GPR

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, AND THE WORLD BANK'S ENGAGEMENT WITH THE GLOBAL FUND

—VOLUME 1: MAIN REPORT—

IEG
INDEPENDENT EVALUATION GROUP

GLOBAL PROGRAM REVIEW
Volume 6 Issue 1

THE WORLD BANK GROUP

WORKING FOR A WORLD FREE OF POVERTY

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IEG WORLD BANK
INDEPENDENT EVALUATION GROUP

Global Program Review

The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund

Volume 1: Main Report

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Public Sector Evaluation

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Cover photo: Children stand in a circle at a day school facility in Richards Bay, South Africa. The school is for children who have lost their parents to AIDS or have been affected in some way by HIV. Photo by Brent Stirton, courtesy of Getty Images.

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IEG Mission: Improving Development Results Through Excellence in Evaluation

The Independent Evaluation Group (IEG) of the World Bank annually reviews a number of global and regional partnership programs (GRPPs) in which the Bank is a partner, in accordance with a mandate from the Bank's Executive Board in September 2004. The three main purposes are (a) to help improve the relevance and effectiveness of the programs being reviewed, (b) to identify and disseminate lessons of broader application to other programs, and (c) to contribute to the development of standards, guidelines, and good practices for evaluating GRPPs. IEG does not, as a matter a policy, recommend the continuation or discontinuation of any programs being reviewed.

A global or regional program review (GPR) is a ***review*** and not a full-fledged ***evaluation***. The preparation of a GPR is contingent on a recently completed evaluation of the program, typically commissioned by the governing body of the program. Each GPR assesses the independence and quality of that evaluation; provides a second opinion on the effectiveness of the program, based on the evaluation; assesses the performance of the World Bank as a partner in the program; and draws lessons for the Bank's engagement in GRPPs more generally. The GPR does not formally rate the various attributes of the program.

Assessing the independence and quality of GRPP evaluations is an important aspect of GPRs in order to foster high-quality evaluation methodology and practice more uniformly across Bank-supported GRPPs. Providing a "second opinion" on the effectiveness of the program includes validating the major findings of the GRPP evaluation. Assessing the performance of the World Bank as a partner in the program provides accountability to the Bank's Executive Board.

In selecting programs for review, preference is given to (a) those that are innovative, large or complex; (b) those in which the Bank is sufficiently engaged to warrant a GPR, (c) those that are relevant to upcoming IEG sector studies; (d) those for which the Executive Directors or Bank management have requested reviews; and (e) those that are likely to generate important lessons. IEG also aims for a representative distribution of GPRs across sectors in each fiscal year.

A GPR seeks to add value to the program and to the World Bank beyond what is contained in the external evaluation, while also drawing upon IEG's experience in reviewing a growing number of programs. It reports on key program developments since the evaluation was completed, including the progress in implementing the recommendations of the evaluation.

A GPR involves a desk review of key documents, consultations with key stakeholders, and a mission to the program management unit (secretariat) of the program if this is located outside the World Bank or Washington, DC. Key stakeholders include the Bank's representative on the governing body of the program, the Bank's task team leader (if separate from the Bank's representative), the program chair, the head of the secretariat, other program partners (at the governance and implementing levels), and other Bank operational staff involved with the program. The writer of a GPR may also consult with the person(s) who conducted the evaluation of the GRPP.

Each GPR is subject to internal and external peer review and IEG management approval. Once cleared internally, the GPR is reviewed by the responsible Bank department and the secretariat of the program being reviewed. Comments received are taken into account in finalizing the document, and the formal management response from the program is attached to the final report. After the document has been distributed to the Bank's Board of Executive Directors, it is disclosed to the public on IEG's external Web site.

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Abbreviations and Acronyms

ACT	Artemisinin combination therapy
AIDS	Acquired immunodeficiency syndrome
AMFm	Affordable Medicines Facility for Malaria
ART	Antiretroviral therapy or treatment
ARV	Antiretroviral drug
ASAP	AIDS Strategy and Action Plan Service (UNAIDS and World Bank)
CAS	Country Assistance Strategy (World Bank)
CCM	Country Coordinating Mechanism (Global Fund)
CFP	Concessional Finance and Global Partnerships Vice Presidency (World Bank)
CHAT	Country Harmonization and Alignment Tool (UNAIDS)
CPA	Country Partnership Assessment
CSO	Civil society organization
DAC	Development Assistance Committee (OECD)
DFID	Department for International Development (United Kingdom)
DGF	Development Grant Facility (World Bank)
DOTS	Directly Observed Treatment Short-Course (for tuberculosis)
FIF	Financial Intermediary Trust Fund (World Bank)
FPM	Fund Portfolio Manager (Global Fund)
FRM	Financial Resource Mobilization Department of CFP (now called IDA Resource Mobilization Department: CFPIR)
FYE	Five-Year Evaluation of the Global Fund
GAMET	Global HIV/AIDS Monitoring and Evaluation Support Team
GAVI	Global Alliance for Vaccines and Immunization (a global partnership program)
GEF	Global Environment Facility (a global partnership program)
GHAP	Global HIV/AIDS Program (World Bank and UNAIDS)
GIST	Global Implementation Support Team
GMP	Good Manufacturing Practice
GPR	Global or Regional Program Review (IEG)
GRPP	Global and/or regional partnership program
HIV	Human immunodeficiency virus
HNP	Health, nutrition and population
HSS	Health systems strengthening
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report (World Bank)
IDA	International Development Association
IDU	Injecting drug user
IEG	Independent Evaluation Group, formerly OED (World Bank)
IETF	Impact Evaluation Task Forces
IHP	International Health Partnership
IHP+	International Health Partnership and Related Activities
JANS	Joint Assessment of National Strategies (a component of IHP+)
LFA	Local Fund Agent (Global Fund)
Logframe	Logical framework
M&E	Monitoring and evaluation
MAP	Multi-country AIDS Program (World Bank)
MDGs	Millennium Development Goals
MOU	Memorandum of understanding
NGO	Nongovernmental organization
NSA	National Strategy Application (Global Fund)
OECD	Organisation for Economic Co-operation and Development
OIG	Office of the Inspector General (Global Fund)
PBF	Performance-Based Funding (Global Fund)
PEPFAR	President’s Emergency Plan for AIDS Relief (United States)

PMTCT	Prevention of Mother to Child Transmission of HIV
PRSP	Poverty Reduction Strategy Paper
PUDR	Progress Update and Disbursement Request (Global Fund)
RBM	Roll Back Malaria (a global partnership program)
SSF	Single Stream of Funding (Global Fund)
Stop TB	Stop Tuberculosis Partnership (a global partnership program)
SWAp	Sector-Wide Approach
TB	Tuberculosis
TERG	Technical Evaluation Reference Group (Global Fund)
TRP	Technical Review Panel (Global Fund)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization

Fiscal Year of the Global Fund

January 1 – December 31

Acknowledgments

This Review has been prepared by a team led by Chris Gerrard under the direction of Mark Sundberg, Manager, IEG Public Sector Evaluations, following the outline and methodology in the Approach Paper that was issued in January 2010. Other members of the core team were Anna Aghumian, Elaine Wee-Ling Ooi, Rogerio Pinto, and Bowen Uhlenkamp. Chris Gerrard and Elaine Wee-Ling Ooi were the principal authors of the main report.

The six country reports were prepared by Ed Burger (on the Russian Federation), Julia Dayton (on Burkina Faso), the late Phil Musgrove (on Nepal), Elaine Wee-Ling Ooi (on Cambodia), and Rogerio Pinto (on Brazil and Tanzania). Judy Twigg prepared an in-depth assessment of a World Bank-supported health project in Lesotho that was specifically designed to increase the capacity of the country to effectively use Global Fund grants for HIV/AIDS. Cheryl Cashin prepared the detailed comparison of the monitoring and evaluation systems of the Global Fund and the World Bank, and Andaleeb Alam prepared an analysis of Study Area 3 of the Five-Year Evaluation on the impact of the collective efforts to reduce the burden of the three diseases.

Martha Ainsworth, Ed Elmendorf, Bernhard Liese, and Pia Schneider have provided invaluable guidance to the team throughout. William Hurlbut, Caroline McEuen, and Margarita Sanchez have provided editorial and other support. None of the people who worked on this Review have previously done any work for the Global Fund.

IEG gratefully acknowledges all those who made their time available for interviews and provided useful information and insights that made this Review possible. IEG especially wishes to acknowledge the cooperation of Global Fund staff in providing all requested information and documents, and World Bank staff in the Bank's country offices for facilitating the visits to Brazil, Burkina Faso, Cambodia, Lesotho, Nepal, the Russian Federation, and Tanzania. The list of persons consulted is contained in Appendix R.

IEG would especially like to acknowledge Emily Bosch in the Development Co-operation Directorate of the Organisation for Economic Co-operation and Development for her extensive assistance in gathering the information necessary to undertake the additionality analysis in Chapter 3.

The draft report was peer-reviewed by Ruth Levine, Director, Global Development and Population Program in the Hewlett Foundation, and Charles Griffin, Senior Adviser in the Europe and Central Asia Vice Presidency of the World Bank.

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Caroline Heider, Director-General, Evaluation
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Chris Gerrard, Task Team Leader

Foreword

The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in January 2002 to mobilize large-scale donor resources for the specific purpose of reducing infections, illness and death caused by the three diseases.

Since then, the Global Fund has become the largest of the 120 global and regional partnership programs in which the World Bank is involved. It disbursed more than $3 billion in grants to developing and transition countries in 2010 to finance investments at the country level, and is supported by the largest financial intermediary trust fund administered by the World Bank.

The Independent Evaluation Group annually reviews a number of global and regional partnership programs in which the World Bank is involved. This Global Program Review is based on the Five-Year Evaluation of the Global Fund that was completed in May 2009, and it focuses on the World Bank's engagement with the Global Fund at the global and country levels. Its principal purpose has been to learn lessons from the experience of the Global Fund about (a) the design and operation of large global partnership programs that are financing country-level investments, (b) the engagement of the World Bank with such programs, and (c) the evaluation of these programs.

This Review found that the Five-Year Evaluation — consisting of three Study Areas and a Synthesis Report — was an independent and quality evaluation. Study Area 1, on the organizational efficiency and effectiveness of the Global Fund, and Study Area 2, on its partner environment at the global and country levels, were formative evaluations that have had major impacts on the Global Fund's organizational and institutional arrangements. Study Area 3 was a summative evaluation of the collective efforts to reduce the burden of the three diseases; it could not, by design, assess the independent contribution of the Global Fund to country-level results.

Official donor commitments to combat the three diseases have increased more than sixfold, from $1.7 billion in 2002 to $11.4 billion in 2009, of which almost 40 percent now flows through the Global Fund. Country Coordinating Mechanisms have successfully brought country-level stakeholders together to submit grant proposals to the Global Fund, but have lacked the authority and the resources to exercise effective oversight of grant implementation.

Collective donor efforts have contributed to increased availability and use of disease-control services, particularly for HIV/AIDS, and increased coverage of affected communities, which should ultimately reduce the disease burden. However, reliance on external funds and inadequate investments in long-term capacity raise concerns about the sustainability of recipient countries' disease-control programs. If external support is not sustained, this will put pressure on governments in recipient countries to reallocate their own budgetary resources to costly treatment activities, and away from other health and non-health priorities. To the extent that resources spent on prevention of new infections decline, the long-term sustainability of treatment programs will be further undermined.

The World Bank has had extensive engagement with the Global Fund at the global level through the Global HIV/AIDS Program, the International Health Partnership, and related initiatives. The Bank has also had some degree of engagement with the Global Fund — from information sharing to active collaboration — in about three-quarters of the 90 countries in which both organizations have been active since 2002.

This Review found that the situation has improved since the Five-Year Evaluation in terms of the World Bank and other partners' providing technical assistance in support of Global Fund activities. There is a need to define these technical support functions with greater clarity and formality within the context of improved donor harmonization. This Review found that country-level stakeholders still tend to regard the Global Fund as another, largely separate, development partner agency with its own distinct modalities that have not been well integrated into existing donor coordination mechanisms.

The Global Fund, the World Bank, and other multilateral organizations have expressed good intentions to coordinate and streamline monitoring and evaluation (M&E) processes at the country level, but this has been difficult to achieve in practice. The organizations have different requirements for project-level M&E — in the case of the Global Fund, to facilitate its performance-based funding approach to grant disbursements. This Review found tensions between these two imperatives in the Global Fund, deficiencies in the application of performance-based funding in three of the six countries visited, and no contribution of the program's grant-level M&E to the summative assessment in the Five-Year Evaluation.

Both the Global Fund and the World Bank could contribute to improved M&E at the project and country levels by making a stronger commitment to the "Three Ones" principles of a common action framework, a single coordinating authority, and one M&E framework to monitor collective efforts in each disease area. Project-level M&E could focus on accountability for achieving the specific outputs of each project, and country-level M&E on tracking the higher-level outcomes and impacts collectively. To build the knowledge base about which approaches most successfully contribute to achieving collective outcomes, the Global Fund could also consider undertaking evaluations of a random sample of the single streams of funding now taking place under its "new grant architecture" and institutionalizing regular country-level evaluations, both of which could feed into subsequent evaluations of the overall program.

Caroline Heider
Director-General, Evaluation

Program at a Glance: The Global Fund to Fight AIDS, Tuberculosis and Malaria

Start date	January 2002. The Board of the Global Fund met in Geneva for the first time. The Global Fund was registered with Swiss legal authorities, and its by-laws were adopted.
Purpose	The purpose of the Fund is to attract, manage, and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness, and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis, and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals.
Principles	A. The Fund is a financial instrument, not an implementing entity. B. The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis, and malaria. C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes. D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases, and interventions. E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases. F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities. G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner, based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.
Major activities	Global Fund grants are used to support a range of a activities, including: • Pharmaceuticals, medical commodities and diagnostics, and insecticide-treated bed nets • Surveillance studies and surveys • Technical assistance to build capacity • Actual service delivery provision • Salaries. Grants target the three diseases, plus strengthening of underlying cross-cutting health systems, such as procurement, supply management, human resources, and health information systems.
World Bank Group contributions	The World Bank is the limited trustee of the Global Fund trust fund, a nonvoting ex-officio member of the Board, and a development partner at the global and country levels. The Bank does not contribute financial resources to the trust fund, but has engaged with Global Fund-supported activities in about 65 of the 90 countries in which both organizations have been active in the health sector since 2002. The nature of this engagement has ranged from sharing information about each organization's activities to active collaboration, including serving on the Country Coordinating Mechanism in about 20 countries and joint supervision missions.

Other donor contributions	More than 50 public and private sector donors contributed US$18.8 billion to the Global Fund trust fund through December 31, 2010. The six largest donors (the United States, France, Japan, Germany, United Kingdom, and the European Commission) contributed two-thirds of these resources.
Location	The Global Fund Secretariat is located in Geneva, Switzerland.
Web site	www.theglobalfund.org
Governance and management	The Global Fund is an independent legal entity incorporated as a foundation under Swiss law. The Global Fund is governed by a constituency-based Board comprising eight representatives of donor governments (including the European Commission), seven representatives of recipient governments, and one representative each from private foundations, affected communities, developed country nongovernmental organizations (NGOs), developing country NGOs, and the commercial private sector. The Board also has six nonvoting ex officio members: the Global Fund Executive Director, UNAIDS, the World Health Organization (WHO), the World Bank, other development partners (currently represented by the Stop Tuberculosis Partnership), and Switzerland. The Global Fund had an administrative services agreement with WHO from 2002 to 2008 under which WHO provided a range of administrative and financial services, including human resources, finance, administration, procurement, and information technology services. The Global Fund became an administratively autonomous organization, effective January 1, 2009. WHO continues to act as a technical partner in many Global Fund recipient countries.
Latest program-level evaluation	Macro International, *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009. Macro International was also the lead contractor for each of the three study areas, as follows: • Study Area 1: *Organizational Effectiveness and Efficiency of the Global Fund*, October 2007 • Study Area 2: *The Global Fund Partner Environment, at Global and Country Levels, in Relation to Grant Performance and Health System Effects, Including 16 Country Studies*, June 2008 • Study Area 3: *The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis and Malaria*, May 2009

Key Bank Staff Responsible during Period under Review

Position	*Person*	*Period*
Global Program Task Team Leader	Ivar Andersen, Sr. Operations Officer, FRM	2002–2003
	Keith Jay, Lead Policy Analyst, FRM	2004–2006
	Alice Miller, CFPMI	2007–2009
	David Crush, Sr. Financial Officer, CFPMI	Sept 2009 – Dec 2010
	Alexandru Cebotari, Financial Officer, CFPMI	Jan 2011 – Mar 2011
	Veronique Bishop, Sr. Financial Officer, CFPMI	April 2011 – present
Bank's Representative on the Governing Body	Geoffrey Lamb, Director, RMC	Jan 2002 – April 2003
	Geoffrey Lamb, Vice President, CFP	Apr 2003 – May 2006
	Philippe Le Hourerou, Vice President, CFP	May 2006 – August 2009
	Axel van Trotsenburg, Vice President, CFP	August 2009 – present
Vice President, Human Development Network (HDN)	Eduardo Doryan	1999–2001
	Jozef Ritzen	2001–2003
	Jean-Louis Sarbib	2003–2006
	Joy Phumaphi	2007–2010
	Tamar Atinc	June 2010 – present
Sector Director, Health, Nutrition, and Population Department (HDNHE)	Christopher Lovelace	1999–2002
	Jacques Baudouy	2003–2007
	Cristian Baeza (Acting)	2007
	Julian Schweitzer	2007–2010
	Cristian Baeza	2010 – present
Director, CFPMI	Susan McAdams	July 2007 – present
Director, Global Programs and Partnerships Group (GPP)	Margret Thalwitz	May 2004 – September 2008
Director, Global Partnerships and Trust Fund Operations (CFPTO)	Junhui Wu	March 2009 – present

Note: CFP = Concessional Finance and Global Partnerships Vice Presidency; CFPMI = Multilateral Trusteeship and Innovative Financing Department; FRM = Resource Mobilization Department; RMC = Resource Mobilization and Concessional Financing Department.

Program Manager

Position	*Person*	*Period*
Executive Director	Richard Feachem	July 2002 – April 2007
Executive Director	Michel Kazatchkine	April 2007 – present

Glossary

Antiretroviral therapy (ART)	The use of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease.
Artemisinin combination therapy (ACT)	An approach to malaria treatment that combines several drugs, including drugs based on an ancient Chinese medicinal plant known as artemisinin. ACT treatment is gradually becoming the treatment of choice under many African countries' drug and treatment protocols. ACTs are much more expensive than current standard treatments that have lost their potency.
Concentrated epidemic	In the case of HIV/AIDS, the epidemic is concentrated when infection levels have risen substantially among those who practice high-risk behavior, but have yet to rise in the general and much larger low-risk population.
DOTS	Directly Observed Treatment Short-Course — the basic treatment package for tuberculosis that is recommended by WHO and underpins the Global Plan to Stop Tuberculosis.
DOTS-Plus	The adaptation of DOTS to respond to multidrug-resistant tuberculosis by adding second-line drugs.
Drug	A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of a disease.
Extrapulmonary TB	Tuberculosis affecting a part of the body other than the lungs.
Generic drugs	Non-proprietary pharmaceutical products.
Genome	All of the genetic information, the entire genetic complement, and all of the hereditary material possessed by an organism.
Global Drug Facility	A mechanism (facility) established as an initiative of the Stop Tuberculosis Partnership to expand access to, and availability of, high-quality tuberculosis drugs to facilitate global DOTS expansion.
Green Light Committee	A committee established by the Stop Tuberculosis Partnership that provides technical policy and procedural support for drug-resistant tuberculosis to WHO and its members. It facilitates procurement of quality-controlled, affordable second-line anti-tuberculosis drugs.
Generalized epidemic	In the case of HIV/AIDS, the epidemic is generalized when HIV has moved out of populations with high-risk behavior and has substantially infected the low-risk population.
Heath systems strengthening	Strengthening the overall performance of health systems (including financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective health, nutrition, and population interventions and a continuum of care to save and improve people's lives (World Bank 2007c, p.14).
High Burden Countries	The 22 countries accounting for approximately 80 percent of all new tuberculosis cases arising each year.
HIV status	The state of being HIV-positive or HIV-negative.
HIV-related TB	Tuberculosis occurring in somebody infected with HIV.

Identification	In the research and development of malaria drugs, the identification of a biological system or target, the inhibition of which will result in parasite death.
Incidence	The number of new cases of a disease arising in a given period in a specified population.
Independent evaluation	An evaluation that is carried out by entities and persons free from the control of those involved in policy making, management, or implementation of program activities. This entails organizational and behavioral independence, protection from outside interference, and avoidance of conflicts of interest.
Indication	A symptom or circumstance indicating the advisability or necessity of a specific medical treatment or procedure.
Indicator	A quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of a development actor.
Latent TB infection	The presence in the body of tuberculosis bacilli that are dormant (usually in the lung) and not causing harm, but that may become active and cause disease.
Logical framework or logframe	A management technique that is used to develop the overall design of a program or project, to improve implementation monitoring, and to strengthen evaluation, by presenting the essential elements of the program or project clearly and succinctly throughout its cycle. It is a “cause and effect” model that aims to establish clear objectives and strategies based on a results chain, to build commitment and ownership among the stakeholders during the preparation of the program or project, and to relate the interventions of the program or project to their intended outcomes and impacts for beneficiaries.
Malaria endemic country	A country in which malaria prevails constantly.
Monitoring	The continuous assessment of progress achieved during program implementation in order to track compliance with a plan, to identify reasons for noncompliance, and to take necessary actions to improve performance. Monitoring is usually the responsibility of program management and operational staff. An effective monitoring system provides the information required for scheduled reporting to the governing body on the use of resources and the progress of activities as well as information on outputs and outcomes that contributes to future evaluations.
Multidrug-resistant TB	Tuberculosis infection that is resistant to treatment by isoniazid and rifampicin (the two most effective anti-tuberculosis drugs).
Oversight	One of the core functions of the governing body of a program: Monitoring the performance of the program management unit, appointing key personnel, approving annual budgets and business plans, and overseeing major capital expenditures.
Pharmacovigilance	The detection, assessment, understanding, and prevention of adverse reactions of patients to drugs — a response to a drug that is noxious and unintended, and which occurs at doses normally used.

Prequalification of manufacturers or suppliers of drugs	Prior approval by a competent authority such as WHO of prospective bidders before the initiation of a procurement process. Prequalification is based upon the capability and resources of prospective bidders to perform the particular contract satisfactorily. Prequalification includes certification following a Good Manufacturing Practice (GMP) inspection.
Prevalence	The number of cases of a disease in a defined population at a specified point of time.
Pulmonary TB	Tuberculosis affecting the lungs.
Resistance	Ability of an organism to develop strains that are impervious to specific threats to their existence. For example, the malaria parasite has developed strains that are resistant to drugs such as chloroquine, and the *Anopheles* mosquito, which transmits the malaria parasite to human beings, has developed strains that are resistant to DDT and other insecticides. The ability to avoid or delay development of resistance is important in research and development for new drugs.
Shareholders	In the case of GRPPs, the subset of donors that are involved in the governance of the program. Therefore, this does not include individual (particularly anonymous) donors who choose not to be so involved, or who are not entitled to be involved if their contribution does not meet the minimum requirement, say, for membership on the governing body.
Stakeholders	Parties who are interested in or affected, either positively or negatively, by a development intervention. Stakeholders are often referred to as “principal” and “other,” or “direct” and “indirect.” While other or indirect stakeholders — such as taxpayers in both donor and beneficiary countries, visitors to a beneficiary country, and other indirect beneficiaries — may have interests as well, these are not ordinarily considered in evaluations unless a principal stakeholder acts as their proxy.
Toxicity	A measure of the degree to which something is poisonous.
Vector	An invertebrate animal, such as a mosquito, capable of transmitting an infectious agent without itself becoming infected.

Source: For evaluation terms, IEG and OECD/DAC, *Sourcebook for Evaluating Global and Regional Partnership Programs: Indicative Principles and Standards* (World Bank, 2007).

Summary

Purpose, Scope, and Methodology

1. The principal purpose of this Global Program Review (GPR) is to learn lessons from the experience of the Global Fund and its interaction with the Bank in three areas: (a) the design and operation of large global partnership programs like the Global Fund that are financing country-level investments, (b) the engagement of the World Bank with these partnership programs, and (c) the evaluation of these programs. The Review has an intensive focus on the Bank's engagement with the Global Fund at the country level because of the potential for competition or collaboration between Global Fund-supported activities and the Bank's lending operations at the country level. Therefore, it also focuses on the design and operation of the Global Fund-supported activities at the country level.

2. The Review has been prepared, first and foremost, for the Bank's Executive Board to facilitate an informed discussion about the Bank's past, current, and future engagement with the Global Fund. Since the Millennium Declaration in 2000, the World Bank has become involved in a growing number of partnership programs like the Global Fund that pool donor resources to finance country-level investments to help countries achieve specific Millennium Development Goals, that have inclusive governance structures, and that subscribe to the 2005 Paris Declaration on Aid Effectiveness. Other programs include the Global Alliance for Vaccines and Immunization (established 2000), the Global Partnership for Education (2002), the Climate Investment Funds (2008), and the Global Agriculture and Food Security Program (2010). The World Bank generally plays three roles in these programs — (a) as a trustee of donor funds supporting the program; (b) in the corporate governance of the program, and (c) as a development partner at the global and country levels.

3. This GPR is a ***review*** and not a full-fledged ***evaluation***. Like other GPRs the Independent Evaluation Group (IEG) has conducted, this is based on an external evaluation that was commissioned by the governing body of the program — in this case, the Five-Year Evaluation (FYE) of the Global Fund, launched by the Global Fund Board in November 2006 and completed in May 2009. The Review (a) assesses the independence and quality of that evaluation; (b) validates the findings of the evaluation; and (c) assesses the extent and nature of the Bank's engagement with the Global Fund at the global and country levels since the Global Fund was founded in 2002.

4. The findings and lessons of this Review are also informed by (a) structured interviews with Global Fund and World Bank staff as well as with other stakeholders; (b) visits to a sample of six recipient countries in which both organizations have been active in the health sector (Brazil, Burkina Faso, Cambodia, Nepal, the Russian Federation, and Tanzania); (c) an in-depth assessment of a World Bank-supported health project in Lesotho that was specifically designed to increase the capacity of the country to effectively use Global Fund grants for HIV/AIDS; (d) an electronic survey of Global Fund staff and World Bank project managers of health projects on the engagement between the Global Fund and the World Bank at the country level; and (e) a detailed comparison of the monitoring and evaluation (M&E) systems of the Global Fund and the World Bank.

5. Following IEG's normal procedures, copies of the draft GPR were sent for review and comment to the Global Fund Secretariat in Geneva, to the two Bank units responsible for the World Bank's engagement with the Global Fund — the Multilateral Trustee and Innovative Financing Department and the Health, Nutrition, and Population Department — and to other Bank units that have responsibility for the Bank's involvement with global partnership programs. Their comments have been taken into account in finalizing the GPR. The formal responses received from the Global Fund and World Bank management are included in this document immediately after this Summary.

6. This Review was initiated before the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund was commissioned in February 2011, and it was drafted before their final report, *Turning the Page from Emergency to Sustainability*, was issued on September 19, 2011. While the two studies are complementary and overlap to some extent, they were conducted independently of each other, for different audiences, and for different purposes.

Background on the Global Fund

7. The Global Fund was officially established in January 2002 "to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals" (Global Fund 2002). The Global Fund has fostered new approaches to development assistance to complement the existing aid architecture. It mobilizes donor resources on a large scale that are earmarked for a specific purpose and that are provided to recipient countries based on principles such as country-owned and aligned programs (Box S-1). Many of these principles were later adopted by signatories to the 2005 Paris Declaration.

Box S-1. Global Fund Guiding Principles

A. The Fund is a financial instrument, not an implementing entity.
B. The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis, and malaria.
C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes.
D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases, and interventions.
E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.
F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.
G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner, based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.

Source: Global Fund (2002), "Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria," pp. 1–2.

8. The Global Fund committed $18.3 billion in grants to developing countries through June 2011, and disbursed $14.0 billion. Nearly three-quarters of these grant resources were awarded to low-income countries, and nearly two-thirds to Sub-Saharan Africa — the region most seriously affected by the three diseases. Almost half were awarded for HIV/AIDS programs, 35 percent for malaria, and 16 percent for tuberculosis. The largest share of the grants was awarded for medicines and pharmaceutical products (18 percent) and health products and equipment (17 percent). More than half of the grants were awarded to government agencies, about one-quarter to civil society organizations (CSOs), and about one-sixth to multilateral organizations such as United Nations Development Program.

The Independence and Quality of the Five-Year Evaluation of the Global Fund

9. The Five-Year Evaluation comprised three Study Areas and a Synthesis Report undertaken over a two-and-a-half year period. Study Area 1, on the organizational efficiency and effectiveness of the Global Fund, was issued in October 2007; Study Area 2, on the Global Fund partner environment at the global and country levels, was issued in June 2008; Study Area 3, on the impact of collective efforts on reducing the burden of the three diseases, was issued in May 2009; and the final Synthesis Report was issued in March 2009.

10. Overall, this Review found that the FYE was an independent and quality evaluation, assessed against the indicative principles and standards of the *Sourcebook for Evaluating Global and Regional Partnership Programs* (IEG and OECD/DAC 2007). The evaluation has helped the Global Fund Board and management make significant strategic adjustments to its organizational and institutional arrangements. The three study areas reinforced each other, and the Synthesis Report effectively pulled together key messages in a coherent and integrated manner. Charged with a complex evaluation and an ambitious scope of work within a tight timeframe, the evaluation teams fulfilled the majority of their terms of references.

11. The conduct of the FYE was organizationally and behaviorally independent. An external body of experts appointed by and reporting to the Global Fund Board — the Technical Evaluation Reference Group (TERG) — oversaw all aspects of the evaluation, including contracting the evaluation to an independent consortium of evaluators. The evaluation teams were able to report candidly about how slowly and less strategically the Global Fund governance processes had developed to guide this new approach to development assistance; about the need for a robust risk management strategy to alert the Global Fund about likely suspension of ongoing treatment activities; and about the risk of increased drug resistance, among other things. Notwithstanding the TERG's very "involved" oversight style, the FYE was protected from outside interference and the potential conflicts of interest that arose were appropriately identified and managed.

12. Although the FYE did not achieve two objectives — developing the "determinants" of good grant performance in Study Area 2 and building evaluation capacity in Study Area 3 countries — it was an innovative and participatory evaluation experience. It sought the active participation of a range of country-level stakeholders throughout the evaluation process. The

formulation of evaluation questions and issues reflected the views and concerns not only of the public health and development community, but also of program beneficiaries and people affected by the diseases. The level of inclusiveness, participation, and transparency helped engender ownership from a broad stakeholder base throughout the world. This generally provided for a quality evaluation and learning experience, but the degree of participation declined toward the end of the evaluation process.

13. The FYE was objectives-based and evidence-based against the stated purpose and principles of the Global Fund. The overall assessment was fair and balanced, portraying both the strengths and weaknesses of the Global Fund. The FYE met three of the four standard IEG criteria for assessing quality — evaluation scope, instruments, and feedback. It did not meet the M&E criterion that the program's activity-level M&E system should contribute to the evaluation's assessment of the overall outcomes of the program because the Global Fund's grant-level M&E system was not initially designed to do so. Therefore, the FYE used other methods, notably the impact assessment in Study Area 3.

14. The FYE was one of the first evaluations of a global partnership program to undertake an extensive assessment of its operational modalities at the country level, based on the 16 country case studies in Study Area 2. This covered all salient Global Fund processes at the country level, such as Country Coordinating Mechanisms (CCMs) and Local Fund Agents (LFAs), their interactions with development partner agencies, the availability of technical assistance, performance-based funding, and grant oversight. Recommendations were directed toward improving the CCMs, LFAs, performance-based funding, and grant oversight functions. This part of the evaluation provided support for the continuation of the Global Fund model, noted how it represented a new approach to development assistance, and underlined the need for strengthening the mostly informal nature of its partnerships. It found that partner agreements to high-level principles of collaboration needed to be translated into operational realities.

15. In spite of the initial ambition, Study Area 3 was not a rigorous impact evaluation. The evaluation teams did not attempt to show attribution or causality between program inputs and the intended development outcomes because Global Fund-supported interventions had not been designed to facilitate impact evaluations, and country-level data were inadequate. Many countries had also not yet completed one five-year grant cycle. Rather, the evaluation approach can best be compared against the analytical framework of a contribution analysis, since it attempted to assess the collective contribution of all donors and countries, based on the 18 country case studies in Study Area 3.

16. On balance, Study Area 3 did an adequate job in this regard, but with some shortcomings. It demonstrated that the collective efforts have resulted in increased access to services, better coverage, and some overall reduction in the burden of the three diseases. The Step-Wise Evaluation Framework that was used emphasized contextual factors, but this Review found that few contextual factors were actually considered, based on an in-depth review of two of the country case studies (Burkina Faso and Cambodia). Assumptions and risks, also important in contribution analysis, were not delineated in the logframe. Instead, they were described in different parts of the document and were not clearly defended. The

evaluation could not, by design, assess the independent contribution of the Global Fund to country-level results.

Validating the Major Findings of the Five-Year Evaluation

17. The Global Fund requires each recipient country, with limited exceptions, to establish a Country Coordinating Mechanism to review and endorse funding proposals for submission to the Global Fund, based on a national strategy for combating the disease in question. Eligible proposals for each round of grants are reviewed by an independent Technical Review Panel. The CCM nominates a Principal Recipient, or lead implementing agency, for each grant. Once a grant is approved and the grant agreement signed, the Global Fund Secretariat instructs the World Bank, as the trustee of the Global Fund, to release funds to the Principal Recipient.

18. Each grant agreement contains a disease-specific performance framework outlining the performance expected over the lifetime of the grant and key indicators that are to be used to measure outputs and coverage on a regular basis. Grants are initially approved for two years, and renewed for up to three additional years in accordance with these principles of performance-based funding. The Global Fund also contracts with an LFA to oversee, verify, and report to the Global Fund on grant performance at every stage of the implementation process, starting with an assessment of the financial, administrative, and implementation capacity of the nominated Principal Recipient to implement the approved grant.

19. The FYE conducted 16 country case studies as part of Study Area 2 in 2007. IEG consultants revisited four of these countries (Burkina Faso, Cambodia, Nepal, and Tanzania), as well as two middle-income countries (Brazil and the Russian Federation) in 2010 to confirm the FYE findings and to assess changes (either improvements or deteriorations) in the intervening three years, using the FYE and the four Study Area 2 country reports as a baseline.

20. The remainder of this section summarizes what IEG found, organized according to eight of the nine major findings of the FYE, as presented in the Synthesis Report. (IEG did not address the ninth major finding because this related to the global governance of the Global Fund, not its country-level activities.)

21. ***Additionality of Global Fund Resources***. This Review confirmed the FYE finding that the Global Fund has provided substantial resources for HIV/AIDS, tuberculosis, and malaria control programs. Global Fund commitments of $4.3 billion in 2009 accounted for almost 40 percent of total official commitments (both concessional and nonconcessional) to combat the three diseases and 19 percent of commitments to the overall health sector, according to data from the Organisation for Economic Co-operation and Development. At the same time, other donor commitments to the three diseases outside of the Global Fund have not decreased, but have also increased, from $1.7 billion in 2002 to $7.1 billion in 2009 (in constant 2008 prices), and commitments to the overall health sector have grown from $9.2 to $18.1 billion. Whether total donor commitments to the three diseases have been higher or lower than they would otherwise have been in the absence of the Global Fund is not known. However, this Review found that other donor commitments for health have been essentially constant since 2002 in three of the four low-income countries visited (Burkina

Faso, Cambodia, and Nepal). Similar to the FYE, this Review did not find evidence that governments have reduced their own expenditures on the three diseases in response to Global Fund grants, except in one country (Tanzania).

22. ***Sustainability of External Financial Support for the Three Diseases.*** The FYE found that reliance on external funds (from the Global Fund and other international donors) and inadequate investments in long-term domestic capacity raised concerns about the long-term sustainability of recipient countries' disease-control programs. This Review found that the low-income countries visited were becoming increasingly dependent on Global Fund support for antiretroviral treatment of people living with AIDS. The Review also found increasing concerns at the global level that other donors' support for treatment may be less forthcoming in the future. The sustainability of resources to support people living with AIDS who are already receiving antiretroviral treatment is of particular concern, since interrupted treatment increases not only the risk of death among those already being treated, but also the risks of new infections and of drug-resistant strains of the virus. Any retreat of bilateral donors from financing treatment is likely to result in increased demand on the Global Fund to finance the shortfall. If overall external support for treatment is not sustained, governments in recipient countries will face pressures to reallocate their own budgetary resources to costly treatment activities, and away from other health and non-health priorities. To the extent that the amounts of Global Fund and government resources spent on the prevention of new infections decline as a result and are not taken up by other donors, the long-run affordability and sustainability of treatment programs will be further undermined.

23. ***Predictability of Global Fund Support.*** This Review also found short-term gaps in the timing of Global Fund financing in several countries due to the uneven pattern of grant proposals and the unpredictability of grant approvals (only half the proposals are approved, on average). Very much aware of this issue, the Global Fund is currently transitioning its entire grant portfolio into single streams of funding (SSFs), which are intended to make it easier for the Global Fund to support a national program approach for each disease that is better aligned with national systems and budget cycles. The Secretariat has so far signed over 80 SSFs and plans to have completed most of the transition to SSFs by the end of 2013.

24. ***Performance of CCMs.*** The FYE found that the CCMs were successful in mobilizing domestic and international partners for submission of grant proposals to the Global Fund and in enabling CSOs and affected communities to participate in the proposal preparation process, but that CCMs were ill-equipped to provide adequate oversight of grant implementation. This Review found that the CCMs were functioning better than the 2007 FYE findings indicated in two countries (Burkina Faso and Cambodia), about the same in two countries (Tanzania and Brazil), and worse in two countries (Nepal and the Russian Federation). The two countries (Cambodia and Tanzania) with their own national-level technical review panels also had the highest grant approval rates. This Review found little improvement since 2007 in the capacity of CCMs to oversee the implementation of Global Fund grants from the country perspective, because they generally lacked the authority and the resources to do so effectively. Inadequate management of the inevitable conflicts of interest that arise in bodies such as the CCMs also hindered effective oversight in some countries. The Global Fund has taken steps over the last two years to strengthen CCMs' capacity to oversee grant implementation and to manage conflicts of interest.

25. ***Effectiveness of Country-Level Partnerships***. The FYE found that country-level partnerships were based mostly on good will and voluntary collaboration rather than on negotiated commitments with clearly articulated roles and responsibilities. They did not yet comprise a fully functioning system — representing more of a "friendship model" than a genuine "partnership model." This Review found that partnerships with other development agencies such as the World Bank and bilateral donors have generally improved since 2007 in terms of other partners' providing technical assistance in support of Global Fund activities. However, country-level stakeholders still see the Global Fund as a largely separate development agency with its own distinct modalities that are not well integrated into the existing donor coordination mechanisms in the countries. This was also true of other large donors such as USAID, the President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank in particular countries. This Review found that civil society representation in decision making was effective in three of the six countries (Brazil, Burkina Faso, and Cambodia). IEG found little evidence of effective partnerships with the commercial private sector at the time of its country visits (April–June 2010).

26. ***Application of Performance-based Funding***. The FYE found that the Global Fund had attempted to implement performance-based funding on a scale unprecedented in the international health arena. However, this "focus on results" remained a work in progress and had evolved into a complex and burdensome system that focused more on project inputs and outputs than on development outcomes and impacts. This Review found that performance-based funding was working reasonably well in three countries (Burkina Faso, Cambodia, and the Russian Federation) in terms of monitoring outputs and coverage in relation to the key performance indicators in the grant agreements. It was not working well in the other three countries — it was hindered by low-quality data in Tanzania, by political instability in Nepal, and by its unsuitability for the types of Global Fund grants in Brazil (focusing on intermediate products in the health system).

27. ***Adequacy of Grant-Level Monitoring and Evaluation***. The Global Fund has very detailed and well-documented requirements for grant-level monitoring, which are tied to its performance-based funding approach. However, the Global Fund does not have a system for end-of-grant evaluations. Its grant-level M&E system is designed more to facilitate grant disbursements than to contribute to an overall assessment of the program. While the FYE was an independent and quality evaluation, it was constrained by the absence of an M&E framework for the cumulative assessment of grant performance; it had to rely on other approaches, such as the in-depth country studies. The lack of such a framework made it unclear what criteria the FYE used to draw conclusions — both positive and negative — about the overall efficacy of Global Fund grants.

28. ***Access and Coverage of Service Delivery***. The FYE found that collective donor efforts had contributed to increased access to disease-control services, particularly for HIV/AIDS, and increased coverage of affected communities, which should ultimately reduce the disease burden. The survival rate of people on antiretroviral therapy had increased, and the incidence of HIV among young people had probably declined in some countries. This Review found that Burkina Faso and Cambodia have used Global Fund grants to expand services for all three diseases, and that Brazil has used the grants to improve the quality of services for tuberculosis and malaria (the only two diseases for which the country has received grants). Tanzania has

had a weaker record of grant implementation, and Nepal and the Russian Federation have yet to put in place an effort of sufficient scale to reach high-risk and marginalized groups of HIV-vulnerable individuals, and thereby thwart the spread of HIV into the general population.

29. ***Equity in Country-Level Governance and Grant Objectives***. The FYE found that the Global Fund had modeled equity in its guiding principles and organizational structure — for example, in ensuring representation of women and marginalized populations on the CCMs. However, few systems had been put in place to monitor gender, sexual orientation minorities, urban-rural, wealth, education, and other types of equity as part of grant performance. This Review also found significant attention to equity issues in most of the six countries visited in terms of membership of affected communities on the CCMs and the objectives of the grants themselves. Expanding access to diagnostic and treatment services in rural areas has been a key focus of Global Fund grants in all four low-income countries. Reaching high-risk groups in the case of HIV/AIDS has been more difficult, and has been more successful in some countries visited, such as Cambodia.

30. ***Impact of Donor Support for the Three Diseases on Domestic Health Systems***. The FYE found that the large increases in external funding for the three diseases had stretched existing, generally weak, health systems to their limit. Health systems needed to be strengthened if countries were to scale up the delivery of services financed by the Global Fund. This Review found mixed results, risks, and opportunities associated with the effects of Global Fund grants for the six countries' health systems. The large inflow of Global Fund resources into small low-income countries with high disease burdens has tended to create dependency on the Global Fund for treatment of the three diseases, and to weaken domestic health systems by drawing talent away from the public sector. However, Global Fund grants have directly expanded the service delivery capability of local health systems in Burkina Faso and Cambodia, where the participation of CSOs, community-based organizations, and faith-based groups has enhanced access to health services in rural areas. The Global Fund model also encourages establishing relationships beyond the conventional ministries of health — for example, with drug enforcement agencies, to help strengthen country systems in the fight against counterfeit drugs and drug resistance.

31. ***Institutional Risk Management by the Global Fund.*** The FYE found that weak management of risks — including financial, organizational, operational, and political risks — was a particular vulnerability of the Global Fund. The main risk-mitigation instruments had comprised LFA assessments, financial disbursement red flags, and the Early Alert and Response System that was intended to provide early identification of underperforming projects and to facilitate timely corrective actions. This Review found that the Global Fund Secretariat has given priority attention to improving risk management at the corporate and country levels following a Board directive in 2007 and in response to the FYE findings and recommendations. IEG found that the LFA's verification and reporting on grant performance was better in four countries (Brazil, Burkina Faso, Cambodia, and the Russian Federation) than indicated in the 2007 FYE findings. However, as already mentioned, the CCMs' programmatic oversight of Global Fund grant implementation was still weak. Communications between the LFAs and the CCMs have proven to be a sensitive matter, since the LFA is an agent of the Global Fund Secretariat, not of the CCM.

The World Bank's Engagement with the Global Fund

THE WORLD BANK'S ROLES IN THE GLOBAL FUND

32. The World Bank plays three major roles in the Global Fund: (a) as the trustee of donor contributions to the Global Fund; (b) in the corporate governance of the program, and (c) as a development partner at the global and country levels. This Review has focused on the third role, and on the first two roles mainly as they contribute to the third.

33. First, as trustee, the Bank receives and invests funds from Global Fund donors, disburses the funds to grant recipients on the instruction of the Secretariat, and provides regular financial reports to the Board. The Global Fund trust fund is the largest of the 15 financial intermediary funds (FIFs) administered by the Bank that are supporting global and regional partnership programs. The income from investing undisbursed funds represented 5.4 percent of the total resources available to the Global Fund during 2002–10, and has more than covered the cumulative administrative costs of the Global Fund since it was established.

34. Second, the Bank is a permanent nonvoting "institutional" member of the Board, along with the World Health Organization (WHO), UNAIDS, and the Stop Tuberculosis Partnership (Stop TB), and a member of two Board committees — the Finance and Audit Committee, and the Policy and Strategy Committee. The Global Fund employs a constituency-based stakeholder model of governance in which voting membership on the Board includes not only donors but also nonfinancial contributors such as recipient countries, affected communities, nongovernmental organizations (NGOs), and the commercial private sector.

35. The FYE found that the Global Fund governance structure and processes had achieved both broad participation and genuine power-sharing among key constituencies in the fight against the three diseases. The participation of civil society and private sector constituencies has been broadly viewed as effective, while that of some other constituencies (such as affected communities) has been less so, due to the size of the constituencies and the absence of easy mechanisms to communicate effectively within them. This Review also found that the Global Fund represented a significant shift in the roles and responsibilities of different stakeholder groups compared with more exclusive shareholder models of governance in which voting membership on the governing body is limited to financial contributors. However, it is doubtful that this diminished status of the Bank and other nonvoting members significantly reduces the Bank's reputational risks of involvement with the Global Fund, given the role that the Bank plays in global health, and its extensive engagement with the Global Fund at the global and country levels, as documented in this Review.

36. Third, the Bank's role as a development partner has been less clearly defined than the first two roles. The Bank plays an operational role, as one of the implementing agencies, in most other global partnership programs supported by FIFs. That it might also play such a role in the Global Fund was never seriously considered by the Transitional Working Group (the precursor to the Global Fund Board) in 2001. However, there were considerable pressures at the outset for the Bank to take on an "enhanced fiduciary role" in addition to being the trustee, to ensure that the Global Fund grants were used for the intended purposes. When the Bank

declined, the Global Fund Board decided in April 2002 to establish the LFA system of contracting out in-country fiduciary functions to LFAs.

37. This Review found that there was a strong expectation among members of the Global Fund Board at the outset that development partner agencies — including WHO, UNAIDS, RBM, Stop TB, and the Bank — would provide technical support to Global Fund-supported activities at the country level. The extent to which the Bank accepted or acknowledged this role appears to have been left deliberately vague due to the tensions surrounding the establishment of the Global Fund in 2002. There was — and remains to this day — no formal agreement or memorandum of understanding (MOU) between the World Bank and the Global Fund in terms of working together at the country level, and there have been no written directives or guidelines issued to staff in either organization for engaging with the other at the country level. Although the Bank was involved in 11 other global and regional health partnerships in 2002, the Global Fund was the first one that was financing country-level investments in which the program expected the Bank to provide such technical support.

THE WORLD BANK'S ENGAGEMENT WITH THE GLOBAL FUND AT THE COUNTRY LEVEL

38. This Review examined more closely an area not covered by the FYE: the engagement between the World Bank and the Global Fund at the country level. There is no systematic record of this engagement. Therefore, this Review has pieced together this record from Bank databases, word searches and reviews of World Bank County Assistance Strategies and Project Appraisal Documents, key informant interviews, and the electronic survey of health sector project managers at the World Bank and Global Fund staff in Geneva, administered in March 2011. Collectively, these results suggest that the Global Fund and the Bank have had some degree of engagement — from sharing information about each other's activities to active collaboration in the pursuit of commonly agreed objectives — in about three-quarters of the 90 countries in which both organizations have been active in the health sector since 2002 (Figure S-1). This amounts to about 65 countries overall, of which 25–30 countries have been in Africa, the region most seriously affected by the three diseases.

39. Engagement has generally started with a request from the government of the country. The government — as the chair or an influential member of the CCM — has often requested the Bank's technical support for preparing grant proposals to the Global Fund, particularly during the earlier Global Fund rounds and for HIV/AIDS proposals in countries in which the Bank was supporting a Multi-country AIDS Program project. Recognizing that the Bank's overarching mission is to contribute to the development of its client countries and their institutions, Bank staff have generally responded positively, to the extent that their time and resources permitted. Bank staff have also become involved in Global Fund-supported activities through their participation in health sector donor-coordination processes in the country, through participation in joint World Bank-Global Fund workshops, and through the direct request of Global Fund Regional Team Leaders and Fund Portfolio Managers. World Bank Sector Managers have also encouraged engagement in some cases.

40. Bank staff and consultants have generally not been involved in specific Global Fund processes at the country level. They have been members of the CCM in at most one-third of the 65 countries, according to survey results, helped to prepare grant proposals in 30 percent,

Figure S-1. Global Fund and World Bank Country-Level Staff: Overall, how would you best characterize the relationship between the World Bank and the Global Fund in the country you were working on?

Collaborative: The two organizations' staff, consul-tants and agents worked together on common activ-ities in the pursuit of commonly agreed objectives.

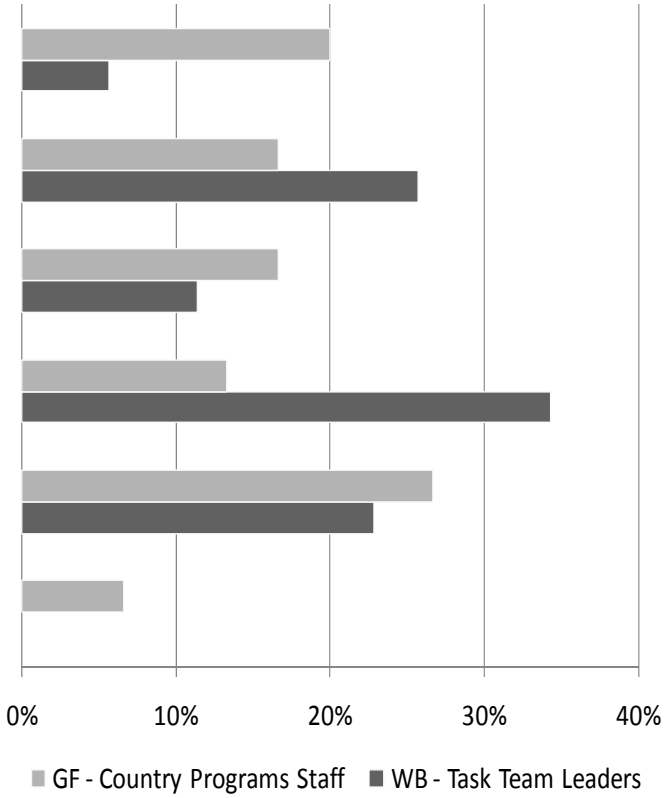
Complementary: The two organizations' staff, consultants, and agents worked alongside each other in the pursuit of common objectives.

Consultative: The two organizations' staff, consultants, and agents consulted each other regularly in the course of their own activities.

Sharing information only: The two organizations' staff, consultants, and agents only shared information about each other's activities.

Unrelated and independent: The two organizations worked independently of each other supporting different health initiatives in the country.

Competitive: The two organizations competed for business among the same potential clients.



Source: IEG Survey of World Bank health sector project managers and Global Fund Secretariat staff, administered in March 2011.
Note: Each respondent was limited to only one choice; therefore, the responses from each organization add up to 100 percent. The survey response rates were 62 percent (36 out of 58) for Global Fund Country Programs staff and 33 percent (42 of 128) for World Bank task team leaders (project managers).

and provided formal technical assistance to the Principal Recipients in 25–30 percent of countries (some of which have also been implementing agencies for Bank-supported projects). Bank staff and consultants have more frequently contributed to other country-level activities, such as strategic and analytical work, that directly or indirectly contributed to the work of the Global Fund.

41. The engagement between the Bank and the Global Fund has also been dynamic in many countries, such as Burkina Faso and Tanzania. Bank-supported Multi-Country AIDS Program projects helped to institutionalize the CCMs in these countries and to prepare the initial grant proposals. Then, as the Global Fund expanded its support, the Bank moved toward providing complementary support to the countries' health sectors more generally. Key factors contributing to positive engagement have been a proactive government and a strong donor coordination mechanism at the country level. The personal commitment of the World Bank's project managers and Global Fund's Portfolio Managers has also played a role in sustaining successful cooperation, as in Lesotho during the implementation of the HIV and AIDS Capacity Building and Technical Assistance Project from 2004 to 2008 and in the

Russian Federation during the implementation of the Tuberculosis and AIDS Control Project from 2003 to 2009.

42. There have been numerous avenues for World Bank-Global Fund engagement at the country level, including corporate-level contacts, the Bank's own support for communicable disease control in client countries, and the various initiatives associated with the Global HIV/AIDS Program (GHAP) and the International Health Partnership (IHP). GHAP, which was established in the Bank in June 2002 in partnership with UNAIDS, led to the establishment of the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET) in 2002, the Global Implementation Support Team (GIST) in July 2005, the AIDS Strategy and Action Plan Service (ASAP) in July 2006, as well as an unsuccessful attempt to formulate an MOU between the Bank and the Global Fund in 2007. The IHP, which was launched in September 2007, led to the Health-8 group in 2007, the Joint Assessment of National Strategies in July 2009, and the Health Systems Funding Platform in early 2010. (UNAIDS has contributed $57.1 million to a Bank-administered trust fund over 2003–10 to support the various activities of GHAP, and WHO has recently established a trust fund at the Bank to support IHP activities.) But none of these avenues has so far led to a formal agreement between the World Bank and the Global Fund on country-level engagement.

PROSPECTS FOR FUTURE ENGAGEMENT AT THE COUNTRY LEVEL

43. There are growing pressures from donors for the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund, and the World Bank — as the three largest multilateral financiers of country-level investments in health — to improve collaboration at the country level. A consultation on Donor Harmonization of AIDS Funding in April 2004 endorsed the "Three Ones" principles to be applied in each recipient country: (a) one agreed HIV/AIDS action framework for coordinating the work of all partners, (b) one national AIDS coordinating authority, and (c) one agreed country-level M&E system. A 2006 study on the comparative advantages of the World Bank and the Global Fund found the Bank's comparative advantage to be systematic strengthening of health systems to support communicable disease control, among other things. The Health Systems Funding Platform has since incorporated these ideas into its efforts to accelerate progress toward achieving all the health-related Millennium Development Goals in addition to combating communicable diseases. While the Three Ones principles were first developed for HIV/AIDS, they are also relevant for other disease areas, and for donor-supported health sector activities in general.

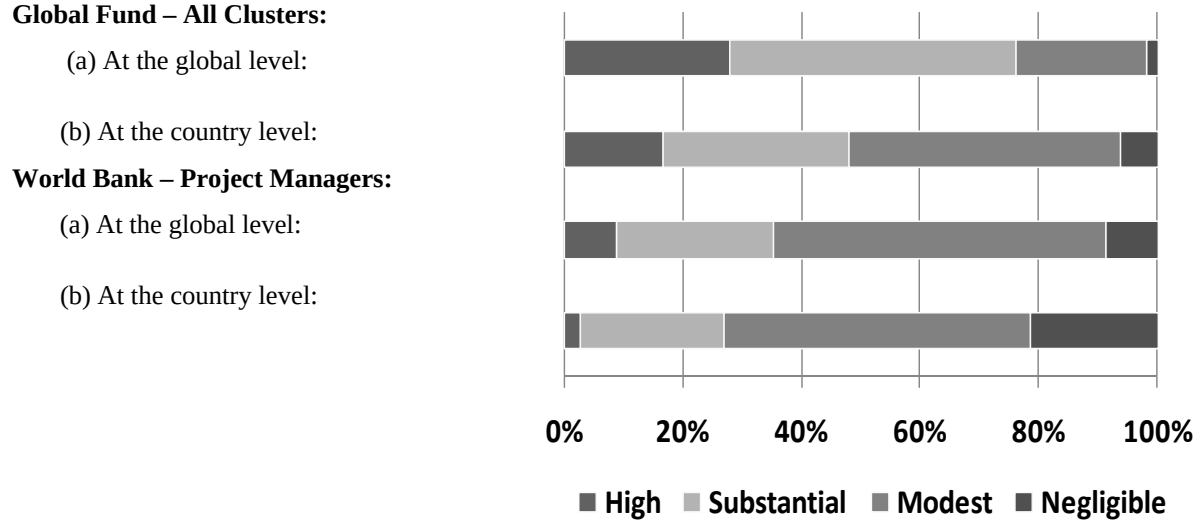
44. The different business models of the World Bank and the Global Fund provide both opportunities and hindrances. The survey of World Bank project managers and Global Fund staff found that both groups tend to have a positive view of the opportunities for engagement associated with the GHAP and the IHP. Global Fund staff generally appreciate the relatively strong country presence of the World Bank and the Bank's support for strengthening country-level health sector M&E systems. Bank project managers generally appreciate the presence of CSOs on the CCMs and the fact that Principal Recipients of Global Fund grants need not be government agencies.

45. Yet both organizations also view engagement as difficult in some respects. Bank project managers regard unprogrammed technical support as an unfunded mandate. Global Fund staff

regard it as problematic that World Bank funding for the health sector has to compete with other sectors for its place in the Bank's Country Assistance Strategy. Both regard their own organizations as more flexible in responding to country needs, based on interviews. But the survey results also suggest that some other factors raised in interviews are not significant impediments to collaboration: the different professional backgrounds of World Bank project managers and Fund Portfolio Managers, the different types of financial support (loans versus grants), the success of the Global Fund in mobilizing donor resources to combat the three diseases, and the role of the LFA in the fiduciary oversight of Global Fund grants.

46. Global Fund staff view the World Bank as a partner of the Global Fund at both the global and country levels to a greater extent than do Bank staff (Figure S-2). Both Global Fund and Bank operational staff would prefer engagement in the context of their own organization's business model. They generally viewed the comparative advantages of the other organization in terms of what the other could contribute to its own method of operation.

Figure S-2. Global Fund and World Bank Staff: To what extent do you consider the World Bank to be a partner of the Global Fund (a) at the global level and (b) at the country level?



Source: IEG Survey of World Bank health sector project managers and Global Fund Secretariat staff, administered in March 2011.
Note: The survey response rates were 49 percent (52 out of 106) for Global Fund staff and 33 percent (42 of 128) for World Bank project managers (task team leaders).

47. Global Fund staff would like the Bank to make a greater effort to include them in high-level government discussions, as has happened in some countries, such as Cambodia, and for the Bank to contribute its health sector expertise to Global Fund processes, such as the CCM at the country level. World Bank project managers would like the Global Fund to contribute to multidonor Sector-Wide Approaches (SWAps) or cofinance World Bank projects in the health sector, and for the Global Fund's donors to establish a trust fund for financing Bank-supervised technical assistance in support of Global Fund-supported activities.

48. Neither World Bank project managers nor Global Fund Portfolio Managers are satisfied with "business as usual." Both groups viewed the absence of an MOU on country-level

collaboration between the two organizations as a significant impediment to such collaboration. Both found the absence of guidelines within their own organizations for engaging with the other organization to be problematic.

49. If World Bank engagement with Global Fund-supported activities remains at current levels, or increases, there needs to be a clearer institutional mandate for Bank staff to work with the Global Fund for the benefit of client countries — particularly low-income countries with high disease burdens — with resources allocated for the purpose and with appropriate institutional recognition of contributions and achievements. Whether or not the Bank reaches a formal or informal agreement with the Global Fund for working together at the country level, the ways in which the Bank's country teams and staff are permitted, encouraged, or required to engage with Global Fund-supported activities at the country level simply need to be defined and resourced. And for sustainability, the relationships need to move beyond the personal to the institutional level. Such directives and guidelines are not contrary to country-driven development; they can allow for case-by-case judgment, taking into account country differences.

Lessons

50. Since it was founded in 2002, the Global Fund has become a prominent example of large global partnership programs that pool donor resources to finance country-level investments to help countries achieve specific Millennium Development Goals in accordance with the Paris Declaration principles of country ownership, alignment, harmonization, managing for results, and mutual accountability. This Review provides a number of lessons for the Global Fund and other similar programs, for the World Bank in engaging with these programs, and for evaluating global partnership programs more generally.

LESSONS FOR THE GLOBAL FUND

51. ***Harmonization.*** *The Global Fund is facilitating donor coordination at the point at which donors contribute to the trust fund and serve on the Global Fund Board, but this has not yet translated into a similar degree of coordination at the country level.* Country-level stakeholders tend to regard the Global Fund as another, largely separate development partner agency with its own distinct modalities that have not been well integrated into existing donor coordination mechanisms in the countries, or with national budget cycles, contrary to the harmonization principle of the Paris Declaration. While this situation may improve as the Health Systems Funding Platform matures and as the Global Fund transitions its grant portfolio to single streams of funding under its new grant architecture, the Global Fund has not generally contributed to harmonization through existing mechanisms for pooling funds at the country level, such as SWAps.

52. ***Technical Support to Enhance Country Ownership.*** *Development partners need to provide greater technical support to strengthen the ability of governments to effectively coordinate donor efforts around agreed national strategies.* This Review found that the situation has generally improved since the FYE in terms of other partners' providing technical assistance in support of Global Fund activities. The Global Fund has also developed a new partnership strategy, signed MOUs with Stop TB and RBM in 2009 and 2010, respectively, and is reaching out to other development partner agencies more generally.

However, the Global Fund needs to find ways to finance such technical assistance, provide it directly, or work effectively with other development partner agencies to do so.

53. ***Sustaining the Benefits of Global Fund Support.*** *The long-term sustainability of the benefits of Global Fund-supported activities depends on the complementary activities of donor partners and strengthening the capacity of recipient countries.* This will require a substantially more coordinated approach to external financial support at both the global and country levels than has occurred to date. It will be difficult for the Global Fund "to adjust its demand-driven model" to support "the most cost-effective interventions tailored to the type and local context of specific epidemics," as recommended by the FYE, if it ends up becoming the residual financier financing others' shortfalls. The scarce resources available to fight the three diseases — including those raised by the country from its own resources and those provided by its external partners, including the World Bank — need to be allocated collectively and proactively in each country in accordance with an agreed long-term strategy for fighting each disease in the country.

54. ***Managing for Results.*** *The M&E requirements of different development partners have so far thwarted their good intentions to coordinate and streamline M&E for the three diseases at the country level.* The Global Fund, the World Bank, and other agencies have endorsed the Three Ones principles of a common action framework, a single coordinating authority, and one M&E framework to monitor collective efforts in each disease area. They jointly prepared an M&E Toolkit in 2004 (revised in 2006, 2009, and 2011) to establish norms and identify indicators to be used by all the agencies, but it has been difficult to achieve their use in practice because each agency has its own project-level M&E requirements. Both the Global Fund and the World Bank could contribute to improved M&E at the project and country levels by making a stronger commitment to the Three Ones principles. Project-level M&E could focus on accountability for achieving the specific outputs of each project, and country-level M&E on tracking the higher-level outcomes and impacts collectively.

55. ***Managing Conflicts of Interest.*** *Real and perceived conflicts of interest are an inherent and essentially unavoidable feature of all partnership programs, deriving in the first instance from the multiple roles that the key partners play in a given program.* The Global Fund has brought recipient countries, CSOs, and affected communities into its governance arrangements at both the global and country levels. It has also established independent review processes at key stages in its operations such as the reviewing of grant proposals (by the Technical Review Panel), verification and reporting on grant performance (by the LFAs), and overseeing evaluations (by the TERG). It has also established, and recently expanded, its conflict of interest guidelines for the operation of CCMs. The key is to identify and manage potential conflicts of interest in a way that does not impede the effectiveness of the program. Reconciling these two imperatives will remain a continuing challenge for the Global Fund and for other global and regional partnership programs.

56. ***Global Public Policy.*** *Neither the Global Fund nor the World Bank can address by itself "global communicable disease governance issues" such as the risk of drug resistance for current treatments of the three diseases.* This Review found that drug resistance is a live issue in the countries visited, amplified by incomplete treatments and the presence of counterfeit drugs. Global Fund grants could help strengthen the capacity of drug regulatory and enforcement agencies in assuring quality compliance by the pharmaceutical industry, and

CCMs could invite drug regulatory agencies to participate in specialized committees of the CCMs. The Global Fund and the World Bank also need to support ongoing efforts by organizations with relevant competence, such as WHO and the United Nations Office on Drugs and Crime, to ensure that the sizable investments that the world has made in combating the three diseases are not diminished by inaction in this area.

LESSONS FOR THE WORLD BANK

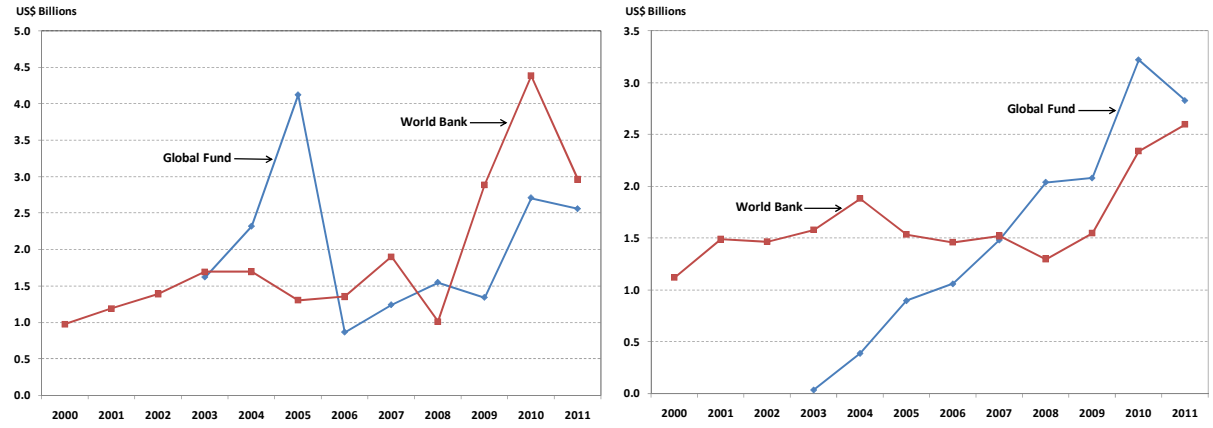
57. ***Financial Intermediary Trust Funds.*** *This Review provides evidence to support IEG's recent recommendation that "the Bank should strengthen its framework for guiding its acceptance and management of FIFs going forward"* (IEG 2011a, p. 85). Like other FIFs, the Global Fund trust fund was established in an ad hoc way in 2001–02 to accommodate the particular requirements of the Global Fund and its donors. This has resulted in some ambiguities in the relationship between the Bank and the Global Fund. For example, the trust fund management agreement was crafted to limit the Bank's responsibility for the development outcomes of the use of trust fund resources, yet Global Fund donors expected that the Bank would contribute technical assistance to Global Fund-supported activities at the country level. Also, the Bank's accountability for the effective governance of the Global Fund as a permanent nonvoting institutional member of the Board has not been clarified. The Bank is currently in the process of preparing a stronger framework for the acceptance and management of FIFs, along the lines recommended by IEG.

58. ***Engagement Strategy.*** *This Review also provides evidence to support IEG's recent recommendation that "the Bank should have an explicit engagement strategy for each GRPP in which it is involved, including . . . the expected roles of the Bank in the program at both the global and country levels, . . . how the program's activities are expected to be linked with the Bank's country operations, and how the risks to the Bank's participation will be identified and managed"* (IEG 2011b, p. 101). This Review has found that the Bank has been actively engaged in the corporate governance of the Global Fund and with Global Fund-supported activities in about 65 countries, in addition to being the trustee of the Global Fund trust fund. Yet the trustee role has been the only one of the Bank's roles in which the Bank's contributions to and expectations of the relationship have been expressed, so that the trustee relationship is bearing the burden of the Bank's entire engagement with the Global Fund, which it was not designed to do. It would be better for the Bank to have a more complete engagement strategy with the Global Fund that encompasses all the roles that the Bank plays in the partnership. This would include guidance to country-level Bank staff for engaging with Global Fund-supported activities at the country level.

59. The Bank is in the process of preparing a new partnership framework for the Bank's engagement with GRPPs more generally. The Bank's 2007 Health Strategy also provides general statements about its engagement with the Global Fund. However, something more than these general statements is also needed to provide guidance to country teams and Bank staff. The Global Fund will likely continue to disburse for communicable disease control more than what the Bank disburses for the entire health sector (Figure S-3). Nine years of experience have shown that the Bank can contribute meaningfully to the work of the Global Fund at the country level without taking on supervisory or operational roles. Undertaking such roles — as the Bank currently performs for the Global Environment Facility — might also be considered on a pilot

basis under certain circumstances, such as a SWAp operation or a common implementing agency (Principal Recipient). The Global Fund or its donors could also establish a trust fund at the World Bank for financing Bank-supervised technical assistance in support of Global Fund-supported activities, following the precedents of UNAIDS for the Global HIV/AIDS Program and WHO for the International Health Partnership.

Figure S-3. Global Fund Grants and World Bank Health Projects, Fiscal Years 2000–11



Source: Global Fund and World Bank data.
Note: Global Fund commitments and disbursements are totals. World Bank commitments and disbursements represent the proportions of total project commitments and disbursements to the health sector.

60. ***Community of Practice.*** *The Bank could establish a community of practice among its project managers who are working with the Global Fund to learn cross-cutting lessons of experience.* This would be similar to the regionally coordinated community of practice that currently exists for the Bank's engagement with the Global Environment Facility. Such a community of practice could lead, among other things, to standard terms of reference for Bank staff serving on CCMs, and could be supported by a central database to keep track of the Bank's engagement with the Global Fund over time. As many have observed, "what gets measured, gets done."

LESSONS FOR THE EVALUATION OF GLOBAL AND REGIONAL PARTNERSHIP PROGRAMS

61. ***Early Stage Evaluations.*** *Formative evaluations, like Study Areas 1 and 2 of the FYE, are more useful in the early stages of a global program in helping the program make strategic adjustments to its organizational and institutional arrangements than the contribution analysis that was undertaken in Study Area 3.* Furthermore, the diversity of components in a global or regional program and the resulting complex causality and aggregation issues by their nature make impact evaluation difficult if not infeasible. Nonetheless, impact evaluations may be valuable in helping to identify the impacts of interventions and key causal linkages for subsets of activities where impacts are more measurable than for the program as a whole.

62. ***Project-Level Monitoring.*** *Good monitoring systems should not only assess progress in implementing activities but also contribute to periodic summative evaluations and to effective policy dialogue.* The Global Fund has established different objectives for M&E at the grant, country, and corporate levels, yet the three levels are not well connected with each other. Its grant-level M&E system is designed more to facilitate its performance-based funding approach to grant disbursements than to contribute to an overall assessment of the outcomes of the program or to policy dialogue. The only country-level evaluations that it has so far undertaken are the 18 country assessments for Study Area 3 of the FYE. The Global Fund could consider undertaking evaluations of a random sample of the single streams of funding for each disease now taking place under its new grant architecture. The Global Fund might also institutionalize regular country-level evaluations, the results of which could feed into, rather than be part of, subsequent evaluations of the overall program. This would also help build the knowledge base about which approaches most successfully contribute to achieving collective outcomes.

63. ***Objectives and Scope of Global Program Evaluations.*** *These are best kept to a manageable size consistent with the most immediate evaluation needs of the program — allowing for realistic schedules and avoiding evaluation fatigue and conflicts with other evaluation efforts in countries.* Large numbers of upstream processes built into the evaluation design can distract instead of facilitate the evaluation process. Sufficient time should also be allowed to adequately pretest new evaluation instruments.

64. ***Participatory Evaluation.*** *Participatory evaluations that engage country partners need to manage expectations, since unmet expectations dampen country ownership of the evaluation process and of the end product.* Evaluation schedules should be realistic and allow for productive exchanges and consultation between evaluation teams and country partners. Otherwise country partners may perceive their roles as largely collecting critical data, with little involvement in the analysis and deliberations about their significance.

65. ***Evaluation Capacity Building.*** *Development activities such as building country-level evaluation capacity within the context of a global program evaluation are commendable but difficult to implement and sustain in the context of a one-off evaluation.* Building M&E capacity is a long-term endeavor that is better undertaken through more conventional approaches given the condensed schedule in a global program evaluation. The tension between the two objectives can be very pronounced: an external evaluation emphasizes independence and objectivity, while capacity building emphasizes learning and strong engagement with the implementing bodies.

Secretariat Management Comments: The Global Fund

> *"The Global Fund values very highly the partnership with the World Bank. It welcomes many of these recommendations. It is implementing many actions as part of its comprehensive transformation plan which is the corporate priority in 2012."*

The Global Fund Secretariat values very highly the partnership with the World Bank, and the opportunities to further improve it at the global and country levels as outlined in this Program Review. We are pleased that the Review recognized the independent and quality evaluations the Global Fund has undertaken so far and the improvements in partnership it has accomplished over time.

Overall, the Secretariat supports most of the recommendations aimed at strengthening the partnership with the World Bank at the global and country levels, and ensuring benefits of joint approaches to project- and program-level M&E.

We are pleased to see that the findings of the IEG Program Review are very much in line with the findings of the Five-Year Evaluation of the Global Fund and that the recommendations of the Review have been quite widely covered by recent review processes undertaken by the Global Fund in the course of 2011, namely by the Comprehensive Reform Working Group and the High-Level Panel.

Many of the proposed new approaches to M&E, including an increased focus on outcomes and impact, are important components of the Global Fund Consolidated Transformation Plan, recently approved by the Global Fund Board, whose implementation represents the Secretariat's major corporate priority in 2012. Through the implementation of the Consolidated Transformation Plan, we will also be able to improve the way we work with our partners, including the World Bank, at the country level.

The Secretariat would like to highlight that there are some limitations in drawing general conclusions from the six country studies covered by this review.

The Global Fund will take many of the lessons of this program review into account in the framework of the Consolidated Transformation Plan implementation, the implementation of the new evaluation strategy and Global Fund strategy in 2012, and in continued efforts to strengthen the formal partnership with the World Bank.

Overall Comments on the Program Review Findings and Recommendations

The Global Program Review is not a full-fledged evaluation and it is based on a recently completed evaluation of the Global Fund—the Five Year Evaluation—that was considered as a good quality and influential independent evaluation exercise.

The Program Review aimed to:

1. Assess the independence and quality of that evaluation, which it found to be "an independent and quality evaluation."
2. Provide a second opinion on the effectiveness of the Program.
3. Assess the performance of the World Bank as a partner in the Program.
4. Draw lessons for the Bank's engagement in the global and regional partnership programs more generally.

The recommendations of the Program Review build on the Five-Year Evaluation, and the Global Fund has responded to many of its major findings, including:

- The implementation of country teams combining functional and Fund Portfolio Manager expertise to manage high-impact and high-risk grants
- The implementation of the new grant architecture, including single streams of funding and periodic reviews built on country evaluations
- The approval of the new evaluation strategy
- The development of the new Global Fund strategy, including modifications to the proposal process and promotion of reprogramming and learning in grants.

We welcome the methodology used for the Program Review based on:

(a) Desk review of key documents and academic literature
(b) Structured interviews with Global Fund and World Bank staff as well as with other stakeholders
(c) An analysis of Global Fund–supported activities
(d) Visits to a sample of six countries in which both organizations have been active in the health sector (Brazil, Burkina Faso, Cambodia, Nepal, the Russian Federation, and Tanzania)
(e) Electronic survey of Global Fund staff and World Bank project managers focused on the partnership, and, in addition, a detailed comparison of the M&E systems of the Global Fund and the World Bank.

However, we would like to stress that there are some limitations in drawing lessons based on such a small sample of countries as they emerge from some of the **findings** of the Program Review:

- The Global Fund–World Bank partnership is stronger at the global than at the country level. Despite recent improvements in coordination with partners on technical assistance, there is a need to define technical assistance functions and funding modalities.
- The Global Fund is facilitating donor coordination at the global level through its Board, which has not yet translated into a similar degree of coordination at the country level.
- There are some sustainability issues with decreasing donor funds in a number of countries, and short-term funding gaps are affecting the Global Fund.
- Disease-control programs are increasingly available, but there are concerns over "inadequate investments in long-term capacity."

- Country Coordination Mechanisms (CCMs), have successfully brought country-level stakeholders together to submit grant proposals, but have failed in exercising effective oversight of grant implementation.
- There is little or no evidence of effective partnerships with the commercial private sector in the six countries.
- The principle of "Performance Based Funding" is working well in three countries, and less well in three other countries.
- The Global Fund is giving priority to improving risk management at the corporate and country level, with more progress in dealing with financial, operations, and organizational risks
- The LFA system is working well in the majority of the countries visited.

In this response, we are focusing primarily on the following **recommendations**:

- **Stronger institutional agreements between the World Bank and Global Fund through**:
  - A Memorandum of Understanding on country-level collaboration between the two organizations
  - Global Fund contribution to World Bank Sectorwide Approaches or other co-financing opportunities in the health sector
  - A trust fund for financing Bank-supervised technical assistance activities
  - Mechanisms such as the International Health Partnership, the Health-8 Group, Joint Assessment of National Strategies, and Health Systems Platform.

We very much welcome the recommendation to improve the partnership with the World Bank by working more closely at the country level, and we believe that we will be able to do so as a result of the transformation process we have recently undertaken. We note with interest the proposal to sign a Memorandum of Understanding on country-level collaboration, but would be interested in discussing further with the World Bank any possible alternative arrangement allowing for increased collaboration in specific country contexts. As to the funding of technical assistance activities to countries, the Global Fund is committed to explore appropriate modalities and mechanisms with its technical partners.

- **Further collaboration on M&E** to define program- and country-level activities, including harmonizing M&E requirements and building evaluation capacity into programs.

The Global Fund welcomes this recommendation and has collaborated strongly with the World Bank in developing its M&E approaches and toolkits. The Global Fund will pursue opportunities to further strengthen this collaboration in both monitoring and evaluation.

- **Build evaluations more routinely in Global Fund programs and initiatives.** IEG suggests considerable scope for improved evaluation and learning, both separately and jointly between the two organizations. In particular, IEG recommends including early-stage and impact evaluations in grants and building evaluation capacity in the programs the Global Fund supports.

The Global Fund shares this concern and has included systematic strengthening of program evaluation capacity in its newly approved evaluation strategy.

- **Managing Conflicts of Interest** – of partner involvement in CCMs and at all levels.

The Global Fund has introduced increasingly detailed conflict of interest policies and monitoring for CCMs, and will continue to strengthen work in this area.

- **Sustaining the benefits** – IEG recommends introducing more coordinated approaches to external financial support at both the global and country levels to promote the sustainability of country programs and avoid dependence on Global Fund financing.

This is a major priority of the Global Fund, and the Consolidated Transformation Plan provides a great opportunity to implement this recommendation.

- **Global Public Policy** – IEG suggests working with partners to address global governance issues and involving drug regulatory and enforcement agencies to ensure quality of programs.

The Global Fund recognizes this as an important issue, but many of these recommendations go beyond the current mandate of the Global Fund and would be best implemented by our technical partners.

Conclusions

The Global Fund is committed to learn and change as necessary in relation to the findings and recommendations of the IEG Program Review. The Global Fund is committed to implement most of the recommendations of the Program Review in the context of the implementation of the Comprehensive Transformation Plan, which will represent the corporate priority for 2012.

Management Comments: The World Bank Group

World Bank management welcomes the opportunity to comment on IEG's Global Program Review (GPR) on the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Bank management strongly supports IEG's function as the independent evaluator of the Bank's performance, including its performance in partnerships.

Bank management highly values its partnership with the Global Fund, which plays a critical role in helping developing countries address the three deadly diseases of AIDS, tuberculosis, and malaria. The work of the Global Fund and the Bank is complementary. The Global Fund focuses on supporting treatment and prevention efforts to achieve Millennium Development Goal 6. As a development institution, the Bank takes a holistic approach to health systems – what is preventing people from being healthy; how countries can promote improved health outcomes, especially for the poor, in a sustainable way; and what impact this will have on development. As set out in our Health, Nutrition and Population Strategy endorsed by the Board in 2007, the Bank helps countries deliver better health for their people by strengthening their health systems and supporting investments in all of the sectors that impact health.

Bank Management notes that the findings of the IEG review are consistent with the findings of the Global Fund's own Five-Year Evaluation, which IEG considered to be an independent and quality evaluation, and that IEG's lessons have been quite widely addressed by the Global Fund's recent review processes, namely the Comprehensive Reform Working Group and the High-Level Panel. Bank management concurs with IEG on a number of points, including (1) the lessons derived from the Global Fund's own evaluations; (2) the importance of paying attention to health systems strengthening while scaling up response to priority diseases; (3) the importance of having strong M&E systems in place to ensure aid effectiveness; and (4) the value of civil society engagement and participation in development assistance for health. We note, however, that given the fundamentally different operational and financing models of the Global Fund and the Bank, and the relatively recent establishment of the Global Fund, it is difficult to compare the two institutions.

Bank management concurs with the Global Fund Secretariat's response to the IEG Review, and notes that the Global Fund is already implementing most of IEG's lessons in the context of its Consolidated Transformation Plan recently approved by the Global Fund Board. In addition, we agree with the Global Fund that there are limitations in drawing lessons based on a small sample of countries.

The lessons of the IEG Report aim to further strengthen the strategic partnership between the Bank and the Global Fund. The Bank remains strongly committed to collaboration with the Global Fund and to doing our part to halt and reverse the spread of these three diseases. As part of this approach, the Bank pioneered the early scale-up of the global AIDS response, before the creation of the Global Fund, and also has provided substantial support to countries to fight malaria and tuberculosis. In fiscal year 2011, the Bank committed $3 billion for new health investments across multiple sectors to help countries strengthen their health systems, boost disease prevention and treatment, and improve maternal and child health and nutrition. There is effective collaboration and coordination between the Bank and the Global Fund at

both the global and country levels. Through our joint participation with the Global Fund in the International Health Partnership platform (with over 50 development partners) and the Health Systems Funding Platform (with Global Fund, the Global Alliance for Vaccines and Immunization, and WHO), we use joint assessments and fiduciary systems in support of the country's health sector plan, reducing burdens on countries and in the spirit of the Paris-Accra-Busan principles. Like the Global Fund, we will look at how we can step up our collaboration and strategic partnership in ways that allow us to respond flexibly to the needs of developing countries within a country-owned framework and harmonized with all partners working at country level.

In addition, Bank management is in the process of developing a Partnership Program Management Framework and Financial Intermediary Fund Framework to provide an institutional foundation for how the Bank engages with partners (e.g., alignment, selectivity, engagement, review, exit, etc.). These framework papers will go to the Board for consideration in the first half of 2012.

In conclusion, while we concur with IEG's lessons with respect to strengthening the Bank's partnership with the Global Fund, we believe that the assessment of the Global Fund's performance is its own responsibility, and we agree with the Global Fund that IEG's lessons have been widely addressed through the Global Fund's recent review processes, including the Global Fund's High-Level Panel and the Consolidated Transformation Plan. As trustee and partner, the Bank will continue to work closely with the Global Fund to maximize our collective impact on global health.

Chairperson's Summary: Committee on Development Effectiveness

The Committee on Development Effectiveness (CODE) considered the documents entitled *IEG Global Program Review: The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), and the World Bank's Engagement with the Global Fund* together with the Global Fund Secretariat Management Response (CODE2011-0067) and Draft World Bank Management Comments. CODE had endorsed the Approach Paper: *Global Program Review of the Global Fund to Fight AIDS, Tuberculosis and Malaria* in February 2010.

Summary

The Committee welcomed the discussion and agreed with the main findings of the Independent Evaluation Group (IEG) Global Program Review (GPR), including the findings on country-level engagement. It noted the important lessons that Review provides with respect to engagement and the considerable convergence of IEG's findings with the Global Fund's Five-Year Evaluation. The CODE Chair highlighted that the main messages of the Global Fund's response supported most of the lessons in the IEG Review, especially those aimed at strengthening the partnership at the global and country levels, underlining the Global Fund's wish to have more of a strategic partnership with the World Bank. The Chair further noted that such a partnership should avoid rigidities and include a flexible framework for country-based approaches involving the Bank's country teams in working to fulfill the commitments made in Paris, Accra and Busan. Acknowledging the Global Fund's constructive response, members agreed on the need to reinforce collaboration in country-level programs and the World Bank's important role in bringing players together, which could sustain the Global Fund's momentum. With respect to enhanced engagement, members noted that, while the overall coordination between the World Bank and the Global Fund is working well, there is room for improvement in country-level engagement and for greater collaboration on project preparation, supervision, monitoring and evaluation. Members urged Management to take stock of the findings to determine what can be improved on the ground, particularly with respect to strengthening health systems capacity, country-level support, monitoring, and evaluation collaboration.

IEG highlighted the main findings of the review, noting that the global scarcity of resources to fight AIDS, tuberculosis, and malaria will require collective and proactive resource allocation, which creates a need for a clearer institutional mandate for Bank staff to work in closer partnership with the Global Fund. IEG also stressed the need for a strengthened framework for managing the Bank's financial intermediary funds and explicit engagement strategies for each global partnership program. Management underlined the complementary work of the Global Fund and the Bank, with the latter focusing on the whole health sector, and the different operational and financial models of the two institutions. Management concurred with the finding regarding health systems strengthening, while scaling up the response to priority diseases, the importance of strong monitoring and evaluation systems, and the value of civil society engagement and participation in development assistance in health. With respect to the IEG finding on the need to strengthen the Bank-Global Fund engagement at the country level, management concurred with the Global Fund's response

that collaboration arrangements should allow partners to respond flexibly to country needs within a country-owned framework. Management added that papers on the Bank's Partnership Framework and Framework for Financial Intermediary Funds were under preparation, which would cover such issues as engagement, alignment, selectivity, evaluation, and potential conflicts of interest, among others.

1. Introduction, Purpose, and Methodology

1.1 This Review has been prepared, first and foremost, for the World Bank's Executive Board to facilitate an informed discussion about the Bank's past, current, and future engagement with the Global Fund. Since the Millennium Declaration in 2000, the World Bank has become involved in a growing number of partnership programs like the Global Fund that pool donor resources to finance country-level investments to help countries achieve specific Millennium Development Goals (MDGs), that have inclusive governance structures, and that subscribe to the 2005 Paris Declaration on Aid Effectiveness. Other such programs include the Global Alliance for Vaccines and Immunization (GAVI, established 2000), the Global Partnership for Education (2002), the Climate Investment Funds (2008), and the Global Agriculture and Food Security Program (2010). The World Bank generally plays three major roles in these programs: (a) as a trustee of donor funds supporting the program; (b) in the corporate governance of the program, and (c) as a development partner at the global and country levels.

1.2 **The principal purpose of this Global Program Review (GPR) is to learn lessons from the experience of the Global Fund about (a) the design and operation of these large global partnership programs that are financing country-level investments, (b) the engagement of the World Bank with these programs, and (c) the evaluation of these programs.** The Review has an intensive focus on the Bank's engagement with the Global Fund at the country level because of the potential for competition or collaboration between Global Fund-supported activities and the Bank's lending operations at the country level. Therefore, it also focuses on the design and operation of the Global Fund-supported activities at the country level. The review framework in Appendix A provides the specific issues and questions addressed.

1.3 Like other GPRs, this Review is based on an external evaluation that was commissioned by the governing body of the program — in this case, the Five-Year Evaluation (FYE) of the Global Fund, launched by the Global Fund Board in November 2006. The final *Synthesis of Study Areas 1, 2, and 3* was issued in March 2009. The Review (a) assesses the independence and quality of that evaluation; (b) validates the findings of the evaluation; and (c) assesses the extent and nature of the Bank's engagement with the Global Fund at the global and country levels since the Global Fund was founded in 2002.

1.4 By design, this GPR does not compare the effectiveness of the World Bank's health sector operations with those of the Global Fund. Nor does it compare the effectiveness of the Global Fund model with that of other financing entities such as the Global Environment Facility. Both comparisons are explicitly beyond the scope of the Review. Nor does the Review assess the effectiveness of Global Fund structures at the corporate level, such as the Global Fund Board and Secretariat, with the exception of the Technical Evaluation Reference Group (TERG) insofar as this body was responsible for overseeing the FYE.

Organization of the Review

1.5 The Review has one primarily descriptive chapter, three substantive chapters, and a conclusion. Chapter 2 describes the origin and evolution of the Global Fund; its objectives

and design; and its governance, management, and financing to provide context for the subsequent chapters of the Review. It also describes the roles of the World Bank in the program, the conduct of the FYE that was completed in 2009, and the principal impacts of the evaluation on the Global Fund to date.

1.6 Chapter 3 presents IEG's findings in relation to the operation of the Global Fund at the country level, based primarily on visits to a sample of six countries in which both the Global Fund and the World Bank have been active in the health sector. The chapter is organized in accordance with eight of the nine major findings of the FYE, as presented in the FYE Synthesis Report. (IEG did not address the ninth major finding because this related to the global governance of the Global Fund, not its country-level activities.) IEG's country visits, which took place from April to June 2010, sought to confirm the findings of the FYE and assess changes (either improvements or deterioration) in the intervening three years since the FYE country visits were conducted in 2007 as part of Study Area 2, using the FYE and the Study Area 2 country reports as a baseline.

1.7 Chapter 4 presents IEG's findings with respect to the World Bank's engagement with the Global Fund at the global and country levels. The first part of the chapter addresses the Bank's engagement at the global level, including the roles that the Bank plays at the corporate level of the Global Fund as well as the initiatives associated with the Global HIV/AIDS Program (GHAP) and the International Health Partnership (IHP) that have provided additional avenues for World Bank-Global Fund engagement at the country level. Therefore, the first part of this chapter also provides context for the second part on the Bank's engagement with the Global Fund at the country level.

1.8 Chapter 5 assesses the independence and quality of the FYE and draws lessons from this experience for the evaluation of other global partnership programs. It assesses independence and quality based on the standard framework that IEG uses for this purpose (Appendix Table A-3), which is based on the Indicative Principles and Standards in the *Sourcebook for Evaluating Global and Regional Partnership Programs* (IEG and OECD/DAC 2007).

1.9 Chapter 6 is a concluding chapter that presents the major lessons of this Review (a) for the Global Fund, (b) for the World Bank, and (c) for the evaluation of global and regional partnership programs.

Methodology

1.10 The findings and lessons of this Review are based on the following:

- Desk reviews of key documents, including the final FYE reports; Global Fund and World Bank strategies; and evaluations of World Bank activities in health, nutrition, and population (HNP).
- Review of the academic literature on the Global Fund.
- Portfolio analysis of Global Fund-supported activities and World Bank HNP lending operations.

- Structured interviews with Global Fund staff, with World Bank staff who have been involved with the Global Fund and its activities, and with other stakeholders.
- Visits to a sample of six recipient countries (Brazil, Burkina Faso, Cambodia, Nepal, the Russian Federation, and Tanzania) during April–June 2010 to consult with country-level stakeholders about Global Fund-supported activities in each country, and the World Bank's engagement with these activities.
- An in-depth assessment of a World Bank-supported health project in Lesotho specifically designed to increase the capacity of the country to effectively use Global Fund grants for HIV/AIDS.
- An electronic survey in March 2011 of Global Fund staff and World Bank project managers of HNP projects on the engagement between the Global Fund and the World Bank at the country level, followed by a focus group of World Bank project managers to discuss the survey results.
- A detailed comparison of the monitoring and evaluation (M&E) systems of the Global Fund and the World Bank.

1.11 The six countries visited were a stratified random sample (two in Africa and one in each of the other four regions) of countries in which both the World Bank and the Global Fund have been active in combating communicable diseases and/or strengthening health systems since 2002, after eliminating six countries that IEG was also visiting at the same time for an evaluation study on trust funds. When it was not possible to arrange visits to two of the countries initially selected (Nigeria and India), these were replaced by Burkina Faso and Nepal (also randomly selected). The draft reports on each country were shared with country-level stakeholders, World Bank project managers, and Global Fund Portfolio Managers (FPMs), and revised in the light of comments received.

1.12 The purpose of these country visits was threefold:

(a) To validate the findings of the FYE and assess changes between 2007 and 2010, using the FYE and the four Study Area 2 country reports as a baseline — presented in Chapter 3.
(b) To learn about the nature and scope of the World Bank's engagement with Global Fund-supported activities in the six countries — presented in Chapter 4.
(c) To assess the familiarity of country-level stakeholders with the findings of the FYE and its impacts on the Global Fund — presented in Chapter 5.

1.13 The findings from the six country visits are intended to be representative of experiences in other, similarly situated countries. They are not intended to single out the performance of individual stakeholders in the individual countries visited.

1.14 The electronic survey was administered to project managers of Bank-supported health projects that were disbursing when, or approved after, the Global Fund became active in the same country (the date of its first grant commitment to the country). A parallel survey was also administered to Global Fund Secretariat staff in the Country Programs Cluster, the External Relations and Partnerships Cluster, and the Strategy, Performance and Evaluation Cluster. The survey results are contained in Appendix Q.

1.15 This Review was initiated before the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund was commissioned in February 2011, and it was drafted before their final report, *Turning the Page from Emergency to Sustainability*, was issued on September 19, 2011. While the two studies are complementary and overlap to some extent, they were conducted independently of each other, for different audiences, and for different purposes.

2. Overview of the Global Fund

2.1 Since its founding in 2002, the Global Fund has become by far the largest of the 15 global health partnerships in which the World Bank is involved, and supported by the largest financial intermediary trust fund that the Bank currently administers. The present chapter describes the origin and evolution of the Global Fund, its objectives and design, and its governance, management and financing to provide context for the subsequent chapters of this Review. It also describes the roles of the World Bank in the program, the conduct of the FYE that was completed in 2009, and the principal impacts of the evaluation on the Global Fund to date.

Origin of the Global Fund

2.2 A confluence of world events in the international health arena led to the creation of the Global Fund. HIV/AIDS was spreading across the developing world in the 1990s, exacting a toll on lives and reversing gains in development at an unprecedented pace. At the same time, there was a resurgence in tuberculosis and malaria in large parts of the globe due to weak control efforts and growing drug resistance. A global consensus was emerging that too little was being done, and done too slowly, to effectively address the three scourges. HIV/AIDS, in particular, had become the defining epidemic of our time, and while there were drugs and a growing body of knowledge to mitigate its impact, these were simply not available or affordable in the developing world.

2.3 Governments in developed countries began responding to strong advocacy movements to marshal large increases in financing to combat HIV/AIDS. The G8 meeting in Denver in 1997 was among the earliest of such occasions, and led to strong donor commitments to combat AIDS. By the time of the G8 meeting in Okinawa in 2000, heads of state and government had broadened their commitments to include tuberculosis and malaria, noting that bilateral and multilateral efforts were woefully insufficient.

2.4 Similar events were also taking place in Africa, the continent most affected by the three diseases. At a special Summit of the African Union in Abuja in 2001, heads of state and government lent weight to the fight, and the UN Secretary General Kofi Annan called for the creation of a special fund for this cause. That same year, the World Health Organization (WHO) Commission on Macroeconomics and Health provided economic arguments in support of these endeavors. Chaired by Jeffrey Sachs, the Commission demonstrated the detrimental effects of the three pandemics on growth and poverty alleviation, and called for urgent reforms and massive new financial resources to combat the diseases.

2.5 A Special Session of the UN General Assembly on AIDS in June 2001 endorsed the creation of the fund. The next month, the donor community pledged $1.3 billion at the G8 Summit in Genoa. The U.S., French and U.K. governments led the way. (See Appendix B for the complete Global Fund timeline through 2011.)

2.6 Starting in the mid-1990s, a number of new global health partnerships had been established, including the Joint United Nations Program on HIV/AIDS (UNAIDS) in 1994, the International AIDS Vaccine Initiative in 1996, Roll Back Malaria (RBM) in 1998, the Medicines for Malaria Venture in 1999, GAVI in 2000, and the Stop Tuberculosis Partnership

(Stop TB) in 2001. Researchers were also producing new drugs and therapies to combat the three diseases: antiretroviral drugs (ARVs) for HIV; new anti-tubercular drugs and the Directly Observed Treatment Short-Course (DOTS) for tuberculosis; and new anti-malarial drugs, artemisinin combination therapy (ACT), and long-lasting insecticide-treated bed nets for malaria. But these innovations required new modalities and financing to deliver them and to facilitate their use. The sheer magnitude and global nature of the AIDS, tuberculosis, and malaria pandemics required concerted and well-coordinated responses on a global scale — far beyond the capacity of individual donors, or that of UNAIDS, RBM, and Stop TB (which were largely technical assistance programs) to address.

2.7 The new partnership programs reflected not only the need for collective action to address global challenges but also the involvement of new actors and constituencies in development and dissatisfaction with the ability of existing aid mechanisms to address emerging global challenges. New philanthropies (such as the Gates Foundation) and international nongovernmental organizations (NGOs) advocated new approaches to development assistance emphasizing country-led development, greater participation of beneficiaries and civil society groups, and stronger ties with the private sector to tap its finances, innovation, and the power of the market.

2.8 Large partnership programs such as the Global Fund and GAVI that are financing country-level investments on a large scale, usually on a grant basis to help countries achieve specific MDGs, have several common features. First, they pool donor resources to finance country-level investments, which distinguishes them from the large majority of much smaller global and regional partnership programs (GRPPs) that are primarily financing technical assistance, or generating knowledge about development. Second, they employ inclusive governance structures in which membership on the governing body is not limited to financial contributors but is also extended to other stakeholders, including recipient countries, civil society organizations (CSOs), and the commercial private sector. Third, they generally subscribe to the 2005 Paris Declaration principles of country ownership, alignment, harmonization, managing for results, and mutual accountability.[1] The programs also raise funds from nontraditional sources outside the public sector, including private foundations and the business community.

2.9 After the G8 Summit in Genoa, a Transitional Working Group was formed in August 2001 to develop general organizational guidelines. The new Fund would need to be a visible entity to mobilize the needed additional resources; to use quick and efficient modalities to operationalize and disburse the funds; and to forge strong ties with country partners, CSOs, and the private sector. The Fund should complement and not duplicate the existing multilateral and bilateral assistance agencies. Indeed, as a financing entity and not an implementing agency, it would need to rely strongly on its development partners to expand and accelerate the response to the pandemics.

2.10 The Global Fund for AIDS, Tuberculosis and Malaria was officially established in January 2002 when the Transitional Working Group was converted into the founding Global Fund Board and held its first meeting. The chair and vice chair were elected, operating

1. Existing multilateral organizations such as the International Development Association also pool donor resources to finance country-level investments and have subscribed to the Paris Declaration principles.

procedures adopted, and a staff member of the Swedish International Development Agency was selected to be the interim head of the Secretariat. Richard Feachem, former World Bank Director for HNP, was appointed the first Executive Director and head of the Secretariat at the Fund's second Board meeting in April 2002.

Objectives and Design

2.11 The stated purpose of the Global Fund is "to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals" (Global Fund 2002). Its Framework Document also establishes principles, scope, financing, country processes, eligibility criteria, grant application processes, and monitoring and fiduciary responsibilities (Appendix C). Seven Guiding Principles form the core values of the Global Fund (Box 1). National ownership of disease-control programs and country-led formulation and implementation processes reflect a strongly held principle and a firm belief that these approaches offer greater promise of fairness and sustainability. The meaning of "country" is not limited to the government but encompasses all other country-level stakeholders, including CSOs, the private sector, and affected communities.

Box 1. Global Fund Guiding Principles

A. The Fund is a financial instrument, not an implementing entity.
B. The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria.
C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes.
D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases, and interventions.
E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.
F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.
G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.

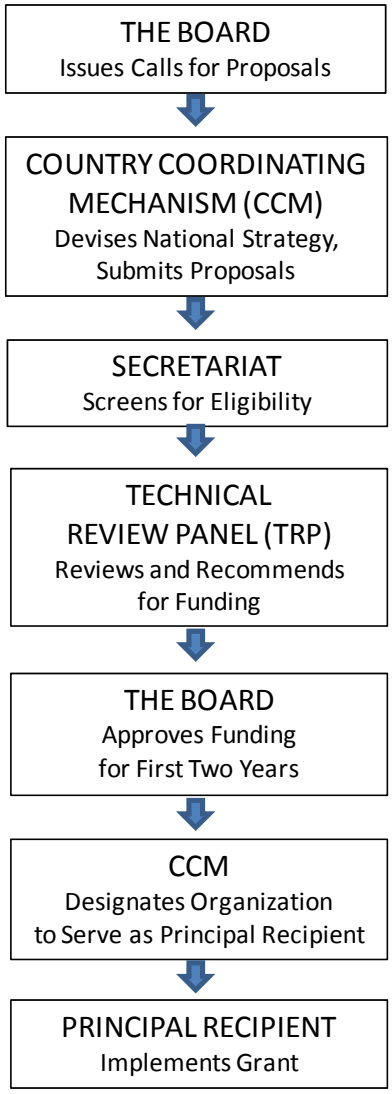
Source: Global Fund, 2002, "Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria," pp. 1-2.

2.12 Global Fund resources are intended to supplement existing efforts to deal with the three diseases — over and above the resources that multilateral and bilateral agencies as well as the governments of recipient countries were already spending. It seeks to strengthen country-level coalitions among public and private actors to reduce the burden of the three diseases. Its founding principles call for it to be efficient, effective, and inclusive, and to act in a transparent and accountable manner. The Fund has a broad mission statement and goals, but has not set physical

targets for disease reduction. It measures itself against its purpose and the guiding principles on which it was founded.

2.13 IEG has found the Global Fund to be the most transparent of the 21 GRPPs that IEG has reviewed in the last five years. The Global Fund Board has mandated a high degree of transparency since its founding and the Global Fund Secretariat has effectively implemented this mandate to the extent that it has become an integral part of its organizational culture. In the interests of its developing country clients who have less access to broadband, its Web site is clean with a minimum of graphics. This site is also organized around its support to individual countries, because the Fund is receiving grant proposals and financing them on a country basis.

Figure 1. Global Fund: Grant Preparation and Approval Processes



Source: Global Fund Web site.

GRANT PREPARATION AND APPROVAL PROCESS

2.14 Each round of Global Fund grants starts with a call for proposals by the Global Fund Secretariat on behalf of the Board (Figure 1). The first call for proposals (Round 1) was issued in February 2002, and the most recent (Round 11) in August 2011. Each round has contained specific policies and guidelines, including eligibility and minimum requirements, published on the Global Fund Web site. Each call for proposals may also prioritize specific themes for that round.[2]

2.15 The Global Fund requires each country, with limited exceptions,[3] to establish a Country Coordinating Mechanism (CCM) to review and endorse funding proposals for submission to the Secretariat, based on a national strategy for combating the disease in question. CCM members are drawn from the government, CSOs, the private sector, academia, affected communities, and external development partner agencies such as bilateral agencies, WHO, UNAIDS, and the World Bank.

2.16 Conceptually, the collective knowledge and ability of CCM members provides the capacity to prioritize country needs for each disease, develop grant proposals in accordance with a national strategy, and identify gaps in financing. There was a strong expectation among members of the Global Fund Board, although this was not formalized in writing, that

2. For example, the minimum eligibility requirements for the composition of the CCM were revised in Round 10. These revisions aimed to enhance (a) inclusiveness; (b) partnerships between government, private sector, and NGOs; (c) participation of affected communities; and (d) alignment with national policies and processes.

3. In the case of the Russian Federation, for example, a consortium of five NGOs, already active there and led by the Open Health Institute, submitted their own proposals for addressing HIV/AIDS and tuberculosis to the Global Fund in Round 3, in the absence of the government's willingness to establish a CCM.

development partner agencies would contribute formal and informal technical assistance to this process as needed. Proposed activities were expected to be part of the overall national program for HIV/AIDS, tuberculosis, or malaria, and linked to other domestic and donor-funded programs.

2.17 Both CCM and non-CCM applicants who submit proposals are first screened by the Screening Review Panel of the Global Fund Secretariat for eligibility and the completeness of their proposals, according to established criteria relating to membership and representation, transparency, and management of conflicts of interest. Proposals from eligible applicants are then reviewed by the Technical Review Panel (TRP), which is made up of technical, scientific, and programmatic experts. The TRP makes its funding recommendations to the Board based on the technical merit of each proposal in terms of effective and proven interventions, cost-effectiveness, potential for scaling up and impact, strengthening of communities, alignment with government/national systems, and a measurable results framework. Over the last five rounds, about 80 percent of the applicants have been found eligible, and about 50 percent of eligible proposals have been recommended to the Board for approval (Table 1). The Board has so far approved all TRP-recommended proposals, but not always at the requested funding levels.

Table 1. Success Rate of Proposals Approved for Grant Funding

	Screening Process			Technical Review Process		
Round	Total Applicants	Eligible Applicants	Success Rate	Number of proposals	Number recommended for funding	Success Rate
6	144	108	75%	196	84	43%
7	110	88	80%	150	74	49%
8	125	98	78%	94	174	54%
9	121	101 [a]	83%	159	85	53%
10	117	105	90%	150	79	53%
Total	**617 500**		**81%**	**792 396**		**50%**

Source: Global Fund Secretariat

a. In Round 9, there were two cases (Kyrgyz Republic and Mali) in which one proposal submitted by the applicant was screened out by the Screening Review Panel, while the other proposal was deemed eligible and reviewed by the TRP.

2.18 Once a grant is approved, the CCM nominates one or more organizations to be the Principal Recipients, or lead implementing agencies for the grant. These may be a government department or agency, a CSO, an academic institution, or even an international organization such as the United Nations Development Programme (UNDP). Then, before a grant agreement is negotiated and signed, the Global Fund Secretariat contracts with a Local Fund Agent (LFA) to assess the financial, administrative, and implementation capacity of the nominated Principal Recipients to implement the approved grant.[4]

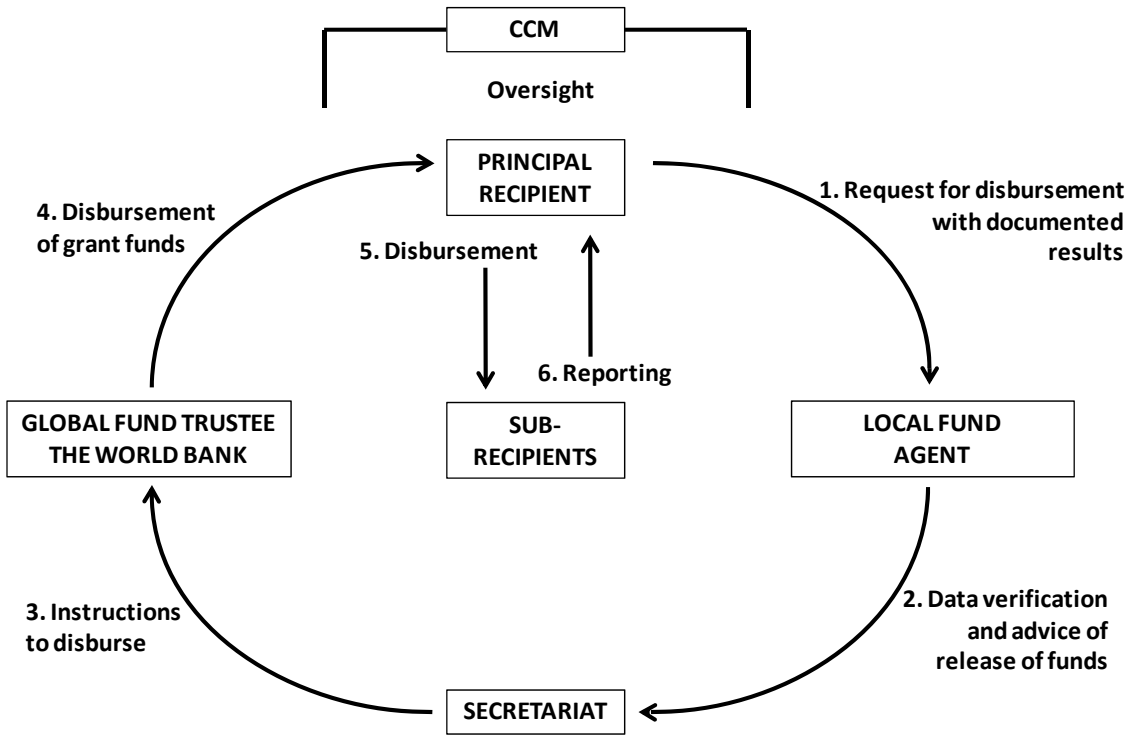
4. The assessment determines whether the nominated Principal Recipient possesses the minimum required capacities in five functional areas: (a) financial management and systems, (b) program management, (c) Sub-Recipient management, (d) pharmaceutical and health product management, and (e) M&E.

2.19 As the fiduciary agent of the Global Fund Secretariat in the country, the LFA plays an important financial oversight and risk management role during the entire grant implementation process, starting with this assessment. If the nominated Principal Recipient fails the LFA assessment, then the CCM nominates a replacement. If the nominated Principal Recipient passes the LFA assessment, then the Global Fund Secretariat starts to negotiate a grant agreement with the Principal Recipient. This specifies both the conditions to be met preceding the first grant disbursement and the programmatic indicators and milestones to be used by the Principal Recipient to track and report on progress.[5]

GRANT IMPLEMENTATION PROCESS

2.20 Once the grant agreement is signed, the Global Fund Secretariat instructs the World Bank, as the trustee of the Global Fund, to release funds to the Principal Recipient to implement prevention, treatment, and care and support activities (Figure 2). It typically takes 12–15 months from grant approval by the Board to the first release of funds by the trustee. Typically, Principal Recipients also enlist other organizations such as service-delivery NGOs — known as Sub-Recipients — to help implement the planned activities. The CCM has the overall responsibility for the oversight of grant implementation from the country perspective in accordance with the Global Fund "Guidance Paper on CCM Oversight."

Figure 2. The Global Fund: Grant Implementation Processes



Source: Global Fund Web site

5. UNDP is a special case. The Global Fund and UNDP reached an umbrella agreement in 2003 under which the UNDP could implement Global Fund grants using its own regulations, policies, and procedures when it acts as a Principal Recipient of Global Fund grants.

2.21 The Global Fund follows the principles of performance-based funding (PBF) in making disbursement decisions. Grants are initially approved for two years (Phase 1) and renewed for up to three additional years (Phase 2), based on the performance of the grant-funded activities. Tied to PBF are detailed and documented requirements and outputs for grant-level monitoring. Each grant agreement contains a disease-specific performance framework outlining the performance expected over the lifetime of the grant and containing key indicators and targets that are used to measure outputs and coverage on a routine basis. Funding is disbursed incrementally every three to six months throughout the life of the grant. The Principal Recipient prepares Progress Update and Disbursement Requests (PUDRs), which link the historical and expected program performance with the level of financing to be provided to the Principal Recipient. The LFA reviews these periodic requests for funding, undertakes site visits to verify results, reviews the Principal Recipient's audit reports, and then makes a confidential recommendation to the Global Fund Secretariat to disburse (or not to disburse) the funds. When the initial two-year grant commitment period is completed, the CCM requests further funding for the remaining three years of the approved grant. The LFA again reviews these requests before the Global Fund Secretariat instructs the trustee to release additional funds.[6]

2.22 IEG's findings in relation to the design and operation of the Global Fund at the country level are presented in Chapter 3 of this Review.

Governance and Management

BOARD

2.23 Like most of the GRPPs in which the World Bank is involved, the Global Fund employs a constituency-based stakeholder model of governance in which membership on the governing body includes stakeholders in addition to financial contributors. The Board comprises eight representatives of donor governments, seven representatives of recipient governments, and one representative each from private foundations, affected communities, developed country NGOs, developing country NGOs, and the commercial private sector (Appendix E). The Board also has six nonvoting ex officio members: the Global Fund Executive Director, UNAIDS, WHO, the World Bank, one representative from other development partners (RBM, Stop TB, and UNITAID), and Switzerland.[7] The Board meets at least semi-annually and is responsible for the overall governance of the organization, including the final approval of grants vetted by the TRP.

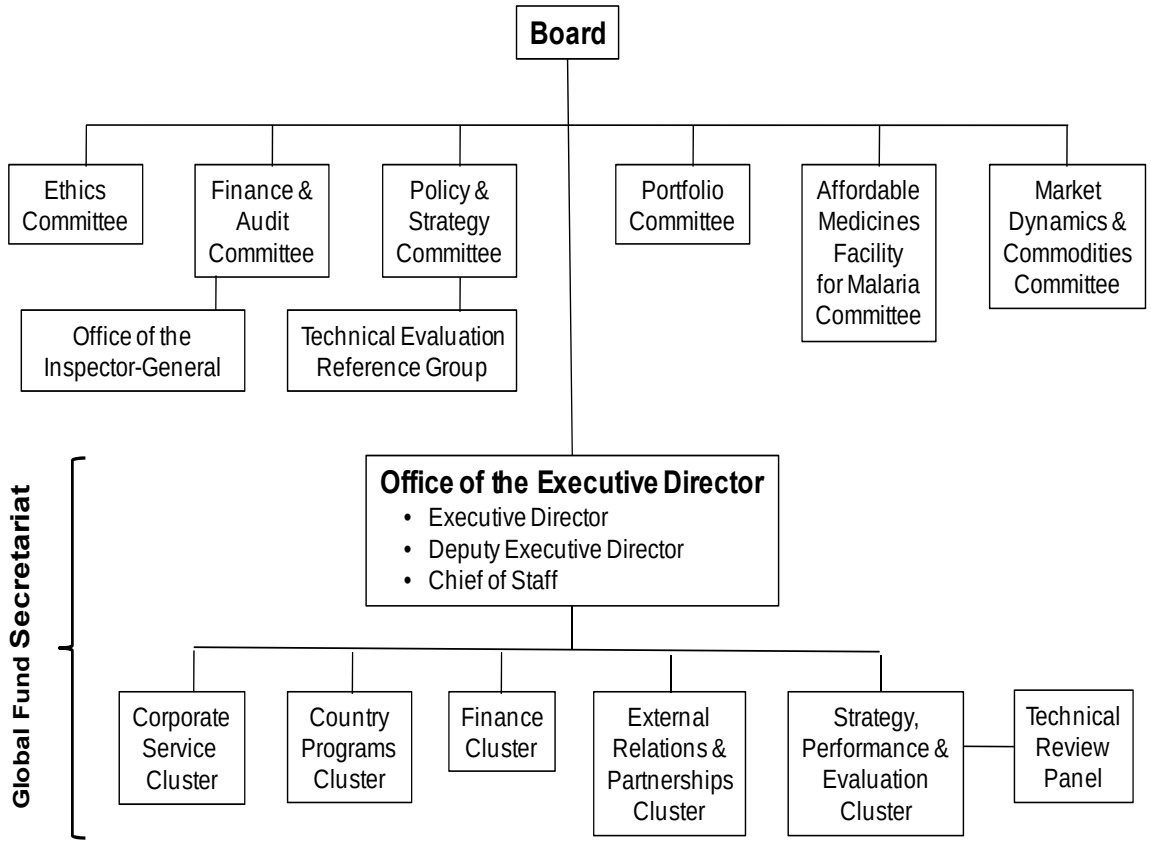
6. Because the Global Fund provides grants for an initial two-year period, its approach to PBF is not, strictly speaking, "output-based aid" as this term is used in the development literature in relation to delivering basic infrastructure services such as water, sanitation, or electrical connections. Under a typical output-based aid scheme, the contracted service provider (usually a private firm) is responsible for pre-financing the project until the services or outputs have been delivered. Only after these have been delivered and verified by an independent agent does the service provider receive the public subsidy to deliver the services or outputs. See the Global Partnership on Output-Based Aid, "Output-Based Aid – Fact Sheet," August 2010.

7. The Deputy Director of the United Kingdom Department for Economic Development is the current Board Chair and the Lesotho Minister of Health and Social Welfare is currently the Vice Chair.

2.24 An even broader group of stakeholders[8] meet at the Partnership Forum that is held every other year. Considered a formal ancillary body of the Board, the Forum provides feedback to the Board on the Fund's strategic direction and implementation framework. The Board is not formally accountable to the Forum, but the Forum plays an important role in mobilizing and sustaining political commitment from a very broad constituency.[9] Four Forums have been held so far (Bangkok, Durban, Dakar, and São Paulo), with approximately 400 stakeholders in attendance each time. An e-forum facilitates an ongoing online debate/ dialogue among members of the Forum in between the meetings.

2.25 The Board is supported by six committees (Figure 3), a Technical Evaluation Reference Group (TERG), and the Office of Inspector General (OIG). The mandates of the respective committees are reviewed during Board meetings, and more responsibilities have been delegated to them as a result of the FYE.

Figure 3. The Global Fund: Organizational Chart, June 2011



Source. Constructed by IEG from information on the Global Fund Web site.

8. Stakeholders include CSOs, service providers, technical experts, people affected with the disease, etc., who are aligned with the Global Fund mission, but are not necessarily actively engaged in Global Fund processes.

9. About a third of the GRPPs in which the World Bank is involved have similar such forums to involve a broader group of stakeholders in the governance of the program. Where the governing body is formally accountable to the forums, they are usually called annual general meetings.

2.26 The Ethics Committee guides the overall value system and code of conduct of the organization, assisting in overseeing the management of reputational risks. The Finance and Audit Committee assists the Board on fiscal management policies and processes and leads the Fund's replenishment process. The OIG, which was established in July 2005, reports to the Board through the Finance and Audit Committee. The Policy and Strategy Committee assists the Board on core governance issues of the Global Fund, including processes and structures of the Board, the Partnership Forum, and CCMs. The largest of the committees, it assists the Board on overall strategic planning and resource mobilization policies. The TERG reports to the Board through this Committee. The TERG oversees independent evaluations (such as the FYE) on behalf of the Board and its Committees, and advises the Global Fund Secretariat on evaluation approaches and practices, independence, reporting procedures and other technical and managerial aspects of M&E at all levels of the program.

2.27 The Portfolio Committee assists the Board on all policy and strategic matters concerning the grant portfolio, including operational partnerships with development partner agencies to facilitate expanded technical assistance support at the country level. It leads on issues pertaining to guidelines for grant proposals, TRP membership and review criteria, and appeal processes. The last two committees are ad hoc committees constituted in 2008. The Affordable Medicines Facility for Malaria (AMFm) Committee oversees the Fund's new business line in the affordable provision of ACT combination drug therapy to the sick who would otherwise be paying 10 times more, or resort to using old antimalarials that are no longer effective due to drug resistance. The Committee on Market Dynamics and Commodities reviews and develops options for the Global Fund to better utilize its buying power in relation to purchasing pharmaceuticals and medical commodities, which account for roughly half its expenditures of grant funds. The Committee also oversees measures to improve aligning and harmonizing Global Fund procurement systems with those of other major donors for the three diseases.

SECRETARIAT

2.28 The Global Fund Secretariat in Geneva is responsible for day-to-day operations, including mobilizing resources; administering grants; providing financial, legal, and administrative support; and reporting information on the Global Fund's activities to the Board and the public. The Executive Director and about 560 employees representing about 100 nationalities work at the Secretariat's headquarters.

2.29 The office of the Executive Director oversees Board relations, Secretariat support for the TERG, and the rolling out of the Fund's new grant architecture (see below). Among the five functional clusters in the Secretariat, the Corporate Service Cluster is responsible for personnel issues, administration, information systems, and legal affairs. The Finance Cluster, headed by the Chief Financial Officer, is responsible for all program accounting and financial reporting.

2.30 The Country Programs Cluster supports country-level activities, including dedicated teams to support CCMs, LFAs, and the grant renewal process. In this cluster, the Unit Directors (for each region) are the closest equivalent to regional HNP Sector Managers in the World Bank, Regional Team Leaders (for each subregion) are the closest equivalent to Lead Specialists or Coordinators, and FPMs are the closest equivalent to Task Team Leaders (the Bank's term for project managers).

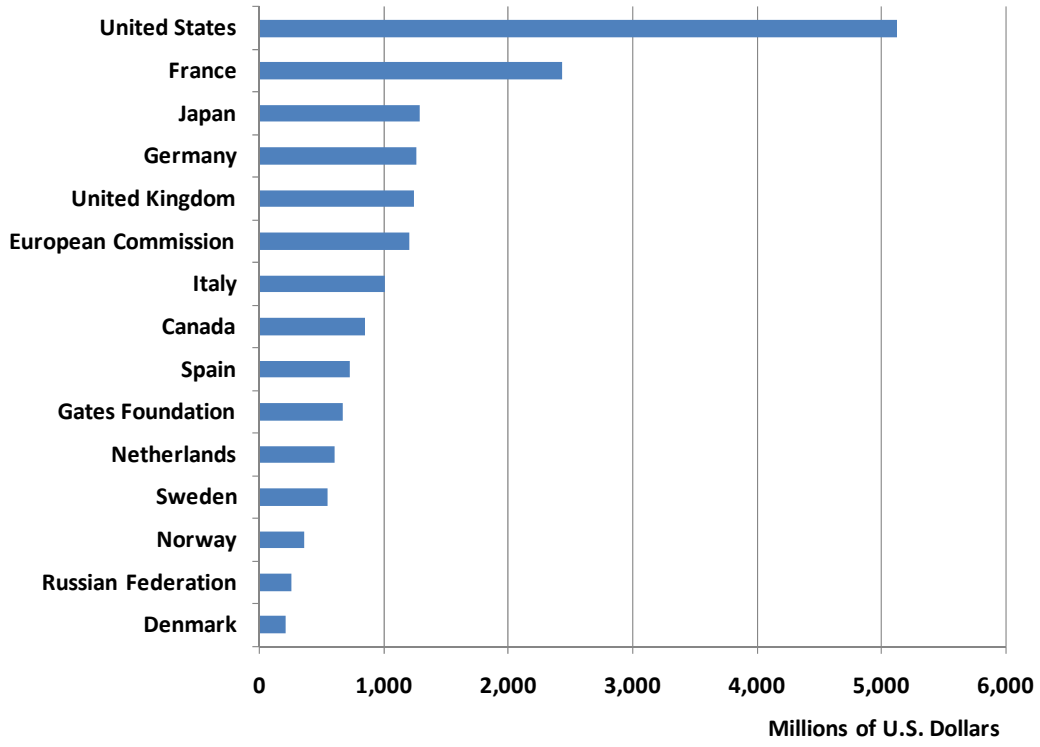
2.31 The External Relations and Partnership Cluster is responsible for consolidating and building partnerships with constituencies in client countries, and with multilaterals, bilateral donors, CSOs, and the private sector at the global level. It oversees all media, communications, and branding of the Global Fund and leads the Secretariat's efforts in resource and demand mobilization at the global level, including recent innovations such as the "Debt2 Health Initiative" (see below). The Strategy Performance and Evaluation Cluster is responsible for overall strategy, policies, M&E, aid effectiveness, and the TRP proposal review process. It is also responsible for facilitating synergies between the various new initiatives of the Fund, including the AMFm and the Voluntary Pooled Procurement.[10]

Financing

RESOURCE MOBILIZATION

2.32 Donor contributions to the Global Fund have increased from about $800 million in 2002 to about $3 billion annually during the years 2007 to 2010 (Appendix Table F-2). The top 15 donors have accounted for 94 percent of all contributions to date (Figure 4). The United States has been by far the largest contributor, with more than $5 billion in contributions. France has been a strong second with close to $2.5 billion, followed by Japan,

Figure 4. Global Fund: Top 15 Donors (as of December 2010)



Source. World Bank as Trustee for the Global Fund. See Appendix Table F-2 for more details.

10. Voluntary Pooled Procurement allows countries to receive price reductions by purchasing pharmaceuticals and other commodities in bulk.

Germany, the United Kingdom, and the European Commission with $1.2–1.3 billion each. The Gates Foundation has been largest foundation contributor with $670 million, and the Russian Federation the largest non-OECD country with $257 million.

2.33 To mobilize resources, the Global Fund follows a periodic replenishment model on a voluntary basis for all public donors, complemented by ad hoc contributions from other donors. There have been three replenishments so far. The third replenishment, which concluded in October 2010, raised $11.7 billion for the 2011–13 period.

2.34 The Fund has undertaken a strong effort to identify and mobilize new resources, including private and foundation sources, for the Global Fund, both at the global level and within grant-recipient countries. One example is the Product Red Initiative launched by Bono of U2 and Bobby Shriver of ONE/DATA at the World Economic Forum in Davos in January 2006. Partner companies create a product with the Product Red logo and donate a percentage of their profits to the Global Fund in return for the opportunity to increase their own revenues through the Product Red products that they sell.[11] "Debt2Health" is another innovation launched in 2007, in which donors forgo debt repayment and recipient countries invest 50 percent of the debt forgiven to support Global Fund activities in their respective countries. Thus far, Côte d'Ivoire, Indonesia, and Pakistan have participated in this initiative through debt cancelled by Australia and Germany. Chevron became a Corporate Champion of the Global Fund in 2008, committing $5 million to Global Fund grant recipients in each of six countries (Angola, Indonesia, Nigeria, the Philippines, South Africa, and Thailand). These focus on improving the reach and performance of Global Fund grants through capacity development initiatives, joint advocacy, awareness campaigns, and workplace wellness initiatives.

EXPENDITURES

2.35 Grant disbursements to Principal Recipients in beneficiary countries have represented about 92.7 percent of its expenditures since 2002 (Table 2). The investment income derived from donor funds received but not yet disbursed has more than covered the Fund's cumulative administrative costs of 7.3 percent for disbursing these grants. The largest categories of administrative expenses have been staff salaries and benefits (2.8 percent), other Secretariat expenses (2.6 percent), and fees to the LFAs (1.7 percent). The Fund has reimbursed the World Bank about $2.0–3.0 million a year (0.15 percent of total expenditures) for administering the Global Fund trust fund.[12]

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11. Participating companies include Nike, American Express (U.K.), Apple Inc., Starbucks, Converse, Bugaboo, Penguin Classics (U.K. & International), Gap, Emporio Armani, Hallmark (U.S.), and Dell.

12. By way of comparison, the World Bank's administrative costs as a percentage of total expenditures and disbursements (loans, credits, grants, and recipient-executed trust funds) were 9.0 percent over the same time period (FY02–10). See Appendix Table F-2. Thus, the administrative costs of the two organizations are comparable when one takes into account the following factors: the Bank has a resident Board, it has large research and training departments that are generating and disseminating knowledge about development, the Bank has become a significant administrator of trust funds, and it spends more resources on self-evaluation and independent evaluation of completed projects, both of which are recorded as part of administrative expenditures.

Table 2. Global Fund: Annual Income and Expenditures, Calendar Years 2002–10

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Share
Income										
Contributions	880.8	1,416.7	1,254.7	1,430.3	2,429.6	2,963.8	3,714.2	2,590.4	2,329.0	95.1%
Bank and Trust Fund income	10.1	28.2	33.8	58.9	126.5	240.5	289.7	150.4	149.7	5.4%
Foreign currency gain/(loss)	0.0	0.0	0.0	0.0	0.0	-50.9	-83.7	124.8	-97.1	-0.5%
Total Income	890.9	1,444.9	1,288.5	1,489.3	2,556.1	3,153.4	3,920.2	2,865.7	2,381.5	100.0%
Expenditures										
Grants disbursed	0.9	231.2	627.5	1,054.3	1,307.0	1,710.8	2,259.3	2,749.5	3,060.7	92.7%
Employment expenses	2.8	9.8	16.9	25.1	30.6	41.1	71.7	91.7	107.1	2.8%
Other Secretariat expenses	7.0	10.8	19.6	27.3	28.9	41.1	63.1	74.8	90.3	2.6%
LFA fees	0.7	10.1	12.2	19.2	23.9	32.9	27.1	57.1	57.9	1.7%
CCM funding	0.0	0.0	0.0	0.0	0.0	0.0	1.4	2.2	4.1	0.1%
Board constituency funding									0.6	0.0%
Trustee fee	2.3	1.9	2.2	2.3	2.4	2.3	2.4	2.6	2.7	0.15%
Foreign currency (gain)/loss	0.0	0.0	0.0	0.0	0.0	13.6	-4.9	-7.5	-35.8	-0.2%
Uncollectible contributions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	26.7	0.2%
Total Expenditures	13.7	263.8	678.3	1,128.2	1,392.8	1,841.6	2,420.0	2,971.4	3,314.3	100.0%
Income - Expenditures	877.2	1,181.1	610.3	361.1	1,163.3	1,311.8	1,500.3	-105.7	-932.9	
Movement in un-disbursed grants [a]	51.1	832.1	226.9	454.9	510.5	871.7	110.5	1,248.8	160.5	

Source: Global Fund Annual Reports. See Appendix Table F-1 for more details.
a. The annual change in the value of grant commitments that have not yet been disbursed.

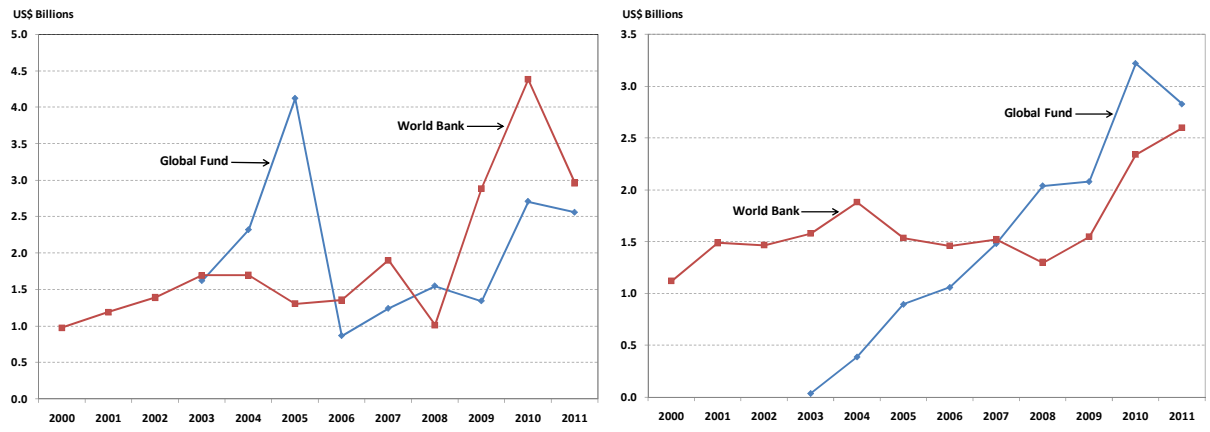
2.36 Global Fund grants can be used to support investments (pharmaceuticals, medical commodities and diagnostics, bed nets), surveillance studies and surveys, technical assistance to build capacity, actual service delivery, and salaries. Grants target the three diseases, plus strengthening of underlying cross-cutting health systems, such as procurement, supply management, human resources, and health information systems. A snapshot of the types of activities, their scale, and geographical distribution is as follows, based on the U.S. dollar amount of grants recommended by the TRP after 10 rounds of proposals:

- By disease: HIV/AIDS (43 percent), malaria (35 percent), tuberculosis (16 percent), health systems strengthening (6 percent)
- By region: Sub-Saharan Africa (62 percent), East Asia and the Pacific (13 percent), Europe and Central Asia (8 percent), Latin American and the Caribbean (7 percent), South Asia (8 percent), Middle East and North Africa (2 percent)
- By income level of recipient country: low income (72 percent), lower middle-income (24 percent), upper middle-income (4 percent)

- By expenditure category: medicines and pharmaceutical products (18 percent), health products and equipment (17 percent), human resources (14 percent), training (11 percent), infrastructure and equipment (10 percent), planning and administration (6 percent), M&E (4 percent), living support to clients/target populations (5 percent), communications materials (5 percent), other (9 percent)
- By type of Principal Recipient: government agency (55 percent), CSOs (24 percent), multilateral organizations (16 percent), private sector (2 percent), other (2 percent).

2.37 The Global Fund committed $18.3 billion and disbursed $14.0 billion in grants to recipient countries between July 2002 and June 2011 — corresponding to the World Bank's fiscal years 2003–11. By way of comparison, the Bank committed $19.2 billion and disbursed $15.8 billion in loans, credits, and grants during the same time period to the health sector.[13] Although the orders of magnitude have been the same, the trends have been somewhat different (Figure 5). World Bank commitments and disbursements were relatively constant at about $1.5 billion a year during 2000–08, the disbursements reflecting commitments made both before and after the Global Fund was founded in 2002. Global Fund disbursements have been rising steadily since 2002, reflecting the rapidly growing commitments during its first three years of operation, before declining significantly in 2006. The World Bank significantly increased its commitments during the last three years, 2009–2011, as part of the Bank's response to the global financial crisis, which then resulted in higher disbursements in 2010–11. The Global Fund also increased its commitments and disbursements significantly in 2010–11.

Figure 5. Global Fund Grants and World Bank Health Projects, Fiscal Years 2000–11



Source: Global Fund and World Bank data.
Note: Global Fund commitments and disbursements are totals. World Bank commitments and disbursements represent the proportions of the Bank's total project commitments and disbursements to the health sector.

13. These are the share of total project commitments and disbursements that are assigned to the four health sector codes in the Bank's coding system: (a) health, (b) public administration–health, (c) compulsory health finance, and (d) non-compulsory health finance.

2.38 More than half of Global Fund commitments and disbursements have been for HIV/AIDS, followed by malaria and tuberculosis (Table 3). Only about 13 percent of World Bank commitments have been for these three diseases, and another 4 percent for other communicable diseases such as avian flu and leprosy. The Bank has a broader mandate; the largest portion of its support (43 percent) is for health systems strengthening (HSS) — an

Table 3. Global Fund and World Bank Health Commitments and Disbursements, by Disease/Theme, Fiscal Years 2003–11

	Global Fund		World Bank	
Disease/Theme	Commitments	Disbursements	Commitments	Disbursements
US$ Millions				
HIV/AIDS	9,913.3	7,470.3	1,728.2	1,564.5
Malaria	5,164.9	4,051.6	729.6	343.8
Tuberculosis	2,872.9	2,127.1	414.3	661.6
HIV/Tuberculosis	202.3	195.2		
Other communicable diseases			837.9	426.1
Health systems strengthening	159.1	170.9	9,359.5	7,035.1
Integrated	3.1	3.1		
Child health			2,644.9	1,871.6
Population & reproductive health			1,728.8	1,541.6
Nutrition & food security			1,118.0	1,081.5
Injuries & non-communicable diseases			1,745.8	1,257.0
Other human development			1,330.0	903.9
Total	18,315.6	14,018.3	21,636.8	16,686.7
World Bank subtotal mapped to the HNP Sector Board			12,863.7	9,144.1
Share of Total				
HIV/AIDS	54.1%	53.3%	8.0%	9.4%
Malaria	28.2%	28.9%	3.4%	2.1%
Tuberculosis	15.7%	15.2%	1.9%	4.0%
HIV/Tuberculosis	1.1%	1.4%		
Other communicable diseases			3.9%	2.6%
Health systems strengthening	0.9%	1.2%	43.3%	42.2%
Integrated	0.0%	0.0%		
Child health			12.2%	11.2%
Population & reproductive health			8.0%	9.2%
Nutrition & food security			5.2%	6.5%
Injuries & non-communicable diseases			8.1%	7.5%
Other human development			6.1%	5.4%

Source: Global Fund and World Bank data. See Appendix Tables F-9 to F-12.
Note: Each World Bank project can identify up to five themes promoted by the project. World Bank commitments and disbursements represent the proportions of total project commitments and disbursements to each theme. The subtotal "mapped to the HNP Sector Board" represents the share of these commitments and disbursements under the control of the HNP Sector Board. That is, each Bank-supported project is supervised by a project manager who reports to a regional manager, who is represented on a Bank-wide sector board. Each project is thereby "mapped" — or becomes the responsibility of — that sector board, in this case the HNP Sector Board.

expansive category that encompasses virtually all activities that aim to bring about improvements in the management, financing, and overall performance of health systems (World Bank 2007c, p. 14). Other important priorities for the Bank are child health, and population and reproductive health.

2.39 The different mandates of the two organizations are also manifested in the geographical distribution of their commitments and disbursements (Table 4). The distribution for the Global Fund reflects, first of all, different countries' income levels, and then other factors such as disease burden, population size, vulnerability, local institutions and policies, and the quality of proposals received. The Global Fund focuses its support on low-income countries as classified by the World Bank — equivalent to International Development Association (IDA)-eligible countries. Only these countries are eligible for all forms of support offered by the Global Fund. Lower middle-income applicants must focus their grant proposals on their countries' poor ***or*** vulnerable populations, and upper middle-income applicants on their countries' poor ***and*** vulnerable populations. Lower middle-income countries must also contribute at least 35 percent of the costs of the proposed interventions, and upper middle-income countries at least 65 percent. Therefore, fully 60 percent of Global Fund support has gone to Africa, which is also the epicenter of the HIV/AIDS epidemic and suffers from rampant malaria. East Asia has large populations and high rates of multi-drug resistant tuberculosis. South Asia and Europe

Table 4. Global Fund and World Bank Health Sector Commitments and Disbursements, by Region, Fiscal Years 2003–11

	Global Fund		World Bank	
Region	Commitments	Disbursements	Commitments	Disbursements
Africa	11,131.2	8,371.9	3,934.8	3,595.0
East Asia & the Pacific	2,611.9	1,984.2	1,277.3	1,159.7
Europe & Central Asia	1,438.7	1,264.7	2,592.5	2,223.5
Latin America & the Caribbean	1,364.9	1,114.5	7,692.2	5,484.2
South Asia	1,505.9	1,068.8	3,359.1	2,777.2
Middle East & North Africa	263.0	214.2	301.8	513.9
World	-	-	11.9	1.9
Total	18,315.6	14,018.3	19,169.6	15,755.3
World Bank subtotal mapped to the HNP Sector Board			12,498.3	9,967.8
Share of Total				
Africa	60.8%	59.7%	20.5%	22.8%
East Asia & the Pacific	14.3%	14.2%	6.7%	7.4%
Europe & Central Asia	7.9%	9.0%	13.5%	14.1%
Latin America & the Caribbean	7.5%	8.0%	40.1%	34.8%
South Asia	8.2%	7.6%	17.5%	17.6%
Middle East & North Africa	1.4%	1.5%	1.6%	3.3%
World	0.0%	0.0%	0.1%	0.0%

Source: Global Fund and World Bank data. See Appendix Table F-13.
Note: World Bank commitments and disbursements represent the proportions of total project commitments and disbursements to the health sector. Bank disbursements to the Middle East and North Africa are slightly higher than commitments because the data also reflects disbursements arising from Bank commitments prior to 2003.

and Central Asia have a high tuberculosis burden and increasingly high risks of HIV/AIDS. Africa and South Asia have the poorest and most vulnerable risk groups. The Middle East and North Africa has a relatively smaller population and a smaller disease burden and risks overall.

2.40 The Bank, in contrast, provides only 40 percent of its commitments in the form of concessional loans and grants to low-income countries, and the remaining 60 percent in the form of nonconcessional loans to middle-income countries. Therefore, while Africa is the Bank's priority region, since most of the countries in Africa are low-income, the Bank also has sizeable health sector portfolios in all regions except the Middle East and North Africa.

2.41 A Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, which met in 2005, found that the Global Fund and the World Bank "increasingly seem to finance the same types of goods and activities in the same countries without any clear sense of their respective comparative advantages or complementarity with each other" (UNAIDS 2005). The above comparisons show that the greatest potential for constructive engagement between the two organizations at the country level occurs in the low-income, high-burden countries where the Global Fund is most active.

2.42 It should also be emphasized that the Bank is a multisectoral organization that takes a multisectoral approach to improving health outcomes, involving contributions from the education, sanitation, nutrition, public administration, and finance sectors, among others, in addition to the health sector. This having been said, health sector project managers — those who are managing projects under the control of the HNP Sector Board — have a greater potential to engage with Global Fund staff and agents at the country level. Such projects account for about 60 percent of the total commitments and disbursements to the health sector (Tables 3 and 4).

World Bank Engagement with the Global Fund

2.43 The World Bank has played three major roles in the Global Fund — as the trustee of the Global Fund trust fund, as a member of the Board and two of its committees, and as a development partner at the global and country levels.

TRUSTEE

2.44 First and foremost, the Bank is the administrator of Global Fund trust fund. Under the trustee agreement (signed in May 2002), the Bank receives and invests funds from Global Fund donors, disburses the funds to grant recipients on the instruction of the Global Fund Secretariat, and provides regular financial reports to the Global Fund Board. The Multilateral Trusteeship and Innovative Financing Department (CFPMI) is responsible for managing the trustee operations of the Global Fund trust fund, the largest trust fund that the Bank administers. As indicated earlier, the Global Fund has reimbursed the Bank about $2.0–3.0 million annually for the costs incurred in administering the trust fund (Table 2).

2.45 In World Bank parlance, the Global Fund trust fund is a financial intermediary fund (FIF) in which the Bank does not have an operational role. That the Bank might play an implementing role in the Global Fund, like the Bank supervises projects financed by the Global Environment Facility, was never seriously considered by the Transitional Working Group. However, there

were considerable pressures in the Working Group for the Bank to take on an "enhanced fiduciary role," in addition to being the trustee, to ensure that Global Fund grants were used for the intended purposes. The Bank was unenthusiastic about exercising fiduciary oversight for projects for which it did not also have programmatic oversight in accordance with its own operational policies, which would have required a substantial scaling up of country-level HNP staff. When the Bank declined, the Global Fund Board decided at its second meeting in April 2002 to establish the LFA system of contracting out in-country fiduciary functions to LFAs.[14]

GOVERNANCE

2.46 The Bank is a permanent (as opposed to rotating) nonvoting "institutional" member of the Global Fund Board, along with WHO, UNAIDS, and one representative from partners (RBM, Stop TB, and UNITAID), and a member of two Board committees — the Finance and Audit Committee by virtue of its trusteeship role, and the Policy and Strategy Committee by virtue of its experience in the health sector.

DEVELOPMENT PARTNER

2.47 As already indicated, the Bank has been a significant lender for strengthening health systems and controlling communicable diseases, as well as for other health priorities such as child health and population and reproductive health. The potential for Bank staff to be engaged in the country-level processes of the Global Fund, and in other ways that contribute directly or indirectly to the work of the Global Fund, is obviously greater where the Bank is financing technical assistance or investment projects related to the three diseases.

2.48 In recent years, the Bank and Global Fund have taken a number of steps to improve coordination and collaboration on country work through various initiatives associated with GHAP, IHP, RBM, Stop TB, and AMFm. But the full extent of the Bank's engagement with the Global Fund at the country level has not been systematically tracked. There have been no Bank-wide directives or guidelines to staff for engaging with the Global Fund at the country level, or a memorandum of understanding (MOU) between the Global Fund and the World Bank for collaborating at the global or country level.

2.49 IEG's findings and lessons in relation to the Bank's role as a development partner of the Global Fund are presented in Chapter 4 of this Review.

The Five-Year Evaluation of the Global Fund

2.50 The Global Fund completed its first five-year evaluation in 2009 — a comprehensive three-part evaluation covering the first years of its existence. Approved by the Board in November 2006, the FYE was launched in April 2007, and the final synthesis report was submitted in March 2009 for discussion at the 19th Board meeting in May 2009.

14. Macro International 2009b, *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria: Synthesis of Study Areas 1, 2, and 3*, pp. 12, 36, and 54; Minutes of the Transitional Working Group, October 11–12, 2001; and Report of the Second Meeting of the Global Fund Board, April 22-24, 2002.

2.51 Overall, this Review found that the FYE was an independent and quality evaluation. Assisted by a team of staff provided by the Secretariat, the TERG oversaw all aspects of the evaluation, including contracting the evaluation to an independent consortium of evaluators. The evaluation teams were able to report candidly about how slowly and less strategically the Global Fund governance processes had developed to guide this new approach to development assistance; about the need for a robust risk management strategy to alert the Global Fund about likely suspension of ongoing treatment activities; and about the risk of increased drug resistance, among other things. Notwithstanding the TERG's very "involved" oversight style, the FYE was protected from outside interference, and the potential conflicts of interest that arose were appropriately identified and managed.

2.52 The evaluation design was organized around three study areas, each of which resulted in one evaluation report:

- Study Area 1: *The Organizational Efficiency and Effectiveness of the Global Fund* — issued in October 2007.
- Study Area 2: *The Global Fund Partner Environment, at Global and Country Levels, in Relation to Grant Performance and Health System Effects, Including 16 Country Studies* — issued in June 2008.
- Study Area 3: *Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis and Malaria* — issued in May 2009.

2.53 The FYE was objectives-based and evidence-based against the stated purpose and principles of the Global Fund. The overall assessment was fair and balanced, portraying both the strengths and weaknesses of the Global Fund. The three study areas reinforced each other, and the Synthesis Report effectively pulled together key messages in a coherent and integrated manner, although the evaluation did not deliver on two objectives — developing the "determinants" of good grant performance in Study Area 2 and building evaluation capacity in Study Area 3 countries. The FYE met three of the four standard IEG criteria for assessing quality — evaluation scope, instruments, and feedback (Appendix Table A-3). It did not meet the M&E criterion that the program's activity-level M&E system should contribute to the evaluation's assessment of the overall outcomes of the program because the Global Fund's grant-level M&E system was not initially designed to do so. Therefore, the FYE used other methods, notably the impact assessment in Study Area 3.

2.54 The total cost of the FYE was $16.2 million, of which $11.7 million was spent on Study Area 3. The high cost of Study Area 3 was largely due to its extensive country-level activities. Eighteen countries were studied to obtain a broad view of progress in different country contexts. Primary data collection and analysis were conducted in eight countries (Burkina Faso, Cambodia, Ethiopia, Haiti, Malawi, Peru, Tanzania, and Zambia) and secondary data analysis was done in ten countries (Benin, Burundi, Democratic Republic of Congo, Ghana, Kyrgyzstan, Lesotho, Moldova, Mozambique, Rwanda, and Vietnam).[15]

15. A large part of the Study Area 3 work also aimed at the participation and evaluation capacity building of country institutions. As planned, 70 percent of the $11.7 million evaluation budget for Study Area 3 was spent on country institutions — 40 percent on data collection/analysis and 30 percent on technical assistance and training. The total cost of the evaluation represented 1 percent of the average annual expenditures of the Global Fund in 2007 and 2008 (not including the movement in undisbursed grants). IEG has observed that independent

2.55 The major findings of the FYE are presented in Chapter 3 in conjunction with IEG's findings from six country visits in 2010 (to Burkina Faso, Tanzania, Cambodia, Nepal, Brazil, and the Russian Federation). IEG's detailed assessment of the independence and quality of the FYE, and its lessons for the evaluation of GRPPs more generally, are presented in Chapter 5 of this Review.

IMPACTS OF THE FIVE-YEAR EVALUATION ON THE GLOBAL FUND

2.56 IEG has found that the FYE was a landmark and influential evaluation exercise, which has had a major impact on the Global Fund. Even the preparatory events leading up to the FYE had impacts, because these generated support and visibility for the organization. The evaluation has helped the Global Fund Board and management make significant strategic adjustments to its organizational and institutional arrangements. The first formal Management Response was presented to the Board in November 2009, and an Update (with time lines) was presented at the Third Replenishment Meeting in The Hague in March 2010.[16] There have also been a number of external and internal review studies — for example, of the CCM mechanism and the LFA system — that were conducted either as inputs into the FYE or to supplement it. Collectively, these have helped to forge new and strategic directions for the Global Fund.

2.57 As a young and rapidly evolving program, the Global Fund was already acting on some evaluation findings before the final findings and recommendations were formally issued, since the TERG regularly updated the Board and the Policy and Strategy Committee on key findings of the interim reports. By March 2009, when the final Synthesis Report was submitted, the Global Fund Secretariat, and in some instances, the Board and its Committees, had already initiated steps in some 20 activity areas, in response to the Study Area 1 and 2 reports, and related TERG recommendations.

2.58 The Global Fund has taken the following actions, among others, in response to the FYE. (Appendix G provides the formal and more detailed response of the Secretariat to the FYE.)

Global Fund Principles

(a) The Global Fund Board has reaffirmed that the Global Fund is a financing entity. The Secretariat is taking steps to communicate the Global Fund's business model more clearly to countries and partners alike. The Board has also reaffirmed its commitment to the country-owned model and to the importance of inclusion and engagement of CSOs at all levels.

(b) As a signatory to the Paris and Accra Accords, the Global Fund will abide by the guiding principles of alignment and harmonization. At the country level, the Global

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evaluations of GRPPs typically cost between 1 and 3 percent of annual expenditures, closer to 1 percent for larger programs such as the Global Fund and closer to 3 percent for smaller programs. (See IEG 2011b, *The World Bank's Involvement in Global and Regional Partnership Programs: An Independent Assessment*, p. 26.)

16. Global Fund, 2010b, "The Five-Year Evaluation: An Update," The Global Fund Third Replenishment (2011–2013).

Fund will emphasize the alignment of its grant cycle with country planning and budgeting cycles, and harmonization of salary support and compensation. The Global Fund will encourage CCMs to be more in line with other national coordinating bodies.

Governance and Management

(c) The Board has delegated more decision-making authority, especially on operational matters, to its Committees and to the Secretariat in order to focus more on core strategic issues, consistent with its governance role.

(d) The Global Fund is now an autonomous international financing agency, having terminated its administrative agreement with WHO in December 2008. The Secretariat is reorganizing itself in order to become more efficient, and is implementing human resource measures to strengthen performance. The Secretariat has proposed that its administrative budget will not exceed 10 percent of total expenditures.

Partnership Strategy

(e) The Secretariat has developed a new Partnership Strategy that has been approved by the Board, which provides a framework for a strategic division of labor, clarity of roles, and coordination. The Global Fund is strengthening existing relationships with RBM, Stop TB, UNAIDS, UNICEF, and WHO, and engaging more with GAVI and the World Bank both directly and through the IHP+ and the Health Systems Funding Platform. In addition, the Global Fund will give more emphasis to HSS, maternal and child health, and the prevention of mother to child transmission of HIV (PMTCT).

(f) Global Fund donors have not agreed to provide funding to development partner agencies to provide complementary technical assistance at the country level. Therefore, the Secretariat is seeking innovative options for financing or providing country-level technical assistance based on studies carried out by the Gates Foundation, GTZ, and UNAIDS, and on additional targeted studies that address key questions with regard to technical assistance planning, access, and financing.

Operational Modalities

(g) The Secretariat is simplifying the grant mechanism and implementing a new grant architecture to move from a project-based approach to a single stream of funding mode (Box 2). This is intended to ensure greater cohesiveness and coherence among grant activities, to foster greater alignment with national strategies for the three diseases, to avoid service disruptions, and to reduce transactions costs. Each Principal Recipient will have a single grant agreement for any one disease (single stream of funding), and may win a subsequent grant to scale up or extend the duration of activities from the first grant, based on periodic reviews of satisfactory performance. Grants will no longer be fragmented and piecemeal, but instead will be approved on the basis of adherence to a sustained national programmatic approach. The Global Fund also plans to shift its funding to support National Strategy Applications — that is, to support a national strategy instead of multiple grants for each disease in a country, and to group all grants under this strategy.

(h) The Global Fund still views PBF as the cornerstone of the management of its grant portfolio. The Global Fund will make greater investments in M&E (including data quality audits) in light of the tremendous data quality issues in recipient countries. It is placing greater emphasis on strengthening country information systems and on aligning Global Fund M&E requirements with the National Health Management Information Systems of countries to reduce the burden of reporting.

(i) The Secretariat has launched a Risk Management Framework[17] to mitigate fraud and corruption with Global Fund grants in countries. It has developed an accountability framework encompassing all of the Global Fund structures, systems, and controls for managing risks at all levels. Board Committees have direct oversight responsibility over risks that have been identified. The Secretariat is providing clearer policy and guidelines to countries, and the OIG now has a stronger role in providing independent and objective assessments of high-risk topics and in establishing Global Fund controls.

Box 2. Changes to the Global Fund Grant Architecture

The Global Fund is currently going through the process of transitioning its entire grant portfolio to single streams of funding (SSF), following Board approval of its "new grant architecture" in November 2009. The first two SSFs were for tuberculosis in Fiji and for HIV/AIDS in Moldova, both effective April 1, 2010, and both with their respective Ministries of Health as Principal Recipients. The Secretariat has signed over 80 SSFs as of October 2011, and expects to sign a total of 145–150 SSFs by the end of 2011, most of these from the remaining Round 10 grant agreements. The Secretariat plans to have completed the better part of the SSF transition by the end of 2013.

Thus, SSFs are becoming the Global Fund's new modality for structuring its funding. The former grants were one grant per Principal Recipient per approved Round, with little or no alignment to any in-country cycles, and with Phase 2 reviews taking place at different times for grants in different Rounds. SSFs represent one grant per Principal Recipient per disease or HSS program (consolidated if a single Principal Recipient was previously implementing multiple grants). The timings of Periodic Reviews (which are replacing Phase 2 Reviews) are now aligned to each country's fiscal and programmatic reporting cycles.

The first 25 or so Periodic Reviews will take place during the first two quarters of 2012. These will cover all Global Fund grants in a disease area (or cross-cutting HSS support), if there are multiple Principal Recipients in that disease area in the country. These will also take into account the available national program review information and impact studies, with the intention of relying more and more on country-driven information over time.

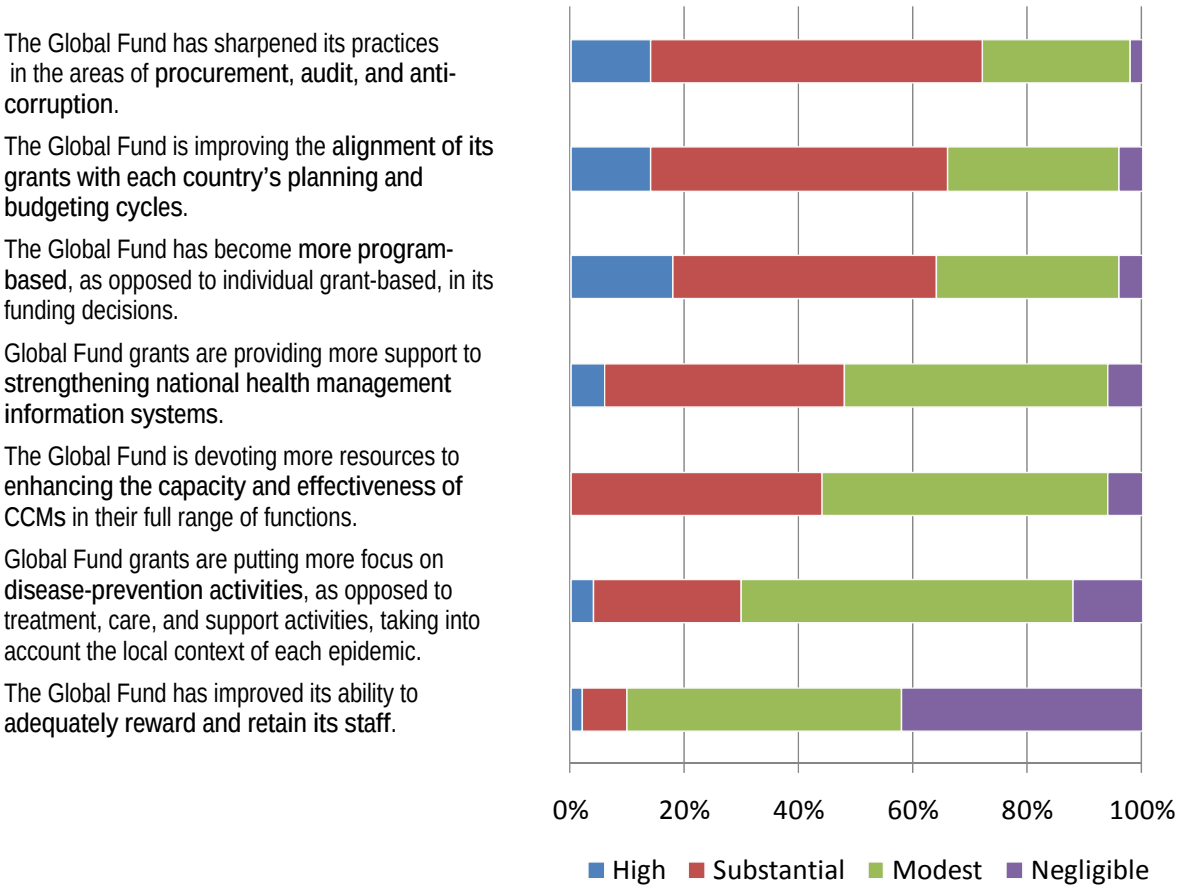
The Global Fund Board approved the First Learning Wave of National Strategy Applications (NSAs) in November 2009 — for China (malaria), Madagascar (malaria), Nepal (tuberculosis), and Rwanda (one each for HIV and tuberculosis). Ten countries are participating in the Second Wave of NSAs that was launched in January 2011. The countries have recently completed a joint assessment of their national disease strategies, which is a prerequisite for submitting an NSA request. The final outcome of these Second Wave NSAs will be determined in 2012.

Source: Global Fund Secretariat. See also "Changes to the Global Fund Grant Architecture: a Fact Sheet for Implementers." www.theglobalfund.org/documents/grantarchitecture/Fact_Sheet_for_Implementers_en.pdf

17. Endorsed at the 20th Board Meeting in November 2009.

2.59 One of the questions on the electronic survey administered to staff of the Global Fund Secretariat related to the impacts of the FYE on the Global Fund. According to the survey results, staff perceive that the Global Fund is making significant progress in some areas in implementing these new directions, such as (a) sharpening its practices in relation to procurement, audit, and anti-corruption; (b) aligning its grants with each country's planning and budgeting cycles; and (c) becoming more program-based in line with its new grant architecture (Figure 6). Other areas are still works in progress, such as strengthening national health management systems and enhancing the capacity and effectiveness of CCMs. Global Fund grants are still focusing more on treatment, care, and support activities than on disease-prevention activities, and Secretariat staff still find the personnel reward system to be lacking, according to these survey results.

Figure 6. To what extent have the findings and recommendations of the Five-Year Evaluation had the following impacts on the Global Fund?



Source: IEG Survey of Global Fund staff, administered in March 2011. See Appendix Q.
Note: There were 52 usable responses to the survey for a response rate of 49 percent (52 out of 106): 36 of these respondents were from the Country Programs Cluster, 7 from the External Relations and Partnerships Cluster, and 9 from the Strategy, Performance, and Evaluation Cluster. There was no significant difference in responses to these questions across the three clusters.

3. Validating the Major Findings of the Five-Year Evaluation

3.1 The Global Fund represents an ambitious attempt by the international community to use a global partnership program to deliver the global public good of controlling HIV/AIDS, tuberculosis, and malaria in high-burden countries, with a particular focus on low-income countries. Guided from the beginning by principles later adopted by signatories to the 2005 Paris Declaration on Aid Effectiveness, it has become a basis of comparison for other global partnership programs that are financing investments at the country level.[18] Thus, the experience of the Global Fund provides lessons not only for the Fund itself, but also for other global partnership programs in relation to issues such as additionality, sustainability, country ownership, alignment, harmonization, and managing for results.

3.2 The FYE presented findings in all these areas. Those on the effectiveness of the Global Fund approach at the country level were drawn primarily from the 16 country case studies carried out in 2007 as part of Study Area 2 — *Evaluation of the Global Fund Partner Environment at the Global and Country Levels, in Relation to Grant Performance and Health System Effects.* IEG consultants revisited four of these countries (Burkina Faso, Cambodia, Nepal, and Tanzania) as well as two middle-income countries (Brazil and the Russian Federation) in 2010 to confirm the findings of the FYE and to assess changes (either improvements or deteriorations) in the intervening three years, using the FYE and the four Study Area 2 country reports as a baseline.

3.3 The current chapter presents what IEG found, organized according to eight of the nine major findings of the FYE, as presented in the Synthesis Report. (IEG did not address the ninth major finding because this related to the global governance of the Global Fund, not its country-level activities.) This introductory section concludes with a summary of the epidemiology of the three diseases in the six countries, and the activities of the Global Fund in those countries. Then each of the sections that follow starts with the major findings of the FYE, followed by the findings from IEG's six country visits, supplemented by other material as appropriate.

3.4 **HIV/AIDS.** HIV/AIDS is a significant public health problem in all six countries visited. Tanzania is the most heavily affected, with an estimated 5.7 percent of the adult population living with AIDS, followed by Burkina Faso, with 1.2 percent of adults infected (Table 5). Unprotected heterosexual sex is the primary mode of transmission in Sub-Saharan Africa. In both Tanzania and Burkina Faso, infection rates are particularly high among people with high-risk sexual behavior, but HIV has moved out of these groups to infect many of their partners who exhibit lower-risk behavior. Women and girls are disproportionately affected (with prevalence rates 2–4 times those of males in some surveys); the high infection rate among women of childbearing age has resulted in significant mother-to-child transmission of HIV.[19]

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18. This would include the Education for All–Fast Track Initiative (established 2002), the Climate Investment Funds (established 2008), and the Global Agriculture and Food Security Program (established 2010). The Global Environment Facility (established 1991) and the Global Alliance for Vaccines and Immunization (established 2000) have also started to compare themselves to certain aspects of the Global Fund. For example, the first evaluation of GAVI specifically compared the organizational efficiency and effectiveness of GAVI with that of the Global Fund, based on the findings of Study Area 1 of the FYE. See Chee and others 2008, pp. 124-127.

19. Information is taken from UNAIDS 2011, *UNAIDS Report on the Global AIDS Epidemic 2010*.

Table 5. Epidemiological Profile of the Six Countries Visited by IEG

	Burkina Faso	Tanzania	Cambodia	Nepal	Brazil	Russian Federation
Population	16,287,000	45,040,000	15,053,000	29,853,000	195,423,000	140,367,000
Income level [a]	Low income	Low income	Low income	Low income	Upper middle-income	Upper middle-income
GNI per capita (Atlas method) [a]	$510	$500	$610	$440	$8,040	$9,340
Total health expenditure per capita [b]	$29	$22	$36	$20	$606	$493
People living with HIV [c]	110,000	1,400,000	63,000	64,000	730,000	980,000
Adult HIV prevalence rate (%), ages 15-49, est. 2009 [c]	1.2	5.7	0.5	0.4	0.3-0.6	1.0
Estimated number of people receiving ART, 2009 [c]	26,448	199,413	37,315	3,226	195,984 [d]	75,900
Estimated ART coverage (%), 2009 [e]	37-58	27-34	68-95	9-13	50-89	16-24
TB incidence, (incl. HIV) (rate per 100,000 population) [f]	215	183	442	163	45	132
Probable and confirmed malaria cases [g]	4,399,837	3,812,350	83,777	132,012	308,498	107

Sources:

a. World Bank, World Development Indicators database 2010.

b. WHO, 2010a, *World Health Statistics*.

c. UNAIDS, 2010, *Report on the Global AIDS Epidemic 2010*.

d. 2008 data.

e. The estimated antiretroviral therapy coverage is based on the 2010 WHO guidelines, as presented in UNAIDS 2010, Annex 2. Coverage rates based on the 2006 WHO guidelines are higher.

f. WHO, 2010b, *Global Tuberculosis Control Report*.

g. WHO, 2010c, *World Malaria Report*.

3.5 In most of South and East Asia, including Cambodia and Nepal, the epidemic is concentrated among commercial sex workers, injecting drug users, men who have sex with men, and migrant labor. About one in two hundred adults is infected in those two countries, but this rate is much higher in the severely affected groups. In Cambodia, a rigorous prevention program targeting the riskiest behavior has reduced the incidence of HIV (number of new infections). The epidemic is no longer considered to be “generalized” in Cambodia,

but threatens to spread more widely in Nepal due to cross-border migration along the India-Nepal border among sexual and drug-using networks. Control of the epidemic is limited by the shortage of voluntary counseling and testing services in Nepal and the limited capacities of the authorities and health workers to address existing cases. Migrants also have less access to health services in the settings to which they have migrated.

3.6 Like Cambodia, Brazil has launched major prevention campaigns among the groups most at risk (commercial sex workers, intravenous drug users, and men who have sex with men), involving federal/state partnerships with broad participation of NGOs. Compared with the other five countries, the Russian Federation is currently experiencing a growing national epidemic that has infected 1 percent of the population. This has been driven by injecting drug users and commercial sex workers, which is now leading to increasing heterosexual transmission and prevalence among women.

3.7 HIV/AIDS is not a curable disease at present; combination antiretroviral therapy (ART) can suppress the infection but must be taken for a lifetime. The six countries differ greatly in terms of the coverage of persons in need of such treatment, from less than a quarter in Nepal and the Russian Federation to more than two-thirds in Cambodia and Brazil (Table 6). Thus, there are a number of low-income countries with relatively high treatment coverage rates.

3.8 **Tuberculosis.** Four of the 6 countries are listed in WHO's list of 22 high-burden tuberculosis countries that account for 80 percent of all new tuberculosis cases arising each year: the Russian Federation (no. 12), Tanzania (no. 14), Brazil (no. 15), and Cambodia (no. 21). Incidence ranges from 150,000 new cases in the Russian Federation in 2009 to 80,000 in Tanzania, 85,000 in Brazil, and 65,000 in Cambodia. Incidence has been declining in Brazil, and is stable in the other three countries. Although incidence is lower in Nepal and Burkina Faso, at 48,000 and 34,000 new cases, respectively, the numbers have been increasing in both countries, and incidence rates per 100,000 population are high. Once a "forgotten disease," tuberculosis has reemerged on a global scale. This is partially due to insecurity in the drug supply, gradually emerging resistance to first-line drugs due to inadequate or interrupted treatment, and HIV/AIDS as an amplifier of tuberculosis incidence and spread. WHO estimates that HIV is prevalent in 47 percent of tuberculosis cases in Tanzania, 12 percent in Brazil, 8 percent in the Russian Federation, and 6.4 percent in Cambodia. Thus, tuberculosis has become a leading killer disease among AIDS patients.

3.9 **Malaria.** Malaria is concentrated in Africa and other tropical regions where climatic conditions are favorable to mosquito breeding. Eighty-five percent of the 250 million annual cases of malaria occur in Africa, and that region accounts for 90 percent of the annual deaths from malaria. Malaria has been the single most significant disease in Tanzania affecting the health and welfare of its 45 million inhabitants. However, the number of reported cases has been declining, from more than 9 million cases in 2003 to 3.8 million in 2008. Malaria is also a leading cause of morbidity and mortality in Burkina Faso, Cambodia, and Nepal — it is most intense in the southern third of Burkina Faso, in the forested areas of Cambodia, and the lowland areas of Nepal, along the Indian border. There were 4.4 million reported cases in Burkina Faso in 2009, 84,000 cases in Cambodia, and 132,000 cases in Nepal. The number of reported cases in Brazil, which are concentrated in the country's Amazon region, has been

declining, from 606,000 cases in 2005 to 308,000 cases in 2009. Malaria is essentially nonexistent in the Russian Federation, with only 100 or so cases annually.

3.10 Each of the four low-income countries has received between 11 and 15 grants from the Global Fund since 2002, about 40 percent for HIV/AIDS, one-third for malaria, and one-quarter for tuberculosis. Brazil has received four grants, two each for tuberculosis and malaria, and the Russian Federation has received six grants, three each for HIV/AIDS and tuberculosis (Table 6).

Table 6. Global Fund Grants by Disease in the Six Countries Visited by IEG, 2002–11[a]

	Burkina Faso	Tanzania	Cambodia	Nepal	Brazil	Russian Federation
Number of Global Fund Grants Approved, 2002–11						
HIV/AIDS	4	7	6	7	-	3
Tuberculosis [b]	4	2	3	3	2	4
Malaria	4	5	5	4	2	-
HSS	-	1	2	-	-	-
Total	12	15	16	14	4	7
Global Fund Commitments, 2002–11 ($ millions) [c]						
HIV/AIDS	123.3	391.4	175.1	47.0	-	261.9
Tuberculosis [b]	30.9	91.0	23.5	33.0	23.0	169.3
Malaria	86.3	330.6	109.6	29.6	24.1	-
HSS	-	74.6	15.2	-	-	-
Total	240.5	887.5	323.4	109.6	47.1	431.2
Global Fund Grant Disbursements, 2002–11 ($ millions)						
HIV/AIDS	59.5	313.1	136.0	23.2	-	258.7
Tuberculosis [b]	24.2	82.0	21.8	18.7	20.0	102.7
Malaria	86.3	273.1	75.5	21.2	18.0	-
HSS	-	15.6	9.0	-	-	-
Total	161.3	683.6	242.4	63.1	38.1	361.4

Source: Global Fund Web site. See Appendix H for more details.

a. Through June 30, 2011. The totals also include three Round 10 proposals that have been approved by the Global Fund Board, whose grant agreements have not yet been negotiated and signed: $53.8 million for HIV/AIDS in Burkina Faso; $16.2 million for HIV/AIDS in Nepal; and $63.5 million for tuberculosis in the Russian Federation.

b. The totals for Tanzania include one grant classified as HIV/TB.

c. These represent commitments in relation to signed grant agreements plus the amounts approved by the Board for the three pending grant agreements in Burkina Faso, Nepal, and the Russian Federation.

Additionality, Predictability, and Sustainability of Global Fund Support

3.11 **FYE Findings.** The FYE found that the Global Fund has provided substantial resources for disease control programs, and has increased the potential pipeline for resources by magnifying the focus on the three diseases. The assessment of country-level additionality in four countries where National Health Accounts data were available did not show a strong

evidence of decline in domestic funding. However, the reliance on external funds raised concerns with respect to (a) external resources replacing national ones; (b) the long-term sustainability of recipient countries' disease control programs, and (c) the cost-effectiveness and maintenance of the programs. The FYE also found that the longer-term capacity investments — which were critical for sustainability of prevention, treatment, and care — had been hindered by the lack of alignment between Global Fund and country systems, and by the shift of staff and resources from the public sector to the NGO sector, serving as implementers of Global Fund grants (Macro International 2009b, pp. 15–17).

ADDITIONALITY OF GLOBAL FUND RESOURCES

3.12 Additionality has two dimensions — from the point of view of donors and from that of recipient governments. To what extent are donors and recipient governments increasing or decreasing their own commitments to combating the three diseases in response to the Global Fund grants to the countries?

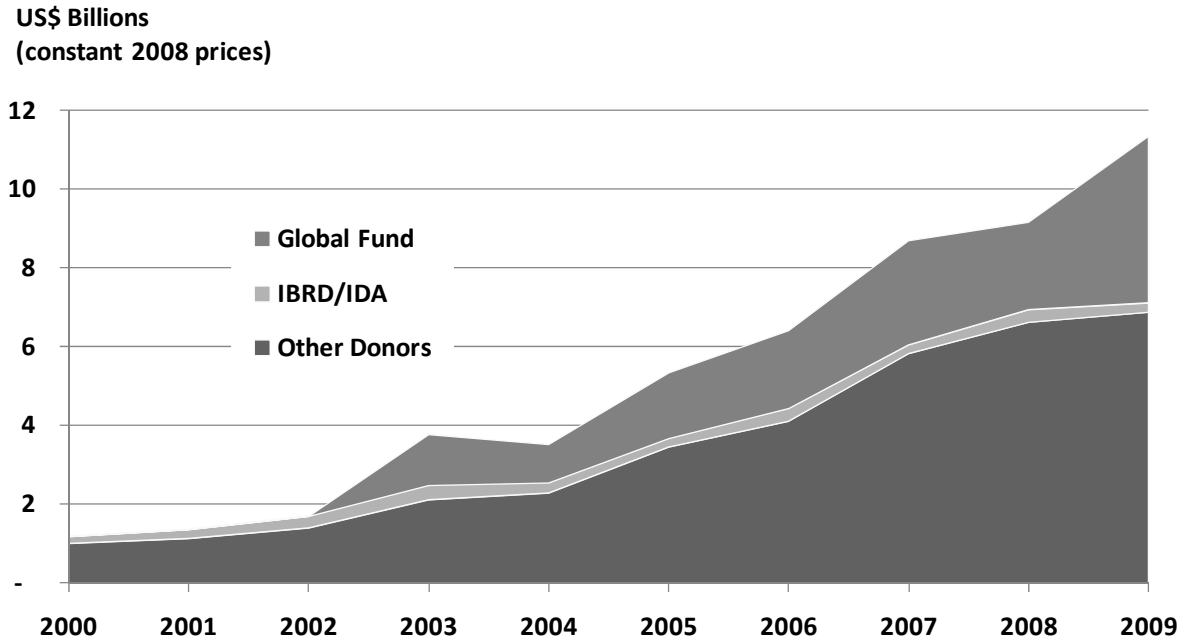
3.13 At the global level, the Global Fund has become a significant contributor to official donor commitments, both to the three diseases and to health overall, since it was founded in 2002. Global Fund commitments of $4.3 billion in 2009 accounted for 37 percent of official commitments to the three diseases and 19 percent of donor commitments to the overall HNP sector, according to Organisation for Economic Co-operation and Development (OECD) data (Figure 7). At the same time, other donor commitments to the three diseases outside of the Global Fund have not decreased, but also increased, from $1.7 billion in 2002 to $7.1 billion in 2009 (in constant 2008 prices), and commitments to the overall health sector have grown from $9.2 billion to $18.1 billion during the same period. Thus, donors have increased their commitments to the three diseases through both the Global Fund and their own bilateral programs. Whether total donor commitments to the three diseases have been higher or lower than they would otherwise have been in the absence of the Global Fund is not known. This general global picture does not change even if one removes the largest donor, the United States, which supports its own large programs for HIV/AIDS and malaria — the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative.

3.14 Notwithstanding this overall picture, IEG found — based on interviews and confirmed by OECD data — that other donor commitments to the health sector have been essentially constant since 2002, although fluctuating from year to year, in three of the four low-income countries visited (Burkina Faso, Cambodia, and Nepal). Other donors have decreased their funding for HIV/AIDS in Burkina Faso in response to Global Fund grants. In Cambodia, government-donor attempts to reduce aid fragmentation in 2006 led to a "division of labor" and the disengagement of the Asian Development Bank — the largest donor in Cambodia — from the health sector in order to focus its efforts on the agricultural sector. The U.K.'s Department for International Development (DFID) was planning to exit the health sector in both Cambodia and Nepal at the time of IEG's country visits. Tanzania was the only one of the four low-income countries visited by IEG in which donor commitments for the three diseases and for health overall have increased steadily since 2002.

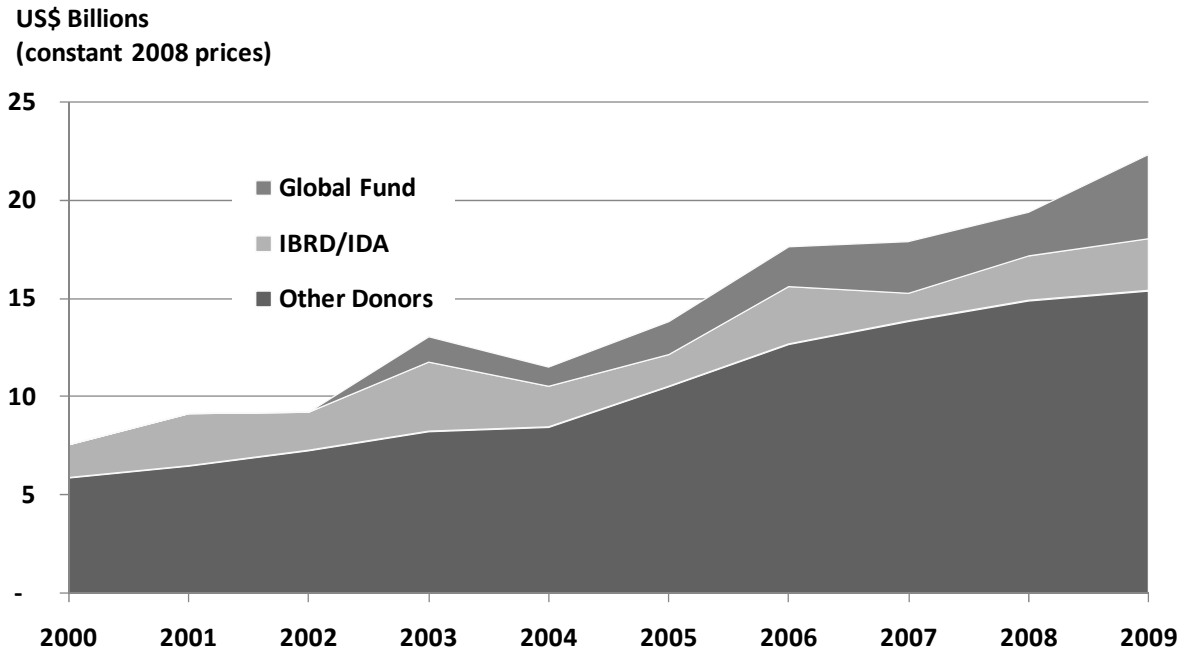
3.15 Similar to the FYE, IEG did not find evidence that governments are reducing their own expenditures on the three diseases in response to the Global Fund grants, except in one

Figure 7. Official Development Assistance and Other Official Flows from OECD/DAC Member Countries and Multilateral Agencies to Developing Countries

a. Commitments to HIV/AIDS, Tuberculosis, and Malaria



b. Commitments to Health, Nutrition, and Population



Source: OECD.
Note: Official Development Assistance represents concessional flows including IDA. Other Official Flows are non-concessional flows such as lending by IBRD and regional development banks. See Appendix Table F-4.

country, Tanzania. Systematic National Health Accounts were not available to answer this question definitively in the countries visited, but the available data indicated that government expenditures on the health sector have been increasing in Burkina Faso, Cambodia, and Nepal.[20] The data for Tanzania indicated that government expenditures on the health sector and on HIV/AIDS had decreased as external assistance had increased. The Tanzania Ministry of Finance and Economic Affairs has been the Principal Recipient for most Global Fund grants, and the Ministry of Health has been the lead Sub-Recipient for grants implemented by the government. Given Tanzania's high dependence on external assistance, the Government of Tanzania appears to have shifted its own expenditures to other priority areas not benefiting from the abundance of resources provided by the Global Fund.

3.16 In Brazil, Global Fund grants have been small relative to the magnitude of national resources dedicated to fighting the three diseases. Government budgets have been set, regardless of the size of Global Fund grants. In the Russian Federation, the Government increased its national budget for HIV/AIDS from $20 to $100 million in 2004 upon conclusion of the Round 3 grant agreement between the Open Health Institute (the Principal Recipient) and the Global Fund, in line with understandings reached during the negotiation stage.

PREDICTABILITY OF GLOBAL FUND SUPPORT

3.17 IEG found short-term gaps in the timing of Global Fund financing in several countries due to the unpredictability of the awarding of Global Fund grants. In Burkina Faso, for example, the long-term sustainability of Global Fund financing for HIV/AIDS was threatened by a funding gap until the country's Round 10 proposal was approved by the Global Fund Board in December 2010. At the time of IEG's visit in May 2010, Round 6 financing was slated to terminate at the end of 2011, and Burkina Faso had failed to secure additional Global Fund financing in Rounds 8 and 9. The failure to achieve Round 9 financing had come as a complete surprise to all stakeholders, since they had viewed the quality of their proposal as very high. As a result, the President of Burkina Faso had publicly called on his Ministry of Finance and Economy to find funds to continue the drug treatment and prevention programs beyond 2011. Other donors had also said that they would look for emergency funds to keep the programs going.[21]

3.18 Country-level stakeholders in Tanzania and Nepal also complained about short-term gaps in Global Fund financing. For the Global Fund as a whole, this relates mostly to the uneven pattern of grant proposals and the unpredictability of grant approvals, as opposed to delays in disbursements flowing from signed grant agreements. However, an analysis of the pattern of Global Fund grant disbursements since the first grants were awarded in 2002 shows a gap of seven months or more between grant disbursements about 29 percent of the time. Such delays in grant disbursements appear to be a bigger issue in Eastern and Southern Africa, South Asia, and

20. National AIDS Spending Assessment (NASA) data in Cambodia show that the government has only increased spending for preventive activities. The government deliberately does not finance treatment activities, relying largely on the United States, the Global Fund, and international NGOs to finance treatment activities.

21. The overall objective of Burkina Faso's Round 10 proposal for HIV/AIDS is to promote universal access through securing ARV treatments, strengthening of PMTCT, and strengthening of HIV prevention for most at-risk populations. The grant agreement is still pending as of November 2011.

the Middle East and North Africa compared to other regions (Table 7). A similar analysis of grant disbursements by disease finds a more uniform pattern among the three diseases.

3.19 The Global Fund has been very aware that country-level grant management has become increasingly complex as countries receive multiple grants for the same disease, each grant with different reporting deadlines in accordance with its own performance framework. As a result, the Global Fund is currently going through the process of transitioning its entire grant portfolio to single streams of funding (SSFs), which are intended to make it easier for the Global Fund to support a national program approach for each disease that is better aligned with national systems and budget cycles. The Secretariat has signed over 80 SSFs as of October 2011, and expects to sign a total of 145–150 SSFs by the end of 2011, most of these from the remaining Round 10 grant agreements. The Secretariat plans to have completed the better part of the transition to SSFs by the end of 2013 (Box 2 in Chapter 2).

Table 7. Disbursement Pattern of Approved Global Grants, by Region and by Disease, 2003–10

	More than 6 months between disbursements	Total number of sequential disbursements	Share of total
By Region or Subregion			
Sub-Saharan Africa: East Africa	210	439	48%
Sub-Saharan Africa: Southern Africa	169	441	38%
South Asia	144	398	36%
North Africa & the Middle East	144	428	34%
Eastern Europe & Central Asia	158	585	27%
Latin America & the Caribbean	172	759	23%
Sub-Saharan Africa: West & Central Africa	199	884	23%
East Asia & the Pacific	181	851	21%
By Disease			
HIV/AIDS / Tuberculosis	23	58	40%
Malaria	369	1,200	31%
Tuberculosis	392	1,338	29%
HIV/AIDS	584	2,159	27%
Health systems strengthening	7	27	26%
Total	1,377	4,785	29%

Source: Calculated by IEG from Global Fund disbursement database.

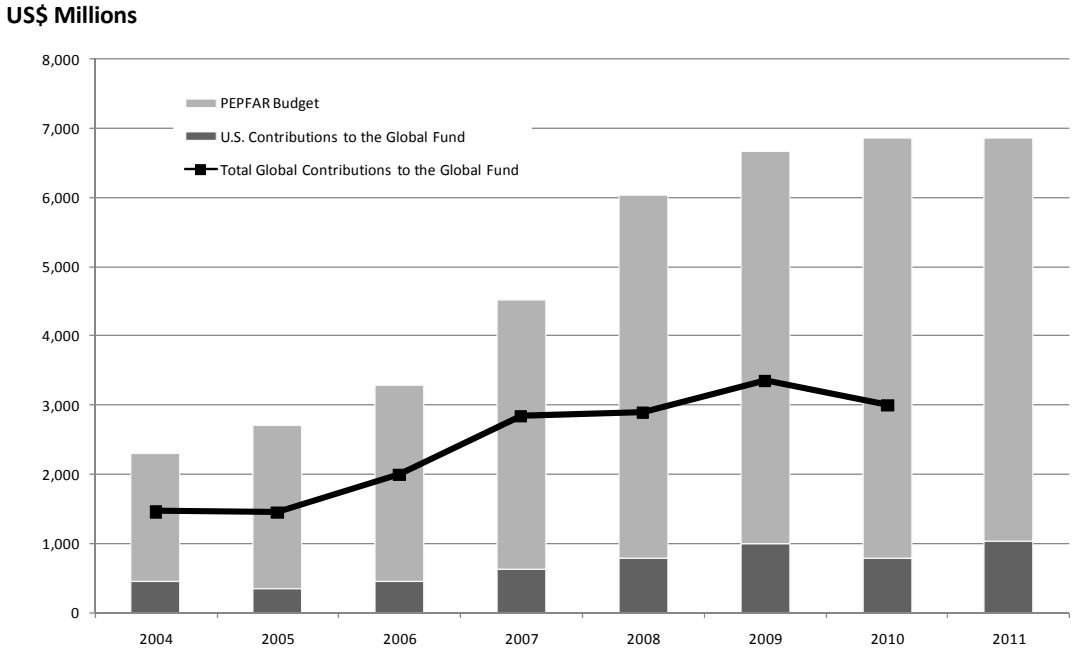
SUSTAINABILITY OF EXTERNAL FINANCIAL SUPPORT

3.20 IEG found that some countries have become heavily dependent on the Global Fund support for antiretroviral treatment of people living with AIDS. In Burkina Faso, the Global Fund is now the only external financier of ARV therapy and drugs to prevent mother-to-child transmission of HIV/AIDS. The Global Fund has become the exclusive supplier of ARVs and related health products into Nepal (except for USAID's providing PMTCT drugs on a small scale to its own projects). In Cambodia, with very high coverage for AIDS treatment, the United States has historically supported ARV treatment through programs implemented by NGOs. However, recent National AIDS Spending Assessment data show an overall decline in bilateral and NGO

financing for AIDS treatment, while that from the Global Fund has increased. Some country-level stakeholders in these countries now view the Global Fund as responsible for sustaining HIV/AIDS treatment. If the Global Fund is unable to sustain its financial support for treating people living with AIDS, then this will put pressure on governments to reallocate their own budgetary resources. The allocation of resources for prevention measures would likely be the first to be adversely affected, since it is morally problematic to terminate ARV treatments for people already receiving treatment, followed by reallocating resources from other (non-health) priorities. Global Fund staff have also exhibited some frustration, based on interviews and the survey results (Figure 6), that the Global Fund has been unable to allocate more to prevention measures due to the political demand for treatment, since the long-run affordability of treatment also depends on financing effective prevention programs to prevent new HIV/AIDS cases.

3.21 There are also increasing concerns at the global level that other donors' support for treatment may be less forthcoming in the future. The sustainability of resources to support people living with AIDS who are already receiving antiretroviral treatment is of particular concern since interrupted treatment increases not only the risk of death among those already being treated but also the risks of new infections and of the development of drug-resistant strains of the virus. A lot depends on the United States, which has been the largest donor to the Global Fund (accounting for 27 percent of donor contributions through 2010), and whose own bilateral program (PEPFAR) is roughly twice the size of the Global Fund (Figure 8). The U.S. Congress had earmarked no less than 55 percent of PEPFAR funds for treatment until 2008.

Figure 8. U.S. Contributions to the Global Fund and the Larger Global Effort



Source: Appendix Table F-3 and the Henry J. Kaiser Family Foundation, "PEPFAR Fact Sheet," March 2011.
Note: U.S. contributions to the Global Fund come from PEPFAR's overall budget. The United States contributed $5.1 billion to the Global Fund through December 2010 and has pledged a further $4 billion for the next three years, subject to Congressional appropriation.

Then U.S. policy shifted in 2009, allocating 50 percent to treatment *and* care services, and allowing more for prevention activities. It also moved from an "emergency" response mode to greater engagement with countries and to increased use of multilateral platforms such as the Global Fund. Nonetheless, PEPFAR still aims to provide ongoing treatment to 4 million people living with AIDS by 2014.

Performance of Country Coordinating Mechanisms

3.22 **FYE Findings.** The FYE found that the CCMs were successful in mobilizing domestic and international partners for submission of grant proposals to the Global Fund, and in enabling CSOs and affected communities to participate, thereby reducing stigma and raising the visibility of the three diseases. However, the CCMs were largely perceived as Global Fund entities rather than as mechanisms for promoting country ownership and representing the country to the Global Fund. Despite the important gains in institutional development in many countries, CCMs fell short of expectations — as the governing body of the Global Fund Partnership in each country — in achieving greater country ownership, coordination, accountability, and partnership. The FYE found that the CCMs were ill-equipped—in terms of resources, capacity, and political will—to provide adequate grant oversight and management. The FYE also found that government members of CCMs were often reluctant to share "policy space" with other members, and that the involvement of the commercial private sector in CCMs has been weak at best (Macro International 2009b, pp. 39–43).

PARTNERSHIP, LEADERSHIP, AND PARTICIPATION

3.23 IEG found that the CCMs were functioning better than the 2007 FYE findings indicated in two countries (Burkina Faso and Cambodia), about the same in two countries (Tanzania and Brazil), and worse in two countries (Nepal and the Russian Federation).

3.24 In Burkina Faso, the CCM now has broad participation in decision making compared with the situation in 2007, at the time of the Study Area 2 Country Program Assessment. Now established as an independent legal entity with its own office space, the CCM is more independent of government than in the past (Table 8). Nongovernment actors such as NGOs, community-based organizations, affected communities, and academia comprise almost half of CCM membership — higher than the Global Fund's 40 percent requirement. The chair is now an academic (rather than automatically the Minister of Health), and the two vice chairs are the WHO representative and an association of people living with the diseases. Members of the CCM are integrally involved in the national strategic planning and program implementation for the three diseases. The CCM's Proposal Development Committee has strong national leadership and broad representation of stakeholders. The process of selecting Principal Recipients and Sub-Recipients is transparent and fair: applications are solicited in the newspapers; then the CCM reviews the applications and selects the winner by voting.

3.25 In Cambodia, strong donor coordination mechanisms, in health and other sectors, preceded the arrival of the Global Fund in the country — a legacy of the large donor commitments to Cambodia after the Paris Peace Agreements in 1992. When the CCM was formed in 2002, it drew its membership from the joint government-donor Committee for Coordination of Health Activities that had been established in 1994, to avoid creating a

Table 8. Country Coordinating Mechanisms in the Six Countries Visited by IEG, 2010

	Burkina Faso	Tanzania	Cambodia	Nepal	Brazil	Russian Federation
CCM Chair	Academia (University of Ouagadougou)	Government (Prime Minister's Office)	Government (National AIDS Authority)	Government (Ministry of Health and Population)	Government (Secretaria de Vigilância em Saúde)	Academia (Central Research Institute for Epidemiology)
CCM Vice Chair(s)	WHO representative, and NGO (AED) represents people living with disease	Faith-based organization (Christian Social Services Commission, CSSC)	WHO representative and NGO network (HAAC)	People living with disease (National Association of People Living with AIDS)	NGO (Movimento Social da Tuberculose)	Government (Central Institute for Organization and Informatization of Health Care, Ministry of Finance)
CCM Legal Status	Independently incorporated legal entity	Not independently incorporated	Not independently incorporated	Not independently incorporated	Not independently incorporated	Not independently incorporated
CCM Secretariat Location	Located in rented office space in the center of Ouagadougou	Embedded in the Tanzania Commission for AIDS – a government agency	Located in the premises of the Ministry of Health	Embedded in the Ministry of Health and Population	Embedded in the Ministry of Health	Embedded in the Central Research Institute for Epidemiology, Ministry of Health and Social Development
International Organizations and Bilateral Donors Represented on the CCM						
WHO	Yes	Yes	Yes	Yes	Yes	Yes
UNAIDS	Yes	Yes	Yes	No	No	Yes
World Bank	Yes	No	No	No	No	Yes
Other	UN, UNICEF, UNDP, World Food Program, France, Italy, Netherlands, USAID	UN, UNDP, USAID	Australia, France, Japan, USAID	International Labour Organization (as a chair of UN theme group), USAID	USAID	USAID, EC delegation

Source: Constructed by IEG.
Note: UNICEF = United Nations Children's Fund.

parallel structure.[22] Restructured in 2010, CCM membership is now more inclusive than before. Representation of nongovernment actors has increased. The chair is now from the National AIDS Authority for Cambodia rather than the Ministry of Health, and the Vice Chairs are the WHO representative and an AIDS NGO network. The CCM Secretariat has been

22. The Cambodia CCM is actually called the Country Coordinating Committee, and that in Tanzania is called the Tanzania National Coordinating Mechanism. However, the present Review uses the term CCM for all these committees for ease of exposition.

professionally staffed, initially with funding from GTZ, then with an annual $44,000 grant from the Global Fund (first introduced in 2008), and subsequently with an expanded grant from the Global Fund, which is providing $218,000 for two years starting June 1, 2010. CSOs feel that the Global Fund approach and engagement provides greater opportunities for them to share "policy space" with the government and donors in the country's development agenda.

3.26 By contrast, both the Tanzanian and Brazilian CCMs have a dominant government presence. The Permanent Secretary in the Prime Minister's Office chairs the Tanzanian CCM and the Secretary for Health Surveillance in the Ministry of Health chairs the Brazilian CCM (permanently so, according to the current by-laws). Both secretariats are currently embedded in government agencies. Both CCMs have extensive representation from CSOs, but less effective representation than in Burkina Faso or Cambodia, based on IEG interviews. The Brazilian CCM also does not have effective representation from multilateral or bilateral development partners in the country.[23]

3.27 IEG found considerable tension between the Ministry of Health and CSOs in Nepal and the Russian Federation. In Nepal, this arose from the lack of capacity of the Ministry of Health to function as the Principal Recipient for the Round 2 grant for HIV/AIDS (approved December 2005). When the Global Fund found that the Ministry lacked capacity, the Ministry sought help from UNDP for management support. The Global Fund formally designated the UNDP as a co-Principal Recipient in 2007, after which UNDP essentially took over the project rather than helping to build up the capacity of the Ministry of Health to implement it. When the Global Fund approved three HIV/AIDS grants in Round 7, it assigned one to UNDP and two others to NGOs, thus bypassing the government entirely. While the Ministry of Health considers itself to be the natural agency to be the Principal Recipient, the NGOs depend on the grant funds to function and want to see results, whoever serves as the Principal Recipient. UNDP, on the other hand, while pleased to help in the fight against HIV/AIDS, does not relish its role as Principal Recipient and would like to discontinue playing this role as soon as another arrangement can be found.

3.28 In the Russian Federation, the early interactions between the Global Fund and the Ministry of Health were difficult. When approached by the Global Fund for what would be Round 3, the government refused to develop a specific proposal and establish a CCM. Instead, a consortium of five NGOs, already active in the Russian Federation and led by the Open Health Institute, submitted their own proposal to the Global Fund (approved in June 2004) in the absence of an established CCM. This action, combined with the publication of a study on the economic and political impact of an unchecked AIDS epidemic in the Russian Federation, led the Russian Federation Government to embrace the AIDS issue more seriously and accept a cooperative association with the Global Fund for the duration of the grant. However, the current climate is not very conducive to Global Fund activities in the country. The CCM lacks substantial representation from the federal Ministry of Health and Social Development. This has led to a

23. Commenting on an earlier draft of this report, the Global Fund Secretariat indicated that the Tanzanian CCM has provided an excellent forum to enhance partnership arrangements among the various country stakeholders and development partner agencies that have contributed to the effective scale up of the country's HIV, tuberculosis, and malaria responses over the last three years. Partners have provided critical support to capacity building and technical assistance, including proposal development.

considerable degree of cynicism concerning the usefulness of the CCM in practice, particularly among recipient NGOs, who see a pronounced adversarial relationship with the Ministry.

PROPOSAL PREPARATION

3.29 Cambodia and Tanzania have had the highest grant approval rates among the six countries (Table 9). They are also the two countries in our sample with their own national-level technical review panels, which review all proposals before submission to the Global Fund.[24] Cambodia actually has one panel each for HIV/AIDS, tuberculosis, malaria, and HSS, which report to the CCM Oversight Committee. WHO, UNAIDS, UNICEF, and to a lesser extent the World Bank have provided technical support. Tanzania has one Technical Working Group, chaired by the CCM Secretariat and reporting to the CCM Executive Committee. The working group initiates discussions on new proposals, contracts with consultants to prepare concept notes, and submits these to the Executive Committee. If cleared, consultants then develop these concept notes into full proposals that are returned to the Executive Committee for final clearance. All members of the Executive Committee must sign off before submitting a proposal to the Global Fund.

Table 9. Six Countries: Grant Proposals Submitted and Approved, Rounds 1–10

	Proposals Recommended by Technical Review Panel [a]	Proposals Submitted to Global Fund	Proportion Recommended
Cambodia	14	25	56%
Tanzania [b]	11	20	55%
Burkina Faso	8	20	40%
Russian Federation [c]	3	8	38%
Nepal	7	19	37%
Brazil	2	8	25%

Source: Global Fund Secretariat.

a. Totals are less than in Table 6 because some recommended proposals have been converted into more than one grant.

b. For Tanzania in Round 9, only the cross-cutting health-systems strengthening part of the HIV proposal was recommended, not the disease part.

c. Results for the national-level CCM in Moscow only, not the subnational CCM, which operates in the Tomsk region.

OVERSIGHT OF GRANT IMPLEMENTATION

3.30 **FYE Findings.** While CCMs had been successful in mobilizing country-level stakeholders to submit grant proposals to the Global Fund, the FYE found that CCMs were ill-equipped — in terms of resources, capacity, and political will — to provide adequate oversight of grant implementation. Country-level stakeholders perceived CCMs as political bodies and questioned how such political structures could have an appreciable role in grant oversight. Both gaps and overlaps had emerged in the oversight and implementation

24. The Study Area 2 Country Program Assessment also noted that its own TRP was a factor in Cambodia's success rate.

responsibilities of CCMs, LFAs, Principal Recipients, and Sub-Recipients, as the Global Fund partnership had changed and developed during its first six years.

3.31 IEG found little improvement during its country visits in April-June 2010 in the capacity or effectiveness of CCMs to exercise programmatic oversight of the implementation of Global Fund grants from the country perspective. Generally speaking, the CCMs had neither the authority nor the resources to exercise effective oversight of grant implementation, as envisaged in the Global Fund "Guidance Paper on CCM Oversight."

3.32 The CCMs generally lacked both the authority and the resources to exercise effective oversight, since they were not a conventional governing body of a partnership program. The CCMs are representative of the clear trend toward stakeholder models of governance in which diverse stakeholder groups are represented, which is changing the power dynamics in many countries. Each CCM also has a secretariat, and therefore an institutional separation of governance and management functions. But these secretariats are small and only responsible for administration and supporting the execution of decisions made by the CCM, such as submitting grant proposals to the Global Fund. Unlike in a conventional governance and management structure, the secretariats are not responsible for implementing the program of Global Fund grants to the country. Rather, the Global Fund Secretariat in Geneva contracts directly with the Principal Recipients to implement the grants. The CCM must endorse the grant agreement for it to be binding. The grant agreement also includes a number of articles that give the CCM the legal authority to carry out its oversight responsibilities and that mandate the Principal Recipient to cooperate with the CCM in performing its role. However, their authority, or their capacity to exercise this authority, was weak at the time of IEG's country visits in April-June 2010.[25]

3.33 The CCMs also had few resources to exercise oversight, since the resources to implement the grants flowed directly from the World Bank (as trustee) to the Principal Recipients on the instructions of the Global Fund Secretariat.[26] If the CCM were the conventional governing body of a partnership program, the resources to implement the program would flow through the CCM and its secretariat to the Principal Recipients, and the Principal Recipients would be directly accountable to the CCM for implementing the grants. The CCM would also use a share of those resources for its own secretariat to effectively supervise, or contract out the supervision of the implementation of the grants on a day-to-day basis from both a financial and a programmatic

25. Commenting on an earlier draft of this report, the Global Fund Secretariat agreed that the CCMs were ill-equipped to conduct their oversight role in 2010, but that this has improved during the last two years due to significant investments by the Global Fund and its partners in strengthening CCM abilities to provide oversight and in improving the funding streams that support their efforts to conduct proper oversight. Under the new grant architecture, CCMs also have enhanced opportunities to make strategic program-level decisions, including reprogramming and reallocation of funding or responsibilities across Principal Recipients, the addition of new Principal Recipients, and/or the discontinuation of existing Principal Recipients.

26. The Global Fund started providing $44,000 a year to CCM Secretariats in 2008. This was expanded in February 2010. (See www.theglobalfund.org/en/ccm/support/funding.) While basic single-year funding requests are limited to $50,000 a year, expanded two-year funding requests may exceed $50,000 a year. For requests exceeding $100,000 a year, the CCM must mobilize at least 20 percent of the amount above $100,000 from other sources. While this direct financial support was welcome, IEG found that this generally only covered core administrative expenses, including office space and salaries for a small number of staff. It did not cover all the costs incurred in grant proposal preparation, including meetings and seminars, preparation of background reports, and technical assistance, let alone programmatic oversight of grant implementation.

perspective. Currently, the FPM is responsible for managing Global Fund grants from both perspectives with the assistance of the LFA, who verifies and reports on grant performance.

CONFLICTS OF INTEREST

3.34 Inadequate management of conflicts of interest has also hindered effective oversight at the country level. IEG has found, based on evaluating and reviewing many partnership programs, that real and perceived conflicts of interest are an inherent and essentially unavoidable feature of partnership programs, deriving from the multiple roles that the principal partners play in a program.[27] For example, when the Minister of Health chairs the CCM, when the CCM Secretariat is embedded in the Ministry, and when the Ministry is the Principal Recipient of the Global Fund grant (all of which are common situations), then the Ministry has at least three potentially conflicting interests in the program. Other potential conflicts of interest that IEG observed on its country visits include: (a) the CCM Secretariat being located in the National AIDS Commission, (b) voting members of the CCM who are Principal Recipients and Sub-Recipients (which actually violates the Global Fund guidelines for CCM membership), and (c) selecting Principal Recipients and Sub-Recipients from among those CSOs that played a role in originating the grant proposals.

3.35 Some CCMs seem to be identifying and managing these conflicts of interest better than others. In Cambodia, the CCM has had a conflict of interest policy since 2003, soon after it was established. The policy was revised in 2010 along with the structural changes that occurred in the CCM that year. Their new policy requires each member to sign a conflict of interest declaration on an annual basis, and for all contracts and agreements involving Global Fund resources to incorporate a conflict of interest clause. Their 2010 proposal development manual further stipulates that any members of the CCM whose organization or department proposes to be the Principal Recipient or Sub-Recipient in the round at issue may not sit on the Proposal Development Committee, and it also lays down requirements for publication of the names of individuals on the selection committees and the technical review panels.

3.36 In Tanzania, the CCM also has rules for identifying and managing conflicts of interest, but these appear to be less effectively enforced, according to local observers interviewed by IEG. The involvement of many interested CSOs in the grant preparation process also appears to have led to a cascading system of Sub-Recipients. A conservative estimate of the overhead costs incurred by each layer in the five-layer deep implementation structure for the Round 4 and Round 8 HIV/AIDS grants left less than 50 cents of every dollar for the ultimate beneficiary. The indirect cost of management and communication through this complex layered system should also be added to these direct overhead costs.

3.37 It will not be possible to completely avoid conflicts of interests in CCMs, any more than in the 100 or so GRPPs in which the World Bank is involved, particularly those located in the World Bank or in other partner organizations. When a conflict of interest situation arises, one is not automatically in the wrong, just facing a problem.[28] Given the

27. IEG, 2011b, *The World Bank's Involvement in Global and Regional Partnership Programs*, pp. 59-60.

28. World Bank, 2007, Global Programs and Partnerships, "Identifying and Addressing Partnership Conflict of Interest in Global Programs and Partnerships," Guidance Note for Bank Staff.

pervasiveness of conflicts of interest in partnership programs, the key is to identify and manage them transparently.

3.38 The Global Fund recognizes the challenges that potential conflicts of interest pose to CCMs. It has recently strengthened the CCM requirement for conflict of interest management. The new CCM guidelines, approved in May 2011, require CCMs to develop, publish, and apply a conflict of interest policy to all CCM members, across all CCM functions, and throughout the life of all Global Fund grants. CCM members must periodically declare conflicts of interest affecting themselves or other CCM members, and not take part in decisions where there is an obvious conflict of interest, including decisions relating to oversight and selection or financing of Principal and Sub-Recipients.[29]

Effectiveness of Country-level Partnerships

3.39 **FYE Findings.** The FYE found that partnerships at the country level depended mostly on good will and voluntary collaboration to achieve shared impact-level objectives, rather than on negotiated commitments with clearly articulated roles and responsibilities, and did not yet comprise a fully functioning system. As such, they represented more of a "friendship model" than a genuine "partnership model." Effective operational relationships between the Global Fund and other international organizations in the international health system were largely absent, particularly in providing essential technical assistance in support of Global Fund grants.

3.40 The FYE found that CSOs were now represented in decision-making processes and involved in scaling up disease prevention and treatment efforts, but that tensions remained concerning how closely CSOs could collaborate with government without undermining their commitment to their membership to counter-balance government perspectives.

3.41 The FYE also found consistent weaknesses, problems, and barriers to establishing effective partnerships with the commercial private sector. One of the reasons was the lack of trust of the private sector toward activities led by the government or CSOs. There also remained a perception within the private sector that the Global Fund's assessment of the private sector's capacity and resources to support the Global Fund's agenda was limited to their cash contributions, without sufficient recognition of in-kind support or capacity to leverage resources through co-investment (Macro International 2009b, pp. 33–38).

PARTNERING WITH INTERNATIONAL ORGANIZATIONS AND BILATERAL DONORS

3.42 Generally speaking, IEG found the Global Fund was finding its way in existing partner environments characterized by different degrees of (a) the ability of the government to effectively coordinate donor efforts around agreed national strategies and (b) the willingness of donors to collaborate among themselves. Three years after the Study Area 2 Country Program Assessments, IEG found that the situation had generally improved in terms of other partners' providing technical assistance in support of Global Fund activities. However, country-level partners (both international and domestic) still saw the Global Fund

29. The full CCM Guidelines are available at www.theglobalfund.org/en/ccm/guidelines.

as a largely separate development partner agency, represented in the country primarily by the CCM and the FPM, and with its own distinct modalities that were not well integrated into the existing donor coordination mechanisms in the countries. Persons interviewed pointed out that the same was also true of some other large donors (USAID, PEPFAR, and the World Bank) in particular countries.

3.43 IEG found that WHO and UNAIDS were the principal technical partners in the four low-income countries visited, providing in-kind technical assistance in the preparation of background papers, grant proposals, and other technical work. (WHO was a voting member of all four CCMs, and UNAIDS of three.) Technical assistance has also been provided by short-term consultants financed by bilateral donors or provided by embedded resident advisors who serve as counterparts to key managers in the health sector. (USAID and the Centers for Disease Control were using the latter modality extensively in Tanzania.)

3.44 Nevertheless, providing in-kind technical support has put a lot of pressure on partner agencies' staff time, since this has represented an unfunded mandate. WHO, which has provided the lion's share of partner agency involvement (followed by UNAIDS) in the CCM and in its technical committees in Cambodia, has only been able to manage this because its office in Phnom Penh (with 23 resident experts) is among the largest in the world. UNAIDS has drawn on its regional office (in Kuala Lumpur) to support the Cambodian program. France and USAID also have dedicated personnel in Cambodia working on Global Fund and CCM activities.

3.45 In Burkina Faso, Tanzania, and Cambodia, multilateral and bilateral donors have negotiated and formalized country-level partnerships with the government in the health sector. These have taken the form of (a) a common funding basket for the general health sector in Burkina Faso and annual plans for HIV/AIDS to coordinate all partners' financial support, (b) the Health Sector Basket and the SWAp for the health sector in Tanzania, and (c) a sector-wide implementation and management approach and various parallel projects in support of the implementation of the Health Sector Strategic Plans I and II in Cambodia. (The World Bank is contributing to these funding pools in Tanzania and Cambodia.)

3.46 Country-level stakeholders expressed some frustration that the Global Fund was not contributing to these common funding pools. Many interviewees said that they would like to see the Global Fund coordinate its support more closely with that of other donors — for example, by contributing to these common funding pools. In Burkina Faso, however, the Global Fund is contributing to agreed national strategies and programs, even though its funds are not pooled. In Cambodia, IEG found that the Global Fund was willingly being drawn into existing government-donor coordination mechanisms, and that it was forging clear connections with national strategies and action plans. The FPM was consistently participating in the annual joint country-donor planning and review processes in the health sector, but not in the CCM technical working group and development partner agency meetings due to the lack of an on-the-ground presence.

PARTNERING WITH CIVIL SOCIETY ORGANIZATIONS

3.47 Some CSOs are primarily engaged in advocacy on behalf of vulnerable groups affected by the three diseases, trying to influence government policies and donor allocations. Other CSOs are providing services to affected persons with grant funds and from their own

resources. Both types of CSOs are now represented in CCM decision making, due to the membership requirements of the Global Fund.

3.48 IEG found that this representation has been effective in Burkina Faso, Cambodia, and Brazil, where CSOs have brought their perspectives to bear on Global Fund-supported activities. CSO representatives interviewed by IEG said they felt that they were able to provide genuine input and to influence the collective decisions regarding grant proposals to the Global Fund. Indeed, they found the process refreshing compared to working with other donors who had more specific preferences regarding programming.

3.49 As already indicated, the relationship between the government and CSOs has been strained in Nepal and the Russian Federation. In Tanzania, the government has chaired and played a dominant role in the CCM. The chair appears to have mitigated tensions by arranging for those CSOs to serve on the CCM that have less tendency to challenge the government on Global Fund business, according to IEG interviews. Service-provision CSOs have also been less inclined to challenge the government to avoid damaging their chances of becoming Sub-Recipients of Global Fund grants.

3.50 The capacity of CSOs to provide health services to affected persons is not a significant issue in Brazil or the Russian Federation. Brazil has a robust CSO sector that has been heavily involved in the country's effective response to the HIV/AIDS epidemic. In the Russian Federation, it was largely the initiative and energies of CSOs that led to the first Global Fund grants to the country, in the absence of a national-level CCM. However, IEG found that the capacity of domestic CSOs to deliver health services to the standards expected of the Global Fund was an issue in the other four countries. Donor preferences for using well-established international NGOs rather than local organizations has hindered opportunities to strengthen the latter's capacity. Their weak technical, programmatic, and management skills have prevented them from being selected as Principal Recipients and Sub-Recipients, although they are generally better connected to local communities, which will be relevant in sustaining services and benefits in the future.

PARTNERING WITH THE COMMERCIAL PRIVATE SECTOR

3.51 IEG found little evidence of effective partnerships with the commercial private sector at the time of its country visits (April–June 2010). While representatives of the commercial private sector have been members of the CCM in five countries (all but the Russian Federation), they have generally been less vocal or influential in decision making, according to IEG interviewees. Other members of the CCM have tended to see the commercial private sector as a potential source of funds for the wider community. Private sector representatives such as the Cambodia Business Coalition on AIDS and the Tanzania AIDS Business Coalition would like to have seen more Global Fund support for their own disease-control programs for private sector workers, such as the Cambodia HIV/AIDS program for garment industry workers (typically poor village girls unfamiliar with urban lifestyles and at higher risk of infection).

3.52 Private sector representatives in Brazil saw, as a possible shift toward greater private sector participation, the recent initiative of the Global Fund to familiarize the Brazilian corporate sector with its operations in Brazil and to promote a sharing of experiences in

fighting the three diseases. This took the form of a seminar organized in São Paulo in March 2010, entitled "Public Private Partnerships to Fight HIV/AIDS, TB and Malaria," with CCM members, the World Bank, and several Brazilian corporations and multinationals based in Brazil in attendance. This initiative could encourage the corporate sector to bring forth some of its own social responsibility initiatives for possible joint funding by the Global Fund and the corporate sector. For this to materialize, however, the Global Fund would need to approach such grant proposals for joint funding with the private sector with some flexibility.

3.53 Commenting on an earlier draft of this report, FPMs cited growing private sector involvement in the countries' responses to the three diseases in the four low-income countries IEG visited (Box 3).

Box 3. Commercial Private Sector Participation in the Four Low-Income Countries

In **Burkina Faso**, the National Coalition of the Private Sector and Enterprises coordinates a range of responses to the HIV/AIDS epidemic for employers and workers, and their families and communities, primarily through a system of committees at the enterprise level. Private sector contributions have included (a) financing the health care of workers and their families (salaries of health workers, medical visits, etc.); (b) setting up contribution funds from enterprises and workers to help workplaces fund their own initiatives; and (c) funds for coordinating activities such as information, education, and communication activities, training peer educators, and condom distribution.[a]

In **Tanzania**, the Medical Stores Department (MSD) is collaborating with Coca-Cola to improve the supply-chain management and distribution of drugs and commodities from the centralized MSD to rural pharmacies. Coca-Cola is transferring distribution expertise from its bottling companies as well as logistical and supply-chain-management skills via Accenture Development Partners.

The Tanzanian Ministry of Health is working with Unilever Tea's employee clinic in the Mufindi area to be one of 91 medical centers to provide ARVs free of charge to the communities, with financial support from the Global Fund and PEPFAR. The Ministry of Health and the MSD are providing ARVs; Deloitte is providing financial management services; and Unilever is providing the hospital building, staff, and equipment to improve treatment for the surrounding community.

In **Cambodia**, the representative of the Business Coalition of Cambodia is an active member of the CCM, and is coordinating private sector contributions to the national response to HIV/AIDS, tuberculosis and malaria. These include (a) HIV prevention activities for factory workers and other businesses, (b) tuberculosis prevention and treatment through public-private DOTS programs, and (c) establishing public-private committees to help address the problem of counterfeit antimalarial drugs including ACTs.

In **Nepal**, the Federation of the Nepalese Chambers of Commerce and Industry launched the Business Coalition on AIDS in Nepal in May 2011 to help reduce HIV infections among the country's workforce. The Coalition aims to put in place HIV prevention, treatment, and care programs for employees and their families living with and affected by HIV.[b]

Source: Global Fund Secretariat.

a. See also IOE and PEC, 2009, *HIV/AIDS Challenges in the Workplace: Responses by Employers' Organizations and Their Members in Africa*, Case Studies and Good Practices, pp. 42–44.

b. UNAIDS, "Business Boost for Nepal's AIDS Response, May 24, 2011. www.unaids.org/en/resources/presscentre/featurestories/2011/may/20110524businessnepal/

Application of Performance-Based Funding

3.54 **FYE Findings.** The FYE found that the scale at which the Global Fund had attempted to implement PBF was unprecedented in the international health arena. However, this "focus on results" remained a work in progress and had evolved into a complex and burdensome system that had thus far focused more on project inputs and outputs than on development outcomes and impacts. The FYE found important gaps in the quality of PBF data. Inadequate M&E capacities at the country level also limited the feasibility of the PBF approach espoused by the Global Fund. While the system was generating extensive data, it often failed to provide the key elements of information required to inform judgments on effectiveness. The Global Fund's efforts to improve the PBF system had made it more confusing at the implementation level, contributing to inconsistent application of the model (Macro International 2009b, pp. 30–32).

FINDINGS FROM THE SIX COUNTRY VISITS

3.55 On its country visits, IEG found that the Global Fund's approach to PBF (Box 4) was working reasonably well in three countries (Burkina Faso, Cambodia, and the Russian Federation) in terms of monitoring outputs and coverage in relation to the key performance indicators in the grant agreements, and not well in the other three countries (Tanzania, Nepal, and Brazil).

3.56 In Burkina Faso, IEG found a significant change in perception among Principal Recipients and Sub-Recipients since the Study Area 2 Country Program Assessment in 2007. While the Principal Recipients had found it difficult to adapt to the PBF system at first, they now found it to be a useful system. Several grant recipients had now integrated the Global Fund performance-based indicators into their own planning processes and relied on them for their own decision making and planning.

3.57 PBF was working reasonably well in Cambodia because the country has had considerable experience with it. The Asian Development Bank had first introduced results-based financing in Cambodia in 1999 for contracting of Preferred Health Care and Maternal-Child Health service delivery to district health authorities and NGOs, based on compensation for results. Subsequently other development partner agencies, including the World Bank, had followed with results based financing-type schemes. The experience with applying the Global Fund's PBF approach has been imperfect, but improving as more Principal Recipients understand the standards against which they are being measured, and the Principal Recipients and the LFA develop a better working relationship. The Principal Recipients viewed PBF as a means to upgrade administrative, procurement, and performance standards to the international level. As in Burkina Faso, this represented a significant improvement from the Study Area 2 Country Program Assessment in 2007. However, the requirement for PBF favors the selection of "established" groups as Principal Recipients such as the Ministry of Health, international NGOs, and the large local NGO networks compared to smaller, local NGOs.

3.58 Both the concept and the details of PBF appear to be well received and well established in Russia. The Local Fund Agent (KPMG) was very satisfied with the way in which the PBF process was working. An important element in its successful implementation

Box 4. Performance-Based Funding in the Global Fund

As described on its Web site, the Global Fund has very detailed and well documented requirements for grant-level monitoring, which are tied to its PBF approach. The performance framework for each grant, which forms part of the grant agreement, contains a summary of key indicators and targets, which are used to measure output and coverage on a routine basis.

Information is collected and used at three main stages of performance evaluation:

(a) Regular disbursements (every six months is the default). A few indicators of progress are used for regular financial release every three-to-six months.

(b) Annual reviews (every 12 months). These collect the results for all indicators for the year and include a self-assessment of progress, barriers, successes, and failures. The Global Fund uses these updates to report on progress in grant implementation across its portfolio.

(c) Phase 2 evaluation (from 18 to 20 months). Funding is committed for an initial period of two years. After 18 months the Principal Recipient makes a submission for Phase 2 funding to cover an additional three years. This overall review of performance includes a comprehensive report on results against targets and against the goals of the grant, and is used as a basis for the Global Fund Secretariat to recommend further funding in Phase 2.

For each reporting period, the Principal Recipient prepares a **Progress Update and Disbursement Request** (**PUDR**), which consists of a progress report on the implementation of the grant, and a request for funds for the next reporting period. The progress report includes information on the results of the grant against targets, and information on expenditures. The PUDR is reviewed by the LFA and submitted to the Global Fund Secretariat. The Secretariat reviews the PUDR and assesses:

- Programmatic achievements: Have programmatic targets been reached?
- Financial performance: Are expenditures in line with budgets?
- Grant management: Are there issues related to M&E, procurement, and/or financial management?

Based on the assessment of the PUDR, the Secretariat assigns a performance rating to the grant on the following scale: A1 – exceeded expectations; A2 – met expectations; B1 – adequate; B2 – inadequate but potential demonstrated; and C – unacceptable. The Secretariat then decides whether to allow the requested disbursement of funds, to allow partial disbursement of funds, or to deny the disbursement request. An outright denial of the request is rare and only happens if a grant is in serious trouble.

The **Grant Performance Report** is prepared by the Global Fund Secretariat when the grant agreement is signed, and it is updated with every PUDR received throughout the life of the grant. Before the end of Phase 1 of the grant, the Global Fund decides whether to continue funding for Phase 2. A **Grant Scorecard** is prepared with a structured assessment of the grant performance, the decision about whether to continue funding Phase 2 of the grant, and justification for the decision. The PUDRs, Grant Performance Reports, and Grant Scorecards are completed consistently and made public.

The Global Fund will only approve Phase 2 funding if the grant is performing adequately. In practice, it is rare to award a grant a "no go" and completely discontinue the grant in Phase 2, and more common for a portion of the funding to be reallocated to better-performing grants. Over the period 2005–09, only 1.9 percent of grants were discontinued after Phase 1, and 13.7 percent of total funding was reallocated from poorer-performing grants (including "no-go") to better-performing grants.

Source: Global Fund Web site.
Note: This box describes the Global Fund's approach to performance-based funding in its own language. The use of concepts and terms is not necessarily the same as for the World Bank or IEG.

in Russia appears to be the contribution of information from the Central Research Institute for Health — the research and epidemiology institute for health within the Ministry of Health and Social Development, which is responsible for monitoring and measurement. The work of this institute has provided some of the basis for establishing appropriate monitorable indicators and their measurement.

3.59 The low quality of data and the lax discipline in its collection have compromised the application of PBF in Tanzania. Credibility and timely availability of data have also been issues.[30] The recent OIG audit found that PUDRs were not being prepared and submitted on time by the Principal Recipient (the Ministry of Finance and Economic Affairs), and that their accuracy and completeness were not verifiable.[31] The LFA has had to contextualize the use of performance information for the purposes of recommending disbursements to the Global Fund Secretariat. Some interviewees suggested that the absence of major disruptions in disbursements to Tanzania has also reduced the effort to ensure that funding is driven by demonstrable performance of results against targets.

3.60 Given the chaotic political situation that prevailed in Nepal until 2008 (covering most of the period of the Rounds 2 and 4 grants), the successful application of PBF is a remote goal. Attention has been focused on the more basic issues of obtaining grants and selecting appropriate Principal Recipients to implement them. The extensive OIG report did not even address the application of PBF in the country.[32] It is hard to see how PBF could be instituted rapidly in new grants to Nepal without risking disruption, particularly for HIV/AIDS.[33] Applying PBF may be more feasible for tuberculosis and malaria, where local capacity for implementation is greater, but it would still require careful specification of what "performance" means. Unlike the situation with respect to HIV/AIDS, the Ministry of Health and Population, backed by WHO expertise and with a well-defined protocol (DOTS), has established a reasonably well-functioning tuberculosis control program, and also has reasonable capacity to deliver malaria control services with financial support from donors.

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30. Commenting on an earlier draft of this report, the Global Fund Secretariat said that two major challenges have been late reporting by the Government Principal Recipient (the Ministry of Finance and Economic Affairs) and the absence of a well-functioning Health Management Information System. The Round 8 HIV grant has plans for strengthening the reporting mechanisms and tracking of funds and health products at all levels; improving overall data quality; and integrating the parallel systems for Global Fund reporting into the mainstream M&E system. The Round 8 grant is also providing funding for satellite installation at the district level to enhance the quality of data collection and the flow of information.

31. Global Fund, Office of the Inspector General, *Audit Report on Global Fund Grants to Tanzania*, Report No.: TGF-OIG-09-001, June 2009.

32. Global Fund, Office of the Inspector General, *Audit Report on Global Fund Grants to Nepal*, Audit Report No: TGF-OIG-09-006, February 2010.

33. Commenting on an earlier draft of this report, the Global Fund Secretariat did not agree that implementing PBF in new grants might lead to disruption of services. The application of PBF is challenging in Nepal, but PBF needs to work in situations where M&E is weak and also provides important incentives for improving M&E. The World Bank, the Global Fund, and other external development partners have contributed to institutional capacity building during the last two years, particularly in the National Centre for AIDS and STD Control, which is now the Principal Recipient for the Round 7 and 10 grants. The external development partners, together with the Ministry of Health and Population, recently agreed to make M&E a core element in the country's HSS grant application for Round 11. Nepal is no different from other countries where support for HIV control is particularly sensitive, and needs constant support and supervision.

3.61 The Brazil LFA has found that PBF is not well-suited for the types of Global Fund grants provided to Brazil. The Principal Recipients have been parastatals and foundations that are providing intermediate products in the health system rather than products at the end of the service delivery chain. For example, the tuberculosis grant seeks "to enhance timely TB detection and quality treatment by improving the current information system and by training health workers from HIV and tuberculosis programs in ten metropolitan and Manaus areas in treatment for co-infections."[34] The multiple data systems associated with the multilayered government health systems in Brazil are also inconsistent and do not lend themselves to an assessment of the performance of grants that are small links in a long service chain. The Principal Recipients can only assume that their intermediate inputs contribute to improved final outcomes. Nevertheless, the LFA has taken upon itself to systematically instruct the Principal Recipients on creating recorded trails that allow it to carry out its verification function.

COMPARING THE GRANT/PROJECT-LEVEL M&E SYSTEMS OF THE GLOBAL FUND AND THE WORLD BANK

3.62 IEG has undertaken a detailed comparison of the project-level M&E systems of the Global Fund and the World Bank (a) to identify whether and how the findings and conclusions that emerge from the two organizations' M&E systems can be compared, and (b) to contribute to the ongoing process of identifying good practices for project-level M&E. The comparison is based on actual experience in three countries: Burkina Faso, Lesotho, and the Russian Federation.[35] Burkina Faso and the Russian Federation were chosen from the six countries visited because of the existence of World Bank-supported projects with similar objectives to those of the Global Fund grants that were being implemented during roughly the same time period, thereby enabling a comparison with the project-level M&E in the World Bank projects. Lesotho was chosen for the same reason and because IEG has recently completed a Project Performance Assessment Report of the World Bank project that was specifically intended to increase the capacity of Lesotho "to use effectively the resources provided through the Global Fund grant to support the implementation of HIV and AIDS programs" in Lesotho.[36]

3.63 Grant-level M&E in the Global Fund is specifically tied to its PBF system (Box 4). Project-level M&E in the World Bank aims to create a traceable pathway from a project's intent and objectives to inputs and activities, to performance against indicators, and ultimately to conclusions about effectiveness — both by the project team and by independent evaluators. This includes an assessment of the Bank's own performance and that of the borrower, in addition to the outcome of the project as a whole. A results framework, which describes the pathway from project activities to intermediate outcomes and ultimately to the project development objective, is a required annex in the Bank's project appraisal documents.

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34. Grant Number BRA-506-G02-T: "Strengthening of the DOTS Strategy in Large Urban Centers with High Tuberculosis Burden in Brazil."

35. Cheryl Cashin, forthcoming, "Comparison of the Monitoring and Evaluation Systems of the World Bank and Global Fund for the Global Program Review of the Global Fund to Fight AIDS, Tuberculosis and Malaria."

36. IEG, Project Performance Assessment Report, *Lesotho Health Sector Reforms Project and HIV and AIDS Capacity Building and Technical Assistance Project*, June 2010.

3.64 IEG found that both World Bank projects and Global Fund grants in the three countries suffered from weak M&E design at the beginning of the projects/grants. There was a particular problem regarding performance indicators. Typically there were too many indicators, they lacked validity, and they often did not fit into a logical framework of inputs, outputs, outcomes, and impacts. The Global Fund has attempted to address the inadequacy of performance indicators by developing a set of "Top Ten" indicators that it recommends to its grantees, but these indicators often were not routinely available in the countries.

3.65 Neither the World Bank nor the Global Fund was successful at identifying data sources up front. The indicators relating to outcomes and impacts were difficult to report due to inadequate data sources in the countries. In general, the performance indicators provided little added value for assessing project/grant performance, for contributing to periodic summative evaluations, or for enhancing policy dialogue. Good monitoring systems do all three — assess progress in implementing activities, facilitate a cumulative assessment of project performance, and identify issues that require policy responses and other solutions beyond the scope of the projects.

3.66 Both the World Bank and Global Fund M&E products were more useful when they were supplemented with other analysis and when results were synthesized and interpreted more broadly. In the projects and grants reviewed, this was done more frequently in World Bank projects. There were also examples of more analytical M&E in Global Fund grants (for example, the Russian Central Public Health Research Institute database used for M&E of the HIV/AIDS grant).

3.67 The World Bank aims to overcome some of these deficiencies in project monitoring with a standardized evaluation process that combines internal self-evaluation and independent review of individual projects. Each project team undertakes a self-evaluation at the completion of every project using a standardized Implementation Completion and Results Report (ICR) submitted to the Bank's Board within six months of the project closing date. Project M&E data, performance-related reports, and other relevant operations documentation provide input into the ICR. The performance of the project is assessed against standard criteria. Then IEG undertakes an independent review of all completed projects and their ICRs using a standardized desk review that assesses both the project experience, based on information in the ICR, and the quality of the self-evaluation.

3.68 An emphasis on learning from implementation has led to a World Bank culture of acceptance of critical evaluations. The overall outcomes of 38 percent of Bank-financed HNP projects approved since 1997 have been rated moderately unsatisfactory or worse.[37] The traceable pathway in the World Bank's M&E system from project inputs/activities to outcomes made it possible for IEG to complete its 2009 evaluation of the World Bank

37. Cheryl Cashin, forthcoming, Appendix G. This compares to 21 percent of all World Bank-financed projects, rated moderately unsatisfactory or worse, during the same time period. IEG has also rated the quality of 92 percent of the ICRs in the HNP sector as satisfactory or better, compared to 90 percent for all Bank-financed projects. However, IEG has rated the overall quality of project-level M&E as modest or negligible (as opposed to substantial or high) in 76 percent of the HNP projects closing since 2006, compared to 67 percent for all Bank-financed projects (consistent with the findings of the three projects IEG examined in depth in Burkina Faso, Lesotho, and the Russian Federation).

Group's support to HNP based on cumulative self-evaluations and independent reviews of individual project outcomes.[38] The conclusions of the evaluation reflected the aggregate performance of projects, which did not lend itself to reinterpretation and subjective conclusions. Given the real challenges that have been faced by the complex nature of World Bank HNP projects in challenging environments, and the willingness to rate projects as unsatisfactory, the evaluation, based on cumulative project performance, was unable to paint an overly positive picture.

3.69 By contrast, evaluation at the Global Fund has a conspicuous gap — the lack of an evaluation at the completion of individual grants. There has been no policy or process until recently within the Global Fund M&E system to determine the overall effectiveness of individual grants, or to generate lessons for future Global Fund activities in the country or in other programs.[39] There was also no contribution of the grant-level M&E of Global Fund grants to the summative assessment in Study Area 3 of the FYE. As discussed below in Chapter 5, the FYE was an independent and quality evaluation, but it was constrained by the absence of assessments of the outcomes of individual grants, both because there was no framework in place to do so and because few grants had been completely implemented at the time of the FYE. Therefore, the FYE was based on other information, studies, and analysis, including the 16 country studies for Study Area 2 and the 18 country studies for Study Area 3. The lack of a framework and cumulative assessment of grant performance made it possible to draw conclusions — both positive and negative — about the overall efficacy of Global Fund grants that were not necessarily supported by objective criteria.[40]

Access and Coverage of Service Delivery

3.70 **FYE Findings.** The FYE found that the additional funds provided by the Global Fund had clearly resulted in greater availability and utilization of disease-control services and better coverage of affected communities, which should ultimately reduce the disease burden. In the majority of high-burden countries, however, it was not possible to directly measure the impact of the advent of the Global Fund on their disease burdens. Death registration systems and expensive population prevalence surveys were absent. The FYE made projections about impacts, based on measured increases in access and coverage (such as HIV tests and counseling, DOTS treatment, and insecticide-treated bed nets). To address weaknesses in health data systems, the FYE recommended strengthening and integrating country — not just disease-specific — health information systems to fully capture important nationwide events in health. The FYE also recommended that prevention and treatment approaches be country-specific due to the wide variation in disease epidemiology in countries, and the different levels of country capacity to respond. Further, Global Fund grants should be supporting the most

38. IEG, 2009, *Improving Effectiveness for the Poor in Health, Nutrition and Population: An Evaluation of World Bank Group Support Since 1997*.

39. The Global Fund now expects this gap to be filled with the use of periodic reviews under the single streams of grant funding, as well as the national program reviews and program evaluations planned under its new Evaluation Strategy that the Board approved in November 2011.

40. IEG has found that the weak M&E frameworks have adversely affected the evaluations of most GRPPs. As a result, few evaluations have found much systematic evidence relating to the achievement of programs' objectives at the outcome level (IEG 2011b, pp. 27 and 34).

cost-effective measures, which would require "adjustment" of the Global Fund's "demand-driven model" (Macro International 2009b, pp. 18–20).

3.71 IEG found that Burkina Faso and Cambodia have used Global Fund grants to expand services for all three diseases, and that Brazil has used the grants to improve the quality of services for tuberculosis and malaria (the only two diseases for which the country has received grants). Burkina Faso and Cambodia have relatively good donor coordination, strong participation of CSOs, appropriate disease-control strategies for their epidemiological conditions, and expanding delivery systems that involve partnerships between central government agencies, local governments, and CSOs. In Brazil, with far less dependence on external funds, Global Fund grants are financing small infrastructure, equipment, and training inputs to improve the quality of diagnosis, treatment, and care within the existing Integrated (federal, state, and local) Health Service.

3.72 Tanzania has a weaker record in grant implementation than in getting grant proposals approved. That the Ministry of Finance and Economic Affairs has been the Principal Recipient for most Global Fund grants, as the financial gatekeeper for all official flows to Tanzania, has led to delays in the flow of funds, such as losses of grant funds in Round 3 and critical delays in the release of funds in Round 8. The Ministry of Finance has continued to put pressure on the CCM to clear new grant proposals, in spite of backlogs in disbursements of existing grants, according to IEG interviewees. Grant performance has been moderate, with some challenges experienced. Two hundred thousand people are currently on ARVs (compared to 20,000 in 2002), over 70,000 pregnant women have received PMTCT, and over 8.5 million people have been treated for malaria using ACT. The Round 8 grant for malaria has financed the distribution of over 18 million insecticide-treated bed nets under the Universal Coverage Campaign.

3.73 Nepal is effectively a post-conflict country. Fortunately, the Ministry of Health and Population had established reasonably well-functioning tuberculosis and malaria programs before the conflict started and was able to sustain these with donor support during the conflict. HIV/AIDS is a newer disease in Nepal that is concentrated in high-risk groups and is threatening to spread more widely due to cross-border migration along the India-Nepal border among sexual and drug-using networks. As indicated above, the Ministry of Health lacked the capacity to function as the Principal Recipient for the Round 2 grant for HIV/AIDS, which led the Global Fund to transfer responsibility to the UNDP. When the Global Fund approved three HIV/AIDS grants in Round 7, it assigned one to UNDP and two others to NGOs, thus bypassing the government entirely. The strained relationship between the government, UNDP, and NGOs has made it challenging to put together an effective response to the disease.[41]

41. Commenting on an earlier draft of this report, the Global Fund Secretariat agreed that the performance of HIV grants in Nepal is vulnerable. Grants have been rated poorly mainly due to dysfunctional governance. But the situation has improved since 2010. The Global Fund has actively supported the CCM in transferring more and more responsibility to the National Centre for AIDS and STD Control. The Global Fund supported the Family Planning Association of Nepal, an important NGO working with most at-risk people, through a difficult phase and despite severe malfunctions, in order to strengthen national capacity. External development partners have joined hands in building capacity in the Procurement Department of the Ministry of Health and Population to take over ARV procurement fully in 2012.

3.74 The Russian Federation has effectively used Global Fund grants to address tuberculosis. Both Global Fund and World Bank resources effectively catalyzed and leveraged substantial additional spending on tuberculosis by the Federation Government. This combined financial support increased the availability of diagnostic laboratory equipment and pharmacologic agents for treating the disease in both civilian and prison settings (preventing discharged and amnestied prisoners from infecting the wider population is a significant tuberculosis-control issue in the Russian Federation). Strong leadership, an effective strategy, and two government orders dealing with treatment have led to successful outcomes. However, the same cannot be said for HIV/AIDS because of the cultural and social forces surrounding the disease and the principal risk groups. Reaching the high-risk and marginalized groups of HIV-vulnerable individuals such as injecting drug users, and preventing the spread of HIV into the general population remains a serious challenge. The relationship between the government and NGOs remains strained. The Principal Recipient NGOs that have been engaged in preventive endeavors remain frustrated over a job only partially accomplished.

Equity in Country-Level Governance and Grant Objectives

3.75 **FYE Findings.** The FYE found that the Global Fund had modeled equity in its guiding principles and organizational structure — for example, in ensuring representation of women and marginalized populations at the level of the Board, Secretariat, and CCMs. However, few systems had been put in place at the country level or in the Global Fund's own systems to monitor gender, sexual orientation minorities, urban-rural, wealth, education, and other types of equity as part of grant performance or impact assessment (Macro International 2009b, pp. 25–29).

3.76 IEG found significant attention to equity issues in most countries, as evidenced by the membership of affected communities on the CCMs and the objectives of the grants themselves. Many of these efforts aimed to address existing inequities in the delivery of health services between urban and rural areas, between males and females, and to high-risk groups for HIV/AIDS (commercial sex workers, injecting drug users, and men having sex with men). Grants for tuberculosis, in particular, are evidence of attention to equity, since the disease mostly affects poor and marginalized populations.

3.77 IEG found that expanding access to diagnostic and treatment services in rural areas has been a key focus of Global Fund grants in all four low-income countries, all of which are predominantly rural societies. Efforts to decentralize service provision have resulted in noticeable improvements in access to services in rural areas. The Nepal tuberculosis program, for example, now offers DOTS throughout the country, although rural populations still have farther to travel to a health post or clinic. Burkina Faso has recently removed user fees for ARVs, lifting what was perceived to be a high financial burden for many.

3.78 IEG found that reaching high-risk groups in the case of HIV/AIDS has been more difficult and had more variable success. Brazil (with its own HIV/AIDS program) and Cambodia (with the support of Global Fund grants) appear to have had the greatest success in targeting and reaching high-risk groups. Global Fund grants in Nepal have targeted high-risk groups, but with less success. The prevention and treatment programs in the Round 10 grant for HIV/AIDS in Burkina Faso will target high-risk groups for the first time. The Russian

Federation Government has yet to face the imbalance in the provision of HIV/AIDS services, which are not reaching marginalized risk groups such as injecting drug users.

3.79 IEG observed some improvements in monitoring the provision of services to previously unserved or high-risk groups. However, further improvements in this area are intimately connected with strengthening the overall country-level health sector M&E systems.

Impact of Donor Support for the Three Diseases on Domestic Health Systems

3.80 **FYE Findings.** The FYE found that the health systems were weak in most developing countries and that large increases in external funding for the three diseases had stretched existing health systems to their limit. The weakness of existing health systems had limited the potential positive impacts of Global Fund-supported activities. While the Global Fund's reporting requirements had contributed to capacity building in the areas of financial management and M&E skills, they had created additional burdens on limited health systems capacity, in part because these requirements were poorly harmonized and aligned.

3.81 The FYE also found a strong relationship between the existing health system capacity and the quality of grant management. Health systems needed to be strengthened in order to scale up the services financed by the Global Fund. The increasing focus on HSS by the Global Fund and its global partners (GAVI, UNAIDS, and the World Bank) presented an opportunity to collectively address this issue (Macro International 2009b, pp. 21–24).

3.82 During the six country visits, IEG found consequences, risks, and opportunities associated with the effects of Global Fund grants on country health systems.

CONSEQUENCES AND RISKS

3.83 IEG found that the large inflow of Global Fund resources into small low-income countries with high disease burdens has tended to create dependency on the Global Fund in the fight against the three diseases. This may be exacerbated because the United States has reduced its earmarked support for ARV treatment, leaving the Global Fund vulnerable to becoming the primary external financier of ART, as has already happened in Burkina Faso and Cambodia. Some Global Fund-supported programs have also become separate and distinct from the broader health sector, as appears to be the case in the Russian Federation, where the Ministry of Health and Social Development is neither represented on the Principal CCM,[42] nor involved in the development and implementation of Global Fund grants.

3.84 IEG found that the Global Fund has also drawn away talent from the public sector, due to disproportionately higher financial compensation allowed in the implementation of

42. The Principal CCM operates at the national (strategic) level in Moscow. There is a subnational CCM which operates at the regional level in the Tomsk region for the Round 3 tuberculosis grant.

Global Fund grants.[43] In Cambodia, the average civil service wage was less than $100 per month, below subsistence level, but salary top-ups approaching $1,800 per month were allowed by Global Fund grants for some very senior positions. This issue has recently been addressed with the adoption of a uniform compensation scheme called the Priority Operating Costs, put forth by the government and signed onto by the Global Fund and other donors.[44]

OPPORTUNITIES

3.85 Going forward, new initiatives such as the Health Systems Funding Platform[45] within the context of the IHP+ should provide opportunities for the Global Fund to better align with country processes. Since the FYE, Platform members (GAVI, the Global Fund, WHO, and the World Bank) have been in joint negotiations with the Cambodian government, and have agreed on (a) joint health reviews, (b) strengthening of the Ministry of Health Management Information Systems and alignment with existing indictors, and (c) harmonization of financial management procedures. In Nepal, large donors (DFID, GAVI, the United Nations Population Fund, UNICEF, USAID, and the World Bank) have recently reached agreement, under the auspices of the Platform, on a common financial management framework — with one report and one audit replacing multiple, agency-specific reports and audits. However, IEG found no evidence during its visit to the country in May 2009 that that the Global Fund was involved in this joint endeavor at the country level.

3.86 It is unlikely, however, that the Global Fund will be able to take the lead in major HSS initiatives, such as that required for the Ministry of Health in Nepal in relation to HIV/AIDS. In practical terms, this means making the Ministry of Health sufficiently competent to receive Global Fund grants for HIV/AIDS and adequately operate as a Principal Recipient. The need is urgent; the country may be losing the fight against the disease. IEG found a consensus among interviewees during its country visit that the World Bank would be best suited to leading such an initiative. The Global Fund could not do so because it lacked a country presence beyond that of the LFA, UNDP appeared eager to withdraw from its unaccustomed position as a Principal Recipient, and none of the NGOs involved in the fight against HIV/AIDS had the capacity to play this role.[46]

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43. Many external agencies have contributed to the loss of institutional capacity in the public sector, as the more talented move to better paying NGOs and project implementation units.

44. An Aid Effectiveness Team in the Strategy, Performance and Evaluation Cluster of the Secretariat is now assisting country teams, including the team in Cambodia, in negotiating and aligning country salaries to local frameworks during grant negotiations. This is pursuant to a coordinated approach to salaries and compensation in Global Fund grants, endorsed by the Policy and Strategy Committee in September 2008. Rather than getting into a detailed analysis of proposed compensation structures, this approach relies on evidence presented by countries of how their proposal is harmonized nationally or based on an interagency framework (if one exists), such as the Priority Operating Costs Framework in Cambodia.

45. The Platform seeks to support health systems and improve health outcomes through improving the harmonization and alignment of member support to countries' health systems.

46. The World Bank effectively played this role in the case of the Lesotho HIV and AIDS Capacity Building and Technical Assistance Project (approved July 2004). The project was explicitly designed to enhance the country's capacity to absorb the large amount of resources offered by the Global Fund. The Bank stepped in to provide such

FLEXIBILITY OF GLOBAL FUND BUSINESS MODEL

3.87 IEG found that the Global Fund grants have facilitated the expansion of the service-delivery capability of local health systems. In Burkina Faso and Cambodia, strong support for the participation of CSOs, community-based organizations, and faith-based groups in grant implementation has led to greater access to health services in the rural areas. These groups have become a bona fide extension of the countries' health service. In Burkina Faso, successive grant support for capacity building of community-based organizations has resulted in one of them achieving Principal Recipient certification to implement a tuberculosis grant. The participation of CSOs in the CCMs of both countries has led to the government's "sharing of policy space" with nongovernmental groups in a constructive way in the country's health agenda. In Brazil, which has a strong health system, Global Fund grants have supported outreach to vulnerable and marginalized groups and facilitated the participation of people affected by diseases in decision-making committees.[47]

3.88 IEG found that Global Fund grants have been sufficiently flexible to support non-conventional or innovative measures, as long as these initiatives have the potential to lead to good health outcomes. Global Fund grants have supported state-of-the-art mobile clinics in Burkina Faso, which are now providing counseling, diagnostic, and treatment services for HIV/AIDS and malaria in isolated parts of the country, and malaria grants are providing increasing support for pharmacovigilance in Burkina Faso, Cambodia, and Tanzania. The Global Fund's AMFm is now providing grant funding to Cambodia, where ACT-resistant malaria has recently been detected, to advance the fight against drug resistance.

STRENGTHENING THE RESPONSE OF COUNTRY SYSTEMS BEYOND THE MINISTRY OF HEALTH

3.89 IEG found that the Global Fund business model encourages establishing relationships that go beyond the conventional ministries of health. The Global Fund could help strengthen country systems in the fight against counterfeit drugs and drug resistance by establishing linkages with drug enforcement agencies, and by strengthening their competencies in ensuring quality compliance by the pharmaceutical industry.[48] Since one-third of the grant amounts go to drugs and medical commodities, drug regulatory agencies could be invited to participate in specialized committees of the CCMs. In Tanzania, there is already some indication of resistance to ARVs.[49] Here, the United Nations Industrial Development Organization — in

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capacity building support when the Global Fund Secretariat was about to issue a "No Go" recommendation for Phase 2 of its first (Round 2) grant to Lesotho, which would have effectively canceled the grant.

47. An example is the Metropolitan TB Committees, which plan, monitor, and provide social accountability for tuberculosis services.

48. A special Session of African Ministers of Health at the Roll Back Malaria Board Meeting in Geneva, May 2011, "called for strengthening of drug regulatory authorities by building capacity of personnel to enforce licensing and marketing bans, and also to conduct surveillance to ensure the removal of counterfeit and substandard products. Ministers also called for strengthening procurement and supply chain management for ACTs to ensure constant availability within both public and private sectors."

49. Mosha and others, 2011, "Prevalence of Genotypic Resistance to Antiretroviral Drugs in Treatment-naïve Youths Infected with Diverse HIV Type I Subtypes and Recombinant Forms in Dar es Salaam, Tanzania." *AIDS Research and Human Retroviruses*, Apr 27(4): 377–82; Epub 2010, Oct 18.

partnership with GTZ, U.S. universities, and faith-based NGOs — has supported quality assurance training, regulatory compliance, and overall quality procedures in the workplace for pharmacists from regulatory agencies, drug manufacturers, and technical training schools.[50]

3.90 There are opportunities here for the Global Fund to scale up such activities in the context of strengthening country systems for good health outcomes. Drug manufacturers who graduate from such courses can now produce selected drugs that meet Good Manufacturing Practice (GMP) standards, and two companies in Tanzania have applied for WHO prequalification for producing ACTs. Ability to manufacture locally (meeting GMP standards and WHO certification) can help reduce domestic stock outages of essential drugs, including pediatric ARVs. Regulatory agents who have graduated can better detect counterfeit and substandard medicines, and contribute to reducing the risks of drug resistance, a global public good. Thus, this relatively small investment can reap significant national and global health gains.

Institutional Risk Management by the Global Fund

3.91 **FYE Findings.** The FYE found that weak management of risks — including financial, organizational, operational, and political risks — has been one of the vulnerabilities of the Global Fund. The main risk-mitigation instruments had comprised LFA assessments, financial disbursement "red flags," and the Early Alert and Response System, which was intended to provide early identification of underperforming projects and to facilitate timely corrective actions.

- **Financial risks** stemmed from poor procurement practices at the Principal and Sub-Recipient levels, and from high reliance on the CCMs (which had no legally binding relationship with the Global Fund) to protect the Global Fund from misuse of funds.
- **Organizational risks** arose from the difficulty in demonstrating the right kind of results to its investors and partners (such as outcomes and impacts as opposed to inputs and outputs), from the weak absorptive capacity of domestic health systems to receive Global Fund grants, and from the absence of a comprehensive partnership strategy that clearly delineated responsibilities among partners.
- **Operational risks** arose from the tensions between the Global Fund Secretariat, CCMs, Principal Recipients, and LFAs around the application of country ownership and PBF principles, weak institutional capacities, and insufficient investment by the Global Fund and its partners in country-level health information systems to report on the outcomes and impacts needed for PBF.
- **Political risks** arose from the Global Fund being misunderstood and being seen to have exclusive responsibility for financing life-saving treatments in poor countries and from unclear responsibility (among the Global Fund and it partners) for addressing "global communicable disease governance issues" such as the risk of drug resistance for the current treatments for the three diseases (Macro International 2009b, pp. 44–49).

50. http://www.unido.org/fileadmin/user_media/Services/PSD/BEP/Flyer%2018%20Nov2010%20TEGLO-0515-08030%20Generics_fin.pdf

3.92 IEG found that the Global Fund Secretariat is giving priority attention to improving risk management at the corporate and country levels following a Board directive in 2007 and in response to the FYE recommendations. An accountability framework has been developed with a new grant-rating system, and a cross-Secretariat Risk Management Working Group has been established to address fraud and corruption in countries. A risk register has been created at the Secretariat with focal persons dedicated to managing each risk area. Clearer policies and guidelines have been provided to countries. The authority and resources of the Office of the Inspector-General have been strengthened to provide independent and objective assessments of topics that pose risks to the Global Fund, and on fiduciary risks and controls.

3.93 The Secretariat started to deploy Country Teams in September 2010 to manage grants in 13 high-impact countries with large volumes of funding, multiple grants, complex operations, or other major challenges. These Country Teams replaced the previous system in which the FPM had to obtain "sign offs" sequentially from other staff responsible for technical compliance, particularly finance, M&E, and procurement. The teams aimed to foster a sense of joint ownership and responsibility among all team members (including the LFA, who is a part of the Country Team), shifting their roles from compliance-checking to a more proactive and supportive stance. The teams are bringing together the full grant-management expertise of the team members, and, based on the initial experience, deepening the involvement of technical experts in grant-related processes, enabling them to develop better relations with in-country stakeholders, and freeing the FPMs to focus more attention on in-country interactions, partnership building, and risk mitigation, which had previously received insufficient attention. The presence of a Partnership Officer on each Country Team is also nurturing links with civil society, the commercial private sector, and other country-level stakeholders. Although the country team approach is significantly increasing the demands on some staff, the Secretariat deployed teams for an additional 29 countries in April 2011, and plans to deploy teams for a further 5 countries by December 2011.

3.94 **Financial risks**. The Global Fund contracts with LFAs to verify and report on grant performance. They make recommendations to the Global Fund on grant disbursements and identify risks relating to grant implementation. As LFAs, PricewaterhouseCoopers and KPMG have been responsible for the largest number of countries and the largest amount of approved funds.[51]

3.95 IEG found that this system was working well in Burkina Faso, Cambodia, Brazil, and the Russian Federation. LFAs have often been criticized for not having enough public health expertise. However, the LFAs in Burkina Faso and Cambodia (from the Swiss Tropical and Public Health Institute) had expertise in both public health and finance, enabling them to "speak the same language" of public health when working with the Principal Recipients and Sub-Recipients. The LFA in Russia (KPMG) was assisted by a Central Coordination Team in San Francisco, which included health professionals.

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51. Global Fund, 2007, *Evaluation of the Local Fund Agent System*, p. 3. Other LFA service providers have been CARDNO Emerging Markets (formerly Emerging Markets Group), Crown Agents, Deloite Touche Tohmatsu, Finconsult, Grant Thornton, Swiss Tropical and Public Health Institute, and the United Nations Office of Project Services (UNOPS). The World Bank was initially the LFA for a Round 1 grant for tuberculosis control in India.

3.96 The Global Fund has undertaken a number of steps to strengthen the performance of LFAs pursuant to a Board decision in April 2007 that "LFAs must be able to monitor financial management performance and program performance and link the two components together." The Secretariat retendered all LFA contracts in 2008, requiring applicants to be able to monitor not just the financial management of the grants but also programmatic health aspects, procurement, supply-chain management, and M&E. The Secretariat updated the LFA Manual in August 2008, providing more explicit guidance on identifying risks to grant performance, and introduced a performance evaluation and feedback system for LFAs in 2009. It is likely that these actions have contributed to the improving situation since the FYE conducted country case studies in 2007. For example, the previous LFA in Brazil was found to be underperforming and was retendered. IEG found that the current LFA in Brazil (Deloite Touche Tohmatsu) was diligent and strict about the use of grant funds. The LFA had recommended rejection of one disbursement application because funds had been shifted from one line item in the grant to another, thereby sending the message that Principal Recipients had to respect the planned use of grant funds.

3.97 IEG was not able to form a judgment on the current situation in Nepal — to what extent things had improved since the chaotic situation that prevailed during the civil war in 2005–06. The LFA in Tanzania (PricewaterhouseCoopers) has identified misuse of funds and fraud, but has faced a government reluctance to prosecute such acts. The LFA welcomed the recent OIG audit which shed light on many irregularities in procurement, a common locus for fraud.[52] Correcting this vulnerability would require rigorous implementation of the many recommendations in the OIG report.[53]

3.98 **Organizational risks**. The principal organizational risk that IEG identified on its six country visits was the failure to implement an effort of sufficient scale in Nepal and the Russian Federation to reach high-risk and marginalized groups of HIV-vulnerable individuals.

3.99 The NGOs whom IEG interviewed in Nepal were justifiably proud of the efforts that had been made to educate people about the disease, to provide voluntary counseling and testing, and to deliver treatment to some HIV-positive patients, but prevalence seems to be rising and expanding treatment increases the financial burden. The Global Fund is not able to take the lead in building up the capacity of the Ministry of Health to effectively deal with the AIDS epidemic; it has to rely on other partners, including the World Bank, to step up to the plate.

3.100 In the Russian Federation, the Government has yet to face up to the challenge of reaching marginalized risk groups such as injecting drug users, and thereby prevent the

52. Global Fund, 2009d, Office of the Inspector General, *Audit Report on Global Fund Grants to Tanzania*, Report No. TGF-OIG-09-001, June.

53. Commenting on an earlier draft of this report, the Global Fund Secretariat said that the LFA in Tanzania has put in place a risk management framework as mandated by the Global Fund. The Global Fund is also working with the CCM and Principal Recipients to ensure that each Principal Recipient has a risk management framework in place. The CCM, Principal Recipients, and development partners are also involved in a graft-theft mitigation initiative to proactively find joint solutions.

disease from spreading into the general population. Nepal and the Russian Federation had the lowest coverage, among the six countries visited, of persons in need of treatment (Table 5).

3.101 **Operational risks.** As already indicated, IEG found that there has been little improvement since the Country Program Assessments in 2007 in the capacity or effectiveness of CCMs to oversee the implementation of Global Fund grants from the country perspective. Communications between the CCM, which is responsible for programmatic oversight, and the LFA, which is responsible for fiduciary oversight, have proven to be a sensitive matter, since the LFA is an agent of the Global Fund Secretariat, not the CCM. While the LFA seeks to preserve his or her independence and obligations to the Global Fund Secretariat, the CCM and the Principal Recipients seek better feedback from the LFA about grant performance.[54] The chair of the Tanzanian CCM, for example, expected complete openness on the part of the LFA, but the LFA viewed its own communications with the Global Fund Secretariat as a confidential matter.[55]

3.102 Both the FYE and the Global Fund Report on the CCM Model found a need for better communication between these two entities.[56] In Burkina Faso, only the chair and the CCM secretary meet regularly with the LFA; neither the CCM nor a CCM committee does so. In Cambodia, the LFA attends CCM meetings as an observer and is well informed about CCM matters. The Cambodia CCM has also stepped up oversight procedures, improved conflict of interest management by disallowing potential Principal Recipient membership on the CCM, and established a separate Oversight Committee. Given the emergence of ACT-resistant strains of malaria in the country, the Cambodian Oversight Committee could potentially invite representation from national drug regulatory authorities in order to improve national oversight and quality assurance of pharmaceuticals procured by Global Fund grants, and help eliminate poor quality and counterfeit drugs (a significant issue in Cambodia). Representation of drug regulatory authorities could also be an important consideration for the Tanzanian CCM or its committees because of the large drug portfolio in its Global Fund-supported activities.

3.103 **Political risks.** The Global Fund is now perceived as the largest external financier of ARV for people living with AIDS and for PMTCT, and the primary financier of first- and second-line tuberculosis drugs, and malaria ACTs. This was evident in all four of the low-income countries visited. Among these countries, only Cambodia was taking immediate steps to more stringently manage all ART programs, introduce cost controls, and strike a better balance between prevention and treatment. This did not appear to be the case in Tanzania, which has a large Global Fund portfolio in all three diseases. In Nepal, the political risks

54. The Global Fund Secretariat is well aware of this issue. See Global Fund 2010g. "Recommendations to Enhance In-Country Communications between the Secretariat, LFA, PR, CCM and Other Partners."

55. Commenting on an earlier draft of this report, the Global Fund Secretariat said that the Tanzanian CCM has now given the LFA a platform during every CCM meeting to highlight key issues in grant implementation/ management and to provide a second opinion on the Principal Recipient's progress reports. The LFA has also made regular presentations to the Development Partners' Group.

56. Global Fund, 2008, *Lessons Learned in the Field: Health Financing and Governance: A Report on the Country Coordinating Mechanism Model,* p. 52.

were specifically associated with the HIV/AIDS program and with securing new Global Fund grants to continue ARV treatment begun with past grants.[57]

3.104 There are also higher-level political risks, such as those relating to the global governance of communicable diseases and drug resistance. The increased risks of drug resistance (and ethical issues) arise from the unprecedented scale of treatment supported by Global Fund grants, should treatment regimens be disrupted for any reason, such as the inability to meet performance standards. One response to date has been the establishment of AMFm — the Fund's new business line in the affordable provision of ACT combination drug therapy, which started pilot activities in 2010. The Global Fund has also improved its operational procedures (single streams of funding and the National Strategy Applications) to reduce disruption of grant activities, but these may not be sufficient to manage the political and reputational risks associated with becoming the world's primary external financier of treatment for AIDS, tuberculosis, and malaria.

3.105 The increasing quantity of counterfeit drugs is accelerating drug resistance. WHO estimates that as much as 25 percent of the drugs sold in the developing world are counterfeit — a lucrative trade that will reach $75 billion a year in 2010 according to the Center for Medicine in the Public Interest in New York City. More than 50 percent of the antimalarial artesunate in South East Asia is counterfeit; some of it has toxic ingredients, while other portions have small amounts of genuine artesunate, which increases the risk of drug resistance. Following IEG's country visit to Cambodia, the Global Fund, through AMFm, planned to flood Cambodia and 10 African countries with cheap, high-quality malaria medications to reduce the use of substandard medications by patients and to make the market less profitable for counterfeiters. By negotiating with legitimate ACT producers and subsidizing the costs of the medicine, AMFm is aiming to reduce retail treatment costs from more than $6.00 to less than 50 cents per patient.

57. Commenting on an earlier draft of this report, the Global Fund Secretariat agreed that the effectiveness of the HIV program in Nepal remains a big concern, but that the situation has improved since IEG's country visit in May 2010. The Global Fund Board approved the country's Round 10 proposal for HIV/AIDS in December 2010, thus securing external financial support for HIV/AIDS for the next five years. The National Centre for AIDS and STD Control is now the Principal Recipient for the Round 7 and 10 grants. Still, strategic and day-to-day management are weak, and forecasting ARV needs remains challenging due to poor stock management and consumption data surveillance.

4. The World Bank's Engagement with the Global Fund at the Global and Country Levels

4.1 The purpose of this chapter is to draw lessons for the future from the past engagement between the World Bank and the Global Fund at the country level. The context for this engagement includes: (a) the Bank's engagement with global health partnerships more generally, (b) the roles that the Bank plays in the Global Fund at the corporate level, (c) the various initiatives associated with GHAP and IHP that have provided additional avenues for World Bank-Global Fund engagement at the country level, and (d) the Bank's own country programs in the health sector. The first part of this chapter describes the World Bank-Global Fund engagement at the global level to provide context for the findings on country-level engagement in the second part.

The Bank's Involvement in Global Health Partnerships Prior to the Establishment of the Global Fund

4.2 The Bank has been involved in global and regional health partnerships for more than 30 years, starting with the Special Programme of Research, Development and Research Training in Human Reproduction in 1972, the Onchocerciasis Control Program in West Africa in 1974, and the Special Programme for Research and Training in Tropical Diseases in 1975, all of which have been financed by the Development Grant Facility (DGF) and its predecessor, the Special Grants Program (Appendix K). Then the Bank became involved in eight more global and regional health partnerships between 1994 and 2001, as follows, all of the them supported by the DGF:

- UNAIDS (the Joint United Nations Program on HIV/AIDS), 1994
- International AIDS Vaccine Initiative, 1996
- European Observatory on Health Systems and Policies, 1997
- Global Forum for Health Research, 1998
- Roll Back Malaria (RBM), 1998
- Medicines for Malaria Venture, 1999
- Global Alliance for Vaccines and Immunization (GAVI), 2000
- Stop Tuberculosis Partnership (Stop TB), 2001.

4.3 Along with the pressures of globalization, the Bank has played important but quite varied roles in contributing to the growth of GRPPs for better health outcomes. Some have suggested that the World Bank's 1993 World Development Report, *Investing in Health*, played a major role in putting health on the global agenda. Bill Gates has explicitly stated that reading the 1993 World Development Report prompted him to become involved in global health, initially by donating more than $1 billion to support vaccinations in the developing world.[58] The 1993 World Development Report, along with the parallel study, *Disease Control Priorities in Developing Countries*, also raised awareness of some important global public goods dimensions of health such as health research and communicable diseases – two of the new

58. Michael Specter, "What Money Can Buy," *The New Yorker*, October 24, 2005.

programs fit into both these categories (the International AIDS Vaccine Initiative and the Medicines for Malaria Venture). Other influences, such as the growing AIDS epidemic, are clearly important. World Bank President James Wolfensohn also explicitly promoted the establishment of such partnerships during his tenure (1995–2005) in order to open up the Bank and improve the efficiency of international development assistance.[59]

4.4 When the Global Fund was established in 2002, the Bank was involved in six global health research programs, three technical assistance programs (UNAIDS, RBM, and Stop TB), and two country-level investment programs (the African Programme for Onchocerciasis Control and GAVI), but the Bank did not have a country-level operational role in any of these programs. The Global Fund was the first global or regional health partnership program that would finance country-level investments in which the program expected the Bank to provide technical support along with other development partner agencies (WHO, UNAIDS, RBM, and Stop TB).[60] However, the extent to which the Bank accepted or acknowledged this role appears to have been deliberately left vague due to the tensions surrounding the establishment of the Global Fund at the time. There was no formal agreement or MOU between the World Bank and the Global Fund to this effect, and there were no written directives or guidelines issued to staff in either organization for engaging with the other at the operational level in the country.[61] The only formal agreement between the two organizations was the trusteeship agreement relating to the Bank's management of the Global Fund trust fund.[62]

4.5 The World Bank's principal prior experience with global programs that financed investments at the country level were the GEF and the Multilateral Fund for the Implementation of the Montreal Protocol, both established in 1991. However, these programs had a different operational model from that of the Global Fund. The Bank was explicitly designated as one of the implementing agencies for both programs, and as such was explicitly responsible for preparing project proposals and supervising their implementation, as for regular Bank projects. The two programs also reimbursed the Bank for services rendered in assisting eligible governments in the development, implementation, and management of their projects. (See Appendix L.)

4.6 When the Global Fund was established, the Bank had also recently reviewed and expanded its own response to the AIDS pandemic to help fight the disease in countries where

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59. James D. Wolfensohn, 2010, *A Global Life*, pp. 305-306.

60. While GAVI was established in 2000, before the Global Fund, the program was initially located in UNICEF in Geneva, and UNICEF was the principal implementing agency for GAVI.

61. World Bank Management made four presentations to the Bank's Board between January 2002 and March 2005 on the Bank's evolving relationship with the Global Fund, but these did not constitute directives or guidelines to country-level Bank staff for engaging with Global Fund-supported activities at the country level. These discuss possible roles for the Bank in the Global Fund in addition to trustee, such as Principal Recipient for some Global Fund grants, and cite examples of existing country-level engagements such as common implementing agencies and coordinated supervision of parallel World Bank projects and Global Fund grants, but do not provide specific guidance in terms of what is permissible, encouraged, or required for country-level Bank staff.

62. More recently, the World Bank's Integrity Vice President and the Global Fund Inspector-General also signed an information-sharing MOU in October 2010 to share information relating to fraud and corruption in the use of each organization's resources.

AIDS was most threatening. The Bank issued an expanded Africa HIV/AIDS Strategy in June 1999, *Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis*,[63] and the Bank's Board approved the first Multi-Country AIDS Program (MAP) in September 2000, earmarking $500 million in IDA credits for financing AIDS projects in Africa, and $155 million in Caribbean countries. The Board approved a second $500 million envelope in February 2002. The second set of MAP projects allowed financing of antiretroviral treatment and, for the first time in the history of IDA, support to client countries in the form of IDA grants.[64] The Bank ended up committing almost $2 billion to MAP projects in Africa and the Caribbean over the subsequent 10 years (Table 10).

Table 10. Multicountry AIDS Program Projects, by Region and Approval Year

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Number of Projects											
Africa	7	9	5	9	5	4	6	4	2	3	54
Caribbean	2	1	3	2	3			1	1		13
Total	9	10	8	11	8	4	6	5	3	3	67
Commitments (US$ millions)											
Africa	287.2	262.3	172.8	355.9	80.0	247.7	185.4	65.8	55.0	55.0	1,767.1
Caribbean	40.2	15.0	30.1	19.0	21.4			10.0	35.0		170.6
Total	327.4	277.3	202.9	374.9	101.4	247.7	185.4	75.8	90.0	55.0	1,937.7

Source: World Bank data.
Note; All projects except one are mapped to the HNP Sector Board. (One Mali project, approved in 2004, was mapped to the Finance and Private Sector Development Sector Board.)

The Bank's Roles in the Global Fund at the Corporate Level

TRUSTEE

4.7 First and foremost, the Bank is the administrator of Global Fund trust fund. Under the trusteeship agreement, the Bank receives and invests funds from Global Fund donors, commits and disburses the funds to grant recipients on the instruction of the Global Fund Secretariat, and provides regular reports to the Global Fund. The Bank is not responsible for mobilizing donor resources or for fiduciary oversight to ensure that grant disbursements are used for the intended purposes, only that fund recipients are legitimate entities.

4.8 In World Bank parlance, the Global Fund trust fund is a financial intermediary fund (FIF) in which the Bank provides "a specified set of administrative, financial, or operational

63. Previous Bank strategies to address AIDS in Africa included *AIDS: The Bank's Agenda for Action* in 1988; *Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank's Agenda for Action* in 1992; the *Regional AIDS Strategy for the Sahel* in 1995; *AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy* in 1996. See IEG 2005, Box 2.1 on page 14.

64. Donors agreed that 18–21 percent of IDA 13 resources (2003–05) should be provided on a grant basis. All AIDS projects or components in low-income countries have been eligible for IDA grants since April 2003, as have 25 percent of AIDS projects or components in blend countries (those eligible for both IDA credits and IBRD loans).

services." It is currently 1 of 16 such funds administered by the World Bank that are providing financing for 13 GRPPs (Appendix K), and that collectively account for more than 50 percent of the trust funds administered by the Bank.[65] In 2002, the Global Fund trust fund was the sixth FIF to be established at the Bank and the second in the health sector (after the Onchocerciasis trust fund that supports the African Programme for Onchocerciasis Control). Subsequently, three more FIFs have been established to support GAVI, four more to support four agriculture and environment programs, and one for the Global Partnership for Education.[66]

4.9 The World Bank plays an operational role, as one of the implementing agencies, in all seven of the agriculture and environment programs that are supported by FIFs, and the Global Partnership for Education. As indicated in Chapter 2, that the Bank might play such an operational role in the Global Fund was never seriously considered by the Transitional Working Group in 2001. However, there were considerable pressures in the Working Group for the Bank to take on an "enhanced fiduciary role," in addition to being the trustee, to help ensure that grant disbursements were used for the intended purposes. The Bank was unenthusiastic about exercising fiduciary oversight for projects for which it did not also have programmatic oversight in accordance with its own operational policies, which would have required a substantial scaling up of country-level HNP staff. When the Bank declined to do so, the Global Fund Board decided in April 2002 to establish the LFA system of contracting out in-country fiduciary functions to LFAs.

4.10 According to the trusteeship agreement signed in May 2002, the World Bank invests undisbursed funds "in such manner, and such form, as it may decide, consistent with its established practice of managing other trust funds held by it." The income from these investments, which is credited to the trust fund, represented 5.4 percent of the total resources available to the Global Fund from 2002 to 2010, and has more than covered the cumulative administrative costs of the Global Fund, including staff salaries, other Secretariat costs, LFA fees, funding for CCMs, and the trustee fee paid to the Bank for administering the trust fund (Table 2 in Chapter 2).

GOVERNANCE

4.11 The Bank is a permanent nonvoting member of the Global Fund Board, along with UNAIDS, WHO, and one representative of partners (RBM, Stop TB, and UNITAID). For the Bank to be a nonvoting member is the usual situation for FIF-supported programs, even those for which the Bank is an implementing agency. The Bank is an official observer on the GEF Council, a nonvoting member of the Trust Fund Committees for the two Climate Investment Funds, and a nonvoting member of the Global Agriculture and Food Security Program (Appendix K). The Bank is only a voting member of the governing bodies of those FIF-supported programs (the African Programme for Onchocersiasis Control, GAVI, and the Consultative Group on International Agricultural Research) in which it has also been a financial contributor, by means of annual grants from the DGF. The Bank is also a voting member of all

65. The World Bank also administers the Debt Relief Trust Fund (formerly the Heavily Indebted Poor Countries Initiative) and two country-level FIFs (for Guyana and Haiti), which are not GRPPs.

66. See IEG, 2011a, *Trust Fund Support for Development: An Evaluation of the World Bank's Trust Fund Portfolio*, Appendix F, for a brief description of all the FIFs managed by the Bank.

the other global health partnerships to which it is contributing financially (also through the DGF), except for the International AIDS Vaccine Initiative and the Medicines for Malaria Venture.[67]

4.12 The Bank is officially represented on the Global Fund Board by the Vice President for Concessional Finance and Global Partnerships, by virtue of this vice presidency being responsible for managing the Global Fund trust fund. However, the Director of the Multilateral Trusteeship and Innovative Financing Department usually attends the Board meetings on behalf of the vice president along with representatives of the HNP Department (the Bank's alternate representative). Each Board member is entitled to send up to 10 representatives to each Board meeting, but the Bank has never sent more than 5 (Appendix J). The Bank is also a member of two Board committees — the Finance and Audit Committee, by virtue of its trusteeship role, and the Policy and Strategy Committee, by virtue of its experience in the health sector.

4.13 The Global Fund is representative of the clear trend toward stakeholder models of governance of GRPPs in which membership on the governing body is not limited to financial contributors, but is also extended to noncontributors such as beneficiary countries and CSOs (and to a lesser extent the commercial private sector).[68] Most of these GRPPs, like the Global Fund, also have constituency-based boards in which various stakeholder constituencies have a certain number of seats.

4.14 However, IEG has not been able to observe that one governance model is more effective than the other. Direct representation does not necessarily translate into effective voice; noncontributing stakeholders may be able to express their interests more effectively in other ways (IEG 2011b, p. 50). For instance, the Bank has a robust civil society engagement around health issues including HIV/AIDS, malaria, tuberculosis, reproductive health, and nutrition. The Bank also launched a Civil Society Consultative Group for HNP in early 2011 to facilitate and expand this engagement.[69]

4.15 In IEG's experience, whether nonvoting members have as much influence over Board decisions as voting members depends on the history and culture of each organization and the extent to which decisions are made by consensus rather than by voting. What is clear, however, is that stakeholder models of governance represent a significant shift from shareholder models in which membership on the governing body is limited to financial contributors and with which the Bank has had more experience in other sectors.

4.16 When the Global Fund was established, the influence of the Bank on the Global Fund Board would not be determined by what the Bank was — that is, the largest external financier of health sector investments in developing countries in 2002 — but by its ability to

67. Unlike the other global health partnerships that have constituency-based boards in which each constituency is assigned a certain number of seats, the International AIDS Vaccine Initiative and the Medicines for Malaria Venture are product development public-private partnerships that are governed by self-perpetuating boards in which board members appoint their successors. Their boards consist of distinguished individuals from industry, academia, and technical agencies. The Gates Foundation is the major donor represented on both these boards.

68. IEG, 2011b, *The World Bank's Involvement in Global and Regional Partnership Programs*, pp. 49–50.

69. Direct representation of CSOs on the Bank's Executive Board would not, of course, be possible without a major change in its Articles of Agreement since the Bank is an intergovernmental organization in which only member countries can be represented on its Board.

make a positive contribution to the governance of the program. It is doubtful that the diminished status of the Bank and other nonvoting members significantly reduces the Bank's reputational risks of being involved with the Global Fund, given the role that the Bank plays in global health and its extensive engagement with the Global Fund at the global and country levels, as documented in this chapter.

4.17 The FYE found that the Global Fund governance structure and processes had achieved both broad participation and genuine power-sharing between key constituencies in the fight against the three diseases. The participation of CSO and private sector constituencies has been broadly viewed as effective, while that of some other constituencies (such as affected communities) has been less effective due to the size of the constituencies and the absence of easy mechanisms to communicate effectively within the constituencies.

4.18 The FYE also found that the Board had tended to focus its attention on near-term and micro issues such as the operational functions of country mechanisms (CCMs, PBF, and the LFAs) to the relative neglect of longer-term and larger issues such as organizational vision and strategy. The FYE suggested that the Board's focus on operational issues was "an unavoidable consequence of a previous decision to establish the LFA system rather than rely on the in-country capacities of the World Bank or other partners" (Macro International 2009b, pp. 50–55). As indicated earlier, the Board has since chosen to delegate more decision-making authority on operational matters to its Committees and the Secretariat and to focus on core strategic issues more consistent with its governance role.

The Global HIV/AIDS Program, the International Health Partnership, and Related Initiatives

4.19 The various initiatives associated with GHAP and IHP have provided additional avenues for the World Bank to engage with the Global Fund at the country level.

THE GLOBAL HIV/AIDS PROGRAM AND RELATED INITIATIVES

4.20 The Bank established GHAP, in partnership with UNAIDS, in June 2002 to support the Bank's efforts to address the HIV/AIDS pandemic from a cross-sectoral perspective, and to lead the M&E efforts of UNAIDS partners through the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET). Supported by a UNAIDS trust fund established for the purpose, GHAP was established to strengthen institutional capacity across the Bank to respond to the AIDS epidemic, provide specialized technical expertise and knowledge, and support cross-cutting and multisector engagement. It has become the central coordination unit that supports the management of the Bank's institutional capacity on AIDS.

4.21 UNAIDS contributed $57.1 million from 2003 through June 2010 to the Bank-administered trust fund to support the various activities of GHAP discussed immediately below (Table 11).[70] By way of comparison, GAVI has also contributed $11.3 million to a

70. It could be argued that 60 percent of the funds to the UNAIDS trust fund have effectively come from the World Bank, since the DGF contributed $36 million to UNAIDS over the same time period. This potential conflict of interest — receiving with the left hand what was given by the right hand, when DGF funds are supposed to leave the Bank — has not been transparently acknowledged in DGF Annual Reports.

trust fund at the World Bank to finance Bank-executed activities in support of GAVI's goals and objectives.

Table 11. Contributions to and Disbursements from UNAIDS and GAVI Trust Funds at the World Bank (US$ millions)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
UNAIDS Trust Fund for GHAP [a]										
Donor contributions	-	3.1	8.4	1.9	6.4	6.9	11.1	9.6	11.2	58.6
Disbursements [b]	-	2.4	3.8	3.8	4.0	6.0	8.4	6.7	10.4	45.6
GAVI Trust Fund										
Donor contributions	0.5	0.3	–	0.6	–	–	5.1	2.5	2.3	11.3
Disbursements	0.4	0.3	0.0	0.4	0.1	0.2	1.3	2.0	2.7	7.4
DGF Grants [c]										
To UNAIDS	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	36.0
To GAVI	0.5	1.5	1.5	1.5	1.0	0.5	–	–	–	6.5

Source: World Bank data.
a. DFID contributed 0.5 million and 1.0 million to GHAP in 2009 and 2010, respectively, for an evaluation of community response to HIV/AIDS.
b. All but $200,000 has been Bank-executed, indicating that Bank staff have been directly responsible for supervising the GHAP activities financed by the trust fund.
c. Contributions from the Bank's DGF to UNAIDS and GAVI.

4.22 **GAMET.** This team aims to improve the quality of HIV/AIDS M&E and to build national capacity for one country-owned M&E system in each country — what has come to be known as the third of the "Three Ones." It helps to strengthen national M&E capacity through an international team of M&E specialists, based primarily in developing countries, who aim to provide rapid, flexible, and practical M&E support to beneficiary countries.

4.23 **The Three Ones.** A consultation on Donor Harmonization of AIDS Funding held in Washington, DC, in April 2004 endorsed the application of the Three Ones principles, to be applied in each recipient country based on consultations among internal and external partners in each country:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners
- One national AIDS coordinating authority, with a broad-based multisectoral mandate
- One agreed country-level M&E system.

4.24 **The Global Task Team.** UNAIDS, the United Kingdom, and the United States co-hosted a high-level meeting in March 2005 — involving leaders from donor and developing-country governments, CSOs, UN agencies, and other multilateral and international institutions — to review the global response to AIDS. Key donors reaffirmed their commitment to the Three Ones and established a Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors to make recommendations to this effect. Composed of representatives of 24 countries and institutions, the Global Task Team reported in June 2005 that the major actors needed to find more

effective ways of working together at the country level in line with their respective comparative advantages. Three of its recommendations were of relevance for Global Fund-World Bank engagement at the country level: (a) to create a Global Implementation Support Team, (b) to undertake a study on the comparative advantages for the Global Fund and the World Bank, and (c) to assist countries in preparing AIDS strategies and action plans.

4.25 **Global Implementation Support Team (GIST)**. This team was formed in July 2005, with a secretariat in UNAIDS, to support country partners in making effective use of the increasingly large funds being made available to fight AIDS. High-level officials from multilateral organizations, national AIDS authorities, and others met regularly (initially monthly) to help countries address urgent implementation issues, to stimulate early diagnosis of technical support needs, and to ensure that the deployment of multilateral support was well-coordinated. Following a 2007 review, GIST revised its mandate to focus on strengthening coordination and mutual accountability with respect to technical support, addressing systemic problems at the global level, and identifying good practices and disseminating lessons learned. Its key initiatives under the revised mandate were (a) the development of a set of Principles of Technical Support for users and providers of technical support; and (b) development of CoATS (Coordinating AIDS Technical Support), which is a real-time global-level database to assist the countries in monitoring technical support to facilitate greater accountability and country ownership. In line with these objectives, GIST has commissioned case studies to assess the effectiveness of technical support for Global Fund-related activities.

4.26 **Comparative Advantage Study**. The Global Task Team had found that the Global Fund and the Bank "increasingly seem to finance the same types of goods and activities in the same countries without any clear sense of their respective comparative advantages or complementarity with each other" (UNAIDS 2005, p. 17). Therefore, the Global Fund and GHAP commissioned a study on the comparative advantages of the Global Fund and the World Bank at the country level. Completed in January 2006, the report recommended, first, that both institutions should make stronger efforts to adhere to the Three Ones principles (along with some concrete suggestions in this regard).[71] Second, the report recommended that the Global Fund should give "much greater strategic and operational precision" to its role as a financing entity, and not an implementing agency. This would require enhanced specificity on "what it will not do as well as what it will do." Third, the report recommended that the World Bank's strategic and programmatic focus should emphasize — to a much greater extent and with enhanced clarity — that its main comparative advantage lay in systemic health sector capacity building. Strengthening health systems was a difficult and complex area, but it was fundamentally important to achieve progress not just on AIDS, but also on other diseases and, more generally, on the sustainability of all efforts to improve human health in poorer countries. The report pointed out that no other agency had the reach, the expertise, and the experience to provide such support.

4.27 **AIDS Strategy and Action Plan Service (ASAP)**. UNAIDS and the World Bank launched ASAP in July 2006 to assist countries in preparing country-owned strategies and action plans. Billed on its Web site as a service of UNAIDS, the coordinating unit is located

71. Alexander Shakow, 2006, "Global Fund–World Bank HIV/AIDS programs: Comparative Advantage Study," Report Prepared for the Global Fund and The World Bank HIV/AIDS Program.

in GHAP in the World Bank. This provides peer reviews of draft national strategies, offers technical and financial support to assist countries in strengthening their strategic response to HIV/AIDS, develops tools to assist countries in preparing strategies and action plans, and organizes capacity-building activities for policymakers and practitioners. The unit receives the most requests from National AIDS Councils, UNAIDS Country Coordinators, and Regional Support Teams.

4.28 The UNAIDS Second Independent Evaluation, 2002–2008 (Poate, Balogun, and Attawell 2009), generally found that GAMET, GIST, and ASAP were effective initiatives, with some shortcomings (Box 5). There was a high-visibility meeting in 2006, in response to the Comparative Advantage Study, between World Bank President Paul Wolfowitz and Global Fund Executive Director Richard Feachem, as well as discussion of the study at the Bank's Executive Board. There was also an effort to develop an MOU between the Bank and the Global Fund to lay out a division of labor and ways of collaborating at the country level, but the high-level changes in the leadership of both the World Bank and the Global Fund in 2007 — Robert Zoellick replaced Paul Wolfowitz and Michel Kazatchkine replaced Richard Feachem — hindered attempts to finalize the MOU. The Global Fund was also evolving and expanding rapidly, and the HNP Department was focused on preparing its new HNP Strategy, *Healthy Development* (World Bank 2007c).

4.29 IEG found that attitudes toward renewing this effort were lukewarm among senior managers of both organizations. Global Fund managers felt that it would not help much unless the Bank actively encouraged its staff to effectively and systematically collaborate with the Global Fund at the country level. There would still need to be an operational framework to execute the MOU, or at least a clear and specific operational understanding of the MOU by staff in both organizations.

THE INTERNATIONAL HEALTH PARTNERSHIP AND RELATED INITIATIVES (IHP+)

4.30 The various initiatives associated with the International Health Partnership (referred to as IHP+) have also provided avenues for World Bank-Global Fund engagement at the country level. But none of these initiatives has so far led to a formal agreement between the two organizations on country-level engagement either.

4.31 Compared to GHAP and its related initiatives, IHP+ represents a broader coalition of partners and efforts to accelerate progress in achieving all the health-related MDGs in accordance with the principles of the Paris Declaration and the Accra Agenda for Action. Launched in September 2007, IHP+ is intended to achieve better health results by mobilizing donor countries and other development partners around a single country-led national health strategy, by improving coordination among actors, by strengthening health systems, and by building momentum at the national level for improving existing country-led health plans. IHP+ is open to all developing and developed country governments, and agencies and CSOs involved in improving health who are willing to sign up to the commitments of the IHP+ Global Compact. IHP+ currently counts 47 members.

Box 5. Findings from the Second Independent Evaluation of UNAIDS

The evaluation commended the work of **Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET)** in some regions and countries. For example, the UNAIDS Regional Support Team for East and Southern Africa and GAMET have jointly led the development of the 12-component framework on M&E and have developed a regional generic training curriculum on M&E together with other partners. The UNAIDS Secretariat and GAMET have provided pivotal support for strengthening M&E in Swaziland, including building capacity in M&E skills and revising the health sector HIV M&E framework. Overall, however, the evaluation found duplication of M&E work at the country level and weak coordination of M&E roles in HIV/AIDS. "It is not clear how the work of GAMET complements that of the UNAIDS Secretariat, which is also supporting expenditure tracking and M&E capacity building, and there appears to be less collaboration in other regions" (p.118). The evaluation recommended a rationalization of support for M&E between GAMET, the UNAIDS Secretariat and WHO.

The evaluation found that the **Global Implementation Support Team (GIST)** and the UNAIDS global coordinators have improved the coordination of technical support in AIDS. "There is a consensus that the GIST has played an important role in addressing management and implementation bottlenecks at global and country levels relating to Global Fund and World Bank procedures and in providing a link between the UN system and the Global Fund" (p. 112). However, the evaluation questioned the value and sustainability of CoATS (Coordinating AIDS Technical Support) since, like all such databases, this depends on users keeping it up to date (p.112). CoATS had been rolled out in ten countries, as of 2009, initially through UNAIDS Country Coordinators, but with the intention that activities would ultimately be managed by National AIDS Commissions.

The evaluation found that the **AIDS Strategy and Action Plan Service (ASAP)** has been active in over 75 countries and has supported 2 regional initiatives and 3 civil society networks. Along with the regional Technical Support Facilities and WHO Knowledge Hubs, ASAP has helped increase the capacity of UNAIDS to expand technical support to national AIDS responses. ASAP has effectively engaged the UNAIDS Secretariat and five UNAIDS' cosponsors (UNESCO, UNDP, UNICEF, International Labour Organization, and WHO) in peer review processes and country missions. However, the evaluation found that National Strategic Plans could benefit from stronger analysis of the evidence base, better links between evidence and strategy, a focus on achieving results, more attention to gender and marginalized groups, and improved operational and human resource planning.

The evaluation conducted a review of the joint UNDP, World Bank, and UNAIDS Secretariat program to strengthen capacity to integrate HIV into Poverty Reduction Strategy Papers (PRSPs) in 7 of the 14 countries that had so far participated in this program. The review found that the program had enhanced the participation of stakeholders in PRSP formulation, enhanced integration of HIV in PRSPs, increased understanding of the links between poverty and AIDS, and improved alignment of PRSPs and national AIDS strategic plans.

The evaluation found that the UNAIDS Secretariat and the program's seven cosponsors have provided significant technical support for CCMs and Global Fund processes and proposal development both directly and through mechanisms such as the ASAP and the Technical Support Facilities (p.111). The evaluation also found that the Bank had been less actively engaged in joint teams at the country level, even though it was the only cosponsor that contributed financially to UNAIDS as well as being an active cosponsor at the global level.

Source: Derek Poate, Paul Balogun and Kathy Attawell for ITAD and HLSP, *UNAIDS Second Independent Evaluation, 2002–2008, Final Report*, September 2009.

4.32 Global and country-level compacts set out a process of mutual responsibility and accountability for the development and implementation of national health plans. Development partners agree to better coordinate external support to help develop and implement comprehensive national health plans; provide aid in ways that strengthen health systems; and, where possible, provide more long-term, flexible support through national systems. Partner countries agree to further invest in their own health systems, address policy constraints to progress, strengthen planning and accountability mechanisms to make them more inclusive and transparent, and better link external support to improvements in health outcomes. CSOs and other stakeholders play an important role in the design, implementation, and review of the IHP at the global and country levels and in holding all parties to account. The performance of all parties is subject to a joint high-level review at the country and global levels.

4.33 IHP+ is not a formal partnership program with a governing body or legally binding agreement between the partners in relation to governance. Its activities are coordinated by an interagency Core Team based in WHO, the World Bank, and WHO-AFRO. The World Bank's contributions to Phase I of IHP+ were supplemented by a grant from WHO,[72] in addition to allocations from the Bank's administrative budget. The Bank's contributions to Phase II are being supplemented by a WHO trust fund at the World Bank, called the IHP+ Trust Fund, established in February 2010 to support country-level coordination work.

4.34 **Health-8**. This is an informal subgroup of IHP+ comprising eight health-related organizations — the Bill & Melinda Gates Foundation, GAVI, the Global Fund, UNICEF, the United Nations Population Fund, UNAIDS, WHO, and the World Bank. Established in July 2007, it meets semi-annually to stimulate a global sense of urgency about reaching the health-related MDGs, to strengthen their own cooperation on global health, and to discuss coordination and aid effectiveness issues in global health.

4.35 **High-Level Taskforce on Innovative International Financing for Health Systems**. This Taskforce was launched in September 2008 to help strengthen health systems in the 49 poorest countries in the world. Chaired by U.K. Prime Minister Gordon Brown and World Bank President Robert Zoellick, the Taskforce released its recommendations in May 2009 and completed its work in September 2009. The Taskforce identified a menu of innovative financing mechanisms to complement traditional aid flows in health. It launched new initiatives to raise more money, and to use money more effectively, to achieve the health-related MDGs.

4.36 **Health Systems Funding Platform**. This idea originated with GAVI and the Global Fund, when their Executive Directors addressed the Taskforce to announce a new initiative of joint programming of GAVI and Global Fund resources for HSS, as a way to enhance the capacity of grant-recipient countries to more effectively absorb the significant donor resources being made available. However, the launching of this initiative was not without issues. Some saw this as being done hastily, shortly after the Global Fund had become administratively autonomous from WHO, and without consultation with GAVI's own Health Systems Strengthening Task Team. The latter pointed out a number of weaknesses, including governance issues and the technical capacity of the two entities to manage joint

72. In World Bank parlance, this was an externally-financed output (EFO) because it was smaller than the minimum amount ($1 million) to establish a Bank-administered trust fund.

programming. As a result, WHO and the World Bank agreed to lend their expertise to raise the technical profile of the new initiative, thereby constituting the new Platform Team of GAVI, the Global Fund, WHO, and the World Bank, under the leadership of the Bank.[73]

4.37 Launched in earnest in early 2010, the Platform is intended, like other IHP+ initiatives, as a mechanism to accelerate progress toward the health-related MDGs, and specifically to "coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies."[74] It is being developed initially by GAVI, the Global Fund, and the World Bank, and facilitated by WHO in consultation with recipient countries and other key stakeholders, including CSOs. The current partners are coordinating efforts to start harmonizing their activities and aligning them to country priorities and budget cycles. While this work varies with each country context, it seeks to develop one common financial management framework, one M&E framework, and one joint review process in support of one national health strategy.[75] The intent is to prepare participating pilot countries to have access to additional funding for HSS. The initial participating countries include those that are already receiving some funding assistance for HSS.

4.38 Following the launching of the new Platform Team, some members of the Global Fund Board expressed concerns that the initiative might shift donor funds away from the three epidemics and toward HSS, where the World Bank had a comparative advantage. The Global Fund had already started funding HSS explicitly by including a specific funding window for HSS during Round 5 grant applications in 2005.[76] However, some donors resisted the continuation of this funding window based on the proposed division of labor in the Comparative Advantage Study, which had found the World Bank to have a comparative advantage in providing such support. As a result, the Global Fund removed the HHS funding window in Round 6. Subsequently, however, the Global Fund's Technical Review Panel recommended to the Global Fund Board that $356 million be allocated for HSS in Round 7 and $594 for Round 8 (Kress and Shaw 2009, p. 9).

4.39 Starting in Round 11 (launched in August 2011), applicants could submit cross-cutting HSS proposals as separate, stand-alone proposals, as for HIV, tuberculosis, and malaria proposals, rather than attaching them to a disease proposal. The Global Fund and GAVI also developed a common HSS proposal form for this purpose. A sub-set of eligible countries could now request support from both the Global Fund and GAVI using the same form (Global Fund 2011a).

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73. Dan Kress and R. Paul Shaw, September 2009, "GAVI and Global Fund Joint Programming for Health Strengthening: Turf Wars or an Opportunity to Do Better?"

74. Recommendation 9 of the Taskforce on Innovative Financing for Health Systems, 2009, *More Money for Health and More Health for the Money*, p. 7.

75. Unlike the Three Ones principle for HIV/AIDS, this alignment effort does not call for one focal point to oversee the national health strategy, potentially resulting in efforts by multiple entities within the Ministry of Health, the Ministry of Planning, and other government entities undertaking policy work to claim ownership over national strategies.

76. Some observers found fault with the Global Fund's initial approach to HSS because it focused on the provision of human resources by way of salary payments or supplements, procurement of equipment, and other logistical inputs. These items did not necessarily translate into strengthened health systems, although they may have mitigated common shortages in the fight against the three diseases.

4.40 **Joint Assessment of National Strategies (JANS)**. This is a shared approach to assessing the strengths and weaknesses of national health strategies, developed by an IHP+ interagency group, and endorsed by IHP+ partners in July 2009. The idea is not new. Renewed interest has arisen from the increased number of international health actors in recent years, and renewed efforts to get more partners to support a single national health strategy/plan. JANS is also becoming a principal precursor to funding national health plans under the Health Systems Funding Platform. A joint assessment helps to strengthen national health strategies and increase partner confidence in those strategies, thereby securing more predictable and better aligned funding. It may also reduce transaction costs arising from multiple separate agency assessments. Five countries — Ethiopia, Ghana, Nepal, Uganda, and Vietnam — had completed formal joint assessments of their new national health sector strategies or plans by early 2011. Other countries are also using the JANS tools more informally at different stages of plan development and implementation.

The Bank's Country Programs in the Health Sector

4.41 The Bank has issued two sector strategies for HNP — in 1997 and 2007. The 1997 Strategy was clear about the Bank's role in health, citing its comparative advantage as its ability to work across multiple sectors and to conduct country-specific research and analysis in support of programs to which it could bring significant financing. The Strategy did not view the Bank as having a comparative expertise in communicable disease control, epidemiology, and the like in comparison with WHO, UNAIDS, and UNICEF. The Bank would focus on the broader aspects of health such as systems stewardship and oversight, systems performance, and health financing.

4.42 The Bank had become the largest single source of donor financing for HNP by 1997, with a portfolio of 154 active and 94 completed HNP projects, for a total cumulative value of $13.5 billion. The Strategy identified three priority areas: (a) to improve health outcomes for the poor; (b) to enhance performance of HNP services; and (c) to improve health care financing. It viewed investing in communicable disease control in the context of poverty alleviation, since communicable diseases disproportionately affected the poor, and the poorest 20 percent of the population experienced about 60 percent of all deaths from communicable diseases. Many who fell ill and recovered still had lowered productivity, spent high out-of-pocket costs for treatment, and became impoverished. Thus, while HSS was the Bank's comparative strength, improving health outcomes for the poor also justified support for communicable disease control.

4.43 The 1997 Strategy did not anticipate the amount of lending that the Bank would provide for communicable disease control over the next 10 years. The Bank responded flexibly to the demand for such lending, among other things, with (a) a strategy for intensifying action against HIV/AIDS in Africa in July 1999, (b) the $1 billion Multi-country AIDS Program (MAP) in September 2000, and (c) the Malaria Booster Program in June 2005. (See Appendix M for more details.) In the event, Bank lending for communicable disease control accounted for 36 percent of HNP projects and 32 percent of HNP commitments between 1997 and 2011 inclusive (Table 12). This has provided more opportunities than might otherwise have been available for engaging with the Global Fund at the country level.

Table 12. World Bank Communicable Disease Projects and Commitments, Fiscal Years 1997–2011

	Approved Projects		*Commitments*	
Project Type	Number	Share	US$ millions	Share
Freestanding communicable disease projects	112	74%	6,580	90%
Single disease projects	97	64%	4,989	69%
HIV/AIDS	70	46%	2,735	38%
Tuberculosis	3	2%	374	5%
Malaria	5	3%	547	8%
Avian influenza	7	5%	65	1%
(H1N1) Influenza	5	3%	723	10%
Cholera	1	1%	15	0%
Leprosy	1	1%	32	0%
Polio	4	3%	474	7%
Schistosomiasis	1	1%	25	0%
Multiple disease projects	15	10%	1,591	22%
Projects with a communicable disease component	40	26%	696	10%
Total number of communicable disease projects	152	100%	7,277	100%
Total number of HNP projects	423		22,729	
Share of HNP projects	36%		32%	

Source: For FY1997–2006, Gayle H. Martin, 2010, "Portfolio Review of World Bank Lending for Communicable Disease Control," IEG Working Paper 2010/3. Updated by IEG through FY2011 from World Bank databases.
Note: The full project commitments are included for freestanding communicable disease projects, and only the commitments to the communicable disease component for projects with components. Therefore, these commitments are somewhat larger than those in Table 3 in Chapter 2.

4.44 The 1997 Strategy also did not anticipate the growth of SWAp operations in the Bank's portfolio. Introduced by the World Bank and other donors as a means to overcome inefficiencies, reduce transactions costs to the country, and bring better development results, SWAps embraced the principles of alignment and harmonization that were subsequently endorsed by the Paris Declaration in 2005. Health SWAps represented (a) higher and more committed levels of donor support and coordination to a country's overall development program in the health sector; and (b) a shift in the relationship between donors and governments, with all parties jointly supporting nationally defined health programs through parallel or pooled financing of general budget support, or a combination of the two. The World Bank approved 45 HNP projects supporting health SWAps in 32 countries between 1997 and 2011 — representing about 11 percent of all (423) approved HNP projects during this period.[77] Almost 60 percent (26) of the projects that supported health SWAps were in Sub-Saharan Africa.

77. Denise Vaillancourt, "Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries," IEG Working Paper 2009/4, and Appendix M.

4.45 The Bank's 2007 HNP Strategy acknowledged that the global HNP aid architecture had changed significantly since 1997, with many new players entering the field, such as GAVI, the Global Fund, and several foundations, bringing with them innovative financing mechanisms, mostly earmarked for specific diseases or issues. The Bank was no longer the largest financier of investments in the HNP sector, as it had been 10 years earlier.

4.46 The 2007 Strategy reaffirmed the Bank's comparative advantages in the following areas: (a) its capacity in HSS (including health financing, insurance, demand-side interventions, regulation, and systemic arrangements for fiduciary and financial management); (b) its intersectoral approach to country assistance; (c) its advice to governments on regulatory frameworks for private-public collaboration in the health sector; (d) its capacity for large-scale implementation of projects and programs; (e) its convening capacity and global nature; and (f) its pervasive country focus and presence (World Bank 2007c, pp. 17–18).

4.47 The 2007 Strategy underscored a focus on results: that is, in health outcomes in addition to operational modalities. It reiterated the contribution of multisectoral approaches and interventions to improve health outcomes, such as safe drinking water and household sanitation, among other health infrastructure investments. It did not see a contradiction between Bank support for health systems and support for the control of priority diseases. Bank investments were seen as necessary to ensure synergies between health system and single-disease approaches, especially in low-income countries where fighting communicable diseases was still a priority. The Strategy also recognized the growing need to support interventions against non-communicable diseases.

4.48 The 2007 Strategy found that the HNP partnership portfolio had become fragmented with a multiplicity of GRPPs and needed "stronger strategic direction." The Strategy stated that the HNP sector would practice greater selectivity when deciding to participate in partnership programs: (a) to complement Bank work in areas in which it has no comparative advantages or to complement other partners needing Bank expertise, all in direct benefit of client countries; and (b) to contribute to the international community's support for global public goods and prevention of global public "bads." The Strategy also proposed the establishment of a Global Health Coordination and Partnership Team in the HNP Department to coordinate partnerships, and to facilitate selective fund-raising and trust fund management, DGF management support, selective joint ventures around comparative advantages, and harmonization. This team has not been established, but a position of Partnerships Adviser has been created in the HNP Department.

4.49 In summary, Box 6 highlights key recommendations and World Bank commitments relating to country-level engagement with the Global Fund since 2006. The 2007 Strategy repeatedly stated that the World Bank would strengthen its engagement with the Global Fund, particularly in low-income countries. However, it did not articulate how this engagement would take place, except that it would reach "specific agreements with WHO and the Global Fund on a collaborative division of labor at the country level (next 12 months)."

Box 6. Key Recommendations and World Bank Commitments Relating to Engagement with the Global Fund

"Global Fund–World Bank HIV/AIDS Programs: Comparative Advantage Study" (Shakow, January 2006)

- Both institutions should make stronger efforts to adhere to the "Three Ones" principles.
- The strategic and programmatic focus of the World Bank should emphasize to a much greater extent and with enhanced clarity that its main comparative advantage lies in systemic health sector capacity building.

Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results (World Bank, April 2007)

- The Bank has played a crucial role in advocacy, awareness, and development of new international initiatives and organizations such as the Global Fund and GAVI. The Bank will reach "specific agreements with WHO and the Global Fund on a collaborative division of labor at the country level (next 12 months)."

Management Response to *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of World Bank Group Support since 1997* (IEG, January 2009)

- The World Bank Group uses a range of engagement instruments, such as . . . working through international networks and partnerships, such as the GAVI, the Global Fund, and the European Union Observatory. Working with partners through pooled funding, country systems and joint strategies and supervision (as opposed to ring-fenced Bank operations) is also anchored in international commitments and agreements such as the Paris and Accra Declarations. The success of UNAIDS, the Global Fund, GAVI, Roll Back Malaria, EU Observatory and other major international partnerships is also the shared success of the Bank Group's HNP work, as we exercise substantial technical and financial influence in these networks and partnerships.

***More Money for Health, and More Health for the Money* (Taskforce on Innovative International Financing for Health Systems, September 2009)**

- Make the allocation of existing and additional funds in countries more efficient, by filling gaps in costed and agreed national health strategies.
- The Taskforce requests OECD/DAC with partners should undertake a review of all current technical assistance, with a view to focusing it on strengthening national and local institutional capacity in priority areas such as public administration and accountability, financing, service delivery arrangements and the non-state sectors.
- Establish a health systems funding platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies.

The Extent and Nature of Bank's Engagement with the Global Fund at the Country Level

4.50 There is no systematic record of the Bank's engagement with the Global Fund at the country level. Therefore, IEG has pieced together this record from Bank databases, word searches

and reviews of World Bank Country Assistance Strategies and Project Appraisal Documents, key informant interviews, and the electronic survey of health sector project managers at the World Bank and Global Fund staff in Geneva, administered in March 2011 (Appendix Q).[78]

4.51 The findings of the survey are indicative rather than determinative. They are more representative of the experience in Africa, East Asia, and South Asia, where survey coverage was better than for other Bank Regions. About one-quarter of the survey respondents from both the World Bank and the Global Fund indicated that they viewed the relationship between the two organizations in the countries in which they were working as "unrelated and independent" (Figure 9). About three-quarters indicated some degree of engagement, ranging

Figure 9. Overall, how would you best characterize the relationship between the World Bank and the Global Fund during the years that you were working on this country?

Collaborative: The two organizations' staff, consul-tants and agents worked together on common activ-ities in the pursuit of commonly agreed objectives.

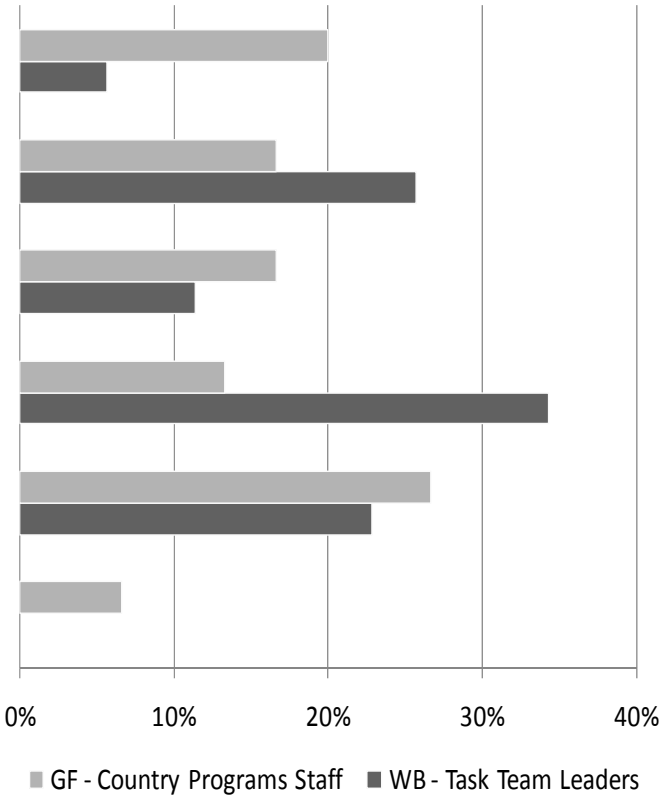
Complementary: The two organizations' staff, consultants, and agents worked alongside each other in the pursuit of common objectives.

Consultative: The two organizations' staff, consultants, and agents consulted each other regularly in the course of their own activities.

Sharing information only: The two organizations' staff, consultants, and agents only shared information about each other's activities.

Unrelated and independent: The two organizations worked independently of each other supporting different health initiatives in the country.

Competitive: The two organizations competed for business among the same potential clients.



Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.
Note: Each respondent was limited to only one choice; therefore, the responses from each organization add up to 100 percent. The survey response rates were 62 percent (36 out of 58) for Global Fund Country Programs staff and 33 percent (42 of 128) for World Bank task team leaders (project managers).

78. The 42 project managers who responded to the survey covered 37 separate countries (since five countries had two responses), which represented 47 percent of World Bank HNP commitments during FY03–11 inclusive, and 54 percent of disbursements during the same period. The 36 responses from the Global Fund Country Programs Cluster covered 42 countries (since some staff covered more than one country), which represented 48 percent of Global Fund commitments during FY03–10 inclusive, and 47 percent of Global Fund disbursements during the same period. Overall, the responses from the 42 project managers and from the 36 Country Programs staff covered 64 different countries.

from “information sharing only” to “collaborative.” Global Fund staff tended to view the relationship as more collaborative and consultative, and World Bank project managers as more complementary and sharing of information. If one were to extrapolate these findings to the 90 countries in which both the Bank and the Global Fund have been active in the health sector since 2002, this would translate into some degree of engagement in about 65 countries overall, of which 25–30 have been in Africa, the Region most seriously affected by the three diseases.

4.52 This extent of engagement is consistent with the number of countries (63) in which the Bank’s Country Assistance Strategies and Project Appraisal Documents over fiscal years 2003–10 inclusive make reference to the Global Fund (Table 13), not including additional countries involved in regional projects in Africa, Central Asia, and Latin America. By way of comparison, this represents about 60 percent more than such references to the Education For All–Fast Track Initiative, a global partnership program started in the same year as the Global Fund (2002) that is also financing investments at the country level, but which has been located in the World Bank and for which the World Bank is an implementing agency.

4.53 The variation in the degree of engagement from “independent and unrelated” to “collaborative” is also consistent with the findings from the seven countries that IEG visited in 2010 for this Review, including an IEG visit to Lesotho to prepare a Project Performance Assessment Report of two health projects. IEG found that the two organizations worked independently of each other in supporting different health initiatives in two countries (Brazil and Nepal), that they collaborated on disease-control projects in three countries (Cambodia, Lesotho, and the Russian Federation), and that they cooperated to a lesser extent into two countries (Burkina Faso and Tanzania).

Table 13. References to the Global Fund and the Fast Track Initiative in Country Assistance Strategies and Project Appraisal Documents, Fiscal Years 2003–10

	Sub-Saharan Africa	East and the Pacific	Europe and Central Asia	Latin America and the Caribbean	Middle East and North Africa	South Asia	Total
Global Fund							
Country Assistance Strategies	23	2	13	6	–	1	45
Project Appraisal Documents	62	8	11	14	–	6	101
Number of Different Countries [a]	31	6	13	8	–	5	63
Education for All – Fast Track Initiative [b]							
Country Assistance Strategies	18	2	7	3	2	–	32
Project Appraisal Documents	18	3	3	6	4	4	38
Number of Different Countries	22	4	5	3	2	4	40

Source: IEG data

a. These do not include the countries involved in six regional projects in Africa, one regional project in Central Asia, and two regional projects in Latin America (in the Andes and Central America).

b. The Fast Track Initiative changed its name to the Global Partnership for Education in 2011.

INDEPENDENT AND UNRELATED ACTIVITIES: BRAZIL AND NEPAL

4.54 The World Bank has been active in the health sector in **Brazil** since 1976, and has supported the government's fight against HIV/AIDS with five projects since 1988 (approved in 1988, 1993, 1998, 2003, and 2010), as well as one malaria project in the Amazon basin (approved in 1989). The Global Fund has approved two grants for tuberculosis (in 2007) and two for malaria (in 2009). Thus, the two organizations have been supporting different disease-control efforts in recent years. While the CCM has submitted grant proposals for HIV/AIDS prepared by the Bank's counterpart in the Ministry of Health (the HIV/AIDS Department), the Global Fund's Technical Review Panel has not yet recommended funding any of these. Neither the government nor the CCM has requested support from the World Bank in relation to Global Fund-supported activities in Brazil, but this could change if an HIV/AIDS proposal were successful. The Bank has not been a member of the CCM, because the Brazil CCM is dominated by government and CSOs, with very little representation from any multilateral or bilateral development partners in the country.

4.55 The World Bank has been active in the health sector in **Nepal** since 1994. It approved a first Health Sector Program project (a SWAp) in 2004 in which IDA, DFID, and later the Australian Agency for International Development pooled their financial support for the Government's health program. The project contained a component to strengthen health service delivery, which included a subcomponent on communicable disease control (HIV/AIDS, tuberculosis, malaria and leprosy). However, this did not result in any significant engagement with the Global Fund-supported activities in the country that were being implemented under the oversight of the CCM.

4.56 As the first Health Sector Program project was closing, the Bank started to identify a specific HIV/AIDS project in 2009, which would have been the first single-disease Bank-supported project in the country. Subsequently, the Bank and the Government of Nepal decided not to pursue this, opting instead for a second HNP and HIV/AIDS project, which was approved in 2010. This second SWAp operation, as its name implies, includes a significant AIDS component in addition to a range of HNP activities. So the Bank is now more significantly involved in one of the three Global Fund diseases, thereby opening the door for greater collaboration with the Global Fund in the future.

4.57 Nepal is currently a pilot country for both JANS and the Health Systems Funding Platform. A joint assessment of the national health strategy was carried out in January 2010, and a Joint Financing Agreement supporting the National Health Support Program, 2011–15, was signed by the government and the major donors in August 2010 (DFID, GAVI, UNFPA, UNICEF, USAID, and the World Bank). Funding for NGOs that cater to most at-risk groups is now transitioning from DFID/UNDP funding to pooled funding, managed by the World Bank. While the Global Fund is not a party to this pooling arrangement, it has become the exclusive supplier of ARVs and related health products into Nepal (except for USAID's providing PMTCT drugs on a small scale for its own projects). The Global Fund is also supporting NGOs and Principal Recipients that are delivering prevention, treatment, and care to people living with AIDS and to people in high-risk groups.

COLLABORATIVE ENGAGEMENT: CAMBODIA, LESOTHO, AND THE RUSSIAN FEDERATION

4.58 The World Bank has supported three health projects in **Cambodia**. The first (approved in 1997) had one component for combating HIV/AIDS, tuberculosis, and malaria ($13 million) and a second component for strengthening health systems ($18 million). The second and third projects (approved in 2004 and 2008) have supported the operationalization of the government's Health Strategy Plans I and II, respectively. Although these projects have not been specific to the Global Fund diseases, the Bank has developed a collaborative relationship with the Global Fund in Cambodia as a member of the CCM from inception in 2002 until it was restructured in 2010. The Bank has contributed to improving the quality of grant proposals and served on the Cambodian technical review panel on occasion. The Bank's analytical work on the role of health in the country's overall development has helped to anchor health issues in policy dialogue at the macroeconomic level, and to facilitate access of the FPM to key government officials in the Ministry of Finance.

4.59 Although the Global Fund does not generally pool funds, the FPM has been participating in joint annual performance reviews and annual operating plans of the Health Sector Support Program. The Global Fund has also endeavored to align its work in Cambodia with other donors under the IHP+. A first joint country mission (including GAVI, the Global Fund, WHO, and the World Bank) took place in early June 2010. As a result of these discussions, all three funding agencies agreed to align their performance indicators with those of the government, and work with the Department of Planning and Health Information in the Ministry of Health to strengthen the M&E system.

4.60 The Bank has also been pursuing reforms in financial management and administration for the overall Cambodian civil service, including a merit-based performance initiative (MBPI).[79] This would have aligned the different ad hoc payment practices of donors and developed a performance culture within the civil service. As a result of these initiatives, and the subsequent emergence of the Priority Operating Costs scheme,[80] the FPM also interacted frequently with Bank's Country Manger and project managers in public and financial administration. World Bank-Global Fund collaboration in Cambodia led to the Global Fund's agreement to significantly reduce its salary top-ups in alignment with these schemes.

4.61 The World Bank has been active in the health sector in **Lesotho** since 1985. The Bank approved a Health Sector Reform Project with an HIV/AIDS component (for $2 million) in June 2000, and started to work with the authorities to prepare a follow-on MAP project in 2003. In the interim, the Lesotho CCM submitted a successful Round 2 proposal to the Global Fund in 2002 for $34 million ($29 million for HIV/AIDS and $5

79. Donors have been paying incentive money to civil servants because the average wage is below the subsistence level ($100 /month). Global Fund grants had allowed very high salary top-ups for some senior posts. The MBPI initiative attempted to align the different ad hoc payment practices of donors, and to apply only to mission-critical categories of staff. The MBPI would only be paid if performance standards were met, and was therefore intended to inculcate a performance culture.

80. The government replaced MBPI with a new incentive scheme, the Priority Operating Costs (POC), which are applied to public functions that are considered critical, and which are donor-financed only. The POC is not performance-based, but will harmonize rates across ministries and categories of staff.

million for tuberculosis). The Principal Recipient was the Ministry of Finance and Development Planning, and the two Sub-Recipients were the Ministry of Health and Social Welfare and the Lesotho AIDS Program Coordinating Authority.

4.62 Given the size of the Global Fund grant, the Bank's long-standing concerns about the country's existing implementation capacity, and the emerging risk that the Global Fund might cancel the grant after two years due to implementation problems, the Bank changed course. Bank and government personnel quickly prepared an HIV and AIDS Capacity Building and Technical Assistance project with the specific objective of increasing Lesotho's capacity "to use effectively the resources provided through the Global Fund grant." This resulted in a close collaboration between the Global Fund and the World Bank during the implementation of the Global Fund grant and the World Bank project, in which the Bank's project manager was essentially supervising both projects through completion. This collaboration has continued with the approval of a follow-on Bank-financed HIV and AIDS Technical Assistance Project approved in August 2009.

4.63 IEG has rated the outcome of the Bank-supported HIV and AIDS Capacity Building and Technical Assistance project as ***moderately satisfactory*** in terms of increasing Lesotho's capacity to effectively use Global Fund resources, based on an in-depth review of the project.[81] The project greatly improved the capacities of the Ministries of Health and Finance and the National AIDS Commission to manage and disburse Global Fund resources, and of the National Drug Supply Organization to procure and distribute drugs, thereby promising to improve the efficacy of treatment programs. However, few project resources were used to strengthen the technical capacity of CSOs to provide interventions, beyond the largest umbrella NGOs. Key positions in the Ministry of Health and Social Work for improving the technical capacity and effective use of funds were not filled due to high staff turnover. The vacant staff positions, particularly in the behavior change communications unit, hindered the formulation and implementation of an effective HIV prevention campaign. In the absence of the Bank's intervention, the Global Fund's Round 2 grant would likely have been cancelled. The Bank-supported project has also increased Lesotho's capacity to mobilize additional resources for the national HIV/AIDS program, as exemplified by additional Global Fund grants (in Rounds 5, 6, 7, and 8), but its capacity to use these funds effectively to prevent HIV and mitigate its impact remains weak.

4.64 The World Bank has been active in the health sector in the **Russian Federation** since 1996. Following a request from the government in early 1999, the Bank initiated work on the development of a tuberculosis project with the Ministry of Health and the Ministry of the Interior, to which HIV/AIDS was later added. Finally approved in April 2003, the Bank provided an IBRD loan of $150 million toward the total project cost of $286 million. Around the same time, a consortium of five NGOs already active in the Russian Federation and led by the Open Health Institute submitted two Round 3 proposals to the Global Fund for HIV/AIDS and tuberculosis that were approved. Both the World Bank project and the Global Fund grants were implemented by the same agency, the Russian Health Care Foundation. By agreement among all parties, the two projects settled on an effective division of labor. The

81. IEG 2010, Project Performance Assessment Report: Lesotho Health Sector Reform Project and HIV and AIDS Capacity Building and Technical Assistance Project, Report No. 55417.

Bank project became responsible for the support of physical facilities, including laboratories, second-line tuberculosis drugs, and professional training. The Global Fund grants financed activities not financed under the Bank project, including second-line tuberculosis drugs and ARVs, together with, to a small extent, support for some equipment. The investment in laboratory infrastructure for HIV and other sexually transmitted diseases throughout the Russian Federation contributed to treatment with ARVs funded by the Global Fund and the Russian Federation national program. The World Bank project manager and the Global Fund Portfolio Manager developed a close collaboration, and the Bank had a seat on the CCM during the life of the projects.

4.65 IEG has rated the outcome of the Bank-supported Tuberculosis and AIDS Control project as ***satisfactory***, but the risks to sustaining the benefits achieved by the project as ***significant***. The project substantially achieved all four of its development objectives, but political, financial, and institutional risks remain high as the Russian Federation transitions away from international support for HIV/AIDS and tuberculosis programs. It is unclear that there is government commitment to addressing high-risk groups or to applying international best practices on harm reduction.

INTERMEDIATE DEGREES OF ENGAGEMENT: BURKINA FASO AND TANZANIA

4.66 The World Bank has been active in the health sector in **Burkina Faso** since 1985. The Bank approved a first-generation MAP project in July 2001 and a second MAP component in a health sector support project in April 2006. A Regional HIV/AIDS Treatment Acceleration Project was also implemented in 2003–08 in Burkina Faso, Ghana, and Mozambique to test different approaches for scaling up existing treatment initiatives. This was the first project to finance ARV therapy in Burkina Faso. Its success helped to secure the large-scale Global Fund support for ARV therapy that came later by giving the Global Fund the confidence to support this endeavor. As the Global Fund has expanded its support to Burkina Faso — it was financing all ARV therapy in the country at the time of IEG's visit — the Bank has moved toward providing complementary support to the Burkinabe health sector, mainly in the form of HSS. The respective roles of the two organizations have been self-selected, and not the result of an explicit agreement or understanding between the two organizations. As a member of the CCM, the Bank has provided technical assistance during the preparation of grant proposals in the form of staff time and the hiring of consultants. The Bank's project manager has been more active in the CCM when resident in the country.

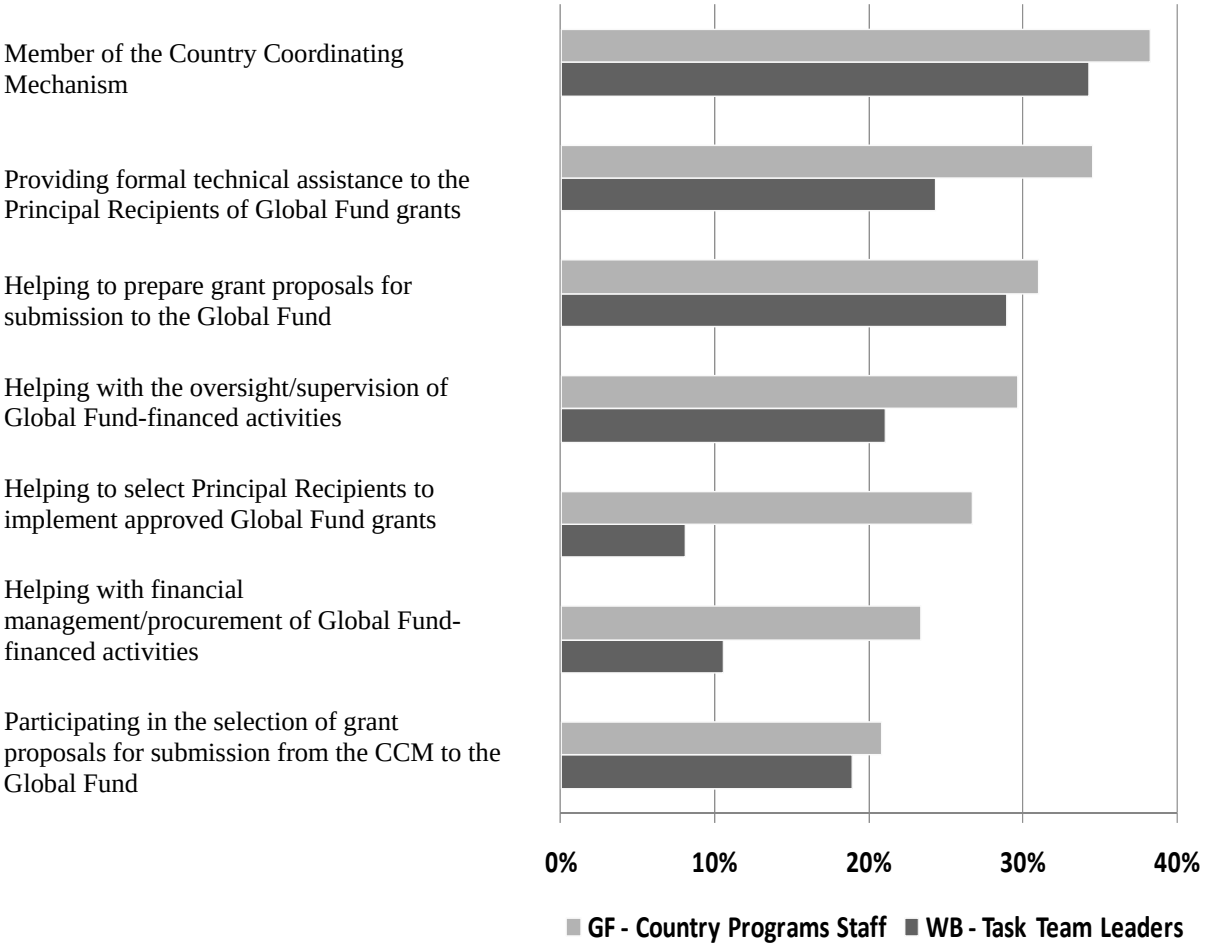
4.67 The World Bank has been active in the health sector in **Tanzania** since 1990 and approved a MAP operation in 2003. This project helped to institutionalize the National AIDS Commission, which hosts the CCM Secretariat, and to build up the capacity of the Tanzanian CCM. As the volume of Global Fund grants for all three diseases grew and the Tanzanian CCM and National AIDS Commission Secretariat took hold, the Bank became less engaged with Global Fund-supported activities. The Bank's attendance at the CCM meetings became less frequent. Subsequent Bank operations (notably the Second Health Sector Development Scale-Up, approved 2007) deliberately addressed areas not covered by Global Fund grants. The Bank is well informed on both health systems and communicable diseases in Tanzania through its small team of health specialists in the country, supported by HNP specialists in Washington. However, the Bank has essentially drifted away from Global Fund-supported

activities; its remaining involvement has taken the form of active participation in the health sector and HIV/AIDS donor groups. What started as active collaboration with Global Fund-supported activities evolved into consultation and information-sharing in relation to what are now essentially independent activities.

BROADER PATTERNS BEYOND THE SEVEN COUNTRIES VISITED

4.68 Interviews with Bank staff and a focus group discussion with project managers to discuss IEG's survey results indicated that World Bank-Global Fund engagement has generally started with a formal or informal request from the government of the country. The government — as the chair or an influential member of the CCM — has often requested the Bank's technical support for preparing grant proposals to the Global Fund. This was particularly the case during the earlier Global Fund rounds and for HIV/AIDS proposals in countries in which the Bank was supporting a MAP project. Recognizing that the Bank's

Figure 10. In which of the following country-level processes of the Global Fund did World Bank staff or consultants participate during the years that you were working on this country? (Percent "Yes")



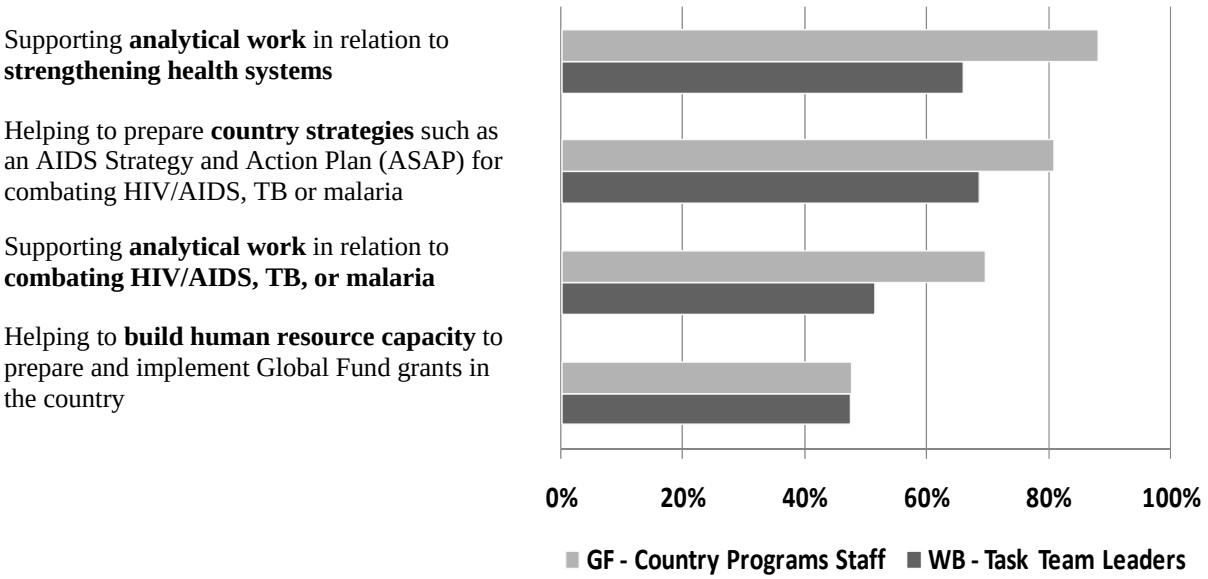
Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.

overarching mission is to contribute to the development of its client countries and their institutions, Bank staff have generally responded positively to the extent of their available time and resources. Bank staff have also become involved in Global Fund-supported activities through their participation in health sector donor coordination processes in the country, through participation in joint World Bank-Global Fund workshops, and through the direct request of Global Fund Regional Team Leaders and FPMs. World Bank Sector Managers have also encouraged engagement in some cases.

4.69 Bank staff and consultants have not generally been involved in specific Global Fund processes at the country level (Figure 10). They have been members of the CCM in at most one-third of the 64 countries in which survey respondents worked, helped to prepare grant proposals in 30 percent, and provided formal technical assistance to the Principal Recipients in 25–30 percent of countries (60 percent of which have been government agencies).[82]

4.70 Bank staff and consultants have more frequently contributed to other country-level activities, such as strategic and analytical work, that directly or indirectly contributed to the work of the Global Fund (Figure 11). Contacts between World Bank and Global Fund staff have occurred primarily at the country level. World Bank project managers have had their most regular contacts with the Principal Recipients of Global Fund grants and with the CCMs, and more occasional contact with FPMs and Regional Team Leaders based in Geneva (Appendix Q).

Figure 11. In what other ways were World Bank staff or consultants involved in country-level activities that directly or indirectly contributed to the work of the Global Fund during the years that you were working on this country? (Percent "Yes")

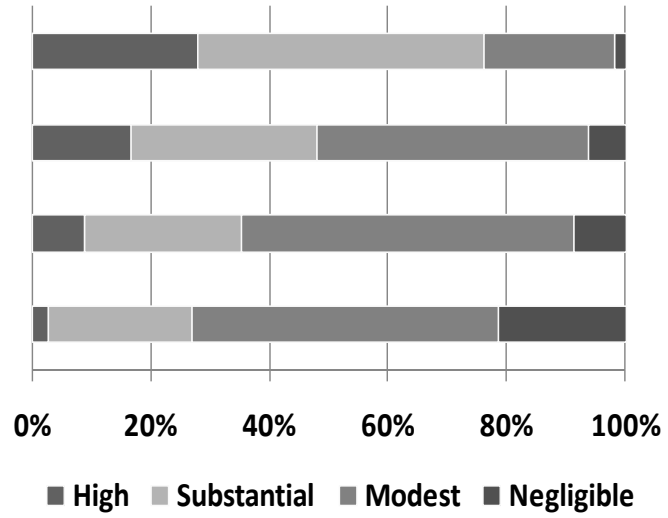


Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.

82. The World Bank is currently (October 2011) serving on 16 CCMs — in 8 countries in Africa, 5 countries in Europe and Central Asia, and 3 countries in South Asia.

4.71 Uniformly, in response to every question in Figures 10 and 11, Global Fund respondents felt that World Bank staff and consultants participated more in Global Fund processes and contributed more to the work of the Global Fund than Bank project managers felt. Global Fund staff also viewed the World Bank as a Global Fund partner to a much greater extent, at both the global and the country levels: 76 percent of Global Fund staff viewed the Bank as a high or substantial Global Fund partner at the global level, and 46 percent at the country level, compared with 31 percent and 26 percent, respectively, of World Bank project managers (Figure 12).

Figure 12. To what extent do you consider the World Bank to be a partner of the Global Fund (a) at the global level and (b) at the country level?



Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.
Note: The survey response rates were 49 percent (52 out of 106) for Global Fund staff and 33 percent (42 of 128) for World Bank project managers (task team leaders).

4.72 World Bank project managers in the focus group suggested two reasons for this pattern. First, participating in Global Fund processes and contributing to the work of the Global Fund generally represents a small part of a project manager's work; his or her primary relationship is with the government and the implementing agency of the Bank project. Second, project managers may be less aware of the contributions that the Bank has made to the work of the Global Fund in the country if these contributions have been mediated by third parties such as the government.

4.73 The relationship between the Bank and the Global Fund has also been dynamic in many countries, such as Burkina Faso and Tanzania, due to number of factors such as a change in the Bank's work program or a change of staff on either side. Whether survey respondents characterized their engagement with the other organization as collaboration, consultation, or information sharing only, successful engagement has had similar characteristics. The engagement often takes place in a broader setting or context where there are other interested partners and stakeholders involved as well. Key factors contributing to positive engagement have been a proactive government and a strong donor coordination mechanism at the country level. The personal commitment of the World Bank's project managers and Global Fund's Portfolio Managers have also played a role in sustaining successful cooperation, as in Lesotho

during the implementation of the HIV and AIDS Capacity Building and Technical Assistance Project from 2004 to 2008, and in the Russian Federation during the implementation of the Tuberculosis and AIDS Control Project from 2003 to 2009.

4.74 Based on interviews, the survey results, and document reviews, World Bank staff and consultants appear to have been most engaged with Global Fund processes at the grant preparation stage rather than at the grant implementation stage, as the following examples illustrate. The two organizations have been least engaged at the strategic level, apparently because Global Fund staff and agents have been less involved with the government in formulating health sector strategies.

4.75 **Grant Preparation Stage**. The engagement of the World Bank with Global Fund-supported activities has often taken place through Bank staff assisting in the preparation of the Global Fund grants; establishing joint funding arrangements at the country level (as in Benin, Ethiopia, and Honduras); and working with the same Project Implementation Units (as in Djibouti and Uganda).

- In **Benin**, the Bank has been represented in the CCM, which has facilitated regular sharing of information and avoided duplication of activities. The two organizations' HIV/AIDS and malaria projects have complemented each other by supporting different activities in different areas and during different time periods. More recently, GAVI, the Global Fund, and the World Bank have established a joint funding platform for HSS.

- In **Djibouti** (as in the Russian Federation), the Global Fund selected the implementing agency of the World Bank's HIV/AIDS project to be the recipient of the Global Fund grants, due to the existing capacity of the agency. This created the opportunity for harmonization of procurement procedures.

- In **Ethiopia**, the Global Fund has built upon the achievements of two Bank-supported MAP projects (approved in 2000 and 2007) in the areas of HIV/AIDS and HSS. More recently, the Bank and the Global Fund are coordinating their support through the establishment of a joint funding platform for HSS.

- In **Uganda** (as in Lesotho), the Bank decided not to proceed with a second MAP project after the first one closed in 2006 because the country was receiving large grants from the Global Fund. The Bank collaborated closely with the Global Fund on its exit strategy. Together, World Bank and Global Fund staff supported a review of the complementarity and sustainability of HIV interventions to ensure that the Global Fund would continue to fund some project components after the Bank project closed. That the same Principal Recipient was implementing both the Bank project and the Global Fund grant facilitated this collaboration.

- In **India**, complementary activities supported by the organizations have helped to build NGO capacity in the country. The Bank helped to build the managerial and fiduciary capacity of a local NGO network, which enabled them to qualify as the Sub-Recipient of a Global Fund grant.

- In **Central Asia,** the Bank-supported Central Asia AIDS Control regional project

(approved in 2005) has helped the Central Asian countries to prepare Global Fund grant proposals at the request of the countries' CCMs.

- In **Central America**, the Bank-supported Central American Integration System for the Regional HIV/AIDS project (approved in 2005) provided the avenue for cooperation. This project aimed at supporting key HIV/AIDS activities that were best addressed regionally and not covered by Global Fund grants, such as regional efforts to develop a regional HIV/AIDS laboratory, to support coordinated surveillance, to systematically share best practices in prevention, and to help prevent HIV in mobile populations. The regional project helped the regional Central American CCM to prepare Global Fund grant proposals, provided technical assistance to CSOs to become eligible as Principal Recipients or Sub-Recipients, and helped design a comprehensive HIV/AIDS program in Honduras to be financed by the Global Fund. However, the Bank and the Global Fund were not able to reach an agreement to ensure the sustainability of the Regional Laboratory by means of an endowment fund to finance the laboratory.

4.76 **Grant Implementation Stage**. World Bank engagement with the implementation of Global Fund grants has often taken place through joint monitoring missions to supervise the projects and harmonize approaches on the ground (as in Bangladesh, Benin, Malawi, and the Maldives). In other cases, the World Bank has provided technical assistance to Principal Recipients of the Global Fund to build local capacity for implementing Global Fund grants.

- In **Côte d'Ivoire,** the Bank is an observer on the CCM and there has been little communication between the two organizations. However, the ministry in charge of HIV/AIDS requested that a Bank-financed project provide continuing support for NGOs that had previously been supported by a Global Fund grant.

- In **Guinea-Bissau**, the Bank has been sharing information at the end of each mission. A World Bank assessment of the National AIDS Secretariat (NAS) in 2008 served as the basis for the government and the Global Fund to restructure the Secretariat, resulting in a leaner and more operational institution, able to implement the Global Fund grant in a satisfactory manner.

- In **Bangladesh**, neither the Bank nor any other donor is a member of the CCM and the Global Fund is not contributing to the Health SWAp. Nonetheless, joint monitoring missions have made efforts to coordinate approaches and to avoid duplicating interventions to reach high-risk groups for AIDS. The Bank and the Global Fund have also carried out a joint review of the portfolio of HIV projects in collaboration with other partners, focusing on government performance and aiming at shared learning.

- In **St. Vincent and the Grenadines**, the government has played a critical role in achieving complementarity and avoiding duplication between Bank and Global Fund-supported activities. The Global Fund grant has provided resources to finance drugs, and the World Bank project has provided other complementary inputs and activities.

4.77 **Strategic Stage**. World Bank-Global Fund engagement at the strategic stage has often taken place around the ASAP, JANS, or other national frameworks.

- In **Burundi**, the Bank was involved in the preparation of the National HIV/AIDS strategy with support from ASAP, and in the design of the national HIV/AIDS M&E system with support from GAMET. There has been a constant policy dialogue since 2005 on how best to use HIV/AIDS resources and on how to set up a steering body for ARV procurement and monitoring. The Bank and the Global Fund have also carried out joint missions. The Bank has provided comments on Project Update and Disbursement Requests. The Bank agreed that funds from the second MAP project (approved 2008) could be used to cover some of the financing gap in HIV/AIDS.

- In the **Maldives,** the Bank collaborated with the CCM, the Principal Recipient (National AIDS Program), UNAIDS, and the United Nations Office on Drugs and Crime in conducting a comprehensive review of the National Strategy Paper (2009). The Bank also helped with the first mapping of high risk groups in HIV — "The Research Proposal on Mapping High Risk Groups for HIV Prevention in the Maldives" — in close collaboration with the University of Manitoba.

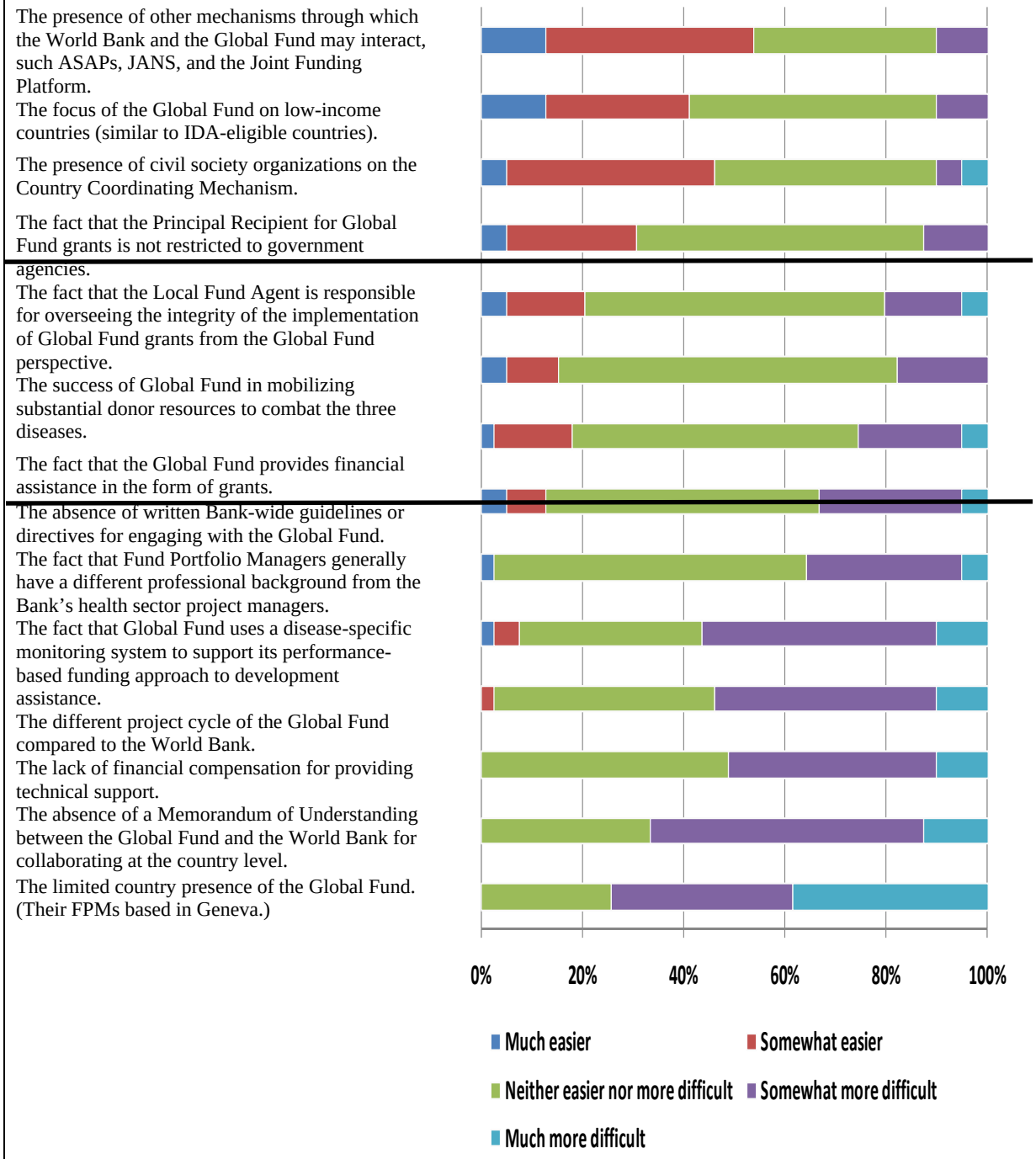
- In **Guyana**, both the Bank and the Global Fund supported the preparation of the new National HIV/AIDS Strategic Plan (2007–11), the implementation of which has been supported by the IDA-financed Guyana AIDS Prevention and Control Project, the Global Fund, the Canadian International Development Agency, PEPFAR, and other bilateral and UN agencies. At the request of the Ministry of Health, the Global Fund is continuing to fund some of the activities previously supported by the World Bank project. Acting flexibly, the Global Fund agreed that some of its support could be reprogrammed to continue funding NGOs previously supported by the World Bank project.

Factors Facilitating and Hindering Effective Engagement

4.78 The World Bank follows a different business model from the Global Fund (Appendix M). The similarities and the differences provide both opportunities and hindrances to effective country-level engagement in support of their clients.

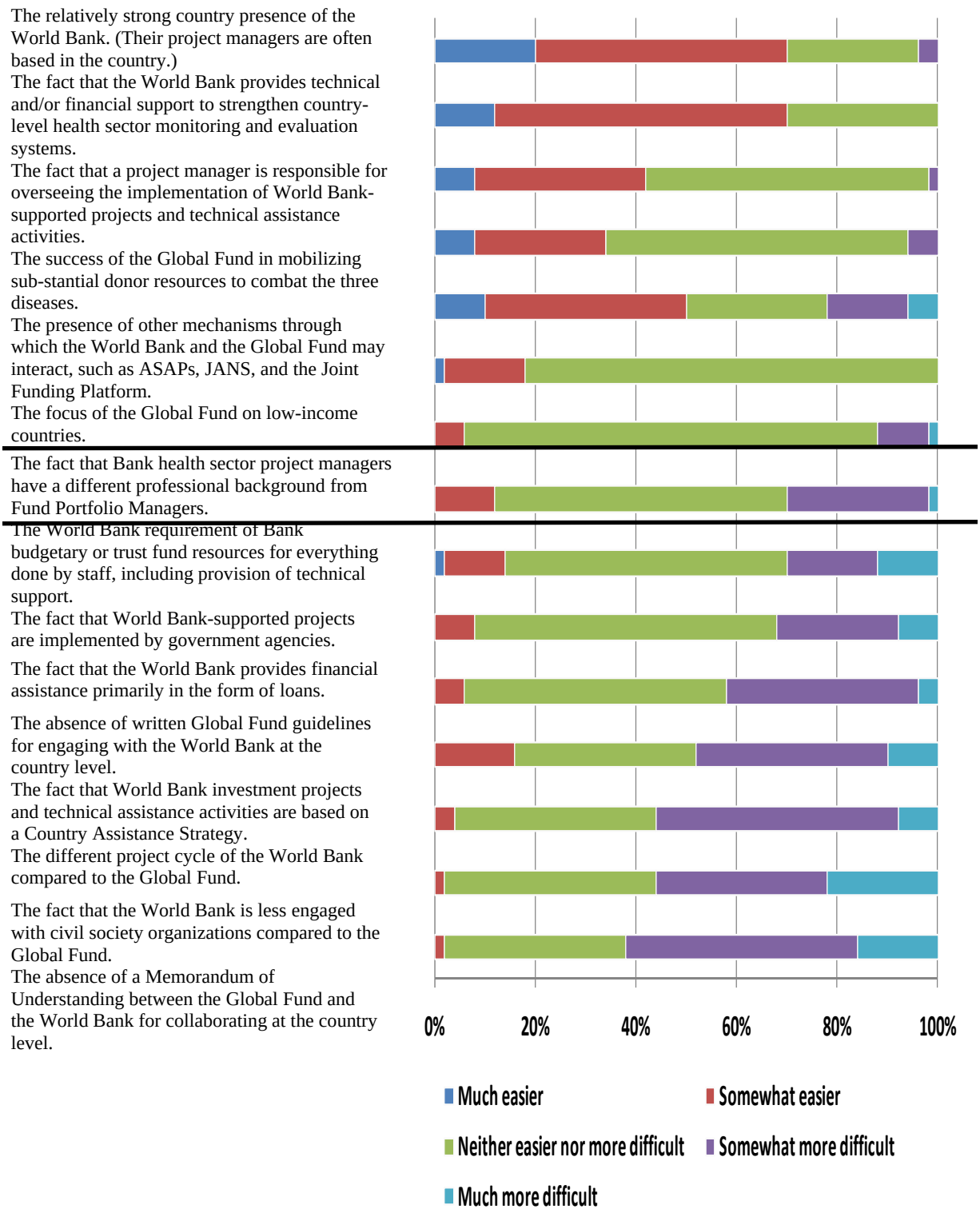
4.79 The Bank's operational involvement in each country is based on periodic Country Assistance Strategies (CASs), negotiated between the Bank and the government. Each sector has to compete for its place in the CAS in accordance with the agreements reached on the priority sectors for Bank support to the country. The CAS lays out a set of activities that the Bank will support over the next 3–4 years, comprising both analytical and advisory work and lending operations. Lending operations are almost always implemented by a government department or agency, although governments may enlist NGOs and CSOs to help implement the project — and generally do so in the case of HIV/AIDS projects. Each lending product has a project manager who is responsible for preparing the project from the point of view of the Bank, and for supervising the subsequent implementation of the project with the support of his/her task team. The majority of Bank project managers are now based in the field, particularly in East Asia and South Asia (Appendix Table M-1). Where the project manager is not based in the country, project supervision involves multiple missions over the 5–7 year life of a project, with the assistance of a range of specialized consultants.

Figure 13. World Bank Project Managers: In your opinion, do the following factors make it easier or more difficult for World Bank staff or consultants to engage with Global Fund-supported activities at the country level?



Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.

Figure 14. Global Fund: In your opinion, do the following factors make it easier or more difficult for Global Fund managers, staff or agents to engage with the World Bank at the country level?



Source: IEG Survey of World Bank HNP Project Managers and Global Fund Secretariat staff, administered in March 2011.

4.80 IEG's interviews with World Bank and Global Fund staff identified more than a dozen key factors that made it either easier or more difficult for the two organizations to engage effectively at the country level. Then IEG asked survey respondents' views in relation to each these factors, as presented in Figures 13 and 14, for World Bank and Global Fund respondents, respectively. The results are presented in descending order in both figures from those factors that make it easier at the top, to those which make it more difficult at the bottom. Horizontal lines have been inserted in the figures to distinguish the factors that make engagement easier, from those that are neutral, and from those that make engagement more difficult, in the overall view of the survey respondents.

4.81 Both Global Fund staff and Bank project managers generally have a positive view of other mechanisms through which the two organizations may interact, such as ASAPs, the JANS, and the Health Systems Funding Platform. They also have a positive view of the focus of the Global Fund on low-income countries. Global Fund staff view positively the fact that a project manager is responsible for overseeing the implementation of World Bank-supported projects and technical assistance activities.

4.82 Global Fund staff generally appreciate the relatively strong country presence of the World Bank, while Bank project managers find the limited country presence of the Global Fund to be problematic. Global Fund staff appreciate the Bank's support for strengthening country-level health sector M&E systems, while Bank project managers find the Global Fund's disease-specific monitoring system that supports its PBF funding approach to be problematic.

4.83 Bank project managers appreciate the presence of CSOs on the CCMs and the fact that Principal Recipients of Global Fund grants are not restricted to government agencies. Global Fund staff found it problematic that the World Bank is less engaged with CSOs and that World Bank-supported projects are generally only implemented by government agencies. Bank project managers who participated in the focus group asserted that the Bank has been more engaged with CSOs, particularly in HIV/AIDS projects, than may be readily apparent. As the Bank's MAP projects have wound down, the CSOs engaged in MAP operations have appreciated the continuing opportunity to be involved in disease-control efforts through participation in the CCM and as Sub-Recipients.

4.84 Yet both Global Fund staff and Bank project managers also view engagement as difficult in some respects. Bank project managers regard the lack of financial compensation for providing technical support to be an unfunded mandate. Global Fund staff regard as problematic that World Bank funding for the health sector, and associated budget support for project supervision, has to compete with other sectors for its place in the Bank's CAS and associated work program. Both regard their own organizations as more flexible in responding to country needs and priorities, based on interviews. But the survey results suggest that some other factors raised in interviews are not significant impediments to collaboration: the different professional backgrounds of project managers and FPMs, the different types of financial support (loans versus grants), the success of the Global Fund is mobilizing donor resources to combat the three diseases, and the role of the LFA in fiduciary oversight of Global Fund grants.

4.85 Neither World Bank project managers nor Global Fund Portfolio Managers are satisfied with "business as usual." Both groups viewed the absence of an MOU on country-level collaboration between the two organizations as a significant impediment to collaborating at the country level — the most significant factor for Global Fund staff and the second-most significant factor for Bank project managers. Both found the absence of guidelines within their own organizations for engaging with the other organization to be problematic.

Prospects for Future Engagement at the Country Level

4.86 There has been growing engagement between the Bank and the Global Fund at the corporate level through the Bank's involvement in Global Fund governance, through secondments of Bank staff to the Global Fund, and through contacts such as that between the Global Fund's Inspector-General and the World Bank's Integrity Vice President. Both organizations are already working together at the global level in the context of the IHP and related initiatives, including the Health-8, the Health Systems Funding Platform, and the JANS. And now there are growing pressures, particularly from donors, for GAVI, the Global Fund, and the Bank — as the three largest multilateral financiers of country-level investments in health — to improve collaboration at the country level.

4.87 Both the Global Fund and the Bank staff recognize that each organization has certain comparative advantages in financing health sector investments at the country level. The current climate also seems more propitious than during the last attempt in 2006–07 to work out a division of labor and ways of collaborating at the country level in the form of an MOU — that is, before the IHP was launched in September 2007 and before the FYE was issued in March 2009. That evaluation found a need to define with greater clarity and formality operational partnerships among the Global Fund, World Bank, and other major multilateral organizations involved in global health and, "as a first priority, resolving the issues that impede the provision of essential technical assistance on a reliable and timely basis" (Macro International 2009b, p. 33).

4.88 However, based on interviews and the survey results, staff in both organizations would clearly prefer to engage on their own terms: that is, in terms of their own organization's business model. They generally viewed the comparative advantages of the other organization in terms of what the other could contribute to their own method of operation. Global Fund staff viewed the principal comparative advantages of the World Bank as (a) facilitating dialogue with Ministries of Finance, Planning, and other central ministries; (b) helping to improve financial management and procurement; and (c) providing finance for long-term investments in health infrastructure (Table 14). They would like the Bank to make a greater effort to include them in high-level government discussions, as has happened in some countries, such as Cambodia, and for the Bank to contribute its health sector expertise to Global Fund processes such as the CCM at the country level.

4.89 World Bank project managers viewed the principal comparative advantages of the Global Fund as (a) mobilizing donor resources to combat the three diseases in the short term, (b) promoting country-owned strategies and other responses to combat the three diseases, and (c) sustaining financial resources to combat the three diseases over the long term. They would like the Global Fund to contribute to multidonor SWAps or cofinance World Bank projects in

Table 14. Comparative Advantages of the World Bank and the Global Fund: Each Organization's Perspectives of the Other Organization (in descending order from "most important" to "least important")

	Global Fund Staff of the World Bank	World Bank Project Managers of the Global Fund
1	Facilitating dialogue with Ministries of Finance, Planning and other central ministries.	Mobilizing donor resources to combat the three diseases in the short term.
2	Helping to improve financial management and procurement.	Promoting country-owned strategies and other responses to combat the three diseases.
3	Providing finance for long-term investments in health infrastructure.	Sustaining financial resources to combat the three diseases over the long term.
4	Helping to design and prepare investment projects in the health sector.	Facilitating an effective rapid response to the three diseases in the short term.
5	Helping to formulate appropriate strategies and policies in the health sector.	Developing specialized expertise in the prevention, treatment, and care and support in dealing with the three diseases.
6	Helping to reform health care finance systems over the long term.	Lowering the transactions costs of development assistance from the point of view of donors.
7	Helping to strengthen health delivery systems over the long term.	Promoting a results focus to development assistance.
8	Organizing and facilitating policy dialogue at the national, sectoral, and project levels.	Lowering the transactions costs of development assistance from the point of view of beneficiaries.
9	Managing country-specific donor trust funds.	Building institutional and human resource capacity to combat the three diseases over the long term.
10	Supervising investment projects and field operations.	Ensuring that aid resources are used efficiently and effectively.

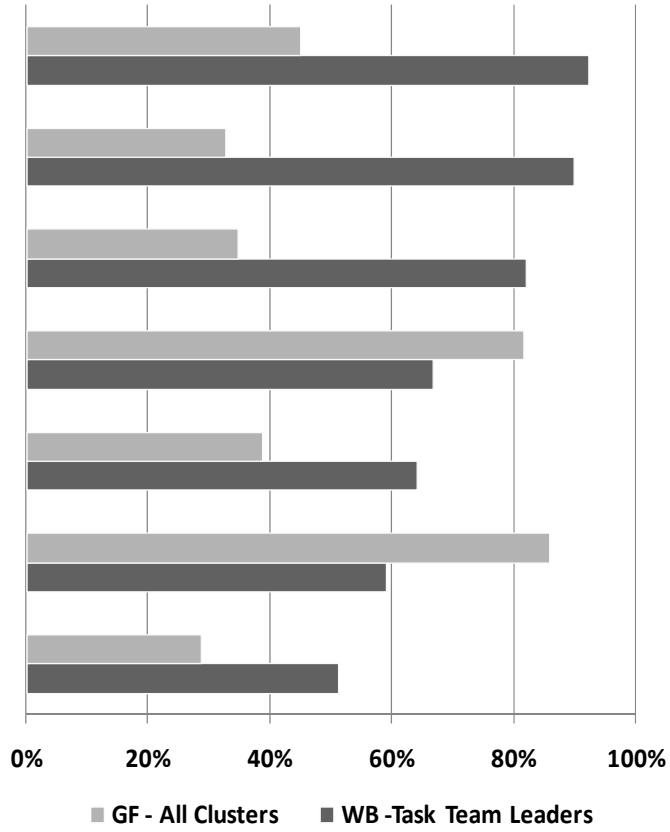
Source: IEG Survey of World Bank HNP Project Managers and Global Fund Secretariat staff, administered in March 2011.

the health sector, and for the Global Fund's donors to establish a trust fund for financing Bank-supervised technical assistance in support of Global Fund-supported activities (Figure 15).

4.90 The two areas of greatest agreement between Global Fund staff and World Bank project managers, in terms of changes each would like to see in the future, were (a) the Bank's being an ex officio member of the CCM whenever the Bank is an active player in the health sector in the country, and (b) the two organizations' establishing an active staff exchange program.

4.91 The Global Fund signed an MOU with UNAIDS in June 2002, in its first year of operation. It has more recently signed MOUs with Stop TB (in February 2009) and with RBM (in April 2010). The Global Fund formed a Partnership Group in the Global Fund Secretariat, and the Board approved a Partnership Strategy in November 2009 in direct response to the findings and recommendations of the FYE (Appendix G). The Global Fund is seeking a strategic division of labor with other development partner agencies, greater clarity of roles, and mechanisms for coordinating and funding technical assistance at the country level.

Figure 15. What changes would you like to see in the Global Fund and the World Bank to facilitate greater engagement between the two organizations to achieve positive results at the country level, while also respecting each organization's fundamental purposes and principles? (Percent "Yes")



Source: IEG Survey of World Bank HNP project managers and Global Fund Secretariat staff, administered in March 2011.
Note: TA = technical assistance.

4.92 On the other hand, senior managers at the World Bank have expressed reservations about the appropriateness of an MOU. MOUs can provide guidelines to staff in both organizations, but they are not usually considered legally binding even if they are signed documents. However, they can raise more expectations than intended on one side or the other, thereby having a practically binding effect. If there is a willingness on the part of senior managers in both organizations to forge greater collaboration at the country level, there are other ways of doing this more clearly and effectively, such as the following:

- Establishing a trust fund at the World Bank, like those that have been established by UNAIDS, GAVI, and WHO (for IHP+), specifying how the resources will be used to support Global Fund activities at the country level.
- Signing a "service agreement" that spells out in detail what the Bank will do and how the Bank will be compensated.
- Strengthening collaboration (without a formal agreement or flow of funds) by means of an exchange of letters, agreed terms of reference, summarized and confirmed

minutes of meetings, workshops, and other events where both sides agree to work together on certain activities.

4.93 Whether or not the Bank reaches a formal or informal agreement with the Global Fund along any of these lines, there needs to be a clearer institutional mandate for Bank staff to work with the Global Fund at the country level, if World Bank engagement with Global Fund-supported activities remains at current levels, or increases. For the benefit of client countries — particularly low-income countries with high disease burdens — the ways in which the Bank's country teams and staff are permitted, encouraged, or required to engage with Global Fund-supported activities at the country level simply need to be defined. Resources need to be allocated for the purpose with appropriate institutional recognition of contributions made and achievements accomplished. Expected contributions of Bank staff should be part of work program agreements, and achievements recognized in performance reviews. If staff are directed to serve on CCMs, they should have a terms of reference specifying the timeframe, their responsibilities, and their reporting requirements.[83] And for sustainability, relationships need to move beyond the personal level (the current situation) to the institutional level. Such directives and guidelines are not contrary to country-driven development; they can allow for case-by-case judgment, taking into account country differences.

4.94 Experience has shown that the Bank can contribute meaningfully to the work of the Global Fund at the country level in ways that also benefit its own programs, but without undertaking supervisory or operational roles for the Global Fund in client countries. Undertaking such roles — as the Bank currently performs for the GEF and as essentially happened for Global Fund grants in Lesotho and the Russian Federation — might also be considered on a pilot basis under certain circumstances, such as a SWAp operation or a common implementing agency implementing related activities supported by each organization. However, the Bank has its own rules of engagement that would have to apply when it takes on such roles. The Bank still needs to be able to carry out its own work program in each country. Thus, agreeing to supervise the implementation of specific Global Fund grants, even on a pilot basis, would need to be viewed as part the Bank's own operations in the country, subject to the Bank's operational policies and procedures, as is currently the case for GEF-financed projects.

4.95 The World Bank, the Global Fund, and other multilateral organizations have expressed good intentions to coordinate and streamline M&E processes at the country level. They have endorsed the Three Ones principles and they have jointly prepared an M&E Toolkit in 2004 (revised in 2006, 2009, and 2011) to establish norms and identify indicators to be used by all the agencies. In terms of developing frameworks and identifying indicators, there has been some progress. The approach and the indicators in the M&E Toolkit make a lot of sense, but these have been difficult to achieve in practice because each agency has its own project-level M&E requirements, which often provide very little value for program assessment, program management, or policy dialogue. Achieving the third "One" — one county-level M&E system

83. This mirrors an IEG recommendation at the global level that Bank staff serving on partnership boards should have standard terms of references. In its formal response, Bank management agreed with this recommendation, only disagreeing that the terms of reference should be standard. See IEG, 2011b, *The World Bank's Involvement in Global and Regional Partnership Programs,* p. xxxii.

in each disease area — is also dependent on achieving the first two “Ones” — a common action framework with a single coordinating authority.

4.96 Both the Global Fund and the World Bank could contribute to improved M&E at the project and country levels by making a stronger commitment to the Three Ones principles. Then project-level M&E — including the Global Fund’s PBF approach to disbursements — could focus on accountability for achieving the specific outputs of each project, and country-level M&E could focus on tracking the higher-level outcomes and impacts collectively. The World Bank should also continue to provide technical assistance to strengthen national M&E capacity through components of health projects and through GAMET, as it has done in the past.

5. Lessons from the Five-Year Evaluation for the Evaluation of Global Partnership Programs

5.1 This chapter assesses the independence and quality of the FYE of the Global Fund and draws lessons for the evaluation of other global partnership programs.[84] The independence and quality of the evaluation is assessed against the standard framework that IEG uses for this purpose (Appendix Table A-3), which is based on the Indicative Principles and Standards in the *Sourcebook for Evaluating Global and Regional Partnership Programs* (IEG and OECD/DAC 2007).

5.2 The FYE comprised three Study Areas and a Synthesis Report undertaken over a two-and-a-half year period. Overall, IEG found that the FYE was an independent and quality evaluation that has helped the Global Fund Board and management make significant strategic adjustments to its organizational and institutional arrangements. The three study areas reinforced one another, and the Synthesis Report effectively pulled together key messages in a coherent and integrated manner. Charged with a complex evaluation and an ambitious scope of work that had to be completed within a tight timeframe, the evaluation teams fulfilled the majority of their terms of references.

5.3 The chapter is organized into four major sections: (a) the oversight and management of the FYE; (b) the evaluation's participation, transparency, and dissemination activities and practices; (c) the quality of Study Areas 1, 2, and 3 in terms of their evaluation approaches, methodology, and instruments; and (d) the evaluation capacity building initiative in Study Area 3. (Appendixes N, O, and P provide additional evidence for the conclusions reached in this chapter.)

Oversight and Management of the Evaluation

BACKGROUND

5.4 The Global Fund did not have an evaluation policy at the outset, even though evaluation was a clear corporate priority. Initial plans for the FYE were conceived as early as October 2003, a year after the establishment of the Global Fund (Table 15). At its first meeting in January 2002, the Board established a Working Group to develop an M&E strategy and program of work. This Strategy, adopted in 2003, called for a review of the Fund's overall performance against its goals and principles after one full grant cycle had been completed. The M&E Strategy also called for the development of an M&E Operations Plan, and the creation of an independent body to provide advice, assessment, and oversight for the Fund's work on M&E. The same body would oversee the execution of the evaluation.

84. This assessment is based on interviews with Global Fund staff, TERG members, country-level stakeholders (government and civil society counterparts, UNAIDS, WHO, and other development partner agencies), members of the Impact Evaluation Task Force in Cambodia, Macro International team members, Social and Scientific Systems, Inc., and extensive reviews of Global Fund Board, TERG, and Secretariat documents. Other parties and supporting research materials were also consulted as necessary.

Table 15. Five-Year Evaluation Timeline

Date	Event
2003	Monitoring and Evaluation Strategy adopted by Global Fund Board in 2003 called for establishment of an independent expert group — the TERG — (a) to advise Global Fund Board and (b) to support the Global Fund Secretariat's M&E work. Nine members appointed by Board and four ex officio members. (October) Board approves undertaking a five-year evaluation of overall performance of the Global Fund against its goals and principles, after at least one full grant cycle has been completed. The FYE to be planned and implemented under TERG oversight. General areas for study: organizational efficiency and effectiveness, effectiveness of the partner environment, and impact of the Global Fund on the burden of HIV/AIDS, tuberculosis, and malaria.
2004	(September) TERG established; evaluation discussion paper issued on FYE.
2006	(March–May) Stakeholder consultation on overarching questions for FYE (March–June) Stakeholder Assessment conducted online, with 900 respondents (July) Global Fund Partnership Forum in Durban endorses FYE's overarching questions. (July–October) Design of the evaluation by Social & Scientific Systems contractor, with Secretariat and TERG (November) Board approves launch of the FYE, based on TERG proposal/evaluation plan.
2007	(January) Requests for Proposals issued for (a) Study Areas 1, 2, and Synthesis Report, and (b) Study Area 3. (April) Contract issued to evaluation consortium, Macro International (May-September) Country work plan development and approval; workshops (June) Inception Report for Study Area 1 and Study Area 2 (October) Study Area 1 Report issued (Nov-Dec) Disbursements to countries for country impact studies — 47 subcontracts as part of FYE.
2008	(June) Study Area 2 Report issued
2009	(March) Synthesis Report issued (May) Study Area 3 Report issued (May) Board and Policy and Strategy Committee (PSC) discuss FYE.

TECHNICAL EVALUATION REFERENCE GROUP

5.5 The independent body formed in 2004 was called the Technical Evaluation Reference Group (TERG). It is a external body of experts, with a range of skills that include public health, evaluation, social science, organizational management, and development. Directly appointed by the Board, the nine members serve three-year terms with an honorarium.

5.6 TERG has two mandates that potentially conflict. On the one hand, it oversees and manages independent assessments, provides advice, and reports directly to the Board. On the other hand, it also advises the Secretariat on evaluation approaches and practices, reporting procedures, and other technical and managerial aspects of M&E. This includes reviewing the

Global Fund's progress toward the implementation of its M&E Strategy and providing guidance to the Secretariat in refining the M&E Strategy as the Global Fund evolves.

5.7 The Global Fund Board and Secretariat are aware of this potential conflict, and are managing it transparently. They believe that the existing set-up allows TERG to be objective, and still able to foster a culture of learning and self-correction in the Secretariat.[85] The Global Fund's internal M&E function is managed directly by the Strategy, Performance and Evaluation Cluster.

TERG'S ROLE DURING THE FIVE-YEAR EVALUATION

5.8 TERG is to act independently of the Secretariat, while reporting to the Board. Both can heed or ignore TERG recommendations. Nonetheless, documentary evidence and interviews by IEG show that TERG has wielded considerable influence and particularly so during the execution of the FYE. TERG was involved with each stage of the FYE, was the ultimate signatory for all FYE evaluation products, and approved the payments to the evaluators.

5.9 According to its terms of reference, TERG can provide independent assessments to the Board, interpret the findings of evaluation reports, and make its own recommendations.[86] Consequently, TERG submitted its own recommendations for the consideration of the Global Fund Board, alongside the full reports and recommendations of the evaluation consortium. TERG also reported on how effectively the consortium had fulfilled its terms of reference. IEG found that these practices contributed to perceptions of micromanagement,[87] and even interference by TERG during the FYE, even though these practices were consistent with TERG's practices during previous evaluations of the CCM model and the LFA system.

5.10 During the later part of the FYE, TERG's relations with the contractors and the Secretariat grew increasingly tense. Changes in senior management at the Global Fund also led to different expectations of TERG's oversight role. These differences and the large TERG demands on Secretariat resources contributed to this tension.[88] The Board, however, reiterated its strong support for TERG, and appreciated its oversight of the FYE.[89]

5.11 At the end of the day, IEG found that the conduct of the FYE was organizationally and behaviorally independent. The evaluation teams were able to report candidly about how slowly and less strategically the Global Fund governance processes had developed to guide this new approach to development assistance, about the need for a robust risk management strategy to

85. This debate continues, as the terms of reference for the TERG are being revised, in the follow up after the FYE. For instance, IEG found that the Global Fund's M&E system does not include a standard end-of-grant evaluation process, the absence of which hinders learning lessons from completed grants for future Global Fund activities (Cheryl Cashin, forthcoming, pp. 40-41).

86. Terms of Reference for TERG, 2007.

87. TERG took seriously its role of quality assurance, and intervened on occasion because it sought to ensure appropriate evaluation methods were used.

88. Staff dedicated to support TERG were under tremendous strain due to the frequent meetings.

89. Board documents, post-FYE, at the 19th and 20th Board Meetings.

alert the Global Fund about likely suspension of ongoing treatment activities, and about the risk of increased drug resistance, among other things. The fact that the TERG reported to the Board did not prevent TERG from submitting findings that were critical of the Board. Notwithstanding TERG's very "involved" oversight style, the FYE was also protected from outside interference, and the potential conflicts of interest that arose were appropriately identified and managed. TERG members themselves signed full disclosure statements, since many had previously been associated in one way or another with the broader Global Fund partnership.[90]

FORMULATING THE EVALUATION PRIORITIES AND QUESTIONS

5.12 Preparation for the evaluation passed through three phases that helped define and frame the evaluation, before it was formally launched in November 2006:

- An initial face-to-face consultation with experts was conducted during March–May 2006 to formulate the overarching questions and priority issues for the evaluation.
- This consultation was expanded to a broader audience through targeted e-mails and a Web survey during March–June 2006 about the Global Fund's reputation, performance, strengths, and weaknesses.
- The cumulative results were presented to the Global Fund's biennial Partnership Forum in Durban, South Africa, in July 2006 for further validation of the evaluation priorities and issues.

5.13 IEG found that these steps allowed for transparency, and strategic and quality input, and engendered ownership and participation from a broad stakeholder base.

EARLY DESIGN AND BUDGETING

5.14 IEG found that the planning for the FYE was carefully done and well resourced. Once the overarching questions and topics were finalized, TERG contracted with Social & Scientific Systems, Inc., to develop a comprehensive work program for the evaluation. A senior evaluation staff member of the Global Fund, who was assigned to work full time with the team, was a key asset. Her in-depth knowledge and familiarity with the Global Fund were invaluable. Not only was she knowledgeable about the Global Fund business model and resources (including relevant research and evaluations that would serve as inputs to the FYE), but she was also able to informally advise on the character of the organization and on its expectations for the FYE.

5.15 Social & Scientific Systems produced the Technical Background Paper (Global Fund 2006b) that outlined the full scope of work, the number of evaluation studies to be produced (Study Areas 1, 2, 3 and Synthesis), and how these would relate to each other. The Paper also described the purpose, methodologies, options for implementation, timelines, and budgets for each study. It recommended sources of data, other studies on which to draw, staffing needs, costs, countries to be visited, and the required skills of evaluation teams to be formed.

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90. IEG has observed that the pool of candidates with the required technical skills, knowledge, and experience to evaluate large GRPPs like the Global Fund and the Global Environment Facility, who have never done any work for the program, is often limited due to the program's overwhelming presence in the sector (IEG and OECD/DAC 2907, p. 41). In such cases, the key is to identify and manage conflicts of interest transparently.

5.16 Social & Scientific Systems consulted TERG closely in the development of the Technical Background Paper, and together they determined the final budget for the FYE.[91] The Global Fund Board approved special budgetary allocations for the FYE. In the interest of collaboration, TERG reached out to development partners such as the U.S. Office of Global AIDS, PEPFAR, and UNAIDS, who participated in and cofinanced selected parts of the evaluation. The Technical Background Paper became the basis for the Evaluation Plan and Framework Document, which the Board approved in November 2006. IEG found that the broad-based consultation also generated high expectations about the product and its anticipated value as a global public good.

REVIEW, REPORTING, FEEDBACK AND PROGRAM RESPONSE

5.17 TERG regularly updated the Board and the Policy and Strategy Committee as the evaluation teams submitted FYE reports to TERG for review, so that the Global Fund often started to make changes before the final evaluation products were publicly disclosed. TERG also invited the Global Fund Secretariat to provide comments on the findings. Then TERG deliberated on the findings and submitted the recommendations to the Board for review and consideration.[92] Some of TERG's recommendations differed from those of the contractors. In all cases, the Board welcomed both the Macro International and TERG reports, and directed the Secretariat to respond and act on them.

5.18 The Secretariat has issued a Formal Management Response and a Management Update (Global Fund 2010b), and has already initiated reforms. The Board delegated the preparation of a formal Board response to an Ad Hoc Committee composed of members from the Board's Finance & Audit, Policy & Strategy, and Portfolio & Implementation Committees.[93]

5.19 ***Conclusions.*** Planning for the FYE was deliberative, systematic, and innovative. The extensive consultations, at the outset, in the identification and formulation of evaluation topics and questions, engendered ownership and support from a broad stakeholder base of donors, governments, and civil society. Significant effort and resources were also devoted to designing and developing the evaluation work program through Social & Scientific Systems. Greater flexibility and discretion could have been accorded to Macro International, however, in the execution of this workplan. It might have been more efficient if the evaluation implementation team had been involved in the original study design and methodology.

Participation, Transparency, and Dissemination

5.20 Judged against the indicative principles and standards of the IEG and OECD/DAC *Sourcebook for Evaluating Global and Regional Partnership Programs*, IEG found that the design of the FYE approached the standard of good practice with respect to participation, transparency, and dissemination. The Board mandated five guiding principles for the evaluation:

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91. Details of Study Area 3 and its budget requirements were handled separately by another contractor, and then combined with the main Technical Paper.

92. TERG deliberations about the FYE products, and the review and management response processes are available on the Global Fund Web site.

93. Board documents GF/B19/11 and GF/B19/DP29.

(a) to be inclusive, (b) to be country focused/led, (c) to build country evaluation capacity, (d) to collaborate with local institutions, and (e) to share and disseminate the knowledge developed as a national and global public good. Overall, the FYE adhered to these principles.

5.21 ***Upstream participation***. To begin with, the TERG chair and a consultant conferred with 23 experts — including Global Fund Board members, government ministers, and directors of donor and civil society groups — in the formulation of the overarching evaluation questions. Then TERG opened up the whole process through a Web survey and targeted e-mails to 5,700 contacts.[94] TERG received questionnaires from 900 respondents on issues related to the evaluation and its intended use. Then TERG presented these results for discussion at the Global Fund's biennial Partnership Forum in Durban, South Africa, in 2007, attended by some 400 participants (many from CSOs) from 118 countries.

5.22 Each phase of the consultation was documented, and a detailed analysis of the issues was made available on the Global Fund Web site. This report, called the "360 Stakeholder Assessment," provided the aggregate profiles of respondent groups, and their respective positions on different issues for the FYE.

5.23 One of the goals of participatory evaluations is to gain greater stakeholder ownership of the evaluation product, process, and intended use. IEG found that this was largely achieved at the global level. The consultation on core issues of the evaluation, carried out at the upstream design stage of the FYE, helped win many supporters for the evaluation. There was also strong support for incorporating the learning and capacity-building functions in the FYE as a global public good.

5.24 ***Participation during planning and execution.*** The FYE sought the active participation of development partners and country clients in its implementation. At the global level, UNAIDS, PEPFAR, and USAID contributed to selected evaluation activities of the FYE. PEPFAR provided $3.5 million to cofinance the data quality management training and dissemination workshops in Study Area 3, while UNAIDS led and coordinated the Impact Evaluation Task Forces (IETFs) at the country level.

5.25 The IETFs were formed to tap country knowledge and expertise in planning, implementing, and coordinating the work for Study Area 3. Comprised of representatives from government, CSOs, development partners, CCMs, and research, academic, and statistical institutions, the IETFs were to strengthen country ownership, and act as sounding boards and reviewers of the evaluation as it progressed. TERG also envisaged that the evaluation processes, techniques, and tools developed collaboratively with the IETFs would continue to be used in the countries after completion of the FYE.

5.26 Many stakeholders were involved in the implementation of the FYE. In Study Area 3 alone, Macro International subcontracted 50 local institutions in the data collection and analysis, where almost $5 million of the evaluation budget was expended. Driven by the desire for a high-quality evaluation product, TERG members participated in some country missions and visited with the IETFs.

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94. E-mail questionnaires were distributed in English, French, Spanish, and Russian.

5.27 The country-led concept was good and had tremendous support at the global level. However, IEG found that its execution was problematic and that the in-country mechanisms and structures were not fully engaged. The tight implementation schedule did not allow for the evaluation teams to fully engage with the IETFs in Study Area 3, some of which needed more time to achieve consensus on issues, while others needed capacity building to do their jobs.

5.28 ***Learning and dissemination.*** Learning workshops called Partners in Impact Forums allowed the IETFs to exchange ideas with one another and with global experts on technical issues about impact evaluation, data quality, and their management. The IETFs discussed how they would "integrate" studies planned for Study Area 3 into their existing evaluation work programs for AIDS, tuberculosis, and malaria. Countries without such a work program received technical assistance to develop them. At the end of the FYE, the Partners in Impact Forums were reconvened to discuss the results of Study Area 3.

5.29 ***Transparency.*** All processes and results of the FYE, from the conceptual to the execution stages, have been made available on the Global Fund Web site. This includes the deliberations by TERG, the Board, and its Committees on the Macro International reports, findings and recommendations. IEG found the overall conduct of the FYE to be highly transparent, as mandated by the Board. However, FYE products have not been translated into other languages.

5.30 ***Conclusions.*** The consultative and participatory nature of the evaluation led to the many preparatory steps, approval/vetting mechanisms, and country-level evaluation task forces that characterized the FYE. Such participatory processes were intended to engender ownership by the stakeholders and shared decision making for the use of evaluation results. Stakeholder ownership was achieved at the global level, but not at the country level among Study Area 3 participants. Based on IEG interviews, documentary review, and direct feedback from two countries, the lack of engagement with IETFs as full partners was a key factor.

5.31 The overall conduct of the FYE has been highly transparent. The learning workshops for Study Area 3 and the Global Fund's Web site were good dissemination mechanisms. However, even though the Web site supports English, French, Spanish, Russian, and Chinese, FYE reports are only available in English, which limits their potential as a public good. The development approach of the FYE was extensive, with $5 million spent in participating countries. Subcontracting institutions in Study Area 3 countries to participate in the FYE was an innovative attempt to build evaluation capacity and to sustain the use of these techniques and tools in these countries after the FYE. However, stronger ownership by Study Area 3 countries would have been necessary to realize the intended development benefits.

Study Areas 1, 2, and 3: Their Evaluation Approaches, Methodology, and Instruments

5.32 Overall, IEG finds that the FYE was a quality evaluation. The evaluation was objectives-based and evidence-based against the stated purpose and principles of the Global Fund (Appendix C). The assessment was fair and balanced, portraying both the strengths and weaknesses of the Global Fund. Although the FYE did not deliver on two objectives — developing the determinants of good grant performance and building institutional evaluation

capacity in the Study Area 3 countries — it was an innovative evaluation experience, from which to draw procedural and methodological evaluation lessons.

5.33 The FYE met three of the four standard IEG criteria for assessing quality (Appendix Table A-3) — evaluation scope, instruments, and feedback. It did not meet the M&E criterion that the program's activity-level M&E system should contribute to the evaluation's assessment of the overall outcomes of the program because the Global Fund's grant-level M&E system was not initially designed to do so. Even if it had been so designed, it would have been too early in the life of the program to make such a contribution. Therefore, other methods, notably the impact assessment in Study Area 3, had to be used.

STUDY AREA 1: ORGANIZATIONAL EFFICIENCY AND EFFECTIVENESS OF THE GLOBAL FUND

5.34 Study Area 1 was charged with evaluating the degree to which the Global Fund (a) had established a business model that adhered to its Guiding Principles, and (b) had built an organizational architecture and governance structure to support that business model.[95] This included reviewing and benchmarking the resource mobilization strategy and efforts against those of comparable institutions. Accordingly, the evaluation consortium led by Macro International set out to assess if the Global Fund model was "fit for the purpose" from the outset and whether it could or should endure as the Global Fund evolved and matured.

5.35 Macro conducted Study Area 1 guided by the Evaluation Plan for the FYE and in accordance with the plans, questions, methods, and tools outlined in the Inception Report. The terms of reference did not require Macro to examine the "relevance" of the Global Fund business model in the global health architecture, or the validity of the assumptions behind the model. Instead, Macro was to assess if the organization had been set up and operated in adherence with the values embedded in the Guiding Principles.[96]

5.36 Like many formative evaluations of GRPPs, there was strong emphasis in the terms of reference on assessing the appropriateness of the program's organizational setup and institutional arrangements — that is, its governance and management arrangements. Consistent with the IEG and OECD/DAC *Evaluation Sourcebook*, there was much greater focus on governance, and a more limited scope of work for examining the Global Fund's management.[97] The Secretariat had also commissioned a separate Management Review in parallel with the Study Area 1.[98]

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95. See Macro International (2007b), Inception Report Summary for Study Areas 1 and 2.

96. IEG has found that the Guiding Principles have been central to the Global Fund mission and have been used extensively to guide the design, makeup, and operation of the organization.

97. "It is neither practical nor appropriate for evaluations to assess all aspects of management. Thus the terms of reference should specify clearly which aspects of management have been selected for assessment. The assessment should focus on those aspects that most directly affect program performance, and avoid the type of 'micromanagement' or 'microevaluation' that is outside the purview of both a program's governing body and an evaluation team" (IEG and OECD/DAC 2007, pp. 74-75).

98. Booz, Allen and Hamilton, *Organizational & Management Review*, Draft Executive Summary, November 2007.

5.37 The Management Review could have been an important input to Study Area 1, but IEG found little reference to it in the Study Area 1 report. It would have been important to apprise the reader of the findings of the Management Review, and the extent to which the findings of the two reviews were consistent. It may be that the Management Review was not completed in time to be shared with the Study Area 1 evaluation team. If so, this fact should have been recorded.

5.38 Study Area 1 used an "organizational development" approach to assess the efficiency and effectiveness of the Global Fund structures, in accordance with plans outlined in the Technical Background Paper. Normally, such an evaluation report would have discussed the underlying theoretical concept and basis for this approach. The Study Area 1 report did not do this.

5.39 Study Area 1 tackled challenging topics. It concluded that the Board had failed to provide adequate strategic direction; that the Board had tended to overly manage the Secretariat; that conflicts and tensions between the Guiding Principles had affected program performance; that the Global Fund had relatively neglected partnership issues despite its high dependence on its partners to achieve objectives; and that the Global Fund lacked a risk management framework.

5.40 Study Area 1 identified risks in four key areas that were mission-critical in nature and needed better management:

- Corporate reputational risks (the Global Fund was dependent on the CCM and Principal Recipient for grant oversight and appropriate use of funds)
- Loss of donor confidence (not meeting expectations of results regarding disease outcomes, especially given the demand-driven nature of Global Fund grants)
- Risks to beneficiaries and control of the three pandemics (PBF increases the risk of stopping already ongoing treatment services and accelerating drug resistance)
- Human resources and institutional intelligence risks (portfolio management was too dependent on individuals and not adequately systematized, coupled with high staff turnover).

5.41 IEG found Study Area 1 to be influential. TERG exercised very close oversight of Study Area 1, to the point of requiring several drafts, which delayed the submission of the final report. Ultimately, TERG expressed overall satisfaction with the quality of the product, noting a number of limitations: the Global Fund was benchmarked against fewer organizations than planned; some interview methods were lacking in clarity; and certain analyses were anecdotal in nature, such as the role of Executive Director on the Board and workplace issues.[99]

99. The Study Area 1 report concluded with some shortcomings of its own, such as: (a) not fully covering the Global Fund's organizational structures; (b) the difficulty of benchmarking the Global Fund due to its unique nature and mission; (c) the limitations in the qualitative assessment of the grant negotiations and rating practices; (d) the poor timing for the assessment of the Board governance review; (e) the limited number of interviews; and (f) the limited review of the TERG, the Partnership Forum, and the Inspector General's Office.

5.42 The Study Area 1 report contributed to six of the nine major findings in the Synthesis Report. The Board and Secretariat have accepted these findings and initiated organizational reforms such as changing the CCM requirements, setting up a Partnership Unit within the Global Fund, and establishing stronger partnership agreements.

5.43 ***Conclusions.*** Formative evaluations like Study Area 1 are very important in the early stages of a global program to help a program make strategic adjustments to its organizational and institutional arrangements. Study Area 1 took a longer time to complete than planned, with considerable involvement of TERG in finalizing the draft report. Part of this may have been due to the longer learning curve needed by the evaluation team who had not been involved in determining the design, methodology, and timeframe for carrying out the evaluation study. Both the commissioner and executor of evaluations need to be prepared for such delays when the design and executing teams are not the same.

5.44 The findings of Study Area 1 are particularly relevant for those GRPPs that have adopted inclusive stakeholder models of governance, with broad representation from beneficiary countries and CSOs in addition to financial contributors, since the report covers in some depth the difficulties of managing an inclusive board like that of the Global Fund.

STUDY AREA 2: EFFECTIVENESS OF THE GLOBAL FUND PARTNERSHIP ENVIRONMENT

5.45 Study Area 2 was tasked with assessing the Global Fund's fit in the overall development architecture at the global and country levels. The study team examined all salient areas such as the CCMs and LFAs, their interactions with development partner agencies and country processes, the availability of technical assistance, PBF (central to the Global Fund business model), and grant oversight. Given the broad scope of the work and the methodological challenges (few benchmarks, tight timelines, and sequencing with other Global Fund studies that were occurring in the same countries), the evaluation team focused largely and most importantly on the partnering arrangements at the country level. In-depth qualitative and quantitative assessments were carried out in 16 countries to examine how the model had played out, and the effects on grant performance and on the countries' health systems.

5.46 Study Area 2 was unable to develop "determinants of good grant performance" by statistical analyses, because the countries selected (through purposive sampling) had insufficient outliers of good and poor performers to allow for generalization of findings. But its impact on the Global Fund has been substantial. Study Area 2 covered topics critical to Global Fund's mission, provided grounds for the continuation of the Global Fund model, and underlined the need for strengthening the mostly informal nature of its partnerships. It directed recommendations toward improving the CCM, LFA, PBF, and grant oversight functions. It found that for many partners, negative perceptions and expectations of the Global Fund had been "filtered through 60 years' experience of the conventional development assistance model," and that partner agreements to high-level principles of collaboration needed to be translated into operational realities.

5.47 Lessons that emerge for other GRPP evaluations call for prudence, to keep the scope of evaluations to manageable size, allow reasonable schedules, and avoid conflicts/competition with other evaluation efforts going on in the same countries. Large

GRPP evaluations normally take more time than expected, despite detailed plans, because of the large number of parties involved. Sufficient time should be allowed to pre-test new evaluation instruments. A common conceptual framework and approach to assess country partnerships would be helpful to save time, avoid confusion, and is feasible. The following section presents such a framework.

Toward a Common Evaluation Instrument for Assessing Country-Level Partnerships[100]

5.48 The Country Partnership Assessment (CPA) instrument used in Study Area 2 was a structured questionnaire with seven modules.[101] It is a good building block toward developing a conceptual evaluation framework for GRPPs that emphasize country-led processes and alignment with country systems and mechanisms. Based on the CPA instrument and comparable instruments used by UNAIDS and the OECD/DAC, IEG has developed a draft generic Partnership Assessment Tool that could be refined, validated, and then used for other GRPPs financing country-level investments and/or technical assistance. (See Appendix O.)

5.49 IEG has compared and contrasted the CPA tool against the UNAIDS Country Harmonization and Alignment Tool (CHAT), and against the analytical framework used in the Phase 1 Evaluation of the Paris Declaration. Each of these instruments assesses the effectiveness of the collective action of members[102] by examining the partnering arrangements on the ground and how they played out. All three frameworks converged on country ownership/commitment, alignment, and harmonization as key elements of their analysis.

5.50 The Study Area 2/CPA had seven modules: private sector resource mobilization, harmonization, in-country partnerships, technical assistance, country ownership and alignment, PBF, and procurement. The UNAIDS/CHAT had four criteria: national AIDS coordinating authority and national strategic framework; M&E; finances; and administration, support, coordination, and communications.[103] The Paris Declaration had five criteria: country ownership, alignment, harmonization, management for results, and mutual accountability.

5.51 All three frameworks were developed and utilized in 2007 and 2008, and reflect a growing trend in development. They have the unifying trait of a strong focus on use, support, and alignment with country systems and mechanisms. The evaluation of the Paris Declaration was cross-cutting, looked at all sectors, and had a country-level perspective, while the Study Area 2/CPA and UNAIDS/CHAT focused on AIDS and the health sector. All three assessments used stakeholder mapping, mixed methods, qualitative and quantitative data analysis, case studies, and a variety of survey instruments, including focus groups and face-to-face interviews.

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100. GRPPs are programmatic partnerships among multiple entities (donors, developing country clients, international organizations, nongovernmental groups). There is joint decision making and accountability at the governance level. The "Assessment Framework" described here applies to these types of partnerships, and not to partnerships in which one organization "collaborates" with another party to achieve a subset of its own goals.

101. The Study Area 2/CPA also had an introductory module, making it eight in all.

102. Members were broadly interpreted to include not only country governments, but also civil society groups, the private sector, and foreign development entities resident in the countries.

103. The elements of country ownership, alignment, and harmonization were embedded in the "National AIDS Authority," "National Strategic Framework," and "Coordination" parts of the CHAT framework.

5.52 Combining the three assessment instruments yields a generic framework with nine criteria, as shown in Table 16. The CPA was the most comprehensive of the three because the Global Fund finances country-level investments and has a complex grant performance component. For the purpose of this generic tool, IEG has extracted only the evaluation criteria and topics common to the Paris Declaration Evaluation and the UNAIDS/CHAT, and more broadly applicable to other GRPPs. The CPA, however, lacked the "mutual accountability" element of the Paris Declaration Evaluation Framework, and the "reporting" requirements of the CHAT that make for a more level playing field between donors and recipient countries. These two criteria have been combined into one in Table 16 and called "mutual accountability (reporting and transparency)."

Table 16. Toward a Common Conceptual Framework for Assessing Country-Level Partnerships

Criteria	Possible Topics for Analysis
A. Country Ownership	Existence of a policy framework and operational work program; existence and performance of country governance and management bodies to direct program activities, e.g., the CCM and National Aids Council
B. Alignment	By donor partners with country policies and strategies, priorities, M&E systems, payment and reward structures and procedures
C. Harmonization	Use by donor partners of existing aid coordinating systems of aid, sharing analytical and diagnostic work, joint or collaborative planning and reporting requirements; joint missions and assessments
D. Finance and Resource Mobilization	Extent of pooled funding for the same development objectives, moving toward multiyear funding for greater aid predictability, inclusion of external aid in national budgets; quality of financial management
E. Managing for Results (M&E)	Use of PBF, linkage between diagnostic results and planning, move toward supporting and using country management information systems, having transparent and monitorable assessment frameworks that allow for tracking progress against national development strategies, goals, and targets
F. Procurement and Supply Management [a]	A key element for partnerships that finance investments. For example, in the health sector, as much as 40–60 percent of a low-income country's total health expenditures may be spent on drugs, medical supplies, and vaccines.
G. Capacity Building and Technical Assistance	Evidence of adequate assessment of external technical assistance needed for key national processes and its funding and execution. Capacity building and technical assistance should be demand-driven and consistent with relevant national strategies. This includes capacity building of country processes and institutions to allow for alignment activities described above.
H. Mutual Accountability (Reporting, Transparency)	Extent of transparent, timely, and accurate communications among different partnership members; processes that advance mutual accountability (for countries and donors alike) for development effectiveness
I. Other Criteria	Depending on the contextual needs of the GRPP in question

Source: Developed by IEG. See detailed Assessment Tool in Appendix O.

a. Coordinated logistics by the different partners in a health GRPP to prevent drug outages, and streamlining or use of the same procurement guidelines, organization, approach, or suppliers brings economy of scale and tremendous savings in reduced drug prices.

5.53 The Framework also includes a ninth criterion to take into account the contextual needs of a given GRPP. The resulting framework could be used to assess the "functionality" of the majority of GRPPs, regardless of sectoral focus. The proposed evaluation criteria and topics for analysis are presented in greater depth in Appendix O.

STUDY AREA 3: IMPACT ON HIV, TUBERCULOSIS, AND MALARIA

5.54 Study Area 3 was called an impact evaluation of the collective efforts of all donors and beneficiary countries on the burden of the three diseases in 18 case study countries. This section assesses the quality and applicability of this approach (impact evaluation of collective efforts) for other GRPPs that are financing investments at the country level.

5.55 The defining characteristic of an impact evaluation is to show attribution or causality between program inputs and the intended development outcomes. In spite of the initial ambition of the Global Fund and TERG to do an impact evaluation, the evaluation teams did not attempt a rigorous impact evaluation to attribute the reduction in the overall disease burden in case study countries to Global Fund-supported interventions, because the interventions had not been designed to facilitate impact evaluations and country-level data were inadequate. In addition, many countries had not yet completed one five-year grant cycle. (Appendix P provides a more detailed analysis of Study Area 3.)

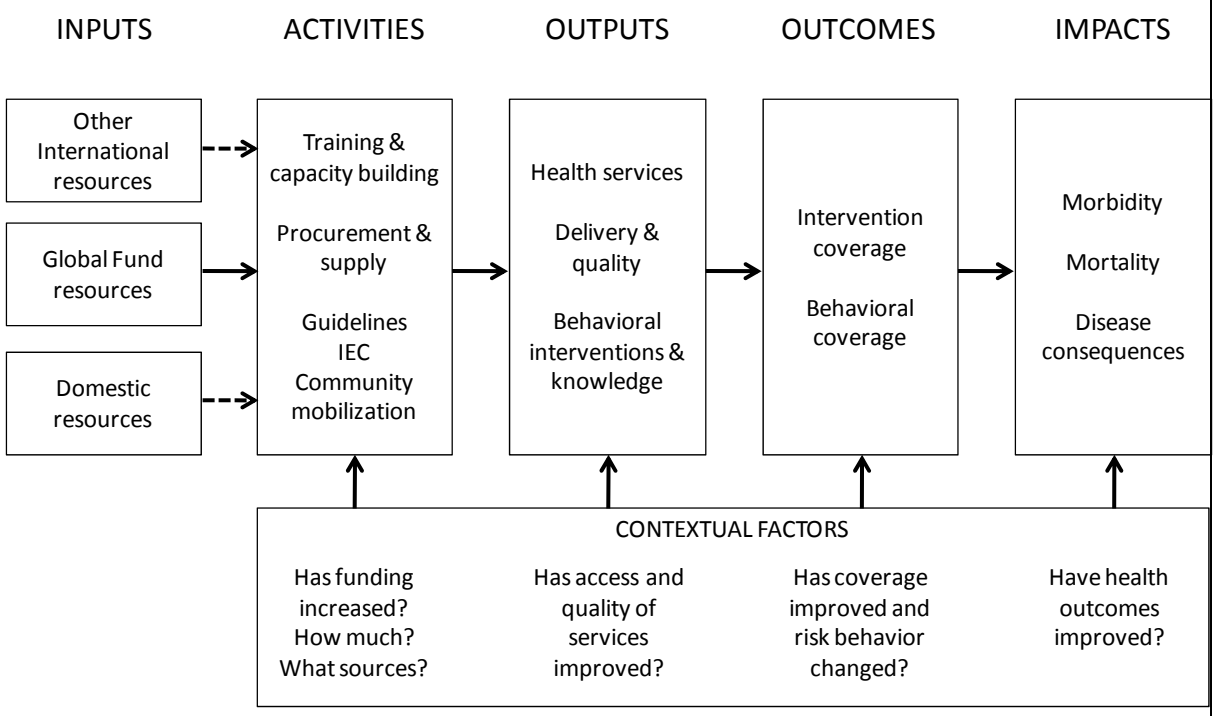
5.56 Given that Study Area 3 attempted to assess the collective efforts of all donors and countries, its evaluation approach may be best compared against the analytical framework of a contribution analysis. In contribution analysis, the program's contributions are not quantified, but plausible association has to be demonstrated. Contextual factors are important considerations in such an analysis.

5.57 On balance, IEG has found that Study Area 3 did an adequate job of conducting a contribution analysis, but with some shortcomings. It was able to demonstrate that the collective contributions have resulted in increased access to services, better coverage, and some overall reduction of disease burden, as presented in more detail below. The Step-Wise Evaluation Framework adopted by Study Area 3 (Figure 16) placed importance on contextual factors, but IEG found that few contextual factors were actually considered, based on an in-depth review of two country case studies in Study Area 3 (Burkina Faso and Cambodia).

5.58 Assumptions and risks, important in contribution analysis, were not clearly delineated in the evaluation framework for Study Area 3. Instead they were described in different parts of the document, and were not clearly defended. Two such assumptions were: (a) in the absence of scaling-up efforts, mortality and morbidity from the three diseases and intervention coverage would have at best remained the same or worsened; and (b) expected expenditure is flat from 2003 to 2006. These assumptions were not adequately defended in the case studies.

5.59 Another important contextual factor that was not discussed in the Study Area 3 studies was the quality of the services provided by the different donors and country institutions. Study Area 3 implicitly assumed that all donor spending was equal in quality and

Figure 16. Evaluation Framework for Study Area 3



Sources: Constructed/adapted by IEG from Technical Background Paper, Synthesis Report, and Study Area 3.
Note: IEC = information, education, and communication

Results, yet the different donor and country programs interact in various ways, and determine final outcomes at the country level. They are implemented by different agents with a variety of strengths and weaknesses. These contextual factors about the different partner inputs were not addressed in Study Area 3.

5.60 The main Study Area 3 findings were that collective efforts had contributed to:

(a) Increased access to services, particularly for HIVAIDS — for instance, in most countries, the number of facilities that provide HIV testing and counseling or ART more than doubled between 2004 and 2007.
(b) Increased coverage of HIV/AIDS and malaria interventions — for instance, major progress has been made in ART coverage for HIV/AIDS; and for malaria, progress in coverage of insecticide-treated bed nets, appropriate treatment for pregnant women, and indoor residual spraying.

Although there were data limitations, there was preliminary evidence to suggest that:

(c) Some countries had experienced a possible decline in HIV incidence rates among young people — for instance, mathematical modeling with HIV prevalence and sexual behavior trend data showed that three countries (Malawi, Tanzania, Zambia) offered evidence suggestive of a decline since 2003.

(d) There had been an increase in the survival rate among people on ART, with the number of adult life years added due to ART estimated to have increased from just 6,607 in 2003 to 576,438 in 2007 in the 18 countries.
(e) A few countries (such as Rwanda and Zambia) provided evidence of reductions in parasite prevalence and a potential decline in malaria-attributed child mortality.

5.61 Using modeling and using the coverage of the interventions as the main input for 11 of the evaluation study countries, Study Area 3 estimated that 110,000 lives had been saved by insecticide-treated bed nets and 24,000 by intermittent treatment of pregnant women.[104] Study Area 3 also emphasized areas of slow progress (for example, ACT treatment for malaria), as well as intervention areas requiring greater attention — for instance, gaps in basic requirements such as trained personnel, guidelines, medicines, and equipment (HIV/AIDS), and scope for improving the quality of diagnostic and treatment services (tuberculosis).

5.62 Study Area 2 was expected to generate determinants of grant success (good outcomes), including country context and the strength of the Global Fund partnership on the ground. These would have indicated the conditions required for the most successful outcomes, which could then have been corroborated by the results of Study Area 3. But Study Area 2 was unable to deliver on this score, because the countries selected were all in the moderate-performers range.

5.63 ***Conclusions.*** Study Area 3 was not an impact evaluation in spite of the title, nor did it set out to be one. This was clear, because there was no attempt at attribution. If the contribution analysis framework is applied, the Study Area 3 reports did not sufficiently take into account contextual factors about the collective action of the different donor and country programs. If these factors were covered in other evaluation studies accompanying the FYE (of which there were many), they were not referred to.

5.64 Regardless of the approach (impact evaluation or contribution analysis), it was too early for the Global Fund to conduct an assessment of the scaled-up efforts to change behavior and reduce disease burden. The usefulness of such a resource-intensive exercise for a young program[105] needs to be seriously considered. It clearly takes time to realize and document the full health impact of such interventions, especially considering the lag between funding and implementation, and the necessary data collection and reporting. The contribution of collective efforts to changing behaviors and reducing the disease burden needs to be interpreted with this in mind. Conducting a multi-level program-wide evaluation like the FYE is an enormous enterprise, especially for GRPPs, given the diversity of components and the resulting complex causality and aggregation issues (IEG and OECD/DAC 2007, p. 95). Nonetheless, impact evaluations may be valuable in helping to

104. The model also indicated that a significant part of this positive effect may have been offset by children with malaria getting less treatment in the Democratic Republic of Congo, where there were an additional 90,000 deaths.

105. See also the life-cycle approach to determining the scope of a GRPP evaluation in Tables 5 and 6 of the IEG and OECD/DAC 2007, pp. 34–35.

identify the impacts of interventions and key causal linkages for subsets of activities where impacts are more measurable than for the program as a whole.

5.65 TERG has proposed a different approach going forward. Evaluations of scale-up and impact will be conducted each year in a selected number of countries, building on the Study Area 3 experience, and with sufficient preparation time to involve development partner agencies and to integrate with country health information systems.

Evaluation Capacity Building in Study Area 3

5.66 The TERG wanted to foster different perspectives and approaches toward organizational learning throughout the Global Fund system. Therefore, an important objective of the FYE was to strengthen country evaluation systems and capacity during Study Area 3, so that countries would continue carrying out impact measurements using harmonized tools and approaches, developed for their use, after the conclusion of the FYE. IETFs comprising country stakeholders[106] were set up in 20 countries. These devised an evaluation work plan for Study Area 3 and oversaw its implementation in their respective countries.[107] The evaluation consortium provided technical assistance and on-the-job training in data collection and analysis, surveillance, study protocols, and tools to 50 local institutions and individuals, and then subcontracted with them to collect and analyze the data. Subsequently, countries were expected to have the capacity and collective experience to replicate (in whole or in part) the same tools and procedures to measure trends, after the FYE.

5.67 Study Area 3 operated on a tight schedule that generally did not allow for adequate stakeholder involvement, consensus building among the different IETF members, nor the use of evaluation findings in country planning exercises.[108] Some of the IETFs had high expectations of being full partners in the evaluation process. When this did not happen, it adversely affected the relationships between the IETFs and the FYE evaluation teams. Thus, in spite of the developmental focus of Study Area 3 (30 percent of the Study Area 3 budget was spent on capacity building), it was largely viewed as a Global Fund product with low ownership by country-level stakeholders. Stronger ownership by Study Area 3 countries would have been necessary to sustain the use of FYE evaluation tools and techniques.

5.68 The total cost of the FYE of $16.2 million represented 1 percent of the average annual expenditures (including grant disbursements) of the Global Fund in 2007 and 2008. This ratio is consistent with program-level evaluations of other GRPPs.[109] As planned, 70 percent of the $11.7 million evaluation budget for Study Area 3 was spent supporting country institutions: 40 percent on data collection/analysis, and 30 percent on technical assistance and training.[110]

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106. Assembled by UNAIDS, they were derived from groups normally engaged in health measurements: relevant development partners, government agencies (Ministry of Health, Bureau of Statistics), and civil society. IETFs also included members of CCMs.

107. Work plans included the use of Study Area 3 results in the countries' health sector reviews and sector planning exercises.

108. USAID has continued to finance some of the Partners in Learning Forums since the FYE.

109. IEG 2011b, *The World Bank's Involvement in Global and Regional Partnership Programs*, p. 26.

110. Board Documents, TERG presentation to 18th Board Meeting.

Whether this represents value-for-money clearly depends on the value placed on learning, capacity building, and country ownership. The Global Fund Board clearly did place value on these when it commissioned the evaluation, judging by the five guiding principles for the evaluation, two of which focused on learning and participation.[111]

5.69 The evaluation has contributed to the availability of approaches and tools for improving the quality of routine and survey data systems. Evaluation by-products also include a data depository of raw data from the country studies on the Global Fund Web site and a "Model Evaluation Platform" — a package of evaluation tools and lessons drawn from the Study Area 3 experience. TERG reports have talked about attempts to standardize and harmonize with other evaluation tools, such as the Health Metrics Network, WHO's Country Health Systems Surveillance, and the IHP+ Evaluation Platform, and to make available the Model Evaluation Platform as an open source resource available for all to use, copy, and modify. It is not known to what extent the specialized training, country data, and knowledge generated by Study Area 3 have been tapped by countries, researchers and academics as intended in the FYE design. There is little indication that the Model Evaluation Platform has moved significantly beyond the conceptual stage, or that the large datasets amassed by the FYE have been tapped by researchers and academics as intended.

5.70 ***Conclusion.*** It is extremely difficult to implement and sustain systematic capacity building in the context of a one-off evaluation like the FYE. Other GRPPs should only attempt to do so with caution. Building M&E capacity is a long-term endeavor that is better undertaken through more conventional approaches, given the condensed schedule in a global program evaluation. External evaluations emphasize independence and objectivity, while capacity building emphasizes learning and strong engagement with the implementing bodies. Managing the inherent tensions between these principles was a challenge for the FYE evaluation team. Greater value-for-money could potentially have been achieved if the same resources had been used to build capacity prior to the FYE, rather than as an integral part of it.

111. **Learning and capacity building:** The evaluation is designed not only as an external audit of performance, but also to support learning and capacity building in close partnership with countries. Capacity building efforts must focus on improving countries' existing data collection and analysis mechanisms or building these mechanisms where they do not exist.
Country-driven processes: The evaluation supports the principles of coordinated program M&E processes and all efforts are to be made to avoid duplication and fragmentation in order to promote national M&E goals. Further, the evaluation must balance the principle of country ownership with the need for independence and maximize the use of existing data and information systems.

6. Conclusions and Lessons

6.1 The Global Fund was officially established in January 2002 "to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals." Since then, the Global Fund has become the largest of the 120 GRPPs in which the World Bank is involved. It disbursed more than $3 billion in grants to developing and transition countries in 2010, and is supported by the largest FIF currently administered by the World Bank. Other such programs include the GAVI (established 1999), the Global Partnership for Education (2002), the Climate Investment Funds (2008), and the Global Agriculture and Food Security Program (2010).

6.2 Large partnership programs such as the Global Fund that are financing country-level investments on a large scale have several common features. First, they pool donor resources to finance country-level investments, which distinguishes them from the large majority of much smaller GRPPs that are primarily financing technical assistance, or generating knowledge about development. Second, they employ inclusive governance structures in which membership on the governing body is not limited to financial contributors but also extended to other stakeholders, including recipient countries, CSOs, and the commercial private sector. Third, they generally subscribe to the 2005 Paris Declaration principles of country ownership, alignment, harmonization, managing for results, and mutual accountability. The programs also raise funds from nontraditional sources outside the public sector, including private foundations and the business community.

6.3 As the largest of these programs, the Global Fund has become a basis for comparison not only for the programs listed above, but also for other global funds that were established a decade earlier, such as the GEF. Thus, the experience of the Global Fund provides lessons not only for the Fund itself, but also for these other programs, for the engagement of the World Bank with these programs, and for evaluating GRPPs more generally.

Lessons for the Global Fund

6.4 ***Harmonization.*** *The Global Fund is facilitating donor coordination at the point at which donors contribute to the trust fund and serve on the Global Fund Board, but this has not yet translated into a similar degree of coordination at the country level.* Country-level stakeholders tend to regard the Global Fund as another, largely separate development partner agency with its own distinct modalities that have not been well integrated into existing donor coordination mechanisms in the countries, or with national budget cycles, contrary to the harmonization principle of the Paris Declaration. While this situation may improve as the Health Systems Funding Platform matures and as the Global Fund transitions its grant portfolio to single streams of funding under its new grant architecture, the Global Fund has not generally contributed to harmonization through existing mechanisms for pooling funds at the country level, such as SWAps, first introduced in the 1990s as a means to overcome inefficiencies and reduce transactions costs to the country.

6.5 ***Technical Support to Enhance Country Ownership.*** *Development partners need to provide greater technical support to strengthen the ability of governments to effectively coordinate donor efforts around agreed national strategies.* This Review found that the situation has generally improved since the FYE in terms of other partners' providing technical assistance in support of Global Fund activities. The Global Fund has also developed a new partnership strategy, signed MOUs with the Stop TB Partnership and Roll Back Malaria in 2009 and 2010, respectively, and is reaching out to other development partner agencies more generally. However, the Global Fund needs to find ways to finance such technical assistance, provide it directly, or work effectively with other development partner agencies to do so.

6.6 ***Sustaining the Benefits of Global Fund Support.*** *The long-term sustainability of the benefits of Global Fund-supported activities depends on the complementary activities of donor partners and strengthening the capacity of recipient countries.* This will require a substantially more coordinated approach to external financial support at both the global and country levels than has occurred to date. It will be difficult for the Global Fund "to adjust its demand-driven model" to support "the most cost-effective interventions tailored to the type and local context of specific epidemics," as recommended by the FYE (Macro International 2009b, p. 18), if it ends up becoming the residual financier financing others' shortfalls. The scarce resources available to fight the three diseases — including those raised by the country from its own resources and those provided by its external partners, including the World Bank — need to be allocated collectively and proactively in each country in accordance with an agreed long-term strategy for fighting each disease. The sustainability of resources to support people living with AIDS who are already receiving antiretroviral treatment is of particular concern, since interrupted treatment also increases the risks of new infections and drug resistance. The long-run affordability and sustainability of treatment also depends on financing effective prevention programs to prevent new HIV/AIDS cases.

6.7 ***Managing for Results.*** *The M&E requirements of different development partners have so far thwarted their good intentions to coordinate and streamline M&E for the three diseases at the country level.* The Global Fund, the World Bank, and other agencies have endorsed the Three Ones principles of a common action framework, a single coordinating authority, and one M&E framework to monitor collective efforts in each disease area. They jointly prepared an M&E Toolkit in 2004 (revised in 2006, 2009, and 2011) to establish norms and identify indicators to be used by all the agencies, but it has been difficult to achieve their use in practice because each agency has its own project-level M&E requirements. Both the Global Fund and the World Bank could contribute to improved M&E at the project and country levels by making a stronger commitment to the Three Ones principles. Project-level M&E could focus on accountability for achieving the specific outputs of each project, and country-level M&E on tracking the higher-level outcomes and impacts collectively.

6.8 ***Managing Conflicts of Interest.*** *Real and perceived conflicts of interest are an inherent and essentially unavoidable feature of all partnership programs, deriving in the first instance from the multiple roles that the key partners play in a given program.* The Global Fund has brought recipient countries, CSOs, and affected communities into its governance arrangements at both the global and country levels. It has also established independent

review processes at key stages in its operations such as the reviewing of grant proposals (by the TRP), verification and reporting on grant performance (by the LFAs), and overseeing evaluations (by the TERG). It has also established conflict of interest guidelines for the operation of CCMs. The key is to identify and manage potential conflicts of interest in a way that does not impede the effectiveness of the program. Reconciling these two imperatives will remain a continuing challenge for the Global Fund and for other GRPPs.

6.9 ***Global Public Policy.*** *Neither the Global Fund nor the World Bank can address by itself "global communicable disease governance issues" such as the risk of drug resistance for current treatments of the three diseases.* This Review found that drug resistance is a live issue in the countries visited, amplified by incomplete treatments and the presence of counterfeit drugs. Global Fund grants could help strengthen the capacity of drug regulatory and enforcement agencies in assuring quality compliance by the pharmaceutical industry, and CCMs could invite drug regulatory agencies to participate in specialized committees of the CCMs. The Global Fund and the World Bank also need to support ongoing efforts by organizations with relevant competence, such as WHO and the United Nations Office on Drugs and Crime, to ensure that the sizable investments that the world has made in combating the three diseases are not diminished by inaction in this area.

Lessons for the World Bank

6.10 This Global Program Review has confirmed findings of previous IEG reviews on global partnership programs and trust funds in the following three areas.

6.11 ***Financial Intermediary Trust Funds.*** *This Review provides evidence to support IEG's recent recommendation that "the Bank should strengthen its framework for guiding its acceptance and management of FIFs going forward"* (IEG 2011a, p. 85). Like other FIFs, the Global Fund trust fund was established in an ad hoc way in 2001–02 to accommodate the particular requirements of the Global Fund and its donors. This has resulted in some ambiguities in the relationship between the Bank and the Global Fund. For example, the trust fund management agreement was crafted to limit the Bank's responsibility for the development outcomes of the use of trust fund resources, yet Global Fund donors expected that the Bank would contribute technical assistance to Global Fund-supported activities at the country level. Also, the Bank's accountability for the effective governance of the Global Fund as a permanent nonvoting institutional member of the Board has not been clarified. The Bank is currently in the process of preparing a stronger framework for the acceptance and management of FIFs, along the lines recommended by IEG.

6.12 ***Engagement Strategy.*** *This Review also provides evidence to support IEG's recent recommendation that "the Bank should have an explicit engagement strategy for each GRPP in which it is involved, including . . . the expected roles of the Bank in the program at both the global and country levels, . . . how the program's activities are expected to be linked with the Bank's country operations, and how the risks to the Bank's participation will be identified and managed"* (IEG 2011b, p 101). This Review has found that the Bank has been actively engaged in the corporate governance of the Global Fund and with Global Fund-supported activities in about 65 countries, in addition to being the trustee of the Global Fund trust fund. Yet the trustee role has been the only one of the Bank's roles in which the Bank's

contributions to and expectations of the relationship have been expressed, so that the trustee relationship is bearing the burden of the Bank's entire engagement with the Global Fund, which it was not designed to do. It would be better for the Bank to have a more complete engagement strategy with the Global Fund that encompasses all the roles that the Bank plays in the partnership. This would include guidance to country-level Bank staff for engaging with Global Fund-supported activities at the country level.

6.13 The Bank is in the process of preparing a new partnership framework for the Bank's engagement with GRPPs more generally. The Bank's 2007 Health Strategy also provides general statements about its engagement with the Global Fund. However, something more than these general statements is also needed to provide guidance to country teams and Bank staff. The Global Fund will likely continue to disburse for communicable disease control more than what the Bank disburses for the entire health sector. Nine years of experience have shown that the Bank can contribute meaningfully to the work of the Global Fund at the country level without taking on supervisory or operational roles. Undertaking such roles — as the Bank currently performs for the Global Environment Facility — might also be considered on a pilot basis under certain circumstances, such as a SWAp operation or a common implementing agency (Principal Recipient). The Global Fund or its donors could also establish a trust fund at the World Bank for financing Bank-supervised technical assistance in support of Global Fund-supported activities, following the precedents of UNAIDS for the Global HIV/AIDS Program and WHO for the International Health Partnership.

6.14 ***Community of Practice.*** *The Bank could establish a community of practice among its project managers who are working with the Global Fund to learn cross-cutting lessons of experience.* This would be similar to the regionally coordinated community of practice that currently exists for the Bank's engagement with the Global Environment Facility. Such a community of practice could lead, among other things, to standard terms of reference for Bank staff serving on CCMs, and could be supported by a central database to keep track of the Bank's engagement with the Global Fund over time. As many have observed, "what gets measured, gets done."

Lessons for the Evaluation of Global and Regional Partnership Programs

6.15 ***Early Stage Evaluations.*** *Formative evaluations, like Study Areas 1 and 2 of the FYE, are more useful in the early stages of a global program in helping the program make strategic adjustments to its organizational and institutional arrangements than the contribution analysis that was undertaken in Study Area 3.* Furthermore, the diversity of components in a global or regional program and the resulting complex causality and aggregation issues by their nature make impact evaluation difficult, if not infeasible. Nonetheless, impact evaluations may be valuable in helping to identify the impacts of interventions and key causal linkages for subsets of activities where impacts are more measurable than for the program as a whole.

6.16 ***Project-Level Monitoring.*** *Good monitoring systems should not only assess progress in implementing activities but also contribute to periodic summative evaluations and to effective policy dialogue.* The Global Fund has established different objectives for M&E at

the grant, country, and corporate levels, yet the three levels are not well connected with each other. Its grant-level M&E system is designed more to facilitate its PBF approach to grant disbursements than to contribute to an overall assessment of the outcomes of the program or to policy dialogue. The only country-level evaluations that it has so far undertaken are the 18 country assessments for Study Area 3 of the FYE. The Global Fund could consider undertaking evaluations of a random sample of the single streams of funding for each disease now taking place under its new grant architecture. The Global Fund might also institutionalize regular country-level evaluations, the results of which could feed into, rather than be part of, subsequent evaluations of the overall program. This would also help build the knowledge base about which approaches most successfully contribute to achieving collective outcomes.

6.17 ***Objectives and Scope of Global Program Evaluations.*** *These are best kept to a manageable size, consistent with the most immediate evaluation needs of the program — allowing for realistic schedules and avoiding evaluation fatigue and conflicts with other evaluation efforts in countries.* Large numbers of upstream processes built into the evaluation design can distract instead of facilitate the evaluation process. Sufficient time should also be allowed to adequately pretest new evaluation instruments.

6.18 ***Participatory Evaluation.*** *Participatory evaluations that engage country partners need to manage expectations, since unmet expectations dampen country ownership of the evaluation process and of the end product.* Evaluation schedules should be realistic and allow for productive exchanges and consultation between evaluation teams and country partners. Otherwise, country partners may perceive their roles as largely collecting critical data, with little involvement in the analysis and deliberations about their significance.

6.19 ***Evaluation Capacity Building.*** *Development activities such as building country-level evaluation capacity within the context of a global program evaluation are commendable but difficult to implement and sustain in the context of a one-off evaluation.* Building M&E capacity is a long-term endeavor that is better undertaken through more conventional approaches, given the condensed schedule in a global program evaluation. The tension between the two objectives can be very pronounced: an external evaluation emphasizes independence and objectivity, while capacity building emphasizes learning and strong engagement with the implementing bodies.

Bibliography

ASAP (AIDS Strategy and Action Plan Service) and UNAIDS. 2008. “The HIV Epidemic in Tanzania Mainland: Where Have We Come from, Where Are We Going, and How Are We Responding? Final Report.” World Bank, Washington, DC.

Baker, J. L. 2000. *Evaluating the Impact of Development Projects on Poverty: A Handbook for Practitioners*. Washington, DC: The World Bank.

Booz, Allen and Hamilton. 2007. “Organizational & Management Review.” Geneva: The Global Fund. www.theglobalfund.org/documents/board/16/BM16_03EDReport_Appendix_en/

Cashin, Cheryl. Forthcoming. “Comparison of the Monitoring and Evaluation Systems of the World Bank and Global Fund for the Global Program Review of the Global Fund to Fight AIDS, Tuberculosis and Malaria.” Prepared for this Review and forthcoming as an IEG Working Paper. IEG, Washington, DC.

Center for Global Development. 2006. *Will We Ever Learn? Improving the Lives through Impact Evaluations*. Report of the Evaluation Gap Working Group. Washington, DC: Center for Global Development.

Center for Strategic and International Studies. 2010. “Global Health Policies: The US Should Slow the Growth of its Bilateral AIDS Treatment Commitments.” Debate Series, CSIS, Washington, DC.

Chee, Grace, Vivikka Molldrem, Natasha Hsi, and Slavea Chankova. October 2008. “Evaluation of GAVI Phase 1 Performance.” Abt Associates Inc., Bethesda, MD.

Dubinsky, Joan Elise. 2008. “Ethics and Reputational Risk Assessment: The Global Fund.” The Rosentreter Group, Kensington, MD.

Duflo, E. 2001. “Schooling and Labor Market Consequences of School Construction in Indonesia: Evidence from an Unusual Policy Experiment.” *American Economic Review* 91(4): 795-813.

Galasso, E., and M. Ravallion. 2004. “Social Protection in a Crisis: Argentina’s Plan Jefes y Jefas.” *World Bank Economic Review* 18 (3): 367–400.

GAO (United States Government Accountability Office). 2005. “Global Health: The Global Fund to Fight AIDS, TB and Malaria Is Responding to Challenges but Needs Better Information and Documentation for Performance-Based Funding.” Report to Congressional Committee. GOA-05-639. Government Printing Office, Washington, DC. www.theglobalfund.org/Documents/library/Library_IE12_Report_en/

———. 2007. “Global Health: Global Fund to Fight AIDS, TB and Malaria Has Improved Its Documentation of Funding Decisions but Needs Standardized Oversight Expectations and Assessments.” Report to Congressional Committee. GOA-07-627. Government Printing Office, Washington, DC. www.theglobalfund.org/Documents/library/Library_SEd07627_Report_en/

GEF (Global Environment Facility). 2007. “Operational Guidelines for the Application of the Incremental Cost Principle.” GEF Council Document GEF/C.31/12, Washington, DC.

———. 2011. “Broadening the GEF Partnership Under Paragraph 28 of the GEF Instrument.” GEF/C.40/09, Washington, DC.

GEF (Global Environment Facility) Evaluation Office. 2006. “Evaluation of Incremental Cost Assessment.” GEF Council Document GEF/ME/C.30/2, Washington, DC.

———. 2009. *Mid-Term Review of the Resource Allocation Framework.* GEF Evaluation Report No. 47. Washington, DC: GEF Evaluation Office.

———. 2010. *The GEF Monitoring and Evaluation Policy 2010*. Washington, DC: GEF Evaluation Office.

———. 2010. OPS4: Progress Toward Impact. Fourth Overall Performance Study of the GEF. Washington, DC: GEF Evaluation Office.

Global Fund to Fight AIDS, Tuberculosis and Malaria. 2002/2003 to 2009. Annual Reports. The Global Fund, Geneva. http://www.theglobalfund.org/en/library/publications/annualreports/

———.2002/2003 to 2010. Board Meeting Documents. The Global Fund, Geneva. www.theglobalfund.org/en/board/meetings/

———.2004 to 2010. TERG Meeting Reports. The Global Fund, Geneva. www.theglobalfund.org/en/terg/reports/

———. n.d. “Guidance Paper on CCM Oversight.” The Global Fund, Geneva. www.theglobalfund.org/documents/ccm/CCM_CCMOversightGuidance_Paper_en/

———. 2002. “The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria.” The Global Fund, Geneva. www.theglobalfund.org/Documents/core/framework/Core_GlobalFund_Framework_en/

———. 2004. “Summary Report of the Technical Evaluation Reference Group (TERG) of the Global Fund: First Meeting.” The Global Fund, Geneva.

———. 2005. “Technical Evaluation Reference Group Report on the Assessment of Country Coordination Mechanisms: Performance Baseline.” Geneva: The Global Fund. www.theglobalfund.org/en/ccm/guidelines/

———. 2006a. *360° Stakeholder Assessment: Perceptions and Opinions of Stakeholders of the Global Fund*. Geneva: The Global Fund. www.theglobalfund.org/en/terg/evaluations/360/

———. 2006b. *Technical Background Document on the Scale and Scope of the Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Geneva: The Global Fund. www.theglobalfund.org/en/terg/evaluations/5year/

———. 2007. “Evaluation of the Local Fund Agent System.” Euro Health Group for the Global Fund, Geneva. www.theglobalfund.org/en/library/evaluationlibrary/specificevaluations/

———. 2008. *Lessons Learned in the Field: Health Financing and Governance. A Report on the Country Coordination Mechanism Model*. Geneva: The Global Fund.

———. 2009a. “Global Fund Aid Effectiveness Scorecard.” http://www.theglobalfund.org/en/performance/effectiveness/aideffectiveness/measuring/

———. 2009c. *Synthesis Report of the Five-year Evaluation of the Global Fund. Technical Evaluation Reference Group Summary Paper*. Geneva: The Global Fund. www.theglobalfund.org/en/terg/evaluations/5year/sr/

———. 2009d. Office of the Inspector-General, *Report on Lessons Learnt from the Country Audits and Reviews Undertaken*. Report No: TGF-OIG-09-002. Geneva: The Global Fund.

———. 2009e. Office of the Inspector-General, “Audit Report on Global Fund Grants to Tanzania.” Report No.: TGF-OIG-09-001. The Global Fund, Geneva. www.theglobalfund.org/.../oig/OIG_TanzaniaCountryAudit_Report_en/ -

———. 2010a. “Changes to the Global Fund Grant Architecture: a Fact Sheet for Implementers.” www.theglobalfund.org/documents/grantarchitecture/Fact_Sheet_for_Implementers_en.p

———. 2010b. “The Five-Year Evaluation: An Update.” The Global Fund Third Replenishment (2011–2013). The Global Fund, Geneva.

———. 2010c. Office of the Inspector-General, “Audit Report on Global Fund Grants to Nepal.” Audit Report No: TGF-OIG-09-006. The Global Fund, Geneva.

———. 2010d. Office of the Inspector-General, “Country Audit of the Global Fund Grants to Cambodia.” Audit Report No: TGF-OIG-09-014.” The Global Fund, Geneva.

———. 2010e. Office of the Inspector-General. “The OIG Review of the Global Fund Grant Application Process.” Audit Report No: TGF-OIG-10-001. The Global Fund, Geneva.

———. 2010f. Office of the Inspector-General. “Review of Oversight of Grant Procurement and Supply Chain Management Arrangements.” Audit Report No: TGF-10-002. The Global Fund, Geneva.

———. 2010g. “Recommendations to Enhance In-Country Communications between the Secretariat, LFA, PR, CCM and Other Partners.” The Global Fund, Geneva, May 11.

———. 2011a. “The Global Fund’s Approach to Health Systems Strengthening (HSS): Information Note.” The Global Fund, Geneva, July.

———. 2011b. *Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria*. Geneva: The Global Fund.

The Global Fund, Health Metrics Network, PEPFAR, Roll Back Malaria Partnership, Stop TB Partnership, UNAIDS, USAID, U.S. Department of Health and Human Services/Centers for Disease Control and Prevention, WHO, and the World Bank. 2004. *Monitoring and Evaluation Toolkit: HIV, Tuberculosis, and Malaria.* Geneva: The Global Fund.

———. 2006. *Monitoring and Evaluation Toolkit: HIV, Tuberculosis, and Malaria.* Geneva: The Global Fund.

———. 2009. *Monitoring and Evaluation Toolkit: HIV, Tuberculosis, and Malaria and Health Systems Strengthening.* Geneva: The Global Fund.

Global Partnership on Output-Based Aid. 2010. “Output-Based Aid—A Fact Sheet.” GOPA, Washington, DC.

Goosby, Eric. 2010. “PEPFAR’s Partnership with the Global Fund Improves the Response to HIV/AIDS.” http://www.pepfar.gov/countries/cambodia/index.htm

Habicht, J.P., C.G. Victora, and J.P. Vaughan. 1999. “Evaluation Designs for Adequacy, Plausibility and Probability for Public Health Program Performance and Impact.” *International Journal of Epidemiology* 28: 10–18.

Haverkamp, C. and K. Janovsky. 2007. *Medium-Term Review: Health Sector Strategic Plan 2003–2007.* An Assessment of Progress under Sector Wide Management (SWIM) and Recommendations to the MOH and Health Partners for Improving Harmonization and Alignment in the Health Sector. Consolidated Report Phase 1 and 2. Phnom Penh, Cambodia,

and Washington, DC: Ministry of Health of Cambodia. http://www.pepfar.gov/countries/cambodia/index.htm

Hendricks, M. 1996. "Performance Monitoring: How to Measure Effectively the Results of Our Efforts." Presented at the American Evaluation Association Annual Conference, Atlanta, November 6.

IEG (Independent Evaluation Group) and OECD/DAC (Organisation for Economic Co-operation and Development/Development Assistance Committee), Network on Development Evaluation. 2007. *Sourcebook for Evaluating Global and Regional Partnership Programs: Indicative Principles and Standards*. Washington, DC: World Bank.

IEG. 2001. *Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector*. Washington, DC: World Bank.

———. 2005. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance: An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control*. Washington, DC: World Bank.

———. 2006a. "Impact Evaluation: The Experience of the Independent Evaluation Group of the World Bank." IEG ECD Series, World Bank, Washington, DC.

———. 2006b. *Conducting Quality Impact Evaluations under Budget, Time and Data Constraints*. Washington, DC: The World Bank.

———. 2007, *The Development Potential of Regional Programs: An Evaluation of World Bank Support of Multicountry Operations*. Washington, DC: The World Bank.

———. 2009. *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of World Bank Group Support Since 1997*. Washington, DC: World Bank.

———. 2010. "Lesotho Health Sector Reforms Project and HIV and AIDS Capacity Building and Technical Assistance Project." Project Performance Assessment Report. IEG, Washington, DC.

———. 2011a. *Trust Fund Support for Development: An Evaluation of the World Bank's Trust Fund Portfolio*. Washington, DC: World Bank.

———. 2011b. *The World Bank's Involvement in Global and Regional Partnership Programs: An Independent Assessment*. Washington, DC: World Bank.

Institute for Health Sector Development. 2003. "Independent External Evaluation of the Global Stop TB Partnership: Report." Prepared for the Stop TB Partnership, Geneva. http://www.stoptb.org/resources/publications/achievement_evaluations.asp

IOE (International Organization of Employers) and PEC (Pan-African Employers' Confederation). 2009. *HIV/AIDS Challenges in the Workplace: Responses by Employers' Organizations and Their Members in Africa. Case Studies and Good Practice*. Geneva: IOE.

Kabell Consulting ApS. 2008. *Evaluation of the Implementation of the Paris Declaration. Synthesis Report of Phase 1*. Copenhagen: Denmark Ministry of Foreign Affairs. www.evaluation.dk

Kaiser Family Foundation. Various years. U.S. Global Health Policy Fact Sheets. www.kff.org

———. 2009-2011. "U.S. Global Health Initiative." www.kff.org/globalhealth/factsheets.cfm

———. 2009-2011. "U.S. President's Emergency Plan for AIDS Relief." www.kff.org/globalhealth/factsheets.cfm

———. 2009-2010. “The U.S. and the Global Fund.” www.kff.org/globalhealth/factsheets.cfm

———. 2011. “U.S. Funding for the Global Health Initiative: The President’s FY 2012 Budget Request.” www.kff.org/globalhealth/factsheets.cfm

Kress, Dan, and R. Paul Shaw. 2009. “GAVI and Global Fund Joint Programming for Health Strengthening: Turf Wars or an Opportunity to Do Better?”

The Lancet. 2009. “Maintaining Momentum for Malaria Elimination.” The Lancet 374 (9686): 266.

Macro International. 2007a. *Evaluation of the Organizational Effectiveness and Efficiency of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Results from Study Area 1 of the Five-Year Evaluation. Report submitted to the Global Fund to Fight AIDS, Tuberculosis, and Malaria.* Geneva: The Global Fund.

———. 2007b. *Global Fund Five-year Evaluation Study Areas 1 and 2: Inception Report Summary*. Geneva: The Global Fund.

———. 2008. *Evaluation of the Global Fund Partner Environment, at Global and Country Levels, in Relation to Grant Performance and Health Systems Effect, Including 16 Country Studies: Final Report.* Report submitted to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Geneva: The Global Fund.

———. 2009a. *Global Fund Five-year Evaluation: Study Area 3: the Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis, and Malaria*. Report submitted to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Geneva: The Global Fund.

———. 2009b. *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*. Geneva: The Global Fund.

Martin, Gayle H. 2010. “Portfolio Review of World Bank Lending for Communicable Disease Control.” IEG Working Paper No. 3, Washington, DC.

Mayne, J. 1999. “Addressing Attribution through Contribution Analysis: Using Performance Measures Sensibly: Discussion Paper.” Discussion Paper, Office of the Auditor General of Canada, Ottawa.

———. 2001. “Addressing Attribution through Contribution Analysis: Using Performance Measures Sensibly.” *The Canadian Journal of Program Evaluation* 16(1): 1–24.

Mosha, F., W. Urassa, S. Aboud, E. Lyamuya, E. Sandstrom, H. Bredell, and C. Williamson. 2011. “Prevalence of Genotypic Resistance to Antiretroviral Drugs in Treatment-naïve Youths Infected with Diverse HIV Type I Subtypes and Recombinant Forms in Dar es Salaam, Tanzania.” *AIDS Research and Human Retroviruses* Apr 27(4): 377–82; *Epub,* 2010, Oct 18.

Osili, U.O., and B.T. Long. 2007. “Does Female Schooling Reduce Fertility? Evidence from Nigeria.” NBER Working Paper 13070. NBER, Cambridge, MA.

PBS Online Newshour. 2009. “Fake and Substandard Drugs Threaten Malaria Treatment in Cambodia.” July 24, 2009. www.pbs.org/newshour/updates/health/july-dec09/malaria_0724.html

Pharma Industry/Biotech Industry. 2009. “Africa Should Manufacture Generic HIV/AIDS Drugs, UNAIDS Head Sidibe Says.” Pharma Industry/Biotech Industry 24 April. www.medicalnewstoday.com/releases/147437.php

Piehl, A., S. Cooper, A. Braga, and D. Kennedy. 2003. “Testing for Structural Breaks in the Evaluation of Programs.” *Review of Economics and Statistics* 85(3): 550-58.

Poate, Derek, Paul Balogun, and Kathy Attawell. 2009. *UNAIDS Second Independent Evaluation 2002–2008: Final Report*. Document prepared for the 25th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 8-10 December.

Purdue University, College of Pharmacy. 2011. "Sustainable Medicine Program in Tanzania." http://www.ipph.purdue.edu/sustain/

Radelet, Steven. 2004. *The Global Fund to Fight AIDS, Tuberculosis and Malaria: Progress, Potential, and Challenges for the Future*. Washington, DC: Center for Global Development.

Ravallion, M. 2008a. "Evaluating Anti-Poverty Programs." In *Handbook of Development Economics*, Vol. 4. Amsterdam: North-Holland.

———. 2008b. "Evaluating Anti-poverty Programs." In *Handbook of Development Economics*, Vol. 4. Amsterdam: North-Holland.

Ritchie, Daniel, and Celina Schocken. 2007. "Incentives for Collaboration and Harmonization among the Global Fund, PEPFAR and the World Bank on HIV/AIDS: Final Report." Global Fund, PEPFAR, and World Bank, Geneva and Washington, DC.

Roll Bank Malaria. 2011. "Strengthening of Drug Regulatory Authorities, Conducting Surveillance to Remove Substandard and Counterfeit Drugs, and Strengthen Logistics and Supply Chain Management for ACTs." Special Session of African Ministers of Health at Board Meeting of RBM Partnership, May 2011, Geneva. www.rbm.who.int/calendarofevents.html

Shakow, Alexander. 2006. "Global Fund–World Bank HIV/AIDS Programs: Comparative Advantage Study." Report prepared for the Global Fund and The World Bank HIV/AIDS Program." Washington. DC, and Geneva. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/GFWBReportFinalVersion.pdf

Smithsonian Magazine. October 2009. "The Fatal Consequences of Counterfeit Drugs." Washington, DC. www.smithsonianmag.com/people-places/Prescription-for-Murder.html

Specter, Michael. 2005. "What Money Can Buy." *The New Yorker,* October 24.

Taskforce on Innovative International Financing for Health Systems. September 2009. *More Money for Health, and More Health for the Money.* http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/Johansbourg/Final%20Taskforce%20Report.pdf

UNAIDS. 2005. "Global Task Team on Improving Coordination Among Multilateral Institutions and International Donors: Final Report." UNAIDS, Geneva.

———. 2007. *Country Harmonization and Alignment Tool (CHAT): A Tool to Address Harmonization and Alignment Challenges by Assessing Strengths and Effectiveness of Partnerships in the National AIDS Response*. Geneva: UNAIDS.

———. 2010. *Report on the Global AIDS Epidemic 2010*. Geneva: UNAIDS.

UNAIDS and WHO (World Health Organization). 2009. *AIDS Epidemic Update*. Geneva: UNAIDS.

UNIDO (UN Industrial Development Organization) Global Project. 2010. *Strengthening the Local Production of Essential Medicines in Developing Countries*. Vienna: UNIDO.

Vaillancourt, Denise. "Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries." IEG Working Paper No. 4, IEG, Washington, DC.

Victora, C.G., R.E. Black, J.T. Boerma, and J. Bryce. 2010. “Measuring Impact in the Millennium Development Goal Era and Beyond: A New Approach to Large-scale Effectiveness Evaluations.” Lancet, 377: 85-95.

Wolfensohn, James, D. 2010. *A Global Life: My Journey among Rich and Poor, from Sydney to Wall Street to the World Bank*. New York, NY: Public Affairs, Perseus Books Group.

World Bank. 1988. *AIDS: The Bank’s Agenda for Action*. Washington, DC: World Bank.

———. 1992. *Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank’s Agenda for Action*. Washington, DC: World Bank.

———. 1993a. *Disease Control Priorities in Developing Countries*. Washington, DC: World Bank.

———. 1993b. *World Development Report 1993: Investing in Health*. Washington, DC: Oxford University Press for the World Bank.

———. 1994a. *Better Health in Africa: Experience and Lessons Learned.* Washington, DC: World Bank.

———. 1994b. *World Population Projections: Estimates and Projections with Related Demographic Statistics (World Bank) 1994-95*. Washington, DC: Johns Hopkins University Press for the World Bank.

———. 1995. *Regional AIDS Strategy for the Sahel*. Washington, DC: World Bank.

———. 1996. *AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy*. Washington, DC: World Bank.

———. 1997a. *Confronting AIDS: Public Priorities in a Global Epidemic*. World Bank Policy Research Study. Washington, DC: Oxford University Press for the World Bank.

———. 1997b. *Health, Nutrition, and Population Sector Strategy*. Washington, DC: World Bank.

———. 1997c. “Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis.” Africa Region, the World Bank, Washington, DC.

———. 2003. *Education and AIDS: A Sourcebook of HIV/AIDS Prevention Programs*. Washington, DC: World Bank.

———. 2004. *HIV/AIDS: A Decision-Maker’s Guide to Procurement of Medicines and Related Supplies*. Washington, DC: World Bank.

———. 2005a. *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn’t, and Why*. Washington, DC: World Bank.

———. 2005b. *Rolling Bank Malaria: The World Bank Strategy and Booster Program*. Washington, DC: World Bank.

———. 2006a. *Disease Control Priorities in Developing Countries*, 2d edition, ed. Dean T. Jamison, Joel G. Breman, Anthony R. Measham, George Alleyne, Mariam Claeson, David B. Evans, Prabhat Jha, Anne Mills, and Philip Musgrove. New York and Washington, DC: Oxford University Press for the World Bank.

———. 2006b. *Health Financing Revisited: A Practitioner’s Guide*. Washington, DC: World Bank.

———. 2006c. *Priorities in Health*, ed. Dean T Jamison, Joel G Breman, Anthony R Measham, George Alleyne, Mariam Claeson, David B Evans, Prabhat Jha, Anne Mills, and Philip Musgrove. Washington, DC: World Bank.

———. 2007a. *The Africa Multi-Country AIDS Program, 2000-2006: Results of the World Bank's Response to a Development Crisis*. Washington, DC: World Bank.

———. 2007b. "Global Programs and Partnerships. Identifying and Addressing Partnership Conflict of Interest in Global Programs and Partnerships." Guidance Note for Bank Staff. GPP Group, World Bank, Washington, DC.

———. 2007c. *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*. Washington, DC: World Bank.

———. 2007d. *Our Commitment: The World Bank's Africa Region HIV/AIDS Agenda for Action 2007-2011*. Washington, DC: World Bank.

———. 2008. *Education and AIDS: A Sourcebook of HIV/AIDS Prevention Programs*. Washington, DC: World Bank.

———. 2009. *Averting a Human Crisis during the Global Downturn: Policy Options from the World Bank's Human Development Network*. Washington, DC: World Bank.

———. 2010. "Unfinished Business: Mobilizing New Efforts to Achieve the 2015 Millennium Development Goals." World Bank, Washington, DC.

———. 2010. World Development Indicators database. Available at http://data.worldbank.org/indicator

White, H., 2009. "Theory-Based Impact Evaluation: Principles and Practice." 3ie Working Paper No. 3, International Initiative for Impact Evaluation, New Delhi.

WHO (World Health Organization). 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO.

———. 2010a. *World Health Statistics*. Geneva: WHO.

———. 2010b. *Global Tuberculosis Control Report*. Geneva: WHO.

———. 2010c. *World Malaria Report*. Geneva: WHO.

———. 2011. "National Health Accounts." www.who.int/nha/developments/en/

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IEG WORLD BANK
INDEPENDENT EVALUATION GROUP

Global Program Review

The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund

Volume 2: Appendixes

February 8, 2012
Public Sector Evaluations

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Contents

Abbreviations and Acronyms

AAA	Analytical and advisory activities
ACT	Artemisinin combination therapy
ACT-Africa	AIDS Campaign Team-Africa
AIDS	Acquired immunodeficiency syndrome
AMFm	Affordable Medicines Facility for Malaria
ART	Antiretroviral therapy or treatment
ARV	Antiretroviral drug
ASAP	AIDS Strategy and Action Plan Service (UNAIDS and World Bank)
CAS	Country Assistance Strategy
CCM	Country Coordinating Mechanism (Global Fund)
CFP	Concessional Finance and Global Partnerships Vice Presidency (World Bank)
CHAT	Country Harmonization and Alignment Tool (UNAIDS)
CPA	Country Partnership Assessment
CSO	Civil society organization
DAC	Development Assistance Committee (OECD)
DFID	Department for International Development (United Kingdom)
DGF	Development Grant Facility (World Bank)
DOTS	Directly Observed Treatment Short-Course (for tuberculosis)
FAO	Food and Agriculture Organization
FPM	Fund Portfolio Manager (Global Fund)
FYE	Five-Year Evaluation of the Global Fund
GAMET	Global HIV/AIDS Monitoring and Evaluation Support Team
GAVI	Global Alliance for Vaccines and Immunization (a global partnership program)
GEF	Global Environment Facility (a global partnership program)
GHAP	Global HIV/AIDS Program (World Bank and UNAIDS)
GPR	Global or Regional Program Review (IEG)
GRPP	Global and/or regional partnership program
HDNHE	Human Development Network Health Team
HIV	Human immunodeficiency virus
HNP	Health, nutrition and population
HSS	Health systems strengthening
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEG	Independent Evaluation Group, formerly OED (World Bank)
IETF	Impact Evaluation Task Force
IHP	International Health Partnership
IHP+	International Health Partnership and Related Activities
ITN	Insecticide-treated bed nets
JANS	Joint Assessment of National Strategies (a component of IHP+)
LDCF	Least Developed Countries Trust Fund
LFA	Local Fund Agent (Global Fund)
MAP	Multi-country AIDS Program (World Bank)
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MOU	Memorandum of understanding
NGO	Nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
OIG	Office of the Inspector General (Global Fund)
PBF	Performance-based funding (Global Fund)
PEPFAR	President’s Emergency Plan for AIDS Relief (United States)
PSM	Procurement supply management
RBM	Roll Back Malaria (a global partnership program)
SCCF	Special Climate Change Trust Fund (GEF)

SIMU	Strategic Information and Measurement Unit
Stop TB	Stop Tuberculosis Partnership (a global partnership program)
SUS	Integrated Health Service (Brazil)
SWAp	Sector-Wide Approach
TB	Tuberculosis
TERG	Technical Evaluation Reference Group (Global Fund)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNITAID	United to Aid
UNDP	United Nations Development Programme
UNEP	United Nations Environment Program
UNFCC	United Nations Framework Convention on Climate Change
USAID	United States Agency for International Development
WHO	World Health Organization

Fiscal Year of the Global Fund:

January 1 – December 31

Appendix A. Review Framework for This GPR of the Global Fund

Note: IEG has a general evaluation framework for Global or Regional Program Reviews (GPRs) that has been designed to cover the wide range of global and regional partnership programs (GRPPs) in which the World Bank is involved, encompassing knowledge networks, technical assistance programs, and investment programs. The present evaluation framework was adapted from that framework to correspond with the nature of the Global Fund and the focus of this GPR on the Bank's engagement with the Global Fund at the country level. The questions in Table A-1 constituted the interview protocol for the six country visits that were conducted. Not all questions were answered during each country visit.

Table A-1. Validating the Major Findings of the Five-Year Evaluation of the Global Fund

1. Additionality and Sustainability

Additionality

- What has been the impact of Global Fund grants on (a) overall health expenditures in the country and (b) expenditures on HIV/AIDS, tuberculosis, and malaria?
- Is there any evidence that the presence of Global Fund grants has led to reduced — or increased —health or disease-control commitments by other donors, or reduced government expenditures on health or disease control?
- Does it make a difference who receives the Global Fund grants?
- Which sources of funds do Principal Recipients find easiest to access and use — from the Global Fund, from other donors (including the World Bank), or from the government?

Sustainability

- How sustainable are Global Fund–supported activities, especially those involving antiretroviral (ARV) treatment, which needs to be sustained for the rest of a recipient's life?
- To what extent is there good collaboration around shared objectives, including sustaining health outcomes for the three diseases and sustaining country systems?
- To what extent are steps being taken today to ensure the long-term sustainability of disease-control programs; for example, by allocating domestic resources and building domestic capacity (institutional arrangements, human resources, and capacity for mobilization and management of funds) to sustain the programs?
- In addition to governments, what role are civil society and the private sector playing and contributing to sustaining the benefits arising from activities supported by the Global Fund?

2. Country Coordinating Mechanisms (CCMs)

Partnership, Leadership, and Participation

- What is the legal status of the CCM? What are its roles and authority in preparation, design, and oversight of Global Fund grants?
- To what extent does the CCM represent all legitimate country-level stakeholders in relation to HIV/AIDS, tuberculosis, and malaria control?
- To what extent are key donors and technical partners for the three diseases (including the World Bank) active members of the CCM?
- Who is effectively running the CCM?
- To what extent do Global Fund–supported activities "reflect national ownership and respect country-led formulation and implementation processes"?
- Has the drive for inclusion and legitimacy hindered the effectiveness of the CCM?

Proposal Preparation

- To what extent is there broad participation and power-sharing in decision making?
- To what extent has the process for the selection of Principal Recipients been clearly defined, open, and

transparent?

- How does the CCM fit in the overall aid coordination in the country?
- To what extent is the CCM contributing to country-led aid coordination based on clear and coherent national health strategies for disease control?

Oversight of Grant Implementation

- How is the CCM itself being financed? Who pays for administration, and for travel and subsistence costs involved in attending meetings?
- To what extent are the communications between the CCMs, Principal Recipients, and Local Fund Agents (LFAs) effectively contributing to grant performance?

Conflicts of Interest

- To what extent are conflicts of interest — such as CCM members receiving funds from Global Fund grants as Principal Recipients or Sub-Recipients — being managed well and transparently?

3. Country-Level Partnerships

Partnering with International Organizations and Bilateral Donors

- To what extent are development partners now providing technical assistance to support the preparation and implementation of Global Fund grants? What kinds of assistance?
- To what extent is the interface between technical assistance and investments improving?

Partnering with Civil Society Organizations

- To what extent have the government and donors been proactive in helping to build the capacity of civil society organizations (CSOs) to participate meaningfully in Global Fund activities as CCM decision makers and grant implementers? How much progress has there been? What is the evidence that this is producing results?
- To what extent are the inevitable tensions between CSOs and governments being addressed in creative ways for the common good?

Partnering with the Commercial Private Sector

- What has been the degree and nature of the involvement of the commercial private sector in Global Fund–supported or other disease-control activities in the country such as (a) CCM participation; (b) mobilizing resources, in cash or in kind; (c) grant implementation; or (d) undertaking their own parallel initiatives.

4. Performance-Based Funding (PBF)

To what extent are performance-based principles being applied and effectively operating in the country? To what extent is the system working well or completely broken? Why?

To what extent are Global Fund agents (CCMs, Principal Recipients, Sub-Recipients, and LFAs) moving toward the goal of PBF? Or are they starting to adopt other approaches to measuring results?

What is the nature of the performance contracts — i.e., between the Global Fund and the Principal Recipients — being used in the country in terms of effectiveness and efficiency?

Who is responsible for monitoring results and enforcing the performance-based contracts?

To what extent are more differentiated approaches to quality assurance being adopted, reflecting existing country-level capacity constraints while still affirming PBF principles?

To what extent do local partners find the PBF elements of Global Fund contracts burdensome, and if so, why? To what extent are the Global Fund requirements getting in the way of doing what is effective?

5. Service Delivery, Prevention, and Treatment

To what extent have Global Fund grants changed the availability and utilization of services during the last few years? What is the evidence for this?

To what extent does the relative emphasis of Global Fund–supported activities on AIDS, tuberculosis, or malaria reflect the needs of the country? If not, why not?

To what extent do Global Fund–supported activities represent an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases? (Global Fund Guiding Principle E) What is the evidence for this?

Is there any evidence of effective innovative approaches, supported by Global Fund grants, to prevention or treatment of the three diseases in the country?

6.	Equity To what extent are disease-control services being provided equitably at the country level? To what extent are marginalized populations being served?
7.	Domestic Health Systems In the opinion of the interviewee, what has been the impact (positive or negative) of Global Fund–supported activities on the country's health systems? To what extent has the focus on fighting the three diseases disrupted health systems? To what extent are we (the country and the donors) managing to do both fighting diseases and building health systems at the same time? In the opinion of the interviewee, does the World Bank have a comparative advantage in strengthening domestic health systems to fill a gap in Global Fund–supported activities? If yes, what is required and what is the Bank doing in this regard? To what extent are promises of greater collaboration among Global Fund partners being reflected at the country level — in practice; in donor dialogue; and, as a minimum, in knowledge and expectations?
8.	Risk Management How well is the LFA system working to mitigate financial risks of Global Fund grants not being used for the intended purposes? To what extent is the weak absorptive capacity of domestic health systems or the absence of a comprehensive partnership strategy posing organizational risks to the Global Fund? To what extent are tensions between the Global Fund Secretariat, CCMs, Principal Recipients, and LFAs around the application of country ownership and PBF principles posing operational risks to the Global Fund. To what extent is dependence on the Global Fund for providing treatments for the three diseases posing political risks to the Global Fund?

Table A-2. The World Bank's Engagement with the Global Fund

1.	Bank's Engagement with the Global Fund at the Global Level What are the Bank's roles in the Global Fund at the corporate level? To what extent do these facilitate or hinder country-level engagement? In what other global health partnerships is the Bank involved? To what extent does this involvement facilitate or hinder country-level engagement with the Global Fund? In what other institutional collaborations is the Bank involved, such as the Global HIV/AIDS Program, the International Health Partnership, and related activities? To what extent do these facilitate or hinder country-level engagement? What other specific efforts have there been at the global level to promote country-level engagement between the World Bank and the Global Fund? What have been their impacts?
2.	Bank's Engagement with the Global Fund at the Country Level What has been the breadth and depth of Bank's engagement with the Global Fund at the country level? To what extent has the Bank been involved in country-level processes of the Global Fund, or in other country-level activities that have directly or indirectly contributed to the work of the Global Fund at the country level? What factors in relation to the two organizations' operational models have made it easier or more difficult for World Bank staff or consultants to engage with Global Fund–supported activities at the country level? What has been the Bank's own support for communicable disease control, health systems strengthening (HSS), and Sector-Wide Approaches (SWAps)? To what extent have these facilitated or hindered country-level engagement with the Global Fund? What are the respective comparative advantages of the two organizations in terms of supporting communicable disease control and HSS at the country level? What changes in the Global Fund and the World Bank would facilitate greater operational engagement at the country level?

Table A-3. The Independence and Quality of the Five-Year Evaluation of the Global Fund

Evaluation Questions
1. Evaluation Process To what extent was the GRPP evaluation independent of the management of the program, according to the following criteria: • Organizational independence? • Behavioral independence and protection from interference? • Avoidance of conflicts of interest? Factors to take into account in answering these questions include: • Who commissioned and managed the evaluation? • Who approved the terms of reference and selected the evaluation team? • To whom the evaluation team reported, and how the evaluation was reviewed? • Any other factors that hindered the independence of the evaluation such as an inadequate budget, or restrictions on access to information, travel, sampling, etc.?
2. Monitoring and Evaluation Framework of the Program To what extent was the evaluation based on an effective monitoring and evaluation (M&E) framework for the program and its activities with: • Clear and coherent objectives and strategies that give focus and direction to the program? • An expected results chain or logical framework? • Measurable indicators that meet the monitoring and reporting needs of the governing body and management of the program? • Systematic and regular processes for collecting and managing data?
3. Evaluation Approach and Scope To what extent was the evaluation objectives-based and evidence-based? To what extent did the evaluation use a results-based framework — constructed either by the program or by the evaluators? To what extent did the evaluation address: • Relevance • Efficacy • Efficiency or cost-effectiveness • Governance and management • Resource mobilization and financial management • Sustainability, risk, and strategy for devolution or exit
4. Evaluation Instruments To what extent did the evaluation utilize the following instruments: • Desk and document review • Literature review • Site visits and for what purpose: for interviewing implementers/beneficiaries, or for observing activities being implemented or completed • Case studies • Consultations/interviews and with whom • Structured surveys and of whom • Other
5. Evaluation Feedback To what extent have the findings of the evaluation been reflected in: a. The objectives, strategies, design, or scale of the program? b. The governance, management, and financing of the program? c. The M&E framework of the program?

Table A-4. Common GRPP Activities

Knowledge, Advocacy, and Standard-Setting Networks	
1. Facilitating communication among practitioners in the sector	This includes providing a central point of contact and communication among practitioners who are working a sector or area of development to facilitate the sharing of analytical results. It might also include the financing of case studies and comparative studies.
2. Generating and disseminating information and knowledge	This comprises three related activities: (a) gathering, analyzing, and disseminating information, for example, on the evolving HIV/AIDS epidemic and responses to it, including epidemiological data collection and analysis, needs assessment, resource flows, and country readiness; (b) systematic assembly and dissemination of existing knowledge (not merely information) with respect to best practices in a sector on a global/regional basis; and (c) social scientific research to generate new knowledge in a sector or area of development.
3. Improving donor coordination	This should be an active process, not just the side effect of other program activities. This may involve resolving difficult interagency issues in order to improve alignment and efficiency in delivering development assistance.
4. Advocacy	This comprises proactive interaction with policymakers and decision makers concerning approaches to development in a sector, commonly in the context of global, regional, or country-level forums. This is intended to create reform conditions in developing countries, as distinct from physical and institutional investments in public goods, and is more proactive than generating and disseminating information and knowledge.
5. Implementing conventions, rules, or formal and informal standards and norms	Rules are generally formal. Standards can be formal or informal, and binding or nonbinding, but establishing standards involves more than simply advocating an approach to development in a sector. In general, there should be some costs associated with noncompliance with established rules and standards. Costs can come in many forms, including exposure to financial contagion, bad financial ratings by the International Monetary Fund and other rating agencies, with consequent impacts on access to private finance; lack of access to Organisation for Economic Co-operation and Development (OECD) markets for failing to meet food safety standards, or even the consequences of failing to be seen as progressive in international circles.
Financing Technical Assistance	
6. Supporting national-level policy, institutional, and technical reforms	This is more directed to specific tasks than to advocacy. This represents concrete involvement in specific and ongoing policy, institutional, and technical reform processes in a sector, from deciding on a reform strategy to implementation of new policies and regulations in a sector. It is more than just conducting studies unless the studies are strategic in nature and specific to the reform issue in question.
7. Capacity strengthening and training	This refers to strengthening the capacity of human resources through proactive training (in courses or on the job), as well as collaborative work with the active involvement of developing-country partners.
8. Catalyzing public or private investments in the sector	This includes improving regulatory frameworks for private investment and implementing pilot investment projects.
Financing investments	
9. Financing country-level investments to deliver national public goods	This refers primarily to physical and institutional investments of the type found in Bank loans and credits (more than the financing of studies), the benefits of which accrue primarily at the national level.
10. Financing country-level investments to deliver global/regional public goods	This refers primarily to physical and institutional investments of the type found in Bank loans and credits (more than the financing of studies) to deliver public goods such as conserving biodiversity of global significance and reducing emissions of ozone-depleting substances and carbon dioxide, the benefits of which accrue globally.
11. Financing global/regional investments to deliver global/ regional public goods	This refers to financing research and development for new products and technologies. These are generally physical products or processes — the hardware as opposed to the software of development.

Appendix B. Timeline of the Global Fund and Related Events in the World Bank and Elsewhere

Date	Global Fund	World Bank	Other
1993		Bank publishes the *World Development Report 1993*: *Investing in Health*, emphasizing global burden of disease and introducing Disability Adjusted Life Years as a metric for performance. Bank-sponsored research study, *Disease Control Priorities in Developing Countries,* contributes to increasing international awareness of disease control challenges and opportunities.	
1994		Bank publishes *World Population Projections 1994–95*, including impact of AIDS, immediately before the International Conference on Population and Development in Cairo. (September) *Better Health in Africa* emphasizes health-systems strengthening (HSS) and gives less attention to disease control.	Joint United Nations Program on HIV/AIDS (UNAIDS) launched as a partnership to lead and inspire the world toward achieving universal access to HIV prevention, treatment, care, and support.
1996		Bank becomes a donor to the International AIDS Vaccine Initiative, providing support from the Bank's Special Grants Program.	International AIDS Vaccine Initiative is launched as a non-profit public-private product development and advocacy partnership.
1997		(September) World Bank HNP (Health, Nutrition, and Population) Sector Strategy launched. Strategy underscores importance of institutional and systemic changes to improve health outcomes for the poor, improve health system performance, and achieve sustainable health sector financing. With a portfolio of 154 active and 94 completed HNP projects, for total cumulative value of $13.5 billion (1996 prices), the Strategy states that Bank has become the largest single source of external HNP financing. Strategy calls for sharpening strategic focus but gives relatively little attention to disease control.	(June) Communiqué of G8 meeting in Denver points out that infectious diseases, including drug-resistant tuberculosis, malaria, and HIV/AIDS, are responsible for a third of all deaths in the world and states that preventing the transmission of HIV infection and the development of AIDS are urgent global public health imperatives.

Date	Global Fund	World Bank	Other
		(November) Bank releases Development Economics Department policy research study *Confronting AIDS: Public Priorities in a Global Epidemic*. Study makes the case for government intervention to control AIDS from epidemiological, public health, and public economics perspectives.	
1998		(April) Development Economics and Human Development Vice-Presidencies initiate an institution-wide AIDS Vaccine Task Force to examine innovative ways to encourage development of an effective and affordable AIDS vaccine. (November) International Development Association (IDA) 12th replenishment agreed among donors — including nearly 40 countries — permitting IDA credits for $20.5 billion, over three years.	(June) 12th World HIV/AIDS conference. (November) World Health Organization (WHO), United Nations Development Program (UNDP), the World Bank, and United Nations Children's Fund (UNICEF) launch Roll Back Malaria (RBM) to provide a coordinated approach to reduction of the prevalence of malaria, ideally by half by 2010; its leadership and secretariat are provided by WHO.
1999		(June) Bank publishes a new African HIV/AIDS strategy, *Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis,* and establishes its AIDS Campaign Team — Africa (ACT–Africa) in the Office of the Africa Regional Vice-Presidents.	(November) Medicines for Malaria Venture launched as a public-private partnership—with seed money from Switzerland, the U.K. Department for International Development (DFID), the Netherlands, the World Bank, and the Rockefeller Foundation—to develop new, affordable malaria drugs and design access and delivery modalities.
2000	(July) Expanding on prior concern with infectious disease limited to HIV/AIDS, G8 meeting in Japan agrees to implement an "ambitious plan" to deal with infectious diseases, notably HIV/AIDS, malaria, and tuberculosis, and announces a conference in Japan to deliver agreement on a new strategy to harness the G8 commitment. The conference should look to define the operations of a new partnership, the areas of priority, and the timetable for action. (December) Further to the G8 Okinawa Summit, Japan hosts meeting of health experts. Agreement is reached that a new funding mechanism to fight the three diseases should be explored.	(January) Bank President Wolfensohn addresses U.N. Security Council on HIV/AIDS at its first-ever meeting on a disease, and calls for increased resource allocation to fight a "War on AIDS." Bank pledges to substantially increase its financial support in the fight against HIV/AIDS and other communicable diseases, with an initial commitment of $1 billion and more resources as national and regional programs are developed. FY2000 HNP commitment: $1.0 billion. (World Bank *Annual Report*) Bank joins Global Alliance for Vaccines and Immunization (GAVI) at inception and provides funding from its Development Grant Facility (DGF).	(January) GAVI launched at World Economic Forum as an alliance of public and private donors hosted by UNICEF to promote and finance vaccines and immunizations. (March) Ministerial Conference on Tuberculosis And Sustainable Development attended by ministers of health and finance from 20 of the 22 high-burden countries, adopts Amsterdam Declaration on Tuberculosis and Sustainable Development. Stop Tuberculosis Partnership endorsed. (February) United States (Clinton Administration) seeks congressional funding of $4 billion for HIV/AIDS and infectious diseases.

Date	Global Fund	World Bank	Other
		(July) According to its communiqué, G8 Summit "strongly welcomed the World Bank's commitment to triple International Development Association (IDA) financing for HIV/AIDS, malaria, and tuberculosis." (September) First Multi-Country AIDS Program (MAP) is approved by the Board, providing $500 million in IDA credits for financing HIV/AIDS projects in Africa. Bank also earmarks $155 million to fight AIDS in the Caribbean.	(September) U.N. Millennium Summit adopts what became known as the Millennium Development Goals (MDGs), including to halt by 2015 and begin to reverse the spread of HIV/AIDS, the scourge of malaria, and other major diseases. (September) European Commission convenes a high-level roundtable in Brussels, with WHO and UNAIDS, to design an action program for the European Union to help developing countries confront the growing epidemics of the three diseases. The Commission, WHO, and UNAIDS announce a common stand against HIV/AIDS, malaria, and tuberculosis in the developing world.
2001	(April) U.N. Secretary General's speech at Abuja Summit of African leaders calls for African leaders and rich countries to commit at least $7–10 billion a year to the struggle against HIV /AIDS and other diseases. He proposes creation of a Global Fund, dedicated to the battle against HIV/AIDS and other infectious diseases. (May) U.N. General Assembly special session on HIV/AIDS adopts Declaration of Commitment, calling for reaching an overall target of annual expenditure on the epidemic of between US$ 7 billion and US$10 billion in low- and middle-income countries by 2005 and supporting the establishment of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic. (May) Donors make initial pledges of support to the Global Fund: U.S. pledges founding support of $200 million; U.K. and France; $300 million; Gates Foundation, $100 million. (July) With the U.N. Secretary-General, G8 Summit in Genoa announces launching of a new Global Fund, to be a public-private partnership, to fight HIV/AIDS, malaria, and tuberculosis. G8 determined to make the fund operational before the end of the year with G8	(May) After cooperating with the U.N. and others on definition of the MDGs, the Bank announces that it will join with the U.N. as a full partner to implement the MDGs and put them at the heart of its development agenda. FY2001 World Bank and IDA commitments for HNP amount to $1.3 billion. World Bank Institute launches Leadership Program on AIDS to build capacity for accelerated implementation of HIV/AIDS programs. (IEG HNP evaluation).	Global Business Coalition on HIV/AIDS, Tuberculosis, and Malaria formed under leadership of Ambassador Richard Holbrooke to mobilize the business community throughout the world in the fight against the three diseases. (April) African Union Abuja Summit commits African governments to devote 15 percent of their budgets to the health sector. (April) Mobilizing action to implement effective nation-wide programs is focus of attention of 4th Roll Back Malaria Global Partnership Meeting. (December) Report of WHO Commission on Macroeconomics and Health launched; Commission calls for donor assistance for health, coordinated by a steering group to be led by WHO and the World Bank, to increase funding from $6 billion annually to $27 billion by 2007 and $38 billion by 2015, with special emphasis on scaling up of programs, especially the fight against HIV/AIDS, tuberculosis, and malaria and global public goods for health, including greater funding of research and development.

Date	Global Fund	World Bank	Other
	commitments to the Fund of $1.3 billion. G8 calls on other countries, the private sector, foundations, and academic institutions to join with their own contributions — financially, in kind, and through shared expertise. G8 stresses low transaction costs, light governance, and a strong focus on outcomes. (August) Transitional Working Group formed with Uganda as its chair; Technical Support Secretariat is led by USAID. General organizational guidelines for the fund are defined; World Bank actively engaged, including offer to serve as interim trustee. (December) Last meeting of the Transitional Working Group decides on major structural elements of the Global Fund at the global level.		
2002	(January) Transitional Working Group converted into founding Global Fund Board. Oversight Committee drafts Framework Document. (January) Global Fund formally created as an independent Swiss foundation, with total pledges of $1.7 billion. First meeting of its Board takes place. U.S. Secretary of Health and Human Services Tommy Thompson elected chair; operating procedures adopted. Swedish International Development Authority staff member is interim head of Secretariat. Working Group on M&E established. (February) First call for proposals issued (Round 1). (March) Technical Review Panel constituted to review 400 proposals. (April) Second Board meeting. Former World Bank HNP Director Richard Feachem appointed Executive Director; trusteeship agreement with World Bank, and administrative agreement with WHO approved; $0.6 billion in grants over two-year period approved for 36 countries; $2 billion in pledges received. LFA arrangements approved. (October) Third Board meeting. Drug procurement	(February) Second $500 million MAP envelope is approved. The second MAP allows finance of ART. Seven country-level African MAP projects are approved, including two financed by the first IDA grants. World Bank becomes trustee of Global Fund financial resources, with responsibility to receive and temporarily invest Global Fund contributions and to disburse them only on instruction from Global Fund. (June) Bank Global HIV/AIDS program (GHAP) is launched, and Bank appoints its first Global HIV/AIDS advisor. Global Monitoring and Evaluation Support Team (GAMET) is created, housed at the World Bank, to facilitate UNAIDS cosponsor efforts to build country-level M&E capacities and coordinate technical support. World Bank commitments for HNP during FY02 were $1.4 billion, including $320 for communicable diseases. More than 30 countries reported to benefit from Bank support for tuberculosis control, with 45 active projects supporting malaria control. (FY02 World Bank *Annual Report*) Bank *Annual Report* highlights Bank engagement on	U.N. Secretary-General Kofi Annan launches Global Health Initiative at the 2002 World Economic Forum Annual Meeting. The Initiative's mission is to engage businesses in public-private partnerships to tackle HIV/AIDS, tuberculosis, malaria, and HSS, but communicable diseases figure relatively less prominently than non-communicable diseases in Forum. (March) External evaluation of RBM completed, finding global spending on malaria has doubled since 1998, but slow progress and need for concentrated effort at the country level. (June) G8 Summit in Canada adopts Africa Action Plan, committing leaders to help Africa combat AIDS and to strengthen health systems by continuing to support Global Fund (Chair's summary).

Date	Global Fund	World Bank	Other
	policies facilitate large-scale purchase of generic and patented medicines by developing countries. (November) Technical Review Panel reviews 200 proposals from 100 countries (Round 2). First grant agreements signed with Ghana, Tanzania, Haiti, and Sri Lanka. (December) First disbursement of $1 million made	communicable diseases, specifically including HIV/AIDS and tuberculosis, at the country level and in international partnerships.	
2003	(Jan) Board refines eligibility criteria, focusing on countries with greatest need, enabling countries with repeated unsuccessful proposals to appeal, and launches Round 3 grants process. (March) More than $10 million disbursed. Resource mobilization of Global Fund undertaken, aided by nongovernmental organizations (NGOs) working at both grassroots and in donor capitals. (May) Global tender issued for LFA support on a country-by-country basis. PBF procedures finalized after consultation with technical organizations, bilateral agencies, and recipients. (August) Global Fund and UNAIDS sign memorandum of understanding (MOU). (Oct) Board of Directors adopts M&E strategy and work program, and decides to form Technical Evaluation Reference Group (TERG), an independent expert group, to (a) advise Global Fund Board and (b) support the Global Fund Secretariat's M&E work; nine members appointed by Board of Directors and four *ex officio* members. (Oct) Board approves undertaking a Five-Year Evaluation (FYE) of Global Fund overall performance against goals and principles after at least one full grant cycle has been completed. FYE to be planned and implemented under TERG oversight. Areas for study: organizational efficiency and effectiveness; effectiveness of the partner environment; and impact of Global Fund on HIV/AIDS, Tuberculosis, and malaria.	(April) 13th Replenishment of IDA becomes effective with three years of funding at $23 billion. (September) Bank launches *Education and AIDS: A Sourcebook of HIV/AIDS Prevention Programs*, which aims to strengthen the role of the education sector in the prevention of HIV/AIDS. (September) Bank *Annual Report* describes its commitment to MDGs and emphasizes four priority sectors, including HIV/AIDS and health. (IEG HNP evaluation). Report includes boxed essay on Bank engagement at country level on HIV/AIDS, tuberculosis, and malaria, summarizing success variables such as sound public policies, strong health care capacity, adequate financing, and effective M&E. Bank/IDA commitments for health and other social services in FY2003 were $3.4 billion, including $1.6 billion for the health sector and $442 million for communicable diseases. (World Bank *Annual Report*)	(January) The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) launched to fight the global HIV/AIDS pandemic, pledges $15 billion over five years (2003–08). (June) G8 "agrees on measures to strengthen Global Fund and other bilateral and multilateral efforts." G8 health action plan encourages "those that have not yet done so" to increase their support to "Global Fund and other bilateral and multilateral efforts" to control AIDS, tuberculosis, and malaria." (Chair's summary and action plan) (December) The 3X5 ("3 by 5") initiative launched by UNAIDS and WHO. Initiative aims to provide three million people living with HIV/AIDS in low- and middle-income countries with ART by end-2005. (December) *Independent External Evaluation of Stop TB Partnership* finds major achievements, including significant progress against tuberculosis, even in difficult environments. Evaluation also finds strong commitment by partners to continuation, but that changes in donor funding priorities and establishment of new funding mechanisms such as the Global Fund have intensified competition for resources and created uncertainties on funding flows for the partnership. Aim of $20–$30 million annual long-term funding for Global [Tuberculosis] Drug Facility appears unrealistic and alternatives were found to be needed.

Date	Global Fund	World Bank	Other
2004	(March) Former Japanese prime minister announces formation of Friends of the Global Fund, Japan, to mobilize support there. (Global Fund *Annual Report*) (April) At its 8th meeting, Global Fund Board allows countries with high drug resistance (15 percent +) to purchase artemisinin combination therapy (ACT) drugs (five times more costly than first-line malaria drugs). Total approved grants: $5.9 billion over five years, $968 million over two years. Board approves periodic replenishment model for financing Global Fund. Global Fund has 51 donor countries, hundreds of private contributors, and received over $7 million in pro bono support. (Global Fund *Annual Report*) Following competitive tender, seven enterprises selected to provide LFA services (Global Fund *Annual Report*). (June) *Global Fund Monitoring and Evaluation Toolkit* published — developed jointly with WHO, World Bank, UNICEF, UNAIDS, U.S. Agency for International Development (USAID), U.S. State Department, U.S. Department of Health and Human Services, and the Centers for Disease Control and Prevention. (July) Friends of the Global Fight launched in the U.S., to mobilize publicity and support in U.S. (Global Fund *Annual Report*) Cable TV channel starts national advertizing campaign on HIV/AIDS "Stopping AIDS before it Stops the World." (July) First biennial Partnership Forum in Bangkok provides voice for 450 participants from Global Fund constituencies and recommendations are submitted to Global Fund Board of Directors. (September) Global Fund launches first media campaign, with newspapers, magazines, TV, and film. (September) TERG established; evaluation discussion paper issued on FYE (November) Ninth Board Meeting in Arusha — first	Bank HIV/AIDS portfolio at end FY04: (a) projects/components in closed projects with $666 million in Bank/IDA commitments; (b) $552 million in active AIDS projects and components; (c) $1,061 million in active Africa Region MAP operations; and (d) $111 million in active Caribbean MAP projects. Total: $1,727 million. (IEG AIDS evaluation) Bank Annual report states Bank has committed more than $2.4 billion for HIV/AIDS-related programs since 1990 and is actively engaged in policy dialogue at the country level to use Poverty Reduction Strategy Papers and the Heavily Indebted Poor Country Initiative to release funds from debt relief for fighting HIV/AIDS. Bank releases technical guide for decision makers on procurement of medicines and related supplies. $60 million Treatment Acceleration Project is approved, to pilot country-level partnerships for scaling up treatment. (July) Bank releases *Battling HIV/AIDS: A Decision-Maker's Guide to the Procurement of Medicines and Related Supplies.*	(January) Global Fund discussed at Davos World Economic Forum. (January) World Bank and WHO cosponsor first High-Level Forum on the Health MDGs and bring together heads of agencies, ministers, and senior officials from 17 developing countries (including 9 ministers of health, finance, economic planning, and local government); heads of 11 bilateral agencies; 8 multilateral agencies; and 9 foundations, regional organizations, and global partnerships (subsequent meetings include December 2004, November 2005, and June and September 2006). (April) "Three Ones" principles formulated by UNAIDS, Global Fund, and the World Bank in cooperation with others are announced at meeting to increase coordination on AIDS operations at the country level: (a) one country strategy; (b) one national HIV/AIDS coordinating institution; and (c) one M&E framework; other donors and developing countries also participate in meeting. (April) World Bank, Global Fund, UNICEF, and Clinton Foundation reach agreement that allows countries supported by the three donor institutions to gain access to ARV drugs and diagnostics at low prices negotiated by the Clinton Foundation. (June) World Bank, Global Fund, UNICEF, WHO, UNAIDS, USAID, U.S. Departments of State and Health and Human Services and Centers for Disease Control and Prevention release M&E toolkit for HIV/AIDS, tuberculosis, and malaria, subsequently revised and reissued in 2006 and 2009. (July) 15th International HIV/AIDS conference held in Bangkok. (July) U.S. Institute of Medicine panel led by Nobel Laureate economist Prof. Kenneth Arrow recommends pooling of malaria drug procurement across countries as means to reduce prices of ACTs

Date	Global Fund	World Bank	Other
	Board meeting in Africa — includes site visits and participation of three presidents of East African countries. Board adopts revised CCM requirements. (December) Headquarters agreement signed with Swiss government giving Global Fund privileges and immunities similar to international organizations. Global Fund press coverage: 3,500 times in main English language media. (Global Fund *Annual Report*) Total pledges to Global Fund: $5.9 billion; total grant commitments: $3.1 billion in 127 countries. (Global Fund *Annual Report*)		and sets the stage for Affordable Medicines Facility for Malaria (AMFm).
2005	(March) First Global Fund replenishment meeting, Stockholm, chaired by U.N. Secretary-General Kofi Annan and former World Bank Managing Director Sven Sandstrom, with participation of 30 countries. (April) Global Fund Board of Directors elects chair of National Commission for HIV/AIDS of Barbados as Global Fund Board of Directors chair. (Spring) Building on recommendations of 1st Partnership Forum, regional workshops are initiated for strengthening CCMs. (*Global Fund Annual Report*) (May) Board committees restructured as per 10th Board Meeting decision (Policy & Strategy; Finance & Audit, Portfolio, and Ethics Committees) (May) U.S. Government Accountability Office recommends changes, welcomed by Global Fund, in disbursement documentation. (*Global Fund Annual Report*) (June) Second Replenishment Meeting; France, Japan, Australia increase pledges to Global Fund. (June) Global Fund launches advertising campaign to grow grassroots support for Global Fund, in anticipation of G8 meeting. (July) Office of Inspector-General established	(January) *Rolling Back Malaria: the World Bank Global Strategy and Booster Program* provides rationale for initiating five-year "Booster Program" for malaria control. Program envisages $500–$1,000 million in new commitments for malaria control over five years. (February) Negotiations on 14th IDA Replenishment concluded, for about $35 billion over three years. (*Annual Report*) IEG evaluation of Bank HIV/AIDS assistance, *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance,* is released. It finds Bank comparative advantage to be building institutions, assessing alternatives, and improving the performance of national AIDS efforts. Concerning the MAP operations, IEG called for a thorough assessment of national strategic plans and government AIDS policies as a standard part of individual project preparation. Bank *Annual Report* states Bank has committed $2.5 billion to fighting HIV/AIDS in 67 countries, more than $600 million to tuberculosis control since 1991 in more than 30 countries, and summarizes malaria booster program. Report cites launching of Bank AIDS Media Center Web site with many partners, to	(January) World Economic Forum in Davos. WHO, UNAIDS, Global Fund, and U.S. present results of progress, especially on expanded access to antiretroviral therapy (ART). (February) Paris Declaration on Aid Effectiveness adopted at OECD meeting emphasizes principles of recipient ownership of externally funded programs and projects; alignment of donor support with recipients' strategies, institutions, and procedures; harmonization and transparency; managing for results; and mutual accountability of donors and partners for development results. (April) European Union develops action plan to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007–11). (June) Following high-level meeting to review global response to HIV/AIDS sponsored by the U.K., U.S., and UNAIDS, Global Task Team on Improving AIDS Coordination among Multilateral and International donors, *inter alia* independent study of comparative advantages of Global Fund and World Bank and assistance to countries in preparing AIDS strategies and plans is recommended. (June) Launch of President's Malaria Initiative in

Date	Global Fund	World Bank	Other
	reporting directly to Board of Directors (2010 *Progress Report*) (July) WHO Internal Oversight Office conducts audit and finds no evidence of fraud, misuse of funds, or violation of conflict of interest policies in Global Fund. (Aug) Global Fund temporarily suspends grants to Uganda and terminates grants to Myanmar. (September) 11th Board of Directors meeting. Independent Panel of experts formed to review disputed "No Go" decisions of Global Fund where phase 2 grants are suspended or stopped. (Global Fund *Annual Report*) (September) International donors pledge $3.7 billion to Global Fund for two-year period, 2006 and 2007, at replenishment conference chaired by U.N. Secretary-General. Global Fund, for the first time, includes in Round 5 financing for HSS to support HIV/AIDS, tuberculosis, and malaria; 10 percent of such proposals accepted. (Global Fund *Annual Report*) First Global Fund grant for HSS approved for Rwanda and Cambodia. Global Fund largest funder of tuberculosis and malaria control programs, and one of three largest for HIV/AIDS, along with U.S. government and World Bank; Global Fund accounts for two-thirds of international spending on both tuberculosis and malaria control. In 2005, total Global Fund disbursements $1.9 billion. (Global Fund *Annual Report*, 2006) Global Fund portfolio valued at nearly $5 billion in 131 countries. (Global Fund *Annual Report*) (December) With Global Fund support, 384,000 people receiving ARVs, 1,000,000 people under Directly Observed Treatment Short-Course (DOTS), and 7.7 million insecticide-treated bed nets (ITNs) distributed. (Global Fund *Annual Report*) (December) First Global Fund Inspector-General	provide journalists in developing countries with a global source for HIV/AIDS news, information, and analysis and to increase the accuracy, quality, and effectiveness of AIDS-related reporting. (November) Bank releases new global World Bank HIV/AIDS strategy, pointing to greater-than-ever need for donors and developing countries to mobilize around common national strategies to better fight the disease. Cumulative Bank lending to fight HIV/AIDS reported to exceed $2.5 billion. (December) Bank study, *Reaching the Poor: What Works, What Doesn't, and Why*, warns of gaps between intentions and verifiable results and reports that health programs designed to reach poor people often end up helping the better off instead. Report offers governments key policy steps to make sure that disadvantaged people get crucial health services.	United States includes a pledge to increase U.S. malaria funding by more than $1.2 billion over five years to reduce deaths due to malaria by 50 percent in 15 African countries. (June) PEPFAR Implementers Meeting, with Global Fund and World Bank. (July) As recommended by the Global Task Team, the Global Joint Problem-Solving and Implementation Support Team is established with secretariat in UNAIDS as a forum for international and multilateral partners to mobilize and harmonize effective support to address challenges to effective use of increasing external support and accelerated implementation of national AIDS responses; U.N. agencies, WHO, World Bank, and Global Fund participate. (July) G8 Summit agrees to double aid for Africa by 2010. Aid for all developing countries will increase, according to the OECD, by around $50bn per year by 2010, of which at least $25bn extra per year will be for Africa. A group of G8 and other countries will also take forward innovative financing mechanisms, including the International Finance Facility for immunization, and an air-ticket solidarity levy. G8 agrees that World Bank should have a leading role in supporting the partnership between the G8, other donors, and Africa, helping to ensure that additional assistance is effectively coordinated. G8 and African leaders agree to provide as close as possible to universal access to HIV/AIDS treatment by 2010. (Chair's summary) (September) Summit of World Leaders at U.N. General Assembly "encouraged" that OECD estimates official development assistance will increase to $50 billion per year by 2010. Leaders recommit to implementing goals of the U.N. Special Session of the General Assembly, including substantial funding of Global Fund and HIV/AIDS programs of U.N. agencies and working to implement

Date	Global Fund	World Bank	Other
	takes office. (Global Fund *Annual Report*) (December) 12th Board of Directors meeting, Marrakech, Morocco. (December) TERG releases study on CCM effectiveness.		the recommendations of the Global Task Team and "Three Ones" principles. Outcome document also welcomes, with less detail, scaling up of bilateral and multilateral efforts on malaria and tuberculosis. (November) Global Strategic Plan to combat malaria, 2005–2015, launched by RBM at Global Malaria Partners Forum in Yaoundé.
2006	(January) Product RED Initiative launched at World Economic Forum in Davos. Sale of RED-branded products benefits Global Fund AIDS programs. (Global Fund *Annual Report*) (March) 13th Board of Directors meeting, Geneva, decides to launch Round 6. (*Global Fund Annual Report*) (April) Friends of the Global Fund, Europe, launched. (Global Fund *Annual Report*) Friends of the Global Fund, Africa, launched. (Global Fund *Annual Report*, nd) (June) Global Fund launches Principal Recipient campaign in Europe with pro bono support. (Global Fund *Annual Report*) (July) G8 Summit held in St. Petersburg agrees on goal of universal access to HIV treatment by 2010. Russian Federation moves from recipient to donor status in Global Fund by committing $217 million through 2010 to reimburse costs of all Global Fund projects in the country to date. (Global Fund *Annual Report*) (July) Second biennial Partnership Forum, in Durban South Africa, with 414 participants from 118 countries, provides CSO input on Global Fund processes. E-Forum is held to expand online discussions preparatory to Partnership Forum. Mid-term review of Global Fund replenishment held. (Global Fund *Annual Report*) (July) Non-U.S. contributions reach amount required	(January) Launching of ASAP program to help countries in designing AIDS Strategy and Action Plans, in partnership with UNAIDS. (May) Bank report, *Health Financing Revisited—A Practitioner's Guide*, raises concerns about global efforts to expand health care systems, says international aid must be increased and made predictable and sustainable. Report notes that development assistance for health has increased and suggests donors need to make a more concerted effort to work with national governments to develop action plans and provide long-term, consistent financing. Profusion of donor efforts is found to have distorted country spending priorities, increased transaction costs, and fragmented health service delivery. In its *Annual Report*, the Bank reports malaria commitments of $167 million in FY06, and total tuberculosis commitments of about $600 million in more than 30 countries. Total health and social services commitments in the year: $2.2 billion. (July) As recommended by Global Task Team in 2005, AIDS Strategy and Action Plan service established by UNAIDS with coordinating unit located in World Bank GHAP to provide technical support to countries on HIV/AIDS strategy and action planning. Bank issues *Disease Control Priorities in Developing Countries, 2nd Edition* (DCP2), covering health conditions, diseases, and services, along with synthesis volume *Priorities in Health*.	(January) "Global Fund – World Bank HV/AIDS Programs Comparative Advantage Study" by Alexander Shakow issued in response to 2005 Global Task Team recommendation. (January) Launch of new Global Plan to Stop TB at 2006 World Economic Forum, where Global Fund, U.S. government, WHO, and UNAIDS announce results of their joint efforts to extend ARV treatment for HIV. (March) Development Assistant Committee (DAC)/OECD meeting with 91 countries adopts Paris Declaration on Aid Harmonization. (May) African Union Summit on Universal Access to HIV/AIDS, TB, and Malaria Treatment by 2010. (July) G8 reaffirms commitments to fight HIV/AIDS, tuberculosis, and malaria and agrees to work further with other donors to mobilize resources for Global Fund and to continue to pursue efforts to achieve as closely as possible universal access to HIV/AIDS treatment by 2010. G8 also resolves to support the Global Plan to Stop TB, aimed at saving up to 14 million lives by 2015, and to provide resources in cooperation with African countries to scale up action against malaria. (Chair's summary) (Sept) United to Aid (UNITAID) international drug purchase facility financed by air ticket levy in participating countries is launched to expand long-term access to low-priced quality drugs for the three diseases. (*Annual Report*)

Date	Global Fund	World Bank	Other
	to permit full U.S. government $414 matching contribution. (August) Global Fund grants to Myanmar terminated for management weaknesses. Global Fund grants to Uganda suspended pending definition of new management modalities with Ministry of Finance; suspension lifted in November following MOU signature with Ministry of Finance. (August) Bill and Melinda Gates laud Global Fund at International AIDS conference in Toronto. Gates Foundation pledges an additional $500 million to Global Fund (August) Global Fund launches "*Hope Spreads Faster than AIDS*" global communications campaign to engage citizens, corporations, and civil society in taking action against AIDS. Global Fund Round 5 is the first Round to include financing HSS to support HIV/AIDS, tuberculosis, and malaria; 10 percent of such proposals accepted. (Global Fund *Annual Report*) (September) Board of Directors unable to approve all grants approved by the Technical Review Panel because of a shortfall of funds pledged for 2005 at the time. Board adds donor seat. (Global Fund *Annual Report*) (September) Two-year Global Fund replenishment of $3.7 billion agreed by Global Fund donors. (October) Product RED launched in United States with New York City press conference and Oprah Winfrey TV show appearance. Total public sector donor pledges in 2006: $2.2 billion (Global Fund *Annual Report*) (November) 14th Board of Directors meeting, Guatemala; elements of Global Fund four-year strategic framework adopted. Board of Directors fails to reach consensus of two-thirds majority within each voting group on new executive director and decides to		

Date	Global Fund	World Bank	Other
	continue the search process. (Global Fund *Annual Report* and press release) (November) Two grants to Chad suspended for Global Fund resource misuse. (*Global Fund Annual Report*) Board of Directors decides to discontinue Global Fund administrative services agreement with WHO. (*Annual Report*, nd) (December) As of end-December, 384,000 people have begun ARV treatment with Global Fund support, 7.7 million ITNs against malaria distributed, and tuberculosis programs detected and treated more than 1 million cases. $1.9 billion disbursed. Sixty-four percent of funding to low-income countries and 57 percent to Sub-Saharan Africa. (Global Fund *Annual Report*) At end-2006, Global Fund had approved $6.9 billion in grants for 450 projects in 136 countries, total cumulative disbursements: $3.2 billion. (Global Fund *Annual Report*)		
2007	(March) As of March 2007, Global Fund had raised $10 billion, 450 projects approved in 136 countries. (Global Fund *Annual Report*) (April) Director of French National Agency for AIDS Research Michel Kazatchkine takes office as second Global Fund Executive Director, initiates two-year Secretariat restructuring for a rapidly growing organization. (April) Global Fund Board of Directors and G8 endorse Global Fund annual resource target of up to $8 billion. Board of Directors elects Rajat Gupta, former managing director of McKinsey & Company, as chair. FYE formally launched. (April) Rolling Continuation Channel introduced — strongly performing grants receive continued funding for additional six years. Grant consolidation on a	With health systems performance a dominant theme, Bank *Annual Report* highlights $1.83 billion in new HNP commitments in FY07, including $300 million for HIV/AIDS. (June) Bank releases Africa Region study of Bank's Africa MAP program to fight HIV/AIDS, which provided $1.3 billion for HIV/AIDS in Africa over six years. Country results achieved with MAP support included infection prevention, activities to mitigate AIDS impact, and treatment of opportunistic infections. (August) Bank releases Policy Working Paper that finds tuberculosis the most important infectious cause of adult deaths after HIV/AIDS in low- and middle-income countries and evaluates economic benefits of WHO DOTS Strategy in Global Plan to Stop TB, 2006–15. Analysis finds that economic benefits of	(April) RBM announces campaign to improve quality of proposals from African countries to Global Fund. Newly formed RBM Harmonization Working Group co-chaired by UNICEF and World Bank to lead campaign, to focus exclusively on supporting and accelerating malaria control implementation at the country level. (June) OECD High-Level Meeting on Medicines for Neglected and Emerging Diseases in the Netherlands focuses on tuberculosis and malaria. (June) G8 summit reaffirms commitment to fighting HIV/AIDS, tuberculosis, and malaria and HSS by providing at least $60 billion "over the coming years." G8 agrees that "the Global Fund continues to enjoy our full support," and to "provide predictable, long-term additional funding" under the replenishment then

Date	Global Fund	World Bank	Other
	country basis begins piloting. (April) Board of Directors decides to increase target for Global Fund grant approvals from $6 billion to $8 billion per year by 2010. (Global Fund *Annual Report*) (September) Second Voluntary Replenishment Conference in Berlin has pledges of $6.3 billion; total expected resources are $10 billion for 2008–10, tripling Global Fund resources. (Global Fund *Annual Report*) (September) Global Fund initiates new "Debt2Health" financing mechanism, supported by Germany, Indonesia, UNAIDS, Gates Foundation, the Global AIDS Alliance, *Erlassjahr.de*, and the Make Poverty History Campaign in Australia. Donor country forgoes repayment of debt, which is converted into health sector investments by recipient country through Global Fund grant process. Germany commits Euro 200 million to Debt2Health. Indonesian debt of Euro 50 million canceled and Indonesia releases Euro 25 million to Global Fund. (Global Fund *Annual Report*) (October) FYE Study Area 1 study issued, *Organizational Effectiveness and Efficiency of the Global Fund.* Technical assistance support (cash and kind) from other development agencies increases. U.S. gave $31 million support for technical assistance. "Idol Gives Back" charity campaign of U.S. TV show generates $6 million for Global Fund in 2007. (Global Fund *Annual Report*) With 76 Round 7 grants approved, Global Fund portfolio reaches $10.1 billion, with 550 grants in 136 countries; 20 percent of Round 7 funding is devoted to HSS. (Global Fund *Annual Report*)	sustaining DOTS at current levels relative to having no DOTS coverage significantly greater than costs in 22 high-burden, tuberculosis-endemic countries and Africa. (September) Updated Bank HNP strategy focuses on HSS and calls for redoubling efforts to improve results, protect households from illness, and improve sector governance. Strategy observes significant increase in complexity of HNP assistance architecture and relatively reduced financial role of Bank. IFC-World Bank study of *Business of Health in Africa* finds that private sector delivers about half of Africa's health products and services and calls for close partnership between public and private sectors. (September) Bank joins International Health Partnership. (November) Norway announces $105 million Health Results Innovation Grant for Bank to pilot *results-based financing* to link funding to verifiable better health care for mothers and their infants, in keeping with MDGs. (December) Negotiations completed on 15th IDA Replenishment, with pledges of $41.7 billion, including debt relief and new financing by 45 donor countries of $25.2 billion. (FY08 *Annual Report*)	being negotiated. (Chair's summary) (July) Informal inaugural meeting of the Health-8 (or H8, as it has become known) — WHO, World Bank, GAVI, Global Fund, UNICEF, United Nations Population Fund (UNFPA), Bill and Melinda Gates Foundation, UNAIDS — aimed at strengthening cooperation on global health; WHO and World Bank provide secretariat. (September) Launching of International Health Partnership (IHP+), bringing together developing countries (15 African and Asian countries in 2007), international agencies, and donors (10 bilateral donors in 2007) in support of mutual accountability for the health MDGs. (September) At Clinton Global Initiative meeting, Norwegian Prime Minister leads launch of a global campaign to save women's and children's lives, and pledges $1 billion in results-based financial support. UNITAID financing of tuberculosis and malaria treatments $145 million in 2007. (Global Fund *Annual Report*)

Date	Global Fund	World Bank	Other
2008	(January) Inspector-General John Parsons joins Global Fund. (Global Fund *Annual Report*) (January) Corporate Champions Program launched. Chevron invests $30 million over three years in Global Fund programs in Asia and Africa. Product RED raises $39 million at Valentine's Day auction of artists' donations. (Global Fund *Annual Report*) Dual-Track Financing introduced, under which Global Fund endorses inclusion of both government and NGOs to act as Principal Recipients under each proposal. (2010 *Progress Report*) Global Fund endorses strengthening of community-based organizations (CBOs) to achieve sustainable delivery systems. Global Fund Board of Directors approves pilot for new Affordable Medicines Facility for Malaria (AMFm) to support ACT treatment.(Global Fund *Annual Report*, nd) (March) Starting with Round 8 grants, Global Fund encourages applicants to include HSS in disease control proposals. (Global Fund *Annual Report*) With Round 8, total portfolio value reaches $15 billion in 140 countries. (Global Fund *Annual Report*) (June) FYE Study Area 2 study issued, *The Global Fund Partner Environment, at Global and Country Levels, in Relation to Grant Performance and Health System Effects, including 16 Country Studies*. Global Fund and UNITAID join forces (Joint Roadmap announced) to improve procurement, pricing and availability of medicines and diagnostics. Second Global Fund Debt2 Health Initiative. (November) Global Fund Board of Directors approves Round 8 grant financing of $2.75 billion. (*Global Fund Annual Report*) (December) Administrative services agreement with WHOI terminated.	(January) Bank announces that Indian government and Bank are joining forces to fight fraud and corruption and systemic deficiencies in India's health sector, with immediate steps to investigate indicators of wrongdoing and implement further safeguards. Government announces intention to reexamine ongoing and future projects to ensure that they incorporate lessons from a Detailed Implementation Review carried out by Bank's Department of Institutional Integrity and publicly released. The Review found serious incidents of fraud and corruption in five health projects. In FY08 International Bank for Reconstruction and Development (IBRD)/IDA committed $948 million to HNP operations. Thanks to a trust fund financed by Norway, the Bank pledged $100 million for results-based HNP financing in at least four countries. (World Bank *Annual Report*) (May) Bank releases its updated African AIDS strategy, *The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011*. Strategy states that for every infected African starting ART for the first time, another four to six become newly infected. Annual Report mentions commitment, from FY05 through FY08, of about $470 million in IDA and trust fund resources for malaria control in Africa through the booster program — more than nine times the volume of resources committed for this between 2000 and 2005. Total FY08 commitments for health and other social services: $1.6 billion. [annual report] (December) Bank launches Phase II of its Malaria Booster program.	(February) U.N. Secretary-General appoints Special Envoy on Malaria. (February) U.S. President Bush announces a five-year, $350 million initiative to combat neglected tropical diseases (TDs) in high-priority countries across Africa, Asia, and Latin America. (July) In Japan the G8 leaders renew the commitments they undertook in 2005 to increase development assistance to Africa by $25 billion yearly by 2010 with respect to the 2004 level. A shorter timescale established for implementation of the commitment undertaken in 2007 to provide $60 billion to support measures to combat infectious diseases and improve health care. G8 leaders also renew their commitment to ensure universal access to HIV/AIDS prevention measures by 2010. In malaria prevention, the G8 leaders agree to provide 100 million mosquito nets by 2010. (August) At International AIDS conference in Mexico, former Botswana President Festus Mogae launches "Champions for an HIV-free Generation," a group of renowned African leaders calling for their peers to rethink and step up efforts to prevent the spread of HIV, including former Presidents of Mozambique, Tanzania, and Zambia, Archbishop Desmond Tutu, an Ethiopian super model, and a South African Supreme Court of Appeal Justice. (September) Accra Agenda for Action (AAA) adopted by donors and development partners, in follow-up to the Paris Declaration, extends beyond aid harmonization at the country level to focus on strengthening country ownership and creative inclusive partnerships, underscoring mutual accountability for results and identifying concrete actions for all development partners. (FY09 *Annual Report*)

Date	Global Fund	World Bank	Other
	(December) First Lady of France Carla Bruni-Sarkozy becomes Global Fund Ambassador for protection of mothers and children against AIDS, visits clinics in Burkina Faso. (*Global Fund Annual Report*) (December) Third Partnership Forum, Dakar, generates 28 recommendations to Board of Directors and Secretariat. (2010 progress report) Round 8 funding: $2.75 billion for malaria (RBM second evaluation) ILFAs: Global Fund *Global Fund Annual Report* lists 12 organizations serving in this capacity, including World Bank and UN OPS. 2008 Global Fund disbursements: $2.3 billion. Of total Global Fund investments, 68 percent are in low-income countries and 25 percent in lower-middle-income countries, 60 percent in Sub-Saharan Africa, 35 percent, or about $4 billion, supporting HSS components. Global Fund providing 23 percent of international financing for HIV/AIDS, 60 percent for malaria, and 57 percent for tuberculosis. Contributions and pledges in 2008: $3.1 billion, $12.8 billion; total approved grants, $14.8 since inception. Private sector: 6.6 percent of total Global Fund contribution. (Global Fund *Global Fund Annual Report*) Product RED brings $68 million to Global Fund in 2008. (Global Fund *Annual Report*) Total staff at end 2008: 392. (Global Fund 2009 *Annual Report*)		(September 25) World leaders and the global malaria community gather on occasion of the 2008 U.N. MDG Summit on September 25, 2008, in New York to endorse a Global Malaria Action Plan facilitated by RBM; substantial new resources mobilized, and partners agree on target to eliminate malaria in 8–10 countries by 2015. (Global Fund *Annual Report*/ RBM 2nd evaluation). (October) CoATS (Coordinating AIDS Technical Support) database launched by UNAIDS to assist countries to monitor technical support and facilitate greater accountability and country ownership of HIV/AIDS technical assistance. Thanks to PEPFAR and Global Fund investments, 3.5 million people reported on ARVs. (Global Fund *Annual Report*)
2009	Thirty-two percent of Global Fund resources to programs implemented by CSOs, 56 percent implemented by government agencies, and 6 percent implemented by UNDP. (Global Fund *Annual Report*.) *Global Fund Annual Report* lists programs and funding by country rather than individual grant. AMFm hosted by Global Fund launched with eight	(March) Progress report to Board on implementation of 2007 HNP strategy underscores HSS and importance of strengthening the HNP portfolio, cites examples of results-based financing, underscores multisectoriality of HNP support, mentions that about one-half of Poverty Reduction Support Credit operations have an HNP aspect, and stresses IHP+	(February) IHP+ organizes health summit in Geneva. (May) High-level Taskforce on Innovative International Financing for Health Systems, co-chaired by U.K. prime minister and World Bank president, releases report recommending *inter alia* establishing a health systems funding platform for the Global Fund, GAVI Alliance, the World Bank, and others to coordinate,

Date	Global Fund	World Bank	Other
	pilots, in follow-up on U.S. Institute of Medicine 2004 study. (February) Global Fund and Stop TB Partnership sign MOU. Core areas for cooperation include support to Global Fund grantees by the Global Drug Facility and Green Light Committee; coordination of technical assistance; and M&E. (February) Pacific Friends of Global Fund joins Friends organizations in Africa, U.S., Japan, Europe, Latin America, and South and West Asia as NGO advocates for Global Fund. (March) FYE synthesis report issued, *The Five Year Evaluation of the Global Fund to Fight AIDS, TB, and Malaria: Synthesis of Study Areas 1, 2, and 3*, with Board of Directors discussion. (May) Global Fund plans Code of Conduct for providers of goods and services financed with Global Fund resources. (May) FYE Study Area 3 study issued, *The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis, and Malaria*. (May) Gender Equality Strategy and the Strategy on Sexual Orientation and Gender Identities adopted. (June) Voluntary pooled procurement approved, for collective purchase of drugs by countries, amounting to 30 countries, 98 orders, total order value $27 million by the end of 2009. (Global Fund *Global Fund Annual Report*) HSS: Round 9 funding $738 million, total funding committed and signed by end-2009: $1.2 billion. (Global Fund *Annual Report*) (July) Minister of Health of Ethiopia elected Global Fund Board of Directors chair. (August) As a result of unaccounted funds, Global Fund stops disbursing funds to Ministry of Health in Zambia, transfers resources to UNDP.	cooperation. (April) IEG releases evaluation of $17 billion in World Bank support for HNP since 1997, two-thirds with satisfactory outcomes, but portfolio performance stalling. IEG finds the Bank financing a smaller share of HNP support and observes that excessive earmarking of foreign aid for communicable diseases (their reduction being an objective of 35 percent of HNP operations) can distort allocations and reduce health system capacity. It recommended that the Bank carefully assess decisions to finance additional freestanding communicable disease programs in countries where other donors are contributing large amounts of earmarked disease funding. (April) Bank report, *Averting a Human Crisis during the Global Downturn: Policy Options from the World Bank's Human Development Network*, presents findings from a March 2009 survey conducted in 69 countries, which offer treatment to 3.4 million people on ART, suggests that 8 countries face shortages of antiretroviral drugs or other disruptions to AIDS treatment. Twenty-two countries in Africa, the Caribbean, Europe and Central Asia, and East Asia and the Pacific expect to face disruptions. These countries are home to more than 60 percent of people worldwide on AIDS treatment. HIV/AIDS prevention programs are also in jeopardy. Thirty-four countries representing 75 percent of people living with HIV already see an impact on prevention programs that target their high-risk groups. FY09 HNP lending reaches $2.9 billion — a threefold increase over previous year. Disbursements and new commitments for HIV/AIDS were $290 million and $326 million. (*World Bank Annual Report*) Analytical work on HIV/IDS in FY09 includes a 71-country survey of the impact of economic crisis on efforts to prevent disruptions in treatment and prevention programs. (*World Bank Annual Report*)	mobilize, streamline, and channel the flow of existing and new international resources to support national health strategies. (May) Under general umbrella of IHP+, launch of Joint Funding Platform for HSS (Global Fund, GAVI, and World Bank, facilitated by WHO, with secretariat in World Bank). Platform based on four principles: (a) one national health strategy; (b) one joint assessment of national health strategy by development partners using the Joint Assessment of National Strategies (JANS) tool; (c) one fiduciary framework, including financial management and procurement; and (d) one M&E framework based on country systems. Platform work program focuses on new funding informed by the JANS, harmonization and alignment of existing support at the country level, and harmonization of GAVI and Global Fund HSS proposal forms. (July) G8 recognizes contributions of Global Fund, WHO, and World Bank to health in developing countries and encourages them to cooperate with developing countries on country-led strategies and plans. G8 reaffirms existing commitments, including $60 billion to fight infectious diseases and strengthen health systems by 2012. G8 encourages multilateral institutions — including WHO, World Bank, GAVI, UNITAID, Global Fund, and U.N. agencies — to continue to support HSS. (communiqué) In cooperation with RBM and other partners, United Against Malaria Campaign launched by private firms in South Africa to mobilize awareness and financial resources for Global Fund, stimulated by South Africa's hosting of World Cup soccer. (Global Fund *Annual Report*) (September) Launch of African Leaders Malaria Alliance on occasion of 64th U.N. General Assembly. (G8 communiqué) (September) Second evaluation of RBM released, covering 2004–08, finding renaissance of

Date	Global Fund	World Bank	Other
	(September) Inspector-General makes recommendations to strengthen grant processes. (*Progress Report*) (November) 20th Board of Directors meeting approves new grant architecture, providing for National Strategy Applications, to be piloted with $434 million in grants. (Global Fund *Annual Report*) (November) Board of Directors approves Debt2Health as permanent feature of Global Fund resource mobilization. (Global Fund *Annual Report*) By end-2009, Global Fund-supported programs saving 3,600 lives a day, AIDS treatment to 2.5 million people, detection and treatment of a total of 6 million new active tuberculosis cases, a cumulative total of 104 million ITNs, total 4.9 lives saved by end 2009. (Global Fund *Annual Report*, 2010 *Progress Report*) Grant portfolio at end-2009, by disease: HIV/AIDS, 55 percent; ; tuberculosis, 16 percent; malaria, 29 percent; 57 percent, Sub-Saharan Africa; planned grant expenditure: 24 percent, human resources and training; 21 percent, medicines; 18 percent, health equipment and products; 12 percent, program management; 4 percent, M&E. (Global Fund *Annual Report*) Total pledges in 2009: $3.3 billion, private sector contributions; $43 million (Global Fund *Annual Report*); total approved proposals, $19.2 billion; total disbursements, $10 billion; portfolio, 144 countries; $5.9 billion in commitments in fragile states, 41 percent of total in fragile states. Total funds raised by end-2009: $21 billion. (Global Fund 2010 *Progress Report*) Nearly $1billion freed up for funding new grants by reallocation from poorly performing grants. (Global Fund 2010 *Progress Report*) 2009 policy adjustments to improve aid effectiveness at the country level: coordination of country program	*Annual Report* reports MAP providing $1.8 billion to Africa since 2001 for prevention and treatment in more than 30 countries. To combat malaria, Bank committed more than $1 billion for Phase II (2009–12) of the Malaria Booster Program in Africa.	engagement on malaria since the founding of RBM in 1998. Confirmed malaria funding grew from $200 million in 2004 to $688 million in 2006, and 2004–08 period was a time of success in the fight against malaria and for RBM and its partners. Successes include seven African countries/areas reporting 50 percent reduction in malaria cases between 2000 and 2006. Agreed malaria goals now include universal coverage by 2010 and zero deaths by 2015. (September) Gates Foundation report issued, *GAVI and Global Fund Joint Programming for Health Strengthening: Turf Wars or an Opportunity to do Better.*

Date	Global Fund	World Bank	Other
	salaries with local or agreed international framework, support for alignment with adequate country systems and cycles for procurement, financial management, and M&E, Global Fund local financial transparency and accountability with guidelines for Global Fund aid reporting. (Global Fund 2010 *Progress Report*) As of end-2009, Product RED has raised $140 million to support programs in four African countries. (Global Fund 2010 *Progress Report*) From 2005 to 2009 nearly 80 percent of grants assessed as performing well, tuberculosis best-performing grants, and CSOs best performing Principal Recipients. (Global Fund 2010 *Progress Report*) Total employees at end 2009: 569. (Global Fund *Annual Report*) <u>Five Year Evaluation:</u> (March) Final report issued (May) Board and Policy and Strategy Committee discuss FYE.		
2010	Global Fund adopts new grant architecture, with single stream of funding per Principal Recipient per disease. Global Fund publishes "Global Fund Aid Effectiveness Scorecard" with data from 2005, 2007, and 2008, with 2010 targets, according to Paris Declaration and DAC criteria (Global Fund 2010 *Progress Report*) Global Fund lists changes in policies and processes made in response to recommendations of Technical Review Panels. (Global Fund 2010 *Progress Report*) Global Fund Inspector-General reports misuse of funds in 4 of 145 countries with Global Fund financial support. (Global Fund press release, early 2011) FYE key recommendations and Global Fund Secretariat response tabulated in Global Fund	(May) Bank releases five-year reproductive health action plan to help poor countries reduce high fertility rates and prevent deaths of mothers and children. Bank warns that family planning and other reproductive health programs have fallen off development radars of many low-income countries, donor governments, and aid agencies. (June) Bank study of results-based financing for health presented, on definitions and concept, measurement, and global experience. FY10 HNP commitments of $4.2 billion exceed previous year. Eleven new projects commit $194 million for HIV/AIDS. Overall HNP portfolio of $10 billion, of which more than half in the poorest countries. To strengthen AIDS operations, AIDS Strategy and Action Plan (ASAP) services reach 65	(June) G8 Summit in Canada reaffirms commitment to "come as close as possible to universal access to prevention, treatment, care, and support with respect to HIV/AIDS." G8 agrees to "support country-led efforts to achieve this objective by making the third voluntary replenishment conference of the Global Fund to Fight AIDS, TB and Malaria in October 2010 a success." G8 encourages "other national and private sector donors to provide financial support for the Global Fund." G8 launches the "Muskoka Initiative, a comprehensive and integrated approach to accelerate progress towards MDGs 4 and 5 that will significantly reduce the number of maternal, newborn and under five child deaths in developing countries." (July) 13th International AIDS conference

Date	Global Fund	World Bank	Other
	Progress Report. (April) Global Fund and RBM sign MOU under which they commit to work together to keep malaria a global health priority, to generate high-quality proposals from as many affected countries as possible, and to monitor the implementation and impact of overall response to malaria. (May) Global Fund launches Round 10 of grant proposals. (September) Board of Directors decides to introduce multi-year contribution agreements with public donors and promissory notes with private donors. (Chair replenishment summary) (October) Global Fund hosts side event with public policy and celebrity *Champions of Global Health* at U.N. MDG review summit. October) Global Fund-sponsored *Born HIV Free* campaign reaches symbolic completion with U.N. Secretary-General receiving a book containing some of the 700,000 names of people who signed up in support of the Global Fund. Names—gathered from the campaign Web site, YouTube, and through advocacy partners—form part of a call for sufficient funds to be made available to achieve elimination of mother-to-child transmission of HIV by 2015. Campaign reached 20 million respondents and 250 million viewers. (October) Global Fund Third Voluntary Replenishment for 2011–13 chaired by U.N. Secretary-General Ban includes pledges and projections of $11.7 billion, with 50 participating delegations; additional $2.5 billion expected by Secretariat beyond the pledged $11.7 billion. Pledges represent 20 percent increase. (Global Fund Web site), but replenishment falls short of investing the $20 billion estimated to be needed to fully fund the fight against the three pandemics. A day after the replenishment meeting, several newspapers, in the U.K., Spain, France, and Germany, showed	countries, and GAMET provides M&E support to 25 countries. Bank works with partners to build a Health Systems Funding Platform to support country progress towards national health goals and the MDGs. (*Annual Report*) (September) Bank releases study of *Unfinished Business: Mobilizing New Efforts to Achieve the 2015 Millennium Development Goals* for U.N. MDG review summit outlining developing countries' progress in overcoming poverty until recent food, fuel, and financial crises. Report estimates that as a result of these crises, 64 million more people are living in extreme poverty in 2010, and some 40 million more people went hungry in 2009. By 2015, 1.2 million more children under five might die, and about 100 million more people might remain without access to safe water. (December) IDA 16 replenishment for $49.3 billion, over three years, agreed, including 51 donors and stress on improving health services and 4 special themes: crisis response, gender, climate change and fragile and conflict-affected countries (World Bank press release, IDA deputies report)	(August) Nepal's leading health aid donors— DFID, World Bank, GAVI, USAID, UNFPA, and UNICEF — agree to funnel financial support through one simplified aid management system, in early application of Health Systems Funding Platform. Arrangement brings together donors able to pool their support (World Bank, DFID, and GAVI) and others such as USAID, UNFPA, and UNICEF that provide on-budget resources but do not pool their funds. (October) MDG Review Summit at U.N. General Assembly "recognizes" that more attention should be paid to Africa. While aid to Africa has increased, it has fallen behind commitments. Leaders commit themselves to redoubling efforts strengthen national health systems and to combat HIV/AIDS. Under MDG 4, on child health, leaders commit to maintaining progress on malaria, including extending use of ITNs. On MDG 6, on combating HIV/AIDS, malaria, and other diseases, leaders commit to redoubling e treatment, care and support. Efforts against HIV/AIDS, tuberculosis, malaria, and other diseases to include adequate funding of Global Fund and other bilateral and multilateral programs efforts for universal access to HIV/AIDS prevention.

Date	Global Fund	World Bank	Other
	support for the Global Fund by donating one-page advertisements to allow Global Fund to thank the general public and government donors for their support. (December) Dow Jones Indexes launches a new index, in collaboration with Global Fund. The Dow Jones Global Fund 50 Index measures performance of the largest companies that support the Global Fund mission. A portion of revenues generated through licensing the index will go to the Global Fund. Global Fund disburses $3 billion in 2010. Secretariat creates 49 single-stream funding arrangements and reduces total number of grants by 10 percent.		
2011	(January) Germany and Sweden, joined separately by Spain and Denmark, suspend total of $180 million in Global Fund contributions pending outcome of review of allegations of misuse of funds. (press reports) (March) Global Fund announces establishment of independent panel reporting to Board of Directors, co-chaired by former President of Botswana and a former Republican U.S. Secretary of Health and Human Services, to review financial safeguards, controls, and anti-corruption protections; initial measures to strengthen financial safeguards announced. Global Fund grant to Mali suspended for misuse of funds. (Global Fund press releases) (May) 23rd Board of Directors meeting. Board endorses five-year strategy, including a "market-shaping" program aiming to optimize price, quality, design, and sustainable supplies of health products, initially ARVs. Board of Directors elects former DFID director-general as chair. (June) Global Fund, Germany, and Egypt sign new type of Debt2Health agreement under which Germany agrees to write off €6.6 million of Egyptian debt, while Egypt agrees to contribute half of this amount to Global Fund programs to fight malaria in Ethiopia.	(June) June 2011 – Bank study resulting from partnership with UNDP and Johns Hopkins School of Public Health provides evidence that better HIV prevention, care, and treatment services for men who have sex with men; improve overall HIV epidemic control (June) World Bank IFC affiliate issues assessment of how governments and private health sector work together in 45 African countries.	(February) U.S. President Obama's budget proposals for FY12 foresee exemption of foreign assistance from freeze in discretionary spending, small increases in funding for HIV/AIDS, tuberculosis, and malaria. (Center for Global Development Web site). (March) Despite overall approach of budget cuts, aid review by new U.K. government reaffirms promise to reach U.N.'s 0.7 percent of GNP aid target by 2013. Global Fund and IDA among 9 of 43 multilateral organizations assessed in top category as providing very good value for U.K. aid money, UNITAID assessed as providing good value, WHO and UNAIDS providing adequate value. Global Fund found to be largest multilateral funder of health MDGs, with weaknesses in its business model because Global Fund systems often take precedence, despite country-led approach; Global Fund insufficiently flexible in fragile states. IDA's internal incentives found to focus on inputs rather than results; review critical of IDA's high transaction costs and limited use of country systems. Review finds Global Fund critical to achievement of health MDGs but concludes that Global Fund is burdensome for countries and partners. Review finds IDA comparative advantage is breadth and quality of technical knowledge, expertise, and global

Date	Global Fund	World Bank	Other
			reach. Review cites partnership behavior as area for reform under IDA 16. (April) Republican alternative to U.S. President Obama's FY12 budget proposals would cut international affairs spending by 40 percent. Final FY11 budget agreed by executive and legislative branches with substantial cuts in domestic and international affairs spending. However, IDA approved at $1.235 billion, without a cut, PEPFAR approved at $4.6 billion, without a cut, and Global Fund approved at $1.05 billion, without a cut. (ONE campaign Web site) (June) U.N. Security Council meets on HIV/AIDS for second time, after initial meeting in 2000; UNAIDS executive director underscores need for a new response to AIDS in U.N. actions to help prevent conflict, ensure security and build peace. U.N. General Assembly holds 2nd High-Level meeting on HIV/AIDS, after 2001 UNGASS session, with 30 presidents, vice presidents and heads of government. U.N. Secretary-General articulates common goal of an end to AIDS within the decade—zero new infections, zero stigma, and zero AIDS-related deaths. General Assembly declaration mentions eightfold increase in funding to combat AIDS from 2001 to $16 billion in 201, but states that funding did not increase in 2010 and that the more than $30 billion donor commitments to Global Fund has fallen short of Global Fund targets. (June) U.N. Secretary-General and U.S. government launch initiative Countdown to Zero to eliminate HIV among babies by 2015, at estimated cost of $2.5 billion; plan developed by UNAIDS and PEPFAR, and supported by Global Fund.

Sources: World Bank Annual Reports at http://search.worldbank.org/all?qterm=annual%20reports;
Global Fund Annual Reports at http://www.theglobalfund.org/en/library/publications/annualreports/;
Global Fund press and media releases at http://www.theglobalfund.org/en/mediacenter/;
World Bank press and media releases at http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,pagePK:34382~piPK:34439~theSitePK:4607,00.html

Appendix C. Global Fund: Purpose, Principles, and Results Chain

Source: "Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria" (Global Fund 2003).

Purpose

The purpose of the Fund is to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals.

Principles

A. The Fund is a financial instrument, not an implementing entity.

B. The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria.

C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes.

D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases and interventions.

E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.

F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.

G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.

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

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

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

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

4. Build on, complement, and coordinate with existing regional and national programs[1] in support of national policies, priorities and partnerships, including Poverty Reduction Strategies and sectorwide approaches.

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

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

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

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

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

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

1. Including governments, public/private partnerships, NGOs, and civil society initiatives.

Table C-1. Global Fund: Results Chain

Activities Financed	Outputs	Outcomes	Impacts
HIV/AIDS			
Support for screening and quality assurance of blood products.	Expanded screening of and improved blood transfusion services.	Safer blood products.	Reduced transmission of HIV through contaminated blood products.
Appropriately designed programs, including support for programs addressing high-risk groups in countries with concentrated epidemics.	Inclusive programs that reach men who have sex with men, sex workers, injecting drug users (needle exchanges, etc.).	High-risk groups have greater access to and seek services.	
Expanded sites for voluntary counseling and testing.	Expanded capability for counseling and testing of pregnant women for HIV and counseling of adolescent in sex behavior.	Pregnant women positive for HIV treated with ART to prevent mother-to-child transmission of HIV; and more responsible sex behavior in adolescents.	Reduced mother-to-child transmission of HIV and reduced infections in adolescents.
Appropriate market and research inputs for information, education and communication (IEC) and community mobilization programs.	Well-designed, effective communications and counseling programs promoting safe sex (condom use) and other behavioral change, e.g., seeking testing and counseling, targeted at high-risk groups.	Desired behavior change in targeted groups, e.g., people with more than one sex partner in past 12 months use condoms in last sexual intercourse.	
Support for ART through public and NGO networks.	Identification of populations affected with HIV and enrolment into treatment. programs.	People living with AIDS treated with ART.	Increased numbers of people living with AIDS continuing to receive ART treatment.
Tuberculosis			
Training and supplies for expanded and improved tuberculosis detection, referral, and treatment (include testing of HIV/ AIDS populations where appropriate).	Improved case detection of tuberculosis and early treatment opportunities.	Early and effective treatment of tuberculosis. Higher cure rate.	Decline in tuberculosis prevalence.
Support and supplies to expand DOTS.	Improved access to tuberculosis DOTS services and drugs.	Early and effective treatment of tuberculosis. Higher cure rate.	
Health systems strengthening.	Tuberculosis interventions integrated into	Efficiency gains – through system	Decline in tuberculosis prevalence.

Activities Financed	Outputs	Outcomes	Impacts
	general health services.	strengthening.	
Support for diagnosis of multiple-drug-resistant tuberculosis and availability of drugs to treat them.	More cases of multiple-drug-resistant tuberculosis identified and treated with appropriate drugs.	Improved control of multiple-drug-resistant tuberculosis.	
Malaria			
Support for pharmacovigilance in countries with drug resistance.	Regulatory authorities equipped with knowledge, skills, and equipment to fight counterfeit drugs.	Regulatory authorities acting on their knowledge and equipment.	Reduced risk of drug resistance.
Support for expanded distribution networks and access to impregnated bed nets; social marketing.	At risk population seeking bed nets and having greater access to them. Improved understanding of risks to children under five.	Increased number of people sleeping under treated bed nets, especially children under five.	Reduced malaria mortality.
Support for programs targeted to expectant mothers.	Intermittent prophylaxis of expectant mothers against malaria in high-burden countries.	Women positive for malaria treated with appropriate antimalarials to prevent transmission to newborn.	Reduced mother-to-child transmission of malaria.
Health Systems Strengthening			
Conduct of surveys (Sentinel Surveillance, Demographic Health, and Behavioral) and epidemiological and analytical studies to strengthen evidence base for national program response. Training and capacity building of institutions (public and private, NGO) to improve skills competency and quality of services (e.g., improved capability in tuberculosis detection and diagnosis, interventions to combat drug resistant strains of malaria).	Appropriately designed programs that are country-specific and contextual; e.g., appropriate mix of prevention, treatment, and care and support strategies for all three diseases as described below.	See above.	See above.

Source: Constructed by IEG.

Appendix D. Global Fund: Core Structures

Source: The Global Fund, www.theglobalfund.org/en/structures/?lang=en

Country Coordinating Mechanism (CCM): At country level, this is a partnership composed of all key stakeholders in a country's response to the three diseases. The CCM does not handle Global Fund financing itself, but is responsible for submitting proposals to the Global Fund, nominating the entities accountable for administering the funding, and overseeing grant implementation. The CCM should preferably be an already-existing body, but a country can instead decide to create a new entity to serve as CCM.

Global Fund Secretariat: This manages the grant portfolio, including screening proposals submitted, issuing instructions to disburse money to grant recipients, and implementing PBF of grants. More generally, the Secretariat is tasked with executing Board policies; resource mobilization; providing strategic, policy, financial, legal, and administrative support; and overseeing M&E. It is based in Geneva and has no staff located outside its headquarters.

Technical Review Panel: This is an independent group of international experts in the three diseases and cross-cutting issues such as health systems. It meets regularly to review proposals based on technical criteria and to provide funding recommendations to the Board.

Global Fund Board: This is composed of representatives from donor and recipient governments, civil society, the private sector, private foundations, and communities living with and affected by the diseases. The Board is responsible for the organization's governance, including establishing strategies and policies, making funding decisions, and setting budgets. The Board also works to advocate and mobilize resources for the organization.

Principal Recipient: The Global Fund signs a legal grant agreement with a Principal Recipient, which is designated by the CCM. The Principal Recipient receives Global Fund financing directly, and then uses it to implement prevention, care, and treatment programs or passes it on to other organizations (sub-recipients) who provide those services. Many Principal Recipients both implement and make sub-grants. There can be multiple Principal Recipients in one country. The Principal Recipient also makes regular requests for additional disbursements from the Global Fund based on demonstrated progress toward the intended results.

Global Fund Trustee: This manages the organization's money, which includes making payments to recipients at the instruction of the Secretariat. The trustee is currently the World Bank.

Local Fund Agent (LFA): Since the Global Fund does not have staff at the country level, it contracts firms to act as LFAs to monitor implementation. LFAs are responsible for providing recommendations to the Secretariat on the capacity of the entities chosen to manage Global Fund financing and on the soundness of regular requests for the disbursement of funds and result reports submitted by Principal Recipients.

Appendix E. Members of the Global Fund Board

Constituency	Member	Position	Organization/Country
Chair			
	Mr. Simon Bland	Deputy Director	Department for International Development
Vice Chair			
	Ms. Mphu Ramatlapeng	Minister of Health and Social Welfare	Government of Lesotho
Donor Governments			
European Commission (Belgium, Finland, Portugal)	Mr. Kristian Schmidt	Director of Human and Society Development DG for Development and Cooperation DEVCO	European Commission
France	Amb. Patrice Debré	Ambassador for the Fight against HIV and Communicable Diseases	Ministry of Foreign and European Affairs, France
Germany (Canada, Switzerland)	Dr. Reinhard Tittel-Gronefeld	Head of Division, Health, Population Policies	Federal Ministry for Economic Cooperation and Development (BMZ), Germany
Italy and Spain	Ms. Elisabetta Belloni	Director General-Directorate General for Development Cooperation	Ministry of Foreign Affairs, Italy
Japan	Mr. Masaya Fujiwara	Deputy Director General for Global Issues	International Cooperation Bureau, Ministry of Foreign Affairs, Japan
Point Seven (Denmark, Ireland, Luxemburg, Netherlands, Norway, Sweden)	Dr. Martin Greene	Consultant to Irish Aid	Ireland
United Kingdom and Australia	Carlton Evans	Programme Manager Department for International Development	United Kingdom
United States	Amb. Eric Goosby	U.S. Global AIDS Coordinator	Office of the U.S. Global AIDS Coordinator, United States
Recipient Governments			
Eastern and Southern Africa	Minister Moina Fouraha Ahmed	Ministère de la Santé, de la Solidarité, de la Cohésion sociale et de la Promotion du Genre	Union of the Comoros
Eastern Europe	Dr. Viorel Soltan	Deputy Minister of Health Ministry of Health	Republic of Moldova
Eastern Mediterranean Region	Amb. Abdulkarim Yehia Rasae	Minister of Public Health	Ministry of Public Health and Population, Yemen

Constituency	Member	Position	Organization/Country
Latin America and Caribbean	Minister Leslie Ramsammy	Minister of Health	Guyana
South East Asia	Minister Rajendra Mahato	Minister Ministry for Health and Population	Nepal
West and Central Africa	Prof. Georges Marius Moyen	Minister	Ministry of Health and Population, Congo
Western Pacific Region	Dr. Huang Jiefu	Vice-Minister of Health	Ministry of Health, China
Civil Society, Private Sector, Private Foundations, and Communities			
Communities	Mr. Shaun Mellors	Head: Treatment, Care and Support Department - Treatment Cluster Foundation for Professional Treatment	South Africa
Developed Country NGOs	Mr Alvaro Bermejo Executive Director	Executive Director	International HIV/ AIDS Alliance United Kingdom
Developing Country NGOs	Dr. Cheikh Tidiane Tall	Executive Director	African Council of AIDS Service Organizations, Senegal
Private Foundations	Dr. Ernest Loevinsohn	Director, Global Health Policy and Advocacy	Bill and Melinda Gates Foundation, United States
Private Sector	Dr. Brian Brink	Chief Medical Officer	Anglo American plc, South Africa
Ex Officio Members without Voting Rights			
Global Fund to Fight AIDS, Tuberculosis and Malaria	Prof. Michel Kazatchkine	Executive Director	Global Fund, Switzerland
Partners (Roll Back Malaria, Stop TB, UNITAID)	Dr. Lucica Ditiu	Executive Secretary	Stop TB Partnership Secretariat, Switzerland
UNAIDS	Mr. Michel Sidibé	Executive Director	UNAIDS, Switzerland
WHO	Dr. Hiroki Nakatani	Assistant Director General, HIV/AIDS, TB Malaria and Tropical Diseases	World Health Organization, Switzerland
World Bank	Mr. Axel van Trotsenburg	Vice President, Concessional Finance and Global Partnerships	World Bank
Board Designated Non-Voting Swiss Member	Mr. Edmond Tavernier	Managing Partner	Tavernier Tschanz (Avocates: Attorneys-at-Law), Switzerland

Source: Global Fund, www.theglobalfund.org/en/board/members/?lang=en

Appendix F. Global Fund: Sources and Uses of Funds

Table F-1. Global Fund: Income and Expenditures (US$ millions, calendar years)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
Income											
Contributions	880.82	1,416.65	1,254.69	1,430.33	2,429.64	2,963.75	3,714.20	2,590.44	2,328.97	19,009.47	95.1%
Contributions received, incl. encashed promissory notes		1,330.86	1,101.01	1,584.34	1,652.78	2,853.37	2,830.71	2,987.26	2,928.64		
Increase in promissory notes to be encashed		10.62	174.99	-168.48	350.44	76.74	13.52	111.08	85.24		
Increase/(decrease) in contributions receivable		75.17	-28.58	2.64	417.31	32.05	869.13	-508.49	-689.97		
Deferred revenue released in Statement of Activities									3.50		
Contributions in kind		0.00	7.27	11.83	9.11	1.60	0.84	0.58	1.57		
Foreign currency exchange gain (loss)		0.00	0.00	0.00	0.00	-50.87	-83.71	124.83	-97.15	-106.90	-0.5%
Bank and trust fund income	10.08	28.24	33.82	58.94	126.50	240.50	289.72	150.40	149.68	1,087.88	5.4%
Total Income	890.89	1,444.89	1,288.51	1,489.27	2,556.13	3,153.38	3,920.21	2,865.67	2,381.50	19,990.46	100.0%
Expenditures											
Grants disbursed during the year	0.90	231.20	627.51	1,054.33	1,306.97	1,710.81	2,259.25	2,749.46	3,060.68	13,001.10	92.7%
Employment costs	2.75	9.79	16.85	25.05	30.63	41.05	71.65	91.68	107.06	396.53	2.8%
Other Secretariat expenses	7.02	10.77	19.57	27.29	28.92	41.07	63.13	74.78	90.34	362.88	2.6%
Administrative services fee	0.86	0.90	0.98	0.99	2.09	1.97	2.51	-	-	10.30	0.1%
Communication materials	0.14	0.97	7.73	8.87	1.22	2.57	4.02	3.73	4.42	33.65	0.2%
Office rental	0.43	0.51	0.75	1.04	2.20	4.68	7.14	7.64	8.24	32.63	0.2%
Office infrastructure costs	0.61	1.00	1.42	3.49	2.11	5.04	10.97	16.45	27.54	68.64	0.5%
Travel and meetings	1.03	3.75	4.67	5.93	8.19	10.93	12.34	18.54	19.53	84.90	0.6%
Other professional services	3.33	2.08	3.52	5.99	12.18	15.00	24.79	27.01	29.70	123.60	0.9%
Other	0.63	1.57	0.49	0.99	0.93	0.87	1.37	1.42	0.90	9.17	0.1%
Local Fund Agent fees	0.67	10.12	12.18	19.20	23.89	32.87	27.07	57.06	57.94	241.01	1.7%
CCM funding	0.00	0.00	0.00	0.00	0.00	0.00	1.40	2.20	4.11	7.70	0.1%
Board constituency funding									0.63	0.63	0.0%
Trustee fee	2.32	1.87	2.15	2.30	2.40	2.25	2.40	2.55	2.70	20.94	0.1%

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
Foreign currency (gain)/loss	0.00	0.00	0.00	0.00	0.00	13.56	-4.94	-7.48	-35.75	-34.61	-0.2%
Uncollectible contributions	0.00	0.00						1.10	26.73	27.83	0.2%
Total Expenditures	13.67	263.76	678.25	1,128.17	1,392.82	1,841.61	2,419.95	2,971.36	3,314.43	14,024.01	100.0%
Income - Expenditures	877.23	1,181.13	610.25	361.11	1,163.32	1,311.78	1,500.26	-105.69	-932.93	5,966.45	
Movement in undisbursed grants [a]	51.12	832.10	226.86	454.95	510.46	871.66	110.50	1,248.81	160.48		

Source: Global Fund Annual Reports, 2002/2003 to 2010.

a. The annual change in the value of grant commitments that have not yet been disbursed.

Table F-2. World Bank Expenditures and Disbursements (Constant 2010 US$ millions)

Type of Funding / Fiscal Year	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	Total	Share
Bank lending and grant disbursements											
IBRD	14,478	14,774	12,034	11,311	13,322	11,845	11,104	18,935	28,711	136,514	51.6%
IDA	8,491	8,643	8,247	10,300	9,999	9,184	9,641	9,468	11,423	85,396	32.3%
Recipient-executed trust funds	923	1,193	1,379	1,714	1,636	2,305	2,742	2,895	2,615	17,401	6.6%
DGF & other below-the-line grants	176	156	179	173	173	171	176	200	170	1,574	0.6%
Subtotal	24,067	24,766	21,839	23,498	25,131	23,505	23,662	31,498	42,919	240,886	91.0%
Administrative expenses											
Bank budget actual [a]	1,977	2,043	2,240	2,339	2,342	2,247	2,244	2,213	2,301	19,946	6.9%
Reimbursements and fee income [b]	200	213	223	234	238	257	255	297	314	2,231	0.8%
Bank-executed trust funds	242	275	321	347	357	420	442	481	575	3,460	1.2%
Subtotal	2,419	2,531	2,783	2,921	2,937	2,925	2,940	2,990	3,190	25,636	9.0%
Total disbursements/expenditures	26,310	27,141	24,443	26,246	27,895	26,258	26,427	34,289	45,938	264,948	100.0%
Share of administrative expenditures	8.5%	8.7%	10.5%	10.4%	9.8%	10.3%	10.3%	8.0%	6.4%	9.0%	

Source: World Bank databases.

a. Bank budget actual is equal to the Bank's gross administrative budget, financed from the Bank's own resources, not including the Development Grant Facility and other below-the-line grants.

b. Reimbursements and fee income are additional sources of revenue that are comingled with other administrative expenses spent by the Bank to help facilitate the disbursement of loans, credits, and grants to client countries.

c. Bank-executed trust funds are a third source of revenue that supports the Bank's work program and that are also comingled with other administrative expenses.

Table F-3. Global Fund: Annual Contributions by Donor (US$ millions, calendar years) [a]

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
United States	275.0	347.7	458.9	352.0	463.7	642.3	789.2	1,010.1	791.3	5,130.2	27.2%
France [b]	59.0	63.8	191.4	181.0	281.3	409.8	434.8	431.9	378.0	2,431.0	12.9%
Japan	80.4	80.0	86.1	100.0	130.1	186.0	183.8	194.4	246.9	1,287.8	6.8%
Germany	12.0	37.4	45.9	103.0	88.1	116.7	312.2	271.4	269.2	1,255.9	6.7%
United Kingdom [c, d]	78.2	40.0	60.3	96.0	198.4	187.2	78.5	182.1	319.1	1,239.8	6.6%
European Commission	-	137.1	314.8	69.1	117.2	91.1	127.0	285.2	62.7	1,204.0	6.4%
Italy	108.6	106.5	-	217.8	-	575.3	-	-	-	1,008.3	5.3%
Canada	25.0	25.0	50.0	110.3	221.2	-	102.0	35.4	276.1	845.0	4.5%
Spain	-	35.0	15.0	-	80.2	104.8	138.9	207.4	137.8	719.1	3.8%
Gates Foundation [d]	50.0	50.0	50.0	-	100.0	100.0	100.0	209.5	10.5	670.0	3.6%
Netherlands	-	51.7	54.3	56.1	76.8	82.7	114.2	83.5	82.8	602.1	3.2%
Sweden	22.4	11.5	41.3	55.9	82.3	64.5	140.1	50.0	74.0	542.1	2.9%
Norway	18.0	17.7	17.9	23.6	43.1	50.2	52.6	67.2	62.0	352.2	1.9%
Russian Federation	1.0	4.0	5.0	10.0	10.0	75.3	50.7	79.0	22.0	257.0	1.4%
Denmark	14.8	13.8	16.2	22.8	23.9	25.9	29.4	31.9	31.2	209.9	1.1%
Australia	-	-	13.8	15.0	12.7	15.3	38.9	32.8	42.5	171.0	0.9%
WHO [d]	-	0.2	-	-	-	-	38.7	65.0	65.0	168.9	0.9%
Global Fund [e]	-	-	-	-	11.0	46.7	39.7	42.9	25.5	165.9	0.9%
Ireland	13.0	8.0	12.3	17.1	26.3	27.4	30.9	14.0	11.5	160.6	0.9%
Belgium	9.4	2.8	17.5	6.1	10.3	16.6	15.9	17.9	32.4	128.9	0.7%
U.N. Foundation	-	4.3	0.3	-	-	-	45.6	0.0	5.3	55.4	0.3%
Switzerland	3.1	6.9	2.3	3.9	4.9	5.7	6.7	6.3	7.2	47.1	0.2%
Saudi Arabia	-	2.5	2.5	2.5	2.5	-	6.0	6.0	6.0	28.0	0.1%
Luxembourg	-	2.1	2.4	2.5	3.5	3.1	3.9	3.3	3.2	24.0	0.1%
Indonesia	-	-	-	-	-	-	8.0	7.2	8.1	23.4	0.1%
Finland	-	-	-	-	3.6	3.3	3.9	4.9	4.4	20.2	0.1%
Nigeria	9.1	-	-	-	-	-	-	-	10.0	19.0	0.1%
China	-	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	16.0	0.1%
Pakistan	-	-	-	-	-	-	-	6.9	6.1	13.1	0.1%
Korea	-	-	0.5	0.3	0.3	3.0	3.0	4.0	2.0	13.0	0.1%
Portugal	-	0.4	0.6	1.5	2.0	3.0	3.0	-	2.5	13.0	0.1%
South Africa	-	-	2.0	2.0	2.0	2.0	0.1	2.1	-	10.3	0.1%
India	-	-	-	-	1.0	1.5	0.5	2.0	5.0	10.0	0.1%

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
Thailand	-	2.0	-	2.0	0.0	2.0	-	2.0	1.0	9.0	0.0%
New Zealand	-	0.7	0.6	0.8	-	-	-	-	0.7	2.8	0.0%
Greece	-	-	-	0.3	-	0.5	-	1.4	-	2.2	0.0%
Tunisia	-	-	-	-	-	-	-	-	2.0	2.0	0.0%
Kuwait	-	-	-	-	-	-	1.0	0.5	-	1.5	0.0%
Uganda	-	-	0.5	0.5	0.5	-	-	-	-	1.5	0.0%
Iceland	-	-	0.2	-	0.2	0.4	-	0.3	-	1.1	0.0%
Austria	-	1.1	-	-	-	-	-	-	-	1.1	0.0%
Singapore	-	-	0.2	0.2	0.2	0.2	0.2	-	-	1.0	0.0%
Liechtenstein	0.1	-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	0.0%
Romania	-	-	-	-	-	0.4	0.1	0.1	0.1	0.7	0.0%
Côte d'Ivoire	-	-	-	-	-	-	-	-	0.7	0.7	0.0%
Slovenia	-	-	-	0.0	0.0	0.0	0.1	0.1	0.1	0.3	0.0%
Mexico	-	-	-	0.1	0.1	-	-	-	-	0.2	0.0%
Zimbabwe	-	0.2	-	-	-	-	-	-	-	0.2	0.0%
Poland	-	0.0	0.0	0.0	0.0	-	0.1	-	-	0.2	0.0%
Brazil	-	-	-	-	0.2	-	-	-	-	0.2	0.0%
Monaco	0.0	0.0	0.0	-	-	-	-	-	-	0.1	0.0%
Andorra	0.1	-	-	-	-	-	-	-	-	0.1	0.0%
Barbados	-	-	0.1	-	-	-	-	-	-	0.1	0.0%
Burkina Faso	0.1	-	-	-	-	-	-	-	-	0.1	0.0%
Hungary	-	-	0.0	0.0	0.0	-	0.0	-	-	0.1	0.0%
Brunei Darussalam	-	-	-	-	-	-	-	0.0	-	0.0	0.0%
Latvia	-	-	-	-	-	-	0.0	-	-	0.0	0.0%
Total	779.3	1,054.5	1,465.2	1,454.4	1,999.8	2,845.0	2,902.0	3,361.0	3,006.8	18,868.0	100.0%

a. The Global Fund Trust Fund is maintained in US dollars and Euro (the "Holding Currencies"). The contributions maintained in Euro are converted to US dollars at the euro/US$ exchange rate as of December 31 each year."

b. Annual contributions include the euro amount of Promissory Notes contributed and not encashed as of December 31, 2010. The encashed Promissory Notes are reflected as contributions in the year when the respective Promissory Notes were issued.

c. Annual contributions include the U.S. dollar equivalent amount of Promissory Notes contributed and not encashed (outstanding) as of December 31, 2010. The U.S. equivalent amount of outstanding Promissory Notes is calculated using the US$/GBP exchange rate as of December 31 of the year when those Promissory Notes were issued. The encashed Promissory Notes are reflected as contributions in the year when the respective Promissory Notes were issued.

d. Includes the contributions to the Affordable Medicines Facility for Malaria (AMFm).

e. These are contributions collected by the Global Fund Secretariat from various donors or from (Product) RED partners and passed on to the trustee.

Table F-4. Official Development Assistance and Other Official Flows from OECD/DAC Member Countries and Multilateral Agencies to Developing Countries

a. Commitments to HIV/AIDS, Tuberculosis, and Malaria (US$ millions, constant 2008 prices)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Global Fund	0.0	0.0	0.0	1,294.6	977.0	1,667.2	1,979.4	2,643.0	2,213.2	4,223.5	14,997.9
IBRD/IDA	187.5	240.3	306.3	374.1	265.2	221.4	324.3	218.5	317.4	233.0	2,688.2
Other donors	996.3	1,121.5	1,393.9	2,109.9	2,283.5	3,454.7	4,113.9	5,839.6	6,637.8	6,894.0	34,845.3
Total	1,183.8	1,361.8	1,700.2	3,778.6	3,525.7	5,343.3	6,417.7	8,701.1	9,168.4	11,350.5	52,531.3
Share of Total											
Global Fund	0%	0%	0%	34%	28%	31%	31%	30%	24%	37%	29%
IBRD/IDA	16%	18%	18%	10%	8%	4%	5%	3%	3%	2%	5%
Other donors	84%	82%	82%	56%	65%	65%	64%	67%	72%	61%	66%

b. Commitments to Health, Nutrition and Population (US$ Millions, constant 2008 prices)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Global Fund	0.0	0.0	0.0	1,294.6	980.7	1,683.8	2,034.7	2,643.0	2,232.8	4,308.5	15,178.1
IBRD/IDA	1,674.6	2,653.0	1,943.1	3,528.6	2,074.7	1,618.9	2,931.2	1,412.0	2,272.4	2,642.2	22,750.8
Other donors	5,873.6	6,479.1	7,262.9	8,236.6	8,457.4	10,525.7	12,687.6	13,866.4	14,912.9	15,419.0	103,721.1
Total	7,548.1	9,132.2	9,206.0	13,059.7	11,512.8	13,828.4	17,653.4	17,921.4	19,418.2	22,369.6	141,649.9
Share of Total											
Global Fund	0%	0%	0%	10%	9%	12%	12%	15%	11%	19%	11%
IBRD/IDA	22%	29%	21%	27%	18%	12%	17%	8%	12%	12%	16%
Other donors	78%	71%	79%	63%	73%	76%	72%	77%	77%	69%	73%

Source: OECD. Official Development Assistance represents concessional flows including IDA. Other Official Flows are non-concessional flows, such as lending by IBRD and regional development banks.

a. This data was obtained on March 25, 2011. The source codes for HIV/AIDS, tuberculosis, and malaria were 13040, Malaria (12262), TB (12263), and HIV/Aids (13040)

Table F-5. Global Fund: Grant Commitments by Region (US$ millions, calendar years)

Region	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
Sub-Saharan Africa: East Africa	78.1	723.7	497.0	1,142.2	305.6	126.3	373.2	613.6	466.7	4,326.4	25%
Sub-Saharan Africa: West & Central Africa	19.9	166.6	330.4	240.4	427.3	269.3	158.6	709.4	635.2	2,956.9	17%
Sub-Saharan Africa: Southern Africa		754.3	405.3	450.6	144.7	192.6	191.7	390.9	81.6	2,611.7	15%
East Asia & the Pacific		551.3	335.0	260.7	215.7	202.5	108.7	271.7	541.7	2,487.3	14%
South Asia	12.7	53.0	414.3	290.4	61.3	224.8	100.9	93.7	231.2	1,482.3	8%
Eastern Europe & Central Asia		194.5	295.4	259.5	61.2	263.6	60.5	123.8	115.5	1,374.1	8%
Latin America & the Caribbean	129.7	211.5	262.9	93.7	109.5	84.9	105.0	105.0	100.3	1,202.4	7%
North Africa & the Middle East		26.1	118.8	198.2	162.0	143.0	147.9	114.4	128.7	1,039.1	6%
Total	240.4	2,681.1	2,659.1	2,935.6	1,487.3	1,507.1	1,246.4	2,422.4	2,300.9	17,480.3	100%

Table F-6. Global Fund: Grant Disbursements by Region (US$ millions, calendar years)

Region	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
Sub-Saharan Africa: East Africa		66.2	137.8	295.0	379.9	420.7	567.1	586.8	883.6	3,337.1	26%
Sub-Saharan Africa: West & Central Africa	0.9	19.2	74.1	149.4	175.0	218.7	292.5	560.7	458.7	1,949.2	15%
Sub-Saharan Africa: Southern Africa		37.1	118.0	167.3	154.4	301.6	371.9	361.3	404.1	1,915.7	15%
East Asia & the Pacific		45.7	103.3	137.1	194.7	220.3	279.6	398.7	453.0	1,832.4	14%
Eastern Europe & Central Asia		21.5	57.6	91.6	143.2	201.6	204.4	215.5	212.0	1,147.4	9%
South Asia		6.1	29.1	31.0	80.4	144.4	210.0	284.9	276.4	1,062.2	8%
Latin America & the Caribbean		32.2	79.2	114.2	110.0	130.4	171.1	184.3	169.5	991.0	8%
North Africa & the Middle East		3.1	28.4	66.6	84.3	89.0	157.0	163.1	192.2	783.7	6%
Total	0.9	231.2	627.5	1,052.3	1,321.8	1,726.7	2,253.5	2,755.1	3,049.6	13,018.7	100%

Table F-7. Global Fund: Grant Commitments by Disease (US$ millions, calendar years)

Region	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
HIV/AIDS	143.9	1,835.0	1,774.8	1,732.8	671.3	842.2	631.7	889.2	1,012.2	9,533.2	55%
Malaria	85.3	334.2	456.5	895.2	347.7	337.6	469.3	1,296.4	649.3	4,871.5	28%
Tuberculosis	11.2	402.7	326.4	249.3	412.9	327.3	145.4	235.9	627.7	2,738.8	16%
HIV/tuberculosis		109.1	98.3	24.4						231.8	1%
HSS				33.9	55.5			0.8	11.7	102.0	1%
Integrated			3.1							3.1	0%
Total	240.4	2,681.1	2,659.1	2,935.6	1,487.3	1,507.1	1,246.4	2,422.4	2,300.9	17,480.3	100%

Table F-8. Global Fund: Grant Disbursements by Disease (US$ millions, calendar years)

Region	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Share
HIV/AIDS	0.4	121.1	360.8	578.1	692.8	1,073.6	1,334.7	1,295.2	1,573.1	7,029.8	54%
Malaria		49.5	135.5	308.2	407.5	351.4	521.2	1,017.2	919.0	3,709.6	28%
Tuberculosis	0.5	40.7	107.2	127.2	195.7	276.2	316.8	387.0	511.8	1,963.0	15%
HIV/tuberculosis		19.9	22.2	30.1	18.4	21.9	52.3	18.5	12.2	195.7	2%
HSS				8.2	6.5	3.7	28.5	37.3	33.4	117.5	1%
Integrated			1.7	0.5	1.0					3.1	0%
Total	0.9	231.2	627.5	1,052.3	1,321.8	1,726.7	2,253.5	2,755.1	3,049.6	13,018.7	100%

Table F-9. Global Fund: Grant Commitments by Disease (US$ millions, World Bank fiscal years)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total	Share
HIV/AIDS	1,050.2	1,662.3	2,617.8	238.6	670.9	793.3	578.3	1,069.0	1,232.9	9,913.3	54%
Malaria	212.1	352.9	1,135.2	303.9	162.8	478.8	573.6	1,314.5	631.1	5,164.9	28%
Tuberculosis	329.6	232.9	285.5	262.9	349.4	274.8	188.7	324.0	625.1	2,872.9	16%
HIV/tuberculosis	26.3	70.0	81.6	24.4						202.3	1%
HSS				33.9	55.5			0.8	68.8	159.1	1%
Integrated			3.1							3.1	0%
Total	1,618.3	2,318.1	4,123.2	863.7	1,238.6	1,547.0	1,340.6	2,708.3	2,557.9	18,315.6	100%

Table F-10. Global Fund: Grant Disbursements by Disease (US$ millions, World Bank fiscal years)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total	Share
HIV/AIDS	20.5	216.0	534.3	480.5	889.7	1,231.0	1,222.7	1,542.5	1,333.1	7,470.3	53%
Malaria	6.7	82.5	209.8	386.3	352.3	424.3	477.6	1,215.2	896.8	4,051.6	29%
Tuberculosis	6.4	67.7	122.3	145.7	222.4	325.8	318.3	406.0	512.5	2,127.1	15%
HIV/tuberculosis	1.7	21.6	27.5	36.4	6.5	46.5	37.0	18.4	(0.4)	195.2	1%
HSS				8.2	9.4	10.6	22.7	36.4	83.6	170.9	1%
Integrated			1.7	0.9	0.5					3.1	0%
Total	35.3	387.8	895.6	1,058.1	1,480.9	2,038.3	2,078.3	3,218.5	2,825.6	14,018.3	100%

Table F-11. World Bank: Project Commitments by Health Theme (US$ millions, fiscal years)

Theme	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total	Share
Health system performance	575.2	556.5	483.6	520.3	747.0	461.5	1,387.9	3,234.3	1,393.2	9,359.5	43%
Child health	232.1	410.4	202.2	200.1	390.7	106.7	625.7	147.9	329.0	2,644.9	12%
HIV/AIDS	325.2	210.3	243.0	87.2	313.7	50.8	218.3	127.4	152.4	1,728.2	8%
Population & reproductive health	196.7	296.3	194.2	135.8	342.6	79.0	92.2	149.5	242.4	1,728.8	8%
Injuries & non-communicable diseases	159.6	314.7	330.9	197.8	477.6	17.5	43.4	55.8	148.4	1,745.8	8%
Nutrition & food security	199.7	32.0	141.4	74.9	136.6	82.3	231.4	76.5	143.1	1,118.0	5%
Tuberculosis	91.1	49.7	66.7	25.5	80.2	11.6	22.5	41.8	25.3	414.3	2%
Other communicable diseases	8.0	45.6	33.8	71.3	84.0	22.1	91.4	383.3	98.3	837.9	4%
Malaria	7.6	9.1	7.3	117.8	77.6	76.5	260.9	26.0	146.8	729.6	3%
Other human development	69.6	133.5	165.8	142.3	214.6	44.7	112.1	220.8	226.5	1,330.0	6%
Total	1,864.8	2,058.1	1,869.0	1,573.0	2,864.6	952.5	3,085.9	4,463.4	2,905.6	21,636.8	100%
Subtotal mapped to the HNP Sector Board	912.9	1,366.9	921.2	782.8	1,535.0	683.1	1,492.4	3,080.1	2,089.3	12,863.7	59%

Source: World Bank data.

Note: Each World Bank project can identify up to five themes promoted by the project. World Bank commitments represent the proportions of total project commitments to each theme. The subtotal "mapped to the HNP Sector Board" represents the share of these commitments under the control of the HNP Sector Board. That is, each Bank-supported project is supervised by a project manager who reports to a regional manager, who is represented on a Bank-wide sector board. Each project is thereby "mapped" — or becomes the responsibility of — that sector board, in this case the HNP Sector Board.

Table F-12. World Bank: Project Disbursements by Health Theme (US$ millions, fiscal years)

Theme	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total	Share
Health system performance	558.0	514.1	409.3	525.5	545.1	418.6	771.4	1,587.4	1,705.7	7,035.1	42%
Child health	167.1	355.0	181.6	153.6	173.7	152.0	196.3	298.2	194.0	1,871.6	11%
HIV/AIDS	68.7	116.3	178.3	238.9	221.3	235.8	168.2	178.7	158.2	1,564.5	9%
Population & reproductive health	156.4	268.8	184.7	143.1	154.7	145.8	166.4	150.8	170.9	1,541.6	9%
Injuries & non-communicable diseases	12.5	20.0	51.0	160.9	186.9	204.4	223.8	237.0	160.6	1,257.0	8%
Nutrition & food security	99.8	101.9	131.9	152.8	94.5	97.1	154.3	165.9	83.2	1,081.5	6%
Tuberculosis	43.0	72.0	83.9	115.5	92.5	87.1	59.7	57.4	50.4	661.6	4%
Other communicable diseases	40.3	32.0	34.2	33.1	44.5	67.5	36.4	75.1	62.9	426.1	3%
Malaria	16.4	20.0	10.5	15.3	45.5	61.0	49.3	70.7	55.1	343.8	2%
Other human development	29.1	16.3	43.3	34.3	71.1	144.4	81.7	213.5	270.3	903.9	5%
Total	1,191.3	1,516.3	1,308.9	1,573.0	1,630.0	1,613.7	1,907.6	3,034.7	2,911.2	16,686.7	100%
Subtotal mapped to the HNP Sector Board	606.7	1,185.5	834.0	866.6	940.1	902.3	875.9	1,192.1	1,741.0	9,144.1	55%

Source: World Bank data.

Note: Each World Bank project can identify up to five themes promoted by the project. World Bank disbursements represent the proportions of total project disbursements to each theme. The subtotal "mapped to the HNP Sector Board" represents the share of these disbursements under the control of the HNP Sector Board. That is, each Bank-supported project is supervised by a project manager who reports to a regional manager, who is represented on a Bank-wide sector board. Each project is thereby "mapped" — or becomes the responsibility of — that sector board, in this case the HNP Sector Board.

Table F-13. Global Fund and World Bank, Commitments and Disbursements by Country, Fiscal Years 2003–11 Inclusive (US$ millions)

	Global Fund		World Bank	
Region/Country	Commitments	Disbursements	Commitments	Disbursements
Africa	11,131.2	8,371.9	3,934.8	3,595.0
East Asia and the Pacific	2,611.9	1,984.2	1,277.3	1,159.7
Europe and Central Asia	1,438.7	1,264.7	2,592.5	2,223.5
Latin America and the Caribbean	1,364.9	1,114.5	7,692.2	5,484.2
South Asia	1,505.9	1,068.8	3,359.1	2,777.2
Middle East and North Africa	263.0	214.2	301.8	513.9
World	-	-	11.9	1.9
Total	18,315.6	14,018.3	19,169.6	15,755.3
Africa	11,131.2	8,371.9	3,934.8	3,595.0
Ethiopia	1,314.7	1,062.8	284.9	328.4
Tanzania	887.5	683.6	274.6	311.0
Nigeria	762.7	528.5	560.9	502.9
Rwanda	631.3	453.8	65.4	66.2
Malawi	548.2	413.2	54.0	30.4
Zambia	456.0	381.1	60.4	47.2
Congo, Democratic Republic of	531.3	378.1	407.1	296.0
Sudan	397.2	309.4	161.1	82.4
Kenya	317.2	282.2	178.5	98.5
Ghana	351.0	273.9	267.1	286.7
Uganda	352.8	262.3	297.7	236.9
Zimbabwe	288.1	244.1	-	-
South Africa	292.7	234.2	-	-
Mozambique	351.1	223.5	124.1	52.9
Cameroon	247.3	202.2	31.2	35.3
Madagascar	230.9	172.4	111.7	162.0
Burkina Faso	186.7	161.3	135.1	125.5
Namibia	201.2	148.0	-	-
Côte d'Ivoire	279.5	138.9	11.2	15.6
Angola	171.5	130.8	92.4	13.5
Swaziland	141.0	121.9	16.4	-
Togo	161.2	116.5	4.1	3.8
Burundi	152.2	115.0	68.3	73.4
Benin	176.6	111.2	88.0	81.6
Somalia	122.9	103.0	0.5	0.8
Eritrea	111.5	100.6	16.1	66.7
Senegal	139.8	99.1	57.0	121.0
Niger	116.5	95.0	94.2	93.8
Lesotho	146.5	90.7	27.2	17.4
Mali	126.0	89.7	50.0	80.8
Liberia	105.7	84.8	8.4	5.9
Gambia, The	90.0	79.4	4.5	30.6
Sierra Leone	100.6	66.8	63.1	64.1
Central African Republic	93.1	62.5	1.2	8.6
Chad	96.8	55.6	23.8	61.7
Congo, Republic of	89.9	38.5	41.9	26.3

Region/Country	Global Fund		World Bank	
	Commitments	Disbursements	Commitments	Disbursements
Multicountry Africa (RMCC)	47.6	36.2	-	-
Guinea	57.0	34.7	25.2	17.9
Guinea-Bissau	33.0	31.7	7.4	16.2
Gabon	37.9	29.7	-	-
Equatorial Guinea	32.9	28.2	-	-
Multicountry Africa (West Africa Corridor Program)	31.4	23.6	-	-
Mauritania	29.5	16.2	11.5	25.2
Zanzibar	20.9	15.9	-	-
Botswana	26.9	15.0	46.5	8.8
Comoros	11.7	9.2	2.5	7.3
Sao Tome and Principe	10.0	7.7	3.4	2.1
Mauritius	5.0	4.1	-	-
Cape Verde	5.0	2.8	8.7	19.1
Multicountry Africa (SADC)	13.2	2.1	-	-
Africa	-	-	147.4	70.6
East Asia and the Pacific	2,611.9	1,984.2	1,277.3	1,159.7
China	834.5	559.6	150.1	228.7
Indonesia	391.3	341.9	264.0	370.1
Thailand	269.3	249.9	0.5	0.8
Cambodia	323.4	242.4	39.2	35.0
Philippines	188.1	167.3	274.8	167.7
Vietnam	142.4	100.2	475.6	286.9
Lao People's Democratic Republic	95.3	77.9	42.1	30.3
Papua New Guinea	103.4	72.4	-	1.0
Multicountry Western Pacific	61.9	52.4	-	-
Myanmar	105.4	47.6	0.5	0.5
Mongolia	25.8	25.8	0.8	0.8
Korea, Democratic People's Republic of	32.8	21.7	-	-
Timor-Leste	24.9	19.9	13.5	18.7
Fiji	5.2	3.5	-	-
Solomon Islands	4.0	1.6	0.2	2.5
Malaysia	4.3	-	-	-
Tonga	-	-	10.6	11.7
Samoa	-	-	5.3	5.2
Europe and Central Asia	1,438.7	1,264.7	2,592.5	2,223.5
Russian Federation	367.7	361.4	174.0	147.9
Ukraine	257.4	217.4	45.0	38.9
Tajikistan	82.9	81.1	29.6	24.5
Kazakhstan	84.3	73.0	97.7	18.1
Romania	64.8	63.6	95.7	76.1
Georgia	68.6	55.8	48.7	61.7
Moldova	60.9	51.2	21.7	26.2
Uzbekistan	61.5	50.8	136.7	52.8
Bulgaria	60.5	50.4	195.4	203.8
Belarus	59.1	48.2	-	-
Kyrgyz Republic	52.7	45.4	31.5	26.6

Region/Country	Global Fund		World Bank	
	Commitments	Disbursements	Commitments	Disbursements
Azerbaijan	52.7	38.5	45.0	20.7
Serbia	29.2	26.5	55.5	48.0
Armenia	31.4	23.1	83.1	68.8
Bosnia and Herzegovina	38.7	21.4	26.4	21.5
Macedonia, former Yugoslav Republic of	16.0	15.5	34.6	36.5
Estonia	10.5	10.5	-	-
Montenegro	7.9	7.1	15.7	7.3
Kosovo	11.7	6.7	1.7	3.2
Albania	6.2	5.6	32.1	28.1
Croatia	4.9	4.9	90.0	79.8
Turkmenistan	5.9	3.4	1.0	1.0
Turkey	3.3	3.3	668.0	641.3
Poland	-	-	433.6	453.9
Slovak Republic	-	-	54.7	60.3
Latvia	-	-	87.2	41.4
Lithuania	-	-	-	16.7
Central Asia	-	-	17.5	16.3
Slovenia	-	-	-	2.1
Hungary	-	-	70.7	
Latin American and the Caribbean	1,364.9	1,114.5	7,692.2	5,484.2
Haiti	253.9	199.8	21.0	6.5
Peru	134.5	123.2	470.2	220.7
Dominican Republic	109.5	97.1	203.0	201.8
Cuba	86.7	72.5	-	-
Honduras	104.9	70.2	9.7	45.9
Guatemala	68.9	64.0	90.5	26.9
El Salvador	54.3	51.7	45.7	171.4
Nicaragua	53.4	48.9	55.2	48.5
Jamaica	55.7	46.8	31.7	33.5
Brazil	50.6	38.4	1,490.9	959.3
Guyana	47.1	38.1	7.6	8.0
Chile	43.0	37.1	10.0	10.0
Ecuador	46.6	30.3	104.9	41.8
Multicountry Americas (Andean)	28.8	28.8	-	-
Bolivia (Plurinational State)	43.7	26.0	36.9	68.9
Colombia	25.0	25.0	706.9	758.3
Argentina	29.3	24.0	2,389.0	1,456.7
Paraguay	23.9	23.9	12.1	4.6
Multicountry Americas (COPRECOS)	19.2	17.3	-	-
Multicountry Americas (CARICOM / PANCAP)	21.5	14.3	-	-
Suriname	23.7	10.2	-	-
Multicountry Americas (Meso)	8.4	8.4	-	-
Costa Rica	4.0	4.0	-	13.3
Belize	3.6	3.6	3.5	0.6
Multicountry Americas (REDCA+)	5.3	3.1	-	-

Region/Country	Global Fund		World Bank	
	Commitments	Disbursements	Commitments	Disbursements
Multicountry Americas (CRN+)	3.9	2.9	-	-
Panama	2.6	2.6	69.1	42.5
Multicountry Americas (OECS)	12.5	1.9	-	-
Mexico	0.6	0.6	1,743.2	1,243.3
Uruguay	-	-	113.4	58.3
Barbados	-	-	35.0	22.0
Trinidad and Tobago	-	-	20.0	20.0
Central America	-	-	6.0	6.0
Grenada	-	-	5.5	3.8
Venezuela, Republica Bolivariana de	-	-	-	3.4
St. Kitts and Nevis	-	-	2.9	2.3
Caribbean	-	-	2.3	2.1
St. Vincent and the Grenadines	-	-	2.0	1.8
St. Lucia	-	-	3.9	1.8
Latin America	-	-	0.1	-
South Asia	1,505.9	1,068.8	3,359.1	2,777.2
India	901.0	642.6	1,732.3	1,754.9
Bangladesh	208.0	171.0	591.9	234.7
Pakistan	127.5	88.4	524.5	456.5
Nepal	93.4	63.1	233.1	125.1
Afghanistan	90.5	54.9	202.9	154.4
Sri Lanka	59.1	34.6	59.8	41.2
Bhutan	8.5	7.4	7.3	7.5
Multicountry South Asia	13.7	3.8	3.7	1.3
Maldives	4.1	2.9	3.6	1.6
Middle East and North Africa	263.0	214.2	301.8	513.9
Yemen, Republic of	49.7	40.0	86.6	70.6
Iran, Islamic Republic of	49.7	38.8	-	81.1
Morocco	38.3	33.0	20.9	61.2
Djibouti	23.5	21.3	14.2	25.2
Iraq	27.3	20.3	45.6	35.4
Egypt, Arab Republic of	22.1	16.5	75.0	108.5
Tunisia	19.9	16.5	0.9	22.8
Jordan	11.2	9.9	-	24.5
Algeria	6.9	6.9	-	-
West Bank and Gaza	6.3	5.2	56.6	64.4
Syrian Arab Republic	7.4	5.1	0.5	0.0
Lutheran World Federation	0.7	0.7	-	-
Lebanon	-	-	0.8	19.6
Middle East and North Africa			0.6	0.5
World	-	-	11.9	1.9
Totals	18,315.6	14,018.3	19,169.6	15,755.3

Source: Global Fund and World Bank data. See Appendix Table F-13.

Note: World Bank commitments and disbursements represent the proportions of total project commitments and disbursements to the health sector. World Bank disbursements to a country can exceed commitments due to projects that were approved before FY03 and still disbursing in FY03–10.

Appendix G. Global Fund Five-Year Evaluation: Major Findings, Recommendations, and Program Response[2]

Findings	Recommendations	Program Response
1. Mobilization of Resources		
The Global Fund, together with major partners, has mobilized impressive resources to support the fight against AIDS, tuberculosis, and malaria.	1. The international development community needs to systematically address the requirements of sustainability in the global response to the three pandemics. As part of this response, the Global Fund replenishment mechanism should further its mobilization of financial resources from existing donors and new sources of funding, including from international donor agencies that have not yet contributed and from nontraditional sources. All Global Fund resources should meet the criterion of additionality—that is, they should be additional to existing AIDS, tuberculosis, and malaria funds and to the health sector overall. 2. The Global Fund should, in particular, increase its efforts to engage the private sector in the partnership, expanding the range and types of contributions, especially to mobilize in-country private-sector resources. 3. The Global Fund should work with other financing entities to help ensure the predictable multi-year funding required to maintain high-quality programs. This should be given urgent priority, especially in areas where the Global Fund has become the largest international donor.	• Greater attention is placed on sustainability and resource mobilization is emphasized to sustain Global Fund-supported activities and achievements. • New resource mobilization strategy being implemented (including diversifying funding sources, developing innovative finance vehicles; achieving efficiency gains in grant portfolio and in Secretariat operations). • Diversification includes stronger push in tapping private sector contributions. • For 2010, there will be zero growth of Secretariat staff and almost zero growth of operational budget.
2. Service Delivery		
Collective efforts have resulted in increases in service availability, better coverage, and reduction of disease burden.	4. The Global Fund's business plan should increasingly differentiate its prevention and treatment approaches in specific countries based on the epidemiological profiles of AIDS, tuberculosis, and malaria and the assessment of a country's capacity to execute its planned disease control programs. 5. The Global Fund should adjust its "demand-driven model" and focus its resources on prevention and treatment strategies that utilize the most	**Grant portfolio and new grant architecture at the country level to improve service delivery** • Move from a project-based approach to a single stream of funding mode. • Support for National Strategy Applications. Instead of multiple grants for one disease in a country, Global Fund support for the national strategy for ONE disease, and all grants will be grouped

2. The FYE report was an important input to the replenishment process. Participants at the Third Replenishment Meeting in 2010 welcomed the updated report from Global Fund management on the implementation of the FYE recommendations and urged acceleration of the proposed reforms. Participants at the meeting underlined the importance of the reforms in areas of: the new grant architecture, the National Strategy Application, Accountability Framework, eligibility and prioritization of countries, and collaboration with other development partner agencies for more effective service delivery.

Findings	Recommendations	Program Response
	cost-effective interventions that are tailored to the type and local context of specific epidemics. 6. The Global Fund and its partners should continue to finance scale-up efforts, in particular for key malaria program interventions in light of the encouraging initial results from several countries and from research. 7. Much higher priority on the strengthening and integration of health information systems required by countries to manage their programs and monitor impact. Specifically: a. The Global Fund and partners should reorient investments from disease-specific M&E toward strengthening the country health information systems required to maximize data quality and use for decision making. b. Countries should be encouraged to increase investment in medium- to long-term capacity building for financial tracking, including through the incorporation of health expenditure data in their population-based surveys and the completion of periodic national health account exercises. c. Countries should also be encouraged to emphasize the development of quality assurance mechanisms that can help to achieve urgently required financial oversight at the sub-recipient level.	under it. • More emphasis to be placed on HSS, maternal and child health, and the prevention of mother-to-child transmission of HIV/ AIDS. • The Secretariat acknowledged the importance of strengthening and integrating national health information systems with Global Fund-supported programs. It reiterated strong support for achieving this objective. (See also the section on performance-based funding.)
3. Health Systems Strengthening		
Health systems in most developing countries will need to be greatly strengthened if current levels of services are to be significantly expanded.	8. The Global Fund and partners should address the major gaps in basic health service availability and readiness—the minimum components for delivery of quality services such as basic infrastructure, staffing, and supplies—as part and parcel of scaling-up against the three diseases. In particular, Global Fund grants for HSS should support overall country health sector strategic plans. 9. The Global Fund and its partners together should clarify, as a matter of urgency, an operational division of labor regarding the provision and financing of technical support for HSS. These efforts should take a longer-term perspective in delivering technical support. They should, in particular, support human-resource capacity building over a horizon of five to ten years, in harmony with other global and regional initiatives. 10. The Global Fund Secretariat should develop and articulate a strategy that allows for a menu of investment approaches to increase the probability that grants will perform well. The assessment of management issues as	• In reference to past "friendship" or "loose" models of the Global Fund's partnership arrangements, a New Partnership Strategy was developed and approved by the Board in November 2009. It provided a framework for strategic division of labor, clarity of roles, and coordination and mechanisms for funding technical assistance. Existing partnerships are being consolidated and strengthened, while new ones will be forged, with GAVI, the World Bank, IHP +, and the HSS joint funding platform. The Global Fund will actively participate in the IHP + and be part of the coordinated response to scale up the fight against AIDS, tuberculosis, and malaria. More effort will be spent strengthening health systems, maternal and child health, and mother-to child transmission of AIDS. • Because "Global Fund donors have not explicitly articulated the need (or approval) to providing complementary technical

Findings	Recommendations	Program Response
	part of the grant rating should include explicit linkage to whether grant technical support budgets are being used for necessary capacity-building measures. In particular, for countries with weak health systems and/or high disease burden, grants should either focus more on investing in long-term capacity building or demonstrate partner contributions to capacity-building. 11. The Global Fund Secretariat should work with internationally-mandated technical partners, country counterparts, and in-country civil society and private sector partners to strengthen country surveillance and M&E systems, taking into account the needs of PBF. In particular and in active collaboration with country-level partners, the Secretariat should systematically identify and address additional requirements for achieving adequate oversight at the sub-recipient level.	assistance funding through technical agencies (development partner agencies), the Secretariat is still trying to find innovative solutions for technical assistance coordination, funding and use"…. Various additional assessments on this topic are being considered by the Global Fund. An Options Paper on this topic is being developed for consideration by the Board. • Secretariat will support strategic investments in health systems as part of proposals to scale up the fight against the three diseases, with priority given to strengthening service delivery platforms and in-country M&E systems. • It will work with the GAVI Alliance and the World Bank, with facilitation of WHO, to align funding for HSS and to roll out a shared investment strategy for such strengthening in 2010.
4. Equity		
The Global Fund has modeled equity in its guiding principles and organizational structure. However, much more needs to be done to reflect those efforts in grant performance.	12. The Global Fund and its partners should ensure that in both applications for funding and country health information systems there is explicit inclusion of indicators for service quality and equity issues related to gender, sexual minorities, urban-rural, wealth, and education in order to more effectively monitor the access to services among vulnerable populations. 13. The Global Fund should integrate and highlight equity issues related to gender, sexual minorities, urban-rural, wealth, and education disparities in the development of its partnership strategies. 14. The Global Fund Secretariat should collaborate closely with technical partners and country stakeholders to develop program strategies and build the in-country capacities required to better identify and reach vulnerable populations.	• The Gender Equality Strategy and Plan of Action 2009—2012 has been developed and is being implemented. Gender expertise in the Technical Review Panel is being strengthened, development partner agencies with gender technical assistance capabilities will be mapped, and gender issues will be included in Secretariat partnership agreements. • Working with development partner agencies, countries will be provided guidance on gender- and equity-related indicators. M&E Toolkits will include such indicators and systems strengthened to monitor and report. • Secretariat is also developing an implementation plan on Sexual Orientation and Gender Identities (SOGI).
5. Performance-Based Funding (PBF)		
The PBF system has contributed to a focus on results. However, it continues to face considerable limitations at the country and	15. The Global Fund should urgently seek a more coordinated approach and the more systematic investment of partners to strengthen country health information systems, which are needed as the basis for monitoring overall progress, enabling PBF, and conducting ongoing evaluations. 16. The Global Fund should comprehensively examine its PBF objectives, policies, procedures, guidelines, and current functioning while reviewing	**PBF and M&E** • PBF is still the cornerstone of Global Fund's management of its grant portfolio. In light of tremendous data quality issues, there will be greater investments in M&E to benefit both the PBF system and the overall focus on results. • New grant performance rating and disbursement decision-making

Findings	Recommendations	Program Response
Secretariat levels.	the PBF experiences of other partners, most notably GAVI. 17. The Global Fund Secretariat should revise quality assurance guidelines to distinguish approaches among settings where existing data systems are or are not capable of providing the outcome-level information required for PBF. As a part of this exercise, the Global Fund should review the implications of weak data systems on the guidelines for the operations of the Technical Review Panel and the LFAs. 18. The Global Fund should reaffirm its aspirations to PBF principles, while proposing more differentiated approaches to quality assurance that are capable of improving performance and accountability monitoring within existing capacity constraints in countries.	methodology has been rolled out. • A Data Quality Task Force has been established to coordinate initiatives such as Data Quality Audits and annual onsite verification of grant data by LFAs. • There will be greater alignment of Global Fund M&E requirements with the national Health Management Information Systems of countries to reduce the burden of reporting. A new Global Fund Evaluation Agenda is under development as a result of the FYE experience. (see TERG 13th Meeting – section 7.2)
6. Global and County-Level Partnerships		
The Global Fund partnership model has opened spaces for the participation of a broad range of stakeholders. This progress notwithstanding, existing partnerships are largely based on good will and shared impact-level objectives rather than on negotiated commitments or clearly articulated roles and responsibilities, and do not yet comprise a well-functioning system for the delivery of global public goods.	19. The Global Fund Board should reaffirm its commitment and reconsider its approach to institutional partnerships at the global level, clearly articulating its partnership priorities and the specific arrangements and agreements required to achieve its objectives. 20. The Global Fund Board should consider what efforts will be required to bring about agreed-upon, effective, and enforceable strategic divisions of labor between the Global Fund and the other main multilateral organizations involved in international health—in particular with the World Bank, UNAIDS, WHO, UNICEF, the Stop TB Partnership, and Roll Back Malaria—to fully capacitate the envisioned partnerships with civil society and the private sector. This should include, as a first priority, resolving the issues that impede the provision of essential technical assistance on a reliable and timely basis. It should also address larger, systemic issues important to HSS. 21. The Global Fund Secretariat should work with partners through the carefully differentiated approaches it seeks in its various areas of work at the global, regional, and country levels – defining in specific terms the institutional arrangements required to bring to bear the added value of particular partners at different stages of the grant life cycle. 22. The Global Fund Board, in consultation with the Secretariat, should ensure that the structure, function, and size of the Secretariat reflects its strategic role in a clearly defined partnership framework, distinguishing functions to be fulfilled by partners versus those to be fulfilled by the Secretariat.	**Global Fund Business Model** • In response to questions about its business model, the Global Fund declared that it was—and will remain—a financing entity. • It reaffirmed its commitment to the country-based model and emphasized the inclusion and engagement of civil society at all levels. • There was stronger commitment to harmonizing Global Fund support for salary supplementation and aligning Global Fund cycles with those of countries. **Engagement with Development Partners** • A Partnership Group has been formed in the Global Fund; the Partnership Strategy developed has been approved by the Board (November 2009). • A framework for strategic division of labor, clarity of roles, and coordination and mechanisms for funding technical assistance has been outlined for Global Fund engagement with development agency partners. • There has been more outreach by the Global Fund to development partner agencies. This included strengthening of relationships with GAVI, the World Bank, and IHP, particularly on HSS. **Global Fund Secretariat** • It is being reorganized to be more efficient. Using international

Findings	Recommendations	Program Response
		benchmarks, the work force will be based on an $8.8 million operational budget per full-time employee. • The Secretariat budget has been capped at 10 percent of total expenditures
7. Country Coordinating Mechanism (CCM)		
As the core partnership mechanism at the country level, CCMs have been successful in mobilizing partners for submission of proposals. However, in the countries studied, their grant oversight, monitoring, and technical assistance mobilization roles remain unclear and substantially unexecuted. The CCMs' future role in these areas and in promoting country ownership is in need of review.	23. The Global Fund should place greater emphasis on the CCM function than on the CCM entity. 24. In the majority of cases where the CCMs are not providing ongoing oversight and monitoring functions, the Global Fund should strengthen CCM capacities and/or focus their efforts more exclusively in the domain of proposal development and submission. 25. The Global Fund should work with partners and country counterparts to incorporate the CCM functions into other CCM-like mechanisms within existing country-level architecture for coordination and planning in the health and social sectors, particularly where the Global Fund is funding national strategies and/or seeking to support HSS. In doing so, the Global Fund should be diligent in ensuring that the principles of transparency and inclusion— in particular with respect to CSO and private-sector in-country partners—are maintained. 26. As an essential measure to assure functional partnerships at the country level, the Global Fund Board should designate in-country representation through explicit institutional partnership arrangements with international partners or—as a last resort—through the direct placement of Global Fund staff representatives. 27. The Global Fund and its partners should take steps to increase the inclusion of in-country CSO and private sector partners in country program efforts. The Global Fund, in particular, should: a. Work with country counterparts and international partners to share effective models for increased participation and strengthening of CSO and private sector efforts across development actors and between countries. b. Continue to advocate with host governments for increased CSO and private sector participation in the CCM function.	• Secretariat will work with CCMs to ensure transparent governance processes and improve their overall effectiveness. Functions of CCMs (including grant oversight) and adherence to minimum eligibility requirements will be reviewed. • The Global Fund is signatory to the Paris and Accra Accords and will abide by the guiding principles of harmonization and alignment. CCMs would be encouraged to be more in line with other national coordinating bodies. • Additionally, the Global Fund will now harmonize its approach to salary support and compensation and align its grant cycle with country planning and budgeting cycles. • The roles and functions the CCM mechanism will be reassessed (by means of direct surveys, comprehensive case study reports, monitoring of membership and funding patterns, adherence to eligibility requirements, etc.) toward improving their effectiveness.

Findings	Recommendations	Program Response
8. Risk Management		
The lack of a robust risk management strategy during its first five years of operation has lessened the Global Fund's organizational efficiencies and weakened certain conditions for the effectiveness of its investment model. The recent work to develop a comprehensive, corporate-wide risk-management strategy is a necessary step for the Global Fund's future.	28. The Global Fund should urgently complete its development of a risk management framework, beginning with the development of a risk register within the Secretariat that makes risk management activities integral components of strategic and corporate planning, operations, and decision making. 29. The Global Fund Secretariat should utilize the parameters associated with risk of poor grant performance--financial, organizational, operational, and political—to determine how resources should be mobilized in support of performance, either by the Secretariat or by in-country partners.	• A Risk Management and Accountability Framework has already been rolled out. • This includes a risk policy, an accountability system with detailed roles and responsibilities across the organization, and a code of conduct. • A corporate risk register will be maintained and updated every six months. • A country risk model will be implemented to reduce fraud and corruption. Clearer policy and guidelines are being provided to client countries. • The role of the Office of the Inspector General (OIG) has been expanded to include independent assessments and assurance over key risks and controls of Global Fund country portfolio.
9. Governance		
The governance processes of the Global Fund have developed slowly and less strategically than required to guide its intended partnership model.	30. The Global Fund Board should consider shifting to a more *partnership-centric* approach to governance in order to reposition the Global Fund in the global health architecture in a way that maximizes the leverage of its financing to effect major efficiencies in the international system of development assistance for health—specifically focused on AIDS, tuberculosis, and malaria, but mindful of the broader national health structures and systems that will require strengthening to achieve its objectives. Such an approach would involve the Board reexamining the roles and responsibilities presently carried out by the Secretariat, considering which of those roles could and should be played by partners. 31. The Global Fund Board should take steps to reconcile its founding principles with the unrealized assumptions required for their actualization. Specifically: a. Improved country-owned coordination, with the full participation	**Strategic Role of the Board** • Consistent with its governance function, the Board now focuses on core strategic issues for the Global Fund. • It has relegated more decision-making authority (especially when operational in nature) to Board committees and the Secretariat. • *Note*: A subcommittee has been formed by the Board (see Global Fund/B21/4 Report of the Policy and Strategy Committee) to respond to Global Fund management responses.

Findings	Recommendations	Program Response
	and inclusion of stakeholders, is required to ensure that the partnership model functions effectively at the country level. b. Strengthened country information capacities are required to support PBF. c. Explicit financing mechanisms are required to fully engage the international technical partners. 32. The Global Fund Board should support the development of a more coherent vision and mission statement that sets a hierarchy and contextual boundaries for the application of the Global Fund Guiding Principles, focuses on issues—especially partnership and M&E—that have not yet received sufficient attention and defines more precisely the current status and future orientations of the Global Fund business model. 33. The Global Fund Board should provide clear guidance to the Global Fund Secretariat with respect to strengthening or limiting its roles relative to those of its partners in the areas of financing, policy, and development assistance in order to better situate and differentiate the Global Fund in the global development architecture.	

Appendix H. Global Fund and World Bank Assistance to the Six Countries Visited

Table H-1. Burkina Faso: Global Fund Grants, Commitments and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	-	2	1	-	1	2	1	2	2	-	11
HIV/AIDS		1			1	1					3
Tuberculosis			1			1			2		4
Malaria		1					1	2			4
Grant amounts (US$ millions)	-	15.6	5.5	-	5.4	66.8	25.4	54.1	14.0	-	186.7
HIV/AIDS		8.8			5.4	55.4					69.5
Tuberculosis			5.5			11.4			14.0		30.9
Malaria		6.8					25.4	54.1			86.3
Disbursements (US$ millions)	-	1.3	6.2	8.7	6.1	9.3	25.4	29.6	62.2	12.4	161.3
HIV/AIDS		0.7	2.0	3.2	3.7	6.1	13.2	12.4	13.4	4.8	59.5
Tuberculosis			1.9	1.3	2.4	3.2	5.0	2.4	5.0	3.0	24.2
Malaria		0.6	2.3	4.2			7.3	14.8	43.8	4.6	77.6

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-2. Burkina Faso: World Bank Projects, Commitments and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved	-	-	1	-	-	0 [a]	1	-	0 [a]	-	1	0 [a]	3
Commitments (US$ millions)	-	-	22.0	-	-	5.0	47.7		15.0		2.7	36.0	128.4
Of which:													
Health system performance			3.1				13.8		2.6				19.5
HIV/AIDS			6.4			3.4	13.8					18.0	41.6
Malaria							6.7		5.0				11.6
Disbursements (US$ millions)	13.2	5.9	4.4	4.6	7.8	7.4	5.7	4.8	15.4	12.6	20.9	5.3	108.0
Of which:													
Health system performance	2.6	1.1	0.7	0.6	1.1	1.0	0.8	1.1	4.5	3.7	6.0	1.5	24.7
HIV/AIDS	1.8	0.8	0.9	1.3	2.3	2.1	1.6	1.4	4.5	3.7	6.0	1.5	27.9
Malaria								0.4	2.2	1.8	2.9	0.7	8.0

a. Supplemental financing for a previously approved project.

Table H-3. Tanzania: Global Fund Grants, Commitments, and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	1	1	1	5	-	1	1	3	-	2	15
HIV/AIDS		1		4				2			7
HIV/tuberculosis			1								1
Tuberculosis						1					1
Malaria	1			1			1	1		1	5
Health systems strengthening										1	1
Grant amounts (US$ millions)	78.1	4.6	66.8	340.7	-	24.2	16.3	221.6	-	135.3	887.5
HIV/AIDS		4.6		265.6				121.1			391.4
HIV/tuberculosis			66.8								66.8
Tuberculosis						24.2					24.2
Malaria	78.1			75.1			16.3	100.4		60.7	330.6
Health systems strengthening										74.6	74.6
Disbursements (US$ millions)	-	2.3	12.2	68.2	60.2	72.2	169.1	106.5	141.4	51.7	683.6
HIV/AIDS		1.8		43.8	27.2	28.4	84.5	47.9	79.0	0.4	313.1
HIV/tuberculosis			7.1	2.6	10.8	14.1	20.3		12.0		66.8
Tuberculosis						7.7	7.5				15.2
Malaria		0.5	5.1	21.8	22.2	22.0	56.9	58.6	50.4	35.7	273.1
Health systems strengthening										15.6	15.6

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-4. Tanzania: World Bank Projects, Commitments, and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved	1	-	-	-	2	-	-	-	0	-	1	-	4
Commitments (US$ millions)	22.0	-	-	-	135.0	-	-	-	60.0	-	40.0	-	257.0
Of which:													
Health system performance	6.4				18.9				19.8		11.6		56.6
HIV/AIDS	6.4				28.0								34.4
Malaria					9.1				19.8		5.6		34.5
Disbursements (US$ millions)	-	0.9	4.3	11.2	6.9	40.7	22.7	31.2	41.0	33.0	49.1	18.7	259.7
Of which:													
Health system performance		0.2	1.2	3.2	1.2	10.8	3.4	4.4	6.0	4.9	11.8	5.4	52.7
HIV/AIDS		0.2	1.2	3.2	2.1	1.4	4.4	6.4	8.1	6.4	3.4		36.9
Malaria					0.2	10.8	3.4	4.4	6.0	2.4	5.7	2.6	35.6

Table H-5. Cambodia: Global Fund Grants, Commitments, and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	-	4	-	2	3	1	1	2	2	1	16
HIV/AIDS		2		1	1		1			1	6
Tuberculosis		1			1			1			3
Malaria		1		1		1		1	1		5
HSS					1				1		2
Grant amounts (US$ millions)	-	45.4	-	46.4	45.7	22.9	22.5	18.519.2	67.9	53.4	323.4
HIV/AIDS		29.5		36.5	33.2		22.5			53.4	175.1
Tuberculosis		6.2			9.0			8.3			23.5
Malaria		9.7		9.9		22.9		10.9	56.1		109.6
HSS					3.5				11.7		15.2
Disbursements (US$ millions)	-	6.5	5.5	18.8	22.2	21.1	37.9	46.4	61.2	22.8	242.4
HIV/AIDS		4.0	4.5	12.4	15.9	13.3	24.0	28.2	15.2	18.6	136.0
Tuberculosis		0.6	0.5	1.3	2.3	3.0	2.0	6.5	4.5	1.2	21.8
Malaria		2.0	0.5	5.2	3.1	4.5	10.6	11.3	35.4	3.0	75.5
HSS					0.8	0.3	1.3	0.5	6.2		9.0

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-6. Cambodia: World Bank Projects, Commitments, and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved	-	-	-	1	-	-	-	-	1	-	-	-	2
Commitments (US$ millions)	-	-	-	27.0	-	-	-	-	30.0	-	-	-	57.0
Of which:													
Health system performance				5.9					9.9				15.8
Tuberculosis				6.2									6.2
Disbursements (US$ millions)	5.3	6.4	6.4	2.8	4.0	1.9	3.7	3.1	6.5	6.5	6.6	8.8	62.0
Of which:													
Health system performance	2.1	2.6	2.6	1.1	0.9	0.4	0.8	0.7	1.4	1.6	1.9	2.6	18.7
HIV/AIDS	2.1	2.6	2.6	1.1									8.4
Tuberculosis					0.9	0.4	0.8	0.7	1.5	1.1	0.6	0.6	6.8

Table H-7. Nepal: Global Fund Grants, Commitments, and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	-	2	-	2	-	1	6	-	1	1	13
HIV/AIDS		1				1	3			1	6
Tuberculosis				1			1		1		3
Malaria		1		1			2				4
Grant amounts (US$ millions)	-	7.3	-	25.2	-	4.6	31.9	-	22.2	2.2	93.4
HIV/AIDS		4.8				4.6	19.2			2.2	30.8
Tuberculosis				7.2			3.6		22.2		33.0
Malaria		2.5		18.0			9.1				29.6
Disbursements (US$ millions)	-	0.2	0.8	0.6	5.5	9.2	12.2	9.8	20.5	4.5	63.1
HIV/AIDS		0.1	0.3	0.6	3.0	3.2	5.9	5.1	3.4	1.7	23.2
Tuberculosis					1.4	1.5	1.8	4.2	7.1	2.7	18.7
Malaria		0.1	0.5		1.0	4.5	4.5	0.6	9.9		21.2

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-8. Nepal: World Bank Projects, Commitments, and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved	-	-	-	-	-	1	-	-	0 [a]	-	1	-	2
Commitments (US$ millions)	-	-	-	-	-	50.0	-	-	50.0	-	129.2	-	229.2
Of which:													
Health system performance						16.5			16.5		25.8		58.8
HIV/AIDS											19.4		19.4
Disbursements (US$ millions)	6.6	5.8	-	-	-	5.6	11.2	13.8	14.0	20.1	24.8	32.0	133.8
Of which:													
Health system performance	1.1	1.0				1.8	3.7	4.5	4.6	6.6	8.2	7.7	39.3
HIV/AIDS												3.3	3.3

a. Supplemental financing for a previously approved project.

Table H-9. Brazil: Global Fund Grants, Commitments, and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	-	-	-	-	2	-	-	2	-	-	4
HIV/AIDS											-
Tuberculosis					2						2
Malaria								2			2
Grant amounts (US$ millions)					23.0	-	-	24.1	-	-	47.1
HIV/AIDS											-
Tuberculosis					23.0						23.0
Malaria								24.1			24.1
Disbursements (US$ millions)						2.4	6.8	10.9	8.5	9.5	38.1
HIV/AIDS											-
Tuberculosis						2.4	6.8	6.1	3.0	1.8	-20.0
Malaria								4.9	5.5	7.6	18.0

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-10. Brazil: World Bank Projects, Commitments, and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved	-	-	1	2	1	-	-	-	2	2	1	2	11
Commitments (US$ millions)	-	-	68.0	130.0	100.0	-	-	-	107.7	365.0	67.0	210.0	1,047.7
Of which:													
Health system performance			9.5	9.9	13.0				22.4	251.9	24.1	150.0	480.9
HIV/AIDS				100.0							19.4		119.4
Disbursements (US$ millions)	74.0	86.3	114.2	58.5	57.2	17.4	88.6	66.2	49.0	19.8	31.0	33.1	695.1
Of which:													
Health system performance	31.0	41.1	46.2	24.7	19.6	2.4	7.8	6.1	4.0	3.9	6.6	6.0	199.2
HIV/AIDS	9.4	10.4	14.1	4.8	5.0	3.1	40.5	28.8	22.6				138.8

Table H-11. Russian Federation: Global Fund Grants, Commitments, and Disbursements, by Disease and by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [a]	Total
Number of grants approved	-	-	3	2	1	-	-	-	-		6
HIV/AIDS			1	1	1						3
Tuberculosis			2	1							3
Malaria											-
Grant amounts (US$ millions)	-	-	129.2	224.7	13.8	-	-	-	-	-	367.7
HIV/AIDS			111.5	136.5	13.8						261.9
Tuberculosis			17.7	88.2							105.8
Malaria											-
Disbursements (US$ millions)	-	-	12.7	29.2	57.4	81.5	75.4	61.5	34.3	9.5	361.4
HIV/AIDS			10.9	22.2	41.9	49.5	55.0	41.2	29.9	8.3	258.7
Tuberculosis			1.8	7.1	15.4	32.0	20.5	20.3	4.4	1.2	102.7
Malaria											-

a. Through June 30, 2011. Data downloaded from the Global Fund Web site on September 5, 2011.

Table H-12. Russian Federation: World Bank Projects, Commitments, and Disbursements, by Fiscal Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Number of HNP projects approved				2									2
Commitments (US$ millions)	-	-	-	180.0	-	-	-	-	-	-	-	-	180.0
Of which:													
Health system performance				30.9									30.9
HIV/AIDS				43.5									43.5
Tuberculosis				43.5									43.5
Disbursements (US$ millions)	24.0	34.0	14.4	3.7	3.3	1.2	16.5	43.7	41.8	32.6	-	-	215.1
Of which:													
Health system performance	12.3	20.3	4.7	0.8	0.7	0.2	3.0	7.6	7.2	6.0			62.9
HIV/AIDS					0.4	0.2	3.7	10.4	10.0	7.3			32.0
Tuberculosis					0.4	0.2	3.7	10.4	10.0	7.3			32.0

Appendix I. Major Findings from the Six Country Visits

Topic	Burkina Faso	Tanzania
1. Additionality and sustainability	Donor governments have decreased their funding for HIV/AIDS in Burkina Faso (a) because they are now contributing to the Global Fund and (b) in response to past scaling up of Global Fund support for Burkina Faso. At the time of IEG's visit In May 2010, the Global Fund was the only financier of ARV therapy and drugs to prevent mother-to-child transmission for HIV/AIDS in Burkina Faso and bore the responsibility for sustaining HIV/AIDS activities there. The long-term sustainability of Global Fund financing for HIV/AIDS programming was threatened by a funding gap until the country's Round 10 proposal was approved by the Global Fund Board in December 2010. At the time of IEG's visit in May 2010, Round 6 financing was terminating at the end of 2011, and Burkina Faso had failed to secure additional Global Fund financing in Rounds 8 and 9, which surprised all stakeholders. Government commitment to health sector funding is generally strong. Global Fund support does not appear to have reduced the government's own funding for the health sector. Global Fund administrative procedures associated with its performance-based funding processes had also caused short-term gaps in Global Fund financing, which had hindered staff retention. It was hoped that the "new grant architecture" would address this issue for malaria and tuberculosis.	Tanzania is heavily dependent on donors for the fight against the three diseases. By one estimate, it will not be self-sufficient in the fight against the three diseases until 2034. Given the high level of dependence on external assistance to fight the three diseases, most Global Fund grants are likely to cause the government to shift expenditures to other priority development areas. Domestic-funded expenditures for HIV/AIDS have decreased as external aid has increased. Some commentators felt that the Global Fund was being too liberal toward Tanzania in approving new grants, contrary to the Global Fund's policy of taking into consideration the speed of implementation of previous grants when considering new grant requests. This has detracted from incentives for effective grant implementation and sustainability. As in Burkina Faso, Global Fund resources have been less predictable than those of other donors (such as the World Bank), given the uneven pattern of grant proposals and the unpredictability of grant approvals.
2. Country Coordinating Mechanisms (CCMs)	The CCM now has broad-based participation in decision making compared to the situation in 2007, at the time of the Study Area 2 Country Program Assessment. There was no consensus on whether Global Fund-supported activities "reflect national ownership and respect country-led formulation and implementation processes." Local NGOs felt that the Global Fund's proposal process allowed them to apply for funding to support their disease-specific agendas. CBOs also found this approach refreshing, compared to their experiences with other donors. Most donors support the two "common baskets" for the health sector and for HIV/AIDS. That for HIV/AIDS is an annual plan organized with all partners to facilitate better use of their financial support, not an actual pooling of funds..	The national/institutional context in Tanzania has resulted in significant adjustments to the Global Fund guidelines for CCMs, some innovative and productive, and others not. The Tanzania National Coordinating Mechanism (TNCM) – its CCM – oversees the fight against all three diseases and avian flu. Its Executive Committee comprises five government members, four development partners, three private sector representatives, and seven CSO representatives. The World Bank only participates when it chairs one of the two multilateral groups represented on the TNCM. The TNCM Secretariat is embedded in the Tanzania Commission for AIDS (TACAIDS) because the Round 1 Global Fund grants covered mostly HIV/AIDS. This arrangement has continued, even though it was intended to be provisional, and the scope of the TNCM has been expanded to include tuberculosis, malaria, and avian flu. Continuing this arrangement is not

Topic	Burkina Faso	Tanzania
		institutionally sustainable or advisable. It has given rise to inherent conflicts of interest and shortcomings in administrative support that TACAIDS provides to TNCM. Tanzania has a good record in producing quality grant proposals due to the perceived quality of its participatory preparation process and the substance assured by competent consultants. Commenting on an earlier draft of this report, the Global Fund Secretariat has noted that having TACAIDS act as CCM Secretariat was very helpful in the beginning, especially since TACAIDS is under the Prime Minister's Office. This helped to strengthen the funding and staffing of the CCM Secretariat. It is now the responsibility of the CCM to review the role of TACAIDS and to propose viable changes if necessary.
Partnership and leadership	The CCM is now more independent of government than before. The chair is now an academic, no longer the Ministry of Health. The vice-chairs are an NGO (of PLWA) and WHO.	The TNCM has a strong government presence. The Permanent Secretary of the Prime Minister's Office chairs the TNCM. Most TNCM meetings are taken up with administrative and procedural matters, leaving little time for strategic discussions. Commenting on an earlier draft of this report, the Global Fund Secretariat said that the CCM has provided an excellent forum to enhance partnership arrangements among the various country stakeholders and development partner agencies, that have contributed to the effective scale up of the country's HIV, tuberculosis, and malaria responses over the last three years.
Governance and CSO participation	NGOs and CSOs represent almost 50 percent of CCM membership, more than the Global Fund's 40 percent requirement. The four main religious groups and persons with the diseases are well represented. Members of the CCM are integrally involved in national strategic planning and program implementation for the three diseases.	An NGO representative is the vice-chair of the TNCM (currently the Christian Social Services Organization). The TNCM chair has shown a preference for NGOs that are not likely to challenge the government on Global Fund business. The TNCM terms of reference do not distinguish advocacy NGOs from service providers. These have different interests in terms of preparing and screening proposals and selecting Principal Recipients and sub-recipients.
CCM Secretariat funding	The Global Fund has made $43,000 a year available to the CCM Secretariat since 2009 – an improvement over what was found during the work for Study Area 2 in 2007. This covers most administrative expenses, including a small office space and salaries for three staff, but not proposal preparation costs, preparation of background papers, technical assistance, or grant supervision costs.	The TNCM Secretariat is funded under the TACAIDS budget and by an annual subsidy of $43,000 from the Global Fund.

Topic	Burkina Faso	Tanzania
CCM oversight practices	The CCM has not developed a systematic, comprehensive way to provide oversight of Global Fund grants. This is the greatest weakness of the CCM – and there has been no change since Study Area 2 in 2007. The CCM reviews quarterly reports and carries out very few field visits, mostly in Ouagadougou. Some CCM members questioned whether this was even an appropriate role for the CCM. Subsequent to IEG's visit in May 2010, the CCM submitted a request to the Global Fund in 2011 for technical assistance to review its structure, governance tools, and procedures, as well as its oversight practices.	The Global Fund's Office of the Inspector General (OIG) report found many shortcomings in the complex system of Global Fund grant oversight in Tanzania.
Principal Recipient and Sub-Recipient selection	This process is transparent and fair. Applications are solicited in the newspapers. The CCM reviews and compares the applications, and then selects the winner by voting.	For reasons of fiduciary controls, the Ministry of Finance and Economic Affairs (MOFEA) is the Principal Recipient for most Global Fund grants, although not all grants are placed on-budget, due to discrepancies in timetables between the national budget and grant approval. The Ministry of Health (MOH) is the lead sub-recipient for all government-implemented grants. Other funds are channeled through NGO partner organizations. The MOFEA representatives on the TNCM have limited availability for Global Fund activities, which has translated into delays in the flow of funds due to its financial gate-keeping role. Losses of grant funds in Round 3 and critical delays in the release of grants for Round 8 were attributed to this. Tanzania has a cascading system of sub-recipients (up to five layers), which has been complex and rendered transactions costly.
Conflicts of interest	No one seems concerned that some Principal Recipients and sub-recipients are members of the CCM during their tenure.	There are numerous conflicts of interest: • TACAIDS, which houses the TNCM Secretariat, is a sub-recipient of several Global Fund grants; the Secretariat is effectively overseeing itself. • There are voting members on the TNCM who are Principal Recipients and sub-recipients, which violates both the Global Fund guidelines and the TNCM's own rules. • The Principal Recipients and sub-recipients are selected from among those that have played a role in originating Global Fund grant proposals. The TNCM appears not to have effectively enforced its own rules in relation to conflicts of interest.

Topic	Burkina Faso	Tanzania
CCM–Principal Recipient–LFA communication	Only the chair and secretary of the CCM meet regularly with the LFA. Neither the CCM at large nor a CCM committee meets with the LFA.	Communications between the chair, the Secretariat, and the implementers, on the one hand, and the LFA, on the other, are a very sensitive matter. While the chair had expectations of complete openness on the part of the LFA, the LFA viewed its own communications with the Global Fund as a confidential matter. Commenting on an earlier draft of this report, the Global Fund Secretariat said that the Tanzanian CCM has now given the LFA a platform during every CCM meeting to highlight key issues in grant implementation/ management and to provide a second opinion on the Principal Recipient's progress reports. The LFA has also made regular presentations to the Development Partners' Group.
Harmonization and alignment	While country disease priorities are represented in the CCM, since CCM membership includes stakeholders from each of the three diseases, the CCM is still seen as a parallel institution that is not fully integrated with country disease management.	Harmonization occurs through donor self-coordination. However, the Bank has not been actively engaged due to lack of staff resources required to attend the many meetings required by this system. Large donors such as USAID and PEPFAR have also preserved their own individual practices and standards, especially on M&E. Donors in Tanzania still resist compliance with the "Three Ones" and the Paris Declaration and giving up their own standards and practices.
3. Country-level partnerships	It remains the case that country-level partnerships are largely based on good will and shared impact-level objectives rather than on negotiated commitments or clearly articulated roles among partners. Other donors and the government have negotiated a "common basket" for the general health sector and a second one for HIV/AIDS. A MOU has been signed for each basket. The Global Fund is contributing to the strategies and national programs funded by the basket. However, its contributions are earmarked, not pooled with those of other donors. The IHP+ initiative to coordinate funding between the Bank, GAVI, and the Global Fund is still a concept and not a practical reality in Burkina Faso.	Technical assistance is currently provided through retained short-term consultants paid by donors or by embedded resident advisors who serve as counterparts to key managers in the health sector. This has increased donor dependence, constitutes a deviation from the Paris Declaration, and is contrary to building local capacity.
International organizations	WHO, UNICEF, UNAIDS, and UNDP contribute in-kind technical assistance for proposal preparation and financing for background papers and other technical work.	Strong in-country partnerships have contributed to the effective scale up of the HIV, tuberculosis, and malaria responses over the last three years. Partners have provided critical support to capacity building and technical assistance, including proposal development. The key partners have included GTZ, Italian Cooperation, UNAIDS, United States (USAID, PEPFAR, Centers for Disease Control, and the President's Malaria Initiative), WHO, and the World Bank. The Development Partners' Groups

Topic	Burkina Faso	Tanzania
		for Health and AIDS have been effective forums for discussions and joint agreements to implement programs in a coordinated way. Examples include joint procurement of first- and second-line ARVs by the Global Fund and PEPFAR, and joint procurement of bed nets by the Global Fund, the President's Malaria Initiative, and the World Bank.
Bilateral donors	These are less involved with the CCM since they view the CCM as an arm of the Global Fund. They are also supporting the "common baskets" for the general health sector and for HIV/AIDS.	While bilateral donors have their individual health assistance programs, they coalesce around the donor working groups, resulting in a coherent position with respect to the three diseases. Most contribute to the health basket, the main funding mechanism for the health SWAp. USAID constitutes a separate donor force, because of its size and the combined efforts of USAID and PEPFAR.
Civil society organizations (CSOs)	Local NGOs felt that the Global Fund's proposal process allowed them to apply for funding to support their disease-specific agendas. CBOs also found the Global Fund's approach refreshing, compared to working with other donors.	NGOs appear to operate in a poorly regulated environment.
Commercial private sector	The involvement of the private sector remains extremely limited, the same finding the Study Area 2 Country Partnership Assessment.	The private sector has participated in the TNCM mostly as a mobilizer of Global Fund resources for programs to benefit private sector workers rather than moblizers of private sector funds for the wider community of citizens affected by the three diseases.
4. Performance-Based based Funding (PBF)	There has been a real change in perception among Principal Recipients and sub-recipients in Burkina Faso since the Study Area 2 work in 2007. Principal Recipients found it difficult to adapt to the Global Fund's PBF system at first, but now they see it as a useful system. Several grant recipients have now integrated the Global Fund performance-based indicators into their own planning processes and rely on them for their own decision making and planning.	The low quality of data and the lax discipline in its collection have compromised PBF in Tanzania. Timely availability of data has also been an issue. The recent Global Fund's OIG audit found that Progress Updates and Disbursement Requests were not being prepared and submitted on time by Principal Recipients (MOFEA) and that their accuracy and completeness were not verifiable. The absence of major disruptions in disbursements also reduces the effort to ensure that funding is driven by demonstrable performance at the results level. Commenting on an earlier draft of this report, the Global Fund Secretariat said that two major challenges have been late reporting by the Government Principal Recipient (the Ministry of Finance and Economic Affairs) and the absence of a well-functioning Health Management Information System. The Round 8 HIV grant has plans for strengthening the reporting mechanisms and tracking of funds and health products at all levels, improving overall

Topic	Burkina Faso	Tanzania
		data quality, and integrating the parallel systems for Global Fund reporting into the mainstream M&E system. The Round 8 grant is also providing funding for satellite installation at the district level to enhance the quality of data collection and the flow of information.
5. Service delivery, prevention, and treatment	Global Fund support has expanded prevention and treatment services tremendously for all three diseases in Burkina Faso. The country report statistics for HIV/AIDS, tuberculosis and malaria support this finding. Global Fund grants have supported innovative ways of working with NGOs and CBOs, in particular with PAMAC (Program to Support Community Associations), which is now the Principal Recipient for the Global Fund tuberculosis grant. There has also been excellent collaboration with religious groups. Mobile health clinics that focus on HIV counseling and testing have been another innovative service delivery mechanism.	Grant performance has been moderate, with some challenges experienced. The number of people on ARVs has increased from 20,000 in 2002 to 200,000 today, over 70,000 pregnant women have received PMTCT (Prevention of Mother to Child Transmission of AIDS), and over 8.5 million people have been treated for malaria using ACT. The Round 8 grant for malaria has financed the distribution of over 18 million insecticide-treated bed nets under the Universal Coverage Campaign.
6. Equity	This is first of all an urban-rural issue in Burkina Faso. The focus of Global Fund grants on decentralization has noticeably improved access to services in rural areas. The prevention and treatment programs for HIV/AIDS in the Round 10 grant will target high-risk groups (sex workers, homosexuals, truck drivers, etc.) for the first time.	Equity is embedded in Tanzanian culture, and equity concerns have translated into a move toward decentralization that gives districts considerable influence in allocating benefits, including health services. There is no evidence that any disadvantaged or minority group has been discriminated against in access.
7. Domestic health systems	Global Fund–supported activities have contributed to the improved delivery of health services, most notably the expanded availability of health services in rural areas. Many stakeholders expressed the desire for the Global Fund to provide more integrated support to the entire health sector, which would be considered a more efficient and coordinated way to support the country's efforts to prevent and fight the three diseases.	The Bank has made a substantial contribution to strengthening health systems through its Health Sector Development Adaptable Lending Program. USAID has also made significant contributions to HSS through its embedded technical assistance approach.
8. Risk management	The LFA for Burkina Faso is the Swiss Tropical and Public Health Institute (Swiss TPH), which has expertise in both public health and finance. A Senior Health Specialist base in Basel oversees the work. One staff person from Swiss TPH, based in Ouagadougou, works full time, and two local staff work part time. The Global Fund risks being perceived as exclusively responsible for funding life-saving treatments in poor countries. This has happened in	Failures of integrity and probity in the use of Global Fund grants are the most costly risk to the program's beneficiaries and reputation. The LFA is aware of these issues and welcomed the recent OIG audit of Tanzania, which pointed out many irregularities in procurement. The LFA appears to be diligent and strict about the use of funds, and has singled out fraud and corruption in many government quarters as the main risk, but has faced government reluctance to prosecute such acts.

Topic	Burkina Faso	Tanzania
	Burkina Faso in the case of ARVs and drugs to prevent mother-to-child transmission. The Global Fund also finances half of the first-line anti-TB medicines and all the second-line anti-TB medicines. and procured 6,678,158 bed nets as part of the Round 8 malaria project. (The government finances the other half of first-line anti-TB medicines.)	Commenting on an earlier draft of this report, the Global Fund Secretariat said that the LFA has put in place a risk management framework as mandated by the Global Fund. The Global Fund is also working with the CCM and Principal Recipients to ensure that each Principal Recipient has a risk management framework in place. The CCM, Principal Recipients, and development partners are also involved in a graft-theft mitigation initiative to proactively find joint solutions.
9. Global Fund governance, organizational vision, and strategy	Stakeholders in Burkina Faso have not noticed any shift in the Global Fund from being a finance-only institution to becoming a more conventional development agency. They view the Global Fund as a financing-only mechanism, with all other aspects of support being provided by other development partners.	Some government respondents requested that the Global Fund simplify its procedures, adopt greater timetable flexibility, and give the LFA more of an "enabler" role than one as "inspector."

Topic	Cambodia	Nepal
1. Additionality and sustainability	The Global Fund has not crowded out other donors—other donors have shifted resources (notably for HIV/AIDS) before and after Global Fund entry. This has not been as much a crowding effect, as it has been a substitution effect. At the same time, independent of the Global Fund, some donors were "experimenting" with "division of labor" and consolidating their programs selectively. For these donors, the Global Fund has allowed movement into areas of their comparative advantage and reduced fragmentation in the sector. Overall financing for health has increased despite the withdrawal by a large financier, the Asian Development Bank, from the health sector. Key national programs have become highly dependent on the Global Fund, however, which poses risks for sustainability and may also reduce incentives for these programs to engage in national planning and review processes. Total external funding (MAP, PEPFAR) for HIV/AIDS has leveled off, accompanied by concerns of sustainability. Prevention programs are beginning to suffer the shortfalls, given the moral obligation and priority to address the needs of the already ill.	The country visit did not yield the data with which to assess the additionality of Global Fund grants. Highly aid-dependent Nepal faces real and imminent sustainability risks. At the time of the country visit in May 2010, it was uncertain if the HIV/AIDS control program would receive another Global Fund grant, and only a fraction of the World Bank HNP/AIDS project ($130 million) is devoted to HIV/AIDS. Grant-funded tuberculosis and malaria programs perform much better and would not be affected. Tuberculosis and malaria also receive other donor funds (through a pooled basket). Since IEG's country visit, the Global Fund Board has approved the country's Round 10 proposal for HIV/AIDS in December 2010, thus securing external financial support for HIV/AIDS for the next five years.
2. Country Coordinating Mechanisms (CCMs)	There were strong preexisting donor coordination mechanisms— e.g., Technical Working Group, Health — which are directly linked to the broader development agenda and architecture for the country. Members of Cambodian CCM were initially drawn from Technical Working Group members, and provided an enabled environment for Global Fund programs to be aligned and harmonized with the National Strategic Action Plan in Health, which enjoys support from the government and other development-partner agencies. Even though the Global Fund did not pool resources in the common basket to implement the Action Plan, it participated in joint review and planning exercises. Recent changes in CCM composition and reduction in members has substantially increased the NGO powerbase and dilution of Ministry of Health influence. This is well received by the NGO community, although there are some concerns with reduced technical and programmatic competency (diminished numbers of Ministry of Health representatives). The World Bank is no longer on the CCM, as seats for multilateral partners have diminished. There is a system of alternates.	The CCM in Nepal has 30 members: 10 from the government, 13 from NGOs, 3 from the private sector, 2 multilateral organizations, 1 bilateral donor, and 1 member from academia. The World Bank is not a member. UNAIDS represents all the multilaterals that participate in the CCM, except for WHO, which has its own seat.
Partnership & leadership	Technical and programmatic leadership was provided by experienced Ministry of Health members (directors of national control programs for the three diseases) and their foreign counterparts from WHO, UNAIDS, and	Nepal is a donor-led country. WHO is viewed as the chief technical agency on the CCM. The Ministry of Health exercises leadership only in tuberculosis and malaria (established programs). In HIV/AIDS there are at least four public and

Topic	Cambodia	Nepal
	USAID. Cambodia created its own Technical Review Panel to help generate quality proposals for Global Fund grants.	quasi-public-sector entities charged with some HIV/AIDS responsibilities, but who do not collaborate well. The two principals, the National Centre for AIDS and STD Control (NCASC) and the Board for HIV/AIDS programs (a political body created in response to NGO pressure and intended to lead and set policy) have no clear definition of functions. Commenting on an earlier draft of this report, the Global Fund Secretariat said that the HIV/AIDS situation in Nepal has improved since May 2010, although obvious concerns remain. NCASC is now the Principal Recipient for the Round 7 grant and will also be the Principal Recipient for the Round 10, single-stream-of-funding grant. The Global Fund, in collaboration with the CCM, has carefully and thoroughly assessed the capacity of the NCASC to manage the grant successfully, supported by some 21 staff paid out of grant funds. WHO is also providing support through a P5 position, and other external partner agencies are also helping build capacity. National ownership has been strengthened and the sustainability of Global Fund support for HIV ensured through the Round 10 grant.
Governance & CSO participation	CSO participation and power sharing among CCM members have progressed since the FYE. They assert that the CCM structure has, more than any other, allowed them to share policy space in the country's development agenda. The current vice chair is a CSO.	NGOs are vocal, largely active in HIV, and the majority (45 percent) on the CCM. There is one NGO Principal Recipient and there are two NGO sub-sub-recipients (all in HIV/AIDS) on the CCM. Sharing of power is unclear. UNDP, an important Principal Recipient implementing HIV/AIDS grants, is not a member.
CCM Secretariat	The Secretariat was professionally staffed at the time of IEG's visit in April 2010, initially with funding from GTZ, and then with an annual $44,000 grant from the Global Fund. The Global Fund subsequently approved an expanded funding agreement for the CCM Secretariat for two years starting June 1, 2010 — $117,842 for the first year and $110,092 for the second year. UNAIDS is also providing $10,882 during the same two-year period. The Secretariat now has three staff — the Secretariat Manager, an Administrative Officer, and a Program and Financial Management Oversight Officer.	The CCM had no substantial secretariat or staff at the time of IEG's visit in May 2010. One CCM Coordinator and one assistant now staff the Secretariat (October 2011) in the Ministry of Health and Population..

Topic	Cambodia	Nepal
CCM oversight practices	Greater focus is placed on grant performance. An Oversight Committee was created (2010) to which four (three diseases and one in HSS) technical working groups report. Representatives of Principal Recipients, sub-recipients, and sub-sub-recipients may not serve on the Oversight Committee, automatically disqualifying the implementing agencies of the three national disease programs. The implementing agencies are still able to contribute their technical and programmatic expertise by serving on the technical groups that report to this Oversight Committee. The World Bank agreed to serve on this committee.	It actively presides over preparation of grants and the selection of Principal Recipients and sub-recipients, but does not oversee grant implementation.
Principal Recipient and sub-recipient selection	The selection committees have strict criteria and assessment tools to grade candidates to be Principal Recipients. Protocols guide every process of the CCM, which was cited by the *CCM Global Report of 2008* as having among the best governance tools and protocols to guide its work. But the LFA is responsible for undertaking the final capacity assessment of nominated Principal Recipients. The CCM nominated an NGO to be a Principal Recipient for the first time. However, the nominated NGO failed the LFA assessment and was not confirmed by the Global Fund Secretariat.	The Ministry of Health was initially the Principal Recipient for the Round 2 grant for HIV/AIDS (approved December 2005). When the Global Fund determined that the Ministry lacked capacity, it formally designated the UNDP as a co-Principal Recipient in 2007, after which UNDP essentially took over the project rather than helping to build up the capacity of the Ministry of Health to implement it. When the Global Fund approved three HIV/AIDS grants in Round 7, it assigned one to UNDP and two others to NGOs, thus bypassing the government entirely. NCASC is now (October 2011) the Principal Recipient for the Round 7 grant and will also be the Principal Recipient for the Round 10, single-stream-of-funding grant. The report focuses mostly on the relationship between the Principal Recipient and its sub-recipients, and between the different sub-recipients under the same Principal Recipient. With respect the relationship between the different actors within a Global Fund grant—i.e., between a Principal Recipient and its sub-recipients—this is a nonissue for tuberculosis (a well-established program), which is exclusively and effectively administered through the Ministry of Health and public health facilities throughout the country. Partnership between two Principal Recipients in malaria is good. There is good division of labor between the two Principal Recipients (PSI/NGO and Ministry of Health) playing out their respective comparative advantages. Based on historical practice, PSI distributes bed nets while Ministry of Health undertakes rapid diagnosis and treatment.
Conflict of interest	There is a formal policy on conflict of interest. The new CCM is restructured to prevent ANY entity associated with a potential Principal Recipient or sub-recipient candidate from sitting on the CCM. Thus many members of the Ministry of Health are disqualified from the CCM.	No substantive concerns about conflict of interest.

Topic	Cambodia	Nepal
CCM-Principal Recipient-LFA communication	The LFA attends all CCM meetings as an observer.	
Harmonization and alignment	See above.	No direct reference in the report, but it may be assumed that there is reasonable alignment and harmonization in the tuberculosis programs, and somewhat less in the malaria programs. The coordination in HIV/AIDS is more problematic. The relations among the different agencies are complicated, including the top-level National AIDS Council that is supposed to set overall policy and the District AIDS Coordination Committees that are meant to oversee the actions of NGOs and community-based organizations.
3. Country-level partnerships	Global Fund is being drawn willingly into existing coordination mechanisms and is interfacing more actively with the government and donor partners. A clear connection to national strategies and action plans is also being forged. Absence of a physical on-the-ground presence hinders the Global Fund's collaborative efforts to some extent, but the Fund Portfolio Manager (FPM) has consistently participated in the yearly Joint Ministry of Health–development partner agency review and planning exercises. As a new actor on the development scene, the Global Fund will need time to forge enduring relationships with the intertwined stakeholder community.	The report focuses on HIV/AIDS where there is absence of good working partnerships between government (Ministry of Health) and the Principal Recipients. The Ministry of Health has been unable to develop and implement clear and effective policies, which has affected Ministry of Health collaboration with its Principal Recipients, and particularly the NGOs that depend on grant support.
International organizations/bilateral donors	WHO, UNAIDS, USAID, Japan, France, DFID, AUSAID, the Japan International Cooperation Agency (JICA), and the World Bank interact quite significantly with either the CCM or with the FPM. All these agencies with the exception of the World Bank provide technical assistance (in kind or directly) to Global Fund–funded activities. Lack of development-partner agency staff time is a major constraint to sitting on the CCM and other committees of the CCM. WHO and UNAIDS draw significantly from their own budget to support CCM–related work.	Donor collaboration has been weak, but is improving. Nepal is currently a pilot country for both JANS and the Health Systems Funding Platform. A joint assessment of the national health strategy was carried out in January 2010, and a Joint Financing Agreement supporting the National Health Support Program, 2011–15, was signed by the government and the major donors in August 2010 (DFID, GAVI, UNFPA, UNICEF, USAID, and the World Bank). Funding for NGOs that cater to most at-risk groups is now transitioning from DFID/UNDP funding to pooled funding, managed by the World Bank.
Civil Society Organizations (CSOs)	But the use of long-term advisers by some development partner agencies and the preferred use of international NGOs over local ones have constrained capacity and institution building. The government has begun to challenge the relevance and cost effectiveness of these measures. Foreign NGOs and workers are abundant in the country. The government, accustomed to working alongside expatriates, hires its own foreign consultants for specific tasks such as writing proposals for Global Fund grants. As in other countries, a distinction should be made between international	A distinction may be made between well-established international NGOs operating in Nepal for decades and with alternative sources of funding and local NGOs that were formed recently and depend on Global Fund finance to exist or survive. The composition of CCM is noteworthy for the large presence of NGOs, but only one of them has been a Principal Recipient; two of them are actually groupings or umbrella organizations of other NGOs, several of which participate as Sub-Recipients. Two of established international NGOs (SCF

Topic	Cambodia	Nepal
	NGOs and local CBOs, who may be more connected to local communities and more relevant in sustaining services and benefits, but may currently be weak in technical and programmatic and managerial skills, which prevents them from being Principal Recipients and sub-recipients.	and PSI) are U.S.-based and are important Principal Recipients, but don't sit on the CCM.
Commercial private sector	Their participation is quite minor at the CCM.	Although this sector occupies three CCM seats, their actual involvement in Global Fund services is minimal, e.g., as vendor of drugs. Their view is that the Ministry of Health sees them as a rival rather than as a partner.
4. Performance-Based based Funding (PBF)	PBF is working well in Cambodia because the country has had considerable experience with it. Results-based financing was first introduced in 1999 by the Asian Development Bank. This entailed the contracting of Preferred Health Care and maternal and child health service delivery to NGOs and district health authorities, based on compensation for results. Subsequently, other development partner agencies, including the World Bank, have followed with PBF-type schemes. PBF processes as applied to Global Fund grants has been varied: imperfect but improving as more Principal Recipients and the LFA develop a better working understanding of one another. The requirement for PBF still favors the selection of "established" groups, with proven programmatic, technical, and financial competency, to serve as Principal Recipients. PBF should be applied to the entire service delivery chain, from Principal Recipients to Sub-Sub-Recipients. Under the new CCM structure, the Technical Working Groups under the Oversight Committee may now monitor and review the work plans of sub-sub-recipients and sub-recipients. Until now this has been the sole responsibility of the Principal Recipients. Overall, the PBF experience of the Global Fund in Cambodia can be characterized as promising but with challenges.	Given the situation (political unrest and capacity problems in HIV), PBF is a remote goal. Stringent application of the concept risks termination and disruption of services already supported. PBF may be more feasible for tuberculosis and malaria but may still require careful specification of what "performance" means and should constitute only a marginal share of grant funding. Commenting on an earlier draft of this report, the Global Fund Secretariat did not agree that implementing PBF in new grants may lead to disruption of services. The application of PBF is challenging in Nepal, but PBF needs to work in situations where M&E is weak and also provides important incentives for improving M&E. The World Bank, the Global Fund, and other external development partners have contributed to significant institutional capacity building during the last two years, particularly in the National Centre for AIDS and STD Control, which is now the Principal Recipient for the Round 7 grant and will be for the Round 10 grant. The external development partners, together with the Ministry of Health and Population, have recently agreed to make M&E a core element in the HSS grant application for Round 11. Nepal is no different from other countries where support for HIV control is particularly sensitive, and needs constant support and supervision.
5. Service delivery, prevention, and treatment	There is little doubt that the significant resources marshaled by the Global Fund in the country have expanded critical services in all three diseases. Cambodia is a success story in AIDS, having reversed the epidemic. Among the achievements are 100 percent condom use among sex workers in 24 provinces and 32,000 people (including 3,000 children) receiving ART. These achievements were the product of good technical and programmatic collaboration among the government, foreign partners, and civil society, and would not have happened without the sustained funding from the Global	Based in large part on data available on the Global Fund Web site, the report posits that the expansion of services could not have happened without Global Fund grants. The tuberculosis program is the most successful and reported having successfully treated 89 percent of cases enrolled. Global Fund support for malaria and HIV/AIDS currently emphasizes preventive measures over treatment. There are signs of drug resistance to tuberculosis and malaria. Global Fund grants for HIV/AIDS have been rated poorly compared to those for tuberculosis and malaria. The short-term need to get results from the

Topic	Cambodia	Nepal
	Fund. Among the innovations jointly supported by Global Fund and UNAIDS is analytical work that gives insight into cost projections for 50 years, modeled after Cambodia as a case study. The country also has the best-costed National Strategy Action Plan in the world, which is population-based.	grant appears to have trumped the long-term interest in making the Ministry and the National Center for AIDS and STD Control (NCASC) more competent. Commenting on an earlier draft of this report, the Global Fund Secretariat agreed that the performance of HIV grants is vulnerable. Grants have been rated poorly, mainly due to dysfunctional governance. But the situation has improved since 2010. Short-term needs have not trumped long-term interests. The Global Fund recognizes the need for national development and ownership, and has actively supported the CCM in transferring more and more responsibility to the NCASC. The Global Fund supported the Family Planning Association of Nepal, an important NGO working with most at-risk people, through a difficult phase and despite severe malfunctions, in order to strengthen national capacity. External development partners have joined hands in building capacity in the Procurement Department of the Ministry of Health to take over ARV procurement fully in 2012.
6. Equity	Global Fund interventions have generally been equitable and in line with the government's Health Sector Strategic Plan and three national disease programs. The focus of services has been on poor, rural Cambodians and on high-risk and marginalized groups (men who have sex with men, intravenous drug users, sex workers). Marginalized groups, often stigmatized, are represented on the CCM. Global Fund data also show that women with AIDS have equal access to ART with men. There is gender parity with respect to getting treatment and drugs. A full package of services is targeted at mothers, which includes antenatal care, HIV testing and counseling, and ARV prophylaxis to prevent mother-to-child transmission. Interventions targeted at the entertainment industry primarily benefit women.	Nepal suffers from some of the inequities common to poor countries, in addition to which, the poorest people live in the most remote and inaccessible parts of the country. By expanding access, Global Fund programs have improved equity, especially for tuberculosis, because DOTs is now available throughout the country. For HIV/AIDS the issue is whether limited resources should be targeted only at the highest-risk groups (migrant workers, sex workers, and intravenous drug users), or should include others at risk. The larger ethical issue may arise in how resources are allocated between prevention and treatment in the HIV/AIDS program.
7. Domestic health systems	The Global Fund has allowed for NGOs being an essential part of the Cambodian health system, where they play an indispensable role serving poor rural populations. Global Fund– supported activities, problematic in the beginning, have given way to greater understanding and commitment by Global Fund and development-partner agencies to work in harmonization and alignment with the country's health systems. The recent Health Systems Funding Platform initiative, involving the Global Fund, the World Bank, and GAVI, facilitated by WHO, creates further opportunities for alignment among partners. During an initial consultation mission in mid-2010, however, the Cambodian government indicated it did not wish to pool funds from the World Bank and the Global Fund, but	The three national programs have very different capacities at the point of delivery and operate quite independently of one another. The strong tuberculosis program operates exclusively through the Ministry of Health, and its public facilities have offered nationwide access to DOTs since 2001. Prevalence has dropped and transmission is slowing. Malaria, on the increase as the population migrates to the valley and lowlands, is beginning to benefit from improved surveillance, rapid diagnostics, and treatment offered by the Ministry of Health and bed net distribution and utilization by the NGO PSI. HIV/AIDS incidence is increasing and treatment is reaching only a fraction of the HIV-infected people who need it – due to weak governmental leadership and uncoordinated donor behavior.

Topic	Cambodia	Nepal
	welcomed efforts to further align systems for M&E, annual reviews, and fiduciary requirements. Discordant salary scales, particularly egregious in the case of the Global Fund, posed serious problems for sustainability of externally funded activities. Domestic health systems were compromised as talent was drained from the public sector to NGOs and project implementation units working for development-partner agencies. Recently the Priority Operating Costs scheme was introduced by the government, and all development partner agencies, including the Global Fund, have agreed to abide by the scheme and rate set by the government.	
8. Risk management	As a highly aid-dependent country, Cambodia has sustainability issues in all its development programs. This is also true with Global Fund grants. There are examples of the government adopting caution in cost containment. For example, in HIV/AIDS, the Ministry of Health has taken over management of all ART programs, in hopes of a better balance between treatment and prevention. This is a direct result of MAP and PEPFAR no longer supporting treatment. While this is a good policy on the country's part, the Global Fund risks becoming the only external agency to fund ART. It also risks being the primary supporter of tuberculosis and malaria in Cambodia and having too many people on ART, which it cannot sustain, Last, with expanded use of ART and ACT and other drugs comes the risk of drug resistance. Cambodia is at risk of introducing drug-resistant strains of the three diseases due to illegal peddling of counterfeits and public preference for such drugs because of price. There may be scope for expanded support for pharmacovigilance by the Global Fund.	The principal risk to the Global Fund–supported activities in Nepal is the inability to contain the HIV/AIDS epidemic where prevalence continues to rise, and expanding treatment increases the financial burden. Political instability presents the biggest hurdle, because services in the rural areas are severely affected by such instability. Lack of managerial capacity in the government has led to grants going to UNDP and the NGO sector. It is not clear how the risk of continuing to bypass the Ministry of Health for HIV/AIDS control should be managed, but there is agreement that government capacity and ownership need to be developed. Of immediate concern is Nepal's difficulty securing HIV grants. Failure to get one in Round 10 would have meant the discontinuation of ART treatment from previous grants. Commenting on an earlier draft of this report, the Global Fund Secretariat agreed that the effectiveness of the HIV program remains a big concern, but that the situation has improved since IEG's country visit in May 2010. The Global Fund Board approved the country's Round 10 proposal for HIV/AIDS in December 2010, thus securing external financial support for HIV/AIDS for the next five years. The National Centre for AIDS and STD Control is now the Principal Recipient for the Round 7 and 10 grants. Still, strategic and day-to-day management are weak, and forecasting ARV needs remains challenging due to poor stock management and consumption data surveillance.
9. Global Fund governance, organizational vision, and strategy	Respondents were satisfied with communications from Geneva in relation to Global Fund policies and guidelines, but expressed concerns about the rigid interpretation of some of the implementation guidelines by the Global Fund Secretariat and the LFA when grants are being executed.	The general perception is that the lack of Global Fund presence constrains its engagement with other country stakeholders. But there was little offered in the way of specific suggestions of how to improve the way the Global Fund operates.

Topic	Brazil	Russian Federation
1. Additionality and sustainability	Additionality: There is no evidence that Global Fund grants have triggered any reduction of funding by the government of Brazil or by donors. Budgets have been set, regardless of grants from the Global Fund. Principal Recipients in Brazil have been parastatals and foundations, and as such have not shifted funds as a result of Global Fund grants. They expressed preference for the use of Global Fund grant funds because of their greater flexibility compared with government funds, which are seen as bureaucratic and with high transaction costs. Sustainability: In relative volume, Global Fund grants in Brazil have been small and their absence is unlikely to have any impact on sustainability. The government of Brazil seeks funding from the Global Fund for strategic reasons, mostly to stay involved with the Global Fund and to fill discrete gaps in national funding to fight the three diseases.	Additionality: There is no indication that Global Fund or World Bank contributions to the Russian Federation have led to a reduction in that nation's own contribution. Agreements reached at the beginning of these programs included the understanding that the Global Fund and World Bank funds would not provoke a decrease in government spending. On the contrary, the government increased its national budget for HIV/AIDS from $20 million to $100 million in 2004 upon conclusion of the Round 3 grant agreement between the Open Health Institute (the Principal Recipient) and the Global Fund. Sustainability: There is substantial concern over the political willingness to sustain the momentum of some of the programs when the Global Fund departs. This appears most pronounced in activities aimed at prevention of risky behavior and exposure to the AIDS virus. A second example of concern for sustainability is the questionable continuing availability of second- line tuberculosis drugs for drug-resistant disease. The cost of these medications, through the established WHO-administered Green Light Committee mechanism, is far less than that in the open market. As a result of concern over noncompletion of the intended missions and anxiety over inadequate sustainability, program extensions have been proposed and, in one case, established (even though Russia's per capita income has exceeded the threshold for eligibility for Global Fund participation).
2. Country Coordinating Mechanisms (CCMs)	The CCM consists of the General Assembly (GA) and the Executive Secretariat (ES). The Assembly is chaired by the head of the CCM, an ex-officio representative from government. The Executive Secretariat consists of the heads of the Principal Recipients and of the government programs for HIV/AIDS, tuberculosis, and malaria, along with CCM members representing civil society and academia, as selected by the General Assembly. The Brazil CCM currently has 26 members, of which 40 percent are from civil society, with the remaining members from government, donor partners, and heads of Principal Recipients. The Principal Recipients attend meetings but do not vote. There are no private sector representatives in the CCM. The number of donor partners in the CCM is limited as well. Neither UNAIDS/Brazil nor the World Bank are members of the CCM. The tuberculosis grant led to the formation of 11 Urban Committees consisting of local CSOs concerned with tuberculosis. The committees implement the social engineering parts of the project and hold service providers accountable. They have gradually evolved to be very like regional	There are two CCMs in Russia. The first (and earliest), termed the "Subnational CCM," is headquartered in Tomsk and is the product of the NGO, Partners in Health. The nominal leadership has been the head of the Department of Public Health. However, the real leadership and technical contribution have come from the Partners in Health organization. The principal CCM, known as "Big Russia CCM," is headquartered in Moscow. The effectiveness of the principal CCM in providing for country ownership appears to be severely compromised by the nonattendance of a recognized representative from the Ministry of Health and Social Development. The current political commitment is uncertain or is focused in other directions. The lack of effective linkage to that Ministry has led to a substantial measure of cynicism concerning its usefulness in practice. These views were particularly pronounced among recipient NGOs who see a pronounced adversarial relationship with them. CSOs and NGOs are accepted as full partners. However, the principal CCM is a weak forum for

Topic	Brazil	Russian Federation
	CCMs, inasmuch as they are based in cities spread out in several of the state governments of the Brazilian federation. Power sharing among members, especially with NGOs, is apparent. However, the CCM by-laws (Regimento Interno) stipulate that the lead government representative — the Secretary for Health Surveillance of the Ministry of Health — shall remain as chair of the CCM General Assembly in perpetuity. This is inconsistent with the intent of Global Fund policies according to paragraph 8, 10 of the CCM guidelines. However, the same guidelines also state that the Global Fund respects local traditions and customs and does not intend to impose/prescribe the composition of the CCM in a uniform manner across all countries. The CCM has been very vigilant with regard to monitoring conflicts of interest among its members.	meeting and exchanging proposals and observations, not a true governing body. There seem to be no private sector representatives in the CCMs.
3. Country-level partnerships	CSOs actively participate in the CCM. There is little need to provide capacity building assistance to the civil society sector in Brazilian society. Moreover, the appointment of a representative of civil society as the vice-chair of the CCM is also an indication of full participation of this sector. The lack of involvement of the commercial private sector was explained by the CCM leadership in terms of its failure to come forward in response to the requests for proposals advertised in the media for each Global Fund Round. This was despite the fact that most Principal Recipients are from the parastatal (foundations) sector, which is strictly nongovernmental. The recent initiative of the Global Fund to familiarize the Brazilian corporate sector with its operations in Brazil is seen as a possible shift in regard to private sector participation. The drive to include donor partners does not seem to have been as proactive in view of the limited number of donors that are members of the CCM, including those active in HIV/AIDS, such as UNAIDS and the World Bank. Many respondents felt that an invitation to the World Bank to join the CCM would be unlikely, given the general attitude of the government toward involvement of donors in matters seen essentially as of national interest.	Both initiative and momentum of health-related activities in the Russian Federation, funded by the Global Fund and the World Bank, have been very much a product of the energies of a series of NGOs. Many of these were present and active before the Global Fund was initiated. As a result, some of the resulting programs and activities are concentrated in specific regions — the legacies of prior relationships. Further, some of the long-standing regional relationships are strong and established but proceed without clear relationship to the federal ministry. However, in many cases, the longevity of their participation has resulted in numerous, strong associations and professional partnerships. Cooperation has proceeded best, perhaps, in the programs for tuberculosis. Here, the leadership and personalities representing WHO and the World Bank appeared to have been particularly important in shaping effective, cooperative programs and in communicating with the federal ministries.
4. Performance-Based Funding (PBF)	The current LFA has found that Principal Recipients are generally not well equipped to provide evidence of grant performance. Data providing this evidence is often unavailable, inconsistent, or outdated. It is also difficult to attribute grant performance to the inputs secured by the grant, especially the one for tuberculosis, since these are intermediate products and not at	Both the concept and the details of PBF appear to be well established and well received in Russia. It has been suggested that an important element in the success of this instrument in practice had been the contribution of information from the Central Research Institute for Health — the research and epidemiology institute for health within the Ministry of Health and Social

Topic	Brazil	Russian Federation
	the delivery end in the service delivery chain. In addition, while all Principal Recipients have M&E teams, they are challenged to monitor performance with data from government databases. The current LFA has therefore taken it upon itself to systematically instruct these teams on creating recorded trails that allow the LFA to carry out its verification function. Certain members of the CCM saw PBF as "inappropriate to local circumstances." The multiple data systems associated with the multilayered government health systems are not consistent and do not lend themselves to assessing the performance of grants that are small links in a long service chain.	Development, which is responsible for monitoring and measurement. The work of that institute provides some of the basis for establishing appropriate monitorable indicators and their measurement. The LFA, KPMG, appears very satisfied with the PBF process and the details of the reporting process. The LFA in Russia is assisted by a Central Coordination Team in San Francisco, which includes health professionals. Further, all of the KPMG LFA groups convene once each year with the Global Fund to review the process generally.
5. Service delivery, prevention, and treatment	Global Fund grants to Brazil provide small inputs for existing health service delivery outlets under the Integrated Health Service (SUS). The tuberculosis grant to Brazil is a case in point of adjusting service delivery to the local context and circumstances. It is hard to conclude that these improvements would not be introduced in the absence of the Global Fund grants. The Principal Recipients of the tuberculosis grants are not directly involved in service delivery per se. Achieving their end results depends on the effectiveness of intermediate structures, which combine federal, state, and municipal levels of governments to make up the Integrated Health System (SUS). The planning of tuberculosis activities covered by the Global Fund grant is developed with participation of the Metropolitan Tuberculosis Committees and cleared by the CCM. All medication for services is provided by the SUS, free of charge. This enhances the effectiveness of Global Fund grants in a complementary way, since the Global Fund grant covers only certain links of the service delivery chain down to the patient. Evidence of innovation by the Global Fund tuberculosis grant is represented by the creation of the Metropolitan Committees for Control of Tuberculosis. These committees bring together all relevant stakeholders that help plan, monitor, and provide social accountability of tuberculosis services, helping to mitigate tuberculosis as a neglected disease of the poor and marginalized social sectors. Innovation in the case of tuberculosis and malaria is related to the involvement of community-based CSOs, which seek to balance prevention, treatment, and care, thereby assisting in monitoring and ensuring accountability of service providers. The malaria grant proposal was prepared by the Ministry of Health National Malaria Control Program with technical advice from the Malaria Consultative Committee and formulated/formatted by PAHO. Left to its current service	The Global Fund and World Bank monies have effectively "catalyzed" and leveraged substantial additional spending by the Russian Federation government. The result of the combined financial support has been enhanced availability of diagnostic laboratory equipment and pharmacologic agents for treatment of disease. In addition, World Bank funds have provided important support for technical assistance and capacity building. Tuberculosis in particular has benefitted from these programs in both civilian and prison settings. Concentration on the improvement of laboratory facilities and methods has brought benefit to two-thirds of the clinical laboratories and brought about the establishment of a series of new reference laboratories. DOTS — the WHO standard of treatment for drug-sensitive disease — has been instituted and accepted widely, although not universally. The importance of compliance with therapy and uninterrupted therapy has not yet been recognized by all physicians. There remain some problems of lower success rates in treatment outcomes and a level of primary multidrug-resistant tuberculosis. However, in general, the programs have been successful. Tuberculosis mortality has been declining since 2006. Conditions making this possible have included an effective strategy, strong leadership, two government orders dealing with treatment standards, and identified leadership from key individuals representing the Global Fund and World Bank programs and responsible for a particularly cooperative division of effort. The corresponding record for HIV/AIDS has been more complicated, ultimately because of the cultural and social forces surrounding that disease and the principal risk groups. True incidence and prevalence are consistently uncertain because of the difficulty of accounting for all cases. There has been an adequate supply of antiretroviral drugs for treatment. Laboratory facilities for clinical determinations have been established. At the same time, putting in place preventive measures targeted at specific and

Topic	Brazil	Russian Federation
	capabilities, the SUS of the 47 malaria-affected municipalities (with 75 percent of malaria incidence in Brazil) would have eventually covered most of the region and provided drugs. However, without the Global Fund grant, this would probably have been done with substandard lab work and treatment services and minimal monitoring of results. At the same time, without the existing local SUS services, the Global Fund grant would not achieve its end results, given its complementarity to existing systems. Moreover, an improved system of testing and case management will be introduced by the grant, effectively strengthening health service for the prevention and treatment of malaria.	important high-risk groups (intravenous drug users, for example) remains a challenge. A great deal of attention has been devoted to tuberculosis among prisoners in certain parts of the Federation. In part, this has reflected a realization that discharged and amnestied prisoners, infected with M. tuberculosis, become a source of new infection in the wider community. As a result, World Bank and Global Fund efforts have been concentrated on prison populations in at least selected parts of the Federation. There are, in addition, some outstanding programs of outreach to patients on tuberculosis drug therapy who are unable to travel to central facilities. The record of reaching high-risk and marginalized groups of HIV-vulnerable individuals such as intravenous drug users remains a substantial challenge. Principal Recipients engaged in preventive endeavors remain frustrated over a job only partially accomplished.
6. Equity	In the case of tuberculosis, the CCM and the Principal Recipients in Brazil regard the tuberculosis grant itself as evidence of attention to equity and the inclusion of the poor and marginalized because it is a disease that affects mostly these populations. However, within these populations there is no evidence of monitoring for inequities of gender or race.	To the extent that HIV/AIDS program activities do not reach a large segment of marginalized risk groups, this is an imbalance in the provision of services. This is, indeed, a serious problem yet to be faced by the national government. Key population segments are left out and prevention is compromised.
7. Domestic health systems	Brazil, has a reasonable level of health system capacity, and health systems generally function, despite many weaknesses. There is no evidence of any partnerships at the country level for Bank-supported projects to provide technical assistance for either the preparation or implementation of Global Fund grants. Implementing Principal Recipients in Brazil have been selected on the basis of their implementation capacity and are accordingly assessed by the LFA. Given the close donor role of the Pan-American Health Organization (PAHO) in regard to the Ministry of Health of Brazil, it has regularly assisted in formulating and formatting grant proposals in both tuberculosis and malaria, despite the Ministry's alleged capacity to do so on its own. The malaria project in the Amazon, funded by a Global Fund grant, is expected to have a discernible impact on health system capacity at the local SUS level, as it provides for health management agents to closely monitor the early diagnoses of malaria cases and prompt treatment by local clinics. The grant intends this protocol to be internalized over its lifetime by the local SUS, ensuring sustainability of health system capacity.	The Global Fund and World Bank programs for tuberculosis have been generally (although not universally) successful in shaping the organization and provision of services for tuberculosis. Not all regions are uniformly covered. Successful programs have depended on the strength of individual leaders and have involved appropriate compromises designed to account for clinical traditions, economic issues, and scientific evidence. The Global Fund and the World Bank efforts for HIV/AIDS have been generally well accommodated insofar as diagnosis and treatment are concerned. Diagnostic laboratory resources and therapeutic drugs have been made available. However, there remains a reluctance to embrace seriously the elements necessary for identifying and treating patients from high-risk groups. The Global Fund and the World Bank programs for HIV/AIDS and tuberculosis in the Russian Federation have been successful in helping to shape the domestic health system to meet the challenge of those diseases. At the same time, there is a competition for attention between these infectious diseases and concern for the burden of non-communicable

Topic	Brazil	Russian Federation
		disease.
8. Risk management	During the Global Fund evaluation of the LFA system in 2007, the first LFA was found to be underperforming and the contract was retendered. The current LFA (Deloite Touche Tohmatsu) appears to be diligent and strict about the uses of funds. In one case, the LFA recommended rejection of a disbursement application because the Principal Recipient had shifted funds from one line item in the grant to another. This was also intended to set a precedent/example that Principal Recipients had to respect fund use, as planned. The LFA has recommended special precautions with regard to the use of funds entrusted to NGOs. On request from the Global Fund, the LFA in Brazil has carried out several procurement reviews, especially with regard to purchases of pharmaceuticals. For the LFA, the greater risk in Brazil is not financial, but failure to achieve set objectives, mostly because of the complexity of the Brazilian SUS health system.	Discussions with both representatives of the LFA and with implementing parties did not reveal problems in financial accounting or financial risks. While there were, on occasion, mild complaints of increased complexity in procedures, Principal Recipients appeared very comfortable with the oversight exercised by the LFA.
9. Global Fund governance, organizational vision, and strategy	Few respondents in Brazil had a view on the evolution of the Global Fund from a purely financial entity to more of a development agency.	Both the Global Fund and the World Bank programs for health entered upon their activities in the Russian Federation in the face of challenge and opposition from the host government. It was the skill and statesmanlike leadership of the Russian Health Care Foundation, the project manager, and key recipients that achieved agreement and accommodation. There followed a highly productive period of contribution and cooperation. The programs for tuberculosis, while not 100 percent successful, remain productive and well-received. The Global Fund programs for HIV/AIDS in the Federation are currently judged by the Global Fund Board as incomplete, resulting in an initiative by the Board to extend the program for an additional three years. The Board's concern is uncertainty over the probability of sustaining the momentum of the accomplishments of the program and the willingness of the Russian Federation government to devote budgetary support to the program. There remains an unresolved tension over the proper strategy to adopt for prevention of exposure and consequent infection. There is a competition for attention between the issue of infectious disease and chronic or non-communicable disease. The World Bank leadership has recognized this competition and the importance of finding an appropriate balance. The more narrowly focused Global Fund (by definition) will encounter this tension.

Appendix J. World Bank Participation at Global Fund Board Meetings, January 2002 to November 2011

Board Meeting Number	Board Member	Alternate Board Member	Focal Point	Delegate	Delegate
BM 1 January 2002	Not recorded				
BM 2 April 2002	Mr. Geoffrey Lamb, Director, Resource Mobilization Department	Mr. James Christopher Lovelace, Health, Nutrition and Population Department	Mr. Ivar Andersen, Sr. Operations Officer, Resource Mobilization Department	Ms. Angelique DePlaa, Senior Economist, Resource Mobilization Department	Mr. Thomas Duvall, Chief Counsel, Legal-Cofinancing and Project Finance
BM 3 October 2002	Not recorded				
BM 4 January 2003	Ms. Kyung Hee Kim, Senior Manager, Finance	Mr. Ivar Andersen, Sr. Operations Officer, Resource Mobilization Department			
BM 5 June 2003	Mr. Geoffrey Lamb, Vice President, Resource Mobilization and Cofinancing	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Ms Kyung Hee Kim, Senior Manager, Finance	Mr. Ivar Andersen, Sr. Operations Officer, Resource Mobilization Department	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department
BM 6 October 2003	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Ms Kyung Hee Kim, Senior Manager, Finance		Mr. Ivar Andersen, Senior Operations Officer Resource Mobilization Department	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department
BM 7 March 2004	Mr. Geoffrey Lamb, Vice President, Concessional Finance and Global Partnerships		Ms Kyung Hee Kim, Senior Manager, Finance	Ms. Deborah Schermerhorn, Principal Financial Officer, Resource Mobilization Department	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department
BM 8 June 2004	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Ms Kyung Hee Kim, Senior Manager, Finance		Ms. Lesley Wilson, Quality Control Analyst, Multilateral Trustee Operations	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department
BM 9 November 2004	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Ms. Kyung Hee Kim, Senior Manager, Finance		Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department	Ms. Sophia Drewnowski, Sr. Partnership Specialist, Concessional Finance and Global Partnerships

Board Meeting Number	Board Member	Alternate Board Member	Focal Point	Delegate	Delegate
BM 10 April 2005	Mr. Geoffrey Lamb, Vice President, Concessional Finance and Global Partnerships	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program		Mr. Francisco Javier Vergara, Financial Officer, Concessional Finance and Risk	
BM 11 September 2005	Ms. Kyung Hee Kim, Senior Manager, Concessional Finance & Global Partnerships	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program		Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department	
BM 12 December 2005	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department			
BM 13 April 2006	Ms. Debrework Zewdie, Program Director, Global HIV/AIDS Program	Mr. Keith Jay, Lead Policy Analyst, Resource Mobilization Department			
BM 14 November 2006	Ms. Debrework Zewdie, Director, Global HIV/AIDS Program	Ms. Susan McAdams, Acting Manager, Multilateral Trustee Operations		Mr. Praveen Desabatla, Financial Officer, Multilateral Trustee Operations	Mr. Keith Jay, Consultant, Multilateral Trustee Operations
BM 1st Special February 2007	Ms. Margaret C. Thalwitz, Director, Global Programs and Partnerships				
BM 15 April 2007	Ms. Debrework Zewdie, Director, Global HIV/AIDS Program	Ms. Susan McAdams, Acting Manager, Multilateral Trustee Operations		Mr. Praveen Desabatla, Financial Officer, Multilateral Trustee Operations	
BM 16 November 2007	Ms. Susan McAdams, Director, Multilateral Trustee Operations	Ms. Alice Miller, Senior Financial Officer, Multilateral Trustee Operations	Dr. Olusoji Adeyi, Coordinator, Public Health Programs	Mr. Suprotik Basu, Public Health Specialist, Malaria Control Booster Program – Africa Region	Mr. Johannes Kiess, Jr. Professional Officer, Multilateral Trustee Operations
BM 17 April 2008	Mr. Phillippe Le Houerou, Vice-President, Concessional Finance and Global Partnerships	Mr. Julian Schweitzer, Director, Health, Nutrition and Population	Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	Dr. Olusoji Adeyi, Coordinator, Public Health Programs	Mr. Praveen Desabatla, Financial Officer, Multilateral Trusteeship and Innovative Financing

Board Meeting Number	Board Member	Alternate Board Member	Focal Point	Delegate	Delegate
BM 18 November 2008	(designated), Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	(designated) Mr. Olusoji Adeyi, Coordinator, Public Health Programs		Dr. Anne M. Pierre-Louis, Coordinator, Booster Program for Malaria, Control in Africa	
BM 19 May 2009	(designated) Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	(designated) Mr. Armin Fidler, Advisor, Policy and Strategy		Mr. Johannes Kiess, Jr. Professional Officer, Multilateral Trusteeship and Innovative Financing	
BM 20 November 2000	(designated) Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	(designated) Mr. Mukesh Chawla, Sector Manager, Health, Nutrition and Population			
BM 21 April 2010	(designated) Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	(designated) Mr. Armin Fidler, Advisor, Policy and Strategy		Mr. David Crush, Sr. Financial Officer, Multilateral Trusteeship and Innovative Financing	
BM 22 December 2010	(designated) David Wilson, Program Director, Global HIV/AIDS Program	Mr. David Crush, Sr. Financial Officer, Multilateral Trusteeship and Innovative Financing			
BM 23 May 2011	(designated) Ms. Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing	(designated) Mr. Armin Fidler, Advisor, Policy and Strategy	Ms. Priya Basu, Manager, Multilateral Trusteeship and Innovative Financing	Ms. Veronique Bishop, Sr. Financial Officer, Multilateral Trusteeship and Innovative Financing	Mr. Alexandru Cebotari, Financial Officer, Multilateral Trusteeship and Innovative Financing
BM 24 September 2011	(designated) Ms. Veronique Bishop, Sr. Financial Officer, Multilateral Trusteeship and Innovative Financing				
BM 25 November 2011	(designated), Mr. Armin Fidler, Advisor, Policy and Strategy	(designated) Ms. Veronique Bishop, Sr. Financial Officer, Multilateral Trusteeship and Innovative Financing			

Appendix K. World Bank Involvement in Global Health Partnerships and Financial Intermediary Trust Funds

Program	Start date	Location of secretariat	World Bank's Roles in the Program			
			DGF financing	Implementing agency	Governing bodies	Bank participation
Global Health Partnerships (Not Supported by Financial Intermediary Funds)						
Special Programme of Research, Development and Research Training in Human Reproduction (HRP)	1972	WHO, Geneva	1998–2011	No	Policy and Coordination Committee / Standing Committee of Cosponsors	Permanent member of Policy and Coordination Committee and Standing Committee of Cosponsors
Special Programme for Research and Training in Tropical Diseases (TDR)	1975	WHO, Geneva	1998–2011	No	Joint Coordinating Board / Standing Committee	Member of the Standing Committee
Joint United Nations Program on HIV/AIDS (UNAIDS)	1994	Geneva	1998–2011	Yes	Programme Coordinating Board	Cosponsor member of Programme Coordinating Board without voting rights
Global Forum for Health Research	1998	Geneva	1998–2011	No	Foundation Council	Voting member
International AIDS Vaccine Initiative (IAVI)	1996	New York	1998–2010	No	Board of Directors	None
European Observatory on Health Systems and Policies	1997	WHO, Brussels	2004–2011	No	Steering Committee	Voting member
Roll Back Malaria (RBM)	1998	Geneva	1999–2011	No	Partners' Forum / Board / Executive Committee	Voting member of the Board and Executive Committee
Medicines for Malaria Venture (MMV)	1999	Geneva	2000–2011	No	Board of Directors	None
Stop Tuberculosis Partnership (Stop TB)	2001	WHO, Geneva	2000–2011	No	Partners' Forum/ Coordinating Board / Executive Committee	Voting member of Board
Health Metrics Network (HMN)	2005	WHO, Geneva	2009–2011	No	Board of Directors	Voting member
Partnership on Maternal, Newborn and Child Health (PMNCH)	2005	WHO, Geneva	2011	No	Partnership Forum/ Board / Executive Committee	Voting member of Board and Executive Committee
Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI)	2006	World Bank		Yes	International Ministerial Conference on Animal and Pandemic Influenza / Advisory Board	Co-chair of the Advisory Board
Medicines Transparency Alliance (MeTA)	2008	Lewes, East Sussex, U.K.		No	Management Board	Voting member

Program	Start date	Location of secretariat	World Bank's Roles in the Program			
			DGF financing	Implementing agency	Governing bodies	Bank participation
Global Health Partnerships Supported by Financial Intermediary Funds						
African Programme for Onchocerciasis Control (APOC)	1995	WHO, Ouagadougou, Burkina Faso	1998-2011	No	Joint Action Forum / Committee of Sponsoring Agents	Voting member of Forum and Committee
Global Alliance for Vaccines and Immunization (GAVI)	2000	Geneva	2001-2007	Yes	Alliance Board/ Executive Committee	Voting member of Board and Executive Committee
Global Fund to Fight AIDS, Tuberculosis, and Malaria	2002	Geneva		No	Partnership Forum / Board	Non-voting member of Board (as trustee)
Other GRPPs Supported by Financial Intermediary Funds						
Consultative Group on International Agricultural Research (CGIAR)	1971	World Bank & FAO, Rome	1998-2010	No	Biennial Funders Forum / CGIAR Fund Council	Chair of Fund Council
Global Environment Facility (GEF)	1991	Washington, DC		Yes	GEF Assembly / GEF Council	Two official observers on Council (as trustee & implementing agency)
Least Developed Countries Fund for Climate Change (LDCF)	2001	GEF		Yes	LDCF-SCCF Council	Two official observers on Council (as trustee & implementing agency)
Special Climate Change Fund (SCCF)	2001	GEF		Yes	LDCF-SCCF Council	Two official observers on Council (as trustee and IA)
Global Partnership for Education	2002	World Bank		Yes	Board of Directors	Yes, representing multilateral and regional development banks
Adaptation Fund (AF)	2008	GEF		Yes	Conference of the Parties / Board	None.
Clean Technology Fund (CTF)	2008	World Bank		Yes	CIF Partnership Forum / MDB Committee / CTF Trust Fund Committee	Member of MDB Committee & non-voting member of Trust Fund Committee.
Strategic Climate Fund (SCF)	2008	World Bank		Yes	CIF Partnership Forum / MDB Committee / SCF Trust Fund Committee	Member of MDB Committee & non-voting member of Trust Fund Committee.
Global Agriculture and Food Security Program (GAFSP)	2010	World Bank		Yes	Steering Committee	Non-voting member (as trustee) & observer (as supervising entity)
Nagoya Protocol Implementation Fund (NPIF)	2011	GEF		Yes	NPIF Council	Two official observers on Council (as trustee and IA)

Appendix L. Overview of the Global Environment Facility and the World Bank's Roles

Objectives and Activities

1. The Global Environment Facility (GEF) was founded by the World Bank, the United Nations Development Program (UNDP), and the United Nations Environment Program (UNEP) in 1991 as an independent financial mechanism to assist developing and transition countries in implementing the following five conventions:

- Convention on Biological Diversity (CBD)
- United Nations Framework Convention on Climate Change (UNFCCC)
- Stockholm Convention on Persistent Organic Pollutants
- United Nations Convention to Combat Desertification
- Montreal Protocol on Substances That Deplete the Ozone Layer.[3]

2. The GEF provides grants to developing and transition countries to cover the "incremental" or additional costs of activities intended to protect the global environment and to promote environmentally sustainable development. GEF grants support projects in six focal areas: (a) stemming biodiversity loss, (b) reducing the risks of climate change, (c) safeguarding international waters, (d) eliminating persistent organic pollutants, (e) preventing land degradation, and (f) preventing ozone layer depletion. The first two focal areas — biodiversity and climate change — accounted for 68 percent of the 2,400 projects that the GEF supported in over 150 countries since the GEF was founded through June 2009, and 64 percent of the $8.6 billion of project funding (Table L-1). This does not include cofinancing of GEF-supported projects by the World Bank and other donors, estimated to have been between $30 and 40 billion during this same time period. The GEF has also made more than 12,000 small grants available through its Small Grants Program directly to nongovernmental and community organizations, totaling around $500 million.

Table L-1. Number of Projects and GEF Funding by Focal Area, 1991–2009

	Projects		Funding	
Focal area	Number	Share	US$ millions	Share
Biodiversity	946	40%	2,792	32%
Climate change	659	28%	2,743	32%
International waters	172	7%	1,065	12%
Persistent organic pollutants	200	8%	358	4%
Land degradation	76	3%	339	4%
Ozone layer depletion	26	1%	180	2%
Multifocal	310	13%	1,114	13%
All focal areas	2,389	100%	8,591	100%

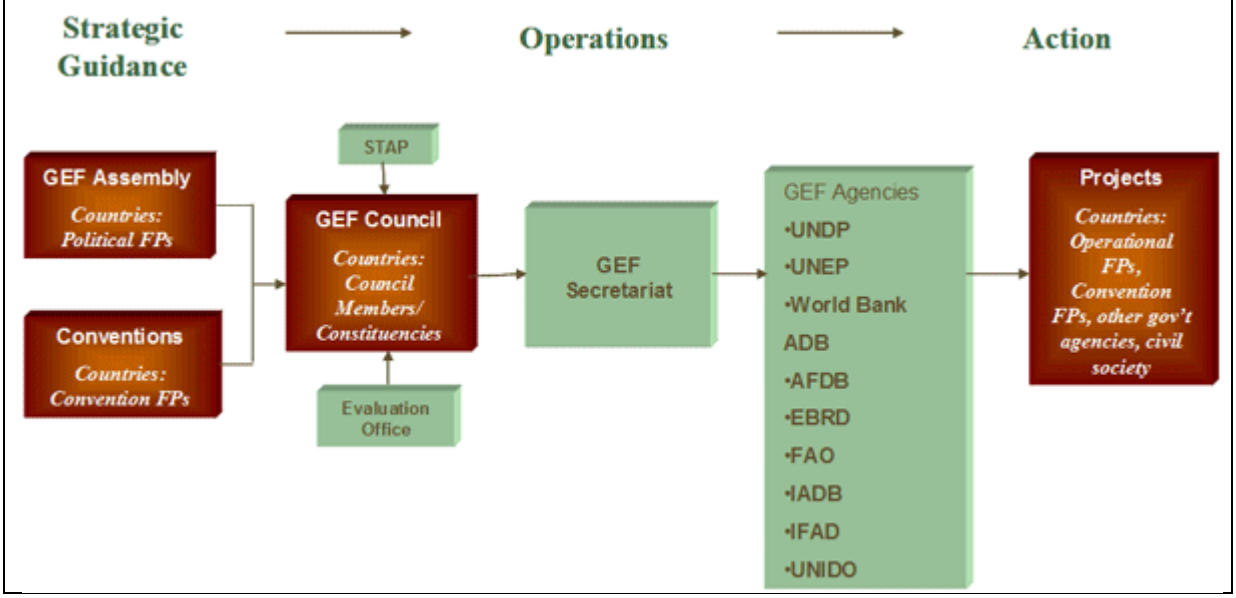
Source: GEF Evaluation Office, Fourth Overall Performance Study of the GEF, 2010, p. 8.

3. Although the GEF is not formally linked to the Montreal Protocol, it supports the implementation of the Protocol in countries with economies in transition.

Governance and Management

3. The GEF is governed by an assembly and a council (Figure 1). The ***GEF Assembly***, which meets every three to four years, is attended by high-level government delegations of all 180 GEF member countries. It is responsible for reviewing the GEF's general policies, operations, and membership, and for considering and approving proposed amendments to the GEF Instrument — the document that established the GEF and sets the rules by which the GEF operates.

Figure L-1. The GEF Structure



4. The ***GEF Council*** is the main governing body of the GEF. It functions as an independent board of directors, with primary responsibility for developing, adopting, and evaluating GEF programs. Council members represent 32 constituencies (16 from developing countries, 14 from developed countries, and 2 from transition countries), and meet semi-annually for three days and also conduct business virtually. Decisions are generally by consensus.

5. The ***GEF Secretariat*** in Washington, DC, reports directly to the GEF Council and Assembly. The Chief Executive Officer and Chairperson of the Council — currently Monique Barbut — heads the Secretariat. The Secretariat coordinates the formulation of projects included in the work programs, oversees their implementation, and ensures that GEF operational strategies and policies are followed.

6. The ***Scientific and Technical Advisory Panel*** provides strategic scientific and technical advice to the GEF on its strategies and programs. This consists of six members who are internationally recognized experts in GEF's key areas of work and are supported by a network of experts. The Panel is also supported by a Secretariat, based in the UNEP regional office in Washington, DC. The Panel reports to each regular meeting of the GEF Council on the status of its activities, and, if requested, to the GEF Assembly.

7. ***GEF Agencies*** are responsible for creating project proposals and for supervising or implementing approved projects. That is, when establishing the GEF, the member countries involved chose to tap the comparative advantages of three founding organizations to implement its projects, rather than construct a new organization to do so. As ***implementing agencies***, the World Bank, UNDP, and UNEP would assist eligible governments and NGOs in developing, implementing, and managing GEF-financed projects. Starting in 1999, an additional seven ***executing agencies*** have been added to the roster of GEF agencies, with similar responsibilities: the Asian Development Bank, the African Development Bank, the European Bank for Reconstruction and Development, the Food and Agriculture Organization, the Inter-American Development Bank, the International Fund for Agricultural Development, and the United National Industrial Development Organization.[4]

8. The GEF provides an administration fee to GEF agencies, equal to about 10 percent of GEF financing, to cover the costs of project preparation and supervision. GEF agencies focus their involvement in GEF projects within their respective comparative advantages. Initially, the comparative advantage of UNEP was viewed as "catalyzing the development of scientific and technical analysis and advancing environmental management in GEF-financed activities,"[5] that of UNDP as developing and managing capacity building programs and technical assistance projects; and that of the World Bank as developing and managing investment projects. In the case of integrated projects that include components where the expertise and experience of one GEF agency is lacking or weak, the agency is expected to partner with another agency and establish clear complementary roles so that all aspects of the project will be well managed.

9. Two types of ***GEF Focal Points*** play important coordination roles regarding GEF matters at the country level as well as liaising with the GEF Secretariat and implementing agencies, and representing their constituencies on the GEF Council. All GEF member countries have Political Focal Points, while recipient member countries eligible for GEF project assistance also have Operational Focal Points. ***Political Focal Points*** are concerned primarily with issues related to GEF governance, including policies and decisions, and with relations between member countries and the GEF Council and Assembly. ***Operational Focal Points*** are concerned with the operational aspects of GEF activities, such as endorsing project proposals to affirm that they are consistent with national plans and priorities and facilitating GEF coordination, integration, and consultation at the country level.

World Bank's Roles in the GEF

10. In addition to being one of the three founding partners of the GEF, the World Bank plays three major roles in the GEF: (a) the trustee and administrator of the GEF and related trust funds; (b) one of the three implementing agencies of the GEF; and (c) a range of administrative support services as the host of the GEF Secretariat, including human resources, communications, and legal services. As such, the World Bank serves as the legal entity for the

4. While the participation of the three implementing agencies in the GEF is governed by the GEF Instrument, the participation of the seven executing agencies is governed by MOUs between the GEF and each agency.

5. GEF, *Instrument for the Establishment of the Restructured Global Environment Facility*, March 2008, Annex D, paragraph 11.

GEF Secretariat. However, unlike other GRPPs whose secretariats are physically located in the World Bank, the GEF has its own independent governance structure, with the CEO reporting only to the GEF Council. That is, the program managers of other GRPPs located in the Bank report both to their own governing body and to a World Bank line manager, who reports ultimately to the World Bank President and the Bank's Executive Board.

11. The World Bank also participates in GEF governance through two official observer positions on the GEF Council (as trustee and implementing agency) and in GEF management as the co-chair (along with the CEO) of the quadrennial replenishment process.

12. As the Trustee, the Bank's duties, as laid out in Annex B of the GEF Instrument, include the following: resource mobilization, managing receipts from donors, investing the liquid assets of the GEF trust fund, entering into financial procedures agreement with other GEF Agencies to facilitate the transfer of funds, preparing financial reports to the Council, and providing for audit functions. The Trustee does not have programmatic or fiduciary responsibility to the GEF for the use of funds transferred to other Agencies.

13. As an implementing agency, the Bank's comparative advantages are generally seen as a multisectoral financial institution operating on a global scale. The World Bank has strong experience in investment lending focused on policy reform, institution building, and infrastructure development across all six focal areas of the GEF.

14. The World Bank has been the largest lender for the environment to developing and transition countries. It has prepared many projects in which World Bank and GEF finance have been "blended," thereby softening the overall financial terms to the borrowing country. The World Bank also houses the secretariats of a number of other environmental partnership programs that are financing investments at the country level, including a series of carbon finance programs and the two Climate Investment Funds (the Clean Technology Fund and the Strategic Climate Fund).

GEF Financing

15. The GEF follows a quadrennial replenishment model of financing. Every four years, donor nations make pledges to fund the next four years of GEF operations and activities. Donors pledged $9.3 billion and contributed $8.8 billion during the pilot phase and the first four replenishments ending June 30, 2010 (Table L-2). The fifth replenishment of the GEF concluded in May 2010, during which donors made new pledges of $3.5 billion. Including the carryover of resources from previous replenishments and projected investment income, the overall replenishment value is $4.3 billion. The fifth replenishment became effective in March 2011, when donors whose contributions aggregated not less than 60 percent of the total contributions to GEF-5 had formalized their contributions by depositing Instruments of Commitment with the World Bank as Trustee. GEF-5 replenishment is expected to fund four years of GEF operations.

16. The GEF also operates two additional programs — the Least Developed Countries Fund for Climate Change (LDCF) and the Special Climate Change Fund (SCCF) — and

Table L-2. GEF Replenishments

Funding	Pilot Phase 1990–94	GEF-1 1994–98	GEF-2 1998–02	GEF-3 2002–07[a]	GEF-4 2007–10	Total 1990–10
GEF funding pledged by donors	843	2,015	1,983	2,211	2,289	9,341
GEF funding received from donors	843	2,012	1,687	2,095	2,169	8,806
Purchasing power		100%	85%	95%	95%	94%
GEF replenishments as share of Official Development Assistance (ODA)	0.28%	0.67%	0.60%	0.50%	0.38%	

Source: GEF Evaluation Office, Fourth Overall Performance Study of the GEF, 2010, p. 35.

a. Generally speaking, replenishment periods have been from July 1 of the beginning year to June 30 of the ending year. However, the third replenishment period ended February 6, 2007, and the fourth began on February 7, 2007.

provides secretariat services for a third — the Adaptation Fund.[6] The LDCF addresses the needs of the 48 least developed countries whose economic and geophysical characteristics make them especially vulnerable to the impact of global warming and climate change. The SCCF finances activities relating to climate change that are complementary to those funded by the resources allocated to the climate change focal area of the GEF trust fund and to those provided by bilateral and multilateral funding in the areas of (a) adaptation; (b) transfer of technologies; (c) energy, transport, industry, agriculture, forestry, and waste management; and (d) activities to assist developing countries whose economies are highly dependent on income generated from the production, processing, and export or consumption of fossil fuels and associated energy-intensive products in diversifying their economies.

17. The Adaptation Fund was established in 2008 under the United Nations Framework Convention on Climate Change (UNFCCC) to finance climate change adaptation projects and programs in developing countries that are Parties to the Kyoto Protocol. However, its primary financing comes not from traditional official development assistance, but from a 2 percent share of proceeds of the Certified Emission Reductions (CERs) issued by the Clean Development Mechanism (CDM) under the Kyoto Protocol.

18. The GEF is one of the four largest GRPPs in which the World Bank is involved, along with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Consultative Group on International Agricultural Research (CGIAR), and the Global Alliance for Vaccines and Immunization (GAVI). Disbursements to GEF projects averaged $464 million during 2002–10. The World Bank as implementing agency supervised about 36 percent of these disbursements (Table L-3).

6. The GEF Council also approved a fourth such program in February 2011 — the Nagoya Protocol Implementation Fund — to support the early entry into force and effective implementation of the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization. Japan has contributed $12.2 million to the NPID trust fund as of June 30, 2011.

Table L-3. Donor Contributions to and Project Disbursements from GEF Trust Funds, Fiscal Years 2002–10 (US$ millions)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Donor Contributions										
GEF	386.3	513.7	1,003.1	734.0	720.2	831.1	787.5	696.0	580.9	6,252.7
LDCF	-	8.6	7.8	4.1	12.4	25.1	37.8	29.0	34.0	158.8
SCCF	-	-	-	8.2	23.7	22.1	21.5	25.0	10.5	110.8
Adaptation Fund	-	-	-	-	-	-	-	18.4	152.1	170.4
Total	386.3	522.4	1,010.9	746.3	756.2	878.3	846.7	768.3	777.3	6,692.7
Project Disbursements										
GEF	208.4	390.3	372.6	391.6	508.9	519.5	674.1	541.8	571.3	4,178.5
LDCF	-	-	3.6	0.7	5.3	1.1	0.2	3.8	12.7	27.4
SCCF	-	-	-	-	-	1.7	1.7	4.3	14.7	22.3
Adaptation Fund	-	-	-	-	-	-	-	-	0.8	0.8
Total	208.4	390.3	376.2	392.3	514.2	522.3	676.0	549.9	599.4	4,229.0
Project Disbursements through World Bank as Implementing Agency										
GEF	143.4	111.7	134.6	147.3	172.2	189.2	229.8	221.4	173.1	1,522.6
LDCF	-	-	-	-	0.2	0.1	0.0	0.0	0.1	0.4
SCCF	-	-	-	-	-	-	0.5	0.1	2.7	3.3
Total	143.4	111.7	134.6	147.3	172.4	189.3	230.3	221.4	175.9	1,526.3
Percent of Total	69%	29%	36%	38%	34%	36%	34%	40%	29%	36%

Source: World Bank trust fund database.

Note: Both the LDCF and SCCF were established under the GEF in November 2001. The LCDF trust fund was set up in 2002 and began disbursing in 2004. The SCCF trust fund was set up in 2004 and began disbursing in 2007. The Adaptation Fund was established under the United Nations Framework Convention for Climate Change in November 2008 and began disbursing in 2010.

19. The GEF has also become a significant financier of other environmental GRPPs. It has provided financial support for three global programs (the Critical Ecosystem Partnership Fund; the Coral Reef Management Program; and the International Assessment of Agricultural Knowledge, Science and Technology for Development) and for six regional programs (the Africa Stockpiles Program, the Nile Basin Initiative, TerrAfrica, the Black Sea-Danube Partnership, the Inter-American Biodiversity Information Network, and the Mesoamerican Biological Corridor), and has pledged up to $50 million for the Global Tiger Initiative. Regional projects and programs are often subregional in scope, with a contiguous geographic dimension to them such as a body of water (like the Aral Sea or Lake Victoria), or a river system (like the Nile or the Mekong). The programs exist to a large extent for the purpose of resolving collective action dilemmas among participating countries regarding the use of the common resource.[7]

7. IEG, 2007, *The Development Potential of Regional Programs: An Evaluation of World Bank Support of Multicountry Operations.*

20. The GEF Instrument stipulated that the GEF will provide "new and additional grant and concessional funding to meet the agreed incremental costs of measures to achieve agreed global environmental benefits." While the incremental cost principle has remained central to GEF financing, a 2006 evaluation study by the GEF Evaluation Office found much confusion about incremental cost concepts and procedures in practice. Most incremental cost assessment and reporting, as then applied, did not add value to project design, documentation or implementation.[8] At the request of the GEF Council, the Secretariat subsequently prepared in 2007 a revised approach for determining incremental costs, based on incremental reasoning, that links incremental cost analysis to results-based management and the GEF project cycle.[9]

Resource Allocation

21. The GEF introduced a new Resource Allocation Framework (RAF) in 2006 — now called the System for a Transparent Allocation of Resources (STAR). This represents "a system for allocating resources to countries in a transparent and consistent manner based on global environmental priorities and country capacity, policies and practices relevant to successful implementation of GEF projects." A midterm review of the RAF conducted by the GEF Evaluation Office found that the new system was proving more successful in channeling GEF resources to countries with high global environmental benefits as measured by the GEF Environmental Index, but less so to countries with strong performance as measured by the GEF Performance Index.[10]

22. The midterm review also found that the RAF, coupled with other operational changes (such as a change in the rules governing the financing of project preparation), affected agency participation. At the time of the review, the World Bank share of GEF commitments had dropped from more than half of GEF resources to 32 percent of the GEF RAF resource utilization in the two focal areas of biodiversity and climate change, while the United Nations Development Program (UNDP) share increased from 28 percent to 43 percent. The role of the seven executing agencies also increased to 17 percent of RAF utilization, compared with 2 percent of all historical resources. These shifts reflected the spreading of small RAF allocations over many countries, which made it more difficult for the World Bank to blend GEF finance with Bank lending, since other environmental funds were now easier to utilize than GEF RAF support. The UNDP has greater ability to provide technical assistance and capacity building supported by local offices and has been more ready to engage in relatively small projects under the RAF (now STAR).

8. GEF Evaluation Office, 2006, *Evaluation of Incremental Cost Assessment*, GEF Council Document GEF/ME/C.30/2.

9. GEF, 2007, *Operational Guidelines for the Application of the Incremental Cost Principle*, GEF Council Document GEF/C.31/12.

10. GEF Evaluation Office, 2009, *Mid-Term Review of the Resource Allocation Framework*, GEF Evaluation Report No. 47.

Direct Access

23. The GEF Council has recently approved two new implementation modalities to provide countries with more direct access to GEF resources without one of the ten implementing agencies playing an intermediary role. These are is seen as being consistent with the 2005 Paris Declaration principle of country ownership, as well as helping to build country capacity.[11]

24. First, the GEF Council has authorized the GEF Secretariat to provide direct grants to countries of up to $500,000 for enabling activities and to provide support for "National Portfolio Formulation Exercises", which are helping countries to formulate their plans for GEF-5. The CEO of the GEF is now allowed to sign agreements with countries on behalf of the World Bank after exercising all proper preparations and ensuring safeguards. The GEF Evaluation Office is planning a mid-term review of this new modality at the end of 2012 or the first half of 2013.

25. Second, the GEF Council decided in November 2010 to initiate a pilot program of accrediting additional agencies — to be called GEF Project Agencies — beyond the initial 10 implementing and executing agencies. It approved the broad principles governing this pilot program in May 2011,[12] including an accreditation process for organizations seeking to become GEF Project Agencies. Some of these are envisaged to be national institutions. The GEF Evaluation Office will also conduct a mid-term review of this pilot program two years after the first five agencies have been accredited. Based on the findings of this evaluation, the Council will then decide “whether to continue accrediting GEF Project Agencies and whether or how the accreditation policies and procedures should be amended.”

GEF Evaluation Arrangements

26. The GEF Council gave early attention to monitoring and evaluation (M&E), and the GEF has commissioned an Overall Performance Study at the end of each replenishment period. The first three studies, which were completed in 1999, 2002, and 2005, were contracted to external teams of evaluators. The fourth study, completed in 2010, was conducted internally by the GEF’s own independent evaluation office, which was established in 2003. Indeed, the GEF is the only GRPP in which the World Bank is involved that has so far established an independent evaluation office that reports directly to the program’s governing body, in this case the GEF Council.[13]

27. Each GEF agency is responsible for undertaking the terminal evaluations of the GEF-financed projects that it supervises. The GEF ***Evaluation*** Office, in turn, has the central role of ensuring the independent evaluation function within the GEF, setting minimum

11. This having been said, the GEF has not formally subscribed to the 2005 Paris Declaration, unlike the Global Fund and GAVI. The GEF Council decided in 2009 that it would show “continued support” for the Paris Declaration principles.

12. GEF, 2011, “Broadening the GEF Partnership Under Paragraph 28 of the GEF Instrument,” GEF/C.40/09.

13. The Consultative Group on International Agriculture Research is also in the process of establishing an interdependent evaluation arrangement.

requirements for project-level M&E, ensuring oversight of the quality of M&E systems on the program and project levels, and sharing evaluative evidence within the GEF.

28. The Evaluation Office also conducts Annual Performance Reviews and independent evaluations that involve a set of projects from more than one implementing or executing agency. These evaluations are typically on a strategic level, on focal areas, or on institutional or cross-cutting themes. The GEF Evaluation Office also supports knowledge sharing and follow-up of evaluation recommendations. It works with the GEF Secretariat and the implementing and executing agencies to establish systems to disseminate lessons learned and best practices emanating from M&E activities, and provides independent evaluative evidence for the GEF knowledge base.

29. The GEF Council approved a formal Monitoring and Evaluation Policy in 2006, and a revised policy in 2010. The 2006 policy affirmed the independence of the Evaluation Office and its direct link to the Council, established the responsibility of the GEF Secretariat and GEF Agencies for monitoring at the portfolio and project levels, and contained minimum requirements for M&E for GEF-funded activities. The main revisions in 2010 included "reference to the new GEF results-based management and other major policies introduced with GEF-5, a better definition of roles and responsibilities for the different levels and typologies of monitoring, [and] a stronger emphasis on country ownership and the role of the GEF focal points in monitoring and evaluation."[14]

14. GEF Evaluation Office, 2010, *The GEF Monitoring and Evaluation Policy 2010*, p. vi.

Appendix M. The World Bank's Programs in the Health Sector

Overview of the Bank's Country-Based Model

1. Since the reorganization of the Bank in 1996 in accordance with a matrix structure,[15] the Bank's operational involvement in each client country has been based on a Country Assistance Strategy (CAS), now called a Country Partnership Strategy, negotiated between the Bank's country team working on that country and the government. Headed by a country director and a country economist, the team also comprises staff working in the various sectors of the economy, such as agriculture and rural development, urban development, education, health, finance, energy, transportation, and water. Each sector has to compete for its place in the CAS in accordance with the agreements reached between the country director and the government on the priority sectors for Bank support to the country.

2. The CAS lays out a set of activities that the Bank will support over the next three to four years, comprising both analytical and advisory work (AAA) and lending products, including ongoing activities and those to be initiated during the CAS period. The CAS is itself based on sectoral and economywide analytic work supported by the Bank, such as Public Expenditure Reviews. Depending on the income level of the client, "lending products" include IBRD loans at market rates of interest, concessional loans (such as IDA credits), and grants (such as IDA grants, GEF grants, and a growing number of other grant instruments financed by global, regional, and country-level trust funds).[16] AAA products include economic and sector work and technical assistance.

3. Except in post-conflict situations where there is no functioning government, lending products are normally implemented by a government department or agency, although governments may enlist NGOs and CSOs to help implement the project — and almost always do so in the case of HIV/AIDS projects. The implementing agency for each project, which usually includes a project implementation unit embedded in the government department, is agreed during project preparation. An institutional assessment of the proposed project implementation unit is conducted as part of the appraisal process, and the project provides capacity-building support if needed.

4. Each project has a project manager who is responsible for preparing the project from the point of view of the Bank and for supervising the subsequent implementation of the project with the support of his/her task team. Project managers are also directly responsible

15. The six Regional vice presidencies comprise the columns of the matrix, and the sectoral and thematic networks comprise the rows. The country director has control over the budget for each country program (both the administrative budget and the lending budget) but "no staff." The country director must "purchase" staff time from the sectoral and thematic networks to undertake the agreed activities in the CAS.

16. The Bank raises funds on international capital markets for its IBRD loans to middle-income countries, and mobilizes donor funds to replenish IDA every three years. The GEF also mobilizes donor funds to replenish its resources every four years. Resource mobilization is less systematic for other trust funds that are financing investments at the country level (such as the Education for All–Fast Track Initiative, the Climate Investment Funds, and the Global Agriculture and Food Security Program).

for overseeing and, in some cases, personally executing AAA products that are financed by the Bank's administrative budget, as well as some that are financed by trust funds (termed Bank-executed trust fund activities). This involves drafting terms of reference, directly recruiting consultants to undertake the work, and ensuring that the work is completed. The majority of trust-funded AAA are, however, "recipient-executed," like Bank lending products. In these cases, the recipient is responsible for recruiting consultants and purchasing goods and services, in accordance with the Bank's procurement guidelines and under the supervision of the project manager. The Bank requires an allocation of Bank budgetary or trust fund resources for all activities carried out by staff, including the provision of technical support.

5. The majority of Bank project managers are now based in the field, either in the recipient country itself or in a neighboring country, as a result of the Bank's decentralization process, which began in 1997. About 45 percent of the Bank's regional HNP staff are now located in country offices, rising to 62 percent in South Asia and 66 percent in East Asia (Table M-1). Where the project manager is not based in the country, supervision involves multiple missions over the five–seven-year life of the project, with the assistance of a range of specialized consultants.

Table M-1. Location of World Bank HNP Sector Staff, as of June 2011

	Field-based in Country Offices				Share in Country Offices (HNP sector)	Share in Country Offices (Bank-wide)
	Internationally recruited	Nationally recruited	HQ-based	Total		
East Asia & Pacific	5	15	9	29	69%	75%
South Asia	7	16	14	37	62%	70%
Africa	18	19	46	83	45%	64%
Europe & Central Asia	1	9	15	25	40%	57%
Middle East & N. Africa	1	2	7	10	30%	45%
Latin American & Caribbean	6	0	21	27	22%	40%
Subtotal	38	61	112	211	47%	61%
HNP Anchor	0	0	45	45	0%	0%
Total	38	61	157	256	39%	39%

Source: World Bank data.

6. If the Bank is actively engaged in the health sector of the country, this will be reflected in the size of the project portfolio, which in turn will be reflected in the quantity and quality of Bank-supported analytical work in the country—that is, the Bank is more likely to have supported studies to provide the evidence base for Bank-financed projects in the country. Such analytical work is usually done in concert with the government and other donors, in which case there is joint determination of the scope of the analytical work and cost-sharing.

7. In principle, the Bank attempts to help country clients formulate an evidence-based, comprehensive national health strategy and plan, typically spanning five years. The greater

the Bank's engagement in the country, such as the size of the lending portfolio, the more important it is for the Bank to ensure the quality of the national strategies and action plans, and for country clients to have high ownership of these processes and products. In countries with multiple donors, and where health is a priority sector (as in many IDA countries in Africa), donor coordination mechanisms exist, but they vary considerably in nature and effectiveness. These mechanisms attempt to bring together some or all of the development-partner agencies active in the sector, including bilateral donor-partners, multilateral development banks, foundations (Gates and Clinton), WHO, UNICEF, and large NGOs to harmonize procedures, avoid duplication, and collaborate.

8. About a decade ago, a new approach —the Sector-Wide Approach (SWAp)—was introduced by the World Bank and other donors as a means to overcome inefficiencies, reduce transactions costs to the country, and bring better development results.[17] SWAps embraced the principles of harmonization and alignment that were later endorsed by the 2005 Paris Declaration on Aid Effectiveness. They represented a shift in the relationship and behavior of donors and governments, with all parties jointly supporting nationally defined health programs through parallel or pooled financing general budget support, or a combination of the two. Health SWAps represented higher and more committed levels of donor support and coordination with a country's overall development program in the health sector.

9. Between FY1997 and FY2010, the World Bank approved 41 HNP projects supporting health SWAps in 32 countries (Figure M-1). Thus, in the 14 years following the launch of the approach, about 11 percent of all (385) approved HNP projects supported a SWAp. Sixty percent (25) of the projects that supported health SWAps were in Sub-Saharan Africa, six were in South Asia, four were in East Asia and the Pacific, three were in Latin America and the Caribbean, and one was in Eastern Europe and Central Asia. Support for health SWAps is mainly found in low-income countries, accounting for a fifth of HNP projects approved in low-income countries (LICs), compared with only 9 percent of those in lower-middle-income countries.

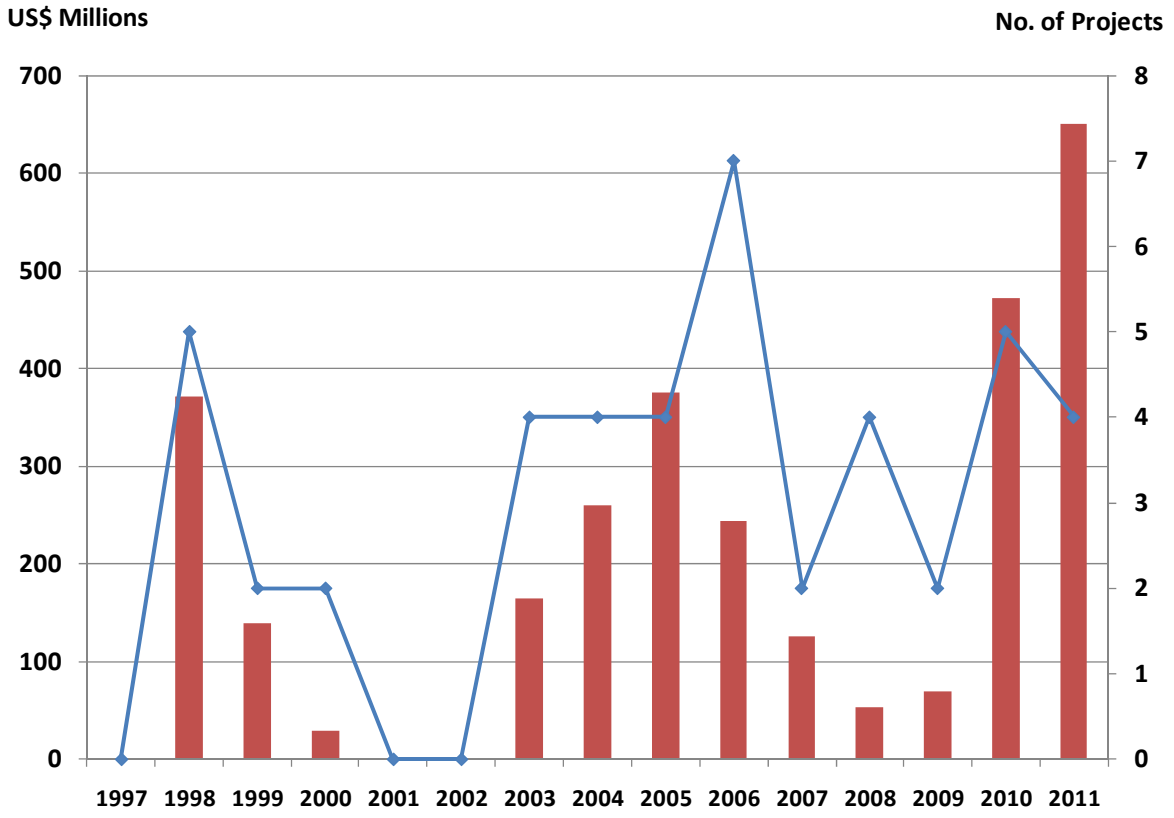
Health Sector Strategies and Bank-Wide Initiatives in Relation to Communicable Diseases and Health Systems Strengthening

10. The World Bank launched a comprehensive strategy for health in September 1997: the *Health, Nutrition, and Population (HNP) Sector Strategy*. The Strategy was clear about the Bank's role in health, citing its comparative advantage as its ability to work across multiple sectors and to conduct country-specific research and analysis in support of programs to which it could bring significant financing. The Strategy did not view the Bank as having a comparative advantage in communicable disease control expertise, epidemiology, and the like in comparison with WHO, UNICEF, and UNAIDS. The Bank would focus on the broader aspects of health such as systems stewardship and oversight, systems performance, and health financing.

17. Denise Vaillancourt, "Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries, IEG Working Paper 2009/4.

11. With a portfolio of 154 active and 94 completed HNP projects, for a total cumulative value of $13.5 billion (1996 prices), the Bank had become the largest single source of donor financing in HNP. The Strategy identified three priority areas (a) to improve health outcomes for the poor; (b) to enhance performance of HNP services; and (c) to improve

Figure M-1. The Evolution of World Bank Lending for Health SWAps, FY1997–2011



Source: Denise Vaillancourt (2009), "Do Health Sector-Wide Approach Achieve Results: Emerging Evidence and Lessons from Six Countries, IEG Working Paper 2009/4, for FY1997 to FY2008, and now updated through FY2011.
Note: These 41 projects had the following characteristics in their design documents: (a) explicit support of a SWAp; (b) appear to support a program or SWAp, but without explicit reference to a SWAp; or (c) provide for the pooling and joint management of donor funding. Among projects included in the initial list, those that were retained had: (d) mechanisms for coordination between the government and donors, and among donors; and (e) a common M&E framework for measuring program performance used by most donors and government and a mechanism for joint reviews of program performance.

health care financing. It viewed investing in communicable disease control in the context of poverty alleviation, since communicable diseases disproportionately affected the poor, and the poorest 20 percent of the population experienced about 60 percent of all deaths from communicable diseases. Many who fell ill but did not perish had lowered productivity, spent high out-of-pocket costs for treatment, and became impoverished. Thus, while HSS was the

Bank's comparative strength, improving health outcomes for the poor also justified support for communicable disease control.[18]

12. Citing the success of the Onchocerciasis Control Program, the 1997 HNP Strategy also recognized the value of partnerships. It would join forces with WHO, UNAIDS, and others to fight HIV/AIDS, tuberculosis, and malaria. The Strategy also mentioned the importance of partnerships that were not disease-specific, such as the Global Forum for Health Research.

13. In the mid-1990s, as the burden from communicable diseases— especially from HIV/AIDs, tuberculosis, and malaria—increased, a growing number of donors, including the Bank, invested in single-disease projects. The Bank issued an expanded Africa HIV/AIDS Strategy in June 1999—*Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis*.[19] The Strategy saw AIDS as the foremost threat to development and to society as whole in the Region. Incredible numbers of African adults, in the prime of their working and parenting lives, were dying, which had a profound impact on the workforce and left behind millions of orphans. The Strategy had four pillars:

- Advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response
- Increased resources and technical support for African partners and Bank country teams to mainstream HIV/AIDS activities in all sectors
- Prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/AIDS treatment and care
- Expanded knowledge base to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices.

The AIDS Campaign Team- Africa (ACT-Africa) was established in the Office of the Africa Regional Vice-Presidency.

14. The next year, the Bank launched a US$1 billion MAP to provide grants to countries where AIDS was most threatening (Table M-2). The Bank's Board approved the first MAP in September 2000, providing $500 million in IDA credit for financing HIV/AIDS projects in Africa. The Bank also earmarked $155 million to fight AIDS in the Caribbean. The Board approved the second $500 million envelope in February 2002. The second MAP provided

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18. An IEG portfolio review of Bank lending for communicable disease control (IEG Working Paper 2010/3) found the reasons most often cited by the Bank for its involvement in communicable disease control were: (a) the Bank was the financier of last resort in "donor-poor" countries; (b) the Bank's convening power, policy influence, and leadership were needed; and (c) the technical quality of Bank experience in project preparation, design, and M&E.

19. Previous Bank strategies to address AIDS in Africa included *AIDS: The Bank's Agenda for Action* in 1988; *Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank's Agenda for Action* in 1992; the *Regional AIDS Strategy for the Sahel* in 1995; *AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy* in 1996. See IEG 2005, Box 2.1 on page 14.

support for the first time in the form of IDA grants, and allowed financing of antiretroviral treatment.[20]

15. The MDGs of 2000 put health in the forefront, and MDGs 4 and 5 targeted reduction of communicable diseases. The MDGs also underscored the value of partnerships (MDG 8). The Bank endorsed the MDGs not long after their adoption.

Table M-2. Multi-country AIDS Program (MAP) Projects, by Region and Approval Year

	Year of Approval										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Number of Projects											
Africa	7	9	5	9	5	4	6	4	2	3	54
Caribbean	2	1	3	2	3			1	1		13
Total	9	10	8	11	8	4	6	5	3	3	67
Commitments (US$ millions)											
Africa	287.2	262.3	172.8	355.9	80.0	247.7	185.4	65.8	55.0	55.0	1,767.1
Caribbean	40.2	15.0	30.1	19.0	21.4			10.0	35.0		170.6
Total	327.4	277.3	202.9	374.9	101.4	247.7	185.4	75.8	90.0	55.0	1,937.7

Source: World Bank data.
Note: All projects except one are mapped to the HNP Sector Board. (One Mali project, approved in 2004, was mapped to the Finance and Private Sector Development Sector Board.)

16. The Bank issued *Rolling Back Malaria: the World Bank Global Strategy and Booster Program* in June 2005, which provided the basis and rationale for initiating a five-year "Booster Program" for malaria control. Recognizing that the pace of gains in controlling malaria had not been as quick as expected since the Abuja Summit of 2000, the Booster Program was the Bank's response as a member of Roll Back Malaria partnership, to assist in "scaling-up for impact." Five key points underpinned the program: (a) the program would be country led; (b) it would emphasize both effective scale-up of interventions and the strengthening of health systems; (c) it would operate through partnerships; (d) it would provide flexible, cross-border, and multisector funding; and (e) it would monitor results against monies spent. The program envisaged $500–$1,000 million in new commitments for malaria control over five years.

1.1 A decade after its 1997 HNP Strategy, the Bank issued a new HNP Strategy in September 2007. The new Strategy reaffirmed the Bank's comparative advantages in the following areas: (a) its capacity in health systems strengthening (including health financing, insurance, demand-side interventions, regulation, and systemic arrangements for fiduciary and financial management); (b) its intersectoral approach to country assistance; (c) its advice to governments on regulatory frameworks for private-public collaboration in the health sector; (d) its capacity for large-scale implementation of projects and programs; (e) its

20. For IDA 13 (2003–05), donors agreed that 18-21 percent of IDA resources should be provided on a grant basis. All AIDS projects or components approved in low-income countries since April 2003 have been eligible for IDA grants, as have 25 percent of AIDS projects or components in blend countries (those eligible for both IDA credits and IBRD loans).

convening capacity and global nature; and (f) its pervasive country focus and presence (World Bank 2007c, pp. 17–18).

1.2 The 2007 Strategy underscored a focus on results: that is, in health outcomes in addition to operational modalities. It reiterated the contribution of multisectoral approaches and interventions to improve health outcomes, such as safe drinking water and household sanitation, among other health infrastructure investments. It did not see a contradiction between Bank support for health systems and support for the control of priority diseases. Bank investments were seen as necessary to ensure synergies between health system and single-disease approaches, especially in low-income countries where fighting communicable diseases was still a priority. The Strategy also recognized the growing need to support interventions against non-communicable diseases.

17. The result of these various initiatives in relation to communicable diseases is summarized in Table M-3. Bank lending for communicable disease control accounted for 38 percent of HNP projects and 33 percent of HNP commitments between 1997 and 2010 inclusive.

Table M-3. World Bank Communicable Disease Projects and Commitments, FY1997–2011

Project Type	*Approved Projects*		*Commitments*	
	Number	Share	US$ millions	Share
Freestanding communicable disease projects	112	74%	6,580	90%
Single disease projects	97	64%	4,989	69%
HIV/AIDS	70	46%	2,735	38%
Tuberculosis	3	2%	374	5%
Malaria	5	3%	547	8%
Avian influenza	7	5%	65	1%
(H1N1) Influenza	5	3%	723	10%
Cholera	1	1%	15	0%
Leprosy	1	1%	32	0%
Polio	4	3%	474	7%
Schistosomiasis	1	1%	25	0%
Multiple disease projects	15	10%	1,591	22%
Projects with a communicable disease component	40	26%	696	10%
Total number of communicable disease projects	152	100%	7,277	100%
Total number of HNP projects	423		22,729	
Share of HNP projects	36%		32%	

Source: For FY1997–2006, Gayle H. Martin, 2010, Portfolio Review of World Bank Lending for Communicable Disease Control, IEG Working Paper 2010/3. Updated by IEG through FY2011 from World Bank databases.
Note: The full project commitments are included for freestanding communicable disease projects, and only the commitments to the communicable disease component for projects with components. Therefore, these commitments are somewhat larger than those in Table 3 in Chapter 2.

18. The 2007 Strategy found that the HNP partnership portfolio had become fragmented with a multiplicity of GRPPs, and needed "stronger strategic direction." The Strategy stated that the HNP sector would practice greater selectivity when deciding to participate in partnership programs: (a) to complement Bank work in areas in which it has no comparative advantages or to complement other partners needing Bank expertise — all of direct benefit to client countries; and (b) to contribute to the international community support of global public goods and prevention of global public "bads." The Strategy also proposed the establishment of a Global Health Coordination and Partnership Team in the HNP Anchor to coordinate partnerships, facilitate selective fund raising and trust fund management, DGF management support, selective joint ventures around comparative advantages, and harmonization. This team has not, however, been established, but a senior partnerships adviser post has been created.

19. The 2007 Strategy repeatedly states that the World Bank would strengthen its engagement with the Global Fund, particularly in low-income countries. However, it does not articulate how this engagement would take place, except for reaching "specific agreements with WHO and the Global Fund on a collaborative division of labor at the country level" in a box on "Next Steps for Implementation."

20. The 2007 Strategy acknowledged that the global HNP aid architecture had changed significantly since 1997, with many new players entering the field, such as GAVI, the Global Fund, and several foundations, bringing with them innovative financing mechanisms, mostly earmarked for specific diseases or issues. The Strategy recognized that the Bank was no longer the largest external financier of investments in the HNP sector in developing countries, as it had been 10 years earlier.

21. In March 2009, a progress report to the Board on implementation of the 2007 HNP Strategy underscored HSS and the importance of strengthening the HNP portfolio. It cited examples of results-based funding, underscored the multisectoriality of HNP support, mentioned that about one-half of Poverty Reduction Support Credit operations had an HNP aspect, and stressed cooperation with other development partners in the context of IHP+.

IEG Health Sector Evaluations

22. IEG has issued three evaluations of the development effectiveness of the Bank's support for HNP since 1997. The first evaluation, in 1999 — *Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector* — found that the Bank had been more successful in expanding health service delivery systems than in improving service quality and efficiency or achieving policy and institutional change. There was little evidence of the impact of Bank investments on health outcomes because of underdeveloped M&E systems and excessive focus on inputs. The lending portfolio had grown rapidly, and many complex projects had been approved in countries with the weakest institutional capacity. The evaluation recommended that the Bank (a) increase its strategic selectivity, (b) focus on enhancing the quality of intersectoral interventions and AAA, (c) strengthen quality assurance and results orientation, and (d) build strategic alliances with other development partners.

23. The second evaluation, in 2005 — *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance* — found that the Bank had contributed to raising political commitment, enhancing and improving access to services in the fight against HIV/AIDS. However, evidence of results in changed health behaviors and improved outcomes was limited because of a failure to monitor and evaluate. The evaluation found that the political commitments needed to be broadened and sustained, and Bank projects needed to invest in the capacity of civil society to design, implement, and evaluate AIDS interventions. It also noted that projects had underinvested in prevention programs for high-risk groups. IEG recommended that the Bank (a) be more strategic and selective, focusing on efforts likely to have the largest impact for their cost; (b) strengthen the capacity of national and subnational AIDS institutions to manage the long-term response; and (c) invest in M&E capacity and incentives to improve evidence-based decision making.

24. The third evaluation, in 2009 — *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition and Population* — assessed the efficiency and effectiveness of the Bank Group's direct support for HNP to developing countries since 1997 and drew lessons to help improve the effectiveness of this support in the context of the new aid architecture. The major findings were as follows:

- Although the Bank Group now funds a smaller share of global HNP support than it did a decade ago, its support remains significant and the Bank continues to play an important role and add value in HNP.
- About two-thirds of the Bank's HNP projects show satisfactory outcomes, but one-third did not do well, mostly due to the increasing complexity of HNP operations, inadequate risk assessment and mitigation, and weak M&E.
- The accountability of Bank Group investments for results for the poor has been weak. The Bank's investments often have a pro-poor focus, but their objectives need to address the poor explicitly and outcomes among the poor need to be monitored.

25. The evaluation also reviewed findings and lessons for three major approaches to improving HNP outcomes — communicable disease control, health reform, and SWAps — that have been supported by the Bank as well as the international community over the past decade. These approaches are not mutually exclusive.

26. The evaluation found that support for communicable disease control can improve the pro-poor focus of health systems, but excessive earmarking of foreign aid for communicable diseases can distort allocations and reduce capacity in the rest of the health system. Bank support has directly built country capacity in national disease control programs as dedicated communicable disease projects have dramatically increased as a share of the overall portfolio since 1997. Support for communicable disease control, with the exception of AIDS projects, has shown better outcomes in relation to objectives than the rest of the HNP portfolio. It was particularly important to address both equity and cost-effectiveness in HIV/AIDS programs, given the huge commitments to that disease, and because HIV does not always disproportionately strike the poor, unlike tuberculosis and malaria. Care should be taken to ensure that progress on communicable disease control remains a priority as the Bank enhances its support to system-wide reforms and SWAps.

27. The evaluation found that the SWAps have contributed to greater government leadership, capacity, coordination, and harmonization within the health sector, but not necessarily to improved efficiency or better health results. The focus of SWAps has been to promote consensus around a common national strategy; country leadership; better harmonization and alignment of partners; joint monitoring; the development and use of country systems; and, in many cases, the pooling of funds. The evaluation found that SWAps have been most effective in pursuing health program objectives when the government is in a leadership position with a strongly owned and prioritized strategy. Country capacity has been strengthened in the areas of sector planning, budgeting, and fiduciary systems. However, weaknesses have persisted in the design and use of M&E systems. Evidence is thin that the approach has improved efficiency or lowered transaction costs, because neither has been monitored. Adopting the approach does not necessarily lead to better implementation or efficacy of the government's health programs. SWAps have often supported highly ambitious programs, involving many complex activities that exceeded the government's implementation capacity. Programs need to be realistic and prioritized, and the processes of setting up SWAps should take care not to distract the players from a focus on results and from ensuring the implementation and efficacy of the overall health program.

Table M-4. Comparing the Global Fund and the World Bank

Feature	World Bank	Global Fund
Basic nature	The World Bank is both a financing instrument and, to some extent, an implementing agency, in the sense that it actively supervises projects that are implemented by government agencies.	The Global Fund is a "financial instrument, not an implementing agency." It is a foundation with specific purposes, created in 2002.
Governance	The World Bank is an international development bank, an intergovernmental organization with a full-time Executive Board that operates largely by consensus. Created in 1944 at the Bretton Woods Conference, its membership is restricted to country governments, its shareholders. With the establishment of IDA in 1960, donor and beneficiary countries were divided into Part I and Part II countries.	The Global Fund is a Global Partnership Program and an expression of the new multilateralism. It is legally incorporated as a Swiss foundation. It has an inclusive stakeholder Board with representatives from private foundations, CSOs, and affected communities, in addition to governments. WHO, UNAIDS, and the World Bank are nonvoting members. The World Bank is the trustee of the Global Fund financial resources.
Resource mobilization	The World Bank mobilizes donor funds to replenish IDA every three years for concessional loans to low-income countries and raises funds in the international financial markets to fund its loans to middle-income countries. It also manages trust funds furnished by governments and private parties.	The Global Fund mobilizes resources using a periodic replenishment model on a voluntary basis for all public donors, complemented by ad hoc contributions from other donors. The third replenishment, which concluded in October 2010, raised $11.7 billion for the 2011–13 period. The Global Fund also raises funds through innovative financing mechanisms such as Product RED and Debt2Health.
Terms of assistance	IBRD loans and IDA credits. Some IDA grants.	Grants.
Country eligibility	The World Bank provides IDA credits and grants to low-income countries, and IBRD loans to middle-income countries. Funds are normally only provided to governments.	The Global Fund focuses on low-income (IDA-eligible) countries. Middle-income countries must focus grant proposals on poor and vulnerable populations in their countries and meet Global Fund cost-sharing requirements.

Feature	World Bank	Global Fund
Country ownership	Loans and credits are prepared jointly by the World Bank and the borrower and approved under legally binding conditions.	The Global Fund supports programs "that reflect national ownership and respect country-led formulation and implementation processes."
Country presence	Strong country presence, depending on the size of the Bank's country program. HNP project managers may be resident in the country.	Weak country presence. FPMs are not resident in the country. Generally, LFAs exercise only fiduciary oversight of Global Fund grants.
Technical capacity	The World Bank brings to bear strong technical expertise at the country level.	Global Fund depends on development partners for technical support.
Country strategy	Lending and technical assistance activities are based on a CAS and the HNP corporate strategy. The health sector has to compete with other sectors for its place in the CAS.	Grant proposals are based on local strategies for control of the three diseases.
Health strategy	The Bank's country-level health strategies are expected to be consistent with the corporate HNP Strategy, and health-specific economic and sector work, such as Health Expenditure Reviews, appropriately applied to the country's circumstances.	The Global Fund pursues an "integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases as defined in disease-specific strategies."
Basic approach to HNP operations	Bank support is tailored to country circumstances and requests, in a dialogue with the country's authorities. The Bank generally takes a sector-wide approach to health sector development, focusing on HSS. It also supports communicable disease control projects, especially HIV/AIDS projects, and coordinates health with related sectors such as nutrition, water and sanitation, infrastructure, public sector management, and macroeconomic and fiscal policy.	Focused, disease-by-disease approach to combating HIV/AIDS, tuberculosis, and malaria. The Global Fund is increasingly supporting HSS through Global Fund grants for disease control, since HSS assists in combating the three diseases.
Project preparation and approval	Projects are identified and prepared collaboratively by World Bank and government staff (usually from the Ministry of Health). Projects are appraised by a World Bank mission, negotiated between the World Bank and the government, and approved by the World Bank Board.	Grant proposals are prepared, reviewed, and submitted by CCMs. Proposals are reviewed by the Technical Review Panel and approved by the Global Fund Board.
Oversight	The Bank's project manager oversees multiple stages of joint project preparation and appraisal.	The CCM oversees the preparation of proposals for grant funding and the implementation of approved projects.
New grant architecture	The World Bank sometimes uses program-based approaches such as the Adaptable Lending Program (APL).	The Global Fund is shifting toward a single stream of funding by disease in some countries.
Implementation	Implementing agency is almost always a government department, such as Ministry of Health for health projects, and usually includes a project implementation unit, embedded in the government department.	The Principal Recipient (the implementer) can be a government agency, an international organization (such as UNDP), CSO, university, or other.

Feature	World Bank	Global Fund
Implementing agency	The implementing agency is selected during the project preparation and appraisal process. The capacity of the implementing agency is an essential aspect.	The Principal Recipient is nominated by the CCM after the grant proposal has been approved by the Global Fund Board. The LFA assesses the financial, administrative, and implementation capacity of the nominated Principal Recipient to implement the approved grant.
Supervision	A Bank project manager supervises the implementation of World Bank-supported projects, either resident in the country or by frequent missions to the country.	The FPM manages the grant from both a financial and programmatic perspective with the assistance a country team and the LFA, who verifies and reports on grant performance.
M&E	M&E design is normally participatory, with stakeholder buy-in. M&E provides a partial basis for disbursement release and a basis for lessons learned for future use at both the country and institutional levels.	M&E provides the basis for disbursement release and to demonstrate results for future funding. Grant-level M&E is not linked to overall performance evaluation.
Role of CSOs	CSOs are normally consulted on the CAS and may be consulted when preparing health sector strategies and Bank-supported projects. With concurrence of the implementing agency, CSOs may implement some project activities, depending on project design.	CSOs are represented on the CCM, help prepare grant proposals, and may implement some Global Fund–funded activities as Principal Recipients, sub-recipients, or sub-sub-recipients.
Role of other donors	Other donors may co-finance Bank projects. The World Bank's presence in the country may facilitate donor cooperation.	The World Bank and other donors participate in country-level health forums (disease-specific or otherwise). They may also participate on the CCM and provide technical support to Global Fund–supported activities. While donor representation on the CCM varies from country to country, there is usually at least one representative of the donor community on the CCM.
Role of WHO, UNAIDS, Stop TB, and RBM	The World Bank may invite technical partner agencies to participate in identification, appraisal, and other missions.	Provide varying levels of technical support to the CCM in preparing grant proposals and overseeing their implementation.
Guidelines for World Bank–Global Fund engagement	The 2007 HNP Strategy provides general guidelines on engaging with the Global Fund. There are no Bank-wide directives that have operationalized these guidelines. HNP sector managers may encourage project managers to engage with the Global Fund in their countries.	No specific guidelines addressed at the World Bank. Senior Global Fund staff encourage the CCMs and FPMs to engage actively with the World Bank country office and field health staff.
MOU	No MOU with the Global Fund on engaging with the Global Fund at the global or country level.	No MOU with the World Bank on engaging at the global or country level.
Professional backgrounds and roles of project managers and FPMs	Project managers are normally health economists, health policy specialists, or public health specialists and are generally responsible for health projects from identification through appraisal and execution to project completion and loan/credit closing.	FPMs are generalists based at Headquarters who manage three-to-four country grant portfolios and supervise by means of frequent trips to the countries.

Appendix N. IEG Assessment of the Independence and Quality of the Five-Year Evaluation

Topics / Criteria	Findings
	1. Oversight and Management of the FYE by the Global Fund Board and the Technical Evaluation Reference Group (TERG)
Background to Evaluation: M&E Strategy, Operations Plan, and the FYE	• The FYE was conceived as part of an M&E Strategy adopted by the Board in 2003. • The Strategy called for: o Development of an M&E Operations Plan o A review of the Global Fund's overall performance against its goals and principles after one full cycle of grants had been completed o Creation of an external body to advise, assess, and oversee the Global Fund's work on M&E and to provide independent advice and assessment to the Board. • Within the Secretariat, the Strategic Information and Measurement Unit (SIMU) was responsible for managing the implementation of the M&E Operations Plan. The SIMU reported directly to the executive director, allowing for some degree of separation and independence from the Portfolio Management Group, which manages the country programs.
Role of TERG	• Conflicted role of TERG. It was to serve as independent advisory body to the Global Fund Board on evaluation matters and to provide oversight of Global Fund–commissioned evaluations. • TERG was also mandated to advise the Secretariat on evaluation approaches and practices of a technical and managerial nature and to monitor Global Fund progress toward corporate M&E goals. • This potential conflict was recognized. At Board and MEFA Committee meetings, the debate over an internal or external evaluation function finally concluded in a compromise. The Global Fund would have an internal M&E unit (SIMU) that handled the M&E work and may also commission external studies and an external and independent technical advisory body that reported directly to the Board. On quality and technical issues of evaluation, the internal body would still defer to the external body. This was considered the best balance of supporting a culture of self-correction and learning within the Global Fund, while at the same time having an independent evaluation capability. • TERG was responsible for the oversight of the FYE. It was responsible for directing all contractual activities, including drafting and approval of all terms of reference.
Independence of TERG oversight	• TERG reaffirmed its role in ensuring the independence and technical soundness of the FYE. TERG confirmed that it was the ultimate signatory on all products of the FYE.
Early design stage: Consultation process and conceptualization of evaluation issues and questions	• Highly consultative, participatory, and inclusive process (360 Degree Stakeholder Assessment) to conceptualize evaluation topics, closely steered by TERG. • First, High-Level Stakeholder Consultation with 23 experts to formulate the first Round of Overarching Questions on Principles and Practices, Partnerships, Results and Impact. • Next, Online Stakeholder Survey, with targeted e-mailing to more than 5,000 contacts. More broadly, visitors to the site could participate in the open survey put on the Web site. Nine hundred completed questionnaires were received on 23 attributes of the Global Fund. • Results were presented and refined at Global Fund Partnership Forum in Durban, S. Africa. • There was broad-based support for FYE and agreement on evaluation topics.

Topics / Criteria	Findings
Evaluation Plan and Evaluation Framework	• Consulting firm assembled to draft Master Evaluation Plan or Framework for FYE. • Senior evaluation officer with in-depth knowledge from Global Fund assigned to assist the firm. • TERG closely supervised the drafting process. The firm developed what was eventually called the Technical Background Paper. It identified and recommended on data sources, studies to be conducted, country visits, staffing and costs, competencies of the consultants, and communications strategies. It also proposed methodologies and options for implementation, timelines, and budgets. • Proposed the conduct of three separate studies (Organizational Effectiveness of the Global Fund; Effectiveness of Partner Environment at Country Level; and Effects of Increased Resources on Burden of Diseases) and a Synthesis Report. • Based on this background paper, TERG proposed an Evaluation Framework to Board for adoption in November 2006. • Budget proposed was 0.6 percent of all funds disbursed to date. • Other development agencies (PEPFAR, USAID, UNAIDS) were invited to TERG planning meetings
Requests for proposals and selection of contractors	• Requests for proposals and terms of reference for contracting of the final evaluation teams closely followed the guidelines in the Technical Background Paper. • Evaluation Consortium was selected by TERG, whose role was to implement the Evaluation Framework and Plan. Evaluation Consortium was to adhere as closely as possible to Evaluation Plan. • There was a limited pool of evaluation expertise suited for Study Area 3. This resulted in a TERG member from WHO resigning his position and taking his place as a member of the Evaluation Consortium when the Study Area 3 contract was awarded to a team comprising members from MACRO, WHO, Harvard, Johns Hopkins, and the African Center for Development Research.
Transparency of evaluation process	• All information about the evaluation process, including who had commissioned it; how it was managed and funded; the reporting and review process; and budget assigned was reported in detail in the Technical Background Paper, which was posted on the Web.
Adequacy of resources to support TERG oversight	• TERG made the FYE its primary responsibility. Enormous TERG and Secretariat resources were expended. • Three full-time Secretariat staff with evaluation background were assigned to assist TERG during the FYE. • The Secretariat eventually ring-fenced the staff and kept them out of the loop of regular Secretariat functions to avoid conflict of interest and ensure arms-length distance between TERG and the Secretariat.
Independence of FYE External factors influencing FYE management	• The FYE was an independent product without interference from the Global Fund. • However, MACRO perceived TERG oversight as highly burdensome and requiring excessive reporting. • At times TERG challenged MACRO on its approach or methodology in Study Area 2. • TERG felt such tight oversight was necessary to ensure good-quality evaluation. • Not only was TERG the oversight body for the FYE , it was also the advisory body on evaluation to the Board. • Time and again, the Global Fund Board noted its satisfaction with TERG's role as oversight body. • During the course of the FYE, the Global Fund went through some structural and senior management changes. These internal structural changes, in themselves a decisive and impactful undertaking, led to new ways of doing things. These included greater separation or fire-walling by

Topics / Criteria	Findings
	the Global Fund Secretariat of Secretariat functions/staff from TERG. • TERGs oversight was further challenged by the deteriorating TERG- Secretariat relationship.
Review, feedback process	• All FYE reports were completed and submitted to 18th Board meeting in May 2009. • The review and reporting process was open and transparent. • Evaluation reports were submitted to the Board through TERG, which kept the Board regularly apprised of findings. • TERG often formulated its own recommendations to the Board, some of which differed from the FYE. • The Secretariat was invited by TERG to comment on findings as they came in. • TERG summary reports accompanied the original MACRO reports during submissions to Board.
Board and management response	• A formal Board Response to the FYE is still pending. Preparation of the formal response has been relegated to an Ad Hoc Board Committee (from Finance & Audit, Policy & Strategy, Country Program Portfolio committees). • Meanwhile, the Board had directed the Secretariat to implement recommendations of FYE and TERG. • The Management Response is available on the Web site, although it is not placed with Evaluation reports, which are listed under TERG evaluations. • An updated Management Response was prepared in March 2010 to inform the Third Replenishment Meeting of the Global Fund.
	2. Participation and Inclusion
	• As a reflection of Global Fund's commitment to country ownership, the FYE placed countries at the center of the evaluation. Country-level mechanisms were established to coordinate impact measurement activities for Study Area 3. At the preparatory stage they consumed time and resources to set up and generated a lot of expectations from participating countries. A great deal more effort was needed during the actual evaluation process to utilize them optimally.
The guiding principles of the FYE were (a) inclusive process, (b) country focused/led, (c) build country evaluation capacity, (d) collaborate with local institutions, (e) share and disseminate as a local and global public good	• The guiding principles were closely adhered to during the FYE. Having a stakeholder governance model, the Global Fund spent considerable resources to ensure the FYE was consultative, inclusive, participatory, and fully legitimate as an evaluation. • When the evaluation framework was conceptualized, a highly consultative and inclusive process was followed that extended beyond the Global Fund's immediate stakeholder base. A 360 Degree Stakeholder Assessment was undertaken that included a (a) high-level expert stakeholder consultation; (b) targeted e-mailing of a structured survey to 5,000 stakeholders and an open solicitation for comments and inputs on the Global Fund Web site; and (c) further discussion at the Global Fund's biennial Partnership Forum. Stakeholder response was very high, as were expectations of the evaluation.
Inclusive and consultative in design	• The report from the Stakeholder Assessment was published, documenting the process followed and the stakeholder views/suggestions received about the evaluation. According to the report, there was broad-based support for the FYE and agreement on its topics and priorities. • UNAIDS, PEPFAR, and USAID were consulted and invited to participate in the evaluation design.

Topics / Criteria	Findings
Country-focused, and participatory in implementation	• The FYE was participatory in its implementation approach and placed the country at the center of the evaluation. For one of the Studies, Study Area 3, Impact Evaluation Task Forces (IETFs), chaired by country clients, were formed in eight participating countries to coordinate all evaluation activities. These IETFs brought together relevant local expertise and institutions (government, civil society, international development partners, local research and teaching institutions) to facilitate and review the in-country work of the evaluation. Based on country knowledge, the IETFs proposed coordinated plans on impact evaluation for their respective countries. • Many local groups were subcontracted to undertake data collection and analysis under the management of MACRO. As stipulated in its Evaluation Framework, the FYE intended to have a developmental impact, and significant evaluation funds would be consumed in the participating countries. • The evaluation convened a Partners in Impact Forum to enable technical exchange between country (IETF representatives) and global partners involved in impact evaluation activities of the three diseases. The Forum served as a training workshop for data quality management and refined the proposed country impact evaluation plans.
Learning and opportunities	• Recipients/implementers of Global Fund grants, beneficiary groups, and other CCM members were eligible to serve on IETFs to facilitate learning and ownership by the CCM. "Linking" the IETFs with the CCM increased the risks of conflicts of interest. As reported by the evaluation report, this was not a good arrangement and necessitated "management of risks" to ensure independence of the country assessments.
Managing potential conflicts of interest	• The above-mentioned mechanisms aimed at extending programmatic learning to the program and to country-level implementers and their beneficiaries during the FYE. But the IETFs needed a level of engagement and management that could not be sustained by the evaluation team during the course of the FYE. • Expectations were high from TERG and IETFs about what could be achieved by these mechanisms. At the conclusion of the FYE, there was little ownership of the country-assessment studies by country-level stakeholders. Programmatic learning was not as high as expected.
	3. Transparency, Disclosure, and Dissemination
Openness of evaluation process Findings discussed at Board meetings and the Partnership Forum Web site dissemination	• The evaluation process was highly transparent. No other GRPP evaluation has achieved the level of transparency of the FYE. • Regular presentations were made by TERG to apprise the Board and the Global Fund Partnership Forum about evaluation findings. • Evaluation products, available only in English, were posted on the Web site. Both MACRO reports and TERG reviews and critiques of the reports were prominently displayed. • Primary data collected by Study Area 3 was posted on the Web.
Discussion of conflict of interest in requests for proposals	• Management of conflict of interest was not well articulated in the planning and design stages. • Requests for proposals did not discuss conflict of interest. Ideally conflicts of interest relating to evaluation team members should be disclosed in the final evaluation report, even if measures are taken to mitigate their effects. • A TERG member from WHO (considered the best-placed person to evaluate the Study Area 3 report) resigned from TERG to become a principal member of the evaluation consortia. The conditions under which he was appointed and the measures taken to mitigate conflict of interest should have been described in the report. • There were no reported perceptions of conflict of interest on this particular arrangement.

Topics / Criteria	Findings
Dissemination budget	• The evaluation plan budgeted for dissemination activities of Study Area 3 country-level evaluation findings. • Workshops were held (some supported by WHO and USAID) to disseminate results and to train country stakeholders on the management and archiving of the micro-level data in the countries.
	4. Study Area 1: Organizational Effectiveness and Efficiency of the Global Fund
	• Study Area 1 sought to determine whether the Global Fund, through its policies and operations, reflects its critical core principles in an effective and efficient manner, especially its role as a financial instrument rather than as an implementing agency.
	• The structure of the Study Area 1 evaluation report consisted of vision and mission, board governance, resource mobilization, effectiveness and performance of Global Fund architecture, institutional arrangements and workforce focus, process management and customer focus, measurement and knowledge management, and procurement.
	• Methodologically Study Area 1 was based on: (a) a study of Board Governance; (b) an organizational development assessment of the Global Fund/Secretariat; (c) a review of the proposal development process and the Technical Review Panel ; (d) an examination of procurement, supply management, and financial management issues; (e) private sector resource mobilization; (f) a management review of specific areas of performance and its ancillary structures, and benchmarking of a number of results and processes.
	5. Building Evaluation Capacity
Building institutional capacity in 18 countries	• All the evidence collected from interviews with the Global Fund, evaluators, and country visits suggested that this effort was largely unsuccessful. There appeared to be little evidence that the specialized training, including country-specific data and knowledge, was being used and tapped by policy makers and other researchers as planned. • The FYE experience showed how difficult it was to incorporate systematic capacity building into an external evaluation. Care should be taken to ensure the evaluation function does not assume a secondary role to the learning function. The dynamics of completing a complex evaluation (described above) did not allow for building evaluation capacity, and ultimately there was not strong country ownership of the evaluation process and product in the eight Study Area 3 countries. • In the early preparatory days, through the IETFs and Partners in Impact Forum, good country participation was engendered. Country teams were hopeful and expectant of a good process and product.
Country capacity	• There was country appreciation of the initial gap analysis of country data and M&E systems. • At the minimum, capacity was developed in collection and analysis of primary data and surveillance. • One should be mindful, however, that skilled local capacity in evaluation exists but it is very difficult to tap due to the high costs (equivalent to international rates) and availability (engaged in other commitments).
Provision for time and effort to ensure participation of key stakeholders	• By and large, while the experience varied in countries, evaluation teams were not perceived to have taken the strengthening of national M&E systems seriously. When the execution pace picked up, there was simply not enough time to effectively engage the IETFs and other national processes and to build national ownership.

Topics / Criteria	Findings
Applying Study Area 3 country results into the country health sector review and planning processes	• This was largely not achieved due to difficulty in synchronizing the timing of Study Area 3 country assessments with existing country review processes.
Country ownership of tools, approach, concept, and commitment to subsequent continuous use of the instruments used in the FYE	• In at least one country, as the evaluation rolled out, there was no consensus reached between country partners and external evaluators regarding methodology, definitions of service coverage, and quality of services. Country partners felt country-specific factors and knowledge were not adequately tapped or factored into the assessment. There were also differences of opinion about the assessment criteria applied by the evaluation team. • Another goal of the FYE was to package the tools and methodologies used into one model evaluation platform that countries, already exposed to them, could continue to use. There is no indication yet (from the TERG report and country visits) that these methodologies and tools will be widely adopted by countries and their counterpart development agencies to conduct national-level impact evaluations. • The FYE was able to generate some collective action between PEPFAR, UNAIDS, and the Global Fund. These partners collaborated in the modeling and archiving of workshops of the Partners in Impact Forum.
Developmental approach of the FYE	• The evaluation intended that the bulk of evaluation monies in Study Area 3 (US$11.7 million) would be used for country data collection, analysis, and capacity building. This was achieved with the majority share of resources spent in the participating countries. Of the US$11.7 million, 40 percent was spent on data collection and analysis in countries and 30 percent on capacity building and technical assistance. The remainder was spent on administration (15 percent), development of instruments and tools (9 percent), and on analysis and reports (6 percent).

Appendix O. Toward A Common Conceptual Framework for Assessing Country-Level Partnerships

Assessment criteria and topics derived from a review of instruments used by Study Area 2 of the Global Fund, by UNAIDS, and by Phase 1 of the Paris Declaration. Examples and questions about the operating environment from these instruments are also presented.

Instruments	Reviewed		
Criteria/Topics	Global Fund Evaluation Country Partnership Assessment (CPA)	UNAIDS Country Harmonization Assessment Tool (CHAT)	Paris Declaration Evaluation Phase I
A. Country Ownership			
Existence of Strategic Development Framework and Plans of Action • Grounded in AAA • Plan of Action/ Implementation that is costed • Sectoral plans aligned and consistent with overall national development strategy • Owned by government and CSO and at subnational and provincial levels • Also owned foreign development partner agencies in the country	Existence of national strategies and plans of action for the three diseases.	National AIDS Council or Coordinating Authority and the National Strategic Framework for AIDS — Conduct partner/ stakeholder mapping exercise	Existence of operational development strategies — Number of countries with national development strategies (including Poverty Reduction Strategies) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets.
			Reliable country systems—e.g., number of partner countries that have procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform program in place to achieve these.

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
Relevant country-level governance and management arrangements for partnership program (e.g., CCM and National AIDS Coordination) That are inclusive and yet collectively have the technical expertise and authority to direct and lead program activities	Assess legitimacy of CCM membership (is it inclusive and representative, with members from academia; educational sectors; private for-profits; government; CSO and CBO; and people living with disease, e.g., AIDS, malaria, and tuberculosis; and religious /faith-based organizations; plus multilateral and bilateral organizations) A key principle of partnership in the Global Fund model is the inclusion and active participation of CSOs. CPA assesses how the Global Fund model has facilitated this over time	Review the NAC and the extent of participation by national partners in the national AIDS strategic framework; their representation in the NAC. CHAT emphasizes the need for multisectoral membership.	
Foreign development partner agencies support fully the national authority charged with leading the Program of Action	Extent to which partners (local and international) on CCM effectively carry out their terms of reference Assess behavior and performance of CCM members with respect to composition and representation, legitimacy, governance and management, communication and reporting, transparency CCM Performance Assessment	Extent to which international partners are supporting and cooperating with the NAC or National AIDS Association	
Need to manage adequately conflict of policy, especially for investment programs. The same groups sitting on the grant-awarding body may be connected to	Assess legitimacy, representation, conflict of interest, ethical issues, effectiveness, and efficiency of local governance and management entities. Policy on conflict of interest (important for grant awarding),		

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
groups applying for investment grants	especially for investment programs		
Assess role and contribution of CSOs: Their comparative advantage? How effective are efforts to increase CSO role?	CPA tool assesses role of CSOs and their contribution and effectiveness as CCM members and as Principal Recipients and sub-recipients (This important assessment looks at point-of-service delivery – close to results)		
	Examine factors that facilitate or act as barriers to country ownership of programs or their activities Do Global Fund policies and procedures respect country-led formulation and implementation of grants; assess which Global Fund policies and procedures actively promote country ownership Extent of external consultancy input or contracting-out proposal preparation, which may reduce country ownership of Global Fund grants Define country ownership from the perspective of local stakeholders and partners, assessing the extent of country ownership and alignment, and gather observations on ownership, alignment, and the Global Fund from key stakeholders		
B. Alignment			
Are development partner agencies supporting the right things?	Extent of alignment with national health systems, existing M&E reporting and procurement and financial management systems Gather observations on ownership, alignment, and the Global Fund from key	Assess extent of alignment between Global Fund HIV grants and Ministry of Health planning cycles (annual or biannual); alignment between Global Fund HIV grants and the indicators used for routine reporting for HIV/AIDS Linkage between Global Fund HIV grant	Evidence of actions to reduce parallel implementation structures; e.g., number of project implementation units in country reduced Phasing out of top-up financing or financial incentives in projects by external

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
	stakeholders	reporting and the national health and finance reporting? A. Alignment between Global Fund HIV Grant auditing and the national auditing system? B. What is the extent of alignment between the Global Fund HIV grant procurement system and the national procurement system?	agencies
	To what extent are the following processes country led? How can country involvement be increased with respect to: Prioritizing interventions and activities, grant proposal development, budget development, work plan development, grant implementation and oversight, selecting indicators for M&E, and reporting		Extent of use of country public financial management system – percent of donor partners that use country's system. Evidence of a reform program in this area that will improve quality of public financial management system
			Strengthened capacity by coordinated support — Percent of donor capacity-development support provided through coordinated programs consistent with national development strategies
Existence of enabling factors in country to allow for alignment by external partners Are there existing collaborative mechanisms to be leveraged?	Identify measures, if any, to improve alignment between Global Fund grant and country systems		Enabling factors in the country that allow for alignment by external partners For example: Operational development strategies that have clear strategic priorities linked to a medium-term expenditure framework. Reliable country systems

Instruments	**Reviewed**		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
C. Harmonization			
Harmonization efforts are also reported under other sections This section will look at evidence of harmonization on any issue	The extent to which Global Fund planning, implementation, and reporting processes are harmonized with other donors' requirements (with implications for reducing transaction costs of receiving Global Fund grants) *Note*: Under this topic, harmonization, the CPA also sought information on the "additionality" of Global Fund assistance. It attempted to gather information on total number of donors and the share of funding provided, pre- and post- Global Fund grants, for each of the three diseases: e.g. changes in level of funding by each donor over time, whether any donors dropped out; and overall level of funding over time.	Extent to which external partners are harmonizing their AIDS administrative and reporting mechanisms Extent to which they are harmonizing their AIDS technical assistance strategies	Use of common arrangements or procedures – and other common arrangement and procedures, for example, SWAps
Harmonization of planning and implementation procedures by different donors within the sector in question	Assess the aggregate effects of the Global Fund on overall funding for the three diseases; the degree of harmonization with other donors' planning and implementation procedures; how well the Global Fund contributes to and adapts to support harmonization and the "Three Ones"; and whether the Global Fund has opportunity to improve donor harmonization at the country level		
Functioning collaborative mechanisms that already exist in-country that can be tapped or piggy-backed on. For example: • Technical working groups in Health and HIV • Joint donor missions and diagnostic work	How does the CCM relate to other donor coordination mechanisms in country?		Evidence of shared analytics —Joint donor missions and country analytic work—(diagnostic work too)?

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
D. Finances, Financial Management, and Resource Mobilization			
Evidence of pooled funding, SWAps	The CPA did not talk about pooled financing because the Global Fund had not decided if it would support this. Pooled funding is neither addressed in the CPA nor in Study Area 2.	Looked for pool funding	SWAp or basket funding Move to budget support, SWAp, or basket funding Scaling up the SWAp beyond the pioneering sectors (education and health)
Mobilization of local/national resources	CPA narrowly focused on mobilizing private sector financing (an operational principle of Global Fund model) at the country level This is a lagging performance indicator. CPA focused on strength of local CCM strategy in mobilizing private money What are the attempts and constraints toward identifying and mapping out potential private sector donors in-country What are constraints—are they due to lack of clarity of roles of partners on the ground, CCM, Principal Recipient, sub-recipient, or LFA to undertake resource mobilization? CPA also addressed perceived urgency of CCM partners about this issue		Tap private sector resource mobilization
Predictable and untied aid		Multiyear, more than three years of funding (aid predictability)	Untied aid Predictability of aid
Public financial management systems			Use of country public financial management systems and evidence of reform program to achieve this At country level, phase out top-up financing or financial incentives for public sector workers

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
Aid flows—where are they going and how are they reflected in the national budget? How are direct flows to CSOs accounted for in national accounting?		External aid reflected in national budgets and medium-term expenditure framework	Aid flows are aligned with national priorities. Percent of aid flows to the government sector that is reported /reflected on partners' national budgets Percent of aid flow directly to CSO
Additionality of aid by the program in question if new to country (This is a useful performance indicator to monitor)	CPA addressed "additionality" of Global Fund assistance. It attempted to gather information on total number of donors and the share of funding provided, pre- and post- Global Fund grants, for each of the three diseases; e.g., changes in level of funding by each donor over time, whether any donors dropped out, and overall level of funding over time.		
E. Managing for Results			
M&E		UNAIDS supports the country's national AIDS M&E system—CHAT does not look for evidence of M&E on the assumption it exists	Evidence of managing for results
Evidence of building country institutional capacity for M&E	Global Fund assists countries by developing tools and processes to monitor performance and respond to gaps (M&E toolkit, scorecards, phase 2 processes, EARS).		Evidence of a transparent and monitorable performance assessment framework and of building institutional capacity by donor program to apply it
Use of PBF	Unlike UNAIDS and the Paris Declaration, the CPA is highly focused on assessing the appropriateness of the design and functioning of the PBF system and how it can be improved		Use of results-oriented performance assessment framework Evidence of transparent and monitorable performance assessment frameworks that allow for assessing progress against national development strategies and against sector programs

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
Assess impact (positive and negative) of M&E system introduced by program into the country as requirement for participation	Assess how has the Global Fund model of PBF changed the way the national disease program (HIV/AIDS, tuberculosis or malaria) operates CPA assessed capability of local implementing agencies to meet the requirements of PBF in the grant implementation. Is there greater accountability and efficiency in providing health services as a result of the PBF system. CPA also looked at details of identifying indicators and how inclusive it is in the process.		
Use of country management information systems	Looks at linkages between Global Fund M&E and the country health management information systems	Use of country management information systems and extent of alignment of partners' M&E for AIDS with the national AIDS M&E system	Evidence of attempts to establish linkages between sectors and the National Integrated M&E Strategy (this includes elaboration of a national strategy for capacity building of M&E systems, which donors would be invited to support through programmatic aid)
Joint annual reviews		Extent of joint annual reviews with government and other development partner agencies;	Shared country analytics including joint assessments
Agreement on analytical tools and use of shared approaches and instruments		Agreement on analytical tools and use of shared approaches and instruments	Joint conduct and use of core diagnostic reviews (Country Financial Accountability Assessments, Public Expenditure Reviews, Country Procurement Assessment Reviews)

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
F. Procurement and Supply Management			
Harmonization of procurement	Look for evidence of coordination by development partners to avoid duplication of procurement? Which development partner agencies involved? How could coordination and harmonization in procurement be improved? Have there been any procurement audits?		Use of country procurement systems – and evidence of reform program in procurement supply management (PSM in the country), e.g., decreasing number of donors that do not use country PSM
Address structural issues of procurement and supply management Highly relevant for an investment partnership program	How were forecasts for drugs and commodities for malaria grants developed? Tools used? Assess how forecasts were coordinated with the needs for the whole sector in country? What effects on cost/quality or supply of products? Consistency of application of Global Fund policy on procurement and guidelines (direct payment and multiyear orders) in selection of vendors by Principal Recipient and sub-recipients Assess extent of disbursement delays, stock outs, (what stop-gap measures are used to compensate for stock-outs due to problems with procurement? [e.g., paying suppliers on time]) Existence of diagnostics to assess structural problems with procurement — and extent to which problem is being solved by procurement practices Extent of partners out-sourcing		

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
	procurement to another organization besides the Principal Recipient Extent to which all partners investing in any one commodity— e.g., HIV or tuberculosis drugs using one procurement approach and one supplier to leverage negotiation of reduced prices and economy of scale		
Routine review of country-level procurement activities—quality and compliance	Conduct sample of tender analysis (not procurement audit) Routine review and assessment of service delivery level of sub-recipient's procurement supply management (PSM) and financial management capacity in cases where sub-recipients routinely undertake substantial PSM functions; and in countries where Principal Recipients are financial pass-throughs, and not implementation agencies Routine monitoring of disbursement and/or procurement delays to sub-recipients. Track and monitor chain of inputs to outputs Assessment of sub-recipient's PSM and financial management capacity prior to grant approvals.		
Procurement auditing	Number and frequency of procurement audits.		
	Extent to which country partners coordinate procurement and/or collectively negotiate commodity (drug) prices with suppliers		

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
No signs that local producers and suppliers are crowded out by procurement practices of large international programs			
G. Capacity Building / Technical Assistance			
Examine Issues around need for technical assistance to first build up the country processes, institutions, and systems, in order that use of country systems (for alignment) can take place How effectively has the program done this?			
Quality, relevance, and usefulness of technical assistance provided by partnership program	Extent to which Global Fund grants and other development partner agencies have increased local capacity Have the PBF requirements increased capacity at the local level? Have Principal Recipients or sub-recipients received training in M&E, financial management, or procurement? Have sub-recipients and Principal Recipients (implementers) changed the way that they perform their functions because of the Global Fund PBF system? Assess usefulness and effectiveness of technical assistance recommendations? How well do technical assistance systems of different donors function?	Relevance, effectiveness, and scope of capacity building efforts of partners to national AIDS M&E response	Strengthen capacity by coordinated support — percent of donor capacity-development support provided through coordinated programs consistent with national development strategies
Country-led technical assistance plans Demand-driven approach to capacity building	Are technical assistance funds from the grant budgets used regularly?		Country led technical assistance plans Demand-driven approach to capacity building

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
Adequacy of external funding for technical assistance	Is there enough funding for technical assistance? Is funding readily accessible?		Evidence of adequate funding by external partners for technical assistance
Guidelines and ease with which to access technical assistance	Usefulness and adequacy of Global Fund guidelines to CCM and Principal Recipient on procuring technical assistance? a. If guidelines exist, were they used? Did guidelines require a competitive technical assistance procurement process? Which partners have been key in facilitating the technical assistance process, and in what ways?		
Harmonization and alignment of technical assistance by donors	Can partners' roles and responsibilities in technical assistance be clarified or coordinated better? What obstacles, if any, affect the ability of Global Fund partners to identify technical assistance needs and coordinate requests?	Extent of alignment of partners' M&E for AIDS with the national AIDS M&E system	Comprehensive capacity building plans that are harmonized and aligned with national needs and strategy. Evidence of strengthened capacity by coordinated support — Percent of donor capacity-development support provided through coordinated programs consistent with partners' national development strategies
How might technical assistance be improved?	How could technical assistance be improved How might Global Fund Secretariat, CCM, LFA, Principal Recipient, sub-recipient, and development-partner agencies overcome technical assistance issues ?		

Instruments	Reviewed		
Criteria/Topics	**Global Fund Evaluation Country Partnership Assessment (CPA)**	**UNAIDS Country Harmonization Assessment Tool (CHAT)**	**Paris Declaration Evaluation Phase I**
H. Accountability			
Issues of reporting, communications, mutual accountability. Reflection of official development assistance in national budget	Extent of alignment between Global Fund grants and Ministry of Health planning cycles (annual or biannual); alignment between Global Fund grants and indicators used for routine reporting for tuberculosis, HIV, and malaria; and grant reporting with the national health reporting and with national financial reporting requirements	Extent to which international partners are harmonizing financial reporting with each other and in relation to the AIDS response. What sort of barriers/bottlenecks exist limiting timely information flows to marginalized groups?	
Openness and transparency		Extent of openness and transparency among national partners and the NAC	Publish timely, transparent, and reliable reports on budget planning and execution that meet INTOSAI (International Organization of Supreme Audit Institutions) standards
Accountability	Has alignment of Global Fund grants with national HIV/AIDS programs increased accountability by country clients?		
Mutual accountability		Extent of transparent, timely, and accurate communications among international organizations and with all members of the NAC	Mutual accountability Donors provide timely, transparent, and comprehensive information on aid flows and program intentions to government Information flows significantly improved through the national M&E system for official development assistance Indicator 12 (mutual assessment of progress) Mutual accountability — Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration

Appendix P. Quality Review of Study Area 3 of the Five-Year Evaluation

1. This quality review is concerned with one component of the FYE framework: Study Area 3 on Impact Evaluation. In October 2003, the Global Fund Board approved a five-year evaluation of the Global Fund's overall performance in terms of its organizational efficiency, success of country partnership systems, and overall impact. Study Area 3 concerns itself with the impact question. The Study Area 3 approach has been to examine collective efforts, including those of other major agencies and programs, and describe their contribution to the overall reduction in burden of these three diseases. Eighteen countries were considered under Study Area 3, of which eight countries had primary data collection activities, while in ten countries, impact evaluation was based on secondary sources. This quality review focuses on the design of the Impact Evaluation of the Global Fund, not its implementation process. An implementation process that is guided by and adheres to sound principles of evaluation management, coordination, partnership building, and capacity strengthening is indeed necessary, but it is not sufficient to ensure the relevance and credibility of inferences made by the evaluation. This is not to say that implementation process aspects are completely ignored in this review, but help frame the discussion around the quality of the Global Fund Impact Evaluation design.

Defining Impact Evaluation

2. ***Impact evaluation is the counterfactual analysis of the impact of an intervention on final welfare outcomes*** (IEG, nd) .[21] According to NONIE, the two underlying premises for impact evaluation are attribution and counterfactual. Asian Development Bank guidelines say: "Impact evaluation establishes whether the intervention had a welfare effect on individuals, households, and communities, and whether this effect can be attributed to the concerned intervention." The Center for Global Development posits "Impact evaluation asks about the difference between what happened with the program and what would have happened without it (referred to as the counterfactual)."[22] The draft chapter on evaluation in the U.N. Management Handbook states that: "IE tries to measure…causal effect…The impact of a program is the difference between beneficiaries' well-being after the program and some benefit of beneficiaries' well-being had there been no program." According to International Initiative for Impact Evaluation (3IE), "high quality impact evaluations measure the net change in outcomes that can be attributed to a specific program." Based on these statements, the defining characteristic of an impact evaluation is its focus on attribution.

3. ***Most of the current debate on design and methodological aspects of impact evaluation centers on resolving the attribution problem.*** This can be accomplished using several methodologies, which fall into two broad categories: experimental designs

21. For example, DIME says "Impact evaluations assess the specific outcomes attributable to particular intervention or program. They do so by comparing outcomes where the intervention is applied against outcomes where the intervention does not exist." Ravaillon (2008) states: "An impact evaluation aims to assess a program's performance against an explicit counterfactual, such as the situation in the absence of the program."

22. Indeed, this was the definition which was intended in the report of the Centre for Global Development, "When Will We Ever Learn?"

(randomized) and quasi-experimental designs (nonrandomized). Each of these methods carries its own assumptions about the nature of potential selection bias in program targeting and participation, and these assumptions are crucial to developing the appropriate model to determine program impacts.

4. ***However, for an impact evaluation to have better policy and operational relevance, it is important to understand not just what works, but why.*** A theory-based impact evaluation design is one in which the analysis is conducted along the length of the causal chain from inputs to impacts, and goes beyond what worked to understand why a program has, or has not, had an impact. White (2009) outlines six key principles of a theory-based impact evaluation,[23] one of which is construction of a comparison group using experimental or quasi-experimental methods- for rigorous evaluation of impact. The evaluation of the *Bangladesh Integrated Nutrition Program* is an example of a theory-based evaluation.

Design of Global Fund Impact Evaluation

5. ***The Study Area 3 evaluation design follows a step-wise approach***. The step-wise approach (Figure 1) consists of four sequentially linked questions on trends in funding, access to services, coverage of interventions and risk behaviors, and health outcomes. Within the limits set by contextual factors, improvements at each step are expected to be plausibly ascribed to improvements in the previous step.

6. ***Given that attribution is the defining characteristic of an impact evaluation, the evaluation study for Study Area 3 is not an impact evaluation.*** One of the criteria for a quality impact evaluation leads from the attribution premise.[24] However, the Study Area 3 evaluation study does not meet this criterion, and it did not set out to do so. From the outset, the Study Area 3 evaluation report says that "the impact evaluation sets out to assess overall impact on the three diseases and the contributions of the Global Fund without direct **attribution,**" and goes on to describe the report as an "**adequacy evaluation."**[25] Although not an impact evaluation, an evaluation study of this type is very useful. According to Victora et al. (2010), such approaches, especially in the early years of implementation, can be telling about the quality of targeting; whether implementation is strong enough to generate impact; and of the multiplicity of delivery methods available, which approaches are likely to rapidly increase coverage in the short-term.

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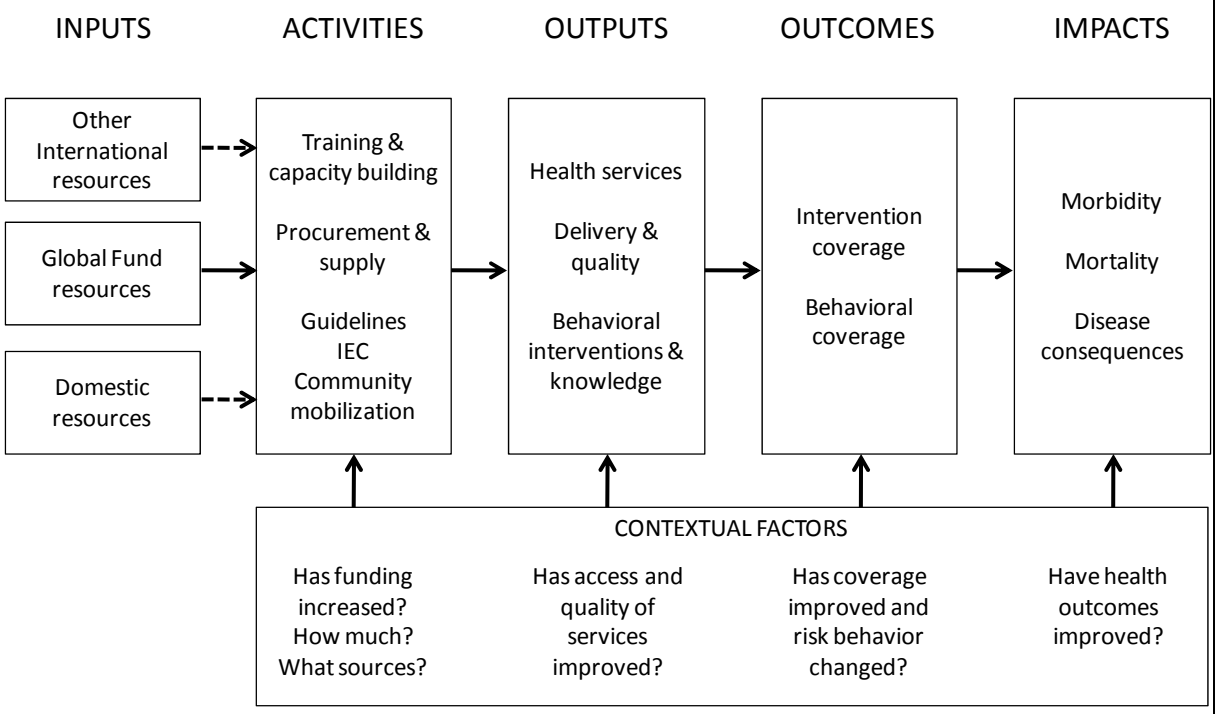
23. Map out the causal chain (program theory); understand context; anticipate heterogeneity; rigorous evaluation of impact using a credible counterfactual; rigorous factual analysis; use mixed methods.

24. "Develop a logically sound counterfactual presenting a plausible argument that observed changes in outcome indicators after the project intervention are in fact due to the project and not to other unrelated factors, such as improvements in local economies or other programs" (IEG 2006).

25. Adequacy evaluations are limited to describing if expected changes have occurred, and are unable to causally link program activities to observed changes (Habicht et al. 1999). By contrast, probability and plausibility evaluations correspond to experimental and quasi-experimental design, respectively.

Figure P-1. Study Area 3 Evaluation Design: Step-Wise Framework



Source: Constructed/adapted by IEG from Technical Background Paper, Synthesis Report, and Study Area 3.
Note: IEC = information, education, and communication

Assessing Quality of Evaluation Design

7. ***Rigorous impact evaluations are resource-, time-, and data-intensive, and not all programs are amenable to an impact evaluation.*** Program managers may decide if it is feasible to carry out an impact evaluation on the basis of some of the following criteria: (1) *timing, (2) plausible counterfactual, (3) data availability*. Any quality review of the Study Area 3 evaluation study must therefore begin by addressing the relevance of the evaluation approach against the feasibility criteria, keeping in mind the challenges that may impede/facilitate choice of evaluation strategy.

- *Timing:* Evaluations are subject to the implementation time frame of the program. Even when projects move forward at the established pace, some interventions take longer to implement, such as infrastructure, and some take longer to manifest themselves in the beneficiary population (Baker 2000). In the case of the Global Fund, the timing of the Study Area 3 evaluation — especially as it pertains to behavioral change and impact levels of the step-wise framework, and irrespective of the design strategy it could have pursued — was premature. Scaling up through the Global Fund, PEPFAR, and other disbursements began in 2003, but only reached a substantial level of funding and number of countries in 2004–05. The time between a Board decision on a proposal and actual implementation can easily reach 15–23

months,[26] while the time between implementation and interventions and reaching high coverage levels, to subsequent population impact, can take an additional few months (e.g., treatment) to several years (e.g., behavior change program). Considering that the evaluation period is 2003–07, the pace of implementation makes it almost impossible to document the full health impact. The advantage of the Study Area 3 evaluation approach in the face of the timing constraint is that, at least for earlier steps in the results chain, the study can document the effects of collective scaling-up efforts with some certainty.

- *Plausible Counterfactual:* As mentioned before, impact evaluations require a comparison group that did not receive the treatment. Collective scaling-up efforts in this context were intended to treat the whole of eligible population and were intended to be countrywide. This makes identifying a counterfactual a very difficult task. The response of Study Area 3 to this problem has been the forfeiting of any claim to attribution in favor of a step-wise framework and reflexive (before vs. after) comparison. Reflexive comparisons are, of course, useful in that they can tell if expected changes have occurred, but this does not mean that the program in question caused this change. A cautionary tale in this respect is that of Bangladesh Integrated Nutrition Project (BINP), a growth-monitoring project, where factual analysis and counterfactual analysis produced contradictory results.

  Although it may appear impossible to do an impact evaluation of complex and large-scale efforts such as the Global Fund, researchers have used creative strategies to construct plausible counterfactuals when one was not easily identified. Duflo (2001) examined the effect of a large-scale school construction program in Indonesia on educational attainment and wages by exploiting regional differences in program intensity and differences in exposure across cohorts induced by the timing of the program. Osili and Long (2007) exploited regional variations in intensity of funding received to examine if introduction of universal primary education caused discontinuities in educational attainment and early fertility. Galasso and Ravallion (2004) evaluated a large social protection program in Argentina, Jefes y Jefas, which was created by the government in response to the 2001 financial crisis. The program was scaling up rapidly, and comparison units were therefore constructed from a subset of applicants who were not yet part of the program. Participants were matched to comparison observations on the basis of propensity-score matching methods. Piehl et al. (2003) used observed outcomes for participants over several years to test for structural changes in outcomes (Ravallion 2008). Having said this, in the case of Study Area 3, these approaches may have been plausible in some of the study countries (in the absence of implementation information, we cannot say if it was or was not doable). Considering the time constraint under which data collection and analysis took place, it may have impinged on a careful examination of data to see if some kind of counterfactual analysis was plausible.

- *Data Availability & Quality:* The Study Area 3 report points to major data gaps and weak health information systems, impinging on the quality and availability of

26. Lag of approximately 9–12 months between Board approval and grant signing, 2–3 months between grant signing and disbursement, and between 4–8 months between disbursements and implementation in country.

relevant data. For instance, baseline data was largely missing; there was lack of data on AIDS morality; there was a long lag time between data collection and availability of results; there was inadequate data on antiretroviral treatment adherence and survival; there was poor-quality data on provision of interventions; there was fragmented information flow; there was incomplete and inaccurate data on community interventions, and so on. Under Study Area 3, data collection efforts were undertaken to bridge some data gaps, but there is still room for improvement. Given the problems with completeness, reliability, and consistency of data, impact evaluations may not be very feasible for all countries, because these require good-quality data. However, the Study Area 3 design has a less rigid approach (for instance, intervention data and outcome data are not always provided for the same period), which makes it a more feasible design in this context.

8. ***To summarize, given the data and timing constraints, the step-wise framework is feasible as an evaluation tool, although in instances where data is complete and reliable, where pace and/or coverage of scaling-up offers the opportunity to construct a plausible counterfactual, and where sufficient time seems to have passed to generate outcomes, an impact evaluation may be feasible.***

Assessing Quality of Evaluation Design—Contribution Analysis

9. ***The Study Area 3 report is not an impact evaluation, nor is it intended to be. Since the evaluation question is to assess the reduction of overall disease burden, and the contribution of the Global Fund, a different analytical framework, rather than one that applies to impact evaluation, must be used to assess the quality of the Study Area 3 evaluation design.*** In this context, contribution analysis is one such analytical framework against which the quality of the Study Area 3 design can be assessed. **Contribution analysis** is defined as “a specific analysis undertaken to provide information on the contribution of a program to the outcomes it is trying to influence” (Mayne 1999). It aims at "finding credible ways of demonstrating that you have made a difference through your actions and efforts to the outcomes” (AusAID 2004). The broader approach to contribution analysis attempts to describe what Hendricks (1996) calls a "plausible association"; where a reasonable person, knowing what has occurred/is occurring in the program, agrees that the program contributed/is contributing to the outcomes. It does not prove a contribution, but provides evidence to reduce the uncertainty about the contribution made (Mayne 1999).

10. ***Next, we assess the extent to which the evaluation study puts forward a credible contribution analysis story.*** For a performance story to be credible, Mayne proposes that a good quality contribution analysis should set out the program context (including the results chain), planned and actual accomplishments, lessons learnt, and the main alternative explanations for the outcomes occurring and show why they had no or limited influence. We found the Study Area 3 study design framework represented by a step-wise/logic model (Figure P-1) to be robust conceptually, in that the model demonstrates plausible and logical links across all levels from activity through intermediate to end outcomes, and highlights the role of contextual factors in affecting outcomes. However:

- *Not all the assumptions behind the Study Area 3 logic model are either explicated or tested in the study.* To the extent that assumptions are spelled out, these can be found

scattered throughout the document and rarely justified. To name a few, the evaluation assumes that (i): In the absence of scaling up efforts, mortality and morbidity due to the three diseases and intervention coverage would have at best remained the same or worsened; (ii) Expected expenditure is flat-lined from 2003 to 2006. These are fairly strong assumptions yet they are not fully addressed. For instance, in Cambodia, national expansion of DOTs was underway since early 2000s reaching completion in 2004. So, under assumption (i), tuberculosis disease burden and coverage in Cambodia would have remained unchanged even worsened which is hard to believe. We cannot also discount lagged effects. For instance, since prevention programs take time to generate outcomes and impact, it is plausible that in some countries, it is not collective efforts since 2003 but prevention initiatives pre-dating the Fund that could have influenced outcomes. This is again a violation of assumption (i).

- *A missing link in the step-wise approach is the absence of implementation quality information, even though the FYE sees it as an important determinant of impact.* Collective efforts represent a complex situation with multiple interventions, each of which interact with each other to influence final outcomes, and are implemented under by multiple agents with their own strengths and weaknesses. The operational issues that arise from the complexity of efforts being evaluated may influence outcomes and were not addressed in Study Area 3. Although Study Area 1 and Study Area 2 address these issues for the Global Fund, there was no information collected on implementation quality of other major funders. Notwithstanding this, linking analysis in Study Area 3 with findings from Study Area 1 and Study Area 2 in the context of the Global Fund would have at least helped understand better the contribution of the Global Fund. Even from the overall evaluation framework of the Global Fund FYE, it is evident that Study Area , Study Area 2 and Study Area 3 were seen as sequential and interlinked. To the extent that concurrent timing of the three evaluations is responsible for this, a clear lesson for the future is to afford enough time to incorporate lessons from different but linked evaluations.

- *Little information was presented on evidence behind external factors that may influence outcomes*. For instance, Boerma et al. (2010) points to changes in socioeconomic welfare, transport and communications, weather conditions, secular changes in disease burden, as well as cyclical patterns in other disease, migratory patterns, etc as factors that influence outcome indicators in the context of these diseases. Although the design framework posits he importance of contextual factors, the actual study makes little effort to integrate evidence of this inn interpreting the contribution of collective efforts. This does not always require additional data collection; there may be existing research available and even if no such studies are available, effort should have been made to make a case there were or not any new initiatives or trends that could have potentially contributed to reducing the disease burden.

- Although data constraints compel looking at outcome/impact level indicators from a "collective efforts" perspective, this is ultimately a Global Fund evaluation. We found that there was little attention to analyzing outcome patterns vis-à-vis intensity of Global Fund contribution, for example, how expected changes trended in countries where the Global Fund was actively involved compared to countries where it was the

dominant financier. This is important because different funders employ different delivery modalities, and any lessons on what works better and where may be operationally useful for the Global Fund and improve the collective performance story.

11. ***To summarize, the design of Study Area 3 study was sound enough to assess the contribution of Collective Efforts to reducing the disease burden; however, the weaknesses has more to do with the execution of the evaluation design, not its concept. Some, if not all, of these weaknesses could be explained by data and timing constraints.***

Lessons:

- The timing of an evaluation is an important determinant of the quality of evaluation and the credibility of analysis. Especially where evaluation focuses on impacts, it is important that ***enough time has passed for program interventions to translate into impact.***

- ***Explore possibilities for doing impact evaluation in specific cases where it may be feasible to do so.*** For instance, in countries where implementation has been phased or there is non-universal coverage, creation of a counterfactual may be plausible. Also relevant is the quality and availability of data, so countries where data is missing or quality is questionable, an Impact Evaluation will not be feasible.

- Any theory of change/program logic that forms the basis of inferring program results is as good as the assumptions underlying it. Going forward, successive evaluation efforts should ***carefully assess the assumptions behind the program logic, as well as the risks,*** to strengthen the contribution story. The ***role of external factors in influencing outcomes must be incorporated in future evaluations***. If the assumption is that no external factors are significant determinants, then this assumption needs to be justified.

- The data collected under Study Area 3 provides a good starting point for future rounds of evaluations. Going forward in the future, there is a ***need to sustain these data collection efforts***, and bridge more crucial data gaps.

- Since this is an evaluation intended to improve performance of the Global Fund, it is important that ***more attention is paid to analyzing the contribution of the Global Fund*** to changes in outcomes. A better understanding of how outcomes trend in countries where the Global Fund is a minority player versus where it is the majority financier is useful and can lead to more efficient use of resources. Related to this is the ***need for more coherence between operational and impact assessments.*** For instance, Study Area 1 and Study Area 2 were intended to be linked with Study Area 3 in a sequential evaluation framework, yet Study Area 3 was not able to use findings from Study Area 1 and Study Area 2 in informing the analysis.

Appendix Q. Results of the Electronic Survey of World Bank Task Team Leaders and Global Fund Secretariat Staff

This electronic survey, which was administered to the staff of both organizations in March 2011, sought their views on the breadth of the engagement between the two organizations since the Global Fund was established in 2002.

In the case of the World Bank, the survey was sent to all the task team leaders (project managers) of Bank-supported health projects that were disbursing when, or approved after, the Global Fund became active in the same country (the date of its first grant commitment to the country). At least one of the designated themes of their projects was HIV/AIDS, tuberculosis, malaria, communicable diseases, or health system performance.

In the case of the Global Fund, the survey was sent to Secretariat staff in the Country Programs Cluster, the External Relations and Partnerships Cluster, and the Strategy, Performance and Evaluation Cluster. IEG gratefully acknowledges the assistance of Oren Ginzburg, Sandii Lwin, and Igor Oliynyk in administering the survey to Global Fund staff.

This appendix presents, in tabular and graphic form, only the responses to the closed-ended questions in the survey. The complete results, including the responses to open-ended questions, will be available on the Web site at www.globalevaluations.org. Most of the questions in the two surveys were identical in order to compare the responses of the staff in the two organizations. Four questions were necessarily different, but still similar in nature. (See questions 6, 10, 11, and 12 below.)

This survey was confidential. The responses are presented in aggregate form, making it impossible to identify individual responses.

Background Questions to World Bank Task Team Leaders (TTLs)

Question 1. Please indicate the countries in which you have been the TTL of record for a Bank-supported health project that was disbursing at the same time that the Global Fund was also active in the same country. If you identified more than one country, please answer this survey from the point of view of the country on which you worked the longest on a health project and in which the Global Fund has been the most active.

World Bank TTL Respondents by Region

Region	Number of Respondents	Share of Respondents
Africa	20	48%
East Asia & Pacific	6	14%
Latin America & Caribbean	6	14%
South Asia	5	12%
Europe & Central Asia	4	10%
Middle East & North Africa	1	2%
Total	**42** /1	**100%**

/1 This represents a response rate of 33 percent (42 of 128).

Question 2. During the time period for which you were the TTL for the country you selected, please indicate where you were based.

TTL Location	Number of Respondents	Share of Respondents
In the World Bank office in the country	21	54%
At World Bank Headquarters in Washington, DC	15	38%
In the World Bank office in a neighboring country	3	8%
Total 39		**100%**

Question 3. Please indicate your professional background.

Professional background	Number of Respondents	Share of Respondents
Health, nutrition, or population specialist	24	62%
Operations officer	7	18%
Health economist	5	13%
Other (please specify)	3	8%
Total 39		**100%**

Question 4. To what extent are you familiar with elements of the Global Fund's current reform agenda such as the new grant architecture and grant consolidation process, National Strategy Applications, and the Country Team Approach?

Level of familiarity	Number of Respondents	Share of Respondents
A great deal	2	5%
Substantially	9	23%
Somewhat	16	41%
Not at all	12	31%
Total 39		**100%**

Background Questions to Global Fund Secretariat Staff

Question 1. Please indicate the Cluster in which you are working.

Cluster	Number of Respondents	Share of Respondents
Country Programs Cluster	36 [a]	69%
Strategy, Performance and Evaluation Cluster	9	17%
External Relations and Partnerships Cluster	7	13%
Total	**52** [b]	**100%**

a. This represents a response rate of 62 percent (36 of 58) for those questions that were only addressed to the Country Program Cluster.

b. This represents an overall response rate of 49 percent (52 of 106) for the questions that were addressed to all three Clusters.

Question 2. Please indicate the geographical area for which you are answering this survey. If you are a Fund Portfolio Manager that has worked on more than one country, please answer these questions from the point of view of the country on which you have worked the longest and in which the Global Fund has been most active.

Country Programs Cluster Respondents by Region

Region	Number of Respondents	Share of Respondents
Africa	14	39%
East Asia & Pacific	7	19%
Latin America & Caribbean	5	14%
South Asia	5	14%
Europe & Central Asia	2	6%
Middle East & North Africa	2	6%
Global	1	3%
Total 36		**100%**

Question 3. Please indicate your professional background.

Professional background	Number of Respondents	Share of Respondents
Public health	18	38%
Business administration	11	23%
Medicine	3	6%
Financial management	1	2%
Accounting	1	2%
Other (please specify)	14	29%
Total 48		**100%**

Questions Addressed to World Bank TTLs and Global Fund Country Programs Cluster Only

Question 4. In which of the following country-level processes of the Global Fund did World Bank staff or consultants participate during the years that you were working on this country? (Sorted in descending order: See Figure 1.)

Responses by Organization	Yes	No	Don't Know	Total
Q4a: Member of the Country Coordinating Mechanism (CCM):				
World Bank Task Team Leader	12	23	7	42
Global Fund – Country Programs Cluster	13	21	2	36
Q4g: Providing formal technical assistance to the Principal Recipients of Global Fund grants:				
World Bank Task Team Leaders	9	28	5	42
Global Fund – Country Programs Cluster	10	19	7	36
Q4b: Helping to prepare grant proposals for submission to the Global Fund:				
World Bank Task Team Leaders	11	27	4	42
Global Fund – Country Programs Cluster	9	20	7	36
Q4f: Helping with the oversight/supervision of Global Fund-financed activities:				
World Bank Task Team Leaders	8	30	4	42
Global Fund – Country Programs Cluster	8	19	9	36
Q4d: Helping to select Principal Recipients to implement approved Global Fund grants:				
World Bank Task Team Leaders	3	34	5	42
Global Fund – Country Programs Cluster	8	22	6	36
Q4e: Helping with financial management/procurement of Global Fund-financed activities:				
World Bank Task Team Leaders	4	34	4	42
Global Fund – Country Programs Cluster	7	23	6	36
Q4c: Participating in the selection of grant proposals for submission from the CCM to the Global Fund:				
World Bank Task Team Leaders	7	30	5	42
Global Fund – Country Programs Cluster	5	19	12	36

Question 5. In what other ways were World Bank staff or consultants involved in country-level activities that directly or indirectly contributed to the work of the Global Fund during the years that you have been working on this region, subregion, or country? (Sorted in descending order: See Figure 2.)

Responses by Organization	Yes	No	Don't Know	Total
Q5c: Supporting ANALYTICAL WORK in relation to STRENGTHENING HEALTH SYSTEMS:				
World Bank Task Team Leaders	25	13	4	42
Global Fund – Country Programs Cluster	22	3	11	36
Q5a: Helping to prepare COUNTRY STRATEGIES such as an AIDS Strategy and Action Plan (ASAP) for combating HIV/AIDS, or malaria:				
World Bank Task Team Leaders	26	12	4	42
Global Fund – Country Programs Cluster	21	5	10	36
Q5b: Supporting ANALYTICAL WORK in relation to COMBATING HIV/AIDS, , or MALARIA:				
World Bank Task Team Leaders	19	18	4	41
Global Fund – Country Programs Cluster	16	7	13	36
Q5d: Helping to BUILD HUMAN RESOURCE CAPACITY to prepare and implement Global Fund grants in the country:				
World Bank Task Team Leaders	18	20	4	42
Global Fund – Country Programs Cluster	10	11	15	36

Figure 1. In which of the following country-level processes of the Global Fund did World Bank staff or consultants participate during the years that you were working on this country? (Percent "Yes")

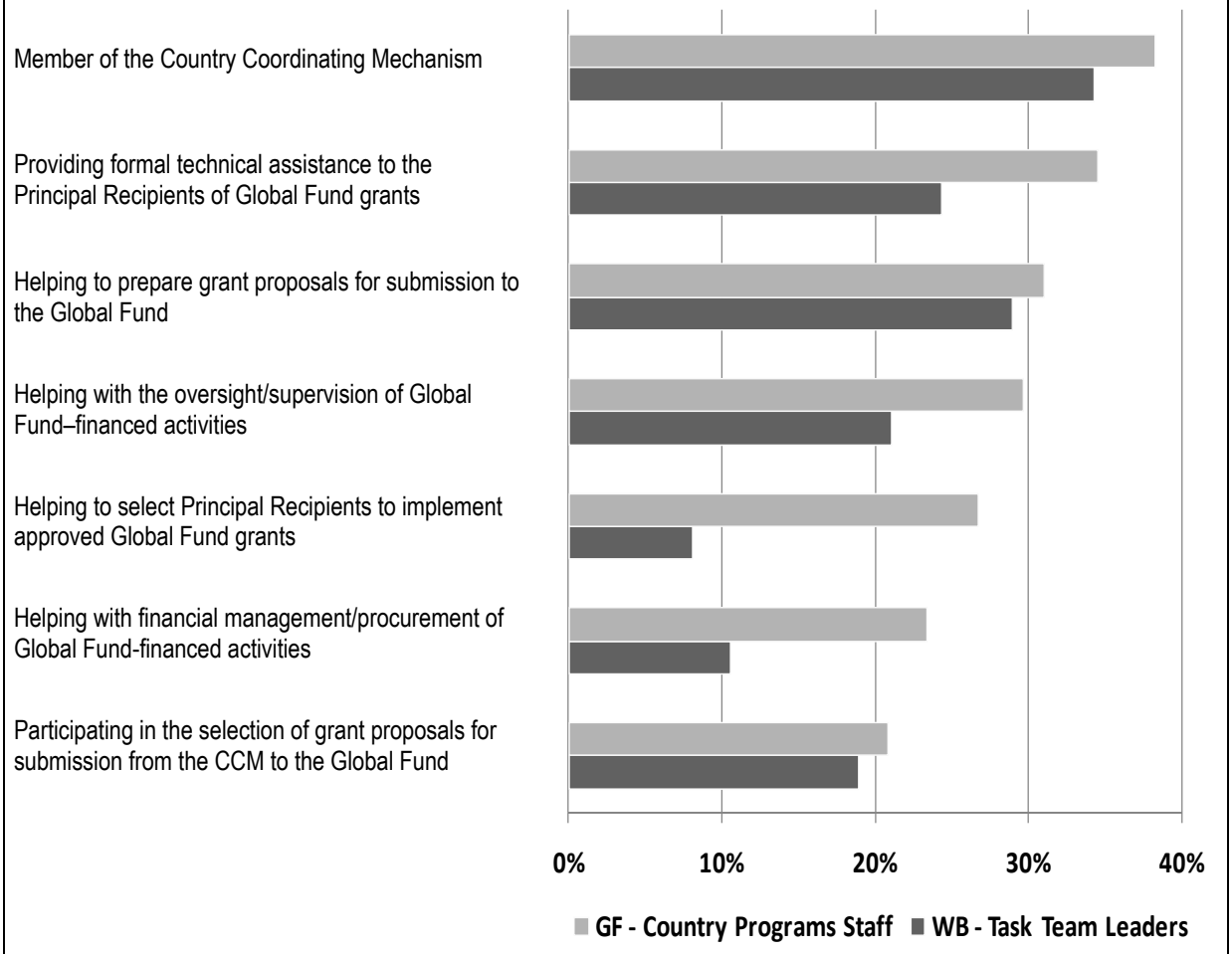
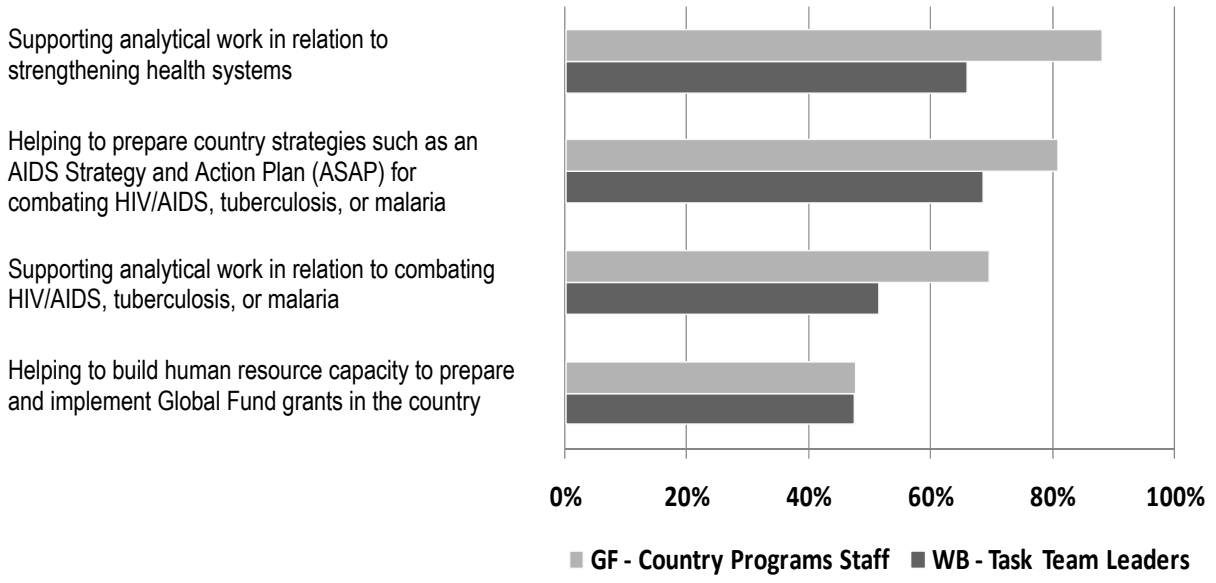


Figure 2. In what other ways were World Bank staff or consultants involved in country-level activities that directly or indirectly contributed to the work of the Global Fund during the years that you were working on this country? (Percent "Yes")



Question 6 (to World Bank TTLs). Which of the following managers/staff/agents of the Global Fund did you contact and work with during the years that you were working on this country? (Sorted in descending order. See Figure 3.)

Responses	Regularly	Occasionally	Not at all	Don't Know	Total
Q6d: Principal Recipients of Global Fund grants, in their role as Principal Recipients:	12	12	18	0	42
Q6c: The Country Coordinating Mechanism (CCM):	11	10	21	0	42
Q6b: The Fund Portfolio Manager (FPM), based at the Global Fund Secretariat in Geneva:	3	17	21	1	42
Q6a: The Global Fund Country Team Leader, based at the Global Fund Secretariat in Geneva:	4	13	24	1	42
Q6e: The Local Fund Agent	3	13	25	1	42

Question 6 (to Global Fund Country Programs Cluster). Which of the following managers and staff of the World Bank did you contact and work with during the years that you have been working on this region, subregion, or country? (Sorted in descending order. See Figure 4.)

Responses	Regularly	Occasionally	Not at all	Don't Know	Total
Q6b: The Task Team Leader (TTL) of World Bank-supported projects in the country:	7	13	14	2	36
Q6c: The Project Implementation Units of World Bank-supported health projects in the country:	2	15	17	2	36
Q6e: Lead Human Development Specialists or Economists:	6	4	21	5	36
Q6d: The Regional Sector Manager for Health, Nutrition and Population:	3	7	22	4	36
Q6a: The Country Director for the country on which you were working:	1	9	22	4	36

Figure 3. World Bank Task Team Leaders: Which of the following managers/staff/ agents of the Global Fund did you contact and work with during the years that you were working on this country?

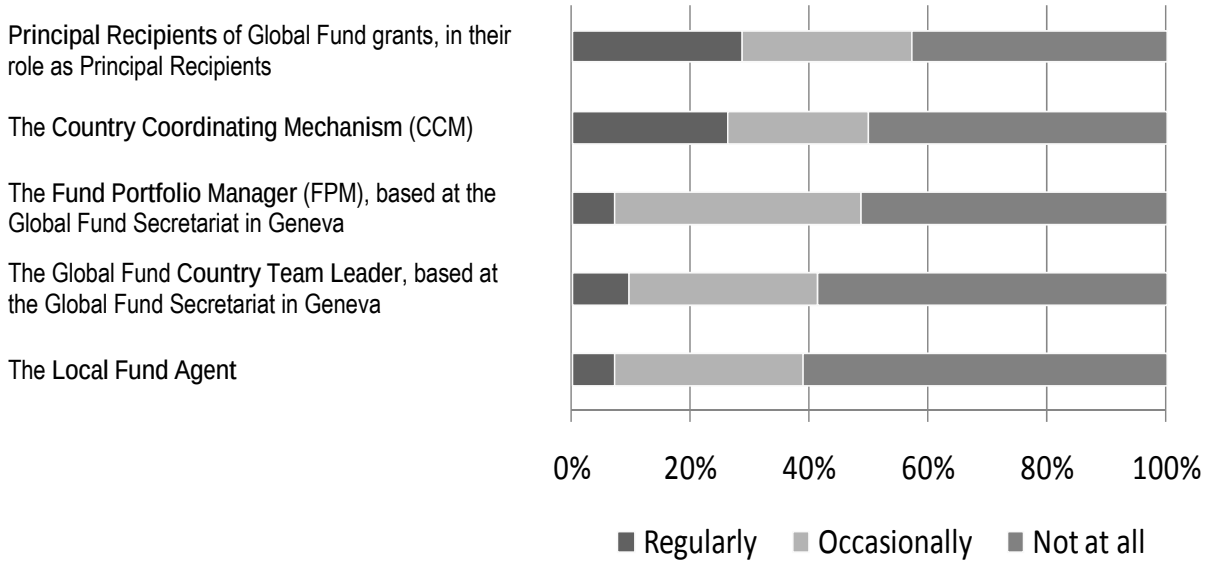
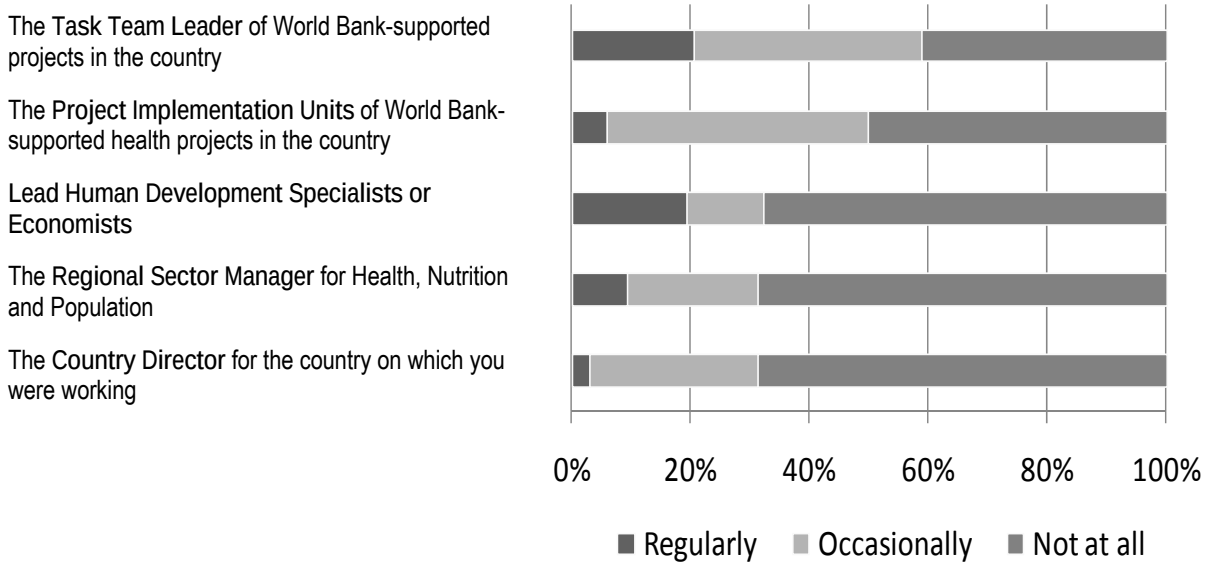


Figure 4. Global Fund – Country Programs Cluster: Which of the following managers and staff of the World Bank did you contact and work with during the years that you have been working on this region, subregion, or country?



Question 7. Overall, how would you best characterize the relationship between the World Bank and the Global Fund during the years that you were working on this country? (Choose only one.)

	Responses by Organization	
	World Bank TTLs	Global Fund – Country Programs Cluster
Collaborative: The two organizations' staff, consultants and agents worked together on common activities in the pursuit of commonly agreed objectives.	2	6
Complementary: The two organizations' staff, consultants, and agents worked alongside each other in the pursuit of common objectives.	9	5
Consultative: The two organizations' staff, consultants, and agents consulted each other regularly in the course of their own activities.	4	5
Sharing information only: The two organizations' staff, consultants, and agents only shared information about each other's activities.	12	4
Unrelated and independent: The two organizations worked independently of each other supporting different health initiatives in the country.	8	8
Competitive: The two organizations competed for business among the same potential clients.	0	2
Other (Please specify.)	7	6
Total	42	36

Figure 5. Overall, how would you best characterize the relationship between the World Bank and the Global Fund during the years that you were working on this country?

Collaborative: The two organizations' staff, consultants and agents worked together on common activities in the pursuit of commonly agreed objectives.

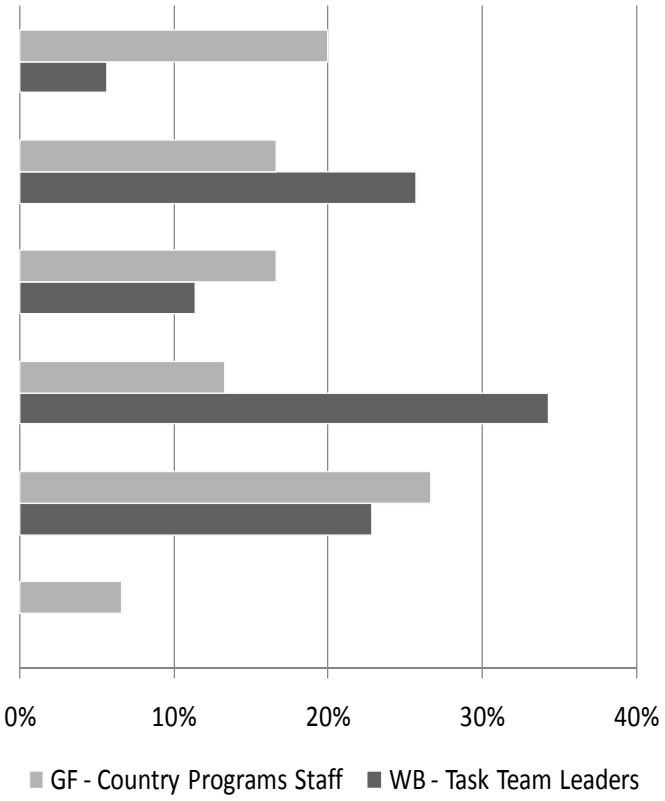
Complementary: The two organizations' staff, consultants, and agents worked alongside each other in the pursuit of common objectives.

Consultative: The two organizations' staff, consultants, and agents consulted each other regularly in the course of their own activities.

Sharing information only: The two organizations' staff, consultants, and agents only shared information about each other's activities.

Unrelated and independent: The two organizations worked independently of each other supporting different health initiatives in the country.

Competitive: The two organizations competed for business among the same potential clients.



Questions Addressed to World Bank TTLs and All Three Clusters of Global Fund Secretariat Staff

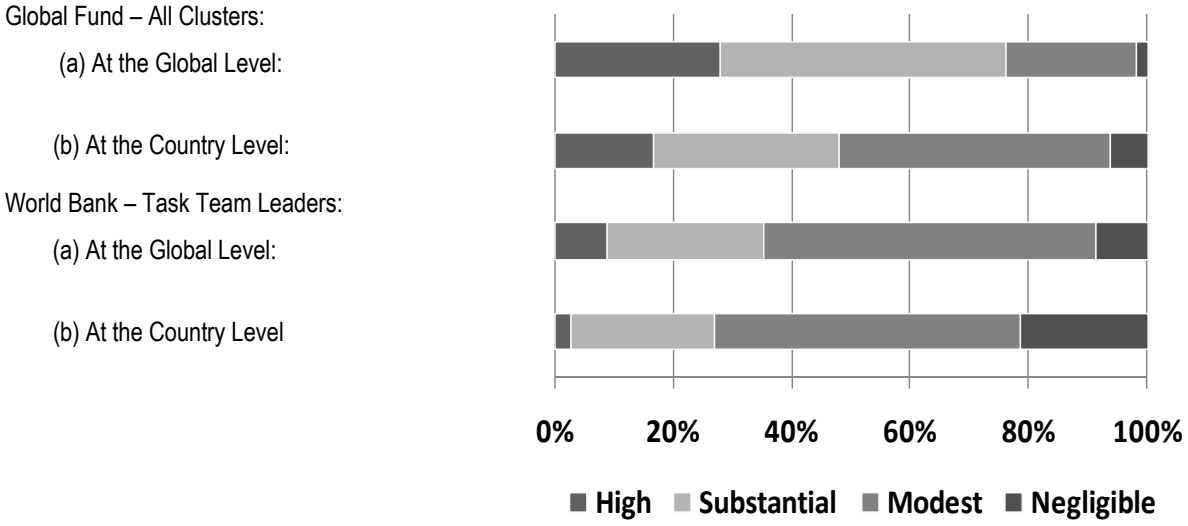
Question 8. To what extent do you consider the World Bank to be a partner of the Global Fund AT THE GLOBAL LEVEL?

Responses by Organization	Negligible	Modest	Substantial	High	No Opinion	Total
World Bank Task Team Leaders	3	19	9	3	5	39
Global Fund – All Clusters	1	11	24	14	0	50

Question 9. To what extent do you consider the World Bank to be a partner of the Global Fund AT THE COUNTRY LEVEL?

Responses by Organization	Negligible	Modest	Substantial	High	No Opinion	Total
World Bank Task Team Leaders	8	19	9	1	2	39
Global Fund – All Clusters	3	22	15	8	2	50

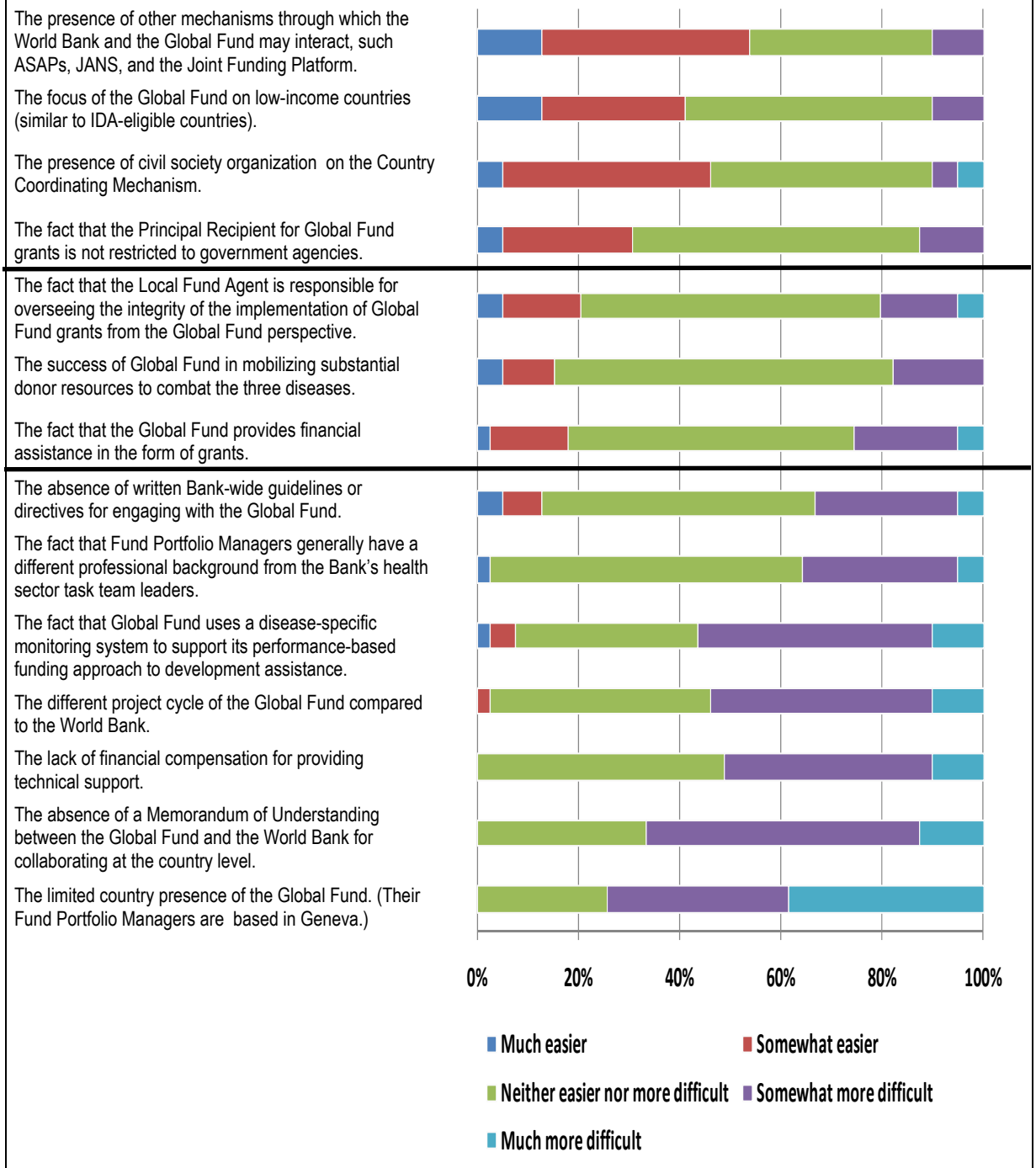
Figure 6. To what extent do you consider the World Bank to be a partner of the Global Fund (a) at the global level and (b) at the country level?



Question 10 (to World Bank TTLs): In your opinion, do the following factors make it easier or more difficult for World Bank staff or consultants to engage with Global Fund-supported activities at the country level? Answer all questions on a five-point scale from "much easier" to "much more difficult". (Sorted in descending order from "much easier" to "much more difficult". See Figure 7)

Response by Sub-question	Much easier	Some-what easier	Neither easier nor more difficult	Some-what more difficult	Much more difficult	Total
Q8n: The presence of other mechanisms through which the World Bank and the Global Fund may interact, such as the AIDS Strategy and Action Plans (ASAPs), the Joint Assessment of National Strategies (JANS), and the Joint Funding Platform for Health Systems Strengthening.	5	16	14	4	0	39
Q8d: The focus of the Global Fund on low-income countries (similar to IDA-eligible countries).	5	11	19	4	0	39
Q8i: The presence of civil society organization on the Country Coordinating Mechanism. (CSOs help prepare grant proposals and may implement some Global Fund-supported activities as Principal Recipients or sub-recipients.)	2	16	17	2	2	39
Q8j: The fact that the Principal Recipient (implementing agency) for Global Fund grants is not restricted to government agencies. (International organizations such as UNDP, CSOs, and universities may be Principal Recipients.)	2	10	22	5	0	39
Q8k: The fact that the Local Fund Agent is responsible for overseeing the integrity of the implementation of Global Fund grants from the Global Fund perspective.	2	6	23	6	2	39
Q8b: The success of Global Fund in mobilizing substantial donor resources to combat the three diseases.	2	4	26	7	0	39
Q8c: The fact that the Global Fund provides financial assistance in the form of grants.	1	6	22	8	2	39
Q8a: The absence of written Bank-wide guidelines or directives for engaging with the Global Fund beyond the general language contained in the 2007 HNP Strategy.	2	3	21	11	2	39
Q8l: The fact that Fund Portfolio Managers generally have a different professional background from the Bank's health sector task team leaders.	1	0	24	12	2	39
Q8h: The fact that Global Fund uses a disease-specific monitoring system to support its performance-based funding approach to development assistance.	1	2	14	18	4	39
Q8g: The different project cycle of the Global Fund compared to the World Bank. (The Country Coordinating Mechanism is responsible for preparing, reviewing and submitting grant proposals to the Global Fund, and for overseeing implementation from the country perspective.)	0	0	19	16	4	39
Q8f: The lack of financial compensation for providing technical support. (This has represented an unfunded mandate.)	0	1	17	17	4	39
Q8m: The absence of a Memorandum of Understanding between the Global Fund and the World Bank for collaborating at the country level.	0	0	13	21	5	39
Q8e: The limited country presence of the Global Fund. (Their Fund Portfolio Managers are based in Geneva.)	0	0	10	14	15	39

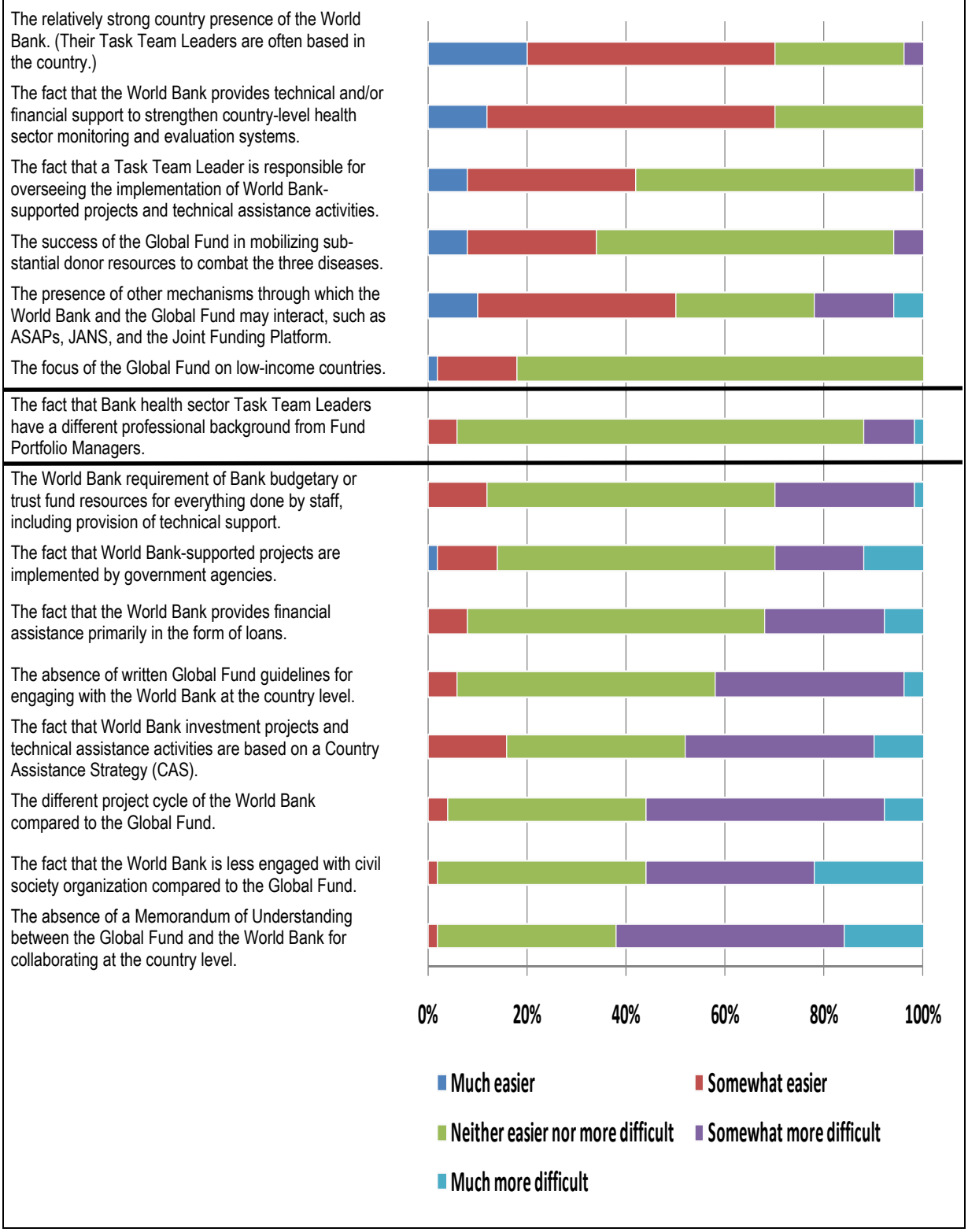
Figure 7. World Bank Task Team Leaders: In your opinion, do the following factors make it easier or more difficult for World Bank staff or consultants to engage with Global Fund-supported activities at the country level?



Question 10 (to Global Fund Staff): In your opinion, do the following factors make it easier or more difficult for Global Fund managers, staff or agents to engage with the World Bank at the country level? Answer all questions on a five-point scale from "much easier" to "much more difficult". (Sorted in descending order. See Figure 8.)

Response by Sub-question	Much easier	Some-what easier	Neither easier nor more difficult	Some-what more difficult	Much more difficult	Total
Q14e: The relatively strong country presence of the World Bank. (Their Task Team Leaders are often based in the country, depending on the size of the Bank's country program.)	10	25	13	2	0	50
Q14i: The fact that the World Bank provides technical and/or financial support to strengthen country-level health sector monitoring and evaluation systems.	6	29	15	0	0	50
Q14l: The fact that a Task Team Leader is responsible for overseeing the implementation of World Bank-supported projects and technical assistance activities.	4	17	28	1	0	50
Q14b: The success of the Global Fund in mobilizing substantial donor resources to combat the three diseases.	4	13	30	3	0	50
Q14o: The presence of other mechanisms through which the World Bank and the Global Fund may interact, such as the AIDS Strategy and Action Plans (ASAPs), the Joint Assessment of National Strategies (JANS), and the Joint Funding Platform for Health Systems Strengthening.	5	20	14	8	3	50
Q14d: The focus of the Global Fund on low-income countries.	1	8	41	0	0	50
Q14m: The fact that Bank health sector Task Team Leaders have a different professional background from Fund Portfolio Managers.	0	3	41	5	1	50
Q14f: The World Bank requirement of Bank budgetary or trust fund resources for everything done by staff, including provision of technical support.	0	6	29	14	1	50
Q14k: The fact that World Bank-supported projects are implemented by government agencies (although governments may enlist NGOs and civil society organizations for implementation).	1	6	28	9	6	50
Q14c: The fact that the World Bank provides financial assistance primarily in the form of loans as opposed to grants.	0	4	30	12	4	50
Q14a: The absence of written Global Fund guidelines or directives for engaging with the World Bank at the country level.	0	3	26	19	2	50
Q14h: The fact that World Bank investment projects and technical assistance activities are based on a Country Assistance Strategy (CAS) negotiated between the World Bank and the Government. (The health sector, including World Bank funding for it and associated budget support for project supervision, has to compete with other sectors for its place in the CAS.)	0	8	18	19	5	50
Q14g: The different project cycle of the World Bank compared to the Global Fund. (Bank-financed projects are generally prepared collaboratively by Government staff and consultants, with World Bank staff support, and negotiated between the Government and the Bank.)	0	2	20	24	4	50
Q14j: The fact that the World Bank is less engaged with civil society organizations compared to the Global Fund.	0	1	21	17	11	50
Q14n: The absence of a Memorandum of Understanding between the Global Fund and the World Bank for collaborating at the country level.	0	1	18	23	8	50

Figure 8. Global Fund: In your opinion, do the following factors make it easier or more difficult for Global Fund managers, staff or agents to engage with the World Bank at the country level?



Question 11 (to World Bank TTLs). The Global Fund and PEPFAR (the U.S. President's Emergency Fund for AIDS Relief) are now the two largest providers of financial resources for combating communicable diseases in developing countries. In your opinion, to what extent has their presence had the following impacts on the World Bank since the two programs were established in 2002 and 2003, respectively?

Response by Sub-question	Much higher	Higher	No Change	Lower	Much lower	Don't Know	Total
World Bank lending for combating communicable diseases is LOWER OR HIGHER than it otherwise would have been.	0	2	4	20	11	2	39
World Bank lending to the overall health sector is LOWER OR HIGHER than it otherwise would have been?	0	2	11	16	8	2	39
World Bank lending for strengthening health systems is LOWER OR HIGHER than it otherwise would have been.	0	5	16	11	4	3	39

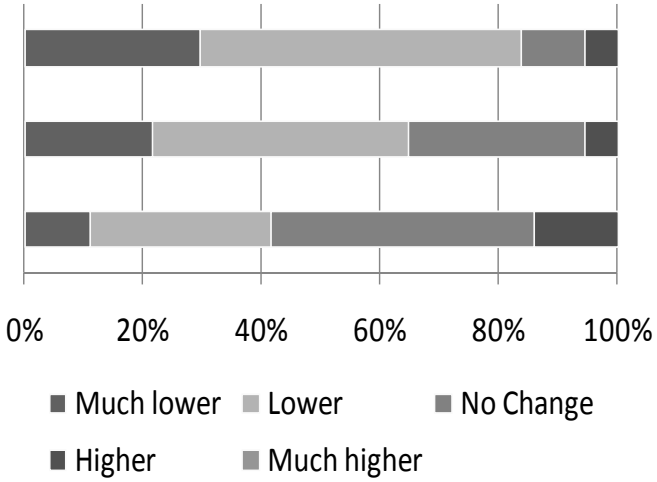
Response by Sub-question	High impact	Substantial impact	Modest impact	Negligible impact	Don't know	Total
The way in which the World Bank operates at the country level has become MORE INCLUSIVE than it otherwise would have been, involving more engagement with civil society organizations.	2	4	13	15	5	39
World Bank lending to the health sector has become MORE RESULTS-FOCUSED than it otherwise would have been.	2	7	8	16	6	39
World Bank-supported activities reflect a greater degree of COUNTRY OWNERSHIP than would otherwise have been the case.	2	8	7	16	6	39

Figure 9. World Bank Task Team Leaders: In your opinion, to what extent has the presence of the Global Fund and PEPFAR had the following impacts on the World Bank since the two programs were established in 2002 and 2003, respectively?

World Bank lending for combating communicable diseases is lower or higher than it otherwise would have been.

World Bank lending to the overall health sector is lower or higher than it otherwise would have been?

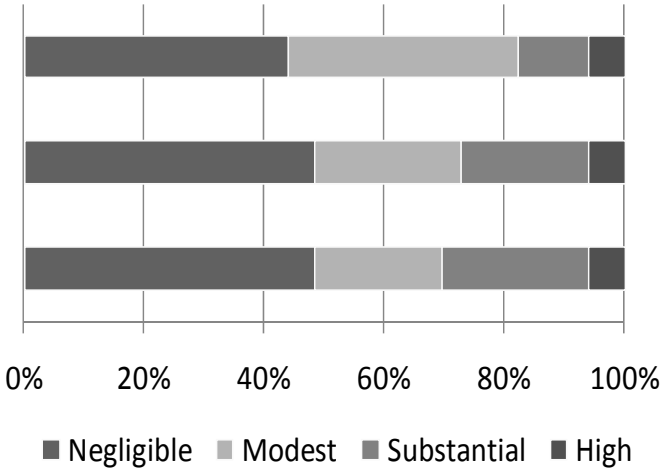
World Bank lending for strengthening health systems is lower or higher than it otherwise would have been.



The way in which the World Bank operates at the country level has become more inclusive than it otherwise would have been, involving more engagement with civil society organizations.

World Bank lending to the health sector has become more results-focused than it otherwise would have been.

World Bank-supported activities reflect a greater degree of country ownership than would otherwise have been the case.

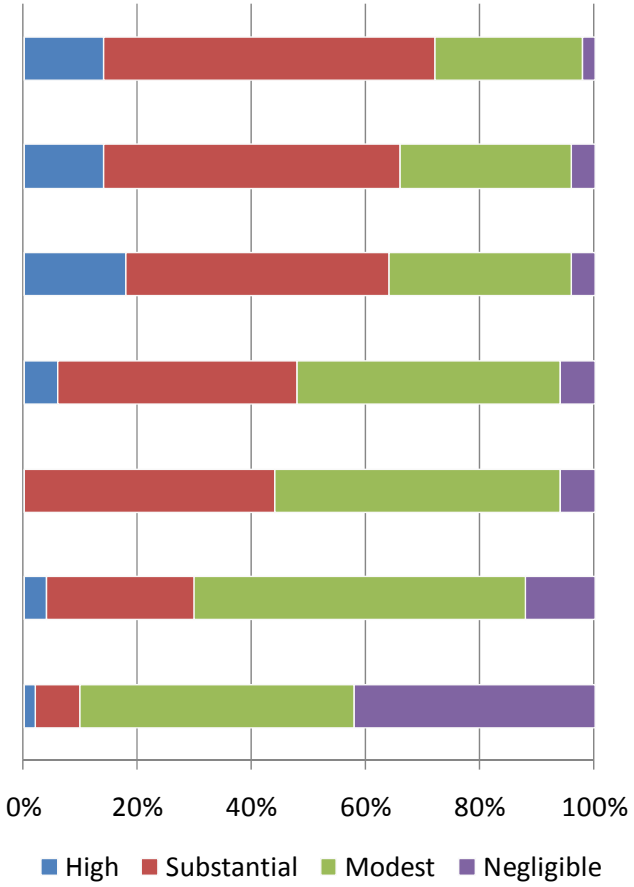


Source: IEG Survey of World Bank HNP Task Team Leaders and Global Fund Secretariat staff, administered in March 2011.

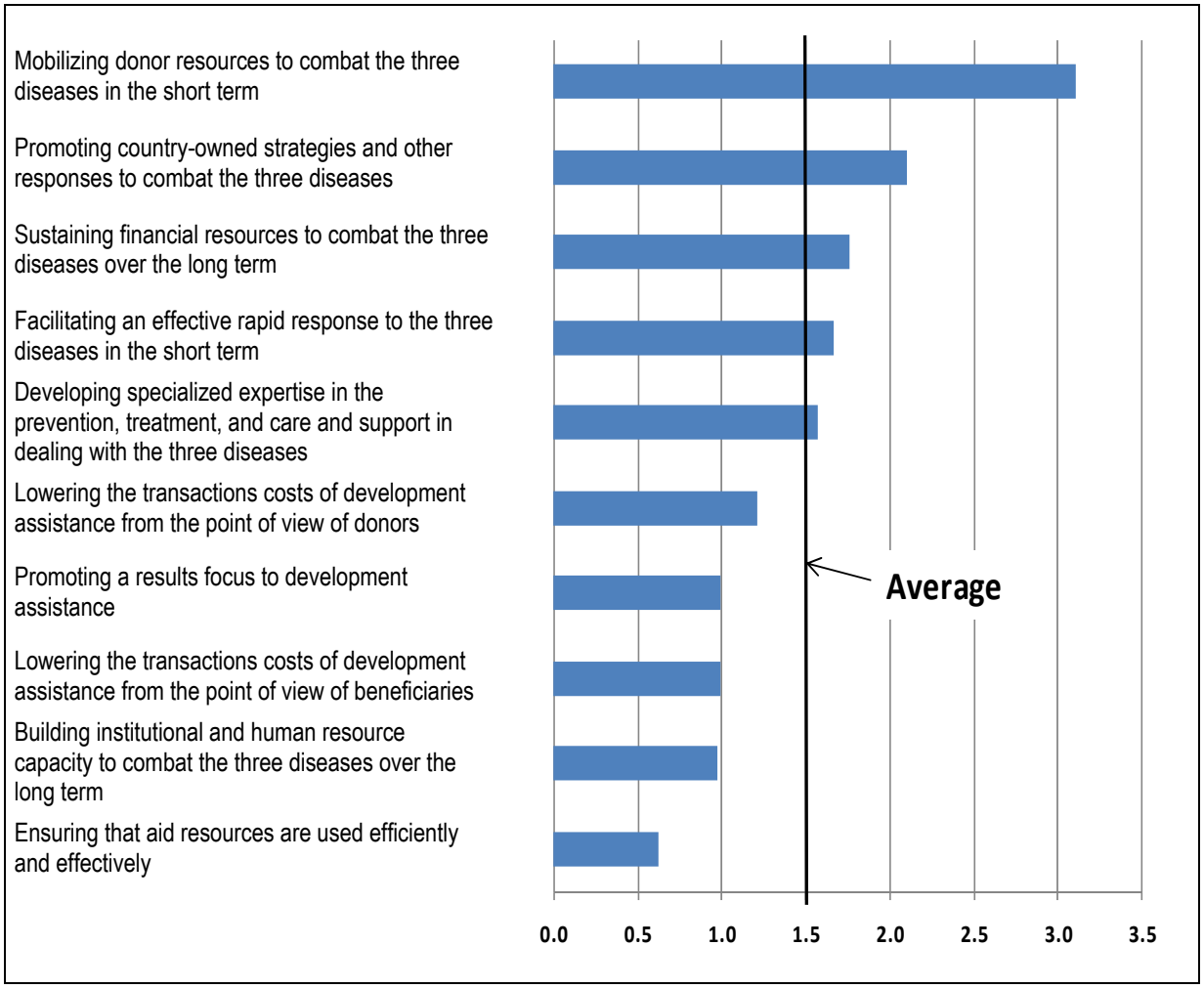
Question 11 (to Global Fund Staff). The Five-Year Evaluation of the Global Fund was completed in May 2009. In your opinion, to what extent have the findings and recommendations of the Five-Year Evaluation had the following impact on the Global Fund? (Sorted in descending order. See Figure 10.)

Response by Sub-question	High	Substantial	Modest	Negligible	Total
The Global Fund has sharpened its practices in the areas of PROCUREMENT, AUDIT, AND ANTI-CORRUPTION.	7	29	13	1	50
The Global Fund has become MORE PROGRAM-BASED, as opposed to individual grant based, in its funding decisions.	7	26	15	2	50
The Global Fund is improving the ALIGNMENT of its grants with each country's planning and budgeting cycles.	9	23	16	2	50
Global Fund grants are providing more support to STRENGTHENING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEMS.	3	21	23	3	50
The Global Fund is devoting more resources to ENHANCING THE CAPACITY AND EFFECTIVENESS OF CCMS in their full range of functions.	0	22	25	3	50
Global Fund grants are putting more focus on DISEASE-PREVENTION ACTIVITIES, as opposed to treatment, care and support activities, taking into account the local context of each epidemic.	2	13	29	6	50
The Global Fund has improved its ability TO ADEQUATELY REWARD AND RETAIN ITS STAFF.	1	4	24	21	50

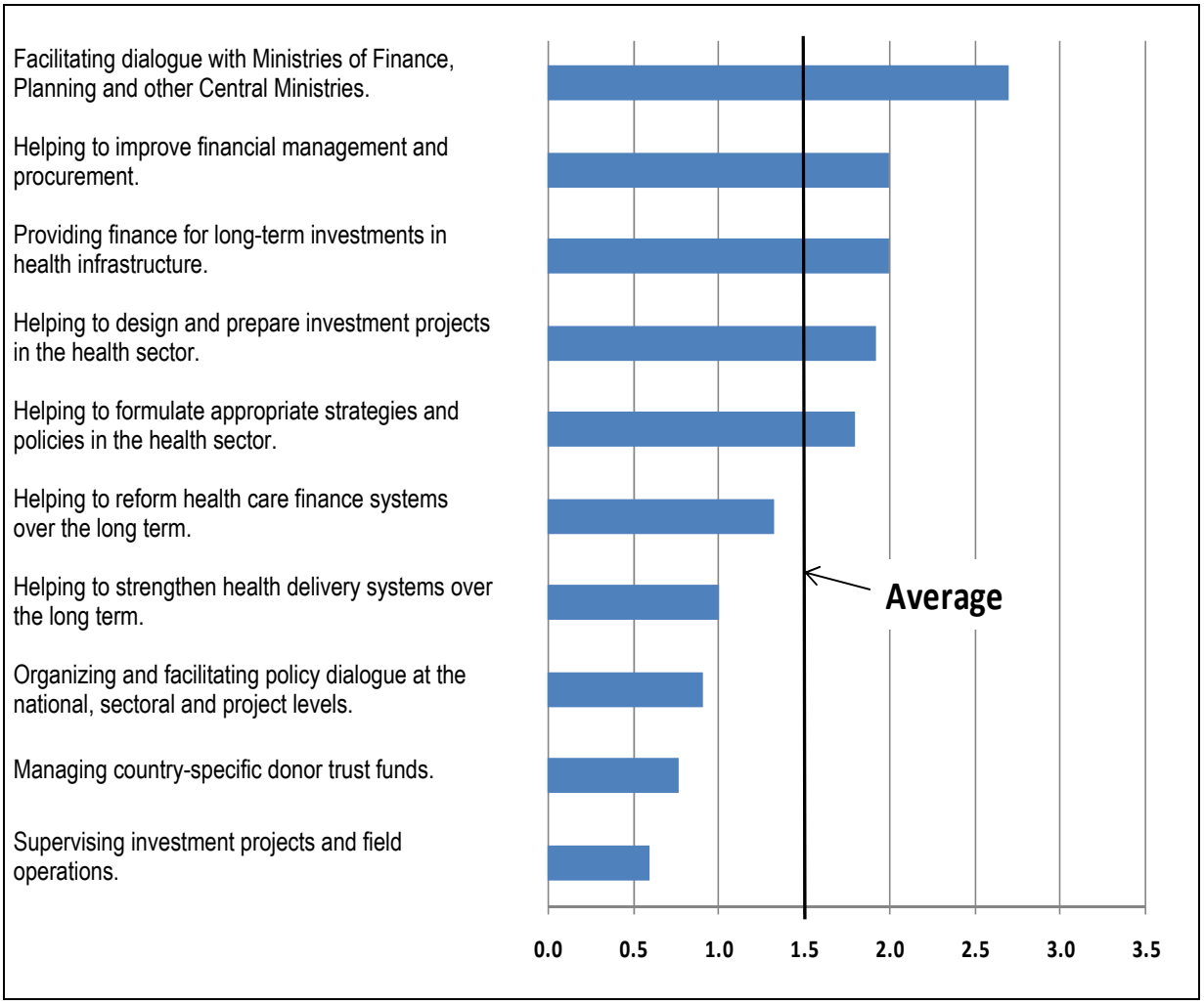
Figure 10. To what extent have the findings and recommendations of the Five-Year Evaluation had the following impacts on the Global Fund?



Question 12 (to World Bank TTLs). Which of the following do you consider the most important COMPARATIVE ADVANTAGES OF THE GLOBAL FUND among international development agencies in terms of achieving positive results for the three diseases at the country level? Please rank the top five in order of importance (1 = most important, 2 = second most important, etc.)



Question 12 (To Global Fund Staff). Which of the following do you consider to be the most important COMPARATIVE ADVANTAGES OF THE WORLD BANK among international development agencies in terms of achieving positive results at the country level?



Question 13. What changes would you like to see in the Global Fund and the World Bank to facilitate greater engagement between the two organizations to achieve positive results at the country level, while also respecting each organization's fundamental purposes and principles?

Responses by Organization	Yes	No	Don't Know	Total
The Global Fund's participating in multi-donor Sector-Wide Approaches (SWAps) in support of nationally-defined programs to combat the three diseases.				
World Bank Task Team Leaders	36	0	3	39
Global Fund – All Clusters	22	20	7	49
The Global Fund's donors establishing a trust fund at the World Bank for financing Bank-supervised technical assistance in support of Global Fund-supported activities.				
World Bank Task Team Leaders	35	1	3	39
Global Fund – All Clusters	16	18	15	49
The Global Fund's co-financing World Bank projects in the health sector, like bilateral donors currently co-finance Bank projects.				
World Bank Task Team Leaders	32	3	4	39
Global Fund – All Clusters	17	26	6	49
The World Bank's being an ex officio member of the Country Coordinating Mechanism wherever the Bank is an active player in the health sector in the country.				
World Bank Task Team Leaders	26	7	6	39
Global Fund – All Clusters	40	4	5	49
The Global Fund's providing direct financing for World Bank-supervised technical assistance activities in support of Global Fund-supported activities.				
World Bank Task Team Leaders	25	5	9	39
Global Fund – All Clusters	19	19	11	49
The two organizations' establishing an active staff exchange program.				
World Bank Task Team Leaders	23	8	8	39
Global Fund – All Clusters	42	3	4	49
The World Bank's playing the role (for a fee) of the Local Fund Agent overseeing selected Global Fund grants, like Bank staff currently oversee projects financed by the Global Environment Facility.				
World Bank Task Team Leaders	21	12	6	39
Global Fund – All Clusters	16	27	6	49
The Global Fund's using the World Bank's Project Implementation Unit as the Principal Recipient for selected Global Fund grants, and World Bank staff overseeing these grants like for Bank projects.				
World Bank Task Team Leaders	20	12	7	39
Global Fund – All Clusters	14	30	5	49

Figure 11. What changes would you like to see in the Global Fund and the World Bank to facilitate greater engagement between the two organizations to achieve positive results at the country level, while also respecting each organization's fundamental purposes and principles? (Percent "Yes")

The Global Fund's participating in multi-donor Sector-Wide Approaches in support of nationally-defined programs to combat the three diseases.

The Global Fund's donors establishing a trust fund at the World Bank for financing Bank-supervised TA in support of Global Fund-supported activities.

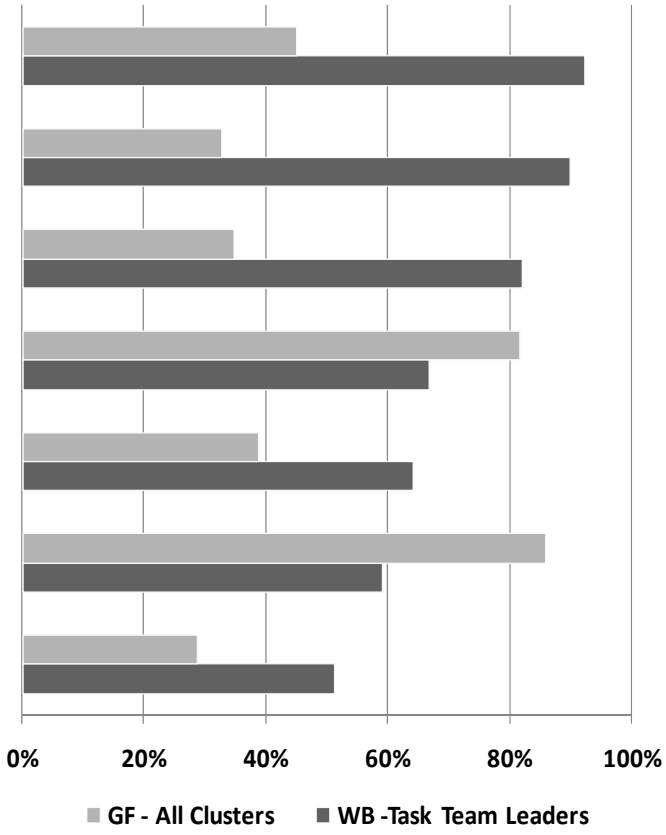
The Global Fund's co-financing World Bank projects n the health sector, like bilateral donors currently co-finance Bank projects.

The World Bank's being an ex officio member of the CCM wherever the Bank is an active player in the health sector in the country.

The Global Fund's providing direct financing for World Bank-supervised TA in support of Global Fund-supported activities.

The two organizations' establishing an active staff exchange program.

The Global Fund's using the World Bank's Project Implementation Unit as the Principal Recipient for selected Global Fund grants, and World Bank staff overseeing these grants like for Bank projects.



Appendix R. Persons Consulted

Name	Position	Organization
Michel Kazatchkine	Executive Director	Global Fund
Debrework Zewdie	Deputy Executive Director	Global Fund
Enrico Mollica	Chief of Staff, Office of the Executive director	Global Fund
George Shakarishvili	Senior Advisor, Health Systems Strengthening	Global Fund
Paula Hacopian	Manager, Board Relations	Global Fund
John Parsons	Inspector General	Global Fund
Lola Dare	Chair, Technical Evaluation Reference Group	Global Fund
Technical Evaluation Reference Group	Group interview and discussion	Global Fund
Heather Allan	Director, Corporate Services Cluster	Global Fund
Josephine M. Mutuku	Director, Human Resources, Administration and Internal Communications Unit	Global Fund
William Patton	Director, Country Programs Cluster	Global Fund
Oren Ginzburg	Unit Director, Quality Assurance and Support Services Unit	Global Fund
David Winters	Manager, Country Coordinating Mechanisms	Global Fund
Cecile Collas	Program Officer, Country Coordinating Mechanisms	Global Fund
Krishna Vadrevu	Program Officer, Country Coordinating Mechanisms	Global Fund
Swarup Sarwar	Unit Director, Asia	Global Fund
Elmar Vinh-Thomas	Regional Team Leader, East Asia & the Pacific	Global Fund
Lelio Marmora	Regional Team Leader, Latin America & the Caribbean	Global Fund
Olivier Cavey	Fund Portfolio Manager, East Asia & the Pacific	Global Fund
Berdnikov Maxim	Fund Portfolio Manager, East Asia & the Pacific	Global Fund
Matias Gomez	Fund Portfolio Manager, Latin America & the Caribbean	Global Fund
Annelise Hirschmann	Fund Portfolio Manager, Latin America & the Caribbean	Global Fund
Luca Ochini	Fund Portfolio Manager, Latin America & the Caribbean	Global Fund
Artashes Mirzoyan	Fund Portfolio Manager, South & West Asia	Global Fund
Daniela Mohaupt	Fund Portfolio Manager, South & West Asia	Global Fund
S. Scott Morey	Fund Portfolio Manager, South & West Asia	Global Fund
Sylwia Murray	Fund Portfolio Manager, South & West Asia	Global Fund
Patience Musanhu	Fund Portfolio Manager, Southern Africa	Global Fund

Name	Position	Organization
Alberto Passini	Fund Portfolio Manager, Southern Africa	Global Fund
Tatanya Peterson	Fund Portfolio Manager, Southern Africa	Global Fund
Christoph Benn	Director, External Relations and Partnerships Cluster	Global Fund
Jon Liden	Unit Director, Communications Unit	Global Fund
Sandii Lwin	Manager, Bilateral and Multilateral Partnerships Team, Partnerships Unit	Global Fund
Rifat Atun	Director, Strategy, Performance and Evaluation Cluster	Global Fund
Olusoji Adeyi	Unit Director, Affordable Medicines Facility for Malaria (AMFm) Unit	Global Fund
Edward Addai	Unit Director, Monitoring and Evaluation Unit	Global Fund
Sai Kumar Pothapregada	Sr. Technical Officer, Monitoring and Evaluation Unit	Global Fund
Mary Bendig	Sr. Evaluation Officer, Monitoring and Evaluation Unit (?)	Global Fund
Daniel Low-Beer	Director, Performance, Impact and Effectiveness Unit	Global Fund
Kirsi Viisainen	Manager, Program Effectiveness Team	Global Fund
Ruwan De Mel	Unit Director, Strategy and Policy Development Unit	Global Fund
Sarah L. Churchill	Manager, Country Proposals Team	Global Fund
Geoffrey Lamb		Gates Foundation
Todd Summers		Gates Foundation
Helen Evans	Deputy Chief Executive Officer	GAVI Alliance
Peter Hansen	Head, Monitoring & Evaluation, Policy and Performance	GAVI Alliance
Abdallah Bchir	Senior Program Officer, Evaluation	GAVI Alliance
Joseph Fortunak	Assoc Prof Chemistry & Pharmaceutical Sciences	Howard University
Martin Vaessen	Sr. Vice President	MACRO International
Leo Ryan	Vice President	MACRO International
Sangheeta Mukherji	Lead Evaluator for Study Area 2	MACRO International
James Sherry	Lead Evaluator for Synthesis Report	MACRO International

Name	Position	Organization
Sebastian Mollo di Massa	Intelligence Director	Pharmaceutical Security Institute (PSI)
Susan Griffey	Vice President & Director, Evaluation Center	Social and Scientific Systems
Rosemary Barber-Madden	Team Lead, Professor Emerita, Columbia University, School of Public Health	Social and Scientific Systems
William Brieger	Professor, Health Systems Program, Department of International Health, Johns Hopkins	Social and Scientific Systems
Alden Zecha	CFO and Strategist	Sproxil Ltd
Paul De Lay	Deputy Executive Director, Program	UNAIDS
Tim Martineau	Director, Technical and Operational Support Department	UNAIDS
Deborah Rugg	Chief, Monitoring and Evaluation, Evidence, Monitoring and Policy Department	UNAIDS
Nils Daulaire	Director of Global Health Affairs	U.S. Department of Health and Human Services
Ties Boerma	Director, Health Statistics and Informatics	World Health Organization
Timothy Evans	Assistant Director- General, Information, Evidence, and Research	World Health Organization
Hiroki Nakatani	Assistant Director-General, HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases.	World Health Organization
Ran Wei	Medical Officer, HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases	World Health Organization
Cristian Baeza	Sector Director, HDNHE, June 2010 – present	World Bank
Julian Schweitzer	Sector Director, HDNHE, 2007–2010	World Bank
Mukesh Chawla	Sector Manager, HDNHE, 2008–2011	World Bank
Nicole Klingen	Sector Manager, HDNHE, July 2011 – present	World Bank
Ok Pannenborg	Senior Health Advisor, HDNHE	World Bank
Armin Fidler	Adviser, Policy and Strategy, HDNHE	World Bank
Peter Berman		World Bank
Finn Schleimann	Sr. Health Specialist, HDNHE	World Bank

Name	Position	Organization
David Wilson	Program Director, Global HIV/AIDS Program	World Bank
Janet Leno	ASAP Coordinator, Caribbean, East/Southern Africa, Asia	World Bank
Rosalia Rodriguez-Garcia	Senior Monitoring and Evaluation Specialist, HDNGA	World Bank
Susan McAdams	Director, CFPMI	World Bank
Alexandru Cebotari	Financial Officer, CFPMI	World Bank
Veronique Bishop	Sr. Financial Officer, CFPMI	World Bank
Siv Tokle	Sr. Operations Officer, ENVGC	World Bank
Andrea Stumpf	Lead Counsel, LEGCP	World Bank
Yvonne Tsikata	Country Director, Caribbean Countries	World Bank
Eva Jarawan	HNP Sector Manager, Africa Region	World Bank
Juan Peblo Uribe	HNP Sector Manager, East Asia & the Pacific	
Keith Hansen	HDN Sector Director, Latin America & the Caribbean Region	World Bank
Joana M. Godinho	HNP Sector Manager, Latin American and Caribbean Region	World Bank
Akiko Maeda	HNP Sector Manager, Middle East & North Africa Region	World Bank
Julie McLaughlin	HNP Sector Manager, South Asia Region	World Bank
John May	Lead Population Specialist, Africa Region	World Bank
Patrick Osewe	Lead Specialist, AFTHE	World Bank
Noel Chisaka	Sr. Public Health Specialist, AFTHE	World Bank
Vincent Turbat	Consultant, EASHD	World Bank
Hope Phillips	Sr. Operations Officer, EASHH	World Bank
Patricio Marquez	Lead Health Specialist, ECSH1	World Bank
Nedim Jaganjac	Sr. Health Specialist, ECSH1	World Bank
Marcelo Bortman	Sr. Public Health Specialist, Latin America and Caribbean Region	World Bank
Rafael Cortez	Sr. Health Economist, LCSHH	World Bank
Fernando Lavadenz	Sr. Health Specialist, LCSHH	World Bank
Shyan Chau	HNP task team leader for Caribbean Region	World Bank
Fernando Montenegro Torres	Sr. Economist, LCSHH	World Bank

Persons Consulted during the Country Visit to Brazil, April 2010

Person	Position	Organization
Government of Brazil		
Dr. Draurio Barreira	Head	National Tuberculosis Program, Secretary for Health Surveillance, Epidemiological Surveillance Department, Ministry of Health
Eduardo Luiz Barbosa	Deputy Director	STS and AIDS Department, Secretariat for Health Surveillance, Ministry of Health
Jose Lazaro de Brito Ladislau	Coordinator	National Malaria Program, Ministry of Health, Brasilia
Global Fund Implementers and Agents		
Nadja Faraone	General Coordinator	Movimento Social de Tuberculose, São Paulo, and Vice Chair of Country Coordinating Mechanism
Dr. Germano Gerhardt Filho	President	Fundação Ataulpho de Paiva (FAP) and Principal Recipient for the Global Fund Project on TB
Dr.Cristina Boaretto	Tuberculosis Project Coordinator, the Global Fund	Fundação para o Desenvolvimento Cientifico e Tecnologico em Saude (FIOTEC)
Alexandre Milagres		Fundação Ataulpho de Paiva (FAP) and Principal Recipient for the Global Fund Project on TB
Patricia Muricy, and Mariangela Louvain Pinudo		Enterprise Risk Services, Deloitte Touche Tohmatsu, Local Fund Agent
Dr. Carlos Eduardo P. Corbett	Global Fund Malaria Project Coordinator	Fundação Faculdade de Medicina (FFM), Universidade de São Paulo
Neusa T. C. Burbarelli	Manager	Health and Work Safety of editora abril and Chairpeson of the Conselho Empresarial de AIDS, CENAIDS
Dr. Alexandre de Marca		Gerente de Saude e Bem Estar, Confederação Nacional de Comercio de Bens, Serviços e Turismo
Dr. Elza Berquió	Demography and Family Health Researcher	Centro Brasileiro de Analise e Planejamento, CEBRAP
Cristiane Jose	Manager	Saude e Qualidade de Vida, Walter Duran, Manager of Social Responsibility of Phillips to Brasil
World Bank		
Michele Gragnolati	Sector Leader, HD	World Bank Brasilia Office
Romero Rocha	Health Economist, HD	World Bank Brasilia Office

Person	Position	Organization
Alexandre Abrantes	Brazil Portfolio Manager, former HNP Sector Manager	
Makhtar Diop	Country Director for Brazil	
Development Partners		
Patricia Paine	Senior Technical Advisor	Health Program, USAID, Brazil, U.S. Embassy
Dr. Pedro Chequer	Country Coordinator	UNAIDS, Brazil
Naiara G. da Costa Chaves	Program Officer	UNAIDS, Brazil
Alfonso Tenorio Gnecco	Profissional Internacional, Tuberculose	Pan American Health Organization-WHO, Brazil

Persons Consulted during the Country Visit to Burkina Faso, April 2010

Person	Position	Organization
Government of Burkina Faso		
Zacharie Balima	Coordinator	Program d'Appui au Développement Sanitaire (PADS)
Sary Mathurin Dembele	Manager	National Tuberculosis Program
Seydou K. Kabre	Management Coordinator	CNLS
Estelle Kabore	Liaison	Direction Générale de la Coopération, Ministère de l'Economie et des Finances.
Lene Sebgo	Director General	Direction Générale de la Coopération, Ministère de l'Economie et des Finances.
Joseph Tiendrebeogo	Director	CNLS
Wamarou Traore	Team Leader	CNLS
Global Fund Implementers and Agents		
Victor Bonkoungou	Tuberculosis Program Officer	PAMAC
Cheik Coulibaly	Consultant	Swiss TPH
Flore-M.Gisele Coulibaly	Tuberculosis Project Officer	PAMAC
Mamadou Dao	HIV/AIDS Prevention Program Officer	PAMAC
Demba Diack	Institutional Support Program Officer	PAMAC
Odette Ky-Zerbo	Evaluation Program Officer	PAMAC

Person	Position	Organization
Christine Kafando	Vice-Chair of CCM	
Boureime Kologo	Director of Operations	PAMAC
Amadou Ouedraogo	Malaria Program Officer	PAMAC
Jean Pare	Pharmacist	Pharmacie de la Concorde
Sedogo	Director	Comite National Catholique de lutte contre le SIDA
Eric Somda	Secretary	CCM
Agathe Sy	Program Director for Strategy	PLAN International
Mahamadou Tounkara	Resident Representative	PLAN International
Kaspar Weiss (Consulted By Telephone)	Senior Public Health Specialist	Swiss TPH
World Bank		
H Ousemane Diadie	Task Team Leader	Burkina Faso Country Office
Galina Sotirova	Country Manager	Burkina Faso Country Office
Jean-Jacques St Antoine	Health Cluster Leader	AFTHE
Development Partners		
Francoise Bigirimania	HIV/AIDS Program Officer	WHO
Djamila Khady Cabral	Representative	WHO
Awa Faye	Country Coordinator	UNAIDS
Paulina Julia	Nurse	United States Embassy
Souhaib Khayati	Program Officer	Cooperation Italienne
Haritiana Rakotomamonjy	HIV/AIDS Program Director	UNICEF
Herve Peries	Resident Representative	UNICEF
Jan Van Der Horst	Health Advisor	Embassy of the Netherlands

Persons Consulted during the Country Visit to Cambodia, May 2010

Person	Position	Organization
Government of Cambodia		
Professor Eng Huot	Secretary of State for Health and Deputy Minister of Health	Ministry of Health
Dr. Tia Phalla	Vice Chair national AIDS Authority Director	National AIDS Authority
Global Fund Implementers and Agents		
Dr. Mao Tan Eang	Director	National Center for TB and Leprosy Control
Dr. Dong Socheat	Director	National Center for Parasitology, Entomology and Malaria Control
Dr. Mean Chhivun	Director	National Center for HIV/AIDS, Dermatology and STD
Dr. Ly Penh Sun	Deputy Director	National Center for HIV/AIDS, Dermatology and STD
Dr. Or Vandine	Manager, Principal Recipient of Global FundATM	MOH
Dr. Kiv Sokha	Chief, M&E Team PR	MOH
Dr. Chiv Bunthy	Secretariat Manager	CCC, Global FundATM
Kith Vanthy	Administrative Officer	CCC, Global FundATM
Dr. Sim Somuny	Executive Director	MEDICAM
Phon Yun Sakara	CCC Chair, and Director HIV/AIDS Program,	CCC Vice Chair and PACT Cambodia
Dr. Kim Souvaun	Local Fund Agent	Swiss Tropical Institute
World Bank		
Annette Dixon	Country Director	Cambodia, Lao PDR, Malaysia, Thailand and Representative for Myanmar
Qimiao Fan	Country Manager,	Cambodia World Bank
Jeeva Perumalpillai-Essex	Sustainable Development Leader	South East Asia
Stephane Guimbert	Senior Country Economist,	Cambodia
Timothy Johnston	Senior Health Specialist	Cambodia
Luc Lecuit	Sr. Operations Officer	Cam Cambodia, Lao PDR, Malaysia, Thailand and Representative for Myanmar

Person	Position	Organization
Development Partners		
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Dr. Steven Bjorge	Scientist, Malaria and Vector Borne Diseases	WHO Cambodia
Dr. Rajendra Yadav		WHO Cambodia
Savina Ammassari	M&E Advisor	UNAIDS Cambodia
Misa Tamura	Senior Advisor	Embassy of Japan
Sasaki Yumiko	Project Formulation Advisor (Health)	JICA Cambodia
Dominique Freslon	Conseiller de Cooperation et d'Action Culturelle	Embassy of France
Gilles Angles	Charge de Mission de Cooperation Multilaterale	Embassy of France
Others		
Kheng Sophal	Executive Director	Positive Women of Hope Organization
Keo Chen	National Coordinator	Cambodian People Living with HIV/AIDS Network
Ly Tek Heng	Chair	Cambodia Business Coalition on AIDS Garment Manufacturers Assoc
Vara Kong	Chairman	Cambodia Business Coalition on AIDS CBCA
Vuthuy Huy	Executive Manager	CBCA
NGO members of HIV AIDS Coordinating Committee		

Persons Consulted during the Country Visit to Nepal, May 2010

Person	Position	Organization
Dr. Krishna Kumar Rai	Director	National Center for AIDS and STD Control
Dr. Ramesh Kumar Kharel	Deputy Director	National Center for AIDS and STD Control
Dr. Shyam S. Mishra	Vice Chairperson	HIV/AIDS and STI Control Board
Mr. Damar Prasad Ghimire	Director/Member	HIV/AIDS and STI Control Board
Mr. Rajiv Kafle	Vice Chair (also) Director	Country Coordinating Mechanism National Association of People Living with HIV/AIDS
Mr. Shailesh Dhimal	Administration and Finance Officer	National Association of People Living with HIV/AIDS
Mr. Sunil Pant	Member (also) Director	Nepal Constituent Assembly Blue Diamond Society and Federation of Sexual and Gender Minorities

Person	Position	Organization
Mr. Krishna Prasad Bista	Director General	Family Planning Association of Nepal
Dr. Giridhari Sharma Paudel	Deputy Director General and Chief of the Program	Family Planning Association of Nepal
Dr. Pulki Chaudhary	Director, Global Fund Project	Family Planning Association of Nepal
Dr. Navin Thapa	Director Resource Mobilisation and External Affairs	Family Planning Association of Nepal
Dr. Maria Elena G. Filio-Borromeo	Country Coordinator, Nepal and Bhutan	UNAIDS
Dr. Lin Aung	Representative, Nepal	WHO
Dr. George Ionita	Project Manager HIV/AIDS Programme Management Unit	UNDP
Ms. Savita Acharya	Senior Programme Officer HIV/AIDS Programme Management Unit	UNDP
Ms. Anne M. Peniston	Director, Office of Health and Family Planning	USAID
Mr. Clifford Lubitz	Deputy Director, Office of Health and Family Planning	USAID
Ms. Susan Clapham	Country Director (?)	DFID
Ms. Susan Goldmark	Country Director	World Bank
Albertus Voetberg	Lead Health Specialist	World Bank
Dr. Nastu Pd. Sharma	Health Sector Specialist	World Bank
Mr. Madan K. Sharma	Local Funding Agent	PricewaterhouseCoopers

Persons Consulted during the Country Visit to the Russian Federation, June 2010

Person	Position	Organization
Government of the Russian Federation		
Anna V. Korotkova	Deputy Director, International Affairs	Central Research Institute for Health Organization and Information, Ministry of Health and Social Development
Global Fund Implementers and Agents		
Urban Weber	Unit Director	Global Fund, Geneva
Dmitriy A. Goliaev	Global Fund Project Director	Russian Health Care Foundation

Person	Position	Organization
Tatiana Ye. Fomicheva	Acting Director, Tuberculosis Component	Russian Health Care Foundation
Dimitry Sukhov	Manager, Advisory Performance	KPMG, Moscow, Local Fund Agent
Boris Lvov	Partner, Performance and Technology, Russia and CIS	KPMG, Moscow, Local Fund Agent
Valentin I. Pokrovsky	Director	Central Research Institute for Epidemiology
	Chair	Country Coordinating Mechanism
Ludmila V. Korshunova	CCM Secretary	Country Coordinating Mechanism
World Bank		
Patricio Marquez	Lead Health Specialist	World Bank, Washington
Vladimir A. Grechuka	Acting Director	ZAO Prospect
	Former Director	World Bank TB/AIDS Project, Moscow
Development Partners		
Dmitry Pashkevitch	Medical Officer/Coordinator, TB Control Programme	World Health Organization
Elena Vovc	Medical Officer HIV/AIDS Programme Coordinator	Health Organization
Denis Broun	Regional Director	UNAIDS, Moscow
Lisa Carty	Global Health Program	Center for Strategic and International Studies
	Former Regional Director	UNAIDS, Moscow
Cheryl Kamin	Health Specialist	USAID, Moscow
Nina B. Khurieva	Tuberculosis Program Specialist	USAID, Moscow
Alexander Golubkov	Tuberculosis Specialist Former member of Tomsk CCM	Partners in Health, Boston
Evgeniy Petunin	Programme Director	Russian Harm Reduction Network
Alexei V. Bobrik	Executive Director	Open Health Institute, Moscow
Grigory V. Volchenkov	Oblast Chief Doctor	Vladimir Oblast, Tuberculosis Dispensary
Andrei G. Zirin	Director	Department of Health, Vladimir Oblast
Judyth Twigg	Professor of Government and Public Affairs	Virginia Commonwealth University

Persons Consulted during the Country Visit to Tanzania, June 2010

Person	Position	Organization
Government of Tanzania		
Dr. Alex M. Mwita	Program Manager	National Malaria Control Program, Ministry of Health and Social Welfare
Dr. Fatma Mirisho	Chairperson and Executive Director	TACAIDS EM
Mrs. Blandina Nyoni	Permanent Secretary	Ministry of Health
Nick Brown	Team Leader	National Malaria Control Program, Ministry of Health and Social Welfare
Dr. Donan W. Mmbando	Director	Preventive Services, Ministry of Health and Social Welfare
Dr. Bwijo A. Bwijo	Global Fund Coordinator	TACAIDS, Prime Minister's Office
Dr. S.M. Egwaga	Program Manager	National Tuberculosis and Leprosy Program, Ministry of Health and Social Welfare
Global Fund Implementers and Agents		
Mr. Nada A. Margwe	Director	PriceWaterhouseCoopers, Local Fund Agent
Focus Lutinwa	Director	Price Waterhouse Coopers, Local Fund Agent
Dr. Amos Nyirenda	Program manager	Global Fund to Fight AIDS, TB, Malaria
World Bank		
Chyo Kanda	Senior Operations Officer	World Bank Country Office
Denis Biseko	Senior PSM Specialist	World Bank Country Office
Emmanual Malangalila	Consultant on Health	World Bank Country Office
John McIntire	Country Director	World Bank Country Office
Development Partners		
Luc Barriere-Constantin	Country Coordinator	UNAIDS
Elise Jensen	HIV/AIDS Team Leader	USAID/Tanzania
Robert F. Cunnane	Mission Director	USAID/Tanzania
Richard Kasasela	Executive Director	AIDS Business Coalition
Dan Craun-Selka	Country Director	PACT Tanzania
Daniel Crapper	Executive Director	Population Services International (PSI)
Christopher Armstrong	Counsellor	Development-Health & HIV/AIDS, High Commission of Canada
Dr. Rik Peeperkorn	First Secretary	Health & HIV/AIDS, Embassy of the Kingdom of the Netherlands
Joan Chamungu	National Coordinator	Tanzania Network of Women Living with HIV/AIDS

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Volume #6,	Issue #1:	The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund

GPR

The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002 to mobilize large-scale donor resources for the specific purpose of reducing infections, illness, and death caused by the three diseases. The Global Fund has since become the largest of the 120 global and regional partnership programs in which the World Bank is currently involved, disbursing more than $3 billion in grants to developing and transition countries in 2010.

The World Bank plays three major roles in the Global Fund: (a) as the trustee of donor contributions to the Global Fund, (b) in the corporate governance of the program, and (c) as a development partner at the global and country levels. This Review found that the Bank has had extensive engagement with the Global Fund at the global level through the Global HIV/AIDS Program, the International Health Partnership, and related initiatives, but has been less engaged at the country level.

The Global Fund has fostered new approaches to development assistance. This Review found that its Country Coordinating Mechanisms have successfully brought country-level stakeholders together to submit grant proposals to the Global Fund, but have lacked the authority and the resources to exercise effective oversight of grant implementation. The situation has improved in recent years in terms of the World Bank and other partners' providing technical assistance in support of Global Fund activities, but these technical support functions need to be defined with greater clarity and formality within the context of improved donor harmonization.

Collective donor efforts have contributed to increased availability and use of disease-control services, particularly for HIV/AIDS, and increased coverage of affected communities. However, sustaining client countries' disease-control programs in the face of decelerating external support will require a substantially more coordinated approach than has occurred to date. The scarce resources available to fight the three diseases — including those raised by each country and those provided by external partners — need to be allocated collectively and proactively in each country in accordance with a long-term strategy for fighting each disease that is agreed among all the principal stakeholders.

IEG
Independent Evaluation Group