About the Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is a global public-private partnership dedicated to raising and disburse financial resources to prevent and treat HIV/AIDS, tuberculosis (TB), and malaria. Since its creation in 2002, the Global Fund has become a major funding channel for programs to fight these three diseases. As of December 2013, it had signed grants worth a total of US$29 billion in more than 140 countries.

The Global Fund provided 22% of all international financing for HIV/AIDS in 2012. In 2013, it is estimated to have supplied around 75% of international funding for TB control. The World Malaria Report 2013 found that the Global Fund was the single largest source of funding for malaria control, accounting for an estimated 50% of total international disbursements in 2013.

As a public-private partnership representing governments, civil society, the private sector, and affected communities, the Global Fund represents a new model of international health financing. Its success relies on the financial pledges of donors, the technical support of multilateral agencies, and the development and implementation of programs by in-country partners. Its governance body is the Global Fund Board (referred to in this profile as “the Board”).

The partnership is currently undergoing a far-reaching reform process with significant changes in its business model. A key element of this process is its strategy for 2012–2016, called Investing for Impact, adopted at the Board Meeting in November 2011 (see Strategic objectives and associated strategic actions on page 2, which shows the five strategic objectives for 2012–2016).

At the same meeting, the Board adopted a Consolidated Transformation Plan which sought to move the Global Fund from a past focus on emergency funding to a new funding approach based on strategic investment of resources for achieving sustainable impact. Among other recommendations, the plan called for:

- establishing a new application process for more strategic investment of resources
- improved fiduciary control and grant management, and
- strengthened governance, e.g. through shifting of staff resources to core grant-related functions.

As a key process in implementing the 2012–2016 Strategy and transformation plan, the Board approved a New Funding Model (NFM) in November 2012. The model establishes a funding allocation system aimed at focusing grants on countries with the highest disease burden and the least ability to pay. It seeks to increase funding predictability by providing countries with an indicative funding amount for a three-year allocation period and gives countries flexibility to decide when to apply for funding within this period. In February 2013, the transition period of the NFM was launched and full implementation will begin in March 2014.

Resource Mobilization

The Global Fund quickly developed into a major engine of international health financing. It contributed 22% of all international disbursements to HIV/AIDS in 2012, about 50% of international disbursements to malaria in 2013, and around 75% of international funding for TB control in 2013. Such a funding record makes the Global Fund the largest channel of international financing for malaria and TB, and the second largest for HIV/AIDS, behind the US President’s Emergency Plan For AIDS Relief (PEPFAR).

Since its launch in 2002, the Global Fund has mobilized large and rapidly growing resources. As of January 2014, it had received a total of US$42.1 billion in donor pledges. Of this amount, 96% (US$40.3 billion) was pledged by donor governments.

**Principles**

- **Country ownership:** Countries determine their own solutions to fighting the three diseases, and take full responsibility for ensuring implementation of these solutions.
- **Performance-based funding:** Initial funding is awarded based on the strength of a proposal, and continued funding is dependent upon demonstration of results.
- **Partnership:** Under the Global Fund business model, all stakeholders work together, including government, civil society, communities living with the disease, technical partners, the private sector, faith-based organizations, academics, and other multilateral and bilateral agencies. All should be involved in the decision-making process.
## Strategic objectives and associated strategic actions

| 1. Invest more strategically | • Focus on the highest-impact countries, interventions and populations while keeping the Global Fund global  
|                            | • Fund based on national strategies and through national systems  
|                            | • Maximize the impact of Global Fund investments on strengthening health systems  
|                            | • Maximize the impact of Global Fund investments on improving the health of mothers and children |
| 2. Evolve the funding model  | • Replace the rounds system with a more flexible and effective model  
|                            | • Facilitate the strategic refocusing of existing investments |
| 3. Actively support grant implementation success | • Actively manage grants based on impact, value for money and risk  
|                                        | • Enhance the quality and efficiency of grant implementation  
|                                        | • Make partnerships work to improve grant implementation |
| 4. Promote and protect human rights | • Integrate human rights considerations throughout the grant cycle  
|                                        | • Increase investments in programs that address human rights-related barriers to access  
|                                        | • Ensure that the Global Fund does not support programs that infringe human rights |
| 5. Sustain the gains, mobilize resources | • Increase the sustainability of Global Fund-supported programs  
|                                        | • Attract additional funding from current and new sources |


In recent years, the Global Fund has mainly mobilized its resources through its Voluntary Replenishment Mechanism. This mechanism, which is complemented by additional ad-hoc contributions, is a dedicated instrument to raise funds from public and private donors. It involves a donor forum, at which donors discuss the operations and effectiveness of the Global Fund, consider its funding needs, and make financial pledges to the Global Fund for the next three years. Before the replenishment mechanism was introduced in 2004, all contributions were made on an ad hoc basis.

To date, four replenishments have taken place (see Resources pledged through the Voluntary Replenishment Mechanism on page 3). At the most recent Fourth Voluntary Replenishment Conference hosted by the U.S. Government in December 2013, donors pledged US$12.0 billion for the funding period 2014–2016, the largest amount ever committed in the Global Fund’s history.
Ten donors account for 87% of all pledges to the Global Fund (see Top 10 donors to the Global Fund on right). The US government is the largest contributor, with total pledges to date of US$13.5 billion. The US government is followed by the governments of France (US$5.4 billion), the United Kingdom (US$3.7 billion), Germany (US$2.9 billion), and Japan (US$2.7 billion). The Bill & Melinda Gates Foundation (BMGF) is the largest private supporter of the Global Fund, with pledges of US$1.6 billion.

In spite of the Global Fund’s success in raising a large amount of additional finance to fight the three diseases, the gap between country demand and available resources remains high. The Global Fund’s resource scenario for the 2014–2016 timeframe indicates that an additional US$26 billion in funding would be required to meet expected country demand in this timeframe. As of December 3 2013, the Global Fund had raised US$12 billion for 2014–2016.

**Financing Portfolio**

Since its launch in 2002, the Global Fund has approved funding support for 156 countries (including 129 countries with single-country grants, and 27 countries that have received funding only through multi-country grants). These have included the poorest countries in the world, including Liberia, the Democratic Republic of the Congo, and Burundi, but also upper middle-income countries, such as Argentina, Brazil, and China.
Key financing terms

- **Approved grant amount**: the Global Fund’s commitments based on signed grant agreements or, in the case of those countries with pending grant agreements (not yet signed), the value of an approved proposal.
- **Disbursements**: actual payments made by the Global Fund to recipients.

**Breakdown of funding by disease type**: Of the US$28.7 billion in grants signed by the Global Fund (as of December 2013), 54% (US$15.6 billion) was allocated to HIV/AIDS, while 28% (US$8 billion) was allocated to malaria, and 16% (US$4.6 billion) to TB (see [Grants signed by disease](#) below.)

**Breakdown of funding by region**: Funding from more than half of all grants signed (54.2%) is allocated to sub-Saharan Africa (SSA) (see [Grants signed by region](#) below). Most of the funding for SSA goes to countries that have been designated by the Global Fund as “high impact.” Such countries account for most of the global HIV/TB/malaria burden and most Global Fund funding, and they have the highest risk of mismanagement. According to the Global Fund Results Report 2012, the share of disbursements to each region is broadly in line with that region’s share of the global burden of HIV, TB, and malaria.

**Grants signed by disease (as of December 2013)**

<table>
<thead>
<tr>
<th>Disease type</th>
<th>Approved funding (US$ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>15.6</td>
</tr>
<tr>
<td>Malaria</td>
<td>8.0</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>4.6</td>
</tr>
<tr>
<td>Other*</td>
<td>0.48</td>
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</tbody>
</table>

*Total=US$28.7 billion*

**Grants signed by region (as of December 2013)**

- High Impact Africa 2*: 54.3%
- High Impact Africa 1**: 5.1%
- Central Africa: 6.1%
- Southern and Eastern Africa: 5.1%
- Eastern Europe and Central Asia: 5.1%
- Latin America and Caribbean: 3.8%
- South East Asia: 7.1%
- Western Africa: 8.4%
- Middle East and North Africa: 7.8%
- Total: US$28.7 billion

*Includes: Ethiopia, Kenya, Mozambique, Tanzania, Uganda, Zambia, Zanzibar, Zimbabwe
**Includes: Congo DR, Côte d’Ivoire, Ghana, Nigeria, South Africa, Sudan
***Includes: Bangladesh, China, India, Indonesia, Myanmar, Pakistan, Philippines

Data source: Global Fund data site, as of December 9, 2013

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*Other refers to eight HIV/TB grants and stand-alone health systems strengthening grants*

Data source: Global Fund data site, as of December 9, 2013
Breakdown of funding by country income group: While 51% of Global Fund financing goes to low-income countries (as of December 2013), 31% is allocated to lower middle-income countries. Upper-middle income countries account for 17% of total funding. The remaining 1.4% goes to multi-country proposals and high-income countries.

Breakdown of funding by top recipient countries: As of December 2013, about 40% (US$11.4 billion) of funding from all signed grants was channeled to 10 out of the 156 Global Fund recipient countries (see Top 10 recipients below).

Breakdown of funding by implementing entity: By the end of 2012, more than one-third (39%) of reported cumulative expenditures was spent by ministries of health, almost one-third (30%) by civil society organizations/academia, and 14% by other government organizations (see Cumulative expenditures by implementing entity below).

Breakdown of funding by service delivery area: The Global Fund's Enhanced Financial Reporting system allows tracking of grant budgets and expenditures, disaggregated by service delivery area. By the end of the 2012 reporting cycle, 52% of TB expenditures, 29% of HIV expenditures, and 25% of malaria expenditures were directed to treatment; the proportion of expenditures spent on prevention was 2% for TB, 30% for HIV, and 51% for malaria (see Breakdown of cumulative grant expenditure by service delivery area on p 6).
Organizational Structures and Governance

Legally, the Global Fund is an independent organization that is registered as a foundation under Swiss law. As a partnership between governments, civil society, and the private sector, the Global Fund represents an innovative approach to international health financing. Its organizational structures include the Board, the Secretariat in Geneva, as well as several other governance, management, and oversight structures at the global and country levels.

Global Level Structures and Governance

a) Global Fund Board and Board Committees

The Board is responsible for overall governance of the Global Fund, for developing new strategies and policies, and for the approval of grants. Compared to other international financing organizations, the Global Fund’s Board has a unique structure and membership (see Global Fund Board membership on p 7).

The Board currently includes 20 members with voting power; these voting members are divided into two groups:

- a donor’s bloc: eight seats for donor governments, one for the private sector, and one for private foundations
- an implementer’s bloc: seven seats for developing countries, two seats for non-governmental organizations (NGOs), and one seat for communities affected by the three Global Fund diseases.

In addition, there are five non-voting members with observer status.

The Board aims for consensus, but if no consensus can be reached, any member of the Board with voting privileges is able to call for a vote. In order to pass, motions require a two-thirds majority of both the donor’s bloc and the implementer’s bloc. The Board usually meets twice a year, typically in April/May and November/December.

Data source: Global Fund website, Funding and Spending, accessed: December 9, 2013
Global Fund Board membership

<table>
<thead>
<tr>
<th>20 voting members</th>
<th>5 ex officio members without voting rights</th>
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<tbody>
<tr>
<td><strong>Donor governments and European Commission</strong> (8 seats)</td>
<td><strong>Joint United Nations Programme on HIV/AIDS (UNAIDS)</strong></td>
</tr>
<tr>
<td>• European Commission (Belgium, Finland, Italy, Portugal, Spain)</td>
<td><strong>World Health Organization (WHO)</strong></td>
</tr>
<tr>
<td>• Point Seven (Denmark, Ireland, Luxembourg, Netherlands, Norway, Sweden)</td>
<td><strong>World Bank</strong></td>
</tr>
<tr>
<td>• Canada, Switzerland</td>
<td><strong>Partners (e.g., UNITAID, Roll Back Malaria)</strong></td>
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<tr>
<td>• France</td>
<td><strong>Board designated non-voting Swiss member</strong></td>
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<tr>
<td>• Germany</td>
<td></td>
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<tr>
<td>• Japan</td>
<td></td>
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<tr>
<td>• United Kingdom, Australia</td>
<td></td>
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<tr>
<td>• United States</td>
<td></td>
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<tr>
<td><strong>Recipient countries</strong> (7 seats)</td>
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<tr>
<td>• Eastern and Southern Africa</td>
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<td>• West and Central Africa</td>
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<tr>
<td>• Eastern Mediterranean Region</td>
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<td>• Eastern Europe and Central Asia</td>
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<td>• Latin America and Caribbean</td>
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<td>• Western Pacific Region</td>
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<td>• Southeast Asia</td>
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<tr>
<td><strong>Non-governmental organizations (NGOs)</strong> (2 seats)</td>
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<tr>
<td>• Developed country NGO</td>
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<tr>
<td>• Developing country NGO</td>
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<tr>
<td><strong>Communities (NGOs representative of the communities living with the diseases)</strong> (1 seat)</td>
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</tbody>
</table>

Data sources: Global Fund website, Board Constituencies, Governance Handbook Section 4—The Global Fund Board

The Board is supported in its decision-making by three committees whose main function is to prepare the Board’s decision-making, complemented by a “Board Coordinating Group” of Board and Committee chairs and vice-chairs:

- Strategy, Investment and Impact Committee
- Finance and Operational Performance Committee
- Audit and Ethics Committee

In addition, the Board is supported by three advisory bodies (which report to the Strategy Committee):

- Technical Review Panel (reviews proposals for Global Fund grants; see below for details)
- Technical Evaluation and Reference Group (independent advisory group overseeing evaluations of the Global Fund business model, investments and impact)
- Market Dynamics Advisory Group (advises on policies/initiatives to improve the Global Fund’s ability to shape health product markets).

b) Global Fund Secretariat

As of December 31 2013, the Global Fund Secretariat was staffed with 606 employees, all in Geneva. Its administrative costs, including both the Secretariat’s expenses and fees for Local Fund Agents, account for about 9% of total annual disbursements, which is low compared to other multilateral or bilateral agencies.

The Secretariat is headed by the Executive Director of the Global Fund, Mark Dybul, appointed by the Board in November 2012. The Executive Director leads the Global Fund’s operational and administrative functions.

Recent organizational reviews, including that of the High Level Independent Review Panel on Fiduciary Controls and Oversight Mechanism (the High Level Panel [HLP]), emphasized the need to strengthen Secretariat leadership and management, to rebalance staff resources to core business, and to improve internal systems/processes. Based on the Consolidated Transformation Plan, the Global Fund implemented various changes to the structure and work of the Secretariat. Key outcomes include:
• **Strengthening of grant management functions:** The distribution of staff within the Secretariat has been restructured to focus on grant management-oriented functions. About 75% of the Secretariat staff now work in the (a) Grant Management and (b) Strategy, Investment and Impact divisions (as of June 2013).

• **Increasing strategic investments:** Three High Impact Departments (two for Africa, one for Asia) have been created to increase strategic investments in **20 prioritized high-impact countries**. These countries were designated by the Global Fund as high impact as they account for roughly 70% of the world-wide disease burden of HIV/AIDS, TB, and malaria, and 65% of Global Fund funding, and they have the highest risk of mismanagement. Full-time Fund Portfolio Managers (FPMs) have been assigned to manage these countries (previously the allocation of FPMs did not take the risk profile of countries into account).

• **Strengthening of risk management:** To strengthen financial oversight and mitigate risks in grant implementation, the Global Fund has adopted a **new operational risk management approach**. This approach includes **risk profiles**, which assess each grant’s operational risks and the contributing factors affecting grant outcomes in 19 risk areas through “heat maps”. During a first assessment of grants in high-impact countries in 2013, **five top risk areas** were identified: (1) treatment disruptions, (2) poor quality of health services, (3) inadequate Principal Recipient (PR) reporting and compliance, (4) inadequate monitoring & evaluation and poor data quality, and (5) sub-standard quality of health products.

• **Disease committees:** Three disease committees (one for each disease) have been created. They provide guidance on strategic investments to maximize the impact of the Global Fund’s grant portfolio and are composed of Global Fund representatives and international and bilateral partners, such as UNAIDS and PEPFAR.

  c) **Office of the Inspector General**

  The Office of the Inspector General (OIG) operates as an independent unit of the Global Fund and reports directly to the Board. The OIG provides objective assurance over all Global Fund operations and programs and is particularly active in the fight against fraud, corruption, and abuse of funds. It has the authority to independently carry out audits and investigations within countries.

  The OIG encourages the reporting of fraud and abuse through its web-based reporting system (the Integrity Hotline) and a toll-free telephone line. OIG reports can be found online.

  d) **Technical Review Panel**

  The Technical Review Panel (TRP) is an independent group of international experts in the three Global Fund diseases and in cross-cutting issues (e.g., health systems) that reviews funding proposals and guarantees the quality, transparency, and consistency of the proposal review process. Its members are appointed by the Board.

  The TRP’s role, composition and working method have recently been revised to adapt it to the NFM. The review process has been redesigned to strengthen the TRP’s interaction with the Secretariat and with applicants through an iterative process, aimed at reaching positive funding recommendations (under the Rounds-based model, the TRP only made a one-time recommendation on whether or not to fund a proposal). In addition, the TRP will meet more often (9 times during the 2014–2016 funding period; before the NFM, the TRP usually met just once a year). While the TRP used to provide funding recommendations directly to the Board, in the NFM, funding recommendations will be made to the Secretariat’s Grant Approvals Committee (GAC; see Funding Process).

  **Country Level Structures and Governance**

  To date, the Global Fund has operated without a country presence, relying on the capacity and expertise of partners or contracted support for in-country assistance and oversight.

  a) **Country Coordinating Mechanisms**

  Country Coordinating Mechanisms (CCMs) include representatives from governments, multilateral and bilateral agencies, non-governmental organizations, academic institutions, private businesses, and people living with HIV, TB, or malaria. CCMs develop and submit grant proposals, nominate the PR, i.e., the organization that is accountable for managing the grants, and oversee the grant’s progress during implementation. Guidelines for CCM composition recommend that civil society organizations (CSOs) and communities affected by the three diseases should be prominently included in the CCM.

  For each grant, the CCM nominates one or more public or private organizations to serve as PRs. PRs can be governmental actors (often the Ministry of Health or the Treasury), international organizations, NGOs, or (less often) corporations. The Global Fund signs a legally binding grant agreement with the PR who is responsible for the program’s implementation. Many PRs both implement and award sub-grants, i.e. they pass a portion of funding on to other implementing organizations (“Sub-Recipients”).

  Based on evidence that CSOs and the private sector play a critical role in scaling up programs and reaching most-at-risk populations, under dual-track financing CCMs are encouraged to nominate both a government entity and a non-governmental entity to be the PRs in a grant proposal. If the proposal is approved, the Global Fund then signs a separate grant agreement with each PR.
To improve CCMs’ performance, the Global Fund has recently developed a set of **CCM minimum standards** to be assessed prior to grant signature, which will be enforced as of 2015. In addition, under the NFM, the Secretariat requires CCMs to conduct **annual performance self-assessments**, which monitor compliance with the existing CCM eligibility requirements and the new minimum standards.

**b) Local Fund Agents**

To oversee and report on grant performance at country level, the Global Fund contracts so-called Local Fund Agents (LFAs). LFAs are typically audit and accounting firms or entities that screen the capacity of organizations nominated as PRs and also verify the progress reports and disbursement requests submitted by PRs. The Global Fund usually has one LFA per country, which is selected through a competitive bidding process. To improve LFA performance, the Global Fund has implemented a series of reforms, including the development of new LFA minimum requirements, LFA training programs, and tailoring LFA services based on grant risks.

**Processes for Funding, Applications, and Grant Management**

The Global Fund is currently in the process of implementing the NFM, a far-reaching **reform of its resource allocation funding process**. The NFM groups countries into four Country Bands with differing income level (high to low) and disease burden (high to low), in order to allocate resources based on need. In addition, the model seeks to align grants with national budget and reporting cycles by allowing countries to request funding on a rolling basis.

In the past, the key window of opportunity for countries to access funding from the Global Fund was the **Rounds-Based Channel**, typically once a year. Eligible countries could submit grant proposals without involvement by the Global Fund Secretariat. CCMs were responsible for designing and submitting proposals. After an initial screening by the Secretariat for timeliness, completeness, and eligibility, the TRP reviewed proposals for technical merit and made a funding recommendation to the Global Fund Board, which the Board usually endorsed.

Under the NFM, the Global Fund provides every eligible country with an **indicative funding amount for a three-year period** in line with the replenishment period (e.g. 2014–2016). Unlike the five-year grant cycle of the rounds-based model (a two-year Phase 1 and then a three-year Phase 2), each grant will have a **length of three years**, to guarantee funding stability while ensuring flexibility to adapt to changing contexts.

While indicative funding is allocated to meet the countries’ prioritized needs, the Global Fund will also award competitive **incentive funding**, which is to be allocated to well-performing programs with a potential for increased impact. The goal is to motivate countries to develop ambitious requests and “full expressions of quality demand” by not having to limit requests to a fixed funding ceiling.

**Funding Allocation Process**

The funding allocation process has four main steps:

1. **The Global Fund determines the amount of total available resources** for the three-year allocation period (e.g. 2014–2016).

2. **Funding envelopes for the three diseases** will be developed by applying a **disease split** to total available resources (for the funding period 2014–2016, the Board approved the following split: 50% for HIV/AIDS, 32% for malaria, and 18% for TB).

3. **The Global Fund determines allocations** to the four Country Bands and countries based on a quantitative allocation formula that considers the countries’ disease burden and ability to pay (gross national income per capita), adjusted by other quantitative and qualitative factors. A separate allocation methodology based on population size will be used for Country Band 4 (higher income/lower disease burden). Composition and cut-off points of Country Bands and the final allocation formula are still under review, and will be approved at the March 2014 Board meeting. A proportion of the allocations to Country Bands 1–3 (but not Band 4) will be set aside for incentive funding. The proportion will be 10–20% for the 2014–2016 period, depending on total available resources (10% for resources up to US$11 billion; 15% for resources over US$11 billion and up to US$13.5 billion; or 20% for resources over US$13.5 billion).

4. **Based on the allocation formula, the Secretariat will communicate the total indicative funding** amount for the three-year period to each country. In addition, it will suggest a funding split by disease components, from which countries may deviate if they provide justification (details to be clarified in March 2014).

The Global Fund approved up to US$1.9 billion in funding for the transition period in 2013/2014, US$1.5 billion of which is made available to 47 ‘interim applicants’ for grant renewals, extensions and redesigned programs. US$393 million (and an extra US$364 million for 2015–2016) are provided to six countries (Democratic Republic of the Congo, El Salvador, Kazakhstan, Myanmar, Philippines, and Zimbabwe) and three regional programs which were invited as “early applicants” to test all new elements of the NFM.
**Application Process**

Under the previous Rounds-Based Model, the Global Fund took a “hands-off” approach during the application process. In contrast, the NFM establishes a **greater involvement of the Global Fund in the proposal preparatory process**, by strengthening the interaction between the Secretariat, implementers, and other partners in the so-called “country dialogue”. Countries may submit concept notes with a request for funding at any point within the three-year allocation period. For the allocation period 2014–2016, the Global Fund has determined **nine funding windows** including dates for proposal submission.

Countries are encouraged to base funding requests on national strategic plans, or, in their absence, investment cases, developed through an inclusive multi-stakeholder process. The **main steps of the application process** are shown below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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| **Country dialogue** | • Conducted with all relevant stakeholders (e.g. CCMs, implementers, Global Fund, technical partners, donors, key populations), aimed at supporting applicants in prioritizing high-impact interventions  
  • Key elements: (1) discussion of country’s disease burden, health-sector and human rights landscape, (2) program reviews, and (3) identification of funding gaps |
| **Concept Note design and submission** | • Concept Notes can be submitted for each disease component and for health systems strengthening.  
  • Key elements:  
    » Description of country context and the national strategic plan  
    » Funding request for prioritized needs to be funded through indicative funding stream  
    » “Full expression of demand,” including program elements to be potentially covered under incentive stream or through unmet quality demand stream |
| **TRP review** | • TRP reviews Concept Notes for technical quality and strategic focus  
  • TRP either (a) considers Concept Notes ready to proceed to grant-making, or (b) asks applicants to submit a revised concept note  
  • If approved, TRP provides funding recommendation to the Secretariat’s Grant Approvals Committee or GAC (includes representatives from Global Fund, partners and civil society organizations) on which elements to fund under the indicative or incentive funding stream |
| **GAC determines upper budget ceilings** | • Based on TRP’s recommendations and application of qualitative factors, GAC determines upper ceiling of grant’s budget, including indicative and, if applicable, incentive funding |
| **Grant making** | • Secretariat communicates amount recommended for grant-making to applicant and begins to negotiate grant implementation arrangements  
  • Secretariat conducts risk and capacity assessments of Principal Recipients (PRs) and Sub-Recipients and may decide to accept or reject a PR, release funding for capacity-building, or outsource certain implementation functions (e.g. procurement of health products) |
| **Board approval** | • Secretariat submits “disbursement-ready” grant to the Board for approval  
  • Following approval, grants are signed and funds released to the PRs |
Program Implementation and Management

For each grant, PRs have to submit progress updates and disbursement requests to the Global Fund Secretariat. These are used by the Global Fund to monitor grant performance and to give performance ratings for each progress period (quarter, semester, or year). These ratings indicate whether a grant has performed well and has achieved the previously defined targets included in the performance framework. The quality of the reported data is verified through the Local Fund Agents (LFAs). Failure of a PR to properly collect performance data can block the disbursement process.

Disbursements are geared to the pace of implementation: when grants are being implemented more slowly than expected, funds can be reduced. When implementation is faster, funds can be accelerated. Funding for weak performers is reduced or stopped.

Results

The Global Fund has played an important role in the scale-up of key interventions to fight HIV/AIDS, TB, and malaria. Key outcomes of Global Fund programs include:

- By the end of 2013, 6.1 million people living with HIV were receiving antiretroviral therapy (ART) under Global Fund-supported programs
- 11.2 million cases of new smear-positive TB have been detected and treated since the Global Fund’s inception
- 360 million insecticide-treated bed nets have been distributed since the Global Fund’s inception.

The Global Fund measures the performance of each of its grants. By December 2013, 592 grants had received a rating (see Grant performance by ratings on right):

- About 78% of programs were assessed as performing well and were rated A (grant exceeds or meets expectations, 37%) or B1 (adequate performance, 41%)
- About 17% were assessed as performing inadequately but showing potential (rated B2)
- Only 5% received a C rating for unacceptable performance.

The ratings of A–C are based on whether a grant recipient reached the targets for the proposed performance indicators (e.g. number of condoms distributed, number of people with advanced HIV receiving ART). Ten of these indicators are considered as being the most important (the “top 10 indicators”), and are given greater weight in calculating the final rating.

By the end of 2011, the latest year for which data are available, Global Fund grants achieved an average of between 29% and 123% of their review targets for each indicator (see Results achieved by Global Fund-supported programs against targets for key services on p 12). The best results were for care and support to orphans (average of 123% of targets achieved), whereas malaria treatment was by far the worst performing indicator (average of only 29% of targets achieved).

There is mounting evidence that the Global Fund has helped to achieve substantial impact on global health through its funding of HIV, TB, and malaria programs. The Global Fund’s 2012 Results Report estimates that programs that it supports have saved 8.7 million lives. In addition, together with other international and national partners, Global Fund support helped to achieve the following results:

- The UNAIDS 2013 Report on the Global AIDS Epidemic shows that Global Fund financing—alongside funding from other donors—has resulted in significant declines in AIDS mortality in countries in which provision of ART has been scaled up.
- The World Malaria Report 2013 found that, globally, malaria mortality rates fell by 45% and incidence rates dropped by 29% between 2000 and 2012 due to the large scale-up of vector control interventions, diagnostic testing, and treatment in recent years.
- The Global Tuberculosis Report 2013 found that in many countries that receive Global Fund support, TB prevalence and mortality rates are falling.
Outlook

As of December 2013, the Global Fund had signed grants totaling US$29 billion, and disbursed $22.9 billion to more than 140 countries, helping to save more than 8.7 million lives.

A decade after its creation, the organization has significantly redesigned its business model following a difficult period in 2011/12 during which allegations of misuse of funds led to a comprehensive independent review of the Global Fund’s processes and management by the HLP. Through a comprehensive reform process and the approval of the NFM in November 2012, the Global Fund has begun to address many of the challenges diagnosed by the HLP. Following the NFM transition period in 2013, the year 2014 will be a crucial year for the Global Fund, during which the remaining funding and application process questions have to be resolved and the full roll-out of the NFM needs to happen. Strong leadership by the Global Fund’s Executive Director Mark Dybul will be critical as the Global Fund enters this important next phase and to ensure the highest professional standards are maintained and organizationally supported.
Funding and Authorship

This profile was funded through a general operating support grant from the Bill & Melinda Gates Foundation to the Global Health Group at UCSF, with a subcontract to SEEK Development. The Foundation played no role in writing the profile. The profile was written by authors at SEEK Development (Raimund Zühr, and Christina Schrade), and E2Pi at the UCSF Global Health Group (Gavin Yamey). For information on authors’ competing interests, see www.e2pi.org (click on Smarter Aid section).