

DI.4 The Global Fund to Fight AIDS, Tuberculosis and Malaria

One of the most prominent new actors within the global health landscape is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), a private foundation based in Switzerland. As of June 2007, GF-supported programmes are said to have extended antiretroviral treatment (ART) to 1.1 million people; provided TB treatment to 2.8 million people; and distributed 30 million insecticide-treated bednets (ITNs).

However, there is a need for a more critical assessment. It is one thing to claim improvements in coverage or the distribution of medical outputs, it is another to demonstrate their impact and cost-effectiveness. Given its focus on three diseases, it is also necessary for the GF to avoid collateral damage to other essential health services.

Generally speaking, the GF's work in funding and catalysing responses to HIV/AIDS, TB and malaria has been successful. Many people have benefited. However, it is not possible to say whether these benefits are sustainable, or have been cost-effective and equitably distributed, without better data and more detailed country-by-country analysis.

History, functions and modus operandi

The beginnings

The GF first took shape at the G8 summit in July 2000 when a commitment was made to address the harms caused by HIV/AIDS, TB and malaria (G8 Communiqué 2000). At a 2001 Organisation of African Unity (OAU) Summit, Kofi Annan called for a 'war chest' of \$10 billion per year to fight HIV/AIDS and other infectious diseases (Annan 2001). The UN Special Session on HIV/AIDS subsequently established a working group to delineate



IMAGE DI.4.1
**HIV activists in
 South Africa**

the functions and structure of the GF. The GF approved the first round of grants in April 2002 – three months after the first meeting of its board.

Throughout this period, treatment activists in civil society played a critical role in creating the political momentum required to create the GF, whilst helping to drive down the cost of medicines and winning the argument that ART was feasible in even the poorest countries. Their use of moral persuasion, legal tactics and calculated acts of civil disobedience were critical aspects of their challenge to both governments and pharmaceuticals companies. By shaping the structure and policies of the GF, civil society organisations (CSOs) thus demonstrated their ability to influence global health governance (GF 2007a).

Functions

From the beginning, the GF was set up as a financial instrument, not an implementing agency. Its aim and purpose were to leverage additional financial resources for health. It would operate transparently, demonstrate accountability and employ a simple and rapid grant-making process. It would support country-led plans and priorities, and there was a particular emphasis on developing civil society, private-sector and government partnerships, and supporting communities and people living with the diseases. It would adopt a performance-based approach to disbursing grants.

Organisational structure

The GF is headed by an executive director and has approximately 240 staff located in Geneva. As it is a non-implementing agency, there are no staff based in recipient countries.

It is governed by a 24-member Board of Directors, of whom 20 are voting members. The voting members consist of: 7 representatives from developing countries (one from each of the six WHO regions and an additional representative from Africa); 8 from donor countries; 3 from civil society; 1 from 'the private sector'; and a Gates Foundation representative. The four non-voting members are representatives of UNAIDS (the Joint United Nations Programme on HIV/AIDS), the World Health Organization (WHO), the World Bank, along with a Swiss citizen to comply with the legal status of the GF. The three civil society seats are designated for: one 'developed country non-governmental organisation (NGO) representative'; one 'developing country NGO representative'; and one person who represents 'communities affected by the diseases'.

Grant-making

The GF responds to proposals received from countries. These are reviewed by a Technical Review Panel (TRP), consisting of various appointed experts. Grants are awarded through specified 'rounds' of funding. Since its inception, there have been seven rounds of grant-making. As of December 2007, the GF had approved a total of US\$10 billion to 524 grants in 136 countries, with US\$4.8 billion having actually been disbursed to recipients in 132 countries (GF 2008a). Proposals take the form of five-year plans – grants are initially approved for two years (Phase 1) and then renewed for up to three additional years (Phase 2). Because the earlier grants have come to the end of their five-year lifespan, there has been much discussion about what should happen next.

As part of its 2007–2010 strategy, the GF has announced the introduction of a Rolling Continuation Channel (RCC). This will allow the continued funding of high-performing grants for up to a further six years. It is said that this will help improve performance in the last years of life of a grant; facilitate the expansion of successful programmes; reduce the risk of gaps in funding; and remove the costs associated with countries having to submit a new proposal.

Allocation of funds

Between 2002 and 2007, 55 per cent of grant funds were disbursed to sub-Saharan Africa countries. When stratified by income, 64 per cent, 28 per cent and 8 per cent of disbursements went to low-, lower-middle- and upper-middle-income countries respectively (Grubb 2007). During this period, 57 per cent, 15 per cent and 27 per cent of grant funds were allocated to HIV/AIDS, TB and malaria programmes respectively. The Fund estimates that it provides two-thirds of all global donor funding for malaria,

TABLE DI.4.1 **Allocation of funding across the spectrum of health interventions (%)**

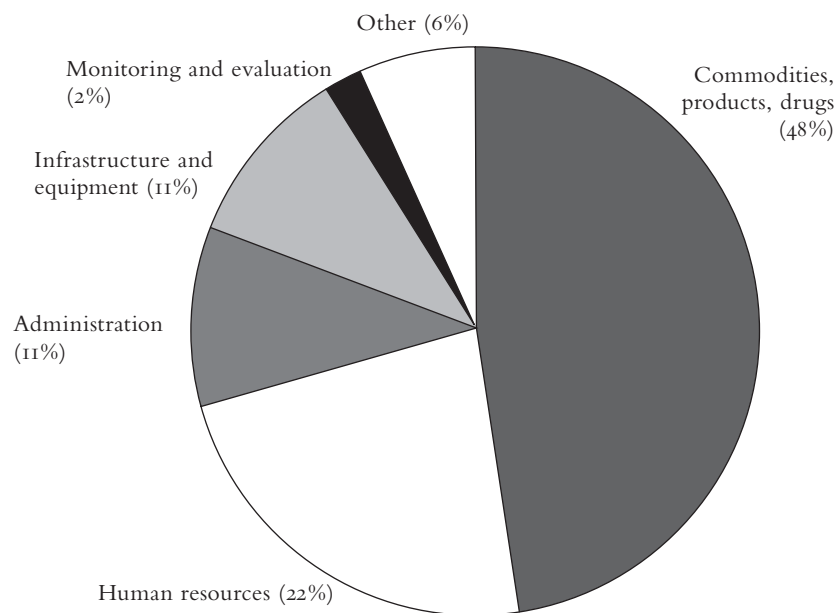
	Treatment	Prevention	Care and support	Other
HIV/AIDS (\$315 million)	32	30	14	24
Tuberculosis (\$223 million)	25	15	6	54
Malaria (\$202 million)	40	35	—	25

Source: Global Fund 2007d.

45 per cent of all global donor funding for TB, and about 20 per cent of funding for HIV/AIDS (CGD 2006). Relatively more funding has been allocated to treatment than to prevention (see Table DI.4.1).

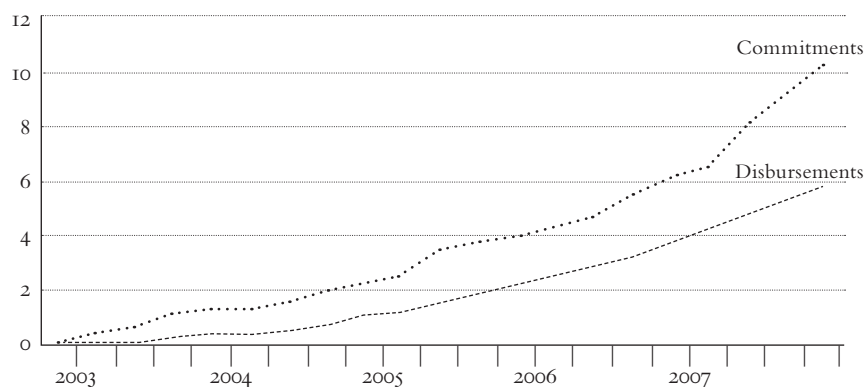
The lion’s share of funding is spent on commodities, products and medicines (Figure DI.4.1). The second largest item of expenditure is ‘human resources’, mostly in the form of training interventions.

FIGURE DI.4.1 **Resources by budget item after Round 6**



Source: Global Fund 2008b.

FIGURE DI.4.2 The rising financial commitments of the Global Fund
(actual and projected commitments and disbursements, cumulative totals,
US\$ billion)¹



Source: Global Fund 2008c.

Funding the Fund

As expected, the annual expenditure and projected commitments of the GF have steadily and rapidly increased (see Figure DI.4.2). In March 2007, the GF presented a three-year funding projection for 2008–10 which amounted to US\$5 billion for existing commitments, and an additional US\$7.2 billion per annum for new grants. In view of these demands, ‘funding the Fund’ has become a critical issue.

About 96 per cent of the GF’s contributions come from donor countries. The biggest contributor is the United States, followed by France, Italy, the European Commission (EC) and the United Kingdom.

Private-sector funding is relatively small, although it increased in 2006, mainly because of a pledge of \$500 million by the Gates Foundation. Another source of private financing has been the (RED)TM Initiative,

TABLE DI.4.2 Funding disbursements of the Global Fund
(as of 1 October 2007)

	Treatment (%)	Prevention (%)	Care and support (%)	Other (%)
HIV/AIDS (\$315 million)	32	30	14	24
Tuberculosis (\$223 million)	25	15	6	54
Malaria (\$202 million)	40	35	—	25

Source: Global Fund 2008d.

BOX DI.4.1 Trends from the 2007 replenishment meeting

- The four countries that pledged (or are projected to pledge) the most for 2008–10 were the US (\$2,172 million), France (\$1,274 million), Germany (\$849 million) and the UK (\$729 million).
- The three countries that pledged the largest percentage of their gross national income (GNI) were Norway (0.087 per cent), Ireland (0.076 per cent) and Sweden (0.075 per cent).
- The three developed countries that pledged the smallest percentage of their GNI were Japan, Finland and Switzerland.
- The three countries whose pledges grew the most since the previous three years were Russia (increased 8.7 times), Saudi Arabia (3.6 times) and Spain (3.4 times).
- The Gates Foundation pledged \$300 million, an increase of 50 per cent from the 2005–07 period.

Source: GFO 2007a.

through which participating companies contribute a percentage of their sales to the Fund. As of March 2008, the Initiative has contributed \$61 million. So far, the GF has discouraged private-sector contributions in the form of earmarked donations or non-financial contributions (GF 2008d).

'Replenishment meetings' take place every two years to discuss the funding of the GF. At the meeting in September 2007 (see Box DI.4.1), the GF was pledged *at least* \$6.3 billion for the period 2008–10 by twenty-six governments and the Gates Foundation (GFO 2007a). With projections that other donors will give a further \$3.4 billion, the Fund has secured a total of \$9.7 billion. This is enough for it to continue operations at its current level for at least another three years, but less than the \$12–18 billion that it predicted it would need for 2008–10.

How the GF works within countries

A general requirement of the GF is the establishment of a Country Co-ordinating Mechanism (CCM) consisting of representatives from government; multilateral or bilateral agencies (e.g. UNAIDS, WHO); NGOs; academic institutions; private businesses; and people living with the diseases. The CCM is expected to oversee the submission of proposals to the GF as well as grant implementation.

In most countries, the CCM is chaired by a representative of government. In order to ensure adequate multi-stakeholder involvement, the GF has a set of criteria for CCM composition which are supposedly used

to determine eligibility of grant proposals (GF 2005). These include the requirement for non-governmental CCM members to be selected through clear and transparent processes, and the inclusion of people living with and/or affected by the diseases. In addition, GF priorities for the future are said to include strengthening ‘community systems’, increasing the representation of vulnerable groups, and providing more support for CCM administration (GF 2007b).

The actual awards of grants are made to a named principal recipient (PR). Government agencies are the PR for about two-thirds of all grants. Nonprofit development organisations and multilateral organisations also act as PRs. In some countries a dual- or multiple-track model is used – where a grant is split across more than one recipient. As part of a set of strategic innovations for the next four years, the GF intends to promote the routine use of ‘dual-track financing’ (GF 2007b).

Government institutions are the main implementing agencies in about 59 per cent of grants, while NGOs represent 30 per cent of implementing agencies. Government agencies make up a higher proportion of implementing agencies in sub-Saharan Africa than in Asia.

Because there is no GF presence in recipient countries, Local Fund Agents (LFAs) are hired to monitor grant implementation, and to rate performance. LFAs may also be used to review budgets and work plans prior to the signing of a new grant agreement. There is normally one LFA per country. Most LFAs come from two of the big private consultancy firms (see Box DI.4.2).

Grant recipient and LFA reports are then used by the relevant GF portfolio manager to score the progress and achievements of the projects. Grant disbursement and renewal ratings are posted onto the GF website to encourage CCMs and other stakeholders to track progress. Countries deemed to be performing poorly can have further disbursements of funding withheld, or the grant cancelled or handed over to another principal recipient.

BOX DI.4.2 List of LFAs and number of countries served

- PricewaterhouseCoopers (69)
- KPMG (28)
- Emerging Markets Group (8)
- Swiss Tropical Institute (8)
- UNOPS (7)
- Crown Agents (1)
- World Bank (1)

Discussion

A model of good global health governance?

A frequent comment about the GF is that civil society and developing-country representatives are prominent in its governance structures. With a board of twenty-four that includes five representatives from low-income countries and three from civil society, this may be true relative to other global institutions. However, numerically, the board is still dominated by donor representatives. And while there are only two representatives of the private sector, one of them is currently chair of the board and the other is the Gates Foundation. In addition, the Gates Foundation funds the McKinsey firm to perform a range of secretariat functions on behalf of the GF.

However, the GF appears to live up to its reputation for transparency. Financial information is readily available, as are details about the approval of proposals and the disbursement of funding. An electronic library houses both internal and external evaluations of the Fund. Transparency has also been enhanced by the regular publication of the *Global Fund Observer* (GFO), a newsletter produced by an independent NGO called Aidspan. It reports on the financing of the Fund; monitors progress and comments on the approval, disbursement and implementation of grants; provides guidance for stakeholders within applicant countries; reports and comments on board meetings. Altogether it provides a useful information service and performs an important 'watchdog' role (GFO 2008).

The GFO reflects the extensive engagement of CSOs with the GF, which arises in part from the existence of a large, well-resourced and well-organised network of disease-based NGOs that feel a degree of ownership over the GF. Not only do they effectively engage with the GF, they have established mechanisms for influencing the policies of other stakeholders, in particular donors, vis-à-vis the GF.

Indeed a form of interdependency exists. Many CSOs which were formed to address HIV/AIDS, TB and malaria view the GF as an important ally. At the same time, the GF understands the importance of CSOs to its own survival and growth. There is a dedicated Civil Society Team within the GF's External Relations Unit, as well as various forums through which CSOs are encouraged to influence GF policies and practices (for example, the biannual Partnership Forum). The GF has even helped create and support a number of 'Friends of the GF' organisations designed to advocate on its behalf.

The GF and its constellation of associated actors thus present a number of features which have broader relevance. For example, there is much about

the GF's provision of information that can and should be replicated by other global health initiatives, and the GFO is an exemplary model of civil society monitoring that should be applied to other institutions.

When it comes to CS engagement, the model may be less transferable. The degree of transparency and 'democratic space' that exists in relation to the GF may have been tolerated because the GF embodies a relatively shared set of aims across a wide range of stakeholders. Northern governments, including the US; developing-country governments; the medical profession; health activists; pharmaceuticals companies; venture philanthropists; and the 'celebrity' spokespersons of the West's conscience – all share an interest in seeing action taken against 'the big three' diseases. It is hard to see how synergy across such diverse constituencies could be replicated in organisations like the WTO or the World Bank, for example. Nonetheless, the GF may provide a useful benchmark for comparison.

National governance

As global institutions become more numerous and prominent, important questions arise about their effect on governance at the national level. National governance is especially pertinent to the GF because an effective and equitable response to HIV/AIDS, TB and malaria ultimately requires the protection of human rights, social development, peace and effective health-sector stewardship, which in turn requires governments to work and democracy to flourish.

Together with its civil society partners, the GF can claim some credit for having enhanced participatory approaches to health policymaking in many countries. A key instrument has been the CCM. While its primary purpose is to help plan and oversee the implementation of GF grants, it is also intended to enhance public accountability and enable the entry of vulnerable and marginalised groups into health policymaking spaces. Some CCMs have been criticised for being tokenistic and lacking representation of rural groups, for example, but in several countries they have become arenas within which relationships between government, civil society and NGOs are being contested and redefined.

The GF has also influenced governance processes by acting on allegations of corruption and financial mismanagement. In 2005, it suspended grants to Uganda following reports of mismanagement and irregularities in procurement and subcontracting (Bass 2005). In 2006 it suspended two grants to Chad and phased out its grants to Myanmar for similar reasons.

It appears therefore that the potential for 'public health' to catalyse positive change within countries is being demonstrated by the GF. However, it should be noted that in some countries CCMs have sometimes been viewed

as an inappropriate, unnecessary and inefficient imposition from outside and a reminder of the need for the GF and health activists to be better informed about the historical, political and social context of governance within countries and to reject the temptation of a one-size-fits-all approach to 'good governance'.

Health-sector governance

The GF impacts on health-sector governance by boosting health budgets and by placing considerable expectations on countries to deliver on various HIV/AIDS, TB and malaria targets. Its influence on health budgets is shown in Table DI.4.3, which lists the five countries where GF grants made up the biggest proportion of total health expenditure between 2003 and 2005. In Burundi, GF grants amounted to more than the entire public budget for health, including direct funding of public services by other donors. GF grants were also a significant proportion of total health expenditure in Burundi (32 per cent), Liberia (17 per cent) and the DRC (15 per cent) respectively.

Concerns have been raised about the ability of countries to absorb such large injections of funding. Initially there was an assumption that capacity within countries would either be sufficient or that technical assistance (TA) would be provided by other agencies to help ensure effective use of GF grants. This did not turn out to be the case. According to one analysis, 'the international community dramatically underestimated TA requirements' and had not anticipated constraints in human resources, basic management and health systems infrastructure (CGD 2006). In addition, the expectation that other agencies would support capacity development caused irritation

TABLE DI.4.3 **The contribution of the GF to national expenditure on health, May 2003²**

	GF disbursements (US\$ million)	GF disbursements as % of total health expenditure	GF disbursements as % of public health expenditure
Burundi	21.8	31.8	118.2
Liberia	14.2	17.6	28.0
Dem. Rep. Congo	48.3	15.3	31.1
Rwanda	53.1	12.6	22.4
Gambia	10.4	12.4	46.0

Sources: Global Fund 2008c; WHO 2007b.

and led to other agencies complaining that supporting GF programmes was an ‘unfunded mandate’.

Such experiences raise the issue of donor and agency coordination. As discussed in Chapter D1.1, there is now greater explicit recognition of the need for external agencies to cooperate and harmonise their activities. One manifestation of this recognition is the 2004 Three Ones Agreement, which was designed to encourage all agencies to work together on HIV/AIDS through one action framework, one national coordinating authority, and one monitoring and evaluation system.³ However, thus far, even the modest goals of this agreement, dealing with only one disease area, have not been met.

While the lack of coordination among donors and global health initiatives isn’t the fault of the GF alone, it should take on the challenge of ensuring maximum harmonisation with the US government’s Presidents Emergency Plan for AIDS Relief (PEPFAR) and the World Bank’s Multi-Country AIDS Programme (MAP). One promising development has been the decision by the GF to invite National Strategy Applications from recipient countries, the purpose of which is to help eliminate parallel planning efforts and improve harmonisation among donors and other relevant health programmes (GF 2007b).

Strengthening health systems

The intense global focus on three diseases has led to concerns about other health priorities being undermined. The expansion of NGO-run projects has further fragmented already disorganised health systems. There is now recognition that general health systems weaknesses are constraining the scale-up of dedicated HIV/AIDS, TB and malaria programmes. So what is the GF doing to prevent the displacement of resources from other essential health services and to avoid undermining the longer-term agenda of health systems development?

At one point the GF had a stand-alone grant application process for ‘health systems strengthening’ (HSS). However, this was stopped due to views (mainly among external stakeholders) that the GF did not have the mandate or ‘comparative advantage’ to fund HSS.

Presently, the GF encourages applicants to budget for HSS activities within disease-specific grant proposals, but states that these activities must be ‘essential to reducing the impact and spread of the disease(s)’ (GF 2007c). The board has also decided that grants can be used to strengthen public, private or community health systems, but only if it helps to combat the three diseases (GFO 2007b). Examples of HSS actions given by the GF consist of activities that one would expect in any disease-based plan (e.g. training health workers, purchasing and maintaining diagnostic equipment).

On paper, therefore, the GF does not support the argument that because of the extraordinary money and public attention that have been captured by the 'big three' diseases, the GF should help strengthen the health system *as a whole* and for the benefit of other health needs.

However, the GF maintains a view that its grants naturally strengthen health systems by pointing, for example, to the huge investments in training health workers. In fact only a quarter of GF expenditure has been on 'human resource' line items, most of which has been training-related, with more than 80 per cent focused on clinical training targeted at the three diseases. By contrast, little has been directed at human resource (HR) recruitment or remuneration, or strengthening systems-wide HR management and administrative capacity. There has also been little analysis of the impact of GF spending on the 'internal brain drain' within countries.

The GF has also had the opportunity to support and strengthen procurement, logistics and supply systems within countries. But in many low-income countries, separate stand-alone systems for HIV/AIDS, TB and malaria supplies remain in place. While this makes sense from the perspective of disease-specific targets, it is also costly and inefficient and can ultimately delay the development of effective and efficient integrated systems.

On a positive note, a WHO report identified seven countries where GF grants were strengthening health systems (WHO 2007a). Most notable was a Round 5 Grant to Malawi, which was used to support a six-year, sector-wide HR programme. Other examples listed were Afghanistan's Round 2 proposal, which included interventions to build managerial and administrative capacity in the Ministry of Public Health; Rwanda's Round 5 grant, which helped expand community-based health insurance schemes, electrify health centres and support generic management training; Kenya's Round 6 proposal, which included plans to renovate a third of all public dispensaries, recruit 155 staff, strengthen district-level planning and management, and train laboratory technicians to provide an essential laboratory package; Ethiopia's Round 1 proposal for TB, which focused on improving drug supply management across the health system.

However, the effect of these grants on strengthening health systems cannot be assumed. For example, although the GF contributed to Malawi's sector-wide HR Programme, it is not known to what extent this has expanded HR capacity as a whole, or mainly expanded capacity for HIV/AIDS, TB and malaria services. The question of whether the privileged funding of these services has strengthened or weakened health systems overall has provoked fierce debates within the international health community. The answer, however, is likely to vary from country to country.



IMAGE DI.4.2
**Sign on tree
 in rural village**

Conclusion

This chapter has provided a broad-brush sketch of the Global Fund, placing it in the context of global health governance more generally, and of weak and fragmented health systems in low-income countries. Any recommendations about the GF have to take into account the many other actors within the global health environment, as well as the particular priorities and health systems requirements at the country level.

The GF has recently completed a strategic planning exercise which has resulted in a number of future plans (GF 2007b). First, the GF intends to grow over the next few years in terms of both the number of grants and its annual expenditure. It is projected that by 2010 the GF will be spending US\$8–10 billion per year, triple the level in 2006. Resource mobilisation efforts will become ever more important. At present it is unclear where this requirement for additional funding will come from.

But as the GF embarks upon Round 8, one is struck by the lack of debate about the optimum and appropriate size of the GF. Just how big should it become? Can it get too big? What should its size be relative to that of other agencies? What will be the opportunity costs associated with the tripling of expenditure from 2006 to 2010? Can it have too many grants spread across too many countries? There are currently 517 grants spread across 136 countries – why so many countries? Would it be prudent to focus attention on a smaller number of ‘struggling’ countries or on high-burden countries? Should its remit be extended to include a broader set of diseases? Should it become a global fund for health systems in general?

Another issue for the GF (together with other initiatives) is its impact on health systems, particularly in relation to five interconnected issues:

- ensuring appropriate, coordinated, country-led and sector-wide health planning and management;
- fixing the current Balkanisation of health systems by bringing order to the disjointed and vertical projects and programmes;
- harnessing the large and unregulated commercial sector to serve the public good;
- reducing the inequity between urban and rural populations, between rich and poor, and between privileged and unprivileged diseases and illnesses;
- guarding against an inappropriate overconcentration on medical technologies and products at the expense of health promotion and tackling the social determinants of ill health.

The GF can and should play a more responsible HSS role in many more countries, especially where it accounts for a significant proportion of public health expenditure. In these countries, the GF should explicitly encourage HSS activities that will improve services for HIV/AIDS, TB and malaria, but only in a way that simultaneously strengthens the whole health system.

Even the Fund's Technical Review Panel (TRP) noted that of the \$2,762 million approved for Round 7 grants, only 13.1 per cent was targeted towards HSS actions, and that there was an opportunity to do more in this area (GFO 2007c). It also felt that many of the proposed HSS actions were focused on the immediate obstacles to health-care delivery, and not enough on planning, financing and other more upstream actions. The TRP therefore recommended that the GF provide intensive technical support on HSS for Round 8 and add health systems indicators to the monitoring and evaluation framework (GFO 2007c).

The GF must avoid creating perverse incentives through its target-driven approach. Coverage targets must not be set in a way that overemphasises numbers 'treated' or 'reached' at the expense of measures of quality, equity or sustainability. The short and quick route to expanding coverage is not always the best route to take in the long term. While it is best to 'raise all boats' rather than to pull back on services for HIV/AIDS, TB and malaria, there must be stronger guarantees that other priority health services are not being harmed.

The GF can help by encouraging better monitoring and research. The difficulties of having to make choices between the three diseases and the health system as a whole, or between short-term/emergency demands and long-term development needs, will be eased with better data. The GF can

also insist on proposals being demonstrably aligned to sector-wide plans or health systems policy. In the long run, the GF should also consider what proportion of its grants should be pooled into sector-wide budgets and set itself some targets accordingly.

In late 2008, a Five Year Evaluation of the Fund is due to be published. In spite of the evaluation being one of the biggest ever commissioned, there are two limitations. First, it is largely reliant on retrospective study methods. Second, it does not address the specific question of the GF's impact on the wider health system.

Interestingly, national debates on the relative priorities of treatment versus prevention have subsided. Although there is consensus that both treatment and prevention are important, and furthermore are interlinked, it is not clear whether the optimum balance between different treatment and prevention strategies has been achieved within countries. The GF's expenditure pattern appears to reflect an emphasis on treatment over prevention. Although there are methodological difficulties in generating the data to determine if this is true or not, it is important to keep asking the question, if only to ensure that careful thought and consideration continue to go into the process of priority-setting.

When all Round 1 to 6 grants are taken into account, 48 per cent of the GF's budget is allocated to drugs, commodities and other products. Most of the 22 per cent of expenditure on human resources is used to train existing health workers to use these drugs, commodities and products. A further 11 per cent is allocated to infrastructure and equipment. Such facts, particularly in light of the heavy involvement of the private sector, must raise further questions about the broader orientation of the GF response to HIV/AIDS, TB and malaria. Is it overly biomedical? Does it reflect the lessons learnt about achieving 'good health at low cost' from countries and settings such as Sri Lanka, Costa Rica and Kerala?

It would not be appropriate to make a list of concrete recommendations to the GF given the need to bring greater coherence and order to the broader global health landscape. However, this chapter aims to provide a good description of a new actor on the global scene and raise some useful questions, in the hope that the relevant actors will seek out the correct answers.

Notes

1. This figure makes a number of assumptions about grant approvals, renewal and disbursement rates and other variables. But it shows the general trend of an increasingly steep rise in both commitments and disbursements.
2. Total health expenditure refers to all spending on health, including by private individuals. Public Health Expenditure refers to spending by public bodies only,

such as the Ministry of Health. However, some funding may have originated from external donors. For example, Burundi spent \$18 million through the Ministry of Health between 2003 and 2005, \$14 million of which was sourced from the GF (the GF spent \$7 million elsewhere in the health economy through private organisations in this time).

3. www.who.int/3by5/newsitem9/en/.

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