The Global Fund: managing great expectations

Ruairí Brugha, Martine Donoghue, Mary Starling, Phillimon Ndubani, Freddie Ssengooba, Benedita Fernandes, Gill Walt

Lancet 2004; 364: 95–100

Department of Public Health Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK (R Brugha MD, M Donoghue PhD, M Starling MSc, Prof G Walt PhD); **Institute of Economic and Social Research, University of Zambia, Zambia** (P Ndubani PhD); **Institute of Public Health, Makerere University, Uganda** (F Ssengooba MPH); **and National Institute of Health, Mozambique** (B Fernandes MM)

Correspondence to: Ruairí Brugha
Ruairi.brugha@lshtm.ac.uk

The Global Fund to fight AIDS, Tuberculosis, and Malaria was created to increase funds to combat these three devastating diseases. We report interim findings, based on interviews with 137 national-level respondents that track early implementation processes in four African countries. Country coordinating mechanisms (CCMs) are country-level partnerships, which were formed quickly to develop and submit grant proposals to the Global Fund. CCM members were often ineffective at representing their constituencies and encountered obstacles in participating in CCM processes. Delay in dissemination of guidelines from the Global Fund led to uncertainty among members about the function of these new partnerships. Respondents expressed most concern about the limited capacity of fund recipients—government and non-government—to meet Global Fund conditions for performance-based disbursement. Delays in payment of funds to implementing agencies have frustrated rapid financing of disease control interventions. The Global Fund is one of several new global initiatives superimposed on existing country systems to finance the control of HIV/AIDS. New and existing donors need to coordinate assistance to developing countries by bringing together funding, planning, management, and reporting systems if global goals for disease control are to be achieved.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria was established in January, 2002, to attract, manage, and disburse additional resources worldwide to control these three diseases, which are having a devastating effect in poor countries, especially in sub-Saharan Africa. The Global Fund is an independent organisation, governed by a board of 18 voting and five non-voting members and supported by a secretariat of about 70 staff in Geneva. Countries apply for fund support by submitting proposals, which are reviewed by a technical review panel of independent experts and considered for approval by the board. By March, 2004, pledged donations were far short of the additional annual US$22 billion in donor aid, of which US$8 billion should go through the Global Fund, recommended by the WHO Commission on Macroeconomics and Health.[1] Countries applied for Global Fund support in March, 2002, September, 2002, May, 2003, and April, 2004. 121 received approval for about US$2 billion over 2 years, for rounds one to three.[2] By March, 2004, two-thirds of approved countries had signed grant agreements, and around US$260 million had been disbursed.[3] So far, sub-Saharan Africa has been approved for over half the committed funds, with about 60% earmarked for HIV/AIDS activities.

If donations to the Global Fund are sufficient, the achievement of its goal will be dependent on the effectiveness of individual country systems and the new structures that recipient countries are required to have in place to manage funded activities; these include a country coordinating mechanism (CCM), principal recipients, and a local fund agent.[3] The CCM is a country-level partnership that prepares proposals for Global Fund support and oversees implementation of successful applications. The Fund requires CCMs to include a broad representation from governments, non-government organisations, civil society, multilateral and bilateral agencies, and the private sector.[4] A principal recipient is a country organisation that receives funds, implements and monitors programmes, and is accountable for how funds are used. The local fund agent is an independent professional organisation, contracted by the Global Fund to provide oversight and verification of progress and financial accountability within the countries receiving funding.

Summary of study approach

- Semi-structured interviews done over 5 weeks in every country, from April 1 to July 31, 2003, with a common interview guide based on a review of Global Fund and other published and unpublished documents.
- CCM members named in round 1 proposals formed initial country sampling frames; CCM respondents were asked to name other government and non-government individuals with a major involvement in early national Global Fund processes or responsibility for implementing funded proposals.
- 137 national-level respondents across the four countries, covering an average of 65% of CCM members and including senior technical staff responsible for HIV/AIDS, tuberculosis, and malaria control (see table 2); only one refusal.
- Data were recorded mainly by note taking with some interviews tape recorded; researchers attended CCM and other national-level meetings as non-participant observers (table 2); a coding framework was devised based on a content analysis of interview transcripts.

Approach

We are tracking early implementation of the Global Fund in four sub-Saharan African countries: Mozambique, Tanzania, Uganda, and Zambia. Table 1 summarises the burden of disease due to HIV/AIDS, tuberculosis, and malaria in these countries and the outcome of country applications for Global Fund support. We selected these countries on the basis of high burden of disease and poverty, submission of proposals to the Global Fund in round one, support

	Mozambique	Tanzania	Uganda	Zambia
Population size (million)*	18	35	23	10
HIV prevalence†, 2001, in 15–49 year olds	13·0%	7·83%	5·0%	21·52%
Total amount (US$) approved by GFATM (aggregate of all awards across three funding rounds)	155 735 362	112 215 584	215 285 345	180 803 000
Successful applications across the three rounds				
HIV/AIDS	Round 2	Round 1and 3‡	Round 1 and 3	Round 1
TB	Round 2	Round 3‡	Round 2	Round 1
Malaria	Round 2	Round 1	Round 2	Round 1
Number of grant agreements signed for first 2 years of approved funding§	0/4	2/3	1/4	7/8¶
Number of principal recipients	2	2 (Round 1)	1 (Round 1)	4
Value (US$) of first 2 year contracts on approved grants				
HIV/AIDS	29 692 640	5 400 000 (√)	36 314 892 (Round 1) (√); 70 357 632 (Round 3)	42 298 000 (√)
TB	12 191 334	23 951 034	6 841 561 (Round 2)	14 755 256 (√)
Malaria	12 273 573	11 959 076 (√)	23 211 300 (Round 2)	17 891 800 (√)
Proportion of first 2 years' disbursement (as of November, 2003)				
HIV/AIDS	0%	33%	0.8% (Round 1); 0% (Round 3)	5%
TB	0%	0%	0%	10%
Malaria	0%	4%	0%	27%
First disbursement received (date)				
HIV/AIDS	..	Oct 17, 2003	May 2, 2003 (Round 1)	July 18, July 21, 2003 for 3 of 4 PRs
TB	..	..	..	July 18, July 21, 2003
Malaria	..	Feb 4, 2003	..	Aug 27, Oct 10, 2003
Government annual health expenditure per capita (US$)‖	9	12	10	18
Annual average GFATM budget per capita (US$)**	1·7 (5 year average)	0·64 (5 year average)	2·3 (4 year average)	3·6 (5 year average)

GFATM= Global Fund to fight AIDS, Tuberculosis, and Malaria; TB=tuberculosis; PR=principal recipient; √=grant agreement signed. *Source: World Development Report 2004. Making services work for poor people. The World Bank. †Source: Human Development Report 2003. Millennium development goals: a compact among nations to end human poverty. http://www.undp.org/hdr 2003. ‡HIV/AIDS and TB application in round 3 submitted as an integrated proposal. §Countries have to satisfy technical review panel queries and the assessment of principal recipients as a precursor to grant signing—currently 'not signed' contracts are going through this process. ¶Disease specific money is divided between multiple Principal Recipients in Zambia hence the larger number of grant agreements to be signed—for example, there are 4 different Principal Recipients for the funds allocated to HIV/AIDS alone and this requires four separate contracts to be signed. ‖Source: 2003 World Development Indicators. The World Bank. Note: Data are for the most recent year available during the period 1997–2000. **Calculated as a annual average on total amounts requested for approved applications. Where grant time spans differ within countries the annual average GFATM budget was calculated for the span between the start of the first grant and the completion of the last grant. A grant life span was considered to start from the year of grant signing—where grant agreements were not yet signed (eg, round 3 grants), these were assumed to start in 2004.

Table 1: **HIV prevalence and details of Global Fund awards by country, for rounds 1–3 (December, 2003)**

from senior government officials, and study sponsors' longstanding involvement in support of these countries in implementation of a sector-wide approach to coordinate support for the health sector.[5] Sector-wide approaches have been strongly promoted in sub-Saharan Africa since the mid 1990s, especially by several European bilateral donor agencies, as a mechanism for reducing fragmentation and duplication of assistance to developing countries through pooling of donor funds, strengthening country coordination of policy making and planning, and agreed systems for monitoring funds and health sector activities.[5]

We aim here to provide a country perspective on the coordination of the Global Fund with existing systems, in countries implementing a sector-wide approach. The rationale for country selection is that, as a new and potentially vertical financing mechanism, the Global Fund could conflict with, but could also provide support to, country-level sector-wide approaches. We report interim findings of country experiences of running CCMs, challenges to fund disbursement, and efforts to manage multiple new global health initiatives. The panel summarises the sampling and data collection processes; and table 2, the numbers and categories of national-level respondents across the four countries.

Participant's views

After three application rounds, all four countries were approved for high levels of support to fight the three diseases (table 1). Despite the positive effect that additional money could have on resource-starved systems, the Global Fund received a mixed welcome in these countries. Governments and non-governmental organisations (NGOs) were most positive. For example, a government respondent in Zambia reported that "the beauty of the process from a country perspective is that it is country led. We haven't had that level of autonomy before to decide which interventions we want, which systems to use, and how we wanted to strengthen ourselves." An NGO respondent in Mozambique, making the case for funding such organisations, stated "there is a big gap in HIV/AIDS funding [and] there are many capable NGOs out there with capacity to do something. If you have to wait for the system to improve, without trying first, people will die in the interim." Country representatives of bilateral donors

	Mozambique	Tanzania	Uganda	Zambia
Total individuals interviewed	43	26	35	33
Government				
Ministry of Health	8	6	8	2
Other line ministries (eg, Education, Finance)	5	5	4	6
NGOs (national and international), faith, private sector and community-based organisations†	14	2	9	8
Academics			2	1
Technical agencies (eg, WHO, CDC)			3	4
Principal recipients				3
Local fund agent‡	-	1	1	1
Bilateral agency representatives	8	7	4	7
Multilateral agency representatives	8	5	4	1
Percentage of CCM interviewed	85%	30%	73%§	71%
Direct observation	2-day joint review and donors meeting	Round 3 proposal process over 2·5 weeks and CCM meeting	One CCM Meeting & a UN/bilateral meeting	-

NGO=non-governmental organisation. *Interviews with CCM members and non-CCM members. †Included representatives from traditional healers and media in Zambia. ‡No local fund agent had been appointed in Mozambique. §Denominator used in this calculation was 26 CCM members—the two newly appointed representatives of people living with HIV/AIDS were not included.

Table 2: **Interviews by respondent category and country***

supporting the sector-wide approach were often sceptical of the Global Fund, suggesting that it is was "reverticalising" health systems and "forcing a disease-specific approach". In three countries, one or more bilateral-donor respondents perceived differences between them and their headquarters, who they saw as more supportive of the Global Fund. The views of local donors contrasted with the Global Fund's perception that it was providing flexible funding support, which could pass through the sector-wide-approach.[6]

Country coordinating mechanisms

CCMs were established in all four countries, in early 2002, as a condition for submitting proposals; countries were given less than 6 weeks to the round 1 application deadline. A comment by a Zambian respondent was indicative of the perception across the four countries: "[The] CCM was formed in response to the dangling of dollars." All CCMs had a broad range of the relevant constituencies, including high-level political representation (table 3). In three of the countries, the government selected representatives to sit on the CCM, whereas in Mozambique, constituencies selected their own representatives, which was regarded as an improvement on previous practices (government had selected such representatives). Although pre-existing national AIDS councils were not judged by some respondents to be appropriate bodies to serve as CCMs—because they represented only one of the focal diseases—they became the core group to which other members were grafted. This was consistent with the Global Fund's preference for the CCM to be "an already existing body".[4] Similar constituencies were represented on AIDS councils and CCMs, the principal difference being that CCMs had an additional remit for the control of malaria and tuberculosis. In Uganda and Tanzania, CCMs doubled in size over the subsequent 15 months. Additional CCM representatives were often co-opted in a deliberate effort to make CCMs more inclusive and to strengthen particular constituency voices, notably NGOs and those living with HIV/AIDS.

Difficulties in the functioning of CCMs, especially of representation and participation, were reported in all countries. CCM members and non-members reported that constituency consultation was usually poor and hindered by lack of time and resources, poor communication infrastructure, inconsistency in attendance at CCM meetings, work overload, and ineffective delegation. In Tanzania, senior government officials frequently delegated attendance at CCM meetings to

	Mozambique (n=13)	Tanzania (n=30)	Uganda (n=28)	Zambia (n=21)
Ministry of Health	2	1	4	1
Government – other ministries	4	10	9	5
NGO & community-based organisations	2	10	3	5†
Private-for-profit	1	2	2	1
People living with HIV/AIDS	1	1	3	1
UN/multilateral agencies	1	1	3	2
Bilateral agencies	1	3	2	2
Academia	0	0	1	2
Faith based organisations	1	2	1	2
CCM Chairperson (specify sector/position)	Minister of Health	Permanent Secretary, Prime Minister's office*	Director General, Ministry of Health	Permanent Secretary, Ministry of Health*

*There has been one change in CCM Chairmanship in Tanzania and Zambia since its inception. †Included representatives from traditional healers and media in Zambia.

Table 3: **Composition of country coordinating mechanism, in May, 2003, by country**

mid-level staff. A drawback in all countries was reported by a multilateral-agency representative from Zambia: "The CCM consists of individuals. There are no structures for within-constituency representativeness and consultation." However, there were some reports of effective representation. For example, an umbrella body for international NGOs in Mozambique, which had a seat on the CCM, was praised by other NGOs for representing and providing feedback to its constituency through e-mail discussions. This body attributed its efforts to regular reminders by the CCM chair to participants to seek the views of their constituencies, which emphasises the importance of CCM leadership.

In three countries, participation in CCM meetings and decision-making processes was viewed by many respondents as poor, with government seen as overly dominant. However, in Mozambique CCM attendance was reported to be regular and consistent, reasonably equal between constituency groups, and discussions were mostly robust and open. Respondents thought that a public airing of views after a contentious CCM process during the round one application had contributed to a new willingness of all partners to work together. An NGO representative in Tanzania, expressing a view also held by many non-government representatives in Uganda and Zambia, said "it feels like a government CCM, not a country coordinating mechanism. There is an imbalance of power in favour of [government], which is talking only on behalf of government. . . Civil society is not willing to talk openly." A government respondent attributed government dominance, in part, to the imposition of the notion of CCMs on the country: "the whole process is like a carpet wedding [ie, a shotgun wedding]; that is, participants are forced to work together."

Efforts were made to improve CCM processes—eg, in Zambia, a donor offered funds to strengthen communication networks. However, CCM members in Tanzania and Uganda reported that difficulties persisted into the round three application process during May, 2003, when they had only 48 h to review draft proposals. Uganda's CCM was described by several respondents as a signing ceremony group. At the time of the field work (mid 2003), CCMs still had no detailed terms of reference and many members were uncertain about the function of these new Global Fund country structures. A respondent in Zambia stated "the role of CCM is not clear after signing. We haven't come together since the signing—what will we be talking about when we meet? We don't control resources." The Global fund had not yet disseminated guidelines for CCMs[7] to those who were successful in the first round of applications 1 year earlier. Although the Global Fund was showing a commendable willingness to learn and incorporate lessons from country experiences, rapid rolling out of new structures without adequate guidelines led to confusion among some CCM members.

Disbursement

The main concerns across all four countries in mid 2003, was the delayed disbursement of funds and difficulties in managing evolving Global Fund processes, as reported by a government respondent in Zambia: "Fast disbursement so far has not happened. The Global Fund has changing information needs and this makes it difficult and frustrating for countries as more [information] keeps being requested." Governments and NGOs reported frustration in having to seek alternative funds because of disbursement delays. High expectations of rapid funding, when grant approval the previous year had received much national media attention, led to a crisis of expectation in the four countries. A principal recipient in Zambia reported: "People are aware there is money and there are problems of expectation. Now people are wondering where is the money? and are they sitting on the money?" The first of the four countries to sign a grant agreement (November, 2002) was Tanzania, one of four fast-tracked countries. A year later, the Global Fund website reported a 4% disbursement on its round one US$12 million malaria grant (table 1).

Respondents in all four countries—government, donor, and local fund agent representatives—expressed concerns about the capacity of principal recipients to meet Global Fund milestones for disbursement and then to monitor the performance of fund recipients. A government respondent in Tanzania, interviewed in May, 2003, cautioned against expectations of rapid disbursement within countries saying "there probably will be delays, as we need dialogue with districts and need to procure [commodities]. . . We may not be off the ground before Christmas 2003." Mechanisms for channelling funds to organisations, which would use these funds to deliver services, had not yet been tested. All countries judged that one of the biggest challenges would be in disbursing funds to numerous NGOs, in that many would not have the capacity to undertake quarterly reporting on monies spent and activities implemented.[8] A government respondent in Mozambique reported: "If we start to open all these accounts here we will not survive—all have different accounting and reporting procedures and timelines."

Systems fit

One or more government and donor respondents in all four countries mentioned other new global HIV/AIDS financing initiatives, which they saw as overlapping with the Global Fund and as creating a coordination problem. These included the World Bank Multi-sectoral AIDS Program (MAP),[9] the Clinton Foundation,[10] and a forthcoming US President's initiative. Respondents in Mozambique were the most forthright in reporting the burden on government in negotiating with these different initiatives. A donor reported: "We spent 7 months last year on the Global Fund, 8 months on the

Clinton Foundation, and 3 months on MAP . . . it is not surprising we talk of capacity shortfalls." A senior government respondent in Mozambique stated: "The whole thing is a huge juggling act." There were conflicting views in all four countries with regard to the respective roles of national AIDS councils and CCMs. National AIDS councils were seen by many as having greater legitimacy than CCMs usually underpinned by national legislation and with clearer lines of accountability to the President or Prime Minister. Others viewed the CCM as having a distinct remit that attempted to address the three diseases. In all countries, the Global Fund and other new sources of funds for HIV/AIDS control seemed to be creating (or exacerbating) tensions between existing country-level bodies—ministries of health and national AIDS councils—over respective roles and control of funds.

Government and donor representatives emphasised the importance of complementarity, or integration of Global Fund resources into an overall resource envelope, to support coordinated national strategies. A government respondent in Zambia reported growing flexibility on the part of the Global Fund: "We wanted to use [the] Global Fund to strengthen our systems and capacity but the Fund saw this as too broad. Now they are learning to be more flexible. We operate a SWAp [sector-wide approach] in the health sector. Global Fund money will now go through SWAp. This has been agreed." Others, often donors but also some government respondents, were still concerned that the Global Fund process might require parallel monitoring and evaluation reporting systems, undermining the coordination of health systems. The biggest obstacles to successful implementation were anticipated to be the Fund's reporting requirements,[8] the limited capacity of long under-resourced systems to absorb and rapidly spend very large levels of resources effectively, and inadequate numbers and ability of health workers to manage the delivery of antiretroviral treatment. In mid 2003, these four countries had yet to develop guidelines on access to antiretroviral treatment, generating fears—especially in people living with HIV/AIDS—that poor rural dwellers and women would be neglected.

Early lessons

The Global Fund is an evolving initiative, which has made a major financial commitment to help countries to tackle HIV/AIDS, tuberculosis, and malaria. Still at an early stage, it is too soon to estimate its effectiveness. Rapid learning and applying lessons to get country-level processes right, are essential to achieving the Fund's goals. For example, the Fund now acknowledges that countries operating sector-wide approaches were not always clearly informed that this was a channel through which its support could flow.[11] The dilemma for the Global Fund has been how to balance the urgent need to control these diseases against the time needed for countries to learn how to manage a new financing mechanism. An important milestone for recipient countries in late 2004 and 2005, will be the requirement for CCMs to assess and report on the performance of principal recipients over the initial 18–24 months of grant implementation, which will determine the level and pace of further disbursements. CCMs could experience difficulty maintaining the necessary independence for this role when the principal recipient is a senior government ministry sitting on, and sometimes chairing, the CCM. Several issues should be considered in the interpretation of our findings: (1) they are not necessarily representative of other countries receiving Global Fund support, although quite similar experiences of CCM processes have been reported from several sub-Saharan African countries;[12–14] (2) they report country-level views rather than facts; (3) with qualitative methods, keeping bias to a minimum partly depended on the researchers' judgment in identifying where there was consensus among different respondents; and (4) the findings are based on fieldwork undertaken 1 year ago on what is a rapidly changing process.

Mozambique, Tanzania, Uganda, and Zambia are among the poorest countries worldwide, with health systems long starved of resources, which meant that their governments did not feel that they could forego a new funding opportunity. A pervasive impression in these countries was that the capacity of governments and their partners was being over stretched. The Global Fund was just one of several new initiatives that these countries were hosting, which were superimposed on pre-existing funding and partnership processes. A survey of donor practices in 11 recipient countries ranked the five highest burdens for countries as: donor-driven priorities and systems, difficulties with donor procedures, uncoordinated donor practices, excessive demands on time, and delays in disbursements.[15] The need for greater donor coordination and commitment to enhance harmonisation[15] has become a mantra in international policy circles.[16] Yet, the funding environment at the country level grows more complex, and processes that facilitate or constrain the effectiveness of development assistance at the national level, and in interactions between countries and international funding agencies, are not well understood.

We have elucidated processes specific to the Global Fund. Representation of the different constituencies on CCMs was helped by representative umbrella bodies and communication networks—two areas in which donors could invest—but also required a willingness among representatives to speak for the interests of fellow constituents. The principles of partnership seemed sometimes to be subsumed by competition for scarce resources between government and non-government bodies committed to controlling HIV/AIDS. CCMs were new entities and there was tension in their organisational fit and function within

overall national AIDS authority frameworks. If countries were able to manage these tensions, there was a greater likelihood that much needed resources for AIDS prevention, treatment, and care would be used effectively. Partnerships between government and civil society are an opportunity to widen country-level commitment to intersectoral action.[17] However, this will require increased understanding of constraints to forming true partnerships; organisation and capacity building of civil society are required if its needs are to be represented at the national policy level.

The four countries we report were attempting to put in place new and untested systems for disbursing funds. The pressure to show results through performance-based disbursement is understandable, as a prerequisite for accountability. A similar condition underlies the Fund's own relation with its contributors, in that its ability to attract additional contributions will depend on it showing results.[11] Excessive or too frequent reporting requirements will be beyond the capacity of countries with weak systems that have the greatest need for additional funds.[18] Building capacity and agreeing to systems that do not overstrain that capacity are essential if donor expectations of accountability are to be realised. The Global Fund has an understandably high profile in recipient countries, bringing in much needed resources to tackle three major diseases. It has also generated great expectations of rapid disbursement of new funds, especially among people living with HIV/AIDS who require access to antiretroviral drugs. Managing and fulfilling these expectations in the face of weak health systems, limited capacity, and competing demands are major challenges for governments, partners, and the Global Fund.

Contributors

All authors contributed to the writing of this report. The study was designed by R Brugha and supported by G Walt. Martine Donoghue conducted the fieldwork in Uganda and Zambia, supported, respectively, by F Ssengooba and P Ndubani; and M Starling conducted fieldwork in Mozambique and Tanzania, supported by B Fernandes in Mozambique. Data analysis was done by M Donoghue, M Starling, and R Brugha and supported by G Walt.

Conflict on interest statement

None declared

Acknowledgments

This study was commissioned and jointly funded by four donors: Development Cooperation Ireland, the Danish Agency for Development Assistance, UK Department for International Development, and the Netherlands Directorate-General for International Co-operation. We thank all who contributed to this study, including Joseph Konde-Lule and staff at the Institute of Public Health, Makerere University, Uganda; Stephen Mwale and staff at the Institute of Economic and Social Research, University of Zambia; Julie Cliff of the University of Eduardo Mondlane; and Isabel Nhatave of the Ministry of Health, Mozambique; and CCM members and other key informants in Mozambique, Tanzania, Uganda, and Zambia who made time in their busy schedules to be interviewed. Global Fund Secretariat staff provided useful background documents and facilitated access to local fund agents. The selection and interpretation of findings are solely the responsibility of the authors. The sponsors set initial terms of reference for the study, advised on country selection, and facilitated country access. They had no involvement in study design, data collection, analysis, interpretation, report writing, or decision to submit this manuscript for publication.

References

1 Commission on Macroeconomics and Health. Macroeconomics and health: investing in health for economic development—report of commission on macroeconomics and health. Geneva: WHO, 2001.

2 http://www.theglobalfund.org/en/files/grantsstatusreport.xls (accessed Mar 18, 2004).

3 The Global Fund to Fight AIDS, Tuberculosis and Malaria. A partnership to prevent and treat AIDS, tuberculosis and malaria. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria, May 2003.

4 The Global Fund to Fight AIDS, Tuberculosis and Malaria. First Board Meeting, Jan 28–29, 2002. Framework document, GFATM/B1/Doc.4. 18.1.02. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria. http://www.theglobalfund.org/en/about/how/ (accessed May 12, 2004)

5 Cassels A, Janovksy K. Better health in developing countries: are sector-wide approaches the way of the future. *Lancet* 1998; **352:** 1777–79.

6 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Annual Report 2002/2003. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

7 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Guidelines on the purpose, structure and composition of country coordination mechanisms. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria, June 2003.

8 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Guidelines for performance-based funding. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria, July 2003.

9 World Bank Multi-sectoral AIDS Program. http://www.worldbank.org/afr/aids/map.htm (accessed Mar 18, 2004).

10 Clinton Foundation. http://www.pgaf.org/newsletter/issue01/clinton_partnership.html (accessed Mar 18, 2004).

11 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Seventh board meeting, Geneva Mar 8–19, 2004. Report of the Executive Director. GF/B7/3. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria.

12 Grace C. Global Fund country case studies report. Final draft: January 2003. DFID Health Systems Resource Centre, 27 Old Street, London, EC1V 9HL.

13 GAO. Global health: Global Fund to Fight AIDS, TB, and Malaria has advanced in key areas, but difficult challenges remain. US General Accounting Office, May 2003. http://www.gao.gov/new.items/d03601.pdf (accessed Mar 18, 2004).

14 Venetsanou E, Madeo M. In-depth assessment of Country Coordinating Mechanism and technical needs assessment in Swaziland, Dec 3–13, 2003 (unpublished report).

15 OECD. DAC guidelines and reference series: harmonising donor practices for effective aid delivery. Paris: Organisation for Economic Cooperation and Development, 2003.

16 Commission on Macroeconomics and Health. Development assistance and health: report of working group 6. Geneva: WHO, 2002.

17 Hanson K, Ranson MK, Oliveira-Cruz V, Mills A. Expanding access to priority health interventions: a framework for understanding the constraints to scaling-up. *J Int Develop* 2003; **15:** 1–14.

18 Brugha R, Starling M, Walt G. GAVI, the first steps: lessons for the Global Fund. *Lancet* 2002; **359:** 435–38.