

40th Board Meeting

Report of the Executive Director

GF/B40/04

14-15 November 2018, Geneva

Board Information

Introduction and Overview

Dear Board Members, Colleagues, Friends,

It is a privilege to be presenting you with my first Report of the Executive Director, setting out our achievements over the last twelve months, sharing some perspectives on the challenges we face, and outlining our priorities for the year ahead.

I will be eight months into this role when we meet for the November Board Meeting. I want to take this opportunity to say how excited I am to be doing this job, and how appreciative I am to the numerous people in the Board, Secretariat and across our many partners, who have made me welcome and helped me climb a steep learning curve. When I accepted the appointment as Executive Director, I knew I was joining a very special organization, a partnership like no other in its breadth and diversity, a mission-driven ecosystem that has delivered extraordinary results. Yet having now seen it from the inside, I am even more impressed – by the people, by the passion, and by the determination to achieve our common goals. Yes, we face huge challenges, and of course there are many things we can and must do much better. But any analysis must start from the fact that the Global Fund partnership works incredibly well: we are saving millions of lives; we are making progress towards ending the epidemics of AIDS, tuberculosis and malaria; and we are helping countries and communities advance towards universal health coverage and the Sustainable Development Goal of *Good Health and Well-being*, known as SDG 3. We should not let the scale of the challenges before us blind us to what has been achieved, but nor should we let our successes make us complacent. We will not achieve the SDG 3 target of ending the epidemics of AIDS, TB and malaria by simply continuing along the current path. We need more resources, more innovation and better execution. Attaining our objectives will require renewed energy and determination from the Board, the Secretariat, and all our partners.

Given the breadth and complexity of our activities, and the multitude and range of the issues the Global Fund faces, any Executive Director's Report of readable length can only focus on certain priority themes, and will inevitably skate over other important matters, so I apologize in advance for not covering everything. I have structured this Report in five parts:

1. The State of the Fight. The ultimate test of what we do is the progress we are making against the three diseases. Yet given current data limitations, we can only talk with confidence about the results achieved with our partners in 2017, rather than what we have achieved in 2018. So the numbers displayed in our 2018 Results Report should be seen as a starting point, not as a measure of our performance during the year. Even so, the picture these numbers paint is crucial to understanding where we have been doing well, what we must do differently, and how our priorities must evolve for the year ahead.

2. Scaling up and Stepping up. The Global Fund's *Strategy 2017-2022* sets out what we must do to accelerate progress in ending the epidemics. In this section I take stock of how we have executed against these strategic priorities during 2018, including in both our core activities of grant-making and delivery, our strategic priorities in specific areas such as human

rights, gender, supply chain and resilient and sustainable systems for health (RSSH), and in the implementation of critical policies such as Sustainability, Transition and Co-Financing (STC) and Challenging Operating Environments (COEs). This section therefore draws on and complements the report on *Strategic Performance Reporting* (also known as the KPI report), separately presented to the Board.

3. Transforming for Efficiency and Effectiveness. To achieve our goal of ending the epidemics, despite constrained resources, we must constantly challenge ourselves to become more efficient and effective, to ensure we maximize value for money. This is a clear imperative for the Secretariat, but also holds true for the Global Fund partnership as a whole, and for how we operate within the broader global health architecture. In this section I take stock of progress we have made within the Secretariat, including the move to the Global Health Campus (GHC), changes in leadership (including my arrival) and advances in organization, systems and processes. I also review initiatives to improve the partnership as whole, such as CCM Evolution, and to strengthen our partnerships, such as deepening the relationship with Gavi, the Vaccine Alliance and our role in developing the SDG 3 *Global Action Plan*.

4. 2019 and the Path Forward. In this section I set out our priorities for 2019, both to ensure we deliver maximum impact in the 2017-2019 grant cycle, and to set up the 2020-2022 grant cycle for optimal success. The year 2022 will be a milestone year for the Global Fund in a number of respects: the 20th anniversary of the creation of the Global Fund, the final year of the 2017-2022 strategy, and the beginning of the final stretch towards the SDG milestone of 2030. Put bluntly, if we are off track in 2022, we are highly unlikely to achieve our 2030 goals. My remarks in this section build on and provide context to the separate papers on *Resource Mobilization & Replenishment* and *2019 Operating Expenses Budget*.

5. Conclusions and Reflections. Finally, I provide some personal perspectives, reflecting on my first several months as Executive Director.

1. The State of the Fight

In my introductory letter to the 2018 Results Report I highlighted the tension between recognizing the extraordinary progress that has been achieved in the fight against AIDS, tuberculosis and malaria, and acknowledging the daunting challenges we still face in ending the epidemics.

The numbers set out in the 2018 Results Report show what has been achieved by national programs, with support from the Global Fund, PEPFAR, PMI and many community and civil society partners. They do not focus on specific results attributable to Global Fund interventions. This is deliberate: while of course we must monitor the performance of the individual programs we finance, we do not want to get stuck in fruitless debates about attribution, and ultimately we are focused on the overall progress countries are making toward ending the epidemics of AIDS, TB and malaria, and thus in delivering SDG 3.

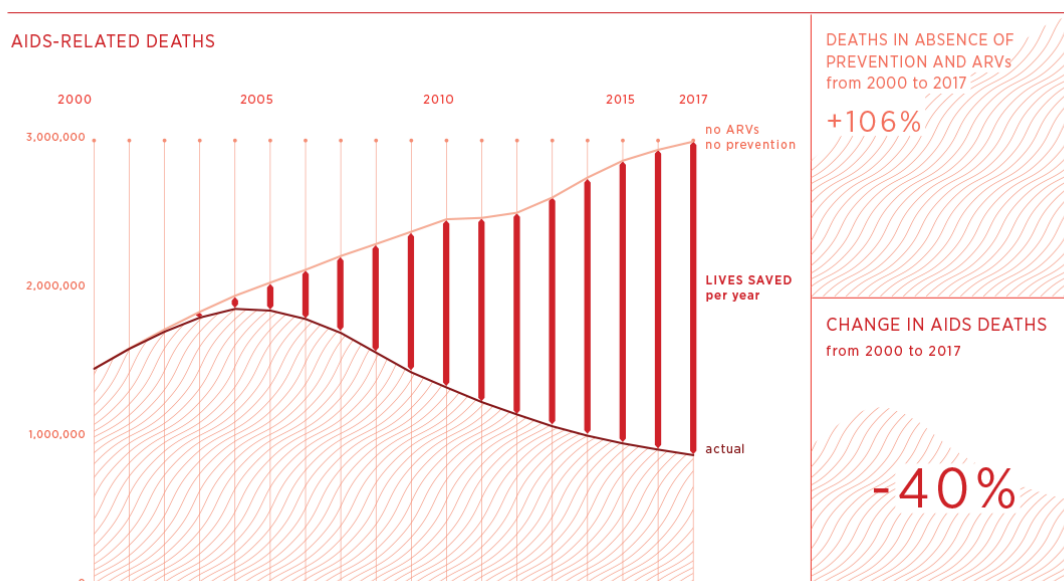


Figure 1: Trends in AIDS-Related Deaths in Global Fund-Supported Countries

The graph in Figure 1 shows that in countries where the Global Fund invests, deaths from AIDS have been cut in half since the peak in 2005, and by 40 percent since 2000. Together, PEPFAR, the Global Fund, other development partners and the governments of affected countries have saved huge numbers of lives. But the absolute number of people dying each year is still far too high, and we can and must do more to bring it down.

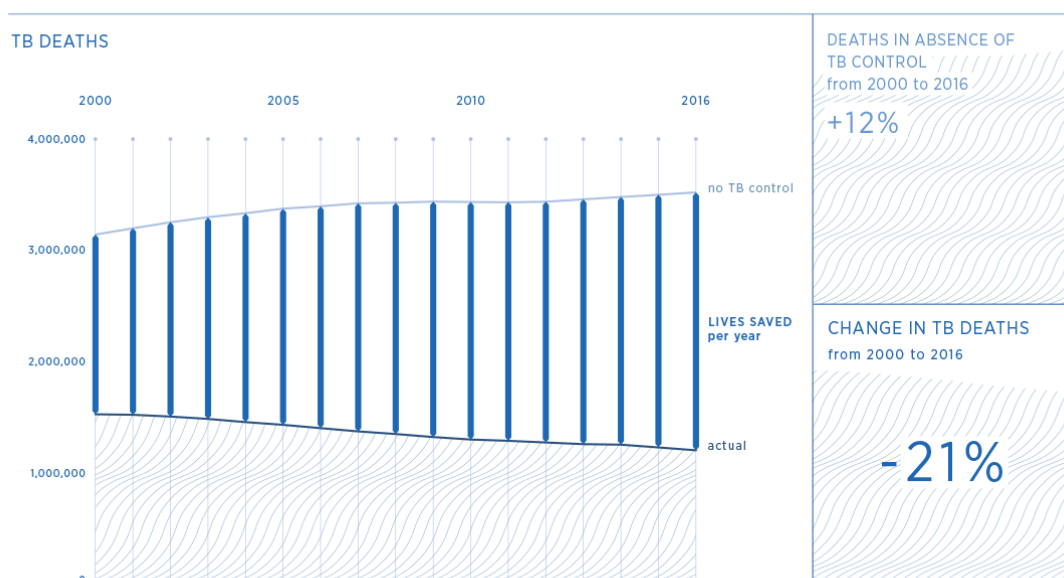


Figure 2: Trends in TB Deaths in Global Fund-Supported Countries

In Figure 2, the equivalent graph on TB shows deaths have been cut by 21 percent since 2000 in countries where the Global Fund invests. But far too many people are still dying, and the number is falling far too slowly – as a result, TB is now the biggest killer among infectious diseases. As I have said elsewhere, with TB we don't just need to bend the curve a bit more, we need to break it. If we are to have any hope of ending the epidemic by 2030, we need a discontinuity.

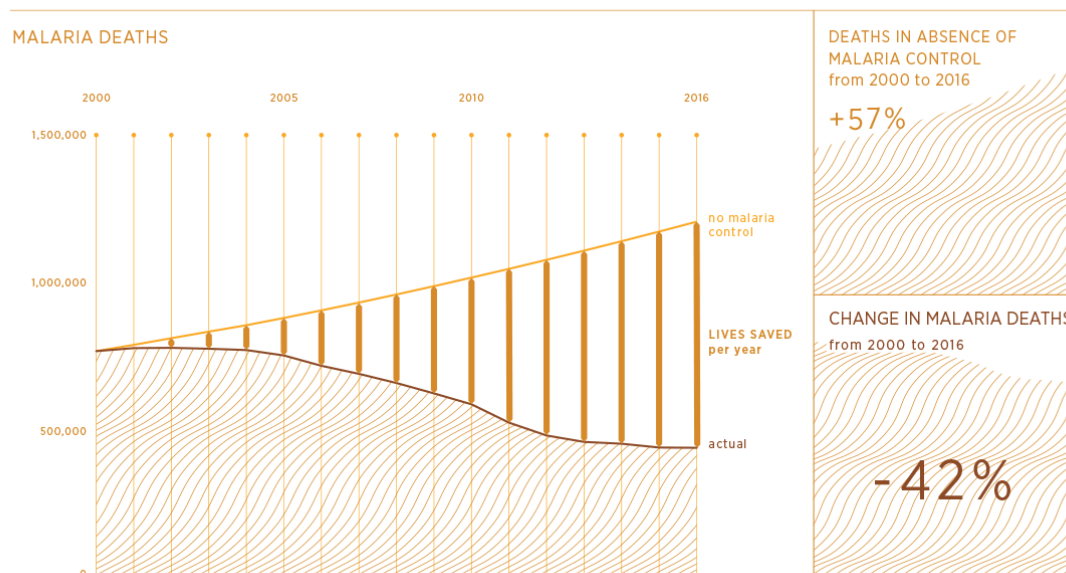


Figure 3: Trends in Malaria Deaths in Global Fund-Supported Countries

Figure 3 shows how more effective vector control plus better case identification and management have cut malaria deaths by 42 percent since 2000, a massive achievement, particularly as the majority of lives saved were children under the age of five. However, the flattening of the curve in recent years is a wake-up call. Unless we redouble our efforts in the highest burden countries, we risk a resurgence.

Achieving these outcomes required a massive scale-up of interventions across all three diseases. As we set out in the 2018 Results Report, in countries where the Global Fund is active, 17.5 million HIV-positive people received antiretroviral therapy in 2017, in large part due to support from PEPFAR and the Global Fund, while nearly 700,000 mothers received treatment to prevent the transmission of HIV to their babies. Five million people were treated for TB, including over 100,000 afflicted with drug-resistant forms of the disease. In the fight against malaria, 197 million bed nets were distributed and 108 million cases of malaria were treated. All these figures reflect full national results, reflecting our collaboration with governments and other external partners.

Everyone involved in the multitude of partnerships that comprise and complement the Global Fund should be proud that together we have supported programs that contributed to saving over 27 million lives while simultaneously building more resilient and sustainable systems of health, and working to dismantle human rights and gender barriers to health. Yet the simple

fact is that too many people are still dying of AIDS, TB and malaria; and far too many are still getting infected. The loss of lives, the impact on families and communities, the cost to economies and societies are still unacceptably high.

Across all three diseases, there are further opportunities to save more of those infected from dying, including through faster diagnosis, better case management, quicker adoption of superior treatment regimens, more holistic treatment of people with co-morbidities and more intensive treatment of severe cases. Across all three diseases, there is a continuing need to tackle inequalities in access to quality health care which all too often are powerful drivers of mortality.

Furthermore, our goal is not just to save lives, but to end the epidemics – and by doing so to save countless future lives. And the more we put the focus on ending the epidemics, the more we have to go beyond saving the lives of people infected today, to preventing new infections. Here we still have far to go.

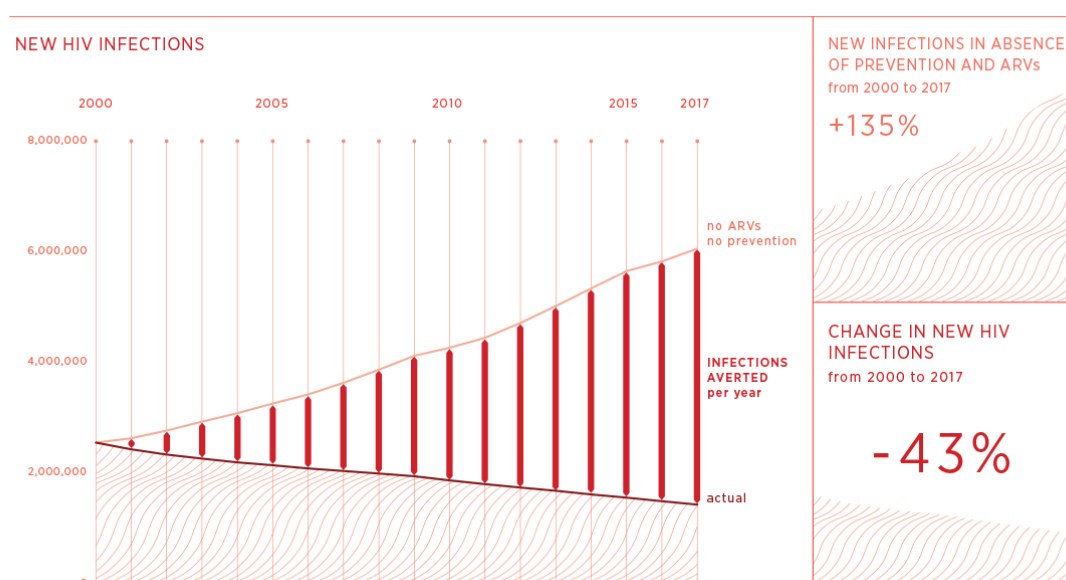


Figure 4: Trends in HIV Infections in Global Fund-Supported Countries

Although it is a tremendous achievement to have reduced the number of infections by 43 percent since 2000, the number of people newly acquiring HIV every year, at just under 2 million, is still far too high. Of particular concern are high rates of infection among adolescent girls and young women in East and Southern Africa, and among key populations in all regions. While we have made significant progress in improving the treatment cascade, with several countries on track to reach or exceed UNAIDS' 90-90-90 targets by 2020, this alone is not enough. Unless we can reinforce primary prevention to protect the most vulnerable, we will not end the epidemic. Finding sufficient resources to deploy into prevention programming, while continuing to sustain and scale-up antiretroviral treatment, represents a significant challenge.

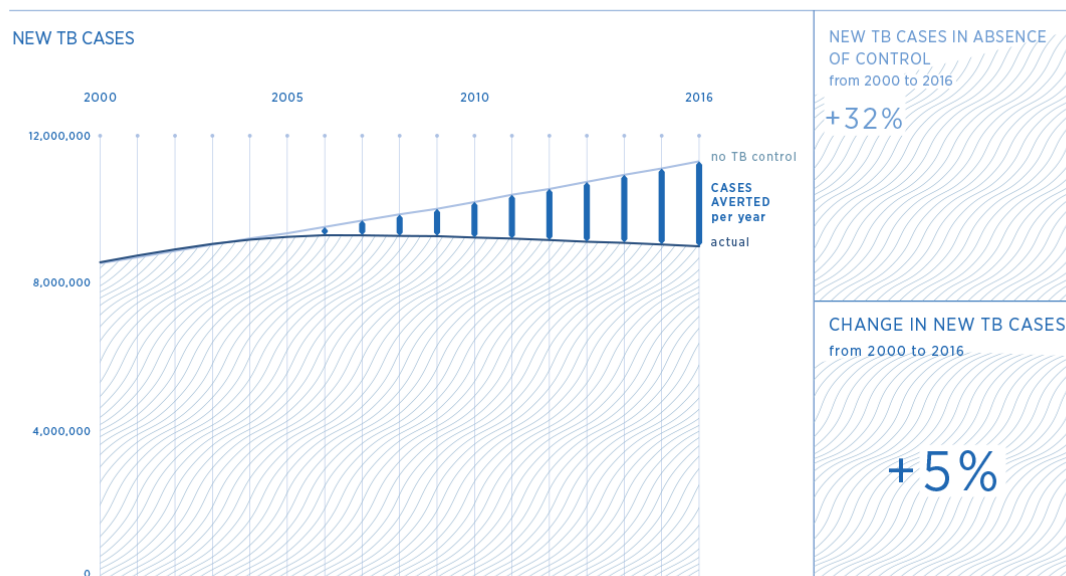


Figure 5: Trends in TB Infections in Global Fund-Supported Countries

On TB, the priority is to ensure many more people are diagnosed and treated. WHO's 2018 Global TB Report asserts that 36 percent of the 10 million people falling ill with TB each year are left undiagnosed and untreated. You don't have to be an epidemiologist to work out that if that many people remain untreated and infectious, we won't beat the epidemic. We need to make rapid progress in closing that gap: the 130,000 increase in people treated between 2016 and 2017 is not nearly enough.

Furthermore, we must dramatically raise our game in identifying and treating drug-resistant TB, arguably one of the most potent threats to global health security. Of the estimated 558,000 cases of drug-resistant TB in 2017, only 25 percent were diagnosed and treated.

Underlying the relative lack of progress on TB has been a fundamental weakness in political commitment. The UN High Level Meeting on TB in September was a great start, but far more has to be done to mobilize political support and ensure sustained commitment to getting the job done.

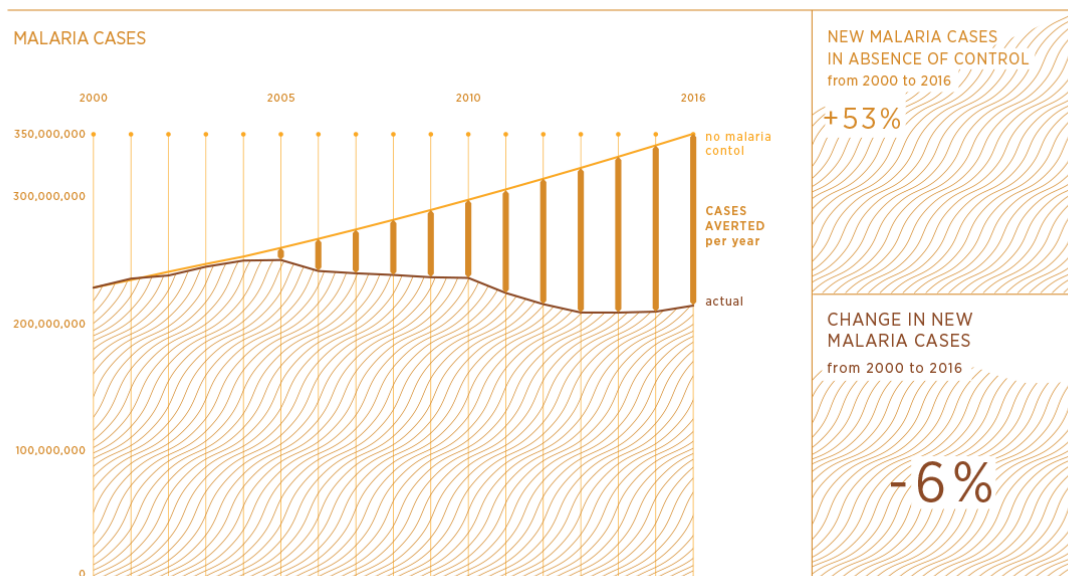


Figure 6: Trends in Malaria Infections in Global Fund-Supported Countries

On malaria, there is good news and bad news. The good news is that a significant number of countries are on track to achieve elimination. Paraguay celebrated elimination in June 2018, as Sri Lanka did in 2016, and a number of other countries, including China, Algeria, Costa Rica and Argentina are likely to emulate this achievement over the next few years.

The bad news is that in the highest burden countries, mainly in Africa – despite progress in reducing the numbers of deaths from malaria – we are not seeing any real reduction in infections. In fact, in 2017 we saw increases in malaria cases in a number of high burden countries, including Rwanda, Nigeria and Democratic Republic of Congo. Underscoring the imperative for greater, and more effective, investment in the highest burden countries is the threat of increasing vector and drug resistance.

Looking across all three diseases, we should not let the enormity of the task ahead diminish what has been accomplished, but nor should we let our past successes blind us to the serious challenges we must overcome. The 2015 investment case for the last Replenishment had the title *The Right Side of the Tipping Point for AIDS, Tuberculosis and Malaria*. I think that is accurate. But it is a delicately poised tipping point. If we mobilize more resources, leverage innovations more effectively, and raise our game in collaboration and execution, we can accelerate progress toward ending the epidemics. But if resource commitments diminish, we lose our relentless focus on outcomes, or we fail to respond effectively to new threats such as increasing drug and vector resistance, we will go backward.

As I have said before, we have in our sights, but not yet firmly in our grasp, the prospect of freeing individuals, their families and entire communities from the burden of HIV, TB and malaria by 2030. Making this happen this would be an extraordinary achievement. But we are not going to succeed by simply continuing as we have done so far. Ending the epidemics will

require us to scale-up – in prevention, in diagnosis and in treatment – and to step-up – in innovation, in execution and in collaboration.

2. Scaling up and Stepping up

The focus of Global Fund efforts during 2018 reflects both where we are in the current grant cycle, and the state of the fight across the three diseases.

Approving and Disbursing Grants under the 2017-2019 Allocation

In *Strategic Performance Reporting*, separately presented to the Board, we note that 219 funding requests have resulted in 239 grants being approved under the current allocation, amounting to \$9.6 billion, or 89 percent of the total for this cycle. From this total, \$4.1 billion has already been committed as grant expenses and \$1.6 billion has already been disbursed. Figure 7 shows the breakdown of the current cycle of grants by Technical Review Panel (TRP) window, and by disease component.

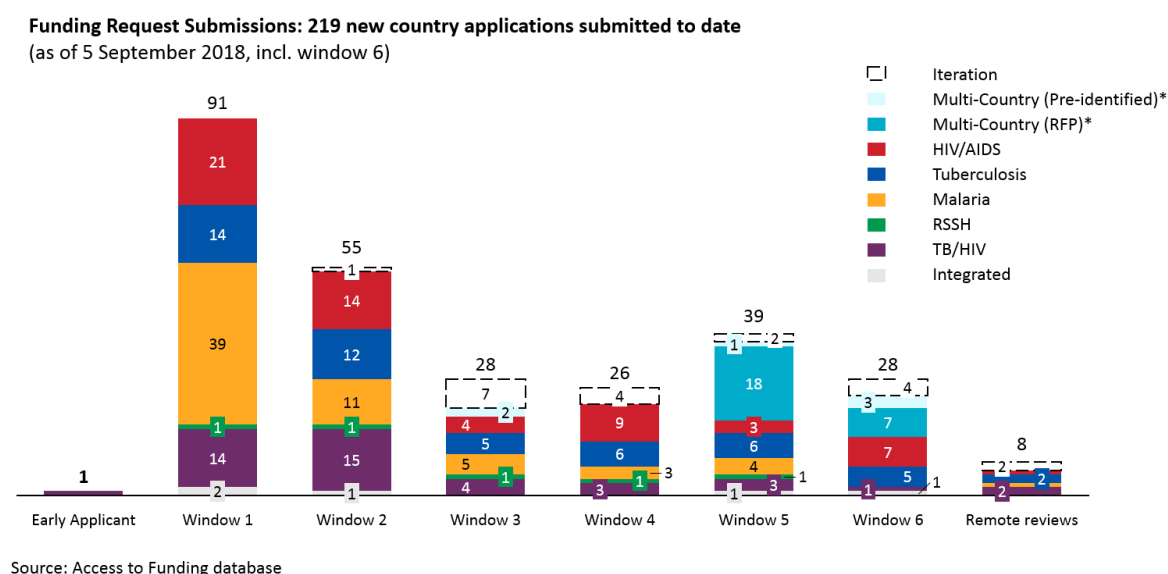
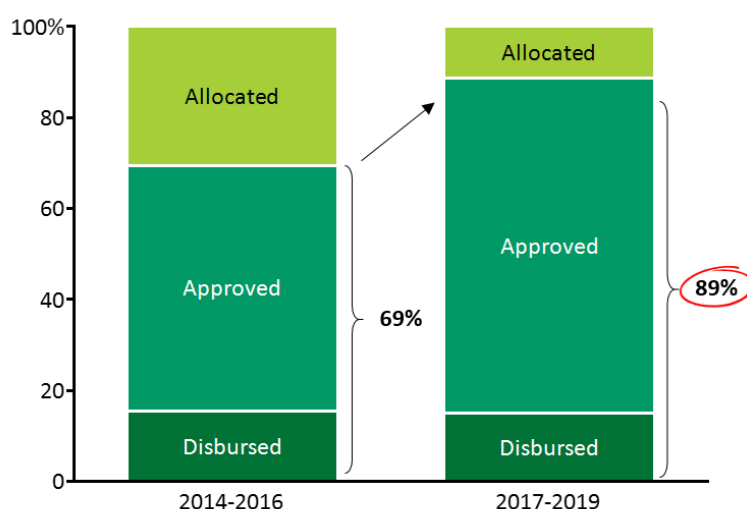


Figure 7: Funding Request Submissions in the 2017-2019 Cycle

This accelerated pace of grant approval and disbursement reflects the benefits of our efforts to streamline the process, as Figure 8 illustrates. This has also enabled us to reduce the share of programs requiring extensions from more than 50 percent in the previous cycle to only 4 percent. Obviously, speed is not the only priority. What matters even more are the quality of the grants. We have also seen a significant improvement in the technical quality of funding requests, as evidenced by the reduction in iterations required by TRP from 23 percent in the 2014-2016 cycle to 10 percent in 2017-2019.

Acceleration of grant approval across allocations (US\$ Billion, status after 630 days)



Source: GF financial system

Figure 8: Acceleration of the Grant Approval Process

The Secretariat and our partners work hard to see that the funds we deploy are effectively utilised. Overall, 75 percent of grant budgets in the Global Fund portfolio have been spent from 2015 through 2017, representing a strong improvement over the 66 percent measured from 2014 through 2016. Through initiatives such as Impact Through Partnership, we continue to tackle barriers to absorption. Figures 9 and 10 demonstrate the gains made in absorption rates across disease component, portfolio and geographic region.

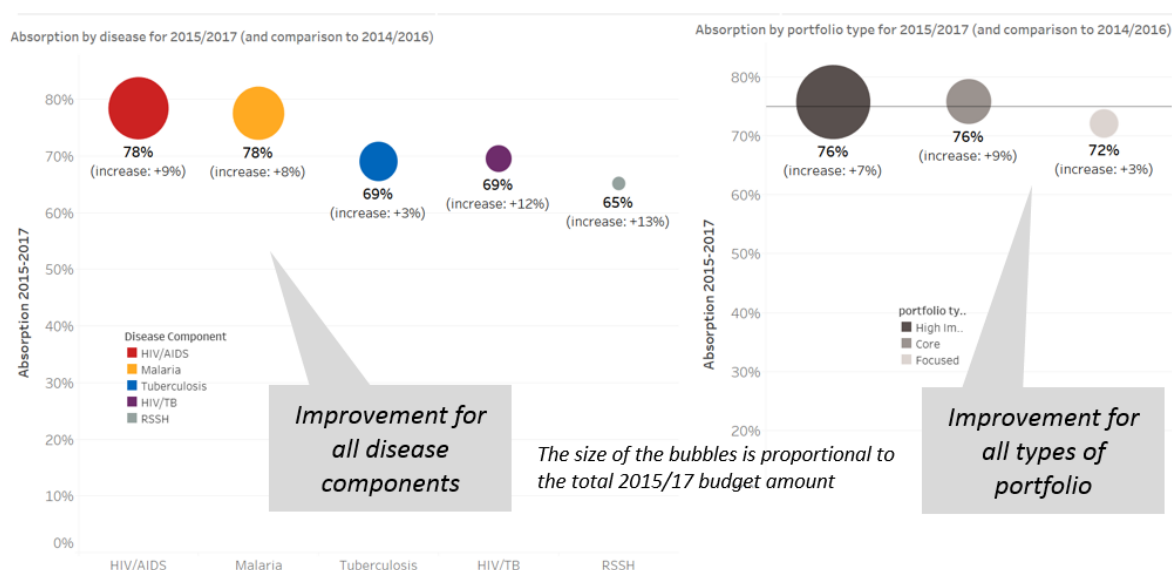


Figure 9: Absorption Rates, by Disease Component and by Portfolio Type, 2015-2017

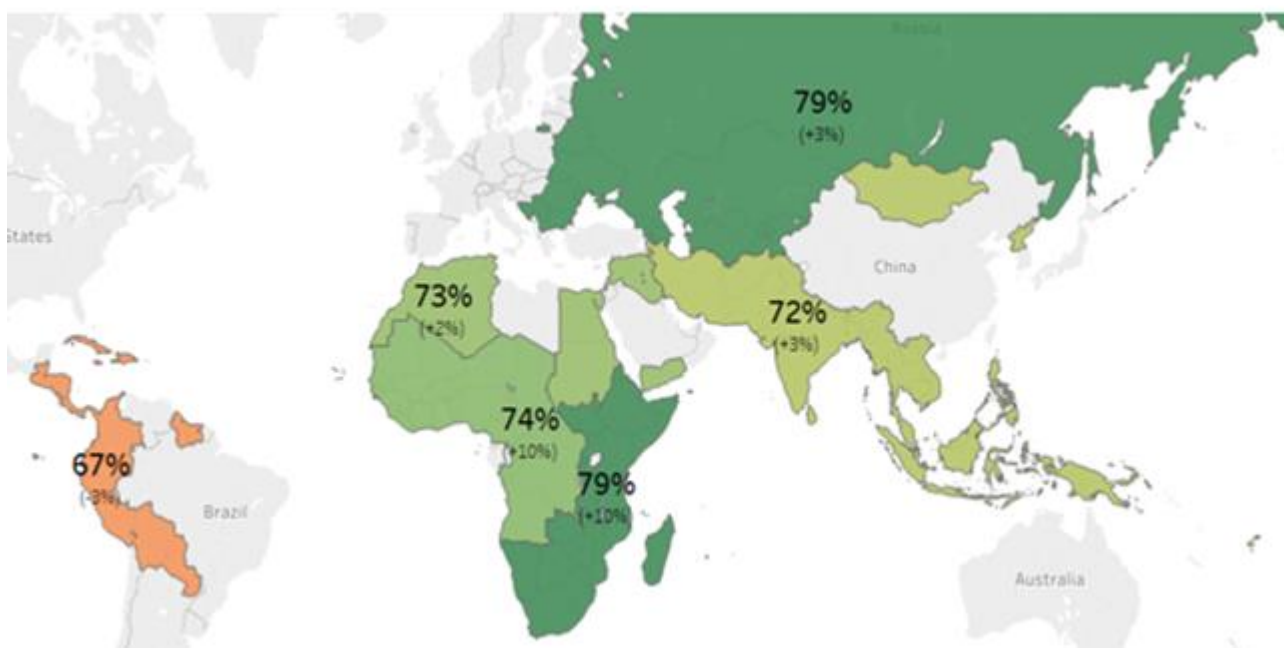


Figure 10: Absorption, by Geographic Region, 2015-2017

Our focus on ensuring rapid and effective deployment of Global Fund resources also extends to portfolio optimisation and reprogramming. In July, we conducted the first portfolio optimisation exercise for this cycle, releasing \$128 million, and next month we expect to deploy another \$100 million. We have also worked closely with partners to reprogram grants to take advantage of savings from our procurement activities and shifts in treatment regimens, notably the shifts to Dolutegravir and shorter course MDR-TB treatments.

Driving Progress on Strategic Priorities

As we translate the allocations into grants and thus into programs being implemented on the ground, we are also executing on the strategic priorities identified for this cycle, using a combination of guidance to Country Coordinating Mechanisms (CCMs) to influence grant submissions, rigorous TRP and Grant Approval Committee (GAC) review, plus catalytic funding (strategic, multicountry and matching) to supplement the core allocation.

Building resilient and sustainable systems for health. Our increased focus on RSSH to complement and support our more disease-focused interventions was clear in the recent report to the Strategy Committee, which incorporated not just the Secretariat perspective, but also input from TRP and the Technical Evaluation Review Group (TERG). As Figure 11 illustrates, 28 percent of grant expenditure went to RSSH in the last cycle. Whether it's investing in health information systems in DRC, community insurance in Rwanda, health extension workers in Ethiopia or supply chains in Tanzania, the Global Fund is investing about \$1 billion per year in building key components of health systems, constructing the foundations for universal health coverage. In fact, I think we often undersell the scale of our commitment

to RSSH: at roughly \$1 billion per year, we are by some margin the largest multilateral provider of grants for building health systems.

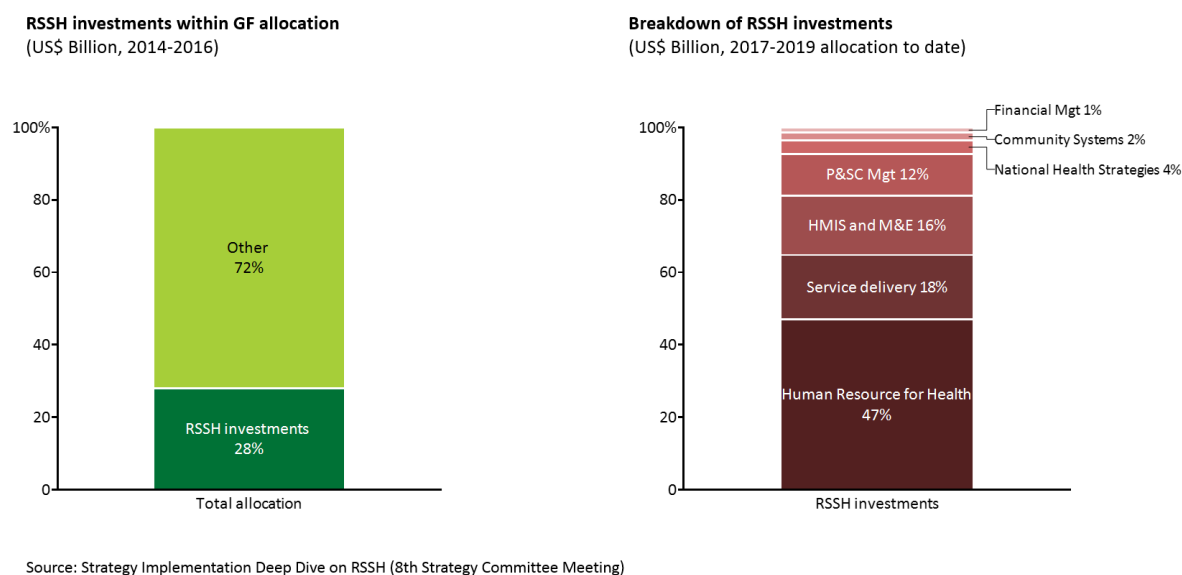


Figure 11: Global Fund Investments in RSSH

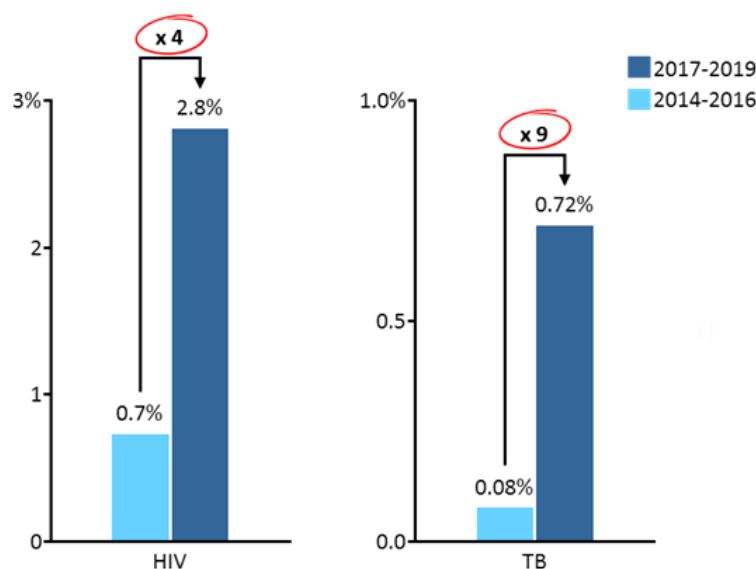
Yet, as the discussion at Strategy Committee demonstrated, it is reasonable to ask whether we could invest in RSSH more effectively, or whether devoting this percentage of our overall spend to RSSH is enough. The answer to the first question is undoubtedly yes: there are ways in which we could improve the effectiveness of our spending on RSSH. We miss opportunities to make our programming achieve broader objectives, and we – like others – struggle to ensure that system interventions achieve the same rates of absorption and outcomes-focus that we achieve with our more disease-focused programming. I suspect part of the problem is the prevalence of siloed institutions and mindsets. I am struck by the fact that despite our efforts to encourage joint HIV/TB programming, including approving joint HIV/TB grants in 35 countries in the current allocation, in practice few countries deliver truly integrated HIV/TB programs. Another reason is that it is harder to sustain the equivalent focus on results with broader system-focused interventions than when pursuing specific disease objectives. Yet this is a nut we need to crack. We won't end the epidemics without stronger health and community systems.

But it doesn't necessarily follow that this means we should increase the percentage of spend devoted to RSSH. Some countries want to leverage our comparative advantages in procurement by focusing on purchasing commodities, freeing up domestic resources to invest in health systems strengthening. Other countries want us more directly engaged in helping them reinforce specific components of the health system. Ultimately, this is for each CCM to determine, given their country's circumstances and priorities. Where country leadership seeks to use Global Fund resources to build a broader health system without compromising on results or accountability, such as in Rwanda or Ethiopia, we have demonstrated the flexibility to make this happen.

Underlying the question of whether we should invest more in RSSH, either overall or in a specific country, is the tricky question of where the incremental money would come from. Unless we increase the overall resource envelope, increasing investment in RSSH would imply reducing spend on medical commodities, such as antiretrovirals, MDR-TB drugs and bed nets. That is not an easy trade-off.

Tackling human rights barriers to health. In too many countries, key and vulnerable populations face multiple barriers to accessing health services, including stigma and discrimination, criminalisation, gender-based violence, or violence perpetrated by police. Such human rights barriers to health underpin the dynamics of the concentrated epidemics that we see persisting (and even growing) in key populations. As Figure 12 shows, we have significantly increased the amount we invest in addressing human rights barriers to health. During 2018 we also finalised 19 human rights baseline assessments, giving detailed information about human rights-related barriers in specific countries, and how they can be overcome. Yet we need to further embed human rights components in our core programming, and having held only four multi-stakeholder workshops thus far, we have just begun to leverage the results of the baseline assessments. Furthermore, while there have been advances, the stark reality is that too many countries have done nothing to reduce such barriers, and there have even been some shifts in the wrong direction.

Increase of budgets to address human rights barriers to health
(for HIV and TB, % share of total budget for HR activities, in selected countries)



Source: GF KPI database; Note: Selected countries for HIV are middle income countries, for TB middle-income countries with highest disease burden.

Figure 12: Increase of Budgets to Address Human Rights Barriers to Health

Reducing rates of HIV infection among adolescent girls and young women.

Within an overall strategy of making our programming more gender responsive, our top priority has been supporting countries to address the problem of high HIV infection rates

among adolescent girls and young women. Building on and complementing the pioneering initiatives of PEPFAR through DREAMS, and working with our country partners, we have the significantly expanded investment in this arena, and are working with countries to design and implement comprehensive, multi-sectoral programs. This includes launching HER (HIV Epidemic Response) in January 2018, an initiative to engage the private sector in innovative partnerships for programs like keeping girls in school.

However, despite good results emerging from individual programs supported by the Global Fund, PEPFAR and governments, I remain concerned that our collective response falls short of what will be required to stem the flow of new infections decisively. The root causes of the problem are an ugly mix of deep structural gender inequalities, including educational disadvantages and economic disempowerment, plus sexual violence, which will require sustained effort from multiple angles to address. Moreover, the scale of the problem is huge, affecting tens of millions of girls and young women across many different types of communities, and demographic trends mean the vulnerable population is growing rapidly. To meet our target of a 58 percent reduction in infections across the 13 most-affected countries, we will need to step-up and scale-up.

Of course, part of the solution to high infection rates among adolescent girls and young women is reducing infection rates among men and boys in the same communities. Young men and boys are typically among the hardest to reach with HIV prevention and treatment services and are also less likely to access and adhere to HIV treatment. Together with partners, we have recognized the need for tailored delivery models, the scaling-up of interventions such as voluntary medical male circumcision (VMCC) and innovations such as self-testing. At the International AIDS Conference in July, we joined the MenStar Coalition with six other partner organizations to expand the diagnosis and treatment of HIV infections in men, particularly in sub-Saharan Africa.

Responding to HIV in key populations. Key populations face persistent and complex challenges in realizing the right of access to appropriate and effective HIV services. Stigma and discrimination, criminalization, violence and marginalization act as obstacles to prevention, treatment, care and support services. We need increased budget allocations for key population prevention programs. We need to work closely with community and civil society partners to drive better data and evidence. Although the Global Fund is the largest multilateral financier of key population programs, with unparalleled global reach, there remain significant opportunities to strengthen the effectiveness of our investments through improvements in program quality and community-led program design and delivery. Ultimately, we need to respond to complex issues, expand programs to remove human rights-related barriers, and increase access to services.

Underlying our focus on prevention interventions for key populations and adolescent girls and young women is a broader concern about how we get HIV prevention higher on the agenda in individual country programs, and how we support them in scaling-up effectively, including with condom distribution, VMMC, pre-exposure prophylaxis, and self-testing. Here we are fully aligned with the priorities of the Global HIV Prevention Coalition led by UNAIDS.

Finding the missing people with TB. Leveraging \$190 million in catalytic funds, we are working with country partners in the most affected countries on programs to close the gap between the number of people falling ill with TB and the number being diagnosed and treated, the so-called “missing cases”, with a target of increasing the number of those receiving treatment by 1.5 million by the end of 2019. This is the first step toward closing the overall gap of about 4 million between the roughly 10 million a year that fall ill with TB and the roughly 6 million a year who are diagnosed and treated.

While it is early days, since most of these programs only got going in 2018, the indications are that we are achieving a significant uptick in screening and diagnosing people with TB and are on track to achieving our target. If this proves true, then this will not just be a significant achievement in its own right, but will be a powerful boost to efforts to meet the commitments resulting from the UN High Level Meeting. That historic gathering, with the energy and work leading up to it, gives us an unprecedented opportunity to “break the curve” on TB. Our challenge now is to ensure the commitments made in the UN High Level Meeting are translated into programs, backed by the necessary resources, and that the leaders and institutions involved (including the Global Fund) are held to account.

Responding to threats of drug and insecticide resistance in malaria. During 2018 we made good progress on both the collaborative initiative to develop the evidence base and prime the market for new types of insecticide-treated nets, and on the Regional Artemisinin Initiative (RAI), the multicountry program to respond to artemisinin resistance in the Greater Mekong sub-region. These initiatives represent good examples of how we can flex our model to achieve strategic objectives. On the new nets, we are working in close partnership with Unitaid, PMI, and the Bill & Melinda Gates Foundation, as well as with private sector manufacturers, and are now coordinating closely with WHO and the RBM Partnership to End Malaria on how we are going to develop the evidence and pilot these new nets. Meanwhile RAI represents our largest multicountry partnership, a powerful demonstration of how countries and development partners can work together to meet a common threat.

Strengthening sourcing and supply chains. Ensuring access to quality, cost-effective medical products is a crucial part of our mission. Through the appointment of Philippe Francois as Head of our newly combined Sourcing and Supply Chain team, I am seeking to increase our impact in this vital area. But even before his arrival, and the combining of the current departments, we have been making progress on some critical issues, including:

- Securing further savings on ARVs through the new framework agreement with suppliers. This will likely enable us to exceed the KPI12b target of \$122 million for 2018, and is expected to deliver total savings of \$324 million by 2021.
- Conducting supply chain diagnostics and transformation programs. Despite some challenges in early stages, we are now making good progress on our strategic initiative to reinforce in-country supply chains. We have started diagnostics in 20 countries, and have reached the transformation phase in nine.

- Working with countries, civil society and partners to help mitigate procurement risks in countries preparing to transition from Global Fund financing or assuming a greater role in procurement of health products through domestic funding. We are acutely aware that in some countries a range of procurement issues have arisen, including poor quality, excessive prices, and stock-outs. While this is not exclusively a Global Fund challenge, and there is no silver bullet to solving these issues, part of the answer is to make it easier for countries to access Global Fund's Pooled Purchasing Mechanism (PPM), or via the Global Drug Facility (GDF), even when they are funding the purchases themselves. As an example, we recently agreed a Memorandum of Understanding with PAHO to enable countries to access PPM-negotiated prices through PAHO's Strategic Fund.

Lifting the Performance and Capability of Country Coordinating Mechanisms.

CCMs play a pivotal role in the Global Fund's operating model, determining priorities in the country context, selecting Principal Recipients and providing oversight. However, they vary widely in effectiveness and maturity, and need somewhat different capabilities and focus depending on where the country sits in terms of disease burden and proximity to transition. Following the Board decision in May, we are now implementing the phased approach to CCM Evolution and the rollout of the code of conduct. The CCM Evolution project is currently being implemented in 18 countries, with three funded by BACKUP Health, working on behalf of the German Federal Ministry for Economic Cooperation and Development and co-funded by the Swiss Agency for Development and Cooperation.

Implementing the Challenging Operating Environments Policy. Our COE policy enables us to flex our operating model to ensure effectiveness in the most challenging contexts. A dedicated team provides targeted support to Country Teams to adopt flexible and innovative approaches such as differentiated budgeting periods (e.g., annual reprogramming in Somalia, South Sudan), or alternative supply chain management approaches and service provider contracting options (e.g., Central African Republic, Mauritania). By working more closely and strategically with humanitarian partners, we are increasing access to health services for vulnerable populations, particularly in zones where access is limited or dangerous. In this context, we recently signed a Letter of Intent with the International Committee of the Red Cross to commit to work together in hard to reach areas and detention centers. Meanwhile our Emergency Fund has continued to serve as an agile funding mechanism for crises in countries like Jordan and Syria. Our Middle East Regional Response (MER) enables us to fund services that follow people, irrespective of borders. Initially an Emergency Fund grant, MER transitioned into a regional grant encompassing Syria, Jordan, Lebanon, Palestine, Iraq, and Yemen. With the International Organization for Migration as a Principal Recipient, the grant facilitates information sharing across countries affected by large numbers of migrants.

Implementing the Sustainability, Transition and Co-financing Policy.

Supporting countries to strengthen sustainability and prepare for transition from Global Fund financing is a critical component of our strategy to end the epidemics. Co-financing requirements have proved an effective tool for catalysing increased domestic commitments for greater overall health spending and financing critical areas of national disease responses, including for health products, human resources, and (increasingly) programs for key and vulnerable populations. While there are always some exceptions, the vast majority of countries

fulfill their co-financing commitments. Countries accessing Global Fund grants in the 2015-2017 implementation cycle spent 31 percent more in fulfilling their commitments than in the previous cycle. The same countries have committed to increasing spending on the three diseases and related health systems by a further 44 percent in this grant cycle.

During 2018, we enhanced our governance mechanisms and processes to operationalize the “transition” piece of the STC policy. We continue to play a proactive role supporting country transition planning, including conducting transition readiness assessments (or equivalents) for almost half of all disease components in the “transition preparedness” portfolio, with more planned. To further strengthen transition planning, we will be providing tailored transition funding for 19 disease components in this allocation cycle. We are also leveraging strategic initiative funding and grant design to address critical transition challenges, including piloting mechanisms for social contracting and supporting countries to develop transition workplans and health financing strategies. Recognizing that this is a challenging and complex area of work, the Secretariat has also invested in strengthening Country Team capacity to manage transitions, launching an STC training course attended by almost 80 percent of Country Team members working with transition preparedness portfolios. And this is just the beginning.

3. Transforming the Way We Work

This has been a year of significant change for the Global Fund Secretariat, not least with my arrival as Executive Director at the beginning of March, and with our move to the Global Health Campus in the same month. Many of the changes initiated this year are just the beginning of transformation processes that will unfold in 2019-2020, but among those worth highlighting I would include:

Refreshing the leadership team. Following my arrival, I have made significant changes to the top leadership team with the appointment of Jacques le Pape as CFO, Francoise Vanni as Head of External Relations and Fady Zeidan as General Counsel. I have also created two new roles at the level of the Management Executive Committee, with the appointment of Michael Johnson as the CIO and Philippe Francois as Head of Sourcing and Supply Chain. Once Fady arrives at the beginning of December, 6 of the 14 members of MEC will be new. Their fresh energy and perspective is contagious.

Moving to the Global Health Campus. The Secretariat moved to the GHC in March, with our partner organizations following us over the subsequent months. Recognizing that the key decisions and most of the hard work were done before my arrival, I would make three observations:

- First, the move itself was managed superbly. Having been involved in several large office transitions earlier in my career, I know such moves can cause enormous disruption to operational activity. This did not happen.
- Second, the costs were managed extremely tightly. Indeed, as was presented to the Audit and Finance Committee (AFC) we have succeeded in halving anticipated transition costs. Moreover, being in the GHC will deliver savings – not just the 40

percent reduction in rental and operating costs, but also the efficiencies generated by sharing services with the other building occupants.

- Finally and most importantly, the GHC offers a much more conducive environment for collaboration, both within the Secretariat itself and with key partners.

Reinforcing the focus on efficiency & effectiveness. This year we have taken both tactical and strategic actions to improve efficiency and effectiveness across the Secretariat, with the intent to be continuously improving value for money:

- Introducing regular integrated reporting of operating costs and workforce, plus tightened controls around recruitment, promotion and use of consultants. Such measures enabled us to absorb the incremental costs of the move to the GHC, which were also tightly managed, within the approved budget for 2018.
- Launching a new integrated HR system to give managers instant access to relevant team data, making people management more efficient.
- Commencing specific projects to streamline key processes, building on the Fit for the Future diagnostic. For example, we have begun a “Simplify and Transform” exercise to implement enhancements to our critical grant management processes.
- Launching a Rewards and Benefits review, to ensure our compensation and benefits packages align with and support our mission. This will complete in early 2019.

Strengthening risk management. During 2018 we have taken significant strides toward strengthening our risk management approach, with the establishment of the risk appetite framework that provides a structured approach to reducing key risks over time. We introduced an Integrated Risk Management module, so Country Teams can assess implementer capacity and capture, track and manage risks, mitigating actions, and assurance activities at the grant and country portfolio levels. We strengthened the Portfolio Performance Committee with increased focus on impact and financial performance as part of the oversight of High Impact and selected Core portfolios.

The steps we have taken to strengthen our second line of defense for risk management complement the third line of defense provided by the Office of the Inspector General (OIG). I have been very encouraged how well the Secretariat and OIG work together, with the right balance of independent challenge and constructive dialogue. This is a credit to the leadership of Mouhamadou Diagne and his team, and to the Secretariat. I am also pleased that we have reduced the number of open Agreed Management Actions (AMAs) to the lowest since we started routine reporting.

Putting greater focus on key functional capabilities, in particular technology and sourcing/supply chain. Even before arriving, I decided that we needed a clearer strategy and stronger capabilities in technology, sourcing and supply chain. My first step was to find new leadership, with Michael Johnson as CIO and Philippe Francois as Head of Sourcing and Supply Chain. Both are moving rapidly to reconfigure their teams as necessary and to review and refresh the strategies for their respective areas.

Encouraging more domestic and innovative finance. In the interlinked areas of domestic and innovative finance, we already have in train a number of successful initiatives. Our co-financing requirements have proved even more effective than anticipated in mobilising domestic resources and spurring greater domestic investment in health. Yet in most countries these increases start from a very low base, as revealed so clearly in the *Africa Scorecard on Domestic Financing for Health* that we developed with the African Union, so there remains significant room for improvement.

On innovative finance, with the support of the AFC and the Strategy Committee, we have devised a “*Structured Approach to Innovative Finance*.” This highlights key areas where financial innovation could complement and provide additionality to standard Global Fund grants, and also highlights why and where specific financial mechanisms could increase the Global Fund’s impact. This approach will provide the overarching framework under which we will build strategic partnerships, support innovation by partners, and leverage our grant funding model appropriately.

Meanwhile we have continued to execute specific transactions, including securing Board approval for our first blended finance transaction, the Regional Malaria Elimination Initiative (RMEI) in Central America, designed to substantially increase country co-financing and harmonize donor and partner efforts toward malaria elimination. We are also progressing other transactions such as Debt2Health transactions with Spain and Germany, and the India TB prevention loan buy-down with the World Bank.

While we have had successes in domestic and innovative finance, I believe we have to raise our game in this vital arena, strengthening our capabilities and reinforcing coordination with other actors. As a first step, I have asked Jacques le Pape to chair a steering committee to provide strategic direction and oversight, to prioritize opportunities and to identify gaps and resource requirements. Part of the challenge is working out how we can best complement the activities of other actors, including the multilateral development banks, other health multilaterals, and the key bilateral agencies. Hence our intense engagement in the development of the *Sustainable Financing Accelerator* as part of the SDG 3 *Global Action Plan*, and our expanding collaboration with partner organizations in health financing including Gavi, the World Bank/GFF and Asian Development Bank (ADB).

Raising the bar on individual performance, collaboration and ethical behaviour. The culture of the Global Fund has many positive aspects, including an inspiring commitment to the mission, and significant diversity. Yet there is scope to reinforce the focus on performance and collaboration. Individual performance ratings are insufficiently differentiated and I have encountered a surprising degree of siloed thinking across the organization. I have been taking a variety of steps to set higher standards on performance and collaboration and will continue to do so in 2019. We have also raised the bar on what constitutes acceptable behaviour. Given the issues around sexual harassment that have occurred in other development and health organizations, we have reviewed our record, revamped our employee handbook, and are rolling out mandatory training on dignity in the workplace. We have also started a review of our HR policies from a gender perspective.

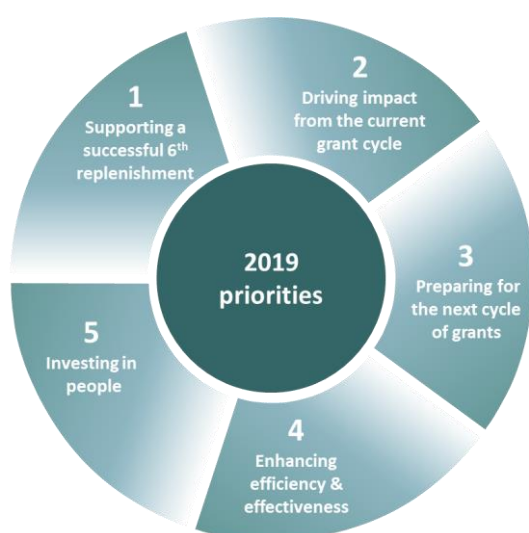
Intensifying purpose-driven collaboration with key partners. To achieve greater impact and minimise duplication and fragmentation, we have taken the initiative to engage with key partners to identify where we can collaborate more effectively. Examples include:

- Taking a comprehensive and strategic approach to collaboration with Gavi, encompassing the full range of activities from operational coordination in-country through to joint advocacy to donors and cost sharing in Geneva. Seth Berkley, CEO of Gavi, and I presented to both our Boards and continue to monitor progress in deepening our partnership.
- Leveraging our move into the GHC to engender real collaboration between colleagues at the Global Fund, Gavi, Unitaaid, Stop TB and RBM.
- Deepening our relationship with WHO. In October we signed a new Framework Agreement, laying out how we will work together more effectively. This agreement will form the basis of linked agreements with WHO's regional organizations, starting with AFRO.
- Playing a very active role in the development of the SDG3 *Global Action Plan*. We were intensively engaged in the development of this plan, which has just been presented at the World Health Summit in Berlin.
- Deepening our engagement with key bilateral partners, such as PEPFAR and the PMI. For example, we are working closely with PMI and the Bill & Melinda Gates Foundation, as well as WHO and RBM, to devise a new, more coordinated, and more data-driven approach to tackling malaria in the highest burden countries.

Laying the foundations for a successful Sixth Replenishment. We do not underestimate the challenges of securing a successful Sixth Replenishment, given diminished enthusiasm for multilateralism in some donor capitals, a host of competing demands and acute pressure on donor budgets. Yet we have worked hard to establish robust foundations for next year's process. With President Macron of France stepping forward to host the Replenishment conference, and the Indian government agreeing to host the Preparatory Conference, we have firm dates and locations for both key milestone events, and are already working closely with both governments on preparations and process. As is described in *Resource Mobilization & Replenishment*, we are also well advanced in developing the investment case and are beginning work on the overall communications and campaign strategy.

4. 2019 and the Path Ahead

Looking ahead to 2019 and beyond, how do I see our priorities? Consistent with what we set out in the *2019 Operating Expenses Budget*, and reflecting where we are in the grant and replenishment cycles, I see five key priorities for 2019:



First, supporting a successful Sixth Replenishment. Clearly, achieving a successful Replenishment in 2019 is a prerequisite for being able to sustain our momentum into the 2020-2022 grant cycle, to deliver the 2017-2022 strategy targets and to get back on track toward the SDG 3 goal of ending the epidemics by 2030. To accelerate our progress, we absolutely need more resources. Replenishment must be a top priority for me, for the Secretariat and for the whole Global Fund partnership. Indeed, we will be relying on all Board members and other stakeholders to support our Replenishment – as decision-makers, advocates and influencers. Together, we need to do everything we can to maximize the resources we can deploy to achieve our goal.

I won't repeat here the detailed discussion of our approach to the investment case and replenishment process set out in *Resource Mobilization & Replenishment*, but I do want to offer some perspectives. Clearly, the core of the investment case will be the progress the replenishment will enable us to make in ending the epidemics of AIDS, TB and malaria, and the resulting benefits in terms of lives saved and economic gains. Yet we must complement this core narrative with other themes. Among them, I would highlight:

- i) **The Global Fund plays a vital and irreplaceable role in the delivery of the SDG agenda and in accelerating the journey toward UHC.** There are three components to this argument:
 - a) Ending the epidemics of AIDS, TB and malaria is one of the most concrete, measurable and visible indicators of SDG 3. Achievement of this milestone will be one of the tests by which people will judge the success of SDG 3 and

Agenda 2030 as a whole. Without a fully funded Global Fund, there is simply no chance of achieving this goal.

- b) Achieving UHC by 2030 will require significant and sustained investment in systems of health. The Global Fund is the largest multilateral provider of grants that strengthen health systems. Tackling AIDS, TB and malaria is a proven route to UHC, since the infrastructure and capabilities required to defeat these epidemics are the foundations for a resilient and sustainable system of health.
- c) The Global Fund is taking a leadership role in driving greater coordination and collaboration across the health system architecture. The Global Fund's deep partnership with Gavi sets a model for others to follow. The Global Fund's intensive engagement with the SDG 3 *Global Action Plan* demonstrates our commitment to making the entire ecosystem work more effectively.

ii) The Global Fund plays a critical role in strengthening global health security.

There are three strands to this argument:

- a) In tackling TB, the Global Fund is addressing one of the most profound threats to global security – multi-drug resistant TB. And since the Global Fund represents about two-thirds of external assistance for TB, no other institution can play this role.
- b) The Global Fund is uniquely positioned to bridge the gap between efforts to tackle endemic diseases, such as AIDS, TB and malaria, and the imperative to counter potential epidemics such as Ebola, SARS or influenza. The global health security agenda has run into the problem that many of the countries that represent the “weakest links” seem unwilling to prioritize spending on prevention and preparedness. But it should not be a surprise that governments of such countries are reluctant to prioritize spending on diseases that *might* kill their people, over spending on disease threats that *are* killing their people. To achieve a sense of common purpose, we need a concept of health security that isn't just limited to new threats that cause alarm in advanced economies, but encompasses existing threats like AIDS, TB and malaria.
- c) In practice, the Global Fund's investments help build the system resilience required to respond to infectious disease threats. For example, in the current Ebola outbreak in the DRC, Gene Xpert devices funded through the TB program are being used to diagnose Ebola, while the health management information system we funded is being used to track cases.

iii) The Global Fund is a powerful partner in tackling some of the worst aspects of gender inequality. High rates of HIV infection among adolescent girls and young women have their root causes in deep structural gender inequalities, including economic disempowerment, educational disadvantage and sexual violence. At the Global Fund we don't pretend to have readymade answers to these complex issues, which stretch well beyond the bio-medical sphere, but we are committed to working with partners in flexible and

creative ways to address them. If we don't, we risk allowing millions of women to become infected with HIV, and thus be even more disadvantaged.

- iv) **The Global Fund partnership plays a unique role in addressing health inequalities**, including those faced by stigmatized (and often criminalized) key populations such as sex workers, transgender people, men who have sex with men, people who inject drugs, prisoners, migrants and displaced people, as well the rural poor and slum dwellers. In striving to leave no one behind, the Global Fund plays a unique role, given our focus on tackling human rights barriers to health, and the deep involvement of civil society, including affected communities, in our delivery model.
- v) Above all, **the Global Fund works, delivering results in difficult environments and ensuring progress towards the ultimate goal of ending the epidemics**. This is a proven model for achieving impact – sharply reducing deaths from AIDS, TB and malaria; building resilient and sustainable systems for health; accelerating the journey toward universal health coverage. No one else in the global health arena has quite the same combination of scale, inclusivity, transparency and effectiveness.

Second, driving impact from the current grant cycle. We are now at the point in the 2017-2019 cycle when almost all the grants have been approved and the programs have started. Much of our focus in 2019 must therefore be on maximizing impact from these programs, whether it's tackling barriers to absorption, refining approaches to reflect early results or incorporate best practices from elsewhere, or responding to external changes, such as shifts in epidemiology, resistance trends, new bio-medical tools, or changes in recommended treatment regimens. We must also reprogram where necessary. This requires intense communication and collaboration between our Country Teams, CCMs, Principal and Sub-Recipients, technical partners, governments, civil society and other bilateral and multilateral partners. In all our debates at Board and Committees about strategy and policy, I think it is sometimes easy to forget that this practical, real-time problem-solving in partnership with those implementing the programs, represents much of what the Secretariat does on day-to-day basis, and is key driver of the impact we have.

We must also remain focused on timely and tightly prioritized portfolio optimization. We do not want funds sitting idle when we have Unfunded Quality Demand (UQD) of over \$2 billion. We have already released \$128 million to scaling up existing programs or launching new projects, and will shortly approve another \$100 million. While higher absorption and more timely portfolio optimization mean that the next allocation cycle will not benefit from a carry-over anything like the \$1.1 billion we transferred from the previous cycle to the current one, this is definitely a good problem to have.

Sustainability and transition will be a key priority. I believe our STC policy represents an effective and forward-looking approach to working with countries to achieve long-term sustainability of health programs, so they can maintain progress and continue to expand services even after Global Fund support ends. But ensuring true sustainability and achieving effective transitions is inherently challenging. We are asking governments to shoulder financial burdens that most would rather we continue to bear. We are requiring governments

to build capacities that many find difficult to develop. We are encouraging governments to reach out to key populations that some are inclined to neglect. As we gain experience in implementing the STC policy we will need to continue to refine our approaches – for example, putting greater focus on early and rigorous planning; on the identification and mitigation of potential bottlenecks to successful transitions (e.g., social contracting, procurement); and on creative partnerships with other actors, such as the regional multilateral development banks. We recognize that the development of robust national health financing strategies is critical to countries being able to achieve sustainability and thus successful transitions. Hence our focus on strengthening our capacities on domestic resource mobilization and working more effectively with other partners in this vital area.

Yet we should also acknowledge that many of the most difficult challenges we face around transition are not technical, but political. Unless governments prioritize health, embrace key populations and root out corruption, transitions will prove extremely difficult. This is why broad engagement across government and with civil society is vital. Political commitment and leadership is the irreplaceable ingredient of a successful transition.

I know some stakeholders would like us to defer or slow transitions to mitigate the inevitable challenges that arise. I agree we have to be realistic about what can be achieved given specific country contexts, careful not to surrender progress that has been achieved, and acutely sensitive to the predicament of key populations. This is why we are putting greater emphasis on transition planning, and providing transition funding. However, we also have to keep in mind two reasons why sustainability and transition are imperatives:

- Ultimately, countries need to be able to finance their own health systems and the fight against AIDS, TB and malaria, without reliance on the Global Fund. So we need to be on the path to this destination from the start. And we should be wary of inadvertently creating incentives for governments to dodge this reality.
- There remains massive unmet need in the highest burden countries. To save more lives and accelerate ending the epidemics, we need to focus our resources where they can have most impact. Getting governments in transition countries to step up their commitments so that we can redirect funding to places with higher disease burdens and less resources is a crucial part of delivering the overall strategy.

Third, preparing for the next cycle of grants. It is at this point in the cycle when we have the opportunity to decide what we want to do differently in the next cycle. Here I would highlight the importance of four key policy issues, on which we will be looking to the Board for timely decisions:

- **Reviewing and refining the allocation model.** While the country allocation model used for the current cycle appears broadly robust in both methodology and outcomes, this is the opportunity to re-examine and refine the key parameters. The Strategy Committee has already begun this process, and it will be critical to ensure that the key decisions made at the May Board to enable us to move swiftly to determine allocations immediately after the Replenishment Conference in October.
- **Determining the scale and composition of catalytic funding.** In the current cycle, \$800 million was set aside from country allocations to be deployed on strategic

priorities through various mechanisms, including matching funds, multicountry grants and strategic initiatives like the Emergency Fund. The Strategy Committee has already begun discussing what lessons we can learn from this cycle, and how we should think about the optimal scale and composition of catalytic funding for the next cycle. The unambiguous conclusion from a joint TERG/TRP and Secretariat review is that we need to further prioritize this funding and make these decisions earlier than in the last cycle. That means approving catalytic funding alongside the allocation formula at the May 2019 Board meeting.

- **Determining the optimal balance between prescriptiveness and CCM flexibility.** Underlying the decisions about catalytic funding is a set of fundamental policy questions about the optimal balance between prescriptiveness and CCM flexibility. For example, matching funds are a powerful mechanism to incentivize certain types of programming, such as interventions to find “missing cases” of TB. Alternative tools include imposing specific requirements on treatment regimens and co-financing, explicit guidance from the Secretariat or TRP on joint HIV/TB programming, or simply encouragement. Here we have to balance the potential advantages of enabling countries to focus on global strategic priorities, versus the potential benefits of giving CCMs more flexibility to deploy Global Fund resources to fit their own national priorities. RSSH, HIV prevention and human rights interventions are all relevant areas in this debate. While the considerations differ across topics, I am wary of rushing to introduce new hard requirements, such as minimum percentages of spend on RSSH or prevention, and would be inclined to focus on offering incentives and providing guidance. Too much prescriptiveness would undermine two great strengths of the Global Fund model: our ability to adapt to the country context; and the principle of country ownership – we want CCMs to own and be accountable for the prioritization decisions they make in grant applications.
- **Deciding the path forward for CCM Evolution.** Although it is too early to derive anything other than indicative findings from the first implementations of the phased rollout of CCM evolution, we will need to make decisions about the path forward, including the funding model.

Fourth, enhancing efficiency & effectiveness. During 2019 we will continue to drive improvements in efficiency and effectiveness across the Secretariat, and will also be looking to make improvements in the way we work with partners and in the governance model.

Across the Secretariat, I see **shifting to a more process-driven operating model** as critical to achieving continuous improvement in efficiency and effectiveness. On joining the Global Fund, I quickly learned that different parts of the Secretariat are at different levels of maturity in terms of codifying and automating key processes, and in defining metrics and controls to enable systematic performance and risk management. Moreover, it appears that over time a variety of approaches to measuring organizational performance and accountability have been established that do not necessarily align with each other. I want us to capture much more of the Secretariat’s activity in clearly defined processes, and to consolidate the various management tools into a coherent performance and accountability framework based on these processes. We have therefore begun to roll out a standardized approach to defining our key

processes and the corresponding metrics and controls, and linked to this, an integrated approach to measuring unit and individual performance and accountability.

Moving to a more process-driven operating model will also facilitate **embedding risk appetite** and our overall risk management approach.

Another priority for the Secretariat in 2019 will be to **reconfigure and strengthen our capabilities in technology, sourcing and supply chain and domestic/innovative finance**. As indicated in the *2019 Operating Expenses Budget*, we anticipate reinvesting some efficiency savings to strengthen these areas. For Sourcing and Supply Chain one key priority will be to deliver on the proposed KPI 12b target of \$115 million for 2019.

Looking beyond the Secretariat itself we need to continue to work together to **streamline the governance model**, ensuring we get the appropriate level of input and debate on strategic decisions, and oversight of risk and performance, while minimizing costs and the burden on the Secretariat. From my perspective, the consolidation of committee meetings into a “Committee Week” is already a significant step forward. We need to continue to work to identify further opportunities for greater efficiency and effectiveness in governance, ranging from the delineation of responsibilities across the committees, to the balance of detail versus strategic oversight in Board and committee decision-making.

Even more broadly, I see it as a strategic priority to work with partners to **enhance the frequency and granularity of outcomes data** to enable more targeted interventions and more dynamic decision-making. This is key to enhancing programmatic performance and efficiency. For example, I would like to see a shift from annual reporting of key outcome metrics, such as deaths and new infections, to quarterly reporting. This would catalyse a much more dynamic approach to programme management, enabling rapid scaling up of effective interventions and course correction where interventions aren’t proving successful. Likewise more granular data on the disease dynamics, such as by district, gender or age, would enable us to target interventions much more effectively, thus optimising the use of resources. Here we can learn from and work with key bilateral partners, such as PEPFAR and PMI, and leverage the capabilities of the Bill & Melinda Gates Foundation and others. In this domain, as elsewhere, we need to ensure we are not just solving the immediate data problem, but helping build capacity at a country level.

Finally, we must ensure that the aspirations for greater collaboration and coordination expressed in the SDG 3 *Global Action Plan* and elsewhere are translated into **realized synergies with partners delivering efficiencies and incremental impact**. Among the multilateral health agencies, we are already creating significant synergies with Gavi and I am confident that more will follow. Meanwhile, the new framework agreement with WHO provides the basis for enhanced cooperation between our organizations, both here in Geneva and with the regional organizations. I have also agreed with Lelio Marmora of Unitaaid that we will conduct the same systematic review of synergy opportunities that we undertook with Gavi, with the objective of presenting the conclusions to both our Boards in 2019.

With the multilateral development banks, there are significant opportunities to work together on blended and other innovative finance solutions, building on experience thus far with the World Bank and IADB, and engaging more deeply with the ADB, AfDB, EBRD and others. One key priority is to streamline our working arrangements with the World Bank, particularly around audit/OIG access, to reduce transaction costs. The multilateral development banks, alongside others such as the IMF, WHO and GFF, will also be key partners as we look to provide more coherent support to countries on the development and implementation of national health financing strategies, as envisaged in the accelerator on sustainable financing supporting the SDG 3 *Global Action Plan*.

I am also keen to reinforce coordination and collaboration with key bilateral partners. Here there are a range of different opportunities, some building on already productive existing relationships, some more of the nature of creating new relationships. For example, our Sourcing and Supply Chain team can intensify data sharing and coordination with PEPFAR, PMI, USAID and GDF. A different example would be the opportunity to scale-up significantly our cooperation with AFD. A third, again very different example, is working with China on co-investment opportunities.

Fifth, investing in people. A highly motivated, high performing workforce, with the right skills and with the right culture, is essential to the delivery of the Global Fund's mission. Here we start from a good place: we have superb people, with distinctive expertise and a deep commitment to the mission. However, in my view we need to raise our game in how we invest in and manage people. To make this happen, during 2019 we will be pursuing four complementary strands of activity:

- i) Completing and implementing the **rewards and benefits review**. The objectives of this exercise are to ensure our rewards and benefits packages are consistent with a rewards philosophy that delivers value for money, ensures competitiveness, underpins organizational agility and rewards performance and collaboration.
- ii) Piloting and rolling out **strategic workforce planning**. We need a more systematic and strategic approach to ensuring the right fit of skills to our needs. So we will start a strategic workforce planning approach in 2019.
- iii) Reinforcing our **performance management approach**. Consistent with my desire to raise the bar on individual performance, we will be reviewing our approach to performance management during 2019, with a particular emphasis on effectively evaluating *how* objectives are achieved, as well as *what* is achieved. Moreover, we want to find ways to build individual manager skills in conducting performance and development conversations. Ultimately, any performance management framework is only as good as the way it is implemented by line managers.
- iv) Developing a more systematic approach to **talent acquisition and development**. As an organization, we have tended to hire people in mid-career with specific skillsets or experience relevant to a particular role, rather than taking a longer-term perspective towards talent acquisition and development. As we take a more strategic approach toward workforce planning, we anticipate that we will want to refine this approach, putting greater

emphasis on recruiting younger talent and more investment into training and development, particularly leadership development.

5. Conclusions and Reflections

Let me close with just a few observations.

Many of the most difficult debates we have within the Secretariat and at the Board and the committees have at their root **the fundamental tension between the scale of our ambitions and the extent of our resources**. Ending the epidemics requires much more than the Global Fund alone can do. Eliminating the human rights barriers faced by so many of the communities we work with is not in our gift. Building resilient health systems requires local leadership and the involvement of many other partners. Achieving successful transitions requires domestic governments to step up their part for their citizens. Despite the extraordinary generosity of our donors, there is a big gap between what we have set out to do and the resources we have to do it.

Yet this gap is not a reason to be defeatist or to reduce our ambitions. On the contrary, this gap must shape our strategy and drive the way we work. It is not enough for us to finance a global portfolio of high quality programs, even if each delivers measurable positive impact. We have to be an effective partner, catalyst and influencer in everything we do, so that we accelerate overall progress towards our ultimate goals of saving lives, ending the epidemics, and thus playing our part in the delivery of SDG 3.

It is right that we are not an organization that measures itself solely by the results of our own projects, but also by the pace of progress toward the larger goal. That's why I think it is appropriate that we put much of our focus on are the full national results, while simultaneously monitoring and reporting on the performance of Global Fund grants to optimize the value of our specific investments. Highlighting full national results keeps us focused on the big picture, and ensures our programming priorities reflect where we can maximise our contribution to a country's overall progress against the three diseases. We want our programming to be integrated into and enhancing the overall performance of the national plan. We do not want to be in a situation where we are feeling good about the performance of specific programs, yet the country is going backwards in health. We therefore need to hold ourselves accountable for both: for the performance of the programs we finance; and for the results of the countries in which we are active.

The same philosophy should underpin the trade-offs we make and the way we work with others. We cannot do everything ourselves, and must focus instead on how we best complement our partners, and how we act most effectively as a catalyst and influencer. For example, in HIV, we are often the "wingman" to PEPFAR, as the largest external funder, and so we need to tightly coordinate and deliberately play to our distinctive strengths, to maximize our combined effectiveness in supporting national programs. In domestic resource mobilization, our funding gives us a seat at the table and an ability to exert pressure. We need to use this influence to complement the efforts of others, such as the World Bank and Gavi, and contribute to solving

the bigger problem of health care finance, not just the narrow problem of funding programs for the three diseases.

And the same mindset should inform the way we talk about our achievements. We need to talk about what countries have done, what partners have done, what communities have achieved. The desire to claim victories corrodes collaboration in global health – in Geneva, New York and Washington as much as in the countries themselves. Perhaps we should consider ourselves the “Intel Inside” of global health, an understated, but extraordinarily powerful enabler of others’ achievements.

A second observation is that there are **disconnects between the debates that dominate global conferences, and the practical realities of in-country implementation**. We need to ground what we do in the realities of what it takes to have impact in the poor and vulnerable communities in which we are most engaged. I am not remotely an expert, but I do bring fresh eyes, so I offer these observations:

- Much more of our programming is more intimately integrated into primary health care delivery than the debates we have at the Board and elsewhere suggest. PMTCT interventions are woven into programs for pregnant mothers and infants. Malaria interventions for families are tied into immunisation programs. While much of the money we deploy in such instances may be focused on relevant commodities, what matters is that the programs we enable to function form part of a coherent primary health care delivery approach. Of course, there are examples of dysfunctional silos and disconnects, but simply equating the financing of commodities with overly disease-focused programming is at odds with reality. Moreover, where such disconnects exist, the root cause appears more often in institutional structures and incentives within the country than anything inherent in the Global Fund model.
- Communities play an even more vital role than we sometimes recognize. In PMTCT programs that I visited recently in Ethiopia and Nigeria, it was evident that the distinction between those that work well, and those that are less successful, is less a function of differences in the bio-medical interventions than in the effectiveness of community outreach. Early and comprehensive identification of pregnancy to enable screening, and the engagement of volunteer “mentor mothers” to support adherence are key drivers of success. Likewise I was struck by the importance of peer support among sex workers in programs I saw in Nigeria. It is not enough to know that engaging in unprotected sex for a higher price is a risky decision. Even more important is peer coaching on how to have that conversation, plus the confidence that comes from knowing that others are taking the same position.
- We don’t always get it right in striking the balance between fiduciary risk and programmatic risk. While of course we must put in place robust controls to ensure money is spent as it should be and must pursue abuses with vigour, we should also recognize that an overly rigid approach can paralyse programs, delaying the release of funds, distorting incentives and reinforcing silo perspectives. There’s no easy answer here, but we must be aware that how we respond to financial control and audit issues can have a significant and prolonged impact on program effectiveness.
- There are many instances of successful collaboration between multilateral and bilateral partners, but also too many examples of poor coordination and friction.

Attitudes on the ground do not always correspond to declarations of intent from the head office. Some of the problems are simply the consequence of well-intentioned attempts to tackle complex problems from multiple perspectives. Turf battles and frictions between local institutions interact with and magnify partner divisions. While collaboration is not an end in itself, reinforcing purpose-driven collaboration is extraordinarily important. The SDG 3 *Global Action Plan* needs to become more than just a declaration and actually shape behaviors and priorities.

- Leadership makes all the difference – at the CCM, in a health ministry, in a primary facility (as well as among partners). I confess to some scepticism about the efficacy of expensive leadership-building programs, but we must recognize that where we are enabling strong leaders to perform, great things happen, and where leadership is weak, we struggle to have the impact we want. So we must wrestle with the challenge of how we contribute to building stronger leadership in pivotal roles. To take one example: the crux of the domestic resource challenge is not the morass of technical issues around fiscal mobilisation, health insurance schemes, budget controls, disbursement mechanisms, and social contracting. It is political leadership. With political commitment to direct more domestic resources to health, these admittedly quite challenging technical issues can be overcome. Without such leadership, we spin wheels.

A third takeaway from my first few months is that there is **huge scope for innovation**, not just in bio-medical interventions, but in the way we use data to inform decision-making and in program design and delivery, including in how we shape incentives, engage communities, leverage mobile-phone based technologies, engage the private sector, etc. I know I am obsessed with the need for granular and more frequent data – not as an end in itself, but to enable us to target interventions more effectively, and to respond to developments (including learnings about what's working well, and what's not) more swiftly. While I don't underestimate what we are doing already, I would like to see the Global Fund even more engaged in identifying and scaling up such innovations. That's why I am taking steps to deepen our relationship with Unitaaid and innovators in the private sector, and to strengthen our capabilities in – among other things – technology, supply chain and financing.

Finally, I want to take this opportunity to thank the Board, the staff of the Secretariat, our partners, and above all the health professionals on the ground for their extraordinary commitment to our collective mission. I have been inspired by the determination to improve the lives of others that I have encountered, the energy and passion, plus the willingness to adapt, be open to new ideas and learn different ways of doing things. It makes me feel enormously privileged to have this role.

The challenges we face are tremendous. To meet the SDG 3 target of ending the epidemics by 2030, we must accelerate our progress against all three diseases. This means mobilizing more resources, leveraging innovations more effectively, targeting our interventions more efficiently, and continuously improving the way we execute. The creation of the Global Fund in 2002 was an extraordinary act of global solidarity - of collective leadership, imagination and courage. When we celebrate the twentieth anniversary of the Global Fund in 2022, I want all of us involved in this incredible partnership to be able to say with confidence that we are back on track towards fulfilling the promise of ending the epidemics of AIDS, TB and malaria

by 2030. What we achieve together in 2019 – in the replenishment, in grant execution and in reinforcing collaboration across the partnership – will in large part determine whether we will be able to make this assertion. We have a demanding, yet exciting, year ahead. I look forward to working with you all to make it hugely successful.