



Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

Twenty-first Board Meeting
Geneva, 28 - 30 April 2010

GF/B21/3
Information
Revision 1

REPORT OF THE EXECUTIVE DIRECTOR

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INTRODUCTION

1. This Board meeting is taking place five months before the world will review progress on the Millennium Development Goals (MDGs). This year, 2010, is also the year of the Global Fund's Third Voluntary Replenishment. In many ways, the outcome of the Replenishment will decide where the world will be with respect to the health-related MDGs in 2015.

2. As part of the preparation for the replenishment, the Fund recently released its 2010 report, "Innovation and Impact". The report shows the remarkable **results** countries have been able to achieve in the fight against AIDS, tuberculosis (TB) and malaria. The programs the Global Fund supports in country have continued to reach and exceed targets and we are seeing impressive increases in delivery of prevention and treatment services. I believe it is fair to say that we have not only met, but indeed often exceeded the high expectations of the Fund and of country capacity to scale up interventions.

3. Increasingly, the **impact** of our collective efforts and investments is becoming visible. This includes substantial reductions in the global disease burden of HIV, TB and malaria, but also improved capacity of health systems and community systems in low- and middle-income countries. Global Fund investments and initiatives have also had a substantial impact on the health of women and children.

4. We will see even more positive results and greater impact in the next three years, as we disburse the funding approved in Rounds 8 and 9.

5. In the six months since the last Board meeting, the Secretariat has further intensified efforts to increase our efficiency and effectiveness, and to respond to countries' needs. This has included:

- a. improving upon the Fund's core business of grant management to ensure grant signings and disbursements are timely;
- b. accelerating implementation of the new, streamlined grant architecture;
- c. further strengthening in-country partnerships and implementing the Partnership Strategy approved by the Board in November 2009;
- d. working with countries toward realizing efficiency gains in every grant and grant renewal, and realizing efficiency gains in every area of the Secretariat's work;
- e. strengthening the monitoring and evaluation of Global Fund-supported programs; and,
- f. enhancing the Secretariat's administrative functions, which will allow us to successfully complete the transition to a fully autonomous organization by the end of 2010.

6. I would like to thank everyone who has contributed to these collective efforts. First, I wish to warmly thank all members and constituencies of the Board for their dedication to the Global Fund and for their commitment to our mission.

7. I particularly wish to thank Minister Tedros for his inspired leadership and the good relationship we have had since he became Chair of the Global Fund Board. His experience in scaling up national programs for the three diseases has been invaluable. I also wish to thank Ernest Loevinsohn for his contribution as Vice-Chair of the Board and his perspective as a donor stakeholder.

8. I thank Tonka Varleva who until recently was the voice of the Eastern Europe constituency on our Board.
9. I warmly welcome our new Board members, Prof. Maksut Kulzhanov, rector of the Kazakhstan School of Public Health, and Dr José Antonio Izazola, director general of the National Center for the Prevention and Control of HIV/AIDS, Ministry of Health, Mexico.
10. I would also like to welcome all the incoming Committee Chairs and Vice-Chairs, and thank them for accepting this important, additional responsibility: Suwit Wibulpolprasert and Todd Summers (PSC), Michele Moloney Kitts and Blandina S. J. Nyoni (PIC), Peter van Rooijen and Clarisse Paolini (FAC), Bobby John and Marijke Wijnroks (Ethics), and Lesley Ramsammy and Kirstem Myhr (AMFm).
11. I thank all partners of the Global Fund and in particular UNAIDS, Roll Back Malaria, Stop TB and UNITAID, for collaborating closely with the Fund and the many contributions they are making to our joint efforts. In recent months, we have also worked closely with GAVI, WHO and the World Bank on the joint platform for health systems strengthening, and I would like to thank them for this and other work we are undertaking together.
12. I would like to thank civil society advocates from both the South and the North for their commitment and mobilization efforts and especially appreciate the support they are providing in the lead-up to the Replenishment.
13. I wish to thank Friends organizations throughout the world for their ongoing support and the special efforts they are making in the year of the Replenishment. During my visits to Japan, Australia and New Zealand earlier this year, Tadashi Yamamoto (Friends of the Global Fund Japan) and Bill Bowtell (Pacific Friends) organized high-level, impactful meetings, bringing home to me once again how important the contributions of Friends organizations to our work are.
14. I extend my sincere appreciation to all staff at the Global Fund Secretariat, including the Executive Management Team, for their especially hard work since the last Board meeting.
15. I wish to salute Barry Greene who has now taken up the position of chief financial officer at the GAVI Alliance but has continued working with the Fund to prepare for the third replenishment - yet another example of his dedication to the Global Fund. I also salute Bill Paton who is leaving the Global Fund after nearly two years as director of Country Programs. On behalf of everyone in the Secretariat, I congratulate and thank Barry and Bill for their work and wish them success in their new endeavors.
16. Since February 2010, Wilfred Griekspoor has been serving as interim director of the Finance Cluster. I would like to welcome him back to the Global Fund, and also warmly welcome Debrework Zewdie who has joined the Secretariat on a full-time basis since the last Board meeting. Wilfred and Debrework have already made an outstanding contribution to the Fund.
17. With this report, my sixth as executive director, I wish to remind the Board of the many reasons why - particularly in difficult economic times - the Global Fund model continues to offer a sound investment for the international community.
18. The report is structured as follows:

- **Part 1, “Results and Impact of Global Fund-supported Programs”**, highlights the results and impact of Global Fund-supported programs across regions and diseases.
- **Part 2, “Overview of the Portfolio”**, provides an overview of key aspects of the portfolio.
- **Part 3, “Innovation in the Fund’s Core Business”**, describes how the Global Fund continues to learn, evolve and innovate, and highlights the progress made in key areas of innovation such as the new grant architecture.
- **Part 4, “Progress on Strategic Initiatives”**, discusses progress on a range of important strategic initiatives.
- **Part 5, “Third Voluntary Replenishment”**, provides an update on the Fund’s efforts and progress towards the pledging conference in October 2010.
- **Part 6, “The Partnership at Work”**, provides recent examples of how the Global Fund partnership has been strengthened.
- **Part 7, “Secretariat Update”**, highlights the work undertaken to complete the Fund’s transition to a fully autonomous organization by the end of 2010.

PART 1: RESULTS AND IMPACT OF GLOBAL FUND-SUPPORTED PROGRAMS

Summary

- Global Fund-supported programs have continued to rapidly scale up activities in the last six months. Results achieved for the top three indicators have exceeded our expectations.
- Even in the most resource-constrained and fragile settings, investments are showing *impact*, ranging from declines in prevalence of infection to vastly reduced morbidity and mortality to system-wide improvements in health care delivery.
- Global Fund investments to combat HIV, TB and malaria are making a substantial contribution towards reaching MDGs 4 and 5.

Results

1.1 A comprehensive overview of the Global Fund's results in the three disease areas at the end of 2009 appears in the new report, *The Global Fund 2010: Innovation and impact*, known in the Secretariat as "the Orange Report", which was published in March.

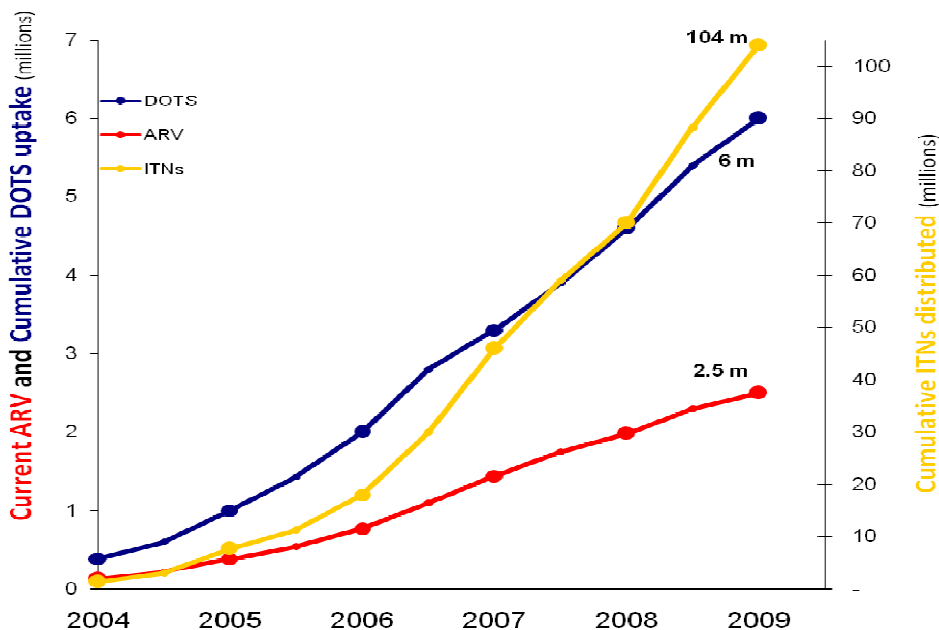
1.2 The report shows that Global Fund-supported programs have continued to rapidly scale up activities in 2009. The Fund exceeded its end-of-year targets for the top three Key Performance Indicators (Table 1).

Table 1: Global Fund top three results indicators, December 2009

Indicator	Dec 2006	Dec 2007	Dec 2008	Dec 2009	% increase in last year	Dec 2009 (Target)
HIV: People on ART	770 000	1.4 million	2 million	2.5 million	25%	2.4 million
TB: DOTS treatment	2 million	3.3 million	4.6 million	6 million	30%	5.8 million
Malaria: ITNs distributed	18 million	46 million	70 million	104 million	49%	100 million

1.3 In the three years since the second replenishment, progress for each of the indicators has been remarkable (Figure 1). In many areas we have achieved results that, only a few years ago, we did not think could be realized.

Figure 1: Scale-up of top three Global Fund indicators, 2004-2009



HIV/AIDS

1.4 **Antiretroviral treatment (ART)** was provided to an additional 500,000 people in 2009. This number does not fully reflect progress achieved in Algeria, South Africa, Thailand and Ukraine, countries that have recently assumed financial responsibility for covering ART and have therefore been excluded or partially excluded from our results. Had we included them, the total number of people receiving ART through Global Fund-supported programs would have been 2.8 million, compared with 2 million at the end of 2008 when a total of 4.03 million people in low- and middle-income countries were receiving ART funded by all sources or 42 percent of the people in urgent need of treatment.

1.5 Programs supported by the Global Fund contributed 26 percent towards international targets for the provision of ART in 2009, compared to 13 percent in 2005 and 31 percent in 2008. In some countries and regions, the Global Fund is the major funder of ART. For example, we finance ART for approximately 50 percent of the people who currently access this treatment in Africa and for approximately 75 percent of all people on treatment in Asia. In the sub-Saharan Africa region alone, programs supported by the Fund were providing 1.9 million people with ART at the end of 2009.

1.6 While the rate of ART scale-up has remained significant, it has been more linear in the last two years. In addition, our data (on progress in providing access to ART in the 25 countries accounting for the majority of Global Fund investments in HIV programs) show that the progress achieved varies significantly from country to country, and sometimes within countries by region and between populations. Some countries are on track to meet the yearly targets they set for themselves to build toward universal access to ART, while others miss them by a considerable margin. Country- and population-specific strategies will have to be developed to ensure that ultimately every person in need will get access to ART in a timely fashion, in accordance with the new WHO treatment recommendations that call for treating people living with HIV at an earlier stage of the disease.

1.7 Results for *HIV prevention-related indicators* are encouraging. Since 2007, the number of HIV testing and counseling sessions supported by the Global Fund has more than tripled from 33.5 million to over 105 million at the end of 2009. In 2009 alone, over 44 million sessions were delivered. The number of community outreach prevention services increased from 91 million by the end of 2008 to nearly 139 million by the end of 2009. The number of condoms distributed with Global Fund support also continued to increase rapidly, with nearly 620 million distributed in 2009, up from 450 million in 2008. Finally, over 2.4 million cases of sexually transmitted infections (STIs) were treated in 2009 (Table 2).

Table 2: Global Fund results for selected HIV prevention interventions, 2009

HIV prevention intervention	Cumulative results (at end 2009)	2009 results	% increase compared to cumulative 2008 results
HIV counselling and testing sessions	105 million	44 million	72%
Community outreach prevention services	138 million	48 million	53%
Condoms distributed	1,839 million	620 million	51%
ARV prophylaxis for PMTCT	790,000	344,000	77%
Cases of STIs treated	6.8 million	2.4 million	55%

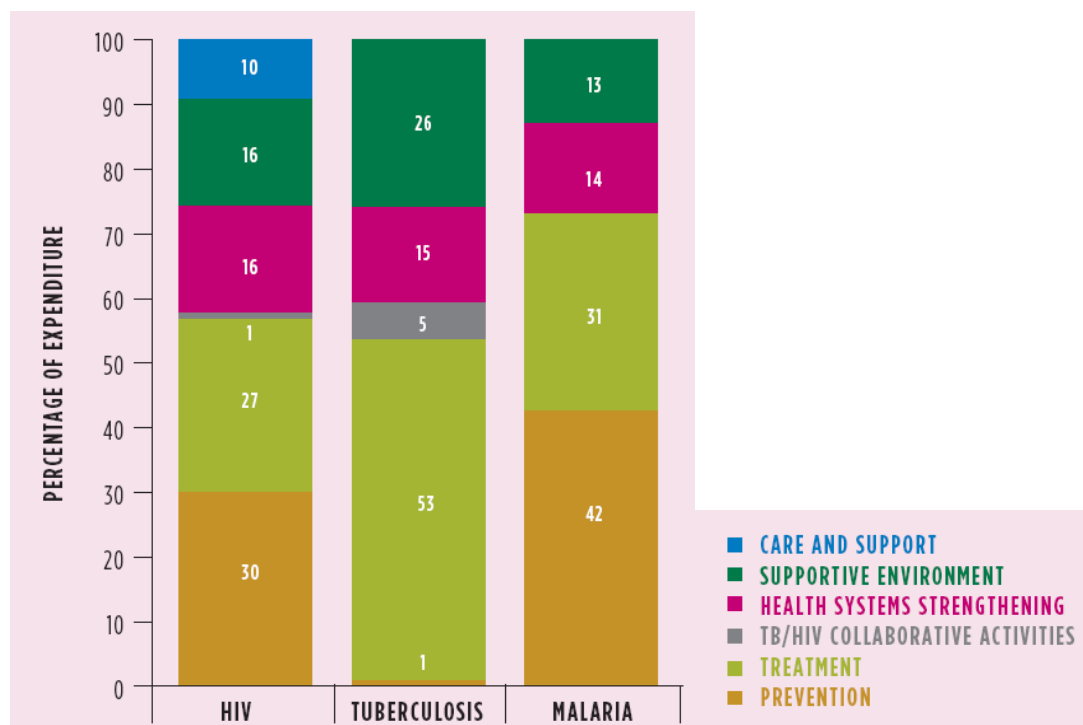
1.8 As in my last two reports to the Board, I would like to emphasize that, while the number of women receiving antiretroviral (ARV) prophylaxis to reduce mother-to-child HIV transmission increased significantly in recent years, quality and global coverage of prevention of mother-to-child transmission (PMTCT) services remains insufficient. Since the last Board meeting, the Secretariat has continued working intensively with countries and partners on our PMTCT initiative. I discuss progress achieved since November in detail in Part 4 of this report.

1.9 I am committed to accelerating the implementation of Global Fund strategies and initiatives to scale up access to evidence-based prevention measures, particularly for those most at risk of HIV, many of whom continue to face technical, legal and sociocultural barriers in accessing services. According to WHO and UNAIDS, in low- and middle-income countries a median of only 37.5 percent of people who inject drugs, 27 percent of men who have sex with men and 56 percent of sex workers were reached with HIV prevention programs in the past 12 months. In addition to activities undertaken to implement our Gender Equality and Sexual Orientation and Gender Identities (SOGI) strategies, since the November 2009 Board meeting the Secretariat has undertaken a number of activities aimed at increasing access to programs for people who inject drugs and for prisoners and pre-trial detainees. These are also described in more detail in Part 4 of this report.

1.10 As part of an effort to increase the success and sustainability of HIV prevention and treatment programming, the Secretariat is amending a number of Global Fund fact sheets. The revised fact sheets clarify that a supportive social, legal and policy environment is a prerequisite of a successful and sustainable response to HIV. They further clarify the value of including in grant applications programs to reduce discrimination and other human rights abuses and increase access to justice in national HIV responses. Such programs include, for example, legal services, law reform programs, training for health care workers and law enforcement agents, and programs to promote the rights of women.

1.11 There have been some claims that the Global Fund may be investing too much on HIV treatment, to the detriment of prevention. Such claims are unfounded. First, an analysis of our spending shows that 30 percent of the amount allocated to HIV was spent on prevention and 27 percent on treatment (Figure 2). Second, as we have known for many years, we cannot successfully prevent the further spread of HIV unless we scale up both - prevention and treatment. Studies demonstrate that people are less likely to come forward for HIV testing if they cannot access treatment should they test positive. Finally, more recently, compelling evidence has emerged that ART plays a key role in decreasing HIV transmission.

Figure 2 Cumulative expenditure by service delivery area for three diseases, through 2008 expenditure reporting cycle)



Source: Global Fund, unpublished Enhanced Financial Reporting data, 2008.

Tuberculosis

1.12 I am encouraged by the fact that approved funding for TB increased substantially from 2008 to 2009, consistent with the Board's decision in 2008 to urge more aggressive scale-up of TB programs and reflecting an increased demand by countries for assistance in controlling TB. Global Fund financing for TB control has become increasingly important. On average, the biggest portion of financing for TB programs continues to come from domestic resources, but in 14 of the 22 high TB-burden countries the Fund's share of financing represents about 30 percent of the countries' total. The Fund's share of external financing for TB control in low- and middle-income countries has also increased significantly in recent years and is expected to exceed two-thirds of all donor funding in 2010. The Fund's contribution toward international targets set by the Stop TB Partnership for the detection of TB cases and treatment through DOTS also continues to increase and reached 48 percent in 2009, compared with 26 percent in 2005.

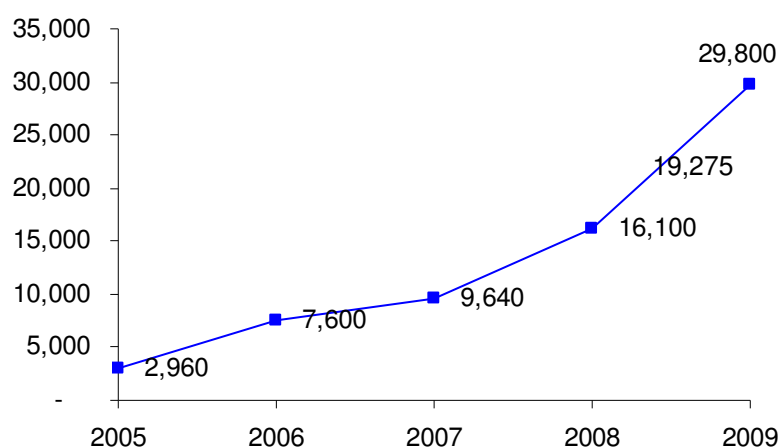
1.13 In 2009, Global Fund-supported programs provided **DOTS treatment for TB** to an additional 1.4 million people infected with active TB, bringing the total since 2004 to 6 million. In the Asia

region alone, Global Fund-supported programs treated nearly 1 million smear-positive TB cases in 2009. Steep increases in TB detection and cure rates have been observed since the first Global Fund grants were awarded in the region, which accounts for 11 of the 22 countries with the highest TB burden worldwide. Ten of these 11 countries have made good progress toward achieving the Stop TB Partnership targets for case detection. In Eastern Europe, 200,000 new TB cases were detected and treated between 2003 and 2009 - almost half of them in 2009 alone, showing how rapidly programs are scaling up.

1.14 Global Fund-supported programs had also provided 1.8 million *HIV/TB services* by the end of 2009, including TB screening for people living with HIV and treatment for preventing other infectious diseases. Over 1.1 million of these services were provided in 2009 alone. However, the HIV epidemic continues to fuel the TB epidemic and critical challenges remain. Chief among them is TB/HIV co-infection, particularly in sub-Saharan Africa. In 2008, there were an estimated 1.4 million new TB infections in persons living with HIV, but only 15 percent of the HIV-positive TB patients currently are on co-trimoxazole prophylaxis. Global Fund investments in TB/HIV services are increasing and this will help address current shortcomings. We are committed to working with countries and the Stop TB Partnership to ensure more effective treatment and prevention of TB/HIV co-infection and to further strengthen the linkages between TB and HIV programs, as is happening in Ethiopia where health extension workers, supported by the Global Fund, are providing integrated TB/HIV services.

1.15 *MDR-TB* is a major challenge, particularly in Eastern Europe and parts of Asia, as it is difficult and expensive to treat and poses serious public health risks. This is a major area of concern, and countries and the international community have been slow in responding. The Global Fund provides the vast majority of international funding for treatment of MDR-TB in low- and middle-income countries. Twenty-four of the 27 countries with high MDR-TB burden are eligible for Global Fund grants, and the Fund supports 23 of these countries for activities related to MDR-TB. This has resulted in the scale-up of treatment. From 2003 to the end of 2009, Global Fund-supported programs enrolled nearly 30,000 people on MDR-TB treatment, of which nearly half (14,000) were enrolled in 2009 alone (Figure 3). A recent focus on MDR-TB will increase treatment enrollments by an additional 70,000 in the coming years with support from Round 9 grants. At the Fund, we are committed to working with countries and partners to overcome constraints to the rapid expansion of diagnosis and treatment for MDR-TB.

Figure 3: Number of people receiving treatment for MDR-TB through Global Fund-supported programs, December 2009

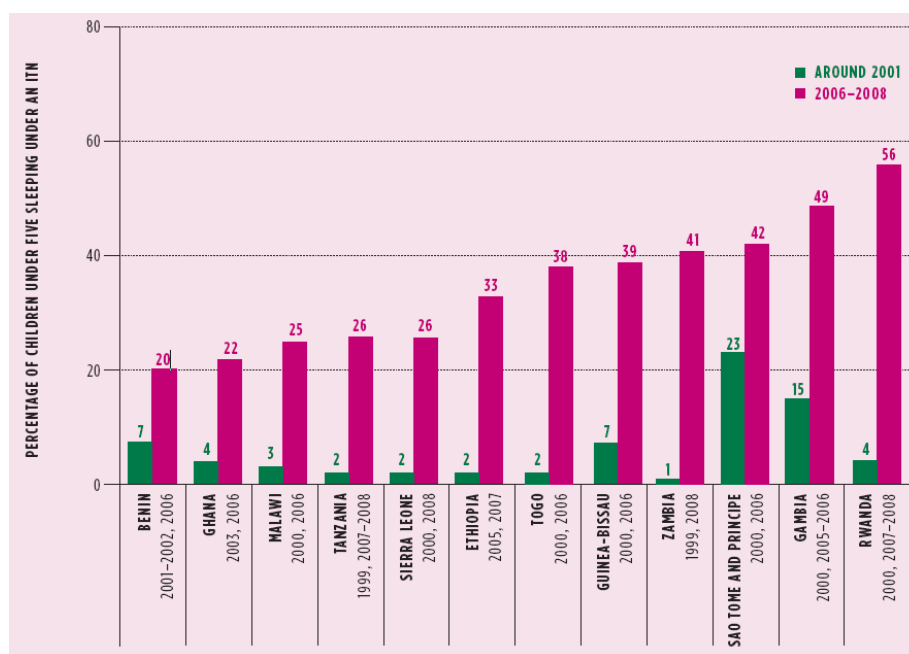


Malaria

1.16 Malaria programs supported by the Global Fund achieved tremendous progress in 2009. An additional 34 million *insecticide-treated nets* were distributed through Global Fund-supported programs in 2009 (48 percent more than in 2008), confirming the very rapid progress that has been made in malaria prevention over the last years. By the end of 2009, a cumulative total of 104 million nets had been distributed, compared with a cumulative total of 18 million by 2006. In sub-Saharan Africa alone, 22.5 million nets were distributed in 2009.

1.17 Data from 22 African countries with a high malaria burden illustrate the remarkable scale-up of provision of nets in recent years. For example, in Rwanda the percentage of children under 5 sleeping under an insecticide-treated net the night before the survey increased from 4 percent in 2000 to 56 percent in 2007. Similar increases were achieved in many other countries (Figure 4), and the numbers have increased further since then thanks to the efforts of the Global Fund and our partners.

Figure 4: Percentage of children under 5 sleeping under an insecticide-treated net the night before the survey, sub-Saharan Africa



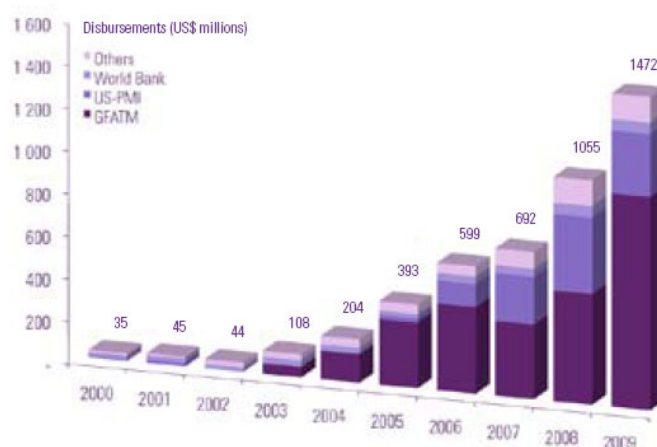
1.18 In sub-Saharan Africa alone, Global Fund grants enabled the provision of 72 million long-lasting insecticidal nets and 90 million courses of malaria treatment. In collaboration with partner agencies, we are now helping fund the largest distribution campaign for long-lasting nets in the history of malaria control. The effort is concentrated in Nigeria and the Congo (Democratic Republic), which together bear 36 percent of the malaria burden in Africa. Grant agreements with Nigeria will enable the distribution of 30 million nets by the end of 2010. In the Congo (Democratic Republic), in a challenging environment, the Global Fund is financing the distribution of 9.4 million nets, also by the end of 2010.

1.19 Malaria prevention programs supported by the Global Fund also provided *indoor residual spraying* in more than 5 million dwellings in 2009, offering protection to millions more people.

1.20 Over 33 million malaria cases were treated in 2009, bringing the total to nearly 108 million **malaria cases treated** according to national treatment guidelines. More and more countries are now using quality-assured rapid malaria diagnostic test kits, thereby reducing the unnecessary use of medicines. Over 50 percent of suspected malaria cases in Angola, Burundi, Equatorial Guinea, Gabon, Liberia, Madagascar, Niger, Rwanda and Senegal, where the Global Fund has significant investments, are now tested. However, it remains important to increase access to artemisinin-based combination therapy (ACT), which many children in endemic countries still lack, and to improve diagnostic capacities.

1.21 The Global Fund plays a leading role in the global response to malaria. According to the Roll Back Malaria report on malaria funding and resource utilization, the Fund accounted for approximately two-thirds of all external malaria-control funds committed and disbursed to malaria-endemic countries between 2003 and 2009. Disbursements continued to increase - by an exponential 95 percent in 2009, or US\$ 1,017 million as compared with US\$ 521 million in 2008 (Figure 5).

Figure 5: International donor disbursements to malaria endemic countries, 2000-2009



Source: The Global Fund, World Bank, US-PMI, OECD database (for 2008); IHME database (for 2000-2007 and 2009).
Notes: PMI disbursements are for the first three quarters of 2009, disbursements of WB and other agencies assumed to be equal to 2008.

1.22 Programs supported by the Global Fund have made an increasingly significant contribution to the international targets for key services such as provision of insecticide-treated nets. With approved financing in Rounds 1 to 8 to distribute a total of 180 million insecticide-treated nets by the end of 2010, we have become the major funder of mosquito nets globally. The international target for malaria is to ensure that insecticide-treated nets are provided to 80 percent of the populations most at risk for contracting malaria by 2010. The contribution of programs supported by the Fund toward reaching this target in sub-Saharan Africa has increased dramatically in recent years, from 5 percent in 2005 to 58 percent at the end of 2009.

Impact

1.23 The number of countries showing evidence of impact against the three diseases is continuing to grow. Globally, there is **increasing evidence of the direct impact of AIDS treatment on adult mortality**. The number of AIDS-related deaths was roughly 10 percent lower in 2008 as compared with 2004. Even in the most resource-constrained and fragile settings, impressive declines in HIV mortality at a population level have been documented. Scale-up of ART has led not only to a significant reduction in AIDS mortality rates, but also to improved

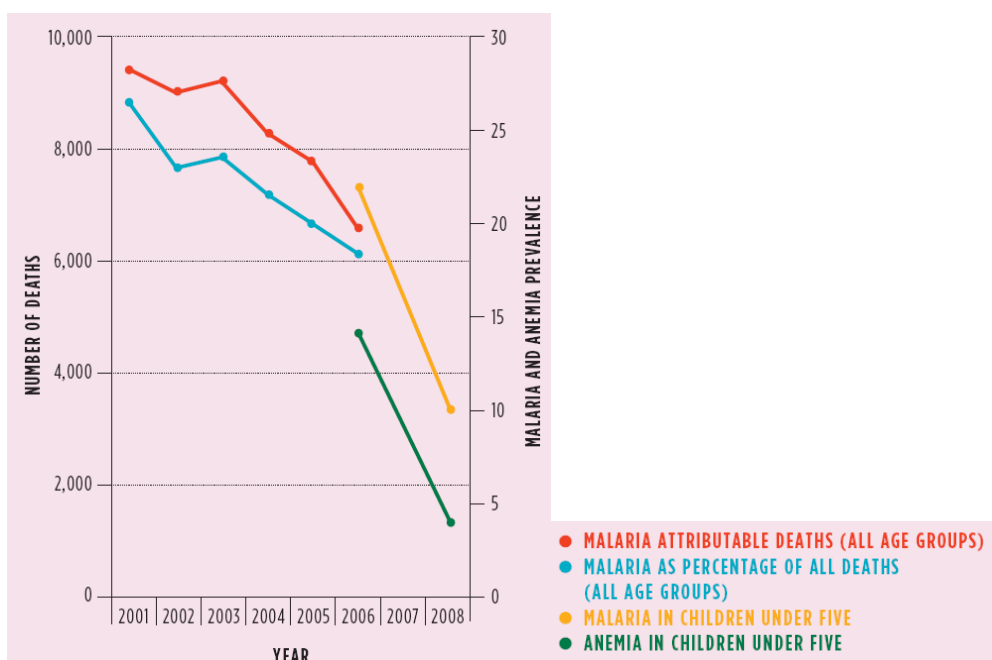
survival and productivity among teachers, health professionals and other workers, and system-wide improvements in health care delivery.

1.24 In a number of countries in sub-Saharan Africa, **substantial declines in HIV prevalence** have been documented, which can at least in part be attributed to the success of efforts undertaken by the Global Fund and other international donors such as PEPFAR.

1.25 In many of the countries with the greatest Global Fund TB investments, **significant declines in TB incidence, prevalence, and mortality** have been achieved, including in Bangladesh, China, Cambodia, Viet Nam, Somalia and the Philippines. Of the 25 countries with the greatest Global Fund TB investments, 12 are on track to halve their TB prevalence by 2015. Another four countries have reduced TB prevalence but need to intensify their efforts to achieve the 2015 target. In the remaining nine countries, all of which are in sub-Saharan Africa, TB prevalence increased since 2000 because of the growth of the HIV epidemic in the region. Overall, efforts to fight TB are on track to achieve some of the international targets under MDG 6. TB incidence is declining and TB prevalence decreased to 170 cases per 100,000 in 2008 from 220 cases per 100,000 in 2000.

1.26 **Malaria control continued to provide the most vivid examples of impact** in 2009, with further declines reported in disease transmission, case numbers, treatment demand and morbidity. A number of countries have reported a reduction in malaria deaths of more than 50 percent, including Eritrea, Rwanda, Sao Tome and Principe, Zambia, Namibia and Swaziland. For example, in Zambia - one of the countries that received substantial support from the Global Fund to increase coverage of both vector control interventions and malaria case management - the number of inpatient malaria cases declined by 61 percent between 2001 and 2008. In the same period, the number of malaria deaths fell by 66 percent. The decline between 2003 and 2006 was 30 percent, compared to a 2 percent decrease between 2001 and 2003. Malaria prevalence in children under 5 declined dramatically (Figure 6). Continued progress will be made in the next few years as Round 8 and Round 9 malaria grants are implemented.

Figure 6 Annual trends in malaria infection prevalence, malaria-attributable deaths and anemia prevalence in Zambia, 2001-2007



1.27 An increasing number of countries, including in Africa, are now aspiring to enter the malaria pre-elimination stage. In Eastern Europe and Central Asia, Global Fund support has greatly increased the prospects for eliminating malaria as a public health problem in the region. With support from the Global Fund and our partners, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan anticipate eliminating malaria as a public health problem within the next few years.

1.28 The massive scale-up of malaria interventions is also freeing up capacity in the health system to manage other health problems. For example, data from selected health facilities in Rwanda show that inpatient malaria cases in 2007 declined by 56 percent compared to the annual average for the years 2001–2006. At the same time, there was a 59 percent increase in non-malaria inpatient cases in 2007, as hospital beds became available for the treatment of other diseases. In addition, as was recently noted in the Roll Back Malaria report on malaria funding and resource utilization, investments made by the Global Fund have resulted in a vastly improved understanding of what it takes to control malaria.

1.29 The data summarized above provide further evidence that, at the midway point to 2015, the Global Fund is making a significant contribution to the attainment of the Millennium Development Goals (MDGs) in terms of increasing available resources, helping to achieve international coverage targets and expanding impact.

The Global Fund's contribution towards MDGs 4 and 5

1.30 Global Fund investments to combat HIV, TB and malaria are also making a substantial contribution towards reaching MDGs 4 and 5. Directly and indirectly, HIV, TB and malaria severely affect the health of women and children. Together, HIV, TB and malaria directly cause 1.1 million deaths a year among women aged 15-59 years and 1.2 million deaths among children aged 0-4 years. In Africa, HIV, TB and malaria account for 21 percent of deaths in children in this age group, and children account for 90 percent of malaria deaths.

1.31 Among women of reproductive age, HIV is the leading cause of death. In Africa, HIV is responsible for 51 percent of all deaths among women in this age group. HIV, TB and malaria are also among the most common indirect causes of maternal deaths. For example, maternal mortality in HIV-positive women is much higher than in HIV-negative women, a factor that was highlighted in a study published in *The Lancet* earlier this month. The study shows that HIV is an important factor in pregnancy-related deaths, with one out of every five maternal deaths - a total of 61,400 in 2008 - linked to HIV. Maternal mortality rates have significantly declined, but progress has been slowed by the HIV epidemic. Many of the countries that have had the most difficulty reducing maternal mortality rates are also those most affected by HIV. Providing greater access to treatment and care for HIV-positive pregnant women must be an essential component of efforts to reduce maternal health risks.

1.32 In many ways, our investments to combat HIV, TB and malaria have enabled countries to expand services that benefit women and children. We are contributing to reduce under-5 mortality by supporting activities for prevention and control of malaria; by increasing access to pediatric HIV treatment; by enabling countries to provide more comprehensive care, support and treatment for infants and children exposed to and infected with HIV; and through our initiative to improve quality and significantly scale up coverage of PMTCT programs. We are also contributing to improved maternal health, particularly in sub-Saharan Africa, through Global Fund-supported programs that are scaling up prevention and treatment of HIV, TB and malaria and thus reducing the largest causes of mortality among women of childbearing age and reducing major causes of maternal deaths.

1.33 In addition, we are facilitating the integration of HIV and sexual and reproductive health services and thus contributing towards the second target under MDG5, universal access to reproductive health. Almost all Global Fund-supported HIV programs provide sexual and reproductive health-related services, including treatment of sexually transmitted infections, behavior change communication on safer sex practices, distribution of condoms, HIV counseling and testing, and care and support to people living with HIV and their families. After HIV services were introduced to primary care centers in Rwanda, for example, a study found a significant increase in uptake of reproductive health services.

1.34 Another way in which Global Fund investments are contributing to maternal and child health is by strengthening health and community systems, which has enabled countries to expand the delivery of primary health care services for women and children. Finally, we are supporting a range of structural interventions to enhance gender equity, increase women's participation in decision-making and protect women against gender-based violence. A review of HIV proposals submitted to the Global Fund in Rounds 1 to 7 showed that 20 percent of proposals that were successful included interventions to address gender-based violence.

1.35 I firmly believe that the Global Fund is well positioned to do even more to accelerate progress on maternal and child health. First, this will require continued, rapid scale up of the HIV, TB and malaria interventions. I am also strongly committed to further stepping up implementation of the Fund's Gender Equality Strategy and of our PMTCT initiative, and to supporting greater integration of sexual and reproductive services and HIV, TB and malaria services. There is much countries can benefit from - by fully exploiting the flexibilities the Global Fund has to offer, we could see even greater progress on maternal and child health. As I shared with leaders in global health at the UN Secretary General's retreat on maternal and child health two weeks ago, the Global Fund stands ready to work with countries and partners to achieve concrete results that will improve the health and lives of millions of women and children.

PART 2 - OVERVIEW OF THE PORTFOLIO

Summary

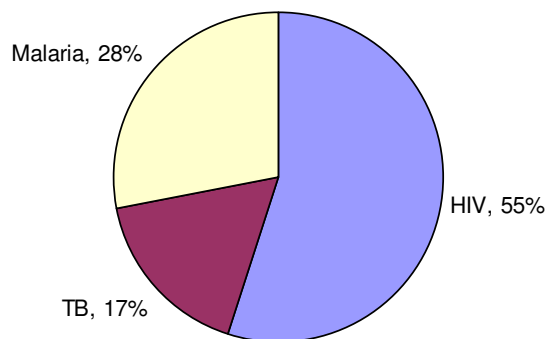
- By the end of 2009, a cumulative total of US\$ 10 billion had been disbursed through more than 620 grants in 138 countries.
- Disbursements increased by 25 percent in 2009, reaching a record amount of US\$ 2.75 billion. This trend continues as the Global Fund recorded its highest-ever first quarter disbursement in 2010, thanks in part to our efforts to streamline and expedite the disbursement process - one of the Secretariat's top corporate priorities for 2010.
- We are on track to significantly reduce the time between approval of funding and first disbursement, to an average of 9.5 to 10.2 months for Round 9 grants.
- Dual-track financing continues to achieve its objective of increasing the number of civil society and private sector Principal Recipients.
- Community systems strengthening (CSS) activities were included in more than 80 percent of Round 9 proposals.
- The Rolling Continuation Channel (RCC) has been discontinued.
- The introduction of a more uniform rating methodology in 2009 has confirmed that overall grant performance continues to be strong.
- We have taken measures to minimize the risk of potential drug stock-outs or other disruptions to treatment supplies.
- Follow-up and action to implement recommendations of the Office of the Inspector General (OIG) is not yet optimal, but I have taken measures to address shortfalls.

2.1 The portfolio continues to grow in size and complexity. By the end of 2009, a cumulative total of US\$ 10 billion had been disbursed through more than 620 grants in 138 countries.

Disease and Regional Composition

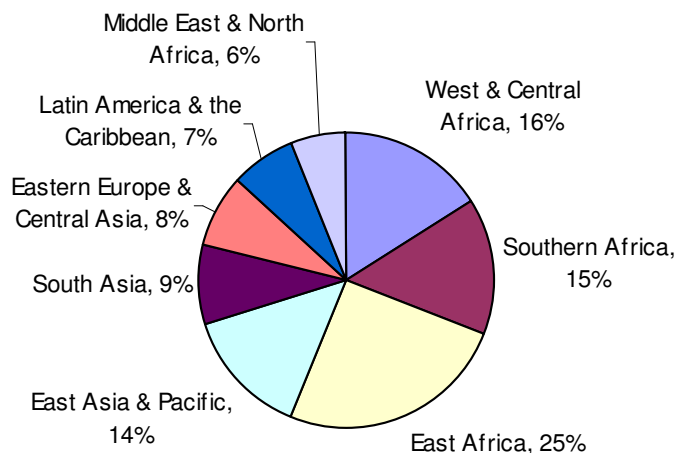
2.2 The proportion of funds approved for each of the three diseases remained relatively stable in 2009. The proportion of the portfolio for TB has increased slightly, with both AIDS and malaria decreasing slightly. Of the cumulative amount approved from Round 1 through Round 9, 55 percent was allocated to HIV, 28 percent to malaria, and 17 percent to TB (Figure 7).

Figure 7: Approved Global Fund grants by disease component, Rounds 1 to 9



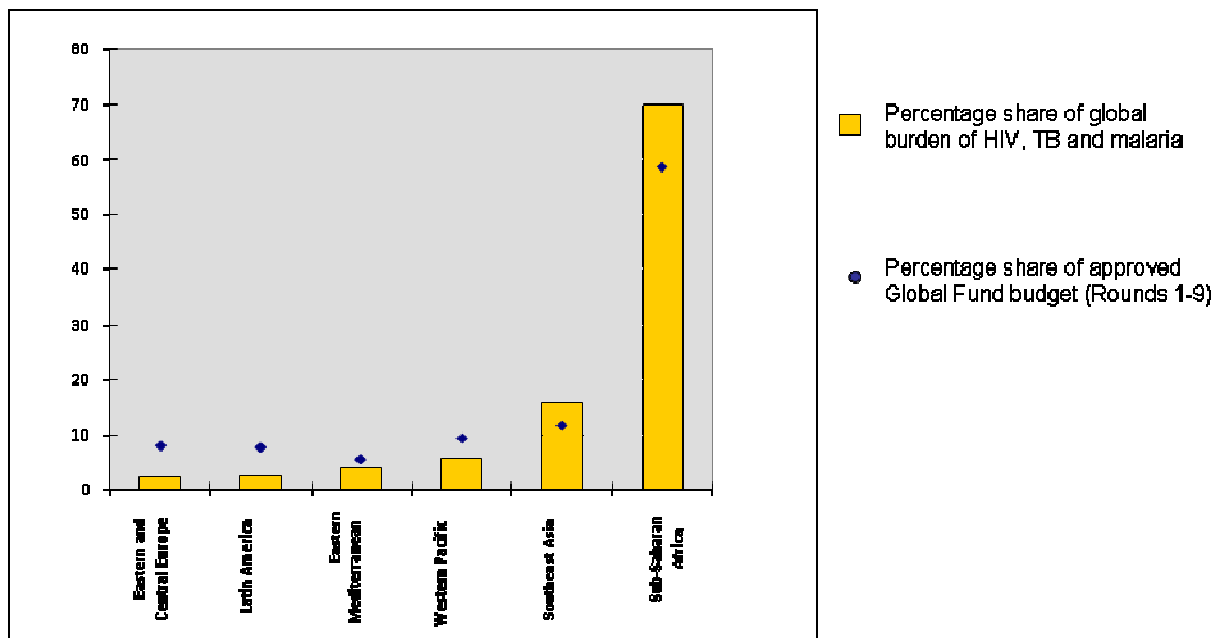
2.3 With respect to regional composition, sub-Saharan Africa continues to be the largest area of investment, accounting for 56 percent of the total approved amount (Figure 8).

Figure 8: Distribution of portfolio by region or subregion, Rounds 1 to 9



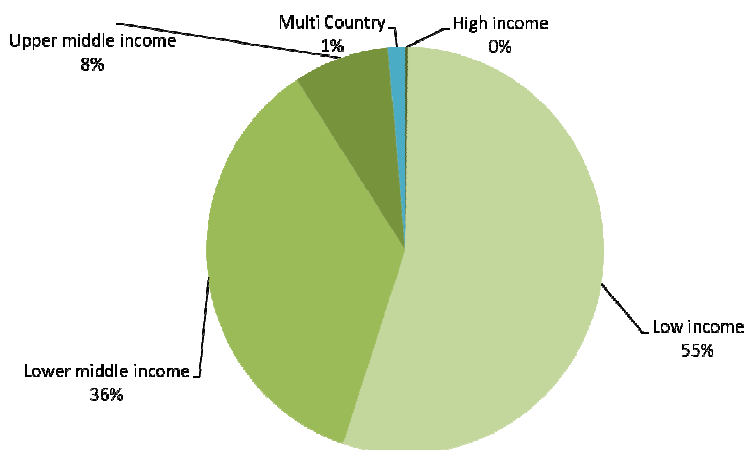
2.4 For our 2010 report, *Innovation and Impact*, we also undertook an analysis of the relationship between burden of disease and the proportion of funding approved to date. The analysis shows that the share of investments in each region has been broadly in line with that region's share of the global burden of HIV, TB and malaria (Figure 9).

Figure 9: Burden of disease (2004) and Global Fund-approved investments in Rounds 1 to 9



2.5 The overwhelming majority of Global Fund resources go to the poorest countries, with over 90 percent of resources in Rounds 1 to 9 approved for either low-income or lower-middle income countries (Figure 10).

Figure 10: Approved Global Fund grants by country income level, Rounds 1 to 9



2009 Disbursements

2.6 2009 was a record year in terms of disbursement as the Fund disbursed US\$ 2.75 billion, the highest annual amount we ever disbursed, representing a 25 percent increase over 2008 and allowing us to come very close to the ambitious target of US\$ 2.9 billion we had set for 2009.

2.7 However, the flow of disbursements was uneven across the quarters and disbursements were lower than expected in the first nine months. I have therefore made streamlining and expediting the disbursement process one of the Secretariat's top corporate priorities for 2010. We have identified bottlenecks and ways to overcome them, and measures have already been implemented to help us achieve our ambitious goals for disbursements in 2010. We are following a cross-cluster team approach to establish joint accountability, improve collaboration and reduce redundancies amongst the various units that are engaged in the disbursement process. We have increased automation to accelerate turnaround time and defined a set of requirements for a thorough yet accelerated disbursement process. More than US\$ 540 million was disbursed in Q1 of 2010, the highest amount ever disbursed in Q1 and an increase of 125 percent over the same period in 2009. We are aiming to disburse an additional US\$ 880 million by the end of June for a total of US\$1.42 billion in the first half of 2010, representing 46 percent of the record total of US\$ 3.1 billion targeted for 2010.

2.8 By the end of 2009, the Fund had disbursed a cumulative total of US\$ 5.7 billion for HIV programs, US\$ 2.8 billion for malaria programs and US\$ 1.5 billion for TB programs (Figure 11).

Figure 11: Cumulative Global Fund disbursements by region and disease, 2002-2009

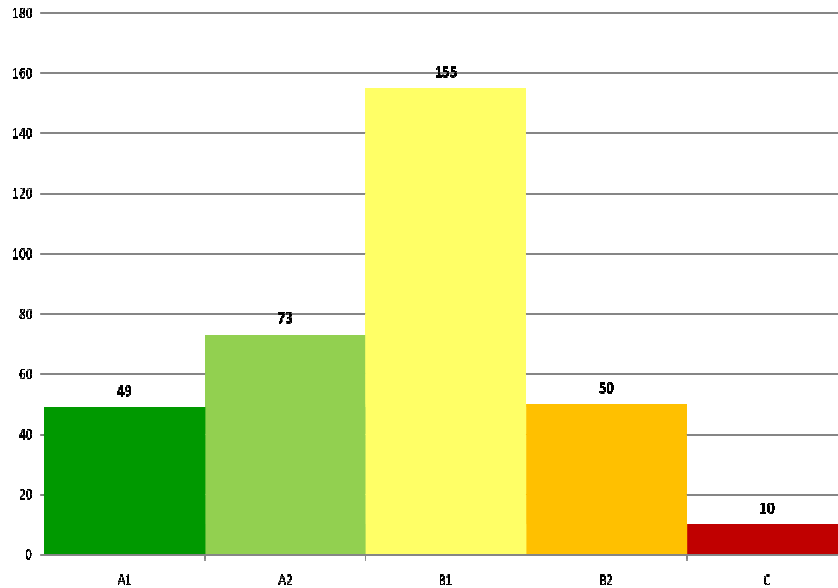
Disbursement to date (end 2009)	HIV (in US\$ millions)	TB (in US\$ millions)	Malaria (in US\$ millions)	Total disbursement by Region
Sub-Saharan Africa	3,104	375	1,976	5,455
Asia	1,093	582	491	2,166
Latin America & the Caribbean	603	129	90	822
Middle East & North Africa	258	120	214	592
Eastern Europe & Central Asia	669	245	20	934
Total	5,727	1,451	2,791	9,969

Overall Grant Performance

2.9 The introduction of a more uniform rating methodology in February 2009 has confirmed that overall grant performance, as measured by the latest performance rating received by a grant at disbursement, continues to be strong. Of the 337 grants active at the end of March 2010, 82 percent had an "A1", "A2", or "B1" rating (Figure 12). Moreover, 60 percent of the grants defined as poor performers (with a rating of "B2" or "C") at the beginning of 2009 were performing at least adequately at the end of the year.

2.10 Over the years, an increasing proportion of grants have performed well. Currently, we are devoting particular attention to further improving the performance of malaria programs and PMTCT programs.

Figure 12: Performance across active grants



Round 8 and Round 9 Signing

2.11 As Board members are well aware, Round 8 was unprecedented in size. With 147 grants valued at US\$ 2.61 billion, it was 2.3 times larger and contained 60 per cent more grants than Round 7. Negotiations for the grants emerging from this round have been significantly more complex than for previous rounds. Some of the many reasons for this are listed in paragraph 2.13 below. They are dealt with in detail in my November 2009 report to the Board.

2.12 Seventy-seven percent of Round 8 grants (113) were signed within the 12-month deadline and 16 were signed after being granted an additional three-month extension. A total of 16 grants remain to be signed within an extended deadline of July or August 2010, and two grants have received an indefinite extension of the negotiation period because the Principal Recipient nominated has been suspended.

2.13 On average, 10.7 months elapsed between proposal approval and first disbursement. Delays were due to a number of factors including the volume and complexity of grants, lengthened negotiations due to the Board's request that the Secretariat achieve a roundwide efficiency gain of 10 percent, and the large number of proposals following dual-track financing guidance.

2.14 The new cross-cluster team approach and other measures we have implemented will allow us to significantly reduce the time between approval of funding and first disbursement of Round 9 grants, as compared with Round 8 grants, to an average of 9.5 to 10.2 months.

2.15 Round 9 is very similar to Round 8 not only in terms of size and number of grants, but also because of the relatively large proportion of civil society and private sector Principal Recipients and of grants with health systems strengthening components. We expect that Round 9 will result in 133 signed grants, of which a few have already been signed.

Efficiency Gains

- 2.16 When approving Round 8, the Board requested that the Secretariat achieve a roundwide efficiency gain of 10 percent of the total amount recommended to the Board by the Technical Review Panel (TRP), as well as similar efficiencies in Phase 2 renewals and RCC grants through to the end of 2010.
- 2.17 Based on signed grants and advanced negotiations on those remaining to be signed, we estimate that the average efficiency gain for Round 8 Phase 1 will be greater than previously expected and reach 14.5 percent. Gains vary across the portfolio with a wide range of efficiencies from 0.1 percent to 41 percent, with most grants achieving between 2 and 20 percent. The efficiency gains achieved have been grant-specific, with no discernable patterns across disease, region, type of Principal Recipient or size of portfolio.
- 2.18 Efficiency gains achieved in the 102 Phase 2 grants approved by the Board in 2009 and the first months of 2010 have amounted to 21 percent of the original proposed Phase 2 amount.

Dual-track Financing

- 2.19 Dual-track financing continues to achieve its objective of increasing the number of civil society and private sector Principal Recipients. Thirty-four percent of Round 9 proposals nominated a nongovernmental Principal Recipient as well as one from the public sector. Civil society and private sector recipients average approximately 40 percent of Principal Recipients in rounds 8 and 9, nearly double the percentage in the previous rounds.

Community Systems Strengthening

- 2.20 CSS activities were included in more than 80 percent of the Round 9 proposals, similar to the figure for Round 8 when CSS was first introduced. More than 80 percent of approved HIV proposals included CSS, compared to 70 percent for TB and 60 percent for malaria.
- 2.21 Since the last report, the Secretariat has developed a CSS framework and monitoring and evaluation indicators. The framework lays out the activities and services that make up the core components of a sustainable community response and will be made available for Round 10. I would like to acknowledge the role played by our nongovernmental organization (NGO) partners the International HIV/AIDS Alliance and ICASO who hosted a multilingual online consultation, as well as a discussion forum, in-depth interviews with key networks and a face-to-face consultation of representatives of key affected groups.

Phase 2 Renewals

- 2.22 In 2009 79 Phase 2 renewals were signed with a total value of US\$ 1.02 billion, representing a quarter of the total amount signed this year. Since the beginning of 2010, 19 Phase 2 renewals have been signed with a total value of US\$ 244 million.
- 2.23 The performance of the grants renewed in 2009 continues strong with 32 percent of grants rated A at the time of renewal, 58 percent rated B1, 9 percent rated B2 and only 1 percent rated C. Sixty-one percent of the grants received a "Go" rating and the remaining 39 percent received a "Conditional Go" rating. At the Secretariat, we see the Phase 2 renewal as an opportunity to improve aspects of aid effectiveness in a grant but also to identify unused funds and efficiency savings in grants that have underperformed in the first two years of implementation. This, in turn, allows for increases in efficiency for subsequent years, and also for the reallocation of funds for reprogramming in areas that require additional attention,

such as gender-based interventions, PMTCT or interventions for most-at-risk populations - or, ultimately, for reallocation between grants.

Rolling Continuation Channel

2.24 In 2009 21 RCC grants were signed for a total of US\$ 667 million, representing a significant increase over 2008 when only eight RCC grants were signed for a total of US\$ 296 million.

2.25 Following the Board's decision at the November 2009 meeting, the Rolling Continuation Channel (RCC), has been discontinued after Wave 8. This wave has allowed countries that had already been invited to apply for the RCC at the time of the Board meeting to submit proposals. It also allowed for resubmissions from Wave 6 and from unsuccessful Wave 7 applicants. There will be no further invitations to apply through this funding channel.

Local Fund Agents

2.26 The Local Fund Agent (LFA) performance evaluation system is now in use. It allows the rating of individual LFA reports against defined quality criteria, with in-country evaluations of selected LFAs to appraise their methodology, communications and quality of work. It tracks performance over time and is linked to the strengthening of the quality of LFA services. So far, implementation of the system has led to the retendering of contracts with poor performing LFAs in five different countries.

2.27 The LFA Principal Recipient assessment tools have been improved for Round 9, with increased focus on identifying efficiency savings. An LFA Risk Management Framework is being developed and will ensure that LFA work is tailored to the specific grant and implementation contexts in each country.

2.28 The Board has approved a budget of US\$ 66.6 million for LFA services in 2010. The Secretariat is finalizing negotiations with LFAs, emphasizing the need to demonstrate value for services.

Risk Management Framework

2.29 The Board endorsed a risk management framework at the Board meeting in November. The framework is enabling us to proactively manage risk events through a more robust approach to risk identification, assessment, mitigation and reporting. As part of this, we monitor nine key corporate risks areas that have been identified by management: meeting demand for funds in a resource-constrained environment; financial fraud within grants; poor quality pharmaceutical products; results and data verification; independence and objectivity of program oversight; misperception of the Global Fund by external bodies; risk of engagement with inappropriate partners; staff security; integrity and security of data repository systems.

2.30 By the end of February we had updated the corporate risk register, with revised controls to mitigate risks in these areas. We also refined key responsibilities assigned and documented any residual risks that need further attention. In the Country Programs Cluster, a dedicated risk management officer is now in place. I also welcome the review of these risks by the FAC, PIC, MDC and PSC.

Preventing Drug Stock-outs and Ensuring Continuity of Services

2.31 We have taken measures to minimize the risk of potential drug stock-outs or other disruptions to treatment supplies. Our work focuses on the following five areas: exploring how the Fund, in collaboration with PEPFAR and other partners, can help improve systems in the pharmaceutical sector at country level; strengthening CCM oversight capacity, including

capacity to oversee procurement issues; identifying, within the Fund's own processes, ways to prevent stock-outs related to a program's schedule of disbursements; systematizing early alerts in relation to low levels of stock for key medicines; and improving the joint emergency response capacity of the Fund and our main partners in cases of stock-outs or critically low stock levels.

2.32 To prevent treatment disruption in countries with grants coming to an end, US\$ 37 million has been approved for 12 countries under our Continuity of Services Policy.

Additional Safeguards Policy

2.33 The Additional Safeguards Policy (ASP) is a risk management tool applied selectively when systems to ensure accountability for the use of Global Fund resources are weak and assets would otherwise be exposed to an unacceptable level of risk. The ASP is invoked at my discretion based on guidance from the responsible line managers. Currently, grants in seven countries are managed under the ASP: Chad, Cuba, Haiti, Iran (Islamic Republic), Korea (Democratic People's Republic), Sudan and Zimbabwe.

2.34 ASP status in Iran (Islamic Republic) is likely to be lifted. There have been some positive changes, and the government and CCM have now accepted the current Principal Recipient arrangement which takes the treasury and procurement functions away from the government entities.

2.35 With the signing of a Round 8 malaria grant on 5 February 2010, Korea (Democratic People's Republic) was recently added to the list of countries with grants managed under the ASP. Key concerns raised include exposure to fiduciary and operational risks that have led the Secretariat to adopt a zero cash policy, nominate the Principal Recipient and all sub-recipients, use an international procurement agent and seek a government guarantee on free access to program sites.

2.36 Most recently, I decided to invoke the ASP policy in Haiti. The dramatic consequences of the earthquake that struck the country at the beginning of January exacerbated concerns that had previously been identified by the Fund, including weak governance and national capacity and poor civil society participation in decision-making processes.

Grant Closures and Suspensions

2.37 In March 2010, 600 grants were in progress (active or in negotiation) and 256 were inactive. Of these, 85 had been formally closed and 157 were in the process of being closed. Eight grants were continuing to supply lifesaving services under the Continuity of Services Policy. During the last year, I took a decision to suspend six grants, in the Philippines, Zambia and Mauritania, based on data provided by the Office of the Inspector General (OIG). Following transferral to a new Principal Recipient, the suspended grant in the Philippines is functional again. In Zambia, the OIG report has recently been made available to the Country Coordinating Mechanism (CCM) and all Principal Recipients, and a formal arrangement is now in place to transfer all grants previously implemented by the Ministry of Health to the United Nations Development Programme (UNDP) on an interim basis. In Mauritania, an independent evaluation of the consequences of the suspension of the grant on access to treatment services concluded that the Fund and our partners had mitigated the impact of the grant suspension by ensuring continuity of treatment for over 1,100 people who had been receiving ARV treatment through programs supported by the grant.

Office of the Inspector General

2.38 Despite recent progress, I am aware that follow-up and action to implement recommendations of the Office of the Inspector General (OIG) is not yet optimal. I have therefore taken measures to address these shortfalls. For example, the Secretariat has reinforced the country team approach to ensure a comprehensive response to recommendations. Together with the OIG, we have also issued protocols on audits and investigations. These provide clarity around key roles and responsibilities within the Secretariat and the Office of the Inspector General, based on a shared understanding of the audit and investigation processes and procedures. Going forward, a cross-function task force will be looking at other areas that need improvement.

2.39 I have also taken action for senior management representation during debriefings of OIG investigations. A good example is the recent Nigeria investigation. Debrework Zewdie went to Nigeria to represent the Secretariat, resulting in a common effort to solve problems together.

2.40 The Secretariat is currently implementing recommendations from 11 reports issued by the Office of the Inspector General. Four of these focus on improvements of the Secretariat's internal processes, controls and procedures. The rest are country audit reports for Tanzania (United Republic), Zimbabwe, India, Congo (Democratic Republic), the Philippines and Nepal. The Secretariat has responded to the country audit reports by taking serious measures, especially where there was evidence of misuse of funds. For instance, we acted swiftly to disengage with the Tropical Disease Foundation, a Principal Recipient in the Philippines. We have since re-signed the grant with a new Principal Recipient. We will continue to deal with any fraud and corruption promptly and work to ensure that all our partners understand the standards we expect.

Five-Year Evaluation

2.41 Many of the new initiatives and efforts to strengthen and improve Global Fund operations, as presented in this report, are directly related to the recommendations of the Five-Year Evaluation. As you will recall, the evaluation was initiated in April 2007 with the final report presented to the Board by the Technical Evaluation Reference Group (TERG) in May 2009.

2.42 As requested by the Board, the Secretariat continues to track and report on (through a PSC subcommittee) progress in addressing the Five-Year Evaluation recommendations. Continuing to address these recommendations is a priority for the Secretariat and we are committed to respecting the timelines for the main areas of work outstanding.

PART 3: INNOVATION IN THE FUND'S CORE BUSINESS

Summary

- Implementation of the new grant architecture is the highest operational priority. Work is well underway and progressing rapidly. The Secretariat has identified consolidation opportunities across the Global Fund portfolio on the basis of feasibility and country interest. By the end of 2010, it is expected that over 60 single streams of funding will have been created.
- The Secretariat has learned many valuable lessons from the first wave of National Strategy Applications (NSAs). The PSC is recommending the initiation of a next NSA funding opportunity for Board decision at this meeting.
- The Secretariat has conducted country consultations and worked with GAVI and the World Bank to establish the operational, financial and policy implications for joint health systems strengthening (HSS) funding and programming. The Board is now being asked to consider a twin-track approach to further develop the platform.
- The Procurement Support Service has made significant progress through the pooled purchasing facility and supply chain management assistance since it became operational less than one year ago.
- One year after its launch, the publicly available Price and Quality Reporting (PQR) system contains an unprecedented dataset on pharmaceutical procurement transactions reported by Principal Recipients from over 100 countries. By Q3 the Secretariat will start sharing price comparison reports with Principal Recipients to facilitate their procurement decisions.
- The Quality Assurance Policy for pharmaceutical products has ensured that all ARVs, anti-TB medicines and antimalarials financed by the Fund meet stringent quality criteria.

New Grant Architecture

3.1 At its last meeting, the Board approved the design and policies for the new Global Fund grant architecture, which marked a major milestone in “retooling” and enhancing the Global Fund operating model for the future. Implementing the new grant architecture is currently the highest operational priority for the Secretariat. It requires a major effort across the entire Secretariat, but also from implementers, partners and the broader Global Fund community. Debrework Zewdie is devoting significant time to this priority and, under her leadership, implementation is well underway and progressing rapidly.

3.2 The following two examples illustrate concretely the changes being implemented, and the impact they are having. First, in March this year the Secretariat signed a single stream of funding TB grant agreement with Fiji's Ministry of Health, Women and Social Welfare, which was the consolidation of recently approved Round 8 and 9 proposals. This was completed with one grant signing process instead of two, and will result in half the reporting requirements and number of disbursements, with one workplan, budget and performance framework instead of two. The grant's next periodic review will be better aligned to the country's reporting cycle than its first, and subsequent funding commitment renewals will be made in sync with Fiji's January-December fiscal cycle.

- 3.3 Second, in early May a single stream of funding malaria grant that is a consolidation of three grants (Rounds 6, 9 and RCC) will commence with the Gambia Department of State for Health as Principal Recipient. Here, Gambia's Department of State for Health will be responsible for significantly reduced reporting requirements and disbursement requests compared to what it would have had to manage under the "old architecture." In compliance with the Board's recommendation of dual-track financing, a nongovernmental Principal Recipient (Catholic Relief Services) was proposed for malaria in Round 9. This Principal Recipient will likewise have its own single stream of funding grant agreement. The performance of the recipients will be assessed at the same time in mid-2012 under the Global Fund's new periodic review system, and the Global Fund will renew the funding commitments on 1 January 2013 to fit within the country's January-December fiscal cycle.
- 3.4 Collectively, these reforms will shift the Global Fund and its implementers progressively away from the current approach to funding toward more program-based financing and significantly improved alignment and harmonization.
- 3.5 The Secretariat has identified consolidation opportunities across the Global Fund portfolio for the coming year on the basis of feasibility and country interest. By 1 July it is expected that a significant number of consolidations will have taken place, resulting in up to 35 single streams of funding. By the end of 2010, it is expected that over 60 single streams of funding will have been created. These figures are preliminary, and consolidation is still voluntary at this time, but implementers are largely responding positively to the new grant architecture and the benefits it promises. For many countries, 2010 will mark a significant transition period. I am committed to making sure that, as one of our highest priorities, we can provide the necessary training, guidance and country-tailored support for these consolidations.
- 3.6 Beyond these grant-specific transition activities, we are also implementing significant reforms to the processes for accessing Global Fund finance. The Secretariat is currently finalizing the Round 10 proposal form and guidelines. Consolidated proposals will assist countries - as we shift from the current grant-by-grant, Principal Recipient-by-Principal Recipient approach - to achieve more holistic, program-based resource planning. They will also be the primary means of maintaining single streams of funding per Principal Recipient per disease over the long term. Consolidated proposals will be the default mode for applications in all subsequent rounds, supported by a major redesign of the current application system. These changes will result in a much simplified proposal process for countries, and facilitate a more explicit link between past programming and performance and future funding requests.
- 3.7 We are of course aware that successful implementation of the new grant architecture will require comprehensive communications and outreach efforts. We are working hard to make sure all stakeholders understand the new grant architecture design, its intended benefits, the expected impact on their work and the timing of the coming changes. Fund portfolio managers will continue to be the Global Fund's primary contact point with countries, and much effort has gone into training them to ensure they are able to consistently advise and guide countries on the new grant architecture. We have also engaged our partners to ensure provision of targeted support to countries and produced a number of communication materials and guidance documents, which are now available on a dedicated page of the Global Fund website.
- 3.8 I am pleased with the progress we have made since the last Board meeting, and even since the Board retreat, on our highest operational priority. I believe that the achievement of so

much in so little time shows once again what a dynamic organization the Fund is, constantly learning and ready to “retool” for the future to serve implementers even better as they continue to scale up to achieve the MDGs by 2015.

National Strategy Applications

3.9 The Board decided that NSAs should be introduced through a phased roll-out, which began in early 2009 with a limited first wave aimed at drawing lessons to guide the broader roll-out. Five NSAs with a total two-year value of US\$ 434 million were approved by the Board in November 2009, for which grant negotiations are currently ongoing. We expect that four of them will be signed under the new grant architecture provisions by mid-2010.

Health Systems Funding Platform

3.10 The goal of a joint platform for health systems funding proposed by the Fund and GAVI is to help develop stronger health systems to improve and scale up coverage and delivery of lifesaving health interventions to achieve better health outcomes in relation to AIDS, TB and malaria, vaccine preventable diseases, and in women and children.

3.11 Following the Board’s decision in November, the Secretariat has conducted country consultations and worked with partners and in close cooperation with the PSC to establish the operational, financial and policy implications for joint HSS funding and programming. The Secretariat has proposed to the PSC a number of options for how a joint HSS platform could be operationalized and funded.

3.12 The PSC has discussed the Secretariat’s proposal and the Board is being asked at this meeting to consider a twin-track approach to further develop the platform. Under Track 1, the Fund, GAVI, the World Bank and WHO would aim to harmonize and align existing investments and programming. This would have no major policy, financial or operational implications. Under Track 2, the four agencies would aim to develop funding models for the platform. Countries could either submit a single application to the Fund and GAVI for joint funding of HSS, or submit a national health plan to the Fund, GAVI and the World Bank for funding of the HSS elements in the plan. This would require defining the appropriate scope of support for HSS, developing appropriate funding channels and volume of funding, providing funding based on national health plans through existing prioritization processes, and maintaining inclusiveness in all country-level processes.

Procurement Support Services

Voluntary Pooled Procurement

3.13 The Procurement Support Service has made significant progress through the pooled purchasing facility and supply chain management assistance since it became operational in June 2009. To date, Voluntary Pooled Procurement (VPP) has registered Principal Recipients from 37 countries with 68 grants, and preliminary discussions are ongoing with an additional 20 countries. Ten countries have registered for capacity building services/supply chain management assistance. The VPP has now registered 130 orders with a total value of US\$ 335 million. Capacity building services are currently ongoing in Nigeria, Gambia and Liberia.

3.14 Pooled procurement is contributing significantly to the global efforts to meet malaria targets for 2010. Some 60 million nets for 17 countries are being procured through this mechanism, with 17 million nets already en route to various countries. This includes the 4.5 million nets delivered to Uganda for the initial phase of its distribution campaign that began

last week on World Malaria Day, an initial shipment of 9 million nets to Nigeria for seven of its 19 states, and a shipment of 1 million nets to Indonesia.

Price and Quality Reporting

3.15 One year after its launch, the publicly available PQR system contains an unprecedented dataset on pharmaceutical procurement transactions to the value of US\$ 345 Million reported by Principal Recipients from over 100 countries. The PQR has allowed the Fund to better track spending on health products within the scope of the system and has facilitated monitoring of our Quality Assurance Policy for pharmaceuticals. The Secretariat continues to verify data accuracy and completeness with the support of LFAs. By Q3 the Secretariat will start sharing price comparison reports with Principal Recipients to facilitate their procurement decisions.

Quality Assurance Policy for Pharmaceutical Products

3.16 The Quality Assurance Policy for pharmaceutical products has been successful in ensuring that all ARVs, anti-TB medicines and antimalarials financed by the Fund meet stringent quality criteria. For situations where as a result of the assessment a monopoly would be created, the Expert Review Panel hosted by WHO has identified finished products that can be procured under stringent assessment. The amendment decided at the last Board meeting permits the continued procurement of certain well-established medicines. A contingency plan to address remaining challenges with four more recent lifesaving ACTs is proposed in the report of the ad hoc Market Dynamics and Commodities Committee (MDC) to the Board.

PART 4: PROGRESS ON STRATEGIC INITIATIVES

Summary

- Significant progress has been made on the Affordable Medicines Facility - malaria (AMFm). Countries will receive the first co-paid ACTs in August 2010.
- We have redoubled our efforts to achieve value for money.
- The Secretariat has been collaborating with partners to strengthen national monitoring and evaluation (M&E) systems and improve data quality.
- Reprogramming to ensure access to the highest standard of treatment and to increase coverage of PMTCT programs has already taken place in nine of the countries with the highest burden of mother-to-child transmission of HIV.
- The number of approved proposals that include a comprehensive package of services for sex workers, men who have sex with men and transgender people increased between Rounds 8 and 9. A gender analysis of proposals will be completed soon.
- The Secretariat has recently scaled up activities aimed at increasing access to services for people who inject drugs, prisoners and pretrial detainees.

Affordable Medicines Facility - malaria

- 4.1 Considerable progress has been made on the AMFm since our last Board meeting. Of the ten pilot proposals approved by the Board, nine will go forward as Rwanda decided not to pursue its application. The Secretariat has worked with implementing countries and partners to amend "host" grant agreements to accommodate AMFm supporting interventions. These agreements will be signed in the next months and in-country activities to support the arrival of co-paid ACTs will start soon.
- 4.2 In response to Board decisions, the Secretariat has commissioned an independent evaluation of AMFm Phase 1. The evaluation will inform the Board decision, expected in 2012, on a potential global roll-out of the AMFm.
- 4.3 The Secretariat will soon sign master supply agreements with the six currently eligible ACT manufacturers. We have also issued countries with the first-line buyer undertaking, which outlines buyer obligations under AMFm. It is now expected that first-line buyers in the fastest-moving countries will be able to order co-paid ACTs starting in May for delivery in August 2010.

Value for Money

- 4.4 Ensuring value for money is a critical priority for the Global Fund at every stage of the financing chain, extending from donors to the people who benefit from program services directly. This is achieved by keeping Secretariat operational expenditures as low as possible, by continuous assessment of value for money throughout the grant lifecycle and by promoting measurement of value for money at program implementation level.

- 4.5 Ensuring the best value for money has always been a priority for the Fund, but the impact of the global recession on government budgets means that it is now more critical than ever. This is why we have recently redoubled our efforts to achieve value for money. I describe many of the measures we are taking, such as increasing efforts to identify efficiency gains in Phase 2 grants and at the institutional level, elsewhere in this report.
- 4.6 Improvements that can be achieved in the value for money of programs at country level are an important part of the Fund's value for money framework. Documentation of the value for money approach has been made more explicit in the revised forms developed for Round 10 proposals. Countries will be encouraged to make their own assessment of the value for money of programs, as well as to incorporate measurement of the unit costs for key services in their proposals. We make clear to applicants that increasing value for money does not imply proposing the "least expensive" interventions, but those that have the biggest impact for the amount of money spent - for example, by targeting most-at-risk populations.
- 4.7 What we hope is that program managers in countries will compare costs of services over time and link them to the outcomes and impact of programs, which will allow them to seek better value for the money invested in the program and so leverage further investments. We are of course aware that the capacity for service unit cost measurement in countries is still weak. Therefore, the Secretariat has recently been working with partners to gather standardized data for service delivery of key interventions and to support capacity building at country level to facilitate cost evaluation and the use of these data for efficiency gains in programs.
- 4.8 Value for money indicators and targets have been included in the revised key performance indicator (KPI) framework for 2010. Our aim is to achieve annual reductions in health product prices and service delivery costs for key services that are comparable across the portfolio, such as ARV drug cost per person per year, DOTS cost per person successfully treated and insecticide-treated net procurement cost.

Data Quality Enhancement

- 4.9 The credibility of the Global Fund's performance-based funding model depends heavily on good quality programmatic, financial and procurement data from countries.
- 4.10 As a key corporate priority, the Secretariat has therefore been collaborating with many partners, including the Health Metrics Network, WHO and UNAIDS, to strengthen national M&E systems and improve data quality. These efforts include annual LFA verification of data reported to the Secretariat by Principal Recipients, as well as an assessment of national M&E systems to inform the development of national plans for strengthening them, and the completion of M&E country profiles that capture information on the capacity and functioning of these systems for 245 disease program in 105 countries.
- 4.11 Currently, the Secretariat is finalizing a corporate data quality strategy. The strategy aims to improve data management at the Secretariat and to contribute to improving M&E systems in country. The Data Quality Strategy is part of the Secretariat's response to the Five-Year Evaluation and the TERG call for action.

Prevention of Mother-to-Child Transmission

- 4.12 Thanks to the efforts the Secretariat is undertaking with our partners, the commitment of implementing countries and the advocacy of our ambassador for protecting mothers and children, Carla Bruni-Sarkozy, I believe we can make great progress in the

coming months and years in scaling up PMTCT programs. Indeed, by 2015 we could virtually eliminate the transmission of HIV from mother to child.

- 4.13 By the end of 2009, a cumulative total of 800,000 HIV-positive pregnant women had been provided with a complete course of ARV prophylaxis to prevent mother-to-child transmission through Global Fund-supported programs. In 2009 alone, over 340,000 women were provided ARV prophylaxis. While this represents a substantial increase over previous years, coverage and quality of PMTCT programs remain insufficient.
- 4.14 The Secretariat is therefore working intensively with partners to implement the Board decision to scale up PMTCT programs. In close collaboration with UNICEF, WHO, UNAIDS, UNFPA, the Children's Investment Fund Foundation, the Clinton HIV/AIDS Initiative and civil society partners, we have found opportunities for reprogramming in Nigeria, Zambia, Tanzania (United Republic), Burundi, Congo (Democratic Republic), Ghana, Ethiopia, South Africa and India. Since the last Board meeting, partners have been working with CCMs and Principal Recipients to strengthen PMTCT programming through grant negotiations and grant consolidation, among other means. The aims are to provide the optimal regimen to prevent transmission of HIV from mother to child, offer more comprehensive services - including treatment for mothers who need it - and scale up coverage. Partners will also work with CCMs to generate strong, ambitious proposals for PMTCT for Round 10. This will not only result in increased coverage and quality of PMTCT programming, but will also be an opportunity for countries to use Global Fund flexibilities to integrate services for maternal and child health with services for HIV and AIDS, TB, malaria and HSS.
- 4.15 The PMTCT Initiative is an excellent example of what I call "partnership in action." Each partner is bringing its expertise and strengths to bear in order to achieve our common goal.

Strategies on Gender, and Sexual Orientation/Gender Identities

- 4.16 The implementation of the Global Fund Gender Equality and Sexual Orientation and Gender Identities (SOGI) strategies continues to be a priority for the entire Secretariat. I follow progress closely and am committed to further scaling up our efforts in the months and years to come so that we can take full advantage of the Fund's ability to catalyze and support country efforts to take the gender and SOGI dimensions of the three epidemics into account in their proposals.
- 4.17 An analysis of the HIV proposals submitted in Rounds 8 and 9 has shown that the number of proposals recommended for funding by the TRP that include a comprehensive package of services for sexual minorities (including but not restricted to sex workers, men who have sex with men and transgender people) increased between Rounds 8 and 9. For example, the percentage of funded proposals that include activities aimed at addressing stigma and promoting human rights of sexual minorities increased from 13 percent in 2008 to 43 percent in 2009. Similarly, the proportion of proposals that include provision of care and support for sexual minorities rose from 29 percent in 2008 to 50 percent in 2009. An analysis of the gender components of HIV proposals will be completed within the next months.
- 4.18 Work to support stronger proposals in relation to gender and SO/GI in Round 10 included revisions to the proposal forms and guidelines, and the production of information sheets to support Round 10 applicants. At country level much of the focus has been on CCM

strengthening. Proposed revisions to the CCM guidelines include strategies to strengthen expertise on gender and SOGI. Efforts are continuing in 2010 to strengthen the TRP by recruiting members with expertise in these areas.

An Initiative for People Who Inject Drugs

- 4.19 Since the November 2009 Board meeting the Secretariat has undertaken a number of activities aimed at increasing access to comprehensive, evidence-based programs for people who inject drugs, including in prisons and pretrial detention centres. The Global Fund is the largest international funder of such services in low- and middle-income countries, but people who inject drugs continue to benefit too little from efforts to achieve universal access to comprehensive HIV services.
- 4.20 The Global Fund is well placed to work with countries and partners to scale up comprehensive programs that are evidence-based and respect, protect and fulfill human rights. As UNODC, WHO and UNAIDS have recommended, such programs should be implemented in the community, and in prisons and pretrial detention centres, and include harm reduction interventions such as needle and syringe programs and opioid substitution therapy, as well as HIV testing and counseling, provision of ART, community outreach and strengthening, psychosocial care and support, and diagnosis and treatment of hepatitis C/HIV co-infection.
- 4.21 At the Secretariat we continue to review and analyze our portfolio in order to identify funding and programmatic gaps, and we will continue to consult with service providers, civil society and people who use drugs on the barriers to access and how they can be overcome. I would very much welcome a strategic discussion during a future Board meeting on the Global Fund's role in ensuring access to HIV prevention, treatment, care and support for people who inject drugs.
- 4.22 The Secretariat will soon hold a meeting with key partners working on harm reduction and drug policy issues, including UN agencies, the Open Society Institute, the International Harm Reduction Association and the International Network of People Who Use Drugs. Partners are committed to providing support to countries in their development of proposals for Round 10 and subsequent rounds, so that programs and services for people who inject drugs can reach the level and scale that is required.

PART 5: THIRD VOLUNTARY REPLENISHMENT

Summary

- The replenishment is critical for the sustainability and further scale-up of AIDS, TB and malaria programs around the world and will to a significant degree determine whether the health-related MDGs are achieved by 2015.
- Participants at the preparatory meeting in The Hague recognized that the Fund is a primary vehicle for making further progress toward the health-related MDG.
- A wide range of activities, from increased engagement with parliamentarians to increased outreach to the public through a number of innovative communications activities to greater collaboration with Southern constituencies, are ongoing or planned to increase support for the replenishment.
- Innovative resource mobilization efforts are continuing in parallel with the replenishment process.

Update on the Replenishment Preparatory Meeting

- 5.1 The preparatory meeting for the Global Fund's third replenishment was held in The Hague from 24 to 25 March 2010. I thank the government of the Netherlands for its warm hospitality, reflecting its strong commitment to the work of Global Fund. I also thank Richard Manning, whose impressive chairmanship of the meeting ensured that the discussion remained focused and resulted in an excellent Chair's Summary.
- 5.2 Participants viewed 2010 as a critical year for global health and see the Fund as a primary vehicle for making further progress toward the health-related MDG. They acknowledged our contribution not only to MDG 6, but also to MDGs 4 and 5.
- 5.3 The 2010 report, *Innovation and Impact*, was welcomed by participants as showing in very clear and quantifiable terms how Global Fund resources are being used to address the three diseases. Donors see a clear link between their investment in the Fund and the impact being achieved on the ground in implementing countries.
- 5.4 A recurring theme during the meeting was the need to ensure the sustainability of programs supported by the Fund. It was also clear that donors are looking to the Secretariat to maximize the return on their investment by accelerating the pace of the architecture reform and continuing to deliver value for money in program implementation. As I mentioned in Parts 3 and 4 of the report, these are priorities for the Secretariat and we are making rapid progress.
- 5.5 The Resource Scenarios paper, in which the Secretariat outlines the health impacts that could be achieved with resources of US\$ 13 billion, US\$ 17 billion and US\$ 20 billion respectively over the three years of the replenishment, was discussed at length. Participants recognized that the Global Fund's resources will have to increase substantially in order to achieve significant further progress toward the health-related MDGs by the year 2015.

- 5.6 Participants recognized the role the Fund is playing as a catalyst for domestic resource mobilization in middle-income countries and the important contribution Global Fund-supported programs are making to efforts to combat the epidemics among most-at-risk, marginalized communities.
- 5.7 I was heartened to see at the meeting that the Global Fund's work is very much seen by all our partners as a collective enterprise. The continued support of all our partners, and of the Board in particular, will be essential at this defining moment of the history of the Global Fund and the fight against the three diseases, as the world makes decisions that will determine whether or not we will be able to reach goals that could be achieved by 2015 - such as elimination of HIV transmission from mother to child and elimination of malaria as a public health problem in many countries.

Preparation for the Pledging Conference

- 5.8 In preparation of the pledging conference, and working jointly with all our partners, we are reaching out to political leaders, parliamentarians, other decision- and opinion-makers and the public, calling for political support for the replenishment from both the North and the South. Meetings with key leaders and ministers in both donor and implementing countries started soon after the November Board meeting and will continue until the time of the pledging conference. This is complemented by work with members of parliament, the public, and our Southern constituencies.
- 5.9 Senior staff have met with foreign affairs or development committee members of the European, German and Danish **Parliaments**, and further meetings have been scheduled with Canadian and French parliamentary committees. In addition, there have been meetings with parliamentarians from Japan, the United Kingdom, Italy, the United States, Australia and New Zealand. I have participated in some of these meetings myself, most recently last week in the United States.
- 5.10 We have also been active in the most important international and regional parliamentary networks, including the Inter-Parliamentary Union, the Africa Caribbean Pacific - European Union Joint Parliamentary Assembly, the Assemblée parlementaire de la Francophonie, the Association of European Parliamentarians with Africa, and others. During these meetings there have been dialogues with members of parliament from many implementing countries, including South Africa, Senegal, Burkina Faso, Uruguay, Zambia and Viet Nam.
- 5.11 A number of site visits to implementing countries are being planned, including visits to Afghanistan, Cambodia, Lao (People's Democratic Republic) and the Caribbean and a visit by U.S. congressional staffers to Peru.
- 5.12 The support we have received from **civil society** partners has always been an essential element of the Fund's resource mobilization efforts. In addition to meeting civil society partners during country visits, the Secretariat participated in a number of meetings with implementing country and developed country NGOs to share our plans and seek their input.
- 5.13 In the run-up to the pledging conference in October, the Fund is making a major effort to reach out to the **public**. Our aim is to show that investments in health work. We have drawn inspiration from the impressive efforts of the Bill & Melinda Gates Foundation's Living Proof project, and hope to make a wider public aware of the successes achieved in the last eight years in the fight against the three diseases and of what could be achieved if the pace of scale-up is maintained - from millions of lives saved to virtual elimination of mother-to-child

transmission of HIV, greatly improved maternal and child health and vastly strengthened health systems in low- and middle-income countries.

- 5.14 We have been facilitating visits to implementing countries by representatives of international media so that they can see the impact of Global Fund-supported programs firsthand. Between October 2009 and October 2010, more than a dozen media visits to implementing countries around the world will take place. We are grateful to the CCMs, Principal Recipients and sub-recipients, as well as to our partners, such as UNAIDS, RBM and many others for their assistance in making these visits a success. We have already seen a significant increase in reporting on the impact of health investments.
- 5.15 We widely publicized our 2010 report, *Innovation and Impact*, in March with a simultaneous launch in four countries, achieving significant media coverage.
- 5.16 Our photography exhibitions, *Access to Life* and *20 Minutes : 50 Lives*, are continuing their tour around the world, with exhibitions in Toronto, Berlin, Melbourne, Tokyo and at the UN in New York planned for this year.
- 5.17 We are launching our new corporate video today. We hope that the video will be a useful tool for all of you when you present the Fund in meetings or through your websites. You will all receive a DVD of the film for your own use.
- 5.18 With the support of our ambassador, Carla Bruni-Sarkozy, we will in May launch an Internet-based campaign focused on ending the transmission of HIV from mother to child by 2015. The campaign, called *Born HIV Free*, will draw attention to the fact that this goal is achievable, and provide opportunities for people to voice their support. Thanks to the support of many media companies, in particular Google/Youtube, Facebook and Orange, this campaign will reach tens of millions of Internet users over the coming months and - we hope - translate into increased awareness of, and support for, the investments in global health that are being made by donor countries around the world.
- 5.19 We are increasing access to performance data on our website. Today, we are launching the "Performance Web" component of our website, which has advanced search features and will allow access to real-time data on our site.
- 5.20 We have also strengthened our efforts to facilitate better communications with and among **implementers** and partners. We have simplified and standardized communications between the Global Fund and CCMs and Principal Recipients, and the upcoming publication of the Global Fund *User's Guide* will help make grant management easier.
- 5.21 **NGO Principal Recipients** have offered to collect and share stories from their programs to highlight the human side of the results achieved by the Global Fund partnership. The stories will be used for advocacy by the NGOs themselves, but will also be made available for the Fund's use.
- 5.22 In four implementing countries (India, Indonesia, Nigeria and South Africa), CCMs and Principal Recipients are working to increase the visibility of Global Fund-supported programs and their implementers. The Secretariat is assisting efforts to draw the attention of local media to the fight against the three diseases and the impact of Global Fund investments.

- 5.23 The eight **Friends organizations** are all particularly active this year in mobilizing public and political support for the Fund, with the aim of securing significant financial contributions to the Fund at the pledging conference.

Private Sector Mobilization

- 5.24 (PRODUCT) RED is continuing to expand. In December 2009, Nike became the first truly global (RED) partner with a presence in Africa and other continents. In March Japan's largest pharmaceutical company, Takeda Pharmaceutical, became a "Corporate Partner" of the Fund and announced that it would invest 100 million Japanese yen (around US\$ 1 million) per year from 2010 to 2019 to support Global Fund-financed programs, with a focus on HSS in Africa. I would like to express my appreciation to the Private Sector board member, Dr. Brian Brink, for initiating a campaign in our replenishment year among a wide range of companies to contribute directly to the Global Fund. In addition, a number of Africa-based corporations, such as MTN and Nando's, are now supporting the Global Fund through their engagement in the United Against Malaria campaign focused around the 2010 FIFA World Cup. Following the Board decision in November, the Secretariat is exploring a number of potential trial donations of nonhealth products. The first such trial will be the donation by UK publisher Medkidz of 500,000 comic books providing HIV information for teenagers, to be distributed to Global Fund implementers in Swaziland.
- 5.25 A number of initiatives are under way to facilitate donations from private donors. UN Secretary-General Ban Ki-moon is initiating a private philanthropic giving campaign which aims to secure in excess of US\$ 100 million in new private donations to the Global Fund over the replenishment period. The UN Foundation has launched a new initiative focused on malaria in partnership with the United Methodist Church and the major Lutheran churches in the U.S. that will start fundraising in 2010. Some of the proceeds will go to the Global Fund. A U.S. charity will be established to provide a channel for tax-efficient contributions to the Global Fund from U.S. private donors. The Secretariat is also seeking to promote private giving in European countries by joining Transnational Giving Europe, a network of accredited foundations based in Europe that facilitates cross-border giving.

Scale-up of Innovative Financing Initiatives

- 5.26 Innovative financing mechanisms, such as UNITAID and Debt2Health, are making an increasingly important contribution to Global Fund resources. The total now stands at US\$ 193.8 million and will continue to grow over 2011-2013 as additional collaborations with UNITAID, new Debt2Health swaps and the first resources from the co-branded indexes with Dow Jones come online.
- 5.27 In March 2010, the Global Fund and Dow Jones Indexes signed an agreement to explore the creation of a series of indexes that could be licensed as the basis for investible products. It is envisioned that the flagship of this series would be a blue-chip index, the Dow Jones Global Fund 50 Index. The co-branded indexes will be licensed to interested financial institutions as the basis for their exchange traded funds (ETFs). The license fee as well as the ETF revenues will be shared with the Global Fund. The initiative is expected to establish a sustainable flow of resources for the Global Fund in the range of US\$ 2 million to US\$ 15 million per year per ETF, depending on the assets under management. In addition, the initiative is expected to provide the Global Fund with significant exposure to institutional investors, foundations and retail investors around the world. In April 2010, a letter of intent was signed between the Global Fund and the National Bank of Abu Dhabi to launch such an ETF on the Abu Dhabi Securities Exchange using an Islamic version of the Dow Jones Global Fund Index. Additional opportunities are under active consideration.

PART 6: THE PARTNERSHIP AT WORK

Summary

- Implementation of the Partnership Strategy is under way, resulting in improved communication and cooperation between the Secretariat and in-country partners.
- The Secretariat is strengthening CCMs to enable them to better fulfill their core functions, with a special focus on oversight of grant implementation, and adapt to the new grant architecture.
- In December 2009, the United Nations General Assembly granted the Fund official observer status.

The Fund's Partnership Strategy

- 6.1 Implementation of the Partnership Strategy adopted at the Board meeting in November is already showing concrete results in improved communication and cooperation between the Secretariat and in-country partners. For example, since the signing of the Global Fund-Islamic Development Bank (IsDB) memorandum of understanding (MOU), IsDB and Fund staff have discussed the modalities of co-financing programs and an action plan for an initial selection of target countries, including Bangladesh, Djibouti, Mali, Mauritania, Togo and Yemen. The IsDB expressed its readiness to finance technical assistance in these countries and offered to extend such financing to a number of other IsDB Member States who are planning to apply for funding in Round 10. Plans are underway to conduct joint Global Fund-IsDB missions to assess the needs in the target countries. The MOU between the Fund and the Organization of the Islamic Conference (OIC) has helped generate strong political support for the Fund's request to obtain observer status in the UN General Assembly, and we are working with the OIC Secretariat to engage potential donors amongst OIC member states.
- 6.2 Earlier this month, on behalf of the Secretariat, I signed an MOU with RBM. Our partnership with RBM continues to be exemplary and the agreement we signed builds on our existing, close collaboration with this key technical partner.
- 6.3 To ensure that such agreements are effectively operationalized at country level, the Secretariat is working with new and existing partners to implement a joint performance and monitoring framework.
- 6.4 Existing relationships with bilateral and multilateral partners continue to strengthen. For example, UNITAID's support has been instrumental in scaling up access to second-line ART and ACT. UNAIDS Executive Director Michel Sidibe and I jointly launched the Global Fund's 2010 report, *Innovation and Impact*, in South Africa and we also made a joint visit to Mali in January. We have continued working closely with Stop TB, another key partner.
- 6.5 The Fund is also working with the International Labour Organization to strengthen our operational partnership with, among other means, a plan to increase private sector engagement in advocacy, as well as with CCMs and Global Fund-financed programs.

6.6 As part of the Fund's Partnership Strategy, the Secretariat has developed a technical assistance paper for presentation to the Board at this meeting. We recognize the need for clearly defined, accountable operational partnerships to provide technical support to countries, and are proposing solutions to address issues related to planning and coordination, funding, and evaluation and quality assurance of technical assistance.

Country Coordinating Mechanisms

6.7 The Secretariat is strengthening CCMs to enable them to fulfill their core functions, with a special focus on oversight of grant implementation, and adapt to the new grant architecture.

6.8 In February 2010, the Secretariat rolled out a revised CCM funding policy that will provide increased resources for improving CCM performance and efforts to ensure a broadly representative membership and integration with other national bodies. The Secretariat estimates that 30 CCMs will apply for expanded funding in 2010.

6.9 The Secretariat is developing a comprehensive performance assessment framework that will enhance its ability to identify CCMs in need of assistance. Fund portfolio managers have a new, additional role. I have instructed them to actively participate in CCM meetings and liaise more regularly with CCM members. Increased interaction and dialogue between CCMs and the Secretariat will help clarify our mutual roles and responsibilities and assist in identifying other areas for CCM strengthening.

6.10 In 2010, the Secretariat is also focusing more attention on improving CCM capacity to provide grant oversight. In collaboration with partners, we are rolling out an oversight tool which CCMs can use to help them provide oversight more effectively. This tool is already being used in 14 countries, including Mali, Côte d'Ivoire, Mongolia, Namibia and China.

6.11 To strengthen communication and knowledge transfer between the Secretariat and CCMs, we have started organizing CCM-specific regional meetings. To date, approximately 300 CCM members have participated in these meetings in South and West Asia, South America, and West and Central Africa. The Secretariat is planning five more CCM regional meetings in 2010.

UN Observer Status

6.12 In December 2009, the United Nations General Assembly granted official observer status to the Fund. This will facilitate dialogue with member states and UN agencies. I would like to thank all Board members and constituencies for the support they provided in achieving observer status.

PART 7: SECRETARIAT UPDATE

Summary

- The Secretariat's operating expenses totaled US\$ 226 million in 2009, representing 89 percent of the expenses budget and 5.3 percent of total expenditures for the year. Savings of US\$ 24 million were achieved through lower expenditures on staff, travel and meeting overheads.
- At the end of 2009, the Secretariat had 569 staff, a substantial increase over 392 staff at the end of 2008 but 4 percent less than budgeted.
- The Secretariat launched a new performance management process to align employee performance objectives with the respective team goals and, ultimately, the corporate priorities. In parallel, we are developing a salary decision framework to ensure equitable salary decisions.
- The Secretariat is actively pursuing an option to rent office space in Geneva's future "Health Campus." We are entering contract negotiations with a developer. Depending on their outcome, rent savings could come close to 40 percent.
- Progress in achieving privileges and immunities has been slow.

Operating Expenses

- 7.1 The Secretariat's operating expenses totaled approximately US\$ 226 million in 2009, representing 89 percent of the expenses budget for the year; 2.2 percent of the value of grants under management in 2009 (well within the KPI boundary of 3 percent); and 5.3 percent of total expenditures (well within the KPI boundary of 10 percent and the budget framework which sets an indicative level of 6 percent). The savings of US\$ 24 million were achieved through lower expenditures on staff, travel and meeting overheads.
- 7.2 The end-of-year staff count was 569, a substantial increase over 392 staff at the end of 2008 and 4 percent lower than budgeted.
- 7.3 A 10 percent savings target had been set for travel costs in 2009. The actual savings exceeded 30 percent thanks to a number of efforts, including new travel regulations.
- 7.4 The AMFm budget was not fully spent for reasons outlined in the FAC report and a request will be made to carry US\$ 2.85 million of the 2009 budget into the 2010 budget.
- 7.5 For 2010, we will again keep operating expenses to a minimum while ensuring the effective functioning of the Fund.

Human Resources

- 7.6 The Secretariat has a headcount budget of 603. At the end of March 2010, we had 85 vacancies. We expect to be fully staffed by the third quarter. To maintain flexibility in our staffing, we will maintain a 75 to 25 percent ratio of ongoing versus defined duration contracts. At the end of March, women comprised 56 percent of the Global Fund workforce

and 28 percent of staff members at senior levels (grade G6 and higher). Staff from implementing countries comprise 41 percent of our workforce.

- 7.7 Early this year, the Fund launched a new performance management process to align employee performance objectives with the respective team goals and, ultimately, the corporate priorities. This has been facilitated through objective-setting workshops and a user-friendly online tool. In parallel, we are developing a framework for making salary decisions that will ensure they are equitable. The framework will include a pay-for-performance element.
- 7.8 Another priority is to strengthen the staff career development program and identify key leadership competencies, which will be the basis for a leadership and management development program over the next two years.
- 7.9 The Fund is putting more effort and resources into internal communications, including a new online magazine called *LIFE Online*, written by staff for staff to share lessons learned and highlight current issues.

Corporate Procurement

- 7.10 Over the past few months, the Corporate Procurement Unit has worked hard to enhance the Fund's procurement processes, including those for LFA procurement which is a major cost driver. The revised LFA procurement process has enabled increased transparency of cost and staffing across all LFA services and reduced negotiation times. In the upcoming months, the unit will focus on improving the procurement and management of consultancy services.

Information Technology

- 7.11 The Fund's administrative functions are now supported by the "Global Fund System", an in-house solution that replaced the WHO IT systems. An upgraded version of the Grant Management System provides enhanced financial reporting and M&E capabilities.
- 7.12 The IT Unit is working with in-country partners and staff to define technology needs for the new grant architecture, including building tools for easier and smoother proposal preparation and follow-up in countries. The team is also developing a long-term approach to managing all grant documents and data.

Privileges and Immunities

- 7.13 Since December 2009, the Secretariat has contacted the Geneva permanent missions and embassies of 167 countries (113 implementing country and 54 nonimplementing country) and provided them with detailed dossiers concerning the Fund's request for privileges and immunities. These dossiers are being reviewed by the missions and embassies and then passed on to capitals for further processing.
- 7.14 The Secretariat's legal team is working with missions and capitals, but progress has been slow and no signatures have been obtained to date. I urge and rely upon all Board members and constituencies to help us progress in acquiring privileges and immunities, which constitute a major milestone in the completion of our transition to a fully autonomous, independent international organization.

Secretariat Office Space

7.15 The Secretariat is continuing to pursue an option to rent office space in Geneva's future Health Campus. The Swiss government supported the Secretariat in identifying a suitable property developer through a competitive process. The Fund recently signed a letter of intent with the developer who was selected, and we are now entering detailed contract negotiations. The annual costs of the lease of the new building are estimated to be in the region of CHF 6.6 million, compared to the CHF 11 million the Secretariat currently pays.

7.16 This year, the decisions will be taken about whether or not we will be able to meet the health-related MDGs by 2015. It could be done. If we continue to scale up at the pace set in the last years, we could come close to, reach or even exceed the MDGs.

7.17 I am conscious of the economic constraints donors face in the current difficult economic environment. But as important decisions are being made this year, we hope everyone involved will also keep in mind the needs that remain unmet and the danger of wavering in our commitment, letting the progress falter and allowing AIDS, TB and malaria to gain force again.

7.18 The results speak for themselves. Countries have demonstrated that they can deliver results and scale up at a pace never achieved before. And we could achieve much more if we can secure resources that would allow us to continue scaling up rapidly - dramatically reduce deaths from AIDS, prevent millions of new HIV infections, eliminate malaria as a public health problem in most malaria-endemic countries, and achieve further, significant declines in TB prevalence and mortality.

7.19 With this report, I hope I was able to remind the Board not only of the many reasons why, particularly in difficult economic times, the Global Fund model continues to offer a sound investment for the international community; but also of why we need to continue to be bold and visionary and realize the hope of the millions of people whose lives depend on the decisions we make.

7.20 I wish the Board well at its twenty-first meeting.

Michel D. Kazatchkine
Geneva, April 20, 2010

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