

Electronic Report to the Board

Mid-year 2015 Corporate KPI Results & 2016 Targets

GF/B34/ER03

For Board Decision

PURPOSE: This report presents two items: (i) the additional information on the Corporate Key Performance Indicators (“KPIs”) requested by the Board during its 34th Meeting held in November 2015, for Board information, and (ii) the proposed 2016 performance targets for the 2014-2016 KPI Framework for 10 indicators, for Board decision.

1. GF/B34/EDP04: Approval of 2016 Targets for the 2014 – 2016 Corporate Key Performance Indicator Framework

I. Decision Point

1. Based on the rationale described below, the following electronic decision point is recommended to the Board:

Decision Point: GF/B34/EDPo4: Approval of 2016 Targets for the 2014 – 2016 Corporate Key Performance Indicator Framework

1. The Board:

- a. Acknowledges the Secretariat’s presentation of the mid-2015 performance assessments for the 2014-2016 Corporate Key Performance Indicator Framework, as set forth in GF/B34/08; and**
- b. Notes the Secretariat’s response to requests by the Board at its November 2015 meeting for additional analysis on certain indicators, including proposed management actions to improve performance, as set forth in GF/B34/ER03 – Annex 1.**

2. Accordingly, the Board:

- a. Approves the 2016 performance targets presented in GF/B34/ER03 – Annex 1; noting the revisions to the 2016 performance targets for KPI 7 (Access to Funding) and KPI 10 (Value for Money); and**
- b. Directs the Secretariat to implement its proposed management actions, continue to identify lessons that can inform the next Corporate Key Performance Indicator Framework, and update the committees and the Board at their first meetings in 2016.**

This decision does not have material budgetary implications.

II. Relevant Past Decisions

1. Pursuant to the Governance Plan for Impact as approved at the Thirty-Second Board Meeting,¹ the following summary of relevant past decision points is submitted to contextualize the decision point proposed in Section I above.

Relevant past Decision Point	Summary and Impact
GF/B33/DP07: Remaining Targets for the 2014-2016 Corporate Key Performance Indicator Framework². March 2015	The Board noted the additional analysis required to finalize the performance targets for the updated Global Fund Corporate Key Performance Indicator Framework for 2014-2016, and accordingly the Board approved the updated 2015 performance targets for Key Performance Indicators 6, 12, and 16, presented in GF/B33/04B.
GF/B32/DP10: Approval of the Global Fund Corporate KPI	The Board approved the updated Global Fund KPI Framework for 2014-2016, acknowledging the methodological work required to finalize certain

¹ GF/B32/DP05: Approval of the Governance Plan for Impact as set forth in document GF/B32/08 Revision 2.

² <http://theglobalfund.org/Knowledge/Decisions/GF/B33/DP07/>

Relevant past Decision Point	Summary and Impact
Framework 2014-2016³. November 2014	indicators. The Board also approved the available performance targets for 2015, as well as the plan to present the remaining 2015 performance targets for approval at the 33rd Board Meeting, as set forth in document GF/B32/24.a – Revision 2.
GF/B30/DP7: The Global Fund Corporate Key Performance Indicator Framework for 2014-2016⁴. November 2013	The Board approved the Global Fund KPI Framework for 2014-2016 as set forth in document GF/B31/7 – Revision 1. The Board asked for annual reports on these indicators, and where available, for interim results to be made available through the Financial Dashboard.

III. Action Required

2. Approval of the 2016 Key Performance Indicator targets will allow the Secretariat to continue monitoring the performance of the Global Fund against the current 2014-2016 KPI Framework, and to provide adequate oversight information to the Board and its Committees. Work is currently ongoing to develop the new Key Performance Indicator framework aligned with the 2017-2022 Global Fund Strategy. These proposals will be presented along with the Strategy to the Board for approval in April 2015.

IV. Background

3. The 2014-2016 Key Performance Indicator Framework was initially approved at the 30th Board Meeting in November 2013. The Board then received updates on the 2014-2016 KPI Framework, as well as proposed annual performance targets for 2015 which were approved by the Board at its 32nd and 33rd Meetings in November 2014 and March 2015, respectively.

4. To facilitate the oversight work of the Board and its Committee, the Secretariat provides performance reports on the Corporate KPIs twice per year. Performance targets for such KPIs for the following fiscal year are reviewed by the Committees and then presented to the Board for approval once per year.

Additional requested information by the Board on KPIs

5. At the 34th Board Meeting held in November 2015, the Secretariat presented mid-year results for 2015 for information, along with proposed performance targets for 2016 for Board approval. Background materials were shared ahead of the Board Meeting in November 2015 and are available to all constituencies in the password protected platform called Board Effect as document GF/B34/08.

6. In that document, mid-year performance assessments for 2015 were made available for 13 indicators. Eight indicators illustrated strong performance, one indicator was performing below expectation, and four indicators were presented as at risk of not meeting performance targets in 2015 or 2016.

7. As follow up to the Secretariat's presentation on the 2015 performance assessments at the November 2015 Board Meeting, during the discussion on KPIs Board Members requested additional

³ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B32/DP10/>

⁴ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B30/DP07/>

information on the indicators illustrating potential under performance. Specifically, additional information was requested on the following indicators:

- a) KPI 3: Strategic service delivery
- b) KPI 5: Health Systems Strengthening
- c) KPI 7: Access to Funding
- d) KPI 10: Value for Money
- e) KPI 11: Grant expense forecast
- f) KPI 12: Human Rights protection

8. Annex 1 to this report provides the information and analysis requested by the Board on KPIs prior to its approval of the 2016 targets. It also outlines 2016 performance targets for 10 indicators for Board approval.

9. Recent analysis conducted by the Secretariat has led to revision of the performance targets for two indicators, namely, KPI 4: Access to Funding, and KPI 10: Value for Money, from those presented at the Board Meeting in November 2015.

V. Recommendation

10. The Board is requested to review and approve the proposed 2016 performance targets for 10 KPIs as outlined in Annex 1 to this report.

34th Board Meeting

Mid-year 2015 Corporate KPI Results & 2016 Targets: Board request for additional information

GF/B34/ER03 – Annex 1
18 December 2015

Overview

- Board request for additional information on six KPIs (page 3)
- Summary response (pages 4-23)
- 2016 performance targets & draft Electronic Decision Point (pages 24-26)
- Detailed response (pages 27-69)

Request from the Board for additional information

KPI	Request	Due Date
KPI 3 Strategic service delivery	<ul style="list-style-type: none"> Estimate size of the inconsistent attribution effect on projected results Analysis of projections and underperformance by country Reasons for underperformance and proposed actions 	Dec 2015
KPI 5 Health Systems Strengthening	<ul style="list-style-type: none"> HSS portfolio overview and proposals for 'tracking indicators' to be used to reported for the remaining period of the Strategy 	Dec 2015
KPI 7 Access to Funding	<ul style="list-style-type: none"> Written version of explanation given during Q&A session 	Dec 2015
KPI 10 Value for Money	<ul style="list-style-type: none"> Additional data on savings by product and forecast Further explanation of reasons and impact of underperformance 	Dec 2015
KPI 11 Grant expense forecast	<ul style="list-style-type: none"> Request for year to date reporting by quarter 	Dec 2015
KPI 12 Human Rights protection	<ul style="list-style-type: none"> Report on investments in key populations, gender and human rights activities <ul style="list-style-type: none"> Preliminary report will be submitted to the 17th SIIC Meeting Full report will be submitted to the 35th Board Meeting Note on plans for system development to allow real time investment tracking 	Mar 2016 Apr 2016 Dec 2015

Summary

KPI 3

Further information requested by Board

Request

- Estimate size of the inconsistent attribution effect on projected results
- Analysis of projections and underperformance by country
- Reasons for underperformance and proposed actions

Response Summary

- Secretariat has updated and deepened analysis used for July 2015 projection
- Analysis has been undertaken in collaboration with targeted Country Teams, and projections are updated where possible with finalized grant targets rather than Concept Note targets
- **Updated projections for all service targets now exceed 90% of expectation**
- Key role for ITP project and partners in supporting implementation to strengthen performance
- **Reasons for under performance:** overestimation of grant targets, inconsistent attribution of results, and weak supply chains. Underreporting of PMTCT not found to be major issue in countries analyzed
- **Proposed actions:** strengthen oversight of target setting, categorization of indicators and guidance on attribution; re-estimation of targets; and close monitoring and corrective action for performance concerns

Results for KPI 3 shared with Board based on data available in July 2015

3 service targets were projected to be less than 100% achieved

Recap

KPI 3 Performance against strategic service delivery targets

Measure

a) # of people alive on ARV therapy

b) # of TB cases treated according to the DOTS approach

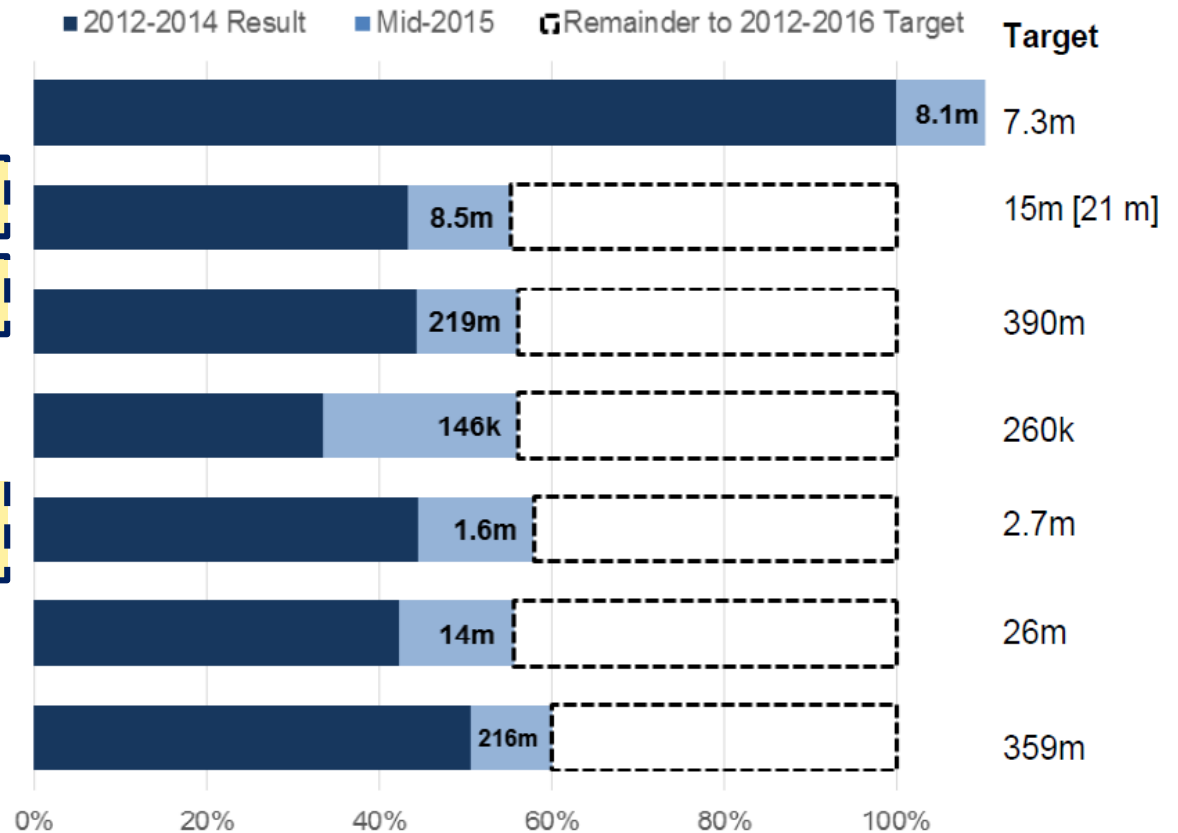
c) # of LLINs distributed

d) # of bacteriologically confirmed drug resistant TB treated with a 2nd line regimen

e) # of HIV positive pregnant women who received ART to reduce the risk of MTCT

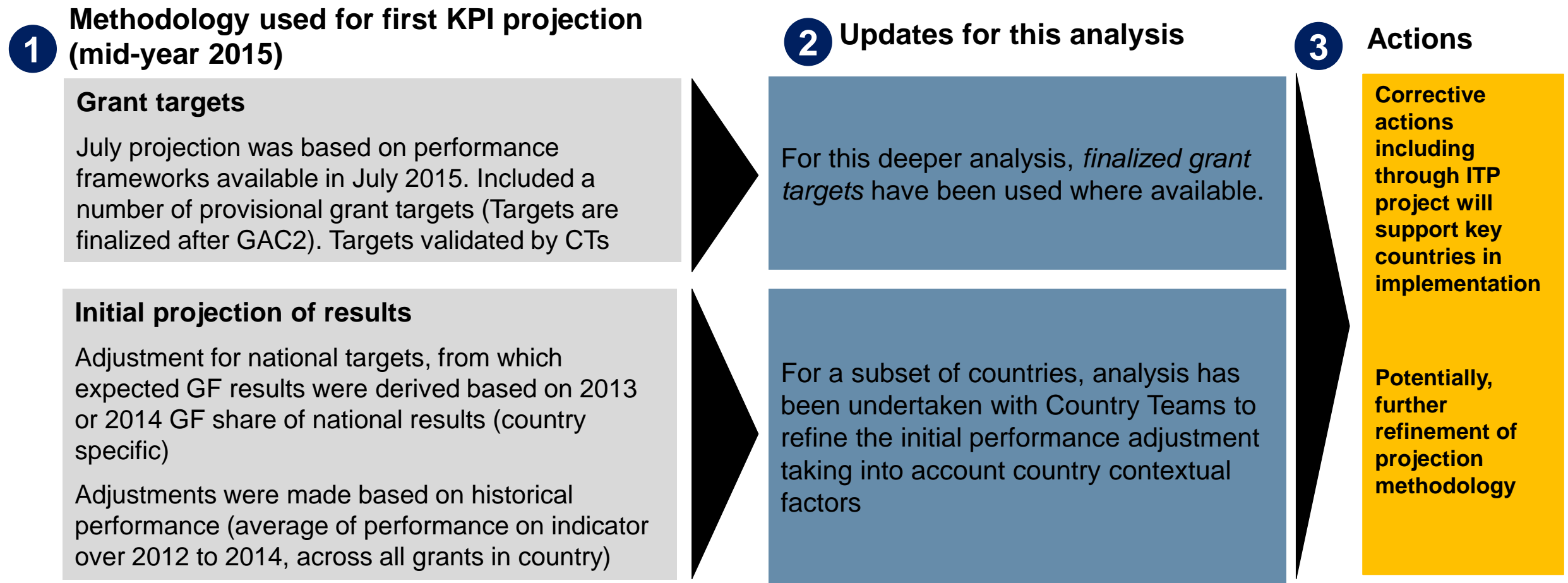
f) # of IRS services delivered

g) # of people who received HIV testing & counseling and know their results



- Current performance-adjusted projections based on Country Team input suggest results in 2016 may miss performance targets for 3 services: b) TB treatment, c) LLIN distribution, and e) PMTCT
- For TB treatment planned service delivery in Concept Notes are insufficient to meet Strategic targets, for LLINs and PMTCT the performance adjustments drive the expected shortfall

Secretariat has updated and deepened analysis used for July 2015 projection

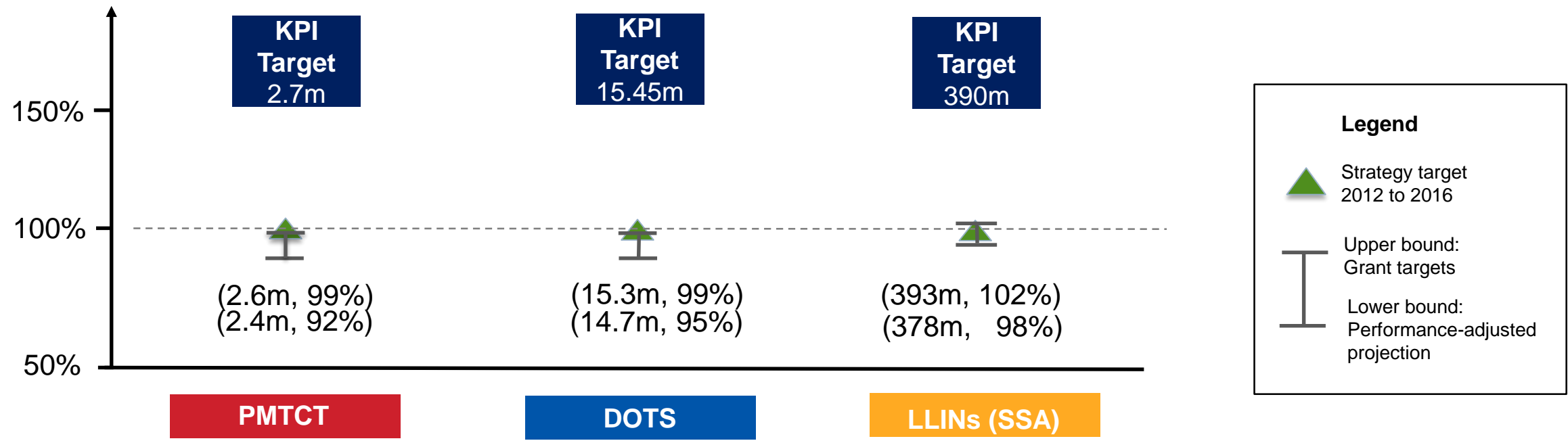


Notes: In July 2015 exercise, Performance Frameworks or latest version of all submitted CNs by end July 2015 (HIV: 41, HIV/TB: 37, TB: 37, Malaria: 60). Forecast of performance has been adjusted by country-specific forecasts for countries contributing most to the 'gap' in each service.

Detailed methodology for December 2015 Projections

1. Calculation of projected performance based on average performance for grants containing service indicator 2012-4
2. Ranking of countries by contribution to share of the target
3. Determination of key countries contributing to 'gap' in indicator performance
4. Analysis / discussions with country team to validate targets and / or refine performance adjustments for key countries
5. Revised projections generated

Projections for 2015-6 all service targets exceed 90%



Key role for ITP project and partners in supporting implementation to strengthen performance

Notes: projection based on average of performance on indicator over 2012 to 2014, across all grants including the service, adjusted by country specific forecasts for countries contributing most to the 'gap' in each service. DOTS indicator includes results not available in GF systems in July 2015.

Analysis of performance on KPI 3

Projection Contributing factors

Further actions

PMTCT

Min 92%
Max 99%

- Overestimation of need in one high burden country contributes to 'gap' to target
- Underreporting not found to be major issue in countries analyzed

- Re-estimation of targets in certain countries
- Close monitoring and corrective action for performance concerns, particularly through ITP

DOTS

Min 95%
Max 99%

- National programs achieving targets
- Inconsistent attribution of results to Global Fund

- Strengthen oversight of targets, categorization of indicators and guidance on attribution
- Close monitoring of performance by country teams for key countries
- Global Fund will move to a consistent contributive model for the Strategy 2017 to 2021/22 period

LLINs

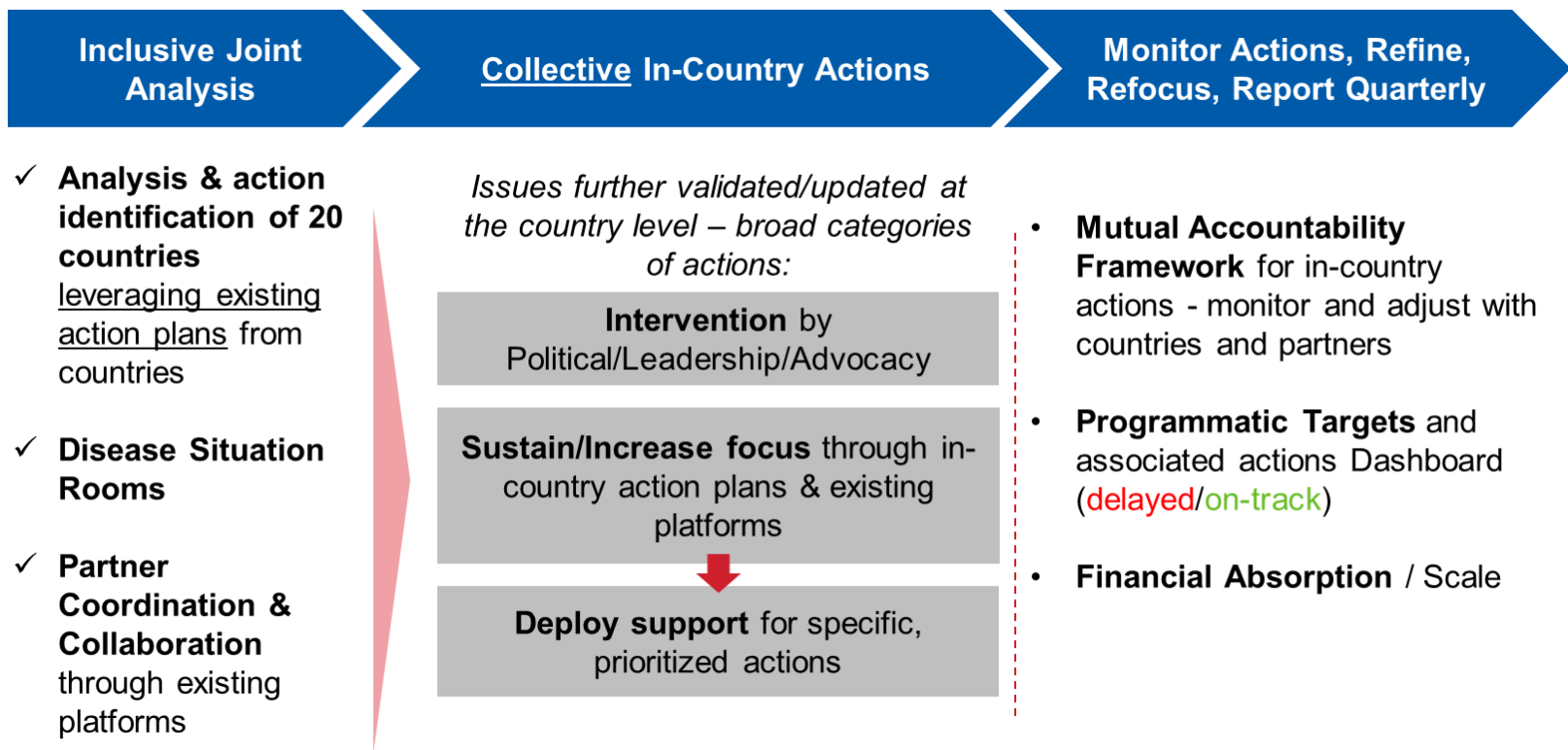
Min 98%
Max 102%

- Ambitious targets set for continuous distribution through ANC/EPI however, weak supply chains / health systems result in performance gaps

- Investments being made in stronger and innovative BCC to improve service uptake
- Close monitoring and corrective action for performance concerns, particularly through ITP
- Monitoring of potential delays and corrective action where possible

Implementation Through Partnership (ITP) project is key vehicle for strengthening implementation

Objective: In collaboration with partners, to increase the effectiveness and efficiency of implementation in 20 countries through shared ownership and mutual accountability



Expected Outcomes: Improved use of funds in key countries; implementation bottlenecks addressed with a diverse group of partners through transparent, results oriented actions in country

ITP leverages resources and partnership collaboration with processes/focus/outcomes to **benefit beyond top 20 countries**

- **Countries and partners aligned to achieve aggressive targets** across disease programs and in strengthening systems for health
- **Collective resources are used and used well** – from absorption to scale
- Shared, prioritized **programmatic bottlenecks are proactively addressed through data use throughout the process** (e.g. NSP development, GAC, etc.) with increased accountability, coordination and a focus on quality

KPI 5

Further information requested by Board

Request

- HSS portfolio overview and proposals for 'tracking indicators' to be used for the remaining period of the Strategy
- Provide data on key HSS programmatic areas supported by the GF and proportionality to the whole of the HSS budget or expenditures
- Provide options for sampling in a spectrum of countries across the three diseases. Create a standard portfolio for performance monitoring that could potentially be used in the ITP process

Response Summary

Portfolio review highlights:

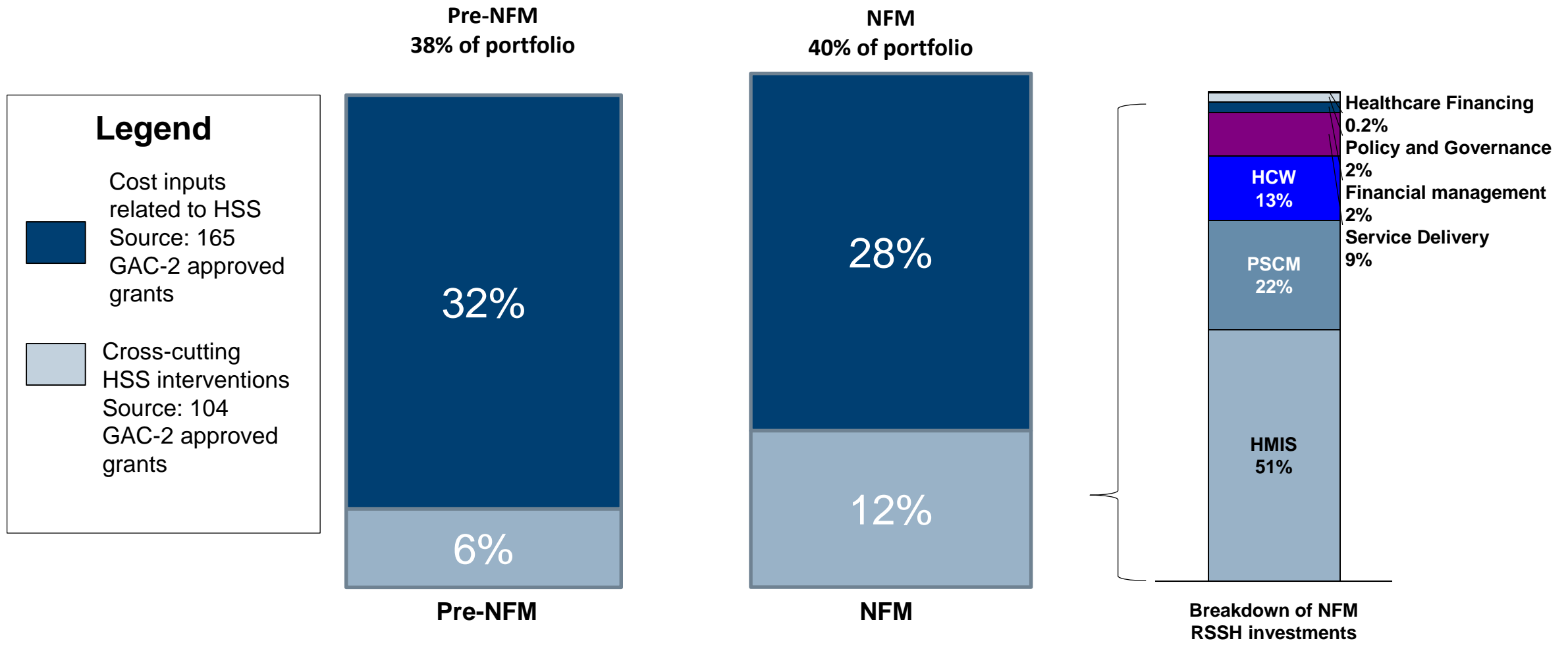
- Current M&E investments make up ~5% of the portfolio
- RSSH investments increased to 40% under NFM – Cross-cutting interventions have doubled

Tracking going forward:

- First programmatic reports of NFM HSS grants are expected in 2016
- Potential list of tracking indicators has been developed
- Additionally at the end of the funding cycle, a segment of portfolio will be selected for in-depth evaluation using a newly developed HSS evaluation tool, which has been designed to be used in conjunction with national disease program reviews

HSS investments increased to 40% under NFM

Cross-cutting interventions have doubled under NFM



HSS measurement approach and reporting timelines

HSS Indicators

- Impact and Outcome Indicators are measured in 3-5 year intervals. Output/Coverage indicators reported annually or bi-annually.
- Secretariat intends to measure performance of HSS output/coverage indicators, for priority health system components.
- Implementation of most NFM grants started in 2015 - the first programmatic reports are expected throughout 2016.
- First measurement of HSS indicators will be done by end of 2016.

Illustrative list of HSS indicators that can be tracked

Health Management Information Systems/M&E

% of HMIS or other routine reporting units submitting timely reports according to national guidelines

Procurement & Supply Chain Management

% of health facilities reporting no stock outs of essential drugs

Financing

Government expenditure on health as percentage of general government expenditure

Health and Community Workforce

Number of health workers per 10,000 population



Additionally, at the end of the funding cycle, a subset of countries will be selected based on agreed set of criteria, where in-depth evaluation will be carried out, by applying a newly developed HSS evaluation tool, which has been designed to be used in conjunction with national disease program reviews

Performance monitoring on HSS

Future strategic directions

- The Global Fund's strategic role in supporting resilient & sustainable systems for health has recently been set out ([Supporting Countries to Build Resilient and Sustainable Systems for Health: The Role of the Global Fund](#))
- Considerable work is currently being conducted to develop the RSSH indicators for the KPI framework for the 2017-2022 Strategy
- Of the indicators proposed on the previous slide, only the PSCM indicator is under consideration for inclusion in the new KPI framework
- KPI proposals for the new strategy will be shared with Board Constituencies in the coming weeks for input, followed by Committee review in March, and Board approval in April 2016

2016 Reporting on HSS

Beyond KPI5, performance monitoring for HSS, will focus on:

- HSS investments
- HSS indicators
- HSS in-country evaluation

Information to be released as data become available

KPI 7

Further information requested by Board

Request

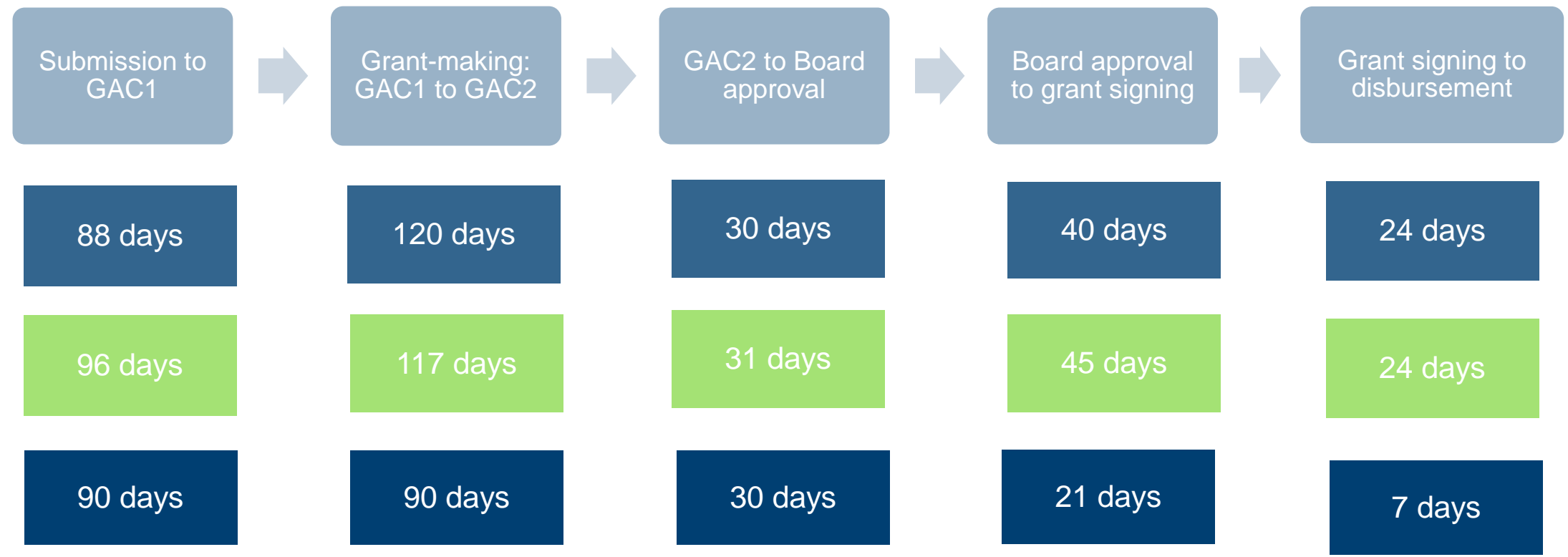
1. Summary of delays in stages as outlined verbally by Mark Edington
2. Summary of key countries with delays in access to funding and causes for delays with proposed management actions

Response Summary

- There are wide extremes in time from submission to disbursement (9.9 months or 10.2 for key countries, on average)
- **Grant extensions** and **sufficient cash in-country** have ensured this timeline has **no program impact**
- Submissions to date would need to lose ~3.5 months to reach an 8 month target, or 1.5 months to reach 10 months. However, proposed management actions estimate saving ~6 weeks from process
- **Recommendation to revise proposed KPI7 target for 2016:**
 - From: 75% grants submitted in 2015/16 take **8 months** or less from submission to first disbursement
 - To: 75% grants submitted in 2015/16 take **10 months** or less from submission to first disbursement
- Intention is to use 8 months as stretch target - but more time will be needed to achieve this

Overall status windows 1-4:

- Average time of submission to disbursement is 9.9 months or 10.2 for key countries; **wide extremes** in length of funding cycle
- Below analysis shows certain stages to focus on (no breakdown available for 10 month target)



Note: A country is classified as a key country if it falls in any one of the following categories: High Impact countries, ITP countries, top 20 countries by funding (including allocation + incentive funding)

Implications of KPI7 Performance

No impact on programs: there are no anticipated or perceived disruptions or gaps in interventions

- Country teams try to anticipate delays in grant-making by processing **grant extensions** (with additional funding or not) to ensure no program disruption
- Where ADMFs were not processed immediately, there were **sufficient cash in-country** and disbursements were not needed urgently

Recommendation

- Submissions to date would need to lose ~3.5 months to reach an 8 month target, or 1.5 months to reach 10 months
- Proposed management actions estimate saving ~6 weeks from the process

Recommendation to revise KPI7 target for 2016

- Keep target of 10 months for 75% of submissions
- Use 8 months as stretch target - need more time to achieve this

KPI 10

Further information requested by Board

Request

1. Additional data on savings by product and forecast
2. Further explanation of reasons and impact of underperformance

Response Summary

- H1 2015 performance on KPI 10 is driven by timing of tenders and specific orders, as well as slightly lower demand than expected for ARVs
- **Based on new information since the H1 results were reported in July:**
 - **full year performance for 2015 is expected to improve to 7%**, driven by lower raw material costs for LLINs and faster-than-expected achievement of price targets for ARVs
 - New information from the recent tender on future LLIN prices indicates **2016 savings may reach 7%**
- Global Fund compares favorably to international reference prices (additional analysis in Annex 2)
- **Recommendation to revise proposed KPI10 target for 2016:**
 - From: 4% reduced spend on equivalent commodities at equivalent quality and volume
 - To: 7% reduced spend on equivalent commodities at equivalent quality and volume

KPI 11

Further information requested by Board

Request

Request for year to date reporting by quarter

Response Summary

- Forecast year-end result will be presented with year-to-date result going forward
- Q3 Update:
 - F3 2015 forecast grant expenses were approximately equal to 2015 budget
 - However, **83% of year-to-date budget was committed as grant expenses** as of September
 - These shifts in grant expenses from original budget are resulting from delays in grant signing, as well as low absorption levels

KPI 12

Further information requested by Board

Request

1. Report on investments in key populations, gender and human rights activities
 - a) Preliminary report to SIIC (*March 2016*)
 - b) Full report to the Board (*April 2016*)
2. Note on plans for system development to allow real time investment tracking

Response Summary

- The Secretariat is working to enhance capabilities for tracking investments in key populations, gender, and human rights
- Under current funding model, grant budgets and performance frameworks include relevant information organized under modules, interventions, cost groupings and inputs
- A framework approach is under development to organize the available data to enhance existing capabilities to track the investments in the respective areas and enable regular routine reporting
- It is important to note that data provision on the impact of investments in these areas is still highly dependent on the readiness of country and implementer level systems
- Further, a review of the existing modules and interventions related to human rights will be undertaken and further enhancements to track progress in the human rights area will be pursued

2016 Targets for Approval

Corporate KPIs: 2016 Targets for approval

Corporate KPIs	2015 Q2 Performance	2016 Target
2 (g) Number of countries with validated population size estimates for key populations	37 countries to date have validated population size estimates for Female Sex Workers, Men who have Sex with Men, and where applicable, Injecting Drug Users	55 countries
4 Efficiency of Global Fund investment decisions	0.56 (15% improvement) to date in alignment between investment decisions and country "need"	0.52 (20% improvement over 2014-2016)
6 Alignment with national reporting systems	94% investments in countries where Global Fund support is reported on National Disease Strategy budgets to date	94% investments in countries where Global Fund support is reported on National Disease Strategy budgets to date
7 Access to funding	54% NFM grants to date took 10 months or less from submission to first disbursement	75% grants submitted in 2015-2016 take 10 months or less from submission to first disbursement
9 Effective operational risk management	1.9 Risk Rating based on grants updating QUART during calendar year	Within range 1.7 to 2.1 10% of 2013 baseline (1.9)
10 Value for money	4% reduced spend on equivalent commodities at equivalent quality and volume	7% reduced spend on equivalent commodities at equivalent quality and volume
11 Grant expenses forecast	1.0 (F2 2015 Grant Expense / Grant Expense Corporate Budget)	Within a range of 0.9 - 1.1
12 Human rights protection	30% human rights complaints resolved and identified through risk assessment tools to date	Year on year improvement with a 100% aspiration
14 Domestic financing for AIDS, TB & Malaria	93% of programs accessing funding are meeting minimum counterpart financing thresholds	90% programs meeting minimum counterpart financing thresholds
15 Efficiency of grant management operations	2.4% operating expenses as a percentage of grants under management (using F2 reforecast)	Below a maximum of 2.75%

PROPOSED DRAFT ELECTRONIC DECISION POINT

GF/B34/EDPO4: Approval of 2016 Targets for the 2014 – 2016 Corporate Key Performance Indicator Framework

1. The Board:
 - a) Acknowledges the Secretariat’s presentation of the mid-2015 performance assessments for the 2014-2016 Corporate Key Performance Indicator Framework, as set forth in GF/B34/08; and
 - b) Notes the Secretariat’s response to requests by the Board at its November 2015 meeting for additional analysis on certain indicators, including proposed management actions to improve performance, as set forth in GF/B34/ERO3 - Annex 1.

2. Accordingly, the Board:
 - a) Approves the 2016 performance targets presented in GF/B34/ERO3 - Annex 1; noting the revisions to the 2016 performance targets for KPI7 (Access to funding) and KPI 10 (Value for money); and
 - b) Directs the Secretariat to implement its proposed management actions, continue to identify lessons that can inform the next Corporate Key Performance Indicator Framework, and update the committees and the Board at their first meetings in 2016.

This decision does not have material budgetary implications.

KPI by KPI: Additional Detail Requested

KPI 3

KPI 3 Service delivery

HIV

Further information requested by Board

PMTCT

- Provide details on 10 countries with lagging results and include:
 - Percent of results from these 10 countries in relation to all PMTCT results
 - Percent under-performance by country
 - Reasons for under-performance including details of reporting and/or program issues and proposed action for course correction. If reporting issues, course of action is requested for improvement and change. If programmatic, is there a broader trend of under-performance in the countries.
- Include plans for improvement beyond the ITP work.

KPI 3 Service delivery

TB

Further information requested by Board

TB treatment

- Summary of the issues of attribution/contribution and/or programmatic performance as it relates to reporting on TB cases treatment according to DOTS. Include:
 - Attribution issue substantiated by data (provided by STOP TB). Provide date by which the attribution issue will be concluded and the systematic way forward on data reporting across all GF supported countries.
 - If programmatic performance issues, provide data from under-performing countries and provide description of issues faced. Provide details of proposed management actions including technical.

KPI 3 Service delivery

Malaria

Further information requested by Board

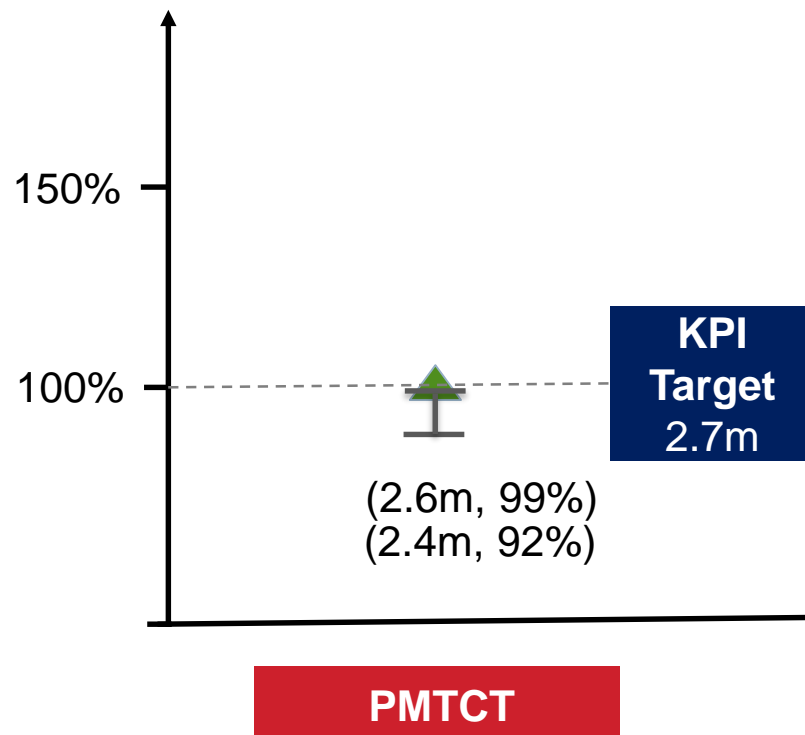
Board request

- Provide details on 10 countries with lagging results and include:
 - Percent of results from these 10 countries in relation to all LLIN results
 - Percent under-performance by country
 - Reasons for under-performance and if not related to delays (unplanned or planned) for net procurement, details of program issues and proposed action for course correction.

Section 1: PMTCT



1 PMTCT projected achievement ranges from 92%-99%



- 85% of projected 2015-16 shortfall in PMTCT services comes from 10 countries. Illustrative actions are listed from the ITP project to address performance.
- To date no systematic evidence of underreporting due to uptake of Option B+
- Concern that the target for one high burden country overestimates need, making current target unrealistic.
- Secretariat is working with partners to improve the quality of data and metrics. Improvements will be incorporated into the next update of partner reporting guidance

Notes: projection based on average of performance on indicator over 2012 to 2014, across all grants including the service, adjusted by country specific forecasts for countries contributing most to the 'gap' in each service.

2 PMTCT performance for top 20 countries – comprising 98% of target

	PMTCT target – national (2015-2016), thousands	Share of PMTCT target (2015-6)	Rating on PMTCT Indicator (2012-14)
Country a	255	15%	C Unacceptable
Country b	213	13%	B1 Adequate
Country c	179	11%	B2 Inadequate
Country d	172	10%	A2 Meeting expectations
Country e	146	9%	A2 Meeting expectations
Country f	134	8%	A2 Meeting expectations
Country g	134	8%	A2 Meeting expectations
Country h	71	4%	A2 Meeting expectations
Country i	63	4%	B1 Adequate
Country j	59	4%	B2 Inadequate
Country k	50	3%	B1 Adequate
Country l	32	2%	B1 Adequate
Country m	23	1%	B1 Adequate
Country n	22	1%	A2 Meeting expectations
Country o	21	1%	B1 Adequate
Country p	19	1%	A2 Meeting expectations
Country q	16	1%	C Unacceptable
Country r	14	1%	A2 Meeting expectations
Country s	10	1%	B1 Adequate
Country t	8	1%	B1 Adequate

Indicator Rating		No. of countries	Average Achievement (Result/Target) (%)
A1	Exceeding expectations	-	>100%
A2	Meeting expectations	8	90-100%
B1	Adequate	8	60-89%
B2	Inadequate but potential demonstrated	2	30-59%
C	Unacceptable	2	<30%

Note: unweighted average performance of country on specific indicator during period 2012-4. Global Fund Grant Indicator rating bands applied to PMTCT indicator only. Percentages capped at 100%

3 Relevant Actions from ITP

Samples from Accountability Framework

Country Target	Associated Actions to Address Bottlenecks with Partners
42% scale-up of HIV testing from 372,139 in Dec 2016 to 530,196 by Dec 2017 (reaching 55% coverage of all pregnant women) and ARV coverage from 38% in Dec 2014 to 65% by Dec 2017	Develop detailed operational plan for PMTCT scale-up, including for EID and transition to option B+. TA to be requested during partnership December visit
	Establish operational committee to follow ongoing implementation of PMTCT scale-up
84,251 HIV positive pregnant women receive ARVs to reduce risk of MTCT by 2017	Work with National Lab TWG, WHO CO, NACA, NASCP and USG (PEPFAR/CDC/DOD) to improve the mapping and document public lab network and referral system (to VCT, PMTCT and ART centers) to improve early infant diagnosis
Reduce the number of new youth and adult infections by 70% and the number of new pediatric HIV infections by 95% by 2020	Operational Support for patient monitoring system, building on existing system for PMTCT

4 Findings and way forward

Drawing on analysis with Country Teams

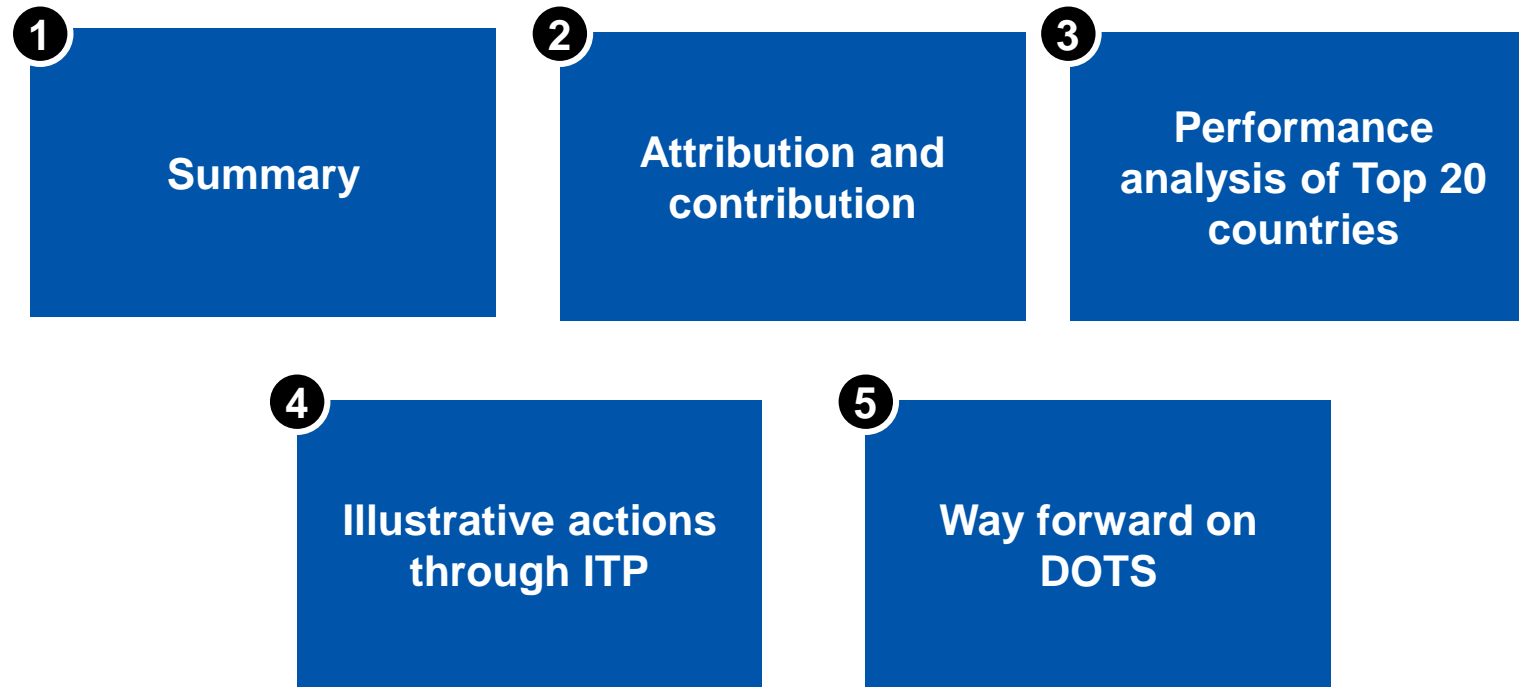
Quality of PMTCT need estimates

- One high burden country accounts for 15% of the total PMTCT target – its national target for PMTCT for 2015/2016 - **254,994**
- Concerns that need may be overestimated in country, making targets impossible to achieve
- Revision of estimated number of women eligible for PMTCT – resulting in potential revision of targets

Under-reporting

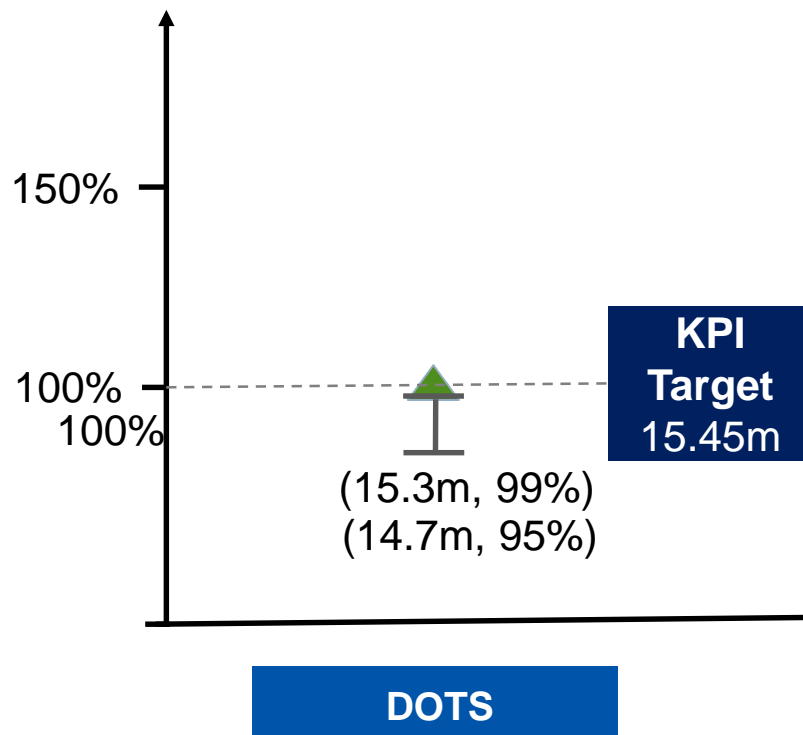
- Limited evidence to date of increased underreporting with the uptake of Option B+, where HIV positive pregnant women are prescribed ART for life - several large countries currently transitioning to B+ so monitoring important

Section 2: TB



1 National results expected to reach **22.6 million** cases for 2014-6

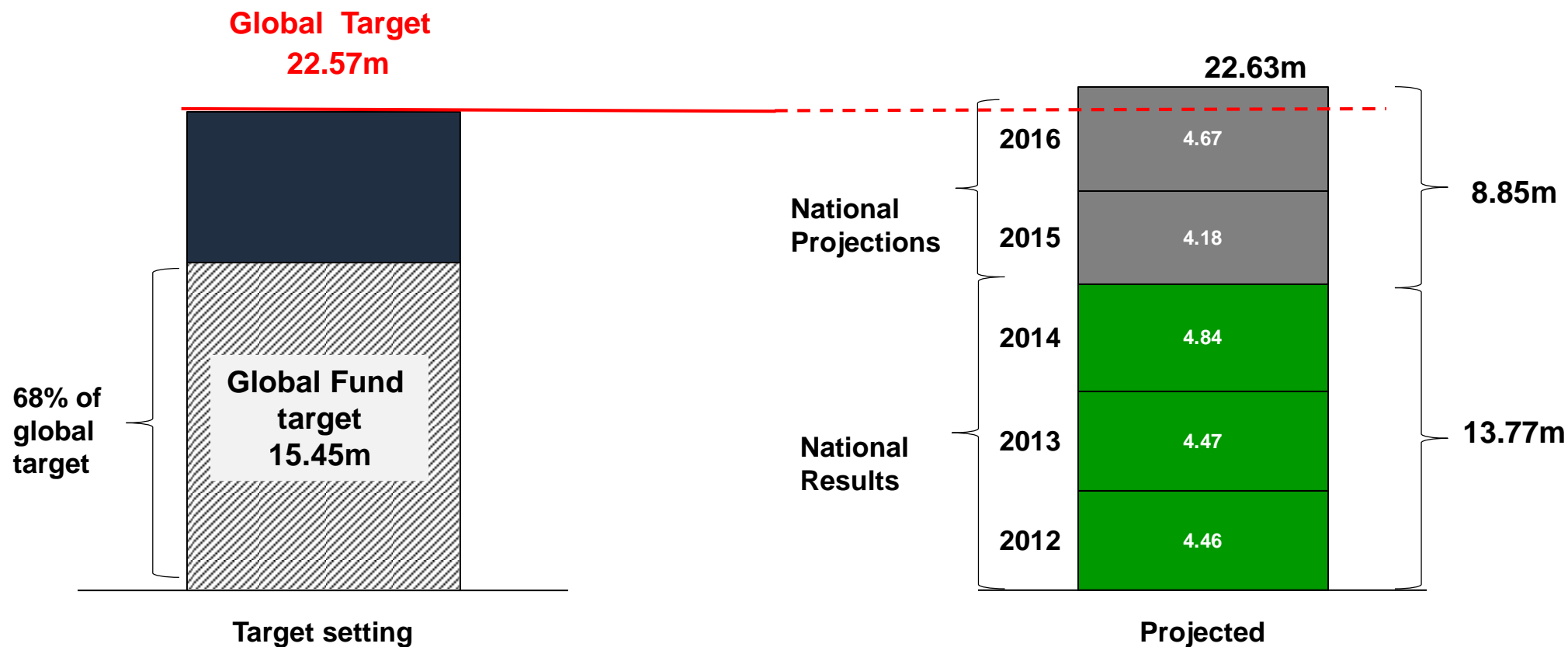
Global Fund projected achievement ranges from 95%-99%



- Initial projections based on non-finalized performance frameworks, have been updated with finalized grant targets
- Comparing national targets with national achievement in Global Fund-eligible countries, supported programs are well on route to achieving anticipated targets
- Global Fund results are projected to reach 95% of strategy target by end 2016, factoring in performance
- Performance on DOTS 2012-14 among Top 20 countries for DOTS treatment exceeds B1 levels

Notes: projection based on average of performance on indicator over 2012 to 2014, across all grants in country. Projection includes some results not available in GF systems in July 2015.

1 National DOTS targets are being met and may be overachieved

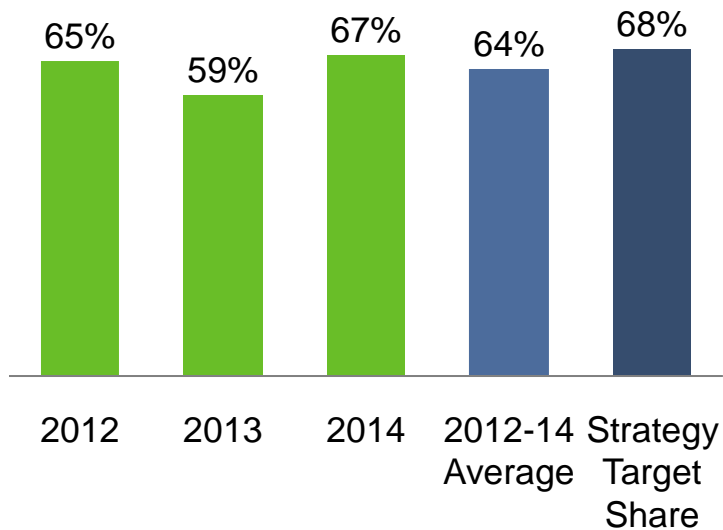


Global Fund DOTS target set based on 68% share of Global Plan targets for 2012-6

Projected National Results imply overachievement of Global Fund share of targets

2 Inconsistency in attribution to Global Fund

Global Fund Share of TB results, eligible countries



Share of national results attributed to Global Fund varies from year to year

Factors contributing to fluctuation in Global Fund share

- Global Fund reporting cycle not aligned to all countries – may result in corrective increases or decreases for results to account for lagging results
- Country may change from reporting national results to sub-national results or vice versa
- Indicators in performance frameworks (esp. pre NFM) may not be clear, resulting in adjustments to results once clarified

3 Performance of Top 20 DOTS countries all at least B1

20 Countries accounting for ~90% of Global TB Targets

	DOTS target -- national (2015-2016), million	Share of DOTS target (2015-2016)	Rating on DOTS Indicator (2012-14)
Country a	2.7	27%	A2 Meeting expectations
Country b	1.0	10%	A2 Meeting expectations
Country c	0.7	7%	A2 Meeting expectations
Country d	0.7	7%	A2 Meeting expectations
Country e	0.5	6%	B1 Adequate
Country f	0.4	4%	B1 Adequate
Country g	0.4	4%	A2 Meeting expectations
Country h	0.3	4%	A2 Meeting expectations
Country i	0.3	3%	B1 Adequate
Country j	0.3	3%	B1 Adequate
Country k	0.2	2%	A2 Meeting expectations
Country l	0.2	2%	A2 Meeting expectations
Country m	0.2	2%	B1 Adequate
Country n	0.1	1%	A2 Meeting expectations
Country o	0.1	1%	A2 Meeting expectations
Country p	0.1	1%	A2 Meeting expectations
Country q	0.1	1%	B1 Adequate
Country r	0.1	1%	A2 Meeting expectations
Country s	0.1	1%	B1 Adequate
Country t	0.1	1%	B1 Adequate

Indicator Rating		No. of countries	Average Achievement (Result/Target) (%)
A1	Exceeding expectations	-	>100%
A2	Meet expectations	12	90-100%
B1	Adequate	8	60-89%
B2	Inadequate but potential demonstrated	0	30-59%
C	Unacceptable	0	<30%

Note: unweighted average performance of country on specific indicator during period 2012-4. Global Fund Grant Indicator rating bands applied to DOTS indicator only. Percentages capped at 100%

4 Relevant Actions to further enhance treatment coverage from ITP

Samples from Accountability Framework

Country Target	Associated Actions to Address Bottlenecks with Partners
Scale up TB coverage from 90 to 213 districts by 2018	Address bottlenecks with procurement and secure additional funding for ambitious scale up of active case finding in all 213 districts in response to TB prevalence survey results (to be coordinated through TB Situation Room)
33% increase in TB case notification (all forms) from 58,261 in December 2014 to 77,685 by Dec 2017	<p>Short and long term: TB program implementation support at central and provincial levels (to be coordinated with TB situation room)</p> <p>Technical assistance for prevalence survey implementation</p>

5 Findings and way forward

Short term actions

- Need to strengthen categorization of indicators within performance framework to improve attribution to Global Fund
- Strengthen the process of review and supervision of target setting within performance framework to ensure targets correctly entered, and aligned with overall strategy targets

Longer term actions

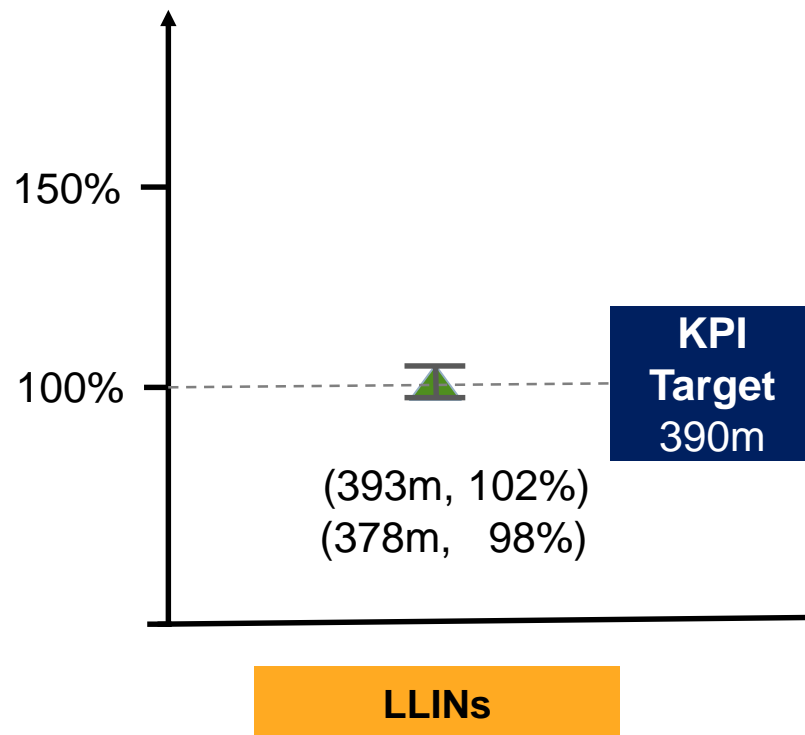
- Efforts are underway with partners and implementers to improve consistency of how tuberculosis treatment is attributed to Global Fund resources
- Global Fund will move to a consistent contributive model for the Strategy 2017 to 2021/22 period

Section 3: Malaria



1 LLIN distribution forecast to be at 98% - 102% of target

Projections for Sub-Saharan Africa target of 390 million LLINs



- Initial projections based on non-finalized performance frameworks; revisions adjust the total number of nets in grant targets
- December 2015 projection based on average of performance on LLIN distribution (2012 -2014), across all grants including the service, adjusted by country specific forecasts for countries contributing most to the 'gap' in each service
- Implementation is supported by ITP Project
- External factors that could delay large campaigns being actively monitored by CTs

2 Recent performance of Top 20 LLIN Countries covering >95% of target

	LLIN distribution target – national (2015-2016), million	Share of LLINs target (2015-2016)	Rating on LLIN distribution Indicator (2012-14)
Country a	34.5	16%	B1 Adequate
Country b	32.7	16%	A2 Meeting expectations
Country c	29.1	14%	B1 Adequate
Country d	16.9	8%	B2 Inadequate
Country e	12.7	6%	B2 Inadequate
Country f	10.7	5%	B1 Adequate
Country g	10.1	5%	B1 Adequate
Country h	9.1	4%	B1 Adequate
Country i	8.6	4%	A2 Meeting expectations
Country j	8.2	4%	B2 Inadequate
Country k	8	3%	B1 Adequate
Country l	4.7	2%	B2 Inadequate
Country m	4.0	2%	B1 Adequate
Country n	3.4	2%	A2 Meeting expectations
Country o	2.9	1%	C Unacceptable
Country p	2.7	1%	A2 Meeting expectations
Country q	2.3	1%	B1 Adequate
Country r	2.1	1%	A2 Meeting expectations
Country s	1.7	1%	A2 Meeting expectations
Country t	1.6	1%	A2 Meeting expectations

Indicator Rating		No. of countries	Average Achievement (Result/Target) (%)
A1	Exceeding expectations	-	>100%
A2	Meet expectations	7	90-100%
B1	Adequate	8	60-89%
B2	Inadequate but potential demonstrated	4	30-59%
C	Unacceptable	1	<30%

3 Relevant Actions from ITP

Samples from Accountability Framework

Country Target	Associated Actions to Address Bottlenecks with Partners
LLIN universal campaign to distribute ~7M LLINs in 2016	Accelerate LLIN mass campaign planning to 1) support technical assistance needs identified through the process and 2) contingency plan depending on delivery dates of bed-nets
First national LLIN universal campaign to distribute 15.7m nets between Q3 2016 to Q4 2017	Strengthen entomological capacity at MOH to implement new vector control strategy (including LLIN distribution) with immediate technical support to increase training in medium term
LLIN mass campaign to reach universal coverage (80%) for 33.4 million people and key populations.	Embed long-term advisors for technical support and capacity building into NMCP

4 Findings and way forward

Drawing on analysis with Country Teams

Continuous distribution

- Historical challenges to performance – weak supply chain/systems for health
- Ambitious targets through ANC/EPI distributions result in performance gaps due to constraints to accessing these services → investments in supply mechanisms being given greater priority
- Investments being made in stronger and innovative BCC to improve service uptake

Mass campaigns

- Suboptimal quantification:
 - First campaign quantifications mostly based on population projections resulting in over/under-quantification; affected strategy and performance
 - Majority of countries now with experience and validated population figures to accurately quantify
- Campaigns extend beyond performance period in some countries

External factors

- Political instability and insecurity in excess of levels foreseen
- Countries may not meet grant conditions (e.g incentive funding conditional on matching funding)

KPI 5

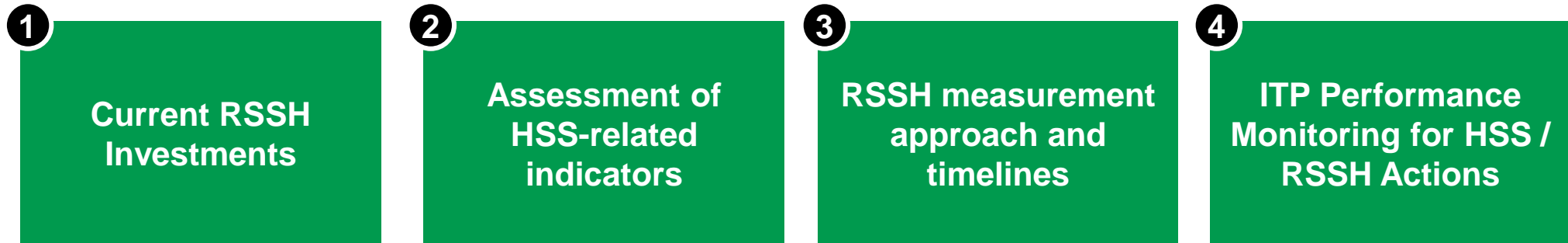
KPI 5

Further information requested by Board

Further information requested

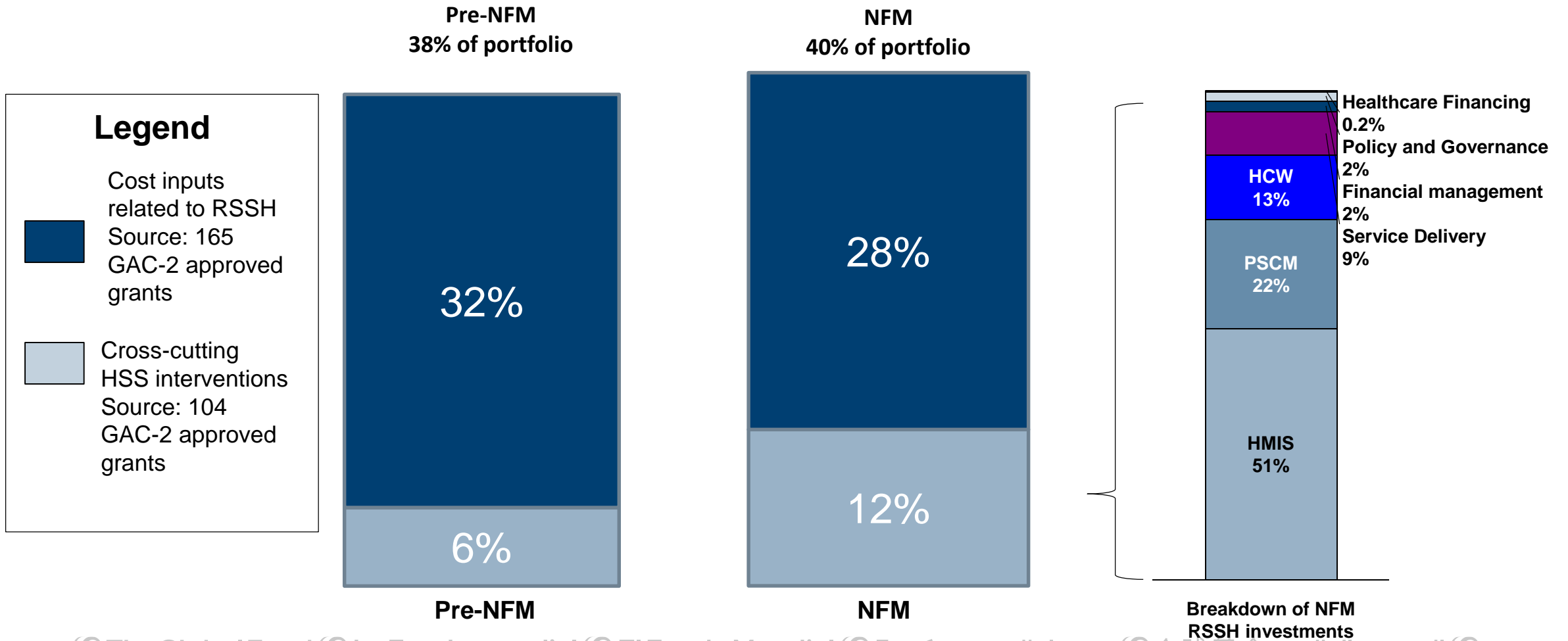
1. Provide data on key HSS programmatic areas supported by the GF and proportionality to the whole of the HSS budget or expenditures.
2. Provide options for indicators directly related to the core HSS programmatic areas that could be utilized for the remaining period of the current strategy.
3. Provide options for sampling in a spectrum of countries across the three diseases.
4. Create a standard portfolio for performance monitoring that could potential be used in the ITP process.

HSS



1 RSSH investments increased to 40% under NFM

Cross-cutting interventions have doubled under NFM



2 Assessment of HSS-related indicators in CAT tool

19 High Impact Countries

	M&E		PSCM		Financial Management		Governance & Project Management	
	At or above the performance benchmark (75%)	Below the Performance benchmark (75%)	At or above the performance benchmark (75%)	Below the Performance benchmark (75%)	At or above the Performance Benchmark (75%)	Below the Performance benchmark (75%)	At or above the Performance Benchmark (75%)	Below the Performance benchmark (75%)
CT Verified results	37.5%	62.5%	37.5%	62.5%	57.14%	42.86%	81.25%	18.75%

New tool introduced in NFM, provides baseline for tracking progress in future

Note: based on 42 PRs in 19 high impact countries. Analysis focused on Government PRs in those countries where they were available. Where the Government PRs were not available, non-government PRs were randomly selected. In case of multiple PRs per country, data was averaged. The overall performance of each country is the average score of all the Principal Recipients per component of the Health System considered, out of the total attainable score of 100%. The benchmark of performance is 75% which corresponds to the rating of “Minor Issues” by the Country Team. Performance below this benchmark is considered underperformance for the country in the corresponding HSS components.

3 RSSH measurement approach and reporting timelines

HSS Indicators

- Impact and Outcome Indicators are measured in 3-5 year intervals. Output/Coverage indicators reported annually or bi-annually.
- Secretariat intends to measure performance of HSS output/coverage indicators, for priority health system components.
- Implementation of most NFM grants started in 2015 - the first programmatic reports are expected throughout 2016.
- First measurement of HSS indicators will be done by end of 2016.

Illustrative list of RSSH indicators that can be tracked

HMIS/M&E

% of HMIS or other routine reporting units submitting timely reports according to national guidelines

PSCM

% of health facilities reporting no stock outs of essential drugs

Financing

Government expenditure on health as percentage of general government expenditure

Health and Community Workforce

Number of health workers per 10,000 population



Additionally, at the end of the funding cycle, a subset of countries will be selected based on agreed set of criteria, where in-depth evaluation will be carried out, by applying a newly developed HSS evaluation tool, which has been designed to be used in conjunction with national disease program reviews

3

ITP Performance Monitoring for HSS /RSSH Actions – Beyond KPI 5

10 indicators identified for HSS, monitoring associated actions and partnership support

Analysis with Partners & Countries



Identified HSS Indicator (as at December 2015)

- SD: # & distribution of health facilities per 10,000 population
- SD: # of outpatients visits per 10,000 population
- HCW: # of health workers per 10,000 population
- HCW: Distribution of health workers
- HCW: # of health workers newly recruited at primary health care facilities in the past 12 months, expressed as a percentage of planned recruitment target
- HCW: Annual rate of retention of service providers at primary health care facilities
- PSM: % of health facilities reporting no stock-outs of essential drugs
- ME: % of HMIS or other routine reporting units submitting timely reports according to national guidelines
- ME: % of deaths registered
- HCF: Government expenditure on health as a percentage of general government expenditure

KPI 7

Strategic Goals & Targets	Strategic Objective 1 Invest more strategically	Strategic Objective 2 Evolve the funding model	Strategic Objective 3 Actively support grant implementation success	Strategic Objective 4 Promote and protect human rights	Strategic Objective 5 Sustain the gains, mobilize resources	Strategic Enablers Enhance partnerships & Improve operations
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KPI 7 Access to Funding

Measure

Time from final Concept Note submission to first disbursement

Board approved KPI definition includes the following clause: Special dispensation will be given to grants where first disbursement is delayed to align with parliamentary approval processes, national cycles, or for legal requirements

Performance

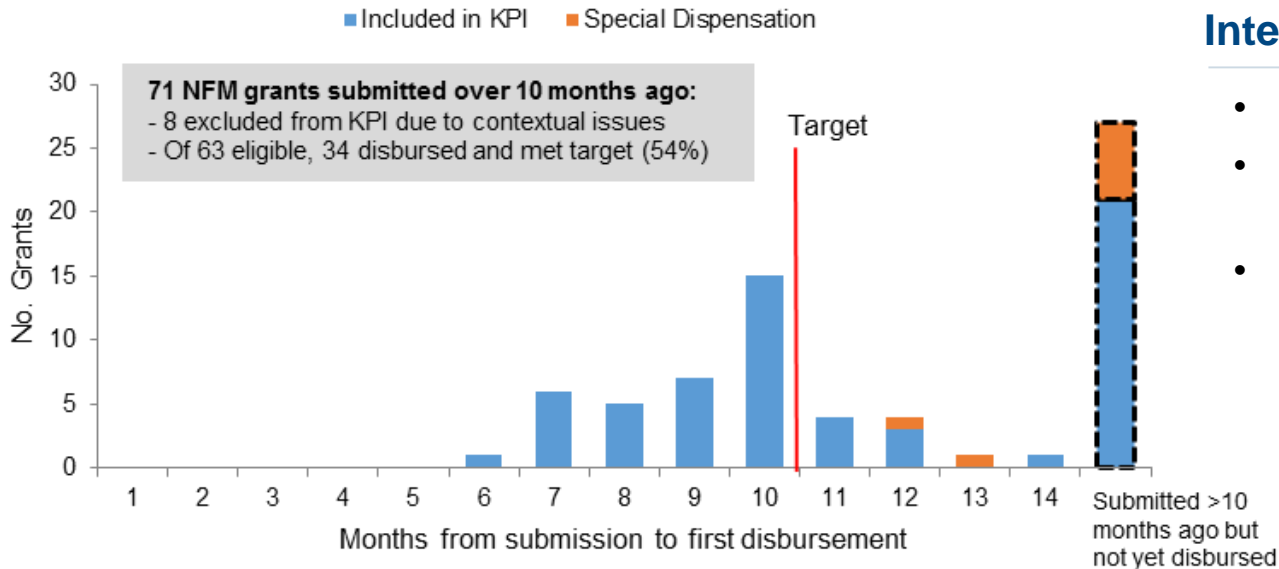
2015 – 2016 Target:

- For grants submitted in 2014, 75% take 10 months or less
- For grants submitted in 2015-2016, 75% take 8 months or less

2015 Q2 result: 54% NFM to date

Interpretation

- At Q2 2015, 63 grants became eligible for KPI assessment
- 34 of them had a first disbursement within the 10 month target (54%)
- Achieving the 10 month target for 2014 submissions looks increasingly challenging, and the 8 month target for 2015 submissions unlikely



Strategic Goals & Targets

Strategic Objective 1
Invest more strategically

Strategic Objective 2
Evolve the funding model

Strategic Objective 3
Actively support grant implementation success

Strategic Objective 4
Promote and protect human rights

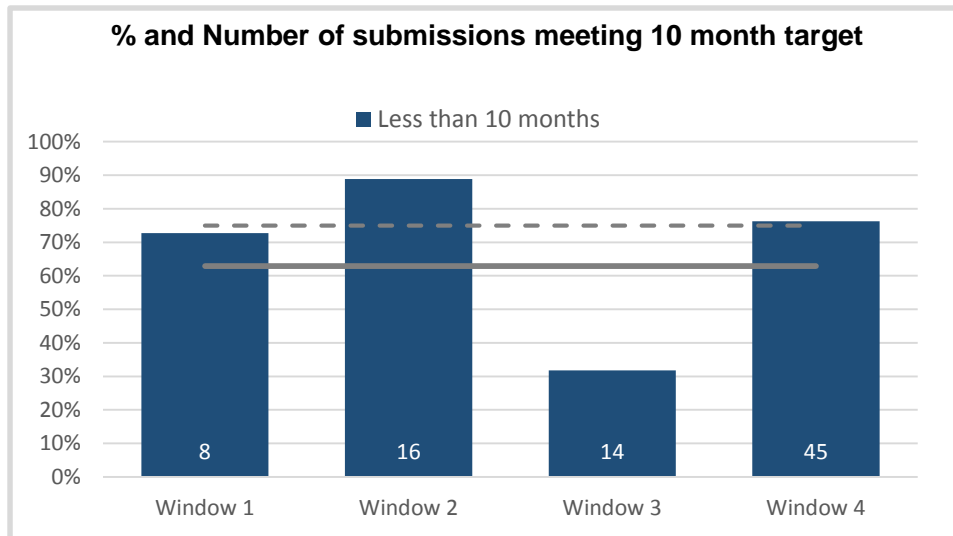
Strategic Objective 5
Sustain the gains, mobilize resources

Strategic Enablers
Enhance partnerships & Improve operations

KPI 7

Access to Funding

2015 Q3 Performance Update



Additional input

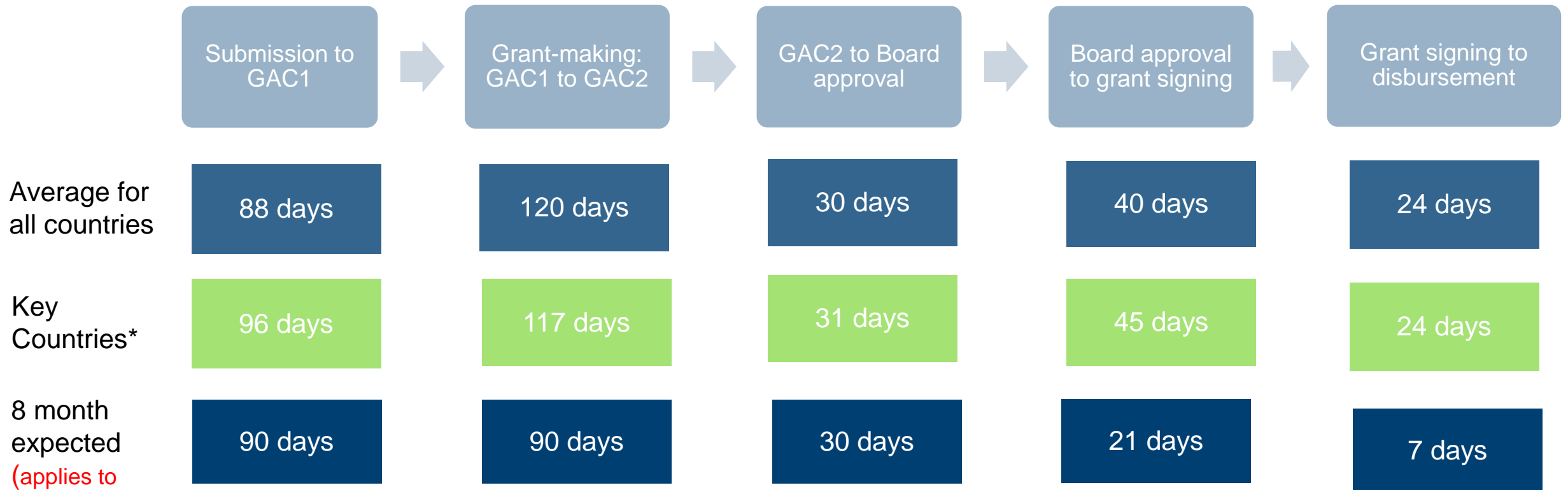
- Performance improved to 63% including Q3 data
- **10 month target has not been met for 2014 submissions**
- Poor performance in Window 3 was the main factor in missing the 10 month target
- Submissions to date would need to lose ~3.5 months to reach an 8 month target, or 1.5 months to reach 10 months
- **Management actions estimate saving 6-8 weeks from the process, but a limited share of the portfolio is expected to see the full 8 week gain**
- Grant extensions have been implemented to avoid service disruptions

Management actions

- Implement already-identified improvements to data, processes and systems by end 2015
- Differentiate approaches to sign-off for small and low risk grants
- The Implementation Through Partnership project will focus partner engagement to accelerate grant making & to improve targeted technical assistance
- Project AIM is undertaking a review of grant-making processes, identifying pain points and potential solutions

Overall status windows 1-4:

- Average time of submission to disbursement is 9.9 months or 10.2 for key countries; **wide extremes** in length of funding cycle
- Below analysis shows certain stages to focus on (no breakdown available for 10 month target)



Note: A country is classified as a key country if it falls in any one of the following categories: High Impact countries, ITP countries, top 20 countries by funding (including allocation + incentive funding)

Submission to GAC1

Findings:

- Clarifications, screening of eligibility requirements 1+2 and translations take ~45 days
- TRP review, GAC review and the development of the review and recommendation form take between 30-45 days, depending on the complexity of the issues.

Management actions:

- Continue to improve and streamline TRP review process: differentiated (simplified) review approach already agreed for sub-set of applications
- Continue quicker turn-around of review and recommendation forms to enable grant-making to start earlier

Grant-making: GAC1 to GAC2

Findings:

- Low capacity within countries has played a key role in extending the duration of grant-making
- Challenges with new tools, templates, systems and processes caused delays
- Other causes include: changing circumstances in-country, identifying new Principal Recipients after concept note submission, and lengthy corporate negotiations (for example, policy indicates 7% overhead; some PRs were trying to negotiate for 8+)

Management actions:

- Dashboard now created for Grant Management Directorate for monthly monitoring
- Incremental enhancements to fix bugs and make grant-making tools more user-friendly
- The Implementation through Partnership project will focus partner engagement to accelerate grant-making & to improve targeted technical assistance
- Project AIM is undertaking a review of grant-making processes; identifying pain points and potential solutions

GAC2 to Board approval

Findings:

- Watch out: the longer Board electronic voting period now under discussion will make this harder to achieve in the future

Management actions:

- Differentiate approaches to GAC sign-off for small and low risk grants
- Explore electronic sign-off for GAC2 fast-track grants

Board approval to grant signing

Findings:

- Country signing processes also take time and cause delays

Management action:

- Communicate expected Board approval date in advance to country teams to facilitate scheduling grant signing

Grant signing to disbursement

Findings:

- Lack of clarity in new grant creation and first disbursement processes + technical challenges in creating disbursements in the online systems led to delays
- Annual funding decisions (ADMF) was not prioritized when there was existing cash balance in-country

Management actions:

- Guidance has been developed on grant creation and disbursement under a new grant
- Country teams to systematically process ADMF immediately following grant signing (even if there is cash in-country)

Implications of KPI7 Performance

No impact on programs: there are no anticipated or perceived disruptions or gaps in interventions

- Country teams try to anticipate delays in grant-making by processing **grant extensions** (with additional funding or not) to ensure no program disruption
- Where ADMFs were not processed immediately, there were **sufficient cash in-country** and disbursements were not needed urgently

Recommendation

- Submissions to date would need to lose ~3.5 months to reach an 8 month target, or 1.5 months to reach 10 months
- Proposed management actions estimate saving ~6 weeks from the process

Recommendation to revise KPI7 target for 2016

- Keep target of 10 months for 75% of submissions
- Use 8 months as stretch target - need more time to achieve this

KPI 10

Additional analysis on *KPI 10: Value for Money* is provided in Annex 2

KPI 11

Strategic Goals & Targets

Strategic Objective 1
Invest more strategically

Strategic Objective 2
Evolve the funding model

Strategic Objective 3
Actively support grant implementation success

Strategic Objective 4
Promote and protect human rights

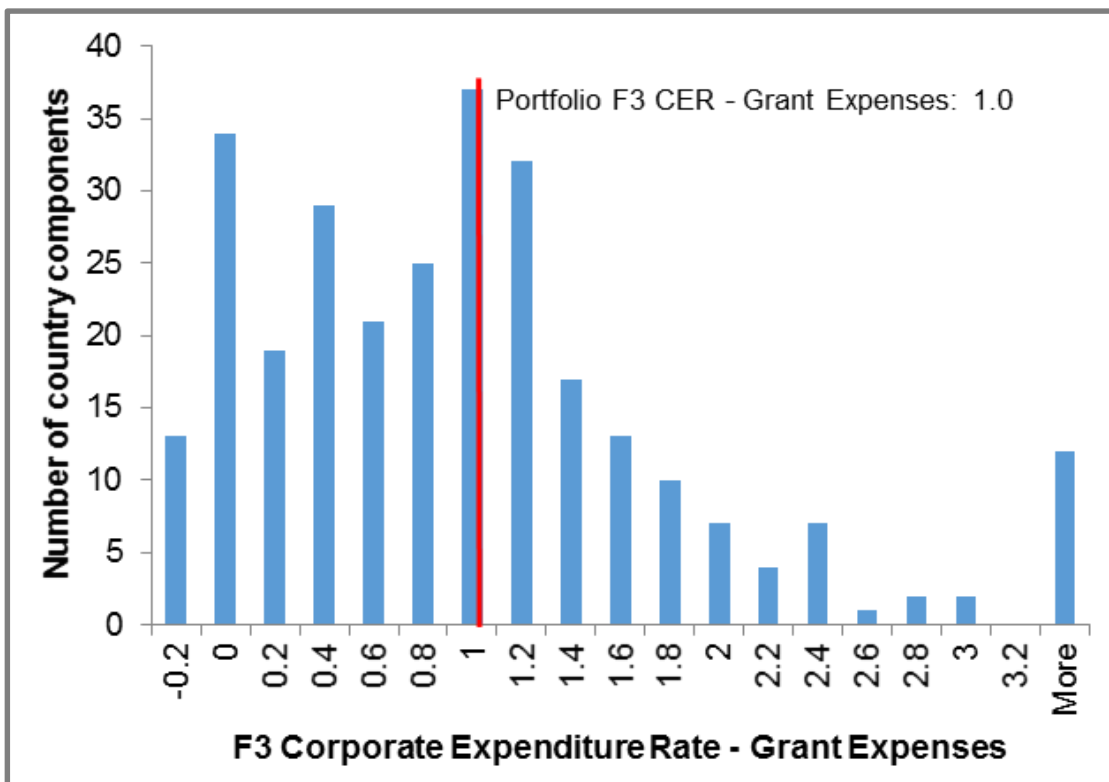
Strategic Objective 5
Sustain the gains, mobilize resources

Strategic Enablers
Enhance partnerships & Improve operations

KPI 11 Grant expenses forecast

Measure

Corporate Expenditure Rate (CER): Proportion of forecast grant expenses made to schedule



Performance

2015 Target: 0.9 - 1.1

Forecast to 2015 year end: 1.0 (USD 4.1bn / 3.9bn)

(F3 2015 Grant Expense / Grant Expense Corporate Budget)

Year to date Q3: 0.83 (USD 3.1bn / 3.7bn)

2016 Target: 0.9 - 1.1

- Total F3 2015 forecast grant expenses are approximately equal to 2015 budget
- However, 83% of year-to-date budget was committed as of September
 - In total, 80% of 2015 total budget was committed as of September
- These shifts in grant expenses from original budget are resulting from delays in grant signing, as well as low absorption levels

Annex 2: Response to Board questions on KPI 10: Value for Money

Board agreed target: Reduce spend by 8% per year for equivalent commodities at equivalent quality and volume

Questions:

- Following a 2014 performance of 9%, 2015 performance has thus far dropped to 4%. We need to understand:
 - The numbers and trends underlying this drop (disaggregated along categories)
 - The forecasted outcome for the full year (disaggregated along categories)
 - The reasons behind underperformance in this KPI
- If the delays in grant signing are not having a negative impact on the ground, then why are delays in procurement driving a halving of savings?
- Against the background of the negotiated Long-Term Agreements for commodities and the prospective bulge in spending for 2016 and 2017, how can a delay in purchasing in 2015 have such a dramatic impact?
- Was this target overestimated? How did this happen?
- Why is the Secretariat proposing to halve the target for 2016, particularly in the area of medical commodities?
- Why were negotiated prices not reduced further? And how does the Global Fund performance compare with appropriate benchmarks in the market? To the extent possible, please provide performance against relevant benchmarks (disaggregated along categories)

Response:

Performance on KPI 10 driven largely by tender timing

Since 2013, the Procurement for Impact (P4I) initiative has already achieved substantial savings on health commodities, reflected in the global price reductions made available to the Global Fund's Principal Recipients (PRs). This includes both PRs that participate in the Pooled Procurement Mechanism (PPM) and some countries that procure directly through national systems or PSAs, either with their own funds or Global Fund financing (e.g., Georgia, PAHO). These lower prices are expected to persist through 2016 and beyond.

Figure 1 displays by category the percent of PPM spend in the first half of 2015 and savings achieved in 2014 and the first half of 2015. Savings are displayed in terms of absolute value and as a percent of spend. Per the methodology for KPI 10, 2014 and H1 2015 savings were calculated based on unit costs from the prior year. H1 2015 savings are also shown if compared to 2013 base prices.

Figure 1: PPM savings (in USD millions) and percent savings on comparable products¹

Category	2014 vs. 2013		2015 H1 vs. 2013		2015 H1 vs. 2014	
	\$	%	\$	%	\$	%
ACTs	5.3	14.3%	3.3	7.4%	-0.4	-0.9%
CPM ACTs ²	26.2	23.9%	19.0	7.6%	2.7	5.2%
ARVs	6.9	2.2%	18.6	7.2%	13.6	5.3%
LLINs	1.5	1.3%	3.8	3.1%	-2.2	-1.8%
HIV Dx	0.1	0.4%	0.0	-0.1%	0.0	-0.2%
Malaria Dx	1.5	11.7%	4.6	29.3%	3.0	21.4%
Other ³	11.8	28.6%	2.5	7.6%	6.9	10.3%
Total	53.2	8.1%	51.7	9.3%	23.7	4.2%

¹ Includes only spend on products that are comparable between years. For example, if a specific product was purchased in only one year, it would not be included.

² Includes ACTs financed through the private sector co-payment mechanism. Savings calculated based on Global Fund share of co-paid ACTs, not entire price.

³ Includes condoms, lab supplies, and non-core drugs (such as those for opportunistic infections).

The key driver of performance on KPI 10 is the timing of Global Fund tenders compared to the timing used to calculate the KPI. For the largest PPM categories (ACTs and co-paid ACTs, ARVs and LLINs), prices are negotiated through two- or three-year framework agreements with manufacturers. Meanwhile, KPI 10 calculates savings on an annual basis. This means that only savings compared to the prior year are counted. Targets were set to expect the same savings every year, even though not all categories are re-negotiated every year. Savings results are cyclical and will align with the timing of tenders. Savings for a given product will also decrease over time.

For the largest categories, which represent more than 90% of spend through the PPM, this timing plays out as below:

ACTs and co-paid ACTs:

- Current framework agreements were implemented in 2014. Figure 1 highlights substantial savings on ACTs and co-paid ACTs in 2014, reflecting these prices.
- 2015 prices are set by the same framework agreements and are essentially the same as in 2014. Therefore, no additional savings are reflected in 2015 KPI performance.

LLINs:

- Similar to ACTs, LLIN framework agreements were implemented in 2014 and set prices for two years. Therefore, savings would be expected in 2014, but not in 2015.
- Prices for LLINs appear to have increased slightly in the first half of 2015. This is largely due to the timing of this analysis. Individual suppliers still have different prices for the same product. If volumes in the beginning of the year are allocated to a higher-priced supplier (for example, due to country registration or lead time requirements), it can look like the price has increased. Annual savings are forecast based on a weighted average of expected allocations over a full year.
- As discussed below, it is anticipated that the weighted average price for LLINs in 2015 will actually be slightly lower than in 2014, resulting in additional savings

ARVs:

- A global tender was implemented in early 2015 and as expected, Figure 1 shows that this is the only major category with substantial USD savings in the first half of 2015.
- The ARV framework agreements also include price roadmaps, which generate additional savings through volume discounts and manufacturer production efficiencies enabled by longer-term contracting.
- Savings from ARVs were slightly lower than expected in 2015 because country demand was also below forecast. However, some additional price reductions were achieved ahead of schedule. Therefore, although demand has been only about 90% of forecast, savings are likely to reach over 95% of projection by year-end.

Other categories:

- There was also a tender for viral load diagnostics completed in June 2015. While this is a smaller category, some savings are expected in the second half of 2015 and 2016. Given the lengthy technology selection process for viral load diagnostics, savings are expected to materialize later.
- Other HIV diagnostics, malaria diagnostics, and other products were not under active management in 2015. These categories continue to be competed through spot tenders on an as-needed basis. Savings in these categories are difficult to predict.

Savings forecast for remainder of 2015 expected to improve

Figure 2 illustrates forecast savings for the rest of 2015. As noted above, additional savings are expected for ARVs. The Secretariat anticipates that stable prices will continue for ACTs.

A reduction in the overall price of LLINs is expected for the full year due to decreasing costs of raw materials, which are reflected through a contractual price adjustment mechanism in the Global Fund's framework agreements.

These factors will allow the Secretariat to come close to achieving the eight percent savings target in 2015, despite the timing mismatch and lower demand for ARVs described above.

Figure 2: Forecast savings for the full year 2015 (in USD millions)

Category	H1 2015 Actual Savings	2015 Total Forecast Savings	2015 Total Forecast % Savings ⁴
ACTs	(0.4)	0.0	0.0%
CPM ACTs ⁵	2.7	2.7	3.2%
ARVs	13.6	35.0	9.9%
LLINs	(2.2)	16.0	6.0%
HIV Dx	0.0	0.0	0.0%
Malaria Dx	3.0	3.0	21.4%
Other ⁶	6.9	9.0	10.2%
Total	23.7	65.7	7.0%

New information allows potential increase in 2016 KPI 10 target

A meaningful savings target for 2016 will consider the framework agreements currently in place and which prices are likely to change during the year. Expectations for the largest PPM categories are discussed below.

Since the KPI targets were originally proposed, new information on future LLIN prices has become available based on manufacturer proposals received in late November for the Global Fund's current LLIN tender. Based on this new information, the Secretariat has revised its savings estimate for 2016 and anticipates savings between 6 and 8 percent of PPM spend. This translates into approximately \$40 to \$55 million. Given that targets have not yet been approved, the Secretariat would propose a revised 7% savings target for 2016.

- **ACTs and co-paid ACTs:** The current framework agreement and prices for ACTs will remain in place throughout 2016, with a new tender expected at the end of the year.
- **LLINs:** The Secretariat is in the midst of re-tendering for LLINs and new framework agreements are anticipated in January. While LLINs are a mature product, pricing has been competitive and further savings are expected.
- **ARVs:** Current framework agreements will remain in place throughout 2015. Price roadmaps should generate additional savings through volume discounts and production efficiencies.
- **Viral load diagnostics:** While savings are expected from the 2015 viral load tender, this category is small in terms of total spend. Savings may be significant for the product, but they are unlikely to drive large impact on overall PPM spend.
- **Other categories:** Likewise, the Secretariat is exploring bringing additional categories under management (such as rapid diagnostic tests), but the remaining categories are relatively small. Further, prices for some products are already quite low (such as malaria RDTs, which are roughly \$0.20 per test). These prices have already decreased over the last two years through spot tenders. Some additional savings may result, but are unlikely to be significant compared to results from LLINs and ARVs.

In addition, some cost savings are anticipated in 2016 from reduced transactional fees. The e-marketplace will also continue to extend the benefits of the Global Fund's framework agreements

⁴ Total spend for 2015 is estimated based on YTD actuals for ARVs and LLINs, and an average of 2013 and 2014 spend for the remaining categories.

⁵ Includes ACTs financed through the private sector co-payment mechanism. Savings calculated based on Global Fund share of co-paid ACTs, not entire price.

⁶ Includes condoms, lab supplies, and non-core drugs (such as those for opportunistic infections).

beyond PPM participants. However, because the existing KPI 10 focuses on PPM spend, it will not capture these savings.

Multi-year framework agreements enable lower prices and more secure supply

The longer-term commitments offered by the Global Fund help manufacturers to plan production and lower their cost base. This ultimately lowers prices and improves affordability, as well as improving the availability of key health products (as evidenced by the improvements in on-time delivery among manufacturers). Framework agreements may include price roadmaps (as noted for ARVs above), which do further reduce prices over time. In addition, all agreements include a “most favoured nation” clause, which requires that any improved pricing offered to other public sector buyers be made available to the Global Fund.

Global Fund compares favourably to international benchmarks

Global Fund prices also compare favourably to other benchmarks. The table below provides indicative pricing for the highest volume products in each major PPM category during the first half of 2015. In all cases, the Global Fund is within international benchmark ranges.

Figure 3: Global Fund reference prices compared to international benchmarks

Category	Product	Global Fund weighted average PPM price, H1 2015	International benchmarks ⁷
LLINs	All LLINs ⁸	\$3.04	\$2.02 - \$5.13
ACTs	A/L 20/120mg FDC, 6x4, Hospital	\$0.93	\$0.63 - \$1.11 ⁹
	A/L 20/120mg FDC, 6x3, Hospital	\$0.73	
	AL 20/120mg FDC, 6x2, Hospital	\$0.52	
CPM ACTs	A/L 20/120mg FDC, 6x4, Individual	\$1.09	
	A/L 20/120mg FDC, 6x2, Individual	\$0.64	
	A/L 20/120mg Disp, 6x2, Individual	\$0.70	
ARVs	TDF/3TC/EFV 300/300/600mg, 30 tabs	\$8.99	\$9.00 - \$11.16
	AZT/3TC/NVP 300/150/200mg, 60 tabs	\$8.30	\$8.11 - \$8.32
	AZT/3TC 300/150mg, 60 tabs	\$6.54	\$6.48 - \$7.04
	AZT/3TC/NVP 60/30/50mg disp, 60 tabs	\$3.60	\$3.50 - \$3.63
	TDF/3TC 300/300mg, 30 tabs	\$4.62	\$4.32 - \$4.78

⁷ ACT reference prices are from a sample of PMI country operational plan budgets for FY 2016. LLIN reference prices are from UNICEF (as of April 2015) and a sample of PMI country operational plan budgets for FY 2016. ARV reference prices are from the CHAI ARV Market Report, published in November 2015. The range of reference prices from 6 buyers is provided, including CHAI, SCMS / PEPFAR, MSF, WHO GPRM, South Africa, and Kenya. Specific details of reference prices can be found in the original CHAI report.

⁸ For UNICEF and Global Fund, does not include PBO or conical LLINs. Unclear whether these are included for PMI.

⁹ PMI operational plans do not always specify which ACT, dosage or pack size are planned for purchase. Where ACTs other than A/L are specified, these were excluded. Highest and lowest values removed.