GPR

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

—VOLUME 2: APPENDIXES—

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 2: Appendixes

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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.

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

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	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

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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

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		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.

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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.

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	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%

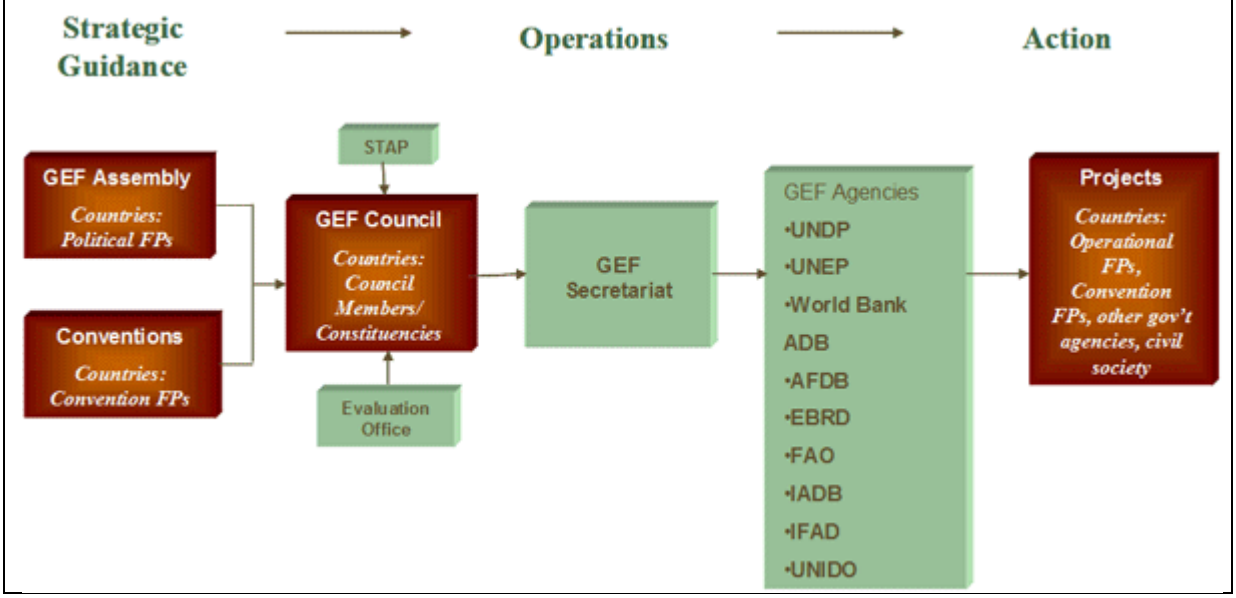
Source: GEF Evaluation Office, Fourth Overall Performance Study of the GEF, 2010, p. 8.

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).

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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.

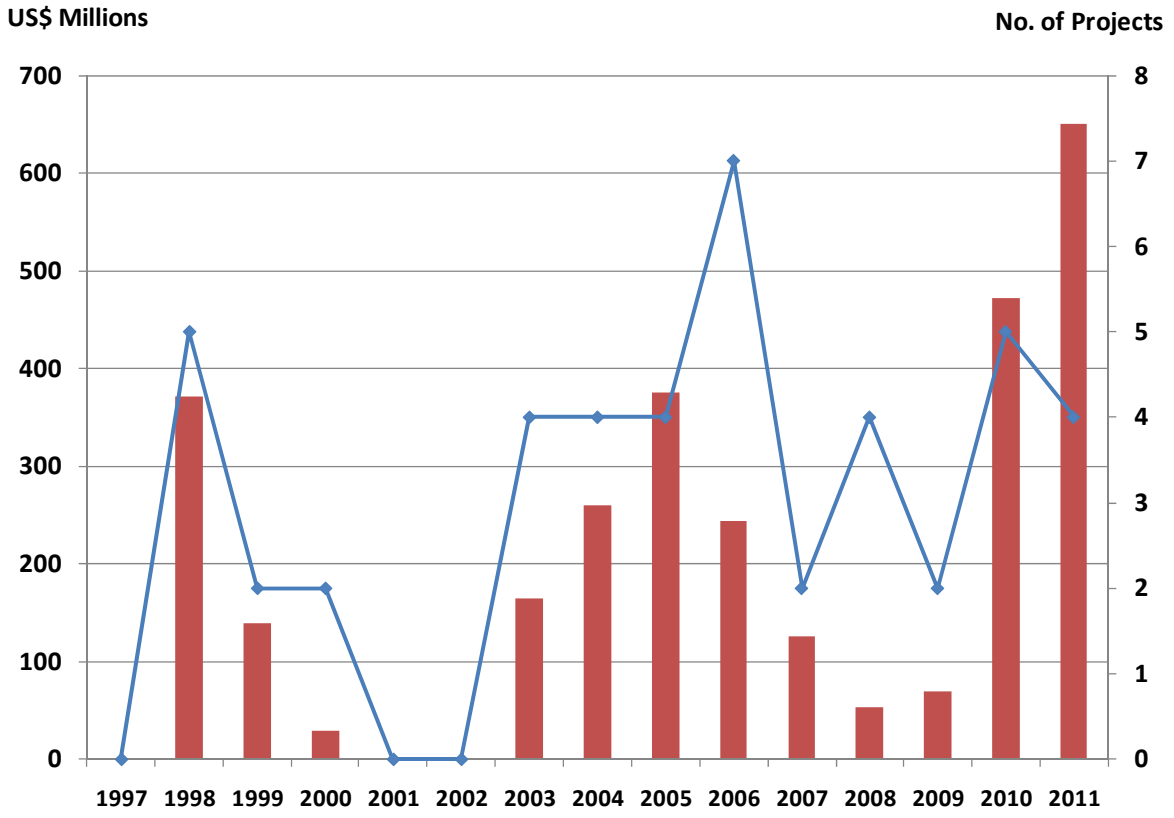
Health Sector Strategies and Bank-Wide Initiatives in Relation to Communicable Diseases and Health Systems Strengthening

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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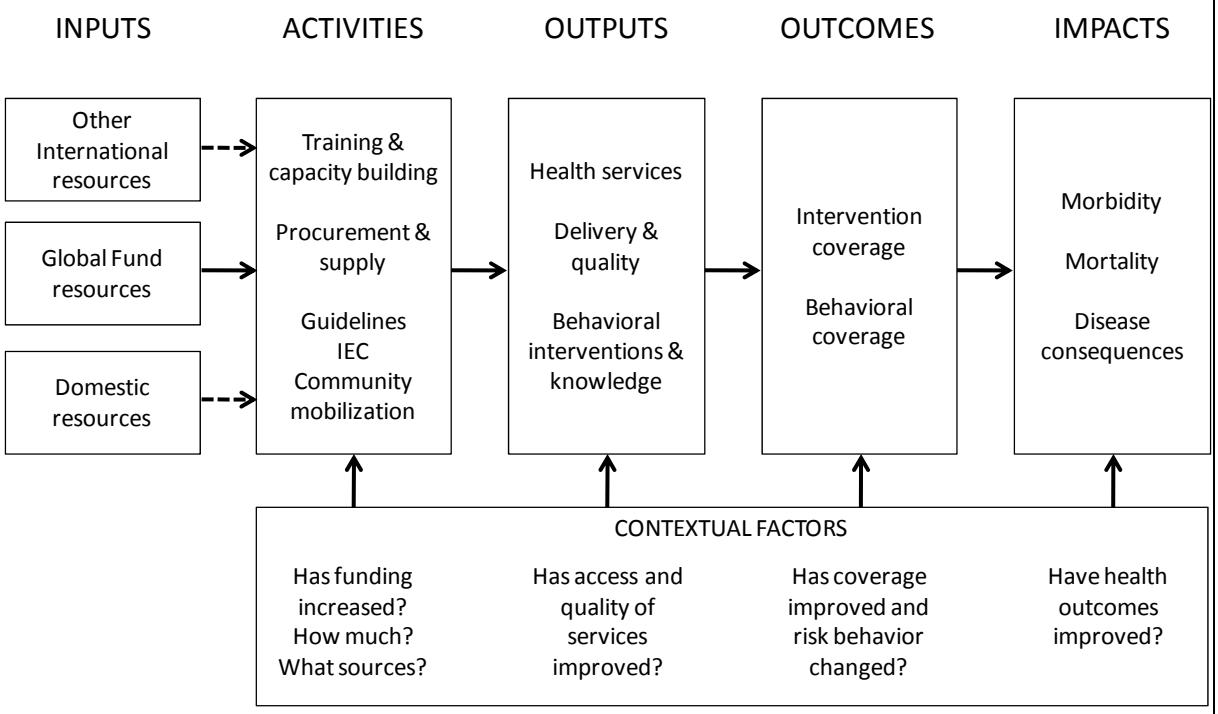
23. Map out the causal chain (program theory); understand context; anticipate heterogeneity; rigorous evaluation of impact using a credible counterfactual; rigorous factual analysis; use mixed methods.

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")

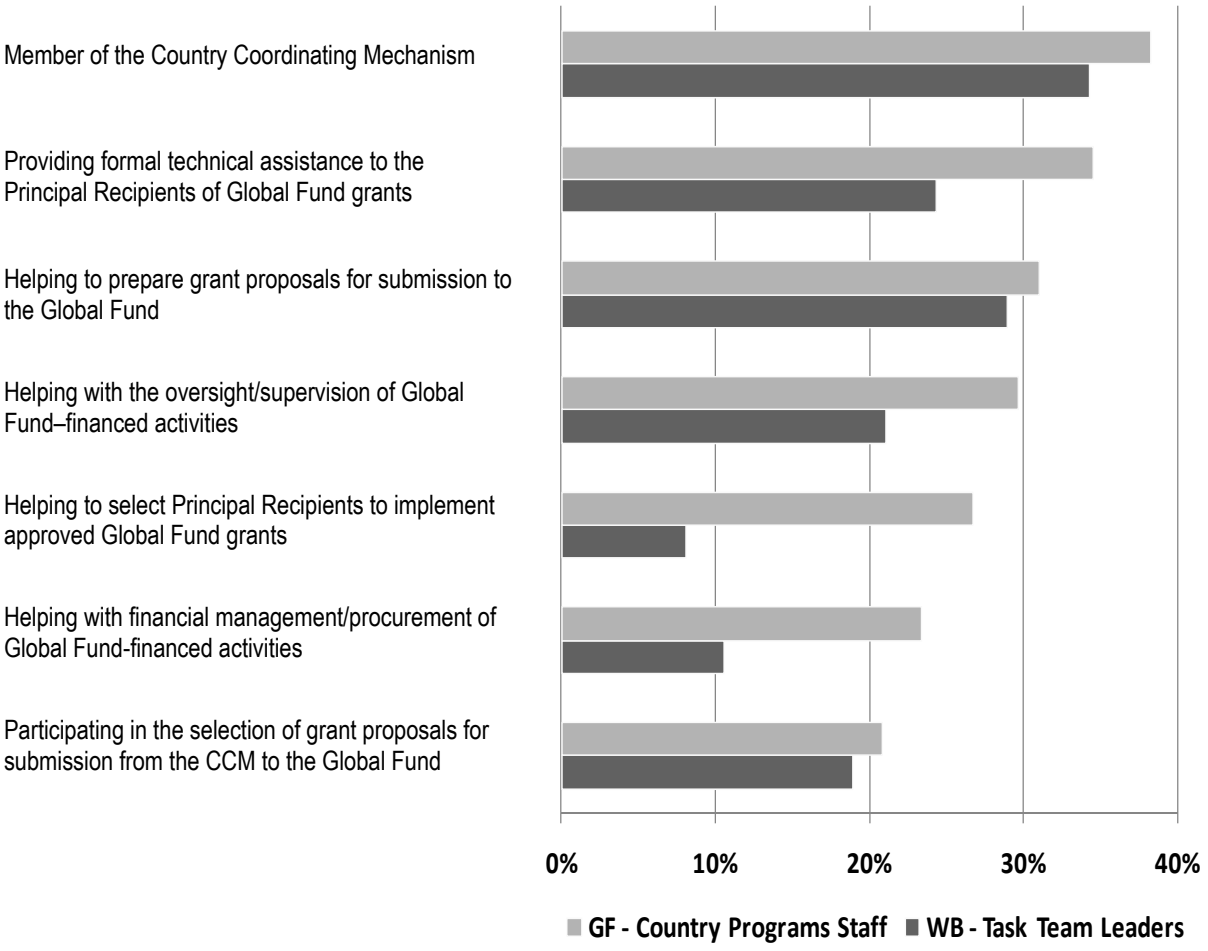
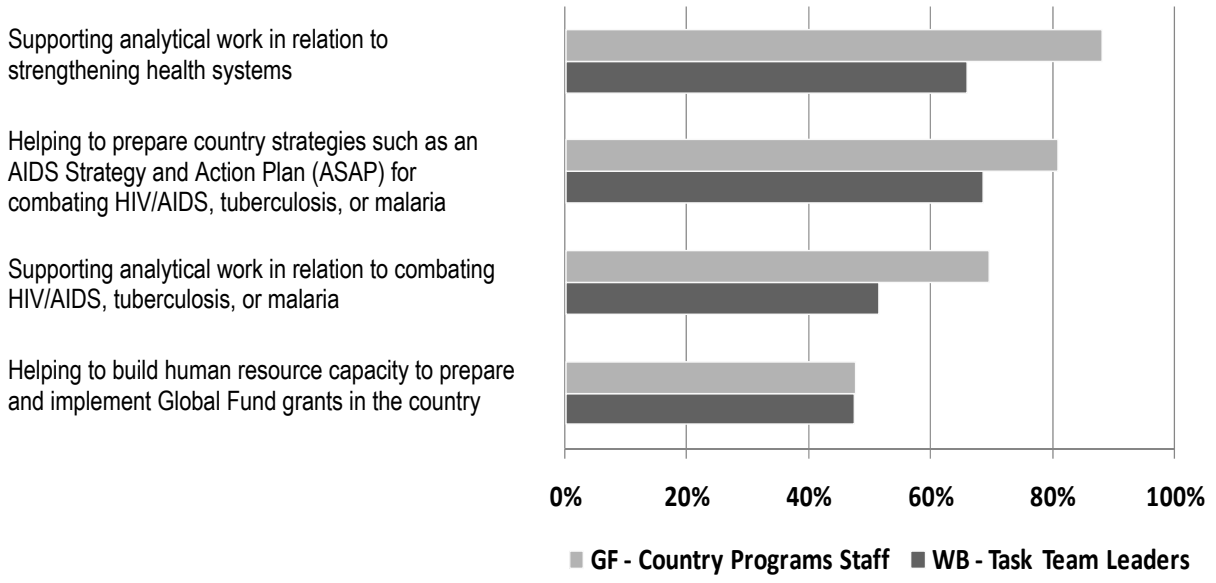


Figure 2. In what other ways were World Bank staff or consultants involved in country-level activities that directly or indirectly contributed to the work of the Global Fund during the years that you were working on this country? (Percent "Yes")



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?

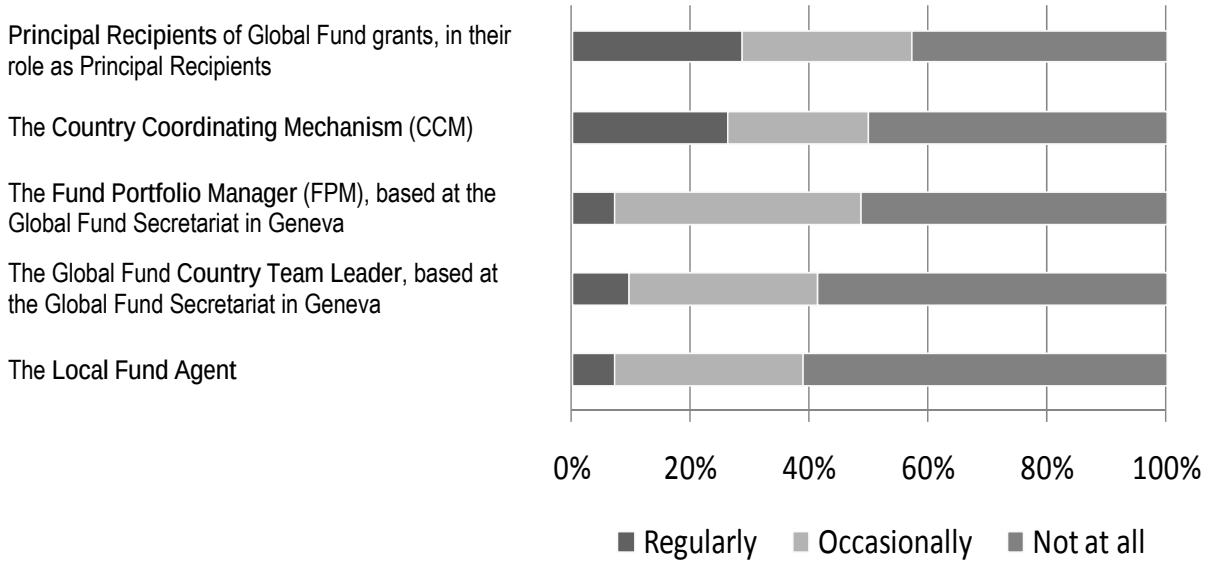
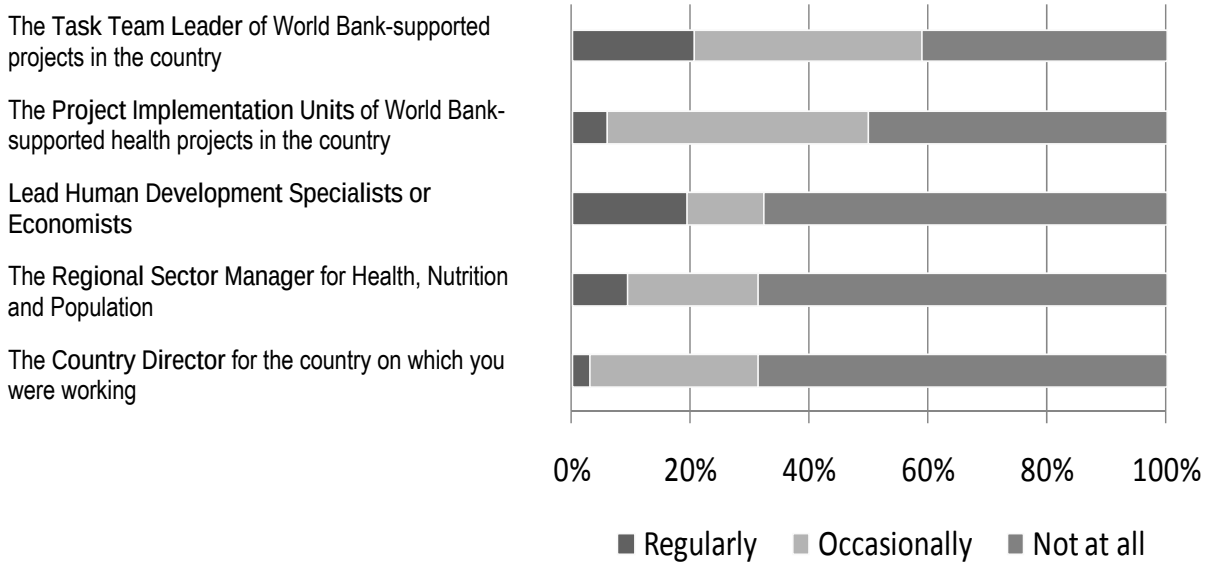


Figure 4. Global Fund – Country Programs Cluster: Which of the following managers and staff of the World Bank did you contact and work with during the years that you have been working on this region, subregion, or country?



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.

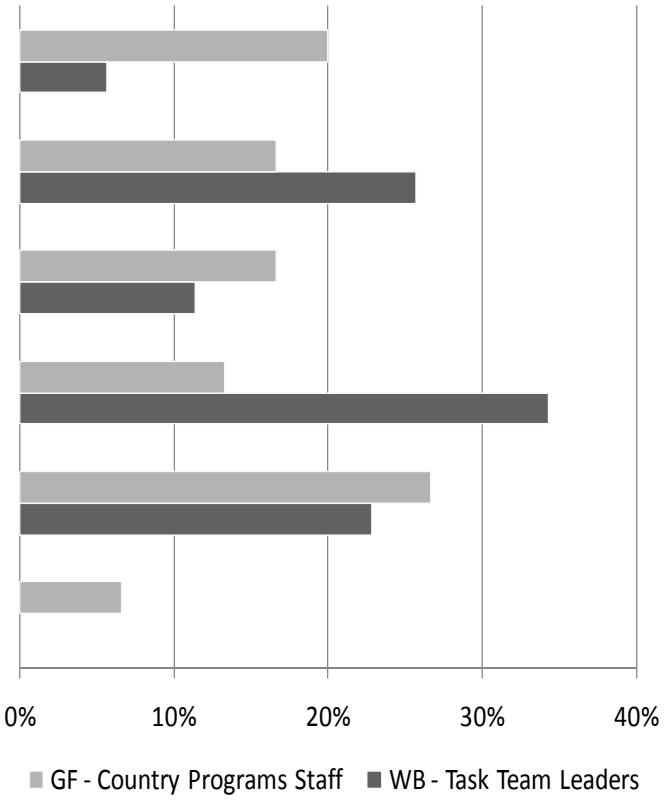
Complementary: The two organizations' staff, consultants, and agents worked alongside each other in the pursuit of common objectives.

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

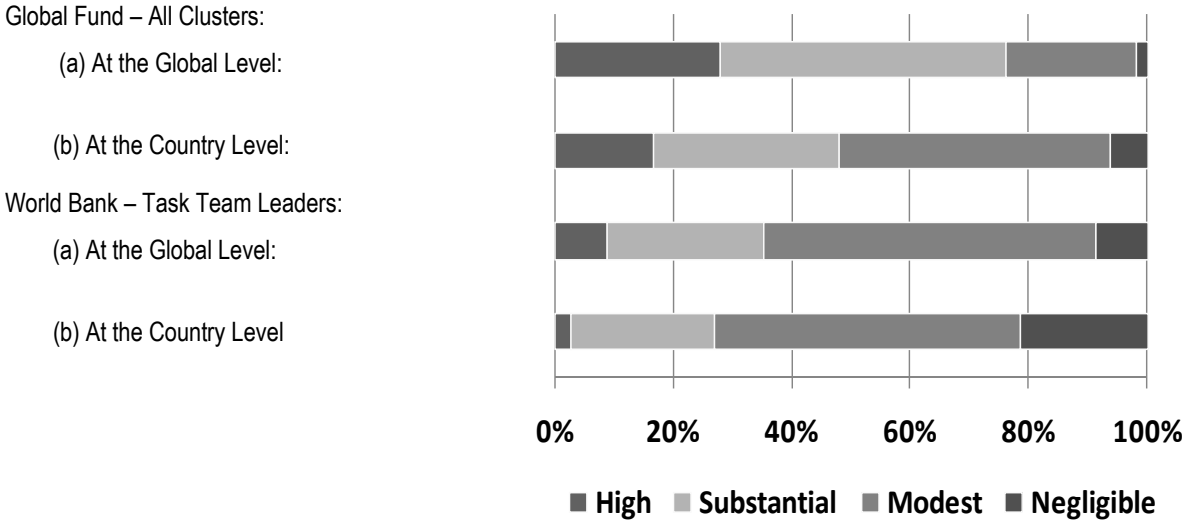
Question 8. To what extent do you consider the World Bank to be a partner of the Global Fund AT THE GLOBAL LEVEL?

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

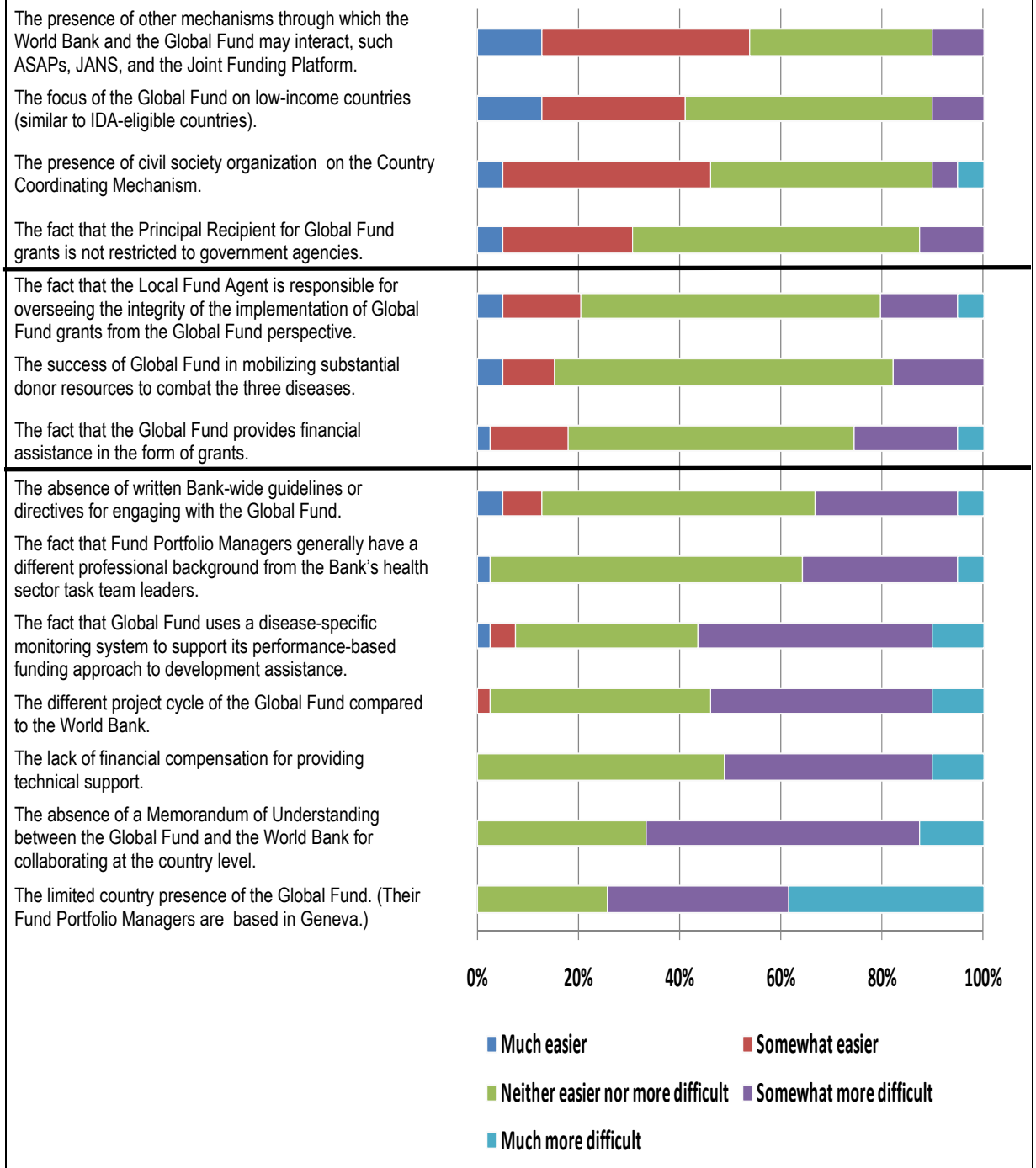
Figure 6. To what extent do you consider the World Bank to be a partner of the Global Fund (a) at the global level and (b) at the country level?



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

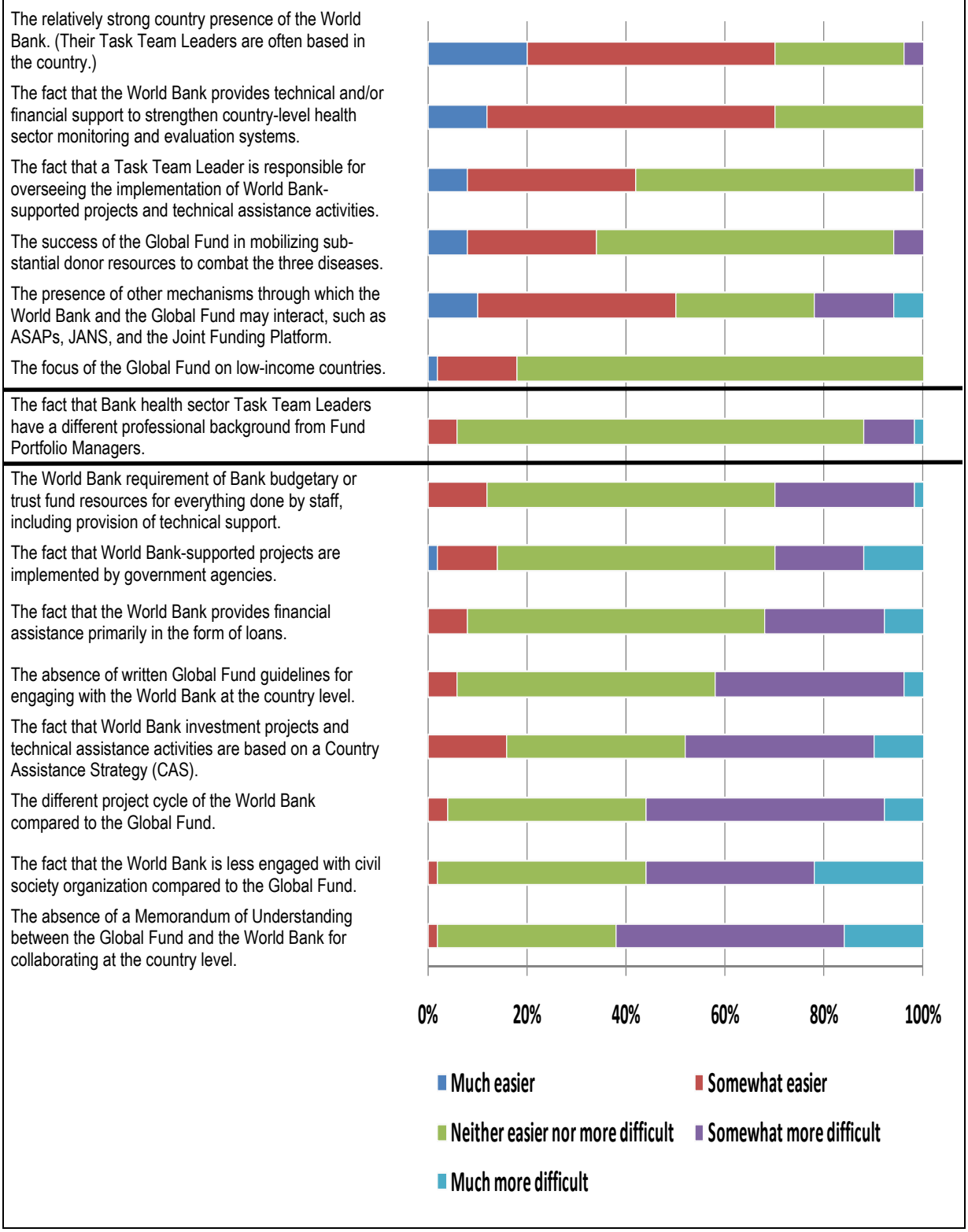
Figure 7. World Bank Task Team Leaders: In your opinion, do the following factors make it easier or more difficult for World Bank staff or consultants to engage with Global Fund-supported activities at the country level?



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

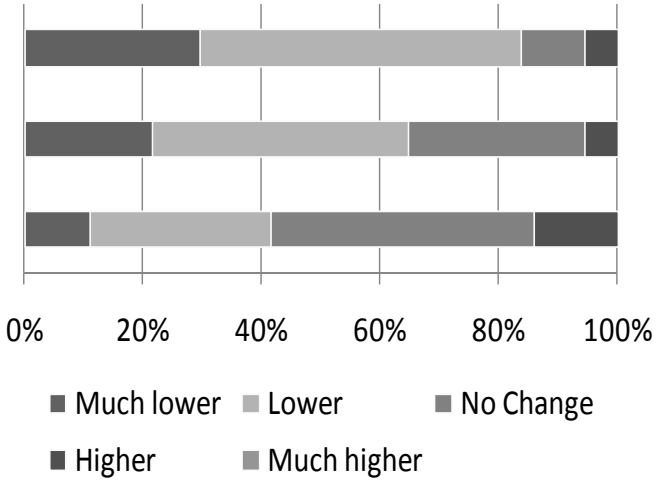
Response by Sub-question	High impact	Substantial impact	Modest impact	Negligible impact	Don't know	Total
The way in which the World Bank operates at the country level has become MORE INCLUSIVE than it otherwise would have been, involving more engagement with civil society organizations.	2	4	13	15	5	39
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?

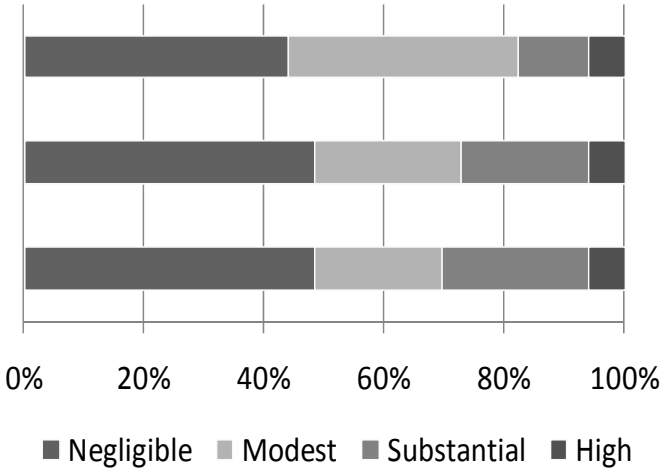
World Bank lending for strengthening health systems is lower or higher than it otherwise would have been.



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?

The Global Fund has sharpened its practices in the areas of procurement, audit, and anti-corruption.

The Global Fund is improving the alignment of its grants with each country's planning and budgeting cycles.

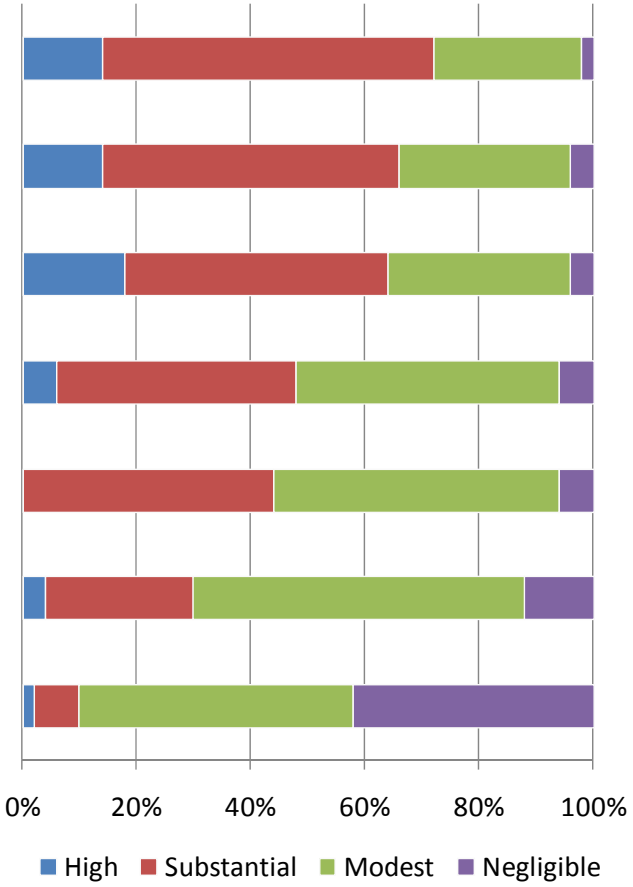
The Global Fund has become more program-based, as opposed to individual grant based, in its funding decisions.

Global Fund grants are providing more support to strengthening national health management information systems.

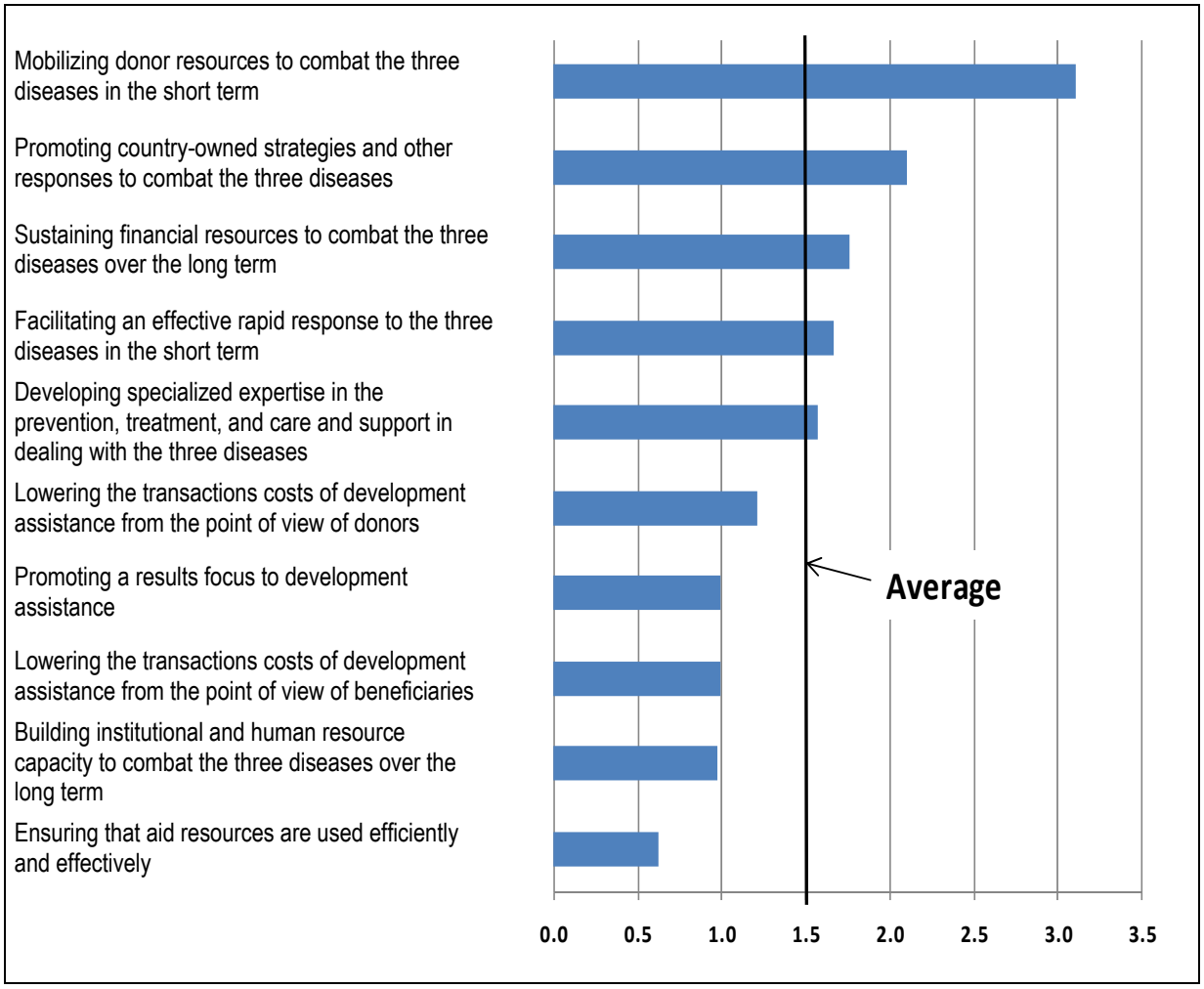
The Global Fund is devoting more resources to enhancing the capacity and effectiveness of CCMs in their full range of functions.

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.

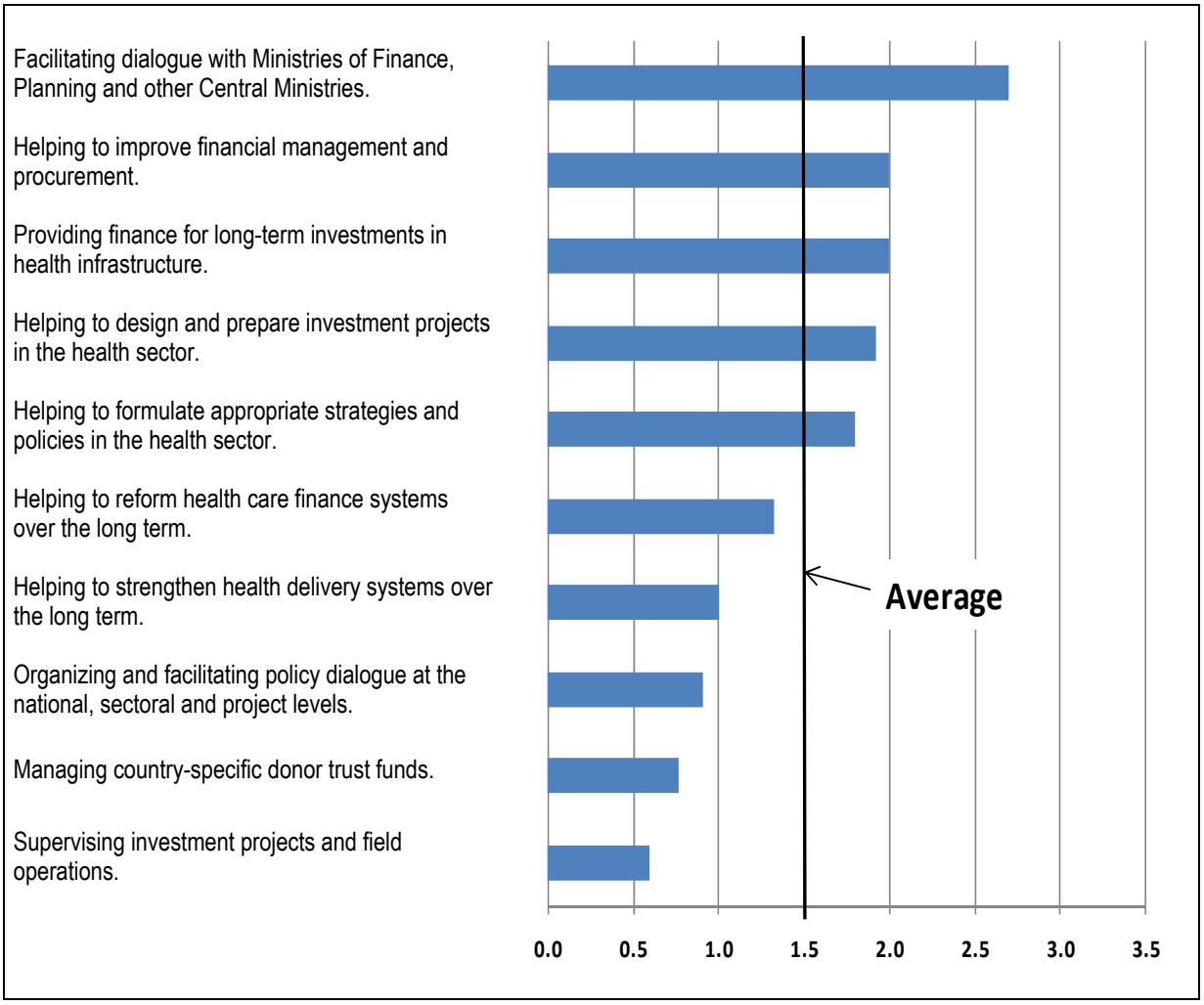
The Global Fund has improved its ability to adequately reward and retain its staff.



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.)



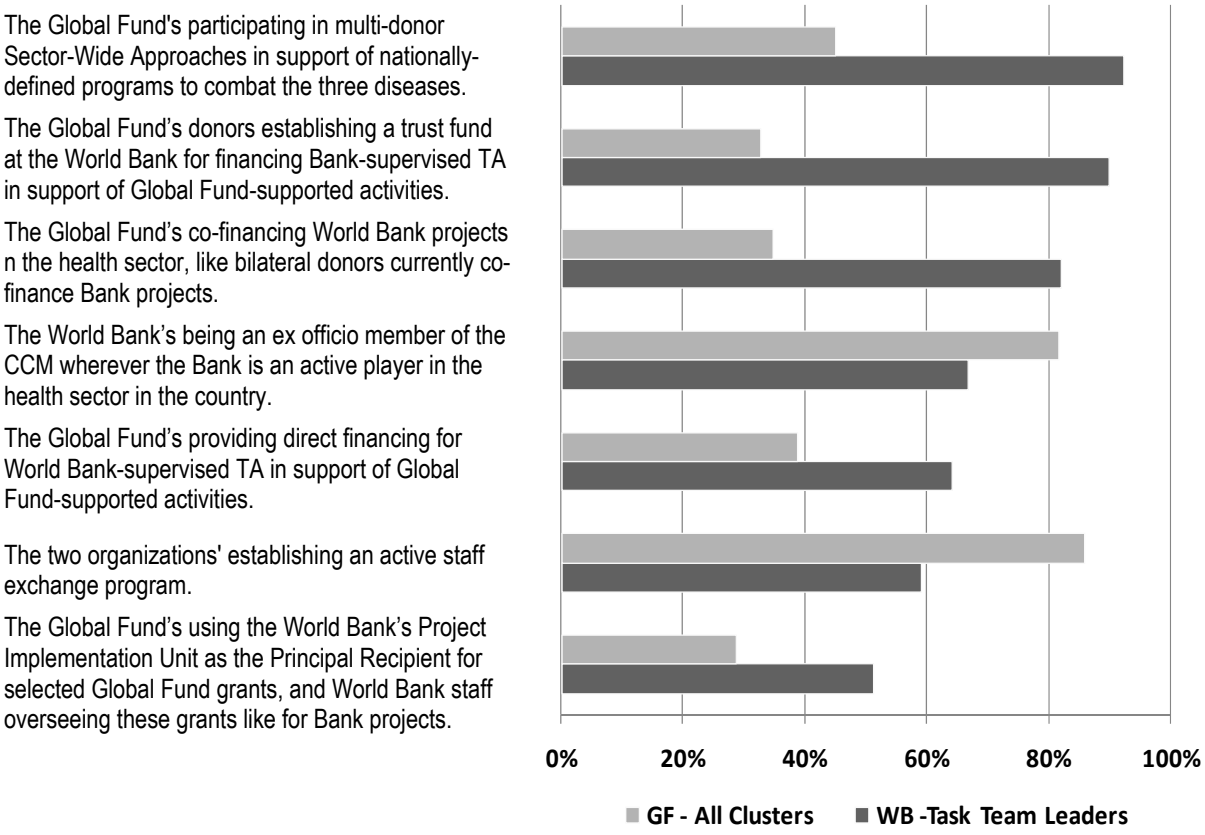
Question 12 (To Global Fund Staff). Which of the following do you consider to be the most important COMPARATIVE ADVANTAGES OF THE WORLD BANK among international development agencies in terms of achieving positive results at the country level?



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")



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		
Dr. Pieter van Maaren	WHO Representative and CCC Vice Chair	WHO Cambodia
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
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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
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Denis Biseko	Senior PSM Specialist	World Bank Country Office
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John McIntire	Country Director	World Bank Country Office
Development Partners		
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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.

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