Seventeenth Board Meeting
Geneva, 28 – 29 April 2008

GF/B17/8
Board Input

THE GLOBAL FUND'S ROLE AS A STRATEGIC AND RESPONSIBLE INVESTOR IN MALARIA (PAPER FROM THE CHAIR OF THE BOARD)

OUTLINE:

1. This paper is a follow up to the discussion the Board considered at its Sixteenth Meeting on the issue of ensuring the Global Fund acts as a strategic and responsible investor and is focused on malaria. The paper includes three components: 1) an introduction note by the Board Chair; 2) a profile on Ethiopia; and 3) an update from the Roll Back Malaria Partnership on the strategic direction in malaria and issues for the Global Fund's consideration.

PART 1: INTRODUCTION

Background

1. At the Sixteenth Global Fund Board Meeting, the Board engaged in a discussion on the Fund's role in shaping the strategic direction for AIDS, tuberculosis, and malaria. I asked the Board to consider this discussion to determine how the Global Fund could act as a strategic and responsible investor, while remaining true to its founding principles, to ensure our resources have maximum impact. I felt that this was an important discussion to begin, because the Global Fund, since its founding, has grown into a leading financier of all three diseases. With this position, whether intended or un-intended, the influence of the Global Fund on whether or not these diseases will or will not be controlled is undeniable.

2. One major theme that emerged from the Board discussion at the Sixteenth Meeting was the question of value for money. For example, is the Global Fund getting maximum value for its investment? Is the Global Fund funding the right things? Several Board constituencies raised the fact that as a financing mechanism, the Board does not spend enough time on assessing its portfolio to determine if its resources are being used as effectively or as efficiently as possible. Other common themes raised included: the growing divide between "have" and "have not" countries; making a greater impact in the "low-hanging fruit" that could fundamentally shift the disease control posture (e.g. PMTCT and mosquito bed-net scale-up) by potentially targeting resources; and encouraging best practices.

3. The TERG Study Area Two report will provide one avenue for addressing some of the issues raised from this discussion. However, the issue of the Global Fund getting value for its investment deserves greater focus. We should be giving more attention to learning from successful investments and asking ourselves if there are opportunities to make major investments that could fundamentally change the landscape for any one of these diseases.

Learning from Successful Investments

4. In keeping with the theme of "acting as a strategic and responsible investor," the Board is requested to review successful case studies of Global Fund investments, by addressing one disease per Board meeting over the next three meetings, and consider how to best learn from these successes so that they may be replicated across the portfolio.

5. For the Seventeenth Board meeting, Dr. Tedros Adhanom Ghebreyesus, the Minister of Health of Ethiopia and Chair of the Roll Back Malaria (RBM) Partnership Board, has been invited to present his country's experience using Global Fund financing to support a dramatic malaria control scale-up that led to an impressive decrease in malaria-related mortality. While many Board constituencies may be familiar with this success, it is important to take note how this success came about, and specifically, the role of the Global Fund in acting as a flexible financier.

6. Having visited Ethiopia recently, one thing that struck me in particular, was the flexibility offered in the Global Fund's response to frontload monies to support scale-up. We are sometimes accused of being a rigid and inflexible donor, and perhaps we have been in some instances. However, Ethiopia might demonstrate best what we were created to do – act as a flexible, performance-based financier that responds to country demand to achieve country-agreed goals. It is also clear to me that Ethiopia is an excellent example of a comprehensive approach to malaria control by not only focusing on rapidly scaling up but also by making investments in the community health care system to be able to deliver effectively. This two-pronged approach is critical for scale-up.

Role of the Global Fund in Rapidly Scaling-Up Malaria Control Efforts

7. The malaria community has agreed that the next 32 months must be a highly aggressive scale-up phase to reach the RBM 2010 targets to achieve 80 percent coverage of an essential malaria control intervention package and to lay the foundation for sustained control, elimination, and perhaps one day - - eradication. On April 25, just before our Board Meeting begins, the malaria community will gather on World Malaria Day to underscore the importance of ensuring that this goal, which would be less than 1000 days away, is achieved.

8. Professor Awa Marie Coll-Seck, Executive Director of the Roll Back Malaria (RBM) Partnership, and Raymond G. Chambers, the United Nation Secretary General's first Special Envoy for Malaria, have been invited to provide an update to the Board on the recent developments in the global malaria strategy and discuss how the malaria community is attempting to apply the lessons learned from Ethiopia more broadly. Specifically, they will discuss and offer recommendations for the role of the Global Fund in achieving this strategy.

9. As the single largest external financier for malaria control, we have a role and responsibility in supporting countries in this scale up. The flexible financing approach of Ethiopia is an important example of how the Global Fund can be a vital partner in this effort. Round 7 also played a significant role with a doubling in the success rate of malaria proposals from Round 6. Given the approaching goals set for December 2010, financing from Rounds 8 and 9 will need to be equally as important. We also need to encourage countries to scale up in a comprehensive approach that builds systems and capacity for the long-term. Our recent decision on health systems is an important link to scale-up efforts.

Concluding Thoughts

10. Many issues will be raised in this portion of the discussion, and it is important for the Board to take an honest and hard look at the institution that we have built and address the challenges in our architecture and policies that present challenges to countries in scaling-up rapidly. We have started this discussion in the PSC on reforming our financing architecture and the changes being discussed there are crucial to addressing some of these issues. But I also want to stress that we remember that a million children a year are dying of malaria and that the more we get bound up in procedures and processes, the more time we waste. We must act with speed and purpose, and I believe we can do this while staying true to our mission.

11. By raising these issues, please make no mistake that I recognize the complexity of these issues and that simple solutions may not always be at hand. What I ask is that we consistently bear in mind what we were set-up to accomplish and the role we now occupy in the external funding environment to bring malaria under control. While our discussion is focused on malaria, these issues plague rapid-scale-up in all of the diseases we address, and I would expect solutions found here to be applicable more broadly.

Discussion Questions

i. How can we replicate Ethiopia's experience in frontloading their existing Global Fund grants to other countries?
ii. How can we get the message to countries that we can be a more flexible financier and encourage them to "frontload" grants if and when appropriate?
iii. How can we encourage countries that now is the time to build the capacity to deliver?
iv. Should the Global Fund take a more active role in directing our investments toward achieving the "low-hanging fruit" (i.e. scaling up access to mosquito nets or PMTCT)?

PART 2: ETHIOPIA PROFILE

Dr. Tedros Adhanom Ghebreyesus, Minister of Health of Ethiopia and Chair of the Roll Back Malaria Partnership Board

1. Malaria infects approximately 15 million Ethiopians every year. But we have made significant progress in intervention coverage over the past two years. Since 2005, eighteen million nets have been distributed in Ethiopia and we aim to deliver another 2 million by 2008. By 2008, we expect that 100% of households in malarious areas will have two nets. We have also rolled out ACTs to 17,500 newly trained health extension workers at community level, significantly increasing access to effective treatment.

2. What has worked in Ethiopia?

i. **Not only increased funding, but a funding mechanism that simultaneously rewards and demands performance.** When we initially received our Global Fund grant, bottlenecks prevented us from delivering our target of 2 million ITNs. We were given as a condition for future funding to start to deliver 1.2 million nets by September 2005. We took advantage of the flexibility built into the Global Fund to frontload the remainder of our three-year grant as one lump US$36 million sum. We identified the problem in procurement using UNICEF for technical support, and the nets were delivered within six months. "What made the difference is [the Global Fund] gave us a clear warning, that we were in the red zone ... we could lose our money if we didn't deliver results. We looked at it, we could focus and we both saw the problem ... and that was the adjustment we made to get the results. Performance-based funding helped us think through implementation."

ii. **Facilities that combine interventions and goals.** Ethiopia has facilities that deliver services for immunization, family planning, and malaria control. These facilities through long lasting insecticide treated nets (LLIN) procurement and malaria drugs distributed free of charge; facility also focuses on strengthening supply chain and building other functions such as M&E.

iii. **A holistic approach to improving health.** A strategic approach to delivering AIDS, TB and malaria to roll out services to rural areas is beginning to improve primary health care and rural health capacity in Ethiopia. We have trained 17,500 health workers and aim to train a total of 30,000 by 2008. Here vertical financing for a single disease has helped to support overall health systems and has had dramatic results.

3. Indeed, DHS survey findings revealed a greater than 20% drop of deaths in children under five between 2000 and 2005. We expect the reduction in child deaths to be much greater for the next survey given our recent efforts.

Challenges and Priority support needs (2008 - 2010)

Challenges

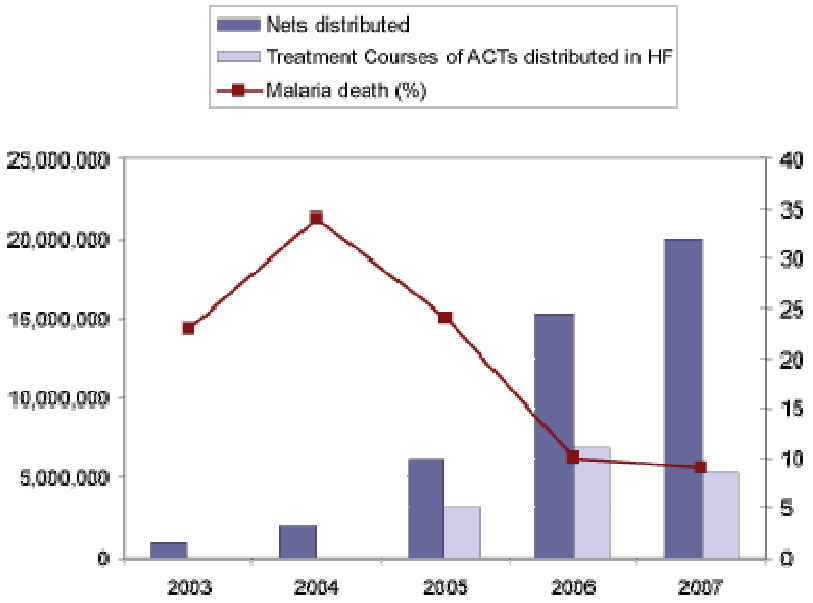
i. Mobilizing adequate resource to keep high coverage of interventions, (e.g. 50 million LLINs to MDG to maintain 80%)
ii. Ensure dependable drugs and commodity supply system
iii. Quality assurance (QA) and quality control (QC) of malaria diagnosis (rapid diagnostic tests (RDTs) + microscopy)
iv. Targeting and delineating the role of indoor residual spraying (IRS) and LLINs

v. Improving community awareness and utilization of interventions (insecticide treated nets (ITNs) Utilization, ACT Compliance)
vi. Malaria surveillance and program monitoring and evaluation
vii. Shortage of human power and high staff turn over

Support needs (TA and Finance)

i. Resource mobilization
ii. Functional drug and logistic supply management system
iii. QA & QC for malaria microscopy & RDT
iv. Database system for routine program monitoring
v. Refine malaria risk stratification
vi. Operationalizing Communication strategy
vii. Establish sentinel surveillance system & strengthen malaria epidemics preparedness and response capacity
viii. Strengthen sentinel site study on efficacy of anti-malarial drugs and Insecticides
ix. Strengthen technical support to FMOH and other partners working in malaria control

Rapid Scale-up of Interventions – Impact on Malaria Death, Ethiopia



View data

Year	Nets distributed	Drugs used	% malaria death	Confirmed cases
2003	850,000		23	450,000
2004	1,960,000	25,000	34	560,000
2005	6,200,000	3,200,000	24	800,000
2006	15,300,000	6,800,000	10	500,000
2007	20000000	5,300,000	9	

PART 3: UPDATE ON GLOBAL MALARIA STRATEGY AND ROLE OF THE GLOBAL FUND

Raymond G. Chambers, United Nations Special Envoy for Malaria
Professor Awa Marie Coll-Seck, Executive Director, Roll Back Malaria Partnership

Introduction

1. The Global Fund to Fight AIDS, TB, and Malaria has dramatically changed the global malaria response since its creation six years ago. The Global Fund now accounts for as much as 75 percent of external development assistance for malaria control. Global Fund resources, along with other partners like the World Bank Booster Program and the President's Malaria Initiative, have helped several African countries make substantial progress toward reducing malaria mortality. Yet, most countries remain off-track and are not expected to reach the 2010 Roll Back Malaria (RBM) and G8 goals of achieving 80 percent coverage of an essential malaria control intervention package on the current trajectory, thereby delaying the achievement of completing the "scale-up" phase, and the entering of control and/or elimination phases.

2. The malaria community has come together under the RBM Partnership to work with countries to develop a 32 month plan to dramatically scale up malaria control efforts to achieve the 2010 targets and work towards the greater goal of elimination. This plan is being developed under the umbrella of the Global Malaria Business Plan**.** The Global Fund, as the largest external financier of malaria control programs, is a crucial partner in this effort.

3. This paper provides: 1) an update on recent changes to the global malaria strategy and the renewed importance of the "scale-up" phase over the next 1000 days; 2) an overview of RBM activities to support the Global Fund; 3) challenges with Global Fund policies and architecture; and 4) recommendations for consideration by the Global Fund Board to better support scaling up malaria programs. The proposed Affordable Medicines Facility for Malaria (AMFm), a crucial component of the RBM strategy, is not discussed in this background document for the Board, as it receives thorough consideration elsewhere on the Board agenda.

Update on Global Malaria Strategy

4. Since the 16th Global Fund Board meeting, there has been significant movement in the malaria community in developing unified short and long term strategies. These developments include:

i. ***Global Malaria Business Plan:*** To respond to the immediate needs of malaria endemic countries and reinforce the current "Scaling Up For Impact" (SUFI) strategy as well as plan for future sustainability of malaria control towards eventual elimination, the 13th RBM Board (November 2007) endorsed the development of one integrated Global Malaria Business Plan (GMBP) by the RBM Partnership. The aim of the GMBP is to define RBM's vision, goals, and strategy, as well as the concrete actions needed to achieve them over the short, medium, and long-term. Strongly grounded on inputs from countries, the GMBP will guide the international community's activities on both the global and country level to maximize impact, prioritize the use of resources, and strengthen alignment across various initiatives to improve overall effectiveness. The GMBP will be finalized by the global malaria community over the coming months, coordinated by the RBM Secretariat and Board.

ii. ***32 Month Rapid Scale-up Plan To Achieve RBM 2010 Targets:*** Recognizing that many countries are dangerously falling short in meeting the 2010 targets, the RBM Partnership has developed a 32 month plan to reach the SUFI 2010 targets with comprehensive malaria

prevention and treatment interventions, including long lasting insecticide treated nets (LLINs), particularly in the lowest two economic quintiles. This is more than just about target setting for its own sake – there are epidemiological factors driving the approach that we would like to bring to the Global Fund's attention. For instance, the achievement of universal net coverage, especially in sub-Saharan Africa, is a clear regional "public good." If greater than 80 percent utilization is achieved, evidence suggests that the malaria transmission cycle will begin to break, making the chances of eliminating the disease in Africa all the more realistic. But the more countries miss the 2010 targets, the more they will be delayed entering the elimination phase. And, perhaps more importantly, as malaria transmission does not respect borders, high-performing countries could be adversely affected by lower performers.

iii. ***Malaria Implementation Support Team (MIST):*** In order to achieve this rapid- scale up plan and help translate dollars into results, the RBM Board has approved the creation of the Malaria Implementation Support Team (MIST). MIST is a three year time limited mechanism through which the RBM Partnership can more effectively respond to country needs and put into place measures to achieve rapid scale-up by 2010. Effectively, the MIST represents the implementation arm of the RBM Harmonization Working Group (HWG), with a lean staff of full-time professionals supplemented by a pool of expert consultants. It is proposed that the MIST will be managed by a Project Director. The Executive Committee of the RBM Board is working to present the RBM Board with a set of options for governance - for discussion and decision. The MIST will work in close collaboration with the Partnership Secretariat and RBM Sub Regional Networks (SRNs).

RBM Partnership Support to the Global Fund

5. The RBM Partnership has reorganized much of its activities to support the effective use of Global Fund financing. RBM Partnership supports the Global Fund in the following ways, and spends over US$6 million a year in its effort (between 20-30 percent of the overall RBM budget):

i. **Supporting the development of GF proposals for malaria grants**
RBM made its first interventions to support countries in the preparation of Round 6. This first modest effort proved that, if assisted, countries were able to secure higher rates of success (in West Africa 70%) whereas unsupported countries (East Africa 30%) faltered. The response by the malaria community was to institutionalize systematic support to countries for grant proposal preparation. This support has, to date, been provided by the RBM HWG (created in 2006). The HWG targeted 19 African countries for proposal development support in Global Fund Round 7 and RCC applications. The overall success rate for Round 7 malaria proposals was 62 percent; and 75 percent (including 3 RCCs) for those supported by RBM. For Round 8, 17 countries and one multi-country cross border initiative have been targeted for support. A success target of 70 percent has been set for RBM-assisted countries, with a goal of 100 percent success in Nigeria and the Democratic Republic of the Congo, given that these two countries make up between 30-40 percent of worldwide malaria mortality. Over US$2 million was committed to this process in Round 7 by RBM partners, and over US$3 million is expected to be spent this year on the support process.

ii. **Accelerating Grant Signature**
RBM, through the HWG, Procurement and Supply Chain Management Working Group, and the Monitoring and Evaluation Reference Group (MERG) is supporting countries to rapidly negotiate and sign Round 7 grants including: responding to TRP queries; developing detailed first-year work-plans and budgets; developing PSM plans; developing M&E plans; and convening M&E Systems Strengthening Tool Workshops. 16 countries have received support

from external consultants to develop PSM plans, and 14 countries were sponsored to participate in a Round 7 grant signing workshop in Uganda (8 -10 April, 2008).

iii. **Emergency support for bottleneck resolution**
The RBM HWG has supported countries to resolve urgent implementation bottlenecks that endangered Phase 2 funding in Cameroon, Guinea, Nigeria, and, to be resolved shortly, Guinea Bissau.

iv. **Country Needs Assessments**
In 2008, 45 African countries are being targeted for support to conduct comprehensive needs assessments. The information from the needs assessments will be used to develop comprehensive Round 8 proposals and identify implementation challenges in existing Global Fund grants. The information obtained through needs assessments will also be used to develop country business plans which will help to coordinate partner activities around one plan; provide a forecast for technical and implementation support needs; and attract additional resources to fill malaria control programme gaps.

v. **Grant Early Warning System**
Each RBM Sub-Regional Network (SRN) will participate in country programme implementation self-assessments to identify potential/existing bottlenecks and mobilize specific support to each country as needed. The U.S. Government has allocated US$ 3 million to RBM SRNs to support countries in identifying and resolving bottlenecks in malaria programming, particularly through Global Fund financing. These self-assessments will occur twice each year (in the first and fourth quarters depending on the country schedules) in each SRN country (some countries may opt out).

vi. **Advocacy in support of the Global Fund**
A large number of RBM partners have actively engaged in advocating for replenishment of the Global Fund through the Malaria Advocacy Working Group (MAWG), including the publication of country success stories, articles, and opinion editorials attributable to Global Fund financing .

Challenges with Global Fund Policies and Architecture in Light of Evolving RBM Approach

6. The RBM Partnership is extremely appreciative of the Global Fund's support for malaria control programs. Global Fund commitments to malaria activities – from recipient/country capability building to commodity purchases (e.g., LLINs) – are critical to the successful achievement of RBM's rapid scale-up objectives. Unfortunately, despite the Global Fund's vital commitment of resources, delays within Global Fund funding and disbursement processes present a substantial challenge to achieving RBM's 2010 goals. The effort to achieve universal coverage with LLINs by 2010 presents an illustrative example to the Board of how current Global Fund processes (and interpretation of Global Fund policy) put these targets at risk.

Example of the current challenges with existing Global Fund policy and practice:

LLIN scale-up in sub-Saharan Africa

7. While only a comprehensive malaria control approach will defeat malaria, one particularly low hanging fruit is universal distribution of LLINs. According to WHO, malaria can be controlled and eventually eliminated only if transmission is properly controlled by killing vector mosquitoes. For transmission control, LLINs (and IRS, where appropriate) must be deployed at full coverage. For LLINs, this means everyone in a target community sleeping under a net (resulting in 2-3 nets per

household) and ensuring replacement of these nets once exhausted. In tandem with expanding access to treatment, we are recommending a massive "catch-up" of LLINs to reach the 2010 goals - - thereby beginning to reduce malaria transmission across sub-Saharan Africa. LLIN distribution is, therefore, a true public good - - but to fully maximize these positive externalities - - at least 80 percent utilization must be achieved as quickly as possible.

8. Reaching the 2010 RBM target in Africa of 80 percent LLIN utilization will require about 280 million new LLINs to be delivered to and utilized by end-users by the end of 2010. The international community currently has committed funding (e.g., approved or disbursed) for about 80-100 million of these LLINs. The remaining need will have to be filled by "softer" commitments to come in the future (e.g., Global Fund Round 8/9, World Bank Booster Phase 2). Assuming the Global Fund continues to fund malaria/LLINs at least at the levels seen in Round 7, the hope would be that Round 8/9 approvals would eventually fund 80-100 million LLINs (40-50% of unfunded gap, $600-800 million). Ultimately, more Global Fund support may actually be needed if commitments from other donors are not forthcoming.

9. The total current funding gap for LLINs is approximately US$1.4 billion. Unfortunately, even if – as hoped by many endemic countries – the Global Fund eventually approves funding for 40-50 percent of the gap (80-100 million LLINs, US$600-800 million) through Round 8/9 grants, current projections are that less than half of those LLINs will reach end-users by the 2010 objective. The Global Fund-related delays and challenges creating this substantial shortfall have three main components:

i. **Delays in access to funds and the disbursement/procurement process**
Delays in process for signature and first disbursement from Global Fund grants often create a 12 month lag between approval and the first opportunity to access funds. In addition, confusion about tender requirements and manufacturing/shipping delays (due to volatility of orders, country specific requirements) can add an additional 5-9 months of delay. Very often, the earliest an LLIN can be delivered to a country is 20+ months after grant approval. Given this lag, some of Round 8 and all of Round 9 grants will be unable to contribute LLINs to reaching the coverage objectives 32 months from now. Without resolution, many countries will have to achieve the 2010 LLIN utilization objective without significant incremental support for commodity purchase from the Global Fund.

ii. **Lack of front-loading/acceleration of LLIN commodity purchases**
While Global Fund financing can be "frontloaded," there is limited understanding about the flexibility within current Global Fund grants, and countries generally follow a formulaic approach to accessing funds (i.e., regular disbursements over 5 years in 2-phases). This often means that recipients/countries will conduct multiple LLIN procurements (e.g., tenders) for a given grant resulting in serial repetition of the disbursement/procurement delays in the current system. In addition, much of the approved funding is unnecessarily delayed for 3+ years (e.g., phase 2). Examples like Ethiopia have demonstrated that more flexibility exists to bring commodity purchases forward (i.e., accelerating program spending and launch of Phase 2 negotiation), a behaviour that should be encouraged other recipients/countries.

iii. **Impact of commodity cost on overall grant application**
A final issue is the impact the scale of the LLIN commodity purchase required to achieve the 100 percent coverage objective can have on individual grants/recipients. As mentioned previously, about US$1.4 billion for LLIN commodity costs are needed to meet 2010 objectives. This amount can have a significant impact on the apparent size of grants. While recipients/countries will face substantial work to build the distribution capabilities required to achieve scale-up, they will not have the opportunity to demonstrate these capabilities before funding would need to be approved to result in LLIN delivery by 2010 (i.e., in Round 8 grants).

Thus, while recipients/countries are being encouraged to urgently request the funding needed to achieve LLIN scale-up, they often downward revise their requests out of concern about the credibility of asking for the full LLIN need.

RBM Recommendations to the Global Fund

10. As mentioned before, countries have less than 1000 days remaining to reach the goals of the scale-up phase. The RBM Partnership is committed to working with countries to achieve these targets, but we are constrained by challenges in the financing environment from the Global Fund and other donors. As the largest financier of malaria programs, we request the Global Fund Board to consider the following recommendations in order to support countries in rapidly scaling up their malaria control efforts, particularly the scale-up of nets. These recommendations are largely being proposed because they are the ones most related to Global Fund institutional practice and policy with regard to funding.

11. We have kept in mind that the Global Fund is a financing mechanism, not an implementing partner, and that many challenges remain at the country level. The RBM Partnership is committed to working with countries to improve in-country implementation challenges, not only when bottlenecks emerge, but to proactively prevent them. Finally, we would like to emphasize the importance of adherence to the demand-driven nature of Global Fund financing and highlight the critical importance of country leadership in driving ambitious proposals and committing to the in-country support required to implement them.

Recommendation 1: Encourage Front-Loading of Existing Grants

Financing from Rounds 7, 8, 9 and the RCC, should be "frontloaded" in order to help countries rapidly scale-up access to nets.

i. We recommend that the Global Fund Board send a strong message to both:
   (a) the Secretariat to place front-loading for net scale up as a priority in grant agreement negotiations; and
   (b) to countries to encourage them to demand frontloading for net scale up and view the Global Fund as a more flexible donor than is currently perceived**.**

Recommendation 2: Simplifying the Financing Architecture

i. While exceptional mechanisms may be required to cover the net gap in the short-term, we strongly support and encourage the current PSC discussions on simplifying the financing architecture, particularly options that allow "topping-up" of existing, well-performing grants, extending Phase 2, and promoting dialogue with the TRP.
ii. In particular, multiple funding windows per year would greatly help countries in their scale up efforts, and a decision at the Eighteenth Board Meeting could dramatically impact scale-up efforts. Multiple funding windows could allow the opportunity to target diseases and potentially interventions, like net-scale up, where existing net distribution programs could be "topped-up" to expand the scope and distribution and "catch-up" to the 2010 targets.

Recommendation 3: Guidance to the Board and TRP on Round 8 and 9

i. We urge the Global Fund Board and TRP to recognize the importance of carefully reviewing large Round 8 and 9 proposals that focus on large, up-front LLIN distribution, even if they are of a scale and scope far greater than in previous rounds.
ii. Countries are responding to a shift in RBM guidance to encourage much larger proposals given the need to finance a continent-wide net scale-up.

iii. The RBM Partnership is committed to mobilizing and providing technical support to assist countries in delivering large scale Global Fund financed LLIN campaigns.

Recommendation 4: Relationship with Global Fund Secretariat

i. The current participation of Global Fund staff in the HWG has been extremely positive and should continue. Global Fund staff play an important role in alerting the HWG to emerging challenges at country level.

ii. In addition, Global Fund Portfolio Managers could also be formalized members of the SRNs and work closely with them in anticipating bottlenecks and provide timely information to alert partners of pending difficulties and support SRNs in responding to more hands-on immediate requests / responses**.**

Recommendation 5: Representation on the Global Fund Board

i. With increasing political commitment by the international community and endemic countries to the fight against malaria, and with the unprecedented increase in financial resources underpinning the malaria response, it is critical that the Global Fund governance structures provide for greater expertise on malaria, to better inform their discussions, and ensure that the entire malaria community is adequately represented in Global Fund decision making processes. This includes a designated Board seat and more appropriate disease-balance amongst all constituencies, particularly the non-governmental and communities delegations.