Health Aid Governance in Fragile States: The Global Fund Experience

Olga Bornemisza, Jamie Bridge, Michael Olszak-Olszewski, George Sakvarelidze, and Jeffrey V Lazarus

Fragile states represent key challenges for global health governance. This study analyzes Global Fund grant data from 122 recipient countries as an initial exploration into how well these grants are performing in fragile states as compared to other countries. Since 2002, the Global Fund has invested nearly US$ 5 billion in 41 fragile states, and most grants have been assessed as performing well. Nonetheless, statistically significant differences in performance exist between fragile states and other countries, which were further pronounced in states with humanitarian crises. This indicates that further investigation of this issue is warranted: variations in performance may be unavoidable given the complexities of health governance in fragile states, but may also have implications for how the Global Fund and others provide aid. For example, faster aid disbursements might allow for a better response to rapidly changing contexts, and there may need to be more of a focus on building capacity and strengthening health governance in these countries.

INTRODUCTION

State fragility remains one of the most significant challenges for the well-being of affected populations, progress towards the Millennium Development Goals, and health and development donors. Fragile states–broadly definable as a state that "cannot or will not deliver core functions to the majority of its people, including the poor"[1]–are home to one-sixth of the world's population, but one-third of those living on less than US$ 1 per day.[2] These states often face the double challenges of fractured health systems and reduced capacity to absorb external funding. Violence, conflict, corruption, exclusion or discrimination of certain groups, and gender inequalities are also common characteristics.[3] These states carry a disproportionate burden of many health problems including HIV/AIDS, tuberculosis and malaria. For example, four fragile states (Democratic Republic of Congo, Nigeria, Sudan and Uganda) together account for 45% of the estimated malaria deaths among children in the world.[4] The greatest burdens in terms of maternal and child health are also found within fragile states.[5] Health aid in these countries is increasing, but is often fragmented between different donors and their programs.[6] This underlines the importance of effective health governance in these contexts. Health governance is defined by the World Health Organization (WHO) in terms of various key health-related state functions such as policy guidance, intelligence and oversight, collaboration and coalition building, regulation and incentives, system design, and accountability to the public.[7]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) was established in 2002 to raise and disburse substantial funding in order to achieve sustained impacts on the three diseases. By mid-2010, it had approved proposals worth US$ 19.3 billion: supporting tuberculosis treatment for seven million people, the distribution of 122 million insecticide-treated nets to prevent malaria, the

distribution of 2.3 billion condoms, and the delivery of 120 million HIV testing and counseling sessions. Global Fund-supported programs are also providing antiretroviral therapy to 2.8 million people.[8] Eligibility for Global Fund grants focuses on country income level and disease burdens rather than political factors, meaning that large investments have been made in fragile states, making health governance in these countries a key issue for the organization. The state has the main responsibility for governance, but non-state actors, including multilateral, regional and bilateral institutions as well as the private sector and civil society, are also important because they often play a major role in funding and providing services.

Previous research and analysis has found that the performance of Global Fund grants in fragile states is comparable to those in other recipient countries. In 2005, an analysis of Global Fund grants found that the 19 grants in fragile states at that time were performing comparably to the 55 grants in other recipient countries. None of the grants in fragile states had been discontinued.[9] Analysis in 2007 concluded that the performance-based funding model used by the Global Fund was working in, and did not penalize, fragile states and poorer countries.[10] This conclusion was reported again in 2010, with program results in fragile states "roughly in line with the monetary commitment," and grants in fragile states "performing only slightly less well than grants in other countries."[11] However, one external analysis in 2006[12] did find a link between grant implementation and political stability: countries with greater political stability (as defined by the World Bank) were more likely to have received a greater cumulative proportion of their total grant amount.[13] Overall, these previous studies suggest that state fragility itself may not be a barrier to the successful delivery of Global Fund grants, but that other linked factors, such as political stability and absorptive capacity, may be.

This article presents an exploratory study to re-test the hypothesis that state fragility itself is not a barrier to the successful delivery of Global Fund grants, and discusses the significance of the findings for the Global Fund. In doing so, it builds upon, and updates, previous research in order to provide further insight into the Global Fund approach and health governance in fragile states.

METHODOLOGY

A secondary analysis was conducted on routinely-collected Global Fund grant data. Table 1 lists the 122 countries which had received Global Fund grants by mid-2010 (excluding those that are only part of multi-country grants or grants that are only for specific territories). These countries were then divided into two groups: 41 fragile states and 81 other recipient countries. There are several lists and definitions of fragile states available in the international literature.[14] For the purposes of this analysis, fragile states included the 28 countries that have experienced humanitarian crises in the last five years, as documented by ReliefWeb in April 2010.[15] These crises may include, for example, national or regional conflicts or natural disasters such as earthquakes and floods. These 28 countries were then supplemented with the 13 additional countries which feature as "alerts" on the Failed States Index 2009 compiled by the Fund for Peace.[16] The Failed States Index scores countries against 12 indicators such as chronic and sustained human flight, economic decline, and the rise of factionalized elites. For each indicator, a score from 0 to 10 is allocated by the Fund for Peace, and countries with an aggregate score of over 90 are termed as "alerts."[17] The combination of these two sources of information was chosen primarily for its concurrence with internal (and unpublished) indices of risk and fragility that are used within the Global Fund for the purposes of grant management and strategic

planning. This approach for the study was also favored for its inclusiveness of different kinds of fragile state contexts. For the purposes of this analysis, countries were assessed in terms of their current status as fragile or otherwise: no consideration was given to changes in status since the Global Fund was founded in 2002, as these were perceived to be minimal. As a means of validation for this approach, only four of the countries with humanitarian crises in the last five years did not also appear as "alerts" on the Failed States Index (Mauritania, Rwanda, the Solomon Islands and Togo). In addition, 32 of the 37 entries on the World Bank's Harmonized List of Fragile Situations for 2010[18] are countries that have received Global Fund grants, and 25 (78%) of these appear in the list adopted for this analysis. The 41 fragile states were compared to the 81 other countries in terms of several descriptive variables: World Bank data on country populations,[19] UNAIDS data on national HIV prevalence,[20] World Health Organization data on national tuberculosis and malaria burdens,[21] and publically available Global Fund data in the grant portfolio of each country.[22] These data were selected to provide context for the remainder of the analysis. In order to best assess the performance of Global Fund grants, six different variables were selected upon which to compare fragile states with other recipient countries, and also to explore differences within the list of fragile states:

1. Percentage of Targets Reached: Each grant has a range of main program indicator targets (such as the number of condoms distributed or the number of people currently receiving antiretroviral therapy) against which the grant implementers must report to the Global Fund. The achievements of active grants with respect to these targets were analyzed (as an average percentage across the main targets) using one-sided t-tests.
2. Disbursement Rating: At the time of each funding disbursement, the Global Fund Secretariat rates each grant as A1 or A2 (exceeded or met expectations), B1 (performed adequately), B2 (potential demonstrated) or C (unacceptable). This rating is based on a range of factors including the achievements made against the grant targets, but also contextual considerations and the efforts that have been made to improve performance where needed. This rating then informs the decision to disburse additional funding. For the purposes of this study, grants were allocated into two groups based on their latest disbursement ratings, with A1, A2 or B1 indicating good performance, and B2 or C indicating weaker performance. Data were analyzed using Pearson's goodness of fit chi-square tests.
3. Phase Two Rating: All Global Fund grants are approved for an initial two-year period (Phase One) and then receive major reviews in their second year to inform decisions for further funding for the next three years (Phase Two). As at disbursement, each grant is rated as A, B1, B2 or C, and these ratings inform decisions to continue or discontinue funding at this stage. All grants (active and closed) which had reached their Phase Two review were included in this analysis and were divided into two groups: those performing well (i.e. receiving A or B1 ratings at Phase Two) and those performing less well (i.e. receiving B2 or C ratings). Data were subjected to Pearson's goodness of fit chi-square tests.
4. Continued Funding: After the five-year lifespan of a grant, applications can be made for continued funding for successful programs (through what is known as the Rolling Continuation Channel). The success rates of applications for continued funding were analyzed using one-sided t-tests.

5. M&E Ratings: In addition to the variables above, each grant is also given a rating by the Global Fund Secretariat in terms of the quality of monitoring and evaluation (M&E) systems. Based on the latest ratings allocated, both active and closed grants were divided into two groups: those performing well (i.e. receiving A or B1 ratings) and those performing less well (i.e. receiving B2 or C ratings). Data were analyzed using chi-square tests.
6. OSDV Ratings: Finally, the Global Fund also commissions independent third parties to perform on-site data verification (OSDV) exercises to assess data quality and reporting systems. Ratings of A, B1, B2 or C are allocated based on deviations. As above, active and closed grants were allocated into two groups: those whose latest available OSDV rating was A or B1, and those whose latest rating was B2 or C. Data were analyzed using chi-square tests.

RESULTS

The 41 fragile states (Table 1) were home to around 1.24 billion people or 19% of the world's population in 2008. However, these countries have a disproportionate burden of disease. It is estimated that 38% of the people living with HIV in 2007 (12.5 million out of 33.2 million people) resided in fragile states. Similarly, in 2008, these states accounted for 44% of the global tuberculosis prevalence, or an estimated 4.8 million cases (Table 2).

Global Fund Grant Portfolio

As of May 2010, there were 489 active Global Fund grants, of which 198 (40%) were in fragile states. The overall share of approved grants allocated to fragile states had not changed significantly since the Global Fund was established in 2002. Both fragile states and other recipient countries averaged between four and five active grants per country. Fragile states were twice as likely to have a multilateral organization, such as the United Nations Development Programme (UNDP), administering their grants than other recipient countries (Table 3). Further analysis identified 741 Global Fund grants for which disbursements had been made (including active and closed grants): 42% (314) in fragile states, collectively accounting for 46% of the total Global Fund disbursements by the end of May 2010. The remaining 58% (427) of grants were in other recipient countries and collectively accounted for 54% of the total Global Fund disbursements (Table 3). Grants in fragile states spent more on cost categories such as health products, infrastructure, medicines and procurement, and spent less on, for example, monitoring and evaluation, planning, technical administration and training (Figure 1).

Global Fund Grant Performance

In fragile states, active grants were, on average, achieving 83% of their agreed targets for main program indicators–slightly below the average for other recipient countries, which were achieving 88% of their targets. This difference was statistically significant, and was slightly more pronounced when considering grants in fragile states with humanitarian crises in the last five years (which achieved 80% of their agreed targets) (Table 4).Grant ratings at disbursement were available for 348 active grants, of which 137 (39%) were in fragile states. Among fragile states, 79% of grants had been rated as performing well (rated A1, A2 or B1), and 21% had been rated as B2 or C. Overall, grants in other recipient countries were rated as performing slightly

better, with 85% of grants rated as A1, A2 or B1 and 15% rated as B2 or C. This difference was nearly statistically significant (p=0.051). There was a significant difference between fragile states with humanitarian crises and non-fragile countries, the former accounting for 92 grants of which 69 (75%) were rated as performing well and 23 (25%) were not (Table 4). A total of 445 grants (including both active and closed grants) had undergone a Phase Two review: 176 (40%) from fragile states and 269 (60%) from other recipient countries. In fragile states, 123 grants (70%) were rated as performing well, and 53 (30%) grants received B2 or C ratings. Of these, seven grants (4%) had their funding discontinued at this stage. Among other recipient countries, 220 grants (82%) were rated as performing well, and 49 grants (18%) received either B2 or C ratings, of which three grants (1%) were discontinued. These differences were statistically significant, and even more pronounced when considering fragile states with humanitarian crises, which had 115 grants assessed, 35% of which were rated as B2 or C, and five of which were discontinued (Table 4).

A total of 209 grants had also applied for continued funding after their five-year lifespan (through the Rolling Continuation Channel): 79 (38%) from fragile states and 130 (62%) from other recipient countries. In fragile states, 14 of these applications (18%) were approved for funding beyond the initial five years, compared to 42 (32%) of the applications from other countries. This difference was statistically significant, and, again, was even more pronounced when considering fragile states with humanitarian crises, among which 55 grants had applied for continued funding, just seven (13%) of which were approved (Table 4).

In fragile states, the M&E systems of 96 disease programs from 37 countries had been assessed by May 2010. Forty-five of these programs (47%) received either A or B1 ratings, whereas 51 (53%) received either B2 or C ratings. In other recipient countries, the M&E systems of 132 disease programs from 62 countries were assessed: 89 (67%) received either A or B1 ratings and 43 (33%) received either B2 or C ratings. This difference in performance was statistically significant, with fragile states two times more likely to receive lower ratings (OR 2.3, 95% CI 1.4–4.0) (Table 4).

Finally, from the fragile states listed in Table 1, ratings for 484 programmatic indicators were available from on-site data verification exercises in 32 countries. From other recipient countries, ratings for 815 indicators from 63 countries were available. Analysis showed that the fragile states were twice as likely to have indicators rated as B2 or C (indicating poor data quality) compared to other recipient countries (OR = 2.0, 95% CI 1.6–2.6) (Table 4). This finding was repeated when analysis was applied individually to HIV/AIDS, tuberculosis and malaria grants (although statistical significance was not reached for malaria grants).

DISCUSSION

This study clearly demonstrates that fragile states are an important set of countries for the Global Fund. By mid-2010, the Global Fund had disbursed 46% of its overall funding to these states, which appears to be proportionate to the reported disease burden. Fragile states represent 34% of Global Fund recipient countries, but accounted for 40% of all active grants including more than half of the malaria grants, as many high malaria burden countries are also fragile states.

The study also demonstrates that Global Fund grants in fragile states, including those in states that have experienced recent humanitarian crises, were performing well overall across all six variables explored. This indicates that successful large-scale health programs, and the accountability and transparency that

this requires, can be achieved in fragile states (including countries with humanitarian crises), and that the Global Fund approach does not necessarily disadvantage these countries. For example, grants in fragile states were, on average, achieving 83% of their agreed targets in terms of main program indicators. This is similar to the previous findings from the Global Fund.[23] This study also showed that there was no difference between fragile states (including countries with humanitarian crises) and other recipient countries in terms of the percentage of submitted proposals which were approved by the Global Fund (Table 4)–implying that capacity exists within fragile states for proposal development and long-term strategic planning (although the role of multilateral partners and consultant proposal writers must also be acknowledged).

Contrary to previous analyses, however, this study identified statistically significant differences in performance between grants in fragile states and those in other recipient countries. Grants in fragile states were reaching, on average, a smaller proportion of their main agreed targets, were performing less well in their second-year review ratings, were less likely to be approved for funding after the initial five-year period, and were more likely to receive lower ratings for their M&E systems and data quality. In addition, a smaller percentage of grants in fragile states were rated as performing well at the time of funding disbursements and, of the ten grants that had been discontinued after the second year by the Global Fund (as of May 2010), seven were in fragile states. The outcome of this exploratory analysis may vary from that of previous findings due to differences in how fragile states were defined. Also, previous research tended to focus solely on Phase Two review ratings as a measure of performance (rather than the six variables employed here), and the Global Fund grant portfolio itself has grown considerably since 2005, meaning that statistical differences in performance may have only recently become apparent.

The differences in grant performance identified in this study became more pronounced in the fragile states with humanitarian crises in the last five years, many of which are conflict-affected. For example, of the ten grants that had been discontinued after the second year, half were in countries with humanitarian crises. By contrast, those countries within the fragile states without humanitarian crises in the last five years appeared to be performing as well as, if not better than, other non-fragile recipient countries. It is, however, important to note that the majority of grants in fragile states with humanitarian crises were still performing well: they were reaching, on average, 79.6% of their agreed targets, and three quarters of them received A or B1 ratings at the disbursements stage. Further analysis is required to better explore factors within the 41 fragile states that may impact on grant performance, such as the degree or duration of state fragility or the type of crises being experienced. However, based on the exploratory analysis presented in this article, some initial hypotheses are discussed below.

Possible Reasons for Differential Performance

There could be several explanations for the differences found between fragile states and other recipient countries in grant performance. However, it is not possible from this preliminary and univariate data analysis to ascertain precisely why this may be the case: multivariate analyses should be employed to try to develop our understanding. For example, does the type of organization implementing the grant (such as a governmental body as opposed to an international third party) make a difference to grant performance? What aspects of state fragility, such as conflict or recurrent natural disasters, have an impact on performance? Previous research has

identified links between the improved implementation of Global Fund grants and greater political stability in low-income countries.[24] This would suggest that countries in conflict, which are inherently politically unstable, would perform worse than those with natural disasters.

Another explanation for differential performance could be that fragile states are more likely to experience corruption. For example, corruption is often a "by-product of poverty."[25] and poverty is closely associated with state fragility. This can be expected to impact program management, delivery and performance. By 2010, so-called "firm action" (such as grant suspensions or early grant terminations) had been taken by the Global Fund in four of the 41 fragile states: Chad, Mauritania, Myanmar and Uganda. By contrast, only two of the 81 other recipient countries had been the subject of such action (the Philippines and Zambia).[26]

Links between Global Fund grant performance and health governance at the country level also warrant exploration. This study suggests that humanitarian crises, many of which are conflict related, may be one of the key factors in grant performance. It is well documented that conflict can have a major impact on disease burdens, and mortality in conflict areas can be two or three times more than in non-conflict areas.[27] Conflict can also cause or exacerbate health inequalities.[28] For example, conflict situations are closely linked to inequalities among refugees and displaced populations, groups which were only accounted for in a minority of Global Fund grants in these countries, according to a recent external analysis.[29]

Against this context of increased disease burden and inequity, conflict poses complex challenges for health governance. Conflict isolates and demotivates health professionals, and greatly weakens government institutions and non-state actors (such as civil society organizations and academic institutions) that help to set policy and regulate, finance and manage health service delivery. These situations are also often associated with fluid and rapidly altering political contexts and changes in leadership.[30] Such institutional weaknesses may hinder Global Fund grant management, service delivery and capacity, and help explain why Global Fund grants in countries with humanitarian emergencies performed less well than grants in other countries.

Global Fund policy requires multilateral organizations to administer grants in countries which lack local capacities.[31] UNDP in particular has a standing arrangement with the Global Fund as a "last resort" grant recipient.[32] This helps explain why two-thirds of grants in fragile states were run by multilateral organizations compared to 32% of grants in other recipient countries (Table 3). In these cases, the multilateral organization is normally expected to strengthen local capacities and then hand over administrative responsibilities to national bodies once sufficient progress and capacity was established (as has been the case in Burkina Faso, Central African Republic, Cote d'Ivoire and Guinea-Bissau). However, working with third parties such as multilateral agencies is likely to have implications for health governance at the country level, as institutional capacity could remain weak when state institutions are not fully engaged.[33] There is a lack of consensus on whether or not the engagement of international third parties as opposed to governments is the best way forward in settings of lower political stability.[34] It should also be noted that the governance of Global Fund grants does not necessarily reflect the capacity of the overall health governance system at the country level, as a strong Principal Recipient[35] can exist in a weak governance environment. More work should be done on whether and how institutional capacity is developed by the presence of multilateral organizations as grant implementers in fragile states; this work requires a long-term perspective, as institutional and economic recovery can take decades.[36]

Finally, it must be acknowledged that it is perhaps inevitable for some grants in fragile states to perform less well, regardless of the funding model or approach taken, due to their inherently difficult operating environments. Fragile states, especially those experiencing humanitarian crises, may opt for a more reactive, responsive approach to health governance: one focused on immediate emergencies and challenges rather than longer-term strategizing and development. This may make it more difficult to implement five-year health programs such as those supported by the Global Fund.

Implications for the Global Fund

Overall, the findings from this study raise important questions for the Global Fund in terms of how it can improve its aid and support for fragile states. However, this is just an initial and exploratory analysis of grant data and further work is required to better understand the findings. This should, for example, examine how health governance, especially the institutional capacities of state and non-state partners, relates to Global Fund grant performance. For instance, how does the capacity of Country Coordination Mechanisms,[37] the Ministry of Health, multilateral organizations and other key non-state actors affect the planning, implementing and monitoring of grant performance? This work ties into the broader debate around state-building in the health sector and how support to the health sector can help strengthen the relationships between state and society, and possibly enhance state stability.[38]

Although the majority of grants were performing well, the significant differences in grant performance present a challenge for the Global Fund. It is well documented that fragile state contexts require sustained and carefully tailored approaches,[39] but there has been much debate about the best ways to engage with and provide support to these countries, particularly to improve health governance.[40] Despite a lack of consensus, the risk of failure in these countries is clearly overridden by the potential costs of inaction,[41] especially as improvements in governance and service capacity may help to reduce state fragility itself.[42] With this in mind, the OECD Development Assistance Committee (DAC) has developed a series of Principles for Good International Engagement in Fragile States and Situations,[43] many of which are congruous with the Global Fund's founding principles.[44] For example, the DAC principles 1 ("Take context as a starting point") and 7 ("Align with local priorities") appear to fit well with the Global Fund focus on country-driven demand: in almost all cases, proposals to the Global Fund are developed and submitted by multi-stakeholder Country Coordinating Mechanisms. Similarly, the DAC principle of continued, predictable engagement and funding fits well with the five-year life-span and regular disbursement of Global Fund grants. Sometimes, however, the DAC Principles may be difficult to adhere to. For example, with regards to Principle 6 ("Promote non-discrimination [of women, youth, and minority groups] as a basis for inclusive and stable societies"), refugees and internally displaced populations are currently discriminated against as they are not included in disease strategies and are under-represented in proposals to the Global Fund.[45] In addition, for Principle 9 ("Act fast"), the average time between approval for grant funding and first disbursement is currently 11 months. If Global Fund processes were improved to better reflect all of the DAC principles, this could better serve fragile states. For example, it has been recommended that HIV/AIDS programs from all donors in conflict-affected countries focus on basic prevention and treatment services through simplified and accelerated funding processes,[46] and the same message could easily be

extended to tuberculosis and malaria as well. It has also been recommended that the Global Fund promote the inclusion of refugees and internally displaced populations into national disease strategies and Global Fund proposals, and allow for greater flexibility to prioritize and transfer funds to these populations as needed (for instance, in response to new rounds of displacement due to outbreaks of fighting or natural disasters).[47]

Limitations

This exploratory study has a number of important limitations. First, it relies on the secondary, univariate analysis of routinely collected grant data. Such data can present an indication of the situation in countries, but not with the same depth as qualitative assessments or field work.[48] Second, this study is based on a list of fragile states drawn from ReliefWeb and the Fund for Peace, which were chosen and combined to closely reflect internal indices of risk and fragility that are used within the organization. There are several lists and definitions of fragile states available in the international literature, with most donor agencies having their own,[49] but no universal consensus on the best list to use. Different results would likely have been obtained if an alternative fragile states list had been compiled or used. Third, differences in grant performance (as reported here) do not necessarily translate into numbers of services delivered or people reached. A Global Fund grant that is performing well against its targets is not necessarily providing more (or better quality) services than a grant which is not, as each grant has country-set targets designed for the local context.

CONCLUSION

In conclusion, the Global Fund has invested heavily in fragile state, with nearly US$ 5 billion disbursed by mid-2010. The majority of these grants, including those in countries with recent humanitarian crises, are performing well and are reaching a large proportion of their targets. This indicates that demand-driven, performance-based financing, such as that provided by the Global Fund, can be successfully used to support the delivery of critical health programs in fragile states. Nonetheless, it would also appear that the performance of grants in fragile states, and particularly those with humanitarian crises, is lower than that of grants in other recipient countries. Weak performance may be caused by myriad challenges and complexities of health governance in fragile states. This has implications for the Global Fund as it seeks to provide better support in fragile state contexts. For example, more focus could be given to speeding up aid disbursement, allowing grants to be more responsive and opportunistic to changing contexts and crises, and to building capacity and strengthening the governance of health systems in these countries.

Further exploration, including multivariate analyses and fieldwork, is required in order to better assess the implications for the Global Fund, its partners and other stakeholders, and to inform discussions about potential responses and actions that need to be taken. International aid is just one component of efforts in fragile states,[50] but the performance of these investments has many implications for the fight against HIV/AIDS, tuberculosis and malaria, for global health governance, and for the race to achieve the Millennium Development Goals by 2015.

Olga Bornemisza, *MSc, MEDes, is the Senior Technical Officer for Health Systems Strengthening at the Global Fund to Fight AIDS, Tuberculosis and Malaria. Prior to this, she conducted research on health issues and fragile states while at the London School of Hygiene and Tropical Medicine, examining topics such as the role of the health sector in state-building, and the links between foreign policy, national security, and development aid.*

Jamie Bridge, *MSc, is a Program Officer for the Technical Publications and Learning Team at the Global Fund to Fight AIDS, Tuberculosis and Malaria. He has a background in HIV prevention for people who use drugs, having worked previously for the International Harm Reduction Association and managed a needle and syringe program in England.*

Michael Olszak-Olszewski*, PhD, is Senior Information Management Officer for the Country Programs Cluster at the Global Fund to Fight AIDS, Tuberculosis and Malaria. His main background is in statistics and he also holds a position of Lecturer in Statistics at the University of Geneva.*

George Sakvarelidze, *MD, MPH, is a Senior Technical Officer for the Monitoring and Evaluation Support Team at the Global Fund to Fight AIDS, Tuberculosis and Malaria. Earlier, he worked with UNICEF coordinating research in Central and Eastern Europe and the development of socioeconomic databases.*

Jeffrey Victor Lazarus*, PhD, MIH, MA, is the Senior Policy Officer, Strategy, Performance and Evaluation, at the Global Fund to Fight AIDS, Tuberculosis and Malaria. He also holds positions as Affiliated Professor at the Medical School in Porto University and External Lecturer in international health at Copenhagen University.*

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Table 1. Fragile States and Other Global Fund Recipient Countries

Fragile States	Other Recipient Countries	
Afghanistan*	Albania	Jordan
Bangladesh	Algeria	Kazakhstan
Burkina Faso	Angola	Kyrgyzstan
Burundi*	Argentina	Lao (People's Democratic
Cameroon	Armenia	Lesotho
Central African Republic*	Azerbaijan	Macedonia (Former Yugoslav
Chad*	Belarus	Madagascar
Congo (Democratic	Belize	Maldives
Congo*	Benin	Mali
Côte d'Ivoire*	Bhutan	Mauritius
Eritrea*	Bolivia (Plurinational State)	Mexico
Ethiopia	Bosnia and Herzegovina	Moldova (Republic)
Georgia	Botswana	Mongolia
Guinea*	Brazil	Montenegro
Guinea-Bissau*	Bulgaria	Morocco
Haiti*	Cambodia	Mozambique
Iran (Islamic Republic)	Cape Verde	Namibia
Iraq*	Chile	Nicaragua
Kenya*	China	Panama
Korea (Democratic People's Republic)	Colombia	Papua New Guinea
Liberia*	Comoros	Paraguay
Malawi	Costa Rica	Peru
Mauritania*	Croatia	Philippines
Myanmar	Cuba	Romania
Nepal*	Djibouti	Russian Federation
Niger	Dominican Republic	Sao Tome and Principe
Nigeria	Ecuador	Senegal
Pakistan*	Egypt	Serbia
Rwanda*	El Salvador	South Africa
Sierra Leone*	Equatorial Guinea	Suriname
Solomon Islands*	Estonia	Swaziland
Somalia*	Fiji	Syrian Arab Republic
Sri Lanka*	Gabon	Tanzania (United Republic)
Sudan*	Gambia	Thailand
Tajikistan	Ghana	Tunisia
Timor-Leste*	Guatemala	Turkey
Togo*	Guyana	Turkmenistan
Uganda*	Honduras	Ukraine
Uzbekistan	India	Viet Nam
Yemen*	Indonesia	Zambia
Zimbabwe*	Jamaica	

Notes: Multi-country grants and grants in territories were excluded. * indicates a country that has experienced a humanitarian crisis in the last five years.[51]
Source: Global Fund Grant Portfolio, http://portfolio.theglobalfund.org (accessed May 2010).

Table 2. Descriptive Characteristics of Fragile States versus Other Recipient Countries

	Fragile States	Other Recipient Countries
Number of countries (% total)	41 (34%)	81 (66%)
Population	1.238,838,237	4,276,217,411
Share of world population	19%	64%
People living with HIV [1]	12,534,500	19,047,900
Share of global HIV prevalence [1]	38%	57%
Prevalence of tuberculosis	4,815,250	6,204,231
Share of global tuberculosis prevalence	44%	56%
Reported, positive malaria cases [1]	15,974,898	13,061,798

[1] Data were not available for all 122 countries in the analysis.

Figure 1. Cumulative Expenditures of Global Fund Grants by Cost Category (as of May 2010)

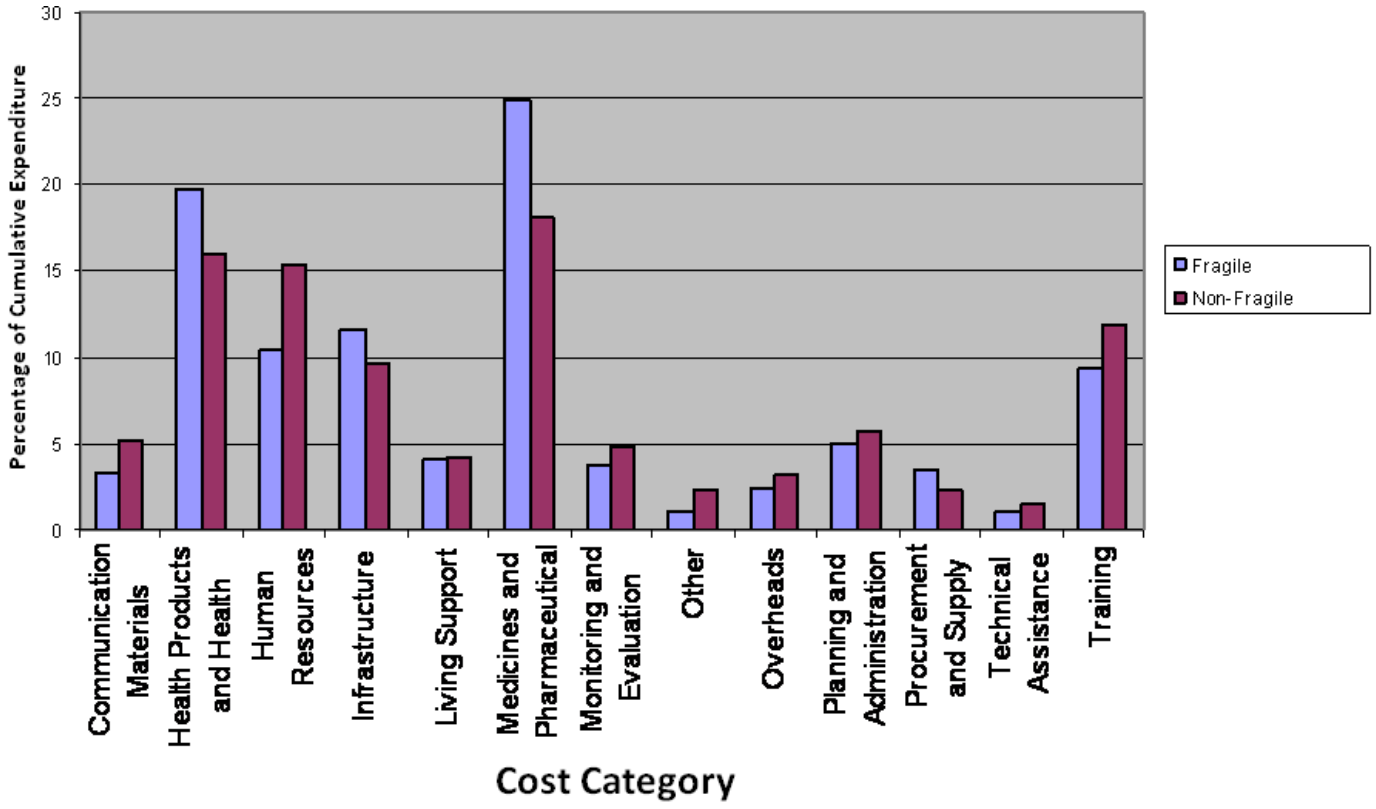

Table 3. Global Fund Grant Portfolio Analyses: Fragile States versus Other Recipient Countries

	Fragile States	Other Recipient Countries
Number of countries (% total)	41 (34%)	81 (66%)
Number of active Global Fund grants (% total)	198 (40%)	291 (60%)
Percentage of total HIV grants	37.14%	62.86%
Percentage of total tuberculosis grants	41.95%	58.05%
Percentage of total malaria grants	50.96%	49.04%
Average number of active grants per country	4.95	4.16
Percentage of grants where the Principal Recipient is:		
Civil society or private sector body	35.68%	64.32%
Governmental body	37.89%	62.11%
Multilateral organization	68.00%	32.00%
Number of Global Fund grants with previous disbursements (% total)	314 (42%)	427 (58%)
Disbursements as of May 2010 (US$)	4,867,424,598	5,802,365,241
Share of total disbursements as of May 2010	46%	54%
Average total disbursements per country as of May 2010 (US$)	118,717,673	73,447,661

Source: Global Fund Grant Portfolio, http://portfolio.theglobalfund.org (accessed May 2010).

Table 4. Performance Ratings of Global Fund Grants

	"Non-fragile" recipient countries	"Fragile" recipient countries		
		All	*Fragile states with humanitarian crises in the last five years*	*Other fragile states*
Number of countries (% total recipient countries)	81 (66%)	41 (34%)	*28 (23%)*	*13 (11%)*
Percentage of submitted proposals approved for funding	43%	42%	*42%*	*41%*
Average percentage of main program indicator targets being reached by active grants	88.1%	82.7%*	*79.6%**	*89.3%*
Percentage of grants with performance rated A or B1 for latest disbursement	84.8%	78.9%	*75%**	*86.7%*
Percentage of grants rated A or B1 at major review in second year	81.8%	69.9%*	*64.7%**	*80%*
Grants with funding discontinued after second year review	3	7*	*5**	*2*
Percentage of assessed grants approved for continued funding after five-year grant period	32.3%	17.7%*	*12.7%**	*29.2%*
Disease programs with performance ratings for monitoring and evaluation systems				
A or B1	89 (67.4%)	45 (46.9%)*		
B2 or C	43 (32.6%)	51 (53.1%)*		
Indicators rated through on-site data verification exercises				
A or B1	637 (78.2%)	308 (63.6%)*		
B2 or C	178 (21.8%)	176 (36.4%)*		

* indicates that there is a statistically significant difference ($p < 0.05$, or 95% confidence level) between the group tested and the "non-fragile" recipient countries.

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