fund[142]

The eight principles of the Global Fund are:

A. Operate as a financial instrument, not as an implementing entity;

B. Make available and leverage additional financial resources;

C. Support programs that evolve from national plans and priorities;

D. Operate in a balanced manner in terms of different regions, diseases and interventions;

E. Pursue an integrated and balanced approach to prevention and treatment;

F. Evaluate proposals through independent review processes;

G. Operate with transparency and accountability.

H. In making its funding decisions, the Fund will support proposals which:

Focus on best practices by funding interventions that work and can be scaled up to reach people affected by HIV/AIDS, tuberculosis and malaria.

Strengthen and reflect high-level, sustained political involvement and commitment in making allocations of its resources.

Support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector; across government departments; and with communities.

Build on, complement, and coordinate with existing regional and national programs1 in support of national policies, priorities and partnerships, including Poverty Reduction Strategies and sectorwide approaches.

Focus on performance by linking resources to the achievement of clear, measurable and sustainable results.

Focus on the creation, development and expansion of government/private/NGO partnerships.

Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals.

[142] Sources: The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria (http://www.theglobalfund.org/en/files/publicdoc/Framework_uk.pdf); Global Fund Principles (http://www.theglobalfund.org/en/files/publications/brochure/TGFBrochure_TheGlobalFundPrinciples.pdf)

Are consistent with international law and agreements, respect intellectual property rights, such as TRIPS, and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need.

Give due priority to the most affected countries and communities, and to those countries most at risk.

Aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups.

Annex 4: The Global Fund: Historical antecedents and first five years of operation

Annex 4

The Global Fund: Historical antecedents and first five years of operation

Contributors: Randall Packard, Will Dyckman, Leo Ryan, Eric Sarriot, Peter Winch

Historical antecedents to the establishment of the Global Fund

The Global Fund was established in 2002 as an independent financial institution designed to raise and distribute massive amounts of monetary support for the fight against AIDS, tuberculosis and malaria. In order to understand the Global Fund and how it operates, one needs to view it within the changing global health environment from which it emerged. The context of that health environment has significantly shaped both the form that the Global Fund has taken as well as the challenges it has faced. Three developments have marked this environment:

The first was the growing recognition that large areas of the globe faced expanding epidemics of HIV/AIDS, tuberculosis, and malaria. The AIDS epidemic, which was leveling off in Western Europe and the United States, as well as in certain countries in Latin America and even Africa, was taking off at an unprecedented rate in southern Africa, India, China, and certain areas of Southeast Asia.[143] Tuberculosis, which had never really been brought under control over much of the globe, was evolving increasingly resistant strains, difficult and expensive to treat, contributing to increased rates of TB mortality.[144] Malaria, which had been the subject of massive efforts to eliminate it as a public health concern during the 1950s, 60s, and 70s, was expanding its hold on many areas of the tropical and sub-tropical world. It was advancing in the wake of the withdrawal of control efforts, drug resistance, and the onslaught of social and economic conditions that fostered its resurgence.[145]

The second development was the appearance of new weapons to combat all three diseases. Antiretroviral drugs permitted AIDS patients to control their infections, greatly reducing AIDS mortality and encouraging more people to be tested for the disease. New anti-tubercular drugs combined with proven forms of effective treatment based on directly observed therapy (DOTS), promised to greatly reduce the global burden of TB. Similarly, new combination antimalarial therapies, which included Artemisinin derivatives, promised to overcome the problem of antimalarial drug resistance. There was promise in the use of insecticide treated bed nets (ITNs), and the intermittent treatment of pregnant women had been shown to significantly reduce malaria-related deaths among the most vulnerable populations in Africa, where 90% of malaria deaths occurred.

These technologies formed the basis of new initiatives aimed at combating these three deadly diseases, and included such programs as the WHO's STOP Tuberculosis and the Roll Back Malaria Partnership. Yet as promising as these technological breakthroughs were, they were in many cases expensive and beyond the reach of the impoverished countries in which the heaviest burden of these three diseases existed (see the following text box).

---

[143] UNAIDS and WHO. 2006. *AIDS Epidemic Update.* (December 2006), Geneva, Switzerland.
[144] WHO, STOP TB Partnership. 2007. *The global MDR-TB and XDR-TB response plan, 2007-2008.* Geneva, Switzerland.
[145] Packard, R. 2007. *The making of a tropical disease: A short history of malaria.* Baltimore, MD: Johns Hopkins Press.

A Brief History of Malaria Funding

A brief look at the history of malaria funding over the past fifty years provides some indication of the financial problems facing malaria control efforts. During the 1950s, a massive effort to eradicate malaria centered on the use of a compound known as dichlorodiphenyltrichloroethane (DDT). Its use was initiated by the World Health Organization, in collaboration with UNICEF, PAHO, UNDP, and a number of bilateral donors. This led to a dramatic increase in spending on malaria control: WHO expenditures on malaria rose from $768,000 in 1955 to $7.7 million in 1964. Between 1957 and 1967, a total of $1,339 million was spent on eradication efforts. Roughly 60 percent of that figure was provided to national malaria control programs by multilateral and bilateral assistance.

The failure of the program to achieve its goal of eradication led the WHO to terminate the program in 1969, amid a general disillusionment with malaria control activities among international donors. Funding levels dropped precipitously. Total assistance in the eight years following the end of eradication totaled only $250 million. WHO's malaria advisory staff decreased progressively from 444 to 155, and UNICEF's staff between 1967 and 1977dropped from 115 to 37. Multilateral and bilateral support in commodities and services dropped from $16.4 million to $6.3 million annually during the same period. Considering the devaluation of the dollar, this represented a drop of 80 percent. In the face of declining financial support, many national malaria programs cut back on control activities. Spraying operations decreased in number, frequency, and coverage. Drug shortages became commonplace. Control programs were integrated into primary health care and in some cases eliminated all together. Not surprisingly, malaria made a comeback in many parts of the globe.

It was not until the 1990s, in the face of a global resurgence of malaria, that renewed interest in malaria led to increases in global funding for control efforts. Expenditures on malaria from international sources in 1998 was approximately $64 million. The Roll Back Malaria (RBM) Partnership, launched in 1999, proposed to greatly increase control efforts in reducing the global burden of malaria by 75 percent by 2015. Support for this new initiative surfaced from UN agencies, development banks, bilateral donors, Organization of Economic Cooperation and Development donor countries (OCED), the research and control communities, industry, the private sector, and NGOs. Yet funding lagged behind program needs. By 2001, there were 13 African countries to have developed national RBM strategies. The combined projected budgets required to complete the first year of these plans was just under US$150 million. At the time, however, only US$32 million had been pledged, or 21 percent of what was needed. By 2004, over $6 billion had been pledged to support the campaign, yet only $146 million had been disbursed. Many malaria control programs remained underfunded, unable to achieve the targeted coverage with anti-malarial drugs and insecticide treated bed nets.

The emergence of the Global Fund played a major role in closing the funding gap between 2002 and 2006, disbursing some $886 million to malaria control programs. Yet, by its own estimates, achieving the RBM goals will cost $2.9 billion annually, and the estimated amount of grants to be given in 2008 is estimated to reach only $312 million.[3]

It was in response to this confluence of promising new technologies and inadequate funding that a number of world leaders called for the creation of a new mechanism for raising the funds needed to effectively combat these diseases. Representatives of G8 countries met in Denver, Colorado in 1997, where they committed their countries to work to provide funds for an accelerated attack on AIDS.[146] This was a commitment that resulted in part from sustained advocacy by organizations and coalitions representing persons affected by HIV/AIDS, such as ACTUP, and also from donor concerns about the constraining effect of the AIDS epidemic on economic and social development. When the G8 met again in Okinawa in 2000, this promise was

[146] G8 Communications Center. 1997. *Draft communiqué: Denver summit of the eight.* (June 22) University of Toronto.

repeated and expanded to include TB and malaria.[147] In September of 2000, halting the prevalence of and beginning to reverse the incidence of AIDS, TB, and malaria was declared to be one of the eight United Nations Millennium Development goals. In a January of 2001, a Lancet article written by Jeffrey Sachs and Amir Attaran[148] calculated that $7.5 billion annually was needed to effectively bring HIV/AIDS under control worldwide. This was in stark contrast to the attained progress of the previous decade, where worldwide oversees development funding had never exceeded $144 million annually. In early May, UN Director-General Kofi Annan called for the creation of a fund that would add $7-10 billion to the current level of spending on AIDS, TB, and malaria. The following July, representatives of the G8 group of nations endorsed the creation of such a fund at their annual meeting in Genoa.[149]

The third development was the growing dissatisfaction with existing mechanisms for funding disease control and prevention programs in poor countries. This dissatisfaction emanated from a number of places and ideological positions. One major source of this dissatisfaction emerged during the 1980s with the neo-liberal critique of government-based programs, which were viewed as inefficient, wasteful, and often corrupt.[150] Neoliberal ideas, often associated with the Reagan and Thatcher governments, had a much wider influence during the 1990s. Thus, elements of neoliberalism could be found in policy discussions during the Clinton years, within the Labor government under Blair in the UK, in 'liberalisme' in France under Chirac, and now even more so under Sarkozy.[151] Neo-liberal critics called for a combination of reforms in development aid which included the privatization of government services, the elimination of structures that impeded market forces from meeting development needs, and the funneling of development monies to non-governmental organizations and representatives of what was called civil society. The last of these prescriptions, echoed by members of both the European Left as well as civil society organizations, was often linked to the process of democratization.

The second critique posited that existing multilateral and bilateral development practices were often inefficient, lacked adequate safeguards to ensure accountability, and resulted in a massive waste of resources. Inefficiency was frequently associated with government-run programs, as reflected in the World Bank's 1993 World Development Report, Investing in Health,[152] while efficiency was equated with privatization and the application of accounting models borrowed from business. This critique led the World Bank in the 1990s to implement a set of accounting practices aimed at ensuring that aid monies were spent in an effective and responsible manner. Beginning in the late 1990s, the Gates foundation, through its billion dollar investment in the Global Alliance for Vaccine and Immunization (GAVI) program, developed performance-based funding models that required recipients of aid to demonstrate that funded programs produced

---

[147] G8 Communications Center. 2000. *Draft communiqué: Okinawa G8 summit.* (July 23) University of Toronto. *Health is key to prosperity. Good health contributes directly to economic growth whilst poor health drives poverty. Infectious and parasitic diseases, most notably HIV/AIDS, TB and malaria, as well as childhood diseases and common infections, threaten to reverse decades of development and to rob an entire generation of hope for a better future. Only through sustained action and coherent international co-operation to fully mobilise new and existing medical, technical and financial resources, can we strengthen health delivery systems and reach beyond traditional approaches to break the vicious cycle of disease and poverty.*

[148] Attaran, A. and J. Sachs. 2001. Defining and refining international donor support for combating the AIDS pandemic. *The Lancet, 357*(2924/January 6), 57-61.

[149] G8 Communications Center. 2001. *Draft communiqué: Genoa.* (July 21) University of Toronto.

[150] Neoliberalism was a theory of political economic practices that proposed that human well-being could best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade, and the elimination of strong governmental constraints. Neo-liberal ideas have been a major force in global health since the 1980s.

[151] Harvey, D. 2005. *A Brief History of Neoliberalism.* New York: Oxford University Press.

[152] The World Bank. 1993. World development report. *Investing in Health.* New York; Oxford University Press.

results, and doled out monies in small tranches with each subsequent payment dependent on demonstrated achievement. To enforce this model the Foundation implemented a system of audits, including surprise visits to development sites. The WHO's STOP Tuberculosis program employed similar tactics. GAVI was also important in that it embodied ideas about the power of the market and the need to establish public-private partnerships, a vehicle to mobilize the resources of private capital and jump start market forces that could play a major role in providing the new health interventions that promised to revolutionize disease control and prevention programs.

Performance-based funding models became increasingly popular during the 1990s. They were at the center of the Clinton administration's efforts to "redefine government." In 2000, representatives of the G8 meeting in Okinawa committed themselves to supporting countries whose governments "have demonstrated a commitment to improve the well-being of their people through accountable and transparent management of resources devoted to development." The need for accountability also informed the Bush administration's criticisms of the inefficiencies and wastefulness of UN agencies. The Bush administration was not alone in their criticism. Helen Gayle of the Gates Foundation, for example, emphasized the importance of accountability in aid programs, noting that this was very different from the way the UN had worked in the past, which she viewed as almost an entitlement system."[153] In fact, no one at the time seemed to believe that funneling new funds through existing UN agencies would achieve the level of efficiency, transparency, and accountability that was needed to manage the new funds. Critics of performance models, it should be noted, argued that they added new layers of oversight, which sometimes delayed the implementation of programs. They also maintained that many poor countries lacked the resources to meet strict accounting requirements.

A third critique of existing funding mechanisms, expressed by both aid recipients and the World Bank, was that there had been a proliferation of donor organizations and control programs generated, in large part, by the move from government to NGOs and civil society organization funding that began in the 1980s. (See text box below.) This had increased support for disease control programs, but had created problems in that there was often limited coordination among various programs, leading to waste and inefficiencies. In addition, the proliferation of programs resulted in an increase in reporting requirements and in overall transaction costs for aid recipients. The Bank had begun to address this problem by pushing for the creation of sector-wide funding mechanisms (SWAp) through which various funding streams would be fed into a single basket which could be allocated according to a sector-wide plan. Alternatively, individual donors would fund parts of a unified program linked to the country's national health plan.[154]

NGO Proliferation

The 1990s saw a massive growth in the number of NGOs throughout the world. Following the collapse of the Soviet Union, western donor countries began to shift aid away from country governments, and new non-governmental organizations quickly emerged as alternatives recipients of aid monies. A brief

[153] Schoofs, M. and M. M. Phillips. 2002. Global disease Fund to be strict for better chance to get results. *Wall Street Journal* (February 13), A-2.

[154] The World Bank. 2001. *Education and health in sub-saharan Africa: A review of sector-wide approaches*. Africa Region Human Development Series. Washington, DC.

Cassels, A. 1997. *A guide to sector-wide approaches for health development: Concepts, issues, and working arrangements*. WHO document (WHO/ARA/97.12). World Health Organization: Geneva, Switzerland.

look at this growth in various African countries provides an idea of the scale of this growth. In 1988, the Environment Liaison Center in Nairobi estimated that there were between 8,000 and 9,000 NGOs in all of Africa. Today, there are nearly 100,000 NGOs in South Africa alone. In Tanzania, only 25 NGO's were registered in 1986. By 1994 there were 1,800 NGOs present, including both registered and non-registered organizations. In Ghana, there were 80 registered NGOs in 1980 and 1,300 in 2001. Outside of Africa the explosion is the number of NGO's has been even more dramatic. Between 1992 and 1997, 100,000 NGOs were registered in the former Soviet Union. Currently, there exist 1 million NGO's in India and 300,000 in Brazil.[155]

Existing funding practices were also criticized by patient activist organizations and the governments of poor countries who claimed that the funding of existing disease programs was wholly inadequate for the needs of those populations afflicted with the three diseases. Effective programs languished due to inadequate resources. AIDS activists also called for the provision of much larger sums of money to provide antiretroviral therapy to the millions already infected with AIDS. While these calls fueled debates among diverse groups over the value of treatment versus prevention, few questioned that the amount of monies currently available to combat these diseases was inadequate. This same set of critics also called for greater participation by country representatives, patient activists, and other stakeholders in the design and direction of funded programs. In this way, they reinforced calls for greater participation of representatives from civil society, neoliberals, and members of the European Left.

> *The Global Fund thus was born from a confluence of factors, including: 1) Increase in awareness regarding the tremendous burden associated with the three diseases. 2) Emerging consensus that massive amounts of funding needed to be mobilized at once to achieve results, and that these amounts exceeded what any one country alone could contribute. 3) Lack of confidence in existing global mechanisms, such as governments and UN agencies, to rapidly and effectively mount a response to the three diseases. 4) Recognition of the need for new funding mechanisms that would be responsive to the needs of local stakeholders, and would be transparent, accountable, and performance based.*
>
> *The Transitional Working Group, which defined the general organizational guidelines that the Global Fund would follow, included; representatives of the G8 countries; the US government, which became the primary source of public funding for the Global Fund; the Gates Foundation, which was the largest private donor and represented on the Global Fund's Board; and the World Bank, which became the Trustee for the Global Fund. Not surprisingly, many of the Global Fund's principles and structures, as laid out in its foundational documents, (see following text box) reflected the concerns expressed by these institutional actors.*

Thus, the Global Fund emerged as an independent funding institution dedicated to raising financial resources for drugs and other commodities to supplement existing control programs. It did not wish to become another player in the design and implementation of control programs.

[155] Igoe, J. and Kelsall, T. 2005. *Between a rock and a hard place: African NGOs, donors, and the state.* Carolina Academic Press: Durham, NC, 6-7.

Instead, it placed a high value on country ownership as defined not by governments, but by countrywide coalitions of stakeholders that included governments, NGOs, and representatives of civil society. These various stakeholders were increasingly required to be represented within the Country Coordinating Mechanism, which was charged with designing and coordinating disease programs. At the same time, the Global Fund stressed the need for accountability, establishing technical review panels that would evaluate country proposals, and a system of independent monitoring (LFAs) and performance-based funding similar to that employed earlier by GAVI. Like GAVI, funding was to be provided in initial two-year grants, which could be renewed for up to five years contingent upon project performance. Thirdly, it stressed the need for harmonization among all organizations involved in fighting AIDS, tuberculosis and malaria in order to insure the coordination of control and prevention efforts, and reduce transaction costs.

Establishment of the Global Fund

The Global Fund launched its grants program with haste and determination, on a time-scale typical of the response of relief agencies to natural disasters. The details of how the Global Fund should be managed, issues such as voting shares, review processes, the composition of CCMs, and the relationships with partners, were only generally defined by the foundational documents. The desire to open up for business overrode the need for advanced organizational planning.[156] Thus, the Global Fund began soliciting grant proposals before the full complement of structures and personnel were in place at the Secretariat in Geneva. In fact, the very need for a permanent secretariat to run the Global Fund was a subject of debate by the Board, and the Board expressed a desire from the outset to limit the size and budget of the Secretariat, for example by hiring temporary rather than permanent staff. About 50 staff members were seconded from WHO and UNAIDS, and additional staff were quickly hired to serve as fund managers. Many of these managers were young, with relatively little work experience. The speed with which the Global Fund moved to disburse funds resulted in countries being given barely a month to respond to the first call for proposals. Nonetheless, the Global Fund's portfolio of funded projects grew in dramatic fashion. By the end of 2002, it had approved 56 proposals in 37 countries worth US$567 million and it had begun to sign grant agreements and disburse funds. One year later, the Global Fund had approved a total of 224 projects in 121 countries for a total value of US$2.1 billion. At the close of 2004, these totals were 295 projects in 127 countries at a value of US$3.1 billion. Disbursements followed a slower trajectory but their pace accelerated rapidly from 2004 on. Cumulative disbursements by June 2007 totaled almost US$3.8 billion.[157]

> *Global Fund challenges faced during first five years conflicted with the needs of grant recipients for technical assistance in the preparation and implementation of funded programs. Related to this, the Global Fund's desire to avoid involvement in health program development, focusing it's funding on projects and commodities, proved to be incompatible with the poorly developed health and financial infrastructures within many recipient countries.*[158]

---

[156] Bezanson, K. 2005. *Replenishing the Global Fund: An independent assessment*. (February 8)

[157] See statistical annex of the SA1 report

[158] *The focus on project assistance also conflicted with the desire to achieve harmonization during the early rounds when proposals that focused on creating system-wide approaches were rejected.*

COUNTRY OWNERSHIP VERSUS ACCOUNTABILITY

The Global Fund's insistence on country ownership, while laudatory in principle, proved to be problematic in practice for several reasons. First, the Global Fund insisted on defining the terms of ownership, requiring that countries form Country Coordinating Mechanism (CCMs) which were supposed to be representative and inclusive of all interested parties (including NGOs, representatives of civil society, patient support groups, and national governments). In a number of cases, these new structures were hastily constructed to meet the short lead-time allowed for first round proposals. The relation of the newly-formed CCMs to the already established recipient organizations, such as the national AIDS councils and NGOs that had previously been recipients of external funds, was often unclear and a potential source of tension.[159] In a number of countries the CCMs were in fact regarded as being imposed by the Global Fund.[160] To further complicate the situation, early on, the Global Fund awarded grants directly to NGOs rather than working through the CCM, thereby raising questions about the role of the CCMs. For example; one of the first grants made by the Global Fund was to a highly innovative patient support program from the KwaZulu-Natal Province of South Africa. The South African minister of health claimed that the money should have gone to the South African National AIDS Council, which had been designated as the CCM shortly before the grant to KwaZulu/Natal was announced, and which had coordinated AIDS programs in-country. The minister went further, claiming that the Global Fund, in making the grant, was trying to bypass the democratically elected government of South Africa. The minister's reaction may have been triggered by ongoing controversies surrounding her management of the AIDS crisis in South Africa. Nonetheless, disagreements between the Global Fund and the South African government over who could legitimately receive external disease control funds delayed the disbursement of funds until 2004. In subsequent rounds, the Global Fund attempted to work with countries to clarify the role and composition of CCMs.

While the Global Fund encouraged country ownership of programs, resisting earlier models of development assistance in which external approaches were imposed by donor agencies, the proposal review process and project monitoring mechanisms tended to undercut country ownership in a number of ways. First, in order to develop proposals that would meet the technical standards required by the Global Fund's review panels, many countries, and particularly African countries, sought technical assistance from external agencies, primarily WHO and UNICEF. As a result, locally defined projects were recast in line with external technical advice.[161] Secondly, the technical review panels set up by the Global Fund were staffed by technical experts who lacked direct knowledge of local conditions in the countries applying for funds. Project evaluations and suggestions for revisions were therefore made on the basis of whether the proposals met a set of external technical criteria rather than whether they made sense in terms of local conditions.[162]

Finally, in order to insure fiscal accountability, the Global Fund required that each country have a Local Fund Agent (LFA), which would be responsible for monitoring projects. While there

[159] Brugha, R. 2005. The Global Fund at three years: Flying in crowded space. *Tropical Medicine and International Health, 10*(7/July), 624.
[160] Brugha, R. 2005. Global Fund tracking study: A cross-country comparative analysis. Final Draft. (August 2), 10.
[161] Brugha, R. 2005. Global Fund tracking study: A cross-country comparative analysis. Final Draft. (August 2), 4.
[162] UK Department for International Development (DFID). 2003. *Global Fund country case studies report.* (January 22-23), DFID.

early discussions within the Transition Working Group focused on how this role should be filled, in the end, the Global Fund decided to employ several established international accounting firms to serve as LFAs. Subsequent reviews of Global Fund activities revealed country-level concerns about the failure of the Global Fund to employ existing monitoring mechanisms and the lack of country specific expertise, as well as general health evaluation and monitoring experience among appointed LFAs. In effect, the LFAs further undercut the notion of country ownership.

Financial versus technical assistance

From its inception, the architects of the Global Fund viewed it as providing additional financial support for existing programs for preventing and treating AIDS, TB, and malaria. There was no mechanism for Fund managers to provide potential recipient countries with the technical assistance needed to prepare proposals or implement programs. Many of the early Fund managers were hired with business rather than health backgrounds. In hiring managers with business backgrounds, it was assumed that other partners, such as WHO, UNAIDS, and bilateral donors, would quickly move in to provide the technical support necessary to implement the funded activities. This did in fact happen, but slowly.

WHO, UNAIDS, and other UN agencies were engaged throughout the early discussions to establish the Global Fund, and many assumed that one of them would become the entity to host the fund. When this did not happen, there was disappointment in some quarters and this, combined with unclear guidance on who would provide technical support and how it would be paid for, delayed the provision of this support. In early trips to countries to explain policies and procedures such as guidelines for Country Coordinating Mechanisms, assumptions were made by Global Fund staff that UN agencies would take responsibility for hosting visits and arranging meetings, in the absence of specific arrangements and budgets to do so.

This absence of any established mechanism for providing technical assistance to applicant countries took its toll during the first round of funding. While there had been a general consensus that African countries had the greatest need for financial support, their limited capacity to write sound proposals restricted the number of proposals funded in Africa. Just 16 of the 36 African countries submitting proposals were funded. Recognition of this problem led the German Agency for Technical Cooperation (GTZ), later joined by other donors, to put together an early initiative to support proposal development. UNAIDS, WHO, USAID, and other agencies subsequently increased technical support to countries preparing and implementing Global Fund projects during 2003 and 2004. Yet, the growing number of funded programs was viewed by donor agencies as stretching their resources. The need for additional financial support for technical assistance was noted by the GAO and other external reviews in 2005.[163] Lack of

[163] For example, Keith Bezanson noted in his external review that: “It is clear that without either new funds from WHO member countries for this technical assistance purpose or new forms of partnership agreements between WHO and the Global Fund, WHO will not be able to keep up with the massive need for technical assistance associated with Global Fund grants.” Bezanson, K. 2005. *The Global Fund strategic situational analysis: Preliminary annotated outline.* Global Health, The Global Fund to Fight AIDS. (July 8), GAO.

Brugha, R. 2005. TB and malaria is responding to challenges but needs better information and documentation for *performance based funding.*(June).

Brugha, R. Global Fund tracking study: A cross-country comparative analysis. Final Draft. (August 2).

technical support remained a problem through 2006 when 41 percent of stakeholders queried rated technical assistance as fair or poor.[164]

PROJECT SUPPORT VERSUS HEALTH SYSTEMS STRENGTHENING

The majority of GFATM approved grants have gone to support the purchase of commodities and specific projects through which to combat the three diseases. Yet, from its inception, GFATM has been aware of the manner in which local health systems influence the efficacy of such projects and procurements, and the question of how—and even whether—to strengthen such systems has plagued GFATM throughout each funding cycle. Inadequate health staffing, health infrastructure, and administrative capacity have hampered GFATM funded programs. There seems to be an inherent conflict between the Global Fund's core organizing principle that insists that projects explicitly target the three diseases and show measurable results within the timeframe of project funding cycles, and the reality of the need to strengthen general national health systems before such projects can be maximally effective.

It is important to recognize that GFATM is aware of this conflict and that throughout the history of the Global Fund differing approaches have been attempted to resolve it. In Rounds 1 through 3, applicants had the option of applying for 'integrated' health systems strengthening (HSS) projects. While Round 4 narrowed the scope somewhat, making more explicit those things which could be applied for, there was little difference in the overall application policy.[165] As a result, HSS proposals during Rounds 1 through 4 had both low application and success rates, with only 1 proposal out of the 10 submitted receiving funding.[166]

In Round 5, GFATM attempted to clarify its position on HSS by instituting a separate HSS-specific funding option. Again, only 10 percent, or 3 out of 30 proposals submitted, were approved.[167] This funding option was subsequently removed in Rounds 6 and 7, during which GFATM has attempted to further clarify its requirements regarding the specific linking of HSS activities to the three diseases.[168]

The TRP, in examining its troubled relationship with HSS-oriented proposals throughout the past seven rounds of funding, has acknowledged that "the Global Fund system is not currently set up to generate strong HSS proposals nor to evaluate these effectively," and that "the Global Fund needs to define the scope, boundaries, and extent of activities that it is willing to fund under the rubric of HSS activities."[169]

---

[164] Global Fund. 2006. *360° stakeholder assessment.* (September).

[165] Consultation. 2007. *The Global Fund's strategic approach to health system strengthening.* Background Note 4 (July 30-31).

[166] Ibid.

[167] Ibid.

[168] It is interesting to note that, despite the lack of a separate HSS category in Round 7, actors such as Physicians for Human Rights have made available guides to assist applicants in how to integrate HSS into their proposals, recognizing the continued need for such approaches and the increased difficulty of obtaining funding for them now that the Global Fund appears to be retreating from soliciting expressly HSS-oriented proposals.
Physicians for Human Rights. 2007. *Guide to using Round 7 of the Global Fund to fight AIDS, tuberculosis and malaria to support health systems strengthening*. (March).

[169] Consultation. 2007. *The Global Fund's strategic approach to health system strengthening.* Background Note 4. (July 30-31), 4-5.

Where's the money?

Above and beyond operational difficulties and the structural problems discussed above, the Global Fund has faced the broader challenge of refilling its coffers. While the numbers of grants made and the amounts of monies disbursed have increased steadily over the Global Fund's first five years of operations, so too has the demand for resources. The total amount of disbursed funds as of September 2006 remained far below the amounts that were originally estimated to be necessary to stem the tide of these diseases. Meeting this demand, moreover, has become increasingly difficult. The Global Fund's major donor was, and remains, the United States. However, this support waned with the creation of the Presidents Emergency Plan for AIDS Relief in 2002. Moreover, while donations flowed rapidly into the Global Fund during its first three years, these years corresponded with a period of rapid economic growth and record overseas development assistance-giving. Beginning in 2005, the economic environment became much tighter, making fund raising much more challenging. To make matters worse, the Global Fund is not the only global financing institution looking for support. African Development Fund, the World Bank's IDA, the Asian Development Fund, the Global Environmental Facility, and the International Fund for Agricultural Development all sought replenishments during this period.[170] Finally, despite the Global Fund's success in disbursing funds, there is, as of yet, little evidence that the global tide of AIDS, TB, and malaria has turned, or that it will do so to a substantial degree over the next decade. The amounts needed to support ARV treatments for AIDS will only increase, in some areas in a dramatic fashion, as those presently on ARVs will continue to require them for life, and as the incidence of new infections keep rising. The Global Fund, therefore, is likely to require increased levels of funding to sustain the programs it has already funded, in addition to allowing for new ones. This represents the Global Fund's ultimate challenge: its ability to sustain high levels of financial support over a long period of time.

Responding to challenges

The Global Fund emerged in response to a collection of diverse interests, as well as to the concerns of a set of powerful institutional actors. These interests and concerns have played a major role in determining how the Global Fund has operated over the past five years, and they have also often created challenges for the Global Fund. Nonetheless, the Global Fund's commitment to openness, self-reflection, and independent evaluation, probably unique in the history of international development organizations, has ensured that these challenges have not gone unnoticed. Nearly every aspect of the Global Fund's activities has been scrutinized over the past five years. The extent to which its awareness of the challenges facing the Global Fund has led to necessary and appropriate responses are indicated in this Evaluation.

[170] Bezanson, K. 2005. *Replenishing the Global* Fund: An independent assessment. Global Fund tracking study. Mozambique country report.

Annex 5: Status of Implementation of Recommendations to Strengthen the Proposals Management Processes of the TRP and the Secretariat

Annex 5

Status of Implementation of Recommendations to Strengthen the Proposals Management Processes of the TRP and the Secretariat

Stat of Implementation by the Secretariat of Recommendations from Round 5 to Further Strengthen the Proposals Management Processes of the TRP and the Secretariat

Recommendation	Source	Round 6 Outcome
Firm deadline for "screening Clarifications"	Euro Health Group Report Executive Summary & Round 5 Report	1 September 2006 end date for technical screening for application completeness
Strengthen TRP membership from recipient countries	Euro Health Group Report Executive Summary	Increased regional representation for Round 7 to 8 pool and Round 6 casual vacancies filled by recipient continent block wherever possible
TRP "category 3 comments" should be strengthened to inform countries of the "reason" for the outcome	Euro Health Group Report Executive Summary & Secretariat	Round 6 TRP review form reformatted (mildly) and a newly introduced "Day 1 - Lessons Learned" session with TRP & Secretariat to further explain country feedback on level of understanding of reasons for Round 5 outcomes, and the further guidance that countries believe would be useful
Standardized country contextual information & potential 'information packs'	Euro Health Group Report Executive Summary, Round 5 Report & Secretariat	Uniform information supplied to the TRP members for countries for which data is available. Internal to the Secretariat, screeners operating on 'buddy' system with Clusters to strengthen the consistency of information on grants
TRP internal self-audit to add to existing internal quality assurance processes	Euro Health Group Report Executive Summary	Discussions between the TRP and the Chair of the TERG as part of an ongoing focus by the TRP on quality assurance.
2 week training of clerk (screening team) on Global Fund processes to strengthen the accuracy and consistency of the screening process	Secretariat	Comprehensive induction on CCM requirements and Global Fund grant processes undertaken over 25 July to 3 August 2006 (closing date of Round 6)