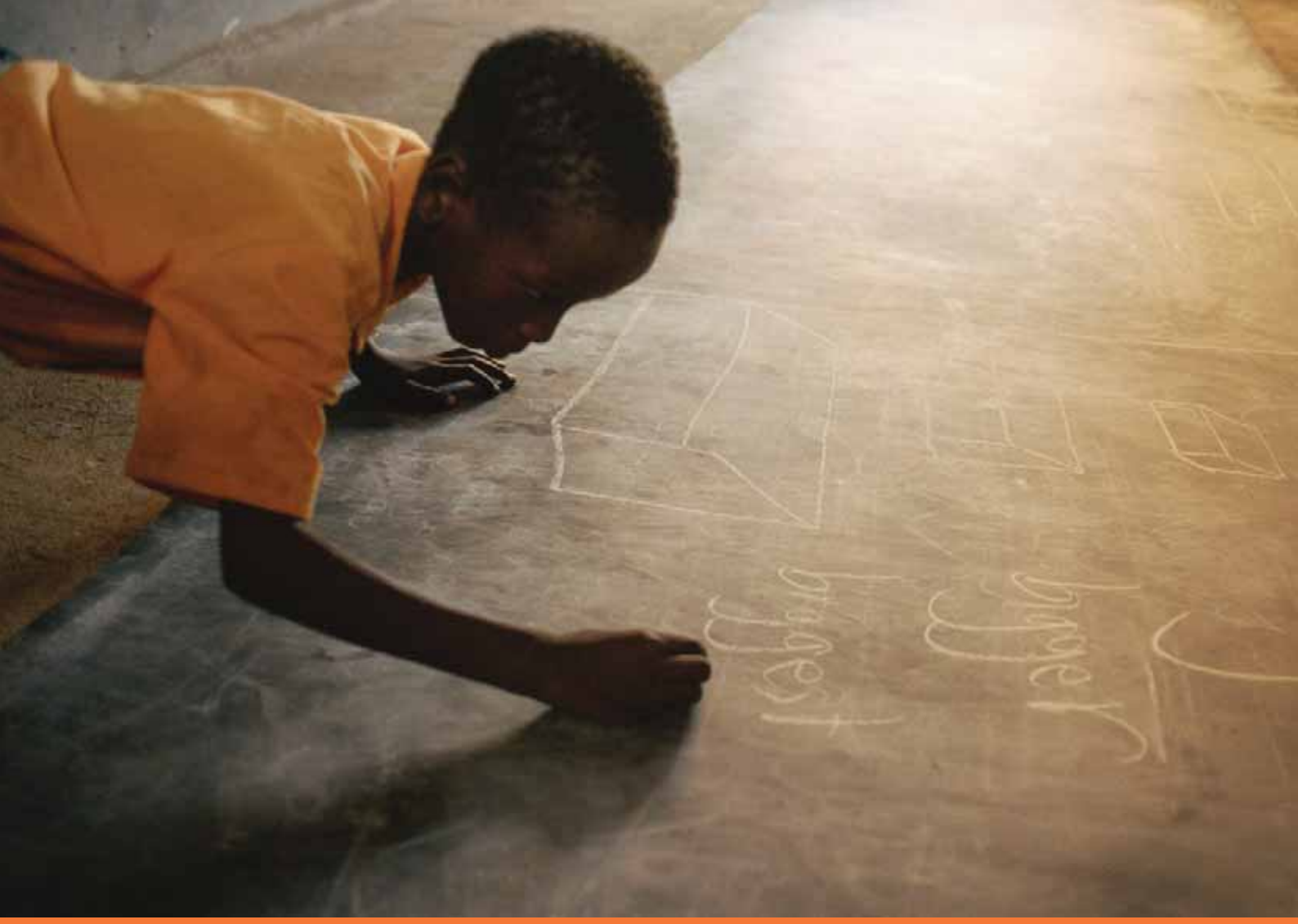

THE GLOBAL FUND 2010
INNOVATION AND IMPACT

GLOBAL FUND-SUPPORTED PROGRAMS SAVED AN ESTIMATED 4.9 MILLION LIVES BY THE END OF 2009

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

The Global Fund 2010: Innovation and Impact **is based on results through the end of 2009. This report was published in March 2010.**

A LAB ASSISTANT IN DELHI CATALOGUES SPUTUM SAMPLES BEFORE THEY ARE TESTED. GLOBAL FUND SUPPORT IS INCREASING THE NUMBER OF SMEAR-POSITIVE TB CASES DETECTED AND TREATED IN INDIA – THE COUNTRY WITH THE HIGHEST NUMBER OF TB PATIENTS.

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LIST OF TERMS AND ABBREVIATIONS

ACT	artemisinin-based combination therapy
AIDS	acquired immunodeficiency syndrome
AMFm	Affordable Medicines Facility – malaria
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CCM	Country Coordinating Mechanism
DOTS	the basic package that underpins the Stop TB strategy
FBO	faith-based organization
HIV	human immunodeficiency virus
IQR	interquartile range
ITN	insecticide-treated net
LLIN	long-lasting insecticide-treated net
M&E	monitoring and evaluation
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PMTCT	prevention of mother-to-child transmission (*of HIV*)
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organization

A TRADITIONAL BIRTH ATTENDANT COMFORTS A WOMAN PREPARING TO HAVE HER FIRST CHILD IN A CLINIC IN SIERRA LEONE. GLOBAL FUND SUPPORT IS CONTRIBUTING TO NATIONAL EFFORTS TO REDUCE MALARIA MORBIDITY AND MORTALITY IN PREGNANT WOMEN AND CHILDREN UNDER FIVE.

EXECUTIVE SUMMARY

THE GLOBAL FUND: PREVENTING DISEASES, PROVIDING CARE AND SUPPORT, AND SAVING LIVES

1. **Every day, programs supported by the Global Fund save at least 3,600 lives, prevent thousands of new infections and alleviate untold suffering.**

2. The Global Fund to Fight AIDS, Tuberculosis and Malaria is **a public-private partnership** established in 2002 to mobilize and intensify the international response to three global epidemics and thereby help achieve the Millennium Development Goals (MDGs). From its founding through December 2009, **the Global Fund Board approved proposals totaling US$ 19.2 billion, and disbursed US$ 10 billion for HIV, tuberculosis (TB) and malaria control efforts**. To maximize impact, every dollar donated goes to fund programs in country. The Global Fund has no country offices, and its operating expenses are almost entirely covered by the interest earned on the Trustee account at the World Bank.

3. The results and impact outlined in this report are **the achievements of all the partners that collaborate as part of the Global Fund model**. The success of the Global Fund relies on the financial pledges of donors, the technical guidance of – and collaboration with – multilateral partners, and particularly the management and implementation of programs by in-country partners including governments, civil society organizations and the private sector.

4. ***HIV***. At the end of December 2009, **programs financed by the Global Fund were providing antiretroviral therapy (ART) to 2.5 million people**. Approved HIV proposals have totaled close to US$ 10.8 billion covering 140 countries. The Global Fund is estimated to have contributed about one-fifth of all disbursements by bi- and multilaterals for the HIV response in low- and middle-income countries in 2008. In addition to providing ART, programs funded by the Global Fund have also distributed 1.8 billion male and female condoms and have provided 790,000 HIV-positive pregnant women with treatment to prevent mother-to-child transmission of HIV, as well as 4.5 million basic care and support services to orphans and other children made vulnerable by AIDS, and 105 million HIV counseling and testing sessions. There is a growing body of evidence showing that Global Fund financing – alongside that of other financiers – has resulted in declines in AIDS mortality in countries in which provision of ART has been scaled up rapidly, accompanied by other significant impacts, such as improved survival and productivity of key professionals and other workers, and systemwide improvements in health care delivery.

5. ***Tuberculosis***. Through 2009, programs funded by the **Global Fund have provided treatment to 6 million people who had active TB**. The Global Fund provides 63 percent of the external financing for TB and multi-drug-resistant TB (MDR-TB) control efforts in low- and middle-income countries. Approved TB proposals have totaled close to US$ 3.2 billion covering 112 countries, contributing 48 percent of the projected coverage required to achieve the Stop TB Partnership targets for the detection and treatment of new smear-positive TB cases. TB programs supported by the Global Fund have also provided 1.8 million TB/HIV services. **In many countries in which the Global Fund supports programs, TB prevalence is declining, as are TB mortality rates**.

6. ***Malaria***. By the end of 2009, **Global Fund-supported programs had distributed 104 million insecticide-treated nets (ITNs) to prevent malaria**. They also supported indoor residual spraying of insecticides in dwellings more than 19 million times and treated 108 million cases of malaria in accordance with national treatment guidelines. **Approved malaria proposals have totaled US$ 5.3 billion covering 83 countries**. In 2008, the Global Fund contributed 57 percent of international disbursements for malaria control. Global Fund investments have played a critical role in introducing and expanding coverage of novel, effective malaria treatments in many countries where drug resistance to older treatments is high. In conjunction with re-energized national and international efforts to combat malaria, **increased Global Fund financing is having a substantial impact on malaria morbidity and mortality worldwide, with an increasing number of countries reporting a reduction in malaria deaths of more than 50 percent**.

7. **The Global Fund supports community-based interventions**. Since 2003, these efforts have delivered 138 million community outreach prevention services for at least one of the three diseases and provided 11.3 million "person-episodes" of training for health and community workers.

8. **These combined efforts saved an estimated 4.9 million lives** by December 2009 and restored hope for the 33 million people living with HIV, the hundreds of millions of people who contract malaria or who are at risk each year, and the 9.4 million who contract active TB annually. The coming years will see even more results, as half of the total disbursements by the Global Fund were delivered in 2008 and 2009. Much of the US$ 5.4 billion of financing approved in Rounds 8 and 9 will reach countries in 2010 and 2011, and will continue to significantly boost health outcomes.

HAVING A WIDER IMPACT: STRENGTHENING HEALTH SYSTEMS AND CONTRIBUTING TO PROGRESS ON THE MILLENNIUM DEVELOPMENT GOALS

9. The Global Fund investments to combat HIV, TB and malaria are having a much wider impact – beyond individuals, their families and communities. **They are major investments in health systems** – bolstering infrastructure, strengthening laboratories, expanding human resources, augmenting skills and competencies of health workers, and developing and supporting monitoring and evaluation (M&E) activities. These enhancements, in turn, improve the sustainability of services, increase national capacity to expand programs further and increase countries' ability to improve services for other health issues. Ultimately, the investments translate into a healthier population and increased productivity, enabling countries to further their development.

10. **These investments have helped accelerate progress towards the MDGs** by contributing directly to MDGs 4, 5, 6 and 8, and indirectly to the others. The US$ 19.2 billion of approved investment by the Global Fund is a direct contribution to MDG 6 ("Combat HIV/AIDS and malaria and other diseases"). In addition, major contributions have also been made to MDG 4 (on child mortality) and MDG 5 (on maternal mortality) by reducing the largest causes of mortality among women and children. This is particularly the case in sub-Saharan Africa, where HIV, TB and malaria are responsible for 52 percent of deaths among women of childbearing age and malaria alone accounts for 16 to 18 percent of child deaths.

ACHIEVING RESULTS AND PROMOTING EQUITY

11. The Global Fund's innovative financing model was designed to respond quickly and effectively to the tremendous need for funding in the countries with the heaviest burdens of AIDS, TB and malaria, while ensuring **transparency and broad accountability to donors and recipients**. This model has continued to evolve, and in 2009 it tested new ways to strengthen country ownership and governance, increase access to lifesaving medicines and other health products, and promote health equity.

12. **Equitable access to services is fundamental to the mission of the Global Fund**. In making grants, great weight is assigned to each country's needs, as measured by indicators such as disease burden and poverty level. The Global Fund also works to ensure that the programs it finances address the needs of the poorest, at-risk and marginalized groups, for instance with its **new strategies on gender equality and sexual minorities**. Further, it has become the world's leading funder of harm reduction services for people who inject drugs, with substantial investments in 42 countries.

13. Between 2005 and 2009, nearly four out of five assessed grants were performing well. Currently, TB grants are the best performers and civil society organizations the best performing Principal Recipients.

CONTINUING TO LEARN, IMPROVE EFFECTIVENESS AND INNOVATE

14. The Global Fund always seeks to **learn, improve and innovate** through its operations, partnerships and evaluations. One key opportunity for learning comes from the engagement of different constituencies in Global Fund governance – governments, civil society, the private sector, affected communities and bilateral and multilateral agencies.

15. **The Global Fund actively contributes to global efforts to improve aid effectiveness**, especially in the area of managing for results, by playing a leading role in monitoring effectiveness and sharing experiences with performance-based funding.

16. Within the Global Fund, the Board, the Board committees, the Executive Management Team, the Technical Evaluation Reference Group and the Office of the Inspector General help identify key areas of the organization's programs and business model in need of evaluation or improvement. **The continuous attention to evaluation and learning helps the Global Fund maximize its responsiveness, effectiveness and cost-effectiveness**.

17. **Ensuring value for money at every stage of the financing chain is a critical priority for the Global Fund**. One of the focus areas is to develop and promote, with partners, standardized methods for countries to measure the efficiency and effectiveness of key HIV, TB and malaria services. The comprehensive performance review which occurs by year two of each grant also contributes to value for money by allowing for the reallocation of funds from poorly performing grants to better-performing grants as well as for the identification of efficiency gains. In 2009 alone, nearly US$ 1 billion was freed up for funding new grants. Voluntary pooled procurement is reducing the cost and improving the quality of pharmaceuticals and health products, and collaboration with technical partners is assessing the efficiency of service delivery models in order to expand and optimize access to life-saving interventions.

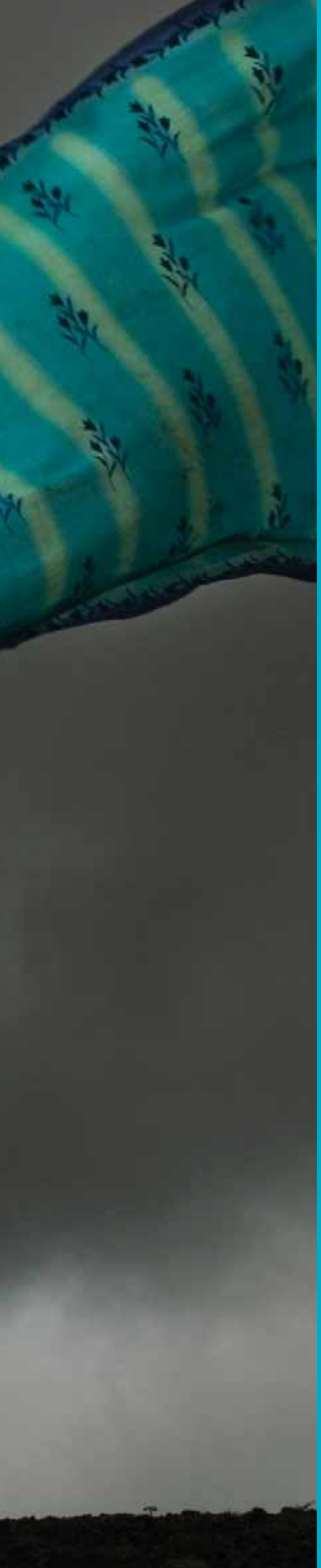
18. **Through its portfolio of grants in 144 countries, the Global Fund has developed and is strengthening data analysis of unit costs for HIV, TB and malaria services**. This analysis will institute savings, reveal best practices and waste, and assist in assessing resource-need estimates in future grant applications.

MAINTAINING THE POSITIVE MOMENTUM FOR ACHIEVING RESULTS AND IMPACT

19. The Global Fund is realizing the extraordinary vision of its founders, donors and implementers: it has dramatically intensified the fight against HIV, TB and malaria while contributing to improving health systems and to progress on achieving the MDGs. Virtual elimination of mother-to-child HIV transmission globally by 2015 can be achieved. Massive scale-up of HIV prevention programs and of provision of ART continues, though universal access to comprehensive and evidence-based HIV prevention, treatment, care and support remains distant. Prevalence of TB has significantly decreased over the last decade and the international target of halving TB prevalence could be met by 2015. Unprecedented coverage with ITNs and effective novel treatments have made great inroads in combating malaria. The rapid scale-up of prevention, treatment, care and support for these three pandemics has meant hope and – as the results in this report testify – a positive impact on millions of lives.

20. Such unprecedented progress would not have been possible without the support of donors and partner organizations. In the coming years, continued, substantial increases in long-term financial commitments by donors will be needed to consolidate these gains and to reach the MDGs by 2015 and universal coverage of HIV, TB and malaria services. 2010 is a year that should inspire extraordinary commitments from the public and private sectors to safeguard and build upon the already substantial achievements made over the past decade.

GLOBAL FUND ASSISTANCE IN INDIA INCLUDES INCREASING THE NUMBER OF FACILITIES PROVIDING TREATMENT FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV.



1. INTRODUCTION

"The Global Fund was established to make a difference by tackling head-on three of the diseases that condemn vast numbers of people to ill health, discrimination and other human rights abuses, poverty and preventable early death. This is the inspiring and noble vision that unites us in our work at the Global Fund."

— MICHEL KAZATCHKINE
EXECUTIVE DIRECTOR
THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

HOPE, INNOVATION, RESULTS AND IMPACT – AROUND THE WORLD

1. The substantial increase in resources dedicated to health through overseas development assistance and other sources during the past years has begun to change the trajectory of AIDS, tuberculosis (TB) and malaria, and more broadly, of the major health problems that low- and middle-income countries have been confronted with. The results and emerging signs of impact presented in this report paint a hopeful and encouraging picture.

2. Ten years ago, virtually no one living with AIDS in low- and middle-income countries was receiving lifesaving antiretroviral therapy (ART), although it had been available since 1996 in high-income countries. At the end of 2008, over 4 million people had gained access to AIDS treatment, representing over 40 percent of those in need. AIDS mortality has since decreased in many high-burden countries. For example, in Ethiopia's capital, Addis Ababa, the rollout of ART has led to a decline of about 50 percent in adult AIDS deaths over a period of five years.

3. Malaria used to be a neglected disease. Today, at least ten of the most endemic countries in Africa have reported declines in new malaria cases and an impressive decline in child mortality of 50 to 80 percent.

4. Prevalence of TB was 220 per 100,000 in 2000. Today, the world is on track to meet the international target of halving TB prevalence by 2015. TB is being diagnosed much more effectively and 6 million additional people have gained access to DOTS (the basic package that underpins the Stop TB strategy) with the support of the Global Fund.

5. Much more remains to be done, but significant reductions in mortality and suffering, as well as in the economic and social toll these pandemics have inflicted on families and societies, have been achieved.

6. The world has an extraordinary opportunity to come close, reach or even exceed the health-related Millennium Development Goals (MDGs) – the eight goals that every United Nations member state agreed to pursue in 2000 (see Box 1.1). Many of the international targets with regard to MDG 6 (Combat HIV/AIDS and malaria and other diseases) could be met, significant progress could be made on MDGs 4 and 5 (reducing child mortality and improving maternal health), and the other MDGs could also be positively impacted.

BOX 1.1 THE MILLENNIUM DEVELOPMENT GOALS

GOAL 1 Eradicate extreme poverty and hunger

GOAL 2 Achieve universal primary education

GOAL 3 Promote gender equality and empower women

GOAL 4 Reduce child mortality

GOAL 5 Improve maternal health

GOAL 6 Combat HIV/AIDS, malaria and other diseases

GOAL 7 Ensure environmental sustainability

GOAL 8 Develop a global partnership for development

Source: Reference 1.

7. If the momentum of the last decade is maintained and countries continue to scale up programs at the current rate, malaria could be eliminated as a public health problem in most endemic countries and indeed there would be hope for a world without malaria deaths by 2015. Millions more HIV infections may be prevented and lives otherwise lost to AIDS saved. The growing threat of multidrug-resistant TB (MDR-TB) may be contained. And it might be possible to virtually eliminate transmission of HIV from mothers to their children. In the process, health systems would be further strengthened so they can take on the many other health-related challenges low- and middle-income countries face.

8. It is rare in the field of international development to see such rapid correlation between investment and desired results and impact as has been the case in the past years' efforts to fight the three pandemics. Increased international investments have, with great speed and efficiency, been turned into health services on the ground, benefitting hundreds of millions of people. Despite a lack of facilities, hundreds of thousands of health workers around the world have used new resources to save millions of lives.

9. The efforts to provide ART for HIV or effective treatment for TB and malaria to people in poor and often inaccessible areas, to provide insecticide-treated nets (ITNs) to millions of families and to undertake other efforts to prevent the spread of the three diseases are significant far beyond the health benefits they provide. They have been uniting the world around a common agenda and humanitarian purpose.

A GRANDMOTHER PLAYS WITH HER GRANDSON. SHE HAS BEEN LOOKING AFTER HIM SINCE HER DAUGHTER MOVED ABROAD TO FIND WORK. IN MOLDOVA THE GLOBAL FUND SUPPORTS TB PREVENTION FOR MOBILE POPULATIONS.

THE GLOBAL FUND AND ITS RESULTS AND IMPACT

10. 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 the achievement by 2015 of the health-related MDGs. 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.

11. At its creation, the Global Fund was designed drawing 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 impact against the three diseases.

12. One of the key principles that guide all of its work (see Box 1.2) is the principle of "performance-based funding". From its application process 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.

13. **Chapter 2, "Results and Progress on International Targets"**, summarizes the results of programs supported by the Global Fund, globally and in the regions in which it funds programs, and highlights the challenges that remain. The chapter – like the report in general – summarizes the results achieved by December 2009, drawing on analysis that uses the Global Fund's evaluation framework on operational and grant performance, system effects and evidence of impact. Chapter 2 also addresses the extent to which the Global Fund contributes to the international effort to respond to HIV, TB and malaria, showing that soon after its founding, the Global Fund became the world's leading multilateral investor in HIV, TB and malaria efforts. It now provides 63 percent of all external financing for TB, 57 percent of external funding for malaria, and about one-fifth of all HIV funding from donor countries. The chapter then discusses how Global Fund investments to combat HIV, TB and malaria have wider impact by strengthening health systems and contributing directly to MDGs 4, 5, 6 and 8, and indirectly to the other MDGs; it examines some of the results of the Global Fund's performance-based funding model; and it describes a variety of approaches the Global Fund employs to achieve greater equity in access to health services, and to improve health outcomes where inequities persist.

14. The Global Fund closely tracks the results flowing from its direct investments in 144 countries – but also the results and signs of impact of the national programs it supports. The results and impact presented in Chapter 2 of the report do not in any way claim to represent a full picture of progress in health over the past few years. However, they demonstrate the changes and improvements global health investments are achieving.

15. The Global Fund is a partnership in the fullest sense. Its success relies on the financial pledges of donors, the technical guidance of – and collaboration with – multilateral partners, and particularly the management and implementation of programs by in-country partners including governments, civil society organizations and the private sector. Whenever "the Global Fund" is mentioned in this report, this should therefore be read as including the collective efforts of all partners who together provide resources and turn them into services on the ground. **All partners should take full credit for their role in making these services possible**.

16. **Chapter 3, "Improving Effectiveness"** shows how the scale and nature of its work as a global financial institution have enabled the Global Fund to position itself as a key partner of other agencies working towards effective investment in health and development. The Global Fund is a signatory of the Paris Declaration on Aid Effectiveness, and works in close collaboration with countries and partner agencies to promote the Declaration's principles of ownership, harmonization, alignment, managing for results and mutual accountability. The chapter describes a number of initiatives taken by the Global Fund in 2009 to improve aid effectiveness and to increase value for money at every stage of the financing chain, including by instituting systems to increase value for money by cost-benefit analyses of the Global Fund's investments in key interventions.

17. **Chapter 4, "Learning and Innovating"**, shows how the Global Fund, taking advantage of the rich experiences and lessons learned through its investments in every part of the world, constantly learns, evolves, undertakes new initiatives and innovates, ensuring that it can respond quickly to demand and to the changing health and development challenges. The chapter summarizes how the Global Fund is responding to the results of the Five-Year Evaluation that were reported to the Global Fund's Board in 2009. It then describes some of the initiatives and innovations the Global Fund has undertaken since it was established, with a focus on initiatives that started or were approved in 2009, including the move to a new grant architecture that will establish a single stream of funding per Principal Recipient per disease.

THE WAY FORWARD

18. **Chapter 5, "Conclusions"**, highlights that the results and impact described in this report should be cause for optimism – but points out that the progress made in the last years is fragile. A reduction – or even stagnation – of efforts would lead to reversals of recent progress. Continued, increased investments in health generally and in HIV, TB and malaria specifically are more important now, at a time of economic and financial crisis, than ever. The financial crisis has hit low- and middle-income countries disproportionately, and they struggle to maintain their investments in health. Continued investments are needed not only to reach or exceed the health-related MDGs, but will also help to preserve global stability and protect countries and communities at risk of disease.

19. This report should inspire hope, but first and foremost it should inspire every sector of society – public and private – and every individual to make a commitment to continue scaling up the response to HIV, TB and malaria, to safeguard and continue building upon the substantial achievements already made.

BOX 1.2
THE GLOBAL FUND PRINCIPLES

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA WAS FOUNDED ON A SET OF PRINCIPLES THAT GUIDES ALL OF ITS WORK, FROM GOVERNANCE TO GRANT-MAKING:

- Operate as a financial instrument, not as an implementing entity.
- Make available and leverage additional financial resources.
- Support programs that evolve from national plans and priorities.
- Operate in a balanced manner in terms of different regions, diseases and interventions.
- Pursue an integrated and balanced approach to prevention and treatment.
- Evaluate proposals through independent review processes.
- Operate with transparency and accountability.

Source: Reference 2.

A MALARIA OUTREACH WORKER REMINDS PEOPLE TO SLEEP UNDER AN INSECTICIDE-TREATED NET AND TO SEEK MEDICAL ASSISTANCE IF THEY HAVE A FEVER. SHE WORKS WITH COTTON PICKERS IN A RURAL AREA OF TAJIKISTAN WHERE MALARIA WAS ONCE ENDEMIC BUT IS CLOSE TO BEING ELIMINATED.

DISEASE PREYS ON PEOPLE LIVING ON POOR DIETS IN CRAMPED CONDITIONS AND IN PERU THE GLOBAL FUND PROVIDES LOANS FOR INCOME-GENERATING PROJECTS. THE SMALL INCOME ENCOURAGES ADHERENCE TO TREATMENT AND ALLOWS PATIENTS TO IMPROVE THE WAY THEY EAT SO THAT THEY RECOVER FASTER.

2. RESULTS AND PROGRESS ON INTERNATIONAL TARGETS

"Before, we used to say this many people died of malaria. Now we say, this many people got sick from malaria but received treatment and got better."

— SEGUNDO TESTA RUIZ
VOLUNTEER HEALTH WORKER
PERU

BOX 2.1 HOW CREDIBLE IS GLOBAL FUND GRANT DATA?

The Global Fund's performance-based funding decisions are based on a transparent assessment of programmatic data against timebound targets. The assessment relies on a country's M&E capacity and data reporting, which Local Fund Agents regularly verify. The Global Fund encourages programs to spend 5 to 10 percent of their funding on M&E, health information systems and analytical capacities.

To ensure quality data, a number of initiatives have been developed to assess grant M&E systems and data quality, including:

- Periodic, systematic assessment of national M&E systems. The results of the assessment should enhance the national M&E system.
- On-site data verifications, required for every grant at least once a year. The objective is to assess the quality of programmatic data submitted to the Global Fund Secretariat.
- Data quality audits, conducted on selected grants annually. The data quality audit tool assesses the ability of M&E systems to collect and report quality data and verifies the accuracy and reporting performance for key indicators.
- Data harmonization exercises with international partners (such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), and PEPFAR.

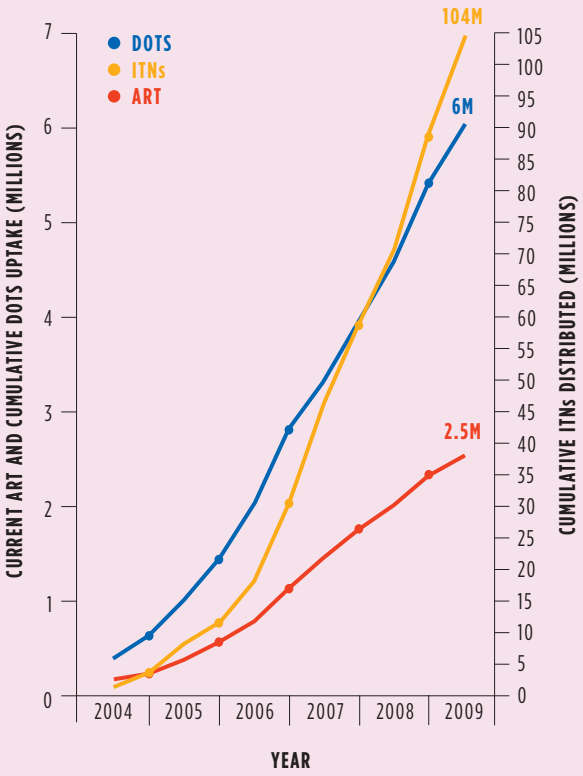
According to the analysis of 90 on-site data verification reports, data quality was strong in 52 percent of grants (47), average in 31 percent of grants (28), and poor in 17 percent of grants (15).

Working with partners, the Global Fund is currently developing an overall strategy for data quality and information use. The strategy calls for identifying existing and potential data quality issues as well as the root causes of these issues. It will also provide strategic direction on a number of issues, including data quality improvement approaches.

Information systems are further scrutinized during the investigations of the Office of the Inspector General, which operates independently of the Global Fund Secretariat and reports directly to the Board. The mission of the Inspector General is to provide the Global Fund with independent and objective assurance of the design and effectiveness of controls in place to manage key risks, such as data quality, impacting programs and operations.

FIGURE 2.1 GLOBAL FUND-SUPPORTED PROGRAMS, (2004–2009): CUMULATIVE YEAR-END RESULTS FOR THE TOP THREE INDICATORS FOR HIV, TB AND MALARIA

(THE NUMBER OF PEOPLE CURRENTLY ON ART, UNDER DOTS AND NUMBER OF ITNs DISTRIBUTED)



Note: Results reported in a year do not necessarily correspond to actual services provided during that year, since grant reporting cycles do not always follow calendar years. Global Fund results may include service and commodity deliverables co-financed by others.

Source: Global Fund, grant data, 2009 www.theglobalfund.org.

TABLE 2.1 GLOBAL FUND-SUPPORTED PROGRAM INTERVENTIONS FOR 2009 AND WORLD TOTALS FOR 2008

	PEOPLE ON ART	NEW SMEAR-POSITIVE TB CASES DETECTED	ITNs DISTRIBUTED
GLOBAL FUND RESULTS, 2009	2.5 MILLION (CURRENTLY ON THERAPY)	6 MILLION (CUMULATIVE) 1.4 MILLION (REPORTED IN 2009)	104 MILLION (CUMULATIVE, ALL REGIONS) 22.5 MILLION (REPORTED IN 2009, SUB-SAHARAN AFRICA)
TOTAL, 2008	4.03 MILLION (1)	2.7 MILLION (3)	38.1 MILLION (2) (SUB-SAHARAN AFRICA)
COVERAGE, 2008	42% (1)	61% (3)	35% (2) (SUB-SAHARAN AFRICA)

Note: New smear-positive TB cases (reported in 2009) and ITNs (reported in 2009) are the difference between the cumulative results reported as of the end of 2008 and 2009, and do not necessarily correspond to actual services provided during 2009, since grant reporting cycles do not always follow calendar years. Global Fund results may include service and commodity deliverables that are co-financed by others.
The latest results and coverage estimates for low- and middle-income countries are for 2008. The total for 2008 includes both Global Fund and non-Global Fund results. "Coverage" is the total in low- and middle-income countries against the estimated need in those countries.

1. The Global Fund financed its first four grants at the end of 2002. Since then, millions of people have begun ART for HIV, and millions have been treated in DOTS programs for TB or protected against malaria with ITNs as a result of programs funded by the Global Fund. **The impact of the initial investments is becoming increasingly visible. It includes substantial reductions in the global disease burden of HIV, TB and malaria, improved health system capacity in low- and middle-income countries, and progress toward international health and disease targets** – most notably the MDGs. The coming years will see even more positive results and greater impact, given the recent intensification of efforts: large amounts of funding were approved in Rounds 8 and 9 and will start reaching countries in 2010 and 2011, further enhancing the achievements made to date.

2. The results and impact outlined in this chapter are **the achievements of all the partners that collaborate as part of the Global Fund model**. The success of the Global Fund relies on the financial contributions of donors, the technical guidance of – and collaboration with – multilateral partners, and particularly the management and implementation of programs by in-country partners including governments, civil society organizations and the private sector.

3. The first sections (2.1 and 2.2) of this chapter present the results from Global Fund-supported programs globally and in the various regions of the world. Section 2.3 provides more details about the Global Fund's contribution to international efforts to finance disease control and about how the funds raised are spent. Section 2.4 reviews the contribution of Global Fund investments to progress on the MDGs and other international targets. Section 2.5 then assesses the impact of the Global Fund's performance-based funding model. Section 2.6 examines how effective programs have been in promoting equity in access to health services and in health outcomes and Section 2.7 sets out some of the many challenges ahead.

2.1 KEY GLOBAL RESULTS OF GLOBAL FUND-SUPPORTED PROGRAMS

4. The Global Fund disbursed a cumulative total of US$ 5.7 billion for HIV programs, US$ 1.5 billion for TB programs and US$ 2.8 billion for malaria programs by the end of 2009. These resources, together with those provided by key partners such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and other donors, have made a major contribution to efforts to achieve universal access to prevention, treatment and care services in the coming years. The year 2009 saw continued impressive increases in service delivery (Figure 2.1) as well as an increased contribution of Global Fund-supported programs towards international targets for HIV, TB and malaria (Table 2.1 and Figure 2.5).

5. Following the approval of Round 9 proposals in November 2009, nearly all countries eligible for funding under the Global Fund's eligibility criteria had at least one proposal approved.

6. At the end of 2009, **2.5 million people in these programs were receiving ART** – an increase of 500,000 from the end of 2008. If results were added from Algeria, South Africa, Thailand and Ukraine (countries that are excluded or partially excluded because they have since assumed financial responsibility for covering ART), the total number of people receiving ART through Global Fund-supported programs would be 2.8 million. A total of 4.03 million people in low- and middle-income countries were receiving ART funded by all sources by the end of 2008, representing 42 percent of the estimated 9.5 million people in need of treatment (1).

7. By the end of 2009, **6 million new smear-positive TB cases had been detected and put on treatment through DOTS** programs – an increase of more than 1.4 million from December 2008.

8. **Financing from the Global Fund enabled countries to distribute 104 million ITNs**. In 2009 alone, programs supported by the Global Fund distributed 34 million nets – 48 percent more than the previous year. Of these, 22.5 million nets were distributed in sub-Saharan Africa, where in 2008 a total of 38.1 million bed nets had been distributed by all sources (2).

9. Through these three interventions, **Global Fund-supported programs had saved an estimated 4.9 million lives by late 2009**.[1] In addition, **countless numbers of lives have been saved and suffering alleviated or avoided through the rapid scale-up of a range of other services** for HIV, TB and malaria that Global Fund-supported programs provide.

10. In line with its operating principles (see Box 1.2), **the Global Fund supports programs that "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. From 2004, when the Global Fund began measuring results of the programs it supports, to the end of 2009, the following results were achieved:

- ***Prevention of mother-to-child transmission (PMTCT) of HIV*. 790,000 HIV-positive pregnant women received a complete course of antiretroviral (ARV) prophylaxis to prevent mother-to-child transmission**. This has helped increase coverage of PMTCT to 45 percent (range: 37–57) (1). In 2009 alone, 340,000 pregnant women in low- and middle-income countries received PMTCT treatment through Global Fund grants. This represents a substantial increase over previous years, and corresponds to more than half of the total number of 630,000 HIV-positive pregnant women in these countries who received PMTCT treatment from all donor-supported programs in 2008 (1).
- ***Behavior change communication interventions***. More than 138 million outreach activities were undertaken, such as behavior change communication interventions targeting at-risk populations for HIV, TB and malaria. This does not include mass media messages or printed materials.
- ***Condom distribution***. 1.8 billion male (and female) condoms were distributed.
- ***HIV counseling and testing*. Global Fund-supported programs provided 105 million HIV counseling and testing sessions** in various settings including antenatal clinics, freestanding centers, youth-friendly reproductive health clinics, TB wards in hospitals, and clinics for sexually transmitted infections (STIs). Since 2007, the number of sessions delivered has more than tripled from 33.5 million to 105 million in 2009.
- ***Services for orphans and other vulnerable children***. 4.5 million basic care and support services were provided to orphans and other vulnerable children through Global Fund-financed programs – 1.3 million in 2009 alone.
- ***TB detection and treatment*. 1.8 million HIV/TB services were provided, including TB screening among people living with HIV, and treatment for preventing other infectious diseases**. This represents a 150 percent increase since the end of 2008. Programs also enrolled nearly 30,000 people on MDR-TB treatment through the end of 2009, an increase of 85 percent from the cumulative number of enrollments to the end of 2008. A recent increased focus on MDR-TB, including in Round 9 approvals, is likely to further increase treatment enrollments in the future.
- ***Malaria treatment and prevention*. Malaria programs supported by the Global Fund achieved tremendous progress in 2009**. By the end of the year – in addition to distributing 104 million ITNs – programs provided indoor residual spraying of insecticides more than 19 million times and treated 108 million cases of malaria (an increase of 43 percent since the end of 2008) according to national treatment guidelines, increasingly using highly effective artemisinin-based combination therapies (ACTs).
- ***Health and community worker training***. The Global Fund also provided significant support to training programs aimed at building the skills and capacity of the health work force to ensure effective delivery of services for the prevention and treatment of HIV, TB and malaria. It supported 11.3 million "person-episodes" of training[2] to health and community workers – 4.3 million in HIV programs, 4.6 million in TB programs and 2.4 million in malaria programs. In 2009 alone, 2.7 million "person-episodes" were supported.

1 For a description of the analyses used to calculate lives saved, see Partners in Impact - Results Report 2007, The Global Fund, www.theglobalfund.org/en/publications/progressreports/.
2 "Person-episodes of training" is a cumulative figure that multiplies the number of persons attending a training program by the number of training programs.

2.2 KEY RESULTS BY REGION

"In Zambia the community burden of malaria has declined... we have seen a reduction in the people who are coming to seek medication. This has given us a chance to intensify health promotion services."

– IGNICIOUS BULONGO
HEALTH OFFICER, MOMBA HEALTH CENTRE
ZAMBIA

11. **The Global Fund is making a major difference and achieving substantial results in each of the regions in which it funds programs: sub-Saharan Africa, Asia, Latin America, the Middle East and North Africa, and Eastern Europe and Central Asia**. This section highlights some of the results achieved in each of these regions (Tables 2.2 and 2.3). The results for the Global Fund's three sub-Saharan Africa regions (East Africa, Southern Africa, and West and Central Africa) are presented together as the sub-Saharan Africa region, and results for the two Asian regions (South and West Asia and East Asia and Pacific) are presented together as the Asia region (for a list of countries in each region, see Annex 2).

2.2.1 SUB-SAHARAN AFRICA

12. The 47 countries in East Africa, Southern Africa, and West and Central Africa (the sub-Saharan Africa region) have a total population of 818 million, with 50 percent living on less than US$ 1.25 a day (4). The Global Fund has invested in 41 countries and territories in this region (see Annex 2), and the greatest overall investment has been in this region – where the greatest need exists. **The Global Fund is the region's single largest multilateral financing mechanism for the health sector**.

13. Between 2002 and December 2009, **the Board of the Global Fund approved US$ 10.9 billion for the sub-Saharan Africa region** (See Table 2.6). Of this total, the Global Fund had disbursed US$ 5.5 billion by the end of 2009 (See Table 2.4). In 2009 alone, US$ 1.5 billion was disbursed for the three diseases (See Table 2.5), a 23 percent increase over 2008 disbursements.

14. **Programs supported by the Global Fund currently provide 1.9 million people with ART**. From 2002 to 2009, the Global Fund-supported programs in the region treated 1.4 million people with new smear-positive cases of TB and distributed 72 million ITNs. **Services are being scaled up rapidly**: from 2008 to 2009, the cumulative number of people treated for MDR-TB, while remaining low, increased by 376 percent, the cumulative number of TB/HIV services delivered increased by 199 percent, and the cumulative number of community outreach prevention services provided to people in the region increased by 90 percent.

15. ***HIV***. In the region, HIV has had a tremendously negative impact on most core health indicators, including adult and child mortality, life expectancy, morbidity, outpatient visits and inpatient care. In many countries, PEPFAR and the Global Fund contribute the majority of international HIV funding. In some countries, such as Malawi, where it accounts for 87 percent of the donor pool for HIV funding, the Global Fund finances most of the national ART program. Global Fund resources have been central to the development and implementation of the extensive treatment and prevention programs needed to respond to the epidemics in countries such as Congo (Democratic Republic), Ethiopia, Kenya, Nigeria, Tanzania and Uganda, and to responses to the epidemics in the highest-prevalence countries of southern Africa: Angola, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. Investments made have facilitated remarkable national scale-ups over the last four years.

TABLE 2.2 2009 RESULTS ATTRIBUTABLE TO GLOBAL FUND-SUPPORTED PROGRAMS, BY REGION

	REGIONS					
SERVICES	EAST AFRICA, SOUTHERN AFRICA, WEST AND CENTRAL AFRICA	SOUTH AND WEST ASIA, EAST ASIA AND PACIFIC	LATIN AMERICA AND CARIBBEAN	NORTH AFRICA AND MIDDLE EAST	EASTERN EUROPE AND CENTRAL ASIA	TOTAL
ADDITIONAL NUMBER OF PEOPLE ON ART REPORTED IN 2009	699,500	151,500	11,400	6000	22,400	**890,800**
SESSIONS OF HIV COUNSELING AND TESTING PROVIDED	12,350,000	13,190,000	4,620,000	301,000	13,780,000	**44,241,000**
HIV-POSITIVE PREGNANT WOMEN RECEIVING ARV PROPHYLAXIS FOR PMTCT	295,300	32,940	3,100	3,000	10,300	**344,640**
BASIC CARE AND SUPPORT SERVICES PROVIDED TO ORPHANS AND VULNERABLE CHILDREN	1,300,000	56,800	9,200	8,100	3,500	**1,377,600**
CONDOMS DISTRIBUTED	325,600,000	63,900,000	156,100,000	23,900,000	49,800,000	**619,300,000**
CASES OF STIs TREATED	727,000	215,900	969,000	444,000	56,700	**2,412,600**
TB/HIV SERVICES PROVIDED	964,900	58,100	13,300	2,800	64,600	**1,103,700**
NEW SMEAR-POSITIVE TB CASES DETECTED AND TREATED	269,000	969,000	35,400	57,300	66,200	**1,396,900**
PEOPLE TREATED FOR MDR-TB	4,590	1,150	1,600	150	6,240	**13,730**
NETS DISTRIBUTED (ITNs AND LLINs)	22,530,000	6,782,000	235,000	4,460,000	24,000	**34,031,000**
CASES OF MALARIA TREATED	29,547,000	1,465,000	75,000	2,218,000	340	**33,305,340**
INDOOR RESIDUAL SPRAYING SERVICES	4,480,000	334,100	14,300	270,000	142,000	**5,240,400**
COMMUNITY OUTREACH PREVENTION SERVICES (BEHAVIOR CHANGE COMMUNICATION)	20,910,000	13,560,000	3,920,000	3,540,000	6,060,000	**47,990,000**
CARE AND SUPPORT SERVICES PROVIDED	1,621,000	115,000	302,000	12,000	102,000	**2,152,000**
"PERSON-EPISODES" OF TRAINING FOR HEALTH OR COMMUNITY WORKERS	557,000	2,018,000	82,800	40,300	67,400	**2,765,500**

Sources: Grant Performance Reports www.theglobalfund.org; The incremental results are the differences between 2008 reporting and 2009 reporting; for further information on ARV numbers, www.theglobalfund.org/documents/publications/factsheets/ARV_Factsheet_2009.pdf.

Note: Figures are rounded. Results reported in a year do not necessarily correspond to actual services provided during that year, since grant reporting cycles do not always follow calendar years. Global Fund results may include service and commodity deliverables co-financed by others. "Additional Number of People on ART Reported in 2009" in this table includes results from countries that have since assumed financial responsibility for covering ART. See also paragraph 6, Section 2.1.

TABLE 2.3 CUMULATIVE RESULTS ATTRIBUTABLE TO GLOBAL FUND-SUPPORTED PROGRAMS, BY REGION (2002–2009)

	REGIONS					
SERVICES	EAST AFRICA, SOUTHERN AFRICA, WEST AND CENTRAL AFRICA	SOUTH AND WEST ASIA, EAST ASIA AND PACIFIC	LATIN AMERICA AND CARIBBEAN	NORTH AFRICA AND MIDDLE EAST	EASTERN EUROPE AND CENTRAL ASIA	TOTAL
PEOPLE CURRENTLY ON ART (2009)	1,930,600	383,300	76,000	35,400	74,800	**2,500,100**
SESSIONS OF HIV COUNSELING AND TESTING PROVIDED	40,284,000	29,100,000	10,000,000	629,000	25,700,000	**105,713,000**
HIV-POSITIVE PREGNANT WOMEN RECEIVING ARV PROPHYLAXIS FOR PMTCT	674,100	65,660	15,000	6,900	28,500	**790,160**
BASIC CARE AND SUPPORT SERVICES PROVIDED TO ORPHANS AND VULNERABLE CHILDREN	4,230,000	248,700	13,800	37,400	20,400	**4,550,300**
CONDOMS DISTRIBUTED	1,057,200,000	238,940,000	356,600,000	62,050,000	125,000,000	**1,839,790,000**
CASES OF STIs TREATED	1,680,000	1,297,000	2,430,000	1,216,000	177,000	**6,800,000**
TB/HIV SERVICES PROVIDED	1,450,000	218,400	29,100	3,900	132,400	**1,833,800**
NEW SMEAR-POSITIVE TB CASES DETECTED AND TREATED	1,401,000	4,061,000	152,000	178,000	201,000	**5,993,000**
PEOPLE TREATED FOR MDR-TB	5,800	3,100	10,700	300	9,900	**29,800**
NETS DISTRIBUTED (ITNs AND LLINs)	72,465,000	21,745,000	1,200,000	8,789,000	139,000	**104,338,000**
CASES OF MALARIA TREATED	90,000,000	8,460,000	344,000	9,030,000	9,300	**107,843,300**
INDOOR RESIDUAL SPRAYING SERVICES	17,180,000	1,086,000	122,000	567,000	432,000	**19,387,000**
COMMUNITY OUTREACH PREVENTION SERVICES (BEHAVIOR CHANGE COMMUNICATION)	44,000,000	46,200,000	21,100,000	9,300,000	18,200,000	**138,800,000**
CARE AND SUPPORT SERVICES PROVIDED	5,030,000	1,446,700	963,000	55,600	389,100	**7,884,400**
"PERSON-EPISODES" OF TRAINING FOR HEALTH OR COMMUNITY WORKERS	3,234,000	6,501,000	1,130,000	162,400	320,500	**11,347,900**

Sources: Grant Performance Reports www.theglobalfund.org; for further information on ARV numbers, www.theglobalfund.org/documents/publications/factsheets/ARV_Factsheet_2009.pdf.

Note: Figures are rounded. Results reported in a year do not necessarily correspond to actual services provided during that year, since grant reporting cycles do not always follow calendar years. Global Fund results may include service and commodity deliverables co-financed by others.

TABLE 2.4 CUMULATIVE GLOBAL FUND DISBURSEMENTS BY REGION AND DISEASE (2002–2009)

DISBURSEMENT TO DATE (END 2009)	HIV (IN US$ MILLIONS)	TB (IN US$ MILLIONS)	MALARIA (IN US$ MILLIONS)	TOTAL DISBURSEMENT BY REGION
SUB-SAHARAN AFRICA	3,104	375	1,976	5,455
ASIA	1,093	582	491	2,166
LATIN AMERICA AND CARIBBEAN	603	129	90	822
MIDDLE EAST AND NORTH AFRICA	258	120	214	592
EASTERN EUROPE AND CENTRAL ASIA	669	245	20	934
TOTAL	5,727	1,451	2,791	9,969

Source: The Global Fund. www.theglobalfund.org.

TABLE 2.5 2009 GLOBAL FUND DISBURSEMENTS BY REGION AND DISEASE

DISBURSEMENT IN 2009	HIV (IN US$ MILLIONS)	TB (IN US$ MILLIONS)	MALARIA (IN US$ MILLIONS)	TOTAL DISBURSEMENT BY REGION
SUB-SAHARAN AFRICA	663	71	775	1,509
ASIA	346	183	155	684
LATIN AMERICA AND CARIBBEAN	136	26	23	185
MIDDLE EAST AND NORTH AFRICA	70	35	57	162
EASTERN EUROPE AND CENTRAL ASIA	136	72	7	215
TOTAL	1,351	387	1,017	2,755

Source: The Global Fund. www.theglobalfund.org.

TABLE 2.6 APPROVED FUNDING AND DISBURSEMENT BY ROUND AND DISEASE (AS OF DECEMBER 2009)

	APPROVED FUNDING (IN US$ MILLION)	DISBURSEMENT TOTAL (IN US$ MILLION)	PERCENTAGE DISBURSED VS. PLANNED (IN 2009)[1]
ROUND 1	1,695	1,374	97%
ROUND 2	2,794	1,724	74%
ROUND 3	1,708	1,328	112%
ROUND 4	3,238	2,174	76%
ROUND 5	1,711	1,120	119%
ROUND 6	1,604	827	93%
ROUND 7	1,111	607	75%
ROUND 8	2,742	815	113%
ROUND 9[2]	2,630	–	–
HIV	10,778	5,727	84%
TB	3,160	1,451	90%
MALARIA	5,295	2,791	116%
TOTAL	19,233	9,969	95%

Source: The Global Fund. www.theglobalfund.org.

Notes: 1 Numerators and denominators are not shown in the table; 2 Includes National Strategy Applications (see Section 4.4)

16. ***TB***. The Global Fund has quickly become the largest international donor of TB programs in the region. **From 2008 to 2009, approved funding for TB increased substantially**, reflecting an increased demand by countries for assistance in controlling TB. The Global Fund has also played a key role in the donor community by highlighting the emerging epidemics of TB/HIV co-infection and MDR-TB, and the TB funding gap.

17. ***Malaria*. Global Fund grants account for 60 percent of all international funding for malaria in sub-Saharan Africa**. In the last seven years, these grants enabled the provision of 72 million long-lasting insecticide-treated nets (LLINs) and 90 million courses of malaria treatment in the region. In collaboration with partner agencies, the Global Fund is now helping fund the largest distribution campaign for long-lasting nets in the history of malaria control. The goal is to achieve the WHO-recommended target of 80 percent coverage for ITNs by the end of 2010. The effort is concentrated in Nigeria and Congo (Democratic Republic), which together bear 36 percent of the malaria burden in Africa. The Global Fund has signed grant agreements with Nigeria that will enable the distribution of 30 million nets by the end of 2010. In Congo (Democratic Republic), in a challenging environment, the Global Fund is financing the distribution of 9.4 million nets in the same time period.

18. ***Health systems strengthening***. As Global Fund financing in Africa – and the need for it – has grown dramatically over the last years, **many countries have requested increased funding to strengthen their health systems**. Following the approval of health system strengthening grants for Ethiopia, Malawi, Rwanda and Swaziland in earlier rounds, the Global Fund has more recently signed such health system strengthening grants with Lesotho, Mozambique, Nigeria and Zimbabwe in Round 8. These grants not only enhance national responses to the three diseases, but also address systemic weaknesses in health worker training and retention, laboratory services, M&E and procurement systems, as well as addressing critical needs for capital infrastructure.

2.2.2 ASIA

19. The Global Fund's East Asia and Pacific region consists of 24 countries (see Annex 2) with a total population of 1.9 billion, of which 18 percent live on less than US$ 1.25 a day; while the Global Fund's South and West Asia region consists of nine countries (see Annex 2) with a total population of 1.4 billion, of which 40 percent live on less than US$ 1.25 a day (4).[3] Results for the two regions are presented together here.

20. Some of the countries in Asia have experienced the world's fastest-growing economic advances in recent times but many countries are still very poor. Regional investment in health as a percentage of gross domestic product is lower for Asia than for any other region in the world. Global Fund investments provide the economic backbone of public health efforts to address HIV, TB and malaria, three of the most prevalent communicable diseases in the adult population. Between 2002 and December 2009, **the total budget of approved proposals in the 33 countries of the East Asia and Pacific and South and West Asia regions amounted to US$ 4.5 billion**. Of this amount, US$ 2.2 billion has been disbursed.

21. ***HIV*. Global Fund-supported programs are providing treatment to two-thirds of the 570,000 people on ART in the East Asia and Pacific and South and West Asia regions**. In some countries, the Global Fund finances nearly all HIV treatment services. Coverage remains low, however, with nearly 1 million additional people estimated to require ART (1).

22. HIV prevention efforts undertaken in recent years have had a greater focus on the people most vulnerable to infection in the region: sex workers, men who have sex with men, and people who inject drugs. Overall, the coverage of prevention services remains low, but the Global Fund is providing increased funding for prevention efforts. For example, it has become the single largest supporter of efforts targeting sex workers in countries in Asia, with the exception of India. In Lao (People's Democratic Republic), one program targeting sex workers has achieved a coverage level of 80 percent. The Global Fund also supports a large number of the harm reduction services for people who inject drugs. In China and the Philippines, among other countries, large numbers of men who have sex with men are being reached by prevention services financed by the Global Fund. Coverage of services for men who have sex with men will increase in the coming years, thanks to a regional proposal for prevention efforts among men who have sex with men that was approved in 2009 and will cover South and West Asian countries.

3 The 33 countries included in this region are classified by the World Bank into two regions (East Asia and the Pacific and South Asia); however, the World Bank regions are not identical to the Global Fund regions of the same names.

23. ***TB***. The Asia region accounts for 11 of the 22 countries with a high TB burden worldwide, with India, China and Indonesia reporting the highest number of new smear-positive TB cases. Ten of these 11 countries have made good progress toward achieving the Stop TB Partnership targets for case detection. The region has seen significant progress in achieving the MDG 6 target of halting and reversing the TB epidemic.

24. Since the first Global Fund grants were awarded in the region, steep increases in TB case detection and cure rates have been observed. Global Fund-supported programs have treated a cumulative total of 4 million smear-positive TB cases.

25. ***Malaria***. Between 2003 and the end of 2009, Global Fund-supported programs distributed 21.7 million ITNs in the region – an increase of 45 percent over the number distributed by the end of 2008. As a result of this and other interventions, the incidence of both probable and confirmed cases of malaria declined sharply, with substantial declines in malaria morbidity and mortality (see section 2.4.4 for more details on one country: Bhutan).

2.2.3 LATIN AMERICA AND CARIBBEAN

26. The Latin America and Caribbean region consists of 33 countries with a total population of 559 million. Approximately 25 percent of the population lives on less than US$ 2 a day (5). Between 2002 and December 2009, the Global Fund approved proposals in all 33 countries (see Annex 2), with a total budget of US$ 1.4 billion, of which US$ 822 million had been disbursed by the end of 2009.

27. ***HIV***. Latin America and Caribbean is the region with the highest HIV treatment coverage, thanks in large part to Brazil, which has been providing ART to people in need for many years. As of December 2008, 445,000 (54 percent) of the 820,000 people in the region estimated to need ART were receiving it (1). Global Fund investments are helping countries in the region to provide ART to 76,000 people.

28. The Global Fund has also fostered close collaboration between governments and civil society organizations, especially those working with most-at-risk populations. Sixty-one percent of the total committed amount of funds in this region has been allocated to grants in which the Principal Recipients were civil society organizations.

29. ***TB*** is a major public health threat in many Latin American and Caribbean countries. **Thanks to programs supported by the Global Fund, 152,000 people in the region have been treated for TB**. Peru has the largest TB program in the region, with one of the world's greatest number of clients requiring MDR-TB and second-line treatment. By December 2009, the Global Fund had supported treatment of more than 10,000 people for MDR-TB.

30. In Bolivia, which has the third-highest incidence rate of TB in the region, about 70 percent of the Bolivian farmers whose mother tongue is not Spanish live in extreme poverty, which makes them especially vulnerable to TB. Their socioeconomic status, coupled with cultural and language barriers, often hinders their access to health services. **The Global Fund TB grant in Bolivia targets indigenous peoples** and, by the end of 2009, treatment had been provided to 3,500 people newly detected as smear-positive for TB.

31. ***Malaria*. Programs supported by the Global Fund distributed more than 1.2 million ITNs in the region**. Country partners in Guatemala – one of the countries with the highest incidence rates of malaria in Central America – distributed 419,465 ITNs and provided universal access to malaria treatment in 552 Guatemalan communities.

32. Malaria is also endemic in Guyana. As of December 2009, 41,000 nets had been distributed with Global Fund support in the country, covering an estimated 74,324 people.

2.2.4 MIDDLE EAST AND NORTH AFRICA

33. The 21 countries of Middle East and North Africa have a total population of 313 million, with 16.9 percent living on less than US$ 2 a day (6). The Global Fund's Middle East and North Africa region, which comprises 16 of these 21 countries and territories (see Annex 2), represents a broad range of cultural and human development profiles. Three countries in the region – Chad, Mali and Niger – are among the ten lowest-ranking countries on the Human Development Index (7).

34. Despite conflict and turmoil in countries such as Chad, Somalia and Sudan, the Global Fund has successfully engaged national stakeholders and development partners in countries throughout the region to fight HIV, TB and malaria.

35. Between 2002 and 2009, the Global Fund approved proposals with a total budget of US$ 1 billion, of which US$ 591 million had been disbursed by the end of 2009. For some national control efforts, the Global Fund provides most of the financial resources (e.g. for TB in most countries and for malaria in some of the countries in the Sahel), while in countries such as Morocco, Tunisia and Algeria the Global Fund has leveraged funds from other sources.

36. Some countries in the region – including Algeria, Jordan, Morocco, Syria and Tunisia – have fairly well-developed health systems, but others suffer from poor health infrastructure and capacity, exacerbated in some cases by conflict and state failure. In almost all the countries, people living with HIV, women, men who have sex with men and members of other vulnerable groups must contend with high levels of stigmatization and discrimination.

37. ***HIV***. The Global Fund has provided critical support to the response to HIV in the region and helped break the silence about HIV and AIDS. Nevertheless, much remains to be done to achieve universal access targets and reduce stigma and discrimination. Through the end of 2009, Global Fund-supported programs distributed 62 million condoms (an increase of 24 million from the end of 2008), delivered close to 9.3 million community outreach services for HIV, enabled more than 35,000 people to start ART, and provided 162,000 "person-episodes" of training to health and community workers.

38. Since the first grant in the region was awarded to Morocco in Round 1, Global Fund support has enabled the Moroccan National AIDS Control Program to create a positive shift in public attitudes and commitment towards HIV and most at-risk groups, including people who inject drugs and sex workers. The first grant included a treatment component, providing access to ART for 1,200 people living with HIV, and a prevention component including condom distribution and voluntary counseling and testing. A Round 6 grant has since enabled scale-up of ART coverage, with almost 2,500 patients and 120 HIV-positive pregnant women receiving treatment in Phase 1 of the grant. The second phase of this grant provides additional funding to a pioneering Moroccan harm reduction program – funded entirely by the Global Fund – which has mobilized people who inject drugs and supports opioid substitution therapy and injecting kits for 400 people who inject drugs as part of a pilot project undertaken from 2009 to 2012.

39. ***TB***. Global Fund support in the region has contributed to, among other things, the detection and treatment of nearly 178,000 new-smear positive TB cases, and treatment of about 3,900 people for TB/HIV co-infection. Decreases in both TB prevalence and mortality have been observed (see Section 2.4.3 for some country examples).

40. ***Malaria***. Malaria is endemic in countries such as Chad, Djibouti, Mali, Mauritania, Niger and Sudan, where it is the leading cause of maternal and child mortality. To date, Global Fund-supported programs have been able to treat 9 million malaria cases, distribute 8.8 million LLINs and carry out indoor residual spraying in nearly 600,000 locations in the region – despite the fact that some of the countries in which the Global Fund operates are fragile countries. For example, **Niger – a country heavily burdened by malaria – has substantially increased ITN coverage to approximately 50 percent of all children under five and pregnant women**. Building on this success, the authorities are now seeking to ensure that, by the end of 2012, 80 percent of all children under five and pregnant women sleep under LLINs. The Global Fund is supporting these efforts with a Round 7 grant to fund the provision of an additional 3.5 million nets.

41. Finally, regional efforts by the Global Fund and national and international partners have supported the emergence and strengthening of new social forums, civil society organizations and advocacy groups that have all contributed to the development of social capital throughout the region. One example is the Global Fund's collaboration with an important network of civil society organizations in Mali involved in providing treatment, care and support to people living with and affected by HIV. National nongovernmental organizations (NGOs) are contributing to this work across Mali with funding from the Global Fund and other partners.

2.2.5 EASTERN EUROPE AND CENTRAL ASIA

42. The 30 countries in the Eastern Europe and Central Asia region have a total population of 441 million, of whom 30 percent are considered either poor or vulnerable (8). By December 2009, the Global Fund had approved proposals in 23 countries and territories (see Annex 2), with a total budget of US$ 1.4 billion and disbursements of US$ 0.9 billion by the end of 2009. Global Fund-supported programs have made an important contribution and delivered vital prevention, treatment, care and support services for the three diseases.

43. ***HIV***. According to the latest WHO data, 85,000 (23 percent) of the 370,000 people estimated to need ART were receiving it as of December 2008. While access remains low, it has significantly expanded across the region in recent years, with **programs supported by the Global Fund providing treatment to over 74,000 people as of the end of 2009**. In high-burden countries such as the Russian Federation and Ukraine, Global Fund financing complements the domestic resources for HIV treatment. In countries in Central Asia, 3,400 people are receiving ART, compared to almost none in 2003.

44. Voluntary testing and counseling services have greatly expanded in recent years. By the end of 2009, Global Fund-supported programs had provided more than 25 million HIV counseling and testing sessions, more than double the cumulative number at the end of 2008. Community-based prevention work has also intensified.

45. By providing the majority of funding for harm reduction in Eastern Europe and Central Asia, **the Global Fund has played a central role in expanding access to, and improving the quality of, services for people who inject drugs**. In Ukraine, prevention services have reached over 250,000 people who inject drugs. In the Russian Federation, the Russian Harm Reduction Network is leading the implementation of a program that focuses on providing harm reduction services to people who inject drugs. From Ukraine, Moldova and the Russian Federation to Romania, Serbia and Armenia, civil society organizations representing those most affected by HIV are working in partnership with governments to implement successful interventions and sometimes manage grants as Principal Recipients.

46. Across the region, the Global Fund has been instrumental in initiating and scaling up opioid substitution therapy. In Ukraine, where the first such program opened in 2004, more than 5,000 people who inject drugs were enrolled in methadone and buprenorphine substitution therapy programs at the end of 2009 – the vast majority in programs supported by the Global Fund. In Moldova and Kyrgyzstan, the Global Fund supports needle and syringe programs and opioid substitution therapy programs operating both in the community and in prisons. However, the quantity and quality of services still varies considerably across the region. The Russian Federation, Turkmenistan and Armenia still have no substitution therapy programs in place, while Uzbekistan recently discontinued this evidence-based intervention.

47. ***TB***. Global Fund-supported TB programs in the region have demonstrated many positive results, contributing to the detection and treatment of more than 200,000 new TB cases between 2003 and 2009 – almost half of them in 2009 alone. In addition, **TB investments have supported upgrades in laboratory networks, improved supplies of consumables and first- and second-line drugs, enhanced surveillance, trained practitioners and strengthened health systems**.

48. At the end of 2009, almost 10,000 patients had received treatment for MDR-TB, which remains a major health challenge in the region. With Global Fund support, over 5,500 patients in the Russian Federation have been enrolled in DOTS-Plus treatment. Coverage remains low. According to estimates by WHO, nearly 85,000 new cases of MDR-TB occurred in Eastern Europe and Central Asia in 2007 (3). Fifteen of the 27 high-burden MDR-TB countries in the world are in this region, which continues to report the highest proportions of drug-resistant TB globally. The expansion of high-quality diagnostic and treatment services in the region is still facing challenges such as insufficient political will and resources, weak laboratory capacities, the vertical organization of TB control programs, limited involvement of key health care providers and, in some places, inadequately trained human resources.

49. ***Malaria*. Global Fund support has greatly increased the prospects for eliminating malaria as a public health problem in the region**. Since 2004, support from the Global Fund and its partners has enabled Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan to initiate aggressive interventions targeting the disease, including the distribution of more than 139,000 ITNs. With continuing support, these countries anticipate eliminating malaria within the next few years.

2.3 CONTRIBUTION TO INTERNATIONAL EFFORTS AND BREAKDOWN OF EXPENDITURES

"I work hard to give other children a chance to be HIV-negative, like my own child."

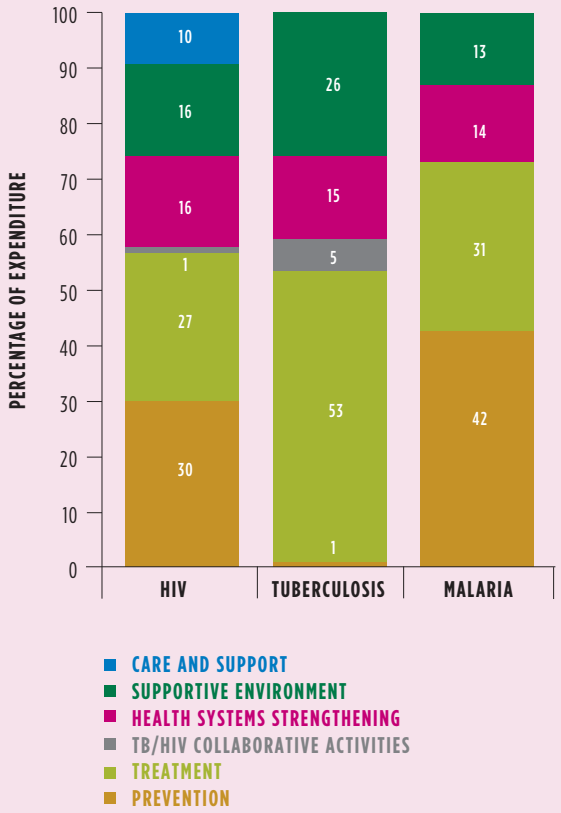
—NHI, VOLUNTEER COUNSELOR
AT A CENTER FOR HIV-POSITIVE PREGNANT WOMEN
VIET NAM

50. To enable it to fund the programs and achieve the results described in the first two sections of this chapter, **by the end of 2009, the Global Fund had raised US$ 21 billion**.

51. ***Increasing finance and disbursement speed***. Following the approval of Round 9 proposals in November 2009, **the Global Fund was supporting programs in 144 countries and had approved proposals totaling US$ 19.2 billion: close to US$ 10.8 billion for HIV programs, US$ 3.2 billion for TB programs and US$ 5.3 billion for malaria programs**.

52. The Global Fund has shown that it can disburse in a responsive, efficient and predictable manner. Typically, money is disbursed incrementally based on program performance.[4] (See Annex 2 for more details.) As of the end of 2009, the Global Fund had disbursed US$ 10 billion: US$ 5.7 billion for HIV programs, US$ 1.5 billion for TB programs and US$ 2.8 billion for malaria programs. Table 2.6 provides a detailed breakdown of funding and disbursements by funding round. The disbursement rate is measured by comparing the amount of funding disbursed to that planned in grants. In 2009, the disbursement rate was 90 percent, with all rounds having a disbursement rate of nearly 90 percent or greater than 90 percent. Disbursement rates in 2009 vary by country, depending on the speed at which countries can absorb funds. Only 40 percent of active grants have a disbursement rate of less than 75 percent. In these cases, implementers are provided with appropriate technical support to improve the disbursement rate.

FIGURE 2.2 ALLOCATION OF CUMULATIVE EXPENDITURE BY SERVICE DELIVERY AREA FOR THREE DISEASES
(THROUGH 2008 EXPENDITURE REPORTING CYCLE)



Source: Global Fund, unpublished Enhanced Financial Reporting data, 2008.

53. ***Contribution to international financing of diseases***. According to a recent estimate, the Global Fund contributed about one-fifth of all disbursements by bi- and multilaterals for the HIV response in low- and middle-income countries in 2008 (9). According to other estimates, it contributed 63 percent of external financing for TB control in these countries in 2009 (10) and 57 percent of international disbursements for malaria control in 2008 (11) – making **the Global Fund by far the major source of international funding in the areas of TB and malaria**.

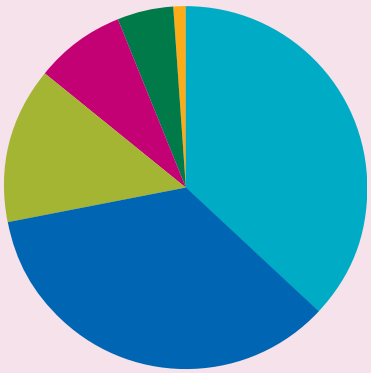
4 The Principal Recipient regularly reports on the progress to date and requests a disbursement for the next period of implementation. The Local Fund Agent reviews the Principal Recipient's programmatic and financial reports, verifies reported data, evaluates performance and makes recommendations to the Global Fund on future disbursements. On receipt of the Local Fund Agent-verified Progress Update/Disbursement Request, the Secretariat evaluates the overall performance of the grant and gives it a performance rating, which is then linked to disbursement.

FIGURE 2.3 CUMULATIVE EXPENDITURE FOR THE THREE DISEASES BY COST CATEGORY
(THROUGH 2008 EXPENDITURE REPORTING CYCLE)

MEDICINES **21%**
HEALTH PRODUCTS AND HEALTH EQUIPMENT **18%**
HUMAN RESOURCES **13%**
PROGRAM MANAGEMENT **12%**
TRAINING **11%**
INFRASTRUCTURE **10%**
OTHER **11%**
M&E **4%**

Source: Global Fund, unpublished Enhanced Financial Reporting data, 2008.

FIGURE 2.4 CUMULATIVE EXPENDITURES BY IMPLEMENTING ENTITY
(THROUGH 2008 EXPENDITURE REPORTING CYCLE)



MINISTRY OF HEALTH **37%**
FBO/NGO/CBO/ACADEMIC INSTITUTION **35%**
OTHER GOVERNMENT BODY **14%**
UNDP **8%**
OTHER MULTILATERAL ORGANIZATION **5%**
PRIVATE SECTOR **1%**

Source: Global Fund, unpublished Enhanced Financial Reporting data, 2008.

54. ***Balance of investments*. One principle of the Global Fund is a balance in its investments – balance among regions, among the three diseases it targets, and among prevention, treatment and care**. In the 2008 reporting cycle, the new Enhanced Financial Reporting system on cumulative expenditures of US$ 5.1 billion for 426 active grants showed that 61 percent of cumulative expenditures went to HIV programs, 15 percent to TB programs and 24 percent to malaria programs. **Of the amount allocated to HIV:**

- **30 percent was spent on prevention**;
- **27 percent on treatment**;
- **16 percent on health system strengthening** (including community systems strengthening, information system and operational research, infrastructure, human resources, procurement and supply management, and M&E);
- **16 percent on activities aimed at creating an enabling environment** (including policy development, civil society strengthening, stigma reduction efforts, and management and administration); and
- a smaller percentage on other activities, including care and support.

Of the amount allocated to TB, 53 percent was spent on detection and treatment, the cornerstones of TB control.

Of the amount allocated to malaria, 42 percent was spent on prevention, covering mostly ITN distribution, indoor residual spraying, and community outreach (see Figure 2.2 for a more detailed breakdown).

55. A breakdown of expenditures by cost category for the three diseases (Figure 2.3) reveals that 21 percent was spent on medicines and pharmaceutical products, 18 percent on health products and equipment, 13 percent on human resources for health (including salaries, wages and recruitment costs), 12 percent on program management (planning and administration, overheads, technical assistance and procurement and supply management), 11 percent on training of the health work force (workshops, meetings, training publications and training-related travel), 10 percent on health infrastructure, 4 percent on M&E, and the rest on other cost categories.

56. Thirty-five percent of the funds were disbursed to civil society organizations (4 percent to faith-based organizations (FBOs)), 37 percent to ministries of health, 14 percent to other ministries, and 8 percent to the United Nations Development Programme (UNDP) (Figure 2.4).

2.4 THE GLOBAL FUND'S CONTRIBUTION TO PROGRESS ON THE MILLENNIUM DEVELOPMENT GOALS AND OTHER INTERNATIONAL TARGETS

"Without the Global Fund, there is no chance that we could have started MDR-TB treatment... I worked in TB in the hard times, I would not want to be doing anything else now that we are in far better times."

—TARIEL ENDELADZE
HEAD OF STATE TB HOSPITAL
ABASTUMANI, GEORGIA

57. **Programs supported by the Global Fund have made an increasingly significant contribution to the international targets for key services** such as provision of ART, treatment under DOTS and ITNs (See Box 2.2 and Figure 2.5).

58. The international target for malaria as set by the Global Strategic Plan 2005–2015 (12) is to provide ITNs to 80 percent of the populations most at risk for contracting malaria by 2010. The contribution of programs supported by the Global Fund towards reaching this target in sub-Saharan Africa has increased dramatically in recent years, from 5 percent in 2005 to 58 percent at the end of 2009.

59. Similarly, in 2009, programs supported by the Global Fund contributed 48 percent towards international targets set by the Stop TB partnership for the detection of TB cases and treatment through DOTS, compared to 26 percent in 2005.

60. Programs supported by the Global Fund also contributed 26 percent towards international targets for the provision of ART in 2009, compared to 13 percent in 2005 and 31 percent in 2008. Although the number of people accessing ART thanks to Global Fund-supported programs is continuing to increase substantially in absolute numbers, these programs' share of the international target has recently decreased slightly.

BOX 2.2 CALCULATING GLOBAL FUND CONTRIBUTIONS TO KEY INTERNATIONAL TARGETS

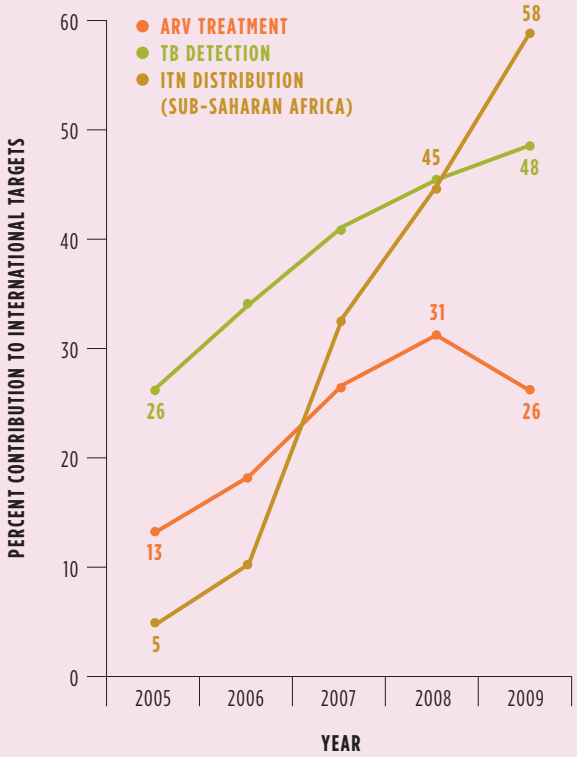
The MDGs are the most prominent global development aims. Covering a wide spectrum of issues and focusing mainly on impact measurements, specialized international agencies and partnerships have set targets for more detailed indicators to better monitor the progress in achieving the MDGs. For each of the three diseases, the Global Fund has selected one such service indicator and compared program results to projected global results.

The first indicator – people currently receiving ART – was formulated by WHO and UNAIDS in 2002. Projected global results to achieve universal access (13) were employed in this report for comparison with actual results.

The second indicator is the number of new smear-positive TB cases detected and treated. The Stop TB Partnership has provided approximate results required for the next decade (14). The projected global results were then cumulated from mid-2004 in order to be comparable to targets and results for Global Fund-supported programs.

For malaria, the number of ITNs distributed was compared to the 80 percent coverage target of people at high risk (children under the age of five and pregnant women), as set by the Global Strategic Plan 2005–2015 of the Roll Back Malaria partnership (12). In 2007, WHO recommended providing ITNs to all age groups and not only to children under the age of five and pregnant women. Most of the results reported as of the end of 2009 are from Rounds 1 to 7, prior to this recommendation. Consequently, it was assumed that ITNs distributed are targeting mainly children under the age of five and pregnant women. Future estimates will take into account the 2007 guidelines.

FIGURE 2.5 CONTRIBUTIONS OF GLOBAL FUND-SUPPORTED PROGRAMS TO INTERNATIONAL TARGETS FOR HIV, TUBERCULOSIS AND MALARIA



Note: Global Fund figures may include service and commodity deliverables that are co-financed by others. Contribution is calculated based on projected global results. See also Box 2.2 for more detail about the international targets.

Source: References 12–14; Grant performance report. www.theglobalfund.org.

A PATIENT IS SUPERVISED TAKING HER DAILY MEDICATION ON THE MULTIDRUG-RESISTANT WARD OF THE ABASTUMANI TB HOSPITAL IN GEORGIA. WITH GLOBAL FUND SUPPORT, THE COUNTRY FIRST OFFERED MDR-TB MEDICATION IN 2008 AND NOW PROVIDES UNIVERSAL ACCESS TO MDR-TB TREATMENT.

2.4.1 THE GLOBAL FUND CONTRIBUTION TO ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS

61. **Global Fund investments to combat HIV, TB, and malaria contribute directly to MDGs 4, 5, 6, and 8, and indirectly to the other MDGs** (see Box 1.1). The three diseases are often rooted in poverty and, as such, affect development in general and impact on all eight MDGs (15, 16). The following are some examples of these contributions.

62. **The Global Fund contributes to achieving MDG 5, "Improve maternal health"** – particularly in sub-Saharan Africa – by reducing the largest causes of mortality among women of childbearing age (defined as between 15 and 44 years of age), reducing major causes of maternal deaths, and facilitating the integration of HIV and sexual and reproductive health services (Table 2.7).

63. The first target under MDG 5 is to reduce by three quarters the maternal mortality ratio. Globally, HIV is the major cause of death among all women of childbearing age (18 percent), followed by maternal conditions (12 percent) and cardiovascular diseases (12 percent) (17). However, in sub-Saharan Africa, HIV accounted for 46 percent of deaths among women in this age group.

64. HIV and, to a lesser extent, malaria also account directly for a large proportion of maternal deaths. In South Africa, at least 38 percent of maternal deaths are due to HIV, TB and other infections unrelated to pregnancy (18). As much as 25 percent of severe maternal anemia – a significant cause of maternal death – may also be due to malaria (19). An autopsy study undertaken in Mozambique in 2002 to 2004 attributed 12.9 percent of maternal mortality to HIV-related conditions and 10.1 percent to severe malaria (20).

65. Universal access to reproductive health is the second target under MDG 5. Integrating HIV programs in settings that have not previously offered HIV services can catalyze the utilization of reproductive health services. Almost all Global Fund-supported HIV programs provide sexual and reproductive health-related services, including treatment of STIs, behavior change communication on safer sex practices, distribution of condoms, HIV counseling and testing, and care and support to people living with HIV and their families (21). After HIV services were introduced to primary care centers in Rwanda, for example, a study found a significant increase in uptake of primary care services, such as reproductive health services (22).

66. **The Global Fund contributes to MDG 4, "Reduce child mortality"**, in particular by supporting:

- unprecedented scale-up of activities for prevention and control of malaria;
- increased access to pediatric HIV treatment (See Table 2.7) and more comprehensive and geographically widespread care, support and treatment for infants and children exposed to and infected with HIV; and
- scale-up of PMTCT programs.

67. Malaria killed 863,000 people in 2008, 85 percent of them children (2), and accounted for 16 to 18 percent of child mortality in sub-Saharan Africa (33, 34). Data published in 2009 from 22 African countries with a high malaria burden illustrate the remarkable scale-up of provision of ITNs in recent years. For example:

- in Rwanda the percentage of children under five sleeping under an ITN the night before the survey increased from 4 percent in 2000 to 56 percent in 2007;
- in Gambia, it increased from 15 percent in 2000 to 49 percent in 2005;
- in Zambia, it increased from 1 percent in 1999 to 41 percent in 2008 (see figure 2.6 for similar data from additional countries).

Several countries have seen a decline in malaria mortality and malaria morbidity as well as declines in child mortality.

68. Global Fund-supported programs dramatically scaled up distribution of ITNs from a cumulative total of 18 million by 2006 to a cumulative total of 104 million by 2009, and countries that have scaled up the distribution of ITNs and/or indoor residual spraying and case management with ACT have started to see a remarkable reduction in child mortality (2). At the end of 2009, US$ 336 million was disbursed to provide over 50 million LLINs to Ethiopia, Kenya, Tanzania, Uganda and Nigeria. By the end of 2010, Global Fund-supported programs are set to distribute 136 million ITNs in sub-Saharan Africa.

69. As mentioned in section 2.1 of the report, as of the end of 2009, 790,000 HIV-positive pregnant women in low- and middle-income countries received a complete course of ARV prophylaxis to prevent mother-to-child transmission through Global Fund grants. In 2009 alone, 340,000 pregnant women received PMTCT treatment, a substantial increase over previous years. Over the next years, the Global Fund, working with its partners, will continue to intensify the scale-up of PMTCT programs, in an effort to reach the goal of virtually eliminating transmission from mother to child in low- and middle-income countries by 2015.

TABLE 2.7 GLOBAL FUND CONTRIBUTIONS TO ACHIEVING MDGs 4 AND 5

	BURDEN OF DISEASE ON WOMEN AND CHILDREN	GLOBAL FUND SUPPORT TO WOMEN AND CHILDREN
HIV	• 50 percent of HIV infections worldwide – and 60 percent in Africa – are among women (23).	• 2.5 million people received ART in 2009, around 60 percent of whom are women.
	• HIV is the leading cause of death in women aged 15 to 44 years worldwide, and a leading underlying cause of maternal mortality in Africa (17, 24, 25).	• 790,000 HIV-positive pregnant women received ARV prophylaxis to prevent mother-to-child transmission.
	• 2 million children were living with HIV in 2007, with a majority infected through mother-to-child transmission (1).	• Around 4.5 million care and support services have been provided to orphans and vulnerable children since 2004. Currently, around 1.5 million orphans are receiving support from Global Fund-financed programs.
	• 5 percent of all deaths among children under five are associated with HIV.	• A growing number of children living with HIV are receiving ART. For example, India's Global Fund-supported programs report that some 15,000 children are on ART. In Cambodia, over 3,300 children are on ART.
	• More than 14 million children have lost one or more parent to AIDS, mostly in Africa (26).	
MALARIA	• Malaria in pregnancy increases the risk of maternal anemia and miscarriage; pregnant women with HIV are at increased risk (27, 28).	• 34 million ITNs were distributed in 2009.
	• Around 10,000 pregnant women and 200,000 infants die each year of malaria in endemic countries (28).	• Between 1999–2004 and 2005–2008, among top 25 Global Fund malaria recipients:[1] – the median percentage of pregnant women who slept under an ITN increased from 2 percent to 21 percent; – the median percentage of children under five who slept under an ITN increased from 2 percent to 23 percent.
	• About 90 percent of all malaria deaths occur in Africa. Malaria accounts for nearly one in five deaths among children under five in this region (28).	• Globally, ITN use by children under five was 24 percent in high-burden countries in 2008 (2).
	• In malaria-endemic areas, nearly 20 percent of low birth weight is attributable to malaria (28).	
TB	• 3.6 million incident TB cases occurred among women in 2008 (3).	• 6 million new smear-positive TB cases were detected and treated between 2004 and 2009 – more than half of all detections worldwide, with similar case detection rates in men and women (3).
	• Women bear a relatively higher burden of TB in countries with high HIV prevalence (3).	
	• Studies show that progression from TB infection to disease is likely to be faster for women compared with men in their reproductive years (29).	

Notes: 1 Based on countries with two successive data points. Pregnant women sleeping under ITN (n=11), Children under five sleeping under ITN (n=18).

TABLE 2.8 GLOBAL PROGRESS ON SELECTED INTERNATIONAL GOALS: AN ANALYSIS OF WHO, UNAIDS AND UNICEF DATA

	ART IN LOW- AND MIDDLE-INCOME COUNTRIES: RECIPIENTS AND PERCENTAGE OF NEED[1]	TB PREVALENCE PER 100,000[2]	UNDER-FIVE MORTALITY PER 1,000 LIVE BIRTHS IN SUB-SAHARAN AFRICA[3]
BASELINE	1.3 MILLION, 20% (2005) (30)	220 (2000) (3)	166 (2000) (32)
INTERNATIONAL TARGET	80% (2010)	125 (2015)	61 (2015)
RESULTS	4.03 MILLION, 42% (2008)(1)	170 (2008) (3)	144 (2008) (32)
PROGRESS TOWARD INTERNATIONAL TARGET	53%	53%	21%
TIMEBOUND PROGRESS (PROGRESS AS PERCENTAGE OF RELEVANT INTERIM GOAL)	72%	99%	40%[4]

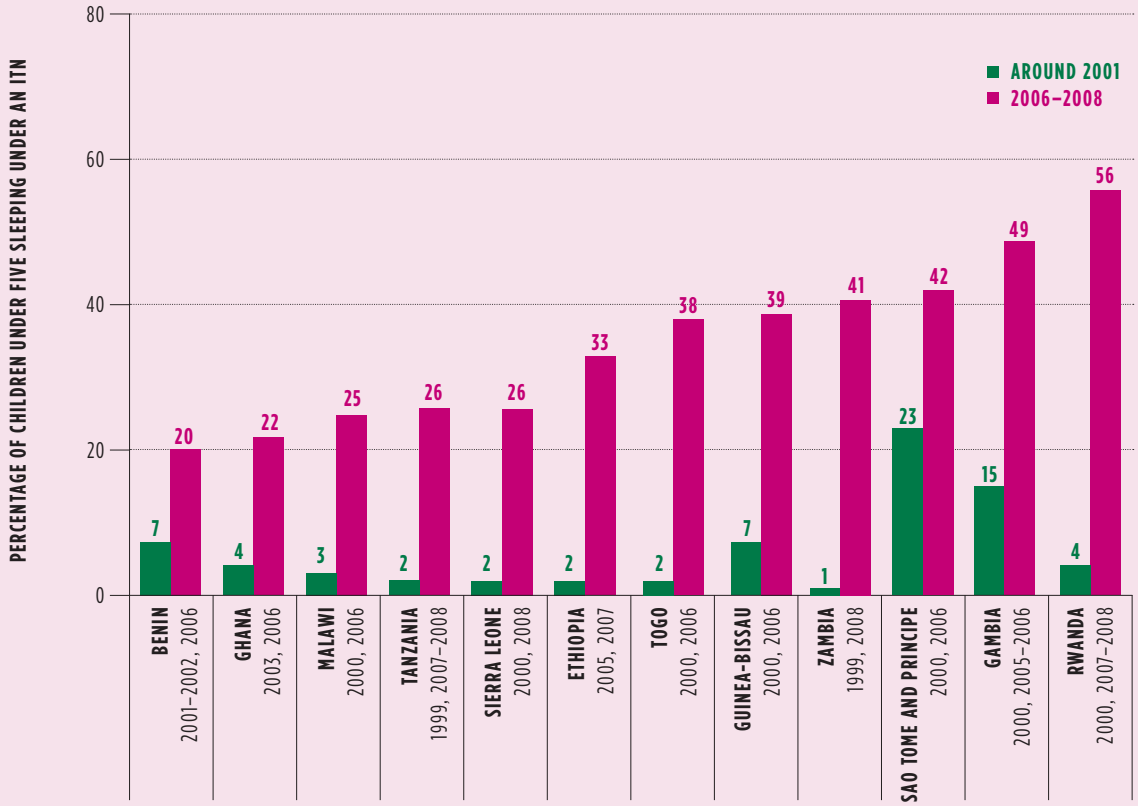
1 Based on the WHO and UNAIDS estimated need to achieve universal access to ART (defined as 80 percent coverage) by 2010 (MDG 6, Target 2). The timebound progress for 2008 was linearly interpolated based on the number of people on ART in 2005 and the 80 percent ART coverage target for 2010.

2 A Stop TB target is to halve the 1990 prevalence (250 people with any form of TB per 100,000 population) by 2015. The target for 2008, the year for which the latest data were available, was interpolated linearly.

3 The target for MDG 4 is to reduce by 2015 under-five mortality by two-thirds from its 1990 level. The table shows data for sub-Saharan Africa, the region where child mortality is most affected by malaria. The baseline target has been linearly interpolated to 2008, the year for which the latest data were available.

4 This figure does not capture recent progress in service scale-up and distribution of ITNs, the impact of which should be visible in 2009 and 2010.

FIGURE 2.6 PERCENTAGE OF CHILDREN UNDER FIVE SLEEPING UNDER AN ITN THE NIGHT BEFORE THE SURVEY, SUB-SAHARAN AFRICA



Source: Modified from reference 35.

70. Generally, **substantial progress is being made toward achieving the MDGs and other international targets, but** data from Global Fund partners (summarized in Table 2.8) on access to ART, TB prevalence and under-five child mortality (which is an important indicator for progress in malaria control in sub-Saharan Africa) show that **scale-up will have to accelerate in order to reach the targets by 2015**.

71. Globally, **there is increasing evidence of the direct impact of HIV treatment on adult mortality**. HIV deaths were roughly 10 percent lower in 2008 than in 2004 (36). The number of people receiving ART has trebled between 2005 and 2008 and coverage more than doubled to 42 percent. Yet the global effort to scale up ART fell short of the 2008 intermediate target of 56 percent (Table 2.8).

72. Overall, **efforts to fight TB are on track to achieve some of the international targets under MDG 6**. TB incidence is declining and TB prevalence decreased to 170 cases per 100,000 in 2008.

73. Malaria causes 16 to 18 percent of child mortality and a large burden of illness in sub-Saharan Africa. In 2008, under-five mortality was 144 per 1,000 live births in sub-Saharan Africa, when the intermediate 2008 MDG target was 110 per 1,000 live births. Declines in child mortality are due to various health interventions such as immunization, antibiotics for acute respiratory infections, Vitamin A supplements, oral rehydration for diarrhea, increased PMTCT and the scale-up of malaria programs. The Global Fund malaria investments in sub-Saharan African countries will increase the total number of ITNs distributed to reach 136 million by the end of 2010, and expand access to ACTs. **A number of countries have reported a reduction in malaria deaths of more than 50 percent**, including Eritrea, Rwanda, Sao Tome and Principe, Zambia, Namibia and Swaziland (2).

74. Data on national progress toward the MDGs reveal important gradients and nuances of regional progress. The following subsections focus on each disease in turn, in the 25 countries where Global Fund investments in that disease are greatest.

TABLE 2.9 ART ACCESS IN THE 25 COUNTRIES WITH THE GREATEST GLOBAL FUND INVESTMENTS IN HIV EFFORTS

COUNTRY	BASELINE – 2005 ART UPTAKE	2008 RESULT – ART UPTAKE	PERCENT INCREASE, 2005–2008	INTERIM 2008 TARGET – ART UPTAKE	2008 RESULT – ART UPTAKE, EXPRESSED AS PERCENTAGE OF INTERIM 2008 TARGET	GLOBAL FUND DISBURSEMENTS TO HIV PROGRAMS (MILLIONS OF US$, BY END OF 2009)
ETHIOPIA	21,000	132,000	544	157,000	82	405.8
INDIA	52,000	235,000	356	321,000	68	353.0
TANZANIA	22,000	154,000	616	220,000	67	288.5
MALAWI	33,000	147,000	345	152,000	95	248.2
CHINA	19,000	48,300	154	99,000	37	225.3
RUSSIAN FEDERATION	5,000	55,000	1000	93,000	57	220.6
ZAMBIA	49,000	226,000	366	178,000	137	225.3
UKRAINE	4,000	11,000	206	45,000	17	151.5
THAILAND	82,000	180,000	121	153,000	139	150.7
NIGERIA	41,000	239,000	483	376,000	59	142.1
RWANDA	19,000	63,000	232	40,000	>200	151.2
HAITI	7,000	19,000	186	20,000	95	130.9
CONGO (DEMOCRATIC REPUBLIC)	8,000	25,000	216	61,000	32	130.4
GHANA	5,000	22,000	378	44,000	44	107.7
CAMBODIA	13,000	32,000	156	24,000	167	102.2
SOUTH AFRICA	207,000	701,000	239	899,000	71	97.2
MOZAMBIQUE	20,000	128,000	540	186,000	65	98.0
NAMIBIA	29,000	59,000	103	40,000	>200	87.6
KENYA	66,000	243,000	268	252,000	95	87.4
CAMEROON	24,000	60,000	155	96,000	50	78.0
UGANDA	75,000	164,000	119	198,000	72	76.8
SWAZILAND	13,000	33,000	152	34,000	96	72.7
SUDAN	500	2,000	360	42,000	4	67.1
ZIMBABWE	25,000	148,000	504	283,000	48	66.6
INDONESIA	4,000	11,000	203	22,000	38	60.4

Note: Universal access to ART is defined in this report as coverage of 80 percent. Targets for 2008 (column 5) were interpolated linearly between the 2005 baseline (column 2) and 80 percent coverage in 2010 (not shown). Progress towards interim 2008 targets (column 6) was calculated as the ratio of observed percent increase (column 4) over expected percent increase (column 5 from column 2). Therefore, 100 percent means right on track to achieve 2010 targets under the linear increase assumption. Disbursements cover all HIV-related activities.

Source: 2005 baseline data, 2007 estimated need and 2008 result data from references 1, 30, 37.

2.4.2 PROGRESS ON MEETING HIV TARGETS: COUNTRY EXAMPLES

75. **Achieving universal access to comprehensive HIV prevention, treatment, care and support would make a major contribution towards achieving the MDGs and, in particular, MDG 6**. Data on progress in providing universal access to ART by the end of 2010 in the 25 countries accounting for 65 percent of Global Fund investments in HIV programs shows that five of these countries are on track to meet the targets they set in relation to universal access to ART: Cambodia, Namibia, Rwanda, Thailand and Zambia. Four more – Haiti, Kenya, Malawi and Swaziland – have also been increasing ART access but will require an intensification of effort to achieve the targets they set. At the other end of the spectrum, several countries, most notably Sudan and Ukraine, will require a substantial scale-up if they are to achieve the targets (see Table 2.9 for more details).

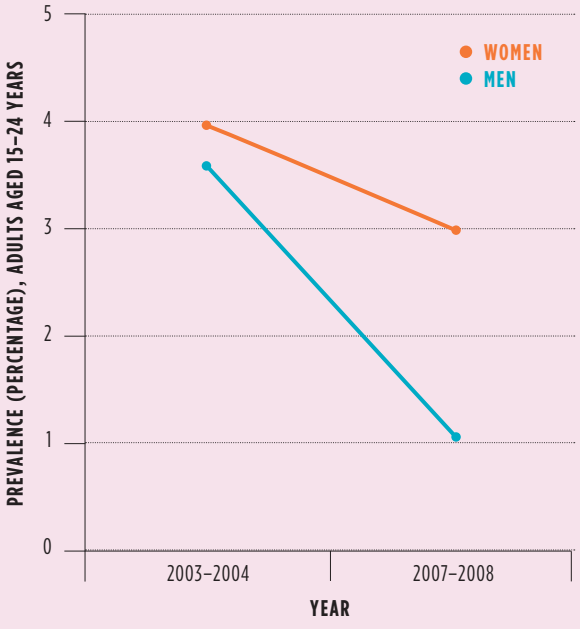
76. Although many challenges remain on the road to achieving MDG 6, country data nevertheless show that the rapid scale-up of HIV prevention, treatment, care and support is having a major impact. Even in the most resource-constrained and fragile settings, steady declines in AIDS mortality within five years of a rapid scale-up in ART have been documented, especially when accompanied by health education campaigns and easily accessible voluntary counseling and testing services. Reports show that scale-up of ART has led not only to a significant reduction in AIDS mortality rates, but also to improved survival and productivity among teachers, health professionals and other workers, and systemwide improvements in health care delivery. The following are some examples of how interventions have been scaled up in countries, and of their impact.

77. ***Tanzania***. HIV prevention and control efforts in Tanzania have been supported with substantial funding from the Global Fund, the World Bank, PEPFAR and others. Of the total approved amount of US$ 528.4 million for HIV and US$ 83.5 million for HIV/TB control, US$ 234 million and US$ 55 million, respectively, had been disbursed as of the end of 2009 by the Global Fund. Tanzania has rapidly scaled up HIV prevention and treatment activities since 2004 (38–40). Between 2003, when Tanzania first received funding from the Global Fund, and the end of 2009:

- 103,000 HIV-positive pregnant mothers received a complete course of ARV prophylaxis for PMTCT – up from 1,800 in 2003;
- 383,000 care and support services were provided to orphans and other vulnerable children;
- 5.4 million people were counseled and tested for HIV; and
- as of the end of 2009, approximately 203,000 adults and children (46 percent of those eligible) were receiving ART, compared to just over 1,500 in 2003.

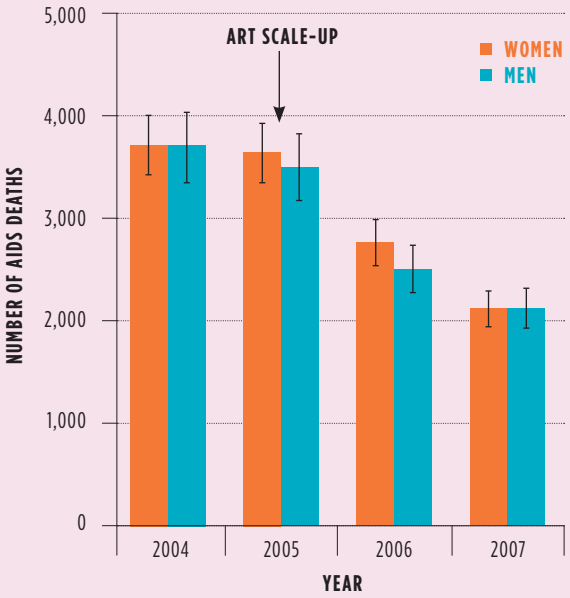
78. A comparison between two population-based surveys shows that between 2003 and 2008, HIV prevalence declined from 4 to 3 percent among 15 to 24-year-old women and from 3.6 to 1.1 percent among 15 to 24-year-old men (Figure 2.7) (36, 40).

FIGURE 2.7 HIV PREVALENCE TRENDS AMONG MEN AND WOMEN AGED 15 TO 24, TANZANIA (2003–2008)



Source: Reference 40.

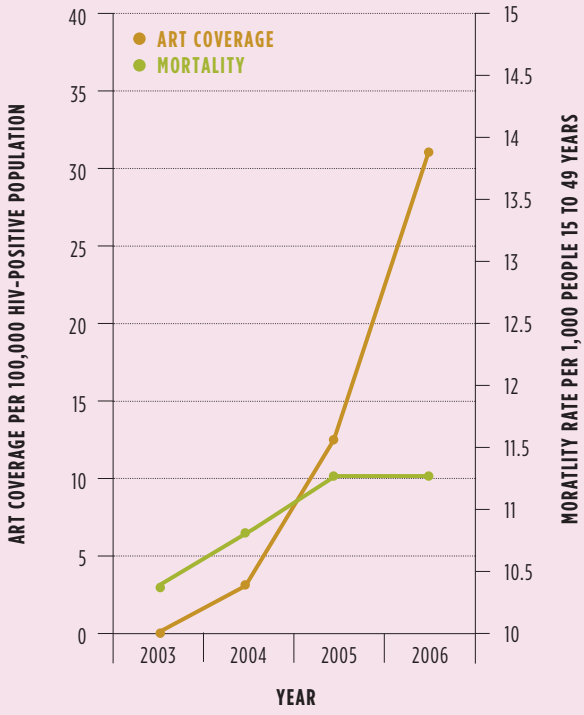
FIGURE 2.8 ESTIMATED NUMBER OF AIDS DEATHS IN ADDIS ABABA, ETHIOPIA (2004–2007)



Note: The whiskers represent 95 percent confidence intervals of the estimates.

Source: Reference 42.

FIGURE 2.9 ART COVERAGE AND ALL-CAUSE MORTALITY IN SOUTH AFRICA (2003–2006)



Source: Reference 1.

79. ***Ethiopia***. Massive investment by the Global Fund has enabled the Ethiopian government – with strong support from various international agencies and civil society organizations – to rapidly scale up HIV prevention and treatment activities. Of the total approved amount of US$ 948.8 million, US$ 405.8 million had been disbursed by the Global Fund by the end of 2009, supporting the following programs and interventions:

- 163,000 adults and children (53 percent of those eligible) were receiving ART, compared to 900 at the beginning of 2005 (41);
- 5.6 million young people benefited from community outreach health education programs in schools;
- 51,000 teachers benefited from health education programs; and
- 5.3 million people were counseled and tested for HIV in 2009 alone.

Recent reports show that ART scale-up in Ethiopia has resulted in a 50 percent decline in population-level AIDS mortality in the country's capital between 2002 and 2007 (Figure 2.8), and substantially improved the survival of patients on ART, with 60 percent (range: 57–63 percent) of the expected number of AIDS deaths in 2007 averted as a result of ART availability (42, 43).

80. ***Dominican Republic***. Of the approved amount of US$ 87.5 million, the HIV prevention and control efforts in the Dominican Republic had received US$ 56.7 million from the Global Fund by the end of 2009, allowing the country to scale up the response to HIV. As of December 2009 (36, 44):

- 2 million people, including 800,000 people belonging to high-risk populations (sex workers, men who have sex with men, migrants, youth and prisoners) were reached through HIV prevention activities;
- 1.4 million people (including 3,800 pregnant women) were counseled and tested for HIV in 155 counseling and testing centers throughout the country;
- 6,400 HIV-positive pregnant women received PMTCT treatment; and
- 13,000 people were on ART.

81. ***Malawi***. Of the approved amount of US$ 375.2 million for HIV programs in Malawi, US$ 248.2 million had been disbursed by the end of 2009. A countrywide scale-up of ART and other interventions began in June 2004, primarily funded by the Global Fund. As of end 2009, 37,000 HIV-positive pregnant mothers had received PMTCT treatment and 170,000 adults and children (45 percent of those eligible) were receiving ART. In 2009 alone, 3.7 million people were counseled and tested for HIV.

82. Reports indicate that the rapid scale-up of ART in the country has had many positive results, including:

- between 2002 and 2006, scale-up of ART allowed 2,380 HIV-positive teachers to access life-prolonging treatment. Around 70 percent of the teachers who started treatment during this period were alive and on treatment at the end of 2006 (45);
- 12 months after treatment initiation, 250 deaths had been averted among health workers in a country with scarce human resources. This translated to a combined work-time of over 1,000 staff-days per week – equivalent to the human resources needed to provide ART at national level (46); and
- within eight months of the introduction of ART, overall adult mortality declined by 10 percent, and mortality among those with better access to ART services declined by 35 percent (47).

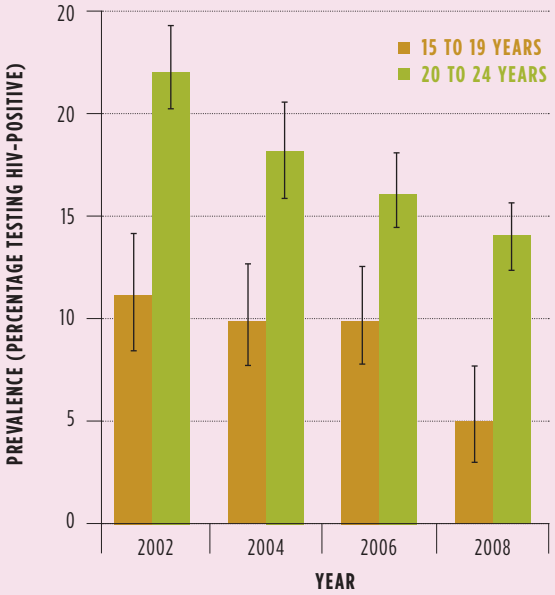
83. ***South Africa***. South Africa has stepped up a rapid expansion of HIV prevention, care and treatment services. Of the total approved amount of US$ 271.3 million, the Global Fund disbursed US$ 97.2 million for HIV grants and US$ 87.2 million for TB/HIV grants by the end of 2009 to support the South African efforts to respond to HIV. The support focused mainly on behavior change communication, provision of ART and TB/HIV collaborative activities.

84. The Provincial Health Department of the Western Cape has been implementing an HIV/AIDS program with the support of the Global Fund since 2004, reaching 1.7 million youths with peer education through 17,500 trained volunteer peer educators. Other Global Fund-supported projects provided 6,750 orphans and other vulnerable children with basic care and support and reached 2,800 people with income-generating activities. Initially, the Global Fund financed much of the scale-up of ART, but more recently the government has assumed financial responsibility for provision of ART.

85. Through the Global Fund, the U.S.-based energy corporation Chevron – the Global Fund's first Corporate Champion – is contributing US$ 5 million to the HIV/AIDS program in the Western Cape, as part of a larger US$ 30 million contribution to efforts to address the three diseases.

86. Between December 2007 and December 2008, the number of people receiving ART in South Africa increased by 53 percent, from 458,951 to 700,500 (1). As ART coverage has increased, mortality rates, which had been rapidly increasing in previous years, stabilized (Figure 2.9).

FIGURE 2.10 PREVALENCE OF HIV AMONG YOUNG WOMEN ATTENDING ANTENATAL CLINICS, NAMIBIA (2002–2008)



Note: The whiskers represent 95 percent confidence intervals of the estimates

Source: Reference 48.

87. ***Namibia***. Of the total approved amount of US$ 213.1 million for HIV programs in Namibia, the Global Fund had disbursed US$ 87.6 million by the end of 2009. Namibia initiated ART scale-up in 2004, with significant support from the Global Fund and PEPFAR, and achieved 69.5 percent ART coverage as of the end of 2009 for adults and children in need of treatment – up from nearly zero in 2003. At the end of 2009, 70,577 people were receiving ART. In addition, through Global Fund-supported programs, by the end of 2009:

- 15,031 HIV-positive pregnant women had received PMTCT treatment;
- 808,000 young people had been reached through extensive school-based and out-of-school youth HIV programs;
- 625,000 adults had been reached through HIV/AIDS awareness community outreach services;
- nearly 400,000 people had been counseled and tested for HIV;
- over 91 million condoms had been distributed through social marketing and public outlets.

88. As shown in Figure 2.10, HIV prevalence among young women declined between 2002 and 2008 (48), from 11 to 5.1 percent in women aged 15 to 19, and from 22 to 13.9 percent in women aged 20 to 24. Many of these declines have occurred since 2006.

2.4.3 PROGRESS ON MEETING TB TARGETS: COUNTRY EXAMPLES

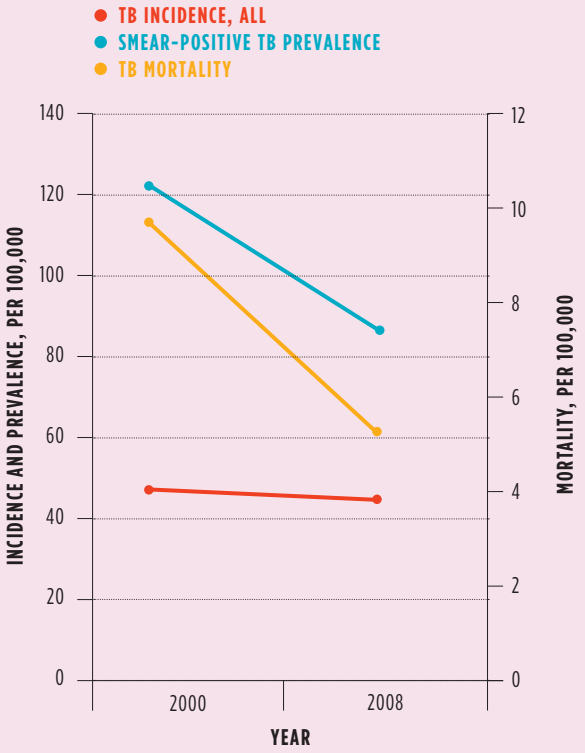
89. Of the 25 countries with the greatest Global Fund TB investments, 12 are on track to halve their TB prevalence by 2015 (Table 2.10). Seven of these countries are in Asia, two in Africa (Somalia and Zambia), one in America (Peru) and two in Eastern Europe (Romania and Tajikistan). Another four countries have reduced TB prevalence but need to intensify their efforts to achieve the 2015 target. In the remaining nine countries, all of which are in sub-Saharan Africa, TB prevalence has increased since 2000 because of the growth of the HIV epidemic in the region.

90. Global Fund investments in TB/HIV services are increasing in a major way and this is expected to help address current shortcomings, but major efforts will be needed to more effectively treat and prevent TB/HIV co-infection. Some of the countries most in need are starting to benefit from grants approved in Rounds 8 and 9. For example, the Round 9 TB proposal of Nigeria was approved in November 2009 for an amount of US$ 113 million. This is in addition to the US$ 64 million already approved for the country's Round 5 TB proposal. In Congo (Democratic Republic), a Round 9 TB proposal will increase almost eight-fold the value of TB proposals approved by the Global Fund there, from US$ 45 million to US$ 352 million. Afghanistan's Round 8 TB proposal has added US$ 32.3 million to the country's Round 4 proposal of US$ 3.5 million, while the Round 8 TB proposal of Bangladesh has nearly doubled approved TB funding from the Global Fund for the country from US$ 86 million to US$ 162 million.

91. Although many challenges remain on the road to achieving MDG 6 and the Stop TB Partnership targets, many encouraging examples of national success are nevertheless emerging, including in countries where the Global Fund has made large disbursements for TB grants. By addressing financing gaps needed to expand national TB programs, the Global Fund has contributed to the positive results achieved in these countries.

92. ***Bangladesh***. The National TB Program of Bangladesh has made great strides in the scaling up of DOTS over the last decade, in part due to the active collaboration between the public health system and NGOs. Since 2004, the program has secured funding from the Global Fund. Of the total approved amount of US$ 90.5 million, US$ 54.3 million had been disbursed by the end of 2009, accounting for nearly half of the total National TB Program budget. The case detection rates for new smear-positive cases improved from 26 percent in 2000 to 66 percent in 2007, and treatment success improved from 81 to 92 percent among such cases. During the same period, there has been an annual decline in estimated incidence (from 239 to 223 per 100,000 population), prevalence (from 500 to 387 per 100,000 population) and mortality (from 58 to 44 per 100,000 population) (10). Bangladesh represents a unique model where NGOs have traditionally supported the national program in expanding the outreach and quality of DOTS through the involvement of communities.

FIGURE 2.11 TRENDS IN TB PREVALENCE AND MORTALITY, CHINA (2000–2008)



Source: References 49, 50.

93. ***China***. The Global Fund has made a substantial contribution to China's TB control efforts, with a total approved amount of US$ 452.3 million, of which US$ 165.6 million was disbursed by the end of 2009, accounting for about 15 percent of the national TB program budget. In 2007, China had achieved 100 percent DOTS coverage and an 80 percent case detection rate for new smear-positive cases (10, 49). Treatment success reached 93 percent, exceeding the international target of at least 85 percent (10, 50).

94. The TB burden in China has been steadily declining (49, 51) (Figure 2.11). Between 2000 and 2008:

- smear-positive TB incidence decreased from 47.4 to 44.2 per 100,000 population;
- smear-positive TB prevalence declined steadily from 122 to 87 per 100,000 population; and
- the TB mortality rate declined from 9.8 to 5.4 per 100,000 population.

A YOUNG MAN VISITS A DISPENSARY FOR HIS DAILY TB TREATMENT. CHINA HAS THE WORLD'S SECOND-HIGHEST NUMBER OF TB PATIENTS BUT WITH GLOBAL FUND ASSISTANCE 80 PERCENT OF NEW CASES ARE TREATED.

TABLE 2.10 TB PREVALENCE IN THE 25 COUNTRIES WITH THE GREATEST CUMULATIVE GLOBAL FUND INVESTMENTS IN TB EFFORTS

COUNTRY	BASELINE – 2000 TB PREVALENCE PER 100,000	2007 RESULT – TB PREVALENCE PER 100,000	PERCENT DECLINE, 2000–2007	2007 INTERIM TARGET – TB PREVALENCE PER 100,000	2007 RESULT – TB PREVALENCE, EXPRESSED AS PERCENTAGE OF INTERIM 2007 TB PREVALENCE TARGET	GLOBAL FUND DISBURSEMENTS TO TB PROGRAMS, MILLIONS OF US$
CHINA	269	194	28	220	152	165.6
RUSSIAN FEDERATION	164	115	30	104	81	97
INDIA	443	283	36	373	> 200	91.5
INDONESIA	326	244	25	277	168	89.1
SOUTH AFRICA	515	692	-34	454	-291	87.2
TANZANIA	391	426	-9	259	-26	70
BANGLADESH	500	387	23	416	134	54.3
PERU	210	136	35	204	> 200	44.3
PHILIPPINES	600	500	17	506	107	44.3
SUDAN	375	402	-7	295	-34	42.5
CONGO (DEMOCRATIC REPUBLIC)	592	666	-13	380	-35	35
ETHIOPIA	486	579	-19	332	-60	34.9
PAKISTAN	413	223	46	321	> 200	33.8
ZAMBIA	658	387	41	453	132	32
NIGERIA	489	521	-7	327	-20	31.7
GHANA	368	353	4	321	32	29.9
RWANDA	442	590	-33	280	-91	27.7
THAILAND	223	192	14	197	121	24.1
ROMANIA	197	128	35	133	107	23.1
MOLDOVA	215	151	30	139	84	21.8
ZIMBABWE	479	714	-49	351	-183	20.4
SOMALIA	414	352	15	360	115	18.7
TAJIKISTAN	56	33	41	75	> 200	16.5
BURKINA FASO	338	403	-19	222	-56	16.2
CAMBODIA	758	664	12	621	69	16.2

Notes: A key target from the Stop TB Partnership is to halve the 1990 TB prevalence (not shown) by 2015. This was used to set 2015 target (not shown). Targets for 2007 (column 5) were interpolated linearly between 2000 baseline figures (column 2) and the 2015 target. Progress towards interim 2007 targets (column 6) was calculated as the ratio of observed percent decline (column 4) over expected percent decline (column 5 from column 2). Therefore, 100 percent means on track to achieve 2015 targets, assuming there will be a linear decline. Disbursement refers to all TB activities.

Source: Reference 10.

95. However, MDR-TB is increasing in some parts of China and is becoming a major challenge.

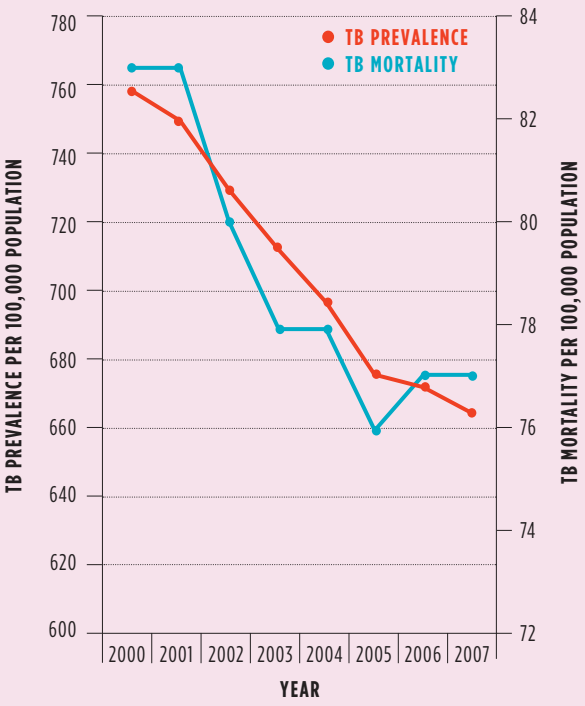
96. ***Cambodia***. Cambodia, one of the 22 high-burden TB countries in the world, has intensified TB control efforts with support from the Global Fund. Of the total approved amount of US$ 22.8 million for TB programs in Cambodia, US$ 16.2 million had been disbursed by the end of 2009. With full geographic coverage with DOTS, Cambodia has achieved a 61 percent case detection rate for new smear-positive TB cases and achieved treatment success in 93 percent of cases (10). Consequently, TB prevalence and mortality rates in Cambodia have declined since 2000 (Figure 2.12).

97. ***Viet Nam***. Since 2004, the Global Fund has been one of the major sources of funding for TB control efforts in Viet Nam. Of the total approved amount of US$ 19.1 million, US$ 10.6 million had been disbursed by the end of 2009. TB case detection rates of 82 percent and treatment success rates of 92 percent exceed international targets, and Viet Nam has seen TB prevalence and mortality decline consistently (Figure 2.13).

98. ***Somalia***. Since 2004, the Global Fund has been able to channel substantial amounts of funding to support TB control efforts in Somalia, despite the country being in a state of civil war. The Principal Recipient has been World Vision Somalia. Of US$ 22.6 million approved to support the TB program, US$ 18.7 million was disbursed by the end of 2009. TB efforts have had impressive results. The smear-positive TB case detection rate has reached 64 percent and treatment success is achieved in 89 percent of cases (10). TB prevalence declined from 414 per 100,000 population in 2000 to 352 in 2007. Over the same period, TB mortality decreased from 67 to 55 per 100,000.

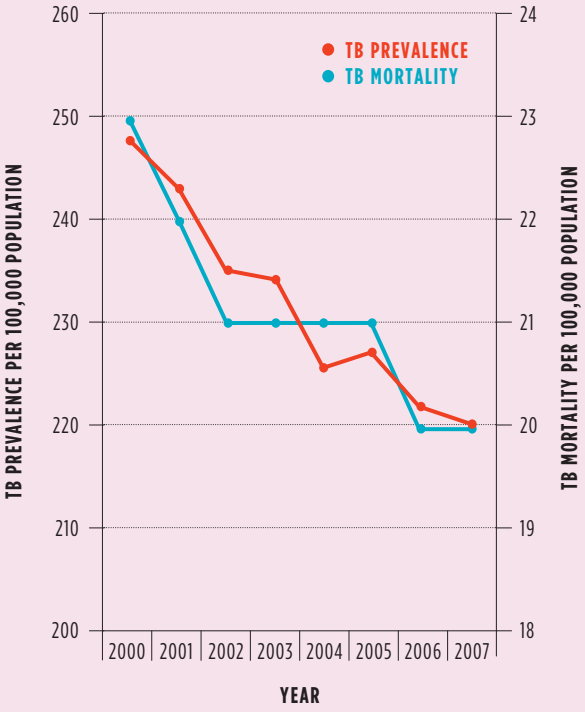
99. ***Philippines***. The TB control program in the Philippines has received support from the Global Fund to support DOTS expansion as well as treatment of MDR-TB and TB/HIV. Of the approved amount of US$ 123.5 million, US$ 44.3 million had been disbursed by the end of 2009. Some encouraging results have been accomplished. Between 2000 and 2007, TB incidence declined from 329 to 290 per 100,000 population. In the same time period, the estimated prevalence of (all forms of) TB also declined, from 600 to 500 per 100,000 population (10).

FIGURE 2.12 TRENDS IN TB PREVALENCE AND MORTALITY, CAMBODIA (2000–2007)



Source: Reference 10.

FIGURE 2.13 TRENDS IN TB PREVALENCE AND MORTALITY, VIET NAM (2000–2007)



Source: Reference 10.

2.4.4 PROGRESS ON MEETING MALARIA TARGETS: COUNTRY EXAMPLES

100. In countries where malaria is endemic, it causes a large proportion of child deaths. Of the 25 countries of sub-Saharan Africa where the Global Fund has made the greatest investments to fight malaria, Malawi and Rwanda have made remarkable progress towards reducing their under-five mortality rate by two-thirds by 2015. Child mortality in 20 of the other countries has declined, with Ethiopia, Ghana, Mozambique and Niger making substantial progress towards the target. In contrast, child mortality rates have not decreased in Kenya, Congo (Democratic Republic) and Somalia (Table 2.11).

101. The Global Fund continues to be the major international funder of the rapid scale-up of malaria vector control activities, notably the distribution of ITNs and indoor residual spraying. Funding it has provided has also played a key role in introducing and scaling up ACT as a first-line malaria treatment in many countries where drug resistance to other treatments is high. In Africa, Swaziland and some island states and territories are now aspiring to enter the malaria pre-elimination stage. The Global Fund also provides resources outside of Africa to eliminate malaria. Of ten countries where malaria elimination programs are underway, five have

TABLE 2.11 CHILD MORTALITY IN THE 25 COUNTRIES WITH THE GREATEST GLOBAL FUND CUMULATIVE INVESTMENTS IN MALARIA EFFORTS

COUNTRY	BASELINE – 2000 CHILD MORTALITY PER 1,000 LIVE BIRTHS	2008 RESULT – CHILD MORTALITY PER 1,000 LIVE BIRTHS	PERCENT DECLINE, 2000–2008	2008 INTERIM TARGET – CHILD MORTALITY PER 1,000 LIVE BIRTHS	2008 RESULT – CHILD MORTALITY, AS PERCENTAGE OF 2008 INTERIM CHILD MORTALITY TARGET	GLOBAL FUND DISBURSEMENTS TO MALARIA PROGRAMS (MILLIONS OF US$, DEC. 2009)
NIGERIA	207	186	10	137	30	296.4
ETHIOPIA	148	109	26	106	93	250.1
TANZANIA	139	104	25	92	75	186.9
UGANDA	158	135	15	106	45	121.1
CONGO (DEMOCRATIC REPUBLIC)	199	199	0	128	0	120.8
RWANDA	186	112	40	117	108	107.5
KENYA	128	128	0	78	0	107.2
SUDAN	115	109	5	75	15	100.3
MADAGASCAR	132	106	20	91	63	76.1
GHANA	111	76	32	73	91	74.8
ZAMBIA	169	148	12	109	35	70.5
ANGOLA	239	220	8	157	23	50.8
NIGER	227	167	26	160	89	50.4
ZIMBABWE	102	96	6	62	15	48.3
SENEGAL	131	108	18	87	53	42.3
CAMEROON	147	131	11	95	31	36.4
MOZAMBIQUE	183	130	29	129	99	36.6
BURUNDI	178	168	6	116	16	33.6
MALAWI	162	100	38	115	132	36.6
BURKINA FASO	188	169	10	123	29	29.2
GAMBIA	131	106	19	88	58	26.2
SOMALIA	200	200	0	129	0	25.1
TOGO	122	98	20	83	62	21.8
LIBERIA	174	145	17	120	53	21.4
CÔTE D'IVOIRE	138	114	17	91	51	20.5

Note: The target for MDG 4 is to reduce under-five mortality by 2015 two-thirds from its 1990 level. The 2008 targets (column 5) were interpolated linearly between the 2000 baseline (column 2) and the 2015 target. Progress towards interim 2008 targets (column 6) was calculated as the ratio of observed percent decline (column 4) over expected percent decline. Therefore, 100 percent means a country is on track to achieve 2015 targets assuming a linear decline. Disbursement totals cover all malaria-related activities.

Source: data on 1990 baselines, 2000 baselines and 2008 results data are from reference 32.

received malaria investments from the Global Fund totaling US$ 19 million: Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. US$ 16 million has been disbursed to Sri Lanka, which has now entered the malaria pre-elimination stage. An increasing number of Global Fund-supported malaria programs are demonstrating reductions in malaria morbidity and mortality.

102. ***Zambia***. Malaria control efforts in Zambia received substantial support from the Global Fund to increase coverage of both vector control interventions and malaria case management. Of the total approved amount of US$ 99.7 million, as of the end of 2009 US$ 70.5 million had been disbursed. Results achieved in Zambia include:

- ACT was adopted as the first-line therapy in 2003 and became available nationwide in 2004;
- 5.6 million ITNs were distributed between 2003 and the end of 2009. In 2008, 62 percent of Zambian households had at least one ITN, compared to 38 percent in 2006. In households with at least one net, 61 percent of children under the age of five and 50 percent of pregnant women slept under a mosquito net (52);
- coverage of indoor residual spraying, in terms of the number of dwellings sprayed, increased nearly ten-fold between 2003 and 2008 (52);
- anemia prevalence in children declined from 14 percent in 2006 to 4 percent in 2008 (52); and
- the number of inpatient malaria cases declined by 61 percent between 2001 and 2008. In the same period, the number of malaria deaths fell by 66 percent. The decline between 2003 and 2006 was 30 percent, compared to a 2 percent decrease between 2001 and 2003 (53).

103. Trends in malaria and anemia prevalence in children under five years of age from two population-based surveys and malaria mortality trends from health facility data in Zambia are shown in Figure 2.14.

FIGURE 2.14 ANNUAL TRENDS IN MALARIA INFECTION PREVALENCE, MALARIA-ATTRIBUTABLE DEATHS AND ANEMIA PREVALENCE IN ZAMBIA (2001–2007)

Source: Reference 52, 53.

104. ***Sao Tome and Principe***. Sao Tome and Principe, two small African islands, have succeeded in reducing the malaria burden to the pre-elimination level. The Global Fund continues to support efforts in Sao Tome and Principe, with approved grants totaling US$ 7.6 million and disbursements of US$ 4.8 million by the end of 2009. Positive results and impacts achieved include:

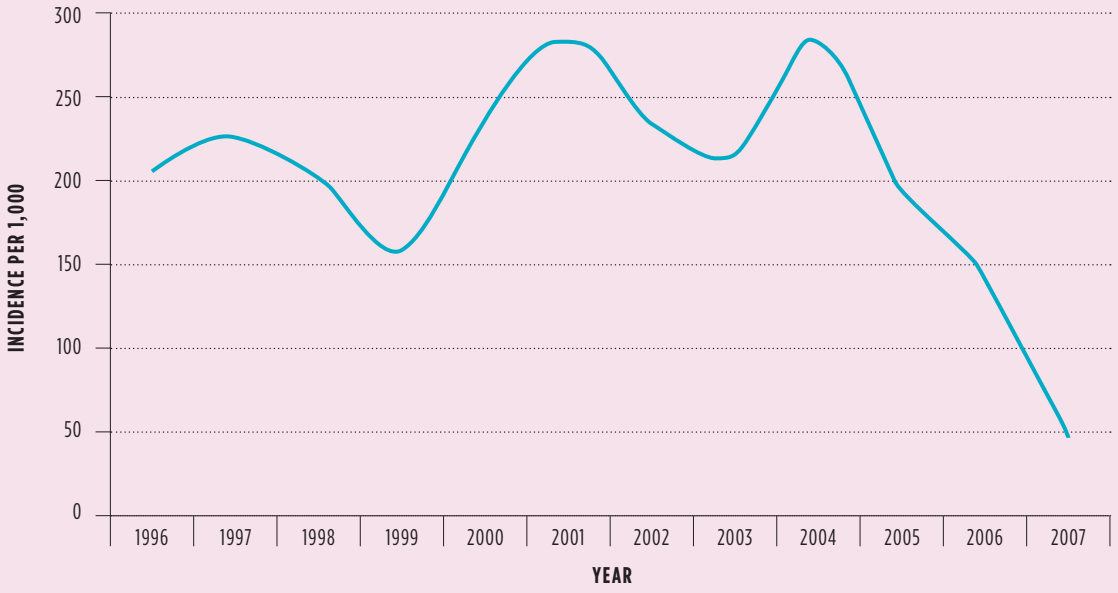
- the introduction of ACT as the first-line antimalarial drug in 2003 (54);
- high population coverage with indoor residual spraying (70 to 80 percent in 2007) (54);
- targeted ITN distribution to pregnant women and to children under the age of five, resulting in 78.3 percent of households owning at least one ITN in 2007;
- an increase in the percentage of children sleeping under ITNs from 1 percent in 1996 to 40 percent in 2004 and 57.9 percent in 2005; and
- a 98 percent reduction in malaria mortality (from 116 per 100,000 population in 2004 to 2 per 100,000 in 2007) and a 95 percent decline in malaria incidence (from 465 per 100,000 population in 2004 to 22 per 100,000 in 2007) (55).

105. ***Namibia***. Namibia is one of only a few southern African nations that are on the verge of entering the malaria pre-elimination phase (56). Of the approved amount of US$ 22.7 million for malaria programs, US$ 14.7 million had been disbursed by the end of 2009. The national malaria control program has used Global Fund contributions to help it achieve the following results:

- 52 percent population coverage with indoor residual spraying in 2008;
- nearly 600,000 LLINs distributed during 2005–2008, with a further 151,000 in 2009;
- ACT introduced as the first-line antimalarial treatment in 2005;
- steep declines in malaria incidence (Figure 2.15) and mortality in recent years (56, 57).

THE NUMBER OF CASES OF PEOPLE DYING OF MALARIA IN NIGER WAS REDUCED BY HALF FOLLOWING A MASSIVE INSECTICIDE-TREATED NET CAMPAIGN. THE GLOBAL FUND FINANCED THE FREE DISTRIBUTION OF MORE THAN 2 MILLION INSECTICIDE-TREATED NETS.

FIGURE 2.15 ANNUAL TRENDS OF MALARIA INCIDENCE, NAMIBIA (1996–2007)

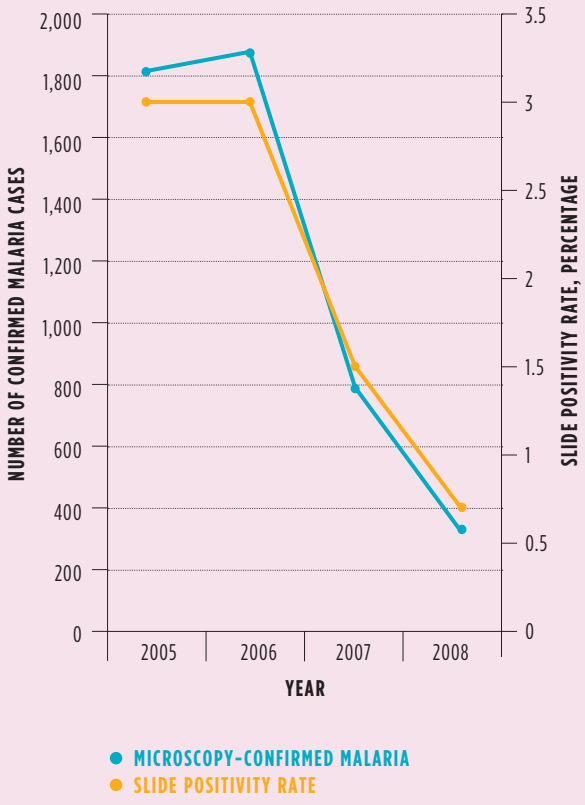


Source: References 56, 57.

106. ***Rwanda***. In 2006, the Rwandan Ministry of Health launched a massive scale-up of LLINs and ACT. Of an approved amount of US$ 131.1 million for malaria grants, the Global Fund had disbursed US$ 107.5 million as of the end of 2009. The massive scale-up of malaria interventions has led to a rapid decline in malaria cases and has freed up capacity in the health system to manage other health problems. Data from selected health facilities show that inpatient malaria cases in 2007 declined by 56 percent compared to the annual average for the years 2001–2006. At the same time, there was a 59 percent increase in non-malaria inpatient cases in 2007, as hospital beds became available for the treatment of other diseases (58).

107. ***Bhutan***. Malaria control efforts in Bhutan have benefited from Global Fund investments, with approved funding of US$ 3.8 million, of which US$ 3.1 million had been disbursed as of the end of 2009. This has helped the country achieve high intervention coverage levels, although providing interventions in some remote and inaccessible rural areas remains a challenge (59). As of the end of 2009, 110,000 ITNs had been distributed thanks to funds provided by the Global Fund, and indoor residual spraying was undertaken in 83,000 dwellings. The incidence of both probable and confirmed cases of malaria declined sharply between 2005 and 2008 (Figure 2.16) Malaria morbidity and mortality also declined, by 20 and 28 percent, respectively (60).

FIGURE 2.16 MALARIA INCIDENCE IN BHUTAN (2005–2008)



Source: Reference 60.

BOX 2.3 GRANT PERFORMANCE RATING AND DISBURSEMENT DECISION-MAKING METHODOLOGY

The Global Fund makes decisions based on performance to ensure that investments are made where impact in alleviating the burden of HIV, TB and malaria can be achieved. Consistent with its performance-based funding model, the Global Fund Secretariat routinely assesses grant performance and links the outcome of this assessment to a disbursement decision.

In 2008, the Global Fund introduced a new *Grant Performance Rating and Disbursement Decision-making Methodology* in order to: 1) ensure a more consistent assessment of grant performance; and 2) strengthen the relationship between grant performance and disbursement decisions.

This methodology comprises two major steps:

1. **Assigning a performance rating:** The performance rating of a grant is based on: 1) the overall progress achieved against time-bound targets for key output indicators; and 2) an assessment of management performance (notably in the areas of M&E, financial management and systems, pharmaceutical and health products management, and program management). The programmatic achievements are the primary factor in deriving the grant performance rating; however this initial rating based on programmatic performance may be downgraded due to critical management issues (e.g. poor data quality, procurement delays and ineligible expenditures).

A1	A2	B1	B2	C
EXCEEDING EXPECTATIONS	MEETS EXPECTATIONS	ADEQUATE	INADEQUATE BUT POTENTIAL DEMONSTRATED	UNACCEPTABLE
>100%	100–90%	60–89%	30–59%	<30%

   At the time of grant renewals, the performance rating of a grant may be upgraded if there is documented evidence of impact towards the goals of the program. Impact is defined strictly by changes in incidence, prevalence and mortality.

2. **Deciding on a disbursement amount:** Each performance rating category (A1, A2, B1, B2, C) has an indicative disbursement range, calculated in order to ensure the relationship between results achieved and funds disbursed by the Global Fund. These disbursement ranges are, nevertheless, only indicative and serve as a "starting point" for the disbursement decision. Ultimately, the final disbursement amount is based on: 1) overall grant performance; 2) contextual factors (force majeure, political and civil issues, etc.); 3) real budget needs in the context of spending ability and (4) actions needed to address identified weaknesses in management capacity.

2.5 RESULTS OF PERFORMANCE-BASED FUNDING

108. Performance of Global Fund programs is measured against country-owned targets that are ambitious yet realistic for the country context. A review of performance is undertaken at the time of each disbursement, and a more comprehensive review including outcomes and impact occurs by year two of the grant. The performance-based funding approach is part of the Global Fund's application of the principle of "managing for results" to all its financing, agreed by donors and countries as central to improving the effectiveness of aid.

109. This section assesses the results of performance-based funding in three areas: overall program performance (Section 2.5.1), learning from program performance (Section 2.5.2) and contributions to value for money (Section 2.5.3).

2.5.1 OVERALL PROGRAM PERFORMANCE

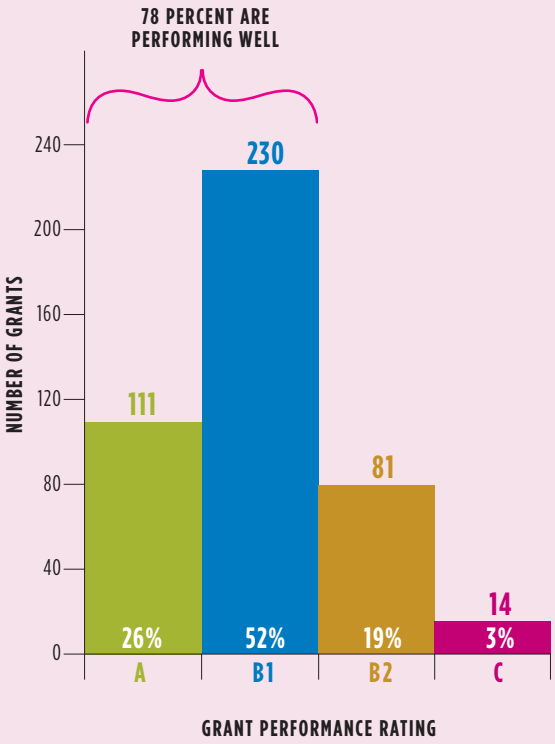
110. By 2009, 436 grants had been reviewed for further funding in year two of implementation. Overall, **78 percent of programs were assessed as performing well** (and were rated A or B1, see Box 2.3 for a description of the grant performance rating methodology). Nineteen percent were assessed as performing inadequately, but demonstrating potential and requiring strong strengthening actions. These programs were rated B2. Three percent of programs were assessed as demonstrating unacceptable performance and rated C (Figure 2.17).

111. **Trends in grant performance**. Over the years, an increasing number of grants have been rated A or B1 ("performing well") and fewer grants have been rated B2 or C (Figure 2.18).

112. ***Performance against key programmatic targets***. Performance against targets for the Global Fund's top ten programmatic areas (See Figure 2.19) shows that, on average, the HIV programs performed well against the targets set in the four programmatic areas relating to HIV, namely the number of people currently on ART (99 percent of the target reached), counseling and testing (122 percent of the target reached), PMTCT (84 percent of the target reached), and orphans and other vulnerable children supported (140 percent of the target reached). TB programs also performed well, with DOTS coverage and treatment reaching 101 percent and MDR-TB treatment reaching 84 percent. Malaria programs were not performing as well. While programs achieved 83 percent of targets for distribution of ITNs, they only reached 61 percent of the target for antimalarial treatment.

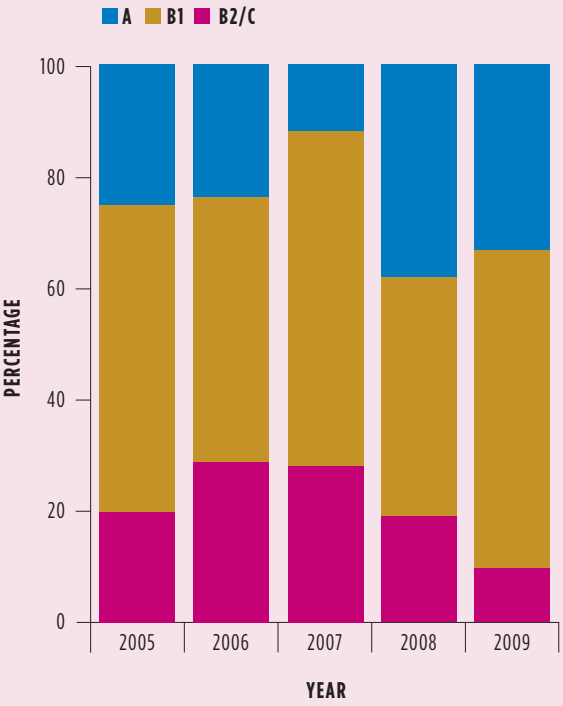
113. Currently, the Global Fund is devoting particular attention to further improving the performance of malaria programs and PMTCT programs. With several partners, it is undertaking an effort to accelerate scale-up of PMTCT services (see Section 2.7 for more information). With regard to malaria programs, the Global Fund is hosting the "Affordable Medicines Facility – malaria" (AMFm – see Section 4.4 for more information) and, together with its partners, undertaking other initiatives to increase access to antimalarial treatment, including improving diagnostic capacities and implementing strategies for home-based management of fevers in endemic countries (61).

FIGURE 2.17 CUMULATIVE DISTRIBUTION OF PROGRAM PERFORMANCE (2005–2009)



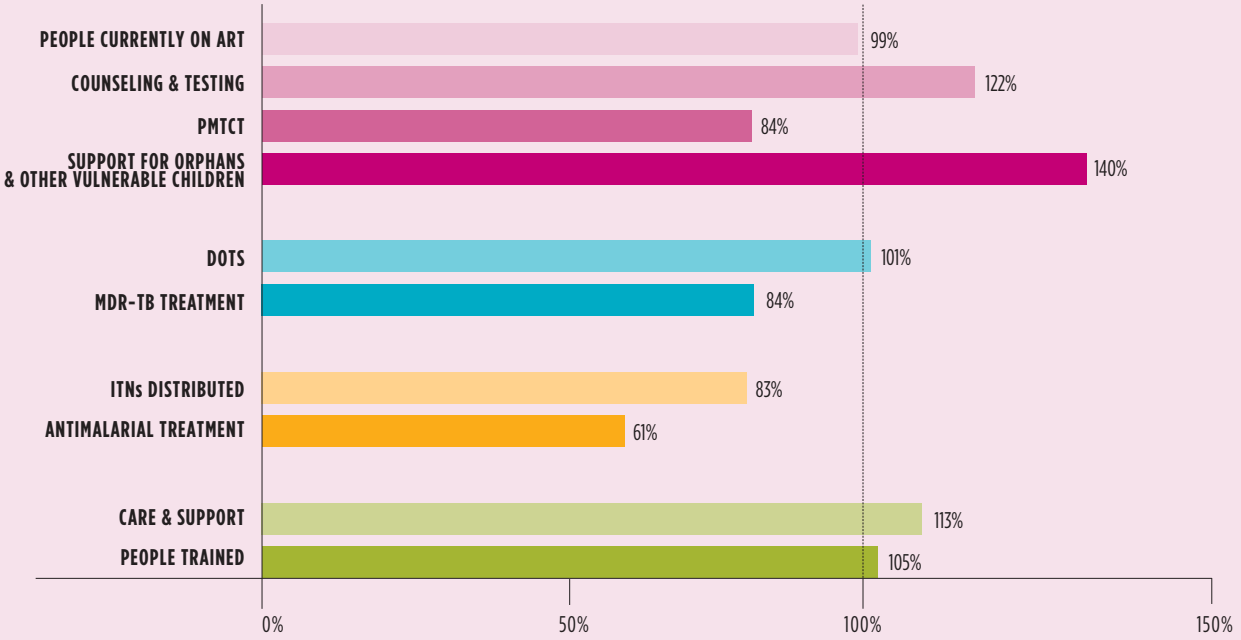
Source: Grant scorecards for grants reviewed at Phase 2 from 2005 through December 2009, www.theglobalfund.org.

FIGURE 2.18 GRANT PERFORMANCE RATINGS AT PHASE 2 REVIEW, BY YEAR (2005–2009)



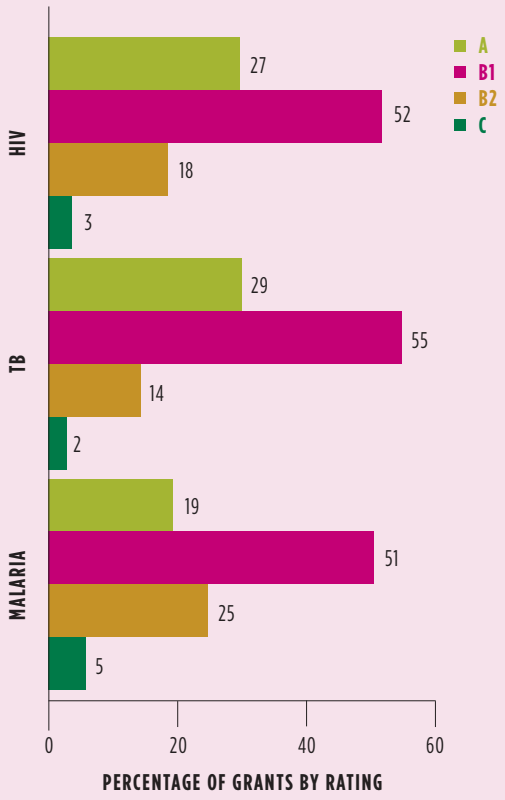
Source: Grant scorecards, www.theglobalfund.org.

FIGURE 2.19 ACHIEVEMENT AGAINST TARGETS FOR KEY PROGRAMMATIC AREAS, CUMULATIVE, FOR ALL PHASE 2 GRANT EVALUATIONS (2005–2009)



Note: Grant scorecards, www.theglobalfund.org.

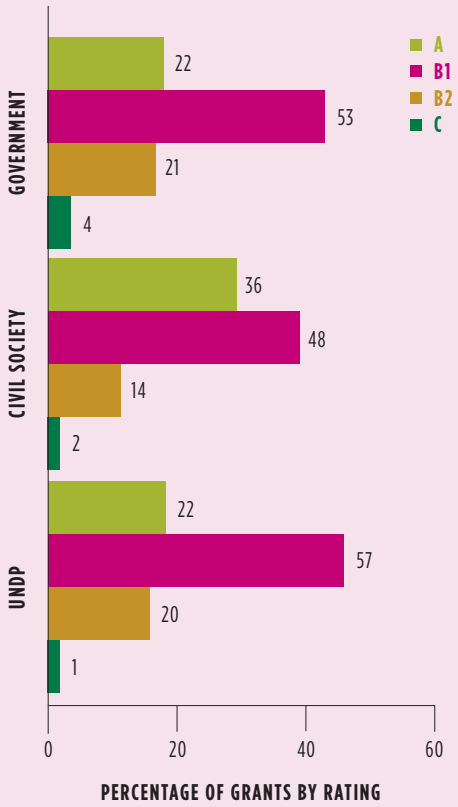
FIGURE 2.20 GRANT PERFORMANCE BY DISEASE, CUMULATIVE TO THE END OF 2009



Note: HIV includes HIV/TB, integrated, and Round 5 health system strengthening components.

Source: Grant scorecards, www.theglobalfund.org.

FIGURE 2.21 GRANT PERFORMANCE BY TYPE OF PRINCIPAL RECIPIENT, CUMULATIVE TO THE END OF 2009



Source: Grant scorecards, www.theglobalfund.org.

2.5.2 LEARNING FROM GRANT PERFORMANCE: TRENDS BY DISEASE, IMPLEMENTER AND REGION

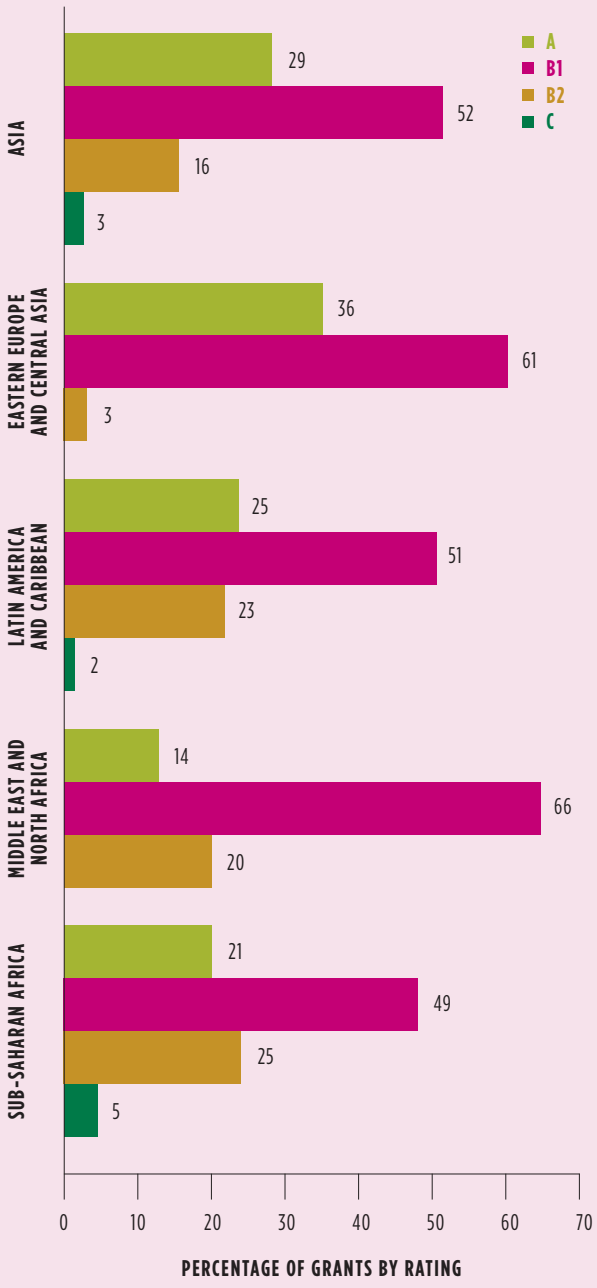
114. The Global Fund aims to learn from trends in program performance by disease, Principal Recipient and region, and monitors developments carefully to ensure that performance-based funding does not penalize poorer countries and those with weaker health systems.

115. **Performance by disease**. TB grants tend to perform slightly better (84 percent with A or B1 ratings) than HIV and malaria grants (with 79 percent and 70 percent, respectively) (Figure 2.20). This could be because TB programs can often build on existing national strategies which, in many countries, have been in place for more than 20 years. In addition, they benefit from a coordinated partnership approach to technical assistance for TB. The Stop TB Partnership, hosted by WHO, provides a comprehensive package of technical assistance to programs, with well-coordinated and well-defined partner roles within national TB strategies.

116. ***Performance by implementer***. On average, 84 percent of grants managed by civil society organizations are rated A or B1, demonstrating the ability of civil society organizations to deliver services, particularly to at-risk and vulnerable populations. Seventy-five percent of grants managed by government Principal Recipients, and 79 percent of those managed by UNDP are rated A or B1 (Figure 2.21). It should be noted that UNDP usually implements grants in difficult situations and fragile states, where local capacity is lacking.

117. ***Performance by region***. Most programs in sub-Saharan Africa perform well, with 70 percent rated A or B1. However, in some regions, 85 percent of programs are rated A or B1 and the proportion of poorly performing programs rated B2 or C in sub-Saharan Africa, at 30 percent, is higher than in any other region (Figure 2.22). The reasons for these differences are being investigated by the Global Fund Secretariat to inform measures to further strengthen support to countries with poorly performing grants.

FIGURE 2.22 GRANT PERFORMANCE BY REGION, CUMULATIVE TO THE END OF 2009



Source: Grant scorecards, www.theglobalfund.org.

TABLE 2.12 FUNDING REALLOCATION AT PHASE 2 BY GRANT PERFORMANCE RATING (2005–2009)

GRANT PERFORMANCE RATING	ORIGINAL PHASE 2 AMOUNT (US$ MILLIONS)	PERCENTAGE OF "NO GO" DECISIONS	REDUCTIONS IN GRANT FUNDING AT PHASE 2 (US$ MILLIONS)[1]	PERCENTAGE OF FUNDING REALLOCATED TO OTHER GRANTS
A	1,644	0	135	8.2
B1	3,916	0	377	9.6
B2	1,327	5.0	361	27.2
C	108	59.1	82	76.1
OVERALL	6,996	1.9	956	13.7

1 Reductions due to performance and efficiency gains, as well as "No Go" decisions.
Note: Figures have been rounded.

118. ***Performance in fragile states***. According to the World Bank, the world's 48 fragile states (62) have a total population of about 1 billion. By the end of 2009, the Global Fund had committed US$ 5.9 billion (41 percent of its overall portfolio) and disbursed US$ 4 billion to programs in fragile states. Programs in fragile states have enabled 883,000 people to access ART, identified and treated 1.9 million new smear-positive TB cases under DOTS, and distributed 60 million ITNs. This represents 31 to 58 percent of the total Global Fund results, which is roughly in line with the monetary commitment.

119. Grants in fragile states are performing only slightly less well than grants in other countries – 73 percent of grants are rated A or B1, compared to 82 percent of grants in other countries.

120. ***Learning from poor performance***. Countries with poorly performing grants have usually been able to respond rapidly to address the problems which led to poor performance. With a few exceptions, country programs that have had a "No Go" grant have shown significant improvements and have since signed new and more successful grants.

121. 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.

2.5.3 CONTRIBUTIONS OF PERFORMANCE-BASED FUNDING TO VALUE-FOR-MONEY

122. ***Improving value-for-money through Phase 2 reviews***. Each grant is initially awarded for a two-year period, the so-called Phase 1 of a grant. The Country Coordinating Mechanism (CCM) then requests funding beyond that period, and the Global Fund Board approves continued funding for Phase 2 of a grant based on a detailed assessment of results against targets and the availability of funds. Phase 2 reviews also allow for identification of unused funds and efficiency savings in grants that have underperformed in the first two years of implementation. This, in turn, allows for increases in efficiency for subsequent years, and also for the reallocation of funds that are not used elsewhere. This process has enabled the reallocation between grants of more than US$ 950 million between 2005 and December 2009 (Table 2.12), contributing to new programs and additional services for people in need.

2.6 ENSURING EQUITABLE ACCESS TO SERVICES

"The Global Fund has been useful in giving visibility and recognition [of HIV] and raising the awareness of populations that are most vulnerable to the epidemic. Above all it helped mitigate prejudices."

– MARIELA CASTRO
PRESIDENT OF NATIONAL CENTER FOR SEX EDUCATION
CUBA

123. Equity (see Box 2.4) is fundamental to the Global Fund's mission of saving lives. The Global Fund supports a variety of approaches to achieve equity in access to health services, and to improve health outcomes where inequities persist. These approaches are described in more detail in this section and include:

- promoting equity in funding by linking country eligibility criteria to disease burden and income level (see Section 2.6.1);
- scaling up the response to HIV, TB and malaria to achieve universal access to prevention, treatment and care services for all people – regardless of economic, social and migration status or geographical location (see Section 2.6.2);
- implementing specific strategies to meet the needs of people most vulnerable or at risk from one or more of the diseases, including women and girls, sexual minorities, sex workers, people who inject drugs and other groups with higher rates of disease prevalence or incidence (see Section 2.6.3);
- supporting health systems interventions to improve access to services, with Global Fund investments in human resources, infrastructures and risk pooling mechanisms to improve access to HIV treatment services and primary care services (see Section 2.6.4); and
- strengthening community systems to mobilize community demand for services and access to populations that have traditionally been marginalized or ignored by service providers (see Section 2.6.5).

2.6.1 EQUITY IN FUNDING ACROSS COUNTRIES AND REGIONS

124. In its grant eligibility criteria, the Global Fund assigns the greatest weight to two factors: 1) a country's disease burden for HIV, TB and malaria; and 2) a country's income level as measured by per capita gross national income.

125. An analysis of the proposals approved by the Global Fund to date shows that the share of investments in each region has been broadly in line with that region's share of the global burden of HIV, TB and malaria (see Figure 2.23).

BOX 2.4
INEQUITIES IN DISEASE BURDENS

The impact of HIV, TB and malaria is often most severe on those who are poorest and most marginalized.

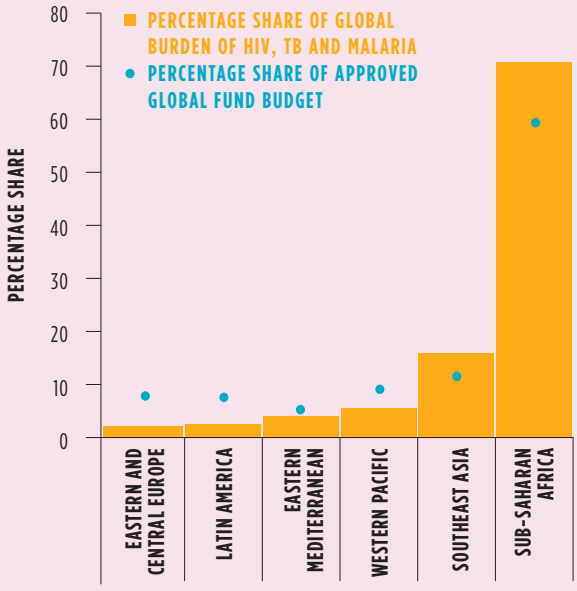
Africa bears most of the burden, including an estimated 80 percent of the global HIV burden and 91 percent of the malaria burden (31). The three epidemics are also concentrated in fragile and conflict-affected states, where malaria mortality is nearly 13 times higher and HIV prevalence four times higher than elsewhere in the developing world (63). In sub-Saharan Africa HIV, TB and malaria disproportionately affect people of working age and account for 40 percent of deaths among women of reproductive age (24). HIV/AIDS worsens pregnancy outcomes and is a leading underlying cause of maternal mortality in Africa (25). Malaria and HIV are responsible for about 21 percent of child deaths in sub-Saharan Africa, where over 45 percent of child mortality in the world occurs (31).

Men who have sex with men, transgender people, sex workers and people who inject drugs face a disproportionately high risk of HIV infection in all parts of the world. Stigma, discrimination and the criminalization of risk behaviors further impede effective responses to HIV for these groups in many settings.

HIV, TB and malaria place a high burden on the health systems in low-income countries where they are concentrated. In the poorest countries, HIV can account for nearly 50 percent of inpatients (64) and malaria for about half of outpatient visits (65).

In many African countries, HIV is a major cause of morbidity and mortality among health workers themselves, placing a dual burden on weak health systems (66–68). Six African countries (Malawi, Zimbabwe, Mozambique, Zambia, Lesotho and Central African Republic) with a health worker crisis have an estimated adult HIV prevalence exceeding 10 percent (69).

FIGURE 2.23 BURDEN OF DISEASE DUE TO HIV, TB AND MALARIA, (2004), AND TOTAL GLOBAL FUND-APPROVED INVESTMENTS IN ROUNDS 1–9, BY REGION



Source: Reference 31 and Global Fund-approved grant budgets, www.theglobalfund.org.

Note: The regions in the figure do not correspond exactly to the eight Global Fund regions. The regional share of Global Fund-approved budget has been estimated using the WHO regions employed in reference 31.

A PREVENTION PROGRAM IN AN AREA OF HIGH HIV PREVALENCE IN CUBA CAPITALIZED ON THE TRUST CLIENTS PLACE IN THEIR HAIRDRESSERS BY TRAINING SALON STAFF TO DISCREETLY PROVIDE CONDOMS AND INFORMATION ON STIs.

2.6.2 ENSURING ACCESS FOR ALL PEOPLE

126. One way to ensure equitable access to necessary services is to make them accessible to everyone in need. To achieve universal access, programs need to be accessible for everyone, including rural populations, the poorest, prisoners and pre-trial detainees, and other vulnerable and marginalized groups. The Global Fund investments support interventions aimed at these groups, including the provision of free or highly subsidized services and products.

127. Subsidized and free ART has had a noticeable effect in Rwanda, Zambia and Tanzania, where, between 2002 and 2006, differences in out-of-pocket spending on health care between the general population and people living with HIV have narrowed considerably. In Zambia, out-of-pocket health expenses for people living with HIV in 2002 were nearly five times higher than for the general population, but only 23 percent higher in 2006. Similarly, in Rwanda and Tanzania, the difference in out-of-pocket spending between the general population and people living with HIV declined from 257 percent to 28 percent and from 136 percent to 75 percent, respectively (70).

128. The Global Fund has been supporting the national malaria strategy in Kenya, where a key intervention was the free distribution of 3.4 million LLINs in 2006 to pregnant women and children. The proportion of children sleeping under an ITN increased from 7 percent in 2004–2005 to 67 percent in 2006–2007, with about two-thirds of them using a net obtained during the free distribution campaign. The campaign was successful in reaching children from the poorest households (71).

2.6.3 STRATEGIES TO ADDRESS THE NEEDS OF THE MOST AFFECTED COMMUNITIES

129. The Global Fund is committed to ensuring that its policies and grants prioritize the needs of the groups who are most affected by – or vulnerable to – HIV, TB and malaria. In 2008 and 2009 the Global Fund adopted two complementary strategies – one promoting gender equality in the response to HIV, TB and malaria (72) (see Box 2.5) and one focusing on the special needs of sexual minorities, including men who have sex with men, transgender people and sex workers (73). Both strategies promote inclusiveness and diversity in Global Fund procedures and decision-making structures, and both emphasize the importance of linking funding decisions to evidence and measurable results.

BOX 2.5 GENDER-RESPONSIVE PROGRAMMING OF GLOBAL FUND GRANTS

Countries are required to provide epidemiological and behavioral data in grant proposals and specify how the proposed interventions will reach affected populations. However, the overall availability of disaggregated data is currently limited and implementation strategies do not always address inequities and barriers faced by women and key affected populations. For example, a study of 211 Global Fund-financed proposals in sub-Saharan Africa from Rounds 1 to 7 found that the majority of proposals included targeted services for women and girls, such as malaria prevention for pregnant women or ARV prophylaxis for HIV-positive pregnant women. However, only a few proposals addressed underlying sociocultural barriers to care (74). This shortcoming is well recognized and the Board of the Global Fund has adopted a gender strategy, recognizing that a concerted, long-term effort is required to address it (75, 76).

In Rounds 8 and 9, the grant proposal forms and guidelines were improved to encourage applicants to address gender and equity issues. Around 67 percent of eligible proposals in Round 8 provided data disaggregated by sex and age. Implementation of the gender strategy includes analysis of disaggregated data by sex in order to improve gender responsive programming in grant implementation (72). The Secretariat monitors the extent to which programs include gender and social equity analyses as part of the grant reviews.

130. In Rounds 8 and 9, nearly four out of five HIV proposals submitted to the Global Fund included at least one activity targeting men who have sex with men, transgender persons or male, female and transgender sex workers. Among proposals recommended for funding by the Technical Review Panel, the percentage of proposals including at least one element related to sexual orientation and gender identity increased from 74 percent in Round 8 to 87 percent in Round 9.

131. The number of proposals that address issues of stigma and rights promotion is also increasing. Overall, 25 percent of all proposals received in Round 8 and 33 percent of all proposals received in Round 9 included at least one activity aimed at addressing stigma or promoting rights, targeting any or all of the key, at-risk population groups. Among funded proposals, 13 percent in Round 8 included at least one such activity, compared to 42 percent in Round 9.

132. Table 2.13 presents examples of successful Round 8 and 9 proposals addressing needs of key affected populations. While some progress is being made, in many countries greater political commitment and sustained support from the Global Fund and other partners will be needed to ensure that HIV services are provided to those who need them most.

TABLE 2.13 EQUITY ANALYSES AND PROPOSED ACTIONS IN SELECTED ROUND 8 AND 9 PROPOSALS

AFFECTED POPULATION	PROPOSAL	BURDEN OF DISEASE	ISSUES IDENTIFIED IN THE PROPOSAL	ACTIONS PROPOSED TO IMPROVE EQUITY IN ACCESS TO SERVICES
WOMEN AND GIRLS	Swaziland (HIV, Round 8)	Adult HIV prevalence: • women: 31% • men: 20%	Gender-based violence	• Post-exposure prophylaxis for women • Shelters for victims of gender-based violence • Training for health care workers on sexual and reproductive rights
			Low uptake of public HIV treatment services by men	• Outreach services in rural clinics • Free ART through the private sector
	Côte d'Ivoire (HIV, Round 9)	Adult HIV prevalence: • women: 6.4% • men: 2.9%	• Low HIV awareness and service coverage • Post-conflict sexual violence	• Free distribution of condoms through community organizations • Training for health professionals on gender-based violence and HIV • Routine offer of HIV testing to women and integration of PMTCT services into antenatal care sites
SEX WORKERS	Côte d'Ivoire (HIV, Round 9)	HIV prevalence among female sex workers: 44%	• High rates of HIV infection • Poor access to health services	• Testing and prevention of STIs through mobile clinics • Empowerment of sex workers by raising their HIV awareness and reducing their illiteracy • HIV seroprevalence survey among sex workers
MEN WHO HAVE SEX WITH MEN	Thailand (HIV, Round 8)	HIV prevalence among men who have sex with men: 8% to 21%	Poor access to the formal health care system	• Training outreach workers and peer educators in HIV prevention and referral • Creating "safe spaces" with basic services in community-run centers • Free distribution of condoms and lubricants
			Stigma and discrimination	• Sensitization of health care workers and law enforcement officers
INTERNAL MIGRANTS	China (TB, Round 8)	National TB prevalence: 194 per 100,000 population	Low TB detection rate and frequent migration among migrant workers	• Free TB diagnosis and treatment • Longer opening hours in clinics, including one day on the weekend • Treatment support through the workplace
PRISONERS	China (TB, Round 8)	National detection rate of new smear-positive TB cases: 77.81%	High TB rate in prisons	• Mobile units for TB screening and treatment services • Collaboration between health and justice ministries to develop an implementation plan
GENERAL POPULATION, INCLUDING REFUGEES AND NOMADS	Djibouti (Malaria, Round 9)	37% of Djiboutians live in regions with a high risk of malaria	• High risk of malaria due to climatic conditions, urban growth and population movement • Low coverage of malaria prevention and treatment	• Free distribution of ITNs through community-based organizations • Rapid diagnosis kits and training for paramedical and community health workers, of whom 50 percent are women • Raising awareness through peer educators working with nomadic populations

Sources: Global Fund proposals, www.theglobalfund.org. For burden of disease see references 31, 77–79.

TABLE 2.14 GLOBAL FUND SUPPORT IN 2008 FOR INCREASING AVAILABILITY OF HUMAN RESOURCES IN GOVERNMENT HEALTH SERVICES IN MALAWI

HUMAN RESOURCES	AVAILABILITY		GLOBAL FUND SUPPORT IN 2008 [2]
	2003 [1]	2008 [2]	
DOCTORS	90	177	160
NURSES	1932	3185	3025
LAB TECHNICIANS	76	143	143
HEALTH SURVEILLANCE ASSISTANTS	4324	10127	10127

Source: 1 Reference 90. 2 Global Fund Portfolio Survey, 2009, www.theglobalfund.org.

Note: Support includes salaries, "top up" of salaries and/or incentives.

133. The Global Fund has become the largest contributor to harm reduction programs for people who inject drugs worldwide (see Box 2.6). In 2008, the Global Fund approved the first grant in the sub-Saharan region that includes targeted programs for people who inject drugs. The grant, worth more than US$ 10 million, was awarded to Mauritius, which has the highest per capita injecting drug use in Africa and where injecting drug use has become the main mode of HIV transmission in recent years.

134. In addition to financing harm reduction programs, the Global Fund has facilitated dialogue between people who use drugs and governments as a result of broad stakeholder involvement in CCMs and the Board. Since its inception, the Global Fund has urged countries to adopt evidence-based approaches, including harm reduction interventions, in policy-making. Eighty-four countries now support harm reduction in policy or practice – including countries with strict drug laws and policies (such as China and Viet Nam) (80).

2.6.4 STRENGTHENING HEALTH SYSTEMS

135. Achieving universal access and equity requires efforts to strengthen health systems in order to deliver services to all those in need, including to those in rural areas and to marginalized and criminalized populations. Often rooted in gender, socioeconomic or ethnic differences, inequities are closely linked to health care access and benefits (86).

136. ***Investing in human resources***. Expanding disease programs in low-income settings requires increased human resource capacity. Successful disease programs can release capacity in health systems by reducing the burden of the three diseases. Sub-Saharan Africa faces the greatest health work force challenges as it has only 3 percent of the world's health workers, with 11 percent of the world's population and 24 percent of the global burden of disease (68).[5] There is a positive correlation between health work force density, service coverage and health outcomes such as maternal mortality and child mortality (87). The Global Fund has invested in both pre-service and in-service training, supported task shifting to maximize utilization of existing workers, and helped develop informal cadres of health and community workers.

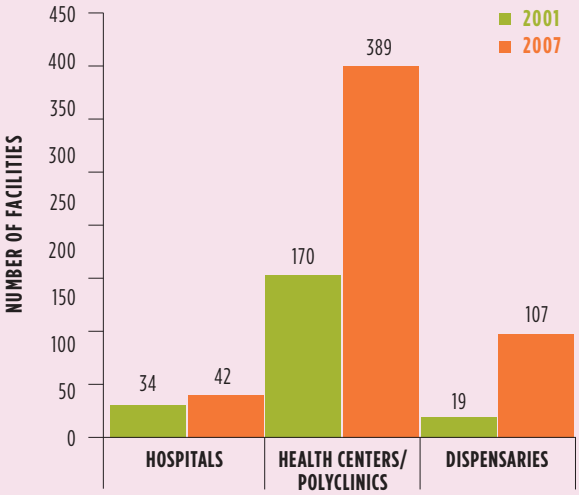
BOX 2.6 PROVIDING HARM REDUCTION SERVICES TO PEOPLE WHO INJECT DRUGS

Injecting drug use accounts for 10 percent of all HIV cases globally (representing 3.3 million people) – and in the countries of Asia and Eastern Europe, prevalence rates among people who use drugs are as high as 50 percent (80). In Africa, drug use is also emerging as an additional risk for HIV transmission – with 90 percent of HIV cases in Mauritius resulting from injecting drug use (81). Harm reduction interventions are an essential component of efforts to prevent the further spread of HIV (and other harms such as hepatitis and overdose) among people who inject drugs. At the same time, they have benefits for society at large and can reduce both demand for drugs and levels of crime. Examples of this approach include needle and syringe programs and opioid substitution therapy programs – both of which have been shown to reverse HIV epidemics related to injecting drug use (82). Yet uptake has been slow in many countries with persistent inequities (83, 84).

The Global Fund has become the largest funder of harm reduction services in the world, investing around US$ 180 million to date in 42 countries (85). By initiating such services and expanding their coverage, Global Fund grants have also helped reduce inequity in access to HIV prevention and treatment services. Of the 16 million prevention services that Global Fund-supported programs had provided by the end of 2009 to people most at risk for HIV, at least 1 million were for people who inject drugs. Several grant recipients in Eastern Europe and Central Asia have reported coverage rates of more than 30 percent among this group. Yet such successes fall far short of need, as this group has difficulty accessing ART around the world.

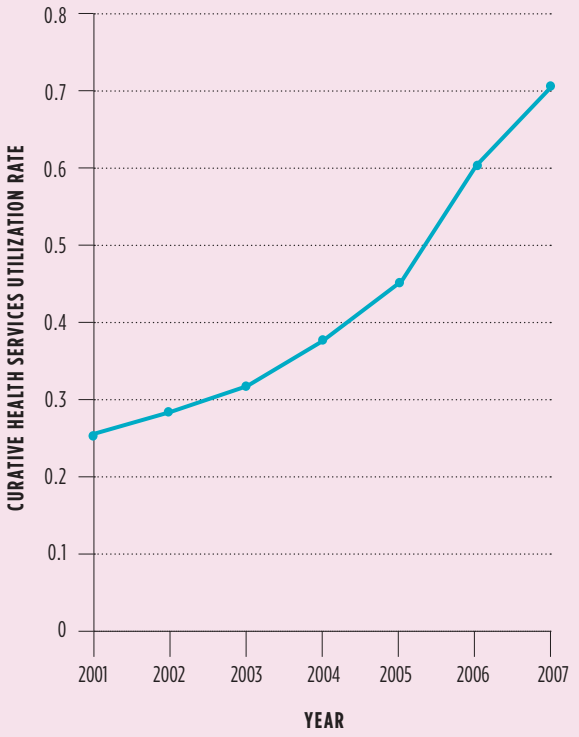
5 For more information, see www.who.int/mediacentre/factsheets/fs302/en/index.html.

FIGURE 2.24 EXPANSION OF FACILITIES PROVIDING BASIC HEALTH SERVICES IN RWANDA (2001–2007)



Source: Reference 88, 89.

FIGURE 2.25 UTILIZATION OF CURATIVE HEALTH SERVICES IN RWANDA, (2001–2007)



Source: Reference 88, 89.

137. In Rwanda, the Global Fund has approved a five-year proposal of US$ 77.8 million to strengthen human resources (salaries and training). This investment has supported efforts of the government and other development partners such as PEPFAR to expand service availability and utilization between 2001 and 2007 (88, 89). During this period, the number of facilities providing basic health services increased substantially (Figure 2.24), with those providing STI services increasing 133 percent.[6] Utilization of curative services increased by 170 percent (Figure 2.25).

138. Malawi, which has a severe human resource shortage, has used Global Fund support to improve the availability of key human resources in government health services (see Table 2.14). Global Fund grants have been used to support recruitment, retention, deployment, pre-service and in-service training of health personnel.

139. Health system bottlenecks due to persistent shortages of human resources in Malawi have been partially alleviated through the achievement of a significant level of "task shifting" in a relatively short period of time using health surveillance assistants (91). The Global Fund-supported assistants have played a critical role in scaling up HIV testing and counseling services and home-based services such as adherence monitoring and dispensing of ART (92). (See Table 2.14)

140. ***Risk pooling***. The Global Fund also supports risk pooling (so that the risk of having to pay for health care is not borne by each contributor individually) to increase equity of access to health services. Without risk-pooling mechanisms, the poor spend out of pocket to meet health care costs, exacerbating their poverty (93).

141. In Rwanda, a Global Fund grant supported the establishment of community-based social insurance to cover people living with HIV, indigents and orphans. The insurance covered around 2.9 million indigents, 520,000 people living with HIV and 296,000 orphans across the country. The overall utilization rate at district hospitals increased from 35 percent in 2005 to 68 percent in June 2009, exceeding expectations (94).

142. In Peru, where nearly 90 percent of HIV treatment was financed out of pocket, Global Fund grants helped set up the national HIV treatment program in 2004. As a result of this investment and the subsequent rollout of ART, out-of-pocket spending on HIV treatment dropped to a negligible proportion of total household expenditure by 2007 (95). The number of persons covered by ART increased from around 2,000 in 2004 (23) to 9,400 by the end of 2006 (96).

6 Basic services: outpatient services for sick children, STI, temporary methods of contraception, antenatal care, immunization, child growth monitoring.

TABLE 2.15 IMPROVEMENTS IN HEALTH SERVICE DELIVERY IN ETHIOPIA (2005–2008)

SERVICE DELIVERY INDICATOR	2005	2008
CHILD IMMUNIZATION RATE DPT3 (%)[1]	70	82
MEASLES IMMUNIZATION (%)[1]	61	76.6
BIRTHS ATTENDED BY HEALTH PROFESSIONALS (%)[1]	13	24.9
CONTRACEPTIVE ACCEPTOR RATE (%)[1]	25	56.2
NUMBER OF ART CLIENTS[2]	20,000	132,000
PROPORTION OF WOMEN AND CHILDREN AMONG ART CLIENTS (%)[3]	25	55
PROPORTION OF ART CLIENTS OUTSIDE NATIONAL CAPITAL (%)[3]	35	75
OPERATIONAL INDOOR RESIDUAL SPRAYING COVERAGE (%)[4]	7.3	51.4
OPERATIONAL ITN COVERAGE (%)[4]	15.8	71.3

Source: **1** Data pertains to 2005 and 2008–2009, reference 100; **2** Reference 1; **3** Reference 98; **4** References 2, 59.

2.6.5 STRENGTHENING COMMUNITY SYSTEMS

143. Working with communities to scale up the response to disease is a cornerstone of the Global Fund model. Investments in community systems have been critical in engaging affected populations and local leaders, mobilizing public awareness and demand for services, tailoring programs to local needs, and delivering services to hard-to-reach, at-risk and vulnerable populations (97).

144. Ethiopia – one of the top five countries in terms of Global Fund investments – is accelerating the expansion of primary care infrastructure and the workforce under the country's Health Extension Program. Over 30,000 health extension workers, recruited from the community, have been trained and deployed in the health services between 2004 and 2009. This program has played a critical role in the rapid scaling-up of HIV and malaria programs as well as reproductive and child health services, especially in rural areas of the country (91, 98, 99) (Table 2.15).

145. HIV grants to Ethiopia in Rounds 2 and 4 have also supported the training of some 64,000 voluntary community dialogue facilitators to deliver behavior change communication in households and "kebeles" (local communities). Working with health extension workers deployed in health services, these facilitators had reached over 87 percent of the adult population by 2007. Community mobilization also enabled the expanded provision of testing and counseling services to cover more than 650 health facilities and the management of sexually transmitted diseases in over 350 clinics across the country (97).

146. The Global Fund has also helped communities expand service coverage in populations with poor access to the health system. In Cambodia, a grant allowed the Khmer HIV/AIDS NGO Alliance to provide financial, technical and capacity-building support to local community organizations for providing home-based care to people living with HIV, as well as to orphans and other vulnerable children. This experience is being used to extend HIV outreach to men who have sex with men and people who inject drugs through a subsequent grant, including Cambodia's first national network of men who have sex with men (101).

SISTER ASTER WEIGHS IN A THREE-MONTH-OLD CHILD AT A CLINIC IN THE SOUTH OF ETHIOPIA. GLOBAL FUND INVESTMENTS IN ETHIOPIA HAVE BEEN EXTENDED TO INCLUDE STRENGTHENING MATERNAL AND CHILD HEALTH PROGRAMS.

2.7 CHALLENGES

147. Though these results demonstrate remarkable progress, significant challenges remain. In the coming years, a rapid increase in investments should help address at least some of them. Around half of the total funds disbursed by the Global Fund were disbursed during 2008 and 2009, benefiting programs that are starting to have an effect on the ground and will show concrete results in the coming years. However, much more will be required to achieve universal access goals.

148. In most countries, access to ART remains far below universal access levels. The estimated coverage of ART in low- and middle-income countries reached 42 percent in 2008. Coverage varied between regions, with Latin America and Caribbean having the highest coverage (54 percent) while in Middle East and North Africa the coverage is as low as 14 percent (1). New WHO treatment recommendations that call for treating people living with HIV at an earlier stage of the disease will further increase the number of people in need of treatment globally. Further, changing drug regimens may increase costs and make scale-up more expensive.

149. Coverage of HIV prevention also remains too low, particularly among population groups at high risk of HIV. As highlighted in the 2009 universal access progress report (1), these groups continue to face technical, legal and sociocultural barriers in accessing health care services. In low- and middle-income countries, only a median of 37.5 percent of people who inject drugs, 27 percent of men who have sex with men and 56 percent of sex workers were reached with HIV prevention programs in the past 12 months (1). Prevention is the pre-condition for a sustainable HIV response and comprehensive and evidence-based prevention programs will have to be vastly scaled up.

150. There are, however, significant challenges to further scaling up prevention and treatment programs, including barriers to access to treatment for most-at-risk groups, the poor integration of ART and drug dependence services, the lack of an adequate response to TB/HIV co-infections, stigma, ideological barriers (particularly regarding the scaling-up of harm reduction programs), laws and regulations or police practices limiting access to evidence-based interventions, and limited access to prevention and treatment services in prisons.

151. PMTCT coverage is improving, yet lags far behind needs and targets. The Global Fund, together with its technical partners (including UNAIDS, UNICEF and WHO), is intensifying the scale-up of PMTCT programs throughout 2010 and 2011. In her speech delivered to the United Nations in September 2009, First Lady of France Carla Bruni-Sarkozy – the Global Fund's ambassador for the protection of mothers and children against HIV – appealed to world leaders to double the number of HIV-positive pregnant women on effective ART in the following 18 months (102).

152. The HIV epidemic has fueled the TB epidemic, particularly in sub-Saharan African countries, and several critical challenges remain. Chief among them are TB/HIV co-infection in sub-Saharan Africa, and MDR-TB, particularly in Eastern Europe and parts of Asia. While the latest global estimates are 1.37 million TB/HIV co-infections and 0.5 million cases of MDR-TB (3, 10), service coverage remains very low, with only 15 percent of the estimated HIV-positive TB patients currently on co-trimoxazole prophylaxis (10). While an increasing number of proposals approved by the Global Fund have included TB/HIV services over the past five years, there is a need to further strengthen the linkages between TB and HIV programs.

153. MDR-TB, which is difficult and expensive to treat, poses serious public health risks. The Global Fund is the major donor for responses to MDR-TB, providing the vast majority of international funding for treatment based on international standards in low- and middle-income countries. Of 24 countries with a high MDR-TB burden eligible for Global Fund grants, the Global Fund supports 23 countries for MDR-TB related activities. This has resulted in a rapid scale-up of treatment; however, there remain significant needs, with only 36,500 of the estimated 500,000 MDR-TB cases expected to be treated in 2009 (3).

154. With regard to malaria, more and more countries are now using quality-assured rapid malaria diagnostic test kits, thereby reducing the unnecessary use of medicines. Over 50 percent of suspected malaria cases in Angola, Burundi, Equatorial Guinea, Gabon, Liberia, Madagascar, Niger, Rwanda and Senegal – where the Global Fund has significant investments – are now tested (2). However, it remains important to increase access to ACTs, which many children in endemic countries still lack, and to improve diagnostic capacities.

155. Countries' health information systems and M&E activities still have much room for improvement in terms of quality and timeliness.

156. The contribution to key services to address the three diseases is closely monitored to ensure that programs are progressing towards international targets set by partners (see Box 2.2). In addition to the current contributions, there are efforts to project future results to identify gaps. Table 2.16 shows the current contributions to international targets and projections for 2012 for three services: ART, detection of TB cases, and ITN distribution.

157. Global Fund-supported HIV programs ambitiously aim to increase ART provision to 3.9 million people in 2012. However, globally, the number of people in need is growing much faster than the pace of ART expansion. As international and national protocols recommend starting treatment earlier, this will further increase the number of people in need, while the introduction of new drug regimens could increase drug costs.

158. The detection and treatment of new smear-positive TB cases will continue to increase in Global Fund-supported programs from a cumulative total of 6 million as of the end of 2009 to a projected total of 10.1 million by 2012, thereby contributing 54 percent of the projected global target for 2012 in order to make a major impact. However, MDR-TB and TB/HIV co-infection remain major challenges for all countries.

159. The distribution of ITNs targeted by Global Fund-supported programs is more ambitious, aiming to more than double the cumulative total to date to 230 million by 2012. Of these, 125 million nets will go to sub-Saharan Africa, enabling countries there to deliver 93 percent of the projected global results to achieve the Roll Back Malaria Partnership target of 80 percent coverage of most-at-risk populations in sub-Saharan Africa. However, as ITNs, even long-lasting ones, will eventually wear out, countries need to carefully plan when, where and how best to replace them. The Global Fund partnership will need to expand and sustain the high level of malaria prevention efforts.

160. To reach international targets, countries will need to accelerate efforts even more to provide ART to those in need, to effectively deliver TB treatment (including that for MDR-TB) and to increase access to effective antimalarial diagnostics and drugs.

161. Weak health systems remain a key challenge to the scale-up of HIV, TB and malaria programs, and to the attainment of the health MDGs overall. The need to invest more in strengthening health system capacity has also been acknowledged by world leaders: the High-Level Taskforce on Innovative International Financing for Health Systems, launched in September 2008, outlined new ways of raising and channeling funds to address current resource gaps in poor countries in order to help them achieve the health MDGs (103). One recommendation was to develop a joint platform for health systems funding between the Global Fund, the GAVI Alliance, the World Bank and others – work which is underway, facilitated by WHO (see Section 4.4).

162. As the first decade of the 21st century draws to a close, the race to achieve the MDGs demands heightened momentum for global and local action. Despite the achievements of the Global Fund partnership over the past eight years, the many lessons learned and the innovations introduced, the challenges ahead continue to be formidable.

TABLE 2.16 GLOBAL FUND AND WORLD RESULTS FOR 2009, AND 2012 ESTIMATES TO MEET INTERNATIONAL TARGETS

	PEOPLE CURRENTLY ON ART	CUMULATIVE NUMBER OF NEW SMEAR-POSITIVE TB CASES DETECTED	ITNs DISTRIBUTED
2009			
PROJECTED GLOBAL RESULTS BASED ON INTERNATIONAL TARGETS	9.7 MILLION[2]	12.5 MILLION[3]	124.6 MILLION[5] (SUB-SAHARAN AFRICA)
GLOBAL FUND RESULTS	2.5 MILLION	6 MILLION[4]	104 MILLION[6] (ALL REGIONS) 72.5 MILLION (SUB-SAHARAN AFRICA)
GLOBAL FUND CONTRIBUTION[1]	26%	48%	58% (SUB-SAHARAN AFRICA)
2012			
PROJECTED GLOBAL RESULTS BASED ON INTERNATIONAL TARGETS	11.9 MILLION[2]	18.8 MILLION[3]	134.5 MILLION[5] (SUB-SAHARAN AFRICA)
GLOBAL FUND TARGETS	3.9 MILLION	10.1 MILLION	230 MILLION (ALL REGIONS) 125 MILLION[6] (SUB-SAHARAN AFRICA)
GLOBAL FUND CONTRIBUTION[1]	33%	54%	93% (SUB-SAHARAN AFRICA)

Notes: Global Fund figures may include service and commodity deliverables that are co-financed by others. The international indicator on ART is people currently on therapy, and the Global Fund does not capture cumulative total. For TB and ITNs, the Global Fund has been collecting and reporting cumulative results.

1 Global Fund results or targets compared to estimated international results or targets.
2 Reference 13.
3 Reference 14.
4 Country reporting might include non-new smear-positive cases up to 10 percent.
5 Reference 12.
6 Global Fund targets for 2012 exclude ITNs distributed four years earlier, assuming they will be worn out.

INDIA HAS, WITH GLOBAL FUND ASSISTANCE, SUCCEEDED IN SCALING UP ARV PROVISION, MOST NOTABLY BY INCREASING THE NUMBER OF CENTERS WHERE DRUGS ARE AVAILABLE. MORE HIV-POSITIVE CHILDREN ARE BEING TREATED AS A RESULT.

THIS COMMUNITY LEADER SET UP A SUPPORT GROUP FOR WOMEN WIDOWED BY AIDS IN HER VILLAGE IN NEPAL. THE COMMUNITY ASSOCIATION OFFERS HOME-BASED CARE AND BENEFITS FROM GLOBAL FUND FINANCING.

3. IMPROVING EFFECTIVENESS

"One of the biggest challenges of development at the moment is how to put countries in the driver's seat and the Global Fund is the one institution that does actually put countries in the driver's seat."

—JOY PHUMAPHI
FORMER MINISTER OF HEALTH OF BOTSWANA
AND VICE-PRESIDENT OF THE WORLD BANK

1. The Global Fund was designed to provide countries with assistance in fighting major diseases effectively and efficiently. This chapter focuses on the effectiveness of the Global Fund, including its work with partners and its grants to country programs. As part of the demand-driven approach, the Global Fund supports country-owned solutions, in which local stakeholders identify the most appropriate ways to manage their programs. In addition to mobilizing more funding for health, the Global Fund must invest responsibly in order to improve health and development outcomes.

2. To continually improve effectiveness, the Global Fund has focused on two priority areas in its investment: optimizing aid effectiveness and achieving value for money.

3. The Global Fund has integrated the principles of aid effectiveness into its operations, from corporate performance to the review of the grant progress, and routinely measures aid effectiveness in all of the programs it supports.

4. In 2009, a value-for-money framework was introduced to improve the efficiency of Global Fund investments in administration, grant-making and service delivery, with clear targets for operational expenditures, as well as for efficiency savings in grant budgeting, implementation and procurement.

3.1 AID EFFECTIVENESS

3.1.1 INCREASING AID EFFECTIVENESS

5. The Global Fund has been acting on its commitments to the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action. The Paris Declaration outlines five key principles: 1) country ownership of program design and implementation; 2) alignment with country priorities and systems; 3) harmonization of donor efforts; 4) managing for results and 5) mutual accountability – all firmly in line with the Global Fund's principles (see Box 1.2).

6. Following an independent evaluation of its progress against the Paris Declaration undertaken in 2008 and participation in the 2007 Paris Declaration monitoring round (Table 3.1), the Global Fund undertook the following three actions in 2009 to boost aid effectiveness:

- institutionalizing aid effectiveness monitoring in its grant portfolio on an annual basis, and including aid effectiveness as a part of the organization's key performance indicators (1);
- systematizing feedback and support to country programs to ensure aid effectiveness is incorporated into grant management;
- integrating aid effectiveness reviews into performance-based funding. Grants are now assessed for aid effectiveness at the Phase 2 grant renewals process in order to identify actions for improvement.

These actions are described in more detail below.

7. ***Aid effectiveness monitoring***. The Global Fund measured its progress on Paris Declaration commitments in 2005, 2007 and 2009 (for the 2008 fiscal year) by employing processes and methodology developed by the Organisation for Economic Co-operation and Development (OECD) (Table 3.1).

8. The scorecard in Table 3.1 shows progress on 13 aid effectiveness targets that the Global Fund established in consultation with the OECD for 2010.[7] Six targets have been met, one nearly met and three are within reach. However, further improvements are needed to reach three targets towards which progress has been limited, namely joint missions with other donors, recording aid in national budgets and recording aid as scheduled.

7 The Global Fund tracks its implementation of the Paris Declaration by measuring progress toward its 2010 targets. A 2005 baseline assessment was followed up in 2007. Country involvement grew in that period, from 32 to 54 countries now committed to measuring progress on the Paris Declaration. In 2009, the monitoring was integrated in the annual Global Fund Portfolio Survey and completed by 79 percent of all recipient countries, with facilitation by Local Fund Agents. Principal Recipients and Local Fund Agents reviewed the survey data jointly, followed by the Secretariat. In 2008, the 54 Paris Declaration monitoring countries represented 67 percent of Global Fund disbursements in that year and 68 percent of disbursements to government recipients.

TABLE 3.1 THE GLOBAL FUND AID EFFECTIVENESS SCORECARD[8]

PARIS DECLARATION PRINCIPLE	INDICATOR	2005 RESULT (N=32)	2007 RESULT (N=54)	2008 RESULT (N=54)	2010 TARGET	2008 RESULT AS PERCENTAGE OF 2010 TARGET
OWNERSHIP AND ALIGNMENT	AID RECORDED IN NATIONAL BUDGETS	15%	23%	29%	85%	34%
	GRANTS ALIGNED WITH COUNTRY CYCLES	62%	62%	75%	90%	83%
	AID USING PUBLIC FINANCIAL MANAGEMENT SYSTEMS	39%	39%	42%	59%	71%
	AID USING NATIONAL PROCUREMENT SYSTEMS	33%	56%	87%	55%	>100%
	COUNTRIES WITH PARALLEL IMPLEMENTATION UNITS[1]	16%	13%	0%	5%	>100%
AID IS PREDICTABLE AND UNTIED	RATIO OF ACTUAL VERSUS EXPECTED DISBURSEMENTS	90%	95%	106%	95%	>100%
	AID RECORDED AS SCHEDULED	16%	30%	29%	60%	48%
	UNTIED AID	100%	100%	100%	100%	100%
HARMONIZATION WITH PARTNERS	AID PROVIDED IN SUPPORT FOR PROGRAM-BASED APPROACHES[2]	74%	68%	79%	66%	>100%
	JOINT MISSIONS WITH OTHER DONORS	15%	14%	14%	40%	36%
	JOINT ANALYTIC REPORTS WITH OTHER DONORS	50%	22%	33%	50%	65%
MANAGING FOR RESULTS AND ACCOUNTABILITY	GRANTS WITH TRANSPARENT AND MONITORABLE PERFORMANCE FRAMEWORKS	100%	100%	100%	100%	100%
	GRANTS ALIGNED TO NATIONAL M&E SYSTEMS	73%	82%	84%	90%	94%

Color legend: **Orange:** 30 to 59 percent of 2010 target achieved in 2008; **Blue:** 60 to 89 percent of 2010 target achieved in 2008; **Green:** More than 89 percent of 2010 target achieved in 2008

1 This indicator aims at reducing the number of parallel implementation units. The target is met when less than 5 percent of countries have parallel implementation units.
2 Excludes aid to UNDP and other multilaterals.

Source: 2005 and 2007 data from references 1, 2; 2008 data collected through the 2009 Global Fund Portfolio Survey, www.theglobalfund.org.

9. The Global Fund's strengths in aid effectiveness include performance-based funding to manage programs for results in alignment with national M&E systems, strong country accountability through transparent performance frameworks and a program-based approach with fewer parallel implementation structures.

10. Of the three targets where progress has been limited, particular attention will have to be devoted to the recording of aid in national budgets; in 2008, only 29 percent of Global Fund aid was reported in national budgets, compared to the target of 85 percent. This is partly due to limited communications between ministries of finance and ministries of health in implementing countries.

11. ***Providing feedback to program stakeholders***. Monitoring data are used to provide feedback to program stakeholders and to actively support country initiatives to improve aid effectiveness. In Rwanda, for example, the Global Fund and the CCM participated in a country-led monitoring exercise to clarify why national budget execution and national audit procedures were not being used, thereby providing the government with an opportunity to change implementation arrangements.

12. Implementing countries have expressed interest in improving aid transparency. Responding to country-led initiatives, the Global Fund worked with Principal Recipients in Burkina Faso, Cambodia, Malawi and Rwanda to improve the reporting of aid, providing ministries of finance with information on financing already received and financing expected for the coming fiscal years.

13. ***Integrating aid effectiveness into performance-based funding***. Since Round 8, the Global Fund's proposal form and guidelines have reflected the commitment to aid effectiveness, providing guidance on how to improve the alignment of funded activities. In addition, the Technical Review Panel uses aid effectiveness monitoring results to guide its review of grant proposals. The Global Fund has furthermore introduced an aid effectiveness support tool as part of the Phase 2 evaluation (see Annex 2 for a more complete explanation of the grant renewal process).

8 The Global Fund Aid Effectiveness Scorecard is based on the Paris Declaration indicators. It omits four indicators that are not measured by donors and a fifth that is not applicable, but includes four additional indicators describing Global Fund overall performance against the full set of Paris Declaration principles: grants aligned with country cycles, actual versus expected disbursements, grants with transparent performance frameworks that can be monitored and grants aligned to national M&E systems.

A WORKER FROM THE COMMUNITY HOSPITAL SPRAYS INSECTICIDE ONTO THE BREEDING GROUNDS OF MALARIA-CARRYING MOSQUITOES IN THE NORTHERN ANSEBA PROVINCE OF ERITREA. THE GLOBAL FUND SUPPORTS THE PROGRAM THROUGH THE ERITREAN MINISTRY OF HEALTH.

14. As part of the grant renewal process, the Secretariat analyzes the effectiveness of grants based on the five Paris Declaration principles. This review informs implementation arrangements for Phase 2. Thirty-two grants were reviewed between May and December 2009. Recommendations mainly focused on improving transparency and alignment at the country level, such as including Global Fund financing in country budgets, recording received disbursements in national accounting books and aligning grants to the country fiscal cycle.

3.1.2 POLICY ADJUSTMENTS TO IMPROVE AID EFFECTIVENESS

15. In 2009, the Global Fund adjusted its policies in order to improve aid effectiveness at the country level. This included: 1) coordination of country program salaries; 2) support for aligning grants with country systems and cycles and 3) improved financial transparency and accountability of Global Fund finances in implementing countries. These changes are described below.

16. ***Coordinated country program salaries***. A coordinated approach to compensate health workers and other in-country program staff was designed and implemented in 2009. Countries are now asked to provide evidence in their proposals about how salaries are harmonized with national levels or an inter-agency framework.

17. ***Alignment with country systems and cycles***. A framework has been developed to encourage the alignment of Global Fund financing with existing national cycles, particularly for financial management and results reporting. It also supports the increased use of country systems for procurement, financial management and M&E, where these are of sufficient quality.

BOX 3.1
CONTRIBUTING TO GLOBAL DIALOGUE

The Global Fund convenes the Global Programs Learning Group – founded in 2006 – to share best practices and responses to the Paris Principles among major international development donors. Members include the GAVI Alliance, the Fast Track Initiative for Education, the Global Environment Facility, the Consultative Group on International Agricultural Research, the Cities Alliance and PEPFAR, with additional input from the Health Metrics Network and the Bill and Melinda Gates Foundation. Collectively, members account for a significant portion of global development financing, and they have advanced the Paris principles substantially, particularly by promoting the principles of country ownership and of managing for results. The group provides a forum to identify strengths and weaknesses in different models and to exchange lessons learned on improving aid effectiveness. In addition to member programs' individual work plans, the learning group has a joint work plan for 2009–2010. Its five priority areas are: 1. Transparency and predictability of financing; 2. Monitoring; 3. Results and impact; 4. Ownership and alignment; and 5. Innovation. The Learning Group reported mid-term progress on actions taken to address these priorities to the OECD Working Party on Aid Effectiveness in December 2009.

18. ***Improved financial transparency and accountability of Global Fund finances to country budgets***. To strengthen communication and information sharing between government health sector recipients, planning authorities, and national treasuries, guidelines have been developed to improve aid reporting in countries.

19. In conclusion, in 2009 the Global Fund played an active role in the international movement to advance aid effectiveness and, within its own processes, integrated aid effectiveness from the proposal to the grant renewals stage (see Box 3.1). Remaining true to its principles of country-owned implementation, the Global Fund will continue to strengthen actions at the country level and will introduce further aid effectiveness improvements and policy adjustments across its portfolio within the new grant architecture that will be introduced in 2011 (see Section 4.4 for more information on the new grant architecture).

3.2 IMPROVING VALUE FOR MONEY

20. Ensuring value for money at every stage of the financing chain is a critical priority, extending from donors to the people who benefit from program services directly. This is achieved by improving resource utilization within the Secretariat and equipping program managers to enact efficiencies at the implementation level. Together with national and international partners, the Global Fund has promoted the routine measurement of unit delivery costs for key interventions to enable countries to compare costs and pursue gains in efficiency. Examples of the measures taken to improve value for money are listed in Table 3.2.

21. ***Increasing value for money at the institutional level***. Every dollar donated to the Global Fund goes to fund programs in country. There are no country offices, and cumulative interest earned on the Trustee account at the World Bank has almost entirely covered the operating expenses for the Global Fund Secretariat operations and Local Fund Agent fees (see Annex 2 for a description of the role of Local Fund Agents). In 2009, administrative costs amounted to no more than 5.3 percent of the Global Fund's total expenditures (Table 3.2). For the grants themselves, planning, administration and overhead typically accounted for 12 percent of reported expenditures in 2008.

22. ***Increasing value for money: the portfolio management level***. The grant management model is designed to achieve value for money in country programs through budget reviews, performance-based funding and efficient procurement.

23. ***Ensuring value for money in grant budgets***. In evaluating proposals, the Technical Review Panel assesses whether "interventions chosen are evidence-based and represent good value for money" (4). Since Round 8, the Technical Review Panel has requested external financial reviews to scrutinize the budgets of large proposals for potential cost efficiencies. In three approved Round 8 proposals, such reviews identified savings of more than US$ 190 million. In Round 9, the budgets of all proposals exceeding US$ 100 million were reviewed, and this practice will continue as part of the proposal evaluation process.

TABLE 3.2 EXAMPLES OF GLOBAL FUND MEASURES TO INCREASE VALUE FOR MONEY

MEASURES	INDICATOR	2009 TARGET	2009 RESULTS
INSTITUTIONAL • Efficient management of Secretariat	• Secretariat operational expenditures (includes Local Fund Agent fees)	• <10% of total expenditure, and <3% of grants under management in recipient countries	• 5.3% of total expenditure, and 2.2% of grants under management in recipient countries
PORTFOLIO MANAGEMENT: BUDGETING • Budget review and adjustment by Technical Review Panel and Secretariat when new grants are signed • Budget reviews and adjustments during Rolling Continuation Channel evaluations • Return of unused funds at end of grant	• Grant budget efficiency savings	• Round 8 grant signing: 10% of Board-approved amount; • Rolling Continuation Channel: 10% of proposed amount • Grant closure: US$ 83 million	• Round 8 grant signing: 13% (US$ 403 MILLION) • Rolling Continuation Channel: 7.4% (US$ 79 MILLION) • Grant closure: >US$ 177 MILLION in recipient countries
PORTFOLIO MANAGEMENT: PERFORMANCE • Performance-based funding in Phase 2 • Budget reviews and adjustments during Phase 2 Reviews	• Difference in allocation, relative to original proposals, between high-performing (A-rated) and low-performing (B2- or C-rated) grants • Phase 2 budget efficiency savings	• Difference between high- and low-performing grants: 30% • Budget reduction relative to original proposed amount: 23.5% (performance-based + efficiency saving)	• Difference between high- and low-performing grants: 26% • Budget reduction relative to original proposed amount: 22% (US$ 317 MILLION) (performance-based + efficiency saving)
PORTFOLIO MANAGEMENT: PROCUREMENT • Improved price and quality reporting	• All grants reporting to Price and Quality Reporting system • Grant procurement budgets through the Voluntary Pooled Procurement facility	Price and Quality Reporting: 100% of grants	• Price and Quality Reporting: 88% of grants • Voluntary Pooled Procurement: 34 COUNTRIES registered for participation and US$ 271 MILLION of orders placed
MEASURES	**INDICATOR**	**2010 TARGET**	**2009 BASELINE**
SERVICE DELIVERY • Promotion (with partners) of programs' routine measurement and reporting of unit costs for key interventions	• ARV unit price (first-line adult regimens) • LLIN unit price • Countries with service delivery unit costs of patients successfully treated by DOTS within an acceptable range[1]	• ARV unit price: 5% annual decline • LLIN unit price: 5% annual decline • 5% annual increase in countries with unit cost of patients successfully treated by dots within an acceptable range	• Median ARV unit price US$ 188 (first-line adult regimens) (baseline) • Median LLIN unit price US$ 5.3 (Baseline) • 82% of TB high-burden countries have a unit cost of patients successfully treated by DOTS within an acceptable range

1 DOTS cost per patient treated (2009): low-income countries: **<US$ 340**; lower-middle income countries: **<US$ 420**; upper-middle income countries: **<US$ 1,250**.

24. Grant negotiation provides another opportunity to review budgets and identify efficiencies by comparing unit costs to benchmarks. By December 2009, when grants for 85 percent of the approved Round 8 funds had been signed, this process had yielded an overall efficiency gain of 13 percent (US$ 403 million) compared to proposal budgets for the round, with minimal impact on service delivery targets. Adjustments varied across the portfolio, with gains of 2 to 20 percent for most grants.

25. ***Performance-based funding***. The comprehensive Phase 2 performance review including outcomes and impact which occurs by year two of each grant allows for the reallocation of funds from poorly performing grants to better-performing grants as well as for the identification of efficiency gains.

26. From 2005 to November 2008, 12 percent of the funds from poorly performing grants were deducted during Phase 2 reviews and allocated to better-performing grants. In 2009, efficiency gains identified in Phase 2 grants amounted to about 22 percent of the original proposed Phase 2 budgets (US$ 317 million), due to an intensified focus on efficiencies. Similarly, approved Rolling Continuation Channel grants achieved an average saving of 7.4 percent. As a result, more than US$ 970 million in efficiency savings in grants were identified in 2009 alone for reinvestment in other programs.

27. ***Procurement***. Approximately 39 percent of grant expenditures are used to procure medicines and other health-related products.

28. Grant recipients are required to conduct procurement through a transparent and competitive process (except in the case of small or emergency orders), to achieve the lowest possible price for products of assured quality (5). They are also required to report price information for key products (ARVs, malaria and TB drugs, ITNs, condoms and rapid diagnostic kits) to the Price and Quality Reporting system, which is linked to the publicly accessible global price-reporting mechanism hosted by WHO (6). These publicly accessible databases facilitate price comparisons, giving grant recipients additional information and leverage to negotiate prices.

BOX 3.2 COLLABORATION WITH TECHNICAL PARTNERS TO SUPPORT STANDARDIZED SERVICE COSTINGS BY NATIONAL PROGRAMS

The Global Fund, with partners, is developing and promoting standardized methods for countries to measure the efficiency and effectiveness of key HIV, TB and malaria services (7). Development of costing methods, as well as in-country technical support for data collection and analysis are carried out together with partners such as WHO and PEPFAR.

In 2009 and 2010, the focus is on measurement of per-unit expenditures for ART, DOTS and ITN distribution. In a common approach across all services, cost measurement is embedded in existing national disease M&E systems.

For ART, national program-level costing for key cost components will be piloted in 20 countries with a high HIV burden, under the guidance of the WHO HIV/AIDS Department and UNAIDS, and with support from PEPFAR. The focus will be on key cost drivers that are amenable to efficiency gains, such as the prices of drugs and laboratory commodities and health staffing.

For DOTS, the Global Fund supports further improvement of national budget and expenditure reporting by national TB programs to the WHO Stop TB department, which started in 2002 (8) – including validation of the top-down costing approach against bottom-up costing studies conducted in selected countries.

For conventional ITNs and LLINs, financial reporting is now included in the questionnaire that national malaria programs submit annually to the WHO Global Malaria Program. Alongside the number of nets distributed, expenditure data will allow for the calculation of unit distribution costs for ITNs from 2010.

For all services, national-level data are triangulated with data from in-depth special costing studies, procurement price reporting through the Global Price Reporting and Global Fund Price and Quality Reporting systems, and grant-specific expenditure tracking through the Global Fund's Enhanced Financial Reporting.

29. Programs supported by the Global Fund collectively have the potential to influence prices and market dynamics. With the launch of voluntary pooled procurement in June 2009 (see Section 4.4 for more information), countries can access a collective purchasing facility established to provide Principal Recipients with greater purchasing power. The prices of comparable services such as LLINs and first-line ARVs are followed (as of 2009) as part of the corporate key performance indicators. A target of an annual 5 percent decrease has been set for both of these items.

30. ***Increasing value for money: the service level***. In conjunction with technical partners, the Global Fund has initiated standardized measurement and reporting of the per-person or per-unit cost of delivering key HIV, TB and malaria intervention services (7) (see Box 3.2). Analysis and benchmarking of unit costs is helping program managers understand cost drivers and enables them to seek out efficiency gains. Service unit costs will be linked to data on service quality and health impact, thereby forming the basis for evaluation of program cost-effectiveness.

3.3 UNIT COSTS FOR KEY INTERVENTIONS IN PROGRAMS

31. In addition to regularly improving administrative and programmatic cost efficiencies, the Global Fund monitors the unit costs of DOTS, ART and LLINs in order to identify areas for improved cost-efficiencies. The range of costs across the Global Fund portfolio is listed in Table 3.3.

3.3.1 DOTS – UNDERPINNING THE STOP TB STRATEGY

32. Annual expenditure reporting by national TB programs shows that the cost of DOTS per patient varies markedly with national income levels (Figure 3.1). These variations are a result of the fact that the cost of key inputs in TB control – particularly the cost of program staff and hospital care – is strongly tied to a country's per capita income level. Among 22 high-burden TB countries, overall, the median DOTS cost per patient in 2006–2008 was US$ 173 (interquartile range (IQR)[9]: US$ 140 – US$ 283).

9 The interquartile range is the middle range within which 50 percent of values fall. i.e. the range from the 25th percentile to the 75th percentile of a distribution.

TABLE 3.3 INITIAL ESTIMATES OF UNIT COSTS FOR KEY INTERVENTIONS IN GLOBAL FUND PROGRAMS (2008)

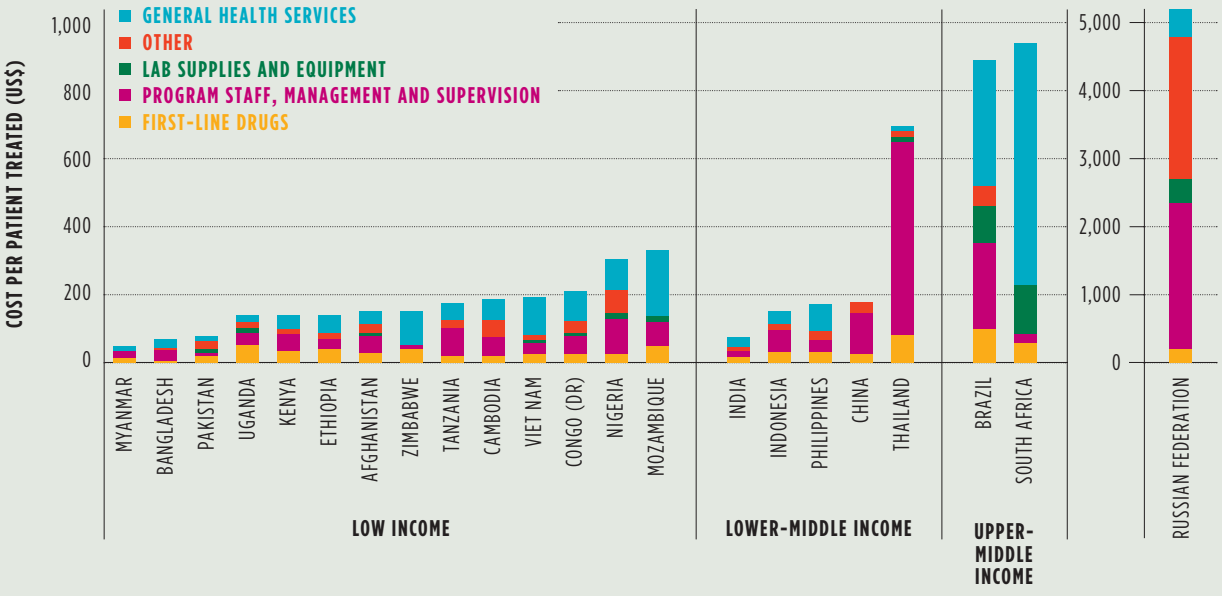
SERVICE AND COST UNIT	NATIONAL INCOME LEVEL AND UNIT COST ESTIMATE (RANGE), US$		
LLIN DISTRIBUTED TO A PERSON OR FAMILY AT RISK FOR MALARIA	ALL INCOMES:[1]	7.3	(6.8–7.8)
DOTS PER TB PATIENT	LOW INCOME:	150	(138–191)
	LOWER-MIDDLE INCOME:	173	(151–177)
	UPPER-MIDDLE INCOME:	1,023	(956–3,148)
ART PER PERSON PER YEAR (*FIRST-LINE*)	LOW INCOME:	526	(513–543)
	LOWER-MIDDLE INCOME:	645	(627–675)
	UPPER-MIDDLE INCOME:	740	(699–763)
ART PER PERSON PER YEAR (*SECOND-LINE*)	LOW INCOME:	1,220	(1,197–1,339)
	LOWER-MIDDLE INCOME:	1,626	(1,391–2,086)
	UPPER-MIDDLE INCOME:	2,939	(2,159–4,607)

Notes: The estimated unit costs are for the median and the interquartile range. Country income levels are based on the 2007 World Bank list of economies (9).

1 For LLINs, there was limited variation by country income level.

Sources: LLINs (10–14); DOTS (15, 16); ART (6, 10, 17–25).

FIGURE 3.1 NATIONAL DOTS EXPENDITURES PER PATIENT TREATED



Notes: Cost per patient treated was obtained by dividing total country-reported expenditures by the total number of TB notifications, both smear-positive and smear-negative, averaged over 2006–2008 (15, 16). Data were available for 22 high-TB burden countries, which collectively account for 80 percent of incident TB cases globally. All these countries have TB grants from the Global Fund. For each estimate, the WHO Stop TB Department added a mark-up representing average expenditure on general health services utilization (mainly hospitalization and outpatient clinic visits) to the reported costs, using country estimates from the WHO Choosing Interventions That Are Cost Effective (WHO-CHOICE) project (16, 26). Expenditures on treatment of MDR-TB and TB/HIV were not included in these unit cost estimates. Country income levels are based on the 2008 World Bank list of economies (9).

Sources: References 15, 16.

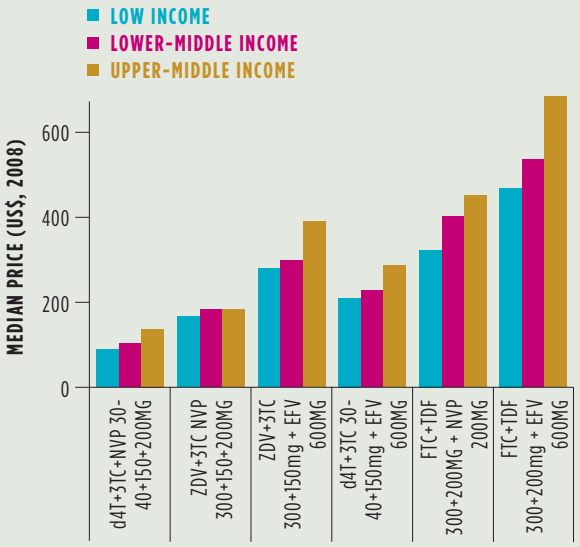
IN PARAGUAY, A HEALTH COORDINATOR MONITORS THE HEALTH OF PRISON INMATES. PEOPLE IN PRISON ARE MORE LIKELY TO CONTRACT TB DUE TO OVERCROWDED CONDITIONS. THE GLOBAL FUND SUPPORTS EFFORTS TO TREAT THE DISEASE AND PREVENT IT FROM SPREADING WHEN THE PRISONER IS RELEASED.

33. The distribution of program costs varied substantially among countries. In most countries, the utilization of general health services (inpatient and outpatient use of facilities not specific to the TB program) was a major contributor to overall DOTS costs, at a median 29 percent of the overall cost per patient.

34. Between 2003 and 2008, DOTS costs per patient fluctuated from year to year in most countries, in part due to variations in program expenditures, notably investment costs. For example, in 2003 Ethiopia used initial Global Fund support to purchase substantial capital goods. In general, the cost per patient tended to increase slightly each year in the 22 countries, by a median amount of 4 percent per year.

35. These unit costs will be reported by the Global Fund Secretariat to countries and to the Technical Review Panel as part of a benchmarking exercise to enable countries to explore areas for efficiency gains. The wide variations demonstrated suggest room for improvement in program costs, especially in relation to cost of service delivery.

FIGURE 3.2 PRICES PAID FOR FIRST-LINE ADULT ARV DRUGS BY COUNTRY INCOME LEVEL



Notes: Prices are medians across 103 Global Fund-supported countries, but include all procurements reported by national AIDS programs irrespective of their financing, which includes the Global Fund, domestic resources, PEPFAR and other sources. For the different regimens and years, between four and 70 countries reported data, totaling 8,069 orders, for a total amount of US$ 614 million, over 2006–2008. Country income levels were based on the 2008 World Bank list of economies (9). Compared to UNAIDS' country estimates of patients on ART, these procurement reports cover around 67 percent of the estimated total first-line ARV procurement volume in low- and middle-income countries by the end of 2008 (27).

Country-reported prices varied in the extent of including charges for freight/shipping, insurance, handling etc., but the reporting systems did not separate out these different price components. Therefore, the analyses did not adjust for the varying definitions on a country-by-country basis, which can account for up to 15 percent of the price (28, 29).

Abbreviations: 3TC: lamivudine; d4T: stavudine; EFV: efavirenz; FTC: emtricitabine; NVP: nevirapine; TDF: tenofovir; ZDV: zidovudine.

Source: Country procurement reports to the Global Fund Price and Quality Reporting system and the WHO Global Price Reporting system for the year 2008 (6, 10).

3.3.2 ANTIRETROVIRAL THERAPY: COST OF FIRST-LINE TREATMENT IN ADULTS

36. To generate the data on ART costs, the Global Fund is using a phased approach that initially focuses on the prices that countries pay for ARV drugs. In 2010, it is developing approaches to routinely measure additional cost components – such as laboratory services and health staffing – to improve cost estimates for delivering ART.

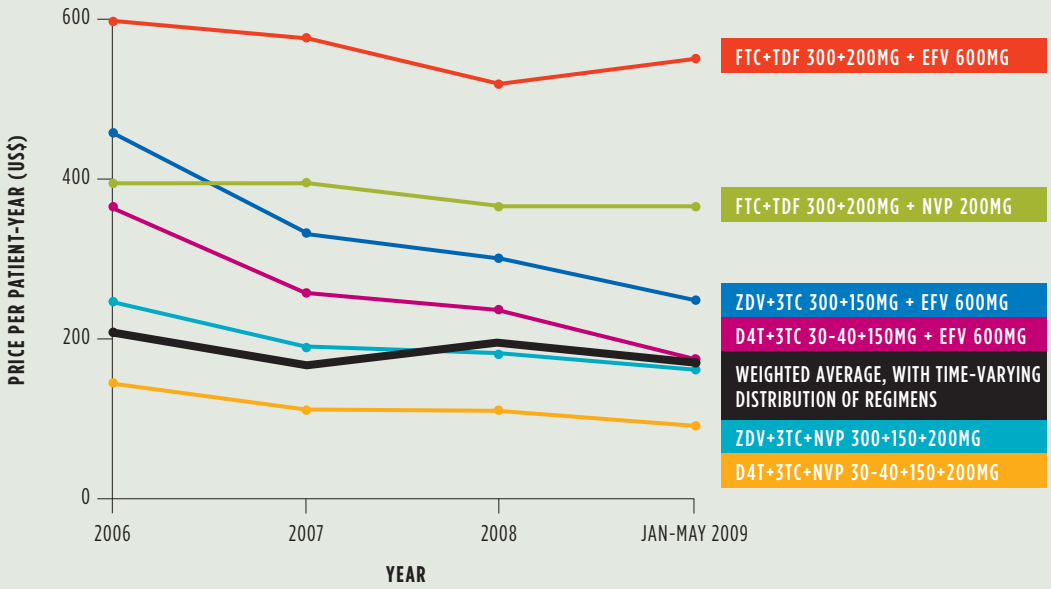
37. In 2008, the overall median price of commonly used drug regimens for all countries with Global Fund programs was US$ 188 (IQR: US$ 171 – $US 209). The median price increased with national income level (Figure 3.2).

38. The median price of all first-line regimens has fallen by an average of 12 percent per year between January 2007 and May 2009 (Figure 3.3). This suggests that as global demand for ARVs increases, country programs are gradually procuring them with greater efficiency. It is important to note, however, that the most common regimens differ considerably in their prices, so that actual ARV cost depends on how many patients use the different regimens. Between 2006 and 2009, countries increased the use of the more effective, yet more expensive, efavirenz and tenofovir-based regimens, and have begun phasing out the use of stavudine (d4T), in line with WHO 2009 treatment recommendations (30). As a result, despite the decreasing price of individual drugs, the average cost of first-line drugs per patient has remained stable (Figure 3.3).

39. In addition to the cost of ARVs, other costs involved in delivering ART include laboratory services, medical staff, infrastructure, M&E, program management and overhead costs. In-depth costing studies from selected programs have estimated that, between 2001 and 2009, these costs averaged about US$ 350, US$ 450, and US$ 500 per patient per year in low-, lower-middle, and upper-middle income countries, respectively (17–23). Adding these estimated costs to the country-specific ARV prices enables computation of an overall median cost per patient-year.

40. Based on these estimates, in 2008, the overall median cost of providing first-line ART for Global Fund programs was around US$ 588 per patient-year (IQR: US$ 571 – US$ 609): US$ 526 in low-income countries, US$ 645 in lower-middle income countries and US$ 740 in upper-middle income countries.

FIGURE 3.3 PRICES PAID FOR FIRST-LINE ADULT ARV DRUGS DECREASING OVER TIME



Notes: The averages weigh the six regimen prices according to their global-level share of patients, using regimen distribution data from 2006, 2007 (31) and 2008 data (32) (thick black line).

Abbreviations: 3TC: lamivudine; d4T: stavudine; EFV: efavirenz; FTC: emtricitabine; NVP: nevirapine; TDF: tenofovir; ZDV: zidovudine.

3.3.3 ANTIRETROVIRAL THERAPY: COST OF SECOND-LINE TREATMENT IN ADULTS

41. In order to improve the effectiveness of both development aid and the available therapeutic options, grant implementers are encouraged to invest in adherence support for first-line treatment. Sticking to a treatment regimen for life that involves taking daily medication, with potential side effects, presents many challenges that must be overcome if patients are to successfully remain on treatment. If drug resistance occurs through failure to adhere to ART, far more expensive second-line therapy may be necessary.

42. The median price of the six second-line ARV combination regimens most commonly used for adult treatment in 2008 was US$ 982 per patient-year (IQR: US$ 858 – US$ 1,413) in reporting countries in 2008: US$ 870 in low-income countries, US$ 1,176 in lower-middle income countries and US$ 2,439 in upper-middle income countries.

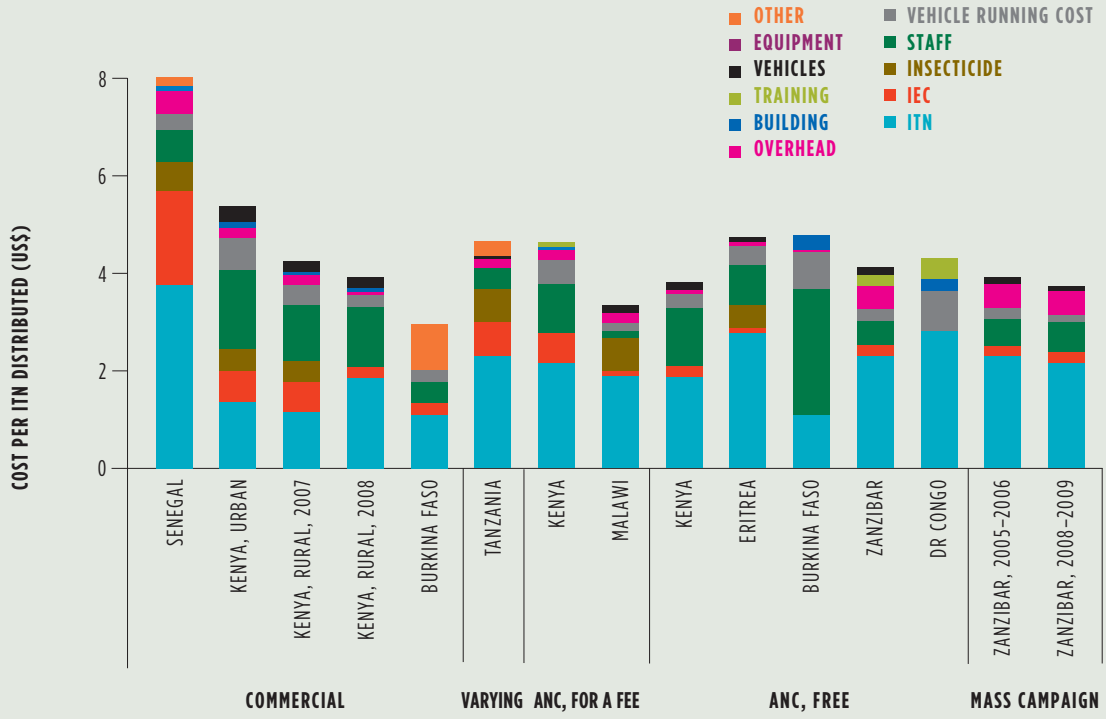
43. Assuming that the fixed non-drug costs are the same as for first-line treatment, the overall cost of providing second-line ART is approximately US$ 1,382 (IQR: US$ 1,258 – US$ 1,813) per patient-year of treatment.

3.3.4 ANTIRETROVIRAL THERAPY: OVERALL AVERAGE COST PER ADULT PATIENT

44. If, on average, 3 percent of adults on ART require second-line regimens (32), the overall average cost per patient-year would be around US$ 612 (IQR: US$ 591 – US$ 645) in 2008. These estimates are in line with expenditure data reported by national HIV programs reporting on progress in implementing the 2001 Declaration of Commitment on HIV/AIDS (United Nations General Assembly Special Session on HIV/AIDS (UNGASS) reporting) for the year 2007 (24, 25).

45. The expenditures included in the UNGASS reports suggest that program age and size influence the per-patient cost of ART, as has also been shown for HIV prevention services (33). Countries with smaller numbers of patients tend to have higher unit costs. This may reflect the fact that ART involves high investment costs (infrastructure, training and equipment) in a program's start-up phase when only few patients are treated, as well as the fact that drug prices and costs tend to fall at higher procurement volumes.

FIGURE 3.4 DISTRIBUTION COSTS FOR INSECTICIDE-TREATED NETS (BOTH CONVENTIONAL AND LONG-LASTING) BY DELIVERY CHANNEL



Note: Costs represent economic (annualized) costs.

Abbreviations: ANC: antenatal clinics; IEC: information, education and communication, ITN: insecticide-treated nets.

Sources: References 11–14.

3.3.5 CONVENTIONAL AND LONG-LASTING INSECTICIDE-TREATED NETS

46. National malaria programs began routine reporting of program expenditures by service delivery area to the WHO Global Malaria Programme in 2009. This will allow for the calculation of unit costs for the procurement and distribution of ITNs from 2010 onwards. For earlier years, data is available chiefly on the prices paid for ITNs, which is the main cost driver.

47. For the 55 countries reporting on procurement of LLINs, the median price decreased over time, from US$ 5.7 in 2004 (IQR: US$ 5.2 – US$ 7.0) to US$ 5.3 in 2009 (IQR: US$ 4.8 – $US 5.8). For conventional nets, which require regular re-treatment with insecticide, no clear trend was apparent in the small number of price reports, in which the overall median price in 2004–2007 was approximately US$ 3.6 (IQR: US$ 2.2 – $US 5.4). No procurements of conventional ITNs were reported after 2007, in line with the WHO recommendation to distribute only the more cost-effective LLINs. These figures are based on procurement records of 51 million and 4.6 million purchases for LLINs and conventional ITNs, respectively, from 2004 to November 2009 (10). They cover around 35 percent of the total estimated global purchases (34).

48. According to several in-depth, program-level costing studies, all of which were undertaken in sub-Saharan Africa, the cost of the ITNs is itself the largest cost driver. Cost patterns do not vary consistently by delivery channel (11–14). Other costs, such as distribution, communication activities, and program management, typically add up to US$ 2.0 per distributed net (IQR: US$ 1.7 – $US 3.4, Figure 3.4). As a result, the median overall cost per LLIN distributed in sub-Saharan Africa in 2008 was estimated at around US$ 7.3 (IQR: US$ 6.8 – $US 7.8).

3.4 MAXIMIZING IMPACT: COST-EFFECTIVENESS AND ECONOMIC RETURNS ON INVESTMENT

49. The Global Fund seeks to maximize the cost-effectiveness of supported interventions for obtaining given health outcomes, from proposal selection by the Technical Review Panel to the measurement of service unit costs that will enable country-specific cost-effectiveness evaluations. Research and evaluations show that ITNs, ACT, DOTS and HIV prevention interventions are highly cost-effective in low- and middle-income settings (11, 13, 21, 23, 35–42). ART and treatment of MDR-TB are somewhat less cost-effective, but essential for a comprehensive response. By investing in the most cost-effective interventions (e.g. prevention) now, it is also possible to save resources in the longer term by reducing the need for more costly interventions such as treatment.

50. For ITNs, DOTS and ART, the estimates of unit costs in Global Fund-supported programs presented in Table 3.3 are in line with the assumptions employed in cost-effectiveness analyses, confirming the cost-effectiveness of these interventions in most Global Fund-supported programs.

51. In addition to contributing to the health MDGs, supported interventions have important ancillary benefits to national economies. The WHO Commission on Macroeconomics and Health estimated that significant investments in health could lead to a direct return of over eight times the investment made per year (43). The wider returns on investments to respond to HIV, TB and malaria include:

- reductions in direct health care costs due to effective diagnosis, prevention and treatment, reducing cases and hospitalizations;
- reduced burden on the health system over time, by reducing mortality among health care workers and reducing the inpatient and outpatient burden of these diseases;
- microeconomic contributions such as reduced absenteeism, recruitment costs, improved productivity among the workforce and increased household income;
- macroeconomic contributions to economic and human development.

52. Direct savings within health systems have been noted as a result of investment in disease-specific programs. In South Africa, for example, the monthly cost to the health system decreased as adherence to ART increased (44). Effective malaria prevention has led to declining demand for treatment, for example, in Global Fund-supported programs in Rwanda and Ethiopia (45).

53. The wider health system benefits of effective disease programs include increased capacity in both inpatient and outpatient settings, and the improved working capacity of health workers. In Rwanda, effective malaria prevention resulted in a 56 percent decline in inpatient malaria cases, releasing the capacity of hospital beds (45). Global Fund-supported ART in Malawi contributed an additional 1,000 health worker days per week to the health care system by keeping HIV-positive staff alive (46).

54. At the microeconomic level, dollars spent on disease interventions – notably ART and malaria control – have brought economic returns in the form of improved worker efficiency, reduced absenteeism from work and reduced recruitment and re-training costs to employers (36, 47, 48). For example, in Cambodia, the rapid scale-up of free ART doubled the number of people living with HIV who worked full-time (49). The implementation of the Global Fund-supported HIV program in Malawi resulted in a decline in worker absenteeism by 40 percent (50), and made possible the enrolment and retention of 1,850 teachers by the end of September 2006 (51), by allowing them to remain alive and in the classroom.

55. Investments in public health have the ability to stabilize households. ART extends the lives of parents living with HIV, allowing them to care for their children and allowing children, who may themselves benefit from ART (52), to stay in school. Every year in India more than 300,000 children leave school to do household or income-generating work as a result of their parents' TB (53).

56. The potential macroeconomic return on health investments to countries is substantial. By strategically investing in health, countries contribute to the development of their economies and contribute to MDG 1 ("eradicate extreme poverty and hunger"). International comparisons and modeling studies suggest that:

- Malaria reduces economic growth by up to 1.3 percent in endemic countries (36).
- AIDS lowers national gross domestic product growth by up to 2.6 percent in high-HIV-prevalence countries in sub-Saharan Africa (47). 2.6 percent per year leads to a gross domestic product which is 67 percent lower than it would have been without AIDS.

- Scaling up DOTS implementation according to the Global Plan to Stop TB would generate an economic gain of US$ 1.6 trillion in the 22 high-TB burden countries alone. In sub-Saharan Africa, economic benefits would outweigh the initial costs by ten-fold within ten years, despite the challenges that HIV/TB co-infection poses (54). The potential societal benefits of DOTS implementation in India have been estimated to equal 4 percent of the gross domestic product (38).

57. By strategically investing in health, programs supported by the Global Fund have the potential to bolster developing economies. Initial evidence from selected programs shows that this generates economic returns that can, in the longer term, partially or even fully compensate the current costs and greatly extend the value of the investments beyond their basic cost-effectiveness (55).

58. Over 50 percent of disbursements of the Global Fund have occurred in the last two years, and recent rounds of funding (Rounds 8 and 9) are contributing to a more comprehensive response in countries. The full economic returns and development benefits of these programs will become increasingly apparent as investments are realized in the period from 2010–2015.

3.5 THE WAY FORWARD: CONTINUING TO IMPROVE AID EFFECTIVENESS AND VALUE FOR MONEY

59. Initial assessments of both aid effectiveness and value for money have identified important opportunities for improving program outcomes, and the Global Fund and its partners are supporting country actions in these areas. The Global Fund will increasingly rely on assessments of the unit costs of key interventions integrated in existing M&E systems.

60. As countries shift toward using the more effective yet more expensive ART regimens that WHO is now recommending for first-line treatment (30), the per-person cost of ART regimens may increase in the coming years, despite the falling prices of individual drugs. Increasing use of second-line treatment may also affect the median cost of treatment per patient. This prospect underscores the importance of combining the evaluation of costs with an assessment of service quality, to determine whether a given intervention or strategy is justified by health outcomes as well as costs, and the importance of investing in activities aimed at improving adherence to first-line regimens.

61. Routine expenditure reporting by national TB programs has revealed considerable variation in cost per patient treated under DOTS (Figure 3.1), consistent with the findings of several in-depth costing studies (56–59). Country income levels explained some of the variations in unit costs, but another major driver was the approach to hospitalization during treatment (16). This presents an opportunity for efficiency gains through collaboration with partners and implementers.

62. For ART and ITNs, the full ranges of cost variations have yet to be determined. The observed variations in drug and commodity prices by country income level nevertheless already indicate that the benchmarking of unit costs will have to be pursued with caution, taking into account country contexts such as local wages and program circumstances.

63. Careful use of unit cost estimates allow countries, grant recipients and the Global Fund Secretariat to compare service costs and improve the value of investments by reducing costs to the level achieved in comparable countries, without compromising the quality of service delivery or equitable access. In turn, this will enable program managers and Principal Recipients to develop sustainable packages of prevention, treatment and care services and ultimately to procure more money for health, and more health for the money.

IN RWANDA THE GLOBAL FUND SUPPORTED THE ESTABLISHMENT OF COMMUNITY-BASED SOCIAL INSURANCE TO COVER ORPHANS AND PEOPLE LIVING WITH HIV.

A CHILD STUDIES AT THE STAR CHILDREN'S HOME IN POKHARA, NEPAL, WHICH RECEIVES FINANCING FROM THE GLOBAL FUND. ALL 15 CHILDREN RECEIVING CARE FROM THE HOME ARE LIVING WITH HIV.

4. LEARNING AND INNOVATING

"The Global Fund is not only the place where we create partnerships, but it's the one where we have actually been able to do that differently – to set the pattern and learn. Maybe it's the place where we, more than anything, have learned to listen."

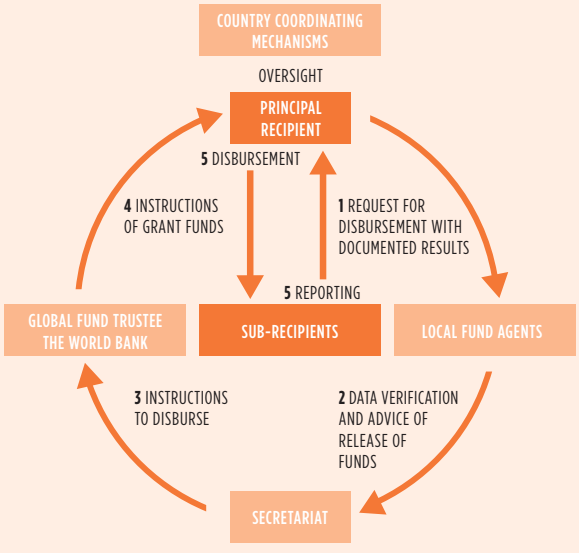
— SIGRUN MÖGEDAL
HIV/AIDS AMBASSADOR
NORWAY
DURING THE THIRD PARTNERSHIP FORUM, 2008

1. The Global Fund is committed to remaining responsive to countries and to continuing to improve the efficiency of its operations and the effectiveness of its investments. It learns through grant and Secretariat operations; evaluations; from studies undertaken by the Office of the Inspector General and through its partnerships. Each of these areas is discussed below.

4.1 LEARNING THROUGH GRANT AND SECRETARIAT OPERATIONS

2. ***Learning throughout the grant life cycle***. The Global Fund grant-making process has built-in feedback mechanisms that allow for ongoing learning and improvements. The grant-making process starts with the preparation of proposals by countries, supported by technical partners. Next, the Technical Review Panel[10] evaluates proposals on technical merit. This is follow-ed by a clarification process based on the panel review before recommendations are made to the Global Fund Board for approval for funding. Once approved, the grants are implemented by the Principal Recipients (see Figure 4.1). Implementation is carefully monitored using the performance-based funding approach, with a major review after 18 to 24 months (Phase 2 assessment), where decisions are made to approve funding for an additional three years. Each stage of the grant life cycle process provides an opportunity for the Global Fund Partnership to learn and innovate. (For a more complete explanation of the grant process, see Annex 2.)

FIGURE 4.1 THE GLOBAL FUND GRANT PROCESS



3. ***Proposal development***. CCMs are responsible for preparing and delivering grant proposals and this process presents learning opportunities for both the countries and the Global Fund. For example, countries learn by reviewing their national disease programs to identify the progress, gaps and constraints that will form the basis for preparing grant proposals. They also learn from the engagement with civil society, the private sector and affected communities that is required as part of the proposal development. Technical partners such as the STOP TB Partnership, the Roll Back Malaria Partnership and UNAIDS have mobilized their resources to support countries to prepare technically sound proposals.

4. The Global Fund Secretariat refines its policies and guidelines in response to lessons emerging from the proposals and recommendations made by the Technical Review Panel. Some of the important contributions and learning emerging from proposal development include the introduction of dual-track financing in 2008 (see section 4.5) and the inclusion of cross-cutting health systems strengthening components in grant proposals. To reflect Board policies and guidance from the Technical Review Panel, the Secretariat has also continuously improved the guidelines for proposal development.

5. ***Proposal review***. The large number of grant proposals reviewed by the Technical Review Panel provides a rich source of comparative information to identify strengths and weaknesses of the proposals submitted. The Technical Review Panel provides written feedback to applicants that can be used to improve the technical merit of subsequent proposals and programs. At the same time, country needs are identified – for example, the need to further simplify the proposal submission process, which over time has become too onerous for some countries. Recommendations from Technical Review Panel reports have informed several major innovations and reforms in the Global Fund (see Table 4.1).

10 The Technical Review Panel is an independent group of international experts in health and development, established by the Global Fund Board to review grant proposals for technical merit and then make funding recommendations to the Board.

6. ***Grant implementation***. In the Secretariat, learning and continuous improvement occur through the management and transfer of knowledge. The Secretariat provides information on all aspects of the grant cycle, through fact sheets, guidelines and other relevant technical materials and makes them publicly available on the Global Fund website. In addition, the Secretariat expects that the Enhanced Financial Reporting system and the recent development of an internal knowledge hub will facilitate rapid and easy access to the latest information related to Global Fund operations. To improve its own processes and to facilitate planning, the Secretariat has created working groups and task forces on themes such as data quality, gender equality, sexual orientation and gender identities, harm reduction, health systems strengthening, and grant signing.

7. ***Phase 2 reviews***. The Phase 2 review process is an important point for reflection and learning in the grant life cycle. Countries take stock of their grant performance at 18 to 24 months and develop a revised proposal for the next three years. A Phase 2 Panel consisting of representatives from various clusters of the Global Fund Secretariat evaluates the Phase 2 requests to determine whether funds are spent efficiently, programs are well managed and achieving the expected results, and funding requests are justified. On the basis of this evaluation, the panel makes recommendations for Board consideration and for funding decisions. The Phase 2 process offers countries the opportunity to address weaknesses and to refine strategies for scaling up interventions. In a few cases, non-performing grants have been suspended.

8. ***Secretariat review of key performance indicators***. Reviewing the key performance indicators provides the Global Fund with another major source of learning (1). These indicators and their associated targets enable the comprehensive assessment of various aspects of the Global Fund's performance including:

- the operational performance of the Secretariat (resource mobilization, administrative effectiveness, portfolio management and special initiatives);
- grant performance (programmatic achievements including health and community systems strengthening and the performance of the Global Fund grant portfolio);
- effectiveness (aid effectiveness, transparency and accountability and overall health and community systems strengthening); and
- impact (the success of the Global Fund, its partners and implementing countries in fighting HIV, TB and malaria, and in helping attain the MDGs).

9. The Board, through its Policy and Strategy and Portfolio Implementation committees, reviews the performance of the Secretariat against the key performance indicators and their associated targets every six months. This internal review of progress, achievements and challenges enables the Global Fund to learn and refine its strategies regularly and to focus on ways to improve grant performance and the Global Fund's overall effectiveness and impact.

TABLE 4.1 EXAMPLES OF INNOVATIONS AND REFORMS BEING IMPLEMENTED IN RESPONSE TO RECOMMENDATIONS BY THE TECHNICAL REVIEW PANEL

ISSUES	RECOMMENDATIONS	RESPONSE
Procurement systems and supply management of health products are major constraints to improved performance.	Address key procurement "bottlenecks", e.g. ensuring transparency and cost efficiency in procurement process and reducing lead time and delays in procurement and deliveries.	Introduction of Voluntary Pooled Procurement and of the associated capacity building services program (see Section 4.5).
Existing national strategies are of variable quality, and donor-supported programs are frequently not aligned to national planning cycles.	Support robust, inclusive and country-owned national strategies and thereby improve alignment to national programs and planning cycles.	Development of the First Learning Wave of the National Strategy Applications (see Section 4.5).
Increased complexity of Global Fund grants leading to: - fragmented, project-style resource planning; - multiple grants in the same disease area; - multiple budgets and performance frameworks; and - different grant-specific timelines for phase 2 reviews.	Simplify grant implementation and management for both program implementers and the Secretariat. Reduce transaction costs related to reporting and disbursements. Facilitate the support of national programs.	Implementation of the new grant architecture designed to lead to a single stream of funding per Principal Recipient, per disease, and a fixed three-year review and commitment cycle (see Section 4.5).
Existing Phase 2 grant performance reviews are focused on specific grants rather than the broader national situation.	Improve performance-based funding through a more transparent and holistic view of Global Fund-financed activities in a country.	Redesign of grant performance report and Phase 2 process introduced in 2010.

4.2 LEARNING THROUGH EVALUATIONS

10. In 2003, the Global Fund Board established the Technical Evaluation Reference Group to provide independent technical advice and assessment on the Global Fund's work in M&E. The Technical Evaluation Reference Group is composed of nine Board-appointed and four ex-officio members from WHO, UNAIDS, the Roll Back Malaria Partnership and the Global Fund Secretariat, representing a broad range of disciplines relevant to M&E. Most recently, it has overseen the Five-Year Evaluation of the Global Fund.

11. ***The Five-Year Evaluation***. In 2006, the Global Fund Board approved a comprehensive external evaluation of its overall performance with respect to its goals and principles after five years of operation (i.e. after the first full grant cycles had been completed). The Board requested that the Technical Evaluation Reference Group oversee the design and implementation of the evaluation and present the final Synthesis Report to the Board in May 2009.

12. The Five-Year Evaluation found that the Global Fund has made significant contributions towards its original aims (2). It concluded that the Global Fund has mobilized and made available high levels of funding to countries within a relatively short timeframe and is making an important contribution to the scaling-up of key interventions for the prevention and control of HIV, TB and malaria and the strengthening of health systems.

13. The evaluation also identified a number of unresolved policy and strategic challenges that needed to be addressed (see Table 4.2). The Secretariat carefully scrutinized the evaluation's 100-plus recommendations and developed a management response, including a set of strategies and timebound actions to further improve the efficiency and effectiveness of its operations. In addition, the Board established a subcommittee of the Policy and Strategy Committee to follow up on the recommendations of the evaluation (see Table 4.2).

14. The Five-Year Evaluation also recommended that, rather than embarking on large-scale, multicountry evaluations every five years, the Global Fund and its partners should establish frequent, rigorous and continuous evaluations of the business model and national programs for the control of the three diseases and health systems strengthening.

TABLE 4.2 KEY RECOMMENDATIONS FROM THE FIVE-YEAR EVALUATION AND THE RESPONSE FROM THE GLOBAL FUND SECRETARIAT

RECOMMENDATION	RESPONSE
RESOURCE MOBILIZATION	
Address concerns about the sustainability, predictability and additionality of further funding	• Developed resource mobilization strategy to diversify funding sources • Initiated measures to achieve efficiency gains in grants portfolio and within the Secretariat • Established working group to address tension between resource demand and supply
THE GLOBAL FUND PORTFOLIO OF INVESTMENTS	
Address gaps in the portfolio of investments to move toward universal access to AIDS, TB and malaria interventions, further strengthen health systems, and improve equity and gender equality	• Review of portfolio of investments to identify gaps in collaboration with partners • Collaboration with CCMs, Principal Recipients and partners to re-program existing grants to address service gaps
THE GLOBAL FUND BUSINESS MODEL	
Develop a corporate strategy that reconciles the inherent tensions within the principles that underpin the Global Fund's business model and refine the performance-based funding system	• Board review of Global Fund principles to address tensions that have emerged • Introduced new grant rating methodology
GRANT-MAKING MECHANISM	
Innovate and simplify grant architecture	• Implemented First Learning Wave of National Strategy Applications • Board-approved architecture review for a single stream of funding, per Principal Recipient, per disease
BUILDING AN EFFICIENT AND EFFECTIVE ORGANIZATION	
Improve efficiency and effectiveness of the Global Fund	• Restructured Secretariat to improve human resource and operational efficiency • Prioritized and began implementing mission-critical systems (such as deployment of information technology, strengthening procurement, and enhancing internal and external communications) • Introduced Risk Management Framework

IN EGYPT, THE GLOBAL FUND SUPPORTS THE NATIONAL TUBERCULOSIS CONTROL PROGRAM. THE COUNTRY HAS SUCCEEDED IN ACHIEVING THE GLOBAL TARGETS FOR TB CASE DETECTION AND TREATMENT SUCCESS.

15. In response, the Secretariat is developing a systematic approach to evaluation, knowledge generation and learning, and working with key technical partners and countries to conduct continuous monitoring of the programs it finances, including evaluations in five to seven countries each year. These evaluations will assist:

- efforts to strengthen country health information, surveillance, and M&E systems, along with analytic capacity and the use of evidence for program management;
- in identifying optimal service delivery designs to effectively scale up HIV, TB and malaria services; and
- in measuring epidemiological impact and health systems effects of Global Fund investments.

16. The Global Fund commissions independent evaluations to complement its own evaluations and those conducted by country partners. The Board, Board committees, Executive Management Team and Technical Evaluation Reference Group decide annually on the focus of these evaluations.

17. The Global Fund adheres to the following fundamental principles for conducting evaluations:

- Be a joint learning process with mutual accountability.
- Use existing systems.
- Align with country governance cycles.
- Build institutional capacity.
- Develop staff member competencies.
- Use standardized tools to allow for comparability among countries and over time.
- Balance scientific rigor and feasibility.
- Seek to be objective.

4.3 LEARNING FROM STUDIES UNDERTAKEN BY THE OFFICE OF THE INSPECTOR GENERAL

18. The Office of the Inspector General was established by the Board of the Global Fund in July 2005 and began work in December 2005. The Office of the Inspector General operates as an independent unit of the Global Fund, reporting directly to the Board.

19. Led by the Inspector General, the mission of the Office of the Inspector General is to provide the Global Fund with independent and objective assurance over the design and effectiveness of controls in place to manage the key risks impacting the Global Fund's programs and operations.

20. The scope of work of the Inspector General encompasses all aspects of the Global Fund's activities. All systems, processes, operations, functions and activities within the Global Fund are subject to the Inspector General's review. The activities of the Office of the Inspector General include audit, inspection, counter-fraud and promotion of ethical conduct, investigations, assurance validation, and functional reviews. In performing these activities the Inspector General has the authority to access all books and records maintained by the Global Fund, including all records relating to grants funded by the Global Fund, whether maintained by Principal Recipients, sub-recipients, Local Fund Agents or Local Fund Agent subcontractors, where permitted under applicable arrangements. The Inspector General can seek any information he needs from any personnel involved in the Global Fund's projects and require personnel to cooperate with any reasonable request made by the Office of the Inspector General. In addition he may obtain independent professional advice and secure the involvement of outside persons with relevant experience and expertise if and when determined necessary.

21. Since its inception, the Office of the Inspector General, as part of its mandate to provide assurance on grant processes and other main business processes, has undertaken a number of country audits and reviews of processes at the Global Fund Secretariat. As part of its 2009 work plan, the Office of the Inspector General synthesized the issues arising from the audits/reviews undertaken to identify common issues emerging as well as their likely causes. In a report published in September 2009, the Office made a number of concrete recommendations aimed at strengthening grant processes.

22. The Secretariat has put in place new systems to further strengthen its approach to managing risk. In particular, this involves a systematic approach and dedicated resources to follow up on the findings and recommendations of the Office of the Inspector General. The Secretariat analyses the recommendations in each of the Office's reports and allocates responsibility for implementing them within a certain timeline. Senior management monitors progress of implementation. For example, the Secretariat is finalizing Principal Recipient Financial Audit Guidelines in response to the Office's recommendations on Principal Recipient audit arrangements.

4.4 LEARNING THROUGH PARTNERSHIPS

23. The Global Fund is a public-private partnership of donor and recipient governments, technical agencies, NGOs, the private sector (including businesses and philanthropic foundations) and affected communities. This diversity is reflected in its Board and Committee structures, the Partnership Forum and the CCMs.

24. ***Country Coordinating Mechanisms***. At the country level, the CCM embodies the Global Fund principles of inclusiveness, country ownership and partnership through multistakeholder collaboration. CCMs include NGOs, governments, multilateral and bilateral agencies, academic institutions, private businesses, and people living with and affected by the three diseases.

BOX 4.1 THE THIRD PARTNERSHIP FORUM, DAKAR, DECEMBER 2008

The overarching theme of the Third Partnership Forum was "*Listening to the voices: stronger and more effective partnership for sustained impact*". The forum examined this theme in five areas: partnership and gender (women and girls), partnership and gender (sexual minorities), partnership and demand, partnership and coordination, and partnership and implementation. The process culminated in a meeting in Dakar attended by around 500 delegates.

The Partnership Forum generated 28 recommendations that are being used by the Secretariat, the Board and its committees to develop new strategies and improve the effectiveness of the Global Fund. Examples of these recommendations include ensuring that partnership agreements of the Global Fund have a component on technical assistance and capacity building, and that countries should work within the frameworks of "know your epidemic" and "know your response" strategies. The Partnership Forum also requested the Global Fund to develop an accountability framework and action plan to prevent grants from performing poorly and to support those that do.

25. The CCM serves as an interface between the national situation and Global Fund policies and funding. By providing a broad platform for national dialogue, the CCM is better able to assess implementation challenges and to recommend solutions that are informed by local context. Through regular interactions with the Secretariat, supported programs and Global Fund partners, CCMs bring the voice of local communities to Global Fund policy.

26. ***The Partnership Forum***. The Partnership Forum is an integral part of Global Fund governance and is designed to enable a platform for frank discussion of strategies and policies, providing stakeholders – including some actors who are not currently involved in Global Fund work – an opportunity to learn from and debate issues with each other. The objectives of the Partnership Forum are to:

- review and provide feedback on Global Fund progress;
- develop recommendations for strategy, policy and practice; and
- mobilize and sustain political commitment for action on HIV, TB and malaria, including sustainable, long-term financing (3).

27. The Partnership Forum takes place every two years. It consists of online discussions, consultations on certain themes at a variety of internal and external events, and a large stakeholder meeting. Partnership fora were held in Bangkok in 2004 (4), in Durban in 2006 (5), and in Dakar in 2008 (see Box 4.1) (6).

4.5 CONTINUING TO UNDERTAKE NEW INITIATIVES AND INNOVATE

28. From the start, the Global Fund has sought to adopt key innovations in the field of development, such as country-driven demand and performance-based funding, and to evolve them further, beyond what other organizations have done before. It has continued to undertake new initiatives and to introduce other major innovations. Some of these developments are summarized in Table 4.3 and described below.

29. ***Country-driven demand***. For the first time, a global institution allowed its resource mobilization goals to be determined primarily by country demand, linking grant eligibility to participatory proposal development and program oversight by the stakeholders themselves. The demand-driven approach has encouraged not only the public sector but also civil society to address the health and health system problems of those most in need: low-income countries, countries with high disease burdens, and vulnerable, at-risk and marginalized groups.

30. Country-driven demand improves planning at the national level by starting the process with assessments of realizable needs rather than second-guessing available resources. It has also enabled global resource planning by introducing a new element between the traditional, global "needs estimates" for each disease on the one hand and expressions of resources available made by individual donors on the other. By introducing a figure for "fundable, high-quality demand" the Global Fund country-driven demand process has been able to convince donors to place substantial additional resources on the table in exchange for reassurances of a positive return on investment.

31. The response to the first nine funding rounds (2002–2009) underscores the huge demand for assistance in low- and middle-income countries, yielding a total of 1,610 eligible proposals for review by the independent Technical Review Panel.

32. ***Performance-based funding***. In less than five years, the Global Fund has developed an operational platform to implement performance-based funding in 144 countries. It has learned and progressively strengthened its performance-based funding model to invest strongly in M&E systems, include impact data, and consolidate reporting. This model has been recognized by the Five-Year Evaluation and other independent evaluations as unique in terms of its innovativeness and the scale at which it has been implemented (2,7).

33. At the same time, challenges and opportunities for improvement have been identified. For example, the simplification of reporting into one-year and three-year cycles could increase alignment and reduce transaction costs. The Global Fund is also placing a greater emphasis on impacts, outcomes, value for money, equity and the quality of services. The implementation of a new grant architecture (described below) will address some of these challenges through single streams of funding, a more holistic assessment of program performance and impact, and increased alignment to national program cycles.

34. ***Country Coordinating Mechanisms***. A CCM's capacity for oversight is critical in ensuring that the country uses its grant resources effectively to achieve its program goals in a sustainable manner (see Annex 2 for more about the role of CCMs). In 2009, the Global Fund continued its efforts to strengthen the governance and grant oversight capacities of CCMs. The Board approved a new CCM funding policy that applies the principle of performance-based funding to CCMs' key governance functions. To date, the Global Fund has provided each CCM with a maximum of US$ 43,000 per year to support its governance functions. Under the new policy, a CCM will be able to access more funds, provided that it invests them in oversight, constituency engagement and alignment with suitable in-country bodies or activities to strengthen its own capacities, particularly those related to gender equality.

35. ***Dual-track financing***. Based on evidence that civil society organizations and the private sector play a critical role in scaling up programs and reaching at-risk populations, a process dubbed "dual-track financing" was introduced in Round 8 (2008) as the default approach to program partnership. Through this new mechanism, CCMs are encouraged to nominate both a government entity and an NGO to be Principal Recipients in a grant. As a result, around 40 percent of Principal Recipients in Rounds 8 and 9 are non-governmental, compared to just 23 percent over the previous seven rounds.

A SOCIAL WORKER MAKES HOME VISITS TO SUPERVISE PATIENTS TAKING THEIR TB MEDICINE IN JORDAN. THE GLOBAL FUND SUPPORTS JORDAN IN OPENING UP TREATMENT FOR ALL, INCLUDING PALESTINIAN SETTLERS AND NON-JORDANIAN NATIONALS – WHO COLLECTIVELY MAKE UP MORE THAN ONE-THIRD OF THE POPULATION.

TABLE 4.3 INNOVATION MILESTONES AT THE GLOBAL FUND (2002–2008)

YEARS	STRATEGIC AREA	INNOVATION
2002–2005	• GLOBAL FUND PRINCIPLES	• The key principles are established and disseminated: a demand-driven approach, performance-based funding, inclusiveness, and independent technical review.
2006–2007	• RESOURCE MOBILIZATION	• (PRODUCT)RED, a source of private funding, is launched. The first Debt2Health agreement is signed between Germany and Indonesia.
2008	• PARTNERSHIPS	• Dual-track financing is introduced in Round 8, enabling governments and NGOs to expand service delivery.
	• EQUITY	• The Board approves the Gender Equality Strategy and pushes for increased representation of vulnerable groups in CCMs.

36. ***Health systems strengthening***. The Global Fund has supported health systems strengthening efforts since its inception, recognizing that to ensure the long-term effectiveness of investments in disease-specific programs, it is necessary to strengthen health systems. However, until 2005 the ways in which Global Fund-supported programs contributed to strengthening health systems could not be explicitly tracked. Round 5 made the first call for separate health systems strengthening grant applications. That option was discontinued because of low uptake. Since Round 7, countries have been able to include funding for strategic health systems strengthening activities as an explicit part of disease-specific grant applications. Health systems elements eligible for funding include human resources, infrastructure and equipment, and M&E. The strategic actions are coordinated with in-country partners as well as with national health plans. To date, a total of US$ 1.2 billion has been approved for cross-cutting health systems strengthening interventions.

37. ***(PRODUCT)RED*** is the best known of the initiatives and partnerships that has enabled the Global Fund to significantly increase private sector resource mobilization in recent years. Initiated in 2006 by rock musician Bono and Bobby Shriver (Chair of Debt, AIDS, Trade and Africa (DATA)), (RED) supports the Global Fund through the sale of popular brand-name products bearing the (PRODUCT)RED logo. Up to 50 percent of the gross profits from the sale of these products are then directed to the Global Fund. Current partners include American Express (UK), Apple, Converse, Dell, Emporio Armani, Gap, Hallmark, Microsoft and Starbucks. New partner launches in 2009 included Bugaboo and Nike. Bugaboo, the Netherlands-based pushchair manufacturer, became the first company to support the Global Fund by offering 1 percent of net revenues across its entire product range. Nike became the first partner to sell (RED) products in Africa. In 2009 (RED) also launched an exclusive concert series – (RED)NIGHTS – benefiting the Global Fund. (PRODUCT)RED has raised US$ 140 million as of the end of 2009 to support programs in Rwanda, Ghana, Lesotho and Swaziland, and continues to be an innovative source of sustainable, additional private funding.

38. ***Debt2Health***. In 2007, the Global Fund launched an initiative which facilitates debt swap agreements between creditors and recipient countries. While debt swaps are known development financing instruments, the innovative feature of Debt2Health is that creditors agree to relinquish interest payments on a country's debt on the condition that the recipient country invests the freed-up resources in public health using the Global Fund system. By the end of 2009, two agreements had been signed and a third was pending signature. These three agreements cover debts with a face value of US$ 146 million and will eventually raise US$ 80 million to fight disease. Another three agreements with a face value of US$ 110 million are being negotiated, with the potential to generate additional resources of US$ 74 million.

39. In 2009 the Global Fund launched a number of innovations and other initiatives aimed at strengthening country governance and health systems and addressing access issues (Table 4.4). They are described in the following sections.

40. ***New grant architecture***. As the Global Fund has grown in size and capacity, demand for financing from countries with heavy disease burdens has accelerated to a point where streamlining procedures and simplifying grant management is critical to ensure operations are efficient. Under the Global Fund's current model, each newly approved proposal results in a separate grant agreement. By contrast, under a new grant architecture approved by the Board of the Global Fund in November 2009, the Global Fund will establish a single stream of funding per Principal Recipient per disease. It will then maintain this grant agreement, updating it each time the Board approves a new funding proposal for the same country and disease. It is anticipated that this new architecture will enable Principal Recipients to manage their programs and finances more efficiently, as well as improve program M&E. By streamlining the grant process, the Secretariat also expects to manage its grant portfolio more efficiently and effectively.

41. ***National Strategy Applications***. A first "learning wave" of so-called "National Strategy Applications" was launched in 2009 on a pilot basis, offering a new way to apply for financing based on a country's national disease strategy, rather than the standard proposal-based grant applications.

42. The anticipated benefits of National Strategy Applications are:

- improved alignment of Global Fund financing with national priorities, program cycles and budgetary cycles, and reduced transaction costs for countries;
- improved harmonization with donors that use similar criteria for reviewing national strategies;
- an opportunity to promote broad stakeholder participation in national strategy development and implementation; and
- encouraging national strategies to focus on managing for results and accountability.

43. In November 2009, the Board approved five National Strategy Applications worth US$ 434 million over two years (and US$ 756 million over the lifetime of the proposals).[11] The Global Fund will negotiate and manage these grants in a manner that maximizes their alignment with national policy and budget cycles while maintaining its core principles, including the principle of performance-based funding. Grants that result from this first learning wave will be managed as part of the new grant architecture.

44. ***Services to prevent vertical transmission***. A new Global Fund initiative aims to improve the quality and coverage of services to prevent vertical transmission. The percentage of HIV-positive women who received ART to prevent transmission of HIV to their children increased from 35 percent globally at the end of 2007 to 45 percent at the end of 2008. While the improved global coverage and rate of scale-up of programs to prevent vertical transmission (commonly referred to as PMTCT services) is encouraging, coverage remains low in many of the countries with the highest need and nearly a third of women received sub-optimal ARV prophylaxis (single-dose Nevirapine).

45. The Global Fund has supported access to PMTCT services for 340,000 HIV-positive pregnant women in 2009 alone – over five times the number of pregnant women reached two years ago by Global Fund-supported programs. As part of a PMTCT initiative, the Global Fund is committed to improving the quality of ARV regimens being offered to pregnant women, newborns and families, increasing the resources directed at PMTCT and ensuring that current funding in this area is being used effectively and efficiently. In order to achieve this, the Global Fund has set two ambitious but achievable targets:

- Target 1: In the next 18 months, the Global Fund will work to ensure that at least 80 per cent of HIV-positive mothers reached through Global-Fund supported programs receive the most optimal regimen to prevent transmission.
- Target 2: In the next 18 months, PMTCT coverage will be scaled up to reach at least 60 percent of HIV-positive mothers in countries in sub-Saharan Africa with the highest burden of mother-to-child transmission and pediatric AIDS: Nigeria, South Africa, Mozambique, Kenya, Tanzania, Uganda, Zambia, Malawi, Zimbabwe, Ethiopia. (While this is not an official UN target, the Global Fund will work with all partners, including the UN, PEPFAR, implementing countries and others to increase coverage and impact).

46. ***The Affordable Medicines Facility – malaria (AMFm)***. Improving access to affordable medicines and other health products is a critical component of efforts to improve health outcomes. AMFm is a pioneering financing mechanism that the Global Fund is hosting. It was originally proposed in a committee report from the U.S. Institute of Medicine (8) in 2004. The AMFm technical design was developed with guidance from the Roll Back Malaria Partnership.

47. Launched in April 2009, AMFm will expand access to ACT for the treatment of malaria through the public, private and civil society sectors. In addition to substantially reducing the burden of disease due to malaria, this is expected to retard the resistance of malaria to artemisinin by replacing artemisinin monotherapy with ACT. AMFm has two key elements:

- reducing prices by negotiating with drug manufacturers and subsidizing a part of the resulting price with a "co-payment"; and
- supporting the proper use of ACT.

48. After negotiating lower drug prices with manufacturers, the AMFm will pay a large part of the resulting price (i.e. make a substantial co-payment) on behalf of eligible first-line buyers – international and national buyers that purchase the drugs directly from the manufacturer, as well as procurement agents acting for them. ACT will then be delivered through a combination of public, nongovernmental and private channels.

49. Public sector and nongovernmental outlets will continue their practice of distributing the treatment for free or for a modest charge. For people who purchase malaria treatment from the private sector, the price of co-paid ACT drugs should be comparable to the price of other antimalarial drugs, such as chloroquine and sulfadoxine-pyrimethamine. The price of ACT is expected to drop from US$ 11 per treatment to less than US$ 1.

11 The successful National Strategy Applications were China (malaria), Nepal (TB), Rwanda (HIV and TB) and Madagascar (malaria).

TABLE 4.4
INNOVATION MILESTONES AT THE GLOBAL FUND (2009)

STRATEGIC AREA	INNOVATION
AID EFFECTIVENESS	• A new grant architecture to streamline grant design, implementation, and M&E • National Strategy Applications
COUNTRY OWNERSHIP	• First Learning Wave of National Strategy Applications
ACCESS TO MEDICINES AND RELATED COMMODITIES	• Affordable Medicines Facility – malaria • Voluntary Pooled Procurement
HEALTH SYSTEMS STRENGTHENING	• Proposal for a joint platform for funding and technical support of health systems strengthening

50. In early 2010, ten pilot projects (in Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Rwanda, Uganda and in the United Republic of Tanzania (mainland and Zanzibar)) will participate in Phase 1 of the AMFm and implement interventions to promote appropriate use of ACT drugs. Financial support for the pilot projects comes from UNITAID, the government of the United Kingdom, and the Bill and Melinda Gates Foundation.

51. ***Voluntary pooled procurement***, also launched in June 2009, revolves around collective purchasing of drugs and related commodities. This initiative aims to influence characteristics such as price, quality and supply by bulk purchasing, thereby facilitating ready access to medicines and other products. Four product categories constitute the initiative's initial focus: first-line ARVs, second-line ARVs, ACT drugs and LLINs. The short-term strategy includes monitoring the prices, cost savings and market share, while the long-term strategy will focus on strengthening national procurement systems and supply chain management. Procurement transactions worth US$ 271.4 million have been processed so far for 16 countries and 24 grants. Another 18 countries have registered for voluntary pooled procurement and have submitted requests for procurement assistance. To date, ten countries have expressed interest in receiving capacity building and supply chain management assistance.

52. ***A common platform for health systems strengthening***. Another new initiative is the proposed common funding platform for health systems strengthening with the World Bank and the GAVI Alliance, facilitated by WHO. Collectively, working with partners and countries during 2010, the four agencies will elaborate the policy, operational and financial implications of this platform. Among the platform components to be developed are common funding policies for health systems strengthening, common country eligibility criteria, joint review mechanisms for proposals, program oversight, harmonization of technical support and a common framework for measuring performance. For the first time, these major global agencies have proposed to jointly use their resources for health systems strengthening in low- and middle-income countries. Some of the expected benefits of the joint platform are reduced transaction costs for countries in accessing funding for this strategic area; increased global focus on health systems strengthening; better long-term predictability of donor funding and improved harmonization and alignment of funding and programming for health systems strengthening at the global and country levels.

GLOBAL FUND ASSISTANCE TO WOMEN AND CHILDREN LIVING WITH HIV IN TANZANIA HAS HELPED INCREASE UPTAKE OF COUNSELING AND TESTING, PROVISION OF ART, AND USE OF PMTCT SERVICES, AND HAS ALSO SUPPORTED PROGRAMS FOR ORPHANS AND OTHER VULNERABLE CHILDREN.

A VILLAGE DOCTOR IN CHINA MONITORS THE HEALTH OF RECOVERING TB PATIENTS, WALKING AN HOUR EACH DAY TO VISIT THEM IN THEIR HOMES AND MONITOR THEIR MEDICATION. THE GLOBAL FUND SUPPORTS THE EXPANSION OF DOTS IN CHINA.

5. CONCLUSIONS

"The Global Fund program has been a good supplement to government programs. The coverage area for prevention activities and treatment has been expanded a great deal and now reaches as far out as the villages. Thanks to the village clinics and doctors everybody has access to services in TB, malaria and HIV."

— DR XU
YUNNAN PROVINCE, CHINA

1. In recent years, the world has made remarkable progress in many areas of global public health. In particular, **there are signs of a dramatic turnaround in the fight against AIDS, TB and malaria**. The coming years will doubtless see **even more positive results and greater impact**, given the recent intensification of efforts – more than half of all the services financed by the Global Fund so far were delivered in 2008 and 2009 and are only just now starting to show results in terms of lives saved and infections averted.

2. **The global effort to fight AIDS, TB and malaria has a wider impact and benefits everyone**. The three diseases are directly responsible for enormous burdens of death and disability, but they also have major repercussions for human development and society. Global Fund programs contribute substantially to the achievement of the MDGs. **The MDG 6 targets for combating HIV, malaria and other diseases can be met, and some can even be exceeded, if progress is allowed to continue at the current rate**. Malaria can be eliminated as a public health problem in most endemic countries, the growing threat of MDR-TB can be contained, and transmission of HIV from mothers to their children can be virtually eliminated.

3. **Global efforts to fight AIDS, TB and malaria**, as channeled through the Global Fund, **also contribute to achieving MDGs 1, 4, 5 and 8**, addressing extreme poverty and hunger, child health, maternal health and global partnership, respectively. The efforts supported by the Global Fund to improve children's and women's health are particularly important, as they support the scale-up of basic services for women and children, in addition to fighting AIDS and malaria, two of the main causes of death among women and children in many regions of the world.

4. **Investments that have been made have also strengthened health systems**. By setting ambitious targets and making funding flows dependent on achieving these, the performance-based funding model of the Global Fund has exposed health systems' weaknesses and provided an incentive and the funding to address them. Investments undertaken, while focused on achieving progress in the fight against the three diseases, have helped strengthen the overall capacity of health systems by expanding community and district health facilities, improving procurement and administration capacity and retaining health workers.

5. For the last eight years, **the Global Fund has been a major engine driving dramatic advances in the fight against HIV, TB and malaria**. The programs it has funded have saved 4.9 million lives and improved the quality of life of many of the some 33 million people living with HIV, hundreds of millions of people who contract or are at risk of contracting malaria each year, and 9.4 million who contract active TB annually. The Global Fund has also been a driver for increased funding. It has proven itself as an efficient channel for this funding to health programs in 144 countries. It has focused international efforts of dozens of public, private and multilateral institutions towards achieving ambitious, measurable targets.

6. In this sense, **the Global Fund is driving a major global effort** that is on the road to achieving impressive successes in the fight for global health. All partners and stakeholders should take considerable pride in the role they play in this work.

7. As the economic crisis of the past two years has led to considerable pressure on government budgets and to tremendous hardship for hundreds of millions of people around the world, **the Global Fund's work to improve value for money, increase efficiency and to channel resources to where they achieve the best results has become even more important** than before.

8. The past year's economic crisis dropped millions of people below the poverty line. It followed a period of solid economic growth in many places that lifted millions out of poverty. Through its programs, **the Global Fund and its partners can help provide a safety net for some of the poorest and most vulnerable populations**, thereby partly alleviating the impact of the financial crisis. These programs can also help bridge the health gaps that often accompany income gaps, for example by helping to retain health workers in impoverished areas where they are needed most, and by providing prevention, treatment and care services to people who are otherwise unable to afford them. In addition, the Global Fund brings together North and South in decision-making, thereby encouraging them to create a shared vision and common purpose.

9. **The Global Fund strives to be a 21st-century international development agency – efficient, transparent and adaptable**. Established as a public-private partnership, it has introduced numerous major advances and best practices to its systems, policies, infrastructure and operations, allowing it to leverage its resources substantially in scaling up the fight against HIV, TB and malaria. The Global Fund is country-focused, and its organizational structure allows it to rapidly respond to the needs of its partners and the people affected by the three diseases.

10. This report describes the gaining of great momentum in global health. Goals that only a few years ago seemed utopian are within reach. **Now is the time to further intensify efforts** and to make a commitment to continue scaling up the response to HIV, TB and malaria, to safeguard and continue building upon the substantial achievements already made. While the results and impact described in this report should be cause for optimism, the progress made in the last years is fragile. A reduction – or even stagnation – of efforts would lead to reversals of recent progress. Continued, increased investments in health generally and in HIV, TB and malaria specifically, are needed, not only to reach or exceed the health-related MDGs, but also to preserve global stability and protect countries and communities at risk of disease.

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CHAPTER 2

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THE GLOBAL FUND SUPPORTS HEALTH AUTHORITIES IN VIET NAM TO STRENGTHEN AND IMPROVE THE MANAGEMENT OF MALARIA CONTROL AT ALL LEVELS, INCLUDING ENSURING ADEQUATE PROVISION OF DRUG SUPPLIES.

ANNEX 1
LIST OF BOXES, FIGURES AND TABLES

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ANNEX 2
THE GLOBAL FUND STRUCTURE AND REGIONS

COUNTRY COORDINATING MECHANISM

The CCM is a central part of the Global Fund structure and key to the Global Fund's commitment to local ownership and participatory decision-making. CCMs 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, nongovernmental organizations, the private sector (including business and foundations) and affected communities. In addition, there are five non-voting members, among whom are key international development partners such as the WHO, UNAIDS, the World Bank (which serves as the Global Fund's trustee) public-private partnerships (including Roll Back Malaria, Stop TB and UNITAID) 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 CCM nominates one or more public or private organization 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 CCM 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 towards 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 600 based in Geneva, Switzerland, and overhead costs consuming approximately five percent of income.

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.

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 CCMs 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 CCMs to include funds for technical assistance in their proposals.

THE GLOBAL FUND GRANT CYCLE

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".

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 Recipients. 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. The Global Fund Board approves continued funding based on a detailed assessment of results against targets and the availability of funds.

ANNEX 2 (CONT.)
THE GLOBAL FUND STRUCTURE AND REGIONS

BLUE = MULTICOUNTRY GRANTS ONLY

SUB-SAHARAN AFRICA
(41 COUNTRIES AND TERRITORIES)

EAST AFRICA AND INDIAN OCEAN

BURUNDI
COMOROS
CONGO (DEMOCRATIC REPUBLIC)
ERITREA
ETHIOPIA
KENYA
MADAGASCAR
MAURITIUS
RWANDA
UNITED REPUBLIC OF TANZANIA
UGANDA

SOUTHERN AFRICA

ANGOLA
BOTSWANA
LESOTHO
MALAWI
MOZAMBIQUE
NAMIBIA
SEYCHELLES
SOUTH AFRICA
SWAZILAND
ZAMBIA
ZIMBABWE

WEST AND CENTRAL AFRICA

BENIN
BURKINA FASO
CAMEROON
CAPE VERDE
CENTRAL AFRICAN REPUBLIC
CONGO
CÔTE D'IVOIRE
EQUATORIAL GUINEA
GABON
GAMBIA
GHANA
GUINEA
GUINEA-BISSAU
LIBERIA
NIGERIA
SAO TOME AND PRINCIPE
SENEGAL
SIERRA LEONE
TOGO

ASIA
(33 COUNTRIES AND TERRITORIES)

EAST ASIA AND PACIFIC

CAMBODIA
CHINA
COOK ISLANDS
FIJI
INDONESIA
KIRIBATI
KOREA (DEMOCRATIC PEOPLE'S REPUBLIC)
LAO PDR
MARSHALL ISLANDS
MICRONESIA (FEDERATED STATES)
MONGOLIA
MYANMAR
NIUE
PALAU
PAPUA NEW GUINEA
PHILIPPINES
SAMOA
SOLOMON ISLANDS
THAILAND
TIMOR-LESTE
TONGA
TUVALU
VANUATU
VIET NAM

SOUTH AND WEST ASIA

AFGHANISTAN
BANGLADESH
BHUTAN
INDIA
IRAN (ISLAMIC REPUBLIC)
MALDIVES
NEPAL
PAKISTAN
SRI LANKA

LATIN AMERICA AND CARIBBEAN
(33 COUNTRIES AND TERRITORIES)

ANTIGUA AND BARBUDA
ARGENTINA
BAHAMAS
BARBADOS
BELIZE
BOLIVIA
BRAZIL
CHILE
COLOMBIA
COSTA RICA
CUBA
DOMINICA
DOMINICAN REPUBLIC
ECUADOR
EL SALVADOR
GRENADA
GUATEMALA
GUYANA
HAITI
HONDURAS
JAMAICA
MEXICO
NICARAGUA
PANAMA
PARAGUAY
PERU
SAINT KITTS AND NEVIS
SAINT LUCIA
SAINT VINCENT AND GRENADINES
SURINAME
TRINIDAD AND TOBAGO
URUGUAY
VENEZUELA

MIDDLE EAST AND NORTH AFRICA
(16 COUNTRIES AND TERRITORIES)

ALGERIA
CHAD
DJIBOUTI
EGYPT
IRAQ
JORDAN
MALI
MAURITANIA
MOROCCO
NIGER
SOMALIA
SUDAN
SYRIAN ARAB REPUBLIC
TUNISIA
WEST BANK AND GAZA STRIP
YEMEN

EASTERN EUROPE AND CENTRAL ASIA
(23 COUNTRIES AND TERRITORIES)

ALBANIA
ARMENIA
AZERBAIJAN
BELARUS
BOSNIA AND HERZEGOVINA
BULGARIA
CROATIA
ESTONIA
GEORGIA
KAZAKHSTAN
KOSOVO
KYRGYZSTAN
MACEDONIA, FORMER YUGOSLAV REPUBLIC
MOLDOVA
MONTENEGRO
ROMANIA
RUSSIAN FEDERATION
SERBIA
TAJIKISTAN
TURKEY
TURKMENISTAN
UKRAINE
UZBEKISTAN

ANNEX 3
SUMMARY OF GLOBAL FUND-SUPPORTED PROGRAMS AT 31 DECEMBER 2009
(IN US$ EQUIVALENTS)[1]

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
REGION: EAST ASIA AND PACIFIC								
CAMBODIA	1	HIV/AIDS	14,701,498	(G2)	Gov: MOH	CAM-102-G01-H-00 (Closed)	01-Sep-03	14,701,498
	2	HIV/AIDS	14,765,625	(G2)	Gov: MOH	CAM-202-G02-H-00	01-Jan-04	14,583,357
	2	Malaria	27,269,519	(M)	Gov: MOH	CAM-202-G03-M-00, (G2)	01-Jan-04	9,683,872
					Gov: MOH	CAM-202-G13-M, (G3)	01-May-09	5,525,141
	2	TB	6,169,733	(G2)	Gov: MOH	CAM-202-G04-T-00	01-Jan-04	6,169,733
	4	HIV/AIDS	36,546,134	(G2)	Gov: MOH	CAM-405-G05-H	01-Sep-05	33,045,356
	4	Malaria	9,857,891	(G2)	Gov: MOH	CAM-405-G06-M	01-Sep-05	9,072,273
	5	HIV/AIDS	34,963,654	(G2)	Gov: MOH	CAM-506-G07-H	01-Oct-06	25,063,560
	5	HSS	4,698,327	(G2)	Gov: MOH	CAM-506-G08-S	01-Nov-06	2,872,690
	5	TB	9,022,696	(G2)	Gov: MOH	CAM-506-G09-T	01-Nov-06	6,194,850
	6	Malaria	14,013,830	(G1)	Gov: MOH	CAM-607-G10-M	01-Jan-08	12,882,779
	7	HIV/AIDS	23,857,767	(G1)	Gov: Oth	CAM-708-G11-H	01-Dec-08	14,783,462
	7	TB	7,597,209	(G1)	Gov: Oth	CAM-708-G12-T	01-Apr-09	3,798,118
	9	HIV/AIDS	63,502,281	(B1)				
	9	Malaria	43,717,857	(B1)				
CHINA	1	Malaria	6,406,659	(G2)	Gov: Oth	CHN-102-G02-M-00	01-Apr-03	6,242,698
	1	TB	91,118,721	(G3)	Gov: Oth	CHN-102-G01-T-00	01-Apr-03	69,027,537
	3	HIV/AIDS	270,566,000	(G3)	Gov: Oth	CHN-304-G03-H	01-Sep-04	140,177,360
	4	HIV/AIDS	63,742,277	(G2)	Gov: Oth	CHN-405-G05-H	01-Jul-05	57,853,608
	4	TB	199,772,040	(T3)	Gov: Oth	CHN-405-G04-T	01-Jul-05	55,234,457
	5	HIV/AIDS	28,902,073	(G2)	Gov: Oth	CHN-506-G06-H	01-Jul-06	21,451,990
	5	Malaria	38,522,396	(G2)	Gov: Oth	CHN-506-G07-M	01-Oct-06	29,676,277
	5	TB	51,275,836	(M)	Gov: Oth	CHN-506-G08-T, (G1)	01-Nov-06	19,100,894
					Gov: Oth	CHN-506-G08-T-e, (G2)	01-Oct-08	13,323,210
	6	HIV/AIDS	5,812,876	(G1)	Gov: Oth	CHN-607-G10-H	01-Jan-08	5,806,623
	6	Malaria	15,465,315	(G2)	Gov: Oth	CHN-607-G09-M	01-Jul-07	9,010,188
	7	TB	5,313,263	(G1)	Gov: Oth	CHN-708-G11-T	01-Oct-08	2,163,165
	8	TB	28,702,917	(G1)	Gov: Oth	CHN-809-G12-T	01-Oct-09	6,723,376
	N1[5]	Malaria	88,719,854	(B1)				
	9	TB*	76,075,195	(B1)				
FIJI	8	TB	4,183,944	(T1)				
	9	HIV/AIDS	1,242,510	(B1)				
INDONESIA	1	HIV/AIDS	5,400,174	(G2)	Gov: MOH	IND-102-G03-H-00	01-Jul-03	5,400,174
	1	Malaria	19,723,871	(G2)	Gov: MOH	IND-102-G02-M-00	01-Jul-03	19,723,871
	1	TB	51,766,003	(G2)	Gov: MOH	IND-102-G01-T-00	01-Aug-03	51,766,003
	4	HIV/AIDS	49,770,446	(G2)	Gov: MOH	IND-405-G04-H	01-Apr-05	43,446,781
	5	TB	49,978,433	(G2)	Gov: MOH	IND-506-G05-T	01-Jan-07	25,522,019
	6	Malaria	27,683,015	(G1)	Gov: MOH	IND-607-G06-M	01-Mar-08	24,599,911
	8	HIV/AIDS	39,821,706	(G1)	Gov: Oth	IND-809-G07-H	01-Jul-09	2,623,610
					Gov: MOH	IND-809-G08-H	01-Jul-09	7,313,110
					CS/PS: NGO	IND-809-G09-H	01-Jul-09	1,568,083
	8	Malaria	63,486,150	(G1)	CS/PS: NGO	IND-809-G13-M	01-Dec-09	4,144,869
					Gov: MOH	IND-809-G14-M	01-Jan-10	24,194,009
	8	TB	24,131,410	(G1)	CS/PS: NGO	IND-809-G10-T	01-Jul-09	2,386,743

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
INDONESIA (CONT.)					Gov: MOH	IND-809-G11-T	01-Sep-09	7,414,380
					CS/PS: NGO	IND-809-G12-T	01-Sep-09	1,980,823
	9	HIV/AIDS	27,723,275	(B1)				
KOREA (DEMOCRATIC PEOPLES REPUBLIC)	8	Malaria	12,309,467	(T1)				
	8	TB	24,545,710	(T1)				
LAO (PEOPLE'S DEMOCRATIC REPUBLIC)	1	HIV/AIDS	3,375,607	(G2)	Gov: MOH	LAO-102-G01-H-00	01-May-03	3,375,607
	1	Malaria	12,709,087	(G2)	Gov: MOH	LAO-102-G02-M-00	01-May-03	12,709,087
	2	TB	3,530,391	(G2)	Gov: MOH	LAO-202-G03-T-00	01-Oct-03	3,439,395
	4	HIV/AIDS	7,747,873	(G2)	Gov: MOH	LAO-405-G04-H	01-Jul-05	6,747,759
	4	Malaria	14,502,222	(G2)	Gov: MOH	LAO-405-G05-M	01-Jul-05	12,835,438
	4	TB	3,617,781	(G2)	Gov: MOH	LAO-405-G06-T	01-Sep-05	3,285,244
	6	HIV/AIDS	7,751,527	(B2)	Gov: MOH	LAO-607-G08-H	01-Nov-07	3,243,046
	6	Malaria	3,633,039	(G2)	Gov: MOH	LAO-607-G07-M	01-Sep-07	2,036,086
	7	Malaria	6,740,783	(G1)	Gov: MOH	LAO-708-G09-M	01-Jul-08	5,547,812
	7	TB	4,368,246	(G1)	Gov: MOH	LAO-708-G10-T	01-Oct-08	2,771,516
	8	HIV/AIDS	8,207,778	(G1)	Gov: MOH	LAO-809-G11-H	01-Nov-09	4,558,861
MONGOLIA	1	TB	5,233,730	(G3)	Gov: MOH	MON-102-G01-T-00	01-May-03	4,635,353
	2	HIV/AIDS	8,810,349	(G3)	Gov: MOH	MON-202-G02-H-00	01-Aug-03	7,528,224
	4	TB	7,051,881	(T3)	Gov: MOH	MON-405-G03-T	01-Apr-05	4,083,764
	5	HIV/AIDS	1,898,775	(G1)	Gov: MOH	MON-506-G04-H (Closed: consolidated with MON-202-G02-H-00)	01-Jul-06	1,898,775
	7	HIV/AIDS	1,440,102	(G1)	Gov: MOH	MON-708-G05-H	01-Jul-08	1,437,217
	9	HIV/AIDS	2,780,049	(B1)				
MULTICOUNTRY WESTERN PACIFIC	2	HIV/AIDS	5,121,886	(G2)	Gov: Oth	MWP-202-G01-H-00	01-Jul-03	5,121,886
	2	Malaria	4,175,008	(G2)	Gov: Oth	MWP-202-G02-M-00 (Closed)	01-Jul-03	4,175,008
	2	TB	2,738,806	(G2)	Gov: Oth	MWP-202-G03-T-00	01-Jul-03	2,738,806
	5	Malaria	2,361,908	(G1)	Gov: Oth	MWP-506-G04-M (Inactive)	01-Jul-06	2,361,908
	5	Malaria	21,371,554	(G3)	Gov: Oth	MWP-507-G05-M	01-Jul-07	11,767,610
	7	HIV/AIDS	10,710,982	(G1)	Gov: Oth	MWP-708-G06-H	01-Jul-08	8,550,256
	7	TB	5,643,975	(G1)	Gov: Oth	MWP-708-G07-T	01-Jul-08	4,057,720
MYANMAR	2	TB	2,659,494	(B2)	MO: UNDP	MYN-202-G01-T-00 (Terminated)	01-Jan-05	2,659,494
	3	HIV/AIDS	5,837,009	(B2)	MO: UNDP	MYN-305-G02-H (Terminated)	01-Apr-05	5,837,009
	3	Malaria	2,169,079	(B2)	MO: UNDP	MYN-305-G03-M (Terminated)		2,169,079
	9	HIV/AIDS	51,716,207	(B1)				
	9	Malaria	37,578,282	(B1)				
	9	TB	34,024,424	(B1)				
PAPUA NEW GUINEA	3	Malaria	20,105,690	(G2)	Gov: MOH	PNG-304-G01-M	01-Aug-04	17,051,813
	4	HIV/AIDS	17,552,150	(G2)	Gov: MOH	PNG-405-G02-H	01-Sep-05	14,157,579
	6	TB	19,193,202	(B2)	Gov: MOH	PNG-607-G03-T	01-Oct-07	5,007,911
	8	Malaria	50,435,031	(G1)	Gov: MOH	PNG-809-G04-M	01-Nov-09	7,936,481
					CS/PS: NGO	PNG-809-G05-M	01-Nov-09	2,584,059
						PNG-809-G06-M	01-Nov-09	13,967,238
PHILIPPINES	2	Malaria	47,060,206	(M)	CS/PS: PS	PHL-202-G01-M-00 (Suspended), (G2)	01-Aug-03	11,828,157
					CS/PS: PS	PHL-202-G01-M-e (Suspended), (G3)	01-Aug-03	4,563,148
	2	TB	106,730,741	(M)	CS/PS: PS	PHL-202-G02-T-00	01-Aug-03	11,438,064
					CS/PS: PS	PHL-202-G02-T-e	01-Aug-03	16,186,998
	3	HIV/AIDS	5,274,139	(G2)	CS/PS: PS	PHL-304-G03-H (Suspended)	01-Aug-04	5,274,139
	5	HIV/AIDS	6,474,660	(G2)	CS/PS: PS	PHL-506-G04-H (Suspended)	01-Oct-06	4,569,400
					Gov: MOH	PHL-509-G10-H	01-Jan-10	

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
PHILIPPINES (CONT.)	5	Malaria	12,968,047	(G2)	CS/PS: PS	PHL-506-G05-M	01-Jun-06	12,968,047
	5	TB	16,687,774	(G1)	CS/PS: PS	PHL-506-G06-T (Closed) (Closed: consolidated with PHL-202-G02-T-e)	01-Oct-06	16,687,774
	6	HIV/AIDS	7,294,891	(G1)	Gov: MOH	PHL-607-G08-H	01-Dec-07	6,552,575
	6	Malaria	17,838,584	(B2)	CS/PS: PS	PHL-607-G07-M (Suspended)	01-Oct-07	14,340,684
SOLOMON ISLANDS	8	HIV/AIDS	785,725	(T1)				
	8	TB	3,283,614	(T1)				
THAILAND	1	HIV/AIDS	146,766,828	(G3)	Gov: MOH	THA-102-G01-H-00	01-Oct-03	109,944,308
	1	TB	12,058,359	(G2)	Gov: MOH	THA-102-G02-T-00	01-Oct-03	10,834,003
	2	HIV/AIDS	30,156,771	(G2)	CS/PS: NGO	THA-202-G03-H-00	01-Oct-03	15,295,580
					Gov: MOH	THA-202-G04-H-00	01-Nov-03	12,783,633
	2	Malaria	5,282,000	(G2)	Gov: MOH	THA-202-G05-M-00	01-Mar-04	5,282,000
	3	HIV/AIDS	1,236,108	(G2)	CS/PS: NGO	THA-304-G06-H	01-Oct-04	1,236,108
	6	TB	16,968,831	(M)	Gov: MOH	THA-607-G07-T	01-Oct-07	4,440,354
					CS/PS: NGO	THA-607-G08-T	01-Oct-07	5,137,640
	7	Malaria	11,939,346	(G1)	Gov: MOH	THA-708-G09-M	01-Jul-08	10,889,633
	8	HIV/AIDS	32,258,521	(G1)	Gov: MOH	THA-809-G10-H	01-Oct-09	6,567,838
					CS/PS: NGO	THA-809-G11-H	01-Jul-09	2,254,750
					CS/PS: NGO	THA-809-G12-H	01-Aug-09	2,634,878
	8	TB	10,240,102	(G1)	Gov: MOH	THA-809-G13-T	01-Aug-09	3,655,220
TIMOR-LESTE	2	Malaria	2,736,768	(G2)	Gov: MOH	TMP-202-G01-M-00	01-Sep-03	2,736,768
	3	TB	657,853	(B2)	Gov: MOH	TMP-304-G02-T	01-Mar-05	657,853
	5	HIV/AIDS	8,361,394	(G2)	Gov: MOH	TMP-506-G03-H	01-Jun-07	5,146,750
	7	Malaria	6,168,687	(G1)	Gov: MOH	TMP-709-G05-M	01-Apr-09	3,006,875
	7	TB	2,894,205	(G1)	Gov: MOH	TMP-708-G04-T	01-Jan-09	1,952,238
VIET NAM	1	HIV/AIDS	12,000,000	(G2)	Gov: MOH	VTN-102-G01-H-00	01-Feb-04	12,000,000
	1	TB	5,404,713	(G2)	Gov: MOH	VTN-102-G02-T-00	01-Jun-04	5,404,713
	3	Malaria	21,177,956	(G2)	Gov: MOH	VTN-304-G03-M	01-Jan-05	21,177,956
	6	HIV/AIDS	26,732,266	(B2)	Gov: MOH	VTN-607-G04-H	01-Jan-08	10,219,180
	6	TB	13,654,280	(B2)	Gov: MOH	VTN-607-G05-T	01-Jan-08	5,161,476
	7	Malaria	13,536,282	(G1)	Gov: MOH	VTN-708-G06-M	01-Jan-09	5,186,568
	8	HIV/AIDS	12,717,957	(G1)	Gov: MOH	VTN-809-G07-H	01-Dec-09	4,790,889
	9	HIV/AIDS	27,363,443	(B1)				
	9	TB*	19,124,977	(B1)				
REGION TOTALS:			**2,743,475,492**					**1,379,335,690**
REGION: EASTERN EUROPE AND CENTRAL ASIA								
ALBANIA	5	HIV/AIDS	4,936,229	(G2)	Gov: MOH	ALB-506-G01-H	01-Apr-07	3,699,052
	5	TB	1,263,490	(G2)	Gov: MOH	ALB-506-G02-T	01-Apr-07	1,116,289
ARMENIA	2	HIV/AIDS	20,436,461	(M)	CS/PS: NGO	ARM-202-G01-H-00, (G2) (Closed: consolidated with ARM-202-G05-H-00, (G3))	01-Nov-03	9,105,913
					Gov: MOH	ARM-202-G05-H-00, (G3)	01-Oct-09	1,876,273
					CS/PS: NGO	ARM-202-G06-H-00, (G3)	01-Oct-09	1,772,608
	5	TB	7,218,635	(G2)	Gov: MOH	ARM-506-G02-T	01-Jan-07	
					Gov: MOH	ARM-506-G02-T-e	as above	4,466,423
	8	HIV/AIDS	1,682,813	(G1)	Gov: MOH	ARM-809-G04-S		
	8	TB	2,500,180	(G1)	Gov: MOH	ARM-809-G03-T	01-Sep-09	531,034

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
AZERBAIJAN	4	HIV/AIDS	10,341,550	(G2)	Gov: MOH	AZE-405-G01-H	01-Jun-05	10,341,550
	5	TB	4,345,006	(B2)	Gov: MOH	AZE-506-G02-T (Closed: consolidated with AZE-708-G03-T)	01-Oct-06	4,345,006
	7	Malaria	3,422,700	(G1)	Gov: MOH	AZE-708-G04-M	01-Oct-08	3,084,293
	7	TB	9,339,320	(G1)	Gov: MOH	AZE-708-G03-T	01-Oct-08	5,566,014
	9	HIV/AIDS	16,958,384	(B1)				
	9	TB	2,842,294	(B1)				
BELARUS	3	HIV/AIDS	25,155,645	(T3)	MO: UNDP	BLR-304-G01-H	01-Dec-04	16,761,658
	6	TB	13,333,654	(G2)	MO: UNDP	BLR-607-G02-T	01-Oct-07	6,829,557
	8	HIV/AIDS	13,698,146	(G1)	MO: UNDP	BLR-809-G03-H	01-Jan-10	5,549,950
	9	TB	10,127,774	(B1)				
BOSNIA AND HERZEGOVINA	5	HIV/AIDS	11,042,257	(G2)	MO: UNDP	BIH-506-G01-H	01-Nov-06	8,867,887
	6	TB	5,804,158	(G2)	MO: UNDP	BIH-607-G02-T	01-Oct-07	3,739,223
	9	HIV/AIDS	20,680,597	(B1)				
	9	TB*	10,444,850	(B1)				
BULGARIA	2	HIV/AIDS	40,866,430	(M)	Gov: MOH	BUL-202-G01-H-00, (G2)	01-Jan-04	15,711,882
					Gov: MOH	BUL-202-G01-H-e, (G3)	01-Mar-09	6,447,148
	6	TB	19,996,904	(B2)	Gov: MOH	BUL-607-G02-T	01-Nov-07	9,712,075
	8	TB	4,705,087	(G1)	Gov: MOH	BUL-809-G03-T	01-Jan-10	
CROATIA	2	HIV/AIDS	4,944,324	(G2)	Gov: MOH	HRV-202-G01-H-00 (Closed)	01-Dec-03	4,944,324
ESTONIA	2	HIV/AIDS	10,483,275	(G2)	Gov: MOH	EST-202-G01-H-00 (Closed)	01-Oct-03	
					Gov: MOH	EST-202-G01-H-e (Closed)	as above	10,483,275
GEORGIA	2	HIV/AIDS	34,430,816	(T3)	Gov: Oth	GEO-202-G01-H-00	01-Mar-04	14,363,254
	3	Malaria	806,300	(G2)	Gov: Oth	GEO-304-G02-M	01-Jul-04	806,300
	4	TB	10,825,845	(T3)	Gov: Oth	GEO-405-G03-T	01-Apr-05	5,536,965
	6	HIV/AIDS	10,857,395	(B2)	Gov: Oth	GEO-607-G06-H	01-Jan-08	6,130,724
	6	Malaria	2,958,186	(G2)	Gov: Oth	GEO-607-G04-M	01-Jul-07	1,587,960
	6	TB	10,373,950	(G2)	Gov: Oth	GEO-607-G05-T	01-Jul-07	9,314,136
	9	HIV/AIDS	10,333,527	(B1)				
GLOBAL(LWF)	1	HIV/AIDS	700,000	(G2)	CS/PS: FBO	WRL-102-G01-H-00 (Closed)	01-Feb-03	700,000
KAZAKHSTAN	2	HIV/AIDS	22,085,999	(G2)	Gov: Oth	KAZ-202-G01-H-00	01-Dec-03	20,297,372
	6	TB	9,114,981	(G2)	Gov: MOH	KAZ-607-G02-T	01-Sep-07	6,753,014
	7	HIV/AIDS	12,485,792	(G1)	Gov: Oth	KAZ-708-G03-H	01-Jan-09	9,021,947
	8	TB	30,329,313	(G1)	Gov: MOH	KAZ-809-G04-T		7,574,536
KOSOVO	4	TB	3,840,804	(G2)	Gov: MOH	KOS-405-G01-T	01-Apr-06	
					Gov: MOH	KOS-405-G01-T-e	as above	3,212,637
	7	HIV/AIDS	2,372,498	(G1)	Gov: MOH	KOS-708-G02-H	01-Oct-08	1,537,388
	9	TB*	3,991,607	(B1)				
KYRGYZSTAN	2	HIV/AIDS	17,073,306	(G2)	Gov: Oth	KGZ-202-G01-H-00	01-Mar-04	17,073,306
	2	TB	2,771,070	(G2)	Gov: MOH	KGZ-202-G02-T-00	01-Mar-04	2,771,070
	5	Malaria	3,426,125	(G2)	Gov: Oth	KGZ-506-G03-M	01-Apr-06	2,877,880
	6	TB	8,287,814	(G2)	Gov: MOH	KGZ-607-G04-T	01-Jul-07	4,330,108
	7	HIV/AIDS	11,845,090	(G1)	Gov: MOH	KGZ-708-G05-H	01-Jan-09	4,997,122
	8	Malaria	2,663,886	(G1)	Gov: Oth	KGZ-809-G06-M	01-Jan-10	
	9	TB*	7,811,886	(B1)				

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
MACEDONIA (FORMER YUGOSLAV REPUBLIC)	3	HIV/AIDS	5,904,367	(G2)	Gov: MOH	MKD-304-G01-H	01-Nov-04	5,844,367
	5	TB	2,976,090	(G2)	Gov: MOH	MKD-506-G02-T	01-Apr-06	
					Gov: MOH	MKD-506-G02-T-e	as above	2,453,648
	7	HIV/AIDS	4,256,810	(G1)	Gov: MOH	MKD-708-G03-H	01-Apr-08	3,696,064
MOLDOVA	1	HIV/TB	11,719,047	(G2)	Gov: MOH	MOL-102-G01-C-00 (Inactive)	01-May-03	11,707,875
	6	HIV/AIDS	15,937,910	(B2)	Gov: MOH	MOL-607-G03-H	01-Jan-08	6,411,072
	6	TB	11,175,507	(G2)	Gov: MOH	MOL-607-G02-T	01-Oct-07	7,044,267
	8	HIV/AIDS	11,012,517	(T1)				
	8	TB	6,638,343	(G1)	Gov: MOH	MOL-809-G04-T	01-Oct-09	2,587,651
					CS/PS: NGO	MOL-809-G05-T	01-Oct-09	486,963
	9	TB*	7,556,048	(B1)				
MONTENEGRO	5	HIV/AIDS	4,720,817	(G2)	MO: UNDP	MNT-506-G01-H	01-Aug-06	3,252,686
	6	TB	2,103,254	(G2)	MO: UNDP	MNT-607-G02-T	01-Jul-07	1,462,797
	9	HIV/AIDS*	3,651,208	(B1)				
ROMANIA	2	HIV/AIDS	26,861,313	(G2)	Gov: MOH	ROM-202-G01-H-00	01-Jan-04	26,519,207
	2	TB	16,743,641	(G2)	Gov: MOH	ROM-202-G02-T-00	01-Feb-04	16,684,709
	6	HIV/AIDS	13,163,540	(G2)	CS/PS: NGO	ROM-607-G03-H	01-Jul-07	10,662,813
	6	TB	10,810,358	(G2)	CS/PS: NGO	ROM-607-G04-T	01-Oct-07	6,425,200
RUSSIAN FEDERATION	3	HIV/AIDS	110,342,354	(G2)	CS/PS: NGO	RUS-304-G01-H	15-Aug-04	91,142,354
	3	TB	17,882,859	(T3)	CS/PS: NGO	RUS-304-G02-T	01-Dec-04	10,766,486
	4	HIV/AIDS	119,873,915	(G2)	CS/PS: NGO	RUS-405-G03-H	01-Sep-05	119,478,219
	4	TB	88,165,448	(G2)	CS/PS: NGO	RUS-405-G04-T	01-Dec-05	86,271,569
	5	HIV/AIDS	18,234,652	(G2)	CS/PS: NGO	RUS-506-G05-H	01-Sep-06	9,961,901
SERBIA	1	HIV/AIDS	3,575,210	(G2)	CS/PS: PS	SER-102-G01-H-00 (Closed)	01-Nov-03	3,575,210
	3	TB	4,087,979	(G2)	Gov: MOH	SER-304-G02-T	01-Dec-04	4,087,979
	6	HIV/AIDS	14,892,653	(G2)	Gov: MOH	SER-607-G03-H	01-Jun-07	8,424,203
	8	HIV/AIDS	5,258,096	(G1)	Gov: MOH	SER-809-G04-H	01-Jul-09	1,071,668
					CS/PS: NGO	SER-809-G05-H	01-Jul-09	1,314,383
	9	TB	3,441,632	(B1)				
TAJIKISTAN	1	HIV/AIDS	2,425,245	(G2)	MO: UNDP	TAJ-102-G01-H-00 (Closed)	01-May-03	2,425,245
	3	TB	7,143,900	(T3)	CS/PS: NGO	TAJ-304-G02-T	01-Nov-04	2,761,877
	4	HIV/AIDS	8,076,667	(G2)	MO: UNDP	TAJ-404-G03-H	01-Jan-05	8,076,667
	5	Malaria	5,383,510	(G2)	MO: UNDP	TAJ-506-G04-M	01-Apr-06	5,383,510
	6	HIV/AIDS	6,327,429	(G2)	MO: UNDP	TAJ-607-G05-H (Closed: consolidated with TAJ-809-G07-H)	01-May-07	6,327,429
	6	TB	6,527,347	(B2)	MO: UNDP	TAJ-607-G06-T (Closed: consolidated with TAJ-809-G09-T)	01-Aug-07	6,527,347
	8	HIV/AIDS	20,028,140	(B2)	MO: UNDP	TAJ-809-G07-H	01-Nov-09	6,307,804
	8	Malaria	7,035,082	(G1)	MO: UNDP	TAJ-809-G08-M	01-Oct-09	3,116,336
	8	TB	20,609,574	(B2)	MO: UNDP	TAJ-809-G09-T	01-Oct-09	7,251,762
TURKEY	4	HIV/AIDS	3,272,763	(B2)	Gov: MOH	TUR-405-G01-H (Closed)	01-Aug-05	3,272,763
TURKMENISTAN	9	TB*	7,268,169	(B1)				
UKRAINE	1	HIV/AIDS	99,121,371	(B2)	CS/PS: NGO	UKR-102-A04-H-00, (B2)		300,000
					Gov: Oth	UKR-102-G01-H-00 (Terminated), (B2)	18-Mar-03	311,889
					Gov: MOH	UKR-102-G02-H-00 (Terminated), (B2)	28-Jan-03	541,682

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
UKRAINE (CONT.)					MO: UNDP	UKR-102-G03-H-00 (Terminated), (B2)	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	131,537,035	(G2)	CS/PS: NGO	UKR-607-G05-H	01-Aug-07	30,660,351
					CS/PS: NGO	UKR-607-G06-H	01-Aug-07	21,849,530
UZBEKISTAN	3	HIV/AIDS	21,075,841	(G2)	Gov: MOH	UZB-304-G01-H	01-Dec-04	18,677,958
	4	Malaria	2,423,089	(G2)	Gov: Oth	UZB-405-G02-M	01-Apr-05	2,423,089
	4	TB	13,267,033	(G2)	Gov: MOH	UZB-405-G03-T	01-Apr-05	12,105,033
	8	Malaria	2,118,038	(G1)	Gov: Oth	UZB-809-G04-M	01-Dec-09	984,904
	8	TB	12,098,445	(G1)	Gov: MOH	UZB-809-G05-T	01-Dec-09	2,794,978
REGION TOTALS:			**1,412,680,598**					**935,109,621**
REGION: LATIN AMERICA AND CARIBBEAN								
ARGENTINA	1	HIV/AIDS	25,370,458	(M)	MO: UNDP	ARG-102-G01-H-00 (Inactive), (B2)	01-Jul-03	9,049,759
					CS/PS: PS	ARG-102-G02-H-00, (G2)	01-Jan-06	16,320,699
BELIZE	3	HIV/AIDS	2,403,677	(G2)	CS/PS: NGO	BEL-304-G01-H	01-Nov-04	2,182,503
	9	HIV/AIDS*	3,190,410	(B1)				
BOLIVIA	3	HIV/AIDS	14,948,532	(B2)	CS/PS: NGO	BOL-304-G01-H (Closed), (B2)	26-Jul-04	2,641,751
					MO: UNDP	BOL-306-G04-H (Closed), (B2)	01-May-06	1,950,412
					CS/PS: NGO	BOL-307-G07-H, (G2)	01-Feb-07	10,084,865
	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)	01-May-06	2,085,356
	3	TB	5,299,074	(B2)	CS/PS: NGO	BOL-304-G03-T (Closed), (B2)	26-Jul-04	1,084,486
					MO: UNDP	BOL-306-G06-T, (G2)	01-May-06	4,214,588
	8	Malaria	6,060,293	(G1)	MO: UNDP	BOL-809-G08-M	01-Oct-09	2,116,856
	9	HIV/AIDS	9,501,866	(B1)				
	9	TB	4,379,037	(B1)				
BRAZIL	5	TB	23,021,005	(G2)	CS/PS: Oth	BRA-506-G01-T	01-May-07	3,997,328
					CS/PS: Oth	BRA-506-G02-T	01-May-07	11,197,229
	8	Malaria	24,627,505	(G1)	CS/PS: NGO	BRA-809-G03-M	01-Oct-09	2,809,966
					CS/PS: NGO	BRA-809-G04-M		2,048,240
CHILE	1	HIV/AIDS	28,835,307	(G2)	CS/PS: PS	CHL-102-G01-H-00	01-Aug-03	28,835,307
COLOMBIA	2	HIV/AIDS	8,669,848	(G2)	MO: Oth	COL-202-G01-H-00	01-Jul-04	8,521,207
	8	Malaria	23,599,048	(T1)				
	9	HIV/AIDS*	23,877,707	(B1)				
COSTA RICA	2	HIV/AIDS	3,583,871	(M)	Gov: Oth	COR-202-G01-H-00 (Closed), (B2)	01-Oct-03	1,767,359
					CS/PS: NGO	COR-202-G02-H-00, (G2)	01-Jan-06	1,799,590
CUBA	2	HIV/AIDS	36,224,962	(G3)	MO: UNDP	CUB-202-G01-H-00	01-Jul-03	30,405,040
	6	HIV/AIDS	32,980,666	(B2)	MO: UNDP	CUB-607-G02-H	01-Oct-07	13,952,277
	7	TB	5,455,745	(G1)	MO: UNDP	CUB-708-G03-T	01-Jan-09	3,709,626
DOMINICAN REPUBLIC	2	HIV/AIDS	87,498,690	(M)	Gov: Oth	DMR-202-G01-H-00, (G3)	01-Jun-04	55,001,523
					CS/PS: NGO	DMR-202-G04-H-00, (G3)	01-Sep-09	1,735,520
	3	TB	11,017,650	(T3)	CS/PS: NGO	DMR-304-G02-T, (T3)	01-Oct-04	4,611,860
					Gov: MOH	DMR-309-G07-T, (T1)	01-Oct-09	480,033

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
DOMINICAN REPUBLIC (CONT.)	7	TB	5,650,022	(G1)	CS/PS: NGO	DMR-708-G03-T	01-Oct-08	1,761,512
	8	Malaria	3,955,506	(G1)	CS/PS: NGO	DMR-809-G05-M	01-Oct-09	300,504
					CS/PS: NGO	DMR-809-G06-M	01-Oct-09	1,095,844
ECUADOR	2	HIV/AIDS	13,809,852	(G2)	Gov: MOH	ECU-202-G01-H-00	01-Mar-05	8,818,311
					CS/PS: NGO	ECU-202-G03-H-00	01-Jun-06	4,297,733
	4	TB	16,353,319	(G2)	CS/PS: NGO	ECU-405-G02-T	01-Nov-05	15,241,511
	8	Malaria	6,928,698	(G1)	Gov: MOH	ECU-809-G04-M		
					CS/PS: NGO	ECU-809-G05-M		
	9	HIV/AIDS	10,813,915	(B1)				
	9	TB	6,834,160	(B1)				
EL SALVADOR	2	HIV/AIDS	32,987,036	(G3)	MO: UNDP	SLV-202-G01-H-00, (G3)	01-Aug-03	22,599,835
					Gov: MOH	SLV-202-G03-H-00, (G3)	01-Nov-06	2,545,930
	2	TB	3,778,225	(M)	MO: UNDP	SLV-202-G02-T-00 (Closed), (B2)	01-Dec-03	2,235,389
					Gov: MOH	SLV-202-G04-T-00, (G2)	01-Nov-06	1,542,836
	7	HIV/AIDS	10,570,700	(G1)	Gov: MOH	SLV-708-G05-H	01-Oct-08	2,679,357
					MO: UNDP	SLV-708-G06-H	01-Oct-08	5,820,306
	9	TB	3,588,887	(B1)				
GUATEMALA	3	HIV/AIDS	40,921,918	(G2)	CS/PS: NGO	GUA-304-G01-H	01-Dec-04	35,595,030
	4	Malaria	13,750,042	(G2)	CS/PS: NGO	GUA-405-G02-M	01-Sep-05	13,369,899
	6	TB	7,428,357	(B2)	CS/PS: NGO	GUA-607-G03-T	01-Aug-07	3,424,948
	9	Malaria	21,452,001	(B1)				
GUYANA	3	HIV/AIDS	40,541,008	(T3)	Gov: MOH	GYA-304-G01-H	01-Jan-05	18,504,708
	3	Malaria	2,079,004	(G2)	Gov: MOH	GYA-304-G02-M	01-Jan-05	1,900,231
	4	TB	1,172,917	(G2)	Gov: MOH	GYA-405-G03-T	01-Oct-05	1,021,028
	7	Malaria	1,841,470	(G1)	Gov: MOH	GYA-708-G04-M	01-May-09	843,861
	8	HIV/AIDS	3,917,696	(G1)	Gov: MOH	GYA-809-G05-S	01-Jan-10	
	8	TB	2,779,969	(T1)				
HAITI	1	HIV/AIDS	159,733,983	(M)	CS/PS: PS	HTI-102-G01-H-00, (G3)	01-Jan-03	102,864,364
					MO: UNDP	HTI-102-G02-H-00 (Inactive), (B2) (Closed: consolidated with HTI-102-G01-H-00, (G3))	01-Jan-03	6,140,386
	3	Malaria	14,431,557	(G2)	CS/PS: PS	HTI-304-G03-M	01-Aug-04	13,632,508
	3	TB	14,860,857	(G2)	CS/PS: PS	HTI-304-G04-T	01-Aug-04	13,682,901
	5	HIV/AIDS	18,821,754	(B2)	CS/PS: PS	HTI-506-G05-H (Closed: consolidated with HTI-102-G01-H-00, (G3))	01-Jan-07	18,821,754
	7	HIV/AIDS	6,199,554	(G1)	CS/PS: PS	HTI-708-G06-H (Closed: consolidated with HTI-102-G01-H-00, (G3))	01-Nov-08	3,047,687
	8	Malaria	33,402,457	(T1)				
	9	TB*	12,260,870	(B1)				
HONDURAS	1	HIV/AIDS	51,756,894	(M)	MO: UNDP	HND-102-G01-H-00, (G2)	01-May-03	26,635,846
					CS/PS: Oth	HND-102-G04-H-00, (G3)	01-May-08	15,205,358
	1	Malaria	11,307,376	(M)	MO: UNDP	HND-102-G03-M-00, (G2)	01-May-03	7,127,623
					CS/PS: Oth	HND-102-G05-M-00, (G3)	01-May-08	1,755,051
	1	TB	6,109,673	(G2)	MO: UNDP	HND-102-G02-T-00	01-May-03	6,109,673
	9	HIV/AIDS	9,821,491	(B1)				
JAMAICA	3	HIV/AIDS	23,318,821	(G2)	Gov: MOH	JAM-304-G01-H	01-Jun-04	22,891,437
	7	HIV/AIDS	15,219,930	(G1)	Gov: MOH	JAM-708-G02-H	01-Aug-08	10,849,289
MEXICO	9	HIV/AIDS	31,008,826	(B1)				

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
MULTICOUNTRY AMERICAS (ANDEAN)	3	Malaria	25,369,116	(G2)	MO: Oth	MAA-305-G01-M	01-Oct-05	23,536,157
MULTICOUNTRY AMERICAS (CARICOM)	3	HIV/AIDS	12,046,368	(G2)	Gov: Oth	MAC-304-G01-H	01-Nov-04	11,111,750
	9	HIV/AIDS	14,458,896	(B1)				
MULTICOUNTRY AMERICAS (COPRECOS)	9	HIV/AIDS*	17,599,678	(B1)				
MULTICOUNTRY AMERICAS (CRN+)	4	HIV/AIDS	3,662,376	(G2)	CS/PS: NGO	MAN-405-G01-H	01-Aug-05	2,577,894
MULTICOUNTRY AMERICAS (MESO)	4	HIV/AIDS	4,008,581	(G2)	Gov: MOH	MAM-405-G01-H	01-Oct-05	3,776,213
MULTICOUNTRY AMERICAS (OECS)	3	HIV/AIDS	8,898,774	(G2)	MO: Oth	MAE-305-G01-H	01-Mar-05	7,427,567
MULTICOUNTRY AMERICAS (REDCA+)	7	HIV/AIDS	1,722,700	(G1)	CS/PS: NGO	MAR-708-G01-H	01-Oct-08	1,362,399
NICARAGUA	2	HIV/AIDS	10,108,320	(G2)	CS/PS: NGO	NIC-202-G03-H-00	01-Mar-04	9,861,804
	2	Malaria	5,584,582	(G2)	CS/PS: NGO	NIC-202-G01-M-00	01-Mar-04	5,584,582
	2	TB	9,166,398	(M)	CS/PS: NGO	NIC-202-G02-T-00, (T3) (Closed: consolidated with NIC-202-G05-T-00, (G3))	01-Mar-04	2,717,097
					CS/PS: NGO	NIC-202-G05-T-00, (G3)	01-Oct-09	2,109,465
	7	Malaria	2,868,542	(G1)	CS/PS: NGO	NIC-708-G04-M	01-Apr-09	2,270,086
	8	HIV/AIDS	23,359,081	(G1)	CS/PS: NGO	NIC-809-G06-H	01-Jan-10	9,283,117
	9	Malaria*	4,299,868	(B1)				
PANAMA	1	TB	553,817	(G2)	MO: UNDP	PAN-102-G01-T-00 (Closed)	01-Apr-03	553,817
PARAGUAY	3	TB	5,046,045	(T3)	CS/PS: NGO	PRY-304-G01-T	01-Dec-04	2,779,326
	6	HIV/AIDS	8,832,117	(G2)	CS/PS: NGO	PRY-607-G02-H	01-Jun-07	5,042,441
	7	TB	2,149,206	(G1)	CS/PS: NGO	PRY-708-G03-T	01-Jul-08	1,999,041
	8	HIV/AIDS	5,092,429	(G1)	CS/PS: NGO	PRY-809-G04-H	01-Aug-09	2,051,990
	9	HIV/AIDS	6,463,831	(B1)				
	9	TB	2,080,336	(B1)				
PERU	2	HIV/AIDS	21,619,940	(G2)	CS/PS: NGO	PER-202-G01-H-00	01-Dec-03	21,619,940
	2	TB	25,198,382	(G2)	CS/PS: NGO	PER-202-G02-T-00	01-Dec-03	25,198,382
	5	HIV/AIDS	12,867,465	(G2)	CS/PS: NGO	PER-506-G03-H	01-Sep-06	9,319,609
	5	TB	29,671,364	(G2)	CS/PS: NGO	PER-506-G04-T	01-Sep-06	19,150,148
	6	HIV/AIDS	33,409,884	(B2)	CS/PS: NGO	PER-607-G05-H	01-Oct-07	21,149,132
	8	TB	13,278,783	(G1)	CS/PS: NGO	PER-809-G06-T		
					Gov: MOH	PER-809-G07-T		
SURINAME	3	HIV/AIDS	4,676,831	(G2)	Gov: MOH	SUR-305-G01-H	01-Feb-05	4,676,830
	4	Malaria	4,603,345	(G2)	CS/PS: NGO	SUR-404-G02-M	01-Feb-05	4,568,302
	5	HIV/AIDS	3,838,706	(G2)	Gov: MOH	SUR-506-G03-H	01-Feb-07	2,363,177
	7	Malaria	2,375,500	(G1)	Gov: MOH	SUR-708-G04-M	01-Apr-09	1,440,500
	9	TB	3,112,254	(B1)				
REGION TOTALS:			1,373,088,703					821,522,533

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
REGION: MIDDLE EAST AND NORTH AFRICA								
ALGERIA	3	HIV/AIDS	6,945,289	(G2)	Gov: MOH	DZA-304-G01-H	01-Jan-05	6,945,289
CHAD	2	TB	3,039,321	(G2)	Gov: Oth	TCD-202-G01-T-00	01-May-04	2,398,019
	3	HIV/AIDS	17,783,344	(G2)	Gov: Oth	TCD-304-G02-H	01-Aug-04	12,382,197
	7	Malaria	10,477,631	(G1)	MO: UNDP	TCD-708-G03-M	01-Mar-09	4,644,509
	8	HIV/AIDS	36,135,742	(T1)				
	8	TB	4,428,278	(T1)				
	9	Malaria	29,823,982	(B1)				
DJIBOUTI	4	HIV/AIDS	11,998,400	(G2)	Gov: MOH	DJB-404-G01-H	01-Mar-05	11,978,365
	6	HIV/AIDS	10,205,678	(B2)	Gov: MOH	DJB-607-G04-H	01-Jun-07	2,719,910
	6	Malaria	3,570,083	(B2)	Gov: MOH	DJB-607-G02-M	01-Jun-07	2,611,945
	6	TB	3,558,810	(B2)	Gov: MOH	DJB-607-G03-T	01-Jun-07	1,116,578
	9	Malaria*	3,357,065	(B1)				
EGYPT	2	TB	4,032,014	(G2)	Gov: MOH	EGY-202-G01-T-00	01-Jul-04	3,965,349
	6	HIV/AIDS	5,320,880	(G1)	Gov: MOH	EGY-608-G03-H	01-Apr-08	5,089,730
	6	TB	9,499,628	(G2)	Gov: MOH	EGY-607-G02-T	01-Sep-07	4,786,676
IRAQ	6	TB	14,500,157	(G2)	MO: UNDP	IRQ-607-G01-T	01-Jan-08	9,893,637
	9	TB*	14,670,783	(B1)				
JORDAN	2	HIV/AIDS	2,427,408	(G2)	Gov: MOH	JOR-202-G01-H-00 (Closed)	01-Nov-03	2,427,408
	5	TB	2,782,864	(G2)	Gov: MOH	JOR-506-G02-T	01-Jul-06	2,192,864
	6	HIV/AIDS	5,996,658	(G2)	Gov: MOH	JOR-607-G03-H	01-Jul-07	3,744,948
MALI	1	Malaria	2,592,316	(G2)	Gov: MOH	MAL-102-G01-M-00 (Closed)	01-Dec-03	2,592,316
	4	HIV/AIDS	52,340,436	(G2)	Gov: Oth	MAL-405-G02-H	01-Jul-05	41,200,338
	4	TB	6,747,610	(G2)	Gov: MOH	MAL-405-G03-T	01-Aug-05	4,933,080
	6	Malaria	18,187,814	(M)	Gov: MOH	MAL-607-G04-M, (G1)	01-Nov-07	2,597,529
					CS/PS: NGO	MAL-607-G05-M, (B2)	01-Sep-07	5,754,839
	7	TB	4,365,958	(G1)	Gov: MOH	MAL-708-G06-T	01-Aug-08	2,953,732
	8	HIV/AIDS	41,794,619	(G1)	CS/PS: NGO	MAL-809-G07-H	01-Jan-10	4,378,330
					Gov: Oth	MAL-809-G08-H	01-Jan-10	4,305,234
MAURITANIA	2	Malaria	2,898,993	(G2)	MO: UNDP	MRT-202-G02-M-00	01-Apr-04	2,051,161
	2	TB	2,727,889	(G2)	MO: UNDP	MRT-202-G01-T-00	01-May-04	2,406,225
	5	HIV/AIDS	15,111,273	(G2)	Gov: Oth	MRT-506-G03-H	01-Sep-06	6,567,216
	6	Malaria	4,315,126	(G1)	MO: UNDP	MRT-607-G04-M	01-Dec-07	2,460,203
	6	TB	4,441,686	(G1)	MO: UNDP	MRT-607-G05-T	01-Dec-07	3,024,357
	8	HIV/AIDS	2,772,376	(T1)				
MOROCCO	1	HIV/AIDS	9,238,754	(G2)	Gov: MOH	MOR-102-G01-H-00	01-Mar-03	9,238,754
	6	HIV/AIDS	24,876,599	(G2)	Gov: MOH	MOR-607-G02-H	01-Jul-07	13,764,566
	6	TB	4,157,800	(G2)	Gov: MOH	MOR-607-G03-T	01-Jul-07	2,475,696
NIGER	3	HIV/AIDS	10,713,876	(G2)	Gov: Oth	NGR-304-G01-H	01-Sep-04	10,419,863
	3	Malaria	5,702,483	(M)	CS/PS: NGO	NGR-304-G02-M, (B2)	01-Sep-04	4,296,559
					MO: UNDP	NGR-306-G06-M, (G2)	01-Dec-06	1,334,692
	4	Malaria	11,257,988	(G1)	MO: Oth	NGR-405-G03-M	01-Jul-05	11,189,739
	5	Malaria	9,631,345	(G2)	MO: UNDP	NGR-506-G04-M	01-Jul-06	6,210,609
	5	TB	14,025,549	(G2)	MO: UNDP	NGR-506-G05-T	01-Jul-06	9,190,688
	7	HIV/AIDS	14,252,753	(G1)	Gov: Oth	NGR-708-G08-H	01-Jul-08	11,006,838
	7	Malaria	31,379,645	(G1)	CS/PS: FBO	NGR-708-G07-M	01-Jul-08	27,367,757

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
SOMALIA	2	Malaria	12,886,413	(G2)	MO: Oth	SOM-202-G01-M-00	01-Jul-04	12,886,413
	3	TB	13,825,351	(G2)	CS/PS: NGO	SOM-304-G02-T	16-Aug-04	13,661,443
	4	HIV/AIDS	24,922,007	(G2)	MO: Oth	SOM-405-G03-H	01-Jun-05	23,147,120
	6	Malaria	24,996,033	(B2)	MO: Oth	SOM-607-G04-M	01-Nov-07	12,226,357
	7	TB	8,732,844	(G1)	CS/PS: NGO	SOM-708-G05-T	01-Oct-08	5,012,980
	8	HIV/AIDS	23,962,544	(G1)	MO: Oth	SOM-809-G06-H	01-Jan-10	
SUDAN	2	Malaria	25,067,660	(G2)	MO: UNDP	SUD-202-G01-M-00	01-Oct-04	24,662,318
	2	Malaria	33,240,453	(G2)	MO: UNDP	SUD-202-G03-M-00	01-Apr-05	33,078,042
	2	TB	14,498,087	(G2)	MO: UNDP	SUD-202-G02-T-00	01-Oct-04	14,498,087
	3	HIV/AIDS	20,682,531	(G2)	MO: UNDP	SUD-305-G04-H	01-Apr-05	18,815,840
	4	HIV/AIDS	26,935,365	(G2)	MO: UNDP	SUD-405-G05-H	01-Aug-06	19,584,060
	5	HIV/AIDS	84,976,035	(G2)	MO: UNDP	SUD-506-G08-H	01-Jan-07	28,652,063
	5	TB	21,613,754	(G2)	MO: UNDP	SUD-506-G06-T	01-Oct-06	14,131,775
	5	TB	15,410,235	(G2)	MO: UNDP	SUD-506-G07-T	01-Jan-07	11,440,986
	7	Malaria	33,512,896	(G1)	CS/PS: NGO	SUD-708-G09-M	01-Dec-08	26,115,395
	7	Malaria	38,296,873	(G1)	MO: UNDP	SUD-708-G10-M	01-Apr-09	16,482,852
	7	TB	6,172,805	(G1)	MO: UNDP	SUD-708-G11-T	01-Jan-09	2,461,028
	8	TB	16,176,758	(T1)				
	9	HIV/AIDS	27,230,100	(B1)				
SYRIAN ARAB REPUBLIC	6	TB	7,377,125	(B2)	MO: UNDP	SYR-607-G01-T	01-Dec-07	3,080,348
TUNISIA	6	HIV/AIDS	16,180,346	(B2)	Gov: MOH	TUN-607-G01-H	01-Sep-07	9,139,305
	8	TB	3,823,256	(T1)				
WEST BANK AND GAZA	7	HIV/AIDS	5,014,330	(G1)	MO: UNDP	PSE-708-G01-H	01-Dec-08	2,355,254
	8	TB	1,266,596	(G1)	MO: UNDP	PSE-809-G02-T	01-Dec-09	391,212
YEMEN	2	Malaria	11,878,206	(G2)	Gov: MOH	YEM-202-G01-M-00	01-Mar-04	11,878,206
	3	HIV/AIDS	14,460,517	(M)	Gov: MOH	YEM-305-G02-H, (B2)	01-Jul-05	2,247,002
					Gov: MOH	YEM-305-G03-H, (B2)	01-Jul-05	1,645,056
					MO: UNDP	YEM-307-G05-H, (G2)	01-Jan-08	6,013,560
	4	TB	6,147,507	(G2)	Gov: MOH	YEM-405-G04-T	01-Jul-05	5,946,847
	7	Malaria	8,013,694	(G1)	Gov: MOH	YEM-708-G06-M	01-Dec-08	3,260,385
	9	TB*	11,136,828	(B1)				
REGION TOTALS:			**1,052,524,052**					**591,431,683**
REGION: SOUTH AND WEST ASIA								
AFGHANISTAN	2	Integrated	3,125,605	(G1)	Gov: MOH	AFG-202-G01-I-00	01-Dec-04	3,125,605
	4	TB	3,448,773	(G2)	Gov: MOH	AFG-405-G02-T	01-Sep-05	2,678,961
	5	Malaria	28,316,682	(G2)	Gov: MOH	AFG-506-G03-M	01-Nov-06	15,190,840
					CS/PS: NGO	AFG-509-G06-M	01-Feb-09	7,171,871
	7	HIV/AIDS	4,767,953	(G1)	Gov: MOH	AFG-708-G04-H	01-Oct-08	285,960
					Gov: Oth	AFG-708-G05-H	01-Oct-08	1,314,764
	8	Malaria	38,782,646	(G1)	Gov: MOH	AFG-809-G08-M	01-Nov-09	
					CS/PS: NGO	AFG-809-G09-M	01-Nov-09	10,260,953
					CS/PS: NGO	AFG-809-G10-M		1,530,640
	8	TB	10,410,999	(G1)	CS/PS: NGO	AFG-809-G07-T	01-Apr-09	3,746,104
BANGLADESH	2	HIV/AIDS	48,968,561	(T3)	Gov: MOF	BAN-202-G01-H-00	01-Mar-04	19,631,639
	3	TB	42,466,601	(G2)	CS/PS: NGO	BAN-304-G02-T	01-Aug-04	26,743,146
					Gov: MOF	BAN-304-G03-T	01-Sep-04	10,185,367
	5	TB	43,300,976	(G2)	CS/PS: NGO	BAN-506-G04-T	01-May-06	11,186,149
					Gov: MOF	BAN-506-G05-T	01-May-06	5,502,085

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
BANGLADESH (CONT.)	6	HIV/AIDS	36,744,320	(G2)	Gov: MOF	BAN-607-G08-H	01-May-07	20,216,223
	6	Malaria	35,531,250	(G2)	CS/PS: NGO	BAN-607-G06-M	01-May-07	9,261,468
					Gov: MOF	BAN-607-G07-M	01-Jun-07	10,435,871
	8	TB	4,729,947	(G1)	Gov: MOF	BAN-809-G09-T	01-Oct-09	
					CS/PS: NGO	BAN-809-G10-T	01-Oct-09	688,820
	9	Malaria	10,280,071	(B1)				
BHUTAN	4	Malaria	1,737,190	(G2)	Gov: Oth	BTN-405-G01-M	01-Apr-05	1,343,198
	4	TB	994,298	(G2)	Gov: Oth	BTN-405-G02-T	01-Apr-05	886,470
	6	HIV/AIDS	1,502,445	(G1)	Gov: Oth	BTN-607-G03-H	01-Feb-08	1,009,740
	6	TB	741,689	(G1)	Gov: Oth	BTN-607-G04-T	01-Jan-08	550,249
	7	Malaria	2,046,986	(G1)	Gov: Oth	BTN-708-G05-M	01-Jul-08	1,691,617
INDIA	1	TB	8,655,033	(G2)	Gov: Oth	IDA-102-G01-T-00	01-Apr-03	8,250,421
	2	HIV/AIDS	224,805,561	(T3)	Gov: Oth	IDA-202-G02-H-00	01-May-04	106,365,233
	2	TB	113,146,342	(G3)	Gov: Oth	IDA-202-G03-T-00	01-Apr-04	40,777,676
	3	HIV/TB	14,819,772	(G2)	Gov: Oth	IDA-304-G04-C	01-Jan-05	14,819,772
	4	HIV/AIDS	292,794,190	(M)	CS/PS: NGO	IDA-405-G05-H, (G2)	01-Apr-05	15,713,025
					Gov: Oth	IDA-405-G06-H, (T3)	01-Sep-05	122,668,637
	4	Malaria	63,544,954	(G2)	Gov: MOF	IDA-405-G07-M	01-Jul-05	47,705,431
	4	TB	19,113,943	(G2)	Gov: Oth	IDA-405-G08-T (Closed: consolidated with IDA-202-G03-T-00)	01-Apr-05	19,113,943
	6	HIV/AIDS	212,202,765	(M)	CS/PS: NGO	IDA-607-G10-H, (G2)	01-Jun-07	11,660,274
					Gov: Oth	IDA-607-G11-H, (B2)	01-Jul-07	59,127,314
					CS/PS: NGO	IDA-607-G12-H, (G2)	01-Jun-07	8,429,160
	6	TB	8,579,594	(B2)	Gov: Oth	IDA-607-G09-T (Closed: consolidated with IDA-202-G03-T-00)	01-Apr-07	8,579,594
	7	HIV/AIDS	30,720,116	(G1)	Gov: Oth	IDA-708-G13-H	01-Sep-08	3,734,625
					Gov: MOH	IDA-708-G14-H	01-Sep-08	5,966,235
					CS/PS: Oth	IDA-708-G15-H	01-Sep-08	4,475,541
	9	HIV/AIDS*	21,000,206	(B1)				
	9	Malaria*	38,105,605	(B1)				
	9	TB	69,477,410	(B1)				
IRAN (ISLAMIC REPUBLIC)	2	HIV/AIDS	15,922,855	(G2)	MO: UNDP	IRN-202-G01-H-00	01-May-05	13,686,763
	7	Malaria	5,615,598	(G1)	MO: UNDP	IRN-708-G02-M	01-Oct-08	3,172,482
	7	TB	12,652,286	(G1)	MO: UNDP	IRN-708-G03-T	01-Oct-08	9,208,798
	8	HIV/AIDS	10,328,021	(T1)				
MALDIVES	6	HIV/AIDS	4,142,457	(G2)	MO: UNDP	MDV-607-G01-H	01-Sep-07	2,350,538
MULTICOUNTRY ASIA (NAZ FOUNDATION INTERNATIONAL)	9	HIV/AIDS	18,660,775	(B1)				
NEPAL	2	HIV/AIDS	10,365,995	(G2)	Gov: MOH	NEP-202-G01-H-00	01-Apr-04	4,849,147
					MO: UNDP	NEP-202-G05-H-00	01-Oct-06	4,551,995
	2	Malaria	23,836,272	(M)	Gov: MOH	NEP-202-G02-M-00, (G2)	01-Apr-04	2,459,501
					CS/PS: NGO	NEP-202-G04-M-00, (T3)	01-Dec-05	4,544,691
	4	TB	10,126,706	(G2)	Gov: MOH	NEP-405-G03-T	01-May-06	6,869,255
	7	HIV/AIDS	12,321,512	(G1)	MO: UNDP	NEP-708-G09-H	01-Dec-08	5,155,578
					CS/PS: NGO	NEP-708-G10-H	01-Dec-08	2,327,461
					CS/PS: NGO	NEP-708-G11-H	01-Dec-08	1,155,657
	7	Malaria	9,126,452	(G1)	CS/PS: NGO	NEP-708-G06-M	16-Sep-08	3,064,866
					Gov: MOH	NEP-708-G07-M	16-Sep-08	1,193,717
	7	TB	4,358,040	(G1)	Gov: MOH	NEP-708-G08-T	16-Nov-08	1,982,292
	N1[5]	TB	16,711,941	(B1)				

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
PAKISTAN	2	HIV/AIDS	8,312,200	(G2)	Gov: MOH	PKS-202-G01-H-00	01-Jan-04	7,647,236
	2	Malaria	3,537,802	(B2)	Gov: MOH	PKS-202-G02-M-00 (Inactive)	01-Jan-04	3,537,802
	2	TB	4,042,900	(G2)	Gov: MOH	PKS-202-G03-T-00	01-Jan-04	3,901,437
	3	Malaria	1,548,636	(G1)	Gov: MOH	PKS-304-G04-M	01-Jan-05	1,382,784
	3	TB	9,903,487	(G2)	Gov: MOH	PKS-304-G05-T	01-Jan-05	8,372,960
	6	TB	46,349,905	(M)	CS/PS: NGO	PKS-607-G06-T	01-Oct-07	9,556,681
					Gov: MOH	PKS-607-G07-T	01-Dec-07	8,629,063
	7	Malaria	12,886,680	(G1)	Gov: MOH	PKS-708-G08-M	01-Sep-08	8,516,287
	8	TB	8,867,642	(G1)	Gov: MOH	PKS-809-G09-T	01-Jul-09	2,109,209
					CS/PS: PS	PKS-809-G10-T	01-Sep-09	1,259,208
	9	TB	40,146,549	(B1)				
SRI LANKA	1	Malaria	7,253,635	(G2)	Gov: MOH	SRL-102-G01-M-00	01-Mar-03	2,077,223
					CS/PS: NGO	SRL-102-G02-M-00	01-Mar-03	4,633,887
	1	TB	5,465,034	(M)	Gov: MOH	SRL-102-G03-T-00, (G2)	01-Mar-03	3,909,835
					CS/PS: NGO	SRL-102-G04-T-00 (Inactive), (B2)	01-Mar-03	268,292
	4	Malaria	3,697,315	(G2)	Gov: MOH	SRL-405-G05-M	01-Oct-05	2,159,122
					CS/PS: NGO	SRL-405-G06-M	01-Oct-05	1,152,684
	6	HIV/AIDS	1,009,700	(G1)	Gov: MOH	SRL-607-G09-H	01-Jan-08	302,600
	6	TB	4,186,195	(G1)	Gov: MOH	SRL-607-G07-T	01-Jan-08	985,674
					CS/PS: NGO	SRL-607-G08-T	01-Jan-08	624,995
	8	Malaria	21,630,381	(G1)	Gov: MOH	SRL-809-G10-M	01-Sep-09	1,836,422
					CS/PS: NGO	SRL-809-G11-M	01-Oct-09	2,810,551
					CS/PS: NGO	SRL-809-G12-M	01-Nov-09	1,471,303
	9	HIV/AIDS*	19,398,656	(B1)				
REGION TOTALS:			**1,787,268,110**					**785,742,616**
REGION: SUB-SAHARAN AFRICA: EAST AFRICA AND INDIAN OCEAN								
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)	01-Oct-03	16,568,331
					Gov: MOH	BRN-202-G05-M-00, (G3)	01-Oct-06	17,036,493
	4	TB	3,381,665	(G2)	Gov: MOH	BRN-405-G03-T	01-May-05	3,050,158
	5	HIV/AIDS	32,353,173	(G2)	Gov: Oth	BRN-506-G04-H	01-Jun-06	28,575,237
	7	TB	4,018,177	(G1)	Gov: MOH	BRN-708-G06-T	01-Sep-08	3,255,533
	8	HIV/AIDS	36,789,591	(G1)	Gov: Oth	BRN-809-G07-H		9,087,521
					CS/PS: NGO	BRN-809-G08-H		3,917,612
	9	Malaria	21,578,809	(B1)				
COMOROS	2	Malaria	2,485,878	(G2)	CS/PS: NGO	COM-202-G01-M-00	01-Jun-04	2,422,471
	3	HIV/AIDS	1,136,900	(G2)	CS/PS: NGO	COM-304-G02-H	01-Jan-05	1,086,463
	8	Malaria	6,495,925	(T1)				
	9	HIV/AIDS	2,627,984	(B1)				
CONGO (DEMOCRATIC REPUBLIC)	2	TB	7,625,773	(G2)	MO: UNDP	ZAR-202-G01-T-00 (Inactive)	01-Aug-03	7,601,673
	3	HIV/AIDS	113,646,453	(G2)	MO: UNDP	ZAR-304-G02-H	01-Jan-05	113,578,847
	3	Malaria	53,936,609	(G2)	MO: UNDP	ZAR-304-G03-M	01-Jan-05	53,936,608
	5	TB	27,051,721	(B2)	MO: UNDP	ZAR-506-G04-T	01-Dec-06	19,230,176
	6	TB	10,584,757	(B2)	MO: UNDP	ZAR-607-G05-T	01-Oct-07	8,182,300
	7	HIV/AIDS	22,675,188	(G1)	MO: UNDP	ZAR-708-G06-H	01-Dec-08	11,626,217
	8	HIV/AIDS	71,309,902	(T1)	MO: UNDP	ZAR-809-G10-H		5,208,606
	8	Malaria	145,520,804	(T1)	CS/PS: NGO	ZAR-809-G07-M	01-Jan-10	66,872,873
	9	TB*	110,092,302	(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	01-Sep-04	16,692,156

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
ERITREA (CONT.)	5	HIV/AIDS	28,658,165	(G2)	Gov: MOH	ERT-506-G03-H	01-Sep-06	17,103,758
	6	Malaria	12,301,265	(B2)	Gov: MOH	ERT-607-G05-M	01-Nov-07	4,622,705
	6	TB	9,724,961	(B2)	Gov: MOH	ERT-607-G04-T	01-Nov-07	3,087,417
	8	HIV/AIDS	15,174,249	(G1)	Gov: MOH	ERT-809-G06-H		5,997,748
	9	Malaria	29,855,990	(B1)				
ETHIOPIA	1	TB	26,980,649	(G2)	Gov: MOH	ETH-102-G01-T-00	01-Aug-03	26,980,649
	2	HIV/AIDS	481,959,415	(T3)	Gov: Oth	ETH-202-G03-H-00	01-Jan-04	129,385,088
	2	Malaria	73,875,211	(G2)	Gov: MOH	ETH-202-G02-M-00	01-Oct-03	73,875,211
	4	HIV/AIDS	401,905,883	(G2)	Gov: Oth	ETH-405-G04-H	01-Mar-05	244,114,173
	5	Malaria	140,687,413	(G2)	Gov: MOH	ETH-506-G05-M	01-Jul-06	104,036,581
	6	TB	11,792,574	(G1)	Gov: MOH	ETH-607-G06-T	01-Feb-08	7,878,422
	7	HIV/AIDS	64,955,789	(G1)	CS/PS: NGO	ETH-708-G07-H	01-Apr-09	3,089,816
					Gov: Oth	ETH-708-G08-H	01-Jan-09	22,443,435
					CS/PS: FBO	ETH-708-G09-H	01-Jan-09	6,780,027
	8	Malaria	133,089,526	(G1)	Gov: MOH	ETH-809-G10-M	01-Nov-09	72,178,615
	9	TB*	19,383,242	(B1)				
KENYA	1	HIV/AIDS	2,650,813	(G1)	CS/PS: NGO	KEN-102-G01-H-00 (Inactive)	01-Apr-03	2,650,813
	1	HIV/AIDS	220,875	(G1)	CS/PS: NGO	KEN-102-G02-H-00 (Inactive)	01-Apr-03	220,875
	2	HIV/AIDS	68,006,881	(G2)	Gov: MOF	KEN-202-G03-H-00	01-Dec-03	68,006,881
	2	Malaria	4,640,447	(G2)	Gov: MOF	KEN-202-G05-M-00	01-Oct-03	4,640,447
	2	TB	3,299,522	(G2)	Gov: MOF	KEN-202-G04-T-00	01-Nov-03	3,299,522
	4	Malaria	162,173,085	(G2)	Gov: MOF	KEN-405-G06-M	01-Feb-06	102,535,157
	5	TB	13,499,895	(B2)	Gov: MOF	KEN-506-G07-T	01-Sep-06	3,511,242
	6	TB	4,206,357	(G1)	Gov: MOF	KEN-607-G08-T	01-Apr-08	2,961,806
	7	HIV/AIDS	46,663,495	(G1)	Gov: MOF	KEN-708-G09-H	01-Jun-09	11,803,456
					CS/PS: NGO	KEN-708-G10-H	01-Apr-09	4,735,494
	9	TB*	23,682,114	(B1)				
MADAGASCAR	1	Malaria	2,000,063	(G2)	CS/PS: NGO	MDG-102-G01-M-00 (Inactive)	01-Feb-03	1,872,363
	2	HIV/AIDS	1,439,778	(G2)	CS/PS: NGO	MDG-202-G02-H-00 (Closed)	01-Nov-03	1,439,778
	2	HIV/AIDS	5,024,116	(G2)	CS/PS: NGO	MDG-202-G03-H-00	01-May-03	4,992,128
	3	HIV/AIDS	14,488,982	(G2)	Gov: Oth	MDG-304-G04-H	01-Nov-04	14,320,111
	3	Malaria	10,035,054	(G2)	Gov: MOH	MDG-304-G05-M	01-Nov-04	10,002,421
	4	Malaria	74,939,490	(M)	Gov: MOH	MDG-405-G06-M, (G2)	01-Apr-05	21,446,655
					CS/PS: NGO	MDG-405-G07-M, (G3)	01-Mar-05	28,070,175
	4	TB	8,323,396	(G2)	Gov: Oth	MDG-404-G08-T	01-Feb-05	7,946,689
	7	Malaria	26,095,449	(G1)	Gov: MOH	MDG-708-G09-M	01-Oct-08	12,559,549
					CS/PS: NGO	MDG-708-G10-M	01-Dec-08	2,150,644
	8	HIV/AIDS	9,799,118	(G1)	Gov: Oth	MDG-809-G11-H	01-Oct-09	2,166,096
					CS/PS: NGO	MDG-809-G12-H	01-Nov-09	1,565,715
	8	TB	8,088,328	(T1)				
	N1[5]	Malaria	81,015,431	(B1)				
MAURITIUS	8	HIV/AIDS	5,191,511	(G1)	Gov: MOH	MUS-809-G01-H		
						MUS-809-G02-H		820.014
RWANDA	1	HIV/TB	14,641,046	(G2)	Gov: MOH	RWN-102-G01-C-00	01-May-03	14,641,046
	3	HIV/AIDS	56,646,465	(G2)	Gov: MOH	RWN-304-G02-H	01-Aug-04	56,646,460
	3	Malaria	38,597,403	(G3)	Gov: MOH	RWN-304-G03-M	01-Oct-04	32,414,495
	4	TB	17,027,672	(T3)	Gov: MOH	RWN-404-G04-T	01-Jan-05	10,556,003
	5	HSS	33,945,080	(G2)	Gov: MOH	RWN-505-G05-S	01-Jan-06	33,397,129
	5	Malaria	39,649,362	(G2)	Gov: MOH	RWN-506-G06-M	01-Mar-06	39,149,502
	6	HIV/AIDS	50,808,370	(B2)	Gov: MOH	RWN-607-G08-H	01-Jun-07	30,196,743
	6	TB	7,426,750	(B2)	Gov: MOH	RWN-606-G07-T	01-Mar-07	2,538,357
	7	HIV/AIDS	63,978,011	(G1)	Gov: MOH	RWN-708-G09-H	01-Oct-08	49,725,380

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
RWANDA (CONT.)	8	Malaria	52,835,617	(G1)	Gov: MOH	RWN-809-G10-M	01-Jul-09	35,985,693
	N1[5]	HIV/AIDS	213,800,858	(B1)				
	N1[5]	TB	33,353,241	(B1)				
TANZANIA	1	HIV/AIDS	5,400,000	(G1)	Gov: MOF	TNZ-102-G02-H-00 (Inactive)	01-Nov-03	4,647,000
	1	Malaria	78,079,834	(G3)	Gov: MOH	TNZ-102-G01-M-00	01-Nov-03	70,222,011
	3	HIV/TB	83,466,904	(G2)	Gov: MOF	TNZ-304-G03-C	01-Nov-04	54,798,490
	4	HIV/AIDS	303,939,165	(M)	Gov: MOF	TNZ-405-G04-H, (G2)	01-Sep-05	160,325,676
					CS/PS: NGO	TNZ-405-G05-H, (G2)	01-Jul-05	36,703,100
					CS/PS: NGO	TNZ-405-G06-H, (T3)	01-Jul-05	9,374,829
					CS/PS: NGO	TNZ-405-G07-H, (G2)	01-Jul-05	21,471,837
	4	Malaria	76,086,764	(G2)	Gov: MOF	TNZ-405-G08-M	01-Aug-05	75,086,764
	6	TB	16,498,948	(G1)	Gov: MOF	TNZ-607-G09-T	01-Nov-07	15,173,156
	7	Malaria	20,707,304	(G1)	Gov: MOF	TNZ-708-G10-M	01-Jul-08	10,170,104
	8	HIV/AIDS	121,142,078	(G1)	CS/PS: NGO	TNZ-809-G12-H		1,143,466
					Gov: MOF	TNZ-809-G13-H		
	8	Malaria	100,427,017	(G1)	Gov: MOF	TNZ-809-G11-M	01-Nov-09	31,467,018
	9	HIV/AIDS	97,901,945	(B1)				
	9	Malaria*	76,050,523	(B1)				
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	46,362,091	(G2)	Gov: MOF	UGD-304-G04-H	01-Jul-05	46,362,091
	4	Malaria	137,467,137	(G2)	Gov: MOF	UGD-405-G05-M	01-Dec-05	59,071,374
	6	TB	8,103,106	(G1)	Gov: MOF	UGD-607-G06-T	01-Mar-08	2,585,105
	7	HIV/AIDS	70,277,726	(G1)	Gov: MOF	UGD-708-G07-H	01-Aug-09	4,250,997
	7	Malaria	51,422,198	(G1)	Gov: MOF	UGD-708-G08-M	01-Dec-09	40,985,476
ZANZIBAR (TANZANIA)	1	Malaria	1,153,080	(G2)	Gov: MOH	ZAN-102-G01-M-00	01-Jun-03	1,153,080
	2	HIV/AIDS	2,302,637	(G2)	Gov: Oth	ZAN-202-G02-H-00	01-Sep-03	1,432,275
	3	TB	1,699,867	(G2)	Gov: MOH	ZAN-304-G03-T	01-Dec-04	1,110,134
	4	Malaria	8,438,788	(G2)	Gov: MOH	ZAN-404-G04-M	01-Jan-05	8,438,788
	6	HIV/AIDS	3,825,619	(G1)	Gov: MOH	ZAN-607-G05-H	01-Dec-07	1,208,108
					Gov: Oth	ZAN-607-G06-H	01-Dec-07	135,695
	8	Malaria	5,191,787	(G1)	Gov: MOH	ZAN-809-G07-M	01-Dec-09	
REGION TOTALS:			**4,787,588,617**					**2,453,494,390**
REGION: SUB-SAHARAN AFRICA: SOUTHERN AFRICA								
ANGOLA	3	Malaria	35,029,872	(G2)	MO: UNDP	AGO-305-G01-M	01-Apr-05	34,833,588
	4	HIV/AIDS	86,120,215	(G2)	MO: UNDP	AGO-405-G03-H	01-Oct-05	45,876,284
	4	TB	10,871,026	(G2)	MO: UNDP	AGO-405-G02-T	01-Aug-05	8,241,814
	7	Malaria	32,512,648	(G1)	Gov: MOH	AGO-708-G04-M	01-Nov-08	15,927,050
	9	TB*	11,384,314	(B1)				
BOTSWANA	2	HIV/AIDS	18,580,414	(G1)	Gov: MOF	BOT-202-G01-H-00 (Inactive)	01-Jul-04	9,019,119
	5	TB	8,285,245	(G2)	Gov: MOF	BOT-506-G02-T	01-Jan-07	3,975,343
LESOTHO	2	HIV/AIDS	29,312,000	(G2)	Gov: MOF	LSO-202-G01-H-00	01-Jan-04	28,884,104
	2	TB	5,000,000	(G2)	Gov: MOF	LSO-202-G02-T-00	01-Jan-04	4,947,928
	5	HIV/AIDS	15,781,572	(G2)	Gov: MOF	LSO-506-G03-H	01-Nov-06	15,781,572
	6	TB	5,543,805	(G2)	Gov: MOF	LSO-607-G04-T	01-Jul-07	3,071,843
	7	HIV/AIDS	10,626,665	(G1)	Gov: MOF	LSO-708-G05-H	01-Jul-08	5,155,757
	8	HIV/AIDS	57,214,789	(M)	Gov: MOF	LSO-809-G06-H, (G1)	01-Nov-09	
					CS/PS: NGO	LSO-809-G07-H, (G1)		

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
LESOTHO (CONT.)	8	TB	9,569,124	(T1)				
	9	HIV/AIDS	10,356,112	(B1)				
MALAWI	1	HIV/AIDS	342,557,595	(G3)	Gov: Oth	MLW-102-G01-H-00	01-Oct-03	225,638,705
	2	Malaria	36,773,714	(B2)	Gov: MOH	MLW-202-G02-M-00	01-Feb-06	17,957,714
	5	HIV/AIDS	17,589,438	(G2)	Gov: Oth	MLW-506-G03-H	01-Oct-06	13,014,913
	5	HSS	51,984,491	(B2)	Gov: Oth	MLW-506-G04-S	01-Jul-07	21,345,667
	7	HIV/AIDS	15,078,417	(G1)	Gov: Oth	MLW-708-G07-H	01-Oct-08	9,529,917
	7	Malaria	36,545,312	(G1)	Gov: Oth	MLW-708-G05-M	01-Jan-09	18,683,204
	7	TB	7,802,037	(G1)	Gov: MOH	MLW-708-G06-T	01-Jan-09	2,825,106
	9	Malaria	33,170,946	(B1)				
MOZAMBIQUE	2	HIV/AIDS	109,338,584	(M)	Gov: Oth	MOZ-202-G01-H-00, (B2)	01-Jul-06	6,156,898
					Gov: MOH	MOZ-202-G02-H-00, (G2)	01-Jan-05	75,822,995
	2	Malaria	28,149,603	(G2)	Gov: MOH	MOZ-202-G03-M-00	01-Jan-05	23,489,200
	2	TB	14,200,659	(G2)	Gov: MOH	MOZ-202-G04-T-00	01-Jan-05	9,323,228
	6	HIV/AIDS	70,041,322	(B2)	Gov: MOH	MOZ-607-G05-H	01-Jul-07	16,012,381
	6	Malaria	33,353,933	(B2)	Gov: MOH	MOZ-607-G06-M	01-Jul-07	13,123,695
	7	TB	6,735,303	(G1)	Gov: MOH	MOZ-708-G07-T	01-Jul-08	2,134,834
	8	HIV/AIDS	11,823,414	(T1)	Gov: MOH	MOZ-809-G08-S		
	9	HIV/AIDS*	69,377,979	(B1)				
	9	Malaria	67,401,102	(B1)				
MULTICOUNTRY AFRICA (SADC)	9	HIV/AIDS*	24,587,661	(B1)				
MULTICOUNTRY AFRICA (RMCC)	2	Malaria	41,101,873	(G3)	CS/PS: NGO	MAF-202-G01-M-00	01-Aug-03	25,237,548
	5	Malaria	6,501,141	(B2)	CS/PS: NGO	MAF-506-G02-M	01-Jul-06	6,501,141
NAMIBIA	2	HIV/AIDS	213,059,806	(T3)	Gov: MOH	NMB-202-G01-H-00	01-Jan-05	87,629,806
	2	Malaria	9,103,621	(T3)	Gov: MOH	NMB-202-G03-M-00	01-Jan-05	6,199,265
	2	TB	2,129,814	(T3)	Gov: MOH	NMB-202-G02-T-00	01-Jan-05	1,294,610
	5	TB	17,204,526	(G2)	Gov: MOH	NMB-506-G04-T	01-Jun-06	12,592,920
	6	Malaria	13,553,569	(B2)	Gov: MOH	NMB-607-G06-M	01-Aug-07	8,450,571
SOUTH AFRICA	1	HIV/TB	20,226,665	(B2)	Gov: MOF	SAF-102-G01-C-00 (Inactive)	08-Dec-03	2,354,000
					Gov: MOF	SAF-102-G02-C-00 (Inactive)	01-Aug-03	17,872,665
	1	HIV/TB	62,476,536	(G2)	Gov: MOF	SAF-102-G03-C-00	01-Jan-04	49,771,823
	2	HIV/TB	24,400,220	(G2)	Gov: MOH	SAF-202-G05-C-00	01-Jan-06	17,168,533
	3	HIV/AIDS	66,501,629	(G2)	Gov: MOH	SAF-304-G04-H	01-Sep-04	62,190,178
	6	HIV/AIDS	55,071,906	(G1)	Gov: MOH	SAF-607-G06-H	01-Jan-08	34,982,161
	9	HIV/AIDS	42,577,518	(B1)				
SWAZILAND	2	HIV/AIDS	49,276,920	(G2)	Gov: Oth	SWZ-202-G01-H-00	01-Aug-03	47,878,166
	2	Malaria	1,478,928	(G2)	Gov: Oth	SWZ-202-G02-M-00	01-Sep-03	1,477,328
	3	TB	2,506,000	(G2)	Gov: Oth	SWZ-304-G03-T	01-Jan-05	2,232,681
	4	HIV/AIDS	45,839,731	(G2)	Gov: Oth	SWZ-405-G04-H	01-Oct-05	19,310,179
	7	HIV/AIDS	28,380,316	(G1)	Gov: Oth	SWZ-708-G05-H	01-Jan-09	5,507,827
	8	HIV/AIDS	7,173,715	(G1)	Gov: Oth	SWZ-809-G08-S		3,473,013
	8	Malaria	5,051,555	(G1)	Gov: Oth	SWZ-809-G06-M	01-Jul-09	2,561,700
	8	TB	4,163,873	(G1)	Gov: Oth	SWZ-809-G07-T	01-Jan-10	970,176
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, (B2)	01-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	35,291,300

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
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 (CONT.)					CS/PS: FBO	ZAM-102-G05-M-00	01-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	01-Dec-05	1,164,676
	4	HIV/AIDS	236,318,738	(G2)	Gov: MOH	ZAM-405-G09-H	01-Nov-05	41,073,687
					CS/PS: FBO	ZAM-405-G10-H	01-Jul-05	59,751,973
					CS/PS: NGO	ZAM-405-G11-H	01-Jul-05	19,878,049
					Gov: MOF	ZAM-405-G12-H	01-Oct-05	7,570,956
	4	Malaria	42,721,807	(G2)	Gov: MOH	ZAM-405-G13-M	01-Nov-05	17,466,449
					CS/PS: FBO	ZAM-405-G14-M	01-Jul-05	10,956,384
	7	Malaria	17,715,924	(G1)	Gov: MOH	ZAM-708-G17-M	01-Jul-08	
					CS/PS: FBO	ZAM-708-G19-M	01-Jul-08	3,443,251
	7	TB	3,882,948	(G1)	Gov: MOH	ZAM-708-G16-T	01-Jul-08	
					CS/PS: FBO	ZAM-708-G18-T	01-Jul-08	1,518,189
					CS/PS: NGO	ZAM-708-G20-T	01-Jul-08	613,668
	8	HIV/AIDS	129,368,645	(T1)	CS/PS: FBO	ZAM-809-G21-H	01-Oct-09	11,488,454
					CS/PS: NGO	ZAM-809-G22-H	01-Dec-09	741,161
					Gov: MOF	ZAM-809-G23-H		2,949,150
ZIMBABWE	1	HIV/AIDS	14,100,000	(M)	MO: UNDP	ZIM-102-G01-H-00, (B2)	01-May-05	6,312,533
					Gov: Oth	ZIM-102-G07-H, (G2)	01-Nov-07	4,836,910
	1	Malaria	8,559,911	(G2)	Gov: MOH	ZIM-102-G02-M-00	01-Aug-04	8,250,984
	5	HIV/AIDS	35,931,159	(G1)	Gov: Oth	ZIM-506-G03-H	01-Aug-07	13,663,668
					CS/PS: FBO	ZIM-506-G04-H	01-Jun-07	1,292,404
					MO: UNDP	ZIM-509-G10-H	01-Aug-09	20,440,040
	5	Malaria	20,121,670	(G1)	Gov: MOH	ZIM-506-G06-M (Closed: consolidated with ZIM-509-G09-M)	01-Oct-07	7,956,505
					MO: UNDP	ZIM-509-G09-M	01-Aug-09	11,784,474
	5	TB	9,230,076	(G1)	CS/PS: FBO	ZIM-506-G05-T (Closed: consolidated with ZIM-509-G08-T)	01-Sep-07	3,410,626
					MO: UNDP	ZIM-509-G08-T	01-Aug-09	5,694,529
	8	HIV/AIDS	84,641,215	(G1)	MO: UNDP	ZIM-809-G11-H	01-Nov-09	20,053,712
	8	Malaria	67,081,814	(G1)	MO: UNDP	ZIM-809-G13-M	01-Nov-09	20,319,314
					MO: UNDP	ZIM-809-G14-S	01-Nov-09	2,093,308
	8	TB	28,236,113	(G1)	MO: UNDP	ZIM-809-G12-T	01-Nov-09	11,260,969
REGION TOTALS:			**2,915,326,027**					**1,511,667,308**
REGION: SUB-SAHARAN AFRICA: WEST AND CENTRAL AFRICA								
BENIN	1	Malaria	2,973,150	(G2)	MO: UNDP	BEN-102-G01-M-00	01-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	01-Nov-03	3,095,158
	3	Malaria	68,448,335	(T3)	CS/PS: NGO	BEN-304-G04-M	01-Nov-04	2,422,783
	5	HIV/AIDS	54,015,572	(G2)	Gov: MOH	BEN-506-G05-H	01-Jan-07	21,766,442
	6	TB	10,102,793	(G2)	Gov: MOH	BEN-607-G06-T	01-Jun-07	5,716,089
	7	Malaria	12,433,054	(G1)	CS/PS: FBO	BEN-708-G07-M	01-Jul-08	5,969,467
	9	HIV/AIDS	69,189,310	(B1)				
	9	TB	4,032,731	(B1)				
BURKINA FASO	2	HIV/AIDS	16,417,522	(M)	MO: UNDP	BUR-202-G02-H-00, (B2)	01-Dec-03	8,789,010
					Gov: MOH	BUR-202-G04-H-00, (G2)	01-Oct-06	5,487,521
	2	Malaria	7,499,988	(G1)	MO: UNDP	BUR-202-G01-M-00 (Inactive)	01-Dec-03	6,812,492
	4	TB	16,984,217	(M)	MO: UNDP	BUR-404-G03-T, (B2)	01-Jan-05	5,492,614
					Gov: MOH	BUR-407-G05-T, (G2)	01-Jun-07	10,685,907
	6	HIV/AIDS	57,694,161	(B2)	Gov: Oth	BUR-607-G06-H	01-Oct-07	27,016,544
	7	Malaria	17,066,985	(G1)	Gov: Oth	BUR-708-G07-M	01-May-08	16,595,227

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
BURKINA FASO (CONT.)	8	Malaria	59,863,987	(G1)	Gov: 0th	BUR-809-G08-M	01-Sep-09	513,513
					CS/PS: NGO	BUR-809-G09-M	01-Sep-09	5,309,836
	8	TB	15,843,549	(T1)				
CAMEROON	3	HIV/AIDS	74,233,620	(G2)	Gov: MOH	CMR-304-G01-H	01-Jan-05	55,500,617
	3	Malaria	31,781,187	(G2)	Gov: MOH	CMR-304-G02-M	01-Jan-05	29,881,464
	3	TB	5,804,961	(G2)	Gov: MOH	CMR-304-G03-T	01-Jan-05	5,478,819
	4	HIV/AIDS	16,194,089	(G2)	CS/PS: NGO	CMR-404-G04-H	01-Jan-05	15,915,458
	5	HIV/AIDS	14,893,203	(G2)	Gov: MOH	CMR-506-G05-H	01-Aug-06	6,555,456
	5	Malaria	15,161,103	(G2)	Gov: MOH	CMR-506-G06-M	01-Nov-06	6,543,795
	9	Malaria	111,499,268	(B1)				
	9	TB	9,779,422	(B1)				
CAPE VERDE	8	HIV/AIDS	5,321,184	(T1)				
CENTRAL AFRICAN REPUBLIC	2	HIV/AIDS	23,056,692	(G2)	MO: UNDP	CAF-202-G01-H-00	01-Oct-03	23,056,692
	4	HIV/AIDS	10,658,677	(G2)	MO: UNDP	CAF-404-G02-H (Closed: consolidated with CAF-409-G06-H)	01-Jan-05	8,495,262
					Gov: MOH	CAF-409-G06-H		1,515,742
	4	Malaria	16,663,897	(G2)	MO: UNDP	CAF-405-G04-M	01-May-05	12,671,585
	4	TB	4,217,417	(G2)	MO: UNDP	CAF-404-G03-T (Closed: consolidated with CAF-409-G07-T)	01-Jan-05	3,111,176
					Gov: MOH	CAF-409-G07-T	01-Jul-09	256,983
	7	HIV/AIDS	15,799,899	(G1)	Gov: MOH	CAF-708-G05-H	01-Jan-09	2,738,868
	8	Malaria	14,341,902	(T1)				
	9	TB*	17,439,384	(B1)				
CONGO	5	HIV/AIDS	46,176,190	(G2)	Gov: 0th	COG-506-G01-H	01-Dec-06	
					Gov: 0th	COG-506-G01-H-e	as above	14,254,161
	8	Malaria	36,248,707	(T1)				
	8	TB	3,146,392	(T1)				
	9	HIV/AIDS*	15,441,609	(B1)				
CÔTE D'IVOIRE	2	HIV/AIDS	49,089,450	(G2)	MO: UNDP	CIV-202-G01-H-00	01-Dec-03	20,987,347
					CS/PS: NGO	CIV-202-G05-H	01-Aug-07	18,929,673
	3	HIV/AIDS	1,023,534	(G1)	CS/PS: NGO	CIV-304-G02-H (Inactive)	01-Apr-04	1,023,467
	3	TB	3,830,107	(G2)	MO: UNDP	CIV-304-G03-T	01-Apr-04	3,742,346
	5	HIV/AIDS	4,031,886	(G1)	CS/PS: NGO	CIV-506-G04-H	01-Aug-06	4,013,260
	6	Malaria	10,335,083	(G1)	CS/PS: NGO	CIV-607-G06-M	01-Dec-07	9,447,380
	6	TB	3,514,025	(G1)	Gov: MOH	CIV-607-G07-T	01-Apr-08	3,099,523
	8	Malaria	146,846,570	(G1)	CS/PS: NGO	CIV-809-G08-M		9,927,880
					Gov: MOH	CIV-809-G09-M		1,122,482
	9	HIV/AIDS	66,026,831	(B1)				
	9	TB	13,863,245	(B1)				
EQUATORIAL GUINEA	4	HIV/AIDS	9,824,836	(G2)	MO: UNDP	GNQ-405-G01-H	01-Jul-05	5,782,477
	5	Malaria	23,074,306	(G2)	CS/PS: NGO	GNQ-506-G02-M	01-Oct-06	15,035,143
GABON	3	HIV/AIDS	7,212,579	(G2)	MO: UNDP	GAB-304-G01-H (Closed: consolidated with GAB-304-G01-H-e)	01-Oct-04	5,092,967
					MO: UNDP	GAB-304-G01-H-e	01-Oct-04	1,797,515
	4	Malaria	8,616,322	(G2)	MO: UNDP	GAB-404-G02-M	01-Jan-05	8,616,322
	5	Malaria	14,502,832	(M)	MO: UNDP	GAB-506-G03-M, (B2) (Closed: consolidated with GAB-509-G04-M, (G2))	01-Aug-06	4,160,323
					Gov: MOH	GAB-509-G04-M, (G2)	01-Apr-09	3,891,808
	8	HIV/AIDS	8,026,965	(G1)	Gov: MOH	GAB-809-G05-H	01-Jan-10	3,004,246

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
GAMBIA	3	HIV/AIDS	14,568,678	(G2)	Gov: Oth	GMB-304-G01-H	01-Oct-04	14,563,907
	3	Malaria	27,956,725	(T3)	Gov: MOH	GMB-304-G02-M	01-Oct-04	14,794,704
	5	TB	5,032,929	(G2)	Gov: MOH	GMB-506-G03-T	01-Jun-06	4,036,797
	6	Malaria	18,060,099	(G2)	Gov: MOH	GMB-607-G04-M	01-Jul-07	11,364,267
	8	HIV/AIDS	18,652,235	(G1)	Gov: Oth	GMB-809-G05-H	01-Jan-10	2,731,690
					CS/PS: NGO	GMB-809-G06-H	01-Dec-09	1,428,999
	9	Malaria	10,611,436	(B1)				
	9	TB*	8,049,144	(B1)				
GHANA	1	HIV/AIDS	14,170,222	(G2)	Gov: MOH	GHN-102-G01-H-00	01-Jan-03	14,170,222
	1	TB	5,687,055	(G2)	Gov: MOH	GHN-102-G02-T-00	01-Jan-03	5,685,493
	2	Malaria	8,849,491	(G2)	Gov: MOH	GHN-202-G03-M-00	01-Sep-03	8,849,491
	4	Malaria	108,489,987	(G3)	Gov: MOH	GHN-405-G04-M	01-Mar-05	57,250,961
	5	HIV/AIDS	97,098,678	(G2)	Gov: MOH	GHN-506-G06-H	01-May-06	68,157,258
	5	TB	31,471,784	(G2)	Gov: MOH	GHN-506-G05-T	01-May-06	24,238,637
	8	HIV/AIDS	49,350,970	(G1)	CS/PS: NGO	GHN-809-G09-H		1,479,958
					CS/PS: NGO	GHN-809-G10-H		1,212,528
					Gov: MOH	GHN-809-G11-H		16,278,881
						GHN-809-G12-H		6,419,944
	8	Malaria	39,639,117	(M)	Gov: MOH	GHN-809-G07-M		2,288,504
					CS/PS: NGO	GHN-809-G08-M		6,395,068
GUINEA	2	HIV/AIDS	9,651,105	(G2)	Gov: MOH	GIN-202-G01-H-00	01-Apr-04	5,236,707
	2	Malaria	6,893,509	(B2)	Gov: MOH	GIN-202-G02-M-00	01-Apr-04	5,125,461
	5	TB	6,782,980	(G2)	Gov: MOH	GIN-506-G03-T	01-Feb-07	4,041,512
	6	HIV/AIDS	4,585,405	(G1)	Gov: MOH	GIN-607-G04-H	01-Jan-08	1,944,841
	6	Malaria	17,339,248	(G1)	Gov: MOH	GIN-607-G05-M	01-Jan-08	1,289,333
	9	TB	4,035,589	(B1)				
GUINEA-BISSAU	3	TB	2,564,139	(G2)	MO: UNDP	GNB-304-G01-T (Closed: consolidated with GNB-309-G06-T)	01-Jul-04	1,927,068
					Gov: MOH	GNB-309-G06-T	01-Jul-04	536,945
	4	HIV/AIDS	3,279,759	(G2)	MO: UNDP	GNB-404-G02-H (Closed: consolidated with GNB-409-G07-H)	01-Nov-04	1,921,443
					Gov: MOH	GNB-409-G07-H	01-Nov-04	1,114,970
	4	Malaria	3,080,328	(G2)	MO: UNDP	GNB-404-G03-M (Closed: consolidated with GNB-409-G08-M)	01-Jan-05	2,120,329
					Gov: MOH	GNB-409-G08-M	01-Jan-05	521,948
	6	Malaria	3,438,484	(G1)	Gov: MOH	GNB-607-G04-M	01-Dec-07	2,671,727
	7	HIV/AIDS	13,182,390	(G1)	Gov: Oth	GNB-708-G05-H	01-Feb-09	3,551,769
	8	TB	853,794	(T1)				
	9	Malaria	8,807,759	(B1)				
	9	TB*	10,290,379	(B1)				
LIBERIA	2	HIV/AIDS	7,658,187	(G1)	MO: UNDP	LBR-202-G01-H-00	01-Dec-04	7,429,767
	2	TB	4,534,017	(G1)	MO: UNDP	LBR-202-G02-T-00	01-Dec-04	4,298,100
	3	Malaria	12,140,921	(G1)	MO: UNDP	LBR-304-G03-M	01-Dec-04	11,876,058
	6	HIV/AIDS	31,147,984	(B2)	MO: UNDP	LBR-607-G04-H	01-Jun-07	16,803,439
	7	Malaria	12,695,907	(G1)	MO: UNDP	LBR-708-G05-M	01-Jun-08	9,474,118
	7	TB	6,408,872	(G1)	MO: UNDP	LBR-708-G06-T	01-Jun-08	5,241,612
	8	HIV/AIDS	19,686,666	(T1)				
MULTICOUNTRY AFRICA (WEST AFRICA CORRIDOR PROGRAM)	6	HIV/AIDS	19,092,500	(G1)	CS/PS: NGO	MAW-607-G01-H	01-Sep-07	17,749,112
NIGERIA	1	HIV/AIDS	6,770,276	(B2)	Gov: Oth	NGA-102-G01-H-00 (Inactive)	01-Jan-04	6,770,276
	1	HIV/AIDS	1,687,599	(G1)	CS/PS: NGO	NGA-102-G02-H-00 (Inactive)	01-Dec-03	816,305

APPROVED PROPOSALS					GRANT AGREEMENTS			DISBURSEMENTS
COUNTRY OR TERRITORY[2]	ROUND	DISEASE COMPONENT	APPROVED GRANT AMOUNT (US$)[3]	STATUS[3]	PRINCIPAL RECIPIENT TYPE[4]	GRANT NUMBER	PROGRAM START DATE	TOTAL AMOUNT DISBURSED (US$)
NIGERIA (CONT.)	1	HIV/AIDS	12,948,323	(B2)	Gov: Oth	NGA-102-G03-H-00 (Inactive)	01-Jan-04	12,948,323
	2	Malaria	20,994,149	(B2)	CS/PS: NGO	NGA-202-G04-M-00	01-Dec-04	20,241,784
	4	Malaria	74,542,287	(G2)	CS/PS: NGO	NGA-404-G05-M	01-Jan-05	38,481,707
					CS/PS: NGO	NGA-407-G10-M	01-Jan-08	25,670,295
	5	HIV/AIDS	161,179,839	(G2)	Gov: Oth	NGA-506-G07-H	01-Jan-07	72,699,420
					CS/PS: NGO	NGA-506-G08-H	01-Jan-07	12,560,992
					CS/PS: NGO	NGA-506-G09-H	01-Jan-07	15,378,638
	5	TB	63,740,481	(M)	CS/PS: FBO	NGA-506-G06-T, (B2)	01-Jan-07	23,932,485
					CS/PS: NGO	NGA-509-G15-T, (G2)	01-Oct-09	7,721,243
	8	HIV/AIDS	55,379,935	(G1)	Gov: Oth	NGA-809-G12-S	01-Nov-09	20,975,288
	8	Malaria	284,906,626	(G1)	CS/PS: NGO	NGA-809-G11-M	01-Aug-09	48,402,067
					CS/PS: NGO	NGA-809-G13-M	01-Nov-09	85,580,403
					Gov: MOH	NGA-809-G14-M	01-Nov-09	78,066,740
	9	HIV/AIDS	61,980,496	(B1)				
	9	TB*	31,515,160	(B1)				
SAO TOME AND PRINCIPE	4	Malaria	3,484,859	(G2)	MO: UNDP	STP-405-G01-M	01-Mar-05	3,024,212
	5	HIV/AIDS	1,370,682	(G2)	MO: UNDP	STP-506-G02-H	01-Oct-06	854,715
	7	Malaria	4,118,449	(G1)	MO: UNDP	STP-708-G03-M	01-Nov-08	1,756,733
	8	TB	1,015,080	(G1)	MO: UNDP	STP-809-G04-T	01-Dec-09	431,990
SENEGAL	1	HIV/AIDS	11,714,285	(G2)	Gov: Oth	SNG-102-G01-H-00	01-Apr-03	8,748,915
					CS/PS: NGO	SNG-102-G04-H-00	01-Apr-06	2,906,326
	1	Malaria	4,285,714	(B2)	Gov: MOH	SNG-102-G02-M-00 (Inactive)	01-Apr-03	1,526,770
	4	Malaria	28,778,260	(G2)	Gov: MOH	SNG-405-G03-M	01-Sep-05	23,697,528
	6	HIV/AIDS	31,156,807	(G2)	Gov: Oth	SNG-607-G05-H	01-Jun-07	10,455,345
					CS/PS: NGO	SNG-607-G06-H	01-Jun-07	6,013,806
	7	Malaria	28,052,446	(G1)	Gov: MOH	SNG-708-G07-M	01-Jun-08	17,107,808
	7	TB	4,204,328	(G1)	Gov: MOH	SNG-708-G08-T	01-Nov-08	3,589,818
	9	HIV/AIDS	41,745,532	(B1)				
SIERRA LEONE	2	TB	5,030,837	(G2)	CS/PS: NGO	SLE-202-G01-T-00	01-Jan-04	5,030,837
	4	HIV/AIDS	17,820,803	(G2)	Gov: Oth	SLE-405-G02-H	01-Jun-05	14,759,969
	4	Malaria	8,886,123	(G1)	CS/PS: NGO	SLE-405-G03-M	01-May-05	6,956,097
	6	HIV/AIDS	9,627,778	(G1)	Gov: Oth	SLE-607-G04-H	01-Feb-08	8,850,975
	7	Malaria	10,011,250	(G1)	Gov: MOH	SLE-708-G05-M	01-May-08	7,634,749
	7	TB	4,336,448	(G1)	Gov: MOH	SLE-708-G06-T	01-Nov-08	1,890,238
	9	HIV/AIDS	35,159,372	(B1)				
TOGO	2	HIV/AIDS	15,455,477	(B2)	MO: UNDP	TGO-202-G01-H-00	01-Oct-03	14,088,308
	3	Malaria	5,885,906	(G2)	MO: UNDP	TGO-304-G02-M	01-May-04	5,856,835
	3	TB	1,801,888	(G2)	MO: UNDP	TGO-304-G03-T	01-May-04	1,801,888
	4	HIV/AIDS	30,559,938	(G2)	CS/PS: NGO	TGO-405-G04-H	01-Apr-05	28,098,692
	4	Malaria	10,694,981	(G2)	MO: UNDP	TGO-405-G05-M	01-Oct-05	10,267,246
	6	Malaria	9,303,058	(B2)	MO: UNDP	TGO-607-G06-M	01-Jan-08	5,724,295
	6	TB	5,920,602	(B2)	MO: UNDP	TGO-607-G07-T	01-Jan-08	2,679,816
	8	HIV/AIDS	39,659,262	(G1)	Gov: MOH	TGO-809-G08-H	01-Dec-09	6,419,308
					CS/PS: NGO	TGO-809-G09-H	01-Dec-09	2,883,854
	9	Malaria	58,931,815	(B1)				
REGION TOTALS:			**3,161,166,679**					**1,490,534,055**
GRAND TOTALS:			**19,233,118,278**					**9,968,837,895**

SPECIAL NOTES FOR ROUND 9 (INCLUDING NATIONAL STRATEGY APPLICATIONS, FIRST LEARNING WAVE [N1]):

- 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
- 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

SPECIAL NOTES FOR ROUND 8 AND ROUND 9 (INCLUDING NATIONAL STRATEGY APPLICATIONS, FIRST LEARNING WAVE [N1]):

- Phase 1 funding: the Board approved a total upper ceiling of US$ 2.75 billion for Round 8 and US$ 2.38 billion for Round 9 (including US$ 390 million for National Strategy Applications). The Global Fund Secretariat will be working with countries to find efficiencies in all proposals to bring the total approved funding for these rounds at or below these ceiling amounts.

NOTES

1 It is recommended that full information on country proposals, grant agreements and latest disbursements be viewed at www.theglobalfund.org

2 Country or territory:
- The Multicountry Africa region includes: Mozambique, South Africa and Swaziland
- The Multicountry Western Pacific region includes: Cook Islands, Fiji, Micronesia (Federated States), Kiribati, Niue, Marshall Islands, Palau, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu
- The Multicountry Americas (Andean) region includes: Colombia, Ecuador, Peru and Venezuela
- The Multicountry Americas (CARICOM) region includes: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines, Suriname and Trinidad and Tobago
- The Multicountry Americas (CRN+) region includes: Antigua and Barbuda, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines, Suriname, and Trinidad and Tobago
- The Multicountry Americas (Meso) region includes: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama
- The Multicountry Americas (OECS) region includes: Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia and Saint Vincent and 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 (Nongovernmental 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)

5 N1 is a pilot round for the National Strategy Application, for more information see http://www.theglobalfund.org/documents/publications/other/Strategy/Innovate.pdf.

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 The Global Fund Secretariat)
- Disbursements: includes all disbursemements 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 US$ equivalent of a euro disbursement is initially calculated using the latest month-end exchange rate from OANDA.com and is replaced by the actual US$ equivalent on the date of disbursement, once confirmed by the Trustee.
- The US$ equivalent of a euro grant comprises the sum of disbursements made (valued in US$ on the date of transfer from the Trustee), plus the undisbursed portion of the grant calculated using the latest month-end exchange rate from OANDA.com.

Programmatic data are based on information reported to the Global Fund by end 2009. Financial data are based on Global Fund activities through 31 December 2009.

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THIS FAMILY IN A MALARIA-ENDEMIC AREA OF TAJIKISTAN USED TO GET BITTEN BY MOSQUITOES BUT NOW TAKE TEA IN THE GARDEN UNDER THEIR INSECTICIDE-TREATED NET. A GLOBAL FUND PROGRAM IS HELPING TO ELIMINATE MALARIA IN THE AREA WITH NETS, SPRAYING AND OTHER FORMS OF VECTOR CONTROL.

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