The Global Fund to Fight AIDS, Tuberculosis, and Malaria: U.S. Contributions and Issues for Congress

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Summary

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund, or the Fund) was established in 2002 as a public-private partnership that could provide significant financial support for global responses to HIV/AIDS, tuberculosis (TB), and malaria. As of May 28, 2010, the Global Fund has committed to grant roughly $19.3 billion for related programs in 144 countries. These funds have been used to treat more than 2.5 million HIV-positive people, about 6 million people infected with active TB, and 107.8 million cases of malaria, saving nearly 5 million lives.

The United States has strongly supported the Global Fund since making a founding pledge in 2001, serving on several Global Fund boards, donating more to the Global Fund than other country, and increasing those contributions annually since FY2005. Donors will meet on October 4, 2010, to make their pledges for the Global Fund over the next three years. Should the United States provide 25% of the Global Fund's budget, as it has done on average since the Global Fund was founded, annual U.S. donations would reach between $3.25 billion and $5 billion in each year from 2011 through 2013. Many urge Congress to meet the Global Fund's budget request, in large part because key donors have begun to follow the lead of the United States in setting their annual contributions. Although the 111th Congress has continued to support the Fund, it has begun to consider other factors that might affect appropriations levels. Such issues include the following:

- **Priorities of the Obama Administration**—When President Barack Obama announced the Global Health Initiative (GHI), he expressed his intent to reshape U.S. global health policy so that global health efforts were better integrated and coordinated. The GHI also emphasizes other health priorities, such as neglected tropical diseases and maternal and child health. The FY2011 budget request for GHI includes a $50 million decrease for the Global Fund from FY2010-enacted levels and a 3% increase for bilateral and multilateral HIV/AIDS programs.
- **Funding trends for HIV/AIDS**—Health experts have long debated the appropriate balance of funding for HIV/AIDS prevention and treatment efforts. The debate has been reignited, as evidence indicates that international goals to ensure universal access to AIDS prevention, treatment, and care will not likely be met. Some question whether the massive funds spent on AIDS treatment would be better spent on less expensive health efforts that keep those living with HIV healthy. HIV/AIDS advocates warn that divestment from AIDS treatment will lead to colossal death tolls, as seen in the early years of the epidemic.
- **Role of the Global Fund in U.S. global health policy**—When the Global Fund was established, U.S. bilateral investments were relatively small. Since then, U.S. bilateral investments in HIV/AIDS and malaria programs have grown significantly, particularly through the President's Emergency Plan for AIDS Relief (launched in 2003) and the President's Malaria Initiative (launched in 2005). As U.S. investments in these programs continue to grow, some question what role the Global Fund will play in U.S. global health policy.

This report provides background information on the Global Fund, summarizes key findings on the Global Fund's progress through 2009, outlines U.S. funding for the Fund, and analyzes issues Congress might consider as it debates the appropriate level of support to provide the Fund.

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Background

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund, or the Fund) was established in January 2002 as a public-private partnership that could provide significant financial support for global responses to HIV/AIDS, tuberculosis (TB), and malaria. At that time, health experts and advocates were particularly concerned about the rapid spread of HIV/AIDS around the world, the massive numbers of deaths that resulted from HIV infection, and limited access to treatments against the three diseases, particularly HIV/AIDS. Health specialists also noted that co-infection seemed to hasten the rate at which people succumbed to any of the three diseases.

The Global Fund was developed to be an innovative financing mechanism that would attract additional financial resources for the global fight against the three diseases in developing countries and was never intended to directly implement related programs.[1] Several distinguishing characteristics purported to make this new entity a unique one, including

- with no implementation mandate, the Global Fund would have relatively low overhead expenses;
- rigorous monitoring and evaluation requirements could ensure performance-based funding;
- transparency in decision-making, including grant funding, could support accountability; and
- partnerships among governments, the private sector, and civil society would be created and expanded, due in part to the grant development process.[2]

Since its inception, the Global Fund has grown both in staff size and budget.[3] In 2001 and 2002, donors pledged $947.2 million to the Global Fund. In its first round, the Global Fund committed to support 58 programs in 43 countries, amounting to $616 million for the first two years of implementation (Phase 1). In November 2009, the Board committed to fund the ninth round of grant proposals and committed to provide some $2.4 billion for Phase 1 implementation of 143 programs to be carried out in 91 countries. As of June 21, 2010, donors pledged $21.6 billion to the Fund, of which $16.4 billion has been paid (**Appendix B**). With these contributions, the Fund has committed to support grants in 144 countries, amounting to roughly $19.2 billion, and to accept additional proposals through August 20, 2010 for its 10th round.[4]

[1] See Global Fund, *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis, and Malaria*, 2001, http://www.theglobalfund.org/documents/TGF_Framework.pdf.

[2] For a compete list of the Global Fund's founding principles, see **Appendix C**.

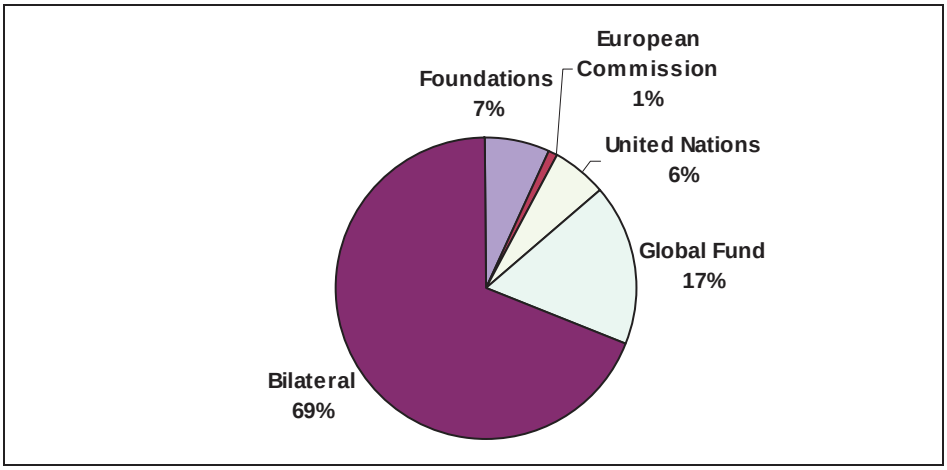
[3] According to a five-year evaluation of the Global Fund, staffing of the Global Fund has increased by about 50% annually. See, Macro International, Inc., *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009, p. 36, http://www.theglobalfund.org/documents/terg/TERG_Synthesis_Report.pdf.

[4] Global Fund, "Global Fund Board Confirms New Funding Round," press release, May 3, 2010, http://www.theglobalfund.org/en/pressreleases/?pr=pr_100503.

Apportionment of Global Fund Resources

The Global Fund has become one of the world's largest donors supporting HIV/AIDS, TB, and malaria programs in developing countries. While tracking donor spending on HIV/AIDS, the Joint United Nations Program on HIV/AIDS (UNAIDS) concluded that the Global Fund provided 17% of all international assistance for global HIV/AIDS programs (**Figure 1**).[5] Other estimates concluded that the Global Fund accounted for about 63% of global TB control and some 57% of all international malaria interventions.[6]

Figure 1. International Assistance for HIV/AIDS Programs, by Source, 2008



Source: UNAIDS, *Outlook 2010: Fresh perspectives on the AIDS epidemic and response*, November 2009,p. 25

Through nine rounds, the Global Fund has committed to provide more than $19 billion in support of nearly 900 grants to be implemented in 144 countries (**Table 1**). About half of all approved funding has been dispersed, including $5.7 billion for HIV programs, $1.5 billion for TB programs, and $2.8 billion for malaria programs.[7]

The Global Fund estimated that by the end of December 2009, related programs had saved nearly 5 million lives, amounting to about 3,600 lives each day. Grants supported by the Global Fund had reportedly treated

- more than 2.5 million HIV-positive people,
- about 6 million people infected with active TB, and
- 107.8 million cases of malaria.[8]

[5] UNAIDS, *Outlook 2010: Fresh perspectives on the AIDS epidemic and response*, November 2009, p. 25, http://data.unaids.org/pub/Report/2009/JC1796_Outlook_en.pdf.

[6] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, March 2010, p. 25, http://www.theglobalfund.org/documents/replenishment/2010/Global_Fund_2010_Innovation_and_Impact_en.pdf.

[7] Ibid, p. 15.

[8] Ibid, p. 19.

Table 1. Approved and Disbursed Funds Through December 2009

($ U.S. millions)

Round	Approved Grants	Disbursed Funds
Round 1	1,695	1,374
Round 2	2,794	1,724
Round 3	1,708	1,328
Round 4	3,238	2,174
Round 5	1,711	1,120
Round 6	1,604	827
Round 7	1,111	607
Round 8	2,742	815
Round 9	2,630	0
Total	**19,233**	**9,969**

Source: Global Fund, *The Global Fund 2010: Innovation and Impact*, Progress Report, p. 20.

Distribution of Global Fund Grants Among the Three Diseases

The Global Fund asserts that one of its core principles is to use a balanced approach to the distribution of its investments among diseases and types of interventions. For example, it reports that through 2008, it spent

- 21% on medicines and pharmaceutical products;
- 18% on health products and equipment;
- 13% on human resources for health (including salaries, wages, and recruitment);
- 12% on program management (planning, administration, and overhead);
- 11% on health workforce training;
- 10% on health infrastructure; and
- 4% on monitoring and evaluation.[9]

Global health experts have long debated the appropriate proportion of resources for HIV/AIDS prevention and treatment. The Global Fund estimates that in 2008, 30% of its resources spent on HIV/AIDS programs were used to prevent HIV infection and 27% to treat the virus. Among TB programs, roughly 53% was spent on detection and treatment and 42% of malaria funds were used on prevention efforts, such as insecticide-treated nets (ITNs) and indoor residual spraying (IRS). Significant resources have also been provided for other interventions (**Appendix D**).

[9] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 26.

Geographic Distribution of Global Fund Grants

The Global Fund contends that it also aims to balance grant requests based on a country's disease burden and income level. More than half of all Global Fund disbursements have supported HIV/AIDS programs and grants in sub-Saharan Africa (**Table 2**), the region that is most affected by HIV/AIDS and that accounts for roughly two-thirds of all adults and children living with the disease. Though the Global Fund supports programs in 144 countries—roughly 40% of the funds have been disbursed among 10 countries (**Table 3**). More than 40% of disbursements for HIV/AIDS were spent in 10 countries, as were more than half of all disbursements for TB and malaria (**Table 4**).

Table 2. Global Fund Disbursements Through December 2009

(U.S. $ millions and percentages)

Region	HIV/AIDS	TB	Malaria	Total Disbursements	% of Total Disbursements
Sub-Saharan Africa	3,104	375	1,976	5,455	54.7%
Asia	1,093	582	491	2,166	21.7%
Latin America & Caribbean	603	129	90	822	8.3%
Middle East & N. Africa	258	120	214	592	5.9%
E. Europe and Central Asia	669	245	20	934	9.4%
Total Disbursements	**5,727**	**1,451**	**2,791**	**9,969**	**100.0%**
% of Total Disbursements	**57.4%**	**14.6%**	**28.0%**	**100.0%**	

Source: Global Fund, *The Global Fund 2010: Innovation and Impact*, Progress Report, p. 20.

Table 3. Top 10 Recipients of Global Fund Grants, by Country, Through April 2010

(U.S. $ millions)

Rank	Country	No. of Grants	Total Disbursements
1	Ethiopia	10	$811.3
2	India	15	$509.2
3	Tanzania	12	$490.6
4	Nigeria	15	$474.5
5	China	13	$437.3
6	Zambia	21	$331.5
7	Russian Federation	6	$318.9
8	Dem. Republic of Congo	12	$317.3
9	Malawi	7	$309.0
10	Sudan	12	$252.3
	Total	**123**	**$4,251.9**
	% of Grand Total		**40.8%**

Source: Global Fund website, *Global Fund Disbursements in Detail*, accessed on March 24, 2010.

Table 4. Top 10 Recipients of Global Fund Grants, by Disease, Through December 2009

(U.S. $ millions)

Country	Disbursements for HIV/AIDS	Country	Disbursements for TB	Country	Disbursements for Malaria
Ethiopia	405.8	*China*	165.6	Nigeria	296.4
India	353.0	*Russia*	97.0	*Ethiopia*	250.1
Tanzania	288.5	*India*	91.5	*Tanzania*	186.9
Malawi	248.2	Indonesia	89.1	Uganda	121.1
China	225.3	South Africa	87.2	*Dem. Rep. of Congo*	120.8
Russia	220.6	*Tanzania*	70.0	Rwanda	107.5
Zambia	225.3	Bangladesh	54.3	Kenya	107.2
Ukraine	151.5	Peru	44.3	*Sudan*	100.3
Thailand	150.7	Philippines	44.3	Madagascar	76.0
Rwanda	151.2	*Sudan*	42.5	Ghana	74.8
Total	2,402.1	Total	785.8	Total	1,441.2
% of Disease Disbursement	42.3%	% of Disease Disbursement	54.2%	% of Disease Disbursement	51.6%

Source: Global Fund, *The Global Fund 2010: Innovation and Impact*, Progress Report, pp. 30, 38, and 40.

Notes: Italicized countries are among the top ten recipients of disbursements.

Five-Year Evaluation of Global Fund

The Global Fund's Board decided at its sixth meeting in October 2003 to hire an independent team of experts to conduct a five-year evaluation of its grants. The impetus was to ascertain the extent to which the Global Fund had reached its performance goals and adhered to its founding principles. At the time this decision was made, grants could be funded up to five years in two phases. After several discussions about the terms of the study, in November 2006, the Board approved the launch of the five-year evaluation, which was overseen by Board-appointed public health experts, known as the Technical Evaluation Reference Group (TERG), and conducted between April 2007 and October 2008 by a team of independent consultants who assessed

- the efficiency and effectiveness of the Global Fund's structure,
- the effectiveness and impact of the Global Fund's partnership system, and
- the impact of Global Fund grants on the three diseases.

It is important to note that independent expert teams have conducted eight different evaluations since the Fund was established, all of which have impacted reforms. However, the five-year evaluation provided the first comprehensive assessment of the Global Fund.[10]

[10] Evaluations overseen by the TERG include 1) Assessment of the Country Coordinating Mechanisms (CCMs); 2) Assessment of the Proposal Development and Review Process; 3) 360 Degree Stakeholder Assessment; 4) Global Fund (continued...)

Key Findings and Recommendations of the Five-Year Evaluation

The team of evaluators published a synthesis of all three assessments in March 2009, which included a broad-range and comprehensive set of findings with accompanying recommendations (**Appendix E**). Many of these observations could be applied to U.S. global health programs like the President's Emergency Plan for AIDS Relief (PEPFAR). As such, this section discusses key findings and recommendations of the synthesis report in the context of ongoing debates on Global Fund programs, as well as those implemented by other actors, as applicable.

Sustainability of Global Fund-Supported Grants

The experts concluded that since the Global Fund's launch in 2001, the organization had become a key donor who contributed a substantial proportion of resources to the spike in global spending on HIV/AIDS, TB, and malaria. The team expressed several reservations, however, regarding the infusion of donor spending on the three diseases. Key concerns were that

- the long-term sustainability of responses against the three diseases are threatened by the extent to which many developing countries rely on external support to fund their national health plans;
- in some countries, it appears that donor funding is replacing national spending on the three diseases; and
- little is known regarding the effectiveness of donor-supported programs aimed at the three diseases.

Health experts have increasingly questioned the impact of donor-led funding on recipient countries' ability to shape and assume ownership over HIV/AIDS, TB, and malaria programs.[11] Questions about sustainability stem from concerns about the poor condition of health systems in many developing countries; possible divergence of priorities between donors and recipient countries; and eventual divestment from HIV/AIDS, TB, and malaria programs, particularly in light of ongoing global financial constraints.[12,13,14]

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Portfolio Review; 5) Evaluation of the Local Fund Agent System; 6) Five Year Evaluation Study Area 1: Global Fund Organizational Efficiency & Effectiveness; 7) Five Year Evaluation Study Area 2: Global Fund Partner Environment; and 8) Five Year Evaluation Study Area 3: Health Impact of Scaling Up Against HIV, TB & Malaria; Links to all evaluation materials for the studies overseen by the TERG can be found at http://www.theglobalfund.org/en/terg/

[11] Devi Sridhar and Rajaie Batniji, "Misfinancing global health: a case for transparency in disbursements and decision making," *The Lancet*, vol. 372, no. 9644 (September 27, 2008), pp. 1185-1191.

[12] For discussions on the capacity of developing countries' health systems to maintain health-specific initiatives, see World Health Organization (WHO), "An assessment of interactions between global health initiatives and country health systems," *Lancet*, vol. 373, no. 9681 (September 5, 2009), pp. 2137-2169; Robert Fryatt, Anne Mills, and Anders Nordstrom, "Financing of health systems to achieve the health Millennium Development Goals in low-income countries," *Lancet*, vol. 375, no. 9712 (January 30, 2010), pp. 419-426; and WHO, *Maximizing positive synergies between health systems and global health initiatives*, June 15, 2009, http://www.who.int/healthsystems/New-approach-leaflet-ENv2-p4p.pdf.

[13] For more debates about donor-driven responses to the three diseases, see Devi Sridhar and Rajaie Batniji, "Misfinancing global health: a case for transparency in disbursements and decision making," *The Lancet*, vol. 372, no. 9644 (September 27, 2008); Editorial, "Who runs global health?," *The Lancet*, vol. 373, no. 9681 (June 20, 2009), p. 2083; and Kammerle Schneider and Laurie A. Garrett, *The Evolution and Future of Donor Assistance for HIV/AIDS*, Council on Foreign Relations, Working Paper, April 2009, http://www.cfr.org/publication/19161/
(continued...)

Impact of National Health Spending on Grant Sustainability

One of the Global Fund's founding principles is to attract additional resources for fighting the global HIV/AIDS, TB, and malaria burden. The consultants found that the Global Fund met this criteria in relation to donor spending but did not consistently attain this goal in regards to spending by recipient countries. As a result, increased spending on HIV/AIDS programs has been dominated primarily by the Fund and other donors, while recipient countries have become increasingly reliant on them to fund their national HIV/AIDS responses.[15] In some instances, recipient countries' investments in interventions against the diseases declined as donor support increased. One study found that, on average, for every $1 provided by donors for health assistance, recipient countries decreased their national health budgets by an average of $0.46.[16] Reductions in national health budgets varied, though they were greatest among African countries that had high HIV prevalence rates and received significant donor support for health.

There is not sufficient information available, however, that would enable analysts to determine what the funding shifts mean. Many developing countries face multiple challenges without enough resources to address them. Should the governments divert resources from HIV/AIDS budgets to other efforts, such as expanding access to clean waters and building roads, overall health outcomes could improve. On the other hand, governments could devote resources to other unrelated priorities, such as defense or meeting loan mandates set by international financial institutions, which might not ameliorate health conditions.

Recommendations of Evaluators and Stakeholders

The evaluators expressed considerable concern with the growing reliance of countries on external support for their national responses, particularly those dealing with HIV/AIDS. The group of experts recommended that the Global Fund and other donors develop systems to ensure that the infusion of capital is used cost-effectively and transparently, particularly at the sub-recipient level. Another team of researchers proposed that donors develop health spending agreements that clearly delineate the trajectory of health spending between donors, ministries of finance, and ministries of health before disbursing funds.[17] Other observers encourage the Global Fund and other donors to include countries in the planning and priority setting stages to ensure that the grants align with the countries' priorities. Although the Global Fund supports projects submitted by developing countries, some experts maintain that the Global Fund's mandate to focus specifically on HIV/AIDS, TB, and malaria predisposes countries to emphasize those ailments.[18] Several experts argue that national governments may not retain their focus on these diseases once donor support for these diseases declines.

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evolution_and_future_of_donor_assistance_for_hivaids.html.

[14] WHO, *The Financial Crisis and Global Health*, January 19, 2009, http://www.who.int/mediacentre/events/meetings/2009_financial_crisis_report_en_.pdf.

[15] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 17.

[16] Chunling Lu et al., "Public financing of health in developing countries: a cross-national systematic analysis," *The Lancet*, vol. 375, no. 9723 (April 9, 2010), p. 1381.

[17] Chunling Lu et al., p. 1384.

[18] Devi Sridhar and Rajaie Batniji, p. 1190.

Impact of Health System Capacity on Grant Sustainability

The five-year evaluation report pointed to the Global Fund as a key contributor to increased access to services aimed at addressing HIV/AIDS, TB, and malaria. The team concluded that the extent to which the Global Fund's resources improved access to related services was affected by investments in health system strengthening (HSS), whereas recipient countries with stronger health systems and higher levels of socioeconomic development more successfully expanded related services.

Having identified a positive correlation between health system capacity and grant performance, the experts warned that recipient countries might not be able to continue receiving assistance at current scale without significant investments in health systems. At the launch of its fifth round, the Global Fund announced that it would accept applications specifically for HSS activities. Of the 63 applications submitted for consideration in that round, roughly 15% were for HSS, and three were approved.[19] Due, in part, to low approval ratings of HSS projects, the Global Fund adapted its strategy in round 6 and directed countries to include HSS components within their disease-specific grant proposals rather than submitting separate ones.[20]

Despite recent increases in support for health infrastructure by the Global Fund and other donors, the World Health Organization (WHO) and other health experts assert that disease-specific initiatives like the Global Fund have exposed preexisting weaknesses in health systems and that such efforts have both strengthened and strained health capacity in many recipient countries.[21] Improvements in health system capacity relate to a better trained health workforce, expanded access to tools to respond to the three diseases, and enhanced supply chain mechanisms for resources related to HIV/AIDS, TB, and malaria.

At the same time, several challenges persist. For example, though health staff in developing countries are better trained due to donor support, health workforce shortages that have long contributed to poor health conditions persist because donors rely primarily on existing staff who are already overburdened. Observers also urge donors to increase application of other approaches, such as task-shifting and support for hiring additional health staff. These strategies are important, experts assert, because disease-specific initiatives often fail to generate sufficient increases in health staffing to meet the additional demand brought on by their investments. Such demands relate to donors' reporting requirements as well as service delivery.

Researchers have also noted skewed investments in supply chain management systems. The WHO and other experts question whether improvements that the Global Fund and other donors have made in supply chains systems are sustainable. Specifically, WHO pointed to donors' tendency to create parallel procurement and management supply systems that function largely outside of national systems. When evaluating the Fund, the team of experts found that in some countries, HIV tests were more readily available than hemoglobin tests, which are used to identify anemia and several chronic infections. The team also found that in a number of clinics, patients

[19] Global Fund, *Report of the Technical Review Panel and the Secretariat on Round Five Proposals*, Annex Six, Eleventh Board Meeting, September 28, 2005, http://www.theglobalfund.org/documents/board/11/gfb116_AnnexVI.xls.

[20] Global Fund, *Report of the Portfolio Committee*, Thirteenth Board Meeting, April 26, 2008, p. 10, http://www.theglobalfund.org/documents/board/13/GF-B13-8_Report_of_the_Portfolio_Committee.pdf.

[21] See WHO, *Report on the 3rd expert consultation on maximizing positive synergies between health systems and Global Health Initiatives*, October 2, 2008, http://www.who.int/healthsystems/PosSyn3rdExpCons_HR.pdf.

had limited access to basic laboratory tests, infection control amenities, and rudimentary diagnostic aids. Some observers conclude that the inability of governments to meet the basic health needs of its citizens, but for that same citizenry to have access to markedly better services for HIV/AIDS detection and treatment indicates an artificial success and is not likely to continue without sustained donor investment.

Recommendations of Evaluators and Stakeholders

While Global Fund grants might include activities for building health capacity within a particular proposal, the evaluators found that Global Fund grants lacked "a strategic perspective on human resource needs or capacity building."[22] The consultants recommended that the Global Fund and other donors support national health plans and address "the major gaps in basic health service availability and readiness … as part and parcel of scaling-up against the three diseases."[23] Such gaps in health system capacity includes basic infrastructure, adequate training, and sufficient staffing and supplies. Specifically, the evaluators suggested the Global Fund Secretariat develop and articulate a strategy that offers a host of strategies that grantees could apply to improve health system capacity and increase the likelihood of successful outcomes. In addition, the team proposed grant evaluators consider the extent to which grants improve health capacity when rating grant performance.

Impact of Global Fund Resources

Although most observers agree the Global Fund has contributed to improved access to key prevention and treatment interventions, little is known about the impact of expanded service coverage. On the one hand, the Global Fund's performance-based approach has fostered a culture of accountability and transparency. On the other, in an attempt to demonstrate progress, recipients have tended to focus more heavily on inputs and outputs rather than health and development outcomes. For example, grant recipients and the Global Fund provide comprehensive documentation on the delivery of key outputs, such as the number of treatments administered, insecticide-treated nets delivered, and prevention services provided. Little is known, however, about the impact of such interventions, like whether those receiving TB drugs complete their regiments, recipients of insecticide-treated bed nets consistently use them, or HIV/AIDS patients develop resistance to treatments from improper usage.

Other observers maintain that the poor quality of health data makes it difficult to assess the progress of efforts supported by the Global Fund and other donors. The evaluators concluded, "[a]cross all three diseases, baseline data quality at country level remains an issue with serious implications for the validity and credibility of grant performance assessments."[24] For example, the group of experts found in most of the countries it visited that health officials could not identify the exact disease that caused the majority of deaths, because they did not have functional vital statistics systems. One study estimated that about 40% of annual births in developing countries are unrecorded and the causes of death are unknown in roughly two-thirds of all

[22] Macro International Inc., *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009, p.23.

[23] Ibid , p. 21.

[24] Ibid, p. 31.

developing countries.[25] In the case of sub-Saharan Africa, only two countries maintained comprehensive counts of births, deaths, and causes of death, and South Africa was the only other African country identified to have high levels of birth and death registrations—though its registration system had high levels of undetermined causes of deaths. The absence of credible health information, the researchers found, made it difficult to evaluate the Global Fund's performance-based funding model. This means that in many cases, decisions on whether to support a project or whether a grant is successful are based on population projections and disease burden estimates that were extrapolated from household surveys rather than primary data.

Recommendations of Evaluators and Stakeholders

Consensus is emerging that data collection and management systems must be improved in order to improve the quality of health systems in many countries. Of particular importance is data for cause of death, which, when available, can be used to set priorities, formulate policies, and monitor and assess such policies. Failure to identify through statistical evidence the number of births and deaths, causes of death, and other related information (such as income level) leaves donors unclear about the impact of their investments. In order to determine whether programs are effective, useful, and ultimately sustainable, the evaluators concluded that the Global Fund and other donors should prioritize developing robust and integrated health information systems aimed at maximizing data quality, financial tracking, and quality assurance mechanisms. Well-functioning health information systems could help to resolve ongoing debates among health activists about how to apportion support for specific diseases and health systems. Without systematic evidence built on credible and comprehensive data, one cannot substantiate arguments in support of disease-specific or health-system approaches to improving global health.[26]

In addition to improving the collection and analysis of vital statistics, some observers urge donors to expand information amassed from recipients to include measurements of project effectiveness. For example, reporting requirements might include "percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy."[27] Analysts at the Center for Global Development (CGD) suggest that donors and implementing partners, including civil society, cooperatively develop common outcome indicators that stakeholders would use to measure progress. The outcome metrics, CGD cautions, should be based on data that can be feasibly obtained and are proven to lead to the desired outcome. Furthermore, such outcome targets would include specific plans to collect baseline data.[28]

One group of experts called on the Global Fund and other donors to apply between 5% and 10% of their grant budgets to bolster information systems and improve monitoring and evaluation practices.[29] The Millennium Development Goals (MDG) Africa Steering Group estimated that it

[25] Philip Setel et al., "A scandal of invisibility: making everyone count by counting everyone ," *The Lancet*, vol. 370, no. 9598 (November 3, 2007), p. 1571.

[26] WHO, *Initial Summary Conclusions: maximizing positive synergies between health systems and Global Health Initiatives*, June 15, 2009, p. Introduction, http://www.who.int/healthsystems/New-approach-leaflet-ENv2-p4p.pdf.

[27] Charles Holmes, Michelle Williams-Sherlock, and Paul Bouey, "Monitoring and evaluation of PEPFAR treatment programmes," *The Lancet*, vol. 374, no. 9681 (October 3, 2009), p. 1146.

[28] See Nandini Oomman, Steven Rosenzweig, and Michael Bernstein, *Are Funding Decisions Based on Performance?*, CGD, April 6, 2010, p. 25, http://www.cgdev.org/files/1424030_file_CGDPerformance_based_funding_FINAL.pdf.

[29] Rifat Atun et al., "Venice Statement on global health initiatives and health systems," *The Lancet*, vol. 374, no. 9683 (September 5, 2009), p. 784.

would cost $250 million annually to create comprehensive information systems across the continent, including $80 million for civil registration and vital statistics collection.[30] Since its inception, the Global Fund has committed to spending more than $10 billion in sub-Saharan Africa, 10% of which could sufficiently support the MDG Africa Steering Group's estimate for bolstering information systems in Africa.

Effectiveness of Global Fund Partnership Model

Among the Global Fund's founding principles is a commitment to support grants that "focus on the creation, development and expansion of government/private/non-governmental (NGO) partnerships."[31] Perhaps the most successful ways in which the Global Fund has fostered public-private partnerships are through broad-based representation in its Board and governing bodies, and the development and application of the Country Coordinating Mechanism (CCM) during grant development. Through the CCM, representatives from recipient governments, local and international NGOs, the private sector, faith-based organizations, and people affected by any of the three diseases collaborate to draft and submit project proposals to the Global Fund.[32] Although the evaluators credited the CCMs with fostering alliances among these groups while drafting project proposals, they noted that the partnership model is not sufficiently applied to the implementation of Global Fund grants.

Several organizations that have developed expertise in global health assistance are committed to supporting the Global Fund and its mission. However, the relationship between the Global Fund and these long-functioning institutions is not formalized and is applied in an ad-hoc fashion, the five-year evaluation concluded. As such, the consultants identified "critical gaps resulting in missed opportunities for funding, early identification of implementation problems, and lack of capacity in-country." In addition, due to a failure to create binding partnership relationships, staffing levels at the Global Fund Secretariat have continued to grow by a third to twice the size planned in each of its fiscal years.[33]

Recommendations of Evaluators and Stakeholders

In order to deliver a coherent system for addressing the three diseases specifically, and improving global health overall, the experts recommended that the Global Fund collaborate with its major implementing partners and other donors to develop binding partnership agreements that clearly delineate the roles, responsibilities, and financing sources of each. Such a formalized mechanism could serve to avoid duplication, preserve resources, and strengthen ongoing programs. Particular areas that the evaluators and other observers urged the Fund to consider improving include the following:

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[30] MDG Africa Steering Group, *Achieving the Millennium Development Goals in Africa*, June 2008, p. 22, http://www.mdgafrica.org/pdf/MDG%20Africa%20Steering%20Group%20Recommendations%20-%20English%20-%20HighRes.pdf.

[31] Global Fund, *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis, and Malaria*, 2001, http://www.theglobalfund.org/documents/TGF_Framework.pdf.

[32] For more on this process, see http://www.theglobalfund.org/en/ccm/.

[33] Macro International Inc., *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009, p.37.

- Clarifying roles of CCMs, local funding agents (LFAs), principal recipients (PRs), and sub-recipients (SRs) in managing and evaluating grants (of note was the capacity of the LFAs to evaluate financial compliance, but not project performance).[34]
- Formalizing the roles of organizations that serve as implementing partners and utilizeing their expertise in the oversight, evaluation, and scaling-up of grants.
- Strengthening engagement with the private sector, particularly in relationship to in-kind support of grants such as technical assistance and use of distribution networks.
- Working with implementing partners and governments to extend the CCM model beyond project development into national health and development planning, particularly in areas related to HSS that the Fund supports.
- Heightening expectations of recipient countries in being sound stewards, capable of effectively monitoring, evaluating, and ultimately implementing global health projects.
- Aligning funding cycles and reporting requirements among donors.

Key Changes to the Global Fund

A founding principle of the Global Fund is to consistently evaluate its grants. In so doing, the Fund continuously adapts its operations and architecture. For example, the Global Fund is working to develop a common platform for funding and planning programs that strengthen health systems with the Global Alliance for Vaccines and Immunization (GAVI) and World Bank, and facilitated by WHO.[35] The purpose of this new platform would be to develop (1) common funding policies for health systems strengthening, (2) common country eligibility criteria, (3) joint review mechanisms for proposals and program oversight, (4) harmonization of technical support, and (5) a common framework for measuring performance.[36] Some of the expected benefits of the joint platform include reduced transaction costs, increased global focus on health systems strengthening, enhanced predictability of donor funding, and improved harmonization and alignment of funding and programming for health systems strengthening.[37] The section below highlights some key changes in the Global Fund's operations that were instituted following independent evaluations and feedback from various stakeholders.

[34] See Nandini Oomman, Steven Rosenzweig, and Michael Bernstein, *Are Funding Decisions Based on Performance?*, Center for Global Development, April 6, 2010, p. 25, http://www.cgdev.org/files/1424030_file_CGDPerformance_based_funding_FINAL.pdf.

[35] Global Fund, Twentieth Board Meeting Decision Points, November 9-11, 2009, http://www1.theglobalfund.org/documents/board/20/GF-BM20-DecisionPoints_en.pdf.

[36] World Bank, GAVI, Global Fund and WHO, "Work Plan for 2010 Health Systems Funding Platform," March 2, 2010, http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1251914777461/HealthSystemsFundignPlatformWorkPlanMarch22010.pdf.

[37] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 88.

Single Stream Agreements

In 2008, at its 18th meeting, the Global Fund Board decided to revise its funding architecture to simplify its business model and harmonize its grants with those supported by recipient countries and other donors. One strategy that the Board approved was to begin funding grants through a Single Stream Agreement (SSA), whereby principal recipients will report on its activities by disease rather than by round.[38] In other words, if a PR has multiple grant agreements for a disease, the grants will be consolidated into a single agreement and the PR will report on its progress through one submission.[39] The Fund hopes that the strategy will reduce the reporting burden on grant recipients and allow countries to more easily align work plans, budgets, and targets. Adherence to the new funding architecture is voluntary for round 10 and required for round 11. The implementation of SSA will discontinue the use of the Rolling Continuation Channel (RCC) for funding.[40]

National Strategy Application

The Board also decided at its 18th meeting to pilot a new grant proposal process known as the National Strategy Application (NSA).[41] The NSA was funded in a limited number of countries and designed to more closely align Global Fund grant proposals with national health strategies and fiscal cycles; reduce transaction costs and paperwork for recipient countries; improve harmonization with other donors who have agreed to use the process; and encourage broad-based use and support of harmonized funding structures and processes. At its 21st meeting, the Board recommended that the Secretariat create a schedule to scale up the NSA.

Dual-Track Financing

In 2007, the Board approved the routine use of dual-track financing, which enables grants to be managed by two primary recipients, one representing national governments and the other civil society organizations (CSOs) or the private sector. Dual-track financing is not required, though any application with one primary recipient must include a justification for not using the method.[42] The TERG and other health experts have long asserted that CSOs fill key roles in advancing

[38] Global Fund, Twentieth Board Meeting Decision Points, November 9-11, 2009, http://www1.theglobalfund.org/documents/board/20/GF-BM20-DecisionPoints_en.pdf.

[39] Global Fund, New Grant Architecture Concept Note, March 2010, http://www.theglobalfund.org/documents/grantarchitecture/Architecture_High_Level_Concept_Note_en.pdf.

[40] In November 2006, the Board established the Rolling Continuation Channel (RCC). This funding channel, which began in March 2007, permits Country Coordinating Mechanisms (CCMs) to request additional funding for grants that are performing well but set to expire. The application process for the RCC is not as rigorous as the Round process. RCC-approved grants can receive support for up to an additional six years, with the funds being awarded in three-year intervals. The channel is intended only for those grants that have demonstrated a significant contribution "to a national effort that has had, or has the potential to have in the near future, a measurable impact on the burden of the relevant disease. Global Fund, *Report on the Final Decisions of the Fourteenth Board Meeting*, October 31- November 3, 2006, at http://www.theglobalfund.org/en/files/boardmeeting14/GF-BM-14_Final_Decisions.pdf, visited January 16, 2008.

[41] For more information on the NSA, see Global Fund, Report of the Technical Review Panel and the Secretariat on funding recommendations for National Strategy Applications of the First Learning Wave, Twentieth Board Meeting, November 9, 2009, http://www.theglobalfund.org/documents/board/20/GF-BM20-11_TRP_ReportToBoard.pdf.

[42] Report of the Policy and Strategy Committee, Global Fund Fifteenth Board Meeting, April 2007, http://www.theglobalfund.org/documents/board/15/GF-BM15-06_ReportPSC.pdf.

global health. Such functions include advocacy, demand creation, service delivery, policy-setting, and accountability. In the long run, the observers maintained, civil society engagement facilitates sustainability of outcomes, health system strengthening, and country ownership.[43] According to the Global Fund, by the end of 2009, 84% of grants managed by CSOs either met or exceeded expectations.[44] Since round 8, dual-track financing has been used with 48% of PRs, including 24% of HIV/AIDS grants, 12% of malaria grants, and 12% of TB grants.[45]

Debt2Health

In 2007, the Global Fund launched an initiative called Debt2Health, through which creditors allow countries to substitute the interest payments on their debt for public health spending via the Global Fund. By the end of 2009, the Global Fund had signed agreements with two countries and was anticipating signing a third. The Fund anticipates that the three agreements will channel $80 million to efforts to fight the three diseases. The Fund is negotiating an additional three agreements that have the potential to generate $74 million.[46]

Affordable Medicines Facility-malaria (AMFm)

The AMFm initiative, launched in April 2009, was originally proposed in a 2004 report by the U.S. Institute of Medicine and developed in consultation with the Roll Back Malaria (RBM) Partnership.[47] The initiative aims to improve access to artemisinin-based combination therapy (ACT) by negotiating lower treatment prices with drug manufacturers and supporting the proper use of the anti-malarial drug. AMFm subsidizes a significant portion of the drug, dropping the purchase price from $11 per course to less than $1. Although the AMFm initiative is managed by the Global Fund, UNITAID, Britain's Department for International Development (DFID), and other donors finance and implement the initiative separately.

Through AMFm, the Global Fund anticipates ACTs supplanting cheaper, commonly used anti-malarial drugs that have high drug resistance rates. Some observers warn, however, that people could take ACTs with the onset of symptoms like fever without being diagnosed with malaria. In light of decreased efficacy of ACTs along the Thai-Cambodia border and that ACTs are the only anti-malarial drugs without widespread resistance, several health experts urge the Fund to finance rapid diagnostic tests to complement AMFm activites and prevent drug resistance to ACTs.[48]

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[43] Rifat Atun et al., "Venice Statement on global health initiatives and health systems," *The Lancet*, vol. 374, no. 9692 (September 5, 2009), p. 784.

[44] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 47. In assessing its grants, the Global Fund rates the performance of each based on their achievement of pre-established goals and targets. "A1" connotes exceeding expectations, "A2" meets expectations, "B1" adequate, "B2" inadequate but potential demonstrated, "C" unacceptable. Eighty four percent of CSO-managed grants are rated A1, A2, or B1. For more on performance ratings, see http://www.theglobalfund.org/cn/performancebasedfunding/methodology/?lang=cn.

[45] Global Fund, "Leveraging the Global Fund Through Dual Track Financing and Community Systems Strengthening," October 2009, http://www.rollbackmalaria.org/partnership/wg/wg_harmonization/ppt/7hwg16.pdf.

[46] Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 86.

[47] The RBM Partnership was launched in 1998 by WHO, the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP) and the World Bank to provide a coordinated global response to the disease. Roughly 500 partners are engaged in the initiative. For more on the initiative, see http://www.rollbackmalaria.org/.

[48] See WHO, "WHO releases new malaria guidelines for treatment and procurement of medicines," press release, March 9, 2010, http://www.who.int/mediacentre/news/releases/2010/malaria_20100308/en/; Rachel Nugent, Emma (continued...)

Voluntary Pooled Procurement

In June 2009, the Global Fund launched the Voluntary Pooled Procurement (VPP) Initiative, which encourages collective procurement of drugs and related commodities to decrease prices, expand access to quality medicines, and improve the reliability of drug supplies. The initiative focuses on four product categories: first-line antiretroviral treatment (ART), second-line ART, ACT drugs, and long-lasting insecticide treated nets (LLINs). By monitoring prices, cost savings, and market shares, the Global Fund hopes to strengthen national procurement systems and supply chain management. Between June and December 2009, the Global Fund had procured goods in 16 countries worth $271.4 million through this mechanism. An additional 18 countries have registered for voluntary pooled procurement and 10 countries have expressed interest in receiving capacity-building and supply chain management assistance.

U.S. Support of the Global Fund

Congress appropriates U.S. contributions to the Global Fund through two annual appropriations bills: State, Foreign Operations; and Labor, HHS, and Education. Officials from the Department of State, USAID, and HHS were all engaged with the Global Fund when it was being created. HHS was reportedly the lead agency during the early stages, and Former Secretary of HHS Tommy Thompson was later elected as the second Chair of the Global Fund's Board. At present, U.S. officials from various agencies sit on several Global Fund Boards.

Since the Global Fund was conceived, the United States has been a key contributor to the organization. In its first budget period, U.S. donations accounted for 33% of all contributions to the Fund, with the United States having provided $300 million of the $894.3 million contributed in the 2001-2002 budget period. Since then, the United States has remained a key contributor to the Fund, providing roughly 25% of all contributions from donor countries (**Table 5**).

(...continued)

Back, and Alexandra Beith, *The Race Against Drug Resistance*, CGD, 2010, http://www.cgdev.org/files/1424207_file_CGD_DRWG_FINAL.pdf; and Mohga Kamal-Yanni, "Affordable medicines facility for malaria: reasonable or rash?," *The Lancet*, vol. 375, no. 9709 (January 9, 2010), p. 121.

Table 5. Total Global Fund Contributions and Pledges Through June 21, 2010

(current $ U.S. millions and percentages)

Contributor	Paid as of 06/21/2010	% of Total Paid	Total Pledges as of 06/21/2010	% of Total Pledges
United States	4,338.9	24.7%	6,578.3	30.4%
European Union	7,084.4	40.8%	9,650.9	44.6%
European Commission	1,141.5	6.5%	1,386.9	6.4%
Other Countries	2,840.7	22.7%	3,190.9	14.7%
Non-Governmental Donors	920.1	5.2%	836.1	3.9%
Total	**16,325.6**	**100.0%**	**21,643.1**	**100.0%**

Source: Global Fund, *Pledges and Contributions*, accessed on June 21, 2010, http://www.theglobalfund.org/en/mobilization/.

Throughout the Bush Administration, Congress consistently exceeded requests and ultimately appropriated roughly $3.6 billion for the Fund from FY2001 through FY2008. In his last budget request, President Bush proposed that the United States provide $500 million to the Global Fund in FY2009. Including supplemental funding, Congress ultimately provided $1 billion for the Fund in FY2009. President Barack Obama included in his FY2010 budget a $900 million request for the Global Fund. Congress exceeded his FY2010 request for the Fund by roughly $150 million and appropriated $1.05 billion to the Fund. In the following fiscal year, President Obama proposed that the United States spend $63 billion on global health initiatives between FY2009 and FY2014, including $1 billion on the Global Fund in FY2011. As of June 21, 2010, U.S. pledges have approached $6.6 billion, including $1.05 billion appropriated in FY2010 (**Table 6**).

Table 6. U.S. Appropriations for Global Fund Through FY2011

($ U.S. current millions)

	FY2001-FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Estimate	FY2004-FY2008 Total	FY2001-FY2008	FY2009 Estimate	FY2010 Estimate	FY2011 Request
Foreign Operations	398.4	397.6	248.0	445.5	625.0	545.5	2,261.6	2,660.0	700.0	750.0	700.0
Labor/HHS	224.0	149.1	99.2	99.0	99.0	294.8	741.1	965.1	300.0	300.0	300.0
FY2004 Carryover	n/a	(87.8)	87.8	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total	**622.4**	**458.9**	**435.0**	**544.5**	**724.0**	**840.3**	**3,002.7**	**3,625.1**	**1,000.0**	**1,050.0**	**1,000.0**

Source: Appropriations legislation, congressional budget justifications, and interviews with Administration officials.

Notes: As of June 21, 2010, the Global Fund reports having received $4.3 billion of the $6.6 billion pledged by the United States. According to the Fund, the United States pledged to pay $300 million in 2001 and 2002 combined, $322.7 million in 2003, $458.9 million in 2004, $414.0 million in 2005, $513.0 million in 2006, $679.4 million in 2007, $840.3 million in 2008, $1.0 billion in 2009, and $1.05 billion in 2010. See http://www.theglobalfund.org/documents/pledges_contributions.xls.

In each fiscal year since FY2005 (except FY2007), Congress has permitted USAID to use up to 5% of Global Fund appropriations for related technical assistance efforts. In FY2006 and FY2008, Congress required the Secretary of State to withhold 20% of the U.S. Global Fund contribution until she certified to the Appropriations Committees that the Fund had strengthened oversight and spending practices. In FY2009, Congress mandated that 10% of U.S. Global Fund contributions be withheld to ensure oversight.

The $87.8 million deducted from the FY2004 total reflects language in the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (P.L. 108-25) that prohibited U.S. contributions to the Fund from exceeding 33% of contributions from all sources (discussed below). Through the FY2005 Consolidated Appropriations (P.L. 108-447), Congress replaced the $87.8 million and added it to the FY2005 contribution.

Issues for Congress

Since making a founding pledge to the Global Fund in 2001, the United States has demonstrated strong support for the organization. The United States continues to be the largest national donor, U.S. officials serve on various Global Fund boards, and Congress has consistently increased appropriations to the Fund since FY2005. At the same time, Congress has enacted several laws that limit U.S. contributions to the Fund, such as a stipulation that prohibits U.S. contributions to the Fund from exceeding one-third of all contributions. Although the 111th Congress has continued to support the Fund, it has begun to consider other factors that might affect appropriations levels. The section below discusses such issues.

FY2011 Budget

U.S. spending on global health initiatives is funded primarily through the Global Health and Child Survival (GHCS) account in the State, Foreign Operations appropriations.[49] The President requested that Congress increase the FY2011 spending level for the GHCS account by nearly 9% more than FY2010-enacted levels (**Table 7**). The bulk of this increase is to be aimed at non-HIV/AIDS programs, especially those seeking to improve child survival and address other infectious diseases. While the President requests a modest increase for the GHCS account, the FY2011 budget includes a $50 million decrease from FY2010-enacted levels for the Global Fund.

The FY2011 budget includes a 3.3% increase for spending on bilateral and multilateral HIV/AIDS, TB, and malaria programs, down from a 12.4% increase between FY2009 and FY2010 (**Table 8**). Some critics contend that smaller increases in global HIV/AIDS spending reflects a shift in U.S. priorities. Other groups maintain that additional issues affect U.S. spending on HIV/AIDS, including absorptive capacity of recipient countries, governance practices, commitment of recipient countries to assume responsibility of HIV/AIDS programs, and increased spending by other donors, such as the Global Fund and the Bill and Melinda Gates Foundation.

[49] Congress also provides funds for improving global health through Labor, HHS, Education Appropriations and Defense Appropriations. For more on U.S. global health spending, see CRS Report R40740, *U.S. Global Health Assistance: Background, Priorities, and Issues for the 111th Congress*, by Tiaji Salaam-Blyther and Kellie Moss.

Table 7. GHCS Account Appropriations, FY2009-FY2011

(U.S. $ millions)

Program	FY2009 Estimate	FY2010 Request	FY2010 Estimate	Change from FY2009-FY2010	FY2011 Request	Change from FY2010-FY2011
CS/MH	495.0	525.0	549.0	10.9%	700.0	27.5%
VC	15.0	13.0	15.0	0.0%	15.0	0.0%
HIV/AIDS	350.0	350.0	350.0	0.0%	350.0	0.0%
OID	715.0	974.5	981.0	44.2%	1,358.0	38.4%
Tuberculosis	*162.5*	*173.0*	*225.0*	*38.5%*	*230.0*	*2.2%*
Malaria	*382.5*	*585.0*	*585.0*	*52.9%*	*680.0*	*16.2%*
Avian/Pandemic Flu	*140.0*	*125.0*	*106.0*	*11.4%*	*75.0*	*-29.2%*
Other[a]	*30.0*	*91.5*	*65.0*	*116.7%*	*373.0*	*473.8%*
FP/RH	455.0	475.0	525.0	15.4%	590.0	12.4%
Global Fund (GF)	100.0	0.0	0.0	-100.0%	0.0	0.0%
Total USAID	***2,130.0***[b]	***2,337.5***[c]	***2,420.0***	***16.0%***	***3,013.0***	***22.0%***
HIV/AIDS	4,559.0	4,659.0	4,609.0	1.1%	4,800.0	4.1%
Global Fund	600.0	600.0	750.0	25.0%	700.0	-6.7%
State Total	***5,159.0***	***5,259.0***	***5,359.0***	***3.9%***	***5,500.0***	***2.6%***
GHCS Total	**7,289.0**	**7,595.0**	**7,829.0**	**7.4%**	**8,513.0**	**8.7%**

Source: Appropriations legislation and correspondence with USAID Budget Office.

Note: USAID global health programs are funded primarily through the GHCS account. Congress makes additional funds available through other accounts, which may include Assistance to Europe, Eurasia, and Central Asia (AEECA), Development Assistance (DA), Economic Support Fund (ESF), and Foreign Military Financing (FMF).

Acronyms: Child Survival and Maternal Health (CS/MH); Vulnerable Children (VC); Other Infectious Diseases (OID); and Family Planning and Reproductive Health (FP/RH).

a. "Other" includes funds for the Neglected Tropical Diseases (NTD) Initiative, which amount to $25 million in FY2009 and $65 million in FY2010. For FY2011, it includes $155 million for the NTD Initiative and $200 million for the integration of nutrition programs with the Global Hunger and Food Security Initiative. For more information on the NTD Initiative, see http://www.neglecteddiseases.gov/. For more information on the Global Hunger and Food Security Initiative, see http://www.state.gov/s/globalfoodsecurity/index.htm.

b. FY2009 estimate includes $75 million provided to USAID through FY2008 Supplemental Appropriations (P.L. 110-252), which mandated that the funds be used for international H5N1 avian flu interventions in FY2009; $50 million provided through FY2009 Supplemental Appropriations (P.L. 111-32) for international pandemic preparedness efforts and $100 million for a U.S. contribution to the Global Fund.

c. FY2010 requested levels drawn from FY2010 State Department Congressional Budget Justification (CBJ). In the FY2010 CBJ, the total requested for USAID global health programs is $2,336.0 million. After adding the figures provided, CRS reached $2,337.5 million. The FY2010 estimate is drawn from P.L. 111-117, FY2010 Consolidated Appropriations Act and the accompanying Conference Report (H.Rept. 111-366).

Although Congress has continued to increase appropriations for the Global Fund since FY2005, the annual growth has been declining since FY2007. While debate about appropriate funding levels for the Global Fund have often focused on investments in HIV/AIDS programs, some

global health experts urge Congress to consider the impact of the Global Fund on addressing the other two diseases, especially tuberculosis. The Global Fund estimates that since it began funding grants, and through the end of 2009, it committed some $10.8 billion on HIV/AIDS programs, nearly half as much as the United States on related bilateral projects (about $23.2 billion) during the same time period. At the same time, the Global Fund committed more than 3.5 times as much resources to TB activities and 2.5 times more on malaria interventions than the United States through 2009.

Table 8. U.S. Global HIV/AIDS, TB, and Malaria Appropriations Through FY2011

(current $ U.S. millions and percentages)

	FY2001-FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Enacted	FY2008 Enacted	FY2009 Enacted	FY2010 Enacted	FY2011 Request
U.S. Global Fund Contributions	622.8	458.9	435.0	544.5	724.0	840.3	1,000.0	1,050.0	1,000.0
Bilateral HIV/AIDS, TB, and Malaria	2,879.4	1,819.6	2,457.5	2,858.4	4,052.9	5,549.6	6,043.6	6,361.6	6,657.9
Total	**3,502.2**	**2,287.5**	**2,892.5**	**3,402.9**	**4,776.9**	**6,389.9**	**7,043.6**	**7,411.6**	**7,657.9**
Global Fund as % of Total U.S. HIV/AIDS, TB, and Malaria Spending	**17.8%**	**20.1%**	**15.0%**	**16.0%**	**15.2%**	**13.2%**	**14.2%**	**14.2%**	**13.1%**

Sources: Prepared by CRS from appropriations legislation and interviews with officials from the Office of the Global AIDS Coordinator (OGAC).

Note: Includes funds from Foreign Operations Appropriations, Labor/HHS Appropriations, and Defense Appropriations.

The Global Fund estimates that the $3.2 billion that it committed to TB programs accounted for 63% of donor spending, far exceeding the $913.3 million in U.S. bilateral spending.[50] Advocates assert that U.S. support for the Global Fund enables the United States to invest in TB programs, an area in which the United States has a relatively limited presence. Those who support increased investments in TB programs are particularly concerned about the emergence of drug-resistant TB, due in large part to the mismanagement of anti-TB drugs.[51] In 2007, more than 500,000 multi-drug resistant TB (MDR-TB) cases were counted, about 85% of which occurred in 27 "high MDR-TB burden countries" (**Table 9**).[52] Advocates of greater spending on TB point to the dire impact of HIV/TB co-infection, particularly in sub-Saharan Africa, which has complicated efforts to control the spread of tuberculosis and accelerated the rate at which people die from either

[50] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 4.

[51] MDR-TB is resistant to two of the first-line drug options and XDR-TB is resistant to all first-line drugs. See WHO, "XDR-TB: Extensively drug-resistant tuberculosis" http://www.who.int/tb/challenges/xdr/en/index.html.

[52] For a geographical representation of the distribution of drug-resistant TB cases, see WHO, *Global Tuberculosis Control Report 2009*, December 2009, p. 18, http://www.who.int/tb/publications/global_report/2009/update/tbu_9.pdf.

disease. According to WHO, an estimated 1.4 million HIV-positive patients are co-infected with TB. In sub-Saharan Africa, TB is the leading cause of mortality among HIV-infected persons.

Table 9. Tuberculosis Burden, by Region, 2008

(thousands)

WHO Region	Prevalence	Mortality	No. of MDR-TB Cases (2007)	No. of TB/HIV Patients
Africa	3,900	410	76	636
Americas	230	31	10	113
Eastern Mediterranean	870	110	23	22
Europe	350	58	93	357
South-East Asia	3,900	490	174	94
Western Pacific	2,000	270	135	152
Global	**11,250**	**1,369**	**511**	**1,374**

Source: WHO, *Global Tuberculosis Control: A Short Update to the 2009 Report*, 2009.

Supporters for a diversified U.S. global health portfolio also point to the role that the Global Fund plays in eliminating malaria. According to the Fund, it has committed roughly $5.3 billion to malaria programs since its inauguration, accounting for some 57% of total donor spending.[53] Since the launch of the President's Malaria Initiative, U.S. investments in global malaria programs has increased substantially, though U.S. spending on malaria from FY2001 through FY2009 amounted to about half as much as Global Fund commitments.

U.S. Leadership in Combating HIV/AIDS, TB, and Malaria

The United States spends more on combating HIV/AIDS than any other country and is a key donor for international malaria and TB programs. Experts continue to debate how the United States should maintain that leadership and what role U.S. support for the Fund should play in the U.S. global health portfolio. Advocates of the Fund argue that U.S. support for the Fund has become even more important since the largest global economies began to experience distress. Many urge Congress to increase appropriations to the Fund, in large part because key donors have begun to follow the lead of the United States in setting their annual contributions. The extent to which the United States can raise its annual contributions is hampered, however, by a stipulation that prohibits U.S. contributions to the Fund from exceeding 33% of all contributions. The condition was first set through the Leadership Act. The law that extended the authorization of U.S. support to the Fund, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293), did not amend this requirement. Many observers speculate that Congress instituted the contribution limit to encourage greater global support for the Fund.

Due to insufficient contributions, the Global Fund announced in November 2009 that it would reduce the budgets of grants approved in round 9 by 10% for the first two years, and by 25% for

[53] Global Fund, *Global Fund 2010 Innovation and Impact*, Progress Report 2010, p. 4.

the subsequent years.[54] Donors will meet for two days starting on October 4, 2010, at the United Nations headquarters in New York City to pledge their support for the next three years of the Global Fund.[55] Should the United States provide 25% of the Global Fund's budget, as it has done on average since the inception of the Fund, annual U.S. contributions to the Fund would reach between $3.25 billion and $5 billion in each year from 2011 through 2013.

The Fund estimates that it will need between $13 billion and $20 billion from 2011 to 2013.[56] The range of required contributions to the Fund represents the rate at which grant approval could escalate in three different scenarios (**Table 10**). However, the Global Fund maintains that it would need some $20 billion between 2011 and 2013 in order to scale up existing programs and advance progress made in attaining the health-related MDGs.

- **Scenario 1**—the Global Fund provides $3.9 billion for new proposals over three years, with the remainder used to support future phases of previously approved grants. The Fund reports that funding under this scenario would not be sufficient to cover the expected demand in future rounds and would decrease the rate at which Global Fund grants have advanced responses to the three diseases. Over three years, the Fund expects the $13 billion to support
    - the allotment of 4.4 million HIV/AIDS drugs, up from 2.5 million in 2009;
    - the supply of 3.9 million annual TB treatments, up from 1.4 million in 2009;
    - the distribution of 110 million LLINs, up from 34 million in 2009;
    - care and support of 2.5 million orphans, up from 1.4 million in 2009; and
    - annual provision of services for 610,000 HIV-positive pregnant women that prevent mother-to-child transmission (PMTCT) of HIV, up from 345,000 in 2009.
- **Scenario 2**—the Global Fund provides $6.8 billion for new grants in three future rounds and the residual supports previously approved projects. The Fund anticipates that the $17 billion spent under this scenario would support historical growth trends and would finance
    - the allotment of 5.8 million HIV/AIDS drugs;
    - the supply of 5.2 million annual TB treatments;
    - the distribution of 147 million LLINs;
    - care and support of 3.4 million orphans; and
    - annual provision of PMTCT services for 820,000 HIV-positive pregnant women.

[54] Global Fund, *Twentieth Board Meeting*, Board Decisions, November 9-11, 2009, http://www.theglobalfund.org/documents/board/20/GF-BM20-DecisionPoints_en.pdf.

[55] For more details on the pledging conference, see http://www.theglobalfund.org/en/replenishment/hague/documents/.

[56] Global Fund, *Resource Scenarios 2011-2013: Funding the Global Fight Against HIV/AIDS, Tuberculosis and Malaria*, March 2010, http://www.theglobalfund.org/documents/replenishment/2010/Resource_Scenarios_en.pdf.

- **Scenario 3**—the Global Fund maintains that the $12 billion that it would spend on the next three rounds reflect the increased demand that the Fund anticipates facing from 2011 through 2013, with the remainder used to support previously approved. Under Scenario C, the Fund asserts that $20 billion in donor contributions would support
    - the allotment of 7.5 million HIV/AIDS drugs;
    - the supply of 6.8 million annual TB treatments;
    - the distribution of 190 million LLINs;
    - care and support of 4.4 million orphans; and
    - annual provision of PMTCT services for 1.1 million HIV-positive pregnant.

Table 10. Funding Requirements for the Global Fund, 2011-2013

($ U.S. current billions)

	2011			2012			2013			
	Phase I	Phase II	RCC	Phase I	Phase II	RCC	Phase I	Phases II	RCC	Scenario Total
Scenario A	1.3	2.6	1.0	1.3	1.6	1.4	1.3	0.9	1.5	
Subtotal		**4.9**			**4.3**			**3.7**		**12.9**
Scenario B	2.2	2.6	1.0	2.3	1.6	1.4	2.3	0.9	3.0	
Subtotal		**5.8**			**5.3**			**6.2**		**17.3**
Scenario C	3.5	2.6	1.0	4.0	1.6	1.4	4.5	0.9	3.0	
Subtotal		**7.1**			**7.0**			**8.4**		**22.5**

Source: Global Fund, *Resource Scenarios 2011-2013*, March 2010.

Despite concerns about the Global Fund's ability to finance qualified grants from developing countries, some observers would like the Global Fund to address its own capacity before urging Congress to increase support for the organization. In the five year evaluation of the Fund, the evaluators concluded that:

> The Global Fund has contributed to the rapid expansion of programming addressing HIV/AIDS, tuberculosis, and malaria in 136 countries through more than 550 grants. In doing so, it has helped to mobilize existing capacity in the most affected countries, perhaps to the limits reasonably achievable without further capacity development. Recent studies, including the Five-Year Evaluation, suggest that the Global Fund is contributing to strengthening health systems but also point to continued systems weaknesses in key areas. Going forward, the weaknesses of existing health systems critically limit the performance potential of the Global Fund. However, the increasing focus on health systems strengthening (HSS) among Global Fund partners presents a unique opportunity to collectively address these issues. [57]

[57] Macro International, Inc., *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009, p. 21.

The Global Fund's Mandate

Observers are debating whether the Global Fund should expand its mandate to address other global health challenges, particularly maternal and child mortality. Supporters of this idea propose that the Global Fund be used as a platform to launch a new Global Health Fund.[58] One group of researchers argues that countries were unable to fully benefit from investments made by donors for key diseases like HIV/AIDS over the past decade because of poorly functioning health systems. The first step the Global Fund and GAVI should take in becoming a Global Health Fund, the group proposes, entails immediately increasing their support for national health plans. Momentum appears to be growing for such a proposal. In May 2010, a group of international health organizations rallied for a united effort on attaining the health-related MDGs.[59] It could be argued that such a movement is already underway, evidenced by the Fund's financing of health system strengthening efforts and implementation of other strategies, like national strategy applications and voluntary pooled procurement.

Other experts caution against expanding the current mandate of the Global Fund. While opponents recognize the contributions and positive advancements made by the Global Fund, they maintain that any efforts the Fund makes to strengthen health systems should be conducted through its original emphasis on the three diseases.[60] Due to global economic conditions, several question whether donors will provide the resources to meet the Fund's minimum requirement of $13 billion for the next three years. At the same time, one observer questions whether the Global Fund would be able to mobilize sufficient contributions to achieve a broadened mission.[61] One estimate indicates that donors would need to provide 20% more resources to reach this goal.[62] To that end, some propose that global health proponents could use the Global Fund's upcoming pledging conference in October 2010 to measure global support for any expansion measures.

Coordinating the Global Fund with U.S. Global Health Programs

Since the Global Fund was launched, the United States has sought to better coordinate Global Fund and related bilateral programs. Through the Global Health Initiative (GHI), the Obama Administration has affirmed its intention to increase cooperation with the Fund, indicating that one of the seven basic principles of GHI is to "strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement" with the purpose of implementing a coordinated strategy across other major donors and national governments.[63] In its

[58] For example, see Giorgio Cometto et al., "A global fund for the health MDGs?," *The Lancet*, vol. 373, no. 9674 (May 2, 2009), p. 1501, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60835-7/fulltext?_eventId=login; and Jeffrey D. Sachs, "Time to finance a new global health fund," March 2010, http://economictimes.indiatimes.com/Comments-Analysis/Time-to-finance-a-new-global-health-fund/articleshow/5710104.cms.

[59] Global Fund, "Global Health Leaders join forces to advocate for increased political and financial support of the Health MDG'S," press release, May 14, 2010, http://www.theglobalfund.org/en/announcements/?an=an_100521.

[60] William J. Fallon and Helene D. Gayle, *A Healthier, Safer, and More Prosperous World*, Center for Strategic International Studies (CSIS), Report by the CSIS Commission on Smart Global Health, 2010, p. 39, http://csis.org/files/publication/100318_Fallon_SmartGlobalHealth.pdf.

[61] Open Society Institute and Soros Foundations Network, *The Global Fund for Health? If Donors Pay Up*, Blog, April 1, 2010, http://blog.soros.org/2010/04/the-global-fund-for-health-if-donors-pay-up/.

[62] Ibid.

[63] USAID, *Implementation of the Global Health Initiative*, Consultation Document, pp. 6-7, http://www.usaid.gov/our_work/global_health/home/Publications/docs/ghi_consultation_document.pdf.

Five-Year Strategy report, the Office of the Global AIDS Coordinator (OGAC) emphasized its partnership with the Global Fund and outlined several steps to ensure the Fund's long-term sustainability, including transferring some PEPFAR programs to the Global Fund and coordinating and aligning activities related to the funding, monitoring, and evaluation of PEPFAR, Global Fund, and UNAIDS programs.[64]

Many observers question the strength of the U.S. commitment to donor coordination. For example, though U.S. representatives have advocated better alignment of project implementation, a common framework for such a notion has yet to be formalized. The Global Fund has begun to develop a joint funding platform for health systems strengthening with other groups, however, like GAVI, the World Bank, and WHO. Though the United States is not party to the platform, OGAC expressed limited support for the undertaking.[65] While OGAC applauded increased coordination among donors of health system strengthening efforts, it also contended that each donor has a unique mandate and role to play in strengthening health systems. WHO and other health experts urge key donors, including the United States, to align reporting and auditing requirements, the frequency and type of data collected and reported, and fiscal cycles in an effort to reduce the transaction costs and staffing requirements of recipient countries.[66]

Transparency, Monitoring, and Evaluation

Some experts applaud the Global Fund's consistent release of evaluations and urge the United States to undertake similar efforts for bilateral health programs.[67] Since the launch of PEPFAR, the United States has become the world's largest donor to global HIV/AIDS programs. Little is known, however, about the performance of PEPFAR programs. As a result of its transparency, the Global Fund has been able to receive feedback from stakeholders and adapt its practices based on such criticisms. In its 2010 report, the Global Fund emphasized that it learns from evaluations of program performance, which enables it to verify that it is meeting its mandate. The Center for Global Development recommends that OGAC develop clearer guidelines for performance-based funding, make funding decisions transparent, and publish data on individual grant performance.[68] The Global Fund publicly releases all such documents.

Some critics of the Fund contend that the Fund's oversight mechanisms are not strong enough to protect against wasteful spending, particularly in countries that have a well-documented history of corruption and poor financial management. Fund supporters counter that the release of evaluations and findings on the Global Fund's website reflect the Fund's commitment to reporting and monitoring its projects. Specifically, the Fund has uploaded onto its website an abundance of information on grant proposals and budgets, grant spending trends, and results of board meetings, which include decisions regarding the suspension of grants. Fund advocates also argue that the

[64] OGAC, *The U.S. President's Emergency Plan for AIDS Relief, Five Year Strategy, Annex: PEPFAR and the Global Context of HIV*, December 2009, pp. 13 and 16, http://www.pepfar.gov/documents/organization/133436.pdf.

[65] OGAC, U.S. Government Positions on Decision Points for the Twentieth Board Meeting of the Global Fund, http://www.pepfar.gov/documents/organization/134924.pdf.

[66] WHO Maximizing Positive Synergies Collaborative Group, "An assessment of interactions between global health initiatives and country health systems," *The Lancet*, vol. 373, no. 9681 (June 20, 2009).

[67] See Chunling Lu et al., "Absorptive capacity and disbursements by the Global Fund to Fight AIDS, Tuberculosis and Malaria: analysis of grant implementation," *The Lancet*, vol. 368, no. 9534 (August 5, 2006), pp. 487-488.

[68] CGD, *Are Funding Decisions Based on Performance?*, 2010, p. 19, http://www.cgdev.org/content/publications/detail/1424030/.

Fund's decisions to suspend temporarily, and in some cases discontinue, poor performing grants demonstrate the effectiveness of the Fund's oversight and funding mechanisms.

Some in Congress have long advocated for stronger oversight of Global Fund spending. Supporters of this idea have welcomed language included in FY2006 and FY2008 foreign operations appropriations, which required the Secretary of State to withhold up to 20% of the U.S. contribution to the Global Fund until she determined the Fund had adhered to U.S. reporting and monitoring standards. In FY2009, the withholding was reduced to 10%, and FY2010 foreign operations appropriations did not include such language. Some Global Fund supporters contend, however, that such action is unnecessary in light of the strides that the Fund continues to make in improving its reporting and monitoring practices. Also, several experts have asserted that no other organization has publicly released as much detailed evaluations and findings as the Fund. As Congress considers the appropriate funding level for the Global Fund in FY2011, Members might debate whether such provisions are necessary.

Conclusion

The Global Fund is a relatively young organization that has quickly established itself. As of May 28, 2010, the Fund has committed to grant roughly $19.3 billion for HIV/AIDS, TB, and malaria programs in 144 countries. These funds have been used to treat more than 2.5 million HIV-positive people, about 6 million people infected with active TB, and 107.8 million cases of malaria, saving nearly 5 million lives. Despite these advancements, observers raise several questions regarding continued U.S. support for the Fund, including the following:

- **U.S. Funding for the Global Fund—**Some health experts are predicting that U.S. support for global HIV/AIDS programs will be flatlined in the coming years. Should the United States choose not to increase spending on HIV/AIDS programs, it is not likely that the Global Fund will meet its funding goals. Since the Global Fund was founded, U.S. contributions have amounted, on average, to about 25% of all donations. The President requested $1.0 billion for the Global Fund in FY2011, far less than the United States would need to contribute to provide 25% of the Global Fund's budget. The Fund estimates that it will need between $13 billion and $20 billion from 2011 to 2013, 25% of which would amount to between $3.25 billion and $5 billion.[69] The House Foreign Operations subcommittee reported out $825 million for the Global Fund and $5.87 billion for total HIV/AIDS spending. The Senate Appropriations Committee reported out $800 million for the Global Fund through Foreign Operations Appropriations (S. 3676) and $5.85 billion for bilateral HIV/AIDS spending.
- **Role of the Global Fund within GHI**—When President Obama announced GHI, he expressed his intent to reshape U.S. global health policy so that global health efforts were better integrated and coordinated. Few details were provided, however, and health experts were unsure about what changes the initiative might engender. As more details about GHI emerge, questions remain about the role of the Global Fund within GHI. Despite references throughout the GHI

[69] Global Fund, *Resource Scenarios 2011-2013: Funding the Global Fight Against HIV/AIDS, Tuberculosis and Malaria*, March 2010, http://www.theglobalfund.org/documents/replenishment/2010/Resource_Scenarios_en.pdf.

Implementation Plan to collaboration with the Global Fund, the extent to which such an effort will occur is not yet clear. While several official U.S. documents support calls from the Global Fund and other groups like UNAIDS and WHO to enhance donor coordination, the United States has expressed limited support for a joint funding platform for health systems strengthening.[70] U.S. officials assert each donor has a unique mandate and role to play.[71]

- **Global Fund's capacity to receive increased funding**—Despite calls by the Global Fund for more financial support, the team of experts who conducted a five-year evaluation of the Fund warned that recipient countries might not be able to continue receiving assistance at current scale without significant investments in health systems.[72] The Global Fund and other donors have increased spending on improving global health systems, nonetheless challenges in this area persist. One of the goals of the Global Health Initiative is to improve health systems through several strategies, such as addressing health system bottlenecks, strengthening data collection systems, improving human resources for health, and donor coordination.[73] Several global health experts recommend that the Global Fund and other donors support national health plans and address the major gaps in basic health service availability and readiness as part of HIV/AIDS, TB, and malaria efforts.

[70] OGAC, U.S. Government Positions on Decision Points for the Twentieth Board Meeting of the Global Fund, http://www.pepfar.gov/documents/organization/134924.pdf.

[71] Ibid.

[72] Macro International, Inc., *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3*, March 2009, p. 21.

[73] Department of State, *Implementation of the Global Health Initiative: Consultation Document*, February 1, 2010, pp. 14-16, http://www.pepfar.gov/documents/organization/136504.pdf.

Appendix A. Glossary

3D Fund	Three Diseases Fund
ACT	Artemisinin-based Combination drug Treatment
ART	Antiretroviral Therapy
CBJ	Congressional Budget Justification
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CGD	Center for Global Development
CSO	Civil Society Organization
DOD	U.S. Department of Defense
DOL	U.S. Department of Labor
DOTS	Directly Observed Treatment Short-Course
EU	European Union
GAO	U.S. Government Accountability Office
GAVI	Global Alliance for Vaccines and Immunization
GHCS	Global Health and Child Survival
GHI	Global Health Initiative
HHS	U.S. Department of Health and Human Services
HSS	Health System Strengthening
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
LFA	Local Funding Agent
LLIN	Long Lasting Insecticide-treated Nets
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistant Tuberculosis
NGO	Non-Governmental Organization
NSA	National Strategy Application
NTD	Neglected Tropical Diseases
OGAC	Office of the Global AIDS Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother To Child HIV Transmission
PR	Principal Recipient
RBM	Roll Back Malaria
RCC	Rolling Continuation Channel
SR	Sub-recipient
SSA	Single Stream Agreement

TB	Tuberculosis
TERG	Technical Evaluation Reference Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
VPP	Voluntary Pooled Procurement
WHO	World Health Organization

Appendix B. Pledges and Contributions to the Global Fund as of June 21, 2010

Table B-1. Pledges and Contributions to the Global Fund as of June 21, 2010

(U.S. $ millions)

Donor	Amount Paid	Amount Pledged
Australia	171,027,145	171,027,145
Belgium[a]	101,874,170	117,819,878
Brazil	200,000	200,000
Brunei Darussalam	50,000	50,000
Cameroon		25,000
Canada	702,064,786	844,239,351
China	16,000,000	16,000,000
Denmark[a]	207,573,309	207,573,309
European Commission	1,141,538,118	1,386,876,686
Finland[a]	15,789,100	20,082,525
France[a]	1,949,962,570	2,384,861,981
Germany[a]	1,117,505,062	1,237,720,960
Greece[a]	2,150,085	2,150,085
Hungary[a]	55,000	55,000
Iceland	1,120,707	1,120,707
India	10,000,000	11,000,000
Ireland[a]	160,535,353	216,901,889
Italy[a]	1,008,260,873	1,312,040,737
Japan	1,287,816,091	1,406,119,676
Korea (Republic of)	11,000,000	11,000,000
Kuwait	2,500,000	2,500,000
Latvia[a]	10,000	10,000
Liechtenstein	668,907	668,907
Luxembourg[a]	24,037,270	24,037,270
Netherlands[a]	519,220,017	629,622,372
New Zealand	2,840,840	2,840,840
Nigeria	9,080,914	19,000,000
Norway	290,277,918	347,990,647
Poland[a]	150,000	150,000
Portugal[a]	13,000,000	15,500,000
Romania[a]	609,798	609,798
Russia	251,543,116	257,000,000
Saudi Arabia	25,000,000	28,000,000
Singapore	1,000,000	1,000,000

Donor	Amount Paid	Amount Pledged
Slovenia[a]	185,309	185,309
South Africa	10,276,704	10,276,704
Spain[a]	590,549,983	836,345,454
Sweden[a]	468,040,397	531,699,794
Switzerland	39,902,259	45,938,197
Thailand	8,000,000	10,000,000
Uganda	1,500,000	2,000,000
United Kingdom[a]	977,785,327	2,113,493,126
United States	4,338,937,895	6,578,356,226
Other Countries	1,874,635	2,949,635
Total Countries	**15,481,513,659**	**20,807,039,208**
Bill & Melinda Gates Foundation	650,000,000	650,000,000
Communitas Foundation	2,000,000	2,000,000
Debt2Health		
Australia (restricted contribution from Indonesia)		31,752,752
Germany (restricted contribution from:)		
Indonesia	15,250,249	33,650,641
Pakistan	6,946,683	25,347,076
UNITAID	38,691,956	38,691,956
Chevron Corporation	30,000,000	30,000,000
Comic Relief	2,984,220	3,273,029
Idol Gives Back	16,600,000	16,600,000
M·A·C AIDS Fund		500,000
(PRODUCT) RED™and Partners	151,008,324	
The United Nations Foundation and its donors:		
Hottokenai Campaign (G-CAP Coalition Japan)	250,000	250,000
Other UNF Donors	6,510,303	4,022,487
Other Donors	22,718	
Total Other Donors	**920,264,453**	**836,087,941**
Grand Total	**16,401,778,112**	**21,643,127,149**
Affordable Medicines Facility—Malaria (AMFm)		
Gates Foundation	9,531,173	19,350,000
UNITAID	65,000,000	130,000,000
United Kingdom	62,510,612	62,510,612
AMFm—Total	**137,041,785**	**211,860,612**

Source: Global Fund, *Pledges and Contributions*, accessed on June 21, 2010, http://www.theglobalfund.org/en/mobilization/.

Notes: Although the AMFm initiative is managed by the Global Fund, financial support for the initiative comes from UNITAID, Britain's Department for International Development (DFID), and other donors. These funds are collected and spent separately from general Global Fund contributions.

a. European Union Country.

Appendix C. Founding Principles of the Global Fund

A. The Fund is a financial instrument, not an implementing entity.

B. The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria.

C. The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes.

D. The Fund will seek to operate in a balanced manner in terms of different regions, diseases and interventions.

E. The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.

F. The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.

G. The Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.

H. In making its funding decisions, the Fund will support proposals which:

    a. Focus on best practices by funding interventions that work and can be scaled up to reach people affected by HIV/AIDS, tuberculosis and malaria.

    b. Strengthen and reflect high-level, sustained political involvement and commitment in making allocations of its resources.

    c. Support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector; across government departments; and with communities.

    d. Build on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships, including Poverty Reduction Strategies and sector-wide approaches.

    e. Focus on performance by linking resources to the achievement of clear, measurable and sustainable results.

    f. Focus on the creation, development and expansion of government/private/NGO partnerships.

g. Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals.

h. Are consistent with international law and agreements, respect intellectual property rights, such as Trade-Related Aspects of Intellectual Property Rights (TRIPS), and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need.

i. Give due priority to the most affected countries and communities, and to those countries most at risk.

j. Aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups.[74]

[74] Global Fund, The Framework Document of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, 2001, http://www.theglobalfund.org/documents/TGF_Framework.pdf

Appendix D. Outputs of Global Fund Support, FY2002-FY2009

Table D-1. Outputs of Global Fund Support, FY2002-FY2009

Services	Africa	Asia & Pacific	Latin America & Caribbean	N. Africa & M. East	E. Europe & C. Asia	Total
HIV/AIDS						
ART provision	1,930,600	383,300	76,000	35,400	74,800	**2,500,100**
ARV for PMTCT	674,100	65,660	15,000	6,900	28,500	**790,160**
Condoms distributed	1,057,200,000	238,940,000	356,600,000	62,050,000	125,000,000	**1,839,790,000**
Tuberculosis						
New cases detected and treated	1,401,000	4,061,000	152,000	178,000	201,000	**5,993,000**
MDR-TB treatment	5,800	3,100	10,700	300	9,900	**29,800**
Malaria						
Nets distributed	72,465,000	21,745,000	1,200,000	8,789,000	139,000	**104,338,000**
Cases treated	90,000,000	8,460,000	344,000	9,030,000	9,300	**107,843,300**
IRS	17,180,000	1,086,000	122,000	567,000	432,000	**19,387,000**
Integrated						
Care and support	5,030,000	1,446,700	963,000	55,600	389,100	**7,884,400**
Care and support of OVC	4,230,000	248,700	13,800	37,400	20,400	**4,550,300**
"Person episodes" of health and community worker training	3,234,000	6,501,000	1,130,000	162,400	320,500	**11,347,900**
STI cases treated	1,680,000	1,297,000	2,430,000	1,216,000	177,000	**6,800,000**
TB/HIV services provided	1,450,000	218,400	29,100	3,900	132,400	**1,833,800**

Source: Global Fund, *The Global Fund 2010: Innovation and Impact*, Progress Report, p.19.

Appendix E. Synthesis Findings and Recommendations of Five-Year Evaluation

Table E-1. Synthesis Findings and Recommendations of Five-Year Evaluation

Synthesis Finding 1: The Global Fund, together with major partners, has mobilized impressive resources to support the fight against AIDS, tuberculosis and malaria.
Recommendation 1: The international development community needs to systematically address the requirements of sustainability in the global response to the three pandemics. As part of this response, the Global Fund replenishment mechanism should further its mobilization of financial resources from existing donors and new sources of funding, including from international donor agencies that have not yet contributed and from non-traditional sources. All Global Fund resources should meet the criterion of additionality—that is they should be additional to existing AIDS, TB and malaria funds and to the health sector overall.
Recommendation 2: The Global Fund should in particular increase its efforts to engage the private sector in the partnership, expanding the range and types of contributions, especially to mobilize in-country private sector resources.
Recommendation 3: The Global Fund should work with other financing entities to help ensure the predictable multi-year funding required to maintain high quality programs. This should be given urgent priority, especially in those areas where the Global Fund has become the largest international donor.
Synthesis Finding 2: Collective efforts have resulting in increases in service availability, better coverage, and reduction of disease burden.
Recommendation 4: The Global Fund's business plan should increasingly differentiate its prevention and treatment approaches in specific countries based on the epidemiological profiles of AIDS, TB and malaria and the assessment of a country's capacity to execute its planned disease control programs.
Recommendation 5: The Global Fund should adjust its 'demand-driven model' and focus its resources on prevention and treatment strategies that utilize the most cost-effective interventions that are tailored to the type and local context of specific epidemics.
Recommendation 6: The Global Fund and its partners should continue to finance scale-up efforts, in particular for key malaria program interventions in light of the encouraging initial results from several countries and research.
Recommendation 7: Much higher priority on the strengthening and integration of health information systems required by countries to manage their programs and monitor impact. Specifically: a. The Global Fund and partners should reorient investments from disease specific monitoring and evaluation (M&E) toward strengthening the country health information systems required to maximize data quality and use for decision-making. b. Countries should be encouraged to increase investment in medium- to long-term capacity building for financial tracking, including through the incorporation of health expenditure data in their population-based surveys and the completion of periodic National Health Account exercises. c. Countries should also be encouraged to emphasize the development of quality assurance mechanisms that can help to achieve urgently required financial oversight at the sub-recipient (SR) level.
Synthesis Finding 3: Health systems in most developing countries will need to be greatly strengthened if current levels of services are to be significantly expanded.
Recommendation 8: The Global Fund and partners should address the major gaps in basic health service availability and readiness—the minimum components for delivery of quality services such as basic infrastructure, staffing and supplies—as part and parcel of scaling-up against the three diseases. In particular, Global Fund grants for health systems strengthening should support overall country health sector strategic plans.

Recommendation 9: The Global Fund and its partners should together clarify, as a matter of urgency, an operational division of labor regarding the provision and financing of technical support for health systems strengthening. These efforts should take a longer-term perspective in delivering technical support. They should in particular support human resource capacity building over a horizon of five to ten years, in harmony with other global and regional initiatives.

Recommendation 10: The Global Fund Secretariat should develop and articulate a strategy that allows for a menu of investment approaches to increase the probability that grants will perform well. The assessment of management issues as part of the grant rating should include explicit linkage to whether grant technical support budgets are being used for necessary capacity-building measures. In particular, for countries with weak health systems and/or high disease burden, grants should either focus more on investing in long-term capacity building, or demonstrate partner contributions to capacity-building.

Recommendation 11: The Global Fund Secretariat should work with internationally-mandated technical partners, country counterparts, and in-country civil society and private sector partners to strengthen country surveillance and M&E systems, taking into account the needs of performance-based funding. In particular and in active collaboration with country-level partners, the Secretariat should systematically identify and address additional requirements for achieving adequate oversight at the sub-recipient level.

Synthesis Finding 4: The Global Fund has modeled equity in its guiding principles and organizational structure. However, much more needs to be done to reflect those efforts in grant performance.

Recommendation 12: The Global Fund and its partners should ensure that in both applications for funding and country health information systems there is explicit inclusion of indicators for service quality and equity issues related to gender, sexual minorities, urban-rural, wealth, and education in order to more effectively monitor the access to services among vulnerable populations.

Recommendation 13: The Global Fund should integrate and highlight equity issues related to gender, sexual minorities, urban-rural, wealth, and education disparities in the development of its partnership strategies.

Recommendation 14: The Global Fund Secretariat should collaborate closely with technical partners and country stakeholders to develop program strategies and build in-country capacities required to better identify and reach vulnerable populations.

Synthesis Finding 5: The Performance-Based Funding system has contributed to a focus on results. However, it continues to face considerable limitations at country and Secretariat levels.

Recommendation 15: The Global Fund should urgently seek a more coordinated approach and the more systematic investment of partners to strengthen the country health information systems which are needed as the basis for monitoring overall progress, enabling performance based funding, and conducting ongoing evaluations.

Recommendation 16: The Global Fund should comprehensively examine its performance-based funding (PBF) objectives, policies, procedures, guidelines, and current functioning while reviewing the PBF experiences of other partners, most notably GAVI.

Recommendation 17: The Global Fund Secretariat should revise quality assurance guidelines to distinguish approaches among settings where existing data systems are or are not capable of providing the outcome-level information required for PBF. As a part of this exercise, the Global Fund should review the implications of weak data systems on the guidelines for the operations of the technical review panel and the LFAs.

Recommendation 18: The Global Fund should reaffirm its aspirations to PBF principles, while proposing more differentiated approaches to quality assurance that are capable of improving performance and accountability monitoring within existing capacity constraints in countries.

Synthesis Finding 6: The Global Fund partnership model has opened spaces for the participation of a broad range of stakeholders. This progress notwithstanding, existing partnerships are largely based on good will and shared impact-level objectives rather than negotiated commitments or clearly articulated roles and responsibilities, and do not yet comprise a well functioning system for the delivery of global public goods.

Recommendation 19: The Global Fund Board should reaffirm its commitment and reconsider its approach to institutional partnerships at the global level, clearly articulating its partnership priorities and the specific arrangements and agreements required to achieve its objectives.

Recommendation 20: The Global Fund Board should consider what efforts will be required to bring about agreed-upon, effective, and enforceable strategic divisions of labor between the Global Fund and the other main multilateral organizations involved in international health—in particular with the World Bank, UNAIDS, WHO, UNICEF, the Stop TB Partnership, and Roll Back Malaria—to fully capacitate the envisioned partnerships with civil society and the private sector. This should include as a first priority resolving the issues that impede the provision of essential technical assistance on a reliable and timely basis. It should also address larger, systemic issues needed for health systems strengthening.

Recommendation 21: The Global Fund Secretariat should work through with partners the carefully differentiated approaches it seeks in its various areas of work at global, regional and country level – defining in specific terms the institutional arrangements required to bring to bear the added value of particular partners at different stages of the grant life cycle.

Recommendation 22: The Global Fund Board, in consultation with the Secretariat, should ensure the structure, function and size of the Secretariat reflects its strategic role in a clearly defined partnership framework, distinguishing functions to be fulfilled by partners versus those to be fulfilled by the Secretariat.

Synthesis Finding 7: As the core partnership mechanism at the country level, CCMs have been successful in mobilizing partners for submission of proposals. Hover, in the countries studied, their grant oversight, monitoring, and technical assistance mobilization roles remain unclear and substantially unexecuted. The CCMs' future role in these areas and in promoting country ownership is in need of review.

Recommendation 23: The Global Fund should place greater emphasis on the "CCM Function" rather than the "CCM entity."

Recommendation 24: In the majority of cases where the CCMs are not providing ongoing oversight and monitoring functions, the Global Fund should strengthen CCM capacities and/or focus their efforts more exclusively in the domain of proposal development and submission.

Recommendation 25: The Global Fund should work with partners and country counterparts to incorporate the CCM functions into other 'CCM-like mechanisms' within existing country-level architecture for coordination and planning in the health and social sectors, particularly where the Global Fund is funding national strategies and/or seeking to support health systems strengthening efforts. In doing so, the Global Fund should be diligent in ensuring that the principles of transparency and inclusion—in particular with respect to CSO and private sector in-country partners—are maintained.

Recommendation 26: As an essential measure to assure functional partnerships at the country level, the Global Fund Board should designate in-country representation through explicit institutional partnership arrangements with international partners or—as a last resort—through the direct placement of Global Fund staff representatives.

Recommendation 27: The Global Fund and its partners should take steps to increase the inclusion of in-country CSO and private sector partners in country program efforts. The Global Fund, in particular should:

a. work with country counterparts and international partners to share effective models for increased participation and strengthening of CSO and private sector efforts across development actors and between countries.

b. continue to advocate with host governments for increased CSO and private sector participation in the CCM-Function.

Synthesis Finding 8: The lack of a robust risk management strategy during its first five years of operation has lessened the Global Fund's organizational efficiencies and weakened certain conditions for the effectiveness of its investment model. The recent work to develop a comprehensive, corporate-wide risk management strategy is a necessary step for the Global Fund's future.

Recommendation 28: The Global Fund should urgently complete its development of a risk management framework, beginning with the development of a risk register within the Secretariat, which makes risk management activities integral components of strategic and corporate planning,, operations and decision making.

Recommendation 29: The Global Fund Secretariat should utilize the parameters associated with risk of poor grant performance—financial, organizational, operational and political—to determine how resources should be mobilized in support of performance, either by the Secretariat or by in-country partners.

Synthesis Finding 9: The governance process of the Global Fund have developed slowly and less strategically than required to guide its intended partnership model.

Recommendation 30: The Global Fund Board should consider shifting to a more 'partnership-centric' approach to governance in order to reposition the Global Fund in the global health architecture in a way that maximizes the leverage of its financing to effect major efficiencies in the international system of development assistance for health—specifically focused on AIDS, TB and malaria, but mindful of the broader national health structures and systems that will require strengthening to achieve its focused objectives. Such an approach would involve the Board re-examining the roles and responsibilities presently carried out by the Secretariat, considering which of those roles could and should be played by partners.

Recommendation 31: The Global Fund Board should take steps to reconcile its founding Principles with the unrealized assumptions required for their actualization. Specifically:

a. improved country-owned coordination, with the full participation and inclusion of stakeholders, is required to ensure that the partnership model functions effectively at country level;

b. strengthened country information capacities are required to support performance based funding;

c. explicit financing mechanisms are required to fully engage the international technical partners.

Recommendation 32: The Global Fund Board should support the development of a more coherent vision and mission statement that sets a hierarchy and contextual boundaries for the application of the Global Fund Guiding Principles, focuses on issues—especially partnership and monitoring and evaluation—which have not thus far received sufficient attention, and defines more precisely the current status and future orientations of the Global Fund business model.

Recommendation 33: The Global Fund Board should provide clear guidance to the Global Fund Secretariat with respect to strengthening or limiting its roles relative to those of its partners in the areas of financing, policy and development assistance in order to better situate and differentiate the Global Fund in the global development architecture.

Source: Macro International, Inc., The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria: Synthesis of Study Areas 1, 2 and 3, March 2009.

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