The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STRATEGIC INVESTMENTS FOR IMPACT

GLOBAL FUND RESULTS REPORT 2012

The Martin Preuss Center in Lilongwe, Malawi, provides ARV therapy and support to thousands of patients. The country is one of the epicenters of the HIV epidemic, but with support from the Global Fund the government of Malawi has achieved remarkable results in scaling up access to treatment, testing, and HIV prevention.

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A TB patient takes her medication at Kingsway Chest Centre in north Delhi, India. Multidrug-resistant TB is a major challenge for the country. India's most recent TB grants (with a total value of more than US$ 70 million) will focus primarily on this issue.

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ABBREVIATIONS

ACT	artemisinin-based combination therapy
AMFm	Affordable Medicines Facility - malaria
ARV	antiretroviral
DOTS	the basic package that underpins the Stop TB Strategy
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PMI	President's Malaria Initiative (U.S.)
PMTCT	prevention of mother-to-child transmission (of HIV)
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

Although Cambodia has managed to reduce HIV prevalence in the last ten years, challenges remain and tens of thousands of people are in need of life-saving ARV treatment. Cambodia's National Strategic Plan for HIV, with support from the Global Fund, aims to better reach most-at-risk populations, and expand services to prevent transmission of HIV from mother to child.

Every dollar invested in the Global Fund to Fight AIDS, Tuberculosis and Malaria can save more lives. We are part of a tremendous effort, together with many partners around the world, to reverse the devastation caused by three deadly diseases. Today, people in the poorest countries can access essential treatment and prevention services — and this is because of highly effective, determined and innovative work by the health professionals, administrators and community workers who we are proud to support. Together, we are turning the tide on HIV, tuberculosis and malaria through one of the most ambitious global health interventions in history.

The *Global Fund Results Report 2012* demonstrates a continuation of outstanding achievements which reflect the commitment of donors, the hard work of implementers, and the dedication of partners to supporting treatment and prevention all over the world. Global Fund-supported programs have worked in 151 countries and are now saving more than 100,000 lives per month. The number of new HIV infections is decreasing worldwide. Tuberculosis incidence rates are declining in all six World Health Organization regions. Malaria incidence has fallen by half or more in several countries. We congratulate all those who have made these changes possible.

This year, however, we face very steep challenges. With the financial climate worsening, we need to ensure that our investments are more strategic and more efficient. In order to achieve the Millennium Development Goals by 2015, we must squeeze more out of every dollar.

Since I began work as General Manager in February 2012, the Global Fund has moved swiftly to implement the new strategy endorsed by the Board. We have reorganized the Secretariat to focus more on our core business of managing grants. We have established dedicated departments to serve the 20 countries in Africa and Asia in which our investments can have the highest impact. We have also initiated a special project within the Secretariat to enhance the entire grant process – from application to implementation. These changes will simplify processes for recipients and improve the way the Global Fund invests for impact, ensuring the best possible value for money.

I have been heartened to see how the rapid changes we are implementing have increased stakeholder confidence and improved our funding outlook. The Global Fund will continue to work with partners and countries to direct available financing to high-impact, urgently needed programs – speeding the implementation of our ambitious strategy.

Yet much remains to be done.

In particular, we must change the way we invest in-country, from looking at results to focusing on impact. This will ensure the highest returns and value for our money, based on a new funding model. We should focus on high service coverage for most-at-risk populations, as we know in public health this is where the returns are greatest. Finally, we must measure – not just model – the impact of our investments to build accountability for impact into our programs.

We are committed to laying the foundations for even greater success in the next ten years. How far we go will depend on the choices made now. By strategically investing for maximum impact, the Global Fund and its partners will strive to fulfill the vision of a world free from the burden of AIDS, tuberculosis and malaria.

Gabriel Jaramillo
General Manager

EXECUTIVE SUMMARY

KEY RESULTS INCLUDE:

3.6 MILLION PEOPLE
currently receiving antiretroviral therapy

9.3 MILLION PEOPLE
treated for tuberculosis

270 MILLION INSECTICIDE-TREATED NETS
distributed to protect families from malaria

8.7 MILLION LIVES SAVED

1. The *Global Fund Results Report 2012* presents the latest data from recipients of Global Fund grants in 151 countries – as well as the latest evidence of impact on the HIV, tuberculosis (TB) and malaria pandemics, and the most up-to-date information on Global Fund financing. It highlights the continued progress and the scale-up achieved by low- and middle-income countries around the world, made possible by the collaboration and efforts of hundreds of governments, donors, recipients, technical agencies, private companies and civil society organizations.

CHAPTER 1: INTRODUCTION

2. The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002 to attract and disburse additional health resources to those in need. In the last ten years it has helped countries launch unprecedented responses to the three diseases with the aim of reaching the Millennium Development Goals by 2015. Against the backdrop of a global financial crisis, the organization is working to become even more efficient and effective, to focus on greater strategic investment and impact, and to implement an ambitious new strategy for 2012-2016.

CHAPTER 2: RESULTS

3. The last 18 months have seen continued scale-up of essential, lifesaving interventions across Global Fund-supported programs. The cumulative results by mid 2012 represent a 50 percent increase from the end of 2010 for several interventions, including the treatment of malaria and multidrug-resistant TB, and the prevention of mother-to-child transmission (PMTCT) – as well as an increase of more than 100 percent for TB/HIV co-infection services.

4. In 2010, programs supported by the Global Fund accounted for nearly half of all people receiving antiretroviral (ARV) therapy around the world and two-thirds of all TB treatment – as well as a third of all insecticide-treated nets distributed in Africa between 2008 and 2010. The Global Fund's investments also play an important role in strengthening health and community systems in many countries. This in turn has helped 77 percent of reviewed grants to perform well – while the organization is working with partners and implementers to improve performance in the remaining 23 percent.

CHAPTER 3: IMPACT

5. Global Fund-supported countries are making good progress toward reducing the burden of HIV, TB and malaria. For all three diseases the coverage of key prevention and treatment interventions is increasing, with associated declines in incidence and mortality being reported. More than half of Global Fund-supported countries are on track to meet international targets for HIV incidence and mortality, as well as for TB incidence, case detection and treatment success. Progress has also been made in recent years for malaria, but further acceleration is needed to reach international targets by 2015. To better support this progress, the Global Fund and partners are developing a new funding model that will enable more strategic investment decisions through enhanced dialogue with applicants and other donors, and the provision of more flexible and predictable funding. This will help ensure financing for the right interventions and the right populations in the right countries.

CHAPTER 4: FINANCING

6. The Global Fund accounts for 21 percent of the international funding for HIV, 82 percent for TB, and 50 percent for malaria – making it the leading international financier for the three diseases. It will make renewal decisions regarding grants worth US$ 8 billion in 2012 and 2013 alone, and has sufficient funding available to fulfill existing commitments, support strategic reprogramming and enable further scale-up. However, additional financing is needed to reach the Millennium Development Goals in three years' time.

CHAPTER 5: LOOKING FORWARD

7. The decisions that are made now – by the Global Fund, recipient countries and donors – will determine whether current progress can be maintained and the health-related Millennium Development Goals be met. The Global Fund is committed to ensuring that the next ten years surpass the achievements of the previous decade. Implementing the Global Fund Strategy 2012–2016 and reforming the organization will allow the Global Fund to invest more strategically, work more effectively with implementers and partners, and simplify its processes to increase efficiency and value for money. By doing this together, the Global Fund and partners can help to bring closer the collective vision of a world free from the burden of AIDS, TB and malaria.

1. INTRODUCTION

A woman sits beneath a mosquito net in the Kibenga Community, Bugesera District, Rwanda, holding a small child. Ten years ago, fewer than 5 percent of households in sub-Saharan Africa owned an insecticide-treated net. By 2010, coverage had increased to 45 percent.

THE GLOBAL FUND'S VISION IS SIMPLE: A WORLD FREE FROM THE BURDEN OF AIDS, TUBERCULOSIS AND MALARIA.

1. Ten years ago the world was struggling to engage in the battle against HIV, TB and malaria, and access to key interventions was limited. Just 50,000 people were receiving ARV therapy in Africa [1]. Among the 22 countries with the highest TB burden, case detection rates were just 43 percent, and the treatment success rate was just 67 percent [2]. In sub-Saharan Africa, fewer than 5 percent of households owned an insecticide-treated net [3]. The economic and human toll from these three diseases was devastating, especially in the poorest countries.

2. This picture has now been transformed. Public sector and community-led health programs in low- and middle-income countries have launched an unprecedented fight against the three diseases. In 2010, 6.7 million people were receiving ARV therapy globally, and 21 countries reported more than 60 percent coverage of those in need [4]. In the same year the TB case detection rate rose to 65 percent and the treatment success rate to 87 percent [2]. In Africa, insecticide-treated net coverage increased to 45 percent, and 13 countries reported more than 60 percent coverage [3]. The scale of the global response was unthinkable at the turn of the century.

3. The United Nations (UN) launched the Millennium Development Goals in 2000 (See Box 1.1), and the G8 meeting in Okinawa called for increased global spending on public health to change the course of the fight against HIV, TB and malaria. In 2001, then-UN Secretary-General Kofi Annan called for the creation of a global "war chest" to overcome these diseases. The G8 responded at its meeting in Genoa that year by pledging the first resources and, following endorsement at the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002.

4. The Global Fund was created to be different. It is an international financing institution dedicated to disbursing additional resources to combat HIV/AIDS, TB and malaria. It is also a unique, innovative partnership between governments, civil society, UN agencies, the private sector and affected communities, with an operational model based on country ownership and performance-based funding. This means that countries use Global Fund financing to implement programs based on their own needs, and that countries are responsible for the results and impact achieved.

5. The Global Fund has supported programs in 151 countries around the world. It has become the main international financier for TB and malaria, and one of the leading international financiers for HIV. The Global Fund has helped to improve partnerships and decision-making at the local level through multisector Country Coordinating Mechanisms that include governmental and nongovernmental stakeholders. Civil society organizations have been meaningfully engaged in the design and implementation of grants – the Global Fund channels approximately 40 percent of its financing through these organizations. The Global Fund has also made important investments in health and community systems across the world to bolster disease control. The results in this report are due to the outstanding work of local programs led by government, civil society and other partners – often in the poorest and most difficult settings. Yet this has also been a global effort to convert strategies into action, results and impact.

BOX 1.1
THE MILLENNIUM DEVELOPMENT GOALS

The Millennium Development Goals are eight interlinked development goals to be achieved by 2015. Although the Global Fund focuses on Millennium Development Goal 6, the results documented in this report also support progress on Millennium Development Goal 4 and Millennium Development Goal 5, among others.

THE GOALS ARE:

1. **Eradicate extreme poverty and hunger**
2. **Achieve universal primary education**
3. **Promote gender equality and empower women**
4. **Reduce child mortality**
5. **Improve maternal health**
6. **Combat HIV, malaria and other diseases**
7. **Ensure environmental sustainability**
8. **Develop a global partnership for development**

Source UN, 2011 [5].

6. Because of these dedicated country programs, increased funding and recent scientific advances, the Millennium Development Goal targets for HIV, TB and malaria have become achievable (See Box 1.2). The world has halted and begun to reverse the spread of HIV: prevalence appears to have stabilized and the number of new HIV infections has steadily declined since the late 1990s [4]. TB incidence rates have been falling since 2002, and the number of TB cases has fallen since 2006 [2]. Progress for malaria has been more recent, but incidence and malaria-specific mortality have both fallen since 2000 [3]. Nonetheless, the global health burden associated with these three diseases remains substantial and they claimed around 3.5 million lives in 2010 alone: 1.8 million AIDS-related deaths [4], a further 1.1 million TB-related deaths [2], and 655,000 malaria-related deaths (86 percent of which were in children under 5) [3].

STRATEGIC INVESTMENTS FOR IMPACT

7. The decisions that are made now are crucial. Much of the world has been struggling with a prolonged financial crisis that threatens to undermine or even reverse the progress achieved to date. While donors are fully cognizant of the risks and costs of reduced support, they are under increasing pressure to demonstrate value for money from their investments. In response, the Global Fund is transforming itself to become more efficient, invest more strategically, maximize impact, and help fill existing programmatic gaps.

8. The Global Fund Strategy 2012-2016 defines the organization's aspirations and actions for the next five years, following extensive consultation with stakeholders and partners [7]. It defines how the Global Fund will accelerate progress toward impact, build on past successes and investments, and evolve to address challenges and seize opportunities (See Chapter 3.4).

9. In 2012 the Global Fund also embarked on an ambitious reorganization to improve and adapt its structure and business practices for a fast-changing – and financially challenged – world. These reforms are strengthening the organization's foundations and refocusing resources and efforts on impeccable grant management, while remaining true to the organization's vision, mission, principles and values. Already, the Global Fund is significantly different now than it was in 2011. The Secretariat has been restructured to ensure that 75 percent of staff are working in grant management or related roles. Three "high-impact" teams – which represent one-fifth of staff resources – have been created to better support grants in the countries where the Global Fund and partners can have the greatest impact. These 20 countries (all from Africa and Asia) account for more than 70 percent of the global burden of HIV, TB and malaria (See Box 1.3).

10. This report demonstrates the unprecedented progress of the last ten years – including country examples to illustrate the results, coverage and impact being achieved and the partnerships that make this happen. But it also highlights the need for strategic investment decisions to be made now in order to achieve the Millennium Development Goals.

BOX 1.2

TARGETS FOR MILLENNIUM DEVELOPMENT GOAL 6: COMBAT HIV, MALARIA AND OTHER DISEASES

6A

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

6B

Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

6C

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Note Although the original target date for 6B has passed, universal access (defined as 80 percent coverage) is still a valid target for 2015. In 2011 the UN announced a new target of 15 million people receiving ARV therapy by 2015 – which broadly represents 80 percent coverage based on the World Health Organization (WHO)-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3. **Source** UN, 2008 [6]

BOX 1.3

THE GLOBAL FUND'S 20 HIGH-IMPACT COUNTRIES

- Bangladesh
- China
- Congo (Democratic Republic)
- Côte d'Ivoire
- Ethiopia
- Ghana
- India
- Indonesia
- Kenya
- Mozambique
- Myanmar
- Nigeria
- Pakistan
- Philippines
- South Africa
- Sudan
- Tanzania (United Republic)
- Uganda
- Zambia
- Zimbabwe

2. RESULTS

Rinchen, a volunteer health worker in the village of Rejung, Bhutan, advises people to use mosquito nets, spray their homes, and clear the bushes around their houses. He has seen rates of malaria incidence plummet since the government, with Global Fund support, committed themselves to fighting the disease.

KEY POINTS

1

The results presented in this report have only been made possible through the collaboration and efforts of hundreds of partners – including governments, donors, recipients, technical agencies, private sector companies and civil society organizations.

2

The scale-up of key services to tackle HIV, TB and malaria has continued. These services have saved an estimated 8.7 million lives – more than 100,000 lives a month in recent years.

3

In June 2012, through Global Fund-supported programs, 3.6 million people were receiving ARV therapy – a 20 percent increase since 2010.

4

By mid 2012 these programs had detected and treated 9.3 million TB cases – a 21 percent increase since the end of 2010.

5

Supported programs have distributed 270 million insecticide-treated nets to prevent malaria – a 73 percent increase since the end of 2010.

6

With the help of the Global Fund and its partners, low- and middle-income countries reached nearly half of those in need of ARV therapy and PMTCT prophylaxis in 2010, and treated more than half of new smear-positive TB cases.

7

The majority of Global Fund-supported programs continue to perform well against their targets across each disease, each region and each type of Principal Recipient.

1. The Global Fund depends on hundreds of partners – including governments, donors, recipients, advocates, technical agencies, the private sector and civil society organizations – to design and implement grants, and to achieve and measure results and impact. The Global Fund's operating model is based on the premise that the disbursement of funds goes hand-in-hand with the responsibility to achieve measurable results in terms of people receiving services. All Global Fund grants have a transparent "Performance Framework" to show the results, targets and timelines agreed for reaching people in need [8]. Recipients report their service delivery results to the Global Fund as part of each periodic request for disbursement, and every three years undergo an extensive review of performance and impact.

2. The Global Fund Secretariat processes, standardizes and aggregates programmatic results for a list of main service indicators as presented in this chapter – covering the breadth of prevention, treatment and care interventions. Local Fund Agents verify all reported results nationally and on-site where services are delivered, and conduct additional spot-checks, data quality assessments and audits on selected grants. The Secretariat also routinely checks for potential double-counting within and between grants, excludes results from countries with serious data-quality issues, and works with international partners to harmonize data twice a year (See *Methodology Web Annex*[1]). To maximize the quality of data and the reliability of results, the Global Fund and partners are addressing common weaknesses in in-country data management and health information systems (See Chapter 2.6).

3. Since 2002, Global Fund-supported programs have helped save an estimated 8.7 million lives.[2] This figure represents a continued scale-up from 1.25 million lives saved at the end of 2006 [9], and 6.5 million lives saved at the end of 2010 [10]. Lives saved are calculated from service results multiplied by their documented mortality outcome. These estimates are based only on three services with a known direct mortality outcome (numbers of people receiving treatment for HIV and TB, plus the number of insecticide-treated nets distributed) and they are therefore likely to be underestimates. The approaches have been agreed and published with technical partners – the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) – and more information can be found in the Methodology Web Annex. The lives saved estimates reported are not based on direct measurement and they have important limitations. The Global Fund is investing in evaluations in all key countries with high investments to measure the number of lives saved by supported programs and to include other services (See Chapter 2.6).

1 For more information, see the Methodology Web Annex available from http://www.theglobalfund.org/documents/publications/progress_reports/Publication_2012Results_Annext_en/

2 The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program.

2.1 KEY HIV RESULTS

4. Globally, an estimated 34 million people were living with HIV in 2010 (the latest available data from partners at the time of writing), including 2.7 million newly infected adults and children [4]. AIDS accounted for approximately 1.8 million deaths in 2010 [4], including 2 percent of all childhood deaths [11]. In sub-Saharan Africa, it is the main cause of death among women of child-bearing age [12]. Yet HIV is fundamentally preventable and treatable given the appropriate resources and enabling environments. Alongside numerous partners, the Global Fund has supported HIV programs in 147 countries, with a total of US$ 12.4 billion in approved funding since 2002. Alongside the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund is one of the leading international donors for HIV, and accounted for around 21 percent of international HIV funding in 2009 (See Chapter 4).

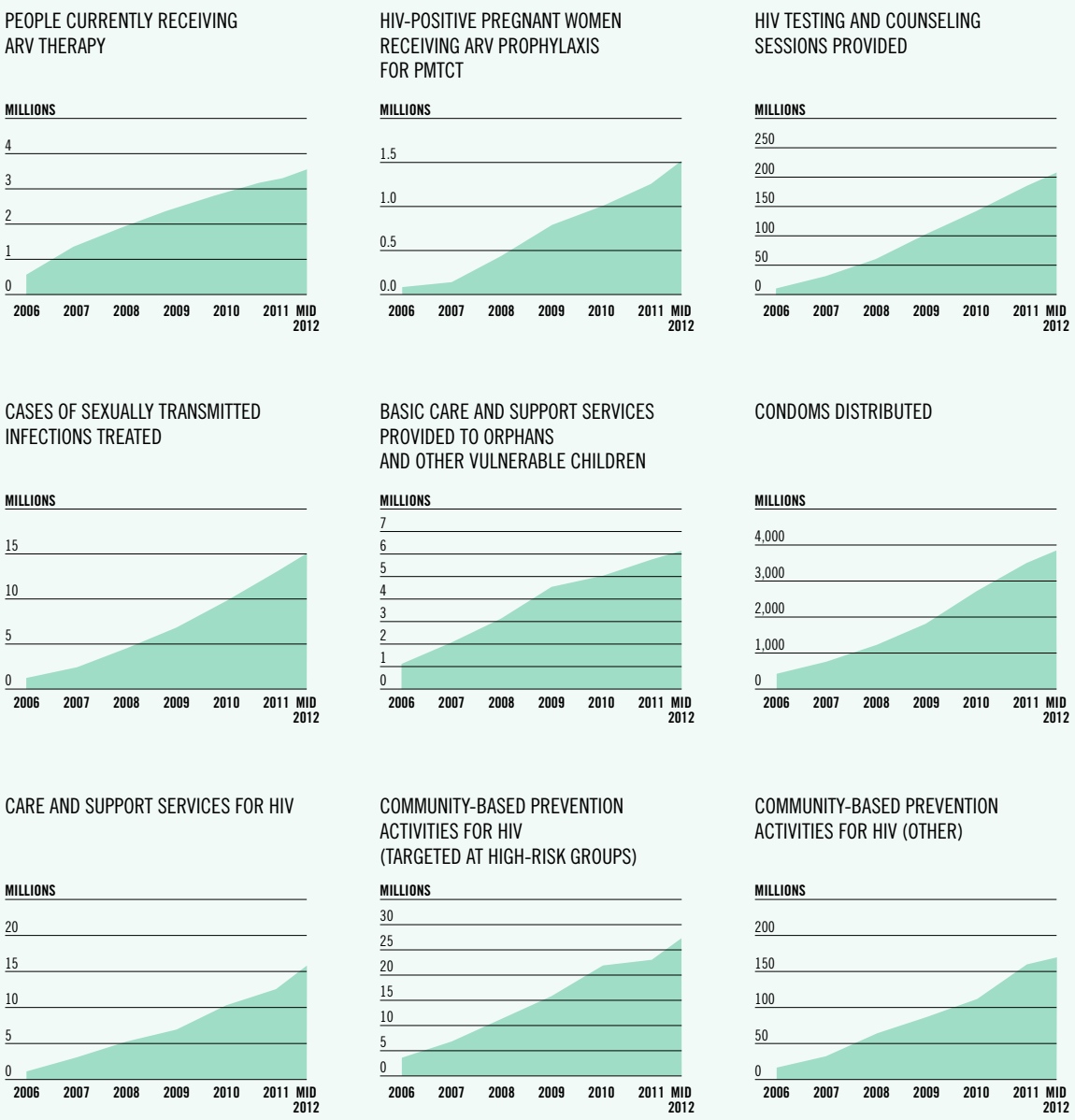
5. As Table 2.1 and Figure 2.1 show, Global Fund-supported programs have continued to scale up key HIV services in recent years with the help of its partners – including increases of up to 51 percent in reported mid 2012 results compared to those from 2010. Of the 3.6 million people who were receiving ARV therapy in June 2012, 590,000 were initiated into treatment in 2011 and 2012 alone. Nearly two-thirds of these individuals were from the 20 "high-impact" countries as defined by the Global Fund (See Box 1.3). Since 2010, sub-Saharan Africa has seen the largest increase in ARV therapy delivery in absolute numbers (driven particularly by results from Zambia and Zimbabwe). The largest proportional increase was in Latin America and the Caribbean, where the number of people who were receiving ARV therapy increased by 31 percent since the end of 2010 (driven in part by increases reported in Haiti).

TABLE 2.1
RESULTS FROM GLOBAL FUND-SUPPORTED HIV PROGRAMS, 2002 TO MID 2012

			GLOBAL FUND REGION				
INDICATOR	**SCALE-UP SINCE END 2010**	**TOTAL**	ASIA	EASTERN EUROPE AND CENTRAL ASIA	LATIN AMERICA AND CARIBBEAN	MIDDLE EAST AND NORTH AFRICA	SUB-SAHARAN AFRICA
People currently receiving ARV therapy	20%	**3,600,000**	560,000	24,000	130,000	79,000	2,800,000
HIV-positive pregnant women receiving ARV prophylaxis for PMTCT	50%	**1,500,000**	98,000	37,000	28,000	15,000	1,300,000
HIV testing and counseling sessions provided	42%	**210,000,000**	60,000,000	37,000,000	17,000,000	2,600,000	89,000,000
Cases of sexually transmitted infections treated	51%	**15,000,000**	2,100,000	210,000	4,200,000	2,900,000	5,200,000
Basic care and support services provided to orphans and other vulnerable children	22%	**6,200,000**	360,000	39,000	52,000	58,000	5,600,000
Condoms distributed	39%	**3,800,000,000**	390,000,000	290,000,000	620,000,000	110,000,000	2,400,000,000
Care and support services for HIV	49%	**16,000,000**	3,600,000	370,000	1,300,000	170,000	10,000,000
Community-based prevention activities for HIV (targeted at high-risk groups)	23%	**27,000,000**	10,000,000	7,000,000	5,000,000	4,000,000	870,000
Community-based prevention activities for HIV (other)	49%	**170,000,000**	35,000,000	13,000,000	17,000,000	7,700,000	96,000,000

Note Figures are cumulative to mid 2012 except for ARV therapy which (in accordance with the indicator used in UN Declaration of Commitment progress reports) is measured at one point in time and not cumulatively. Figures are rounded. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. High-risk groups include sex workers, people who inject drugs, men who have sex with men, women who have sex with women, migrants, and truck drivers.

FIGURE 2.1
RESULTS FROM GLOBAL FUND-SUPPORTED HIV PROGRAMS, 2006 TO MID 2012



Note Graphs present cumulative data – except for ARV therapy which (in accordance with the indicator used in UN Declaration of Commitment progress reports) is measured at one point in time and not cumulatively. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. High-risk groups include sex workers, people who inject drugs, men who have sex with men, women who have sex with women, migrants, and truck drivers.

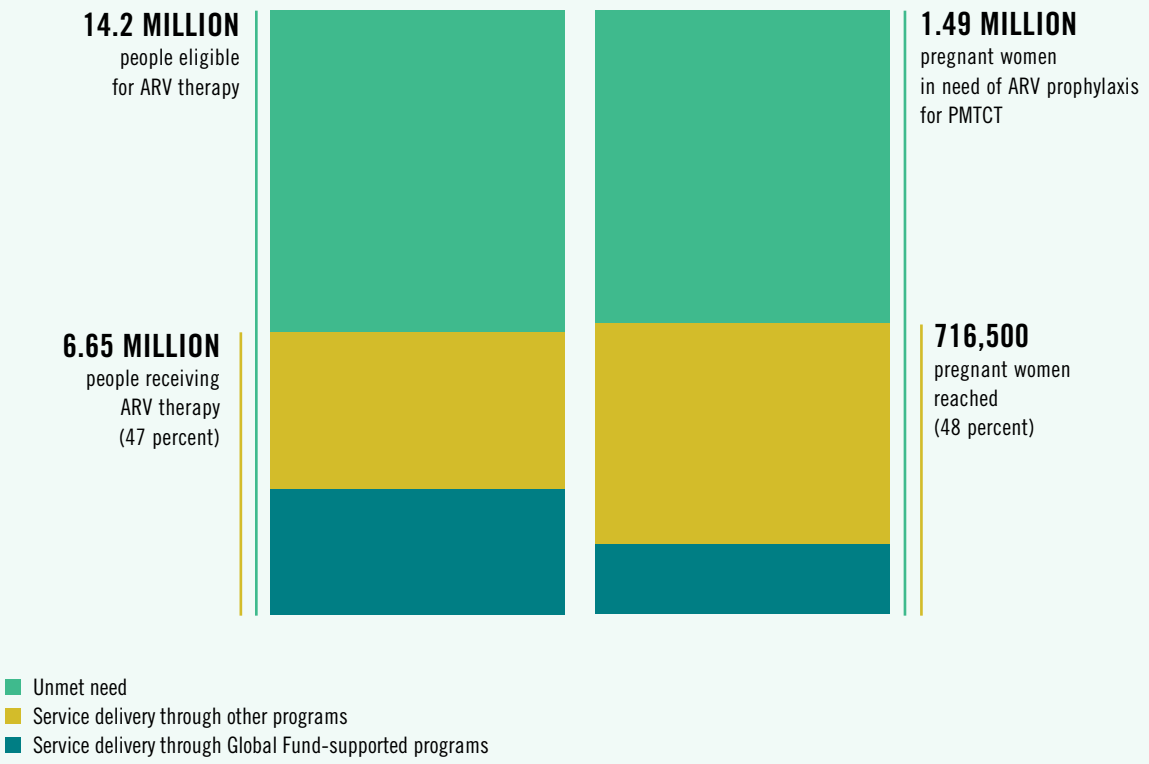
6. By mid 2012, 1.5 million pregnant women living with HIV had received ARV prophylaxis through Global Fund-supported programs for PMTCT. This represents an increase of 50 percent compared to the end of 2010, and 90 percent compared to the end of 2009. Sub-Saharan Africa accounts for 54 percent of the scale-up since 2010, driven by results in Tanzania and Zimbabwe – both of which are part of a special initiative by the Global Fund, UNAIDS, WHO and the United Nations Children's Fund (UNICEF) to further expand and improve PMTCT programs. This initiative focuses on India and the 20 countries in sub-Saharan Africa with the highest burden of HIV among pregnant women, and aims to achieve at least 60 percent coverage of this lifesaving intervention. By the end of 2011, 13 of these countries had completed or were completing reprogramming efforts to reinvest approximately US$ 84 million into PMTCT programs [13]. These ongoing efforts support the global call for the elimination of mother-to-child (or "vertical") HIV transmission – a key opportunity for strategic investments and impact.

7. In terms of HIV testing and counseling, Asia reported the largest increase in service delivery, with a 58 percent scale-up since the end of 2010 – where India accounted for 87 percent of the regional increase in absolute numbers. Across all regions, Global Fund-supported programs have reported 60 million HIV testing and counseling sessions in 2011 and 2012 alone with the help of partners.

8. Since 2002, Global Fund-supported programs have delivered 27 million community-based prevention activities targeted at most-at-risk populations (such as sex workers, men who have sex with men, and people who inject drugs), including 4 million activities reported in the first half of 2012 alone (See Figure 2.1). Despite accounting for nearly half the community-based prevention activities overall, sub-Saharan Africa reported just 3 percent of the activities that targeted most-at-risk populations.

9. Figure 2.2 shows the Global Fund's estimated contributions to global need and service delivery in 2010. Of the estimated 14.2 million people in need of ARV therapy in low- and middle-income countries, 6.65 million were receiving it (an increase of 11 percent compared to 2009) [4] – with Global Fund-supported programs reaching just under half the total service delivery in that year. For PMTCT, an estimated 1.49 million women in need were living in low- and middle-income countries, of whom the Global Fund and partners reached 48 percent (excluding those who received single-dose Nevirapine – a less effective treatment no longer recommended by WHO [14]) [4]. Global Fund-supported programs accounted for nearly a quarter of the global PMTCT service delivery in 2010. This is a smaller proportion than reported the year before [10] because several countries with large grant portfolios did not report results in 2010.

FIGURE 2.2
ESTIMATED GLOBAL FUND CONTRIBUTIONS TO INTERNATIONAL NEED AND SERVICE DELIVERY FOR KEY HIV INTERVENTIONS, 2010

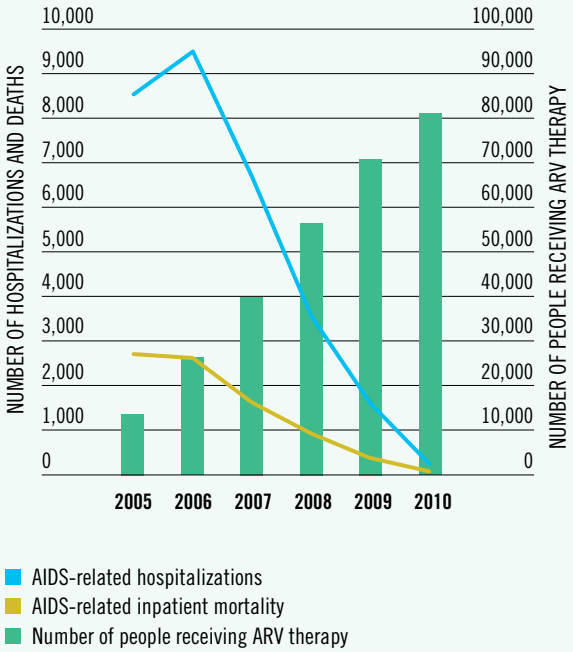


Note Figures are rounded, and are for low- and middle-income countries only. Global Fund results reported for 2010 do not necessarily correspond to the actual services provided during that year, since the reporting cycles of Global Fund grants vary. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. The need for ARV therapy is based on the WHO-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3. The Global Fund data for HIV-positive pregnant women who are receiving ARV prophylaxis for PMTCT have been adjusted to exclude the estimated number of women who received single-dose Nevirapine (which is no longer recommended by WHO [14]). **Sources** WHO, 2011 [4]. The Global Fund, 2011 [10].

NAMIBIA

The Republic of Namibia has a population of 2.3 million people, and an estimated adult HIV prevalence of 13 percent. In the space of just five years, the country has reduced AIDS-related inpatient mortality by 98 percent.

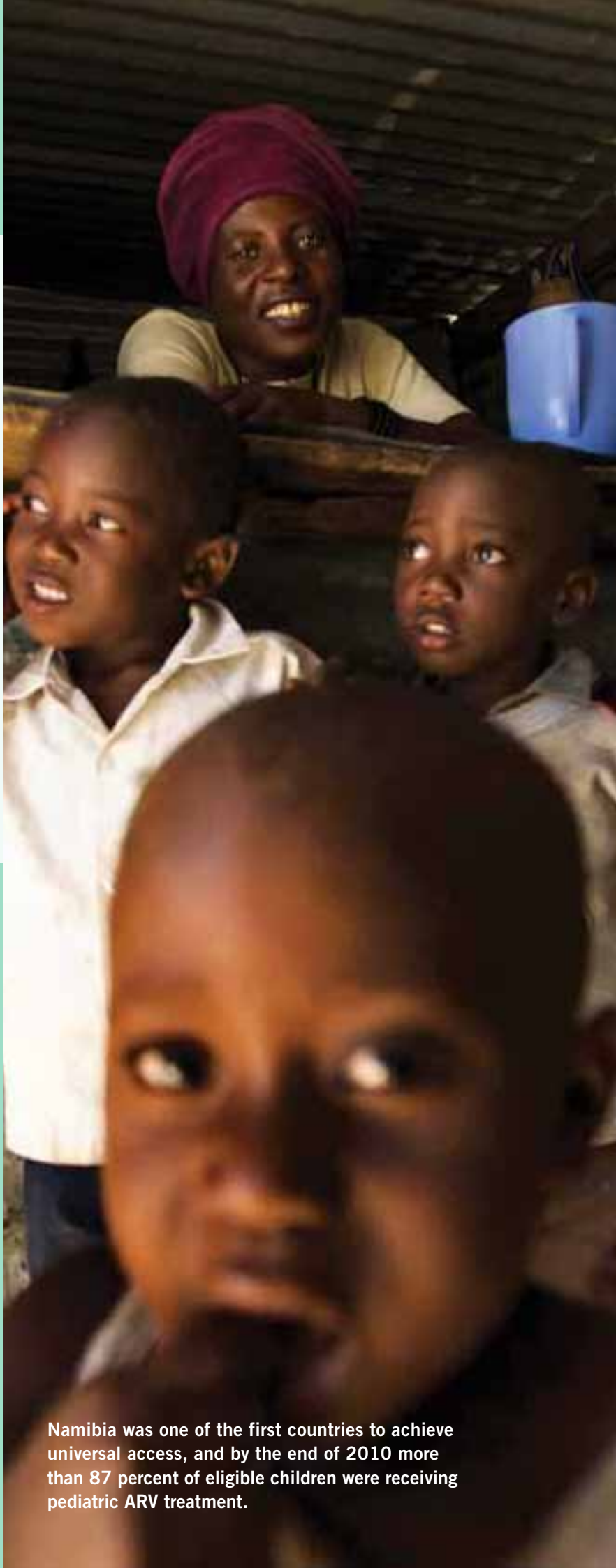
ANTIRETROVIRAL THERAPY SCALE-UP, AIDS-RELATED HOSPITALIZATIONS AND INPATIENT DEATHS IN NAMIBIA, 2005-2010



Source Ministry of Health, 2011 [15].

The government of Namibia launched a national ARV therapy program in June 2003, scaled up with support from the Global Fund and PEPFAR. By the end of 2010, the country had achieved universal access – 88 percent of eligible adults and more than 95 percent of eligible children were receiving ARV therapy. As a result, it is estimated that the program has saved at least 35,000 lives and has helped avert around 70,000 new infections.

By the end of 2011 the Global Fund had disbursed US$ 123 million for HIV programs in Namibia and contributed to 47 percent of all ARV therapy expenditures [16]. This funding also supported the expansion of HIV prevention activities, HIV testing and counseling, condom distribution and PMTCT.



Namibia was one of the first countries to achieve universal access, and by the end of 2010 more than 87 percent of eligible children were receiving pediatric ARV treatment.

2.2 KEY TUBERCULOSIS RESULTS

10. In 2010 (the latest available data from WHO), there were an estimated 8.8 million incident cases of TB, 290,000 cases of multidrug-resistant TB, and 1.1 million TB-related deaths globally [2]. These figures exclude deaths associated with TB/HIV co-infection, and approximately 13 percent of TB cases occur among people living with HIV [2]. With invaluable assistance from its partners, the Global Fund has supported TB programs in 117 countries and approved a total of US$ 3.8 billion in funding since 2002. The Global Fund is the leading international donor for TB and is estimated to account for 82 percent of international TB funding in 2012 (See Chapter 4).

11. As Table 2.2 and Figure 2.3 show, Global Fund-supported TB programs have continued their significant scale-up of key services alongside the efforts of partners. The cumulative number of TB cases detected and treated through DOTS (the basic package that underpins the Stop TB Strategy) increased by 21 percent between 2010 and mid 2012. Recipients of Global Fund financing have detected and treated 9.3 million new smear-positive TB cases – 84 percent of which were in the 22 high TB-burden countries, a consistent share relative to TB burden [2]. More than 70 percent of the cases detected and treated by Global Fund-supported programs were in the Asia region, and the countries with the largest cumulative results are Bangladesh, China, India, Indonesia and Pakistan (five of the top six countries globally in terms of notified cases in 2010). However, the greatest scale-up (30 percent since 2010) has occurred in southern, western and central Africa, where many countries have high rates of TB/HIV co-infection.

TABLE 2.2
RESULTS FROM GLOBAL FUND-SUPPORTED TUBERCULOSIS PROGRAMS, 2002 TO MID 2012

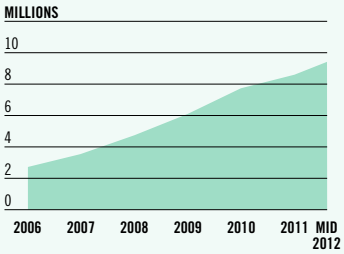
			GLOBAL FUND REGION				
INDICATOR	**SCALE-UP SINCE END 2010**	**TOTAL**	ASIA	EASTERN EUROPE AND CENTRAL ASIA	LATIN AMERICA AND CARIBBEAN	MIDDLE EAST AND NORTH AFRICA	SUB-SAHARAN AFRICA
New smear-positive TB cases detected and treated	21%	**9,300,000**	6,600,000	340,000	170,000	270,000	1,900,000
People treated for multidrug-resistant TB	48%	**64,000**	12,000	23,000	16,000	680	13,000
TB/HIV services provided	119%	**5,200,000**	1,100,000	210,000	55,000	81,000	3,800,000
Community-based prevention activities for TB (targeted at high-risk groups)	43%	**250,000**	16,000	170,000	56,000	–	–
Community-based prevention activities for TB (other)	47%	**13,000,000**	1,500,000	1,500,000	6,800,000	400,000	3,200,000

Note Figures are rounded and are cumulative to mid 2012. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. High-risk groups include people living in poverty, people living with HIV, people who use drugs (including tobacco), and people living with diabetes.

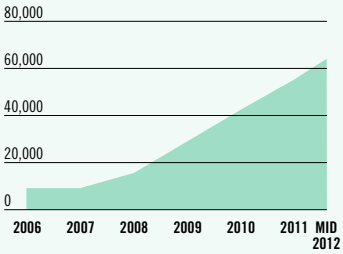
FIGURE 2.3

RESULTS FROM GLOBAL FUND-SUPPORTED TUBERCULOSIS PROGRAMS, 2006 TO MID 2012

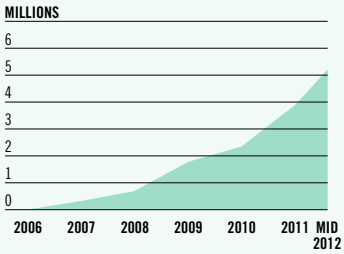
NEW SMEAR-POSITIVE TB CASES DETECTED AND TREATED



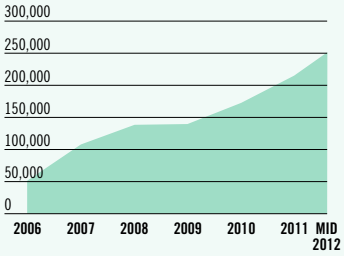
PEOPLE TREATED FOR MULTIDRUG-RESISTANT TB



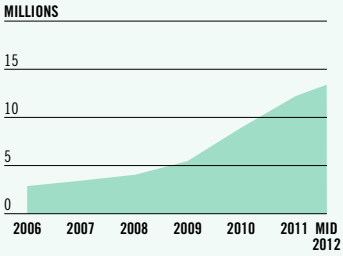
TB/HIV SERVICES PROVIDED



COMMUNITY-BASED PREVENTION ACTIVITIES FOR TB (TARGETED AT HIGH-RISK GROUPS)



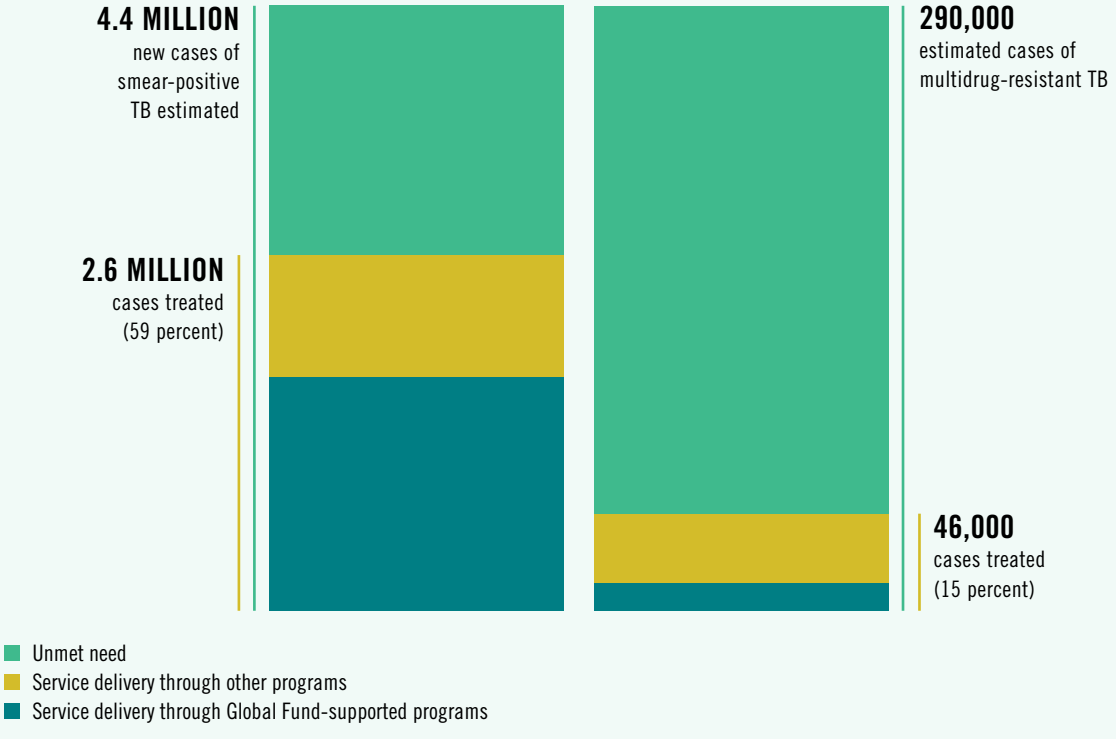
COMMUNITY-BASED PREVENTION ACTIVITIES FOR TB (OTHER)



Note Graphs present cumulative data. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. High-risk groups include people living in poverty, people living with HIV, people who use drugs (including tobacco), and people living with diabetes.

FIGURE 2.4

ESTIMATED GLOBAL FUND CONTRIBUTIONS TO INTERNATIONAL NEED AND SERVICE DELIVERY FOR TUBERCULOSIS TREATMENT, 2010



Note Figures are rounded. Results reported for 2010 do not necessarily correspond to the actual services provided during that year, since the reporting cycles of Global Fund grants vary. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. The number of new smear-positive TB cases is estimated from all forms TB incidence based on WHO recommendations.
Sources WHO, 2011 [2]. The Global Fund, 2011 [10].

12. Multidrug-resistant TB continues to pose a major risk globally, but reported cases are concentrated in 27 high-burden countries [2], 20 of which have received Global Fund support for treatment of this form of the disease. These 20 countries account for two-thirds of the 64,000 cases treated by recipients of Global Fund grants since 2002.

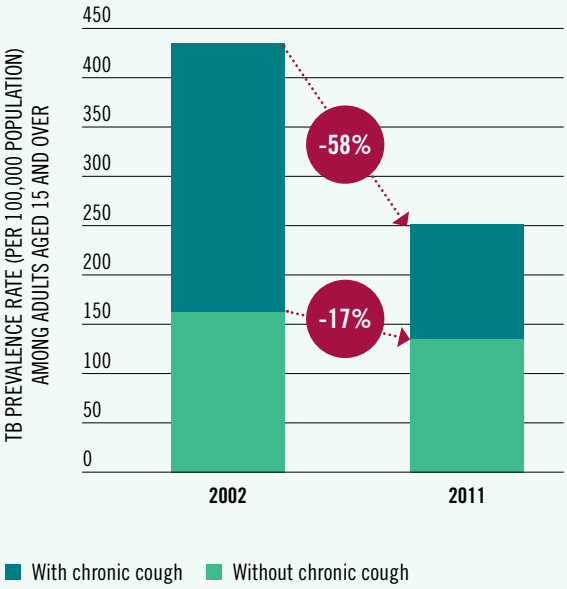
13. Alongside the efforts of partners, Global Fund-supported programs delivered 5.2 million TB/HIV services (such as screening for co-infections) – more than double the number reported at the end of 2010. The greatest scale-up has been in eastern and southern Africa, and especially in Kenya, Mozambique, Nigeria, South Africa, Tanzania and Uganda. There are 41 high TB/HIV-burden countries that account for more than 90 percent of the estimated 1.1 million co-infections [2] – 35 of which have received Global Fund support to tackle this issue. Programs in these 35 countries are responsible for 96 percent of the 5.2 million services delivered with financing from the Global Fund between 2002 and mid 2012. However, there is an urgent need to further strengthen co-infection services in order to maximize impact, especially in sub-Saharan Africa [2].

14. Figure 2.4 shows the contribution that recipients of Global Fund grants made toward the estimated need for TB care in 2010. Around the world, 2.6 million new smear-positive TB cases were notified to national TB programs [2], and Global Fund-supported programs reported the detection and treatment of 1.7 million cases (approximately two-thirds of the global total – up from 54 percent in 2009 [10]). In 2010, there were also 46,000 cases of multidrug-resistant TB enrolled on treatment globally (double the number reported in 2009). Global Fund-supported programs treated 13,000 multi-drug-resistant TB cases that year, or 28 percent of the global total. This is a smaller share of the global total compared to the 59 percent share reported in 2009 [10], reflecting the recent scale-up for this intervention from other sources. However, further progress is necessary to address the large unmet treatment need that is estimated to remain.

CAMBODIA

Over the past ten years Cambodia has documented important declines in TB prevalence, incidence and mortality [2]. Preliminary findings of two national TB disease prevalence surveys found a 43 percent decline in the prevalence of smear-positive pulmonary TB between 2002 and 2011 – an average decline of 4.7 percent per year. These declines are temporally associated with improvements in the national TB control program, notably decentralization of TB treatment from hospitals to communities (although ongoing socioeconomic development in Cambodia is also likely to have contributed). The reduction in TB prevalence is especially large among patients with chronic cough or other common TB symptoms, illustrating the success of the program's focus on these symptomatic patients. Smaller declines in prevalence among people without chronic cough underscores the importance of efforts to better reach asymptomatic TB cases, while maintaining focus on symptomatic TB cases.

PREVALENCE OF SMEAR-POSITIVE TUBERCULOSIS IN CAMBODIA, 2002 AND 2011



Source National Tuberculosis Control Program and JICA/CENAT National Tuberculosis Control Project, 2012 [17].

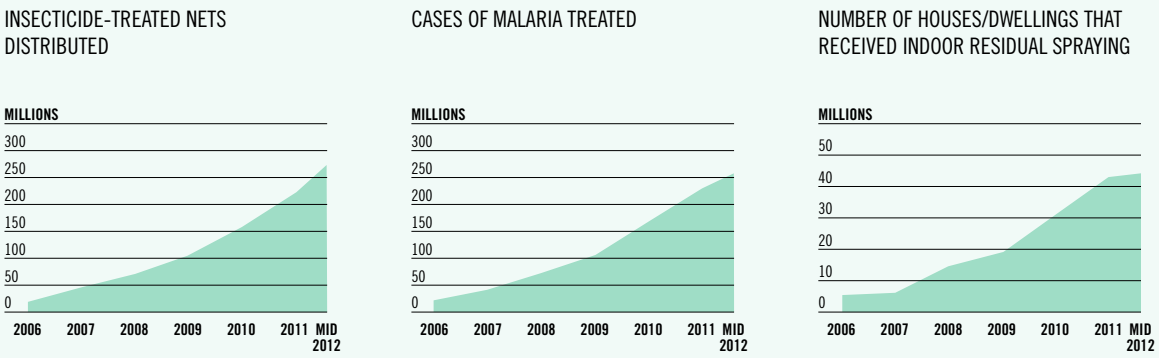
By the end of 2011, Cambodia had received US$ 24 million through Global Fund TB grants, and these grants accounted for 31 percent of the national TB control budget in 2012 [2]. With help from the Global Fund and partners, the national TB program has increased case detection rates to 65 percent, compared to 31 percent in 2000. In addition, the treatment success rate has remained consistently high at around 91 to 95 percent between 2000 and 2010.

2.3 KEY MALARIA RESULTS

15. An estimated 216 million episodes of malaria occurred around the world in 2010 (the latest available data from WHO), of which around four-fifths were in Africa [3]. In the same year the disease accounted for an estimated 655,000 deaths, including 7 percent of all childhood deaths [11]. Through its network of partners and recipients, the Global Fund has supported malaria programs in 97 countries, and approved a total of US$ 6.5 billion in funding since 2002. The Global Fund is the leading international donor for malaria alongside the U.S. President's Malaria Initiative (PMI), and accounted for around half of all international malaria funding in 2011 (See Chapter 4).

16. Because of the hard work of partners and recipients, the scale-up of key malaria services through Global Fund-supported programs has accelerated rapidly in recent years (See Figure 2.5 and Table 2.3). For insecticide-treated net distribution, the rate of annual increase between 2009 and 2011 in absolute numbers is 20 times the rate for 2006-2009. By mid 2012, recipients of Global Fund grants had distributed 270 million insecticide-treated nets and treated 260 million malaria cases. The highest rate of expansion for both interventions was in west and central Africa, where eight of the 16 countries with an extreme malaria burden are located [18]. For indoor residual spraying with insecticides, financing from the Global Fund has helped partners in eastern Africa more than double the cumulative number of houses and dwellings reached since 2010 – in particular, Ethiopia and Kenya made major contributions to this result.

FIGURE 2.5
RESULTS FROM GLOBAL FUND-SUPPORTED MALARIA PROGRAMS, 2006 TO MID 2012



Note Graphs present cumulative data. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. Figures for insecticide-treated nets include long-lasting insecticidal nets.

TABLE 2.3
RESULTS FROM GLOBAL FUND-SUPPORTED MALARIA PROGRAMS, 2002 TO MID 2012

			GLOBAL FUND REGION				
INDICATOR	SCALE-UP SINCE END 2010	TOTAL	ASIA	EASTERN EUROPE AND CENTRAL ASIA	LATIN AMERICA AND CARIBBEAN	MIDDLE EAST AND NORTH AFRICA	SUB-SAHARAN AFRICA
Insecticide-treated nets distributed	73%	**270,000,000**	46,000,000	590,000	2,000,000	15,000,000	210,000,000
Cases of malaria treated	51%	**260,000,000**	13,000,000	13,000	530,000	23,000,000	220,000,000
Number of houses/ dwellings that received indoor residual spraying	40%	**44,000,000**	2,100,000	1,100,000	170,000	1,300,000	39,000,000

Note Figures are rounded and are cumulative to mid 2012. The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. Figures for insecticide-treated nets include long-lasting insecticidal nets. While many malaria grants include the provision of community-based prevention activities, these often take place alongside insecticide-treated net distribution, so they do not appear as a separate indicator here.

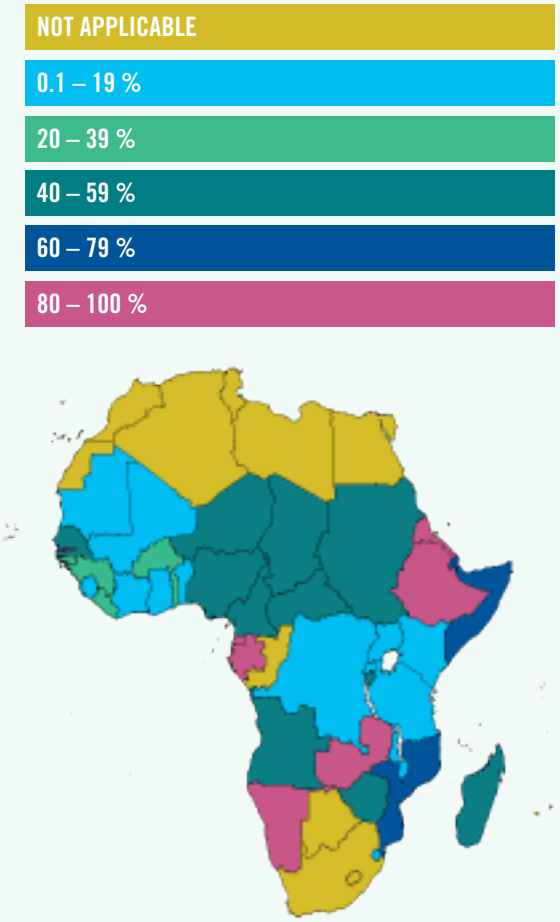
This young boy in the Solomon Islands has just received an insecticide-treated net through a Global Fund-supported program. By mid 2012, recipients of Global Fund grants had distributed 270 million insecticide-treated nets and treated 260 million malaria cases.

17. The Global Fund has also supported the distribution of rapid diagnostic tests for malaria, but their scale-up is lagging behind that for artemisinin-based combination therapy (ACT). In 2010 the coverage of ACT through national malaria programs in sub-Saharan Africa was more than twice the number of tests conducted (including microscopy and rapid diagnostic tests) – indicating that many patients received treatment without having their diagnosis confirmed. Greater investments in quality-assured diagnostic tests will maximize impact and value for money by ensuring more effective use of ACT [3].

18. Between 2008 and 2010, households in 42 African countries received an estimated 237 million insecticide-treated nets. As Figure 2.6 shows, the Global Fund has supported programs to distribute insecticide-treated nets in 41 of these countries (the only exception being Botswana), and its support accounted for 83 million of the nets distributed (35 percent) [3]. Global Fund grants financed more than 80 percent of national insecticide-treated net distribution in Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Namibia and Zambia. In 2010, 22 sub-Saharan African countries reported a total of 111 million treatment courses delivered to malaria patients, and Global Fund-supported programs accounted for more than one-third of these [3].

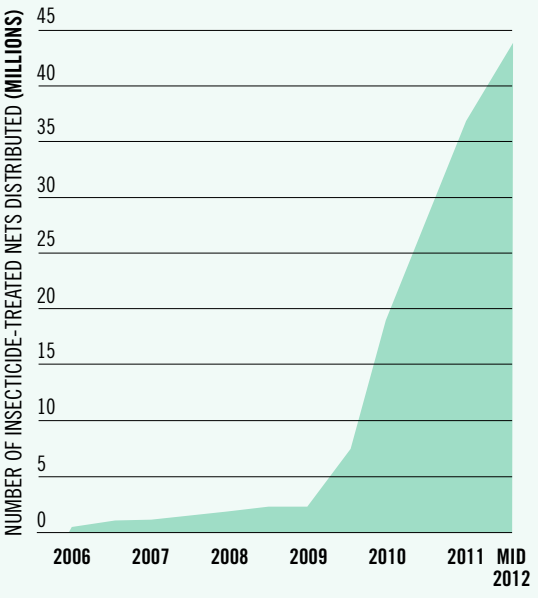
19. Despite rapid expansion in coverage, the Global Fund's malaria grants continue to underperform relative to their agreed targets (See Chapter 2.5). This is largely attributable to the challenges faced by some of the largest malaria grants in the portfolio, and to the setting of over-ambitious targets. In Nigeria, for example, significant achievements have occurred in insecticide-treated net distribution in recent years [10]. The scale-up has been dramatic – from 2.4 million nets by the end of 2009 to 44 million by mid 2012 (See Figure 2.7). However, the original target to distribute 63 million nets by the end of 2010 has still not been reached. Ensuring success in high-burden countries such as Nigeria will be critical to reaching global malaria targets.

FIGURE 2.6
ESTIMATED GLOBAL FUND CONTRIBUTIONS TO INSECTICIDE-TREATED NET DISTRIBUTION IN AFRICA, 2008-2010



Note "Not applicable" refers to countries/territories that have not received Global Fund malaria grants or do not have available data.

FIGURE 2.7
CUMULATIVE NUMBER OF INSECTICIDE-TREATED NETS DISTRIBUTED BY GLOBAL FUND-SUPPORTED PROGRAMS IN NIGERIA, 2006 TO MID 2012

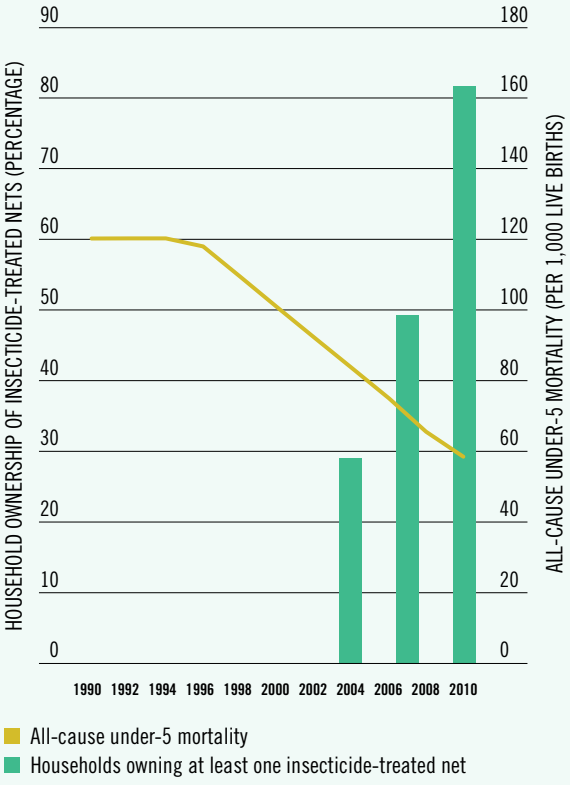


In 2004 WHO recommended ACT as the treatment of choice for malaria. Although more expensive than previous generations of medication, the three-day course of pills has proven to be extremely effective in treating the disease.

TANZANIA

Tanzania (including Zanzibar) has been rolling out insecticide-treated net distribution nationwide since 2004, and adopted ACT as the first-line malaria treatment in 2006. These intensified malaria control efforts have helped bring about marked declines in all-cause under-5 mortality, as well as in anemia and parasitemia prevalence among young children. Based on epidemiological modeling, insecticide-treated net distribution alone had lowered under-5 mortality in Tanzania by an estimated 15 percent by the year 2010 (with additional contributions attributed to improved maternal and child health services, including vitamin supplements and vaccines) [19].

HOUSEHOLD OWNERSHIP OF INSECTICIDE-TREATED NETS AND ALL-CAUSE UNDER-5 MORTALITY IN TANZANIA, 1990-2010



Source Roll Back Malaria Partnership [19].

The Global Fund and PMI have, respectively, contributed 55 percent and 32 percent of the Tanzanian malaria control budget between 2000 and 2010. Household ownership of at least one insecticide-treated net increased from 23 percent in 2004 to 63 percent in 2010. In addition, 56 percent of pregnant women and 65 percent of children under 5 reported sleeping under an insecticide-treated net the previous night in 2010 [19].

2.4 OTHER KEY RESULTS

KEY PERFORMANCE INDICATORS

20. The Global Fund uses a framework of key performance indicators to ensure its effectiveness and hold itself accountable as an international financing institution [20]. The aim is to support the organization's continuous improvement, focused on four levels of performance:

- the impact that Global Fund-supported programs achieve in tackling HIV, TB and malaria (See Chapter 3);
- the effectiveness of the Global Fund's aid in achieving development results, strengthening health and community systems, and promoting gender equity and value for money;
- the performance and results of Global Fund grants in comparison to agreed-upon targets (See Chapter 2.5); and
- the Global Fund's own operational performance, including the execution of Secretariat functions such as portfolio management, administrative effectiveness and resource mobilization.

21. At the end of 2011, 90 percent or more of the targets had been achieved for ten key performance indicators. A further ten indicators achieved between 60 and 89 percent of their targets, and two performed below expectations (the speed of grant signing and aid effectiveness) [21]. Achievements include continued strong performance in terms of value for money (See Chapter 4.3), the solid performance of Global Fund-supported programs, improvements in performance-based funding (See Chapter 2.5), and resource mobilization within the private sector (See Chapter 4.1).

HEALTH SYSTEMS STRENGTHENING

22. In addition to investing in HIV, TB and malaria interventions, the Global Fund also provides considerable support to partners and recipients that work across health systems. It provides crosscutting funding to support interventions that help improve sustainability, equity and efficiency of health systems in general, and enhance quality of care for all patients. Disease-specific investments also help to strengthen essential components of health care such as service delivery, procurement and supply-chain management, stewardship and governance, finance, human resources, and health information systems.

23. For example, the Global Fund supports social health insurance schemes for disadvantaged populations in **Rwanda**, as well as community-based health insurance schemes in the informal sector. In **Liberia**, Global Fund grants have been used to strengthen hospital capacity and meet the staffing requirements for delivering a nationally defined "Essential Package of Health Services." In **Indonesia**, support is being given to improve pharmaceutical supply chain management and drug safety by building laboratory capacity for the sampling and testing of drugs, and improving the monitoring of adverse events. In **Tanzania**, money from the Global Fund has enabled warehouse space for medical products to double, and has strengthened the Ministry of Health's procurement unit. In **Nicaragua**, Global Fund grants have helped to develop the governance capacities required to implement a national policy for sexually transmitted infections.

24. Between 2002 and mid 2012, recipients of Global Fund grants delivered 14 million "person episodes" of training to health and community workers.[3] By the end of 2011, key activities for health systems strengthening were performing well: Global Fund grants reached 94 percent of their targets for health workforce activities, 83 percent for procurement and supply management activities, and 92 percent for health information system activities.

3 "Person episodes" is a cumulative measure of training program attendance that accounts for the fact that one individual could attend more than one program.

COMMUNITY SYSTEMS STRENGTHENING

25. The term "community systems strengthening" refers to the provision of financial, technical and other support to organizations and agencies that work directly with and in communities. From the Global Fund's perspective, most of this support is for grassroots civil society organizations and networks – but both civil society and government bodies can provide community-based services. Following finalization of the Global Fund's Community System Strengthening Framework in 2010 [22], a new key performance indicator has assessed overall performance of key community systems indicators.

26. By the end of 2011, 76 Global Fund grants had included indicators measuring community systems strengthening activities (i.e. the number of community-based organizations that are participating in national program reviews, or the number of community volunteers provided with incentives). These grants reached 95 percent of their targets for the relevant activities in 2011 [21].

27. In **Cambodia**, community system strengthening programs underwritten by the Global Fund have supported lay health volunteers to act as a bridge between the health system and the community. This has improved awareness and service uptake, while community engagement has also contributed to reduced stigma and increased treatment adherence [23]. The Global Fund also supports a multicountry grant in **East Asia and the Pacific** that provides support to networks of people living with HIV in Bangladesh, Indonesia, Lao (People's Democratic Republic), Nepal, Pakistan, Philippines and Viet Nam. The program is helping to strengthen networks, communication, training and advocacy. In addition, community system strengthening features in TB and HIV programs financed by the Global Fund in **Kenya**, which support 17 civil society organizations focused on the diagnosis of TB cases in the community, whereby existing community groups are receiving training to provide home visits, nutritional assessments and social support for people with TB.

AID EFFECTIVENESS

28. In 2011 the Global Fund measured its aid effectiveness for the 2010 fiscal year by calculating results for 74 of the 80 countries that participate in the Paris Declaration monitoring process [24].[4] Of the nine aid effectiveness indicators, the Global Fund continues to perform well on four. For example, most Global Fund financing (96 percent) supports program-based approaches, in which donor coordination bodies are in place and grants are part of national disease programs. In addition, most Global Fund-supported purchases used national procurement systems, and all Global Fund financing is "untied" (meaning that no restrictions govern from which countries recipients can procure goods and services). Closer relationships are required between in-country health and finance ministries to ensure that Global Fund financing is recorded in country budgets, and that the predictability of Global Fund financing increases – both of which will improve country ownership, effective planning and aid transparency.

4 The remaining six countries only have nongovernmental Principal Recipients, whereas the Paris Declaration monitoring exercise focuses on government recipients.

2.5 GRANT PERFORMANCE

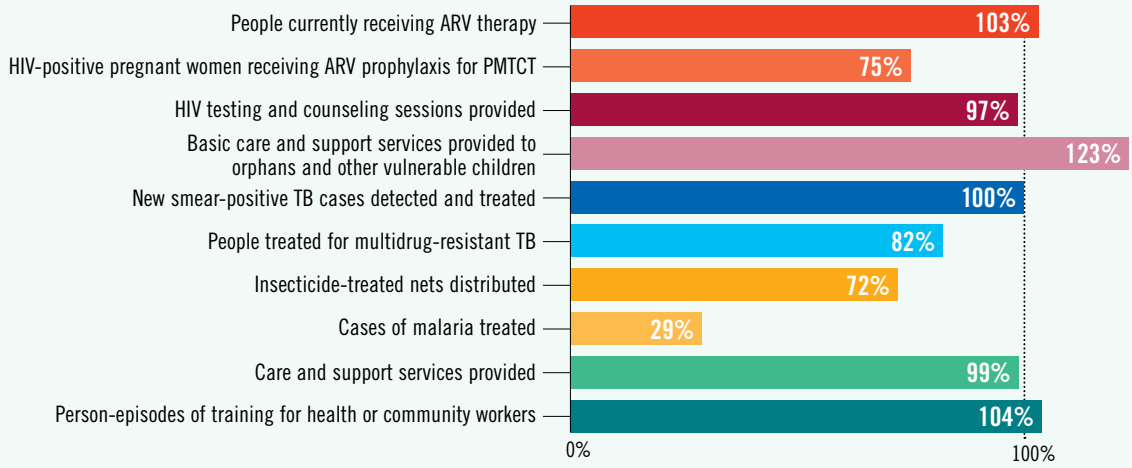
29. The Global Fund model is built on performance-based funding: the premise of its grant-making is that funding for country-owned programs goes hand-in-hand with the responsibility to achieve verifiable results at every stage. Programs have to account for any deviations from their targets, and must take action to build capacity and improve results where required. This ensures that recipients not only measure but also manage their programs well, using funding to strengthen implementation with the support of partners. Each grant has a performance framework of ambitious yet realistic targets for delivery of key services agreed between the Global Fund and the Principal Recipient(s) [8]. To inform renewal decisions, all Global Fund grants receive performance ratings during in-depth progress reviews that take place after two or three years of implementation, assigned through a systematic methodology. The Global Fund uses predefined disbursement ranges for each performance rating (A1, A2, B1, B2 or C) to maximize the likelihood that future funding is linked to past performance, while also working hard with partners to support those grants that are underperforming or facing difficulties. Chapter 2.6 describes changes to the grant renewal process in more detail.

30. Figure 2.8 documents the aggregate performance reported by the Global Fund's grants in terms of their agreed targets for selected interventions at the time of renewal. By the end of 2011, Global Fund grants had achieved more than 80 percent of their targets for most indicators. Grant recipients were meeting or exceeding targets for ARV therapy, services for orphans and other vulnerable children, TB treatment, and training. There was notable underperformance for malaria treatment, which has been a consistent issue in previous years but has further declined from 59 percent since the end of 2010 [10]. **Nigeria** alone accounted for more than half this underperformance, as Global Fund malaria grants in the country faced delays in the procurement of medicines, resulting in the treatment of 16 million malaria cases compared to a target of 138 million.

31. By the end of 2011, 628 of the Global Fund's grants had been through in-depth progress reviews. As Figure 2.9 shows, 25 percent received an A rating to indicate that they had met or exceeded expectations. A further 52 percent received a B1 rating to indicate that they performed adequately. One-fifth of the reviewed grants received a B2 rating which means they performed inadequately but demonstrated potential, and the remaining 3 percent received a C rating to indicate that they performed unacceptably. Since Global Fund grant reviews began, the proportion of grants rated as A or B1 has averaged 70 to 80 percent (See Figure 2.10). In 2011, grants rated A1 or A2 received an average of 84 percent of their original renewal amounts, while those rated B2 or C received an average of just 40 percent – which helps demonstrate the organization's adherence to the performance-based funding approach that ensures funding goes to programs that can use it most effectively [21].

FIGURE 2.8

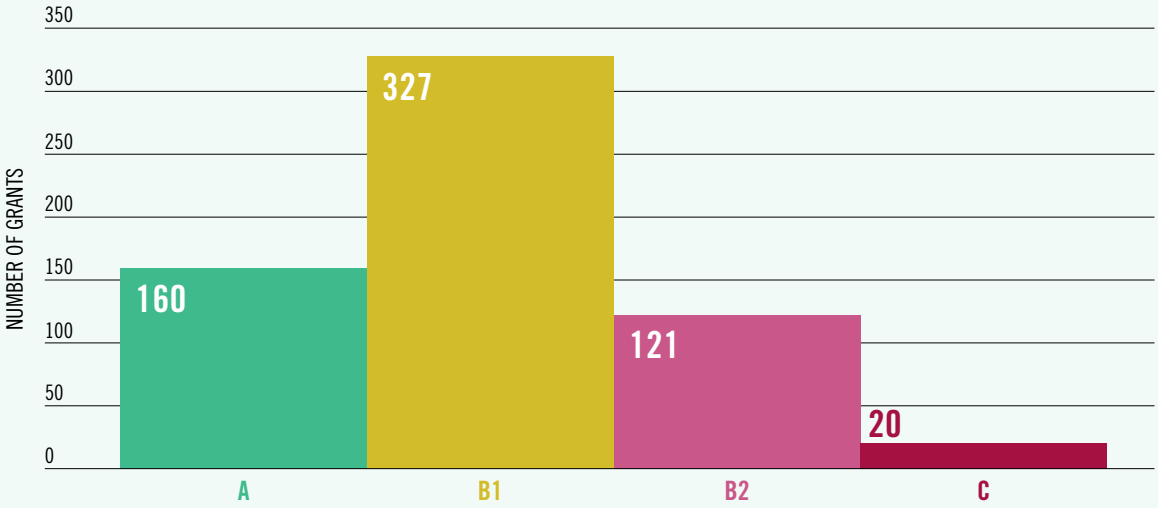
CUMULATIVE RESULTS ACHIEVED BY GLOBAL FUND-SUPPORTED PROGRAMS AT REVIEW AGAINST TARGETS FOR KEY SERVICES, END 2011



Note Figures for insecticide-treated nets include long-lasting insecticidal nets. "Person episodes" is a cumulative measure of training program attendance that accounts for the fact that one individual could attend more than one program.

FIGURE 2.9

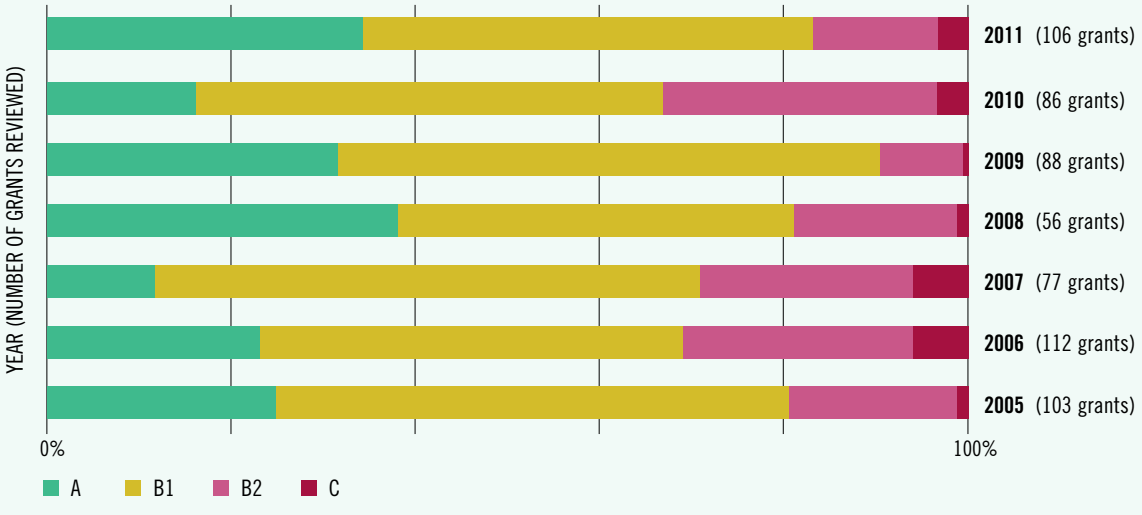
CUMULATIVE DISTRIBUTION OF PERFORMANCE RATINGS DURING GRANT REVIEW, END 2011



Note "A" refers to grants that received A1 or A2 ratings.

FIGURE 2.10

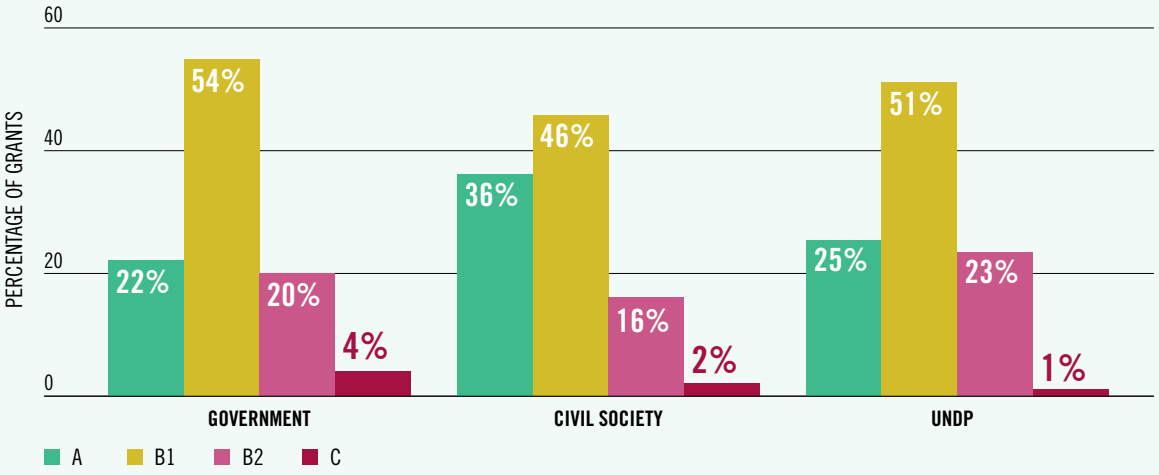
DISTRIBUTION OF PERFORMANCE RATINGS DURING GRANT REVIEW, 2005-2011



Note "A" refers to grants that received A1 or A2 ratings.

FIGURE 2.11

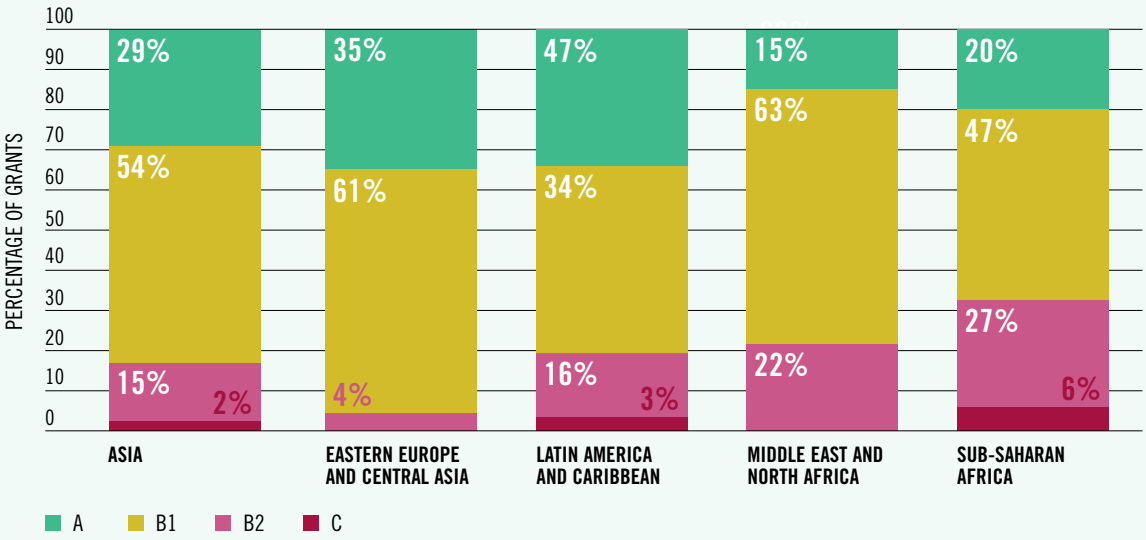
CUMULATIVE DISTRIBUTION OF PERFORMANCE RATINGS DURING GRANT REVIEW BY TYPE OF PRINCIPAL RECIPIENT, END 2011



Note "A" refers to grants that received A1 or A2 ratings.

FIGURE 2.12

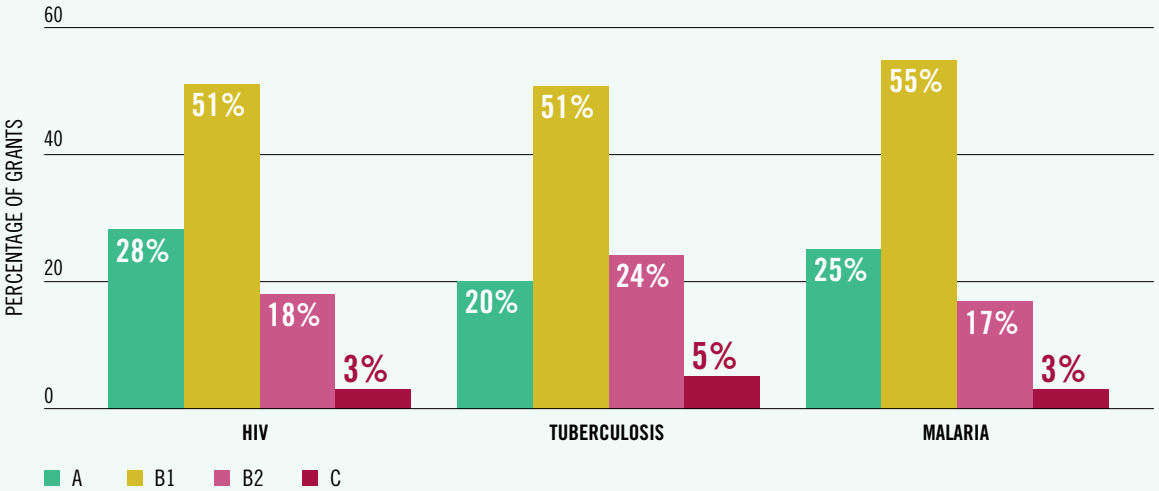
CUMULATIVE DISTRIBUTION OF PERFORMANCE RATINGS DURING GRANT REVIEW BY REGION, END 2011



Note "A" refers to grants that received A1 or A2 ratings. The Global Fund's definitions of regions differ from those used by partners – for more information, see http://portfolio.theglobalfund.org

FIGURE 2.13

CUMULATIVE DISTRIBUTION OF PERFORMANCE RATINGS DURING GRANT REVIEW BY DISEASE, END 2011



Note "A" refers to grants that received A1 or A2 ratings. HIV grants include those for TB/HIV.

32. Figure 2.11 shows that the majority of grants were performing well across the different types of Principal Recipient. Civil society Principal Recipients continued to perform particularly strongly – 82 percent of their grants were rated as A or B1 by the end of 2011, compared to 76 percent of the grants managed by government agencies, and 76 percent of the grants managed by the United Nations Development Programme (UNDP). UNDP typically serves as the Principal Recipient under difficult circumstances, or where local implementing capacity is limited. UNDP works with other partners to increase the capacity of local implementers with a view to handing over control of the grant when appropriate. In **El Salvador**, for example, UNDP has managed HIV and TB grants since 2003, and is helping strengthen national systems to ensure a smooth handover to local Principal Recipients in 2012 for the TB program and 2013 for the HIV program.

33. Grant performance was largely consistent across the five Global Fund regions by the end of 2011, although a higher proportion of grants in sub-Saharan Africa underperformed (See Figure 2.12), which possibly reflects the increased complexity and size of these grants, as well as a need for further capacity building. Since 2002 no grants in Eastern Europe and Central Asia or the Middle East and North Africa have received a C rating to indicate that they are performing unacceptably. Grant performance has also been consistently strong across the three diseases, as more than 70 percent of HIV, TB and malaria grants have received A or B1 ratings (See Figure 2.13).

IMPROVING PERFORMANCE

34. When underperformance is identified during the review of grants, this serves as a warning for program implementers, partners and the Global Fund, and acts as a stimulus for corrective actions to be taken. Of the 75 grants that received B2 or C ratings at the end of 2010, 30 were able to improve their performance ratings to B1 or above during 2011 [21]. The remaining grants generally operate in high-risk environments and have typically suffered from oversight and governance issues, weak management capacity, insufficient procurement and supply management safeguards, poor financial controls, and/or significant delays in implementation. Since 2002 the Global Fund has made just 16 decisions not to renew grant funding at the review stage (including for four grants in 2011 alone) – which indicates the organization's commitment to rectifying issues and turning around grants that are struggling to deliver, rather than cancelling grants at the first sign of difficulties.

35. In **Zimbabwe**, for example, special procedures were introduced in 2008 due to the underperformance of Global Fund grants across all three diseases. This was linked to the country's hyperinflation crisis, and to financial controls imposed by the government (meaning that Principal Recipients were unable to access grant funds). In response, and after careful assessment, Principal Recipient responsibilities were transferred to UNDP – allowing funds to flow again toward the national organizations contracted to deliver essential services. This move had an immediate and sustained effect on performance, with grant ratings improving from B2 or C to A1 and A2. Discussions are underway to transition grant management responsibilities from UNDP back to national Principal Recipients, and the situation will be re-examined after the country's elections in 2013.

2.6 IMPROVING MEASUREMENT OF RESULTS AND IMPACT

36. As the Global Fund's grant portfolio has grown in size and complexity over the last ten years, the ways that performance of supported programs are assessed have also evolved. In the early years, the organization and its partners placed their focus on urgently disbursing money to programs, and analyzed performance in terms of outputs, such as the delivery of lifesaving services (i.e. the number of people receiving treatment or the number of insecticide-treated nets delivered). After a decade of success and innovation, the Global Fund and its investments are now maturing and the scale-up in services is having measurable effects on reducing the burden of the three diseases in many places (See Chapter 3). The focus is now on working with partners to assess what *impact* has been collectively achieved (i.e. changes in incidence, prevalence and mortality), and ensuring that new resources are invested strategically to make the impact sustainable.

37. The maintenance of the Global Fund's model of performance-based funding requires an underpinning of valid and reliable programmatic data. This, in turn, requires the strengthening of in-country monitoring and evaluation systems. Shifting to a greater focus on outcomes and impact puts additional emphasis on supporting the production of high-quality data on mortality, morbidity, prevalence and incidence. The Global Fund will be improving the ways that it reports and uses results, as described below.

STRENGTHENING COUNTRY SYSTEMS

38. The Global Fund recommends that recipients invest between 5 and 10 percent of their grant budgets in strengthening monitoring and evaluation systems. Between 2002 and the end of 2011, recipients spent more than US$ 780 million on these activities – approximately 5 percent of total reported expenditure. By the end of 2011, more than 60 percent of Global Fund-supported programs had submitted a national monitoring and evaluation plan (compared to 49 percent in 2009), thereby increasing alignment between data requirements of Global Fund grants and those of national disease programs.

39. The Global Fund is working closely with technical and in-country partners to strengthen monitoring and evaluation systems, with a focus on the common challenges related to health information systems, surveys, surveillance, vital registration and analytical capacity. Assessments of in-country monitoring and evaluation systems will lead to the development of remedial action plans where required, and the Global Fund will promote the redirection of grant funds toward identified strengthening measures. The Global Fund will also continue to use tools such as the On-Site Data Verification (an assessment conducted by Local Fund Agents at least once a year) and Data Quality Audits (conducted on a selected number of grants each year) to monitor the quality of data reported to the organization.

IMPROVING MEASUREMENT STANDARDS

40. The Global Fund provides standardized indicators and definitions for recipients to use [8], but allows flexibility so they can be aligned with implementers' national reporting systems. However, the organization currently manages a vast number of different programmatic measures that require substantial effort to analyze and aggregate. The Global Fund has worked with partners to develop a more focused and prescriptive choice of indicators. For example, the refined indicator package for insecticide-treated nets includes a programmatic indicator (the number of insecticide-treated nets distributed to target populations), an outcome indicator (the percentage of individuals who slept under an insecticide-treated net the previous night), and impact indicators (malaria-specific deaths and confirmed malaria cases per 1,000 persons per year). This streamlining should enable better data analysis and will be complemented by better disaggregation of data in terms of target groups, age, sex and location.

LEVERAGING NEW TECHNOLOGIES

41. To strengthen routine data reporting, the Global Fund is working with partners (including the private sector) to leverage new technologies and ensure that the collection and reporting of data is timely and of high quality. For example, the widespread availability of mobile phones can improve the speed and completeness of data reporting, particularly from remote locations.

When Grace was admitted to the General Hospital in Port Moresby, Papua New Guinea with severe TB of the spine, she was effectively paralyzed. After receiving treatment she made a strong recovery and is now beginning to walk again. Her husband is being encouraged to learn some physiotherapy so he can further aid Grace's recovery once she is discharged.

42. In **Swaziland**, the recipients of Global Fund malaria grants use an Immediate Disease Notification System, which allows health workers to report confirmed malaria cases by calling a toll-free number. The system has significantly improved reporting by health facilities, while centralized data collection has reduced the administrative burden on health care workers and strengthened information systems. In **Nigeria**, the Global Fund and partners supported the government's roll-out of the Logistics and Health Program Management Information Platform. This system transmits routine HIV data from 215 service delivery points by using mobile phone technology, while also sending key program and logistics information back to the field. In **Colombia**, financing from the Global Fund has supported the piloting of a system which reads malaria rapid tests and sends results to the central disease surveillance system – thus minimizing human error and reporting delays. In **Ethiopia**, the Global Fund-supported TB program works alongside an innovative community-based TB project funded by TB REACH, whereby community health workers use mobile phones to facilitate communication with supervisors, collection of smears and treatment for confirmed cases. The project has doubled TB case notification in the first year alone [25]. In **Ukraine**, the International HIV/AIDS Alliance Ukraine (a civil society Principal Recipient) has used financing from the Global Fund to introduce a specially developed database to monitor the provision of HIV services to most-at-risk populations – using unique identifier codes to prevent the double-counting of individuals and enabling better assessments of service coverage. The software allows for real-time reporting to the Global Fund, and is used by more than 150 nongovernmental organizations in Ukraine (as well as groups from Belarus, Kazakhstan, Kyrgyzstan, Malaysia and Tajikistan).

FOCUSING ON IMPACT

43. As the Global Fund focuses more on measuring impact and ensuring more strategic investments, the decision-making processes for reviewing and renewing grants have also evolved. Every grant undergoes a major review after two or three years of implementation to assess the progress made and to approve further funding. These reviews now include a seven-step decision-making process that includes an assessment of impact (or "progress toward proposal goals") (See Figure 2.14), and each program will receive a systematic impact rating based on data from countries and partners. The Global Fund's new strategy emphasizes the need to incentivize and facilitate reprogramming, so the assessment of impact at this stage will help recipients adapt, improve and focus their programs where necessary (See Chapter 3.4). This approach was used for the first time during the review of malaria grants in Bangladesh in early 2012. The new methodology informed the decision to redirect malaria funding toward high-risk districts to address an existing imbalance in coverage (See Page 50).

FIGURE 2.14
DECISION-MAKING INPUTS DURING GRANT RENEWALS

Source The Global Fund, 2012 [26].

44. In line with the objectives of its new strategy, the Global Fund has also invited key technical partners to participate more actively in the grant renewal process, including as part of the Secretariat's grant renewals panel. This enhanced partnership approach has yielded positive results already. Guidance from partners has been crucial in the following grant renewal recommendations: accelerating toward universal access to insecticide-treated nets in **Nigeria**; enhanced targeting of investments toward affected populations in **Ghana**; the reprogramming of grant funds to strengthen multidrug-resistant TB treatment in **Tajikistan**; and the provision of follow-up assistance to grants in **Armenia** to better define interventions for HIV testing among migrants. Partners are also playing a crucial role in supporting countries where available data show limited impact from the investments that have so far been made.

45. Much of the data used to assess progress toward the health-related Millennium Development Goals, as presented in Chapter 3, stems from estimation models of the Global Fund's technical partners – predominantly UNAIDS and WHO. All model-based estimates are subject to inherent limitations and assumptions, however, these data do undergo regular updates and revisions as new information and methods become available. To help build a more complete epidemiological picture, the Global Fund Secretariat is working with implementers, partners and its own independent Technical Evaluation Reference Group to conduct a series of program impact evaluations over the next three years (See Box 2.1). These evaluations will support grant reviews, enable informed decisions on grant renewals and reprogramming, and contribute to building an evidence base in preparation for the Global Fund's ten-year evaluation. They will also feed into the review of global progress toward the health-related Millennium Development Goals, in preparation for 2015. The Global Fund also provides financial support for countries to undertake comprehensive program reviews and assess progress toward the Millennium Development Goals [26], and these reviews are key sources of information for grant renewal decisions.

BOX 2.1
THE GLOBAL FUND APPROACH TO EVALUATIONS

The Global Fund's independent Technical Evaluation Reference Group has agreed on the following definition of impact evaluation:

"Impact evaluation assesses the overall impact on the burden of cases and deaths due to the three diseases. It will assess causation and the contribution of the Global Fund and other explanations along the results chain from inputs to outcomes".

This definition draws on work by the World Bank, the Organisation for Economic Co-operation and Development, and other sources – while applying it to the context of the Global Fund and its recipients. The process will involve baseline analyses of secondary data, in-country reviews and analyses building on existing program reviews, and the production of evaluation reports.

46. To implement this new initiative, the Global Fund's evaluation strategy will build upon and complement in-country reviews and the activities of partners, including WHO, the World Bank, the GAVI Alliance, PEPFAR, PMI and UNAIDS. The evaluations will primarily focus on changes in disease incidence, prevalence, mortality and/or morbidity – both positive and negative – as well as any measurable changes in related behaviors. These evaluations are designed to help build the capacity of supported programs to measure and act on their evidence of impact on HIV, TB and malaria. They will also directly measure lives saved, enabling the Global Fund strategy to be evaluated against its targets in 2014 and 2016.

3. IMPACT

Villagers sit in front of their house in a remote area of South Sudan where malaria is endemic. Through a Global Fund grant, members of the community have been trained in malaria diagnosis and treatment, and these services are provided for free to the villagers.

KEY POINTS

1

HIV incidence and mortality are declining across the world – 41 percent of countries that have received Global Fund support are on track to meet the international target for ARV therapy coverage, and 32 percent are on track to achieve the international PMTCT prophylaxis target.

2

TB mortality has reduced dramatically since 2000 – at least half the countries that have received Global Fund support are on track to meet the international targets for case detection, treatment success and TB disease incidence.

3

For malaria, important declines in case incidence and mortality have been seen in recent years alongside significant increases in the coverage of insecticide-treated net distribution – yet further acceleration is needed to achieve the relevant international targets by 2015.

4

The Global Fund is developing a new funding model that will increase the strategic allocation of resources to maximize impact. Based on enhanced dialogue with applicants, technical partners and donors, this model will provide more flexible and predictable funding opportunities.

KEY TERMINOLOGY FOR CHAPTER 3

Incidence: The number of new cases reported among a given population in a given time period (i.e. a calendar year). It is often presented as a rate per unit of population (i.e. per 100,000 people) to account for changes in population size.

Mortality: The number of reported deaths in a given population in a given time period (i.e. a calendar year). Like incidence, it is often presented as a rate per unit of population.

High-burden countries: Countries that are defined by the relevant UN agencies as having the largest health burdens associated with HIV, TB or malaria.

High-impact countries: A Global Fund list of 20 countries with the highest collective burdens of HIV, TB and malaria, and in which the Global Fund has the greatest investments (See Box 1.3).

1. As a result of increased funding, scientific and technological advances, and strengthened capacity, low- and middle-income countries are continuing to make steady progress toward reducing the burden of HIV, TB and malaria. Progress toward achieving the Millennium Development Goal targets for HIV and TB is on track [5]. Progress toward the international targets for malaria has been slower, yet significant gains have been achieved. However, many countries still have much to do between now and 2015.

2. This chapter summarizes the impact achieved toward the health-related Millennium Development Goals and other key international targets, and draws on the best available estimates from technical partners. Although these data are based on country reports, they come with inherent methodological limitations.[5] This analysis does not directly attribute impact to Global Fund support – instead it demonstrates what is being achieved alongside partners in recipient countries with the help of the scale-up in key services presented in Chapter 2.

3. The Global Fund measures impact with a set of 12 indicators selected with technical partners based on the Millennium Development Goals [5] and other international targets [2, 3, 27] (See Box 3.1). These indicators focus primarily on MDG6 ("Combat HIV/AIDS, malaria and other diseases"). However, Global Fund investments also contribute toward MDG4 ("Reduce child mortality") and MDG5 ("Improve maternal health") (See Box 4.1).

BOX 3.1

INDICATORS AND TARGETS USED BY THE GLOBAL FUND TO ASSESS IMPACT

1. Declining trend in HIV incidence rate (all ages), by 2015
2. Declining trend in HIV mortality rate (all ages), by 2015
3. 80 percent coverage of ARV therapy for those in need, by 2015
4. 90 percent coverage of PMTCT for those in need, by 2015
5. Declining trend in TB incidence rate (all forms), by 2015
6. 50 percent reduction in TB mortality rate (excluding people living with HIV/AIDS) between 1990 and 2015
7. 70 percent case detection rate for all forms of TB, by 2015
8. 90 percent treatment success rate for new smear-positive TB cases, by 2015
9. 75 percent reduction in malaria disease incidence rate between 2000 and 2015
10. 75 percent reduction in mortality rate associated with malaria disease between 2000 and 2015
11. 80 percent household ownership of insecticide-treated nets, by 2015
12. 67 percent reduction in all-cause under-5 mortality rate between 1990 and 2015 (in countries with more than 5 percent of under-5 mortality due to malaria)

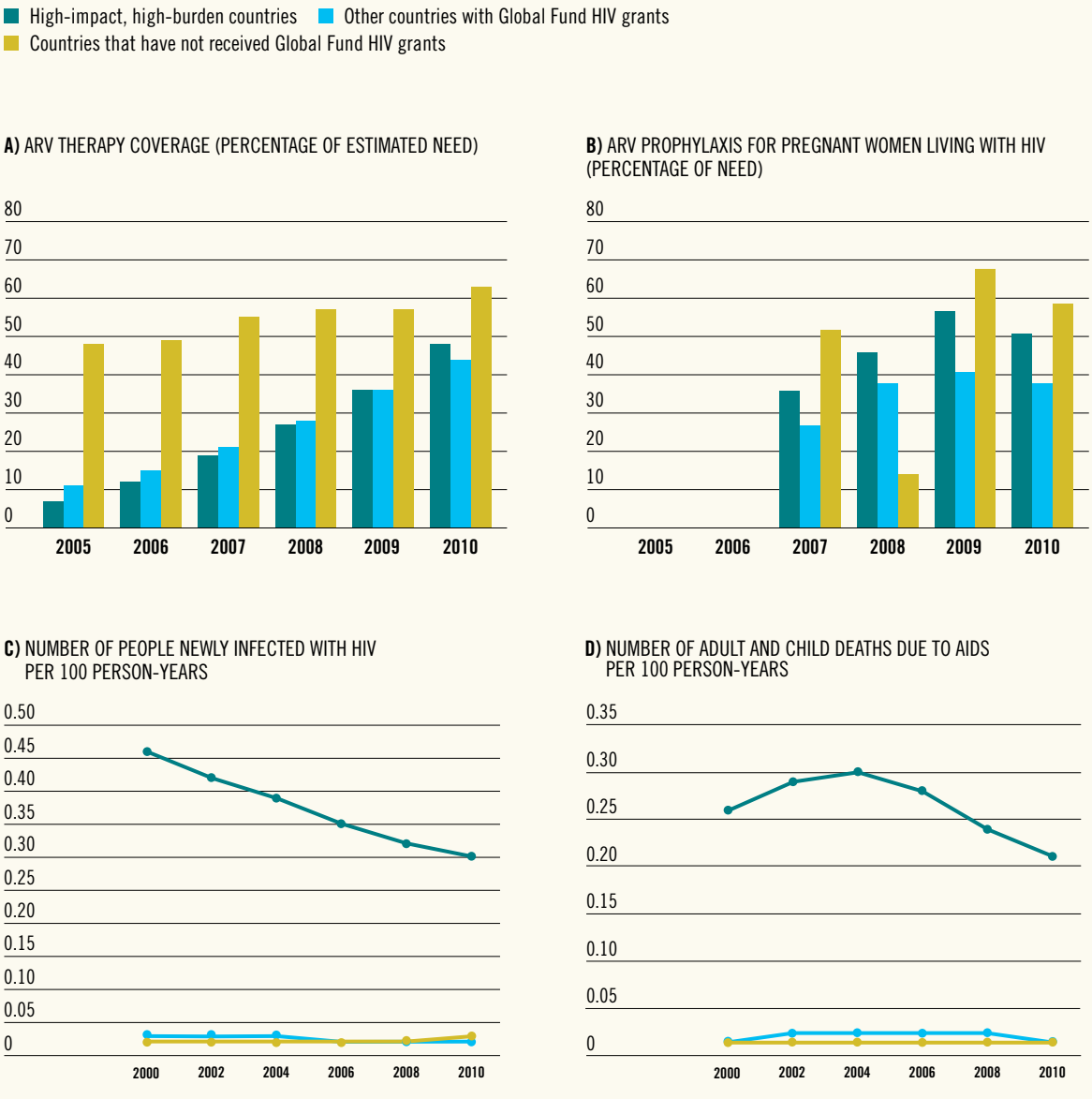
5 For more information, see the Methodology Web Annex available from http://www.theglobalfund.org/documents/publications/progress_reports/Publication_2012Results_Annext_en/

A lab technician checks a blood film for the presence of malaria parasites at Sultan Hassanudin Hospital, Indonesia. The Global Fund finances microscopes as part of a program that aims to reduce the number of malaria-related deaths in the Kalimantan and Sulawesi island region.

3.1 CONTRIBUTIONS TOWARD INTERNATIONAL TARGETS FOR HIV

4. Figure 3.1 presents the trends in key HIV outcome and impact indicators across low- and middle-income countries. The coverage of ARV therapy for those in need has increased dramatically, from 9 percent in 2005 to 47 percent in 2010. The scale-up has been particularly fast in Global Fund-supported countries, but there is still much to do if the target of 80 percent global coverage is to be reached by 2015.

FIGURE 3.1
KEY HIV TRENDS IN LOW- AND MIDDLE-INCOME COUNTRIES



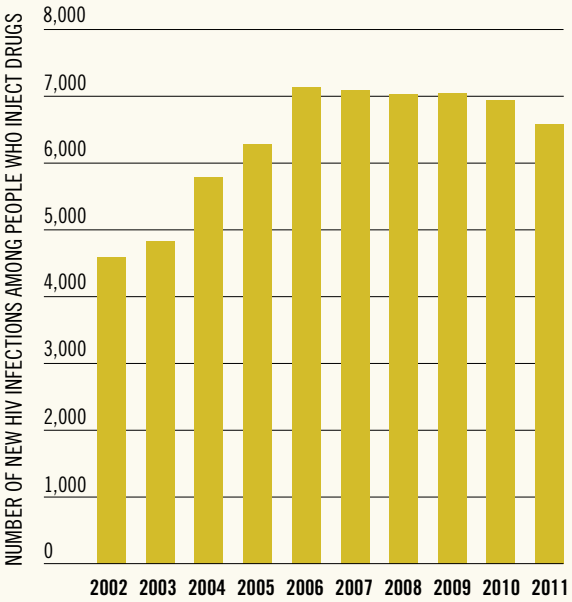
Note ARV therapy and PMTCT coverage is based on the estimated number of people who are receiving treatment compared to the estimated need (using UNAIDS/WHO methodology). The need for ARV therapy is based on the WHO-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3. In the case of missing data for ARV therapy coverage in 2010, the latest available data (i.e. from 2009 or 2008) were used instead. For PMTCT coverage, data from 2005 and 2006 were unavailable. Estimates of HIV incidence and mortality are provisional, and the 2010 data point was extrapolated using data from previous years. Countries with only multicountry grants were excluded from this analysis, and Graphs C and D also exclude Ethiopia because of the lack of available data. For the list of "high-impact, high-burden" countries, see Table 3.1. The low- and middle-income countries that had not received Global Fund HIV grants were: Brazil, Fiji, Latvia, Lebanon, Lithuania, Malaysia, Panama and Uruguay. **Source** UNAIDS, 2010 [32].

With Global Fund support, services to prevent and treat HIV have reached 25,000 prisoners in Ukrainian prisons between 2005 and 2011. Among these and other at-risk populations, HIV incidence has been steadily declining in recent years.

UKRAINE

The HIV epidemic in Ukraine is driven primarily by most-at-risk populations – people who inject drugs, men who have sex with men, and sex workers. Interventions to reach these populations have been implemented by civil society organizations, and have included prevention campaigns as well as outreach, peer support and ARV therapy. Between 2005 and 2011 these services reached 160,000 people who inject drugs (including more than 6,600 people receiving opioid substitution therapy), 30,000 sex workers, 20,000 men who have sex with men, and 25,000 prisoners.

HIV INCIDENCE AMONG PEOPLE WHO INJECT DRUGS IN UKRAINE, 2002-2011



Source Ministry of Health of Ukraine, 2010 [30]. Ministry of Health of Ukraine, 2012 [31].

Several years of collaborative efforts with local and international partners have resulted in the stabilization of the epidemic and steady declines in HIV incidence among these groups. Results of routine and sentinel surveillance indicate a significant impact on HIV incidence and prevalence among people who inject drugs: the number of newly diagnosed HIV infections among this population started to decline in 2006 after several years of growth. HIV prevalence among people who have been injecting drugs for less than three years also showed a sharp decline: from 30 percent in 2004 to 5.5 percent in 2011 in the eight cities most affected by the epidemic. Model estimates suggest that addressing the remaining unmet service need among this population would reduce HIV prevalence by a further 41 percent by 2015 [29].

Between 2005 and 2010, the Global Fund accounted for 35 percent of the total HIV funding in Ukraine, and 72 percent of the international funding. By the end of 2011 the Global Fund had disbursed US$ 213 million to civil society Principal Recipients in Ukraine.

5. The coverage of ARV prophylaxis for PMTCT across low- and middle-income countries increased from 33 percent in 2007 to 52 percent in 2009 (See Figure 3.1), compared to a global target of 90 percent for 2015 [28]. Coverage fell slightly between 2009 and 2010 because the data now exclude provision of single-dose Nevirapine, as WHO no longer recommends this regimen for PMTCT [14].

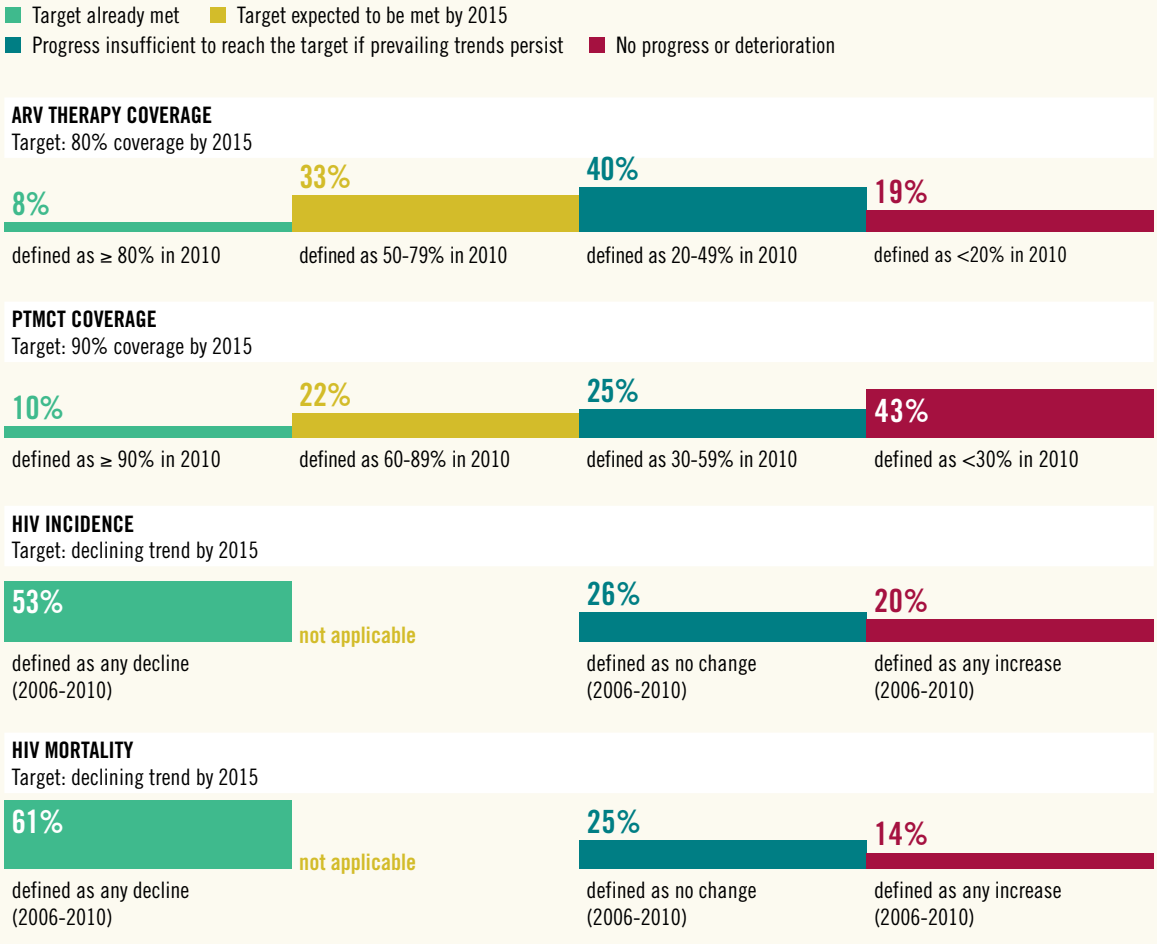
6. As Figure 3.1 also shows, HIV incidence has been in consistent decline since 2000 across Global Fund-supported countries, with a faster rate of decline in high-impact and high-burden countries (those highlighted in bold in Table 3.1).

7. The decline in HIV mortality started around 2004 and has accelerated since 2006. The rate of decline was faster in the high-impact and high-burden countries that have received grants from the Global Fund. Between 2006 and 2010, low- and middle-income countries in the WHO Africa region reported the fastest rate of decline in HIV mortality (1.5 percent per year), compared to other regions.

8. Across 105 Global Fund-supported countries with sufficient data, 41 percent have met, or are on track to meet, the international target of universal access to ARV therapy by 2015 (See Figures 3.2 and 3.3). For PMTCT prophylaxis coverage, 32 percent have met, or are on track to meet, the target by 2015 (See Figure 3.2). More than half the countries are on track to meet the targets for HIV incidence and mortality (See Figures 3.2 and 3.4).

9. Among the 24 "high-burden" countries (those with a national all-age HIV prevalence of 1 percent or higher), the Global Fund considers 11 to be "high-impact" (See Table 3.1). One-third of the 24 high-burden countries exhibited a decline of more than 50 percent in HIV prevalence among young adults (thereby achieving the target set for 2010 by UNGASS). Six other countries reported a decline of between 25 and 50 percent, and a significant and positive change in sexual behavior among this age group has accompanied these declines [4].

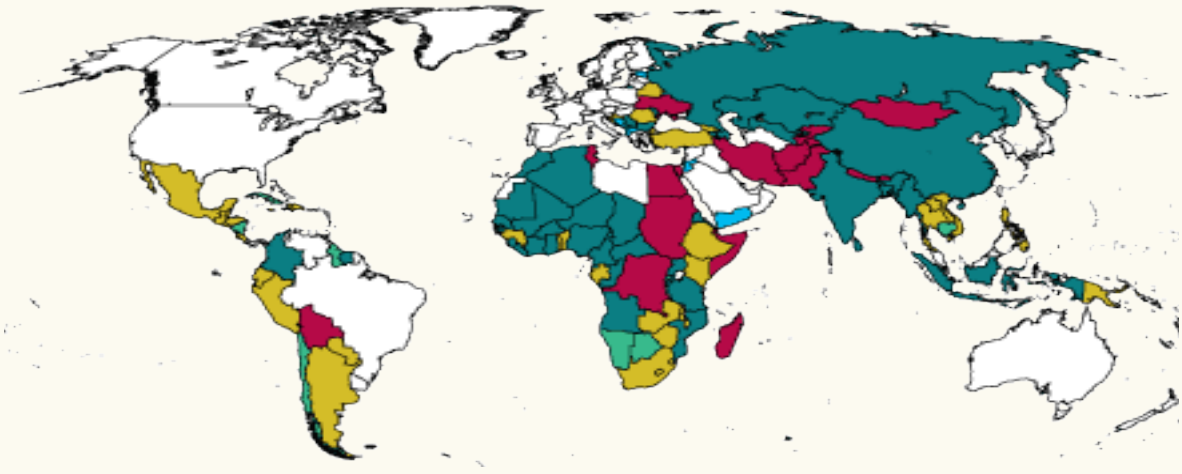
FIGURE 3.2
PROGRESS TOWARD INTERNATIONAL TARGETS FOR HIV IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND HIV GRANTS



Note Figures include 105 countries that have received Global Fund HIV grants and have available data (excluding those with only multicountry grants). ARV therapy and PMTCT coverage is based on the estimated number of people who are receiving treatment compared to the estimated need (using UNAIDS/WHO methodology). The need for ARV therapy is based on the WHO-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3. For HIV incidence and mortality, increases and declines are defined as any statistically significant trends between 2006 and 2010. **Sources** WHO, 2011 [4]. UNAIDS, 2010 [32].

FIGURE 3.3

COVERAGE OF ANTIRETROVIRAL THERAPY IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND HIV GRANTS, 2010

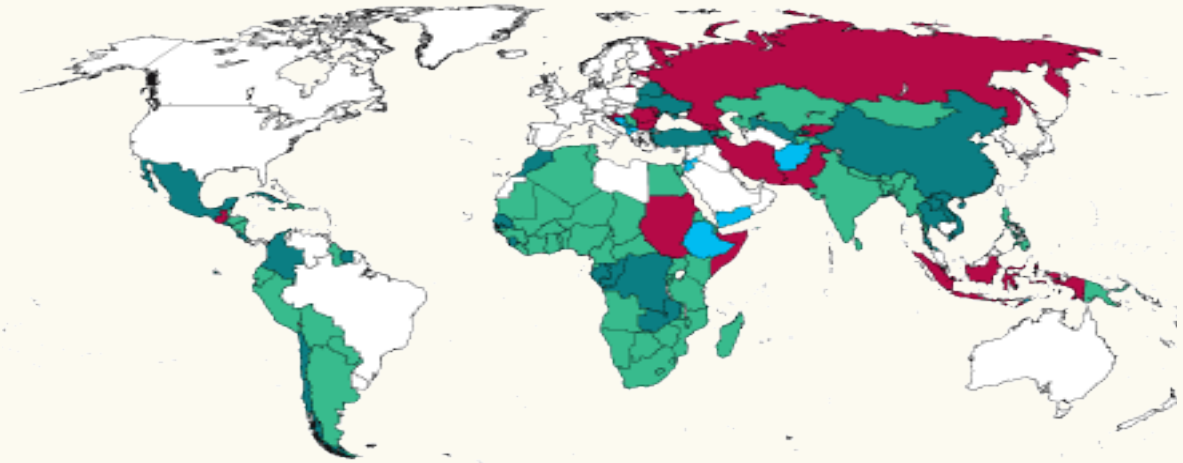


Target already met · Target expected to be met by 2015 · Progress insufficient to reach the target if current trend persists
No progress or deterioration · Missing or insufficient data · Has not received Global Fund HIV grants

Note For definitions of the different categories, see Figure 3.2. ARV therapy coverage estimates are based on the estimated number of people who are receiving ARV therapy compared to the estimated need (using UNAIDS/WHO methodology). The need for ARV therapy is based on the WHO-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3. In the case of missing data for 2010, the latest available data (i.e. from 2009 or 2008) were used instead. Countries/territories with only multicountry grants were excluded. **Source** WHO, 2011 [4].

FIGURE 3.4

TREND IN HIV MORTALITY IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND HIV GRANTS, 2006-2010



Target already met · Progress insufficient to reach the target if current trend persists · No progress or deterioration
Missing or insufficient data · Has not received Global Fund HIV grants

Note For definitions of the different categories, see Figure 3.2. Estimates of HIV mortality are provisional, with the 2010 data point extrapolated from previous years. Countries with only multicountry grants were excluded. For HIV incidence and mortality, increases and declines are defined as any statistically significant trends from 2006 to 2010. **Source** UNAIDS, 2010 [32].

TABLE 3.1

TRENDS IN HIV PREVALENCE AMONG YOUNG ADULTS (15-24 YEARS) IN 24 LOW- AND MIDDLE-INCOME COUNTRIES WITH REPORTED HIV PREVALENCE OF 1 PERCENT OR MORE, 2000-2010

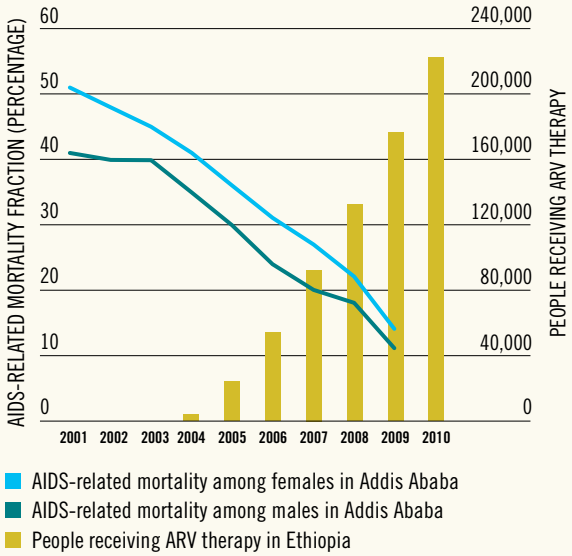
>50% DECREASE IN HIV PREVALENCE	**25-50% DECREASE** IN HIV PREVALENCE	**<25% DECREASE** IN HIV PREVALENCE	**NO DECREASE** IN HIV PREVALENCE
Burkina Faso	Bahamas	Gabon	Angola
Ethiopia	Botswana	Haiti	**Uganda**
Kenya	Chad	Lesotho	
Malawi	**Congo (Democratic Republic)**	**Mozambique**	
Namibia	**Ghana**	**South Africa**	
Togo	**Nigeria**	Swaziland	
Tanzania (United Republic)		**Zambia**	
Zimbabwe			

Note HIV prevalence among young adults (15-24 years) is a proxy for general HIV incidence for the purpose of this target. The countries highlighted in bold are on the Global Fund's list of "high-impact" countries (See Box 1.3). **Source** WHO, 2011 [4].

ETHIOPIA

Ethiopia is one of the sub-Saharan African countries to have witnessed significant declines in HIV incidence and mortality. Between 2001 and 2010, HIV prevalence among young antenatal clinic attendees declined by 82 percent [4]. Data from prospective burial surveillance in Addis Ababa showed a 37 percent decline in AIDS-related mortality among women and a 30 percent decline among men between 2001 and 2009. If the current trends continue, Ethiopia will reach the Millennium Development Goal targets for ARV therapy coverage, HIV incidence and HIV mortality.

TRENDS IN ANTIRETROVIRAL THERAPY COVERAGE AND HIV MORTALITY IN ETHIOPIA, 2001-2010



Note The AIDS-related mortality fraction refers to the proportion of all-cause deaths that were attributed to AIDS in the specified year. **Source** Araya T et al., 2011 [33].

By the end of 2011 the Global Fund had disbursed US$ 754 million to Ethiopia through a number of HIV grants, and accounted for 29 percent of total HIV funding in that country from 2007 to 2010. These investments helped the Ethiopian government to implement an aggressive scale-up of HIV prevention, care and treatment services throughout the country. The funding also helped to: strengthen the health infrastructure through community health teams; underwrite the renovation and upgrading of primary health care facilities; and improve laboratory and supply chain capacity. More than 30,000 health extension workers received training between 2004 and 2009 through support from the Global Fund, and these individuals played a critical role in service delivery and health data systems.

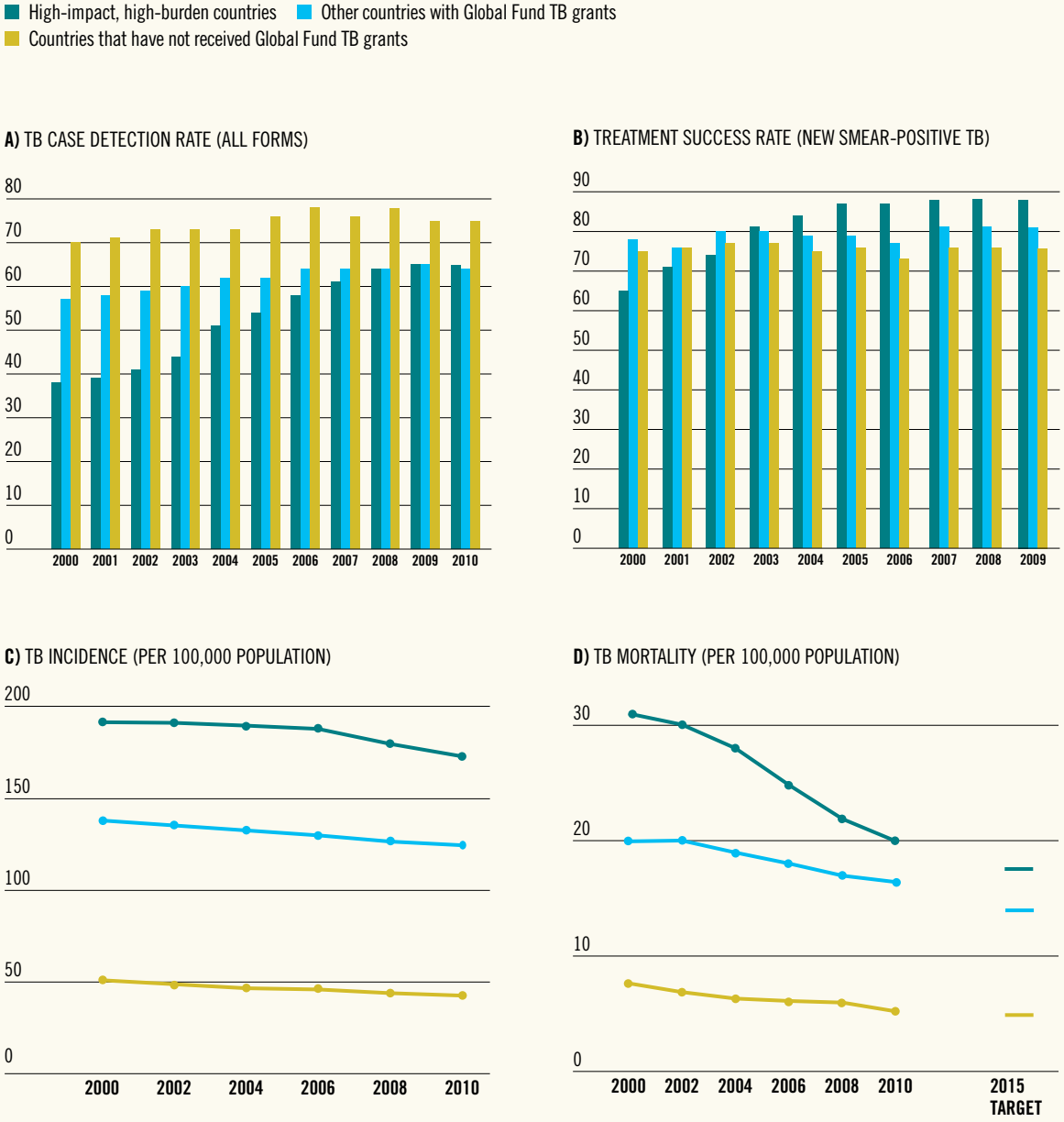
As a result of these investments, the number of Ethiopian adults and children who are receiving ARV therapy increased dramatically from less than 1,000 in 2004 to more than 200,000 in 2010. By the end of 2011, community health education programs reached 15 million young people in the country. In 2011 alone, 7 million HIV testing and counseling sessions took place. The coverage of PMTCT-related services remains low in Ethiopia, but is gradually increasing.

This young girl is keeping warm after bathing in the Arto Hot Springs in Ethiopia. In recent years, the number of HIV-positive Ethiopians receiving ARV therapy has risen dramatically.

3.2 CONTRIBUTIONS TOWARD INTERNATIONAL TARGETS FOR TUBERCULOSIS

10. Figure 3.5 presents the trends in key TB impact indicators across low- and middle-income countries. Overall, the TB case detection rate (all forms) has increased from 43 percent in 2000 to 65 percent in 2010, compared to the Stop TB Partnership target of 70 percent [34].[6] Since 2008, the overall case detection rate across low- and middle-income countries has leveled off at just below the international target.

FIGURE 3.5
KEY TUBERCULOSIS TRENDS IN LOW- AND MIDDLE-INCOME COUNTRIES



Note For the TB treatment success rate, 2009 is the latest year with available data given the one-year lag from treatment onset to reporting treatment outcomes. TB mortality rates exclude deaths associated with TB/HIV co-infection. In the case of missing data for case detection and treatment success rates, the latest available data (i.e. 2009 data for case detection or 2008 data for treatment success) were used instead. Countries with only multicountry grants were excluded from this analysis. For the list of the Global Fund's "high-impact, high-burden" countries, see Table 3.2. This analysis includes 38 low and middle income countries that have not received Global Fund TB grants – predominantly from Latin America, the Caribbean and the Pacific. **Source** WHO, 2011 [2].

6 The 1991 World Health Assembly initially set the "at least 70 percent" target for TB case detection rate (all forms) with a deadline of 2000, later extended to 2005. Because of recognized uncertainties in estimated TB incidence, WHO and partners are giving less emphasis to this indicator, and the Stop TB Strategy no longer includes any target for case detection. However, the case detection rate is still an MDG6 indicator and therefore is still included in this analysis.

11. Between 2002 and 2009, treatment success rates increased from 76 percent to 87 percent – compared to an international target of 90 percent for 2015 [34]. The rate has increased across the 16 high-impact and high-burden countries that received grants from the Global Fund (See Table 3.2) – while treatment success rates have remained fairly constant at around 76 percent across the low- and middle-income countries without Global Fund TB grants (See Figure 3.5).

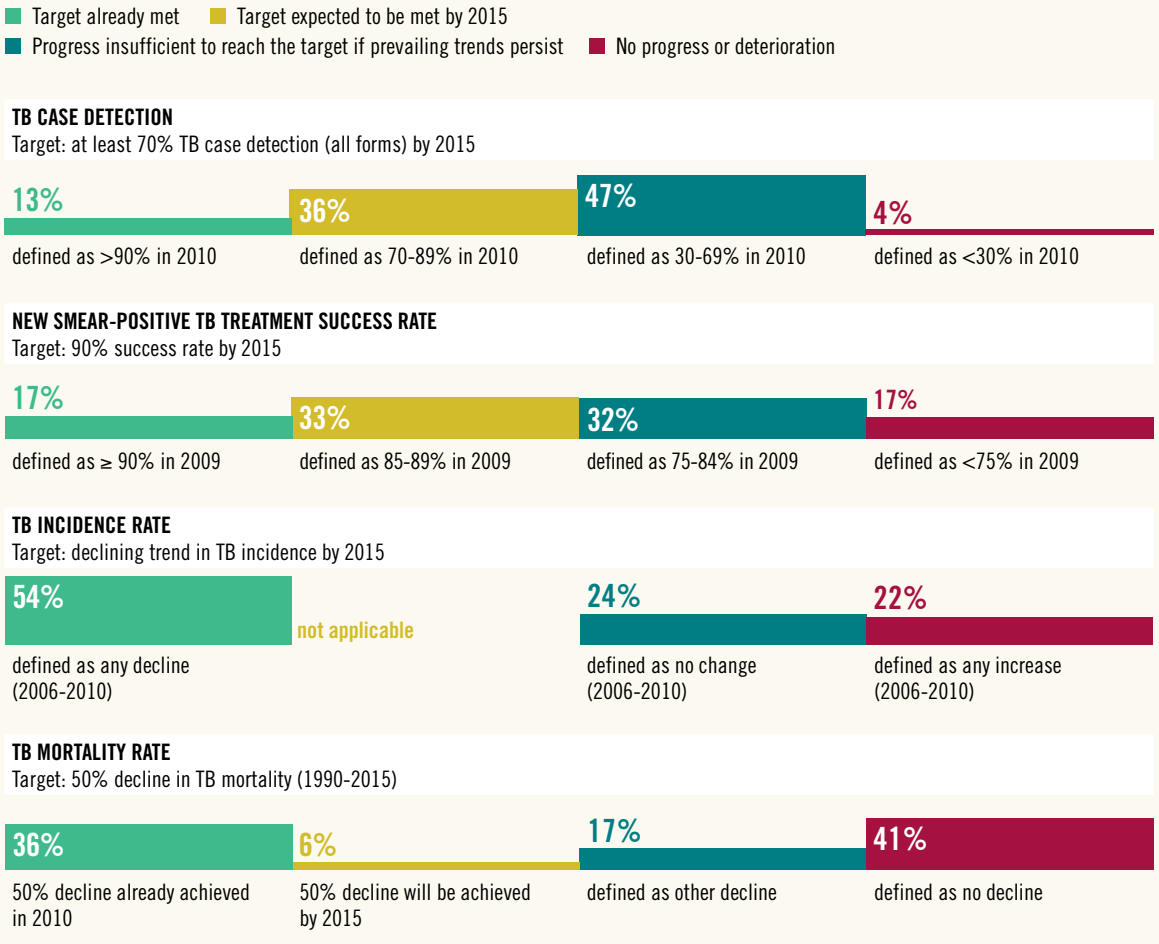
12. Overall, TB incidence rates have declined since 2000 – but they remain around three times higher in the countries with Global Fund TB grants compared to other low- and middle-income countries. The overall decline in TB incidence rates accelerated since 2006 and, if the current trends continue, this indicator is on track to meet the Millennium Development Goal target by 2015 (See Figure 3.5).

13. TB mortality rates remain around four times higher in countries that receive Global Fund TB grants compared to other low- and middle-income countries, but have shown steady declines since 2000 (See Figure 3.5). These figures do not include deaths associated with TB/HIV co-infection. If these additional deaths were included, low- and middle-income countries would not be on track to halve TB-related mortality by 2015, particularly in sub-Saharan Africa.

14. Across 105 countries with sufficient data that have received Global Fund grants, more than half are on track to meet the 70 percent TB case detection target and the 90 percent target for treatment success rates by 2015 (See Figures 3.6 and 3.7). For TB incidence, 54 percent are on track to meet the target of any statistically significant decline. For TB mortality, 42 percent are on track to meet the international target of halving the burden by 2015 from the 1990 baseline – and 38 countries have already met the target – but a similar number of countries have shown no progress (See Figures 3.6 and 3.8).

15. Among the 22 high TB-burden countries defined by the Stop TB Partnership, the Global Fund considers 16 as "high-impact" (See Table 3.2). Incidence rates have declined in eleven of the high-burden countries (nine of which are also Global Fund high-impact countries), and they are relatively stable in a further nine high-burden countries.

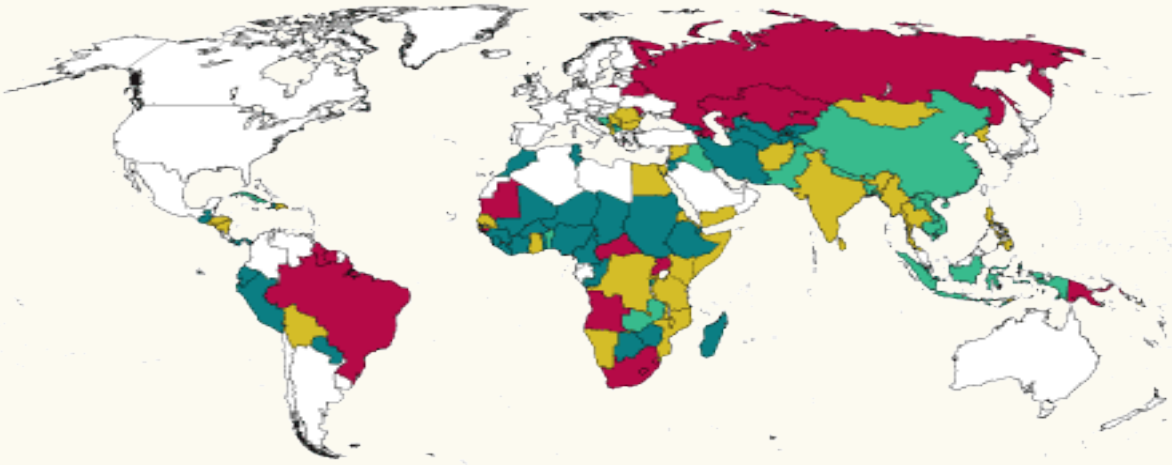
FIGURE 3.6
PROGRESS TOWARD INTERNATIONAL TARGETS FOR TUBERCULOSIS IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND TUBERCULOSIS GRANTS



Note Figures include 105 countries that have received Global Fund TB grants and have available information (excluding those with only multicountry grants). For the TB treatment success rate, 2009 is the latest year with available data given the one-year lag from treatment onset to reporting treatment outcomes. TB mortality rates exclude deaths associated with TB/HIV co-infection. For TB incidence, increases and declines are defined as any statistically significant trend between 2006 and 2010. **Source** WHO, 2011 [2].

FIGURE 3.7

NEW SMEAR-POSITIVE TUBERCULOSIS TREATMENT SUCCESS RATES IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND TUBERCULOSIS GRANTS, 2009

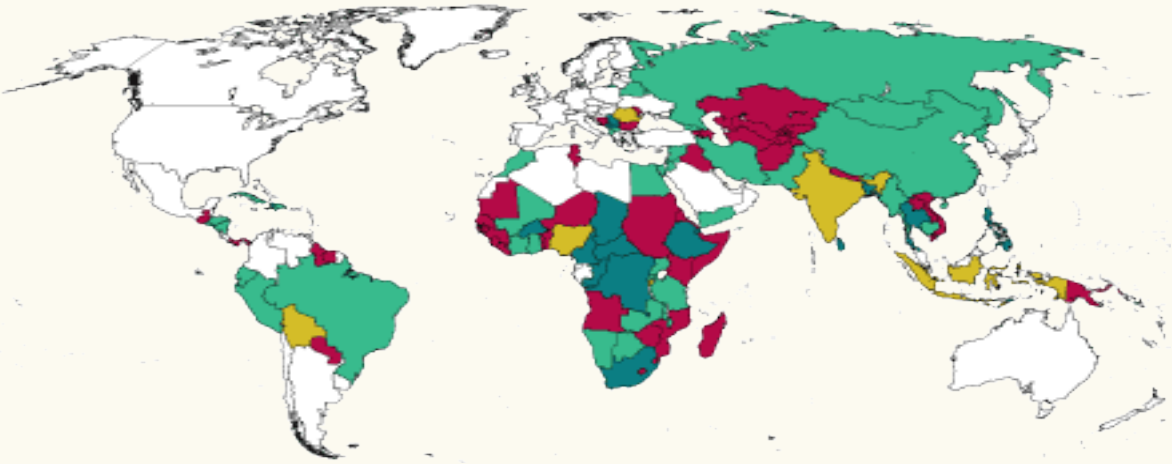


Target already met · Target expected to be met by 2015 · Progress insufficient to reach the target if current trend persists
No progress or deterioration · Missing or insufficient data · Has not received Global Fund TB grants

Note For definitions of the different categories, see Figure 3.6. For the TB treatment success rate, 2009 is the latest year with available data given the one-year lag from treatment onset to reporting treatment outcomes. In the case of missing data for 2009, the latest available data were used instead. Countries with only multicountry grants were excluded. **Source** WHO, 2011 [2].

FIGURE 3.8

PROGRESS TOWARD INTERNATIONAL TARGET FOR TUBERCULOSIS MORTALITY RATE IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND TUBERCULOSIS GRANTS, 2010



Target already met · Target expected to be met by 2015 · Progress insufficient to reach the target if current trend persists
No progress or deterioration · Missing or insufficient data · Has not received Global Fund TB grants

Note For definitions of the different categories, see Figure 3.6. The international target for TB mortality rates is a 50 percent reduction between 1990 and 2015. TB mortality rates exclude deaths associated with TB/HIV co-infection. Countries with only multicountry grants were excluded. **Source** WHO, 2011 [2].

TABLE 3.2

TRENDS IN TB INCIDENCE RATE IN 22 HIGH-BURDEN COUNTRIES, 1990-2010

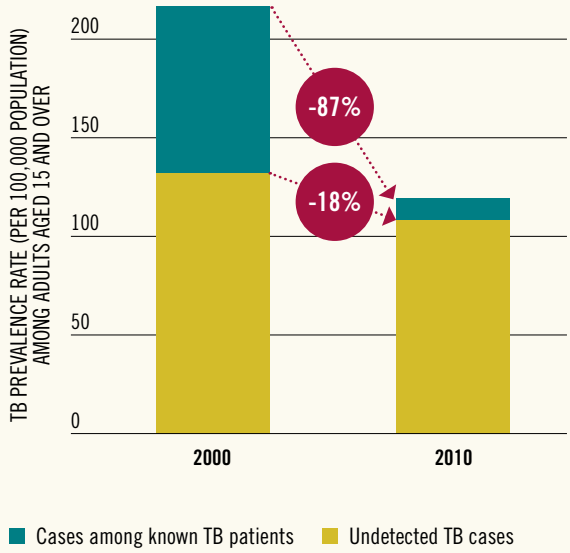
DECREASING TREND IN TB INCIDENCE	**NO CHANGE** IN TB INCIDENCE	**INCREASING TREND** IN TB INCIDENCE
Brazil	Afghanistan	**Mozambique**
Cambodia	**Bangladesh**	**South Africa**
China	**Congo (Democratic Republic)**	
Ethiopia	**Indonesia**	
India	**Nigeria**	
Kenya	**Pakistan**	
Myanmar	Russian Federation	
Philippines	Thailand	
Tanzania (United Republic)	Viet Nam	
Uganda		
Zimbabwe		

Note The countries highlighted in bold are included in the Global Fund's list of "high-impact" countries (See Box 1.3). **Source** WHO, 2011 [2].

CHINA

The national TB control program in China has reported dramatic reductions in TB incidence and mortality [2]. National disease prevalence surveys documented a 45 percent decline in the prevalence of smear-positive pulmonary TB between 2000 and 2010. This success stems from the expanded implementation of the DOTS strategy and the strengthening of TB surveillance, and the largest declines have taken place among known TB cases. To further improve impact, the Chinese TB program is working to diagnose cases earlier and reach asymptomatic TB cases (which now account for a major part of the TB burden in the country).

PREVALENCE OF SMEAR-POSITIVE TUBERCULOSIS IN CHINA, 2000 AND 2010



Source WHO [35].

China has used Global Fund grants to support the development of strong surveillance and measurement systems for TB, combining prevalence surveys with vital registration and Internet-based case notification systems. This initiative has been cited by WHO as a model for other countries to follow [2]. The Global Fund has provided around US$ 270 million for TB control efforts in the country [2].

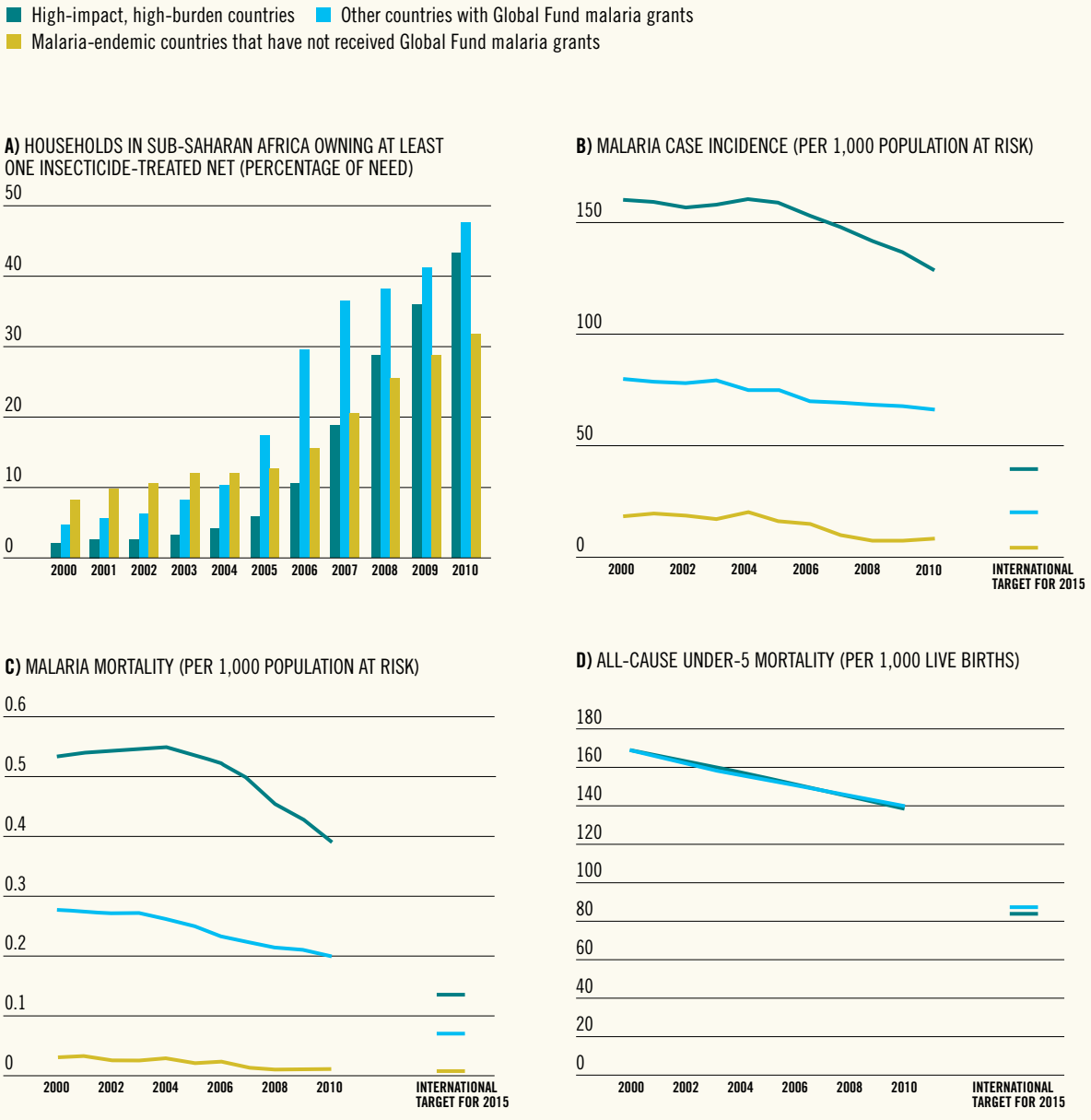
A farmer near Yichuan, a poverty-stricken area in Shanxi province, China, where the Global Fund-supported national TB control program has made a big impact, thanks to increased TB detection rates, training of local medical staff and health education in villages.

3.3 CONTRIBUTIONS TOWARD INTERNATIONAL TARGETS FOR MALARIA

16. Many countries in Africa and Asia have made great strides toward targets set by the Roll Back Malaria Partnership by rapidly scaling up malaria prevention and control services. With support from the Global Fund and partners, the coverage of key vector control interventions – most notably insecticide-treated nets and indoor residual spraying – has continuously risen over the last decade (as described in Chapter 2.3). Recipients of Global Fund grants have also played a key role in introducing and scaling up ACT as a first-line treatment for malaria.

17. Figure 3.9 presents the trends in key malaria impact indicators across low- and middle-income countries. Household ownership of insecticide-treated nets in sub-Saharan Africa increased from 3 percent in 2000 to 45 percent in 2010 – a remarkable achievement,

FIGURE 3.9
KEY MALARIA TRENDS IN LOW- AND MIDDLE-INCOME COUNTRIES

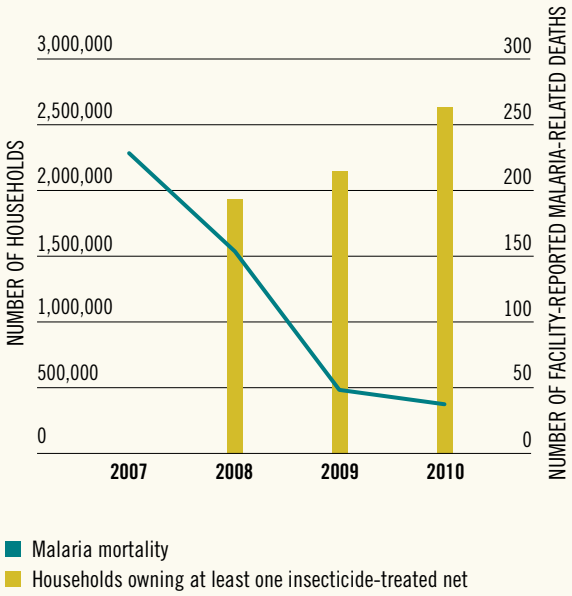


Note WHO country estimates of malaria case incidence and mortality are provisional, and are in the process of country consultation. Graph A shows data only for sub-Saharan Africa. Graph D shows data only for the 34 countries where malaria is endemic and where malaria accounted for more than 5 percent of all-cause under-5 mortality in 2002. Countries with only multicountry grants were excluded from this analysis. For the list of the Global Fund's "high-impact, high-burden" countries, see Table 3.3. The low- and middle-income countries that have not received Global Fund malaria grants are Botswana, South Africa, plus a number of additional countries mostly from Latin America. **Source** WHO, 2011 [3].

BANGLADESH

Malaria is endemic in 13 of the 64 districts of Bangladesh, although more than 80 percent of cases and deaths are reported in the three hill tract districts. The country has received support from the Global Fund since 2007 to scale up malaria control efforts. A joint malaria program review in 2011 showed that the coverage of malaria prevention and treatment services has rapidly increased since 2007: 55 percent of households own two or more insecticide-treated nets, including more than 80 percent coverage in the hill tract districts. The Bangladeshi Ministry of Health worked closely with a consortium of 21 nongovernmental organizations – led by the Bangladesh Rural Advancement Committee – to establish a network of community-level programs that focus on the use of rapid diagnostic tests and microscopy, effective treatment of confirmed cases, providing insecticide-treated nets to people who live in endemic areas, and implementing behavior change and community mobilization programs. The impact of these efforts was monitored through an established surveillance and reporting mechanism from communities to the central level.

COVERAGE OF INSECTICIDE-TREATED NETS AND TRENDS IN MALARIA MORTALITY IN BANGLADESH, 2007–2010



Source Ministry of Health and Family Welfare, 2011 [36].

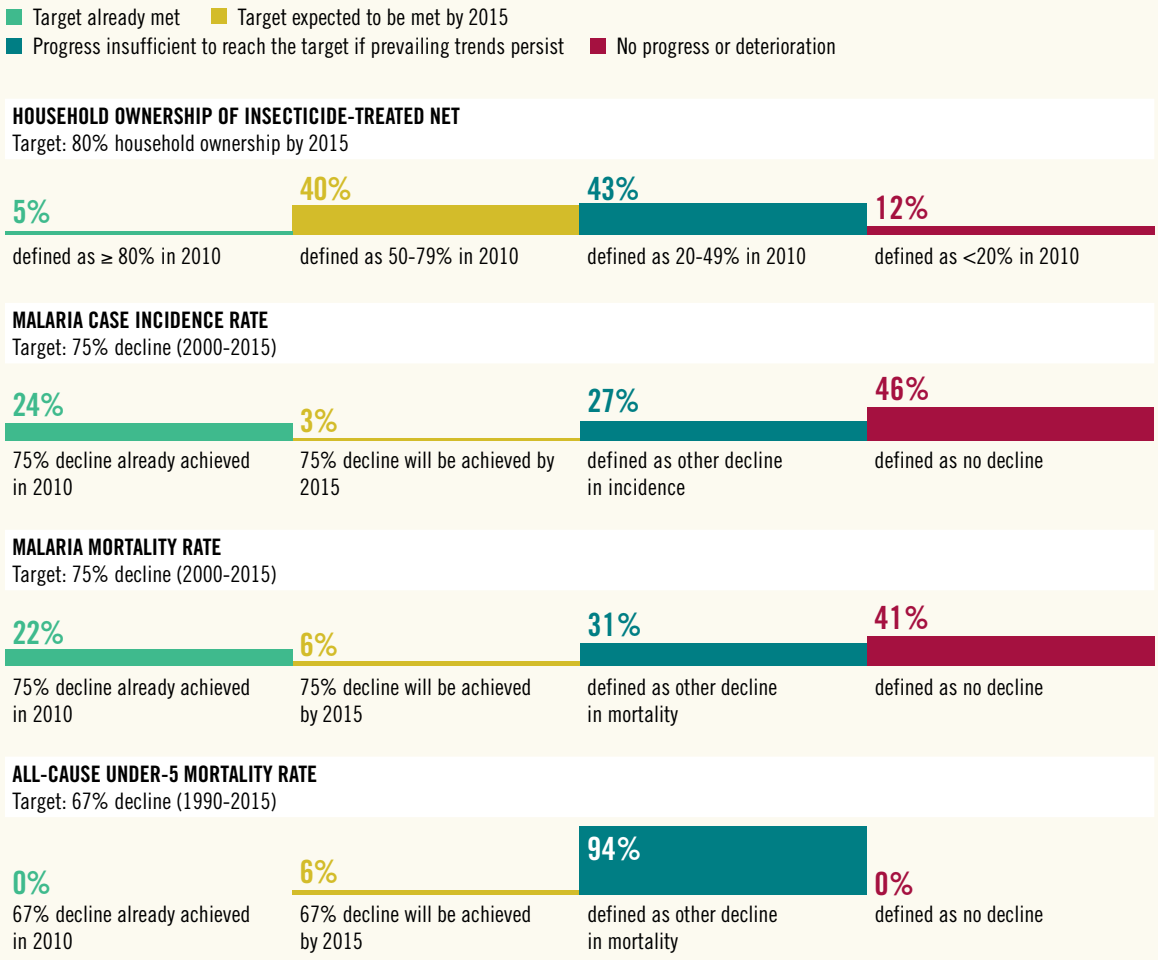
At the national level, malaria-related mortality decreased as insecticide-treated net coverage increased. Malaria incidence also decreased in some of the districts, but it remained largely unchanged in others. Following the in-depth program review, the Global Fund and the Bangladeshi Ministry of Health agreed to refocus resources to the hill tract areas and support district-specific approaches to malaria control (such as outdoor personal protection in heavily forested areas).

A group of villagers of the Marma community in Bangladesh learns about malaria prevention measures. Coverage of malaria prevention and treatment services has increased rapidly since 2007, and 55 percent of households now own two or more insecticide-treated nets.

yet still below the international target of 80 percent coverage [3]. The rate of increase accelerated between 2005 and 2010. The 12 countries categorized as high-impact and high-burden (See Table 3.3) have lower levels of insecticide-treated net coverage than other Global Fund-supported countries, but the gap between these groups has narrowed in recent years. Of 42 Global Fund-supported countries in Africa with sufficient data, only Djibouti and Namibia had met the 80 percent coverage target (See Figure 3.10), but clear progress has been made compared to as recently as 2005 (See Figure 3.11).

18. Malaria case incidence and mortality around the world began a consistent decline in 2004, but despite these achievements, most malaria-endemic countries are not on track to reach the Millennium Development Goal targets. Estimated malaria case incidence and mortality trends stem from reported malaria cases as well as epidemiological modeling where reliable surveillance data are not available. Of 78 countries that have received Global Fund support, 27 percent are estimated to be on track to achieve the target of a 75 percent reduction in malaria case incidence, and 28 percent are on track to achieve the same reduction for mortality (See Figure 3.10). Across Africa, health information systems require strengthening to enhance monitoring of malaria trends – this requires improvements in routine disease surveillance, focusing on confirmed cases and the medical certification of causes of death.

FIGURE 3.10
PROGRESS TOWARD INTERNATIONAL TARGETS FOR MALARIA IN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND MALARIA GRANTS

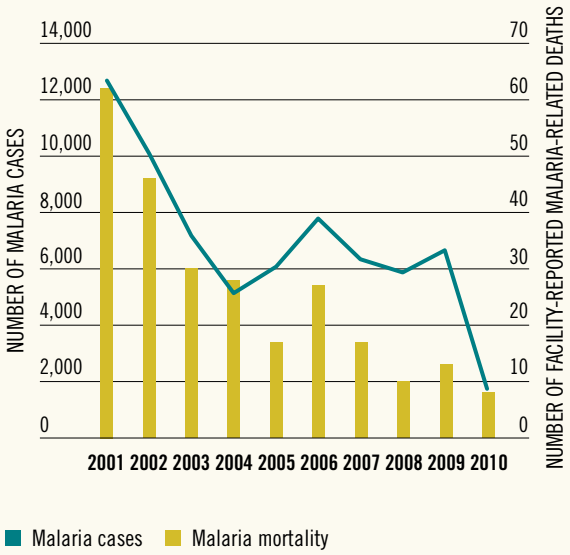


Note Data on malaria case incidence and mortality are based on WHO country-specific estimates which are provisional and in the process of country consultation. Insecticide-treated net ownership is assessed for countries in sub-Saharan Africa only. Analyses of all-cause under-5 mortality refer to 34 countries where malaria is endemic and accounted for more than 5 percent of all-cause under-5 mortality in 2002. Countries with only multicountry grants were excluded from this analysis. **Source** WHO, 2011 [3].

SWAZILAND

The Kingdom of Swaziland has a low level of malaria transmission and has achieved steep declines in malaria case incidence and mortality over the last ten years. Between 2005 and 2010, the Global Fund was one of the major sources of malaria funding in the country – accounting for 42 percent of the national malaria budget [3].

TRENDS IN MALARIA INCIDENCE AND MORTALITY IN SWAZILAND, 2001-2010



Source WHO, 2011 [3].

With around US$ 5 million from the Global Fund to date, the country is now preparing to enter the malaria pre-elimination phase. By the end of 2011, Swaziland had achieved:

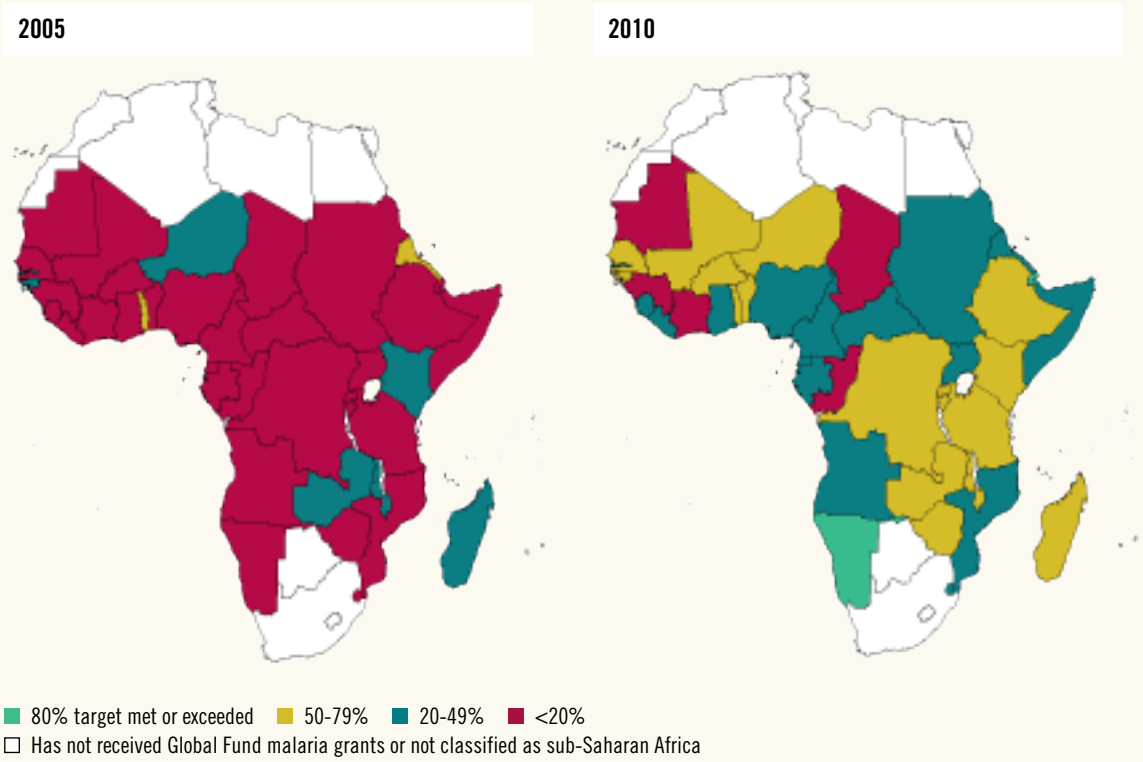
- 100 percent coverage of indoor residual spraying and 47 percent insecticide-treated net household coverage in high-transmission areas;
- high treatment coverage with ACT (following its introduction in Swaziland in 2005);
- a 95 percent decline in the number of reported malaria cases between 2001 and 2010; and
- a 92 percent decline in the number of reported malaria deaths between 2001 and 2010.

19. In 32 malaria-endemic countries with Global Fund malaria grants, the disease accounted for 5 percent or more of the total under-5 mortality in 2002. For these countries, all-cause under-5 mortality is considered an impact indicator for malaria. A consistent decline has occurred for this indicator, associated with the scale-up of malaria control activities (See Figure 3.9). However, just two of these countries – Madagascar and Malawi – are on track to meet the target of a 67 percent reduction in all-cause under-5 mortality between 1990 and 2015 (See Figure 3.10).

20. In 2011 an Inter-Agency Working Group defined 39 countries as having an "extreme" or "severe" malaria burden for the purposes of deciding eligibility to apply to the Global Fund [18]. Whereas Figures 3.9 and 3.10 use unpublished WHO estimates which rely on epidemiological modeling where required, Table 3.3 summarizes trends in malaria cases reported through national health information systems. According to these data, just six of the 39 high-burden countries had achieved a decrease of more than 50 percent in malaria case incidence between 2000 and 2010, while reductions in malaria incidence of more than 50 percent had also been observed at sub-national levels in Cambodia, The Gambia and Tanzania. Of the 39 high-burden countries, the Global Fund considers 12 as "high-impact" (See Table 3.3).

FIGURE 3.11

PERCENTAGE OF HOUSEHOLDS OWNING AT LEAST ONE INSECTICIDE-TREATED NET IN SUB-SAHARAN AFRICAN COUNTRIES THAT HAVE RECEIVED GLOBAL FUND MALARIA GRANTS, 2005 AND 2010



Note Countries with only multicountry grants were excluded. Figures for insecticide-treated nets include long-lasting insecticidal nets. **Source** WHO, 2011 [3].

TABLE 3.3

TRENDS IN REPORTED MALARIA CASE INCIDENCE IN 39 HIGH-BURDEN COUNTRIES, 2000-2010

MORE THAN 50 PERCENT DECREASE IN MALARIA CASE INCIDENCE	**BETWEEN 25 AND 50 PERCENT DECREASE** IN MALARIA CASE INCIDENCE	**LESS THAN 25 PERCENT DECREASE** IN MALARIA CASE INCIDENCE	**UNABLE TO ASSESS TRENDS** IN CONFIRMED MALARIA CASES	
			RECENT SCALE-UP OF DIAGNOSTIC TESTING	**INSUFFICIENT DATA**
Namibia	Ethiopia	**India**	Burkina Faso	Angola
Sao Tome and Principe	Senegal		Burundi	Benin
Solomon Islands	Zambia		**Congo (Democratic Republic)**	Cameroon
Suriname			Liberia	Central African Republic
Thailand			Myanmar	Chad
Viet Nam			Sierra Leone	Congo
Cambodia*			Togo	**Côte d'Ivoire**
Gambia*			Uganda	Djibouti
Tanzania (United Republic)*			Zimbabwe	**Ghana**
				Guinea
				Guinea-Bissau
				Malawi
				Mali
				Mozambique
				Niger
				Nigeria
				Somalia

*More than 50 percent decrease in malaria case incidence has been reported sub-nationally, rather than nationally.

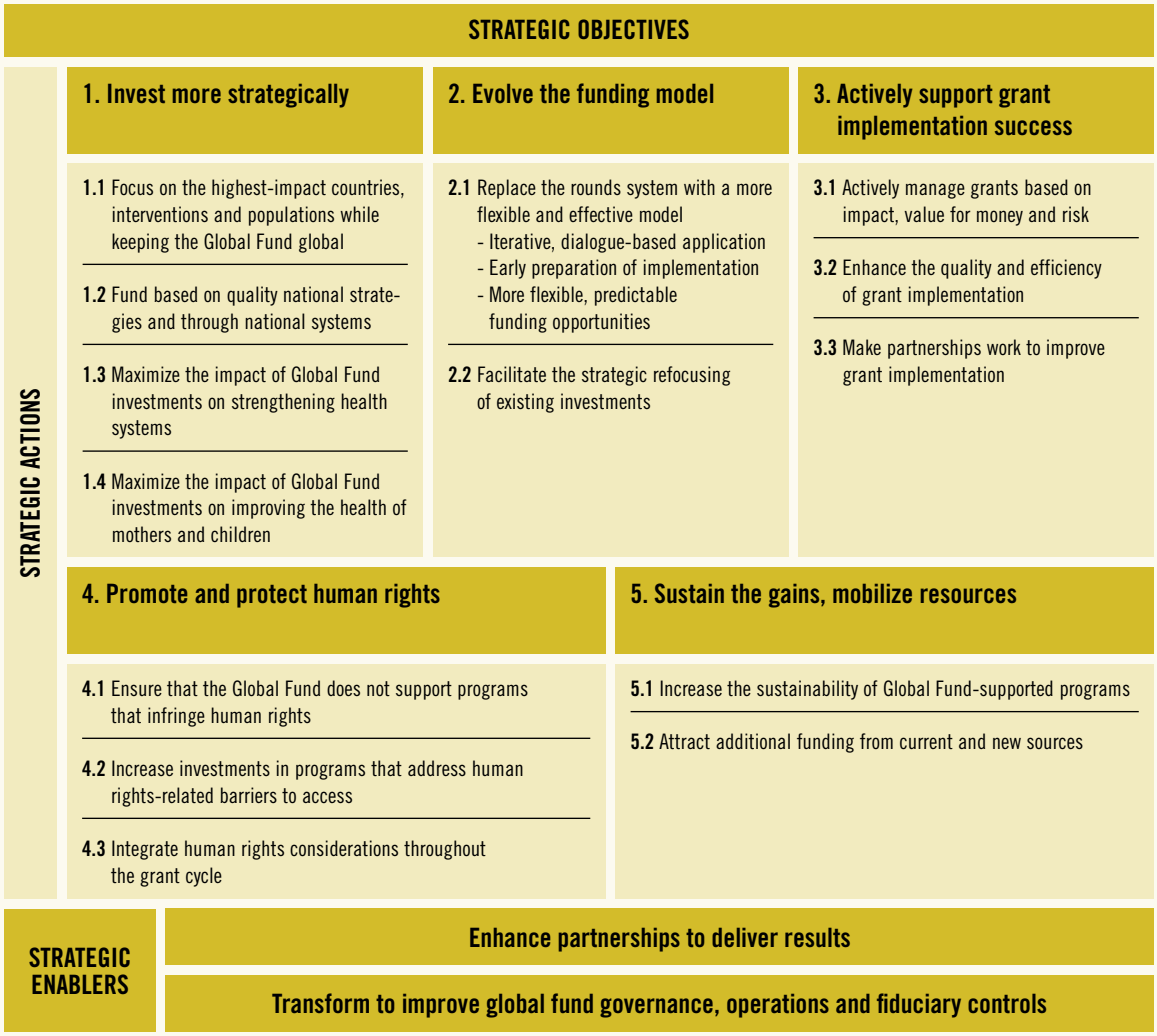
Note An Inter-Agency Working Group defined these 39 countries as having "extreme" or "severe" malaria burden for the purposes of deciding eligibility to apply to the Global Fund [18]. The countries highlighted in bold appear on the Global Fund's list of "high-impact" countries (See Box 1.3). **Source** WHO, 2011 [3].

3.4 STRATEGIC INVESTMENT OPPORTUNITIES

21. The Global Fund has developed a strategy for 2012-2016 which aims to maximize returns by investing funds more strategically and increasing impact. The strategy comprises five interlinked, interdependent objectives and two crosscutting "strategic enablers": partnerships and internal transformation (See Figure 3.12). The strategy was developed following consultation with partners, implementers and stakeholders, and focuses on how the Global Fund, partners and implementers can ensure that they are targeting the right populations in the right countries with the right interventions.

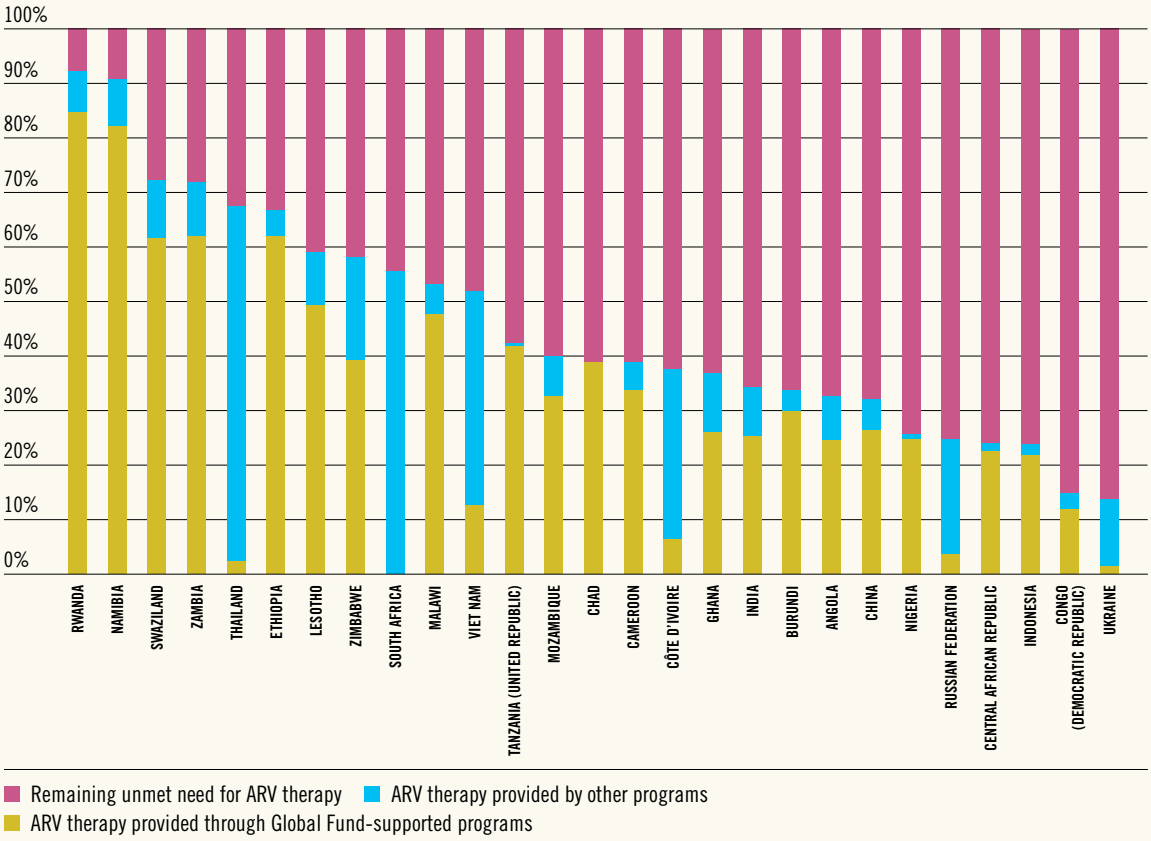
22. The Global Fund's model to date has been largely demand-driven: applicants decide their own priorities and develop proposals during funding "rounds" that occur on a periodic basis. The Global Fund then responds to requests that pass an independent review of technical quality. However, there remain significant gaps in funding and the proposals received by the Global Fund do not always target their activities to match the unmet need for key lifesaving interventions – as Figure 3.13 demonstrates in the case of ARV therapy.

FIGURE 3.12
OVERVIEW OF THE GLOBAL FUND STRATEGY 2012-2016



Source The Global Fund, 2011 [7].

FIGURE 3.13
UNMET NEED FOR ANTIRETROVIRAL THERAPY IN SELECTED COUNTRIES, 2010



Note The results of Global Fund-supported programs can include the delivery of services or products co-financed by partners, and stringent criteria are applied to ensure results from supported programs are only included when the Global Fund is a significant funder to the program. The need for ARV therapy is based on the WHO-recommended eligibility criteria of CD4 counts at or below 350 cells/mm^3.
Sources Global Fund data. WHO, 2011 [4].

23. The Global Fund Board and Secretariat are in the process of working with partners to develop a new funding model – one that will maintain an emphasis on "programs that reflect national ownership and respect country-led formulation and implementation processes," and will operate "in a balanced manner in terms of different regions, diseases and interventions" [37]. However, through dialogue with applicants and partners, this new model will also aim to more strategically direct resources toward programmatic and financial gaps. This involves using epidemiological evidence and country evaluations more proactively (See Chapter 2.6), and ensuring improved guidance to countries. Although the new funding model was still being finalized at the time of this report, this section outlines some of the underlying issues and challenges that it will seek to address.

24. Moving toward a more strategic investment model requires strong national disease strategies guided by evidence from national evaluations as well as from global plans and frameworks produced by the relevant technical partners. The alignment of funding with national strategies and systems is a key principle of aid effectiveness [38]. Building on initiatives such as National Strategy Applications [39], the new funding model will increasingly seek to support programs that are based on high-quality national strategies.

25. The challenge for the Global Fund, in redefining its funding model, is to address some inherent tensions:

- Being a responsive and demand-driven funder, yet becoming more proactive in terms of what should be funded and where – i.e. maintaining but revisiting the concept of country ownership.
- Focusing on the highest-impact countries while keeping the Global Fund global.
- Targeting those most in need and least able to pay, while recognizing that national income level does not always correlate with disease burden, and can hide significant inequities between population groups.
- Targeting the highest-impact interventions, while supporting critical enablers such as health system strengthening, community system strengthening and advocacy for human rights.
- Targeting interventions with the strongest evidence base, while retaining the flexibility to support rapid roll-out of new technologies and interventions when they emerge.
- Identifying where the unmet need is greatest and also where funds can be used most effectively to deliver the greatest returns.
- Providing flexibility to recipients in quickly changing environments, while also maintaining consistent grant management, risk management and performance-based funding.

26. The new funding model will reduce transaction costs for applicants, implementers and the Secretariat. As described in the Global Fund Strategy 2012-2016, the Global Fund will seek to replace the existing rounds-based system with a model comprising:

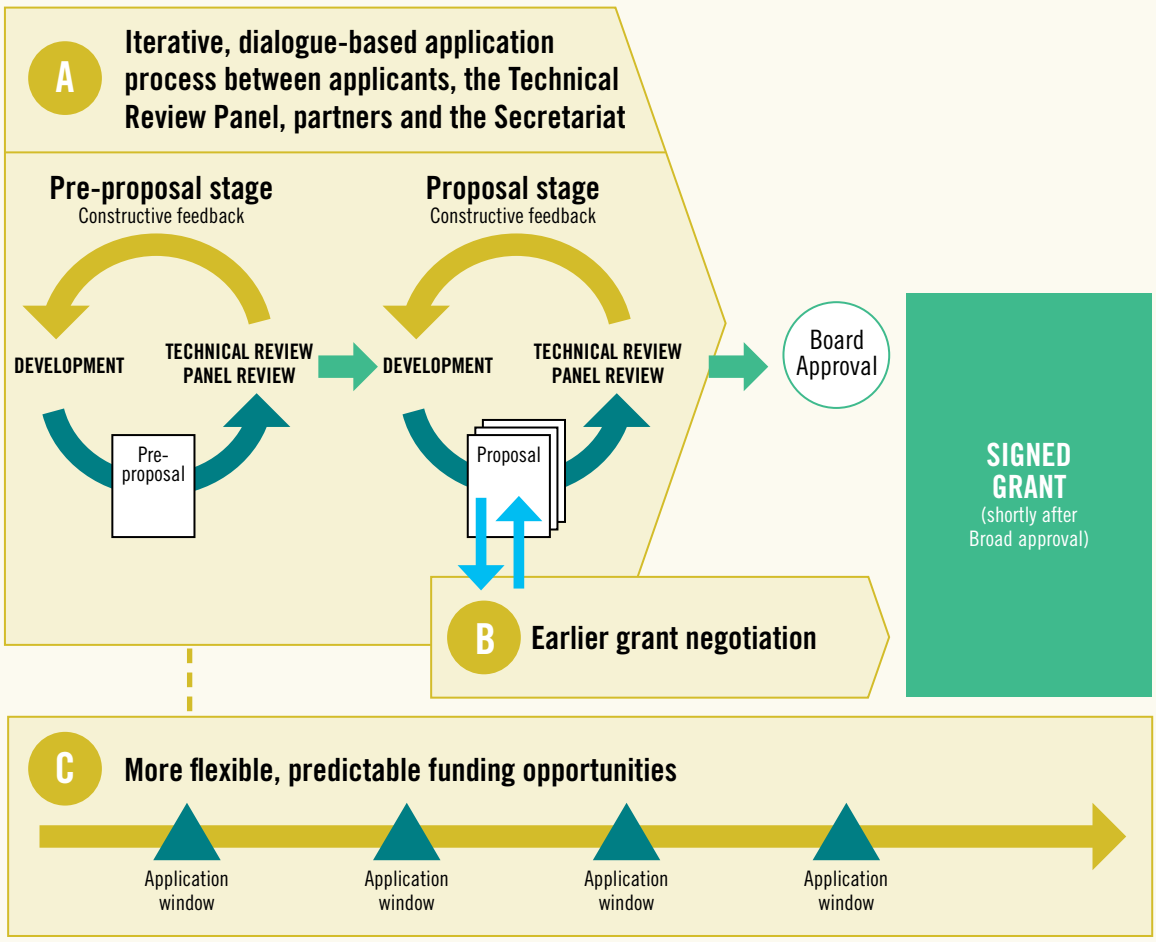
A. An iterative application process based on dialogue with countries and partners to strengthen and better target proposals, to ensure that global guidance is adapted to the national needs and contexts, and ensure complementarity and maximum efficiency through collaboration with other donors.

B. Early preparation for grant implementation, requiring negotiation between countries, partners and the Global Fund Secretariat prior to grant approval (so that grants can be signed shortly after approval).

C. The establishment of more flexible opportunities for application and more predictable funding. These will involve analysis of what other donors are already funding in a country, and assessments of the gap between service coverage and need (See Figure 3.14).

27. To respond quickly to changes on the ground, there is also a strong case for facilitating and incentivizing reprogramming throughout the grant life cycle (especially at the time of grant renewal). As part of the Global Fund's strategy, the Secretariat is rolling out a more systematic yet flexible approach to reprogramming with the support of partners. This incorporates a thorough review of grant activities and the impact of broader national disease programs (See Chapter 2.6), and should promote an optimal spread of services that aligns with the evolving epidemiology and context in a country. In **Afghanistan**, for example, the Global Fund and partners agreed to reprogram existing malaria grants in 2012 to focus investments on scaling up the procurement and distribution of insecticide-treated nets to fill a projected gap in coverage over the next three years.

FIGURE 3.14
THE GLOBAL FUND'S PROPOSED FUNDING MODEL



Source The Global Fund, 2011 [7].

WHAT THIS COULD MEAN FOR RECIPIENTS

28. **HIV:** UNAIDS and partners have outlined a "Strategic Investment Framework" that could potentially avert an estimated 12.2 million new HIV infections and 7.4 million AIDS-related deaths by 2020 [40]. The framework is based on three main elements:

- "basic program activities": the six interventions and services that have the strongest proven impact on HIV risk, transmission, morbidity and mortality;
- "critical enablers": social and programmatic interventions that are crucial to the success of the basic program activities; and
- strategic synergies with development sectors and allied fields such as social, legal and health systems.

29. Particular strategic opportunities arise from the scale-up of ARV therapy coverage and treatment retention to maximize prevention effects, voluntary medical male circumcision in high HIV-prevalence settings (and where there are currently low numbers of circumcised men), the elimination of mother-to-child HIV transmission, and the provision of comprehensive services to most-at-risk populations (especially in concentrated epidemics, but also in generalized and low-level epidemics where these groups still play a key role).

30. Taking the lead from the UNAIDS Framework, lower-impact interventions could be deprioritized if they do not match the local epidemiological context. A study commissioned by UNAIDS in 2012 examined the budgets of Global Fund grants in 13 countries.[6] The results showed performance-based funding led to an increasing focus on high-impact interventions: from 36 percent of the HIV investments in 2008 to 51 percent in 2012. In several countries with concentrated HIV epidemics an increased focus was also applied to activities for most-at-risk populations, while funds for services targeting the general population decreased [41].

31. **TB:** The *Global Plan to Stop TB 2011-2015* outlines areas that implementers should prioritize for funding in the coming years. Around three-quarters of the estimated funding needed should focus on: the delivery of the full DOTS package; the prevention, detection and treatment of drug-resistant TB; interventions for TB/HIV co-infection; laboratory strengthening; and technical assistance [34]. Additional strategic opportunities arise from: improving case detection and treatment success (i.e. through community-based interventions); preventing and treating drug-resistant TB; reaching most-at-risk populations such as migrants, indigenous peoples, children, people who inject drugs, and prisoners (See Box 3.2); and implementing new evidence-based diagnostic technologies (i.e. cartridge-based nucleic acid amplification tests). Prospective new TB drugs are also in the research and development pipeline that could be available in the next two or three years to offer shorter treatment courses.

32. **Malaria:** The *Global Malaria Action Plan* outlines the proven, cost-effective interventions that need to be scaled up for impact: long-lasting insecticidal nets; indoor residual spraying; other vector control interventions; intermittent preventive treatment during pregnancy; rapid diagnosis; and the prompt provision of appropriate, effective antimalarial treatments [43]. It also emphasizes the need for strengthened health systems, ongoing research, and the promotion of elimination efforts where feasible. Particular strategic challenges arise from the roll-out of the "Test, Treat and Track" initiative, and from addressing the emerging issue of artemisinin resistance in the Greater Mekong sub-region. In addition, the large numbers of insecticide-treated nets distributed through Global Fund grants between 2008 and 2011 will need to be replaced in 2012 and 2013 in order to sustain the gains achieved.

BOX 3.2
TB SERVICE DELIVERY GAPS FOR PRISONERS

The *Global Plan to Stop TB 2011-2015* calls for the scale-up of TB services that address the needs of vulnerable populations, such as prisoners [34]. Around 10 million people are estimated to be held in penal institutions globally, and TB is a major cause of illness and mortality among this population as a result of overcrowding, poor nutrition and poor hygiene. Prevalent high-risk behaviors for HIV (such as unsafe sex and drug injection) further fuel TB/HIV co-infections, while poor access to quality TB treatment is a major factor in the spread of multidrug-resistant TB.

According to analysis published in 2012, 53 countries with TB grants from the Global Fund deliver services within penitentiary settings, and nongovernmental recipients deliver one-third of these grants [42]. However, the picture varies greatly between regions: 16 out of 18 countries in Eastern Europe and Central Asia provide such services, compared to just one out of 10 countries in southern Africa. Several high TB-burden countries – such as Afghanistan, Bangladesh, India, Mozambique, Pakistan, South Africa and Zimbabwe – have not included TB services for prisoners in their Global Fund grants. This demonstrates one of the strategic investment opportunities to target support toward a most-at-risk population, fill an existing unmet need, and maximize the impact of the Global Fund's resources.

6 Cambodia, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Rwanda, Tanzania, Thailand, Ukraine, Zambia and Zimbabwe.

4. FINANCING

A health worker gives counseling and psychological support to a rice farmer at Sultan Hassanudin Hospital in Indonesia. Voluntary counseling and testing is key component of a Global Fund supported program that aims to reduce HIV-related illness and death in 33 provinces of Indonesia.

KEY POINTS

1

The Global Fund promotes and ensures value for money – securing efficiency savings of 27 percent during grant renewals in 2011, and reporting continued declines in the unit prices of key health products.

2

Since it was founded in 2002, the Global Fund has received a total of US$ 22.6 billion in contributions from donors and innovative financing mechanisms.

3

By the end of 2011, the Global Fund had disbursed US$ 15.7 billion to programs around the world.

4

In 2012 and 2013 alone the organization will make renewal decisions to approve up to US$ 8 billion for existing grants.

5

The Global Fund accounts for 21 percent of international funding for HIV, 82 percent for TB, and 50 percent for malaria – which makes it the leading international financier for the three diseases.

About 90 percent of the population of Viet Nam is at risk for malaria, and re-treatment of insecticide-treated nets is an important element of a community-based malaria control program in the country. This initiative, supported by the Global Fund, targets a population of 5.4 million people, particularly pregnant women and children under 5.

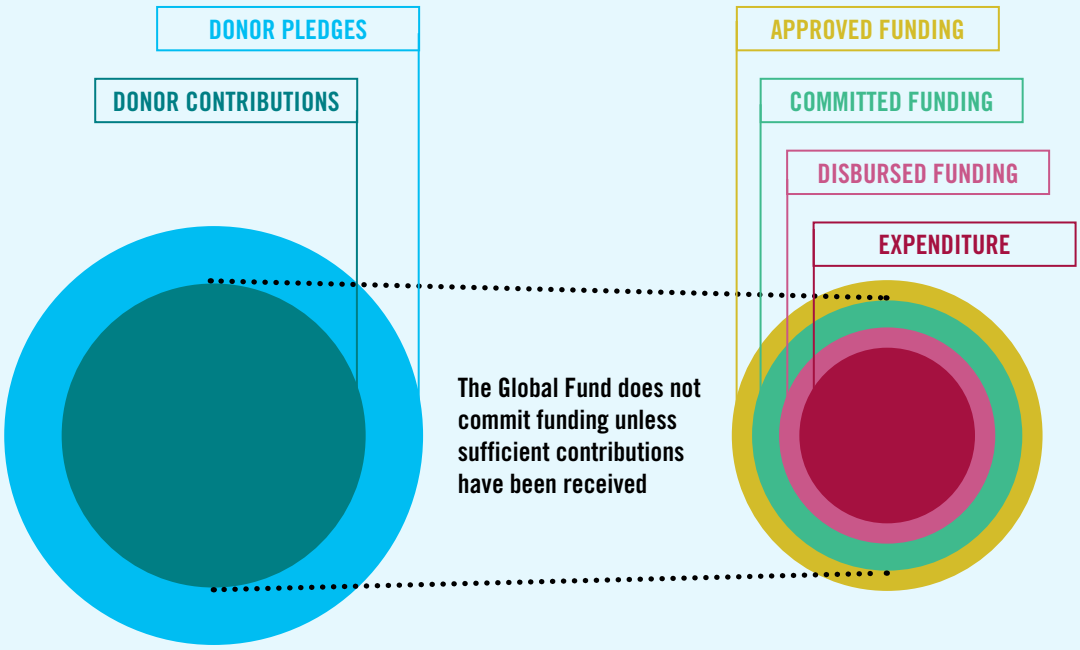
4.1 FUNDING THE GLOBAL FUND

1. The Global Fund is an international financing institution that seeks to secure new resources to invest in reducing the burden of HIV, TB and malaria. The investments made to date have enabled a remarkable scale-up of key services (See Chapter 2) and contributed to demonstrable impact on incidence and mortality across low- and middle-income countries (See Chapter 3). This chapter presents the Global Fund's financial portfolio – showing how donors have responded in providing funds, where these funds have been invested and how the Global Fund ensures value for money.

2. The Global Fund uses certain financial terms when describing its portfolio of income and investments (See Figure 4.1). **Pledges** refer to official statements from donors about planned or projected payments to the Global Fund. These may differ in volume and timing compared to the eventual **contributions** made – as contributions represent actual income received from donors and innovative financing mechanisms. In parallel, the Global Fund reports its **approved funding** for programs, which corresponds to the maximum funding envelope allocated to successful proposals. Within this amount is the actual level of **committed funding** – the resources that have been set aside as part of the signed, legally binding grant agreements (subject to grant recipients fulfilling their agreed commitments). The Global Fund only commits funding once it has received sufficient contributions. **Disbursed funding** is the sum actually paid out to Principal Recipients, while **expenditure** is the amount that Principal Recipients have actually spent on service delivery and other grant costs.

3. In its early years the Global Fund received ad hoc contributions from donors, but in 2005 it adopted a periodic, voluntary replenishment model to improve the reliability and predictability of contributions. For every cycle, the Global Fund has organized a series of donor meetings to review results achieved alongside partners and implementers, discuss the potential demand for resources, and explore investment opportunities. These culminate in a "pledging conference" during which donors make public offers of financial support. The Global Fund continues to actively seek and welcome ad hoc pledges and contributions throughout the three-year replenishment cycle to provide flexibility, particularly for non-public donors.

FIGURE 4.1
KEY GLOBAL FUND FINANCIAL TERMINOLOGY



4. By the end of 2011 the Global Fund had received a total of US$ 30.8 billion in pledges from donors (some of which cover the period up to 2015). It has received a total of US$ 22.6 billion in actual contributions, with an overall upward trend over the last ten years (See Figure 4.2). These significant sums are a reflection of the commitment and support of governments and other donors around the world, and clearly show that the Global Fund remains in a strong financial position to support countries to achieve the health-related Millennium Development Goals. Over time, however, the annual conversion of pledges into contributions as scheduled has fallen from nearly 100 percent in the organization's first few years, to 89 percent in 2008, and then to 79 percent in both 2010 and 2011 [21]. This figure mostly reflects contributions that have been delayed, rather than unpaid.[7]

5. The majority of the Global Fund's income comes from donor governments, which represent around 92 percent of all of the contributions received. Figure 4.3 shows the ten leading public sector donors since 2002, but more than 40 countries have made financial pledges in recent years [45]. For the Third Replenishment period (2011-2013), 24 public donors made pledges, including, for the first time, pledges from Namibia and Tunisia. In addition, significant pledges came from the Bill & Melinda Gates Foundation and the Chevron Corporation, as well as the first pledges from AngloAmerican PLC, Gift from Africa, the Lutheran Malaria Initiative, Takeda Pharmaceutical and the United Methodist Church.

6. As Figure 4.4 shows, non-public and innovative sources of funding – including corporations, philanthropic foundations and nongovernmental donors – are important to the Global Fund, contributing nearly US$ 1.8 billion by the end of 2011. The private sector plays a key role in shaping and implementing health care in low- and middle-income countries, and is widely engaged at the local and global levels. Financially, the private sector contributes through direct pledges to the Global Fund, through global agreements to fund certain program components in specific countries, and through country-level cooperation (including co-financing). Crucially, private sector entities also provide invaluable knowledge and expertise through technical assistance and advisory programs that take the form of in-kind contributions, such as those provided by Standard Bank (which offers financial and management expertise to grant recipients in Africa) [46] and The Coca-Cola Company (which provides supply chain support and expertise to selected countries) [7]. In addition, the private sector has provided innovative funding mechanisms such as (PRODUCT) RED™, through which several high-profile companies contribute a portion of profits from the sale of designated products to Global Fund-supported HIV programs in Africa [47]. By the end of 2011, (RED)™ had generated more than US$ 180 million for the Global Fund (See Figure 4.4).

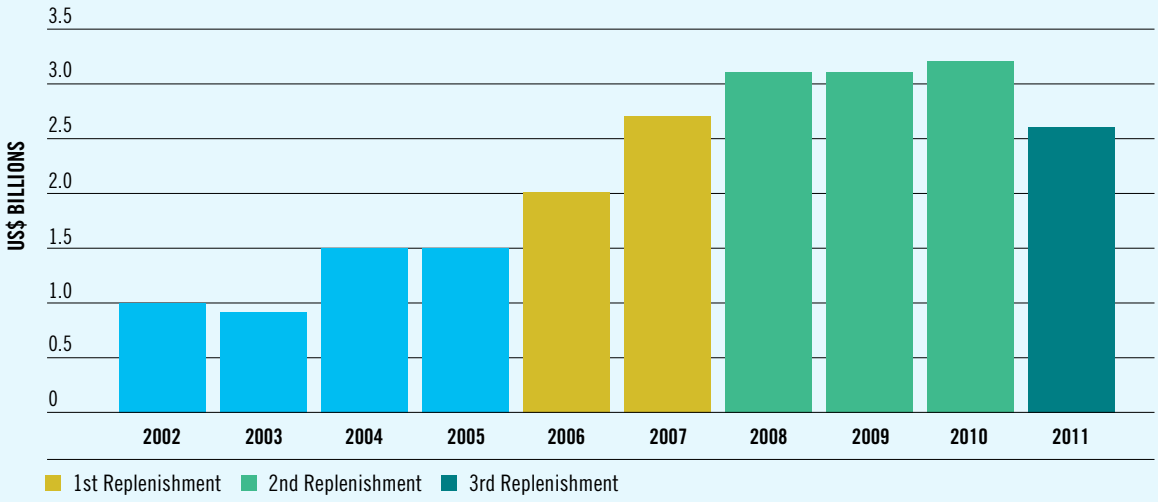
7. In addition, the innovative Debt2Health scheme enables existing debt between developing and developed countries (principally Australia and Germany to date) to be converted into funding for health. By the end of 2011 this scheme had facilitated agreements worth more than US$ 200 million, of which half has been pledged to the Global Fund for reinvestment in lifesaving health services for people in need (creditor countries then write off the other half) [48]. So far around half has been contributed.

8. In 2010 the Third Voluntary Replenishment Conference forecast a gross total of US$ 11.7 billion in pledges: US$ 9.2 billion in direct donor pledges, and a further US$ 2.5 billion projected at the time from donors who were unable to pledge during the meeting itself [49]. However, the global financial crisis created heightened uncertainty around the size and timing of future contributions, and several donor currencies also weakened against the U.S. dollar. This meant that assumptions made in earlier forecasts proved to be too optimistic and, in November 2011, the Global Fund Board took the difficult decision to cancel Round 11 of funding as a result of reductions in the forecast of available funding. Considerable resources are still available to the Global Fund, but priority is given to the renewal of existing grants: the organization will be making decisions to approve up to US$ 8 billion in grant renewals in 2012 and 2013 alone. The Global Fund Board created a "Transitional Funding Mechanism" to ensure the maintenance of essential programs without disruption [50].

9. The situation has since improved and, in May 2012, the Global Fund Board requested that the Secretariat progress with plans for the approval of up to US$ 1.6 billion in new funding in the coming years [51]. This funding includes approximately US$ 0.6 billion invested through the Transitional Funding Mechanism, and is in addition to the resources needed for grant renewals during this period (as well as in addition to a US$ 0.5 billion provision for unanticipated risk, which provides for volatility in donor contributions and payment schedules, currency exchange fluctuations and other eventualities). However, 2012 and 2013 are crucial years for donors to maintain their investments to support the scale-up necessary to achieve the health-related Millennium Development Goals by 2015.

7 By mid 2012, 96 percent of the pledges due in 2011 had been paid.

FIGURE 4.2
CONTRIBUTIONS MADE TO THE GLOBAL FUND, 2002-2011



Note Figure shows contributions made to the Global Fund – i.e. actual income (in cash or non-cash forms) received from donors and innovative financing mechanisms. **Source** The Global Fund [44].

FIGURE 4.3
CONTRIBUTIONS FROM THE LEADING PUBLIC SECTOR DONORS, 2002-2011

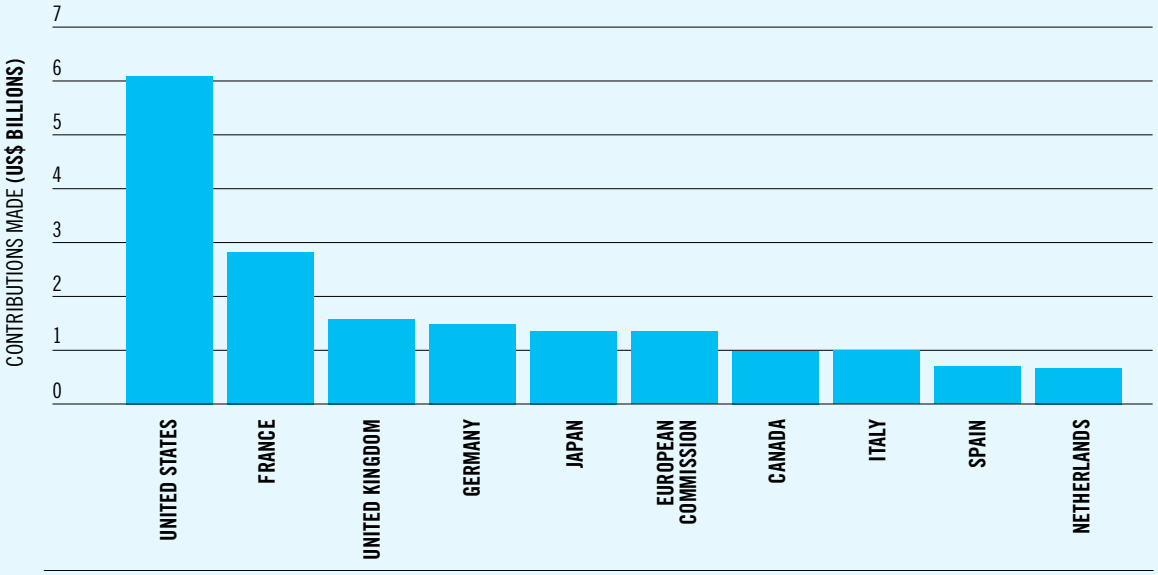
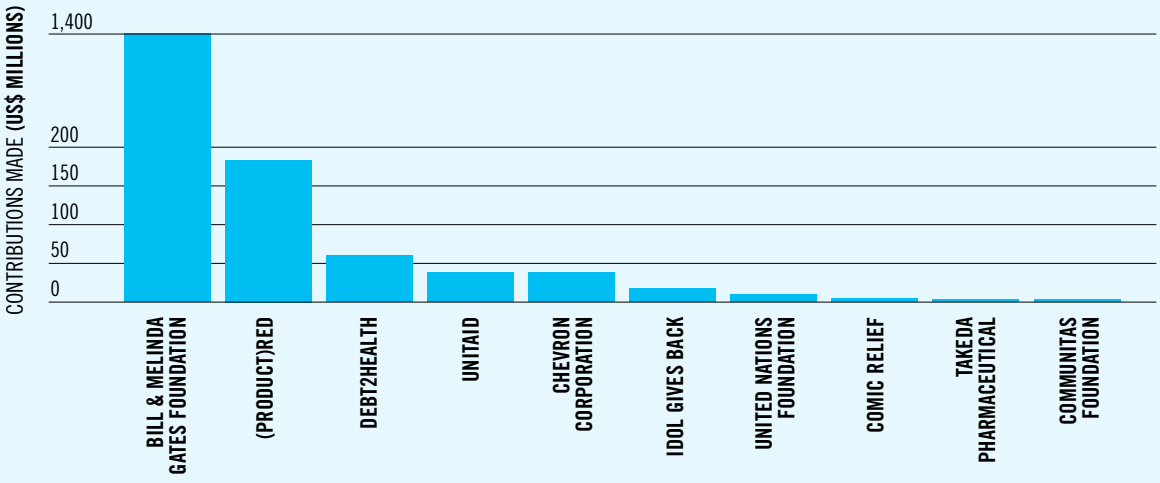


FIGURE 4.4
CONTRIBUTIONS FROM THE LEADING NON-PUBLIC SECTOR DONORS AND INNOVATIVE FINANCING MECHANISMS, 2002-2011



Note (PRODUCT) RED™ partners include American Express, Apple, Bugaboo, Converse, Dell, Emporio Armani, GAP, Hallmark, Motorola Foundation, Nike, Penfolds, Penguin Classics and Starbucks. The United Nations Foundation data include contributions from its donors.

4.2 GLOBAL FUND FINANCING TO DATE

10. Between 2002 and the end of 2011 the Global Fund approved US$ 22.9 billion in funding for programs around the world (See Table 4.1). Just over half this amount (US$ 12.4 billion, or 54 percent) was for HIV and TB/HIV grants, US$ 3.8 billion (17 percent) was for TB grants and US$ 6.5 billion (28 percent) was for malaria grants. Over time, the proportion of approved funding allocated for malaria has grown, the share devoted to TB has remained constant, and the allocation to HIV has decreased slightly. Following several years of rapid increases – with US$ 12 billion approved since the end of 2007 (See Table 4.1) – the growth in approved funding slowed in 2011 as a result of the cancellation of Round 11 (See Figure 4.5).

11. The Global Fund had disbursed a total of US$ 15.7 billion by the end of 2011 (See Table 4.1) – including US$ 8.8 billion (56 percent) for HIV and TB/HIV grants, US$ 2.4 billion (15 percent) for TB grants, and US$ 4.4 billion (28 percent) for malaria grants. The Global Fund invested more than US$ 2.6 billion in programs during 2011 alone – including US$ 1.5 billion for HIV and TB/HIV, US$ 0.4 billion for TB, and US$ 0.6 billion for malaria. A significant proportion of Global Fund disbursements also go toward supporting maternal and child health (See Box 4.1). As Figure 4.6 shows, the overall annual disbursement amount increased substantially between 2002 and 2010 as the grant portfolio grew in size, but then fell in 2011.

TABLE 4.1
CUMULATIVE APPROVED AND DISBURSED FUNDING FROM THE GLOBAL FUND, 2002-2011 (US$ BILLIONS)

YEAR	APPROVED FUNDING	DISBURSED FUNDING
2002	1.4	< 0.1
2003	2.8	0.2
2004	4.1	0.9
2005	6.1	1.9
2006	7.9	3.2
2007	10.1	5.0
2008	14.0	7.2
2009	18.4	10.0
2010	21.7	13.0
2011	**22.9**	**15.7**

Note Figures are rounded.

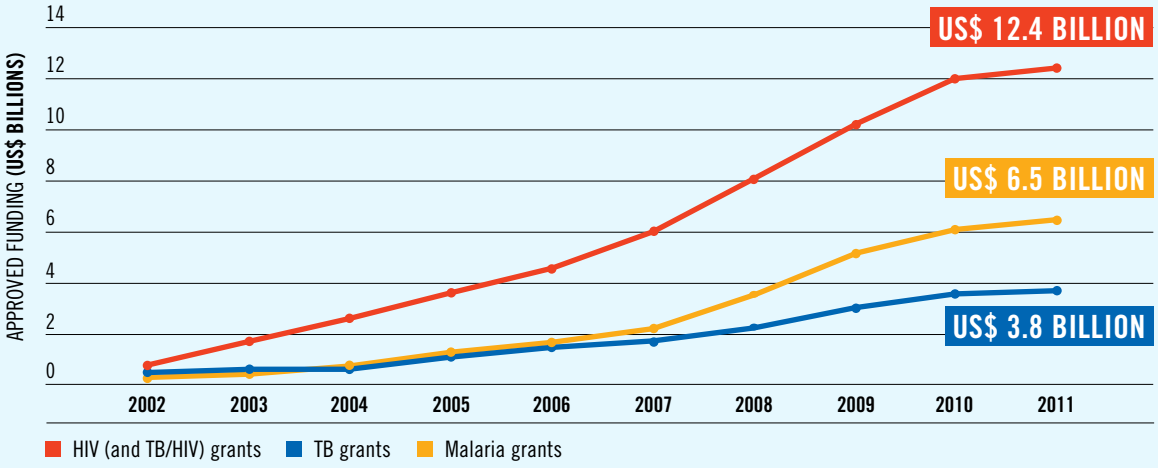
BOX 4.1
GLOBAL FUND CONTRIBUTIONS TO MATERNAL AND CHILD HEALTH

Global Fund investments focus primarily on MDG6 (combating HIV, malaria and other diseases) – but these diseases also heavily affect MDG4 (reducing child mortality) and MDG5 (improving maternal health). As Chapter 2 demonstrates, Global Fund-supported programs are continuing to scale up delivery on a range of lifesaving interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth, and infant and child care. Malaria accounted for an estimated 7 percent of the 7.6 million child deaths globally in 2010, and AIDS accounted for a further 2 percent [11]. AIDS, TB and malaria also remain the leading causes of death among women of child-bearing age in sub-Saharan Africa. As a result, the Global Fund's investments in PMTCT, ARV therapy, and the prevention and treatment of malaria have particular impact on maternal and child health – alongside broader efforts to strengthen health and community systems, and to promote gender equality.

Based on disbursements made for 12 key interventions (including PMTCT, ARV therapy and insecticide-treated nets) as well as for health systems strengthening, approximately 42 percent of the total disbursements from the Global Fund (around US$ 6.5 billion) have contributed to maternal and child health globally [53].

12. The Global Fund accounts for a large share of international aid to fight the three diseases (See Figure 4.7), although it relies on strong partnerships with bilateral, multilateral and in-country organizations to deliver financing and results. The Global Fund and PEPFAR are the leading international sources of HIV funding in low- and middle-income countries, and the Global Fund provided 21 percent of the total international investments for HIV and AIDS in 2009 [32]. In addition, the Global Fund was the main source of international HIV and AIDS funding in 52 of the 92 recipient countries that reported financial data to UNAIDS [32]. The Global Fund is the largest international donor for TB, and is expected to account for 82 percent of total international funding in 2012 – including 81 percent of international funding for the 22 high TB-burden countries (up from 65 percent in 2009) [2]. The Global Fund is also one of the main sources of international funding for malaria control alongside PMI, and accounted for an estimated 50 percent of international funding in 2011 [3]. Although this is down from 65 percent in 2010 due to increased funding from other sources [52], the Global Fund has been a major driver for the global scale-up of international malaria financing from US$ 149 million in 2000 to US$ 1.8 billion in 2010 [3].

FIGURE 4.5
CUMULATIVE APPROVED FUNDING FROM THE GLOBAL FUND BY DISEASE, 2002-2011



Note Does not include stand-alone health systems strengthening funding.

FIGURE 4.6
ANNUAL DISBURSEMENTS FROM THE GLOBAL FUND, 2002-2011

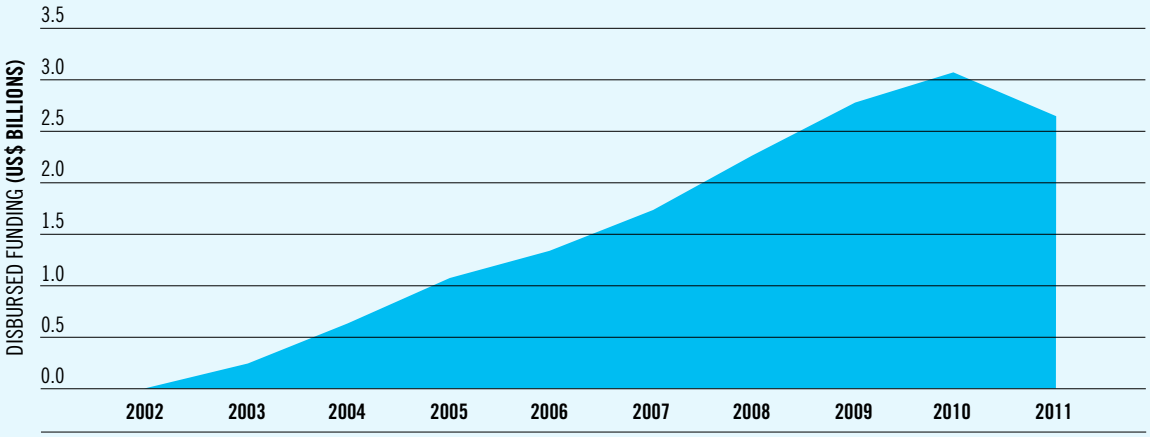
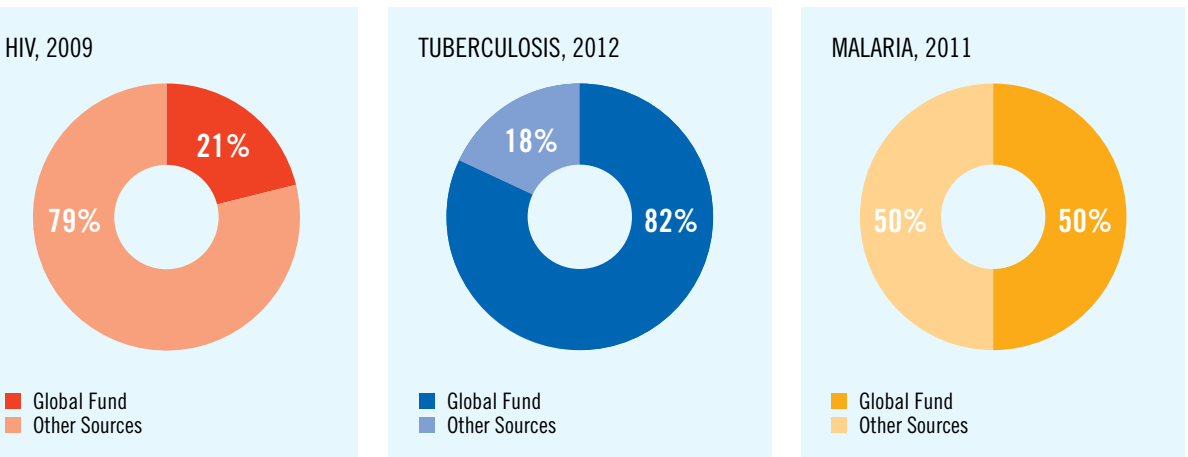


FIGURE 4.7
GLOBAL FUND CONTRIBUTIONS TO TOTAL INTERNATIONAL FUNDING, BY DISEASE



Sources UNAIDS, 2010 [32]. WHO, 2011 [2]. WHO, 2011 [3].

TB patient Regiane stopped taking her treatment after several weeks because she felt ashamed of having TB, but a community outreach worker (seen in the background) from a nongovernmental organization supported by the Global Fund came to her home to offer support and encouragement. Back on treatment and nearly finished with the six-month program, she says the regular visits and caring attitude of the community workers helped her to see the treatment through.

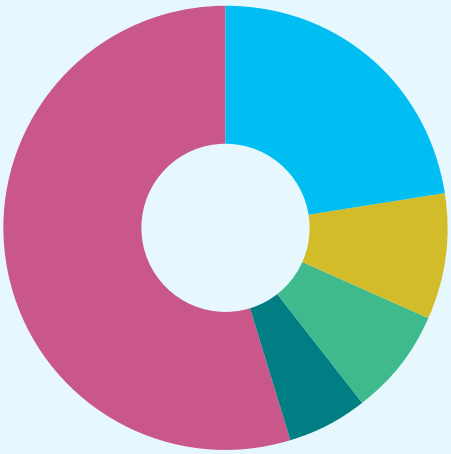
RESOURCE ALLOCATION

13. The distribution of Global Fund disbursements between different regions broadly reflects the geographical distribution of the burden of the three diseases. Sub-Saharan Africa accounts for more than half the total disbursements across all three diseases (See Figure 4.8) – and receives a much higher proportion of disbursements for HIV (56 percent) and malaria (69 percent), compared to TB (24 percent). This is because the region accounts for two-thirds of global HIV prevalence [32] and 81 percent of the estimated malaria caseload [3], but only around a quarter of incident TB cases in 2010 [2]. For TB, 43 percent of all Global Fund disbursements by the end of 2011 were to the Asia region, which accounted for 59 percent of the estimated global TB cases in 2010 [2]. A further 17 percent of the disbursed TB funding went to Eastern Europe and Central Asia. Although this region only accounts for around 5 percent of global TB prevalence, it is disproportionately affected by multidrug-resistant TB – accounting for 15 of the 27 high-burden countries for this strain of the disease that is more difficult and more expensive to treat.

14. In addition to measuring approved and disbursed funding, the Global Fund also tracks annual expenditure by grants through its Enhanced Financial Reporting system. Since 2008 the Global Fund's grant recipients have used this system to report expenditures disaggregated by service delivery area, implementing entity and cost category. By the end of 2011 the system had tracked a cumulative expenditure of US$ 11.4 billion through 448 grants (compared to the US$ 15.7 billion that has been disbursed in total).

15. Figure 4.9 shows the breakdown of expenditures by implementing agency. Government entities spent slightly more than half the reported expenditure, civil society organizations more than one-third, and multilateral agencies (such as UNDP) the remaining 11 percent. Figure 4.10 shows the breakdown of reported expenditure by the main cost categories. By the end of 2011 the largest proportions of expenditure were for health products and health equipment (21 percent) and medicines (19 percent). Expenditure in areas such as human resources, training, infrastructure, and monitoring and evaluation contribute to health system strengthening in recipient countries beyond the three diseases (See Chapter 2.4) – these four cost categories combined account for 38 percent of the Global Fund's reported expenditure by the end of 2011.

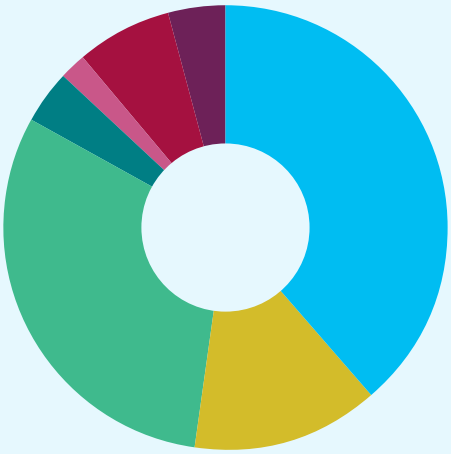
FIGURE 4.8
DISTRIBUTION OF DISBURSEMENTS BETWEEN GLOBAL FUND REGIONS, 2002-2011



23%	ASIA
6%	EASTERN EUROPEAN AND CENTRAL ASIA
8%	LATIN AMERICA AND CARIBBEAN
6%	MIDDLE EAST AND NORTH AFRICA
55%	SUB-SAHARAN AFRICA

Note Total disbursed funding, 2002-2011 = US$ 15.7 billion. Global Fund region definitions differ from those used by partners – for more information, see http://portfolio.theglobalfund.org

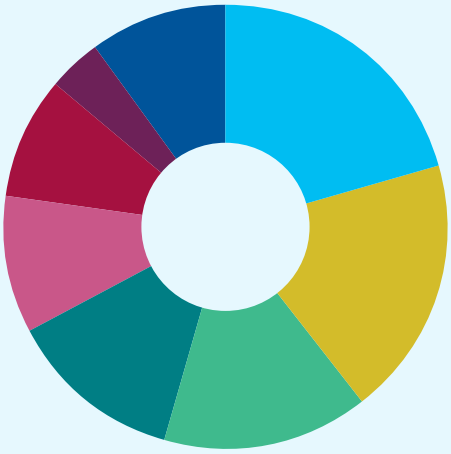
FIGURE 4.9
CUMULATIVE GRANT EXPENDITURES BY IMPLEMENTING ENTITY, 2002-2011



39%	MINISTRIES OF HEALTH
14%	OTHER GOVERNMENT ORGANIZATIONS
31%	CIVIL SOCIETY AND ACADEMIA
4%	FAITH-BASED ORGANIZATIONS
2%	PRIVATE SECTOR ORGANIZATIONS
7%	UNDP
4%	OTHER MULTILATERAL ORGANIZATIONS

Note Expenditures are reported through the Global Fund's Enhanced Financial Reporting System.

FIGURE 4.10
CUMULATIVE GRANT EXPENDITURES BY COST CATEGORY, 2002-2011



21%	HEALTH PRODUCTS AND HEALTH EQUIPMENT
19%	MEDICINES
15%	HUMAN RESOURCES
13%	PROGRAM MANAGEMENT
10%	TRAINING
9%	INFRASTRUCTURE AND OTHER EQUIPMENT
4%	MONITORING AND EVALUATION
10%	OTHER

Note Expenditures are reported through the Global Fund's Enhanced Financial Reporting System. "Program management" includes planning and administration, overheads, procurement and supply management, and technical assistance. "Other" expenditures include communication materials and living support to clients.

16. Figure 4.11 shows the cumulative expenditure reported to the Global Fund, disaggregated by the main service delivery areas for each disease. By the end of 2011, 30 percent of the reported expenditure by HIV grant recipients was for prevention activities – including community-based activities, testing and counseling, PMTCT activities, distribution of condoms, and programs for most-at-risk populations (See Box 4.2). Approximately 18 percent of reported HIV expenditure was for supportive environment interventions such as strengthening civil society, program management, stigma reduction and policy development. For TB grants, more than half the reported expenditure was for the detection and treatment of the disease in line with the DOTS approach. Within this service delivery area, multidrug-resistant TB treatment accounted for 13 percent of the cumulative TB expenditure, and community TB care for a further 4 percent. Recipients of malaria grants reported that more than half of their expenditure was for prevention activities – and this proportion has been progressively increasing in recent years (from around 42 percent in 2008). This service delivery area includes insecticide-treated nets, indoor residual spraying and malaria prevention in pregnancy. The relative share of expenditure for malaria treatment declined from 31 percent in 2008 to 25 percent in 2011.

BOX 4.2

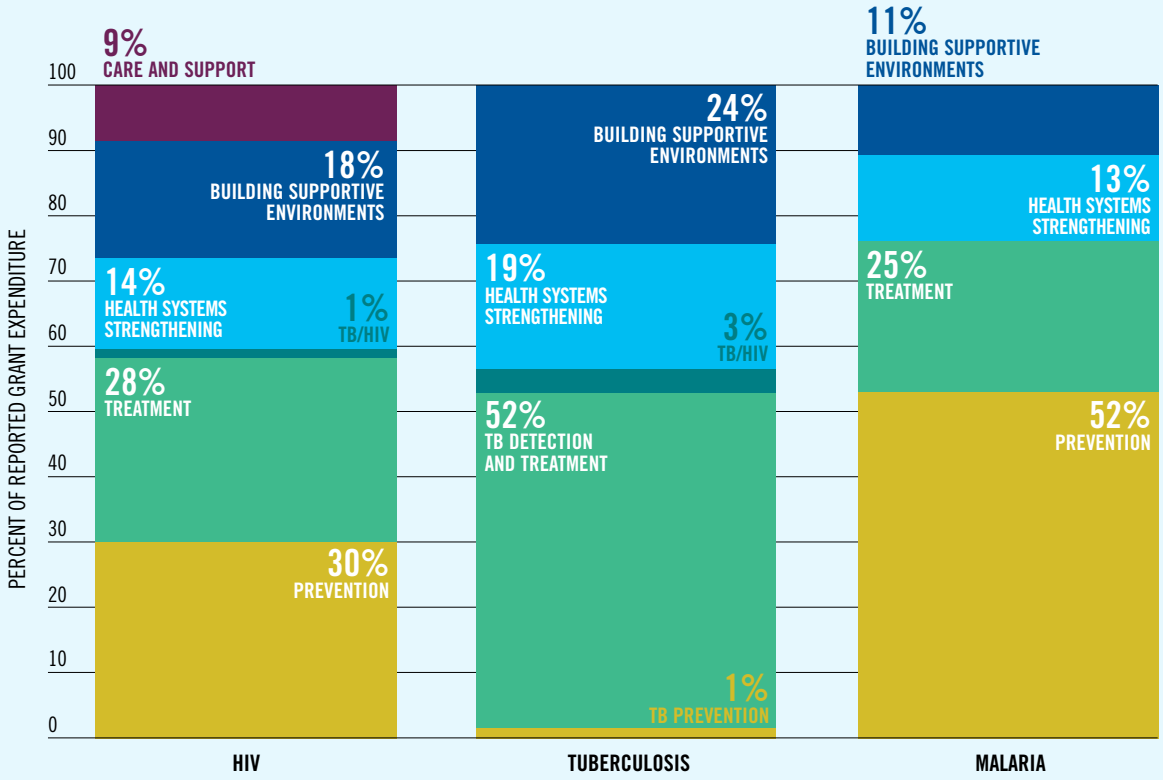
GLOBAL FUND INVESTMENTS FOR PEOPLE WHO INJECT DRUGS

In 2012 the Global Fund published new data to detail its investment in programs that target people who use drugs, a key most-at-risk population for HIV transmission around the world. By analyzing grant budgets, it was estimated that US$ 430 million had been approved for this population between Round 1 (2002) and Round 9 (2009) [54]. These investments were made through 120 grants in 55 countries and territories, predominantly in Eastern Europe and Asia. Two-thirds of the budgeted amounts went to the core package of harm reduction activities defined by the UN, including the distribution of sterile needles and syringes, and the provision of opioid substitution therapy [55]. In Round 10 (2010) the Global Fund introduced a dedicated funding reserve for HIV grants that target most-at-risk populations, and released its first explicit guidance on harm reduction programming [56]. Unpublished analysis from the Global Fund's Round 10 grant budgets shows an additional estimated investment of US$ 152 million for people who inject drugs – which takes the ten-year total to US$ 582 million.

These results confirm the Global Fund's position as the leading multilateral donor for harm reduction programs. Nonetheless, the provision of harm reduction services for people who inject drugs is still far lower than the need [57], and investments in harm reduction from the Global Fund, other donors and domestic governments must increase if HIV transmission among this population is to be halved by 2015 as targeted [27].

FIGURE 4.11

CUMULATIVE GRANT EXPENDITURES BY SERVICE DELIVERY AREA AND DISEASE, 2002-2011



Note Expenditures are reported through the Global Fund's Enhanced Financial Reporting System.

4.3 VALUE FOR MONEY

17. To improve the effectiveness of the funding it provides, the Global Fund continues to place a strong emphasis on value for money at every level. This means more than just monitoring health product costs – it looks at the cost-effectiveness of products and services, the efficiency of processes, and whether Global Fund support is additional to that from governments and other donors. Value for money is a core element of the Global Fund's commitment to invest for impact (See Chapter 3.4), and entails:

- working with implementers and partners to fund the right interventions for the right populations in the right countries;
- making the Secretariat and grant recipients as efficient as possible;
- considering cost-effectiveness during grant reviews and negotiation;
- leveraging the Global Fund's investments in health products to impact markets; and
- ensuring recipients procure quality-assured health products at the lowest possible market prices, and in a competitive and transparent manner.

EFFICIENCY SAVINGS

18. When grants are renewed at the end of their first phase of operation, the Global Fund and the Principal Recipient review progress and identify any developments that might affect value for money in the country – such as reduced costs for goods or medications. This frequently provides the opportunity for cost efficiencies, freeing up resources to be re-allocated to other activities or other grants. In 2011 the Global Fund Board made decisions on grant renewals worth more than US$ 2.3 billion, and eventually approved a total of US$ 1.7 billion. This represents an efficiency saving at the grant renewal stage of approximately US$ 600 million (27 percent).

19. For Round 10 (2010) the Global Fund introduced an internal value-for-money checklist to support the grant negotiation stage and to formally document cost-effectiveness considerations. The Global Fund Secretariat used the checklist for more than 80 new grants, contributing to important efficiency gains of around US$ 270 million (15 percent) for grants signed in 2011. These efficiencies were most commonly identified in the budgets for human resources, training, program overheads and health equipment.

20. In **Burkina Faso**, for example, the Round 10 HIV proposal included some of the first services to target most-at-risk populations, with provisions for capacity strengthening in the community and private sectors. Significant savings were achieved during negotiation by streamlining some of the targeted activities in terms of proposed training, communication materials and living support. The implementers agreed to partially re-invest these savings in medicines, supply management and monitoring systems to strengthen the grants. For the Round 10 malaria grant in **Sierra Leone**, the Global Fund worked with recipients to increase targets and ensure consistency with the national malaria strategy. It was also agreed to use Voluntary Pooled Procurement for long-lasting insecticidal nets, ACT and rapid diagnostic tests (See Box 4.3). The result was a saving of approximately US$ 1.6 million from the original procurement budget and an expected increase in value for the number of patients who can be reached.

MARKET SHAPING

21. In May 2011 the Global Fund Board approved an ambitious Market Shaping Strategy to improve health impact and value for money from the procurement of health products for its grants [58]. By the end of 2011, 40 percent of the reported expenditure by Global Fund-supported programs was for health products, health equipment and medicines (See Figure 4.10). The Market Shaping Strategy has identified a set of interventions the Global Fund Secretariat and partners could use to leverage these significant investments and pursue four objectives: accelerating the uptake of new, superior products; ensuring that recipients procure the most cost-effective products; strengthening procurement capacity at the local level; and ensuring the sustained availability and affordability of products.

22. The tools identified for implementation include Voluntary Pooled Procurement – especially for new, superior products that emerge. The Market Shaping Strategy also recommends the coordinated procurement of pediatric ARV drugs to secure a currently fragmented and fragile market [58]. By focusing initially on these drugs and optimizing product selection, the Market Shaping Strategy anticipates savings of US$ 250 million in Global Fund resources over five years.

PRICE MONITORING

23. The Global Fund's framework of key performance indicators (See Chapter 2.4) monitors value for money by tracking prices paid by grant recipients for three key interventions. The latest price data for ARV drugs, DOTS delivery and insecticide-treated nets purchased with financial support from the Global Fund have demonstrated improvements [21]:

- **ARV therapy:** The median price paid for the most common adult first-line regimens fell by 12 percent: from US$ 144 in 2009 to US$ 127 in 2010 (although this is a slower rate of decline than in previous years).
- **DOTS:** Between 2008 and 2010, 21 of the 22 high-TB-burden countries delivered first-line TB treatment at a per-patient cost that was below

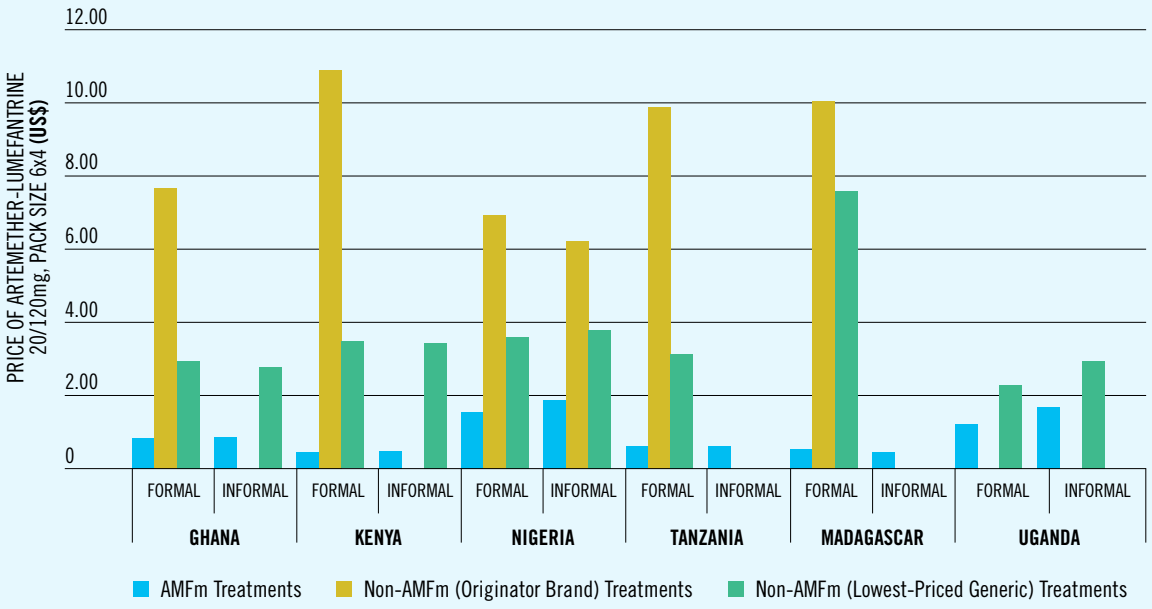
the WHO-recommended ceiling. However, the actual costs per patient increased by 11 percent across the 22 countries.

- **Insecticide-treated nets:** The median insecticide-treated net procurement price has declined by 4 percent – from US$ 4.60 in 2009 to US$ 4.50 in 2010. As prices and price trends vary between different types, colors and designs of insecticide-treated net, this decline reflects a combination of decreases in prices for some common net types, as well as a general shift away from procuring the more expensive types.

24. The Global Fund and partners have also achieved price reductions for ACT through the **Affordable Medicines Facility – malaria (AMFm)** which is hosted and managed by the Global Fund. AMFm aims to improve the availability and affordability of quality-assured ACT – thereby saving lives and delaying widespread drug resistance. International donor funding, including the majority of Global Fund grants, is often channeled through the public sector, yet patients in many countries seek treatment in the private sector. High prices and low availability of quality-assured ACT have meant that they can only access less-effective medicines or artemisinin monotherapies which can contribute to the development of artemisinin resistance. Working primarily through the private sector, in addition to the public and nongovernmental sectors, AMFm combines price negotiations with manufacturers and global subsidies through "co-payments" with activities to support implementation at the local level (such as public awareness campaigns, training and programs to improve access among children) [59].

25. Phase 1 of AMFm began operation in 2010 in eight countries. Based on the results of an independent evaluation of impact, the Global Fund Board will take a decision on the facility's future at the end of 2012. The first round of negotiations with drug manufacturers in 2010 resulted in price decreases of up to 80 percent. By June 2012, the Global Fund had approved AMFm payments for approximately 260 million courses of ACT. A series of independent price tracking studies in 2011 and 2012 also report an increased availability of treatment and a drop in the retail price of ACT in the six countries surveyed (See Figure 4.12). These achievements mean that patients can more easily obtain the highest-quality, most effective drugs at an affordable price, often by reducing the barrier of travelling long distances to reach public sector health clinics.

FIGURE 4.12
MEDIAN TREATMENT PRICES OF THE MOST COMMON ARTEMISININ-BASED COMBINATION THERAPY, JANUARY 2012



Note "Formal" refers to registered retail pharmacies, while "Informal" includes unregulated, unlicensed outlets. AMFm received funding from contributions from UNITAID, the government of the United Kingdom, the government of Canada, and the Bill & Melinda Gates Foundation. **Source** Health Action International, 2012 [60].

26. The Global Fund will continue to closely monitor procurement prices and trends through tools such as the Enhanced Financial Reporting system, the Price and Quality Reporting system, the key performance indicator framework, and the procurement and supply management plans (which recipients must submit for each grant). In addition, Voluntary Pooled Procurement is generating important results in terms of lower unit prices and increased value for money in several countries (See Box 4.3). The Global Fund systematically uses the data generated by these tools during grant reviews and renewals to ensure value for money and promote efficiency savings at every opportunity.

BOX 4.3

SUPPORTING THE PROCUREMENT OF KEY HEALTH PRODUCTS

Since their inception, the Global Fund's Voluntary Pooled Procurement mechanism and the Supply Chain Management Capacity Building Services have played a key role in improving grant performance, managing risk and obtaining greater value for money for health products. More than US$ 60 million has been saved on the budgets for health products, procurement timelines have been reduced, and in-country procurement challenges have been resolved (which has facilitated grant disbursements and provided timely access to health products for those in need) [61].

Between June 2009 and December 2011, Voluntary Pooled Procurement has been the channel for US$ 0.7 billion of confirmed health product orders across 103 grants in 47 countries. This total includes the procurement of 90 million long-lasting insecticidal nets, 57 million courses of ACT, 10 million rapid HIV tests, 27 million rapid malaria tests, and 310 million daily doses of ARV medicines for HIV [62]. In 2012, the Global Fund will begin implementing the necessary changes to its financial and operational policies to further facilitate Voluntary Pooled Procurement and strategically manage demand.

In **Cameroon**, for example, Voluntary Pooled Procurement supported the budgeting, planning, ordering and distribution of 8.6 million long-lasting insecticidal nets in 2011 as part of a universal coverage campaign – saving an estimated US$ 5.7 million compared to the original procurement budget. In parallel, Capacity Building Services facilitated the technical support required through the Roll Back Malaria partnership, to address in-country storage issues, improve the distribution plan and support the campaign implementation – overcoming a number of conditions that the Global Fund had placed on the grant and enabling the timely release of funds.

LATIN AMERICA

SUSTAINABLE HIV TREATMENT

Between 2008 and 2011, the Global Fund supported ARV therapy provision in 21 countries of its Latin America and Caribbean region. In recent years, however, several countries have made significant progress in ensuring the long-term sustainability of ARV therapy coverage, which has reduced their overall dependency on international donors.

When the Round 3 (2003) Global Fund HIV grant ended in **Belize**, the Ministry of Health agreed to cover ARV therapy costs through the government budget. The country subsequently obtained Global Fund financing in Round 9 (2009) for ARV therapy, but redirected these resources toward HIV testing and other key activities. Since 2010, the government of Belize has budgeted for full, free coverage of ARV therapy for those in need, aided by efficiency savings from the procurement of cheaper ARV drugs from generic manufacturers.

During negotiations for a consolidated HIV grant in **El Salvador** in 2011, the Ministry of Health and the Global Fund agreed a detailed plan for the gradual absorption of ARV therapy costs into government budgets. By December 2013, the Ministry of Health will support 80 percent of ARV therapy patients (while the Global Fund will finance the remaining 20 percent). With help from the Global Fund and partners, the Ministry of Health will also improve the national ARV therapy database to enable better tracking of patients.

The free provision of ARV therapy in **Peru** is one of many activities initiated through Global Fund grants and subsequently absorbed into national or regional budgets by a strongly committed government. More than 16,000 patients were receiving ARV therapy in Peru at the end of 2008 when the government took over the costs from the Global Fund grants.

In **Suriname**, the Global Fund initially covered around 80 percent of ARV therapy costs through grants in Round 3 (2003) and Round 5 (2005). When these grants ended the government committed to taking over the procurement of ARV drugs, and committed approximately US$ 1.5 million. The government has since continued to increase budget allocations for the HIV response in the country.

The examples above demonstrate how the commitment and leadership of governments in Latin America have helped to ensure the sustainable provision of ARV therapy for those in need. Faced with a leveling-off or decline in external support for HIV programs, these local investments have allowed Belize, Peru and Suriname to earn the classification of "no dependency" on donors for ARV therapy in 2011 and 2012, while El Salvador (as well as Ecuador, Honduras and Paraguay) has moved into a "low dependency" category [63].

5. LOOKING FORWARD

In Kenya, the Global Fund supports malaria prevention through indoor residual spraying and distribution of insecticide-treated nets. The home of Mary, a farmer in Mount Elgon district, was sprayed just before the rainy season, and since then no one in her household has had malaria.

1. With a newly-approved five-year strategy and a successful transformation underway, the Global Fund is well positioned to support grant recipients in their efforts to achieve the Millennium Development Goals by 2015. The organization has redoubled focus on its core business of grant management, and dedicated additional staff resources to countries with the largest share of the global disease burden. Furthermore, the implementation of the strategy will encourage work with partners and implementers to optimally invest resources for new and existing grants for the greatest impact and value for money [7]. Multilateral aid reviews have recognized the strengths of the Global Fund as an organization with strong results [64, 65] – while these reviews and others have also identified areas for improvement, helping shape a reform process to make the organization even more responsive and effective. The changes that have already been made have given a number of key donors the confidence to confirm or increase their commitments. This has, in turn, contributed to an improved financial forecast that reaffirms the organization is continuing to move in the right direction [51].

2. The next phase of transformation will focus on accelerating the implementation of the strategy, which commits the Global Fund to:

- ensure strategic investments drive decisions on grant renewals and new applications;
- work with partners and countries on long-term strategic plans to combat HIV, TB and malaria (especially in the 20 high-impact countries listed in Box 1.3);
- reduce the time taken between approving proposals and signing grant agreements;
- improve risk management tailored to country contexts;
- simplify its processes and procedures to reduce administrative burden and increase efficiency; and
- to implement joint program evaluations in all high-impact countries to ensure focus and accountability to measuring outcomes and impact.

3. Crucially the Global Fund will also develop a new and improved funding model by the end of 2012, in close collaboration with partners, implementers and other stakeholders – focusing on dialogue to ensure that, together, the right populations in the right countries are targeted with the right interventions. The organization will aim to offer more predictability for recipients, but also ensure sufficient flexibility to respond to the complex and changeable contexts on the ground. In essence, the new approach should help the Global Fund's investments save even more lives.

THE NEXT 10 YEARS: CHALLENGES AND OPPORTUNITIES

4. The transformation comes at a crucial time for the global response to HIV, TB and malaria. Against a backdrop of the international financial crisis, 2012 and 2013 are critical years for donors to invest: both to sustain momentum toward the achievement of the health-related Millennium Development Goals, and to maintain progress for goals beyond 2015 – for which health will continue to be an important determinant of sustainable development. As Chapter 4 describes, the financial crisis led to greater uncertainty about future contributions from donors – which ultimately resulted in the cancellation of Round 11 in 2011. But this should not detract from the continuing successes achieved by the recipients of Global Fund support. The organization will be making grant renewal decisions worth US$ 8 billion in 2012 and 2013. Resources are available to ensure approved funding is maintained for all existing grants, as well as enabling strategic reprogramming of grants to maximize impact for beneficiaries and patients. In addition, the most recent forecasts indicate the availability of new funding opportunities for scale-up between now and 2014 [51].

5. However, sustained effort is needed to reach the Millennium Development Goals and the additional impact achieved will depend on the strategic funding decisions made over the next two years. The key challenges are to invest strategically to fill the gaps and the unmet need – addressing the difficult questions and key tensions described in Chapter 3.4. This is at the forefront of the new strategy, and is a challenge that the Global Fund is determined to take on in collaboration with partners and implementers.

CONCLUSION

The last ten years have seen the Global Fund and its partners overcome daunting challenges, make remarkable progress, strengthen community and health systems, and support an incredible global scale-up of services and lifesaving interventions. These successes were difficult to imagine when the Global Fund was created in 2002. The organization has since become the largest international financier of programs focused on the three diseases, and has played a major role in the global partnership to fight HIV, TB and malaria. Whether the next ten years can accelerate the achievements of the last decade will depend on the choices made today: the choices of the Global Fund and implementers in terms of which programs and interventions to fund; the choices of new and existing donors; and the choices of the global partnership that is working to overcome the three pandemics. By strategically investing for impact, the newly transformed Global Fund is committed to working with partners to drive progress toward a new decade of achievement, meet the health-related Millennium Development Goals, and fulfill the vision of a world free from the burden of AIDS, TB and malaria.

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At the Serrekunda Health Clinic in Banjula in Gambia, a nurse welcomes women as they prepare to receive voluntary counseling and testing. All women visiting the clinic are given general health information, including information on HIV, testing, and mother-to-child transmission.

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ANNEXES

Global Fund-financed programs to fight tuberculosis in Brazil specifically target large urban areas, where poverty and population density facilitate the spread of the disease. Activities of these programs include training of health workers, timely TB detection, and quality treatment.

ANNEX 1. GLOBAL FUND GLOSSARY

The following section is a non-exhaustive list of terms commonly used by the Global Fund.

BOARD

The body responsible for the overall governance of the Global Fund and the approval of proposals. The Global Fund Board is comprised of 28 members or constituencies. Eight of these are non-voting seats. The 20 voting constituencies are equally divided between donors and recipients and include governments, nongovernmental organizations, the private sector and affected communities. A full list of Global Fund Board Members is available at http://www.theglobalfund.org/en/board/members/

COMMUNITY SYSTEMS STRENGTHENING

Interventions and approaches that aim to develop community engagement in the design, delivery, monitoring and evaluation of services and activities to improve health outcomes. Community can refer to key affected populations (including people living with the diseases), community organizations and networks, and public or private sector actors that work in partnership with civil society at the community level. Community systems strengthening often has a strong focus on capacity building and improving service uptake and awareness.

COUNTRY COORDINATING MECHANISM

A country-level partnership with representatives from government, multilateral and bilateral partners, affected communities, academic institutions, nongovernmental and faith-based organizations, and the private sector. These bodies must meet certain requirements to ensure transparency, consultation, and the inclusion of people living with and/or affected by the diseases. The Country Coordinating Mechanisms develop and submit proposals to the Global Fund based on the country's needs. They nominate Principal Recipients, and are responsible for overseeing grant implementation.

COUNTRY OWNERSHIP

The concept that countries are responsible for meeting their own challenges, given the necessary support and appropriate tools. In the Global Fund context, this means that each country is responsible for determining its own needs and priorities, while also being responsible for ensuring the implementation of their programs.

DISBURSEMENT

The periodic, scheduled payment of the funds allocated to an individual grant. Disbursements are requested by the Principal Recipient of the grant. Disbursement requests are approved by the Secretariat after review of grant performance.

DONORS

Governments, private businesses, foundations and individuals that make contributions to the Global Fund.

ELIGIBILITY

The criteria detailing which countries are eligible to apply for Global Fund support, and under which conditions. Eligibility is currently assessed through a combination of income level, disease burden, and whether the country has a history of recent funding with the Global Fund.

GLOBAL FUND-SUPPORTED PROGRAMS

Activities undertaken by stakeholders using full or partial funding from Global Fund grants. These vary from specific projects designed and funded entirely through Global Fund grants, to more comprehensive national responses for which Global Fund grants provide contributions or support.

GRANT

A grant is an agreement by the Global Fund Board to provide a set amount of funding for technically sound health programs. Once a proposal has been approved for funding by the Global Fund Board, it becomes a grant.

Gaodali, shown here with his wife, was trained to supervise TB treatment in his village as well as raise awareness about the disease. One of Gaodali's patients became something of a local hero when, upon returning from working abroad, realized he had symptoms and went straight from the airport to get tested and receive treatment. Although the villager longed to see his family after being away for so long, he chose to protect them instead.

GRANT AGREEMENT

A legally binding agreement between the Global Fund and a Principal Recipient that outlines the terms of Global Fund financing and the targets to be achieved. A grant agreement will typically include a workplan, a budget, a procurement and supply management plan, and a performance framework.

GRANT RENEWAL

The Global Fund Board approves proposals for a period of up to five years, but initially commits funding only for an initial implementation period of two or three years. Continued funding is conditional upon an in-depth review (also known as a Periodic Review or Phase 2 Review) to evaluate progress, performance and impact. Following this review, the Secretariat makes recommendations to the Global Fund Board to commit the next phase of funding.

HEALTH SYSTEMS STRENGTHENING

An array of initiatives and strategies to build capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes. These include service delivery, human resources, supply systems, information and monitoring systems, policies and regulations, and financing. The health system itself refers to all the organizations, institutions, and resources that are devoted to improving health in a certain country or region – including service providers, donors, private sector and voluntary organizations, and community organizations.

HIGH-IMPACT COUNTRIES

A Global Fund list of 20 countries – all from Africa and Asia – which account for more than 70 percent of the worldwide burden of HIV, TB and malaria (See Box 1.3).

LOCAL FUND AGENT

Local, independent firms contracted by the Global Fund to provide oversight of a grant. Prior to grant signing, the Local Fund Agent assesses the capacity of the nominated Principal Recipient to administer grant funds and be responsible for implementation. On an ongoing basis the Local Fund Agent also verifies disbursement requests and progress updates, and reviews the Principal Recipient's annual reports.

MONITORING AND EVALUATION

These are fundamental aspects of good program management. Effective monitoring and evaluation provides data on progress, supports decision-making, and enhances future planning. Monitoring refers to the routine tracking of key program results through record-keeping, regular reporting, surveillance, health facility observation and/or client surveys. Evaluation is the episodic assessment of results and impact that can be attributed to the program – linking outcomes and impact to interventions after a period of time has passed.

PARTNERS

The success of the Global Fund depends on a range of partners. For example, the Global Fund is a financing mechanism and does not provide technical assistance and capacity-building support to current or potential grant recipients. Instead, the Global Fund relies on partners such as UNAIDS, WHO, other multilateral and bilateral agencies, and international and local nongovernmental organizations. Partners also play crucial roles in resource mobilization, proposal development, promoting the Global Fund's work, and ensuring a policy environment which is conducive for programs to operate effectively.

PERFORMANCE-BASED FUNDING

An underlying principle of the Global Fund model, whereby funding for country-owned programs goes hand in hand with the implementer's responsibility to achieve verifiable results at every stage. Programs have to report results as a basis for disbursements, account for any deviations from targets, and suggest strengthening measures to improve results. It requires programs not just to measure but to manage their programs effectively.

PRINCIPAL RECIPIENT

The organization legally responsible for implementing a grant, as set out in a Grant Agreement between the organization and the Global Fund. The Principal Recipient is nominated by the Country Coordinating Mechanism, receives disbursements from the Global Fund, and uses this money to implement programmatic activities. In most cases, Principal Recipients also pass this funding on to sub-recipients for service delivery. The Principal Recipient assumes both programmatic and fiduciary responsibility for themselves and any sub-recipients. Principal Recipients report on progress to both the Country Coordinating Mechanism and the Global Fund.

PROPOSAL

A written application for Global Fund support, which specifies the intended beneficiaries, objectives and activities. Because the Global Fund works directly at the country level, proposals are submitted by Country Coordinating Mechanisms in the vast majority of cases.

REPLENISHMENT

Periodic campaigns through which a wide range of donors discuss the Global Fund's progress and voluntarily make financial pledges to the organization.

REPROGRAMMING

Programmatic and/or financial changes made to a grant after the signing of a Grant Agreement, allowing countries to adapt the scope or scale of a grant in order to improve results and impact. Reprogramming can also be used to re-invest efficiency savings, to respond to epidemiological or contextual changes in a country, or to include the delivery of new technologies and interventions that have recently been approved. Reprogramming can occur at any time during the grant life cycle, but is most common during grant renewal.

ROLLING CONTINUATION CHANNEL

A (now discontinued) mechanism through which well-performing grants can seek continued funding to extend their original five-year implementation.

ROUNDS

The Global Fund issues open calls for proposals from eligible applicants, which are referred to as funding "Rounds." The new funding model built into the 2012-2016 Global Fund Strategy will look to change this process.

SECRETARIAT

The body of staff responsible for the day-to-day operations of the Global Fund, including the management of grants and the provision of strategic, policy, financial, legal and administrative support. The Secretariat comprises approximately 600 employees and is solely located in Geneva, Switzerland.

SINGLE STREAM OF FUNDING

A grant that has been consolidated to create a single Grant Agreement to cover all Global Fund financing to a Principal Recipient for a particular disease, as opposed to having separate agreements each time a new proposal is approved. This allows grant implementation, monitoring and evaluation to be streamlined.

SUB-RECIPIENT

An organization that receives Global Fund financing through a Principal Recipient in order to carry out activities that are part of a grant agreement.

TECHNICAL REVIEW PANEL

An independent group of international experts in the three diseases as well as crosscutting issues such as health systems. The Technical Review Panel is appointed by the Global Fund Board to review submitted proposals based on technical criteria and provide recommendations.

TRANSITIONAL FUNDING MECHANISM

A one-off, limited funding window announced in 2011 for programs that faced the disruption of essential services supported through Global Fund grants that are due to expire before 2014, and for which no alternative sources of funding can be secured.

ANNEX 2. RECIPIENT COUNTRY PORTFOLIOS

		DISEASE BURDEN			DISBURSEMENTS 2002-2011 (US$ MILLIONS)				
COUNTRY/TERRITORY	INCOME CATEGORY	HIV	TB	MALARIA	HIV	TB	MALARIA	**TOTAL**	NUMBER OF GRANTS IN PROGRESS*
GLOBAL FUND HIGH-IMPACT COUNTRIES									
Bangladesh	LI	low	severe	high	64	87	39	**190**	7
China	UMI	high	severe	low	258	267	101	**626**	5
Congo (Democratic Republic)	LI	high	severe	extreme	192	47	167	**406**	10
Côte d'Ivoire	Lower-LMI	severe	severe	severe	55	9	93	**157**	6
Ethiopia	LI	severe	severe	severe	754	58	330	**1,142**	6
Ghana	Lower-LMI	high	severe	severe	163	37	105	**305**	8
India	Lower-LMI	high	severe	extreme	594	148	59	**802**	16
Indonesia	Upper-LMI	high	severe	high	118	138	128	**385**	11
Kenya	LI	severe	severe	high	118	20	158	**297**	8
Mozambique	LI	extreme	severe	extreme	155	13	67	**235**	6
Myanmar	LI	high	severe	severe	28	12	15	**55**	6
Nigeria	Lower-LMI	severe	severe	extreme	223	64	327	**615**	9
Pakistan	Lower-LMI	high	severe	moderate	10	62	18	**90**	8
Philippines	Lower-LMI	low	severe	moderate	21	81	64	**167**	3
South Africa	UMI	extreme	extreme	high	247	-	-	**247**	5
Sudan	Lower-LMI	high	severe	high	88	30	83	**201**	5
Tanzania (United Republic)	LI	severe	severe	extreme	464	20	292	**776**	11
Uganda	LI	severe	severe	extreme	118	9	162	**288**	8
Zambia	Lower-LMI	extreme	extreme	severe	351	40	81	**472**	10
Zimbabwe	LI	extreme	extreme	severe	141	35	95	**271**	6
OTHER COUNTRIES AND TERRITORIES									
Afghanistan	LI	high	severe	moderate	8	10	38	**56**	7
Albania	UMI	moderate	low	low	5	1	-	**6**	2
Algeria	UMI	low	high	low	7	-	-	**7**	0
Angola	Upper-LMI	severe	severe	severe	62	10	62	**135**	3
Argentina	UMI	high	low	low	27	-	-	**27**	1
Armenia	Upper-LMI	high	high	low	19	9	-	**28**	4
Azerbaijan	UMI	high	severe	moderate	23	24	4	**51**	4
Belarus	UMI	high	severe	low	36	18	-	**55**	3
Belize	Upper-LMI	severe	high	moderate	3	-	-	**3**	1
Benin	LI	high	high	severe	75	13	39	**127**	6
Bhutan	Lower-LMI	low	severe	high	2	2	4	**8**	3
Bolivia (Plurinational State)	Lower-LMI	high	high	moderate	23	7	11	**41**	3
Bosnia and Herzegovina	UMI	low	moderate	low	20	10	-	**30**	2
Botswana	UMI	extreme	extreme	high	9	6	-	**15**	1

		DISEASE BURDEN			DISBURSEMENTS 2002-2011 (US$ MILLIONS)				
COUNTRY/TERRITORY	INCOME CATEGORY	HIV	TB	MALARIA	HIV	TB	MALARIA	**TOTAL**	NUMBER OF GRANTS IN PROGRESS*
Brazil	UMI	high	high	moderate	-	21	18	**39**	0
Bulgaria	UMI	high	high	low	36	20	-	**56**	3
Burkina Faso	LI	high	high	extreme	62	27	83	**172**	6
Burundi	LI	severe	severe	severe	70	10	55	**135**	6
Cambodia	LI	high	severe	severe	167	24	88	**278**	5
Cameroon	Lower-LMI	severe	severe	severe	94	7	104	**205**	5
Cape Verde	Upper-LMI	moderate	high	moderate	4	-	-	**4**	3
Central African Republic	LI	severe	severe	extreme	47	4	14	**66**	3
Chad	LI	severe	severe	extreme	33	3	32	**67**	5
Chile	UMI	high	low	low	29	-	-	**29**	0
Colombia	UMI	moderate	moderate	high	19	2	15	**36**	5
Comoros	LI	low	low	high	2	-	8	**10**	2
Congo	Lower-LMI	severe	severe	severe	31	1	13	**45**	6
Costa Rica	UMI	high	low	moderate	4	-	-	**4**	0
Croatia	HI	low	low	low	5	-	-	**5**	0
Cuba	UMI	low	low	low	62	6	-	**68**	3
Djibouti	Lower-LMI	severe	extreme	severe	18	2	3	**23**	3
Dominican Republic	UMI	high	high	low	83	12	4	**99**	6
Ecuador	UMI	low	moderate	moderate	18	19	5	**41**	6
Egypt	Lower-LMI	high	low	low	7	10	-	**17**	2
El Salvador	Upper-LMI	high	moderate	low	47	7	-	**53**	4
Equatorial Guinea	HI	severe	severe	severe	8	-	23	**31**	0
Eritrea	LI	high	severe	moderate	63	9	38	**110**	5
Estonia	HI	high	high	low	10	-	-	**10**	0
Fiji	Upper-LMI	low	moderate	low	-	4	-	**4**	1
Gabon	UMI	severe	severe	high	12	-	18	**30**	0
Gambia	LI	severe	severe	severe	32	10	42	**84**	6
Georgia	Upper-LMI	moderate	severe	moderate	33	24	3	**61**	4
Guatemala	Upper-LMI	high	high	moderate	57	6	22	**85**	4
Guinea	LI	high	severe	extreme	15	6	19	**39**	7
Guinea-Bissau	LI	severe	severe	extreme	17	6	15	**38**	4
Guyana	Upper-LMI	high	severe	high	28	3	4	**35**	3
Haiti	LI	high	severe	moderate	159	18	31	**208**	3
Honduras	Lower-LMI	high	high	moderate	59	8	11	**78**	3
Iran (Islamic Republic)	UMI	high	low	moderate	23	14	8	**45**	3
Iraq	Lower-LMI	low	moderate	moderate	-	24	-	**24**	1
Jamaica	UMI	high	moderate	low	54	-	-	**54**	1
Jordan	UMI	low	low	low	7	3	-	**10**	2
Kazakhstan	UMI	moderate	severe	low	38	44	-	**82**	3
Korea (Democratic People's Republic)	LI	low	severe	moderate	-	19	13	**32**	2
Kosovo	Upper-LMI	low	moderate	low	3	5	-	**8**	2
Kyrgyzstan	LI	high	severe	moderate	35	15	5	**55**	4
Lao (People's Democratic Republic)	Lower-LMI	low	high	high	29	15	43	**86**	4
Lesotho	Lower-LMI	extreme	extreme	low	90	9	-	**99**	5
Liberia	LI	high	severe	extreme	46	14	35	**94**	4

		DISEASE BURDEN			DISBURSEMENTS 2002-2011 (US$ MILLIONS)				
COUNTRY/TERRITORY	INCOME CATEGORY	HIV	TB	MALARIA	HIV	TB	MALARIA	**TOTAL**	NUMBER OF GRANTS IN PROGRESS*
Macedonia (Former Yugoslav Republic)	UMI	low	low	low	15	5	-	**20**	2
Madagascar	LI	low	severe	high	29	15	149	**194**	12
Malawi	LI	extreme	severe	severe	387	3	87	**477**	6
Malaysia	UMI	high	high	moderate	1	-	-	**1**	1
Maldives	UMI	low	moderate	low	3	-	-	**3**	1
Mali	LI	high	high	extreme	67	8	15	**90**	1
Mauritania	Lower-LMI	high	high	high	4	6	5	**15**	1
Mauritius	UMI	high	low	low	4	-	-	**4**	2
Mexico	UMI	high	low	moderate	13	-	-	**13**	1
Moldova	Lower-LMI	high	severe	low	33	20	-	**54**	4
Mongolia	Lower-LMI	low	severe	low	17	14	-	**30**	3
Montenegro	UMI	low	low	low	6	2	-	**8**	2
Morocco	Upper-LMI	low	high	low	36	4	-	**40**	4
Namibia	UMI	extreme	extreme	severe	123	14	17	**154**	6
Nepal	LI	high	severe	moderate	27	22	21	**71**	7
Nicaragua	Lower-LMI	moderate	moderate	moderate	29	7	12	**48**	4
Niger	LI	high	severe	extreme	28	11	57	**96**	3
Panama	UMI	moderate	high	moderate	-	1	-	**1**	1
Papua New Guinea	Lower-LMI	high	severe	high	14	12	55	**81**	5
Paraguay	Upper-LMI	high	moderate	moderate	17	9	-	**26**	4
Peru	UMI	high	severe	moderate	63	64	-	**127**	4
Romania	UMI	moderate	high	low	38	26	-	**64**	1
Russian Federation	UMI	high	severe	low	261	104	-	**365**	1
Rwanda	LI	severe	severe	high	390	41	145	**575**	3
Sao Tome and Principe	Lower-LMI	high	high	extreme	1	1	7	**9**	3
Senegal	Lower-LMI	high	high	severe	65	4	46	**116**	7
Serbia	UMI	high	moderate	low	22	7	-	**29**	5
Sierra Leone	LI	high	severe	extreme	48	9	29	**87**	4
Solomon Islands	Lower-LMI	low	high	severe	-	2	-	**2**	1
Somalia	LI	high	severe	severe	47	31	33	**111**	4
South Sudan	LI	high	severe	high	43	43	80	**167**	5
Sri Lanka	Lower-LMI	low	moderate	high	4	11	26	**41**	7
Suriname	UMI	high	moderate	severe	9	2	8	**18**	2
Swaziland	Upper-LMI	extreme	extreme	high	125	5	5	**135**	4
Syrian Arab Republic	Upper-LMI	low	low	low	-	5	-	**5**	2
Tajikistan	LI	high	severe	moderate	37	36	14	**86**	4
Thailand	UMI	high	severe	severe	217	42	33	**293**	8
Timor-Leste	Lower-LMI	low	severe	high	8	5	9	**22**	3
Togo	LI	severe	high	severe	70	6	51	**128**	5
Tunisia	UMI	high	moderate	low	14	3	-	**18**	3
Turkey	UMI	low	moderate	moderate	3	-	-	**3**	0
Turkmenistan	Upper-LMI	low	high	low	-	6	-	**6**	1
Ukraine	Upper-LMI	high	severe	low	221	13	-	**234**	6
Uzbekistan	Lower-LMI	high	severe	low	28	22	4	**53**	3
Viet Nam	Lower-LMI	high	severe	severe	68	25	37	**131**	3
West Bank and Gaza	Lower-LMI	low	low	low	5	1	-	**6**	2
Yemen	Lower-LMI	low	moderate	high	14	8	19	**42**	3

MULTICOUNTRY / TERRITORY GRANTS

GRANT	COUNTRY/TERRITORY	HIV	MALARIA	TB	**TOTAL**	NUMBER OF GRANTS IN PROGRESS *
Multicountry Africa (RMCC)	Mozambique, South Africa, Swaziland	-	36	-	**36**	0
Multicountry Africa (SADC)	Angola, Botswana, Congo (Democratic Republic), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania (United Republic), Zambia, Zimbabwe	2	-	-	**2**	1
Multicountry Africa (West Africa Corridor Program)	Benin, Côte d'Ivoire, Ghana, Nigeria, Togo	24	-	-	**24**	1
Multicountry Americas (ANDEAN)	Colombia, Ecuador, Peru, Venezuela	-	24	-	**24**	0
Multicountry Americas (CARICOM / PANCAP)	Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Jamaica, Martinique, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos Islands	17	-	-	**17**	1
Multicountry Americas (COPRECOS)	Argentina, Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Paraguay, Peru, Uruguay	5	-	-	**5**	1
Multicountry Americas (CRN+)	Antigua and Barbuda, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines, Suriname, Trinidad and Tobago	3	-	-	**3**	0
Multicountry Americas (MESO)	Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama	4	-	-	**4**	0
Multicountry Americas (OECS)	Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines	8	-	-	**8**	0
Multicountry Americas (REDCA+)	El Salvador, Honduras, Nicaragua, Panama	4	-	-	**4**	1
Multicountry East Asia and Pacific (APN+)	Bangladesh, Indonesia, Lao (Peoples Democratic Republic), Nepal, Pakistan, Philippines, Viet Nam	0	-	-	**0**	1
Multicountry East Asia and Pacific (ISEAN-HIVOS)	Indonesia, Malaysia, Philippines, Timor-Leste	1	-	-	**1**	1
Multicountry South Asia	Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka	5	-	-	**5**	1
Multicountry Western Pacific	Cook Islands, Kiribati, Marshall Islands, Micronesia (Federated States), Nauru, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu	21	23	10	**54**	3
Lutheran World Federation	Argentina, Bangladesh, Belarus, Bolivia, Botswana, Brazil, Cameroon, Central African Republic, Chile, Colombia, Congo (Democratic Republic), Costa Rica, Croatia, Ecuador, El Salvador, Eritrea, Estonia, Ethiopia, Russian Federation, Philippines, Ghana, Guatemala, Guyana, Honduras, India, Indonesia, Jordan, Kazakhstan, Kenya, Kyrgyzstan, Liberia, Madagascar, Malawi, Mauritius, Mexico, Mozambique, Myanmar, Namibia, Nicaragua, Nigeria, Papua New Guinea, Peru, Korea (Democratic Peoples Republic), Romania, Rwanda, Senegal, Sierra Leone, Sri Lanka, South Africa, Suriname, Thailand, Tanzania (United Republic), Ukraine, Uzbekistan, Venezuela, Zambia, Zimbabwe	1	-	-	**1**	0

Note Income categories are based on the World Bank (Atlas Method) Income Classifications: Low Income Countries (LI); Lower-Middle Income Countries (LMI); and Upper Middle Income Countries (UMI); July 2011. The Global Fund further divides LMI countries into two groups, Lower-LMI countries and Upper-LMI countries based on the midpoint of the GNI per capita range of the World Bank's LMI category. Disease burden data are provided to the Global Fund Secretariat by technical partners (WHO and UNAIDS) December 2011. Disbursements under HIV include HIV, HSS and HIV/TB grants. Data for Tanzania include Zanzibar. Kosovo, West Bank and Gaza and Zanzibar are not counted in the 151 countries that have received funding from the Global Fund. Data valid June 2012.
*Where the number of grants in progress is zero, all grants previously approved for this country/territory have been closed.

ACKNOWLEDGMENTS

THIS REPORT WAS WRITTEN BY a Global Fund team of Jamie Bridge, with Yoko Akachi, Nicolas Bidault, Ange-Joel Djoman, Tarek Elshimi, Seth Faison, Korah George, Mehran Hosseini, Andrew Hurst, Andrew Kennedy, Ryuichi Komatsu, Eline Korenromp, Donna Lee, Daniel Low-Beer, Sai Pothapregada, Estifanos Shargie, Simon-Pierre Tegang, Mohammed Yassin and Jinkou Zhao. It was overseen by a review group comprising Beatrice Bernescut, Tarek Elshimi, Stefan Emblad, Seth Faison, Andrew Hurst, Andrew Kennedy, Ryuichi Komatsu, Daniel Low-Beer and Urban Weber. The production team included Vincent Becker, Beatrice Bernescut, Murad Hirji and Rosie Vanek.

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SUGGESTED CITATION
Strategic Investments for Impact:
Global Fund Results Report 2012.
Geneva: The Global Fund; 2012.

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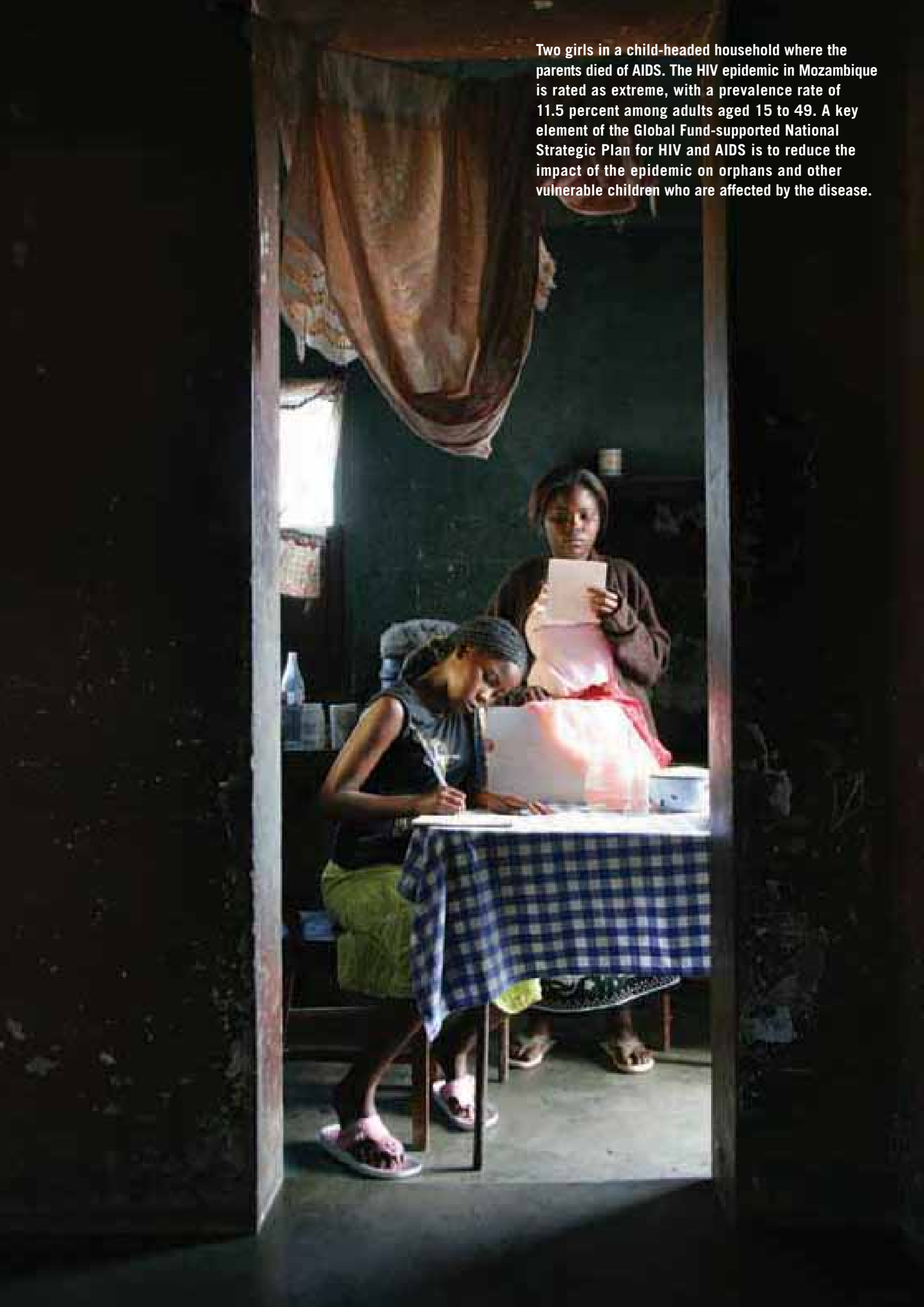

Two girls in a child-headed household where the parents died of AIDS. The HIV epidemic in Mozambique is rated as extreme, with a prevalence rate of 11.5 percent among adults aged 15 to 49. A key element of the Global Fund-supported National Strategic Plan for HIV and AIDS is to reduce the impact of the epidemic on orphans and other vulnerable children who are affected by the disease.

FRONT COVER

A pregnant woman undergoes her antenatal examination at a rural health clinic in Nepal. With the right interventions, a woman can reduce the chances of transmission of HIV to her child to less than 2 percent.

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ISBN 978-92-9224-339-5