SCALING UP FOR IMPACT
RESULTS REPORT

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

March 2009

AT THE KASSANGE COMMUNITY CLINIC IN THE GAMBIA, TB PATIENTS FROM THE VILLAGE AND SURROUNDING AREA COLLECT THEIR MEDICINE. THIS LOCAL HEALTH CENTER ALLOWS COMMUNITY MEMBERS TO AVOID TRAVELING THE LONG DISTANCE TO THE HOSPITAL IN BANJUL, AND IMPROVES ADHERENCE TO TREATMENT.

TABLE OF CONTENTS

LIST OF TERMS AND ABBREVIATIONS

ACT	artemisinin-based combination therapy
API	Annual Parasite Index
ARV	antiretroviral drugs
CADRE	Centre for AIDS Development, Research and Evaluation
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
DFID	Department for International Development (U.K.)
DOTS	internationally approved tuberculosis control strategy
GDF	Global TB Drug Facility
JICA	Japan International Cooperation Agency
MoH	Ministry of Health
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PMTCT	prevention of mother-to-child transmission (of HIV)
PSI	Population Services International
RBM	Roll Back Malaria Partnership
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
ZNAN	Zambia National AIDS Network

A WIDESPREAD COMMUNICATIONS CAMPAIGN ON HIV/AIDS ATTRACTS A CROWD AT A COMMUNITY VOLUNTARY COUNSELING AND TESTING DAY IN SARE ALPHA, THE GAMBIA.

EXECUTIVE SUMMARY

THE GLOBAL FUND: INVESTING THE WORLD'S MONEY TO SAVE LIVES

1. **Since 2000, the fight against the diseases of poverty has turned from resignation to one driven by "evidence-based hope".** Motivated by a desire to ensure sustainable development for a safe, just world at the outset of a new century, the global community committed to setting specific targets for poverty reduction, disease control and other critical factors for international development through the Millennium Development Goals and provided unprecedented levels of resources to fight AIDS, tuberculosis (TB), malaria and vaccine-preventable diseases.

2. Only five years after the additional resources first were translated into a scale-up in health interventions on the ground, the world can already see signs that the investments work. More than three million people have gained access to antiretroviral drugs (ARVs) for HIV treatment. TB programs are expanding and getting more effective in several high-burden countries and TB mortality is declining despite new challenges with HIV/TB co-infection. Malaria interventions have seen spectacular initial success in reducing mortality, leading to a Global Malaria Action Plan (launched in September 2008) to control malaria worldwide in less than a decade.

3. **The Global Fund to Fight AIDS, Tuberculosis and Malaria** was established in 2002 as a major tool for the world community to ensure that increases in resources would be used effectively and turned into improved health services, strengthened health systems and lives saved in developing and middle-income countries worldwide.

4. **This report looks at the extent to which the Global Fund is succeeding in its mission.** This is the fourth annual progress report the Global Fund has published. Like the others, it provides a snapshot of the results that can be drawn from the data collected from its increasingly extensive portfolio of grants. It also looks at the limited and uneven but growing body of evidence that its financing – alongside that of other financiers of the fight against the three diseases – results in lasting impact on the disease burden and contributes to the achievement of the Millennium Development Goals.

SCALING UP INVESTMENT TO SAVE LIVES

5. In line with the internationally agreed strategies for fighting the three diseases effectively, the Global Fund has supported comprehensive prevention, treatment and care programs in 137 countries through investments of US$ 7.2 billion. **By December 2008, 3.5 million people who otherwise would have died of AIDS, TB or malaria over the past five years were alive as a result of the interventions delivered by programs supported by the Global Fund.**[1]

6. This estimate is derived from the results Global Fund-supported programs achieved by 1 December 2008:

- Two million people on ARV therapy for HIV
- 4.6 million people provided with effective TB treatment
- 70 million insecticide-treated bed nets distributed to protect families from malaria.

7. These results represent one-third to one-half of international targets in 2008. This gap will decrease for malaria and TB, but will increase for AIDS services by 2010 due to the growing number of people living with HIV in need of services. **To close the gaps and meet international targets, the global community needs to scale up services two- to three-fold.**

8. In addition to these major indicators, programs supported by the **Global Fund have also benefitted tens of millions of people through a wide range of services:**

- 62 million people have been reached with HIV counseling and testing
- 445,000 HIV-positive pregnant women have received preventive treatment to halt mother-to-child transmission (PMTCT) of HIV
- 91 million people have been reached with community outreach services
- 3.2 million orphans and vulnerable children have been provided with basic care and support
- 74 million cases of malaria have been treated according to national treatment guidelines with an increasing use of highly effective artemisinin-based combination therapy (ACT)

9. Rapid scale-up of Global Fund-supported HIV treatment programs has meant that for the first time we are witnessing declines in mortality among adults of working age in some African countries. In Malawi, scaling up HIV treatment has led to reductions in mortality by 40 percent in some working populations and by more than ten percent in some rural populations. In Botswana, Tanzania and Zambia effective HIV treatment has led to reduced hospitalization of people with AIDS.

10. **Increased treatment coverage for TB** – in several high-burden countries (including India, China and Indonesia) – **has not only led to declines in deaths**, but by reducing the number of infected people, it has contributed to reduced TB prevalence globally.

11. In countries where effective prevention and treatment coverage exists, malaria cases and deaths have declined by 50 percent or more. In Rwanda, Zanzibar (Tanzania), Eritrea, Burundi, parts of Mozambique, Swaziland and South Africa there is evidence of dramatic reductions in morbidity and mortality.

12. But the impact of programs supported by Global Fund investments goes beyond numbers: **the people whose lives are saved are now active – working and caring for families, contributing to the development of their communities and generating wealth.**

13. **Investments in effective malaria and TB interventions and in HIV prevention provide some of the highest value for money in health.** These services are within the range of low-cost interventions for childhood illnesses and maternal care. HIV treatment is more expensive (US$ 922 per disability-adjusted life-year saved) but has wider economic, social and humanitarian benefits. It is estimated that the Global Fund provides 60 percent of international financing for malaria, 57 percent for TB, and 23 percent of all international funding for HIV.

14. **Evidence suggests that the past years' investments have strengthened countries' ability to undertake large health programs.** Round 8 of grant financing of US$ 2.75 billion over two years, approved by the Board in November 2008, was more than 2.5 times larger than any previous round. It also had a higher rate of proposals recommended for funding (54 percent) than any other round. This suggests that countries are now able to scale up their ambitions for future health services, set more ambitious targets and demonstrate a capacity to execute such ambitious plans.

1 Lives saved are based on partner-agreed mortality outcomes for high-level services of insecticide-treated bed nets, TB treatment under DOTS, the internationally approved tuberculosis control strategy, and HIV treatment.

THE GLOBAL FUND MODEL

15. **The Global Fund's model of country ownership, performance-based funding and inclusive partnerships has proven to be central to the scale-up of effective and equitable services.** In a large number of countries, the Global Fund has dramatically scaled up investment in cost-effective interventions within a short space of time, enabling these countries to provide free or low-cost services not previously available and to expand pilot programs to a national scale. By financing the country's priorities according to their national strategies and plans, and by promising to be a trustworthy, long-term source of funding for commodities and services as well as for health infrastructure and management, the Global Fund has enabled countries to undertake ambitious expansions of their health services and has strengthened health systems.

TARGETED INVESTMENT

16. **The demand-driven model of the Global Fund means that funding is in line with country needs and priorities.** In practice, this has meant that investment has followed need. Around 68 percent of Global Fund investments are in low-income countries, with a further 25 percent in lower-middle-income countries. In Rounds 1 through 8, around 60 percent of the approved funds were for programs in sub-Saharan African countries.

17. However, gaps are emerging, with some countries receiving insufficient funds compared to their disease burden. This may require more focused partner support for proposal preparation and grant implementation. In addition, major efficiencies in grant management are possible, based on a careful segmentation of the grant portfolio by grant size, risk assessment, strength of a country's health system, management capacity and previous grant performance to focus Global Fund and partner support where it is needed most.

PERFORMANCE-BASED FUNDING

18. **Performance-based funding has promoted learning and improved program management.** In many cases, risk of reduced funding in poorly performing programs has encouraged countries to take corrective action to address inherent weaknesses. For example in Senegal, poor performance which led to failure to secure continued funding for a grant has spurred the country to reform its Country Coordinating Mechanism to increase civil society participation. This action led to the development and submission of a proposal which was approved, resulting in a highly successful program.

19. Well-performing programs can accelerate their use of grant funding. For example, the malaria program in Ethiopia was able to utilize funds from its year-five budget in year three of its grant lifecycle to successfully deliver ten million insecticide-treated bed nets.

20. Performance-based funding informs strategic reprogramming of grant money. For example, Malawi shifted US$ 40 million to human resources after the Phase 2 evaluation highlighted weaknesses in this area.

21. **Performance-based funding does not penalize poorer countries.** Only 12 percent of funds are reallocated from the poorest third of countries due to weak performance, less than the 13 percent from the wealthiest third of countries. This is because the Global Fund measures performance against targets proposed by the countries themselves – based on what is possible to implement within the country context.

22. **Programs are performing well in most fragile states and in most countries with weaker health systems.** Seventy percent of programs in fragile states are performing well, slightly less than the overall performance of programs (75 percent of all programs are performing well). Similarly, 73 percent of programs in countries with weak health systems are performing well compared to 79 percent in countries with stronger health systems capacity. Nevertheless, improvements in performance in countries with weaker health systems and many fragile states will require a focused effort from partners.

PARTNERSHIPS TO IMPROVE AID EFFECTIVENESS

23. **Partnership is at the heart of the Global Fund model.** As it does not have country offices, the Global Fund relies on partners to design, implement and monitor the programs in which it invests. Both at the global and at the country level, the Global Fund strives to work in close collaboration with its partners to maximize the effectiveness of its financing.

24. **The Country Coordinating Mechanism** – which brings together civil society, state actors, multilateral and bilateral agencies, the private sector and affected communities – is the Global Fund's partnership platform at the country level. There is substantial evidence that Country Coordinating Mechanisms are strengthening countries' capacity to do comprehensive, national planning for the health sector with the broad participation of both government and non-governmental actors. Country Coordinating Mechanisms have increasingly been able to develop technically sound proposals that reflect country needs and priorities and also effectively oversee programs supported by the Global Fund.

25. However, the concept of a multistakeholder platform for health planning and the oversight of large national resources for health is still a revolutionary one in several countries. In many cases, much more work is needed to make Country Coordinating Mechanisms work effectively and equitably.

26. **Strengthening civil society partnerships at the community level is critical in order to intensify prevention and to achieve sustainable disease impact.** In addition to state actors, civil society organizations, nongovernmental organizations, faith-based organizations and community-based organizations are critical to the implementation of Global Fund-supported programs. More than one-third of Global Fund resources goes to programs that are implemented by civil society organizations. These organizations also play an essential role in governance by ensuring the broad accountability of other program implementers to citizens. Expanded participation of civil society actors is vital to community systems strengthening and the successful scale-up of programs to reach the poor and the vulnerable and to improve the effectiveness of the Global Fund partnership.

27. **The Global Fund is committed to improving the effectiveness of partnerships based on the principles set out in the Paris Declaration on Aid Effectiveness.**[2] The Global Fund systematically reviews its performance against the indicators the Paris Declaration has set to track progress. Measurement of the Global Fund's compliance with these principles shows that the majority of Global Fund-supported programs use national monitoring and evaluation systems (82 percent) and procurement systems (56 percent). There is, however, room for improvement in a number of areas: for example, data show that the Global Fund too often uses separate financial systems even when they could be merged with those of other donors (in 61 percent of programs), that in too few cases are joint missions organized with other donors or partners (14 percent of missions), and joint analytical work is done in too few cases (only 22 percent of analytical reports are jointly undertaken with other development partners).

28. The Global Fund is simplifying and strengthening its business model to ensure better coordination of the programs it finances with national strategies. In addition to country-level efforts, it has convened a "Learning Group" among global programs in health, education and the environment to document results and share best practices in aid effectiveness.

2 The Paris Declaration on Aid Effectiveness is an international agreement signed in 2005 which calls for increased efforts to harmonize, align and manage aid for results with a set of monitorable actions and indicators.

INVESTING IN HEALTH SYSTEMS FOR SUSTAINED SUCCESS

29. **The Global Fund is a major investor in health systems.** So far, approximately 35 percent of Global Fund committed funding (US$ 4.2 billion) has been intended to bolster infrastructure, strengthen laboratories, expand the numbers of human resources, augment skills and competencies of health workers and develop and support monitoring and evaluation systems. Countries are now able to specifically request funding for health systems strengthening as part of disease-specific grant applications. Since 2007, US$ 660 million has been committed for "cross-cutting" health system strengthening actions that apply to more than one of the three diseases.

30. Flexibilities in Global Fund financing have been successfully utilized by countries to strengthen their health systems: for example, to support the implementation of a primary health care plan in Ethiopia, to expand coverage of health insurance in Rwanda and to contribute to pooled funding in Malawi and Mozambique.

31. Global Fund-supported programs have also indirectly strengthened health systems by reducing mortality among health workers who are able to return to work as well as by effective prevention and treatment, leading to reductions in the caseload due to the three diseases – thereby enabling use of existing health system capacity for other conditions.

ACCELERATING PROGRESS TOWARD ACHIEVING MILLENNIUM DEVELOPMENT GOAL TARGETS

32. **Global Fund investments have helped accelerate progress toward the achievement of a number of the Millennium Development Goals by 2015.** The Global Fund estimates that annually it provides around 57 percent of all international financing for TB, 60 percent for malaria and 23 percent of all financing for HIV. The progress in malaria and TB control is contributing significantly to achieving Millennium Development Goals 4 and 6, which call for a reduction of child mortality by 50 percent and the reversal of malaria and TB incidence, respectively.

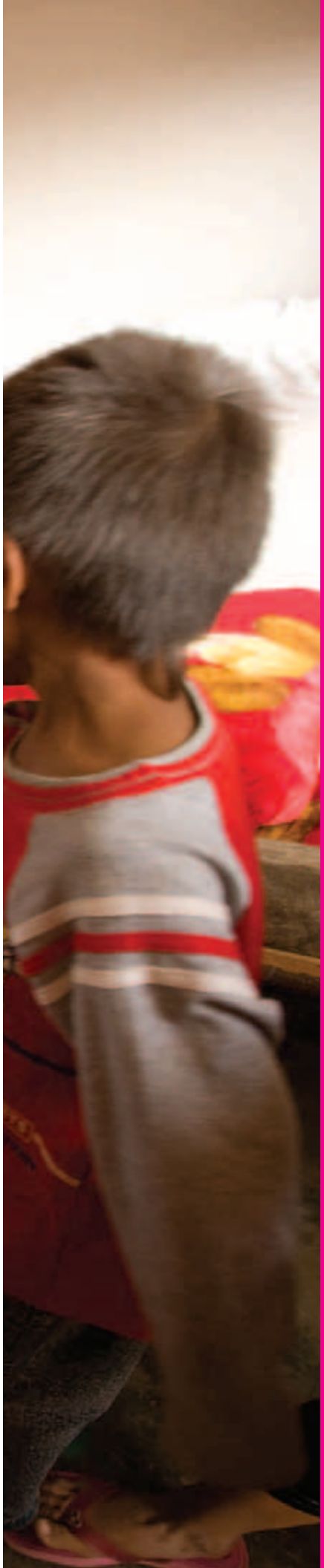
33. This report shows some of the most exciting results so far: the first population-level declines in adult mortality due to HIV treatment, declines in TB prevalence and systematic declines in child mortality due to malaria interventions. Programs supported by the Global Fund are estimated to contribute 50 percent of international TB targets and 60 percent of insecticide-treated bed net targets for malaria by 2010. However, for HIV treatment, the number of people who actually receive treatment out of those who need it will decline from 31 percent to 21 percent with currently agreed grants, as the number of people needing treatment increases faster than the number of people who can be given access to it.

34. The Global Fund is participating in several initiatives aimed at improving aid effectiveness in countries, including the International Health Partnership and the Global Campaign for the Health-Related Millennium Development Goals, spearheaded by the Norwegian government.

35. There is also a significant measurement challenge to invest in surveys and surveillance now, if countries are to systematically measure progress toward the Millennium Development Goals by 2015.

36. In spite of significant achievements to date, reaching the health-related Millennium Development Goals by 2015 and universal coverage of HIV, TB and malaria services will require continued, substantial increases in long-term financial commitments by donors. The development of strong health systems will be needed along with investment in prevention to complement successes achieved in treatment and care to save lives.

IN ZUNNUN – A RURAL AREA OF CHINA NEAR THE BORDER WITH MYANMAR – CHILDREN LIVE AT SCHOOL DURING THE WEEK. GLOBAL FUND SUPPORT HAS ENABLED THE SCHOOL TO EQUIP THE DORMITORIES WITH INSECTICIDE-TREATED BED NETS.



1. INTRODUCTION

At the beginning of this decade, the world's nations united around one ambitious aim: to use the beginning of a new millennium to take a leap forward in reducing inequality and poverty, putting the world on the track for sustainable, equitable development. By agreeing on the Millennium Development Goals – which aim to reduce extreme poverty by half in addition to a number of other ambitious targets that would prevent millions of deaths, improve life quality and reduce the burden on the environment – and by setting a deadline of 2015, the United Nations General Assembly focused the efforts of all who engage in development work in one direction for a common goal.

BOX 1: THE GLOBAL FUND MODEL

THE GLOBAL FUND STRUCTURE

COUNTRY COORDINATING MECHANISM

The Country Coordinating Mechanism is a central part of the Global Fund structure and key to the Global Fund's commitment to local ownership and participatory decision-making. Country Coordinating Mechanisms develop and submit proposals to the Global Fund, oversee implementation of funded programs, review reports of Principal Recipients and ensure cross-sector coordination. They include representatives from all sectors: governments, nongovernmental organizations, academic institutions, people living with the diseases, and multilateral and bilateral development agencies.

TECHNICAL REVIEW PANEL

To support the Global Fund in financing effective programs, the Global Fund Board relies on an independent panel of health and development experts. The Technical Review Panel reviews eligible proposals for technical merit and makes funding recommendations to the Board.

THE GLOBAL FUND BOARD

The international Board is made up of 20 voting members, which include representatives of donor and recipient governments, non-governmental organizations, the private sector (including business and foundations) and affected communities. In addition, there are four non-voting members, among whom are key international development partners such as the World Health Organization (WHO), the Joint United Nations Programme on AIDS (UNAIDS), the World Bank (which serves as the Global Fund's trustee) and the government of Switzerland, given the Global Fund's status as a Swiss foundation. The Board is responsible for overall governance of the Global Fund, for developing new policies and for the approval of grants. The Chair and Vice-Chair of the Board each serve for a term of two years. Each position alternates between a donor constituency and a recipient delegation, so that both donors and recipients are equally represented in the Board leadership at all times.

PRINCIPAL RECIPIENT

For each grant, the Country Coordinating Mechanism nominates one or more public or private organizations to serve as Principal Recipient. The Principal Recipient is legally responsible for local implementation of the grant, including oversight of sub-recipients of grant funds and communications with the Country Coordinating Mechanism on grant progress. The Principal Recipient also works with the Global Fund Secretariat to develop a two-year grant agreement that sets program targets to be achieved over time. Over the course of the grant agreement, the Principal Recipient requests additional disbursements based on demonstrated progress toward these targets. This performance-based system of grant-making is key to the Global Fund's commitment to results.

THE GLOBAL FUND SECRETARIAT

The Global Fund's staff is responsible for day-to-day operations, including mobilizing resources from the public and private sectors, managing grants, providing financial, legal and administrative support and reporting information on the Global Fund's activities to the Board and the public. The Global Fund aspires to be as lean as possible, with a staff of about 400 based in Geneva, Switzerland, and overhead costs consuming less than five percent of income. (The Global Fund has no country offices.)

LOCAL FUND AGENT

The Global Fund does not have a country-level presence outside its offices in Geneva. Instead, it relies on independent advice from local auditors referred to as Local Fund Agents. In the initial stage, a Local Fund Agent assesses the capacity of a nominated Principal Recipient to administer grant funds and be responsible for implementation. During the life of a grant, the Local Fund Agent will also verify the Principal Recipient's periodic disbursement requests and progress updates. In addition, Local Fund Agents are responsible for reviewing the Principal Recipient's annual report and advising the Global Fund on matters involving disbursements and other actions.

THE TECHNICAL PARTNERS

As a financing mechanism, the Global Fund does not itself provide technical assistance and capacity-building support to current or potential grant recipients. Instead, the Global Fund relies on development partners to provide such support to grantees. These organizations – including UNAIDS, WHO, the World Bank and other UN and bilateral agencies as well as international and local nongovernmental organizations – work with Country Coordinating Mechanisms to develop proposals, strengthen capacity and implement approved programs. The Global Fund recognizes that some countries may face difficulties in implementing grants and therefore encourages Country Coordinating Mechanisms to include funds for technical assistance in their proposals.

1. Improving health plays a central role among the Millennium Development Goals. Three of the eight goals focus on health: child health (MDG4), maternal health (MDG5) and the fight against AIDS and other infectious diseases (MDG6). With time, it has become clear that health plays an even more fundamental role in enabling development and reducing poverty than first assumed. The impact of improved health has increasingly shown itself in assisting poverty reduction (MDG1) and also plays a positive role in improving gender equality (MDG3) and improving children's ability to complete their primary education (MDG2).

2. The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in 2002 to strengthen the global response to the three major pandemics and to accelerate progress toward and the achievement by 2015 of the Millennium Development Goals related to these three diseases. The Global Fund is an independent international financing institution which raises and disburses resources on a large scale to countries in need of funding to fight the three diseases and to strengthen health systems.

3. At its creation, the Global Fund was designed based on lessons from previous experiences in development assistance and recent models in international collaboration. It provides financing based on high-quality demand and relies on national planning and priorities to ensure that its funding reaches those who need it and is invested in the right interventions to achieve effective impact against the three diseases.

4. Its design is built around the principle of "performance-based funding". From its application process through to the decisions to disburse money and continue funding at key milestones of each grant, the measurement and assessment of results remains the sole deciding factor.

5. Since its inception in 2002, the Global Fund has expanded its operations rapidly to become the leading multilateral investor of funds to fight AIDS, TB and malaria. By 31 December 2008, the Global Fund had received total pledges of US$ 19.2 billion, approved US$ 15.2 billion to nearly 600 programs in 140 countries and disbursed US$ 7.2 billion.

6. As a financing institution, the Global Fund does not implement programs directly but relies on its inclusive partnership model, which brings together governments, civil society, the private sector and people living with the diseases (see Box 1 for the Global Fund model). This partnership is reflected at every level from the Global Fund Board through to countries (in the Country Coordinating Mechanisms) to the communities where programs are implemented.

BOX 2: GLOBAL FUND GUIDING PRINCIPLES

The purpose of the Global Fund is to attract, manage and disburse additional resources through a new public/private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by AIDS, TB and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals.

The Framework Document articulates the principles guiding the Global Fund, defining it as a financial instrument – not an implementing entity – and stating that it will:

- make available and leverage additional financial resources to combat AIDS, TB and malaria;
- base its work on programs that reflect national ownership and respect country-led formulation and implementation processes;
- seek to operate in a balanced manner in terms of different regions, diseases and interventions;
- pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases;
- evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities;
- seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities.

These principles also state that the Global Fund should make use of existing international mechanisms and health plans, and when making its funding decisions, the Global Fund will support proposals which:

- Focus on best practices by funding interventions that work and can be scaled up to reach people affected by AIDS, TB and malaria;
- Strengthen and reflect high-level, sustained political involvement and commitment in making allocations of its resources;
- Support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector, across government departments and with communities;
- Build on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships, including poverty reduction strategies and sector-wide approaches;
- Focus on performance by linking resources to the achievement of clear, measurable and sustainable results;
- Focus on the creation, development and expansion of government/private/nongovernmental organization partnerships;
- Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals;
- Are consistent with international law and agreements, respect intellectual property rights and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need;
- Give due priority to the most affected countries and communities and to those countries most at risk;
- Aim to eliminate stigmatization of and discrimination against those infected and affected by AIDS, especially for women, children and vulnerable groups.

Source: The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

BOX 3: THE GLOBAL FUND GRANT PROCESS

Each country is responsible for deciding the strategies, priorities and programs it wishes to implement and determines the level of financing it needs from the Global Fund by submitting proposals in funding rounds. These proposals and strategies are developed as the result of a close partnership between governments, civil society, the private sector and affected communities.

Step 1 Global Fund Secretariat announces a "Call for Proposals". By decision of the Board in November 2006, calls will be issued once a year on approximately 1 March, with a deadline four months later.

Step 2 Each country's Country Coordinating Mechanism prepares a proposal based on local needs and financing gaps. As part of the proposal, the Country Coordinating Mechanism nominates one or more Principal Recipients. In many cases, development partners assist in the preparation of the proposal.

Step 3 The Secretariat reviews proposals to ensure they meet eligibility criteria and forwards all eligible proposals to the Technical Review Panel for consideration.

Step 4 The Technical Review Panel reviews all eligible proposals for technical merit and makes one of four recommendations to the Global Fund Board: (1) fund; (2) fund if certain conditions are met; (3) encourage resubmission; and (4) do not fund.

Step 5 The Board approves grants based on technical merit and availability of funds.

Step 6 The Secretariat contracts with one Local Fund Agent per country. The Local Fund Agent certifies the financial management and administrative capacity of the nominated Principal Recipient(s). Based on the Local Fund Agent assessment, the Principal Recipient may require technical assistance to strengthen capacities. Development partners may provide or participate in such capacity-building activities. The strengthening of identified capacity gaps may be included as conditions precedent to disbursement of funds in the grant agreement between the Global Fund and the Principal Recipient.

Step 7 The Secretariat and the Principal Recipient negotiate a grant agreement, which identifies specific, measurable results to be tracked using a set of key indicators.

Step 8 The grant agreement is signed. Based on a request from the Secretariat, the World Bank makes initial disbursement to the Principal Recipient. The Principal Recipient makes disbursements to sub-recipients for implementation, as called for in the proposal.

Step 9 Program and services begin. As the coordinating body at the country level, the Country Coordinating Mechanism oversees and monitors progress during implementation.

Step 10 The Principal Recipient submits periodic disbursement requests with updates on programmatic and financial progress. The Local Fund Agent verifies information submitted and recommends disbursements based on demonstrated progress. Lack of progress triggers a request by the Secretariat for corrective action.

Step 11 The Principal Recipient submits a fiscal-year progress report and an annual audit of program financial statements to the Secretariat through the Local Fund Agent.

Step 12 Regular disbursement requests and program updates continue, with future disbursements tied to progress.

Step 13 The Country Coordinating Mechanism requests funding beyond the initially approved two-year period (Phase 1). The Global Fund Board approves continued funding (Phase 2) based on a detailed assessment of results against targets and the availability of funds.

7. An innovative public/private partnership, the Global Fund is a signatory to the Paris Declaration on Aid Effectiveness and is committed to closely working with countries and its health and development partners to ensure the programs it supports are effective and in line with the Paris Principles of ownership, harmonization, alignment, managing for development results and mutual accountability. As such, the Global Fund model emphasizes country ownership, inclusive partnership both globally and at the country level (including civil society, the private sector and affected communities), and performance-based funding (See Box 2 for an explanation of the Global Fund's guiding principles. Box 3 goes on to illustrate the steps of the Global Fund grant process.)

8. As previous results reports have shown,[3] the Global Fund model has demonstrated fundamental strengths in country ownership, performance-based funding and inclusive partnerships, which provide a basis to achieve its purpose of a "sustainable and significant contribution to the reduction of infections, illness and death" and the realization of the Millennium Development Goals.

9. This report summarizes the achievements to date, and highlights the important challenges that the Global Fund must face to help achieve its objectives and accelerate progress toward achieving health-related Millennium Development Goals by 2015. The report summarizes the results achieved by December 2008, drawing on analysis that uses the Global Fund's evaluation framework on operational and grant performance, system effects, and evidence of impact (see Figure 1).

10. This report shows the major role of the Global Fund in investing in systems strengthening at both the national and the community levels, and the need to continue to scale up investment in these areas. It stresses the importance of partnerships at the community level to ensure that quality services are delivered to those who need them and that risky behaviors and other drivers of the epidemics are appropriately addressed.

3 The Global Fund, *Investing in Impact*, 2006 and *Partners in Impact*, 2007.

11. Progress and challenges are presented at each stage of the report, illustrated with concrete examples from well-performing and less well-performing programs. The report examines a number of cross-cutting issues:

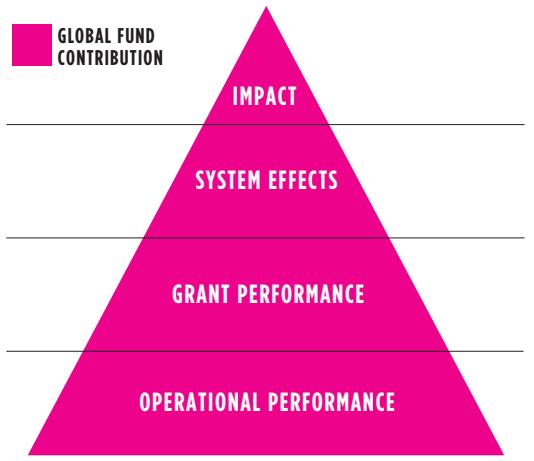
a. **Health systems strengthening**: what is the evidence that disease programs strengthen health systems?
b. **Impact on HIV, TB and malaria**: what is the impact of Global Fund-supported programs on adult and child mortality for the three diseases?
c. **Value for money**: what is the cost per life saved of AIDS, TB and malaria interventions?
d. **Working better with partners**: are Global Fund-supported programs aligned with countries, working well with partners and contributing to improving the effectiveness of aid?
e. **Managing for results**: are programs managed to ensure a focus on and accountability to those in urgent need of services? How reliable are the data on the delivery of these services? How does performance-based funding work in different country contexts?
f. **Intelligent implementation**: what can the Global Fund learn from programs that have succeeded, and from those that have failed to perform?
g. **Reaching people at risk and by gender**: are services reaching people in need in an equitable manner? Is the Global Fund partnership working at community level to ensure engagement with people at risk and vulnerable groups, and to ensure equity and implementation of gender transformative programs?
h. **Flexible financing**: How have countries used flexibilities in Global Fund financing to scale up services, finance health and community systems and to deliver results? Is the Global Fund able to respond to challenges in global health to ensure strong disease programs and effective health systems?

12. The report, which systematically explores the themes above, is organized into five sections:

- **Section 1: Introduction** has set the scene and the context for the report;
- **Section 2: Results: Scaling Up Investments to Save Lives** provides an overview of the results of Global Fund-supported programs, speed of financing, where the money goes, delivery of services and results against targets. It assesses evidence of reaching people at risk and by gender and the quality of data;
- **Section 3: Partnerships: Investing in Sustainable Health and Community Systems** assesses the progress in supporting health and community systems through Global Fund grants. It measures Global Fund progress against the aid effectiveness indicators agreed by development partners and countries, and defines future actions needed to improve the effectiveness and impact of Global Fund financing;
- **Section 4: Country Performance: Learning from Experience** assesses the performance of programs supported by the Global Fund, including their strengths and weaknesses and implementation challenges. It assesses performance by region, disease and implementer;
- **Section 5: Towards Global Impact: Progress Towards International Goals** provides evidence of the impact of country programs by disease and reviews progress and challenges to reaching the Millennium Development Goals and other international goals in 2015.

13. As a learning organization which operates with transparency and openness to change, the Global Fund's inclusive partnership model that emphasizes performance-based funding enables lessons from successes and challenges encountered in the fight against the three diseases to inform policy and practice so that innovative approaches are continually developed to target resources most effectively and in an equitable manner.

FIGURE 1: THE GLOBAL FUND EVALUATION FRAMEWORK



4. IMPACT the ultimate measure of the Global Fund's success. Impact indicators are included in all grant agreements – for example reduction of infections, illness and death from HIV, TB and malaria.

3. SYSTEM EFFECTS assesses the effects of Global Fund investments on the health systems through which it works, as well as aid effectiveness.

2. GRANT PERFORMANCE measures grant results against targets: for example, people reached by services (prevention, treatment and care).

1. OPERATIONAL PERFORMANCE includes measures for the performance of the core functions of the Global Fund and its Secretariat, including resource mobilization, grant management and performance-based funding.

WITH THE SUPPORT OF THE GLOBAL FUND, INDIA HAS BEEN ABLE TO RAPIDLY SCALE UP THE PROVISION OF HIV PREVENTION SERVICES TO WOMEN OF CHILD-BEARING AGE. OVER 3,000 CLINICS ACROSS THE COUNTRY NOW OFFER VOLUNTARY COUNSELING AND TESTING, ARV PROPHYLAXIS AND COUNSELING ON INFANT FEEDING.

2. RESULTS

SCALING UP INVESTMENTS TO SAVE LIVES

"We are entering the new phase of AIDS because we have results ... To have problems because we have progress is good."

—PETER PIOT, EXECUTIVE DIRECTOR UNAIDS, KAMPALA 2008

2.1 SCALING UP SERVICE DELIVERY TO SAVE LIVES

1. The Global Fund supports more than 600 programs in 140 countries. These programs have been rapidly scaled up to reach millions of people in need with access to lifesaving services and treatments, and they are doing so thanks to an extraordinary effort and show of leadership by health workers and health managers in countries around the world. Behind the dry results figures lies a story of a global surge in health activities this decade, driven by a newfound belief among health ministers, health officials, nongovernmental organization leaders, doctors and nurses that it now is possible to make inroads in the fight against AIDS, TB and malaria as additional resources are becoming available.

2. This enthusiasm is feeding on its own results: the expanded coverage of prevention, treatment and care for HIV has meant in some settings reductions in adult mortality among working populations of up to 40 percent, and following effective malaria interventions, declines in child mortality by more than 50 percent in some countries. Such promising results, together with the growing capacity of health systems to take on large-scale programs, are driving more ambitious proposals for funding to the Global Fund, as witnessed in the 2008 funding round with a two-year approved amount of US$ 2.75 billion.

3. This section summarizes the results of programs supported by the Global Fund and compares them to international targets. It assesses the levels of financing, the speed of disbursement, and the ways in which these resources are allocated. It examines the extent to which the services supported by the Global Fund reach the people at risk, especially vulnerable groups and communities.

4. The programs supported by the Global Fund are people-centered: they focus on rapidly scaling up services to reach people to quickly and dramatically reduce illness and death, while in parallel building sustainable systems over time. The way program results are measured and monitored mirrors this: it counts real people receiving services relevant to preventing or treating an infection from any of the three diseases.

5. The results reporting follows the shifting phases of a Global Fund grant: monitoring of results builds from capacity strengthening (after six months of the grant), to people reached by services (by year two), to impact on infection, illness and death in the later stages of grants (after year two).

6. However, the core accountability for program performance is the delivery of services for AIDS, TB and malaria to people in need as measured by the top three indicators:

- the number of HIV-positive people receiving ARV treatment;
- the number of smear-positive TB cases detected and started on internationally approved treatment regimens;
- the number of insecticide-treated bed nets distributed for protection against malaria.

7. To date, the results point to substantial achievements across all the key indicators used to track the success of programs supported by the Global Fund. There is strong evidence demonstrating rapid scale-up of Global Fund-supported interventions between 2007 and 2008.

FIGURE 2: ACHIEVEMENTS OF GLOBAL FUND-SUPPORTED PROGRAMS FOR THE TOP THREE INDICATORS FOR HIV, TB AND MALARIA BY END OF 2008

TOP THREE INDICATOR RESULTS	RESULTS (END 2008)	PERCENTAGE INCREASE OVER ONE YEAR	PERCENTAGE OF END 2008 TARGETS MET
HIV: PEOPLE ON ARVs	2,000,000	43%	111%
TB: TREATMENT UNDER DOTS	4,600,000	39%	102%
MALARIA: INSECTICIDE-TREATED BED NETS DISTRIBUTED	70,000,000	54%	100%

8. Results show that Global Fund-supported programs are rapidly scaling up service delivery, such that by end of 2008 (see Figures 2 and 3) there were:

- Two million HIV-positive people receiving lifesaving ARVs (an increase of 560,000 from December 2007);
- 4.6 million new smear-positive TB cases detected and put on treatment through DOTS programs (an increase of 1.3 million from December 2007);
- 70 million insecticide-treated bed nets distributed to protect families from malaria (an increase of 24 million from December 2007).

9. The Global Fund partnership at the global and country levels has collectively succeeded in attaining the targets set for the top three indicators for 2008, with 111 percent of the target reached for the number of HIV-positive people receiving ARVs; 102 percent of the target reached for number of smear-positive TB cases detected and started on DOTS; and 100 percent of the target reached for the number of insecticide-treated bed nets for protection against malaria distributed (see Figure 2).

10. The tremendous growth in the distribution of insecticide-treated bed nets took off in the last 24 months as programs resolved initial capacity constraints in procurement and management. The improved capacity and delivery has provided the foundation for optimism in the fight against malaria in developing countries for the first time in several decades. Over this 24-month period, Global Fund-supported programs reported the distribution of 52 million insecticide-treated bed nets, almost thrice the number reported in the preceding four years. It is ten times the global distribution of insecticide-treated bed nets in 2002 (five million nets), showing how far the fight against malaria has come.

11. HIV and TB treatment showed strong and more linear growth in the last year. The results from HIV and TB have contributed significantly to global progress, but the rate of growth will need to accelerate considerably to achieve universal access.

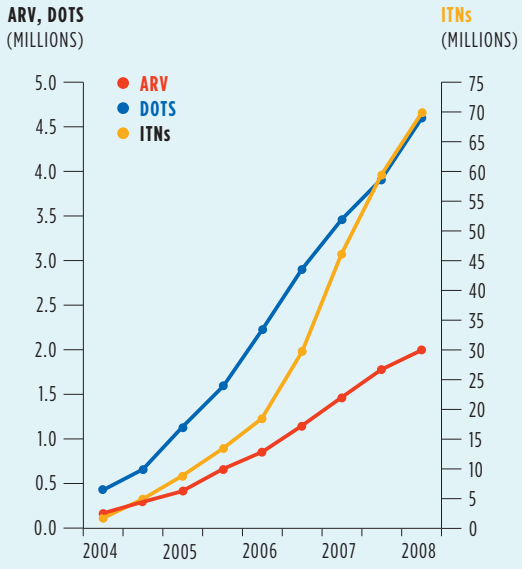
12. In line with its operating principles (see Box 2), the Global Fund supports programs which "pursue an integrated and balanced approach covering prevention, treatment, care and support in dealing with the three diseases." In addition to the top three indicators described above, a range of additional indicators are used to measure the success of Global Fund-supported programs against this principle. Results to date show that since 2004, when the Global Fund began measuring results of the programs it supports:

- 62 million people have been reached with HIV counseling and testing;
- 445,000 HIV-positive pregnant women have received PMTCT treatment;
- 91 million people have been reached with community outreach services for HIV;
- 3.2 million vulnerable children orphaned due to AIDS have been provided with basic care and support;
- 74 million cases of malaria have been treated.

13. The Global Fund also provides significant support to training programs aimed at building the skills and capacity of the health workforce to ensure effective delivery of services for the prevention and treatment of AIDS, TB and malaria. Since systematic measurements began in 2004, the Global Fund has supported 8.6 million "person episodes"[4] of training.

14. By the end of 2008, 91 million people had been reached by outreach activities such as behavioral change communication interventions, including approximately 11.8 million most-at-risk persons such as injecting drug users, sex workers, men who have sex with men, and prisoners. Outreach activities have also reached 11 million people at risk of malaria, providing education and training in the correct use of insecticide-treated bed nets.

FIGURE 3: RAPID PROGRESS WITH TOP THREE INDICATORS FOR HIV, TB AND MALARIA BETWEEN 2004 AND END 2008



4 "Person episodes of training" is a cumulative figure that multiplies number of persons attending training with the number of training programs.

BOX 4: CASE STUDIES – COUNTRY PARTNERSHIPS FOR SCALING UP SERVICES TO SAVE LIVES

RWANDA: Through Global Fund-supported programs, 59,900 people were started on ARVs and 3.2 million insecticide-treated bed nets were delivered to families. In addition, the Global Fund has supported strengthening of the health system. For example by (i) supporting the Rwandan health insurance scheme by providing financing to extend coverage of insurance to the poorest (ii) pooling procurement activities with the President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank and other donors under the leadership of the country to improve efficiency and to secure better prices for the commodities purchased (iii) jointly investing in human resource development by providing incentives to health workers.

WESTERN CAPE PROVINCE, SOUTH AFRICA: With Global Fund support, pilot programs for HIV treatment were scaled up dramatically. Initially only a few hundred persons were receiving HIV treatment. The pilot programs have become a fully fledged provincial program that is responsible for starting 9,500 HIV-positive persons on treatment and establishing home-based services, hospice care, PMTCT, condom distribution and behavioral components. The sustainability of the program has now been guaranteed by the South African government, with the support of the Global Fund gradually being phased out.

RUSSIA: The Global Fund has supported the scale-up of prevention and treatment for the national HIV program with more than 790,000 people reached with outreach interventions, 9.5 million people tested for HIV and 47,430 people started on ARVs. Financially, additional contributions by the Global Fund have enabled a greater than tenfold increase in national commitments to AIDS. Programmatically, by involving civil society, groups not reached by the original national response have been included in programs. The value of Global Fund-supported programs has been recognized by the Russian government, which now refunds the Global Fund each dollar disbursed.

INDIA: More than US$ 70 million has been committed to extend the National TB Control Program through an innovative partnership with nongovernmental organizations and the private sector (one of the largest in the world for health and the first point of contact for nearly 60 percent of TB patients). The program, also supported by WHO and other technical partners, has successfully filled gaps in the national program by financing services for vulnerable populations, including those working in slum districts in four urban areas. The most recent grant provides funding to the TB program to start an additional 440,000 patients on DOTS; thereby saving 80,000 lives and preventing 900,000 new infections.

15. Since 2004, when service delivery in Global Fund grants began on a significant scale, Global Fund-supported programs have provided HIV counseling and testing to 62 million people in various settings that include free-standing centers, prenatal clinics, TB wards in hospitals and clinics for sexually transmitted infections. The number of people tested and counseled for HIV in Global Fund-supported programs has almost doubled, from 33.5 million in 2007 to 62 million in 2008. These programs have often targeted the most-at-risk populations.

16. Between 2004 and 2008, a total of 445,000 HIV-positive pregnant women have received preventive treatment to halt transmission of HIV from mother to unborn child. The number of pregnant women receiving preventive treatment has more than tripled from 138,000 in 2007 to 445,000 in 2008.

17. Since 2004, care and support programs financed by the Global Fund have reached 5.9 million people living with AIDS and 3.2 million orphans and vulnerable children with a wide range of services that include psychological counseling, nutritional support and assistance with school fees.

18. The Global Fund has also invested in programs that link sexual and reproductive health interventions and those for HIV prevention and control. Between 2004 and 2008, around 4.4 million people with sexually transmitted diseases received treatment – thereby reducing their risk of contracting HIV during sexual encounters, as those with sexually transmitted diseases who engage in unprotected sex are more likely to contract HIV.

19. The Global Fund supports integrated approaches to malaria prevention and control. In addition to the approximately 70 million insecticide-treated bed nets distributed in Global Fund-supported programs between 2004 and 2008 (with 71 percent of these distributed in sub-Saharan Africa), 74 million cases of malaria have been treated according to national treatment guidelines with an increasing use of highly effective ACTs. These lead to higher cure rates and lower treatment resistance. Globally, malaria prevention programs supported by the Global Fund have provided indoor residual spraying of insecticides in ten million dwellings, thereby offering protection to millions of additional people.

20. A number of case studies shown in Box 4 illustrate the partnership approach adopted by the Global Fund at the country level to ensure the effective use of financing provided to local counterparts.

THE PENAL INSTITUTION NO 2, IN ST. PETERSBURG, RUSSIA, HAS APPROXIMATELY 1,000 INMATES, OF WHOM SOME 30 PERCENT ARE HIV-POSITIVE. PRISONERS RECEIVE ARV TREATMENT THROUGH THE GLOBUS PROJECT, WHICH IS SUPPORTED BY THE GLOBAL FUND.

BOX 5: GLOBAL FUND TARGETS

1. PROGRAM TARGETS

Each program supported by the Global Fund has a number of indicators and targets proposed by the country in its grant proposal and if successful, agreed by the Global Fund and the Principal Recipient in the grant agreement (see Box 1, which describes the Global Fund model). Funds are disbursed incrementally based on progress against these targets.

2. GLOBAL FUND PORTFOLIO TARGETS

The Global Fund Secretariat also sets targets for the grant portfolio as a whole. These include the targets for the three top-level indicators as well as for key program areas in relation to HIV, TB and malaria (for the full list of indicators for each programmatic area see Annex 2). Using these indicators, the performance of all grants are averaged and compared with the targets.

As all grants are evaluated at Phase 2 (see Box 3 for the Global Fund grant lifecycle), it is possible at this point to compare performance for these grants against the targets set at the time of grant signing (See Annex 3). As of 1 December 2008, 348 grants had had Phase 2 evaluations, providing a rich dataset with which to ascertain the performance of the grant portfolio by disease area, country, region, type of Principal Recipient and programmatic area.

3. INTERNATIONAL TARGETS

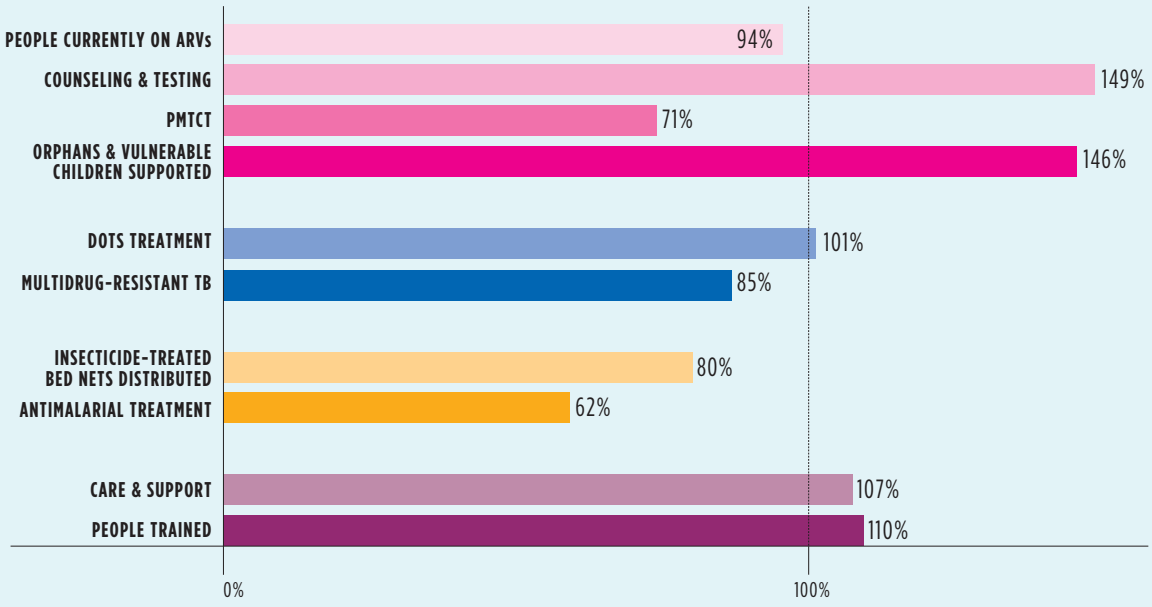
The Global Fund portfolio results make up a substantial part of global service-delivery results. These results are compared against global, regional or country-specific service-delivery targets which need to be reached if the Millennium Development Goals are to be achieved. Working with international partner agencies and organizations (such as WHO, the Stop TB Partnership and UNAIDS), and by drawing on peer-reviewed publications, the Global Fund estimates the contribution of its investments toward achieving these international targets. Section 5 of this report, which focuses on impact, assesses the Global Fund portfolio's results against global impact targets more fully.

2.2 GLOBAL FUND RESULTS VERSUS GRANT, PORTFOLIO AND INTERNATIONAL TARGETS

21. Measuring results is a core function of the Global Fund's performance-based funding. But the results also accumulate toward the larger purpose of achieving global targets for disease control. The Global Fund measures performance at the level of the grants it finances (see Figure 1 and Box 5), its portfolio as a whole, and against internationally set targets. This section presents the results at these various levels.

22. Analysis of the "Top Ten" programmatic indicators for the 348 grants evaluated at Phase 2 by end of 2008 (see Figure 4) shows that, on average, the HIV programs performed well against targets set in the four programmatic areas relating to HIV (namely, the number of people currently on ARVs (94 percent of the target reached), counseling and testing (149 percent of the target reached), PMTCT (71 percent of the target reached), and orphans supported (146 percent of the target reached)). TB programs also performed well: with DOTS coverage and treatment reaching 101 percent and multidrug-resistant tuberculosis treatment reaching 85 percent. However, malaria programs at the time of the Phase 2 evaluation were not performing as well

FIGURE 4: ACHIEVEMENT AGAINST TARGETS FOR TOP TEN PROGRAMMATIC AREAS



Note: Results of the 348 grants which had been evaluated for Phase 2 as of December 2008.

as the others. While programs achieved 80 percent of targets for distribution of insecticide-treated bed nets, they only reached 62 percent of the target for antimalarial treatment.

2.2.1 GLOBAL FUND TARGETS INTO THE FUTURE, 2008-2010

23. Programmatic targets for the Global Fund portfolio to 2010 are calculated by adding targets set in the grant agreements against the top three indicators. This provides cumulative numbers of persons on ARVs, treated using DOTS and number of insecticide-treated bed nets distributed through the portfolio over time (see Figure 5).

24. It is estimated that by 2010, Global Fund-supported programs will provide ARVs for 2.9 million, treat 7.2 million TB patients using DOTS and distribute 130 million insecticide-treated bed nets.

2.2.2 PROGRESS TOWARD INTERNATIONAL TARGETS

25. Increasingly, the success of the Global Fund will be measured in terms of its contribution to the achievement of the Millennium Development Goals by 2015. A number of targets have been set for 2010 as a milestone toward the final Millennium Development Goal deadline five years later. At the end of 2008, Global Fund-supported programs contributed results which represent 31 percent to 45 percent of international targets. While contributions to international targets will increase substantially for malaria and TB by 2010, HIV treatment programs will require considerably greater resources to achieve universal access.

26. Global Fund-supported programs contributed to achieving 31 percent of international targets for AIDS treatment in 2008. International targets are set higher for each successive year toward 2010, the year for achieving universal access. Our estimates, using programmatic targets in existing grants, suggest that Global Fund-supported programs will contribute 21 percent of the target envisaged by 2010. Hence, in spite of excellent performance to date in scaling up AIDS treatment, there is a need to accelerate progress in coming rounds if international HIV treatment targets are to be reached.

27. Programs supported by the Global Fund contributed 45 percent of the 2008 estimated international targets for detection of TB cases and treatment using DOTS. By 2010, this figure is projected to increase to 49 percent of the target.

28. Programs receiving Global Fund support contributed 44 percent of the 2008 estimated international targets for number of insecticide-treated bed nets distributed. By 2010, the Global Fund contribution is projected to increase to 60 percent.

FIGURE 5: ESTIMATED GLOBAL FUND TARGETS FROM CURRENT GRANT AGREEMENTS 2008-2010

GLOBAL FUND TARGETS 2008-2010	2008	2009	2010
HIV: PEOPLE ON ARVs	1,800,000	2,400,000	2,900,000
TB: TREATMENT USING DOTS	4,500,000	5,800,000	7,200,000
MALARIA: INSECTICIDE-TREATED BED NETS DISTRIBUTED	70,000,000	100,000,000	130,000,000

2.3 REACHING THE VULNERABLE AND PEOPLE AT RISK

29. Reaching the most vulnerable and those most at risk for infection is not only a moral imperative based on human rights, it is a crucial factor in achieving internationally agreed targets for the fight against the three diseases. Ambitious targets can only be reached if programs implement as widely as possible and involve all sectors of society – government, nongovernmental organizations, community organizations and the private sector. Moreover, it is essential that interventions ensure quality engagement at the community level, where transmission occurs.

30. The Global Fund model, with its emphasis on multisectoral participation at both the country and the Board level and its insistence on giving a voice to the most vulnerable groups in both governance and implementation, makes it well positioned to drive a widening of services and a strengthening of outreach to the most vulnerable and stigmatized groups. To further strengthen its ability to finance interventions for such groups, the Global Fund is developing a strategy on gender and sexual minorities (Box 6).

31. Through its substantial financing, the Global Fund has contributed to making prevention and treatment much more widely affordable for countries, which, in turn, has made services and drugs more widely available and affordable for the poorest and most vulnerable. The support of programs that target particular at-risk groups and the support of Principal Recipients and sub-recipients that include communities living with the diseases have helped in widening services to people who previously have been excluded and have contributed to lower stigma in many countries. In addition, the Global Fund has supported the capacity-building required to reach the most remote places and the populations at the greatest risk.

JAJJA HOME'S OUTREACH WORKERS ARE REGULAR VISITORS TO THE COMMUNITY, BRINGING ADVICE AND PRACTICAL HELP TO MANY FAMILIES WHICH MAY NOT HAVE SUFFICIENT RESOURCES TO CARE FOR THEIR HIV-POSITIVE CHILDREN PROPERLY.

BOX 6: FOCUS ON GENDER INEQUALITIES

The Global Fund is committed to supporting programs which show how they will ensure that women, vulnerable groups and children receive health services. The Global Fund requires all proposed programs to explain how their goals and activities will address gender issues and support populations in need, and these requirements are becoming a material part of performance reviews at Phase 2.

In 2007, the Global Fund Board requested the Secretariat to produce a strategy on gender issues, focusing on women and sexual minorities. This is consistent with the commitment to gender issues expressed in the Global Fund's founding principles. **"In making its funding decisions, the Global Fund will support proposals which: .... Aim to eliminate stigmatization of and discrimination against those infected and affected by AIDS, especially for women, children and vulnerable groups."**

ELEMENTS OF THE STRATEGY INCLUDE:

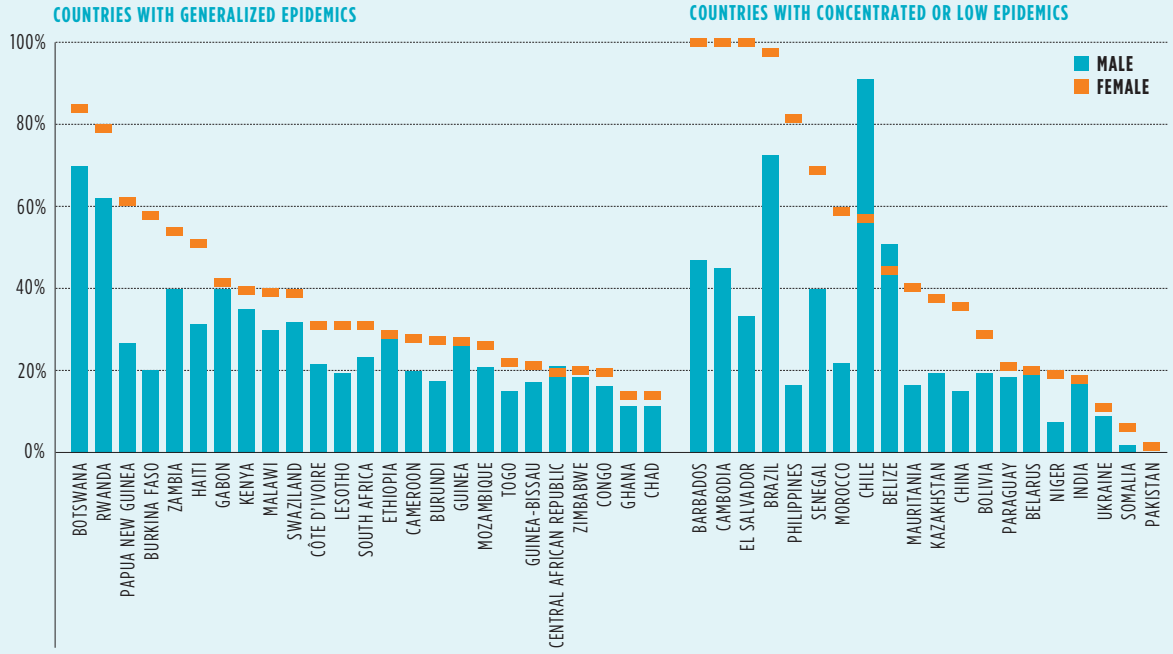
- Improve focus of interventions on gender issues
- Ensure appropriate gender expertise on relevant bodies: Secretariat, Technical Review Panel and Country Coordinating Mechanisms
- Include disaggregation of key services by gender and vulnerable groups as a material part of performance reviews at Phase 2.

Many services in Global Fund-supported programs focus on women and vulnerable groups: for example, insecticide-treated bed net distribution, malaria prophylaxis and treatment for pregnant women and PMTCT. Others reach more women than men due to their more frequent contact with the health system: for example, HIV treatment and HIV testing. Of the programmatic areas covered by the top ten indicators, three pose gender concerns: PMTCT, community-based prevention and TB treatment. For malaria interventions and HIV prevention, there is growing recognition that men have not been targeted as a priority.

HIV TREATMENT The available evidence for end 2007 suggests that more than half of the three million people on ARVs in low- and middle-income countries are women (see Figure 6). UNAIDS and WHO consider that there is no systematic bias against women for ARV access globally. Gender-disaggregated data on ARV uptake for end 2007 is available on the WHO website in its 2008 progress report *Towards Universal Access*.[5]

Towards Universal Access describes the nature of the HIV epidemic across the globe. In sub-Saharan Africa, it is estimated that almost 61 percent of people living with HIV are women, while in the Caribbean 43 percent are women, and the proportions of women living with HIV in Latin America, Asia and Eastern Europe are slowly growing. This has implications for prevention programming for HIV. In sub-Saharan Africa where the AIDS epidemic has hit hardest, HIV prevention needs to tackle the drivers of the epidemic among both men and women.

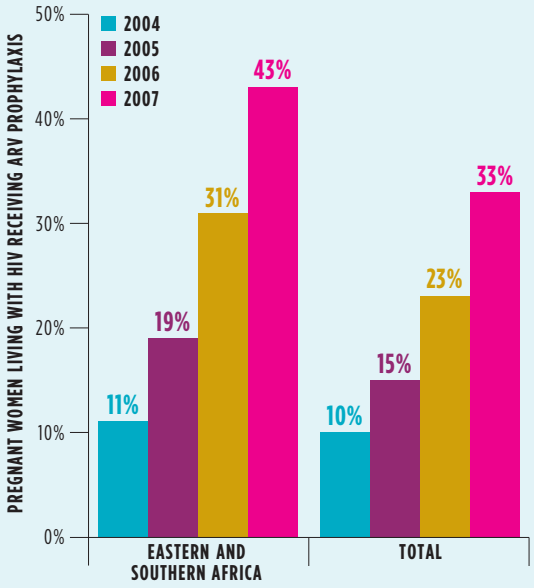
FIGURE 6: COMPARISON OF ANTIRETROVIRAL THERAPY COVERAGE IN 2007 BETWEEN MALES AND FEMALES (FOR COUNTRIES WITH REPORTED DATA ON THE NUMBER OF PEOPLE ON TREATMENT FOR BOTH SEXES SEPARATELY)



Notes: Coverage estimates are based on applying the ratio of number of males and number of females receiving antiretroviral therapy to the final projected value of all people receiving antiretroviral therapy as of December 2007. This provides December 2007 estimates of number of males and females receiving antiretroviral therapy that are then divided by the estimated number of males and females in need of antiretroviral treatment respectively. **Source:** WHO, *Towards Universal Access,* 2008.

Programs for PMTCT have been underperforming but recent reports show an improvement in global coverage. WHO and UNAIDS estimate 33 percent global coverage of PMTCT in 2007 compared to ten percent in 2004. Improving the links between HIV services and primary health care for women remains central to improving the success of PMTCT.

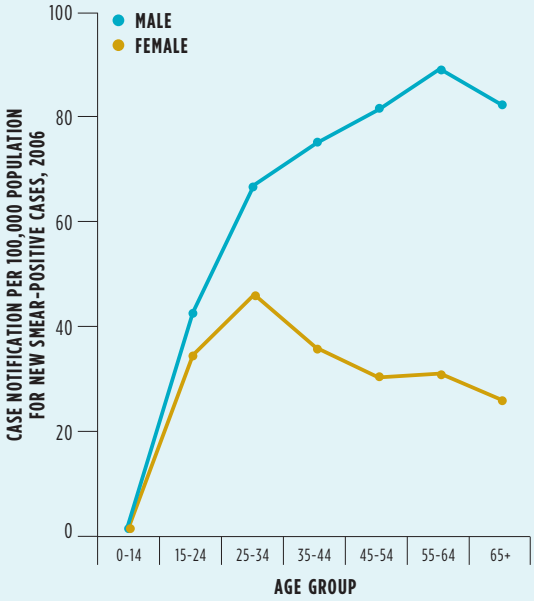
FIGURE 7: ESTIMATED COVERAGE OF HIV-POSITIVE WOMEN WITH ARVs FOR PMTCT (2004-2007)



Note: Highlighting Eastern and Southern Africa.
Source: WHO, *Towards Universal Access*, 2008.

TB CONTROL WHO global statistics on TB treatment are reported according to gender. The total number of new smear-positive cases reported by developed, middle- and low-income countries in 2006 was 1.6 million men and 884,000 women.

FIGURE 8: TB CASES NOTIFIED TO WHO BY COUNTRY PROGRAMS (2006)



Source: WHO, *Global Tuberculosis Control*, 2008

Current research on gender and TB across different settings (Malawi, Bangladesh, India and Colombia) emphasizes the need to take into account the sociocultural features of TB and local gender issues (gender differences in illness experiences, perceived causes and prior help-seeking experiences) if the capacity and performance of TB control programs locally are to be enhanced.[6]

MALARIA CONTROL Guidance on malaria control from WHO (2007) calls for the distribution of insecticide-treated bed nets to all adults, ensuring an overall population saturation of nets rather than focusing on families with small children alone. Where necessary, vulnerable groups should remain a priority to achieve better community-wide effects in controlling malaria.

5 http://www.who.int/hiv/mediacentre/2008progressreport/en/index.html
6 Weiss et al., eds. Social and cultural dimensions of gender and TB. *INT J TUBERC LUNG DIS*, 2008, 12(7): 829-830.

BOX 7: REACHING VULNERABLE PEOPLE AND THOSE AT RISK

1. REACHING REMOTE PLACES

Global Fund-supported programs have helped to build systems for delivery into rural areas, remote regions and hard-to-reach communities. Providing malaria prevention and treatment to isolated communities is a challenging task that demands comprehensive approaches, such as training lay community members in malaria prevention, diagnosis and treatment, alongside other health services. Global Fund-supported programs train and equip community health workers practicing in rural areas in Ethiopia and in the Amazon region of South America, where deforestation has led to a resurgence of malaria. In Guyana and Suriname, training has been provided for 3,400 professional health workers and community members and more than 80,000 insecticide-treated bed nets have been distributed to remote rural and border areas. As a result of these activities, the number of malaria cases in Suriname and Guyana has declined. Similar HIV services are provided to Guatemala's indigenous Mayan people and in the most remote areas of Ethiopia.

2. GLOBAL FUND-SUPPORTED PROGRAMS IN CONFLICT SITUATIONS

In countries in conflict, Global Fund resources are often used by innovative partnerships of governments, nongovernmental organizations or multilateral organizations to deliver services. In Côte d'Ivoire, the Global Fund supports CARE International in implementing HIV and malaria prevention and treatment programs. The country experienced a 75 percent to 88 percent reduction in health staff during the period 2001 to 2004 as the result of civil unrest. In Haiti, Latin America's poorest country, US$ 124 million to combat the three diseases has been channeled through Fondation SOGEBANK, a foundation linked to a private bank. The early implementation of Global Fund-supported programs in Haiti was slow due to political unrest, economic slowdown and natural disasters. Nevertheless, by the end of 2008, these programs had reached 1.9 million people with prevention activities, treated 18,500 new smear-positive TB cases, distributed 180,000 insecticide-treated bed nets and, together with PEPFAR, provided HIV treatment to 17,700 patients. Fondation SOGEBANK works with the Ministry of Health to improve its capacity to manage the program over the medium term. Such local capacity-building is an integral part of Global Fund support.

3. EXTENDING PARTNERSHIPS TO REACH MORE PEOPLE IN COMMUNITIES

In Zambia, a comprehensive partnership of government, civil society and faith-based organizations provides treatment, prevention and care at the community level. The Zambia National AIDS Network (ZNAN) and the Churches Health Association of Zambia (CHAZ) identify community-based organizations that can deliver essential services as sub-recipients of Global Fund financing and manage community programs to fight the diseases. Alongside the government program, civil society forms an essential part of Zambia's health system. Various donors also provide assistance. For example, PEPFAR provides technical assistance to national ARV programs, while the Japan International Cooperation Agency (JICA) focuses on improving the quality of testing and HIV treatment. By the end of 2008, Zambia had 172,600 people on ARVs.

4. USING GLOBAL FUND RESOURCES TO REACH MIGRANT AND REFUGEE POPULATIONS

Thailand has an estimated 2.5 million migrant workers and refugees from neighboring countries, yet few government programs provide health services for this population, due to difficulties of language and access (exacerbated in many cases by their illegal status). Providing migrants and refugees with HIV services has been a priority for Thailand's Country Coordinating Mechanism and today there are grants for two programs, one providing HIV services and the other TB services for this population. Both programs are run by nongovernmental organizations in close collaboration with the government.

32. Grant proposals are required to show how they will reach particular groups of people at risk, and how they will address issues surrounding gender and sexual minorities. It is essential that the interventions the Global Fund supports ensure meaningful engagement at the community level to effectively reach those affected by the three diseases and those at risk.

33. In Ethiopia, health delivery at the community level has been strengthened with the deployment of 30,000 community health workers for AIDS, TB, malaria and other health issues. Most importantly, programs are engaging community networks and organizations to boost prevention. Similarly, in China and Russia many of the benefits of Global Fund-supported programs have resulted from the engagement of community organizations that can reach the high-risk groups of injecting drug users, sex workers, men who have sex with men, and prisoners. Illustrations of how results, and therefore the attainment of targets, stem from strategies to reach people at risk and tackle gender issues in programming are shown in Box 7.

2.4 FINANCE AND THE SPEED OF DISBURSEMENT

34. The results achieved by countries depend on the effective delivery of funding from the Global Fund and other partners. Global impact also depends on funding being channeled to where the disease burden is the largest or where potential growth can be prevented through effective interventions. This section reviews the amount of Global Fund commitments and disbursements, the speed of disbursement, and the allocation of funds by disease burden, region and service area.

2.4.1 INCREASING FINANCE AND DISBURSEMENT SPEED

35. As of 31 December 2008, the Global Fund had signed 581 grants worth US$ 10.3 billion in 137 countries. It had disbursed US$ 7.2 billion to countries.

36. The Global Fund typically approves a five-year proposal and disburses money incrementally based on program performance. It then approves the extension of financing for well-performing grants for an additional six years, providing a total of eleven years of funding within one grant. This promise of obtaining 11 years of uninterrupted funding (as long as results warrant a continuation of funding) represents a long-term commitment to countries in line with the general consensus about the desirability of sustainable funding.

37. The disbursement rate is measured by comparing the amount of funding disbursed to that planned in grants. In 2008, the disbursement rate was 96 percent, with all rounds having a disbursement rate nearly or greater than 90 percent (see Figure 9). Disbursement rates vary by country, depending on the speed at which countries can absorb funds. Only 16 percent of active grants have a disbursement rate less than 75 percent. These Principal Recipients are provided with appropriate technical support to improve disbursement rate.

38. To continue to attract donor support, the Global Fund must show that it can disburse in a responsive, efficient and predictable manner. The administrative costs of the Global Fund (which include both the expenses related to the Global Fund Secretariat and the fees paid to Local Fund Agents for in-country oversight) are relatively low, comprising approximately five percent of total annual expenditures.

FIGURE 9: FINANCIAL STATUS OF THE GLOBAL FUND: APPROVALS, COMMITMENTS AND DISBURSEMENTS BY FUNDING ROUND AND TOTAL (US$)

FUNDING ROUND	APPROVALS TOTAL	GRANT AGREEMENTS TOTAL	DISBURSEMENTS TOTAL	MEAN PERCENT DISBURSED	MEAN TIME ELAPSED	DISBURSEMENT/ TIME ELAPSED
ROUND 1 — APRIL 2002	1,736,000,000	1,458,000,000	1,232,000,000	88%	96%	92%
ROUND 2 — JANUARY 2003	2,591,000,000	1,847,000,000	1,536,000,000	87%	94%	93%
ROUND 3 — OCTOBER 2003	1,405,000,000	1,405,000,000	1,127,000,000	82%	86%	95%
ROUND 4 — JUNE 2004	2,818,000,000	2,647,000,000	1,760,000,000	72%	75%	96%
ROUND 5 — SEPTEMBER 2005	1,500,000,000	1,058,000,000	755,000,000	75%	83%	90%
ROUND 6 — NOVEMBER 2006	872,000,000	872,000,000	527,000,000	66%	63%	105%
ROUND 7 — NOVEMBER 2007	1,111,000,000	1,044,000,000	277,000,000	29%	13%	
ROUND 8 — NOVEMBER 2008	3,119,000,000					
TOTAL	**15,152,000,000**	**10,331,000,000**	**7,214,000,000**	**70%**	**73%**	**96%**

Notes: For Round 8 grants, while this figure represents all grants approved in principle, some will only receive funding approval when financing becomes available as per the terms of the Comprehensive Funding Policy. The Global Fund Board approves funds, which are then committed through grant agreements with Principal Recipients. Funds are then disbursed incrementally by the Global Fund to Principal Recipients based on performance.

2.4.2 WHERE DOES THE MONEY GO?

39. The Global Fund assesses how the funding it provides to countries is invested and whether its investments are balanced in terms of region and disease.

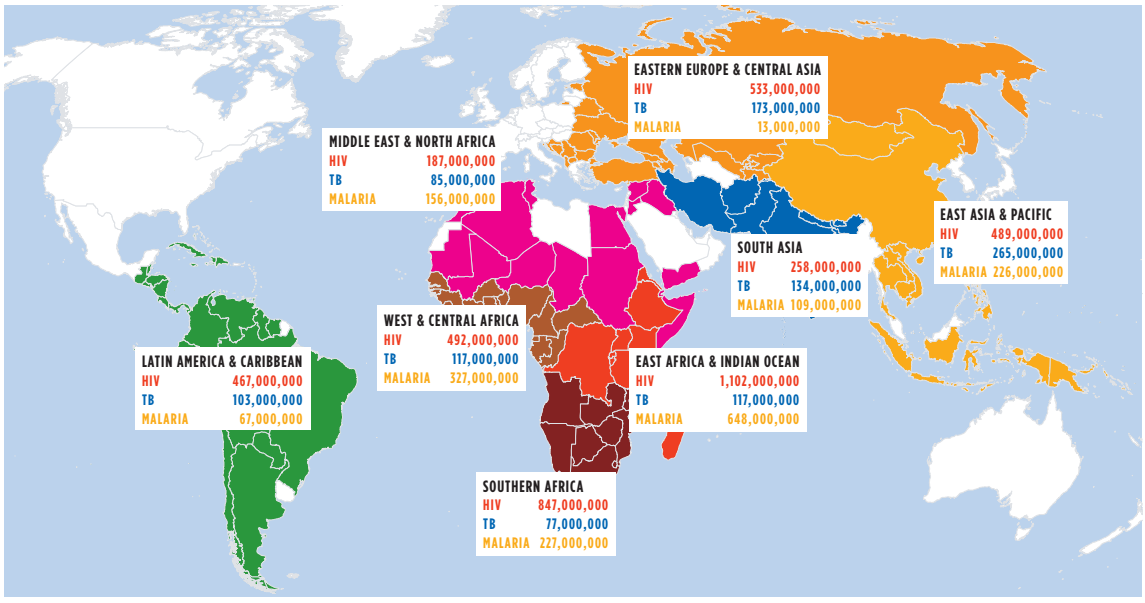
40. The distribution of funding by region and disease is shown in Figure 10. It shows that as of 31 December 2008, 25 percent of funding was for malaria, 15 percent for TB and 60 percent for HIV. Around 55 percent of the funds disbursed were to countries in sub-Saharan Africa.

41. A survey of Global Fund recipients[7] showed that approximately 32 percent of the budgeted funds is allocated to activities implemented by nongovernmental organizations, 38 percent goes to programs implemented by ministries of health, 18 percent is distributed to programs implemented by other government institutions, six percent is allocated to activities implemented by the United Nations Development Programme (UNDP), with programs operated by the private sector and other multilaterals accounting for three percent of budgeted funds (see Figure 11).

42. The survey revealed that around 44 percent of Global Fund resources were committed for medicines, health commodities (such as condoms) and other health products (such as bed nets or diagnostics), 25 percent for human resources and training, 14 percent for planning and administration, 11 percent for infrastructure and equipment and five percent for other expenses, as shown in Figure 11. Approximately five percent was budgeted for monitoring and evaluation. Overhead expenses, not previously captured in any Global Fund data collection, were reported as two percent of the entire budgeted amount.

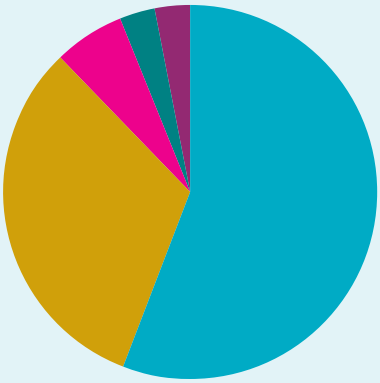
43. By service delivery area, roughly 33 percent of the reported budget amount was for prevention, 38 percent for treatment, mainly for HIV grants, nine percent was spent on care and support and 23 percent for supportive environment (see Figure 12). This last category covers all other activities, including program management costs – especially where the Principal Recipient plays an agency role – management support and activities that are not specifically prevention, treatment or care and support.

FIGURE 10: DISTRIBUTION OF DISBURSEMENTS BY REGION AND DISEASE UP TO 31 DECEMBER 2008



7 The survey (with responses representing 65 percent of the active portfolio with total budgets of approximately US$ 1.49 billion) for calendar year 2007 provides a cross-sectional view of budgets broken down by implementing entity (nongovernmental organization, government, private sector, faith-based organization), standard cost category (human resources, drugs, infrastructure, equipment, etc.) and service delivery area (prevention, treatment, care and support, and supportive environment).

FIGURE 11: DISTRIBUTION OF GRANT BUDGETS BY IMPLEMENTING ENTITY AND STANDARD COST CATEGORY, 2007 CALENDAR YEAR



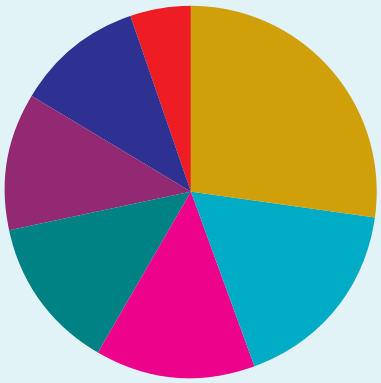
GOVERNMENT (MoH-68%; OTHERS-32%) **56%**

NONGOVERNMENTAL/COMMUNITY-BASED/FAITH-BASED /ACADEMIC ORGANIZATIONS **32%**

UNDP **6%**

OTHER MULTILATERAL ORGANIZATIONS **3%**

PRIVATE SECTOR **3%**



COMMODITIES & PRODUCTS **17%**

DRUGS **27%**

PLANNING & ADMINISTRATION **14%**

TRAINING **12%**

HUMAN RESOURCES **13%**

INFRASTRUCTURE & EQUIPMENT **11%**

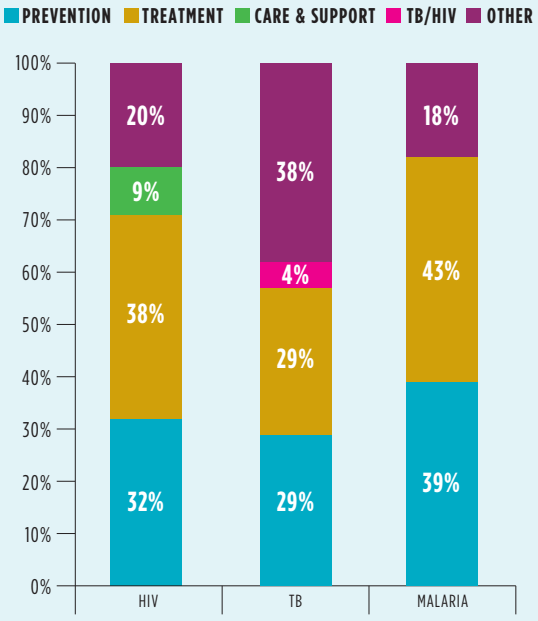
OTHER **5%**

Source: Survey of Principal Recipients, Global Fund, 2008.

44. Health commodities and drugs were major elements of most reported budgets. In AIDS program budgets, 16 percent was allocated for the purchase of ARVs (first- and second-line); in TB programs, 16 percent was budgeted for the purchase of first- and second-line drugs and in malaria programs, 25 percent was allocated for ACTs and 24 percent for the purchase of insecticide-treated bed nets.

45. Analysis of budget allocations by service delivery area in AIDS programs showed that ARV monitoring and treatment comprised 33 percent of program budgets and HIV counseling and testing approximately nine percent.

FIGURE 12: DISTRIBUTION OF GRANT BUDGETS BY SERVICE DELIVERY AREA WITH DISEASE BREAKDOWN, 2007 CALENDAR YEAR



Source: Survey of Principal Recipients, Global Fund, 2008.

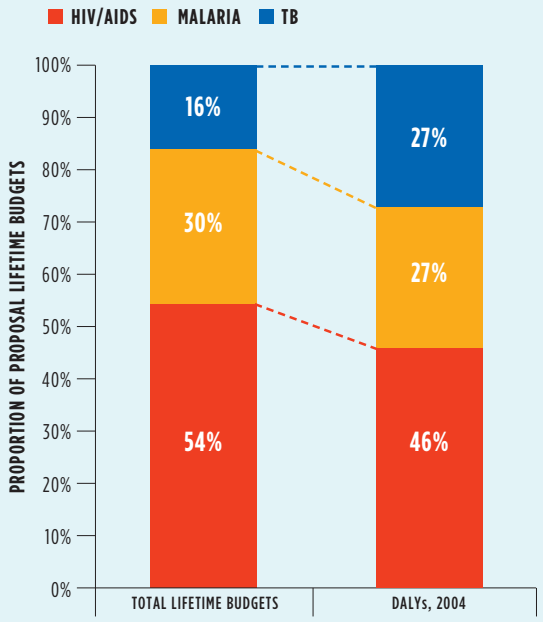
2.4.3 INVESTMENT IN RELATION TO DISEASE BURDEN

46. The Global Fund financing model is demand-driven. An important strength of the demand-based portfolio is its responsiveness to evolving global disease priorities. An analysis of the total committed lifetime budgets for grants in Rounds 1 to 8 (as opposed to disbursements analyzed in the previous section) for AIDS, malaria and TB shows the proportional share for these diseases to be 54 percent, 30 percent and 16 percent, respectively, in line with WHO estimates of global burden of disease for AIDS and malaria, 46 percent and 27 percent respectively, but below that of TB, which accounts for a 27 percent share of global disease burden (see Figure 13).

2.4.4 GLOBAL FUND SHARE OF INTERNATIONAL FINANCING TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

47. By the end of 2008, the Global Fund had disbursed US$ 4.4 billion to AIDS programs. The Global Fund's contribution to international financing for AIDS doubled between 2003 and 2005, from eight to 18 percent and further increased to 23 percent in 2007 when US$ 1.1 billion was disbursed by the Global Fund to AIDS programs (see Figure 14).

FIGURE 13: DISTRIBUTION OF FUNDING COMPARED TO ESTIMATED RELATIVE DISEASE BURDEN



Note: Aggregate lifetime budgets of approved proposals (Rounds 1 to 8).
Source: Disability-adjusted life years data taken from WHO, *Global Burden of Disease 2004 Update Report*, 2008.

48. The Global Fund is the major international financier for TB. In 2008, the Global Fund contributed an estimated 57 percent of external (non-domestic) financing for TB control. Given the rapid increase in funding for malaria, no comprehensive figures for global spending on malaria are available for 2007 or 2008. Tentative figures suggest that the Global Fund contributed 60 percent of external funding for malaria control – a figure which is likely to increase beyond 2008, given the largest-ever funding round in Round 8, which led to the recommendation of around US$ 1.6 billion over two years for malaria grants.

2.4.5 MALARIA, TUBERCULOSIS AND HIV INTERVENTIONS PROVIDE VALUE FOR MONEY

49. Many malaria, TB and HIV interventions provide very good value for money and cost effectiveness in terms of disability-adjusted life years[8] per US$. Malaria prevention interventions are some of the most cost-effective health interventions identified by the disease-control priorities project,[9] and are some of the cheapest of neglected low-cost interventions for childhood illnesses (US$ 9 to US$ 218 per disability-adjusted life year). They are also cost-effective when compared to maternal and neonatal care interventions (US$ 80 to US$ 409 per disability-adjusted life year).

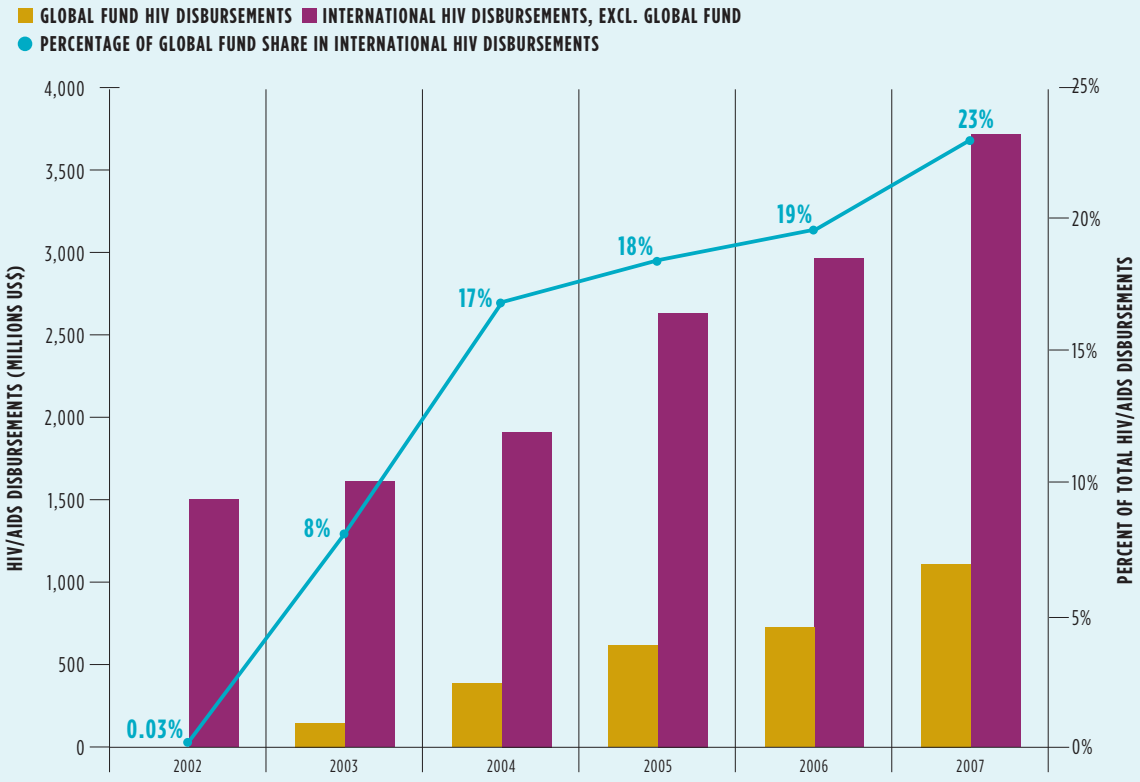
50. TB treatment and even treatment for multidrug-resistant TB also compares favorably to the range of low-cost interventions, as does HIV prevention (although the range there is very large, suggesting that its cost effectiveness needs to be looked at more closely).

51. HIV treatment is more expensive (US$ 922 per disability-adjusted life year). However, this does not include the wider benefits of HIV treatment as part of a package of HIV interventions, its population-level impact on reducing adult mortality and the burden on the health system and communities.

52. The Global Fund ensures the value for money of its investments through careful review of budgets against results and the use of the Price & Quality Reporting System for procurement. However the Global Fund is generally only one source of financing in a country disease program (alongside government, civil society and other donors (for example PEPFAR, World Bank and bilateral donors)). It is therefore impossible to separate the disability-adjusted life year value of Global Fund financing on its own.

8 For a definition of disability-adjusted life years, see WHO's website on the Global Burden of Disease at: http://www.who.int/topics/global_burden_of disease/en/
9 http://www.dcp2.org/pubs/PIH

FIGURE 14: GLOBAL FUND AND TOTAL INTERNATIONAL DISBURSED FUNDS FOR HIV (2002-2007)



Note: Data is based on comparable disbursements, although definitions may vary between agencies.
Source: UNAIDS/Kaiser Report, 2008.

FIGURE 15: GLOBAL FUND SHARE OF INTERNATIONAL FINANCING FOR TUBERCULOSIS AND MALARIA CONTROL

GLOBAL FUND **57%**

GRANTS (EXCLUDING GLOBAL FUND) **25%**

LOANS **18%**

THE GLOBAL FUND **60%**

THE WORLD BANK **15%**

BILATERALS **11%**

UN AGENCIES **9%**

PRESIDENT'S MALARIA INITIATIVE **5%**

Sources: WHO Stop TB data, 2008; WHO World Malaria Report 2008.

FIGURE 16: COST EFFECTIVENESS IN DISABILITY-ADJUSTED LIFE YEARS FOR HIV, TUBERCULOSIS AND MALARIA INTERVENTIONS

	INTERVENTION	TYPE	COST EFFECTIVENESS (US$/DISABILITY-ADJUSTED LIFE YEAR)	ACCEPTABLE RANGE (US$/DISABILITY-ADJUSTED LIFE YEAR)
MALARIA	INSECTICIDE-TREATED BED NETS	SUB-SAHARAN AFRICA	11	5-17
	INDOOR RESIDUAL SPRAYING	SUB-SAHARAN AFRICA	17	9-24
TB	DOTS	EPIDEMIC	102	15-189
	MANAGEMENT OF DRUG RESISTANCE	EPIDEMIC	207	201-212
HIV	PREVENTION ACTIVITIES (PEER COUNSELING, CONDOMS, BLOOD SAFETY, PMTCT)	SUB-SAHARAN AFRICA	6-377	
	ART	SUB-SAHARAN AFRICA	922	350-1,494

Source: The World Bank, *Disease Control Priorities Project in Developing Countries*, 2nd Edition, 2006.

53. To generate more direct information on unit costs and value for money of its investments, the Global Fund is implementing the following tools:

- Enhanced financial reporting to better track financing by results area from 2008;
- Unit cost tools with partners (WHO, UNAIDS, Roll Back Malaria Partnership (RBM), WHO Stop TB) to provide per person unit costs of the delivery of insecticide-treated bed nets, TB treatment and ARVs from 2009;
- Increasingly including this information in performance reviews, and to negotiate unit costs with Principal Recipients of grants.

54. The cost per disability-adjusted life year will depend on better information on the impact of grants in terms of disability-adjusted life years saved. This is a major measurement challenge, and will require investment in country surveillance and surveys. However, the Global Fund is committed to developing tools to measure impact and value for money. Increasingly this will be the important measure of Global Fund investments and their effectiveness in countries.

2.5 IMPROVING THE QUALITY OF DATA USED FOR GENERATING RESULTS

55. Ensuring the quality of programmatic data is critical for performance-based funding to work. Since 2006, the Global Fund has developed and progressively implemented methodologies to strengthen and assess the quality of programmatic data reported by the Principal Recipients of Global Fund grants.

56. Global Fund-supported programs report on implementation progress using a set of indicators drawn up and agreed upon in the grant performance framework. These indicators are classified into three levels: capacity building, people reached with services and impact on the diseases. The top ten indicators for people reached with services and impact are shown in Annex 2 and described in the *Monitoring and Evaluation Toolkit*[10] (developed jointly with development partners and technical agencies). The Global Fund does not develop its own indicators but uses those agreed internationally and commonly used in countries. See Annex 5 for details on the Global Fund's monitoring and evaluation systems and data quality control.

10 http://www.theglobalfund.org/en/me/?lang=en

WITH GLOBAL FUND SUPPORT, A COMMUNITY HEALTH CENTER IN VIET NAM'S KHANH VINH DISTRICT IS ABLE TO ACQUIRE A NEW MICROSCOPE. QUALITY DIAGNOSIS IS VITAL TO PRESERVING THE EFFICACY OF ACTs IN FIGHTING MALARIA.

WOMEN AT THE AXUM HEALTH CENTRE, ETHIOPIA ARE GIVEN TRAINING AND A STIPEND OF 200 BIRR (OR ABOUT US$ 17) PER MONTH TO TEACH OTHER WOMEN ABOUT HOW TO PREVENT TRANSMISSION OF HIV FROM MOTHER TO CHILD.

3. PARTNERSHIPS

INVESTING IN SUSTAINABLE HEALTH AND COMMUNITY SYSTEMS

"The real issue is sustaining the scale up … we needed to prepare the health system for a bigger impact by training local health workers to help scale up treatment. But above all, community prevention should lead. Supporting community organizations and health systems is critical to sustaining the scale up towards impact."

—MINISTER OF HEALTH, ETHIOPIA

3.1 THE GLOBAL FUND PARTNERSHIP: FROM THE GLOBAL AND COUNTRY LEVELS TO THE COMMUNITY LEVEL

1. The Global Fund constitutes a unique partnership, bringing together recipient governments, donors, civil society, the private sector, foundations, representatives of communities living with the three diseases and technical partners. These partners, united by a common stake in public health, are involved at all levels of the Global Fund model, from membership of the Board through to country coordination and implementation of programs in communities. This partnership is a source of innovation and essential to effective performance of the Global Fund model. The inclusive range of the partnership also provides a crucial opportunity to ensure people in need are reached with services, whether from government, civil society or private sector providers and to ensure that the drivers of the epidemics are addressed at the community level.

2. Since the Global Fund is dependent on a network of partners to execute its core functions, it is important that the systems underlying them be supported to deliver results. Reaching a mother with HIV in a rural community relies on several such systems, from the capacity of the national disease program to trained district health workers to community networks that reach into the household. The Global Fund has therefore become a major financier of systems to ensure the delivery of health services into the community and household.

3. This section stresses the importance of encouraging programs to support systems alongside delivering services and extending activities so that the epidemic can be managed at the community level – a core message of this report. It also reviews the Global Fund partnership, from global development, to national health system, to the critical engagement at community level. First, the section looks at the need to support the delivery of services into communities, then at investments to support health systems and finally at progress against the aid effectiveness indicators agreed by development partners and countries in the Paris Declaration.

3.2 COMMUNITY SYSTEMS: WORKING WITH PARTNERS ON THE GROUND

"We have very good programs, but the only problem is how exactly we can reach the people in need … in AIDS, I think the Global Fund definitely plays a very important role in inspiring civil society to play a more active role in prevention to help the people who are exactly in need … that is a sort of very historic revolution in Chinese disease prevention history."

—MINISTRY OF HEALTH, CHINA

4. The Global Fund recognizes that some of the most innovative services are provided by nongovernmental organizations and community organizations. Along with health systems strengthening, the Global Fund strongly supports community systems strengthening and the delivery of AIDS, TB and malaria services through community organizations.

BOX 8: COMMUNITY SYSTEMS STRENGTHENING

Community systems strengthening refers to initiatives that contribute to the development and/or strengthening of community-based organizations and networks in order to improve knowledge of, and access to, improved health service delivery and prevention. The Global Fund strongly supports the inclusion of community systems strengthening in grant proposals to achieve:

- Improved outcomes for HIV, TB and malaria prevention, treatment and care and support programs;
- Improved community mobilization around HIV, TB and malaria activities through the leveraging of local networks including local leaders, private sector, faith-based organizations and groups working with gender and sexual minorities.

Community systems strengthening areas of activity may include a focus on:

- Building capacity: of the core processes of community-based organizations to provide an increased range, or quality of services, through for example:
  - Training and human resource development;
  - Mentoring younger community organizations;
  - Organizational systems development, including financial management, strategic planning, monitoring and evaluation and information management.
- Mobilizing community networks: at the local level to ensure involvement of relevant networks that can mobilize the community around interventions including local politicians, leaders, private sector and networks working on gender and with sexual minorities.

COUNSELING ON HOW TO PREVENT HIV INFECTION IS GIVEN BACKSTAGE TO PERFORMERS IN A MEN'S BAR IN CHONGQING CITY, CHINA. OUTREACH TO VULNERABLE POPULATIONS SUCH AS TRANSSEXUALS AND MEN WHO HAVE SEX WITH MEN IS A KEY ELEMENT OF CHINA'S PREVENTION STRATEGY.

3.2.1 STRENGTHENING COMMUNITY ORGANIZATIONS

5. With support from the Global Fund, the Center for AIDS Development, Research and Evaluation (CADRE) in Johannesburg, South Africa, has been conducting research in communities to identify some of the actions needed at the community level to improve implementation. CADRE has identified three critical needs for growing and sustaining community-based organizations, namely

- building capacity;
- mobilizing community networks, and
- securing sustainable financing (see Figure 17).

6. Programs supported by the Global Fund can include community systems strengthening components in their funding requests,[11] based on the actions outlined in the CADRE study and on additional actions developed by the Global Fund in its proposal forms.

7. There are good examples of Global Fund-supported activities to strengthen the capacity of nongovernmental organizations and community-based organizations. For example, in Russia there has been strong coordination of and investment in nongovernmental organizational capacity, with some of the most innovative and transparent monitoring and evaluation systems in the Global Fund portfolio. Implementers receive support to report on their activities and share them, together with lessons learned, on an Internet portal. In Zambia, Principal Recipients representing nongovernmental organizations, faith-based organizations and government implement separate elements of the program to fight HIV. This is an example of the multi-sectored approach advocated by the Global Fund in its policy for "dual-track financing" to support direct implementation of programs by civil society alongside government.

11 http://www.theglobalfund.org/en/rounds/9/faq/

COMMUNITY-BASED TRAINING CLINICS PLAY AN IMPORTANT PART IN THE SUCCESSFUL REDUCTION OF MALARIA PREVALENCE IN ZANZIBAR. THIS COMMUNICATION CAMPAIGN WAS A KEY ELEMENT IN ZANZIBAR'S FOUR-PRONGED STRATEGY TO FIGHT MALARIA, WHICH RESULTED IN A 50 PERCENT REDUCTION IN THE NUMBER OF MALARIA CASES.

BOX 9: STRENGTHENING COMMUNITY SYSTEMS

Recent work by CADRE has identified specific organizational needs and the appropriate actions to lead to more efficient community organizations.

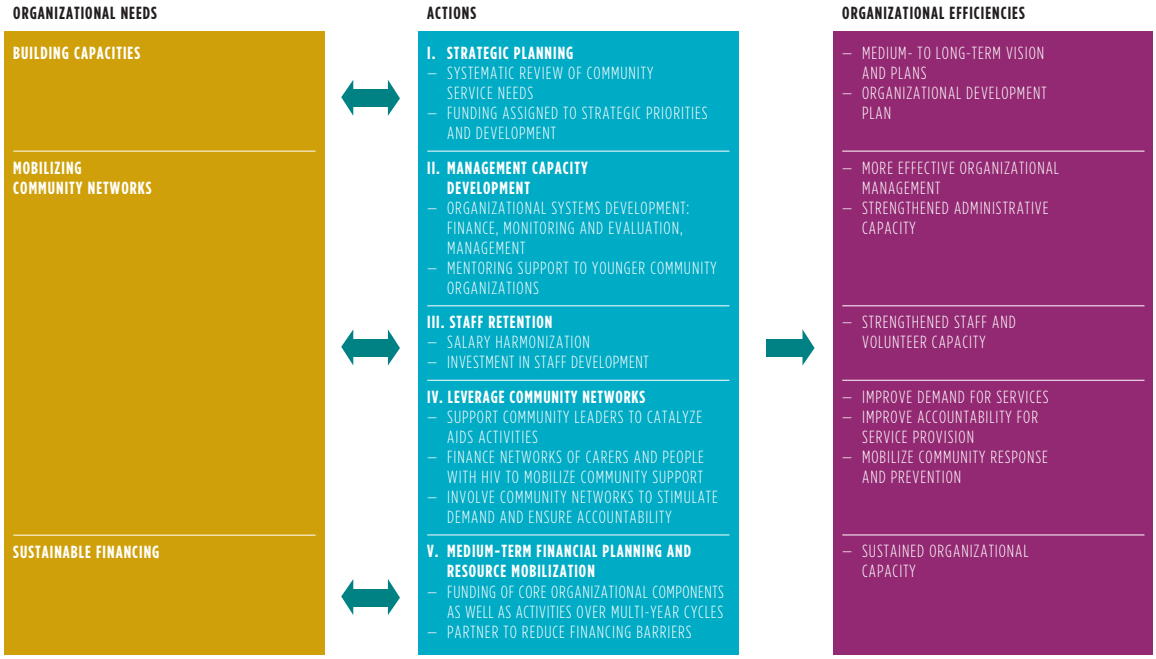


FIGURE 17: MECHANISMS TO STRENGTHEN COMMUNITY SYSTEMS

Source: CADRE, Global Fund, 2008.

The actions aim to ensure the sustained development of organizational capacity, long-term plans, more effective management, staff capacity and increased organizational learning and coordination. They are described below:

a. **Balance between funding of core organizational resources and activities.** Community organizations are often established by one or more committed individuals addressing community needs. Such interests unfold over time into formal structures that are initially self-funded, with expansion being triggered by access to external funding. There is a danger they rely on activity funding without an underlying administrative or core budget:

> **"When we were established we operated without funding. I was responsible for everything in the organization, even using my own money to get necessities like food and clothing for the children. That was before we got funding … When we got our first funding, that was when we began functioning as a real organization. We managed to get staff members to help me with the day-to-day running of the organization as I could afford to give them stipends".**
>
> —DIRECTOR, CHILDREN'S PROJECT, WESTERN CAPE

> **"When we started we did not think paperwork would be involved. The problem we have is illiteracy. People do work, but the problem comes when they have to record their work".**
>
> —DIRECTOR, HBC ORGANIZATION 1, LIMPOPO

b. **Strategic and medium to long-term planning**. Turning points in organizational development were explored in the CADRE study. These included both negative and positive events and transitions. Receipt of first funding provided a stable basis from which organizations could begin their work. However, inability to access long-term funding limited organizational development and long-term planning, producing uncertainty and instability.

> **"You know, in an organization there is one thing. When there are no funds, even if a person is serious about being in the organization, if at month end they don't get paid, they will sit down and say 'I can't work for nothing'"**
>
> —DIRECTOR, AWARENESS PROGRAMME, GAUTENG

c. **Growing management and administrative capacity.** Directors typically take on multiple functions, including areas where they have little or no skills and training, and with little opportunity to delegate responsibilities to others. As a result, systems to support and train directors and staff are needed, as one director in Gauteng noted, making an analogy with soccer:

> **"I have eleven people in my team, but I am the scorer, the goalkeeper and the defender."**

d. **Staff retention and salaries.** In many organizations, commitment amongst founding individuals and core members was high, but a consistent risk was staff members and volunteers leaving organizations as a product of having developed skills or for higher salaries.Harmonization of salary scales, taking into account the market value, can provide a solution.

> **"Because of the skills they have acquired, some have been taken as lay counselors by government because of their training … We groom them, but they are taken by others because they promise higher salaries … that is our challenge".**
>
> —DIRECTOR, HBC ORGANIZATION 2, LIMPOPO

e. **Establishment of systems of networking and dialogue.** Organizations reviewed by CADRE's study recognized that networking was valuable in overcoming isolation and lack of resources. Networking with other similar organizations included a range of benefits such as shared learning, links to funders and complementarity between organizations. This is important for organizations and funders, and can produce funding for networking and mentoring opportunities, too.

> **"Networking is significant because these community organizations cannot stand on their own. They must be in contact with organizations running similar programmes. It's an opportunity for them to learn from one another and be exposed to the bigger picture"**
>
> —DIRECTOR, NETWORKING ORGANIZATION, WESTERN CAPE

BOX 10: STRENGTHENING HEALTH SYSTEMS THROUGH HIV, TUBERCULOSIS AND MALARIA PROGRAMS

FLEXIBLE INVESTMENT IN HEALTH SYSTEMS

Global Fund-supported programs in AIDS, TB and malaria invest in health systems. The Haiti AIDS/TB program has contributed to improved public health outcomes generally. An analysis of health indicators for a 14-month period found that the program in Haiti also contributed to improved delivery of vaccines and prenatal care visits. In addition, procurement, management and staff morale were improved. In Rwanda, HIV funds supported the establishment of integrated HIV services at health centers. The renovation of entire health centers was undertaken.

MORTALITY REDUCTION IN HEALTH WORKERS

Health workers are severely affected by the AIDS epidemic. The Malawi AIDS program, supported by the Global Fund, has saved the lives of a significant number of health workers through its AIDS treatment program. Two hundred and fifty health care workers were required to deliver the AIDS treatment program, which has provided treatment to more than 1,000 health workers as well as to more than 100,000 people nationally. Supporting health care workers in Rwanda, Ethiopia and Mozambique has included shifting specific tasks to non-physicians to relieve the burden on physicians.

REDUCTION IN HOSPITAL BURDEN

AIDS and malaria cases in Africa place substantial strain on the health system. In Rwanda, AIDS and malaria programs have reduced the burden on hospitals, freeing up resources which can be used to expand general health care.

BOX 11: HUMAN RESOURCES FOR HEALTH SUPPORTED BY GLOBAL FUND GRANTS

COUNTRY EXAMPLE	PEOPLE TRAINED AND ACTIVITIES THROUGH GRANT FINANCES
CHINA	More than 770,000 service providers trained for TB to increase case detection by strengthening collaboration between the hospitals and the TB dispensary systems. These included community workers as well as health personnel.
ETHIOPIA	More than 63,000 facilitators trained nationwide for community mobilization, including youth, women, farmers, members of faith-based organizations and community-based organizations, community leaders, development agents and health extension workers who are living in the community or kebele.
INDIA	More than 150,000 staff trained to increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at the community level. These include staff from nongovernmental organizations, community-based organizations, private practitioners, women's groups, people living with HIV or AIDS support groups, community and home-based care programs.
ZAMBIA	More than 100,000 health care workers trained to implement the Stop TB strategy.

Source: Performance Reports, Global Fund, 2008.

3.3 INVESTING IN HEALTH SYSTEMS

8. The Global Fund is now one of the major financiers of health systems. Almost one-third of its funds are used to directly strengthen health systems to deliver health services effectively.

9. The Global Fund recognized early on that fighting the three diseases and support for health systems go hand in hand. Since 2005, the Global Fund has also financed cross-cutting actions that apply to more than one disease to strengthen health systems.

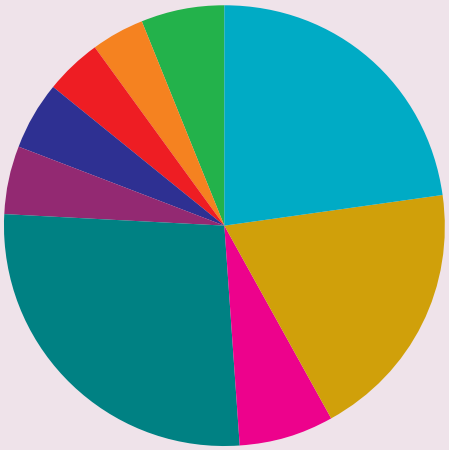
10. Disease programs funded by the Global Fund strengthen health systems indirectly with financing, by reducing mortality among health workers and by reducing burden on the health system by tackling the three diseases, thereby creating capacity to address other conditions (see Box 10).

11. Human resources are a critical area for health systems support and to scale up access to treatment and prevention for the three diseases. Through the HIV, TB and malaria programs it finances, the Global Fund is contributing to efforts to increase the number and capacity of human resources in developing countries (see Box 11).

12. In Round 7, health systems support was requested in 113 of the 150 eligible proposals (75 percent). Forty percent of the value of health systems strengthening strategic actions (US$ 186 million, and up to US$ 363 million over five years) identified by applicants in eligible Round 7 proposals was recommended for funding by the Technical Review Panel.

13. Similarly, in Round 8, strategic actions aimed at strengthening health systems were requested in 45 of 174 eligible proposals. Fifty-five percent of the value, US$ 283 million (up to US$ 593 million over five years), was recommended for funding by the Technical Review Panel, which is a similar success rate to disease components for the round. In Figure 18, the breakdown of approved funding for health systems strengthening in Round 8 shows the range of activities requested by countries.

FIGURE 18: DISTRIBUTION OF HEALTH SYSTEMS STRENGTHENING STRATEGIC ACTIONS IN 2008



HUMAN RESOURCES 23%

TRAINING 19%

MONITORING AND EVALUATION 7%

INFRASTRUCTURE AND EQUIPMENT 27%

HEALTH PRODUCTS 5%

MANAGEMENT 5%

COMMUNICATION 4%

PROCUREMENT 4%

OTHER 6%

Note: Range of activities requested by countries.
Source: Global Fund Board-approved Round 8 proposals, 2008.

14. The introduction in 2007 of a Rolling Continuation Channel for well-performing programs enables such programs to continue an additional six years beyond the standard five-year Global Fund grant lifecycle. This new funding channel is another means by which health systems strengthening can be financed. Since 2007 more than US$ 1.2 billion has been approved (up to US$ 2.5 billion for six years) through this channel, out of which US$ 191 million (up to US$ 450 million over six years) has been approved for strategic actions aimed at strengthening health systems strengthening.

15. In Thailand, finances from the Rolling Continuation Channel will be used to integrate the disease programs into the general health system to sustain and expand the impact that has already been achieved.

BOX 12: EXAMPLES OF SYSTEMS STRENGTHENING

IN RWANDA THE GLOBAL FUND SUPPORTS HEALTH INSURANCE AND HUMAN RESOURCES

The Global Fund-supported program in Rwanda subsidizes improved access to health care for the poor, people living with HIV, and orphans, and also strengthens and improves the performance and quality of the health service delivery system. Financing for the community insurance scheme and infrastructure costs make up more than 90 percent of the budget. This supports long-term, sustainable impact and has contributed to increasing health insurance coverage from 44 percent to 73 percent. With Global Fund financing, more than 1.5 million yearly insurance subscriptions were paid for very poor people and 146,130 yearly subscriptions were provided for people living with HIV.

Overall, the successful Rwanda program has improved the health system through training health workers, improving disease surveillance and investing in infrastructure, in addition to resulting in declining prevalence of HIV infection and reduced child mortality as a result of malaria interventions.

THE GLOBAL FUND SUPPORTS GREATER INVOLVEMENT OF THE NON-HEALTH SECTOR AND NONGOVERNMENTAL ORGANIZATIONS IN THAILAND

The HIV program in Thailand is well established and successful, supported with Global Fund financing for ongoing access to comprehensive prevention and care services through infrastructure improvements, better service delivery of essential medicines and greater involvement of non-health sector actors and nongovernmental organizations.

Prevention efforts funded by this grant are focused on young people, people in the workplace and migrants. Financing also supports ARV therapy and care and support for people living with HIV or AIDS and HIV-positive mothers and their families, as well as HIV management training for medical and nursing staff and laboratory strengthening. Global Fund money also supports the development of procurement and condom distribution systems.

IN ETHIOPIA, THE GLOBAL FUND AND PARTNERS ARE EXPANDING ACCESS TO PREVENTION AND TREATMENT

Supporting the HIV program in Ethiopia has had many positive effects on the health system. By 31 December 2008, a total of US$ 560 million had been disbursed by the Global Fund in support of AIDS, TB and malaria activities in Ethiopia. These finances have strengthened and expanded counseling and testing in more than 650 health facilities and freestanding centers, expanded and improved clinical management of HIV infection, expanded management of sexually transmitted diseases in more than 350 clinics across the country and improved the safety of medical practices through strict application of universal precautions in health facilities.

Joint implementation with PEPFAR, the World Bank and other partners has expanded entry points for ARVs and improved access to treatment and care with the construction of 432 health centers. More than 180,000 patients have received prophylaxis and treatment for opportunistic infections. Global Fund-supported programs identified human resources limitations and the recent Round 7 proposal addresses the need to support human resource bottlenecks. Funds are used to train data clerks deployed to health facilities, and support the improvement of health management with clinical mentorship services. Funding also builds storage and distribution capacity for the procurement and supply of drugs.

TUBERCULOSIS IS THE NUMBER ONE OPPORTUNISTIC INFECTION FOR THOSE LIVING WITH AIDS. IN PARAGUAY, TESTING FOR TB IS PART OF A RANGE OF COUNSELING AND SUPPORT SERVICES PROVIDED TO HIV-POSITIVE CLIENTS.

FIGURE 19: VALUE OF HEALTH SYSTEMS STRENGTHENING STRATEGIC ACTIONS SINCE 2007

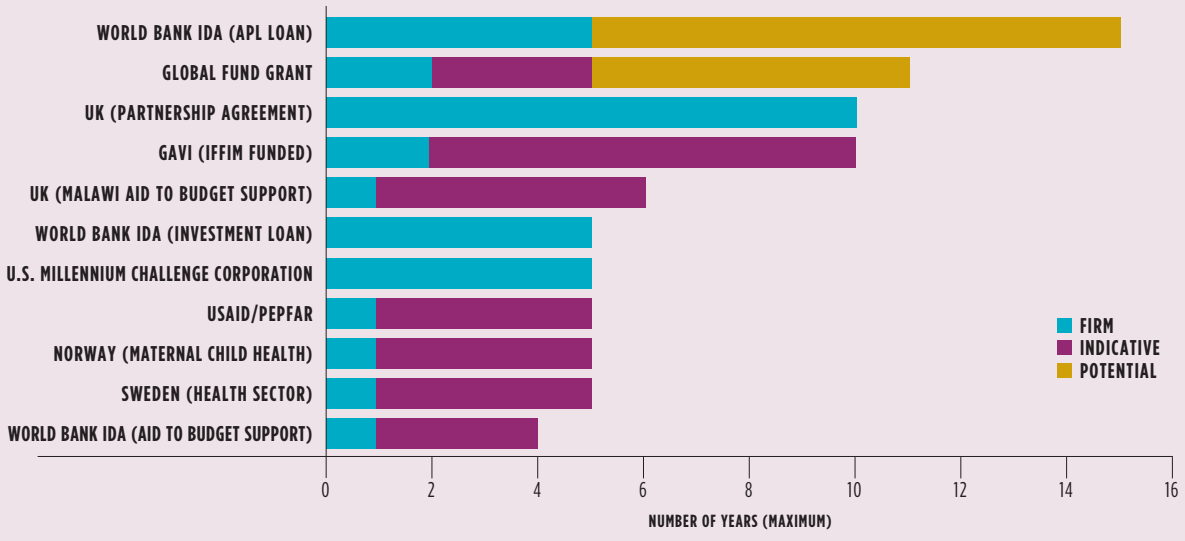
FUNDING STREAM	YEAR(S)	APPROVED TOTAL (US$ MILLIONS)	LIFETIME TOTAL (US$ MILLIONS)
ROUND 7	2007	186	363
ROLLING CONTINUATION CHANNEL (RCC)	2007-2008	191	450
ROUND 8	2008	283	593
TOTAL		660	1,406

Source: Global Fund Board-approved proposals.

16. Meeting the Millennium Development Goals for HIV, TB and malaria will require a significant increase in available resources: a total of US$ 28 billion to US$ 31.2 billion annually for 2008-2010 is needed to fight the three diseases. The price tag for health systems is larger still – critically so for human resources, where an estimated US$ 92 billion is required by 2015, with an additional US$ 39 billion for salary support, to fill the gap of 2.4 million doctors, nurses and urgently needed health-care workers. WHO estimates 38 countries in sub-Saharan Africa do not have the statutory 20 physicians per 100,000 people and 17 have less than half of the required number of nurses at fewer than 50 per 100,000 people.

17. For health systems, the partnership platform still needs financial reinforcement. To maintain support of health systems, particularly for recurrent expenditures such as salaries, will require sustainable commitments to countries. A study on donor commitments to long-term development aid (referenced in Figure 20) found that the model of the Global Fund provides predictable financing for 11 years – significantly longer than many bilateral agencies.

FIGURE 20: GLOBAL FUND GRANTS CAN PROVIDE LONG-TERM PREDICTABLE FUNDING



Notes: IDA—International Development Assistance; APL—Adaptable Program Lending; IFFIM—International Financing Facility for Immunization.
Source: Chris Lane, WHO.

FIGURE 21: 2007 PARIS DECLARATION MONITORING RESULTS

PARIS DECLARATION PRINCIPLE	THE GLOBAL FUND'S AID EFFECTIVENESS SCORECARD	2005 RESULTS (N=32)	2007 RESULTS (N=32)	2007 RESULTS (N=54)	2010 TARGETS
OWNERSHIP AND ALIGNMENT	AID RECORDED ON BUDGET	15%	35%	23%	85%
	GRANTS ALIGNED WITH COUNTRY CYCLES	62%	62%	62%	90%
	USE OF COUNTRY FINANCIAL MANAGEMENT SYSTEMS	39%	44%	39%	59%
	USE OF COUNTRY PROCUREMENT SYSTEMS	33%	59%	56%	55%
	USE OF PARALLEL PROJECT IMPLEMENTATION UNITS	16%	8%	13%	5%
AID IS PREDICTABLE AND UNTIED	ACTUAL/EXPECTED DISBURSEMENTS	90%	98%	95%	95%
	AID RECORDED AS SCHEDULED	16%	35%	30%	60%
	AID IS UNTIED	100%	100%	100%	100%
HARMONIZATION WITH PARTNERS	SUPPORT TO PROGRAM-BASED APPROACHES	74%	79%	68%	66%
	JOINT MISSIONS WITH OTHER DONORS	15%	15%	14%	40%
	JOINT COUNTRY STUDIES WITH OTHER DONORS	50%	17%	22%	50%
MANAGING FOR RESULTS AND ACCOUNTABILITY	TRANSPARENT AND MONITORABLE PERFORMANCE FRAMEWORKS	100%	100%	100%	100%
	GRANTS ALIGNED TO NATIONAL M&E SYSTEMS	73%	82%	82%	90%

Source: Survey of countries with Global Fund support – representing 59 percent of disbursed grants in 2007.

BOX 13: GLOBAL FUND STRENGTHS AND WEAKNESSES (FROM THE PARIS MONITORING PROCESS)

STRENGTHS

- Untied and largely predictable financing to recipients
- Continued support for the use of public systems, including procurement
- Financing in support of a program approach
- Alignment with country cycles and support for monitoring and evaluation systems (though improvements are needed)

WEAKNESSES

- Collaboration on missions and reports
- Reduction in parallel implementation units
- Use of national auditing procedures

BOX 14: ACTIONS TO IMPROVE AID EFFECTIVENESS OF THE GLOBAL FUND

ACTION AGENDA OF POLICY, STRATEGY AND COMMUNICATION CHANGES DEVELOPED IN 2008

1. National strategy applications will simplify application and reporting procedures by harmonizing support to one national strategy.
2. Performance lines of credit for successful programs will allow countries to access continuous funding based on financial and programmatic performance.
3. Dual-track financing maximizes channels for delivery in countries by directly financing civil society and non-state actors.
4. Salary support policy has been harmonized with partners.
5. Communication strategy to Country Coordinating Mechanisms and those outside the health sector will be developed to encourage collaboration and coordination.

3.4 ACTIONS TO IMPROVE AID EFFECTIVENESS

"Achieving development results – and openly accounting for them – must be at the heart of all we do."

—ACCRA AGENDA FOR ACTION, 2008

18. The Global Fund is committed to improving aid effectiveness with partners. It has signed the Paris Declaration, which emphasizes strong support for country-owned and aligned programs, a partnership model and commitment to delivering accountable results: principles which guide the Global Fund.

19. The Global Fund is also collaborating closely to measure progress against the 2010 targets set to track achievement of Paris Principles. The 2005 baseline measures were followed up in 2007. Country interest in the Paris Declaration monitoring has grown from 32 to 54 countries now committed to measuring progress (see Figure 21). These countries represent 59 percent of financing disbursed in 2007 and US$ 3.4 billion of commitments.

20. The Global Fund is using lessons learned from the results as a basis for actions to improve aid effectiveness. The analysis above shows that the areas for improvement include collaboration on missions and reports, however the volume of these is considerably lower than for many other donors and the burden on government time is comparatively less. There is also room for improvement in reducing the number of parallel implementation units. The use of country procurement systems has met the 2010 target set with 56 percent of financing using national systems. Overall, 2007 results show little change from baseline data, in part due to stricter criteria employed in measurement and in part due to the fact that actions to improve aid effectiveness have only recently been implemented.

3.4.1 THE GLOBAL FUND ACTION AGENDA TO IMPROVE AID EFFECTIVENESS

21. Responding to these challenges, the Global Fund is measuring its performance, learning from its own findings and independent evaluations and as a result taking continuous actions to strengthen its aid effectiveness. An action agenda for the Global Fund has been developed (see Box 14).

22. The Global Fund was an active participant at the 3rd High-Level Forum on Aid Effectiveness, Accra, in September 2008. In addition, the Global Fund convened the learning group of global programs founded in 2006 to share best practices and respond to the Paris Principles. In addition to the Global Fund, the learning group includes the GAVI Alliance, Fast Track Initiative for Education, Global Environment Facility, Consultative Group on International Agricultural Research and Cities Alliance. The group provides a forum in which to identify strengths and weaknesses of the respective models and exchange lessons to improve aid effectiveness.

23. The Global Fund is participating in a number of initiatives aimed at improving aid effectiveness in countries, including the International Health Partnership and the Global Campaign for the Health-Related MDGs, spearheaded by the Norwegian government.

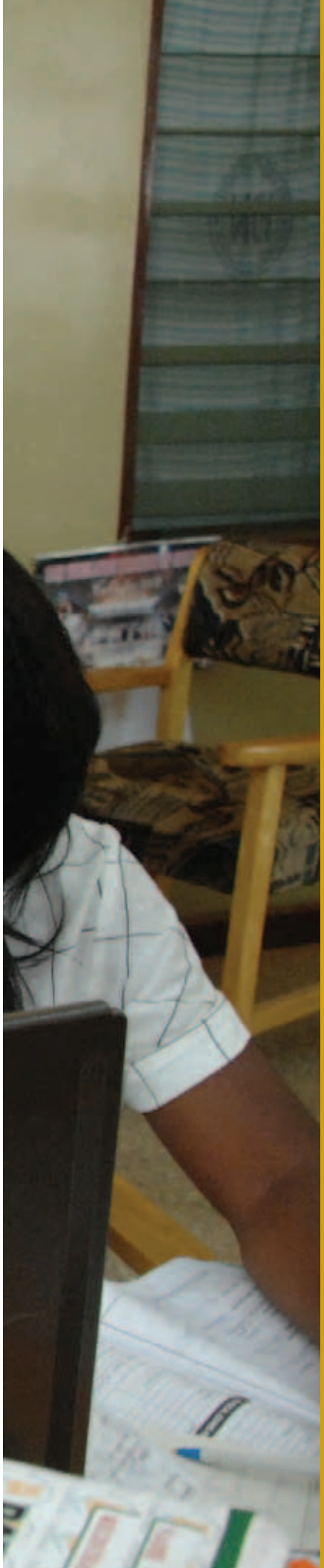
24. MDG8 calls for the development of a global partnership for development. The partnership model needs all partners to respond to aid effectiveness challenges. Increasing the effectiveness of aid will require actions from the Global Fund, countries and other donors. Actions required from partners to improve effectiveness of Global Fund financing include:

- Adaptation of public sector spending limits to reflect Global Fund financing;
- Transparently allocated budgets across sectors to show health and disease spending;
- Donor agreement to ensure continued increases of additional funds, including the target to provide 0.7 percent of gross domestic product to overseas development assistance;
- Development of strong performance monitoring frameworks in pooled funds;
- Reduced transaction and transition costs to join multi-partner country agreements;
- Streamlined bilateral and multilateral presence at country level through delegated or other representation.

25. In Ghana, the Global Fund supports the health sector-wide approach through financing that is harmonized and aligned with the World Bank, the UK Department for International Development (DFID), the Danish International Development Agency (Danida) and the European Commission. With partners, it delivers the Health Sector Five-Year Program of Work, in which the three diseases are priority areas. The Global Fund contributes toward achieving the sector-wide approach objectives with US$ 377 million in financing approved for HIV, TB and malaria by the end of 2008. Funds are included in the sector annual plans and annual reports and reported in the national budget. The Global Fund-supported sector-wide approach in Malawi provides a very good example of positive outcomes where the various donors have taken action to improve aid effectiveness, including clear financial and results reporting and harmonized and aligned procedures.

26. The Global Fund continues to improve the effectiveness of its financing by strengthening partnerships and investing in health and community systems. It has made major contributions to the practice of aid effectiveness, in particular by promoting management for results, mutual accountability and wide-based country ownership. The Global Fund also continues to improve the alignment and harmonization of its financing through important initiatives to fund national strategies, simplify its grant architecture, and support civil society.

MEDICAL STAFF AT TEMA ANTIRETROVIRAL THERAPY CLINIC IN GHANA DELIGHT IN THEIR YOUNG PATIENT'S IMPROVMENT. PEDIATRIC ARVS MEAN THAT CHILDREN WITH HIV CAN NOW BE CARED FOR WITH THE APPROPRIATE DRUGS.



4. COUNTRY PERFORMANCE

LEARNING FROM EXPERIENCE

"Money is there for results, it is uncomfortable, it is not just for meetings, it is percolating through our systems, people are beginning to ask for results at all levels, it is good and has also widened the partnerships, it ensures we have focus to achieve real things not a small bit of everything, but results."

—GHANA PRINCIPAL RECIPIENT

4.1 MANAGING FOR RESULTS

1. Performance-based funding combines two key principles of the Global Fund: managing for results and country ownership. The Global Fund creates the framework for results through its performance-based funding and does not micromanage implementation, leaving it to countries to decide how to achieve their goals. The country owns implementation and reports on progress against transparent targets, reasons for deviation and plans to improve results. Within the Global Fund portfolio, over 75 percent of programs have demonstrated good performance.

2. Performance-based funding not only provides incentives to improve programs that are underperforming; it also encourages strengthening the management of programs that are performing well and programs that need system strengthening. Results provide a strong basis for country ownership of the program.

3. The Global Fund financing model allows reprogramming during the lifespan of grants, so that grants that are performing well can identify ways to further accelerate their results. In Niger, for example, the program partnered with the International Red Crescent to accelerate the delivery of insecticide-treated bed nets to families. In Ethiopia, once the program had delivered its target of two million insecticide-treated bed nets, the budget for year five was brought forward two years so that it could deliver a further seven million bed nets ahead of the initially planned time.

4. Programs that are performing less well can also make adjustments to address bottlenecks and build capacity. For example, the Malawi HIV program identified human resources as its major bottleneck to scaling up prevention and treatment and by reprogramming of Global Fund-supported activities was able to reallocate US$ 40 million of its budget to improve capacity. The Mali HIV program used technical support from UNDP to build its capacity for procurement.

5. The Global Fund approach that fosters management for results creates incentives to poorly performing programs to improve. For example, in Senegal the malaria grant was stopped due to underperformance. This spurred reform of the Country Coordinating Mechanism, encouraged greater involvement of civil society in the Country Coordinating Mechanism and catalyzed improvement of the program. Similar improvements in performance were seen in Nigeria, Laos, Lesotho and Honduras after their programs were reviewed and results fed back to the countries.

6. Programs are increasingly using results to improve management at all levels within the country. In Tanzania, the Country Coordinating Mechanism has developed a tool to jointly review the results of its many grants and improve the efficiency and effectiveness of its oversight activities, in the process halving the length of its meetings. In Russia, nongovernmental organizations regularly publish their results on the Internet to compare their performance and better target their technical support to areas which deserve attention. In Rwanda, results are used at the hospital level and as the basis of contracts between the president and local mayors to deliver services for the three diseases and beyond.

7. Results provide a tangible basis for improving alignment and harmonization of systems used by development partners with those of countries. In Ethiopia, the Global Fund and PEPFAR agreed to use the national indicators to measure the success of scale-up with HIV treatment, so that rather than counting patients separately started on ARVs in clinics funded by their respective programs, a unified approach was developed, thereby enabling a more efficient coordination of service delivery and monitoring.

FIGURE 22: EXAMPLES OF COUNTRIES THAT HAVE USED GLOBAL FUND FLEXIBILITIES TO MORE EFFICIENTLY MANAGE THEIR PROGRAMS FOR RESULTS

PERFORMANCE CATEGORY (A-BEST, C-UNACCEPTABLE)	COUNTRY EXAMPLE	ADJUSTMENT TO MANAGE BY RESULTS
A	NIGER, MALARIA	Partnered with International Red Crescent to further accelerate insecticide-treated bed net delivery to protect families from malaria
B1	MALAWI, HIV	Human resources identified as the bottleneck to improve results. US$ 40 million of the budget reallocated to this area to improve capacity
B2	MALI, HIV	Procurement bottleneck identified, UNDP and UN provided technical support to build local capacity
	ETHIOPIA, MALARIA	Government focused on the problems, sought technical support from UNICEF, grant became A-rated and delivered almost ten million insecticide-treated bed nets to protect from malaria
C	SENEGAL, MALARIA NIGERIA, HIV	Grants stopped. In Senegal, Country Coordinating Mechanism was reformed, civil society involved and successful new grant signed. In Nigeria, monitoring and evaluation system was rebuilt and new grants successfully signed. Both countries benefited from clear performance evaluation, even with a C rating.

Source: Grant Performance Reports, Global Fund, 2008.

4.2 "RESULTS-DRIVEN" IMPLEMENTATION

"What made the difference is you gave us a clear warning, that we were in the red zone … we could lose our money if we didn't deliver results. We looked at it, we could focus and we both saw the problem … and that was the adjustment we made to get the results. Performance-based funding helped us think through implementation".

—ETHIOPIA PRINCIPAL RECIPIENT

4.2.1 COUNTRY PARTNERS MAKING THE MONEY WORK

8. As of 1 December 2008, 75 percent of grants[12] showed adequate or good performance (A- or B1-rated) (based on the evaluation of 348 grants near the end of their first phase of implementation (18 to 24 months)). Twenty-one percent showed inadequate performance but demonstrated potential (B2-rated), and four percent showed unacceptable performance (C-rated). Principal Recipients implementing B2-rated grants are asked to develop plans to address weaknesses and achieve results. The overall evaluation rating for the first phase of implementation is reviewed by the Local Fund Agent in country and by the Secretariat. Final decisions rating Phase 1 performance are made by a panel in the Secretariat, while Phase 2 funding decisions are made by the Global Fund Board.

9. In line with the principle of transparency, the information and scorecards for performance decisions are publicly available on the Global Fund website.

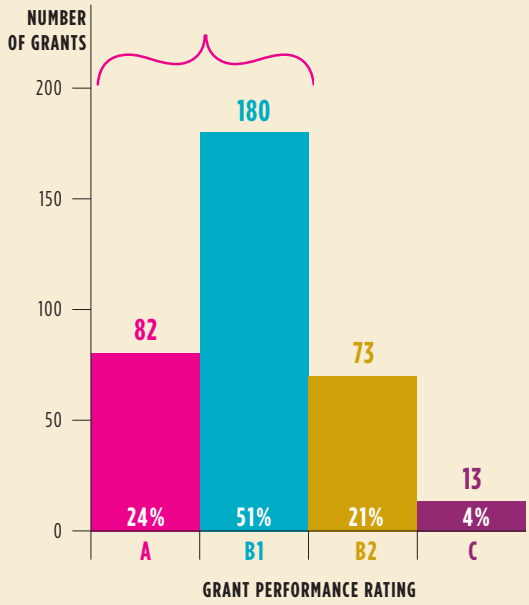
10. Performance-based funding also examines the distribution of performance. For example, in the top ten programmatic areas, A-rated grants achieved 124 percent of their targets at the start of the program, B1-rated achieved 102 percent of the target set, B2-rated achieved 64 percent and C-rated 37 percent, respectively.

"In China, everyone says we should copy the very clear targets, timetables and financial support from the Global Fund … the national system wants to copy this … they see it as a leading element to allow strategic planning and improve the culture of management."

—CHINA PRINCIPAL RECIPIENT

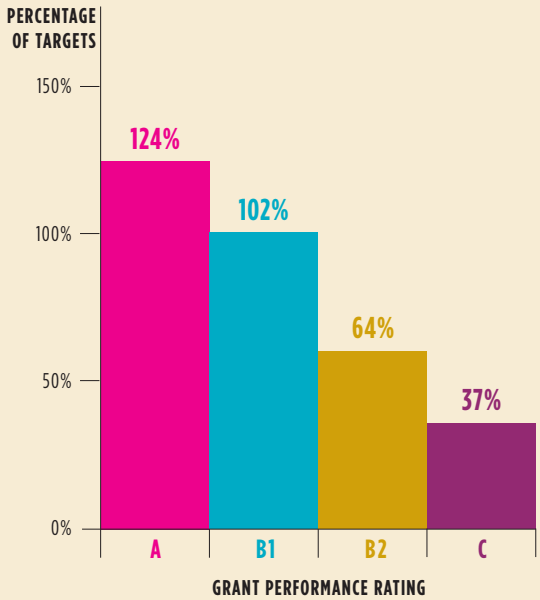
12 A grant is the agreement used by the Global Fund to support a country program. Each grant is given a performance rating. A country program may have more than one grant.

FIGURE 23: 75 PERCENT OF GRANTS HAVE RECEIVED GOOD/ADEQUATE PERFORMANCE RATINGS



Note: Performance of all grants evaluated for Phase 2 as of December 2008

FIGURE 24: AVERAGE RESULTS AGAINST TARGETS FOR THE TOP TEN PROGRAMMATIC INDICATORS BY PERFORMANCE RATING OF ALL GRANTS EVALUATED FOR PHASE 2 AS OF DECEMBER 2008



BOX 15: FIVE MAJOR IMPLEMENTATION CHALLENGES

1. MANAGEMENT AND TECHNICAL CAPACITY-BUILDING

Technical and management support are critical for improving capacity and paving the way for more-effective program implementation. This is particularly important for helping local civil society organizations to rapidly scale up the programs they manage. This support can come from several sources. For example, the private sector can play an important role in this regard, as evidenced by experience in Haiti, where Fondation SOGEBANK assists partners in implementing the HIV program. Improved supervision and training at the point of service delivery is also critical, especially where programs extend over large areas and have a significant number of sub-recipients – in China, for example, grants have more than 1,000 sub-recipients, requiring very strong management competence.

2. STRENGTHENING PROCUREMENT AND NATIONAL SUPPLY CHAIN SYSTEMS

Global supply constraints for long-lasting insecticide-treated bed nets, ACTs and second-line ARVs, combined with limited ability of many country systems to deliver these to regions, districts, villages and difficult-to-reach populations have hindered rapid scale-up in many settings. Aid effectiveness indicators identify limited country capacity for procurement as a major constraint which needs to be addressed along with weaknesses in supply chain management systems if they are to ensure predictable availability of drugs and commodities.

3. EXTENDING SERVICE DELIVERY FROM TOWNS TO COMMUNITIES

As programs scale up services, they face major challenges in extending service delivery into rural regions. These are best addressed by building partnerships at the local level (including local politicians, leaders, private sector and networks working with gender and sexual minorities) and strengthening community systems to mobilize the community around interventions to augment what is achieved through health systems.

4. TRAINING, DEPLOYING, RETAINING NEW HUMAN RESOURCES FOR HEALTH

A number of countries have faced major bottlenecks in human resources, and have shifted funds to systematically support human resource strategies.

At Phase 2 evaluation, Malawi was able to reprogram US$ 40 million to its health human resources budget to build the capacity to roll out its human resource expansion program. Ethiopia has trained and deployed 24,000 community health workers (with a target of 30,000) to ensure HIV, TB and malaria service delivery in rural areas.

5. "KNOW YOUR EPIDEMIC"

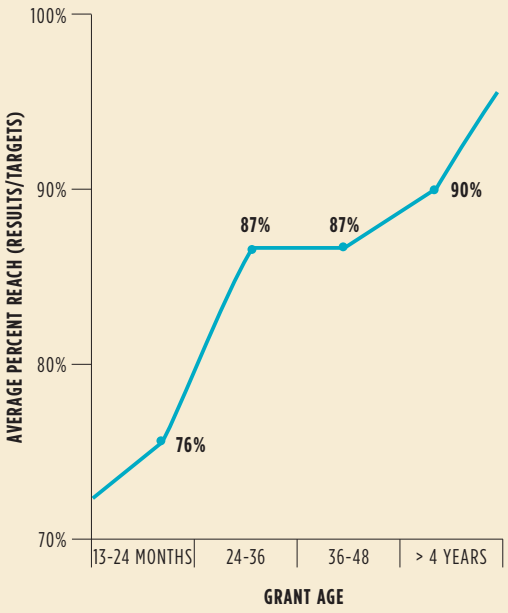
In many countries the nature of the changing epidemic is inadequately understood to develop a long-term strategic approach to reach those at risk and address systemic bottlenecks to rapidly scale up interventions.

11. There is also variability in performance of grants by programmatic area. The performance of all grants against aggregate targets ranges from 62 percent for indicators pertaining to "antimalarial treatment" to 149 percent for "counseling and testing", with an overall average of 101 percent achievement against the ten indicators. Monitoring of performance against programmatic targets identifies areas which require particular attention – for example, PMTCT (71 percent of targets achieved), insecticide-treated bed nets distributed (80 percent), and multidrug-resistant TB (85 percent).

12. Early identification of under-performance and appropriate investments to address this has rapidly improved the performance of malaria programs (see Figure 25), from 76 percent for programs in the first 24 months of their implementation to 90 percent for those in the fourth year of the grant lifecycle. This improvement demonstrates the importance of learning through performance-based funding to improve implementation success. The Global Fund Board made decisions to cut or sharply reduce funding for programs in Mozambique, Uganda, Nigeria and Sudan that were not performing well early in 2007. Some countries – Uganda, for example – did not get funding for Phase 2. However, most showed improvements in implementation soon after transparent evaluation.

13. Performance-based funding is of particular benefit to grants that perform less well, as it highlights areas of poor performance and encourages changes in activities to address implementation bottlenecks (see Box 15).

FIGURE 25: PERFORMANCE-BASED MANAGEMENT IMPROVES MALARIA IMPLEMENTATION OVER TIME



Note: Average performance of programmatic indicators for malaria grants by grant age.

FIGURE 26: US$ 5 BILLION COMMITTED AND US$ 639 MILLION REALLOCATED AT PHASE 2, DECEMBER 2008

FUNDING IMPLICATIONS OF PHASE 2 DECISIONS		PERCENTAGE OF PHASE 2 AMOUNT	PERCENTAGE REALLOCATED
ORIGINAL PHASE 2 AMOUNT IN PROPOSAL	5,631,000,000	100%	
AMOUNT AFTER PHASE 2 EVALUATION	4,992,000,000	88.6%	
TERMINATED GRANTS	131,000,000		2.3%
BUDGET REDUCTIONS	508,000,000		9.1%
OVERALL REALLOCATED FUNDS	**639,000,000**		**11.4%**

Note: Numbers rounded to nearest million.

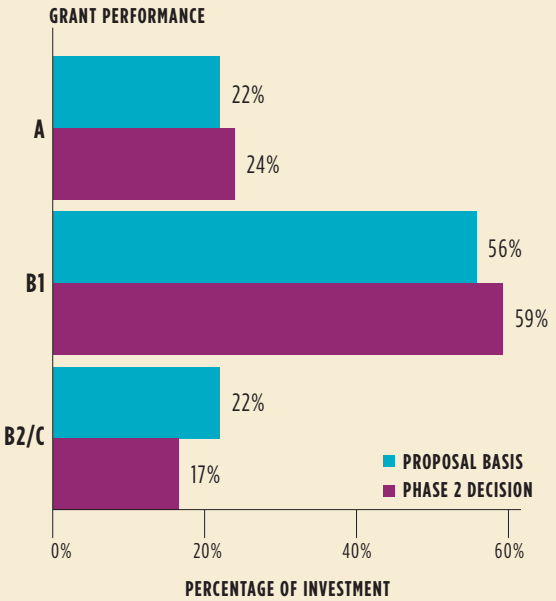
4.2.2 INVESTING IN PERFORMANCE

14. By December 2008, a total of 348 grants had been evaluated for Phase 2 with nearly US$ 5 billion approved on the basis of documented performance. Just in 2008, around US$ 1 billion was invested into ongoing programs at Phase 2, making it a significant source of commitments alongside new rounds (in Round 8 US$ 2.75 billion was approved by the Board[13]).

"If sub-recipients see their results falling into the red, they telephone us and we talk it through and find solutions. Equally important, we feed back to the Country Coordinating Mechanisms our performance and we have a mature debate, not just on politics but implementation and progress, real grant issues".

—GUATEMALA PRINCIPAL RECIPIENT

FIGURE 27: SHIFTING INVESTMENT TO PERFORMANCE



Note: Percentage of total Global Fund investments at proposal and Phase 2 stage by grant performance rating, as of December 2008.

15. The Global Fund model allows unused funds from grants in Phase 1 to be reallocated in Phase 2. To date, around US$ 639 million of unused funds in Phase 1 has been reallocated at Phase 2 on the basis of performance. This represents 11.4 percent of total proposed amounts (see Figure 26).

16. As a funding stream, Phase 2 is an investment in performance. Eighty-two percent of funding in Phase 2 went to A- or B1–rated grants. The remaining 18 percent involved investment decisions for grants with documented potential (B2-rated grants). These grants (Ethiopia, Pakistan and Kenya among them) were provided with Board-mandated conditions for continued access to funding.

13 While US$ 2.75 billion of grants was approved in principle, in line with the Comprehensive Funding Policy, final funding approval for some of these grants will only be possible when financing is available, during 2009.

4.3 PERFORMANCE-BASED FUNDING IN DIFFERENT CONTEXTS

17. Performance is measured against country-owned targets that are ambitious yet realistic for the country context. Therefore, the performance-based funding approach should not disadvantage countries with weaker health and community systems, as the performance is measured in relative terms against the targets set by the country.

18. Figure 28 assesses the reallocation of funds in the top, middle and lowest third of countries categorized according to wealth, health systems performance and human resources for health based on WHO data.[14] Overall, there is little difference in the relative amounts reallocated from the wealthiest third of countries at Phase 2 (13 percent of total funds allocated at Phase 2) compared with that for the poorest countries (12 percent), with few differences between the amounts reallocated from countries that differ in terms of health systems strength and availability of human resources.

19. Global Fund analysis shows that poorer countries do not have more poorly performing grants (rated B2 or C) as compared with the wealthiest countries (23 percent, compared to 29 percent in the middle categories and 23 percent in the wealthiest third). However, countries with weaker health systems and those with lower human resource capacity have a greater number of poor-performing grants (27 percent and 26 percent, respectively) compared to countries which have stronger health systems and human resource capacity (21 percent and 17 percent, respectively) (see Figure 29).

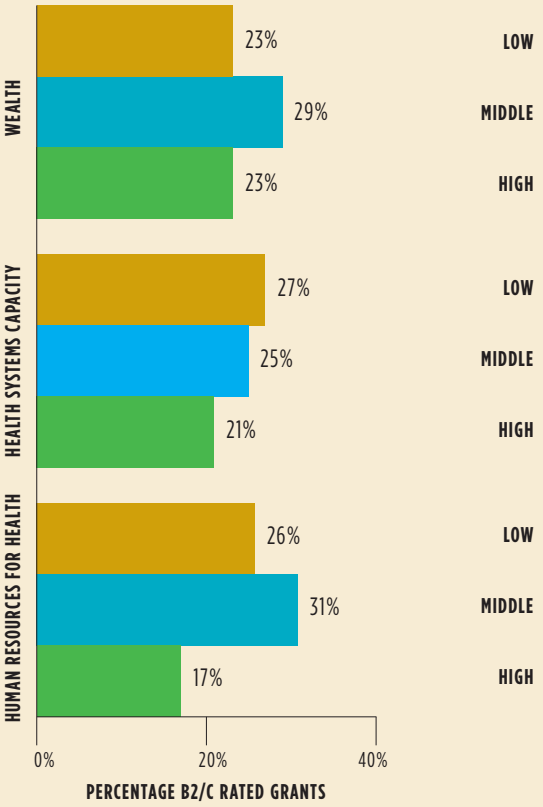
14 Even categories were generated across grants with relative measures of a) wealth categories based on gross national income per capita; b) health systems capacity based on *The World Health Report 2000*, Statistical Annex 10; and c) human resources for health capacity based on the ranking of countries in *The World Health Report 2006*, Statistical Annex 4.

FIGURE 28: IS MORE MONEY REALLOCATED FROM POORER COUNTRIES?

PERCENTAGE OF FUNDS REALLOCATED	LOW	MIDDLE	HIGH
WEALTH	12%	9%	13%
HEALTH SYSTEMS	10%	13%	12%
HUMAN RESOURCES FOR HEALTH	10%	12%	12%

Note: Percentage of funds reallocated from grants at Phase 2 by level of wealth, health systems and human resources for health (equal low, middle, high categories).

FIGURE 29: GRANT PERFORMANCE IS NOT SIGNIFICANTLY WORSE IN POORER COUNTRIES AND THOSE WITH WEAK HEALTH SYSTEMS COMPARED WITH WEALTHIER COUNTRIES OR THOSE WITH STRONGER HEALTH SYSTEMS



Note: Grant performance assessed by levels of wealth, health system strength and human resources for health capacity.

LAOTIAN VILLAGERS GATHER TO VIEW AN HIV DOCUMENTARY SHOWN BY POPULATION SERVICES INTERNATIONAL'S TRAVELING EDUCATION UNIT. MESSAGES ABOUT AVOIDING RISKY BEHAVIOR ARE A CRUCIAL PART OF HIV PREVENTION.

4.4 LEARNING FROM STRENGTHS AND WEAKNESSES

20. In addition to the lessons from individual programs described in this section, there are also lessons that may be derived when grants are examined by disease categories and by Principal Recipient. This section assesses variations in performance by disease and Principal Recipient type.

21. Detailed individual grant performance reports are available on the Global Fund's website.[15] They give financial information, results against targets and contextual information on country programs. They also each tell a story of implementation, highlighting the results and challenges of fighting AIDS, TB and malaria in particular countries.

4.4.1 PERFORMANCE BY DISEASE

22. TB programs have the fewest B2- or C-rated grants. Around 82 percent of TB grants were A- or B1-rated, compared to 76 percent for HIV and 69 percent for malaria. Malaria programs have fewer A-rated grants (17 percent) compared with 25 percent for HIV and 29 percent for TB (see Figure 30). This variation may be explained in part by the fact that TB programs build on existing national strategies which, in many countries, have been in place for more than 20 years, and a coordinated partnership approach to technical assistance for TB. The Stop TB Partnership, created in 2000 and hosted by WHO, currently has more than 500 partners with a very wide representation of all stakeholders, including civil society and the private sector. The Stop TB Partnership – which aims to reduce the global burden of TB by increasing access to treatment through DOTS and addressing challenges such as TB/HIV co-infection and multidrug-resistant TB – offers a comprehensive package of technical support with well-defined partner roles, covering the full range of implementation from management to dealing with technical issues to procurement.

4.4.2 PERFORMANCE BY IMPLEMENTER

23. Around 82 percent of grants implemented by civil society are A- or B1-rated, demonstrating the ability of civil society organizations to deliver services to people at risk. UNDP – which manages grants in difficult situations and fragile states – stands out as a successful implementer, with 73 percent of the grants it manages rated A or B1 (see Figure 31).

4.4.3 PERFORMANCE BY REGION

24. The majority of programs in sub-Saharan Africa are well-performing, with 69 percent A- or B1-rated. However, 31 percent of the grants in the region are B2- or C-rated, as compared to 22 percent in Asia and 25 percent elsewhere (see Figure 32).

25. While performance doesn't vary greatly by region, there is a need for a more nuanced approach to managing grants in countries that need intensive humanitarian support.

26. The "fragile states" (as defined by DFID[16]) using the World Bank's Country Policy and Institutional Assessment Rating, comprise 48 countries with a total population of more than 870 million people, representing 14 percent of the world's population.

27. As of 1 December 2008, the Global Fund had committed US$ 3.9 billion and disbursed US$ 2.5 billion to 244 grants to programs in fragile states: more than one-third of the Global Fund's total commitments. The performance of programs supported in these countries is therefore critical to the overall performance of Global Fund investments.

28. Analysis of grant performance in these states show that around 17 percent of grants are rated A and 53 percent rated B (as compared with 28 percent and 51 percent, respectively, in states that are not classified as fragile), with a higher proportion of B2- and C-rated grants (30 percent as compared with 21 percent for states that are not classified as fragile).

29. It is important to note that following Phase 2 evaluation around 38 percent of the total amount of funds was committed to fragile states, in line with the 38 percent share of the total funding at the initial proposal stage. The Global Fund performance model does not seem to disadvantage fragile states, and enables commitment of funding throughout the five-year grant period.

15 http://www.theglobalfund.org/programs/search.aspx?search=2&lang=en
16 http://www.dfid.gov.uk/mdg/aid-effectiveness/fragile-states.asp

FIGURE 30: VARIATIONS IN GRANT PERFORMANCE BY DISEASE FOR THE 348 GRANTS EVALUATED FOR PHASE 2 AS AT DECEMBER 2008

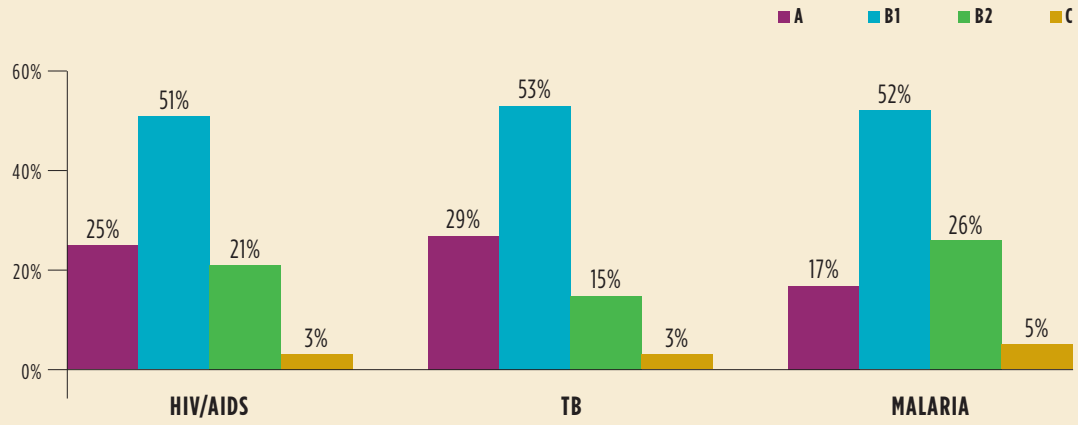


FIGURE 31: VARIATION IN GRANT PERFORMANCE BY PRINCIPAL RECIPIENT TYPE FOR THE 348 GRANTS EVALUATED FOR PHASE 2 AS AT DECEMBER 2008

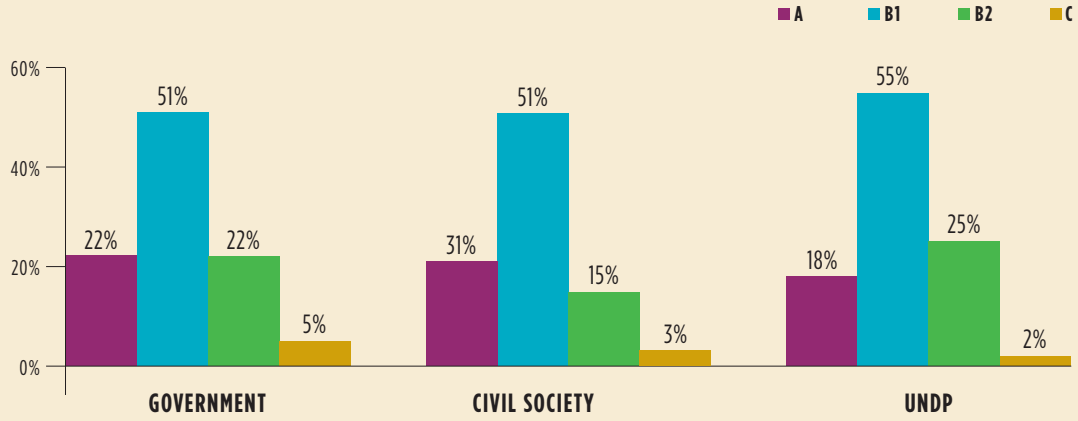
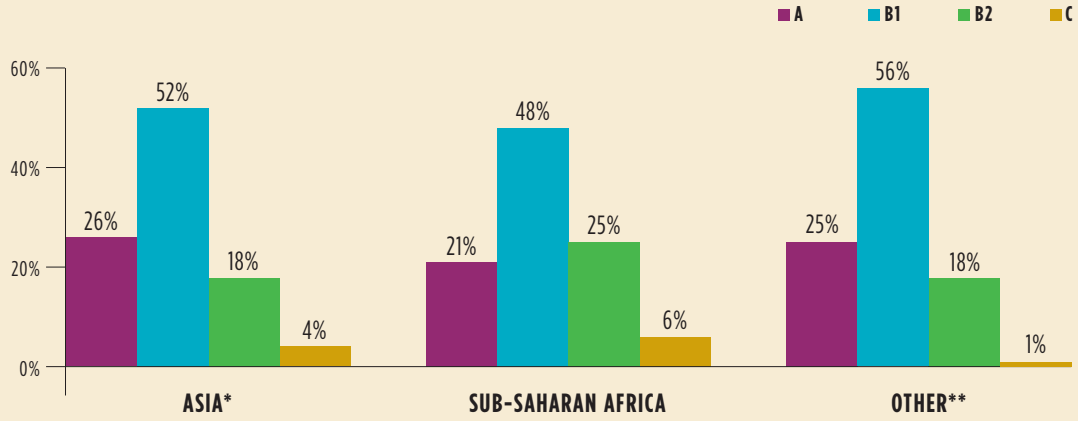


FIGURE 32: VARIATION IN GRANT PERFORMANCE BY REGION FOR THE 348 GRANTS EVALUATED FOR PHASE 2 AS AT DECEMBER 2008



* South West Asia, East Asia and the Pacific

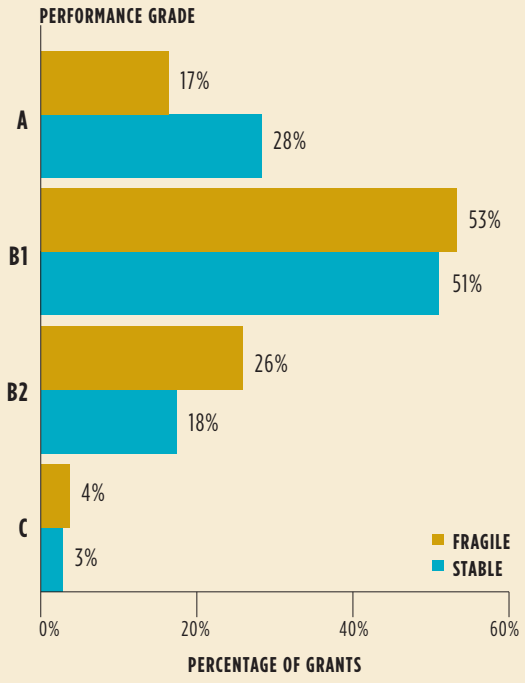
**Latin America and Caribbean, Eastern Europe and Central Asia, Middle East and North Africa

4.4.4 LEARNING FROM POOR PERFORMANCE

30. Countries which have experienced poorly performing grants have been able to respond rapidly to address the problems which led to poor performance. Almost all country programs which have had a "No Go" grant – with a few exceptions – have shown significant improvements and have since signed new and more successful grants. For example, in Senegal, the decision not to continue funding for Phase 2 ("No Go") for the malaria grant was followed by an immediate reform of the Country Coordinating Mechanism, involvement of previously excluded civil society and actions to improve the performance of the national program. A grant was then signed for a program which has since proved to be much more successful. Similar benefits were seen in Nigeria, Laos, Lesotho and Honduras. Examples of poor performance, the reasons for it and actions taken to resolve it are shown in Annex 4.

31. In many funding systems for development, problems may lie hidden or difficult decisions can be delayed for years, preventing corrective action until a full failure occurs. The advantage of the Global Fund's performance-based funding system is that difficult issues can be discovered and addressed rapidly, transparently and constructively.

FIGURE 33: PERFORMANCE RATINGS OF GRANTS IN FRAGILE AND NON-FRAGILE STATES



THE GLOBAL FUND FINANCES ARV DRUGS, TRAINING OF HEALTH WORKERS AND HOSPITAL EQUIPMENT IN THE FIGHT AGAINST HIV/AIDS IN NIGERIA.

WORKING AT THE COMMUNITY LEVEL IS KEY TO FIGHTING THE AIDS EPIDEMIC. IN ZAMBIA, HUNDREDS OF SMALL CIVIL SOCIETY ORGANIZATIONS PROVIDE EDUCATION, PREVENTION AND TREATMENT SERVICES TO THEIR LOCAL COMMUNITIES, SUCH AS THIS HEALTH CARE MEETING WITH LOCAL VILLAGERS.

5. TOWARDS GLOBAL IMPACT

PROGRESS TOWARDS INTERNATIONAL GOALS

"I found hospitals with empty beds in Zambia for the first time ... before you had to step over people, there is for the first time an ease-up of hospital occupancy, very visual and obvious, you don't even need to look for it in statistics, it is staring at you in hospitals."

—ELIZABETH MATAKA, ZAMBIA PRINCIPAL RECIPIENT

1. Although it is still early to see a significant global reduction in the burden of the diseases, some of the most exciting results in 2008 have shown the impact of HIV treatment and malaria prevention and treatment on adult and child mortality. Given that the Global Fund finances a substantial share of programs fighting these diseases, this suggests that the Global Fund model, involving additional finance, inclusive partnerships and high-level coverage of services is taking hold in countries to impact upon the burden of disease.

2. However, building on these results to achieve the Global Fund goal of "a sustainable and significant contribution to the reduction of infections, illness and death" remains a significant challenge. In particular, there is an urgent need to intensify HIV prevention activities, while addressing the co-existing TB, multidrug-resistant TB and HIV epidemics in sub-Saharan Africa. While malaria programs are showing strong impact in countries where over 60 percent of the population at risk is reached with prevention and treatment, a major effort is required to ensure more countries reach these levels of coverage.

3. The Five-Year Evaluation[17] of the Global Fund highlights five key challenges to:

- strengthen country partnerships through Country Coordinating Mechanisms;
- invest heavily in health systems;
- intensify prevention at community level;
- ensure consistent communications to implementers;
- and invest in the surveys and surveillance to measure impact.

This last point is critical not only to show disease impact but also to provide the necessary information to help programs manage the epidemics as well as the delivery of services. Together, meeting these five challenges will help the Global Fund achieve its purpose of a sustainable and significant impact on AIDS, TB and malaria.

4. This section presents the evidence of impact and the progress toward achieving the Millennium Development Goals for each disease, and summarizes the contribution of Global Fund-supported programs towards achieving international targets to 2010.

5.1 ACCELERATING PROGRESS TO REACH THE MILLENNIUM DEVELOPMENT GOALS

5. The Global Fund was established to contribute directly to MDG6 (combat AIDS, malaria and other diseases). Global Fund resources also contribute to MDG4 (reduce child mortality) and MDG5 (improve maternal health). In addition Global Fund-supported programs provide services which contribute to MDG1 (eradicate extreme poverty and hunger) (see Box 16).

6. Achievement of the Millennium Development Goals is a collective global effort in which country programs lead a broad range of partners – including multilateral and bilateral agencies, civil society organizations, various private technical partners and foundations and others – to deliver health and other services.

7. Measuring progress against the Millennium Development Goal targets is also a joint effort, facilitated by various UN agencies, but the UN Department of Economic and Social Affairs (UN Statistics Division)[18] officially tracks countries' progress toward achieving the Millennium Development Goals. The progress shown in this section is harmonized with these sources as much as possible.

8. At present, midway toward the Millennium Development Goal end date of 2015, there is evidence that malaria and TB programs are making a significant contribution to achieving MDGs 4 and 6. In addition, there is emerging evidence of the direct impact of HIV treatment on adult mortality.

9. In several of the countries that have shown significant declines in malaria cases and deaths, the declines can be linked to malaria prevention (insecticide-treated bed nets and indoor residual spraying) and treatment (particularly ACTs) for which the Global Fund is the major financier. A significant challenge remains to ensure that more than 60 percent of the populations at risk have access to affordable prevention and treatment to consolidate progress on MDGs 4 and 6.

17 The Five-Year Evaluation originated from a Board decision in 2003 to review the Global Fund's overall performance against its goals and principles after at least one full grant cycle had been completed five years after the Global Fund's creation. The Five-Year Evaluation examines the Global Fund's organizational efficiency, the effectiveness of its partner environment and the combined impact that the Global Fund, domestic investments and other donors have had on the reduction in burden of AIDS, TB and malaria.

18 http://unstats.un.org/unsd/mdg/Default.aspx

10. The number of new TB cases globally is now estimated to be declining, due to accelerated progress made in several high-burden countries including India, China and Indonesia. WHO Stop TB estimates that if this trend is continued, MDG6 will be achieved well before 2015. However, critical challenges remain in sub-Saharan Africa in detecting TB cases in communities with HIV/TB co-infection, and with multidrug-resistant TB, especially in Eastern Europe.

11. The first signs of decline in adult mortality in working populations (those aged 20 to 49) attributed to AIDS treatment in Africa were identified during the last year. These provide encouraging evidence of progress in scaling up AIDS treatment. Evidence of wider impact includes declining mortality among health workers and declining absenteeism and deaths in the general workforce. HIV prevention remains one of the major challenges, although several countries (Rwanda, Kenya and Zimbabwe among them) have been showing success in recent years. These successes are not clearly related to financing, however, and suggest that prevention activities at community level need intensifying. The number of new HIV infections globally is probably stabilizing, as much due to the stage of the epidemic as to successful prevention.

BOX 16: MILLENNIUM DEVELOPMENT GOALS AND TARGETS INFLUENCED BY GLOBAL FUND FINANCING[19]

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

TARGET 1.A	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
TARGET 1.C	Halve, between 1990 and 2015, the proportion of people who suffer from hunger

GOAL 4: REDUCE CHILD MORTALITY

TARGET 4.A	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

GOAL 5: IMPROVE MATERNAL HEALTH

TARGET 5.A	Reduce by three-quarters, between 1990 and 2015, maternal mortality ratio

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

TARGET 6.A	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
TARGET 6.B	Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
TARGET 6.C	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases

19 Represents the current official Millenium Development Goal framework. (http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/About.htm).

BOLIVIA IS USING A GRANT FROM THE GLOBAL FUND TO EXPAND DOTS TREATMENT THROUGHOUT THE COUNTRY, WORKING THROUGH NONGOVERNMENTAL ORGANIZATIONS, GOVERNMENT CLINICS AND COMMUNITY HEALTH UNITS.

FIGURE 34: EXAMPLES OF IMPACT ON HIV, TUBERCULOSIS AND MALARIA IN SELECTED COUNTRIES

COUNTRY	EVIDENCE OF IMPACT	SERVICES SUPPORTED
RWANDA	- 64% decline in child malaria cases - 66% decline in child malaria deaths (Facility data, 2005-2007) - Declining treatment demand	- By end 2007, more than 2.4 million insecticide-treated bed nets were distributed, achieving 60% coverage - National roll-out of effective antimalarial drugs (ACTs)
ZANZIBAR	- 52% decline in child mortality (2002-2005) - 77% decline in outpatient malaria cases (2002-2005) - Significant decline in ACT demand due to improved diagnosis and almost no new malaria cases reported	- Introduced ACT in 2003 - Comprehensive 90% insecticide-treated bed net coverage - Indoor residual spraying: 90% coverage - Nongovernmental organizations training on net use
BURUNDI	- 45% decline in malaria incidence (2000-2005) - Independent review showed impact of malaria interventions on new cases	- One of first countries to introduce ACTs, 3.9 million cases treated - More than one million insecticide-treated bed nets distributed
ERITREA	- 71% decline in malaria deaths (2000-2006) - 91% decline in outpatient malaria cases (2000-2006) - 42% decline in malaria cases in facilities (2005-2006)	- insecticide-treated bed net coverage increased to 60% - Introduced ACT in 2007 - Strengthened community-based activities: community health workers, diagnosis and education programs
MOZAMBIQUE, SWAZILAND, SOUTH AFRICA	- 87% to 96% reduction in malaria incidence - 82% to 87% reduction in malaria mortality - 53% to 94% reduction in malaria parasite prevalence - Declining demand for drugs	- Five million people protected by indoor residual spraying - Universal coverage with effective drugs
ETHIOPIA, ZAMBIA	- Some initial signs of protective effect of insecticide-treated bed nets and of declines in malaria cases - Evidence of significant declines in child mortality which require careful evaluation	- Insecticide-treated bed net distribution: 9.4 million (Ethiopia), 1.9 million (Zambia) - ACT introduced
CHINA	- 38% decline in TB prevalence to 2006 - 38% decline in TB mortality to 2006	- DOTS: increased coverage leading to case-detection rate increases
PHILIPPINES	- Decline in TB mortality, from 57/100,000 to 47/100,000	- DOTS: successful public/private mix
MALAWI	- 44% decline in mortality in workers - 32% decline in HIV prevalence among pregnant women aged 15-24 from 2003 to 2007	- Comprehensive HIV prevention and treatment
THAILAND	- 33% decline in HIV prevalence among pregnant women from 2003 to 2007	- ARV program strengthening

Notes: Based on analysis of performance data reported by Global Fund-supported programs. Malaria: Rwanda and Zanzibar now published (see section 5.2.6); Burundi, Multi-country Southern Africa and Eritrea from Global Fund grant performance reports. TB: data from WHO, *Tuberculosis Control Report*. HIV: Malawi data from UNGASS 2006 and 2008 reports; Thailand data from UNGASS 2008 report.

REGULAR PRESENTATIONS ON MALARIA PREVENTION AT RURAL HEALTH CENTERS IN RWANDA OFTEN INCLUDE INTERVIEWS AND VIDEO CLIPS OF LOCAL PEOPLE, HELPING TO ATTRACT PARTICIPATION AND RAISE AWARENESS.

5.2 EVIDENCE OF IMPACT AGAINST HIV, TUBERCULOSIS AND MALARIA

12. There is important evidence that the Global Fund model, with its combination of additional finance, inclusive partnerships, a high level of coverage of services and funding based on results, is taking hold in countries and having an impact upon the burden of disease. AIDS treatment is beginning to reduce adult mortality among working populations but HIV prevention requires a renewed and intensified effort. The most exciting emerging evidence is for impact on disease transmission, particularly for malaria, where after a very short time we can see a significant decline in child mortality. Global TB control is also showing accelerating progress.

13. However, the unprecedented expansion of funding for the three diseases, with the resulting dramatic increase in activities, is causing substantial challenges in measuring impact accurately and comprehensively and therefore measuring progress towards the Millennium Development Goals by 2015.

14. Lack of baseline data, weak data gathering and monitoring and evaluation capacity and expertise in-country, and not least the dramatic pace of the scale-up currently taking place, together make it very difficult to assess impact with any certainty. For example, less than US$ 2 billion out of the US$ 7.2 billion disbursed by the Global Fund to programs was disbursed prior to 2006, the latest year for which most national mortality and morbidity statistics are available. Similarly, of the two million people given access to ARVs through Global Fund-supported programs, more than 1.6 million began treatment after 2005, making any assessment of the wider impact of this treatment difficult beyond the data made available from specific research limited to one or a few countries and population groups.

15. Improving this situation will require investment by partners in impact surveys and surveillance now. The Five-Year Evaluation of the Global Fund is a concerted effort to invest in systems to measure impact in selected countries. However it has also revealed major gaps in the basic components of surveys, surveillance, mortality registration, and country analytic capacity required to measure health impacts. Systematic investments by partners to fill these gaps would be a major contribution to health systems strengthening.

16. We are now midway between the declaration of the Millennium Development Goals in 2000 and the 2015 target date. The Global Fund's main responsibility is to ensure that health services reach people in need, and progress is made towards the collective goals of the Millennium Development Goals. In this section progress towards Millennium Development Goals is presented. Moreover, country examples of reductions in infections, illness and death are shown for each of the three diseases along with a summary in Annex 6 of published evidence from various studies on the impact of Global Fund-supported programs on the three diseases.

5.2.1 HIV: GLOBAL HIV INCIDENCE LIKELY TO HAVE PEAKED

17. UNAIDS and WHO estimates suggest that global HIV incidence likely reached its peak in the late 1990s. Reductions in incidence that reflect the natural trend of the epidemic and – in a few situations – behavioral change, are beginning to emerge. The trends suggest that part of Target 1 of MDG6 (to halt and begin to reverse HIV prevalence among the population aged 15 to 24 years) might have been achieved but that the United Nations General Assembly Special Session (UNGASS) target of reducing HIV prevalence by 25 percent by 2010 will require substantial additional efforts. Measuring HIV incidence is still a scientific challenge, so trends in HIV prevalence among young people are often used as a proxy estimate for trends in new HIV infections. Caution is required in interpreting trends from sentinel surveillance data.

18. Progress toward the Millennium Development Goal targets has been summarized for 14 countries across the world that have some of the largest Global Fund investments in HIV control (see Figure 35). These include the sub-Saharan African countries with the largest HIV investments overall, as well as countries with large investments in East Asia and Latin America and the Caribbean. Some favorable trends in HIV prevalence among pregnant women can be seen in some countries:

- In Ethiopia, sub-Saharan Africa's second-most populous nation, HIV prevalence among pregnant women aged 15 to 24 has declined, both in urban and in rural areas;
- Decreases in HIV prevalence were also reported in Malawi (in urban areas among younger age groups), Cambodia, Zimbabwe, Rwanda (in Kigali) and Kenya;
- The two countries with the highest number of people living with AIDS (South Africa and Nigeria) have seen modest declines in HIV prevalence.

19. Between 2004 and 2008, there has been a significant scale-up of HIV treatment in low- and middle-income countries, in substantial part thanks to investments by the Global Fund and PEPFAR, so that more than 3.5 million people now receive ARVs.

FIGURE 35: TRENDS IN HIV PREVALENCE AMONG PREGNANT WOMEN IN SELECTED COUNTRIES

COUNTRY	BASELINE (YEAR)	RESULT (YEAR)	AGE GROUP	TREND
MALAWI	18.2% (2003)	12.3% (2007)	15 to 24	DECREASE
UGANDA	6.1% (2000-1)	6.5% (2003-4)	ALL AGES	STABLE
TANZANIA	8.7% (2003-4)	8.2% (2005-6)	15 to 24	STABLE
ETHIOPIA	8.6% (2003)	5.6% (2005)	15 to 24	DECREASE
SOUTH AFRICA	16.1% (2000) 29.1% (2000)	13.5% (2006) 28% (2006)	15 to 19 20 to 24	STABLE
KENYA	8.7% (2001)	4.6% (2006)	ALL AGES	DECREASE
NIGERIA	5.4% (2001)	4.4% (2005)	ALL AGES	STABLE
THAILAND	1.38% (2000)	0.84% (2007)	ALL AGES	DECREASE
MOZAMBIQUE	12.2% (2000)	16.2% (2007)	15 to 24	INCREASE
SWAZILAND	26.3% (2000) 42.5% (2000)	26% (2006) 40.3% (2006)	15 to 19 20 to 24	STABLE
HAITI	4.4% (2000)	4.4% (2006)	ALL AGES	STABLE
GHANA	3.8% (2002)	2.5% (2006)	15 to 24	STABLE
CAMBODIA	2.9% (2002)	1.2% (2006)	ALL AGES	DECREASE
NAMIBIA	17.9% (2002)	14.2% (2006)	15 to 24	DECREASE

Notes: based on UNGASS 2006 and 2008, confidence intervals were not provided to the figures in the source documents; Ethiopia 2003 data are from Ministry of Health *AIDS in Ethiopia: Fifth Report*, unadjusted antenatal-clinic (ANC) data comparable to UNGASS 2008 report; Cambodia figures are from the National Centre for AIDS Dermatology and STDs (NCHADS) of Cambodia. Countries with major issues with their trend data were excluded.

20. Generalizing the limited current examples of impact on HIV transmission would require a substantial scale-up of prevention efforts, including intensified delivery and engagement at community level. Some areas and countries are still seeing rising HIV epidemics and may have to intensify prevention efforts among vulnerable groups: for example, Ukraine, Russian Federation, Viet Nam, China, Mozambique, Papua New Guinea and Indonesia.

5.2.2 HIV: COUNTRY EXAMPLES

21. The scale-up of HIV treatment, especially in low- and middle-income countries, has been a significant humanitarian achievement. There are exciting signs of the impact of AIDS treatment on adult mortality in a few settings, and examples of reductions in prevalence due to HIV prevention activities. However, much of the progress in expanding ARV treatment is so recent that it is too early to measure impact.

Malawi

22. Malawi has shown that HIV treatment can be scaled up nationally even in the poorest countries with weak health systems. The ARV program, implemented by the National AIDS Control Program in close collaboration with the private sector, was providing nearly 100,000 people with ARVs by the end of 2007, up from 1,600 in 2003. The majority of people on ARVs are women (about 60 percent). ARV uptake has resulted in substantial numbers of lives saved, including those of health workers who are now contributing to the management of the ARV program itself.[20]

23. Benefits of the national ARV scale-up are starting to emerge in various sectors. For example, the number of military personnel on ARVs has increased over six times while annual deaths have decreased by over two-thirds. Similarly, an increasing number of teachers every year are starting ARV treatment.[21]

20 Makombe SD et al. A national survey of the impact of rapid scale-up of antiretroviral therapy on health-care workers in Malawi: effects on human resources and survival. Bulletin of the World Health Organization, 2007, 85:851-857.

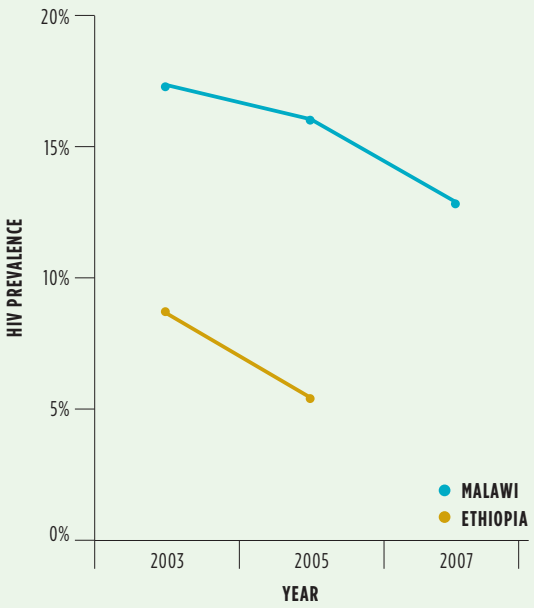
21 Banda AC et al. Antiretroviral therapy in the Malawi defense force: access, treatment outcomes and impact on mortality. PLoS ONE, 2008, 3(1):e1445.

24. Malawi also conducted extensive prevention activities to reach nearly 2.4 million youths aged 14 to 24 years. Between 2003 and 2007, the HIV prevalence among pregnant women aged 15 to 24 years declined by 25 percent from 17.6 percent to 13.2 percent in urban areas. (Similarly, in Ethiopia, between 2003 and 2005 the HIV prevalence among 15-to-24-year-old pregnant women declined by 35 percent from 8.6 percent to 5.6 percent) (see Figure 36). This is very encouraging, especially because of the drop in HIV prevalence in the younger age group, but much remains to be done to reduce transmission significantly.

Tanzania

25. Partnerships with the private sector are important to ensure that HIV services reach working populations (in particular men, who are often neglected in HIV prevention activities). In Tanzania, the Unilever Tea Tanzania company hospital at Mufindi has been providing AIDS care and treatment free of charge to company employees and community members since 2005 under the Tanzania National Care and Treatment Plan. This public/private partnership and co-investment leverages the resources of the private sector infrastructure with financial and technical support from the Global Fund, PEPFAR, Family Health International and the Tanzanian Ministry of Health. By the end of May 2007, Lugoda Care and Treatment Centre had enrolled 1,620 people, 48 percent of whom are on ARVs; 35 percent were company employees and the remainder from the surrounding community.

FIGURE 36: HIV PREVALENCE AMONG PREGNANT WOMEN



Note: data for pregnant women aged 15 to 24 in Malawi and pregnant women aged 15 to 19 in Ethiopia.

26. Since 2005, a general decline in medical terminal leave has been observed (see Figure 37). A decline in HIV-related deaths also occurred in 2007. Taken together, these two findings suggest that medical attrition dropped dramatically in 2007. HIV-positive employees with illnesses were encouraged to seek ARVs on-site and to return to work when they presented with clinical improvement. This policy may explain the decline in medical terminal leave in 2005 and 2006. The apparent increase in HIV-related deaths in 2005 and 2006 may relate to more employees remaining in employment to take advantage of free access to ARVs that had been introduced even for the severely ill. The mortality rate is high among patients who start HIV treatment very late.

27. Private sector collaboration for implementation of AIDS treatment is adding to the impact.

Thailand

28. Global Fund financing has been used by Thailand for capacity building for human resources and laboratory equipment, which would otherwise have taken much longer to procure if government finance had been the only option. This facilitated a rapid expansion of ARV services in Thailand. By end 2007 more than 93,000 people were on ARVs, up from 10,000 in 2002.

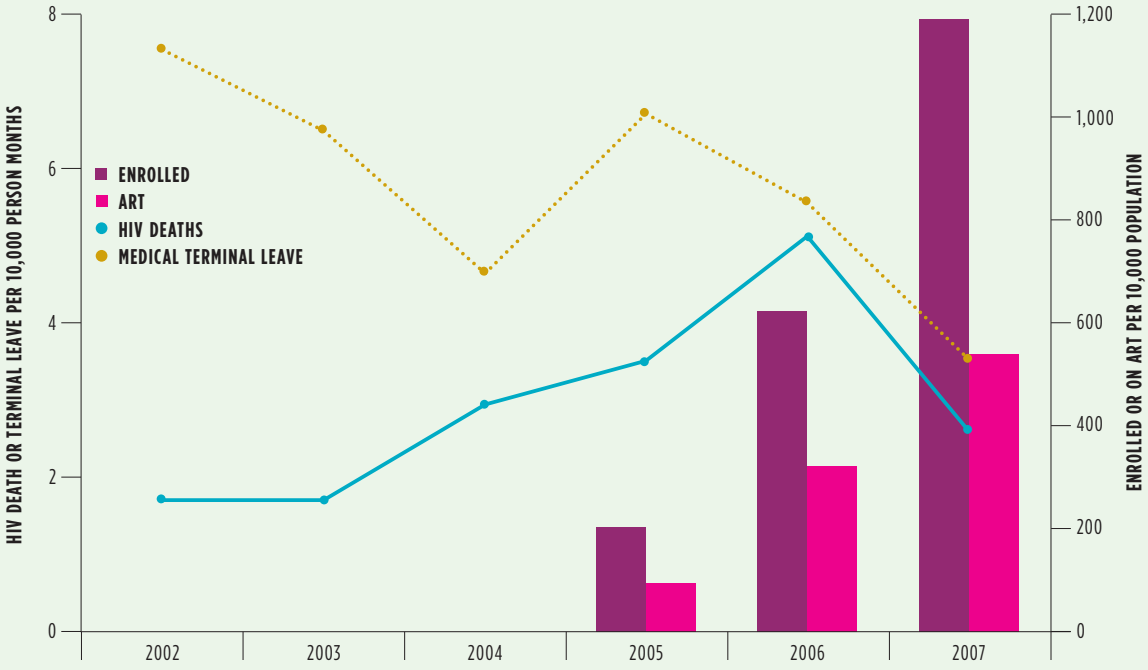
29. More than 500,000 young people have been reached with prevention activities both in schools and other settings. The HIV epidemic in Thailand peaked in the early 1990s following a massive behavior change campaign in the commercial sex industry, which led to declines in new HIV infections. Evidence for the past few years (cited in the 2008 UNGASS report) suggests continuing declines in HIV prevalence: a 33 percent decline in prevalence among young, pregnant women between 2003 and 2007.[22]

Georgia

30. In Georgia, the Global Fund supports the national initiative to provide peer educators for communication and counseling for sex workers and men who have sex with men, as well as substitution programs for injecting drug users. It also supports life-skills programs for the promotion of knowledge and prevention among youth at schools, and access to ARVs for people living with HIV. Seventy percent of female sex workers now report that they use condoms. HIV prevalence among female sex workers has declined by 54 percent (see Figure 38). HIV prevalence among men who have sex with men has declined by 16 percent, as reported in the 2008 UNGASS report.

22 UNGASS Reports (http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp).

FIGURE 37: RATES OF HIV DEATHS, MEDICAL TERMINAL LEAVE AND ART USE AMONG UNILEVER TEA TANZANIA EMPLOYEES, MUFINDI (2002-2007)

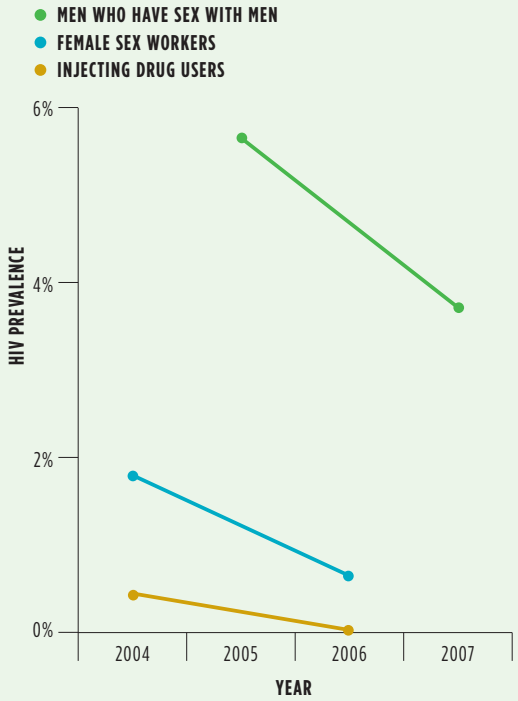


Source: Report to the Global Fund, Rand Stoneburner, 2008.

Dominican Republic

31. The goal of the Dominican Republic's AIDS national control program is to scale up existing HIV prevention and treatment services with a special focus on vulnerable populations including sex workers, men who have sex with men, youth, pregnant women, migrant populations and the armed forces. Targeted behavioral change communication activities are developed for vulnerable groups, with intensified condom distribution. Condom use has improved fivefold, from 11 percent in 2001 to 57 percent in 2007 among youths aged 15 to 24 years. Preliminary results from the 2007 population-based survey indicate that HIV prevalence among 15-to-49-year-olds has declined by 20 percent. Among young people (15-to-24-year-olds), prevalence was halved.[23]

FIGURE 38: HIV PREVALENCE AMONG MOST-AT-RISK POPULATIONS IN GEORGIA



23 http://www.measuredhs.com/hivdata/reports/start.cfm

5.2.3 TUBERCULOSIS: SUCCESS IN ASIA AND MAJOR CHALLENGES IN AFRICA

32. WHO Stop TB set an ambitious target to halve the prevalence of TB between 1990 and 2015. The increased funding of tuberculosis control programs by the Global Fund has contributed to rapid scale-up of effective DOTS programs worldwide, with increased involvement of nongovernmental service providers, including the private sector. The Global Fund is also providing essential funding to conduct tuberculosis disease prevalence surveys to help better understand evolving tuberculosis epidemiology, particularly in sub-Saharan Africa.

33. WHO Stop TB estimates show that TB prevalence was already on the decline by 1990 and mortality peaked before 2000. Declining trends should continue globally as populous high-burden TB countries such as China and India are showing impact on a trajectory toward achieving MDG6. However, countries in sub-Saharan Africa as well as some Eastern European countries show increases, mostly exacerbated by the HIV pandemic.

34. Asian countries are steadily progressing toward achieving impact but progress in Africa is more limited. In addition to TB/HIV co-epidemics, the challenges in Africa also include weak health systems and the need to detect TB more actively in communities.

35. Among the 15 countries with the largest Global Fund investments to fight TB, there are clear differences between Africa and Asia (see Figure 39).

- The majority of the Asian countries have exceeded their 2006 target toward 2015, including the three countries with the largest number of people with TB (India, China and Indonesia).
- Many countries in sub-Saharan Africa – where the HIV pandemic has hit hardest – including those with a high TB burden such as South Africa and Nigeria, are showing increases in TB prevalence despite increasing financial resources.
- At the same time, WHO Stop TB estimates indicate that TB prevalence has been decreasing since 2000 on a trajectory to achieve the Millennium Development Goals in some African countries such as Zambia and Somalia.

FIGURE 39: TUBERCULOSIS PREVALENCE PER 100,000 POPULATION IN 15 COUNTRIES WITH HIGHEST TUBERCULOSIS INVESTMENTS FROM THE GLOBAL FUND

COUNTRY	BASELINE (2000)	RESULTS (2006)	TARGETS 2006	RESULTS TO TARGETS
CHINA	271	201	227	159%
PHILIPPINES	554	432	496	>200%
INDONESIA	327	253	284	171%
RUSSIA	168	125	115	81%
BANGLADESH	499	391	424	143%
INDIA	464	299	392	>200%
SUDAN	396	419	320	-30%
ZAMBIA	1,052	568	758	165%
ETHIOPIA	545	641	388	-61%
PAKISTAN	416	263	335	189%
NIGERIA	565	615	395	-29%
PERU	274	187	265	>200%
DR CONGO	584	645	404	-34%
SOMALIA	442	293	424	>200%
KENYA	406	334	270	53%

Notes: 2006 targets are estimated from baseline 2000 to achieve Stop TB Partnership target of halved prevalence of TB between 1990 and 2015 (not shown); all TB forms per 100,000 in 1990, 2000 and 2006 (results) are from WHO; results to targets are computed as actual progress (2006 results from baseline) over targeted progress (2006 from baseline).

5.2.4 TUBERCULOSIS: COUNTRY EXAMPLES

36. The increased funding available to TB control programs is catalyzing the scale-up of effective DOTS programs worldwide. The Stop TB Partnership aims to drastically reduce TB transmissions by 2015, but does not envision eliminating TB globally before 2050. The strategy is focused on detecting and treating new cases of TB. Country programs are now expanding the coverage of DOTS – both geographically and by involving the private sector.

37. As well as supporting DOTS expansion, the Global Fund also provides essential funding for some country programs to conduct prevalence surveys to help them better understand the epidemiology of TB and inform TB estimation models. In response to country requests to better understand the evolving TB and HIV epidemics and to track progress against Millennium Development Goal targets for TB and HIV, the Global Fund has financed TB prevalence surveys in Uganda, Malawi and Nigeria.

China

38. The Chinese national TB program used Global Fund support to expand DOTS coverage to provinces not previously covered. Also, resources from the Global Fund have allowed the national TB program to intensify service coverage for migrants, and provide treatment and care for TB/HIV co-infection and multi-drug-resistant TB. Case detection dramatically improved from 20 percent to 79 percent and the success rate for DOTS treatment improved to 91 percent. Currently, WHO Stop TB Department estimates show that TB prevalence and mortality have declined by 37 percent since 1990. Incidence of new smear-positive cases declined by 15 percent in the same period. The acceleration of detection and treatment through DOTS programs in China will have a significant effect on the progress of TB control toward the Millennium Development Goals in the Western Pacific region as a whole.

Somalia

39. For a long time, no major donor had provided significant support to Somalia for TB control. The Round 3 (2003) Global Fund grant changed the situation, providing local partners with sufficient and predictable financial support to improve the quality of care in existing health care facilities and to increase the number of health facilities providing TB care throughout the country. By the end of 2007, there had been no reports of stock-outs of TB medicines or laboratory supplies. The number of health facilities providing TB care increased from 37 in September 2004 to 48 by the end of 2007. More than 36,000 TB cases had been detected and treated under DOTS from 2004 to 2006, and more than 85 percent had been successfully treated. In addition, transparency required for Global Fund support has facilitated interaction amongst all stakeholders despite the ongoing civil war. WHO Stop TB estimates show that TB prevalence has been declining. As of 2006, TB prevalence was estimated at 293 per 100,000, compared to 795 per 100,000 in 1990.

India

40. Global Fund support has enabled India's Revised National TB Control Programme to expand DOTS coverage to the country's two poorest states with a population of approximately 120 million, drawing from experiences of other states with successful TB control strategies. Currently, 87 percent of detected infectious cases nationally are successfully treated. WHO Stop TB Department estimates that between 1990 and 2006 TB prevalence declined by 47 percent and TB mortality by 33 percent, suggesting that the country is steadily progressing toward the Millennium Development Goal targets.

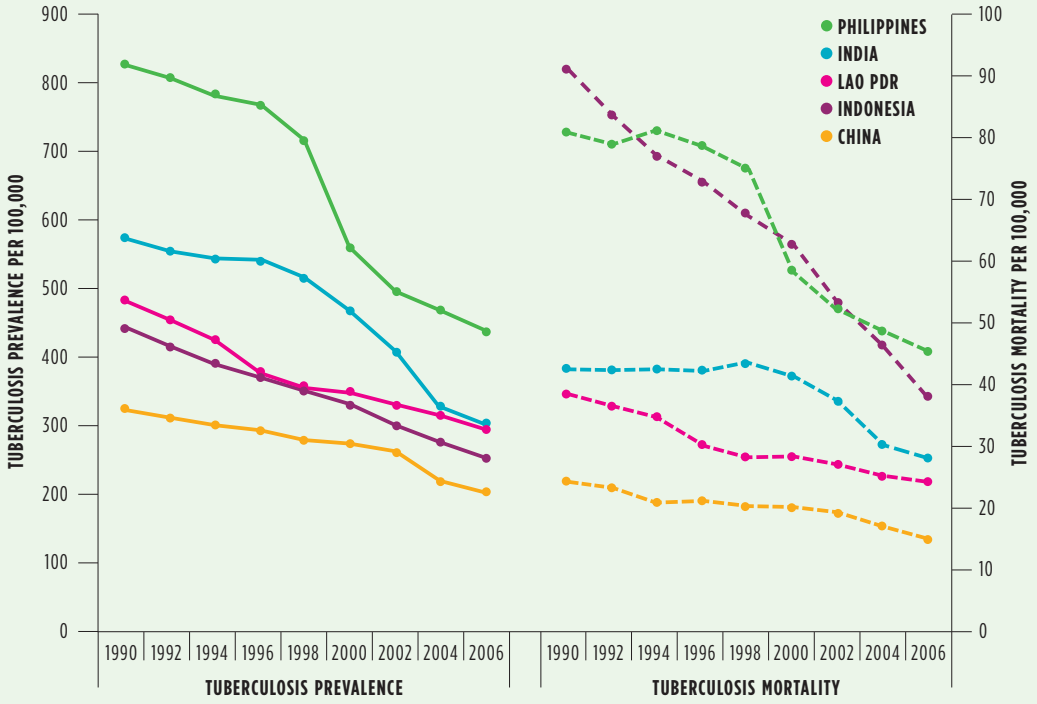
Indonesia

41. In 2005, Indonesia expanded the national control program with the launch of the "Equitable Quality DOTS for All" project, supported by the Global Fund. The main program goals include scaling up the involvement of nongovernmental, community-based and faith-based organizations in DOTS expansion with strong links to the provincial and district DOTS management teams. WHO Stop TB Department estimates that there was a 42 percent decline in prevalence from 1990 to 2006. National prevalence surveys have demonstrated a similar trend.

Philippines

42. DOTS coverage in the Philippines has been expanded to involve the private sector. This collaboration has facilitated a rapid improvement in the case detection rate to 72 percent in 2006, up from 56 percent in 2002. WHO Stop TB Department estimates that TB prevalence has declined by 47 percent, TB mortality by 43 percent and the incidence of new smear-positive cases by 15 percent, suggesting that achieving the Millennium Development Goals is now a realistic possibility. Preliminary results from the 2007 National TB Prevalence Survey, conducted with Global Fund support, are showing a significant decline in TB prevalence. Progress toward the Millennium Development Goals in the Philippines is ahead of targets but challenges remain, specifically regarding the country's ability to reach the most vulnerable populations (including the urban and rural poor, children with TB, prisoners, displaced populations, autonomous regions and some remote islands).

FIGURE 40: TUBERCULOSIS PREVALENCE AND MORTALITY ESTIMATES FOR SELECTED COUNTRIES



Source: Global Health Atlas Database (http://www.who.int/globalatlas) – as of 17 March 2008.

5.2.5 MALARIA: MAJOR PROGRESS IN SOME COUNTRIES

43. Malaria is a major cause of death for children under five years old in malaria-endemic areas and therefore influences the achievement of Target 4 of MDG4 (reduce by two-thirds the under-five mortality rate between 1990 and 2015). Malaria control has provided the most vivid examples of impact in the last year. For the first time, national coverage of preventive interventions (insecticide-treated bed nets and spraying) has reached more than 60 percent in a number of countries. This is leading to declines in disease transmission, in the number of malaria cases, in treatment demand and, ultimately, in the burden on hospitals due to reduced malaria morbidity.

44. The UNICEF estimate for the global number of deaths of children under five is now below ten million per annum, compared to 13 million in 1990. The use of insecticide-treated bed nets to reduce malaria and integrated management of childhood illness interventions have strongly contributed to this positive trend. Progress towards the Millennium Development Goals for the 15 countries with the highest Global Fund investments is summarized in Figure 41, and suggests:

- The average achievement of Millennium Development Goal child mortality 2006 targets was 28 percent in sub-Saharan Africa.
- There have been substantial declines in child mortality in Malawi, Mozambique and Ethiopia, reaching between 84 percent and 107 percent of their 2006 targets, setting these countries on a trajectory toward achieving the Millennium Development Goals.
- Declines in child mortality in Rwanda, Benin and Zanzibar may be specifically linked with malaria prevention and treatment interventions.

45. In addition to Target 6.C under MDG6 (see Box 16), the RBM aims to reduce malaria morbidity and mortality by 75 percent between 2005 and 2015. Success stories are emerging: declines in the burden on health facilities are starting to be seen in Burundi, Eritrea, Zanzibar, Kenya and Rwanda, as well as regionally in the collaborative zones of Lubombo in Southern Africa.

46. A recent study in Tanzania has shown the accelerated declining trend in child mortality, owing to widespread insecticide-treated bed net use and increased provision of other prevention and treatment services for children. It is now feasible for Tanzania to achieve the health-related Millennium Development Goals. Similarly, in Rwanda there have been rapid, recent declines in malaria deaths and child mortality. The promising evidence of impact in the last year now needs to be generalized to affect malaria transmission and child mortality generally.

5.2.6 MALARIA: COUNTRY EXAMPLES

47. An increasing number of Global Fund-supported malaria programs are reporting successes in achieving significant coverage and are demonstrating reductions in countries' malaria burden.

Rwanda

48. Since 2003, Rwanda has intensified its malaria control efforts by rolling out two important interventions. Insecticide-treated bed nets were distributed (using a measles vaccination campaign in order to ensure high community coverage) and ACTs were introduced nationwide. By the end of 2007, more than 2.4 million insecticide-treated bed nets had been distributed, achieving 60 percent coverage. Child malaria cases have declined by 64 percent and child malaria deaths by 66 percent. There is also initial evidence that health system capacity has been freed up by the decline in malaria cases

FIGURE 41: TRENDS IN ESTIMATED UNDER-FIVE MORTALITY PER 1,000 LIVE BIRTHS IN 15 COUNTRIES WITH HIGHEST MALARIA INVESTMENTS FROM THE GLOBAL FUND

COUNTRY	BASELINE (2000)	RESULTS (2006)	TARGETS 2006	RESULTS TO TARGETS
UGANDA	145	134	108	30%
SUDAN	97	89	74	35%
ETHIOPIA	151	123	118	84%
TANZANIA	141	118	106	66%
KENYA	117	121	83	-12%
MADAGASCAR	137	115	105	68%
ZAMBIA	182	182	133	0%
ANGOLA	260	260	191	0%
SENEGAL	133	116	100	51%
MALAWI	155	120	122	107%
NIGERIA	207	191	155	31%
RWANDA	183	160	133	46%
NIGER	270	253	205	26%
MOZAMBIQUE	178	138	138	100%
CAMEROON	151	149	109	5%

Source: 2006 targets are estimated from 2000 baseline to achieve MDG reduction of two-thirds between 1990 and 2015 of under 5 mortality (not shown); 2000 baseline data, and 2006 results data are from UNICEF; results to targets are computed as actual progress (2006 results from baseline) over targeted progress (2006 targets from baseline: http://www.childinfo.org/mortality_underfive.php).

to enhance other health activities. In parallel there was an increasing trend in other health consultations due to the scale-up of health insurance coverage for the poor, made possible by financial assistance from the Global Fund. The interim demographic health survey shows early indications of reductions in child mortality in the last few years of a scale that suggests that Rwanda is on course to achieve the Millennium Development Goals. Continued funding is critical to sustain the control effort.

United Republic of Tanzania

49. Zanzibar is showing the extensive impact that malaria interventions can have on disease transmission. A recent evaluation of malaria control in Zanzibar showed that following initiation of ACTs and intensive scale-up of insecticide-treated bed net distribution, the malaria burden was halved both in terms of outpatient cases as well as hospital admissions. In addition, child mortality had declined by 52 percent (see Figure 43). The introduction of indoor residual spraying further suppressed malaria cases and, consequently, the demand for antimalarial treatment. This progress has encouraged the authorities on Zanzibar to aim for a full eradication of malaria before 2015.

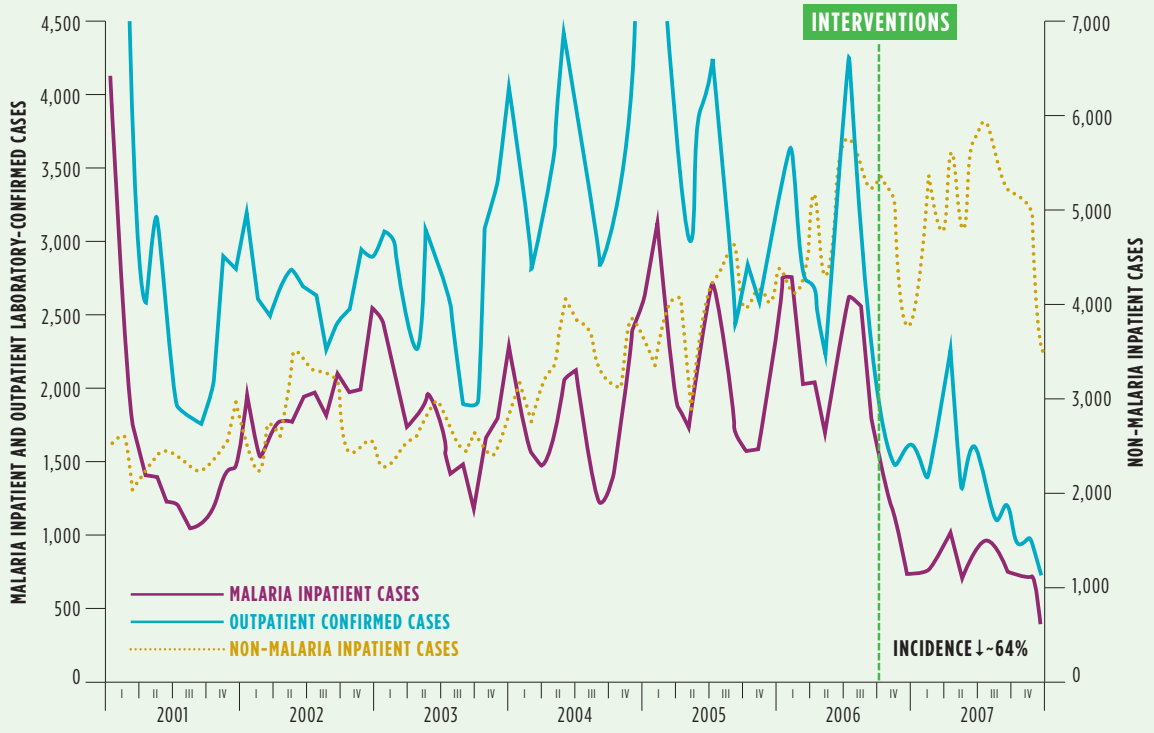
50. On mainland Tanzania, the decline in child mortality has started to accelerate in the last several years, driven mainly by a reduction in death from malaria. The rate of decline had not been sufficient for the country to become on track to achieve MDG4 by 2015. However, the rate of progress is now accelerating.[24]

Burundi

51. Burundi was one of the first countries to introduce ACTs at the national level. The key malaria control achievements include the provision of effective antimalarial treatment to almost four million patients and the distribution of more than one million long-lasting insecticide-treated bed nets. Incidence of malaria has declined by 45 percent from 2000 to 2005, and this is widely attributed to the national malaria program – in particular, to effective treatment with ACTs.

24 Masanja H et al. Child survival gains in Tanzania: analysis of data from demographic and health surveys. Lancet, 2008, 371:1276-1283.

FIGURE 42: DECLINE IN MALARIA CASES AT SAMPLED HEALTH FACILITIES



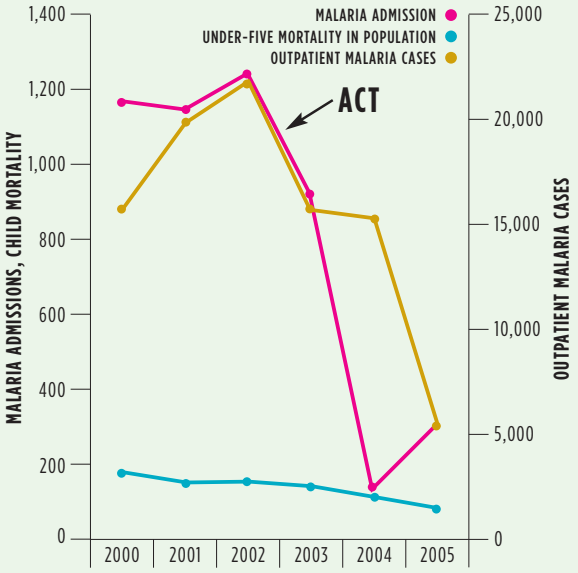
Source: Otten M et al. Initial evidence of reduction of malaria cases and deaths in Rwanda and Ethiopia due to rapid scale-up of malaria prevention and treatment. *Malaria Journal*, 2009 Jan 14; 8(1):14.

Multi-country Southern Africa

52. One of the now well-known success stories is the Lubombo Spatial Development Initiative. By being among the first malaria projects that have shown dramatic and sustained reduction in malaria incidence and mortality, the Lubombo project has emerged as an inspiration and a flag-bearer for the "new wave" of malaria programs initiated during the past few years. The program forms a part of an ongoing collaborative public/private project of the governments of Mozambique, South Africa and Swaziland that aims to develop the cross-border Lubombo region into a competitive economic area.

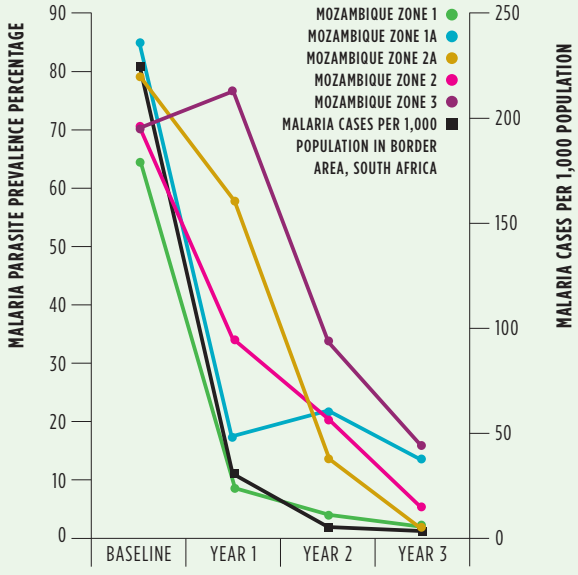
53. By achieving universal coverage of effective anti-malarial treatment (ACTs) and indoor residual spraying in the target areas in the three countries, this program has demonstrated considerable success in fighting and controlling malaria. Sentinel surveillance among children under five shows declines in malaria parasite prevalence varying from 53 percent to 94 percent in the target zones. Malaria incidence in the South African target area and in Swaziland has been reduced by 87 percent and 96 percent, respectively (see Figure 44). The savings resulting from the reduced need for treatment were used to strengthen monitoring and evaluation capacity. Most importantly, the reported malaria burden continues to drop. Another Global Fund-approved proposal in Round 5 expands the geographical coverage to serve an additional 1.28 million people living in neighboring Gaza province in Mozambique, protecting almost five million people with indoor residual spraying.

FIGURE 43: MALARIA CASES AT ALL HEALTH FACILITIES IN ZANZIBAR'S NORTH A DISTRICT AND UNDER-FIVE MORTALITY ESTIMATED FROM VITAL STATISTICS AND CENSUS*



* **Source:** Bhattarai A et al. Impact of artemisinin-based combination therapy and insecticide-treated nets on malaria burden in Zanzibar. PLoS Medicine, 2007, 4:e309.

FIGURE 44: DECLINING MALARIA PREVALENCE IN LUBOMBO PROJECT AREA (MULTI-COUNTRY SOUTHERN AFRICA PROGRAM)



Source: Based on analysis from performance data of the program.

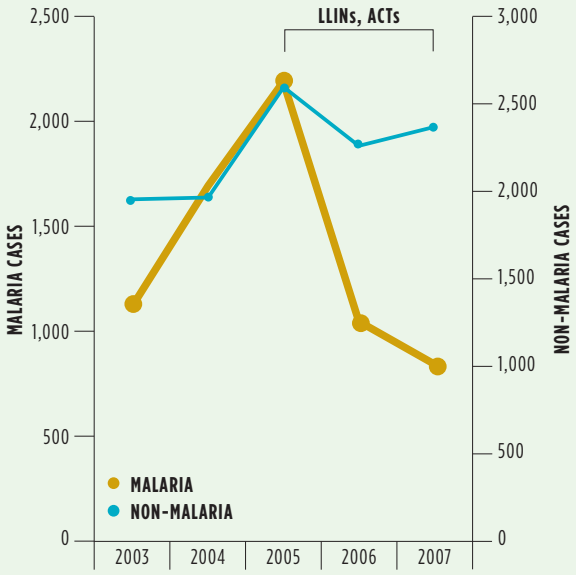
Ethiopia

54. Initial signs of the protective effect of long-lasting insecticide-treated bed nets are now emerging in some regions in Ethiopia. The country's malaria control program conducted mass distributions of long-lasting insecticide-treated bed nets in 2005 and 2006. ACTs were also introduced in the public sector in 2005. By the end of 2007, 20 million long-lasting insecticide-treated bed nets had been distributed with resources from a number of partners, the Global Fund among them. The distribution of almost half this total (9.4 million) was solely financed by the Global Fund, resulting in an estimated coverage of almost two long-lasting insecticide-treated bed nets per household in the malaria-endemic regions of the country. A recent survey showed that inpatient child malaria cases have declined by 60 percent in some areas, and child malaria deaths have declined by 51 percent between 2005 and 2007 (see Figure 45).

Kenya

55. Kenya has conducted mass distribution of insecticide-treated bed nets and introduced the use of effective malaria treatment. Health facilities in coastal areas in Kenya report that malaria admissions among children declined by 61 percent from 1999 to 2006.[25] Free nationwide distribution of insecticide-treated bed nets helped to achieve an equitable coverage of insecticide-treated bed nets by wealth status of

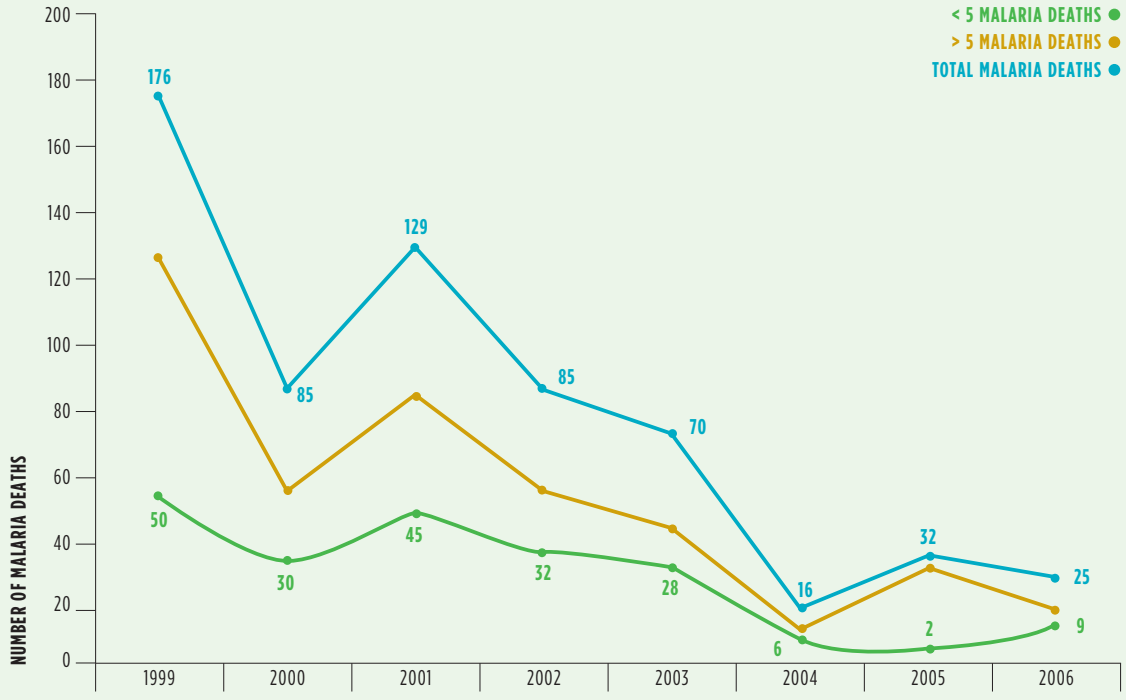
FIGURE 45: MALARIA CASES IN SAMPLED HEALTH FACILITIES IN ETHIOPIA BETWEEN 2003 AND 2007*



* Otten M et al. Initial evidence of reduction of malaria cases and deaths in Rwanda and Ethiopia due to rapid scale-up of malaria prevention and treatment. *Malaria Journal*, 2009 Jan 14; 8(1):14.

25 Okiro EA et al. The decline in pediatric malaria admissions on the coast of Kenya. *Malaria Journal*, 2007, 6:151.

FIGURE 46: ANNUAL MALARIA-RELATED DEATHS IN ERITREA



Source: National malaria control program surveillance report, 2007

beneficiaries.[26] By 2006, more than three million free insecticide-treated bed nets had been distributed, targeting the poorest children in particular. Studies are needed to document the reduction in child mortality following recent scaling up of insecticide-treated bed net distribution.

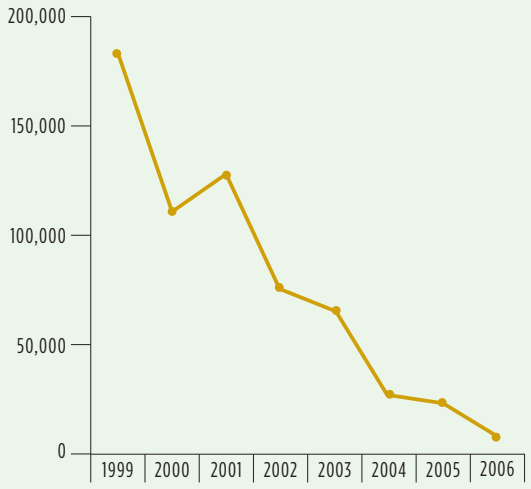
Eritrea

56. The Eritrea malaria program has improved insecticide-treated bed net coverage to 60 percent over the past few years. Early diagnosis and treatment has also improved, resulting in a reduction in malaria deaths of children under five by 70 percent between 1999 and 2006 (see Figure 46). Inpatient and outpatient malaria cases were reduced by 42 percent and 91 percent, respectively (Figure 47), with the Global Fund providing additional support to the national program.[27]

Nicaragua

57. Malaria continued to be a public health problem in Nicaragua (particularly in Atlantic coastal areas) until control efforts were intensified with Global Fund support. With increased financial resources, the government embarked on a scale-up of insecticide-treated bed nets and indoor residual spraying in high-risk areas. Consequently, only one malaria-related death was reported in 2007. The reduction of malaria cases was 55 percent between 2005 and 2006, with a similar reduction in the Annual Parasite Index (API).[28]

FIGURE 47: OUTPATIENT MALARIA CASES IN HEALTH FACILITIES IN ERITREA



Source: National malaria control program surveillance report, 2007.

26 Noor AM et al. Increasing coverage and decreasing inequity in insecticide-treated bed net use among rural Kenyan children. PLoS Med, 2007, 4:e255.
27 National malaria control program surveillance report, 2007, submitted to the Global Fund.
28 Grant performance documentation (Rolling Continuation Channel).

ERITREA IS WORKING TO FIGHT STIGMA SURROUNDING AIDS AND TB THROUGH PEER EDUCATION ACTIVITIES. CHILDREN ATTEND WEEKLY CLASSES TO LEARN ABOUT THE DISEASES AND THEN SPREAD THE WORD TO FRIENDS AND FAMILY.

5.3 CONTRIBUTION OF PROGRAMS TO MILLENNIUM DEVELOPMENT GOALS AND OTHER INTERNATIONAL TARGETS

58. The international targets for key services such as ARVs, DOTS and insecticide-treated bed nets are the following:

a. **Malaria:** estimates for insecticide-treated bed nets required in sub-Saharan Africa to achieve universal coverage (80 percent) of most-at-risk populations (children under five and pregnant women) by 2015;

b. **AIDS:** UNAIDS estimates for the number of people requiring HIV treatment at the end of each year to 2010 to achieve universal access;

c. **TB:** Stop TB Partnership estimates of new smear-positive cases to be detected and put on treatment under the Global Plan to Stop TB (2006-2015).

These targets have been broken down to yearly milestones that have to be achieved if the final targets are to be met.

5.3.1 MALARIA: UNIVERSAL ACCESS TO MALARIA CONTROL MEASURES IN AFRICA

59. On World Malaria Day 25 April 2008 the UN Secretary-General announced a new initiative to provide universal access to malaria control measures in Africa by 2010. Global Fund-supported programs have already significantly scaled up their control efforts. However, to meet this challenge, more will have to be done.

- RBM aims to achieve 80 percent insecticide-treated bed net coverage for most-at-risk populations by 2010, which has been translated into a need for 128 million insecticide-treated bed nets in sub-Saharan Africa
- By the end of 2008, Global Fund-supported programs had distributed 70 million insecticide-treated bed nets (53 million of them in sub-Saharan Africa). By 2010, it is estimated that they will have distributed 77 million insecticide-treated bed nets in sub-Saharan Africa. This represents 60 percent of the bed nets required to achieve the RBM target.

FIGURE 48: INSECTICIDE-TREATED BED NET TARGETS AND GLOBAL FUND RESULTS IN SELECTED COUNTRIES

	INSECTICIDE-TREATED BED NET NEED FOR MOST-AT-RISK POPULATIONS AT END 2008	INTERNATIONAL INSECTICIDE-TREATED BED NET TARGET FOR END 2008	END 2008 GLOBAL FUND RESULTS	GLOBAL FUND-SUPPORTED PROGRAMS CONTRIBUTION TO INSECTICIDE-TREATED BED NET INTERNATIONAL TARGETS
ETHIOPIA	12,500,000	10,000,000	10,800,000	108%
MADAGASCAR	3,300,000	2,600,000	5,000,000	191%
ZAMBIA	2,800,000	2,300,000	4,300,000	193%
KENYA	5,300,000	4,200,000	3,700,000	87%
RWANDA	1,500,000	1,200,000	3,200,000	264%
GHANA	4,200,000	3,400,000	2,400,000	72%
NIGER	3,700,000	3,000,000	2,100,000	71%
CAMEROON	3,400,000	2,700,000	1,600,000	58%
BURUNDI	1,400,000	1,100,000	1,300,000	115%
LIBERIA	900,000	700,000	500,000	71%

Note: Needs are based on Miller et al. (Miller JM, Korenromp EL, Nahlen BL, Steketee RW. Estimating the number of insecticide-treated nets required by African households to reach continent-wide malaria coverage targets. *Journal of the American Medical Association*, 2007, 297:2241-2250) taking into account population growth; targets are estimated as 80 percent of the need.

60. Most African countries benefiting from Global Fund resources have exceeded the targets set by the UN Secretary-General, although not all will achieve them by 2010:

- Insecticide-treated bed net distribution in Rwanda is far ahead of targets to achieve universal coverage by 2010;
- Madagascar and Zambia have delivered sufficient insecticide-treated bed nets to cover 80 percent of children and pregnant women (see Figure 48);
- Niger has achieved 71 percent of the country's coverage target for 2008, estimated at three million insecticide-treated bed nets. A major portion of the insecticide-treated bed nets were distributed through a polio vaccination campaign, prior to which only four percent of households owned an insecticide-treated bed net. After the campaign 65 percent of households owned an insecticide-treated bed net, a 16-fold increase.

61. The challenge in the coming years for the Global Fund and the countries it supports is to plan and propose even more aggressive insecticide-treated bed net delivery targets, and to enable behavior change among those at risk so that they use insecticide-treated bed nets correctly and seek health care promptly when family members show symptoms of malaria.

5.3.2 HIV: SCALE-UP TOWARDS UNIVERSAL ACCESS FOR HIV SERVICES

62. To achieve universal access to ARVs (defined as access for 80 percent of those in need), UNAIDS currently envisages two scenarios: a) universal access by 2010; and b) a phased scale-up scenario to achieve universal access by 2015. For 2008, the phased scale-up scenario had an estimated target of 5.2 million on ARVs compared to 6.5 million for the universal access scenario.

63. Collectively, Global Fund-supported programs have provided two million people with ARVs as of end 2008 and are conservatively projected to provide HIV treatment for 2.9 million people by 2010.

Estimates show that some countries in Africa have already attained universal access to ARVs, while others are on track to achieve it by 2010 (figure 49).

- Some countries have reached universal access to ARVs (for example, Namibia) or are near to achieving it (for example, Rwanda and Thailand), according to UNAIDS
- Kenya and Zambia have made significant progress toward their international targets. They exceeded the 2007 estimated targets.
- Malawi reached 88 percent of its 2007 target, including providing access to ARVs for health workers who are running the ARV program nationwide.

FIGURE 49: ARV NEEDS, TARGETS AND GLOBAL FUND RESULTS IN SELECTED COUNTRIES

COUNTRY	ARV NEED DECEMBER 2007	GLOBAL ARV TARGETS (ESTIMATED)	END 2007 GLOBAL FUND RESULTS	PERCENT OF GLOBAL TARGETS
KENYA	470,000	150,000	166,000	114%
MOZAMBIQUE	370,000	118,000	78,000	68%
TANZANIA	440,000	141,000	97,000	71%
ZAMBIA	330,000	105,000	123,000	120%
MALAWI	290,000	93,000	79,000	88%
CAMEROON	180,000	57,500	29,000	52%

Notes: Source for ARV needs as of end 2007, WHO, *Towards Universal Access 2008*; collective country targets for 2007 (3.1 million) represent 32 percent of the 9.7 million global need (UNAIDS 2007, *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support*). Targets have been used for 2007, as these are the latest country targets released by UNAIDS.

5.3.3 TUBERCULOSIS: STEADY INCREASE IN RESULTS TO ACHIEVE INTERNATIONAL TARGETS

65. In addition to the Millennium Development Goals for TB, in its Global Plan to Stop TB 2006-2015 the Stop TB Partnership has set a target to achieve a 76 percent case detection rate. By the end of 2008, the global cumulative number of new smear-positive TB cases was estimated at 10.3 million, with the Global Fund-supported programs reporting 4.6 million new smear-positive cases detected. This represents 41 percent of the estimated global total. This number is projected to reach 7.2 million by 2010 through grants with approved Global Fund financing.

66. Some of the countries with the largest Global Fund investments in TB have already either achieved or exceeded their estimated portion of the case detection target set in the Global Plan to Stop TB (see Figure 50). For example, in China – the country with the second largest estimated number of people with new smear-positive TB in the world – the National TB Control Program reached 100 percent of its national target, while in Somalia and Egypt, the target has either been reached or exceeded, with DR Congo reaching 97 percent of its 2008 target.

5.3.4 OVERALL PROGRESS AND GAPS

67. Results from Global Fund-supported programs represented 31 percent of the estimated 2008 international target for HIV treatment. Results for detection and treatment of TB cases through DOTS programs represented 45 percent of the 2008 international target. In sub-Saharan Africa, results represented 44 percent of the 2008 international target for insecticide-treated bed net distribution.

68. The contribution of Global Fund-supported programs to international targets between 2005 and 2008 is shown in Figure 51. While that for ARVs increased from 13 percent in 2005 to 31 percent in 2008, in the same period, for TB, the contribution almost doubled from 26 to 45 percent. Similarly, for insecticide-treated bed nets, Global Fund-supported programs in sub-Saharan Africa improved their contribution to the international target ninefold, from five percent by 2005

FIGURE 50: DOTS NEEDS, TARGETS AND GLOBAL FUND RESULTS IN SELECTED COUNTRIES

COUNTRY	DOTS NEED 2005–2007	ESTIMATED GLOBAL DOTS TARGETS 2005–2007	GLOBAL FUND RESULTS 2005–2007	PERCENT OF ESTIMATED GLOBAL TARGETS
CHINA	2,362,000	1,720,000	1,714,000	100%
BANGLADESH	618,000	450,000	342,000	76%
DR CONGO	404,000	294,000	284,000	97%
SOUTH AFRICA	669,000	487,000	245,000	50%
ETHIOPIA	526,000	383,000	167,000	44%
CAMBODIA	125,000	91,000	85,000	93%
RUSSIAN FEDERATION	280,000	204,000	76,000	37%
CÔTE D'IVOIRE	134,000	98,000	67,000	68%
NEPAL	88,000	64,000	32,000	50%
SOMALIA	33,000	24,000	28,000	117%
EGYPT	32,000	23,000	23,000	100%

Notes: DOTS needs for 2005 to 2006 are from WHO *The Global Plan to Stop TB 2006-2015*; calculation of 2007 need was based on 2006 figures; 2007 targets were based on interpolation of 2006 and 2010 targets of the Global Plan to Stop TB 2006-2015; numbers are rounded.

69. Although ARV targets for Global Fund-supported programs are projected to increase substantially in absolute numbers, their share of the international target will be around 21 percent by 2010 (see Figure 52). For the TB target, the contribution of Global Fund-supported programs is projected to increase from 45 percent to 49 percent and for insecticide-treated bed net from 44 percent in 2008 to 60 percent in 2010.

70. A growing number of countries are showing evidence of impact on HIV, TB and malaria and progress towards the Millennium Development Goals, to which Global Fund-supported programs have made a major contribution. Increased and sustainable financing is needed to continue this momentum towards achieving the Millennium Development Goals and other international targets.

FIGURE 51: INCREASING GLOBAL FUND-SUPPORTED PROGRAMS' CONTRIBUTION TO INTERNATIONAL TARGETS

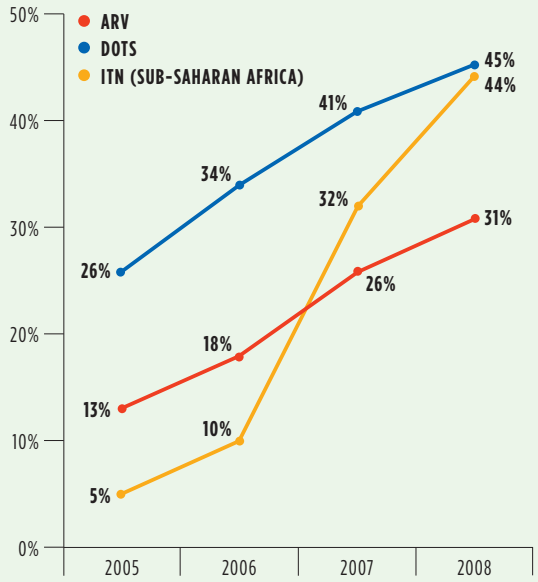
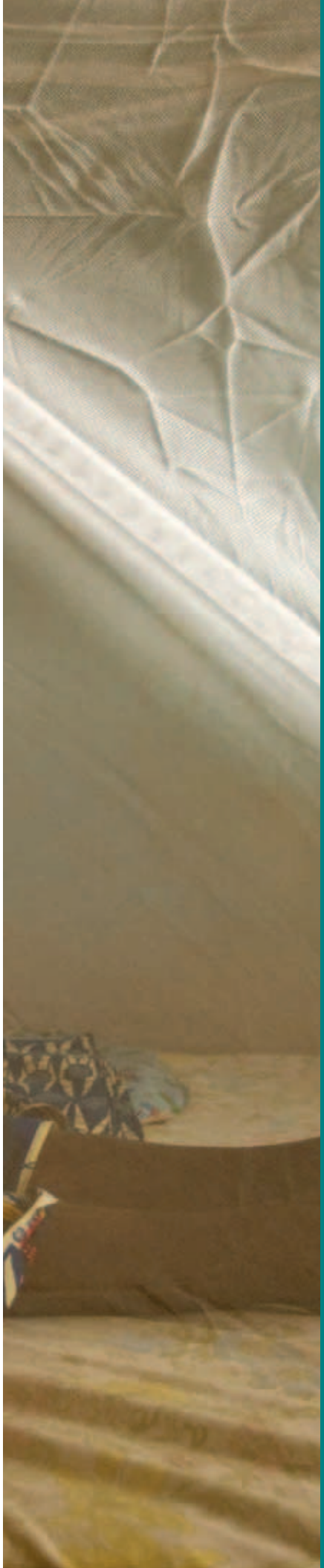


FIGURE 52: INTERNATIONAL AND GLOBAL FUND DELIVERY TARGETS: PROGRESS BY END 2008

TARGETS AND RESULTS	PEOPLE ON ARVs	CASES DETECTED UNDER DOTS	INSECTICIDE-TREATED BED NETS DISTRIBUTED (SUB-SAHARAN AFRICA)
INTERNATIONAL TARGETS (2008)	6.5 MILLION	10.3 MILLION [3]	121.4 MILLION [5]
GLOBAL FUND RESULTS (2008)	2 MILLION	4.6 MILLION [4]	53 MILLION [6]
GLOBAL FUND CONTRIBUTION (2008) [1]	31%	45%	44%
INTERNATIONAL TARGETS (2010)	13.7 MILLION [2]	14.7 MILLION	127.8 MILLION [5]
GLOBAL FUND TARGETS (2010)	2.9 MILLION	7.2 MILLION	77 MILLION [6,7]
GLOBAL FUND CONTRIBUTION (2010)	21%	49%	60%

Notes: Global Fund figures may include service and commodity deliverables that are co-financed by others. 1 Global Fund results compared to estimated international targets. 2 Based on UNAIDS universal access scenario by 2010. The phased scale-up scenario from UNAIDS has a 2008 target of 5.2 million and a 2010 target of 8.2 million, resulting in a Global Fund contribution of 38% in 2008 declining to 35% in 2010. 3 Estimated cumulative number of new sputum smear-positive cases detected under DOTS strategy since mid-2004. 4 Country reporting may include non-new smear-positive cases up to ten percent. 5 Estimates based on 80 percent of high-risk population in sub-Saharan Africa. 6 Figures for sub-Saharan Africa. 7 The international target for 2008 and 2010 excludes insecticide-treated bed nets distributed before 2005 and 2007 respectively, as they are likely to wear out.

THE GLOBAL FUND FINANCES MALARIA PROJECTS COVERING A POPULATION OF 4.4 MILLION PEOPLE, WITH THE AIM OF REDUCING MALARIA MORTALITY AND MORBIDITY IN CHILDREN UNDER FIVE AND PREGNANT WOMEN.



6. CONCLUSIONS AND CHALLENGES

1. The **Global Fund partnership is a unique platform which brings together governments, civil society, communities living with the diseases and the private sector to achieve a sustainable and significant reduction in infections, illness and death** due to HIV, TB and malaria. This report shows some of the most exciting signs of impact so far: the first population-level declines in adult mortality due to HIV treatment, declines in TB prevalence and systematic declines in child mortality due to malaria interventions. Country programs supported by the Global Fund have rapidly scaled up lifesaving services to millions of people, and many countries are increasingly in a position to manage their epidemics.

2. **Global Fund-supported programs are substantially contributing to achievement of the Millennium Development Goals.** The key strengths demonstrated in country ownership, performance-based funding and inclusive partnerships have provided the basis for saving over 3.5 million lives. The Global Fund is the main force behind efforts to reach milestones like universal coverage of long-term insecticide-impregnated bed nets against malaria by 2010, and a substantial financier for the efforts to achieve universal access to HIV and AIDS treatment, care and prevention, as well as to scale up effective case detection and treatment for TB.

3. **The Global Fund has proven itself as an efficient mechanism for channeling donor money to where the best results are achieved.** Its overhead is the lowest of any comparable development institution and its funding model has so far allowed the overhead to be covered by interest income – ensuring that all donor contributions benefit health programs in countries directly. Its flexibility, based on country ownership and performance-based funding, enables it to quickly respond to changing needs and to limit spending on activities that prove not to bring results.

4. **As an innovative learning organization, the Global Fund is committed to continually improve from both failures and successes.** The Global Fund has shown itself to be a "learning partnership", capable of adapting to changes in global health priorities as these emerge, including growing recognition of the importance of health systems strengthening, gender, aid effectiveness and national strategies, and the advent of new treatments such as ACT for malaria. The Global Fund's future will depend on whether it can maintain this "learning approach" based on transparent evidence and performance. Some of the greatest achievements of the Global Fund have involved improving poorly performing programs through careful performance diagnosis, funding decisions and providing clear incentives to address capacity bottlenecks. Similarly, the Global Fund has shown its ability to continue to innovate and adapt in response to the challenges of achieving the Millennium Development Goals.

5. **There are a number of areas where the Global Fund needs to improve to ensure that its model continues to be efficient and serve recipients' needs.** Rapid development and expansion of the grant portfolio have led to an increasingly complex set of guidelines, rules, precedents and practices and a growing challenge in applying them consistently across the portfolio. The Global Fund must review, harmonize and simplify its interactions and its operations with recipients and continue to engage partners to facilitate implementation and strengthen management skills among recipients. It must also urgently develop a strategy to communicate more, better and more clearly with recipients and partners and to encourage and facilitate better communication among and between recipients and partners. It needs to diversify its management model so that all grants are not treated in the same manner, but that grant management is guided by the size of the grant, past performance and risk profile. It must integrate its new and future funding windows and practices (national strategy applications, dual-track financing and the Rolling Continuation Channel) so that these do not conflict with or add new layers of bureaucracy to existing practices.

6. There is **an urgent need for increased levels of sustained financing to build on recent successes and to finance existing high-quality demand for funding of ambitious health programs**. The increases in resources for health have led to a virtuous cycle where initial positive results and strengthened health systems encourage increasingly ambitious expansions of national disease control efforts. This has led to a sharply growing demand for Global Fund resources, illustrated by the more than 2.5 times increase in high-quality proposals approved by the Global Fund Board in November 2008 compared to previous funding rounds.

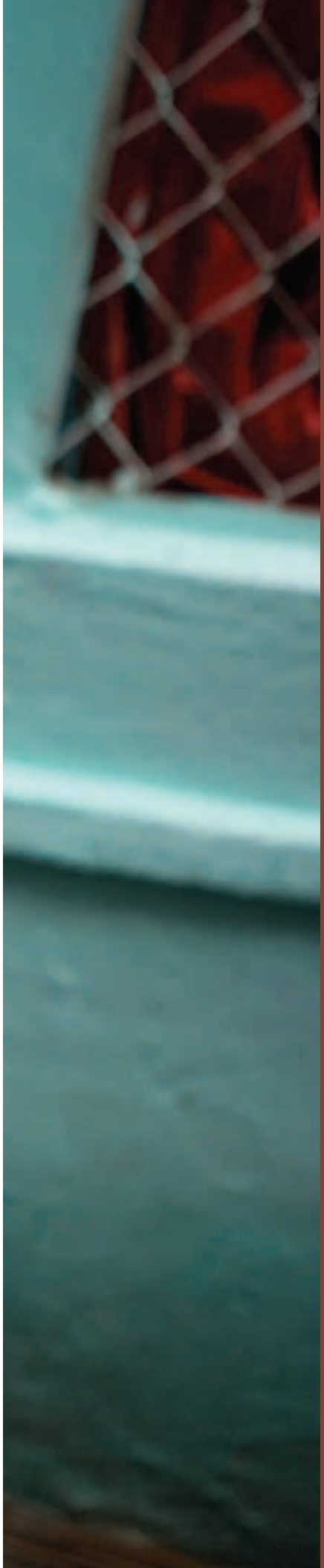
7. **While results are encouraging and impact can be seen in several areas, much work remains if these gains are to be expanded** into comprehensive, universal and equitable access to prevention, treatment and care. In particular, there is a need for

- intensified prevention at the community level;
- investment in health and community systems and country systems to scale up access and to reach vulnerable populations;
- novel approaches to address gender inequalities;
- strengthening of partnerships at country level to rapidly scale up prevention, treatment and care interventions;
- strengthening of disease surveillance, vital registration and surveys to measure impact and progress towards the Millennium Development Goals, and to ensure disease-control efforts are focused on the most effective means to reduce infections, illness and death.

8. Building on the financial and partnership challenges identified in the preceding results reports, the **ultimate challenge of the Global Fund is to encourage and assist partners and programs to scale up their activities to manage the epidemics and achieve disease impact**. Partners often support separate service delivery projects but are not organized into a partnership system focused on the country's national disease-control program. The goal of a "sustainable and significant contribution to the reduction in infections, illness and death" cannot be achieved by any one partner but only through comprehensive programs which can tackle the underlying behaviors and determinants of disease.

9. This will require a **shift in mindset from supporting separate projects and grants to financing strategies that can manage and measure impact on disease transmission over time**. It will also require the full force of the Global Fund partnership working globally, nationally and in communities. For the first time in decades, the foundation is now laid to achieve significant and sustainable impact against AIDS, TB and malaria.

BOYS IN NA TRANG, VIETNAM PLAY OUTSIDE WHILE THEIR FATHER RECEIVES A VISIT FROM A COMMUNITY HEALTH VOLUNTEER TRAINED IN TB DETECTION. THE GLOBAL FUND SUPPORTS TB OUTREACH SERVICES FOR RURAL COMMUNITIES IN MANY REGIONS OF VIET NAM.



ANNEXES

ANNEX 1

SUMMARY OF GLOBAL FUND-SUPPORTED PROGRAMS AT 31 DECEMBER 2008 (IN US$ EQUIVALENTS)[1]

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
EAST ASIA & THE PACIFIC								
Cambodia	1	HIV/AIDS	15,714,629	(G2)	Gov: MOH	CAM-102-G01-H-00	1-Sep-03	14,700,370
	2	HIV/AIDS	14,765,625	(G2)	Gov: MOH	CAM-202-G02-H-00	1-Jan-04	13,995,727
	2	Malaria	29,270,458	(T3)	Gov: MOH	CAM-202-G03-M-00	1-Jan-04	9,622,532
	2	TB	6,169,733	(G2)	Gov: MOH	CAM-202-G04-T-00	1-Jan-04	6,169,733
	4	HIV/AIDS	36,546,134	(G2)	Gov: MOH	CAM-405-G05-H	1-Sep-05	20,424,351
	4	Malaria	9,857,891	(G2)	Gov: MOH	CAM-405-G06-M	1-Sep-05	8,240,954
	5	HIV/AIDS	34,963,654	(B2)	Gov: MOH	CAM-506-G07-H	1-Oct-06	17,742,673
	5	HSS	5,602,756	(B2)	Gov: MOH	CAM-506-G08-S	1-Nov-06	2,420,809
	5	TB	10,076,616	(B2)	Gov: MOH	CAM-506-G09-T	1-Nov-06	3,494,071
	6	Malaria	13,105,131	(G1)	Gov: MOH	CAM-607-G10-M	1-Feb-08	8,011,542
	7	HIV/AIDS	23,857,767	(G1)	Gov: Oth	CAM-708-G11-H	1-Dec-08	7,137,934
	7	TB	8,707,480	(T1)				
China	1	Malaria	6,406,659	(G2)	Gov: Oth	CHN-102-G02-M-00	1-Apr-03	6,347,448
	1	TB	96,585,809	(T3)	Gov: Oth	CHN-102-G01-T-00	1-Apr-03	53,537,490
	3	HIV/AIDS	97,888,170	(G2)	Gov: Oth	CHN-304-G03-H	1-Sep-04	90,695,827
	4	HIV/AIDS	63,742,277	(G2)	Gov: Oth	CHN-405-G05-H	1-Jul-05	50,011,184
	4	TB	56,140,000	(G2)	Gov: Oth	CHN-405-G04-T	1-Jul-05	45,494,764
	5	HIV/AIDS	28,902,073	(G2)	Gov: Oth	CHN-506-G06-H	1-Jul-06	17,190,537
	5	Malaria	38,522,396	(B2)	Gov: Oth	CHN-506-G07-M	1-Nov-06	20,052,630
	5	TB	51,439,765	(B2)	Gov: Oth	CHN-506-G08-T	1-Nov-06	19,100,894
	6	HIV/AIDS	5,812,876	(G1)	Gov: Oth	CHN-607-G10-H	1-Jan-08	4,647,498
	6	Malaria	7,047,932	(G1)	Gov: Oth	CHN-607-G09-M	1-Aug-07	5,701,864
	7	TB	5,313,263	(G1)	Gov: Oth	CHN-708-G11-T	1-Nov-08	413,119
	8	HIV/AIDS	21,915,366	(B1)				
	8	TB*	33,418,220	(B1)				
Fiji	8	TB*	4,789,119	(B1)				
Indonesia	1	HIV/AIDS	7,829,764	(G2)	Gov: MOH	IND-102-G03-H-00	1-Jul-03	5,714,668
	1	Malaria	23,704,947	(G2)	Gov: MOH	IND-102-G02-M-00	1-Jul-03	21,231,148
	1	TB	68,663,564	(G2)	Gov: MOH	IND-102-G01-T-00	1-Aug-03	51,125,056
	4	HIV/AIDS	49,770,446	(G2)	Gov: MOH	IND-405-G04-H	1-Apr-05	33,285,569
	5	TB	49,978,433	(B2)	Gov: MOH	IND-506-G05-T	1-Jan-07	6,778,433
	6	Malaria	27,683,015	(G1)	Gov: MOH	IND-607-G06-M	1-Mar-08	17,100,276
	8	HIV/AIDS	45,384,545	(B1)				
	8	Malaria*	73,453,889	(B1)				
	8	TB	28,106,251	(B1)				
DPR Korea	8	Malaria	13,280,313	(B1)				
	8	TB*	24,614,195	(B1)				
Lao PDR	1	HIV/AIDS	3,407,664	(G2)	Gov: MOH	LAO-102-G01-H-00	1-May-03	3,404,028
	1	Malaria	12,709,087	(G2)	Gov: MOH	LAO-102-G02-M-00	1-May-03	12,709,087
	2	TB	3,530,391	(G2)	Gov: MOH	LAO-202-G03-T-00	1-Oct-03	3,530,391
	4	HIV/AIDS	7,747,873	(G2)	Gov: MOH	LAO-405-G04-H	1-Jul-05	5,409,078
	4	Malaria	14,502,222	(G2)	Gov: MOH	LAO-405-G05-M	1-Jul-05	9,766,025
	4	TB	3,617,781	(G2)	Gov: MOH	LAO-405-G06-T	1-Sep-05	2,535,172
	6	HIV/AIDS	3,418,698	(G1)	Gov: MOH	LAO-607-G08-H	1-Nov-07	2,605,230
	6	Malaria	1,726,701	(G1)	Gov: MOH	LAO-607-G07-M	1-Sep-07	1,599,698
	7	Malaria	6,740,783	(G1)	Gov: MOH	LAO-708-G09-M	1-Jul-08	3,801,109
	7	TB	4,368,246	(G1)	Gov: MOH	LAO-708-G10-T	1-Oct-08	2,034,179
	8	HIV/AIDS	9,114,326	(B1)				
Mongolia	1	TB	5,233,730	(G3)	Gov: MOH	MON-102-G01-T-00	1-May-03	2,717,767
	2	HIV/AIDS	8,810,349	(G3)	Gov: MOH	MON-202-G02-H-00	1-Aug-03	4,674,370
	4	TB	4,083,764	(G2)	Gov: MOH	MON-405-G03-T	1-Apr-05	3,447,743
	5	HIV/AIDS	1,898,775	(G1)	Gov: MOH	MON-506-G04-H (Closed: consolidated with MON-202-G02-H-00)	1-Jul-06	1,898,775
	7	HIV/AIDS	1,440,102	(G1)	Gov: MOH	MON-708-G05-H	1-Jul-08	644,960
Multi-country Western Pacific	2	HIV/AIDS	5,163,925	(G2)	Gov: Oth	MWP-202-G01-H-00	1-Jul-03	5,121,886
	2	Malaria	4,175,008	(G2)	Gov: Oth	MWP-202-G02-M-00 (Closed)	1-Jul-03	4,175,008
	2	TB	2,738,806	(G2)	Gov: Oth	MWP-202-G03-T-00	1-Jul-03	2,738,806
	5	Malaria	2,361,908	(G1)	Gov: Oth	MWP-506-G04-M (Inactive)	1-Jul-06	2,361,908
	5	Malaria	22,948,633	(T3)	Gov: Oth	MWP-507-G05-M	1-Jul-07	1,772,911
	7	HIV/AIDS	10,710,982	(G1)	Gov: Oth	MWP-708-G06-H	1-Jul-08	2,778,173
	7	TB	5,643,975	(G1)	Gov: Oth	MWP-708-G07-T	1-Jul-08	1,823,906
Myanmar	2	TB	2,735,234	(G1)	MO: UNDP	MYN-202-G01-T-00 (Terminated)	1-Jan-05	2,735,234
	3	HIV/AIDS	6,103,009	(G1)	MO: UNDP	MYN-305-G02-H (Terminated)	1-Apr-05	6,103,009
	3	Malaria	2,291,409	(G1)	MO: UNDP	MYN-305-G03-M (Terminated)		2,291,409

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Papua New Guinea	3	Malaria	20,105,690	(G2)	Gov: MOH	PNG-304-G01-M	1-Aug-04	15,158,589
	4	HIV/AIDS	17,552,150	(G2)	Gov: MOH	PNG-405-G02-H	1-Sep-05	8,960,146
	6	TB	5,007,911	(G1)	Gov: MOH	PNG-607-G03-T	1-Oct-07	2,904,104
	8	Malaria	70,139,822	(B1)				
Philippines	2	Malaria	45,264,008	(T3)	CS/PS: PS	PHL-202-G01-M-00	1-Aug-03	11,828,157
	2	TB	78,171,136	(T3)	CS/PS: PS	PHL-202-G02-T-00	1-Aug-03	11,438,064
	3	HIV/AIDS	5,528,825	(G2)	CS/PS: PS	PHL-304-G03-H	1-Aug-04	5,274,139
	5	HIV/AIDS	6,478,058	(G2)	CS/PS: PS	PHL-506-G04-H	1-Oct-06	4,569,400
	5	Malaria	14,308,637	(G2)	CS/PS: PS	PHL-506-G05-M	1-Jun-06	11,895,062
	5	TB	51,231,120	(B2)	CS/PS: PS	PHL-506-G06-T	1-Oct-06	16,687,774
	6	HIV/AIDS	7,294,891	(G1)	Gov: MOH	PHL-607-G08-H	1-Dec-07	5,326,784
	6	Malaria	16,285,198	(G1)	CS/PS: PS	PHL-607-G07-M	1-Oct-07	14,340,684
Solomon Islands	8	HIV/AIDS*	845,725	(B1)				
	8	TB*	3,608,714	(B1)				
Thailand	1	HIV/AIDS	161,021,022	(G3)	Gov: MOH	THA-102-G01-H-00	1-Oct-03	105,233,780
	1	TB	12,058,359	(G2)	Gov: MOH	THA-102-G02-T-00	1-Oct-03	10,834,003
	2	HIV/AIDS	30,156,771	(G2)	Gov: MOF	THA-202-G03-H-00	1-Oct-03	14,147,657
					Gov: MOH	THA-202-G04-H-00	1-Nov-03	12,563,156
	2	Malaria	5,282,000	(G2)	Gov: MOH	THA-202-G05-M-00	1-Mar-04	5,282,000
	3	HIV/AIDS	1,275,292	(G2)	Gov: MOF	THA-304-G06-H	1-Oct-04	1,274,240
	6	TB	7,726,767	(G1)	Gov: MOH	THA-607-G07-T	1-Oct-07	3,523,322
					CS/PS: NGO	THA-607-G08-T	1-Oct-07	2,747,762
	7	Malaria	11,939,346	(G1)	Gov: MOH	THA-708-G09-M	1-Jul-08	5,170,981
	8	HIV/AIDS	38,254,259	(B1)				
	8	TB	12,420,804	(B1)				
Timor-Leste	2	Malaria	2,876,903	(G2)	Gov: MOH	TMP-202-G01-M-00	1-Sep-03	2,736,768
	3	TB	967,650	(B2)	Gov: MOH	TMP-304-G02-T	1-Mar-05	657,853
	5	HIV/AIDS	3,681,713	(G1)	Gov: MOH	TMP-506-G03-H	1-Jun-07	2,510,268
	7	Malaria	6,866,605	(T1)				
	7	TB	2,895,449	(T1)				
Viet Nam	1	HIV/AIDS	12,000,000	(G2)	Gov: MOH	VTN-102-G01-H-00	1-Feb-04	12,000,000
	1	TB	5,404,713	(G2)	Gov: MOH	VTN-102-G02-T-00	1-Jun-04	5,404,713
	3	Malaria	21,177,956	(G2)	Gov: MOH	VTN-304-G03-M	1-Jan-05	21,177,956
	6	HIV/AIDS	10,219,180	(G1)	Gov: MOH	VTN-607-G04-H	1-Jan-08	6,964,603
	6	TB	6,209,622	(G1)	Gov: MOH	VTN-607-G05-T	1-Jan-08	2,921,302
	7	Malaria	13,536,282	(G1)	Gov: MOH	VTN-708-G06-M	1-Jan-09	4,082,038
	8	HIV/AIDS	14,577,204	(B1)				
EASTERN EUROPE & CENTRAL ASIA								
Albania	5	HIV/AIDS	2,502,858	(G1)	Gov: MOH	ALB-506-G01-H	1-Apr-07	2,502,858
	5	TB	776,298	(G1)	Gov: MOH	ALB-506-G02-T	1-Apr-07	776,298
Armenia	2	HIV/AIDS	8,239,769	(G2)	CS/PS: NGO	ARM-202-G01-H-00	1-Nov-03	8,239,769
	5	TB	7,080,369	(B2)	Gov: MOH	ARM-506-G02-T	1-Jan-07	3,625,140
	8	HIV/AIDS	2,041,527	(B1)				
	8	TB	2,792,267	(B1)				
Azerbaijan	4	HIV/AIDS	10,341,550	(G2)	Gov: MOH	AZE-405-G01-H	1-Jun-05	9,949,792
	5	TB	4,345,006	(B2)	Gov: MOH	AZE-506-G02-T	1-Oct-06	4,345,006
	7	Malaria	3,415,715	(G1)	Gov: MOH	AZE-708-G04-M	1-Jan-09	1,295,872
	7	TB	9,275,543	(G1)	Gov: MOH	AZE-708-G03-T	1-Nov-08	1,896,040
Belarus	3	HIV/AIDS	16,763,830	(G2)	MO: UNDP	BLR-304-G01-H	1-Dec-04	13,587,230
	6	TB	5,864,925	(G1)	MO: UNDP	BLR-607-G02-T	1-Oct-07	4,744,323
	8	HIV/AIDS	15,476,834	(B1)				
Bosnia and Herzegovina	5	HIV/AIDS	11,042,257	(G2)	MO: UNDP	BIH-506-G01-H	1-Nov-06	6,627,679
	6	TB	2,715,486	(G1)	MO: UNDP	BIH-607-G02-T	1-Oct-07	2,045,696
Bulgaria	2	HIV/AIDS	40,680,945	(M)	Gov: MOH	BUL-202-G01-H-00, (G2)	1-Jan-04	15,711,882
					Gov: MOH	BUL-202-G01-H-e, (G3)	1-Jan-04	
	6	TB	9,948,803	(G1)	Gov: MOH	BUL-607-G02-T	1-Oct-07	3,220,405
	8	TB*	5,095,619	(B1)				
Croatia	2	HIV/AIDS	4,944,324	(G2)	Gov: MOH	HRV-202-G01-H-00 (Closed)	1-Dec-03	4,944,324
Estonia	2	HIV/AIDS	10,483,275	(G2)	Gov: MOH	EST-202-G01-H-00 (Closed)	1-Oct-03	
					Gov: MOH	EST-202-G01-H-e (Closed)	as above	10,483,275

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Georgia	2	HIV/AIDS	12,125,644	(G2)	Gov: Oth	GEO-202-G01-H-00	1-Mar-04	12,111,223
	3	Malaria	806,300	(G2)	Gov: Oth	GEO-304-G02-M	1-Jul-04	806,300
	4	TB	5,536,965	(G2)	Gov: Oth	GEO-405-G03-T	1-Apr-05	4,245,476
	6	HIV/AIDS	6,130,724	(G1)	Gov: Oth	GEO-607-G06-H	1-Jan-08	2,763,821
	6	Malaria	1,587,960	(G1)	Gov: Oth	GEO-607-G04-M	1-Jul-07	1,587,960
	6	TB	9,314,136	(G1)	Gov: Oth	GEO-607-G05-T	1-Jul-07	4,821,091
Global (LWF)	1	HIV/AIDS	700,000	(G2)	CS/PS: FBO	WRL-102-G01-H-00 (Closed)	1-Feb-03	700,000
Kazakhstan	2	HIV/AIDS	22,085,999	(G2)	Gov: Oth	KAZ-202-G01-H-00	1-Dec-03	20,297,372
	6	TB	5,442,598	(G1)	Gov: MOH	KAZ-607-G02-T	1-Sep-07	5,247,000
	7	HIV/AIDS	12,485,792	(G1)	Gov: Oth	KAZ-708-G03-H	1-Dec-08	5,459,507
	8	TB*	37,557,518	(B1)				
Kosovo	4	TB	3,862,199	(G2)	MO: Oth	KOS-405-G01-T	1-Apr-06	
					MO: Oth	KOS-405-G01-T-e	as above	2,728,775
	7	HIV/AIDS	2,325,254	(G1)	MO: Oth	KOS-708-G02-H	1-Nov-08	744,758
Kyrgyzstan	2	HIV/AIDS	17,073,306	(G2)	Gov: Oth	KGZ-202-G01-H-00	1-Mar-04	17,073,306
	2	TB	2,771,070	(G2)	Gov: MOH	KGZ-202-G02-T-00	1-Mar-04	2,771,070
	5	Malaria	3,426,125	(G2)	Gov: Oth	KGZ-506-G03-M	1-Apr-06	2,705,810
	6	TB	4,244,578	(G1)	Gov: MOH	KGZ-607-G04-T	1-Jul-07	3,201,476
	7	HIV/AIDS	11,845,090	(G1)	Gov: MOH	KGZ-708-G05-H	1-Dec-08	4,997,122
	8	Malaria	4,530,888	(B1)				
Macedonia, FYR	3	HIV/AIDS	5,904,367	(G2)	Gov: MOH	MKD-304-G01-H	1-Nov-04	5,844,367
	5	TB	2,946,211	(G2)	Gov: MOH	MKD-506-G02-T	1-Apr-06	
					Gov: MOH	MKD-506-G02-T-e	as above	1,946,620
	7	HIV/AIDS	4,222,526	(G1)	Gov: MOH	MKD-708-G03-H	1-Jun-08	2,612,547
Moldova	1	HIV/TB	11,719,047	(G2)	Gov: MOH	MOL-102-G01-C-00 (Inactive)	1-May-03	11,712,033
	6	HIV/AIDS	6,411,072	(G1)	Gov: MOH	MOL-607-G03-H	1-Jan-08	3,713,128
	6	TB	5,675,507	(G1)	Gov: MOH	MOL-607-G02-T	1-Oct-07	5,483,684
	8	HIV/AIDS*	11,977,516	(B1)				
	8	TB	7,349,626	(B1)				
Montenegro	5	HIV/AIDS	4,140,679	(G2)	MO: UNDP	MNT-506-G01-H	1-Aug-06	2,670,605
	6	TB	1,179,888	(G1)	MO: UNDP	MNT-607-G02-T	1-Jul-07	1,179,888
Romania	2	HIV/AIDS	26,861,313	(G2)	Gov: MOH	ROM-202-G01-H-00	1-Jan-04	26,859,207
	2	TB	16,743,641	(G2)	Gov: MOH	ROM-202-G02-T-00	1-Feb-04	16,735,175
	6	HIV/AIDS	9,305,653	(G1)	CS/PS: NGO	ROM-607-G03-H	1-Jul-07	7,818,818
	6	TB	5,267,038	(G1)	CS/PS: NGO	ROM-607-G04-T	1-Oct-07	4,871,725
Russian Federation	3	HIV/AIDS	88,742,354	(G2)	CS/PS: NGO	RUS-304-G01-H	15-Aug-04	88,742,354
	3	TB	10,766,486	(G2)	CS/PS: NGO	RUS-304-G02-T	1-Dec-04	10,766,486
	4	HIV/AIDS	119,873,915	(G2)	CS/PS: NGO	RUS-405-G03-H	1-Sep-05	83,755,385
	4	TB	88,165,448	(G2)	CS/PS: NGO	RUS-405-G04-T	1-Dec-05	65,966,114
	5	HIV/AIDS	16,566,957	(G2)	CS/PS: NGO	RUS-506-G05-H	1-Sep-06	6,917,529
Serbia	1	HIV/AIDS	3,575,210	(G2)	CS/PS: PS	SER-102-G01-H-00 (Closed)	1-Nov-03	3,575,210
	3	TB	4,087,979	(G2)	Gov: MOH	SER-304-G02-T	1-Dec-04	4,087,979
	6	HIV/AIDS	6,607,189	(G1)	Gov: MOH	SER-607-G03-H	1-Jun-07	5,224,651
	8	HIV/AIDS*	5,242,517	(B1)				
Tajikistan	1	HIV/AIDS	2,425,245	(G2)	MO: UNDP	TAJ-102-G01-H-00 (Closed)	1-May-03	2,425,245
	3	TB	2,761,877	(G2)	CS/PS: NGO	TAJ-304-G02-T	1-Nov-04	2,269,178
	4	HIV/AIDS	8,076,667	(G2)	MO: UNDP	TAJ-404-G03-H	1-Jan-05	5,742,331
	5	Malaria	5,383,510	(G2)	MO: UNDP	TAJ-506-G04-M	1-Apr-06	4,594,812
	6	HIV/AIDS	4,889,461	(G1)	MO: UNDP	TAJ-607-G05-H	1-May-07	4,443,077
	6	TB	6,527,347	(G1)	MO: UNDP	TAJ-607-G06-T	1-Aug-07	
	8	HIV/AIDS	18,460,568	(B1)				6,527,347
	8	Malaria	7,271,349	(B1)				
	8	TB	13,694,890	(B1)				
Turkey	4	HIV/AIDS	3,272,763	(G1)	Gov: MOH	TUR-405-G01-H (Closed)	1-Aug-05	3,272,763
Ukraine	1	HIV/AIDS	99,117,634	(B2)	CS/PS: NGO	UKR-102-A04-H-00, (G1)		300,000
					Gov: Oth	UKR-102-G01-H-00 (Terminated), (G1)	18-Mar-03	311,889
					Gov: MOH	UKR-102-G02-H-00 (Terminated), (G1)	28-Jan-03	541,682
					MO: UNDP	UKR-102-G03-H-00 (Terminated), (G1)	17-Feb-03	452,948
					CS/PS: NGO	UKR-102-G04-H-00, (G2)	15-Mar-04	
					CS/PS: NGO	UKR-102-G04-H-e, (G2)	as above	97,386,078
	6	HIV/AIDS	29,649,187	(G1)	CS/PS: NGO	UKR-607-G05-H	1-Aug-07	11,557,298
					CS/PS: NGO	UKR-607-G06-H	1-Aug-07	8,604,060

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Uzbekistan	3	HIV/AIDS	21,075,841	(G2)	Gov: MOH	UZB-304-G01-H	1-Dec-04	12,753,484
	4	Malaria	2,423,089	(G2)	Gov: Oth	UZB-405-G02-M	1-Apr-05	2,423,089
	4	TB	13,267,033	(G2)	Gov: MOH	UZB-405-G03-T	1-Apr-05	9,573,658
	8	Malaria*	2,789,923	(B1)				
	8	TB*	13,881,631	(B1)				
LATIN AMERICA & THE CARIBBEAN								
Argentina	1	HIV/AIDS	26,066,374	(M)	MO: UNDP	ARG-102-G01-H-00 (Inactive), (B2)	1-Jul-03	9,049,759
					CS/PS: PS	ARG-102-G02-H-00, (G2)	1-Jan-06	16,320,699
Belize	3	HIV/AIDS	2,403,677	(G2)	CS/PS: NGO	BEL-304-G01-H	1-Nov-04	1,769,419
Bolivia	3	HIV/AIDS	14,948,532	(B2)	CS/PS: NGO	BOL-304-G01-H (Closed), (G1)	26-Jul-04	2,641,751
					MO: UNDP	BOL-306-G04-H (Closed), (G1)	1-May-06	1,950,412
					CS/PS: NGO	BOL-307-G07-H, (G2)	1-Feb-07	5,256,836
	3	Malaria	5,111,092	(B2)	CS/PS: NGO	BOL-304-G02-M (Closed)	26-Jul-04	3,025,736
					MO: UNDP	BOL-306-G05-M (Closed)	1-May-06	2,085,356
	3	TB	5,299,074	(B2)	CS/PS: NGO	BOL-304-G03-T (Closed), (G1)	26-Jul-04	1,084,486
					MO: UNDP	BOL-306-G06-T, (G2)	1-May-06	3,851,823
	8	Malaria*	6,744,407	(B1)				
Brazil	5	TB	11,602,427	(G1)	CS/PS: Oth	BRA-506-G01-T	1-May-07	2,427,260
					CS/PS: Oth	BRA-506-G02-T	1-May-07	6,704,137
	8	Malaria*	28,751,293	(B1)				
Chile	1	HIV/AIDS	38,059,416	(G2)	CS/PS: PS	CHL-102-G01-H-00	1-Aug-03	28,835,307
Colombia	2	HIV/AIDS	8,669,848	(G2)	MO: Oth	COL-202-G01-H-00	1-Jul-04	8,632,605
	8	Malaria*	23,654,853	(B1)				
Costa Rica	2	HIV/AIDS	3,583,871	(M)	Gov: Oth	COR-202-G01-H-00 (Closed), (B2)	1-Oct-03	1,767,359
					CS/PS: NGO	COR-202-G02-H-00, (G2)	1-Jan-06	1,816,512
Cuba	2	HIV/AIDS	36,490,859	(T3)	MO: UNDP	CUB-202-G01-H-00	1-Jul-03	26,717,861
	6	HIV/AIDS	14,369,743	(G1)	MO: UNDP	CUB-607-G02-H	1-Oct-07	7,360,045
	7	TB	5,455,745	(G1)	MO: UNDP	CUB-708-G03-T	1-Jan-09	
Dominican Republic	2	HIV/AIDS	94,254,870	(T3)	Gov: Oth	DMR-202-G01-H-00	1-Jun-04	41,477,634
	3	TB	4,611,860	(G2)	CS/PS: NGO	DMR-304-G02-T	1-Oct-04	4,363,807
	7	TB	5,650,022	(G1)	CS/PS: NGO	DMR-708-G03-T	1-Oct-08	1,272,724
	8	Malaria*	4,492,517	(B1)				
Ecuador	2	HIV/AIDS	13,809,852	(G2)	Gov: MOH	ECU-202-G01-H-00	1-Mar-05	7,105,506
					CS/PS: NGO	ECU-202-G03-H-00	1-Jun-06	3,790,987
	4	TB	16,353,319	(G2)	CS/PS: NGO	ECU-405-G02-T	1-Nov-05	11,453,377
	8	Malaria*	8,374,965	(B1)				
El Salvador	2	HIV/AIDS	34,611,491	(M)	MO: UNDP	SLV-202-G01-H-00, (G2)	1-Aug-03	18,033,344
					Gov: MOH	SLV-202-G03-H-00, (T3)	1-Nov-06	2,180,116
	2	TB	3,791,943	(M)	MO: UNDP	SLV-202-G02-T-00 (Closed), (B2)	1-Dec-03	2,235,389
					Gov: MOH	SLV-202-G04-T-00, (G2)	1-Nov-06	1,542,836
	7	HIV/AIDS	10,618,310	(G1)	Gov: MOH	SLV-708-G05-H	1-Nov-08	977,990
					MO: UNDP	SLV-708-G06-H	1-Nov-08	209,803
Guatemala	3	HIV/AIDS	40,921,918	(G2)	CS/PS: NGO	GUA-304-G01-H	1-Dec-04	32,368,988
	4	Malaria	13,750,042	(G2)	CS/PS: NGO	GUA-405-G02-M	1-Sep-05	12,026,251
	6	TB	3,728,437	(G1)	CS/PS: NGO	GUA-607-G03-T	1-Aug-07	3,335,343
Guyana	3	HIV/AIDS	20,150,872	(G2)	Gov: MOH	GYA-304-G01-H	1-Jan-05	12,737,444
	3	Malaria	2,079,004	(G2)	Gov: MOH	GYA-304-G02-M	1-Jan-05	1,414,982
	4	TB	1,172,917	(G2)	Gov: MOH	GYA-405-G03-T	1-Oct-05	752,503
	7	Malaria	1,841,470	(G1)	Gov: MOH	GYA-708-G04-M		
	8	HIV/AIDS	4,637,491	(B1)				
	8	TB*	3,087,615	(B1)				
Haiti	1	HIV/AIDS	130,464,486	(M)	CS/PS: PS	HTI-102-G01-H-00, (T3)	1-Jan-03	76,048,459
					MO: UNDP	HTI-102-G02-H-00 (Inactive), (G1)	1-Jan-03	6,140,386
	3	Malaria	14,431,557	(G2)	CS/PS: PS	HTI-304-G03-M	1-Aug-04	12,631,744
	3	TB	14,034,665	(G2)	CS/PS: PS	HTI-304-G04-T	1-Aug-04	13,201,730
	5	HIV/AIDS	49,428,486	(B2)	CS/PS: PS	HTI-506-G05-H	1-Jan-07	18,821,754
	7	HIV/AIDS	6,199,554	(G1)	CS/PS: PS	HTI-708-G06-H	1-Nov-08	2,450,766
	8	Malaria*	33,402,457	(B1)				
Honduras	1	HIV/AIDS	52,439,797	(M)	MO: UNDP	HND-102-G01-H-00, (G2)	1-May-03	27,116,707
					CS/PS: Oth	HND-102-G04-H-00, (G3)	1-May-08	6,665,002

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Honduras (continued)	1	Malaria	10,657,797	(M)	MO: UNDP	HND-102-G03-M-00, (G2)	1-May-03	7,200,165
					CS/PS: Oth	HND-102-G05-M-00, (T3)	1-May-08	726,096
	1	TB	6,597,014	(G2)	MO: UNDP	HND-102-G02-T-00	1-May-03	6,383,185
Jamaica	3	HIV/AIDS	23,318,821	(G2)	Gov: MOH	JAM-304-G01-H	1-Jun-04	21,510,644
	7	HIV/AIDS	15,219,930	(G1)	Gov: MOH	JAM-708-G02-H	1-Aug-08	2,795,107
Multi-country Americas (Andean)	3	Malaria	25,369,116	(G2)	MO: Oth	MAA-305-G01-M	1-Oct-05	18,100,513
Multi-country Americas (CARICOM)	3	HIV/AIDS	12,046,368	(G2)	Gov: Oth	MAC-304-G01-H	1-Nov-04	10,096,818
Multi-country Americas (CRN+)	4	HIV/AIDS	3,662,376	(G2)	CS/PS: NGO	MAN-405-G01-H	1-Aug-05	2,577,894
Multi-country Americas (Meso)	4	HIV/AIDS	4,008,581	(G2)	Gov: MOH	MAM-405-G01-H	1-Oct-05	2,818,540
Multi-country Americas (OECS)	3	HIV/AIDS	8,898,774	(G2)	MO: Oth	MAE-305-G01-H	1-Mar-05	4,425,039
Multi-country Americas (REDCA+)	7	HIV/AIDS	1,722,700	(G1)	CS/PS: NGO	MAR-708-G01-H	1-Oct-08	311,319
Nicaragua	2	HIV/AIDS	10,130,529	(G2)	CS/PS: NGO	NIC-202-G03-H-00	1-Mar-04	9,745,025
	2	Malaria	5,593,279	(G2)	CS/PS: NGO	NIC-202-G01-M-00	1-Mar-04	5,348,934
	2	TB	9,973,467	(T3)	CS/PS: NGO	NIC-202-G02-T-00	1-Mar-04	2,623,248
	7	Malaria	2,868,542	(G1)	CS/PS: NGO	NIC-708-G04-M		
	8	HIV/AIDS*	31,385,337	(B1)				
Panama	1	TB	553,817	(G2)	MO: UNDP	PAN-102-G01-T-00 (Closed)	1-Apr-03	553,817
Paraguay	3	TB	2,799,545	(G2)	CS/PS: NGO	PRY-304-G01-T	1-Dec-04	2,417,223
	6	HIV/AIDS	3,471,892	(G1)	CS/PS: NGO	PRY-607-G02-H	1-Jun-07	3,269,346
	7	TB	2,149,206	(G1)	CS/PS: NGO	PRY-708-G03-T	1-Jul-08	946,773
	8	HIV/AIDS	6,632,512	(B1)				
Peru	2	HIV/AIDS	22,166,497	(G2)	CS/PS: NGO	PER-202-G01-H-00	1-Dec-03	21,619,940
	2	TB	25,552,603	(G2)	CS/PS: NGO	PER-202-G02-T-00	1-Dec-03	25,198,382
	5	HIV/AIDS	12,967,865	(B2)	CS/PS: NGO	PER-506-G03-H	1-Sep-06	7,502,202
	5	TB	32,306,243	(B2)	CS/PS: NGO	PER-506-G04-T	1-Sep-06	12,814,527
	6	HIV/AIDS	24,153,662	(G1)	CS/PS: NGO	PER-607-G05-H	1-Oct-07	7,247,110
	8	TB	15,983,148	(B1)				
Suriname	3	HIV/AIDS	4,676,831	(G2)	Gov: MOH	SUR-305-G01-H	1-Feb-05	3,325,370
	4	Malaria	4,603,345	(G2)	CS/PS: NGO	SUR-404-G02-M	1-Feb-05	4,272,617
	5	HIV/AIDS	2,395,000	(G1)	Gov: MOH	SUR-506-G03-H	1-Feb-07	1,720,802
	7	Malaria	2,375,500	(G1)	Gov: MOH	SUR-708-G04-M		
NORTH AFRICA & THE MIDDLE EAST								
Algeria	3	HIV/AIDS	8,869,360	(G2)	Gov: MOH	DZA-304-G01-H	1-Jan-05	6,945,289
Chad	2	TB	3,039,321	(G2)	Gov: Oth	TCD-202-G01-T-00	1-May-04	1,816,721
	3	HIV/AIDS	17,783,344	(G2)	Gov: Oth	TCD-304-G02-H	1-Aug-04	8,815,312
	7	Malaria	10,477,631	(T1)				
	8	HIV/AIDS	41,337,564	(B1)				
	8	TB*	4,769,986	(B1)				
Djibouti	4	HIV/AIDS	11,998,400	(G2)	Gov: MOH	DJB-404-G01-H	1-Mar-05	11,978,365
	6	HIV/AIDS	2,719,910	(G1)	Gov: MOH	DJB-607-G04-H	1-Jun-07	2,419,385
	6	Malaria	2,611,945	(G1)	Gov: MOH	DJB-607-G02-M	1-Jun-07	2,462,984
	6	TB	1,143,735	(G1)	Gov: MOH	DJB-607-G03-T	1-Jun-07	814,177
Egypt	2	TB	4,032,014	(G2)	Gov: MOH	EGY-202-G01-T-00	1-Jul-04	3,965,349
	6	HIV/AIDS	5,320,880	(G1)	Gov: MOH	EGY-608-G03-H	1-Apr-08	2,346,075
	6	TB	5,375,548	(G1)	Gov: MOH	EGY-607-G02-T	1-Sep-07	3,404,870
Iraq	6	TB	6,443,900	(G1)	MO: UNDP	IRQ-607-G01-T	1-Jan-08	6,443,900
Jordan	2	HIV/AIDS	2,483,900	(G2)	Gov: MOH	JOR-202-G01-H-00	1-Nov-03	2,427,408
	5	TB	2,782,864	(G2)	Gov: MOH	JOR-506-G02-T	1-Jul-06	1,622,864
	6	HIV/AIDS	3,069,508	(G1)	Gov: MOH	JOR-607-G03-H	1-Jul-07	1,747,280
Mali	1	Malaria	2,592,316	(G2)	Gov: MOH	MAL-102-G01-M-00 (Closed)	1-Dec-03	2,592,316
	4	HIV/AIDS	52,340,436	(G2)	Gov: Oth	MAL-405-G02-H	1-Jul-05	35,298,749
	4	TB	6,747,610	(G2)	Gov: MOH	MAL-405-G03-T	1-Aug-05	4,252,560
	6	Malaria	9,222,572	(G1)	Gov: MOH	MAL-607-G04-M	1-Nov-07	2,597,529
					CS/PS: NGO	MAL-607-G05-M	1-Sep-07	5,754,839
	7	TB	4,310,477	(G1)	Gov: MOH	MAL-708-G06-T	1-Aug-08	2,394,861
	8	HIV/AIDS	56,401,212	(B1)				

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Mauritania	2	Malaria	2,898,993	(G2)	MO: UNDP	MRT-202-G02-M-00	1-Apr-04	2,051,161
	2	TB	2,727,889	(G2)	MO: UNDP	MRT-202-G01-T-00	1-May-04	2,406,225
	5	HIV/AIDS	15,111,273	(G2)	Gov: Oth	MRT-506-G03-H	1-Sep-06	6,184,934
	6	Malaria	4,315,126	(G1)	MO: UNDP	MRT-607-G04-M	1-Dec-07	1,918,349
	6	TB	4,441,686	(G1)	MO: UNDP	MRT-607-G05-T	1-Dec-07	3,024,357
	8	HIV/AIDS	2,772,376	(B1)				
Morocco	1	HIV/AIDS	9,238,754	(G2)	Gov: MOH	MOR-102-G01-H-00	1-Mar-03	9,238,754
	6	HIV/AIDS	10,680,798	(G1)	Gov: MOH	MOR-607-G02-H	1-Jul-07	8,767,182
	6	TB	2,221,975	(G1)	Gov: MOH	MOR-607-G03-T	1-Jul-07	1,707,411
Niger	3	HIV/AIDS	10,713,876	(G2)	Gov: Oth	NGR-304-G01-H	1-Sep-04	10,424,468
	3	Malaria	5,702,483	(M)	CS/PS: NGO	NGR-304-G02-M, (B2)	1-Sep-04	4,317,190
					MO: UNDP	NGR-306-G06-M, (G2)	1-Dec-06	1,334,692
	4	Malaria	11,257,988	(G1)	MO: Oth	NGR-405-G03-M	1-Jul-05	11,189,739
	5	Malaria	9,631,345	(G2)	MO: UNDP	NGR-506-G04-M	1-Jul-06	5,117,509
	5	TB	13,857,549	(G2)	MO: UNDP	NGR-506-G05-T	1-Jul-06	7,708,984
	7	HIV/AIDS	13,862,119	(G1)	Gov: Oth	NGR-708-G08-H	1-Aug-08	4,308,593
	7	Malaria	31,533,877	(G1)	CS/PS: FBO	NGR-708-G07-M	1-Aug-08	11,008,007
Somalia	2	Malaria	12,886,413	(G2)	MO: Oth	SOM-202-G01-M-00	1-Jul-04	12,886,413
	3	TB	13,825,351	(G2)	CS/PS: NGO	SOM-304-G02-T	16-Aug-04	11,557,127
	4	HIV/AIDS	24,922,007	(G2)	MO: Oth	SOM-405-G03-H	1-Jun-05	18,923,333
	6	Malaria	13,096,409	(G1)	MO: Oth	SOM-607-G04-M	1-Nov-07	10,267,095
	7	TB	8,732,844	(G1)	CS/PS: NGO	SOM-708-G05-T	1-Nov-08	2,824,544
	8	HIV/AIDS	25,669,049	(B1)				
Sudan	2	Malaria	25,067,660	(G2)	MO: UNDP	SUD-202-G01-M-00	1-Oct-04	17,805,106
	2	Malaria	33,240,453	(G2)	MO: UNDP	SUD-202-G03-M-00	1-Apr-05	32,414,424
	2	TB	14,498,087	(G2)	MO: UNDP	SUD-202-G02-T-00	1-Oct-04	9,086,483
	3	HIV/AIDS	20,682,531	(G2)	MO: UNDP	SUD-305-G04-H	1-Apr-05	14,610,205
	4	HIV/AIDS	28,435,365	(B2)	MO: UNDP	SUD-405-G05-H	1-Aug-06	8,394,216
	5	HIV/AIDS	29,421,145	(G1)	MO: UNDP	SUD-506-G08-H	1-Jan-07	20,094,068
	5	TB	21,613,754	(B2)	MO: UNDP	SUD-506-G06-T	1-Oct-06	7,837,109
	5	TB	15,410,466	(B2)	MO: UNDP	SUD-506-G07-T	1-Jan-07	6,830,013
	7	Malaria	38,296,873	(T1)				
	7	Malaria	33,512,896	(G1)	CS/PS: NGO	SUD-708-G09-M	1-Dec-08	19,591,964
	7	TB	6,172,805	(G1)	MO: UNDP	SUD-708-G11-T	1-Nov-08	
	8	TB*	17,979,663	(B1)				
Syrian Arab Republic	6	TB	4,578,047	(G1)	MO: UNDP	SYR-607-G01-T	1-Dec-07	2,432,411
Tunisia	6	HIV/AIDS	9,565,500	(G1)	Gov: MOH	TUN-607-G01-H	1-Sep-07	6,229,530
	8	TB*	4,400,014	(B1)				
UN Theme Group on HIV/AIDS (West Bank and Gaza)	7	HIV/AIDS	5,014,330	(G1)	MO: UNDP	PSE-708-G01-H	1-Dec-08	2,355,254
	8	TB	1,353,270	(B1)				
Yemen	2	Malaria	11,878,206	(G2)	Gov: MOH	YEM-202-G01-M-00	1-Mar-04	9,456,929
	3	HIV/AIDS	14,460,517	(M)	Gov: MOH	YEM-305-G02-H, (G1)	1-Jul-05	2,247,002
					Gov: MOH	YEM-305-G03-H, (G1)	1-Jul-05	1,645,056
					MO: UNDP	YEM-307-G05-H, (G2)	1-Jan-08	2,205,368
	4	TB	6,147,507	(G2)	Gov: MOH	YEM-405-G04-T	1-Jul-05	4,625,642
	7	Malaria	8,013,694	(G1)	Gov: MOH	YEM-708-G06-M	1-Dec-08	3,260,385
SOUTH ASIA								
Afghanistan	2	Integrated	3,125,605	(G1)	Gov: MOH	AFG-202-G01-I-00	1-Dec-04	3,125,605
	4	TB	3,448,773	(G2)	Gov: MOH	AFG-405-G02-T	1-Sep-05	2,678,961
	5	Malaria	28,316,682	(B2)	Gov: MOH	AFG-506-G03-M	1-Nov-06	13,273,362
	7	HIV/AIDS	4,767,953	(G1)	Gov: MOH	AFG-708-G04-H	1-Nov-08	285,960
					Gov: Oth	AFG-708-G05-H	1-Oct-08	
	8	Malaria*	41,856,136	(B1)				
	8	TB	10,290,608	(B1)				
Bangladesh	2	HIV/AIDS	19,711,030	(G2)	Gov: MOF	BAN-202-G01-H-00	1-Mar-04	19,631,639
	3	TB	42,466,601	(G2)	CS/PS: NGO	BAN-304-G02-T	1-Aug-04	25,550,784
					Gov: MOF	BAN-304-G03-T	1-Sep-04	10,185,367
	5	TB	43,300,976	(G2)	CS/PS: NGO	BAN-506-G04-T	1-May-06	4,198,392
					Gov: MOF	BAN-506-G05-T	1-May-06	4,062,880
	6	HIV/AIDS	13,998,843	(G1)	Gov: MOF	BAN-607-G08-H	1-May-07	10,001,899
	6	Malaria	18,587,179	(G1)	CS/PS: NGO	BAN-607-G06-M	1-Jun-07	5,740,051
					Gov: MOF	BAN-607-G07-M	1-Jun-07	10,435,871
	8	TB	5,627,763	(B1)				

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Bhutan	4	Malaria	1,737,190	(G2)	Gov: Oth	BTN-405-G01-M	1-Apr-05	1,343,198
	4	TB	994,298	(G2)	Gov: Oth	BTN-405-G02-T	1-Apr-05	781,031
	6	HIV/AIDS	1,502,445	(G1)	Gov: Oth	BTN-607-G03-H	1-Feb-08	622,600
	6	TB	741,689	(G1)	Gov: Oth	BTN-607-G04-T	1-Jan-08	315,975
	7	Malaria	2,046,986	(G1)	Gov: Oth	BTN-708-G05-M	1-Jul-08	964,723
India	1	TB	8,655,033	(G2)	Gov: Oth	IDA-102-G01-T-00	1-Apr-03	7,228,840
	2	HIV/AIDS	92,702,000	(G2)	Gov: Oth	IDA-202-G02-H-00	1-May-04	90,997,450
	2	TB	98,305,839	(T3)	Gov: Oth	IDA-202-G03-T-00	1-Apr-04	20,738,976
	3	HIV/TB	14,819,772	(G2)	Gov: Oth	IDA-304-G04-C	1-Jan-05	6,166,686
	4	HIV/AIDS	140,878,118	(G2)	CS/PS: NGO	IDA-405-G05-H	1-Apr-05	12,117,587
					Gov: Oth	IDA-405-G06-H	1-Sep-05	47,907,364
	4	Malaria	63,544,954	(G2)	Gov: MOF	IDA-405-G07-M	1-Jul-05	47,705,431
	4	TB	25,823,483	(G2)	Gov: Oth	IDA-405-G08-T	1-Apr-05	17,526,467
	6	HIV/AIDS	75,954,670	(M)	CS/PS: NGO	IDA-607-G10-H	1-Jun-07	6,601,056
					Gov: Oth	IDA-607-G11-H	1-Jul-07	16,731,833
					CS/PS: NGO	IDA-607-G12-H	1-Jun-07	4,170,300
	6	TB	9,072,464	(G1)	Gov: Oth	IDA-607-G09-T	1-Apr-07	7,726,838
	7	HIV/AIDS	30,720,116	(G1)	Gov: Oth	IDA-708-G13-H	1-Sep-08	1,317,750
					Gov: MOH	IDA-708-G14-H	1-Sep-08	3,215,711
					CS/PS: Oth	IDA-708-G15-H	1-Sep-08	3,065,926
Iran (Islamic Republic of)	2	HIV/AIDS	15,922,855	(G2)	MO: UNDP	IRN-202-G01-H-00	1-May-05	10,006,226
	7	Malaria	5,615,598	(G1)	MO: UNDP	IRN-708-G02-M	1-Nov-08	2,797,683
	7	TB	12,652,286	(G1)	MO: UNDP	IRN-708-G03-T	1-Nov-08	1,157,969
	8	HIV/AIDS*	10,328,021	(B1)				
Maldives	6	HIV/AIDS	2,655,685	(G1)	MO: UNDP	MDV-607-G01-H	1-Sep-07	1,258,623
Nepal	2	HIV/AIDS	10,365,995	(G2)	Gov: MOH	NEP-202-G01-H-00	1-Apr-04	4,849,147
					MO: UNDP	NEP-202-G05-H-00	1-Oct-06	4,551,995
	2	Malaria	7,424,607	(G2)	Gov: MOH	NEP-202-G02-M-00	1-Apr-04	2,362,775
					CS/PS: NGO	NEP-202-G04-M-00	1-Dec-05	4,544,691
	4	TB	10,126,706	(G2)	Gov: MOH	NEP-405-G03-T	1-May-06	3,908,421
	7	HIV/AIDS	12,321,512	(G1)	MO: UNDP	NEP-708-G09-H	1-Dec-08	1,807,803
					CS/PS: NGO	NEP-708-G10-H	1-Dec-08	1,046,449
					CS/PS: NGO	NEP-708-G11-H	1-Dec-08	729,606
	7	Malaria	9,126,452	(G1)	CS/PS: NGO	NEP-708-G06-M	1-Sep-08	3,064,866
					Gov: MOH	NEP-708-G07-M	1-Oct-08	716,734
	7	TB	4,358,040	(G1)	Gov: MOH	NEP-708-G08-T	16-Nov-08	776,876
Pakistan	2	HIV/AIDS	8,312,200	(G2)	Gov: MOH	PKS-202-G01-H-00	1-Jan-04	7,257,676
	2	Malaria	3,537,802	(B2)	Gov: MOH	PKS-202-G02-M-00 (Inactive)	1-Jan-04	3,537,802
	2	TB	4,042,900	(G2)	Gov: MOH	PKS-202-G03-T-00	1-Jan-04	3,901,437
	3	Malaria	1,548,636	(G1)	Gov: MOH	PKS-304-G04-M	1-Jan-05	1,382,784
	3	TB	9,903,487	(G2)	Gov: MOH	PKS-304-G05-T	1-Jan-05	8,372,960
	6	TB	22,568,553	(M)	CS/PS: NGO	PKS-607-G06-T	1-Oct-07	6,290,023
					Gov: MOH	PKS-607-G07-T	1-Dec-07	4,992,049
	7	Malaria	12,886,680	(G1)	Gov: MOH	PKS-708-G08-M	1-Sep-08	1,642,417
	8	TB	9,810,559	(B1)				
Sri Lanka	1	Malaria	7,253,635	(G2)	Gov: MOH	SRL-102-G01-M-00	1-Mar-03	2,077,223
					CS/PS: NGO	SRL-102-G02-M-00	1-Mar-03	4,633,887
	1	TB	5,465,034	(M)	Gov: MOH	SRL-102-G03-T-00, (G2)	1-Mar-03	2,550,611
					CS/PS: NGO	SRL-102-G04-T-00 (Inactive), (G1)	1-Mar-03	268,292
	4	Malaria	3,697,315	(G2)	Gov: MOH	SRL-405-G05-M	1-Oct-05	1,683,840
					CS/PS: NGO	SRL-405-G06-M	1-Oct-05	1,152,684
	6	HIV/AIDS	1,009,700	(G1)	Gov: MOH	SRL-607-G09-H	1-Dec-07	302,600
	6	TB	4,186,195	(G1)	Gov: MOH	SRL-607-G07-T	1-Jan-08	684,900
					CS/PS: NGO	SRL-607-G08-T	1-Jan-08	188,874
	8	Malaria*	24,040,444	(B1)				
SUB-SAHARAN AFRICA: EAST AFRICA								
Burundi	1	HIV/AIDS	8,657,000	(G2)	Gov: Oth	BRN-102-G01-H-00	31-Mar-03	8,657,000
	2	Malaria	39,089,883	(M)	Gov: MOH	BRN-202-G02-M-00 (Closed), (G2)	1-Oct-03	16,568,331
					Gov: MOH	BRN-202-G05-M-00, (G3)	1-Oct-06	12,504,434
	4	TB	3,381,665	(G2)	Gov: MOH	BRN-405-G03-T	1-May-05	2,554,489
	5	HIV/AIDS	32,353,173	(G2)	Gov: Oth	BRN-506-G04-H	1-Jun-06	20,355,559
	7	TB	4,018,177	(G1)	Gov: MOH	BRN-708-G06-T	1-Sep-08	1,745,915
	8	HIV/AIDS*	41,315,145	(B1)				
Comoros	2	Malaria	2,485,878	(G2)	CS/PS: NGO	COM-202-G01-M-00	1-Jun-04	2,189,586
	3	HIV/AIDS	1,136,900	(G2)	CS/PS: NGO	COM-304-G02-H	1-Jan-05	1,042,237
	8	Malaria	7,349,473	(B1)				

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Congo	2	TB	7,625,773	(G2)	MO: UNDP	ZAR-202-G01-T-00 (Inactive)	1-Aug-03	7,601,673
(Democratic Republic of the)	3	HIV/AIDS	113,646,453	(G2)	MO: UNDP	ZAR-304-G02-H	1-Jan-05	85,925,597
	3	Malaria	53,936,609	(G2)	MO: UNDP	ZAR-304-G03-M	1-Jan-05	49,864,628
	5	TB	14,598,930	(G1)	MO: UNDP	ZAR-506-G04-T	1-Dec-06	14,478,856
	6	TB	8,532,548	(G1)	MO: UNDP	ZAR-607-G05-T	1-Oct-07	8,182,300
	7	HIV/AIDS	22,675,188	(G1)	MO: UNDP	ZAR-708-G06-H	1-Dec-08	2,744,687
	8	HIV/AIDS	79,225,696	(B1)				
	8	Malaria	153,997,553	(B1)				
Eritrea	2	Malaria	7,911,425	(G2)	Gov: MOH	ERT-202-G01-M-00	28-Nov-03	7,233,883
	3	HIV/AIDS	17,354,035	(G2)	Gov: MOH	ERT-304-G02-H	1-Sep-04	16,692,156
	5	HIV/AIDS	29,139,010	(B2)	Gov: MOH	ERT-506-G03-H	1-Sep-06	10,681,726
	6	Malaria	5,943,130	(G1)	Gov: MOH	ERT-607-G05-M	1-Nov-07	4,416,105
	6	TB	5,470,834	(G1)	Gov: MOH	ERT-607-G04-T	1-Nov-07	2,877,800
	8	HIV/AIDS	17,071,740	(B1)				
Ethiopia	1	TB	26,980,649	(G2)	Gov: MOH	ETH-102-G01-T-00	1-Aug-03	26,980,649
	2	HIV/AIDS	481,959,415	(T3)	Gov: Oth	ETH-202-G03-H-00	1-Jan-04	129,385,088
	2	Malaria	73,875,211	(G2)	Gov: MOH	ETH-202-G02-M-00	1-Oct-03	70,599,857
	4	HIV/AIDS	401,905,883	(G2)	Gov: Oth	ETH-405-G04-H	1-Mar-05	244,114,173
	5	Malaria	140,687,413	(B2)	Gov: MOH	ETH-506-G05-M	1-Jul-06	58,008,789
	6	TB	11,792,574	(G1)	Gov: MOH	ETH-607-G06-T	1-Feb-08	3,519,970
	7	HIV/AIDS	64,955,789	(G1)	CS/PS: NGO	ETH-708-G07-H		
					Gov: Oth	ETH-708-G08-H		22,443,435
					CS/PS: FBO	ETH-708-G09-H		5,236,147
	8	Malaria	148,412,502	(B1)				
Kenya	1	HIV/AIDS	2,650,813	(G1)	CS/PS: NGO	KEN-102-G01-H-00 (Inactive)	1-Apr-03	2,650,813
	1	HIV/AIDS	220,875	(G1)	CS/PS: NGO	KEN-102-G02-H-00 (Inactive)	1-Apr-03	220,875
	2	HIV/AIDS	106,786,807	(G2)	Gov: MOF	KEN-202-G03-H-00	1-Dec-03	68,006,881
	2	Malaria	27,700,377	(G2)	Gov: MOF	KEN-202-G05-M-00	1-Oct-03	4,640,447
	2	TB	8,761,405	(G2)	Gov: MOF	KEN-202-G04-T-00	1-Nov-03	3,299,522
	4	Malaria	162,173,085	(B2)	Gov: MOF	KEN-405-G06-M	1-Feb-06	76,103,617
	5	TB	7,912,684	(G1)	Gov: MOF	KEN-506-G07-T	1-Sep-06	3,511,242
	6	TB	4,206,357	(G1)	Gov: MOF	KEN-607-G08-T	1-Apr-08	1,710,684
	7	HIV/AIDS	46,663,557	(M)	Gov: MOF	KEN-708-G09-H		
					CS/PS: NGO	KEN-708-G10-H		
Madagascar	1	Malaria	2,000,063	(G2)	CS/PS: NGO	MDG-102-G01-M-00 (Inactive)	1-Feb-03	2,000,063
	2	HIV/AIDS	1,439,778	(G2)	CS/PS: NGO	MDG-202-G02-H-00 (Closed)	1-Nov-08	1,439,778
	2	HIV/AIDS	5,024,116	(G2)	CS/PS: NGO	MDG-202-G03-H-00	1-May-03	5,024,116
	3	HIV/AIDS	14,488,982	(G2)	Gov: Oth	MDG-304-G04-H	1-Nov-04	14,111,354
	3	Malaria	10,035,054	(G2)	Gov: MOH	MDG-304-G05-M	1-Nov-04	9,201,991
	4	Malaria	41,140,706	(G2)	Gov: MOH	MDG-405-G06-M	1-Apr-05	21,467,970
					CS/PS: NGO	MDG-405-G07-M	1-Mar-05	19,459,660
	4	TB	8,323,396	(G2)	Gov: Oth	MDG-404-G08-T	1-Feb-05	6,887,439
	7	Malaria	26,095,449	(G1)	Gov: MOH	MDG-708-G09-M	1-Oct-08	9,712,843
					CS/PS: NGO	MDG-708-G10-M	1-Dec-08	2,150,644
	8	HIV/AIDS	11,768,300	(B1)				
	8	TB*	8,987,239	(B1)				
Mauritius	8	HIV/AIDS	5,640,090	(B1)				
Rwanda	1	HIV/TB	14,641,046	(G2)	Gov: MOH	RWN-102-G01-C-00	1-May-03	14,641,046
	3	HIV/AIDS	56,646,465	(G2)	Gov: MOH	RWN-304-G02-H	1-Aug-04	50,069,683
	3	Malaria	38,597,403	(G3)	Gov: MOH	RWN-304-G03-M	1-Oct-04	25,927,879
	4	TB	10,563,602	(G2)	Gov: MOH	RWN-404-G04-T	1-Jan-05	9,704,413
	5	HSS	33,945,080	(G2)	Gov: MOH	RWN-505-G05-S	1-Jan-06	27,257,809
	5	Malaria	39,649,362	(G2)	Gov: MOH	RWN-506-G06-M	1-Mar-06	39,149,502
	6	HIV/AIDS	31,563,456	(G1)	Gov: MOH	RWN-607-G08-H	1-Jun-07	27,554,110
	6	TB	2,681,140	(G1)	Gov: MOH	RWN-606-G07-T	1-Mar-07	2,438,357
	7	HIV/AIDS	63,978,011	(G1)	Gov: MOH	RWN-708-G09-H	1-Oct-08	27,590,463
	8	Malaria	58,567,001	(B1)				
United Republic of Tanzania	1	HIV/AIDS	5,400,000	(G1)	Gov: MOF	TNZ-102-G02-H-00 (Inactive)	1-Nov-03	4,647,000
	1	Malaria	78,079,834	(G3)	Gov: MOH	TNZ-102-G01-M-00	1-Nov-03	48,139,110
	3	HIV/TB	83,466,904	(G2)	Gov: MOF	TNZ-304-G03-C	1-Nov-04	54,798,490
	4	HIV/AIDS	283,092,248	(G2)	Gov: MOF	TNZ-405-G04-H	1-Sep-05	135,137,370
					CS/PS: NGO	TNZ-405-G05-H	1-Jul-05	21,324,613
					CS/PS: NGO	TNZ-405-G06-H	1-Jul-05	8,756,686
					CS/PS: NGO	TNZ-405-G07-H	1-Jul-05	15,871,814
	4	Malaria	76,086,764	(G2)	Gov: MOF	TNZ-405-G08-M	1-Aug-05	75,086,764
	6	TB	16,498,948	(G1)	Gov: MOF	TNZ-607-G09-T	1-Nov-07	15,173,156
	7	Malaria	20,707,304	(G1)	Gov: MOF	TNZ-708-G10-M	1-Jul-08	5,161,417
	8	HIV/AIDS	145,848,085	(B1)				
	8	Malaria	111,586,404	(B1)				

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Uganda	1	HIV/AIDS	48,878,417	(B2)	Gov: MOF	UGD-102-G01-H-00 (Inactive)	15-Jun-03	26,160,888
	2	Malaria	23,211,300	(B2)	Gov: MOF	UGD-202-G02-M-00	15-Mar-04	21,054,781
	2	TB	4,692,021	(G1)	Gov: MOF	UGD-202-G03-T-00	15-Mar-04	4,599,506
	3	HIV/AIDS	82,586,057	(G2)	Gov: MOF	UGD-304-G04-H	1-Jul-05	46,362,091
	4	Malaria	137,467,137	(B2)	Gov: MOF	UGD-405-G05-M	1-Dec-05	59,071,374
	6	TB	8,103,106	(G1)	Gov: MOF	UGD-607-G06-T	1-Mar-08	901,385
	7	HIV/AIDS	70,277,726	(G1)	Gov: MOF	UGD-708-G07-H		
	7	Malaria	51,422,198	(G1)	Gov: MOF	UGD-708-G08-M		
Zanzibar (United Republic of Tanzania)	1	Malaria	1,153,080	(G2)	Gov: MOH	ZAN-102-G01-M-00	1-Jun-03	1,153,080
	2	HIV/AIDS	2,302,637	(G2)	Gov: Oth	ZAN-202-G02-H-00	1-Sep-03	1,432,275
	3	TB	1,699,867	(G2)	Gov: MOH	ZAN-304-G03-T	1-Dec-04	959,482
	4	Malaria	8,438,788	(G2)	Gov: MOH	ZAN-404-G04-M	1-Jan-05	7,041,523
	6	HIV/AIDS	3,825,619	(G1)	Gov: MOH	ZAN-607-G05-H	1-Dec-07	1,208,108
					Gov: Oth	ZAN-607-G06-H	1-Dec-07	135,695
	8	Malaria	7,860,795	(B1)				
SUB-SAHARAN AFRICA: SOUTHERN AFRICA								
Angola	3	Malaria	35,029,872	(G2)	MO: UNDP	AGO-305-G01-M	1-Apr-05	34,833,588
	4	HIV/AIDS	86,120,215	(G2)	MO: UNDP	AGO-405-G03-H	1-Oct-05	37,410,671
	4	TB	10,871,026	(G2)	MO: UNDP	AGO-405-G02-T	1-Aug-05	8,045,886
	7	Malaria	32,512,648	(G1)	Gov: MOH	AGO-708-G04-M	1-Dec-08	6,312,280
Botswana	2	HIV/AIDS	18,580,414	(G1)	Gov: MOF	BOT-202-G01-H-00 (Inactive)	1-Jul-04	9,019,119
	5	TB	5,515,900	(G1)	Gov: MOF	BOT-506-G02-T	1-Jan-07	3,949,978
Lesotho	2	HIV/AIDS	29,312,000	(G2)	Gov: MOF	LSO-202-G01-H-00	1-Jan-04	24,263,141
	2	TB	5,000,000	(G2)	Gov: MOF	LSO-202-G02-T-00	1-Jan-04	3,372,923
	5	HIV/AIDS	39,776,038	(B2)	Gov: MOF	LSO-506-G03-H	1-Nov-06	8,866,316
	6	TB	3,798,805	(G1)	Gov: MOF	LSO-607-G04-T	1-Jul-07	2,973,586
	7	HIV/AIDS	10,626,665	(G1)	Gov: MOF	LSO-708-G05-H	1-Aug-08	2,841,914
	8	HIV/AIDS	39,773,696	(B1)				
	8	TB*	10,967,381	(B1)				
Malawi	1	HIV/AIDS	351,943,678	(T3)	Gov: Oth	MLW-102-G01-H-00	1-Oct-03	176,389,575
	2	Malaria	36,773,714	(B2)	Gov: MOH	MLW-202-G02-M-00	1-Feb-06	17,957,714
	5	HIV/AIDS	7,708,331	(G1)	Gov: Oth	MLW-506-G03-H	1-Oct-06	7,708,331
	5	HSS	22,643,238	(G1)	Gov: Oth	MLW-506-G04-S	1-Jul-07	17,207,360
	7	HIV/AIDS	15,078,417	(G1)	Gov: Oth	MLW-708-G07-H	1-Nov-08	5,076,095
	7	Malaria	36,545,312	(G1)	Gov: Oth	MLW-708-G05-M		14,961,664
	7	TB	7,802,037	(G1)	Gov: MOH	MLW-708-G06-T		2,825,106
Mozambique	2	HIV/AIDS	109,338,584	(M)	Gov: Oth	MOZ-202-G01-H-00, (B2)	1-Jul-06	6,156,898
					Gov: MOH	MOZ-202-G02-H-00, (G2)	1-Jan-05	66,105,538
	2	Malaria	28,149,603	(G2)	Gov: MOH	MOZ-202-G03-M-00	1-Jan-05	22,968,335
	2	TB	14,200,659	(G2)	Gov: MOH	MOZ-202-G04-T-00	1-Jan-05	9,323,228
	6	HIV/AIDS	22,748,853	(G1)	Gov: MOH	MOZ-607-G05-H	1-Jan-08	16,012,381
	6	Malaria	25,591,825	(G1)	Gov: MOH	MOZ-607-G06-M	1-Jan-08	13,123,695
	7	TB	6,735,303	(G1)	Gov: MOH	MOZ-708-G07-T	1-Nov-08	2,134,834
	8	HIV/AIDS	13,177,452	(B1)				
Multi-country Africa (RMCC)	2	Malaria	35,816,816	(T3)	CS/PS: NGO	MAF-202-G01-M-00	1-Aug-03	20,926,193
	5	Malaria	17,550,861	(B2)	CS/PS: NGO	MAF-506-G02-M	1-Jul-06	6,501,141
Namibia	2	HIV/AIDS	104,004,211	(G2)	Gov: MOH	NMB-202-G01-H-00	1-Jan-05	58,868,803
	2	Malaria	6,235,950	(G2)	Gov: MOH	NMB-202-G03-M-00	1-Jan-05	5,262,571
	2	TB	1,294,610	(G2)	Gov: MOH	NMB-202-G02-T-00	1-Jan-05	1,215,436
	5	TB	17,204,526	(G2)	Gov: MOH	NMB-506-G04-T	1-Jun-06	6,764,535
	6	Malaria	8,538,063	(G1)	Gov: MOH	NMB-607-G06-M	1-Aug-07	5,589,556
South Africa	1	HIV/TB	20,226,665	(B2)	Gov: MOF	SAF-102-G01-C-00 (Inactive)	8-Dec-03	2,354,000
					Gov: MOF	SAF-102-G02-C-00 (Inactive)	1-Aug-03	17,872,665
	1	HIV/TB	62,476,536	(G2)	Gov: MOF	SAF-102-G03-C-00	1-Jan-04	44,504,639
	2	HIV/TB	24,400,220	(G2)	Gov: MOH	SAF-202-G05-C-00	1-Jan-06	12,579,554
	3	HIV/AIDS	66,501,629	(G2)	Gov: MOH	SAF-304-G04-H	1-Sep-04	54,273,592
	6	HIV/AIDS	55,071,906	(G1)	Gov: MOH	SAF-607-G06-H	1-Jan-08	16,799,580
Swaziland	2	HIV/AIDS	52,544,145	(G2)	Gov: Oth	SWZ-202-G01-H-00	1-Aug-03	49,276,920
	2	Malaria	1,820,500	(G2)	Gov: Oth	SWZ-202-G02-M-00	1-Sep-03	1,431,733
	3	TB	2,506,000	(G2)	Gov: Oth	SWZ-304-G03-T	1-Jan-05	1,430,739
	4	HIV/AIDS	45,839,731	(G2)	Gov: Oth	SWZ-405-G04-H	1-Oct-05	11,566,190
	7	HIV/AIDS	28,380,316	(G1)	Gov: Oth	SWZ-708-G05-H		2,310,374
	8	HIV/AIDS	8,180,726	(B1)				
	8	Malaria	5,637,713	(B1)				
	8	TB	4,785,540	(B1)				

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Zambia	1	HIV/AIDS	90,325,778	(M)	Gov: MOH	ZAM-102-G01-H-00, (G2)	25-Jul-03	35,757,291
					CS/PS: FBO	ZAM-102-G04-H-00, (G2)	25-Jul-03	22,840,611
					Gov: MOF	ZAM-102-G07-H-00, (G1)	1-Mar-05	3,057,134
					CS/PS: NGO	ZAM-102-G08-H-00, (G2)	25-Jul-03	20,204,481
	1	Malaria	39,273,800	(G2)	Gov: MOH	ZAM-102-G02-M-00	15-Aug-03	28,499,341
					CS/PS: FBO	ZAM-102-G05-M-00	1-Aug-03	3,382,491
	1	TB	47,337,256	(G2)	Gov: MOH	ZAM-102-G03-T-00	25-Jul-03	18,354,137
					CS/PS: FBO	ZAM-102-G06-T-00	25-Jul-03	10,364,690
					CS/PS: NGO	ZAM-102-G15-T-00	1-Dec-05	1,164,676
	4	HIV/AIDS	236,318,738	(G2)	Gov: MOH	ZAM-405-G09-H	1-Nov-05	29,665,720
					CS/PS: FBO	ZAM-405-G10-H	1-Jul-05	46,077,638
					CS/PS: NGO	ZAM-405-G11-H	1-Jul-05	14,575,239
					Gov: MOF	ZAM-405-G12-H	1-Oct-05	7,382,073
	4	Malaria	42,721,807	(G2)	Gov: MOH	ZAM-405-G13-M	1-Nov-05	16,940,617
					CS/PS: FBO	ZAM-405-G14-M	1-Jul-05	10,784,439
	7	Malaria	17,715,924	(G1)	Gov: MOH	ZAM-708-G17-M	1-Jul-08	
					CS/PS: FBO	ZAM-708-G19-M	1-Dec-08	2,422,691
	7	TB	3,882,948	(G1)	Gov: MOH	ZAM-708-G16-T	1-Jul-08	
					CS/PS: FBO	ZAM-708-G18-T	1-Oct-08	835,246
					CS/PS: NGO	ZAM-708-G20-T	1-Nov-08	373,708
	8	HIV/AIDS	144,079,863	(B1)				
Zimbabwe	1	HIV/AIDS	14,100,000	(M)	MO: UNDP	ZIM-102-G01-H-00, (G1)	1-May-05	6,312,533
					Gov: Oth	ZIM-102-G07-H, (G2)	1-Nov-07	4,836,910
	1	Malaria	8,559,911	(G2)	Gov: MOH	ZIM-102-G02-M-00	1-Aug-04	8,250,984
	5	HIV/AIDS	35,931,159	(G1)	Gov: Oth	ZIM-506-G03-H	1-Aug-07	7,444,080
					CS/PS: FBO	ZIM-506-G04-H	1-Jun-07	1,292,404
	5	Malaria	20,121,670	(G1)	Gov: MOH	ZIM-506-G06-M	1-Oct-07	6,798,371
	5	TB	9,230,076	(G1)	CS/PS: FBO	ZIM-506-G05-T	1-Sep-07	3,410,626
	8	HIV/AIDS	86,821,730	(B1)				
	8	Malaria	70,994,472	(B1)				
	8	TB*	29,538,652	(B1)				
SUB-SAHARAN AFRICA: WEST & CENTRAL AFRICA								
Benin	1	Malaria	2,973,150	(G2)	MO: UNDP	BEN-102-G01-M-00	1-May-03	2,955,032
	2	HIV/AIDS	17,324,228	(G2)	MO: UNDP	BEN-202-G03-H-00	25-Jul-03	16,729,577
	2	TB	3,104,104	(G2)	MO: UNDP	BEN-202-G02-T-00	1-Nov-03	3,095,158
	3	Malaria	2,456,930	(G2)	CS/PS: NGO	BEN-304-G04-M	1-Nov-04	2,208,412
	5	HIV/AIDS	22,620,942	(G1)	Gov: MOH	BEN-506-G05-H	1-Jan-07	13,302,477
	6	TB	5,334,067	(G1)	Gov: MOH	BEN-607-G06-T	1-Jun-07	3,731,185
	7	Malaria	12,245,455	(G1)	CS/PS: FBO	BEN-708-G07-M	1-Jul-08	5,969,467
Burkina Faso	2	HIV/AIDS	16,417,522	(M)	MO: UNDP	BUR-202-G02-H-00, (B2)	1-Dec-03	9,037,494
					Gov: MOH	BUR-202-G04-H-00, (G2)	1-Oct-06	5,487,521
	2	Malaria	7,499,988	(G1)	MO: UNDP	BUR-202-G01-M-00 (Inactive)	1-Dec-03	7,119,071
	4	TB	16,984,217	(M)	MO: UNDP	BUR-404-G03-T, (G1)	1-Jan-05	5,599,615
					Gov: MOH	BUR-407-G05-T, (G2)	1-Jun-07	8,179,733
	6	HIV/AIDS	29,256,089	(G1)	Gov: Oth	BUR-607-G06-H	1-Oct-07	14,349,845
	7	Malaria	16,991,708	(G1)	Gov: Oth	BUR-708-G07-M	1-May-08	7,283,872
	8	Malaria	73,927,526	(B1)				
	8	TB*	16,764,414	(B1)				
Cameroon	3	HIV/AIDS	55,500,617	(G2)	Gov: MOH	CMR-304-G01-H	1-Jan-05	38,968,748
	3	Malaria	31,781,187	(G2)	Gov: MOH	CMR-304-G02-M	1-Jan-05	22,569,758
	3	TB	5,804,961	(G2)	Gov: MOH	CMR-304-G03-T	1-Jan-05	4,448,457
	4	HIV/AIDS	16,194,089	(G2)	CS/PS: NGO	CMR-404-G04-H	1-Jan-05	13,035,051
	5	HIV/AIDS	12,516,078	(B2)	Gov: MOH	CMR-506-G05-H	1-Aug-06	3,662,574
	5	Malaria	14,395,954	(G1)	Gov: MOH	CMR-506-G06-M	1-Nov-06	4,248,021
Cape Verde	8	HIV/AIDS*	5,321,184	(B1)				
Central African Republic	2	HIV/AIDS	24,904,652	(G2)	MO: UNDP	CAF-202-G01-H-00	1-Oct-03	23,056,692
	4	HIV/AIDS	15,126,131	(G2)	MO: UNDP	CAF-404-G02-H	1-Jan-05	8,495,262
	4	Malaria	16,663,897	(G2)	MO: UNDP	CAF-405-G04-M	1-May-05	12,671,585
	4	TB	4,569,039	(G2)	MO: UNDP	CAF-404-G03-T	1-Jan-05	3,027,935
	7	HIV/AIDS	15,799,899	(G1)	Gov: MOH	CAF-708-G05-H		1,845,868
	8	Malaria	15,130,330	(B1)				
Congo (Republic of the)	5	HIV/AIDS	42,588,489	(B2)	Gov: Oth	COG-506-G01-H	1-Dec-06	10,586,465
	8	Malaria*	35,440,388	(B1)				
	8	TB*	3,205,209	(B1)				
Côte d'Ivoire	2	HIV/AIDS	46,139,043	(G2)	MO: UNDP	CIV-202-G01-H-00	1-Dec-03	22,918,332
					CS/PS: NGO	CIV-202-G05-H	1-Aug-07	18,929,673
	3	HIV/AIDS	1,023,534	(G1)	CS/PS: NGO	CIV-304-G02-H (Inactive)	1-Apr-04	1,023,467

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Côte d'Ivoire (continued)	3	TB	3,830,107	(G2)	MO: UNDP	CIV-304-G03-T	1-Apr-04	3,623,541
	5	HIV/AIDS	4,031,346	(G1)	CS/PS: NGO	CIV-506-G04-H	1-Aug-06	4,013,260
	6	Malaria	10,203,600	(G1)	CS/PS: NGO	CIV-607-G06-M	1-Dec-07	4,325,690
	6	TB	3,476,612	(G1)	Gov: MOH	CIV-607-G07-T	1-Apr-08	2,276,737
	8	Malaria	193,955,480	(B1)				
Equatorial Guinea	4	HIV/AIDS	9,824,836	(G2)	MO: UNDP	GNQ-405-G01-H	1-Jul-05	4,554,955
	5	Malaria	23,074,306	(B2)	CS/PS: NGO	GNQ-506-G02-M	1-Oct-06	11,589,369
Gabon	3	HIV/AIDS	7,017,219	(G2)	MO: UNDP	GAB-304-G01-H, (G2)	1-Oct-04	5,092,967
					MO: UNDP	GAB-304-G01-H-e, (G2)	1-Oct-04	1,797,515
	4	Malaria	9,348,388	(G2)	MO: UNDP	GAB-404-G02-M	1-Jan-05	8,616,322
	5	Malaria	17,458,478	(B2)	MO: UNDP	GAB-506-G03-M	1-Aug-06	4,160,323
	8	HIV/AIDS	9,573,545	(B1)				
Gambia	3	HIV/AIDS	14,568,678	(G2)	Gov: Oth	GMB-304-G01-H	1-Oct-04	12,675,866
	3	Malaria	13,861,866	(G2)	Gov: MOH	GMB-304-G02-M	1-Oct-04	12,335,143
	5	TB	5,032,929	(G2)	Gov: MOH	GMB-506-G03-T	1-Jun-06	3,193,653
	6	Malaria	9,145,120	(G1)	Gov: MOH	GMB-607-G04-M	1-Jul-07	7,902,282
	8	HIV/AIDS	21,224,487	(B1)				
Ghana	1	HIV/AIDS	14,170,222	(G2)	Gov: MOH	GHN-102-G01-H-00	1-Jan-03	14,170,222
	1	TB	5,687,055	(G2)	Gov: MOH	GHN-102-G02-T-00	1-Jan-03	5,685,493
	2	Malaria	98,613,734	(T3)	Gov: MOH	GHN-202-G03-M-00	1-Sep-03	8,849,491
	4	Malaria	38,887,781	(G2)	Gov: MOH	GHN-405-G04-M	1-Mar-05	38,887,781
	5	HIV/AIDS	97,098,678	(G2)	Gov: MOH	GHN-506-G06-H	1-May-06	49,218,985
	5	TB	31,471,784	(G2)	Gov: MOH	GHN-506-G05-T	1-May-06	22,556,665
	8	HIV/AIDS	51,498,200	(B1)				
	8	Malaria	39,639,118	(B1)				
Guinea	2	HIV/AIDS	9,651,105	(G2)	Gov: MOH	GIN-202-G01-H-00	1-Apr-04	4,898,172
	2	Malaria	6,893,509	(G2)	Gov: MOH	GIN-202-G02-M-00	1-Apr-04	5,125,461
	5	TB	4,003,908	(G1)	Gov: MOH	GIN-506-G03-T	1-Feb-07	3,424,115
	6	HIV/AIDS	4,585,405	(G1)	Gov: MOH	GIN-607-G04-H	1-Jan-08	979,566
	6	Malaria	17,339,248	(G1)	Gov: MOH	GIN-607-G05-M	1-Jan-08	1,289,333
Guinea-Bissau	3	TB	2,646,003	(G2)	MO: UNDP	GNB-304-G01-T	1-Jul-04	1,927,068
	4	HIV/AIDS	3,363,634	(G2)	MO: UNDP	GNB-404-G02-H	1-Nov-04	1,921,443
	4	Malaria	3,613,397	(G2)	MO: UNDP	GNB-404-G03-M	1-Jan-05	2,120,329
	6	Malaria	3,438,484	(G1)	Gov: MOH	GNB-607-G04-M	1-Dec-07	1,552,193
	7	HIV/AIDS	13,182,390	(G1)	Gov: Oth	GNB-708-G05-H		
	8	TB	829,013	(B1)				
Liberia	2	HIV/AIDS	7,658,187	(G1)	MO: UNDP	LBR-202-G01-H-00	1-Dec-04	7,429,767
	2	TB	4,534,017	(G1)	MO: UNDP	LBR-202-G02-T-00	1-Dec-04	4,298,100
	3	Malaria	12,140,921	(G1)	MO: UNDP	LBR-304-G03-M	1-Dec-04	11,876,058
	6	HIV/AIDS	12,005,984	(G1)	MO: UNDP	LBR-607-G04-H	1-Jun-07	9,772,654
	7	Malaria	12,695,907	(G1)	MO: UNDP	LBR-708-G05-M	1-Jun-08	9,128,543
	7	TB	6,408,872	(G1)	MO: UNDP	LBR-708-G06-T	1-Jun-08	1,935,730
	8	HIV/AIDS	20,199,587	(B1)				
Multi-country Africa (West Africa Corridor Program)	6	HIV/AIDS	19,092,500	(G1)	CS/PS: NGO	MAW-607-G01-H	1-Sep-07	13,297,979
Nigeria	1	HIV/AIDS	8,708,684	(B2)	Gov: Oth	NGA-102-G01-H-00 (Inactive)	1-Jan-04	6,770,276
	1	HIV/AIDS	1,687,599	(G1)	CS/PS: NGO	NGA-102-G02-H-00 (Inactive)	1-Dec-03	816,305
	1	HIV/AIDS	17,772,103	(B2)	Gov: Oth	NGA-102-G03-H-00 (Inactive)	1-Jan-04	12,948,323
	2	Malaria	20,994,149	(B2)	CS/PS: NGO	NGA-202-G04-M-00	1-Dec-04	20,241,784
	4	Malaria	74,542,287	(G2)	CS/PS: NGO	NGA-404-G05-M	1-Jan-05	38,481,707
					CS/PS: NGO	NGA-407-G10-M	1-Jan-08	13,316,023
	5	HIV/AIDS	89,312,225	(M)	Gov: Oth	NGA-506-G07-H, (G1)	1-Jan-07	50,225,606
					CS/PS: NGO	NGA-506-G08-H, (B2)	1-Jan-07	6,394,885
					CS/PS: NGO	NGA-506-G09-H, (G1)	1-Jan-07	9,506,579
	5	TB	25,570,061	(G1)	CS/PS: FBO	NGA-506-G06-T	1-Jan-07	22,877,723
	8	HIV/AIDS	75,055,363	(B1)				
	8	Malaria*	334,351,033	(B1)				
Sao Tome and Principe	4	Malaria	3,484,859	(G2)	MO: UNDP	STP-405-G01-M	1-Mar-05	2,948,356
	5	HIV/AIDS	1,407,452	(B2)	MO: UNDP	STP-506-G02-H	1-Oct-06	645,628
	7	Malaria	4,118,449	(G1)	MO: UNDP	STP-708-G03-M	1-Nov-08	1,756,733
	8	TB	1,132,914	(B1)				
Senegal	1	HIV/AIDS	11,714,285	(G2)	Gov: Oth	SNG-102-G01-H-00	1-Apr-03	8,807,907
					CS/PS: NGO	SNG-102-G04-H-00	1-Apr-06	2,906,326
	1	Malaria	4,285,714	(B2)	Gov: MOH	SNG-102-G02-M-00 (Inactive)	1-Apr-03	1,526,770

COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
Senegal (continued)	4	Malaria	28,778,260	(G2)	Gov: MOH	SNG-405-G03-M	1-Sep-05	23,697,528
	6	HIV/AIDS	11,571,991	(G1)	Gov: Oth	SNG-607-G05-H	1-Jun-07	5,455,669
					CS/PS: NGO	SNG-607-G06-H	1-Jun-07	4,333,283
	7	Malaria	26,966,235	(G1)	Gov: MOH	SNG-708-G07-M	1-Jun-08	2,797,163
	7	TB	4,074,299	(G1)	Gov: MOH	SNG-708-G08-T	1-Nov-08	863,252
Sierra Leone	2	TB	5,698,557	(G2)	CS/PS: NGO	SLE-202-G01-T-00	1-Jan-04	5,030,837
	4	HIV/AIDS	17,820,803	(G2)	Gov: Oth	SLE-405-G02-H	1-Jun-05	11,711,849
	4	Malaria	8,886,123	(G1)	CS/PS: NGO	SLE-405-G03-M	1-May-05	6,956,097
	6	HIV/AIDS	9,627,778	(G1)	Gov: Oth	SLE-607-G04-H	1-Feb-08	3,864,426
	7	Malaria	10,011,250	(G1)	Gov: MOH	SLE-708-G05-M	1-Nov-08	4,840,240
	7	TB	4,336,448	(G1)	Gov: MOH	SLE-708-G06-T	1-Nov-08	1,494,842
Togo	2	HIV/AIDS	15,455,477	(B2)	MO: UNDP	TGO-202-G01-H-00	1-Oct-03	13,906,404
	3	Malaria	5,885,906	(G2)	MO: UNDP	TGO-304-G02-M	1-May-04	5,856,835
	3	TB	2,617,655	(G2)	MO: UNDP	TGO-304-G03-T	1-May-04	1,801,888
	4	HIV/AIDS	30,559,938	(G2)	CS/PS: NGO	TGO-405-G04-H	1-Apr-05	22,877,463
	4	Malaria	10,694,981	(G2)	MO: UNDP	TGO-405-G05-M	1-Oct-05	7,285,434
	6	Malaria	6,551,298	(G1)	MO: UNDP	TGO-607-G06-M	1-Jan-08	4,180,204
	6	TB	2,805,183	(G1)	MO: UNDP	TGO-607-G07-T	1-Jan-08	1,588,130
	8	HIV/AIDS	44,222,435	(B1)				

SPECIAL NOTES FOR ROUND 8

— All Category 1, 2 and 2B components have been approved by the Board, in principle
— Those currently approved for funding are: all Category 1, and all Category 2 with a composite index of 8, 6 and 5
— The remaining Category 2 proposals and all Category 2B proposals (those currently marked with an asterisk ["*"]), will be presented to the Board for funding approval, according to the comprehensive funding policy and as / when funding becomes available
— Phase 1 funding: the Board approved a total upper ceiling of US$ 2.75 billion. The Global Fund Secretariat will be working with countries to find efficiencies in all proposals to bring the total approved funding for Round 8 at or below US$ 2.75 billion
— Phase 2 funding: the Global Fund Secretariat will be looking for efficiencies to reduce the amount of Phase 2 funding, which will be addressed during the Phase 2 renewal process

NOTES

1 It is recommended that full information on country proposals, grant agreements and latest disbursements is viewed at www.theglobalfund.org
2 Country or Territory:
— The Multi-country Africa region includes: Mozambique, South Africa and Swaziland
— The Multi-country Western Pacific region includes: Cook Islands, Fiji, FSM (Federated States of Micronesia), Kiribati, Niue, Marshall Islands, Palau, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu
— The Multi-country Americas (Andean) region includes: Colombia, Ecuador, Peru and Venezuela
— The Multi-country Americas (CARICOM) region includes: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname and Trinidad & Tobago
— The Multi-country Americas (CRN+) region includes: Antigua & Barbuda, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, and Trinidad & Tobago
— The Multi-country Americas (Meso) region includes: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama
— The Multi-country Americas (OECS) region includes: Antigua & Barbuda, Dominica, Grenada, St. Kitts & Nevis, St. Lucia and St. Vincent & the Grenadines
3 Status of Approved Grant Amount:
(B1) = Board-approved upper limit, pending TRP clarifications and grant negotiations (Phase 1)
(T1) = After TRP clarifications, pending grant negotiations (Phase 1)
(G1) = Per grant agreement (Phase 1)
(B2) = Board-approved upper limit, pending grant negotiations (including Phase 2)
(G2) = Per grant agreement (including Phase 2)
(B3) = Board-approved upper limit, pending TRP clarifications and grant negotiations (RCC 1)
(T3) = After TRP clarifications, pending grant negotiations (RCC 1)
(G3) = Per grant agreement (including RCC 1)
(M) = Multiple-grant component with different budget status (see under grant number)
Re: approved grant funding for Round 8, please see Special Notes for Round 8 above
4 PR Type (abbreviations):
— Civil Society / Private Sector: CS/PS: FBO (Faith-Based Organization), CS/PS: NGO (Non-Governmental Organization), CS/PS: Oth (Other), CS/PS: PS (Private Sector)
— Government: Gov: MOH (Ministry of Health), Gov: MOF (Ministry of Finance), Gov: Oth (Other)
— Multilateral Organization: MO: UNDP (United Nations Development Programme), MO: Oth (Other)

GENERAL NOTES

Section Headings:
— Approved Proposals: includes all proposal amounts approved by the Board
— Grant Agreements: includes all amounts related to signed grants (re: grants signed by both the PR and GFATM Secretariat)
— Disbursements: includes all disbursements made (where instructions to disburse have been sent to the Trustee)
Euro grants:
— For Rounds 1 – 4, only the Phase 2 portion of grants are eligible for denomination in Euro
— For Round 5 onwards, both Phase 1 and Phase 2 portions of grants are eligible for denomination in Euro
— The USD equivalent of a Euro disbursement is initially calculated using the latest month-end IMF Representative Exchange Rate and is replaced by the actual USD equivalent on the date of disbursement, once confirmed by the Trustee.
— The USD equivalent of a Euro grant comprises the sum of disbursements made (valued in USD on the date of transfer from the Trustee), plus the undisbursed portion of the grant calculated using the latest month-end IMF Representative Exchange Rate.

ANNEX 2:
TOP TEN INDICATORS

TOP TEN SERVICE INDICATORS OF PEOPLE REACHED (FOR ROUTINE REPORTING [GENERALLY EVERY SIX MONTHS])

1. Number of people currently receiving antiretroviral therapy **(ARVs)**
2. Number of **a.** New smear-positive **TB cases detected**,
   b. cases successfully treated and **c.** TB cases enrolled for multidrug-resistant treatment
3. Number of **insecticide-treated bed nets** distributed to people
   (or, where appropriate, houses receiving Indoor Residual Spraying)
4. Number of people receiving **antimalarial treatment** (as per national policy)
5. Number of people **counseled and tested for HIV**, including provision of results
6. Number of HIV-positive pregnant women receiving a complete course of ARV prophylaxis
   to reduce mother-to-child transmission **(PMTCT)**
7. Number of **condoms** distributed to people
8. Number of people benefiting from **community-based programs**
   (specify **a.** Prevention **b.** Orphan support **c.** Care and support)
9. Number of people receiving **treatment for infections associated with HIV**
   (specify **a.** Preventive therapy for TB/HIV **b.** Sexually transmitted infections with counseling)
10. Number of **service deliverers trained** (**a.** Health services **b.** Peer & community programs)

TOP TEN OUTCOME/IMPACT INDICATORS (FOR MEDIUM TERM REPORTING [1-5 YEARS])

1. Percentage age 15-24 who are HIV infected **(HIV prevalence)**
   (applicable to most-at-risk populations in concentrated/lower epidemics)
2. Percentage still alive 12 months after initiation of ARV **(reduced mortality)**
3. Percentage of infants born to HIV-positive mothers who are HIV infected
   (reduced mother to child HIV transmission)
4. Percentage age 15-24 who had **sex with more than one partner** in last year
5. **Primary abstinence** (percentage never had sex, in 15-19 year olds);
   Secondary abstinence (percentage never had sex in the last year of those who ever had sex, in 15-24 year olds)
6. Percentage age 15-24 with non-regular partners in the last year who reported
   consistent use of condoms with these partners
7. **TB case detection rate** and **treatment success rate**
8. Estimated all active TB cases per 100,000 population **(TB prevalence rate)**
9. **Malaria-associated deaths** (in high endemic areas, all-cause under-five mortality)
10. **Incidence of clinical malaria cases** (estimated and /or reported)

ANNEX 3:
HOW DO WE MEASURE RESULTS FROM GLOBAL FUND-SUPPORTED PROGRAMS?

Programmatic results are based on the reported achievements of programs supported by the Global Fund. These programs are conceived, planned and implemented at the country level with the financial, capacity-building and technical support of numerous stakeholders, including national governments and organizations, donors, technical partners and financial institutions such as the Global Fund. The results are therefore those of country programs, with the support of partners and the Global Fund.

This report presents results from Global Fund-supported programs that have been verified by the Local Fund Agents (agents of the Global Fund in-country) and reported to the Global Fund Secretariat up to end-2008. ARV figures refer to the number of people who are currently on HIV treatment. Other "Top Ten" results presented in this report are cumulative results measured from the time that the program started to receive Global Fund support. However, results are not solely due to Global Fund financing, and programs are encouraged to use other sources and commit their own funds to ensure sustainability. Where the Global Fund is a major financier of the national program, supports an essential nationwide component and the performance of the program is adequate, national results can be reported. ARV results reported are cross-checked and reviewed with other major financing and programmatic partners twice per year, including PEPFAR, WHO and UNAIDS, to ensure that duplicate results are not reported by different organizations.

There are five important checks and safeguards on the quality of results data:

1. The monitoring and evaluation capacity of each program is assessed in its early stages by the Local Fund Agent.
2. Two independent Local Fund Agent verifications of programmatic data are undertaken each year. This involves record checking; it should also involve at least one site assessment per year.
3. Comprehensive review after 18 months of implementation, including review by the Country Coordinating Mechanism (the country mechanisms made up of public-health stakeholders which provide oversight of country proposals and implementation), Local Fund Agent, and the Performance and Finance functions in the Global Fund Secretariat.
4. Joint partner data-sharing: partners have agreed on common indicators as part of the joint *Monitoring and Evaluation Toolkit*. Data are shared twice-yearly to identify inconsistencies, overlap and plan strengthening measures.

In 2008 systematic data quality audits have been introduced on a sample of grants.

ANNEX 4:
EXAMPLES OF GRANTS WITH POOR PERFORMANCE, THE REASONS FOR THIS AND THE ACTIONS TAKEN BY THE GLOBAL FUND AND THE COUNTRIES TO ADDRESS IT

Any performance-based funding system requires clear follow-up actions. At the same time, it is important to assess the reasons for unacceptable performance. Seven major issues have been identified:

a. **Failure to implement goals.** Unwillingness to implement key objectives of the grant, for example, excluding prevention and focusing only on treatment in a grant with mainly prevention goals
b. **Exclusion of key constituencies.** Exclusion of key constituents and implementers, for example, civil society organizations
c. **Severe capacity constraints.** Inability to use the funds (very low spending rates) and limited capacity to implement activities
d. **Lack of accountability.** Dysfunctional monitoring systems that do not allow follow-up of people on treatment or accountability for services
e. **Inability to contract activities.** Failure to contract sub-recipients or to procure so that activities are still not initiated after several years
f. **Governance concerns.** The Country Coordinating Mechanism is unable to provide guidance or oversight to country programs and excludes key partners, resulting in chronic performance problems
g. **Management and oversight of sub-recipients.** Serious issues concerning Principal Recipient management and oversight of sub-recipients, or very severe political instability which is unlikely to allow implementation of the proposal.

Each program with performance problems has individual issues. It is important that these issues be appropriately diagnosed and addressed. This is illustrated in the figure below, together with some of the actions implemented to resolve the performance problems. Some of the major successes of the Global Fund have been with programs that were initially poor performers.

SOME PERFORMANCE ISSUES AND HOW THEY HAVE BEEN ADDRESSED

COUNTRY	DISEASE	PROBLEM AREA	RESOLUTION
ETHIOPIA	Malaria (Round 2)	- Procurement delays and limited commitment among implementers (as noted by the Principal Recipient). Government regulations and supply chain capacity. The underlying issue was commitment which was transformed after the grant was evaluated as poorly performing. Non-achievement of distribution of insecticide-treated bed nets to vulnerable populations.	Program given six months (before the next malaria season) to resolve issues or funding would be stopped. Government resolved procurement issues, received capacity from UNICEF, and now is a leading malaria program.
NIGERIA	HIV/AIDS (Round 1)	- Targets for many services not met - Serious data quality concerns regarding people on ARVs - Country Coordinating Mechanism had serious problems - Many conditions precedent to the grant agreement not fulfilled.	Phase 2 funding reallocated (i.e. grant discontinued). Capacity was improved with partners, and a new grant was signed soon afterwards. The Country Coordinating Mechanism has been reorganized and streamlined to perform its oversight function properly.
	Malaria (Rounds 2, 4)	- Slow procurement, affecting both grants' ability to deliver services - Weak Country Coordinating Mechanism oversight.	After Phase 2 evaluation, grant amounts were reduced and consolidated to improve management and absorption of funds. Management and procurement radically overhauled.
BOLIVIA	Malaria (Round 3)	- Management problems with Principal Recipient and poorly managed tendering processes - Poor results in many service areas.	The Country Coordinating Mechanism was given the opportunity to revise the program, but eventually Phase 2 funding was reallocated (i.e., grant discontinued) as revisions were not deemed sufficient for continued funding.
PAKISTAN	HIV/AIDS, TB (Round 2)	- Poor performance, but potential demonstrated over six months prior to Phase 2 evaluation.	Programs given one year to catch up on targets, and to make corrective actions.
	Malaria (Round 2)	- Very poor performance, procurement problems cited leading to missing service delivery during malaria transmission seasons. - Severe management issues in the Principal Recipient.	Performance was unacceptable, Phase 2 funding reallocated (i.e. grant discontinued). Actions taken and a new grant will be signed this year.
SENEGAL	Malaria (Round 1)	- Poor performance with serious problems with the Country Coordinating Mechanism - Poor monitoring, could not report progress - Had used only 36 percent of its funds.	Phase 2 funding reallocated (i.e., grant discontinued), country reformed Country Coordinating Mechanism and program and signed Round 4 grant for program which has proved successful.
	HIV/AIDS (Round 1)	- Poor performance, same Country Coordinating Mechanism problems but some achievements in ARV provision - Other objectives significantly behind.	Conditions precedent used to improve grant performance for all services and not only the treatment service area.
HONDURAS	HIV/AIDS (Round 1)	- Poor performance in all but one service area of ARV provision, very slow prevention activities. Issues at the level of the Country Coordinating Mechanism.	Conditions precedent used to improve grant performance for all services and not only the treatment service area. Performance is now significantly improved and they have signed to a total of 11 years of funding.
UGANDA	Malaria (Round 2)	- Poor coordination between key agencies involved - Severe delays in procurement of long-lasting insecticide-treated nets - Poor financial management - Unfulfilled conditions precedent.	Phase 2 funding reallocated (i.e., grant discontinued). Malaria control support continued under Round 4 grant.
	TB (Round 2)	- Poor coordination between different agencies involved - Delayed procurement for essential health products - Data quality concerns (TB/HIV activities not reported on).	Phase 2 funding reallocated (i.e. grant discontinued). Round 6 grant subsequently signed.
LAO PDR	HIV/AIDS (Round 1)	- Poor monitoring and poor financial management - Concerns over the quality of reported data - Poor management of sub-recipients.	Strengthening measures implemented with the strong support of partners. Revisions of the grant accepted and performance has now improved.
TIMOR-LESTE	TB (Round 3)	- Poor results, program behind significantly in three of four objectives - Quality of services issues - Inadequate procurement and supply management, weak oversight.	Risks deemed too severe, Phase 2 funding reallocated (i.e. grant discontinued). New grant scheduled to start in 2009.
SIERRA LEONE	Malaria (Round 4)	- Critical management issues in monitoring and sub-recipient oversight - Weaknesses in Country Coordinating Mechanism governance and oversight and donor coordination.	Phase 2 funding reallocated (i.e., grant discontinued), actions taken and new grant scheduled to start in 2009.
LESOTHO	HIV/AIDS (Round 2)	- Low disbursement of funds - Principal Recipient and sub-recipient management capacity issues - Monitoring and evaluation plan not implemented and data quality concerns - Absence of clearly defined procurement strategy.	The government and donors responded with a very strong action plan which has greatly improved the program.

ANNEX 5:
GLOBAL FUND DATA QUALITY CONTROL

Ensuring the quality of programmatic data is critical for performance-based funding to work. Since 2006, the Global Fund has developed and progressively implemented methodologies to strengthen and assess the quality of programmatic data reported by Principal Recipients. These methods include:

Assessment of monitoring and evaluation systems

(i) To identify capacity gaps in data-management systems, and

(ii) To develop a costed action plan that can be financed through the Global Fund grant.

Routine data quality verifications

Data-quality verifications are carried out by Local Fund Agents throughout the grant lifetime. Data quality verifications include:

a. A systematic review of all progress updates submitted by the Principal Recipient;

b. On-site data verification that it is recommended be performed once a year.

The on-site data verifications involve tracing and re-aggregating data from primary records at service delivery points and comparing the re-counted numbers with results contained in the summary reports reaching the national level and reported to the Global Fund.

External data quality audits

These are performed on a sample of Global Fund grants each year. The data quality audit is a very resource-intensive and in-depth exercise carried out by external independent providers with expertise in public health. The data quality audit methodology is based on internationally agreed standards that have been developed in collaboration with major partners, including WHO, the Stop TB Partnership, the Roll Back Malaria Partnership, PEPFAR, United States Agency for International Development (USAID) and MEASURE Evaluation.

This combination of capacity building and data verification is intended to

a. promote monitoring and evaluation systems strengthening, and

b. improve the quality of reported data.

Ultimately, more reliable data will lead to improved program management at the country level and more robust and evidence-based funding decisions by the Global Fund, countries and partners.

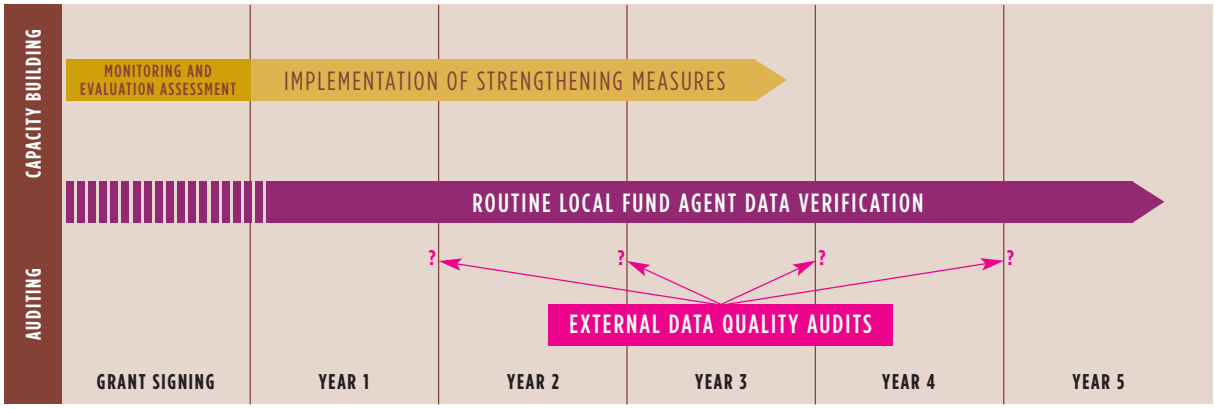
Routine data verifications confirm the overall reliability of results reported to the Global Fund. However, there are significant variations in the quality of reported data by country and disease. The results of Local Fund Agent on-site data verifications carried out in 2006 and 2007 showed that:

a. 151 indicators (58 percent) were within a ten percent error margin;

b. 61 indicators (24 percent) were between a ten percent to 20 percent error margin;

c. 48 indicators (18 percent) were above a 20 percent error margin.

SCHEDULE OF MONITORING AND EVALUATION ASSESSMENTS AND DATA QUALITY VERIFICATIONS



The Local Fund Agents cited the following reasons for poor data quality:

a. lack of unified reporting systems with different data-collection forms, reporting tools and processes for the same indicator;
b. transcription and re-aggregation errors;
c. weak data quality controls and mechanisms;
d. missing data and reports leading to underreporting or estimation of missing information;
e. misunderstanding of indicator definitions at service delivery points.

The Global Fund recommends that five to ten percent of grant funds are spent on strengthening monitoring and evaluation systems. Important priorities for investment in monitoring and evaluation systems include:

(i) **Vital registration systems.** The Global Fund encourages countries to invest in community registration and vital registration systems to capture the basic information (disaggregated by age and sex if cause is not feasible) permitting the tracking of trends over time and an estimation of lives saved by programs.
(ii) **Disease surveillance systems** (and health management information systems). To provide accurate and timely data on people reached by services and basic disease trends
(iii) **Complete survey schedules.** Regular population-based surveys which provide the best estimates of disease burden with the least bias (including demographic and health surveys, malaria surveys and, where relevant, TB prevalence surveys)
(iv) **Country analytical capacity.** The use of data is absolutely central to strengthening and sustaining surveillance and monitoring and evaluation systems. This requires analysts in countries to produce regular surveillance reports.

The Global Fund is undertaking studies to demonstrate value for money of its investments (see section 2.4.5 for discussion on value for money for interventions typically funded by the Global Fund). A series of standardized tools for key indicators are being developed with partners (WHO, UNAIDS, RBM, WHO Stop TB) and will be available for use in 2009 to enable analysis of the effectiveness of Global Fund investments alongside programmatic results.

ANNEX 6

SUMMARY OF EVIDENCE FOR IMPACT ON AIDS, TUBERCULOSIS AND MALARIA FROM GLOBAL FUND-SUPPORTED PROGRAMS

FINANCE[1]	MAJOR PARTNERS	SERVICES	SIGNS OF IMPACT
Zanzibar Malaria: US$ 9.6 million	Ministry of Health (MoH), USAID (PMI), WHO, Italian Cooperation, UNICEF	- Insecticide-treated bed nets distributed (90% household coverage) - Effective ACT rolled out - indoor residual spraying (90% coverage) - Nongovernmental organization household education	- 86% decline in out-patient malaria cases - 75% decline in malaria admission - 52% decline in child mortality - Large decline in treatment demand
Rwanda Malaria: US$ 67.2 million (+HSS: US$ 34 million)	MoH (National Malaria Program), USAID, PEPFAR, Belgium Technical Cooperation, World Bank	- By end 2007, more than 2.4 million insecticide-treated bed nets had been distributed, achieving 60% coverage - National ACT roll-out	- 64% decline in child malaria cases - 66% decline in child malaria deaths
Eritrea Malaria: US$ 13.9 million	MoH, World Bank, USAID	- Insecticide-treated bed nets coverage increased to 60% - Effective treatment with ACTs introduced in 2007 - In 2006, 21,184 mosquito breeding sites were filled/leveled or drained	- 71% decline in malaria deaths - 70% decline in malaria deaths in children under five years old - 91% decline in out-patient malaria cases - 42% decline in in-patient malaria cases
Multi-country Southern Africa Malaria: US$ 28 million	Private Sector, Medical Research Council, Governments of Mozambique, South Africa and Swaziland	- Universal coverage of IRS and ACT in target areas with approximately five million population	- 81% decline in annual total malaria cases notified in South Africa - 68% decline in *falciparum* parasite prevalence
Zambia Malaria: US$ 100.8 million	MoH, Churches Health Association of Zambia, UNICEF, WHO, USAID, JICA	- Availability of ACT - National roll-out of insecticide-treated bed nets	- 12% decline in disease incidence - 90% decline in malaria deaths in some Southern provinces, 2001-2005
Kenya Malaria: US$ 109.5 million	MoH, Population Services International (PSI), Johns Hopkins University (JHPIEGO), Mission for Essential Drugs (MEDS), WHO, UNICEF, USAID	- National roll-out of insecticide-treated bed nets - Availability of ACT	- 61% decline in malaria cases in some health facilities in coastal provinces
Ethiopia Malaria: US$ 133 million	MoH, UNICEF	- National coverage of insecticide-treated bed nets - ACT provision	- 60% decline of in-patient child malaria cases in some districts
Burundi Malaria: US$ 40.5 million	MoH, PSI, World Bank, Médecins Sans Frontières (MSF), UNICEF	- One of first countries to introduce ACTs - Insecticide-treated bed nets coverage	- 39% decline in malaria cases
Nicaragua Malaria: US$ 8.5 million	MoH, NicaSalud, Movimundo	- Insecticide-treated bed net and indoor residual spraying scale-up in high-risk areas	- 83% decline to only one reported malaria death - 55% reduction of malaria cases - 56% reduction in Annual Parasite Index (API)
Malawi HIV: US$ 201.4 million (+HSS: US$ 22.6 million)	MoH, Canadian International Development Agency (CIDA), DFID, Norway, World Bank, Asian Development Bank (ADB), US Centers for Disease Control and Prevention, USAID, UNICEF and others	- By 2007, nearly 100,000 people put on ARVs, from a baseline of 1,600 in 2003; - Nearly 2.4 million youths aged 14 to 24 were reached by behavioral change communication prevention activities	- 32% decline in HIV prevalence among pregnant women aged 15 to 24 years - 17% decline in HIV prevalence among antenatal clinic women aged 20 to 24 years - Declines in adult mortality (age 20-49) in working populations and in Karonga community site
Ethiopia HIV: US$ 606.3 million	PEPFAR, World Bank	- By 2007, nearly 82,000 people put on ARVs, from a baseline of 3,000 in 2003; - Over 1.1 million people received counseling and testing	- 35% decline in unadjusted HIV prevalence among pregnant women aged 15 to 24 years. This may be due to improved measurement as well as changes in the epidemic

FINANCE[1]	MAJOR PARTNERS	SERVICES	SIGNS OF IMPACT
Thailand HIV: US$ 138.8 million	MoH, RAKS Thai Foundation, UNAIDS, WHO, World Bank, UNICEF, UN Population Fund, UN Educational, Scientific and Cultural Organization, International Labour Organization, USAID	- By 2007, over 93,000 people put on ARVs, from a baseline of 10,000 in 2002 - Intensified prevention activities	- 33% decline in HIV prevalence among young adults aged 15 to 24 years - 25% decline in HIV prevalence among female sex workers - 41% decline in HIV prevalence among injecting drug users
Georgia HIV: US$ 18.3 million	Georgia Health and Social Projects Implementation Center, WHO and other international donors	- Intensified prevention activities	- Decline in HIV prevalence among injecting drug users - 16% decline in HIV prevalence among men who have sex with men - 54% decline in HIV prevalence among female sex workers
Dominican Republic HIV: US$ 48.5 million	Consejo Presidencial del Sida (COPRESIDA), World Bank	- Intensified prevention activities - Condom use among youth has increased from 11% in 2001 to 57% in 2007	- 20% decline in HIV prevalence (among 15-49 year-olds) - 50% decline in HIV prevalence (among 15-24 year-olds)
China TB: US$ 127.3 million	MoH, World Bank, DFID, JICA, Damien Foundation of Belgium (DFB)	- Expansion of DOTS-covered provinces - Intensified service coverage for migrants, TB/HIV co-infection, and MDR-TB - Case detection rate increase from 20% to 79% - DOTS treatment success rate increase to 91%	- 38% decline in estimated TB prevalence (1990-2006) - 38% decline in estimated TB mortality (1990-2006) - 15% decline in estimated smear-positive TB incidence (1990-2006)
India TB: US$ 72.7 million	MoH, World Bank, WHO	- Expansion of DOTS-covered states to cover additional population of 120 million - 87% of cases successfully treated	- 47% decline in estimated TB prevalence (1990-2006) - 33% decline in estimated TB mortality (1990-2006)
Indonesia TB: US$ 87 million	MoH and multisectoral response[2]	- System strengthening by improved management - High quality laboratory services - Expansion of quality DOTS - Improvement of patient education and community participation - Strengthening partnerships with NGOs and CBOs	- 42% decline in estimated TB prevalence (1990-2006) - 58% decline in estimated TB mortality (1990-2006)
Philippines TB: US$ 27.8 million	MoH, Philippine Coalition Against TB (PhilCAT), JICA, USAID, Tropical Disease Foundation (TDF), Medicos del Mundo, World Bank, CIDA, GDF, WHO	- Public-private mix DOTS - Rapid increase of case detection rate to 72% in 2006 from 56% in 2002	- 47% decline in estimated TB prevalence (1990-2006) - 43% decline in estimated TB mortality (1990-2006) - 15% decline in estimated smear-positive TB incidence (1990-2006)
Somalia TB: US$ 22.6 million	World Vision, GDF, WHO	- DOTS expansion - Training of service providers - Provision of supplies - Support to TB centers	- 63% decline in estimated TB prevalence (1990-2006) - 64% decline in estimated TB mortality (1990-2006)
Nicaragua TB: US$ 2.8 million	MoH	- DOTS - Active case finding - Expanded laboratory network - Increased human resources for health staff and community	- 62% decline in estimated TB prevalence (1990-2006) - 66% decline in estimated TB mortality (1990-2006) - 59% decline in estimated smear-positive TB incidence (1990-2006)

Notes: 1 Finance refers to Global Fund Board-approved amounts to end 2007. **2** Multisectoral response: WHO, KNCV (Dutch TB Foundation), Management Sciences for Health (MSH), MJM (private sector), Gorgas Hospital DOTS and Linkage project, Netherlands Leprosy Relief, Dutch government, DFID, USAID, Global TB Drug Facility (GDF), ADB, AusAID, JICA.

ACCURATE DATA IS ESSENTIAL TO TRACKING THE SPREAD OF TB. THIS LOCAL CLINIC IN MATARIA, EGYPT, IS PREPARING TO ADOPT ELECTRONIC HEALTH RECORDS AS A MEANS OF IMPROVING THEIR EPIDEMIOLOGICAL INFORMATION.

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