



South and West Asia **REGIONAL OVERVIEW**

SUCCESSES, CHALLENGES AND
ACHIEVEMENTS TO DATE



Investing in our future

The Global Fund

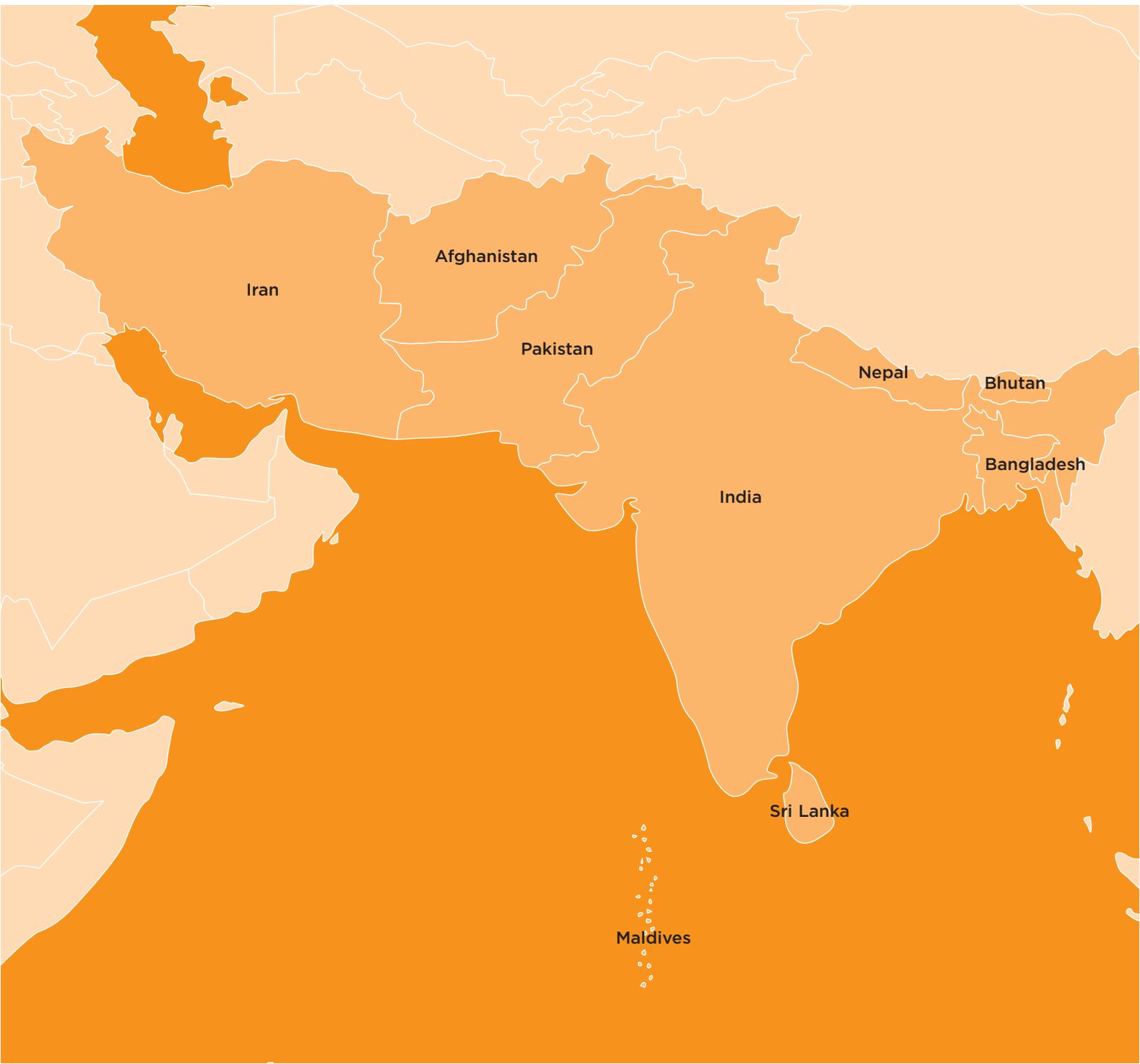
To Fight AIDS, Tuberculosis and Malaria

AUGUST 2007

The Global Fund's grant portfolio is organized into eight regions, which are managed by eight corresponding clusters in the Global Fund Secretariat. The South and West Asia cluster manages nine countries:

AFGHANISTAN
BANGLADESH
BHUTAN
INDIA
IRAN
MALDIVES
NEPAL
PAKISTAN
SRI LANKA

This overview provides a brief insight into the burden of HIV/AIDS, malaria and tuberculosis in each of these countries and offers a brief description of the Global Fund grants active there. The overview features a number of success stories from these states and shares the latest performance indicators for grants attributed to countries in the South and West Asia region.



Contents

LIST OF TERMS AND ABBREVIATIONS	2
THE GLOBAL FUND	
THE GLOBAL FUND: GOALS AND GUIDING PRINCIPLES	3
THE GLOBAL FUND GRANT PORTFOLIO AND ACHIEVEMENTS TO DATE	4
THE SOUTH AND WEST ASIA REGION	
FOCUS ON SOUTH AND WEST ASIA	6
THE ROLE OF PARTNERSHIPS	8
THE ROLE OF COUNTRY COORDINATING MECHANISMS	10
COUNTRY PROFILES	
AFGHANISTAN	16
BANGLADESH	20
BHUTAN	26
INDIA	30
IRAN	36
THE MALDIVES	40
NEPAL	42
PAKISTAN	46
SRI LANKA	50
GLOBAL FUND PROPOSAL PROCESS	54
GRANT IMPLEMENTATION AND PERFORMANCE-BASED FUNDING	55
SOURCES	56

List of terms and abbreviations

ACT	artemisinin-based combination therapy
ART	Antiretroviral treatment
ARV	antiretroviral
BCC	behavior change communication
BRAC	Bangladesh Rural Advancement Committee
CBO	community-based organization
CCM	Country Coordinating Mechanism
DOTS	the internationally-recommended strategy for tuberculosis control
FBO	faith-based organization
GIST	Global Implementation Support Team
ICTC	Integrated Counseling and Testing Centres
IDU	injecting drug user
IRS	indoor residual spraying
ITN	insecticide-treated bed net
LFA	Local Fund Agent
LLIN	Long-lasting insecticide-treated bed nets
LSE	life skills education
M&E	monitoring and evaluation
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
NGO	nongovernmental organization
OI	opportunistic infection
PATA	Pakistan Anti-TB Association
PC	Portfolio Committee (of the Global Fund Board)
PFI	Population Foundation of India
PLWHA	people living with HIV/AIDS
PPM	public/private mix
PR	Principal Recipient
RNTCP	Revised National Tuberculosis Control Program
STI	sexually-transmitted infection
TB	tuberculosis
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCT	voluntary counseling and testing
WHO	World Health Organization

The Global Fund to Fight AIDS, Tuberculosis and Malaria: Goals and Guiding Principles

THE GUIDING PRINCIPLES OF THE GLOBAL FUND

The Global Fund:

Operates as a **financial instrument**,
not an **implementing entity**;

Makes available and leverages
additional financial resources;

Supports programs that reflect
national ownership;

Operates in a balanced manner in terms of
different regions, diseases and interventions;

Pursues an integrated and balanced approach
to **prevention and treatment**;

Evaluates proposals through
independent processes;

Establishes a **simplified, rapid and innovative
grant-making process** and operates
transparently and with **accountability**.

Conservative estimates say that HIV/AIDS, tuberculosis (TB) and malaria are responsible for at least six million deaths per year and exponentially greater numbers of people falling ill. The HIV/AIDS, tuberculosis and malaria pandemics take their highest toll in developing countries, causing up to thirty times more damage than in wealthy nations. The impact goes far beyond the devastation of families and communities: decades of development progress have been lost and life expectancy has dropped significantly in some countries, driving up the risk of social disintegration and political instability. The only obstacle to prevention and treatment in these areas is a lack of resources – not a lack of know-how.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was formed in 2002 in response to the unacceptably high losses from the pandemics. It is a unique global public/private partnership dedicated to the massive scale-up of financing to prevent and treat these diseases in lower-income countries. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other organizations to supplement and support existing efforts dealing with the three diseases.

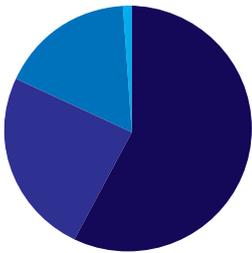
The Global Fund requires a high standard of technical quality in the programs it finances, and it holds grant recipients accountable for results. Beyond that, the Global Fund attaches no conditions to its grants.

About half of the Global Fund's financing is spent on medicines and other health commodities (such as mosquito nets to prevent malaria). The other half is spent on strengthening health services. All programs are monitored by independent organizations contracted by the Global Fund to ensure that funding has an impact in the fight against HIV/AIDS, TB and malaria.



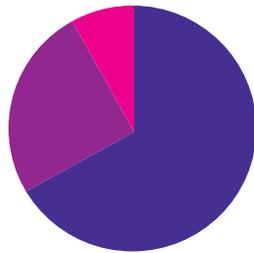
The Global Fund Grant Portfolio and Achievements to Date

DISTRIBUTION OF THE GLOBAL FUND GRANT PORTFOLIO



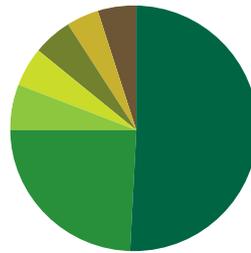
BY DISEASE

58% HIV/AIDS
24% MALARIA
17% TUBERCULOSIS
1% HEALTH SYSTEM STRENGTHENING



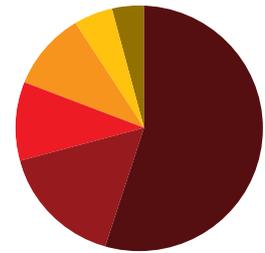
BY INCOME

67% LOW INCOME
25% LOWER-MIDDLE INCOME
8% UPPER MIDDLE INCOME



BY TYPE OF IMPLEMENTING ENTITY

51% GOVERNMENT
24% NONGOVERNMENTAL AND COMMUNITY-BASED ORGANIZATIONS
6% PRIVATE SECTOR
5% FAITH-BASED ORGANIZATIONS
5% ACADEMIC
4% COMMUNITIES
5% OTHER



BY REGION

55% SUB-SAHARAN AFRICA
16% EAST ASIA & PACIFIC
10% EASTERN EUROPE & CENTRAL ASIA
10% LATIN AMERICA & CARRIBEAN
5% SOUTH AND WEST ASIA
4% MIDDLE EAST & NORTH AFRICA

The Global Fund has proven to be a potent weapon in the fight against the pandemics. By mid-2007, the Global Fund had approved more than 450 grants worth US\$ 7.6 billion across 136 countries and had disbursed more than US\$ 4 billion to grant recipients.

Results as of 1 June 2007 include:

- **1.1 million people on antiretroviral (ARV) treatment for HIV** through Global Fund-supported programs;
- **2.8 million TB cases** were being treated under DOTS, the internationally-recommended treatment strategy; and
- **30 million insecticide-treated bed nets (ITNs)** had been distributed to protect families from malaria.

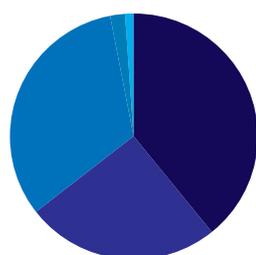


Focus on South and West Asia

STATUS OF GRANTS TO DATE IN SOUTH AND WEST ASIA

Funding Round	Date	Value of approved proposals (US\$) ¹	Value of grant agreements signed (US\$) ²	Grant amounts disbursed (US\$)	Mean percent of the grants disbursed
1	April 2002	22,068,668	21,373,702	14,789,400	69%
2	January 2003	194,244,994	184,020,139	123,268,547	67%
3	October 2003	68,738,496	64,440,440	33,987,898	53%
4	June 2004	255,750,838	87,404,331	52,050,525	60%
5	September 2005	73,954,353	24,229,681	9,640,660	40%
6	November 2006	441,693,262	60,589,033	13,402,098	22%
All		1,056,450,611	442,057,326	247,139,128	60%

DISTRIBUTION OF THE GRANT PORTFOLIO BY IMPLEMENTING ENTITY



SOUTH AND WEST ASIA

39.4%	MINISTRY OF HEALTH
25.1%	NGO/CBO/FBO/ACAD
32.5%	OTHER GOVERNMENT
2.2%	UNDP
0.8%	PRIVATE SECTOR

With a combined population of more than 1.5 billion, the South and West Asia region is home to half of the world's poor. While some of the countries in the region are going through a period of unprecedented growth, others have suffered an increasingly unstable political and security situation and growing impoverishment. But all of them, regardless of their economic and political realities, have paid a heavy toll to three deadly - but easily preventable - diseases: AIDS, tuberculosis and malaria.

APPROVED GRANT PROPOSALS³

Disease	Value of approved grant proposals (US\$)	Number of approved grants (US\$)
HIV/AIDS	597,396,955	13
TB	279,484,872	19
Malaria	161,623,407	13
Other	17,945,377	2
Total	1,056,450,611	47

The challenging social and economic situation of the majority of nine countries covered by the Global Fund's South and West Asia cluster is exacerbated by the growing health risk represented by the rapidly-spreading HIV/AIDS pandemic. The other deadly diseases - malaria and tuberculosis - continue to claim thousands of lives daily, jeopardizing economic and social development, stalling domestic reforms, and contributing to the cycle of poverty.

Many countries in the region are increasingly reconsidering the importance they assign to social challenges, particularly in the area of public health. Across the region, both the public and the private sectors and civil society - from Ministries of Health to a wide range of nongovernmental organizations (NGOs) - have embarked on a challenging endeavor: to diminish the disease burden in their countries, educate the population (especially its most vulnerable groups) on the risks of each of the three diseases and the measures to prevent them, train highly-qualified health personnel capable of attending to the needs of those infected and provide treatment, care and support.

Assistance from the Global Fund is playing a significant role in this endeavor. With 42 grants currently active in the region as approved in the first six rounds, and 20 more proposals submitted for Round 7, the nine countries in the South and West Asia region have been able to scale up their national health programs and achieve important and highly-needed results.

¹ Proposal lifetime budget (usually 5 years)

² Includes Phase I grants (first 2 years) and Phase II grants (years 3-5)

³ Including inactive and awaiting signature.

The Role of Partnerships

Poverty and social and economic inequalities increase vulnerability to HIV/AIDS, tuberculosis and malaria which in turn lead to rising poverty, creating a vicious cycle that is very difficult to break. HIV/AIDS, tuberculosis and malaria disproportionately affect the most vulnerable populations. As a result, the three diseases have become a major source of concern not only for governments in the region but also for a large number of civil society actors as well as the private sector.

Civil society, including NGOs, faith-based organizations (FBOs), community-based organizations (CBOs) and other associations of citizens is fundamentally involved in all areas of the Global Fund architecture, from Board-level representation to program implementation on the country level. It has a proven and effective role in targeting hard-to-reach communities and improving prevention and treatment literacy.

Collaboration with civil society and the private sector can be extremely beneficial for the success of Global Fund projects in all parts of the world due to the extensive expertise, experience, and resource potential of these actors. Their contribution may be especially valuable in the context of country ownership of Global Fund grants. The concept of country ownership means that the Global Fund neither acts as an implementing agency nor designs the content of grant-funded programs. Instead, it relies on the countries' planning to ensure that resources are directed to programs for those most in need. Its performance-based approach to grant-making ensures that funds are used efficiently to support positive change for people and communities.

As a financing mechanism, the Global Fund does not provide direct technical assistance or capacity-building support to current or potential grant recipients, relying instead on the Global Fund's development partners (including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the World Bank and other UN and bilateral agencies, as well as local organizations). These agencies participate in virtually every stage of program development and implementation, from drafting proposals to implementing approved programs.

Support of these development partners is crucial for countries that lack experience and adequate knowledge to successfully address their disease challenges on their own. In order to help countries make the best use of their grants, the Global Fund joined forces with the World Bank and AIDS-related agencies and set up a Global Implementation Support Team (GIST). Currently, GIST deals exclusively with bottlenecks in HIV/AIDS grants, but projects are underway to create similar groups to assist programs targeting tuberculosis and malaria.

An entirely different – although equally important – set of partners are the public and private sectors of countries that suffer from effects of the three diseases. In South and West Asia, governments increasingly turn to their private sectors for expertise at all stages of the grant implementation process, from drafting proposals to implementing programs in the field. Almost all the countries in the South and West Asia region have already developed strong partnerships with civil society actors, taking advantage of their capacity to work with the hard-to-reach populations in communities that government infrastructure often has difficulty serving. So far, however, there have been few partnerships with the private sector. This situation is likely to evolve in the years to come, as countries realize that collaboration with private sector companies can offer great benefits in terms of expertise, management skills and financial resources.

It should be noted that some countries in the region benefit from the public/private collaboration more than others. Some of the reasons for low level of public/private partnerships are a lack of history of such collaboration, insufficient experience to successfully initiate one and/or a domestic environment that makes development of such public/private links more challenging. The Global Fund actively encourages development of public/private partnerships in fighting the three diseases. In the five years since the Global Fund was created, considerable progress has been made toward this goal. Today, a number of new proposals specifically address the issue of closer collaboration of various sectors of the society in the fight against the three diseases. Government as well as civil society in recipient countries is increasingly establishing functioning and rapidly-evolving partnerships that contribute to countries' efforts to scale up their response to the diseases. By involving a wide range of civil society and private partners in designing and implementing grant proposals, recipient countries generally reach higher efficiency and better performance results.

Early evidence suggests that the Global Fund has the potential to achieve significant impact on the three diseases through the combined efforts of all partners involved – countries, governments, the private sector, civil society and the communities affected by the diseases. The Global Fund encourages further progress in the development of public/private relations in grant recipient countries.

The Role of Country Coordinating Mechanisms



Grant proposals are developed and submitted by country-level partnerships known as Country Coordinating Mechanisms (CCMs). CCMs are central to the Global Fund's commitment to local ownership and participatory decision-making. They include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses and people living with the diseases.

Basing grant proposals on priority needs at the national level, CCMs reflect their knowledge of the disease burden in the country and the key challenges that need to be addressed. Their role does not stop with proposal approval: once the grant is signed, they are also responsible for overseeing its progress during the implementation stage.

A number of factors need to be respected in order for the CCM to be truly effective in fulfilling its role: they should always include representatives of communities living with diseases, ensure the input of a broad range of stakeholders in the proposal development and grant oversight process, and use a transparent and documented process in nominating Principal Recipients (PRs).

India's CCM reform and selection of NGO partners

India's CCM was established in December 2001, soon after the creation of the Global Fund. It is a country-level "national consensus group" that has developed and submitted grant proposals to the Global Fund based on priority needs at the national level for all of the rounds, including the latest, Round 7. India's CCM is a multi-stakeholder partnership with representatives from NGOs (including FBOs), the private sector, the academic and research sector, multilateral/bilateral organizations and people living with the disease - which together form nearly 60 percent of the total membership. The remaining members are generally government officials. The government, however, is represented not only through the health ministry but also includes representatives from the women and child development department and the finance ministry. The diversity of high-level membership is also seen with the Secretary of Health & Family Welfare as the Chair of the CCM while the Vice-Chair represents the People Living With HIV/AIDS (PLWHA) constituency.

The CCM secretariat was set up and an independent CCM coordinator was hired. A CCM webpage was launched in order to promote transparency and so as to reach out to all stakeholders.

The selection of representatives from the civil society sector was held through an online enrollment and polling mechanism put in place at the India CCM website with nationwide newspaper and website announcements for the selection of the civil society representatives by their own constituency. Close to 300 organizations enrolled through the online process. This was followed by an electronic announcement of both the eligible electorate and the candidates, after which online polling commenced through a web-based interface. The selected representatives began participating in March 2007.

Recently the Global Fund Board has invited the Additional Secretary and Director General, National AIDS Control Organization (AS&DG-NACO) and a member of the Indian CCM, to represent the South East Asia constituency

as Chair of the Portfolio Committee (PC). The PC is entrusted with providing advice on all policy and strategy issues of the Global Fund's portfolio as well as renewal, management, alignment, harmonization and sustainability of Global Fund grants.

Pakistan's CCM – Reaching out to Rural Constituencies in Pakistan

Pakistan's CCM includes representatives of both the governmental and NGO sectors at the highest level. Members representing the public sectors are nominated by the respective ministries/departments while NGO members are elected from their constituencies through a transparent election process according to the by-laws of the Pakistan CCM.

Asia Foundation (a registered international NGO) and UNAIDS were brought in to help facilitate and organize the elections. To access hard-to-reach communities and to ensure that as many civil society organizations were involved in the process as possible, a web-based election was organized.

Four allotted slots on the CCM were reserved for civil society - three of them for national NGOs which would represent each of the three diseases and one for an international NGO. Once the different organizations had been elected, UNAIDS worked with them to discuss how they could work together and how they could develop proper feedback mechanisms to the constituencies they now were responsible for representing.

CCM Pakistan operates on a two-way (CCM member-constituency) feedback mechanism. CCM standard operating procedures are that before convening formal meetings, a draft agenda indicating tentative dates and times of meetings are shared among CCM members electronically to get their members' consensus and approval. The CCM secretariat communicates with and obtains feedback from other national structures and key bodies.

Civil society members along with PLWHA and various other federal ministries play a vital role in oversight and program harmonization in the health sector. The financial and physical progress of these programs both with respect to federal projects and progress of district-based activities are monitored on a quarterly basis. The impact of all activities in the country in HIV/AIDS, TB and malaria is critically examined by the Centre for Poverty Reduction with regard to Millenium Development Goals (MDG) indicators and reported to the Prime Minister.

Country Profiles





Afghanistan

COUNTRY INDICATORS

Size of population	25,067,000
Gross national income per capita	N/A
HIV Prevalence	<0.1%
Estimated HIV cases	<1,000
TB incidence	50,249
Estimated TB cases	85,875
Reported malaria deaths	22
Reported malaria cases	591,441



SUMMARY OF GRANTS

All grants

Total proposal amount	\$34,891,060
Signed grant amount	\$20,030,184
Total disbursed to date	\$9,557,835

Integrated: HIV/AIDS, TB, Malaria

Total proposal amount	\$3,125,605
Signed grant amount	\$3,125,605
Total disbursed to date	\$3,125,605

Tuberculosis

Total proposal amount	\$3,448,773
Signed grant amount	\$2,339,323
Total disbursed to date	\$1,300,020

Malaria

Total proposal amount	\$28,316,682
Signed grant amount	\$14,565,256
Total disbursed to date	\$5,132,210

Principal Recipient The Ministry of Public Health
of the Islamic Republic of Afghanistan

Local Fund Agent PricewaterhouseCoopers

ACHIEVEMENTS TO DATE

HIV/AIDS

126 service providers received training on HIV/AIDS and sexually-transmitted infections (STI) management

73 laboratories have a staff technician trained in blood screening for HIV

Tuberculosis

12,460 new smear-positive cases detected under DOTS

25,443 new TB patients registered under DOTS

4,922 new sputum positive TB patients successfully treated through DOTS

Malaria

300,000 ITNs distributed in six high-risk provinces

Emergency preparedness and response teams established in 14 high-risk provinces

70 master trainers educated in a basic package of health services to assist NGOs in implementing malaria diagnosis and management.

Devastated by protracted armed conflicts, Afghanistan is facing numerous social, political, and security challenges. It has one of the poorest countries in the world and has one of the world's lowest life expectancies (44.5 years). The country lacks adequate social and health infrastructures, and continued domestic instability aggravates the problem still further, making reform a highly challenging task. High internal migration and continued refugee flows together with poor living conditions and the inadequate status of women leave the Afghani population vulnerable to health risks.

HIV/AIDS

Even though WHO and UNAIDS estimate the current prevalence of HIV/AIDS in Afghanistan to be low (less than 0.01 percent), exact and reliable data is hard to obtain. The true number of people living with HIV/AIDS in Afghanistan may be much higher than the currently-recorded 61 cases. Some experts fear that the real count may be well into the thousands. Poor living conditions, a high number of refugees and internally-displaced people, a large number of drug users and alarmingly inadequate access to diagnostic and treatment services favor the rapid spread of HIV.

Moreover, Afghanistan risks seeing a rapid increase in the number of AIDS cases due to the massive influx of

returning refugees from countries where the HIV/AIDS problem has already reached alarming levels (such as Pakistan and Iran). For comparison, whereas Afghanistan had only 61 known cases of AIDS in 2006, Pakistan had 74,000 and Iran 14,000.

The unstable security situation in the country contributes to the difficulty in assessing the true extent of the epidemic and prevents people from being diagnosed and treated. Besides, the deeply negative social stigma associated with the disease harms the prospects of successfully addressing the potential HIV/AIDS crisis.

Afghanistan has a grant to provide integrated services for the three diseases. This grant, managed by the Afghanistan's Ministry of Public

Health, targets populations with inadequate access to health services – in particular women – who carry 65 percent of all cases of adult TB. It strives to develop capacity for communicable disease control in the country through reinforcing the management and administrative functions of the Ministry of Health, building partnerships, and designing new mechanisms for support and coordination.

Implementation of the project's goals has been challenging. In spite of that, the grant has performed well, meeting the majority of its targets: it provided specialized training in addressing the three diseases to hundreds of Ministry of Health staff members and service providers; staffed 73 laboratories with technicians trained in blood screening

for HIV and opened a pilot voluntary counseling and testing center (VCT) with qualified and specially trained personnel, to name just a few of the grant's recent achievements.

In order to fully reach the targets outlined in the original proposal, additional efforts are needed, particularly in training personnel in malaria and TB treatment and developing efficient partnerships and networks. However, the program's success may be jeopardized by unfavorable security conditions in some of Afghanistan's provinces, which have long been the main hurdles to successful advancement of the country's developmental and health targets.

ACCOMPLISHMENTS IN DIAGNOSTICS AND TREATMENT OF THE THREE DISEASES

The Global Fund approved and signed its first grant to Afghanistan in 2004. The grant aimed to address all three of the deadly diseases that the Global Fund struggles to eliminate by providing more than US\$ 3.1 million to activities devoted to strengthening the capacity of this conflict-ridden state to address the growing health challenges associated with AIDS, TB and malaria.

Three years into the implementation period, the results are positive and encouraging. Integrated training on all

three diseases has been given to 110 service providers and an additional 126 were trained in HIV/AIDS and STI management. Six offices with at least one trained specialist in each of the diseases have been opened.

Sixteen laboratories in Afghanistan now benefit from at least one technician trained in laboratory TB and malaria diagnosis. In addition, the project has surpassed its targets of increasing the number of laboratories that benefit from the expertise of a skilled technician trained in blood screening for HIV.

Afghanistan

TUBERCULOSIS

Among the three diseases that Global Fund grants help to fight, tuberculosis has taken a particularly heavy toll on Afghanistan's population.

The country ranks 17th out of the world's 22 high-burden TB countries, according to the WHO Global Health Report 2006. It also has the second-highest TB burden in the Eastern Mediterranean region, with over 160,000 confirmed TB cases. Each year, approximately 70,000 new cases of TB are registered, claiming close to 20,000 lives annually. What makes the situation even more alarming is the fact that the majority of TB victims (65 percent, or 14,000) in Afghanistan are women of reproductive age. In 1997, Afghanistan's National TB Control

Program (NTP) adopted the treatment strategy DOTS, and by 2002 its coverage had reached 38 percent. Although the DOTS detection rates remain low (19 percent), those detected have been treated with an 86 percent success rate.

The grant, managed by the country's Ministry of Public Health, aims to drastically increase detection and treatment rates of tuberculosis throughout the country. By 2010, the program aims to establish political commitment towards addressing the issue of TB, ensure regular supply of TB drugs at central, regional and health service delivery levels, reduce stigma about the disease, increase treatment-seeking behavior among urban and rural populations and involve the private sector in identifying

and treating TB cases in 20 provinces.

In the two years since the start of the program, the country has shown steady progress in a number of its objectives despite the challenging security situation in some of the provinces. The program has fully reached its targets of procuring anti-TB drugs from reliable suppliers, registering new patients under DOTS and implementing community outreach activities.

Additional efforts are required in training qualified medical personnel on a district level and expanding general access to diagnostics and treatment of the disease. This is likely to be done before the grant expires in August 2008.

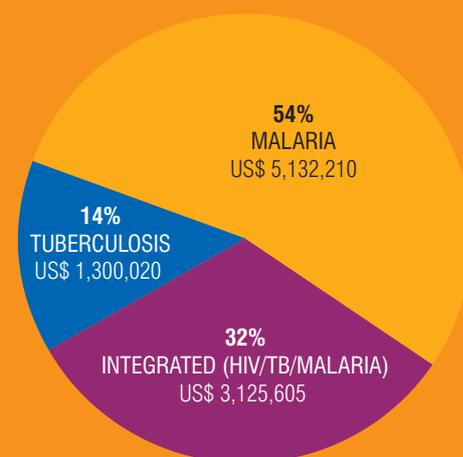
AFGHANISTAN'S FIGHT TO COMBAT MALARIA

Afghanistan has suffered from internal conflict for the last 30 years. The result has been disastrous for the country and contributed to the malaria epidemic. Having nearly eradicated malaria in the late 1970s, today Afghanistan has the second-highest prevalence among countries outside Africa.

Afghanistan was one of the first Asian countries where more than a decade ago HealthNet TPO (a Dutch NGO then called Health Net International) started a small project as a first step to control malaria. A number of pilot projects and operational research activities in close collaboration with WHO and the

Ministry of Public Health and with technical support from the London School of Hygiene and Tropical Medicine were started, including anti-malarial drug efficacy studies, larvacidal control activities, environmental control programs, cattle sponging, use of repellents and ITNs. Several surveys were conducted to identify high prevalence areas in the country to help target interventions.

Afghanistan adopted a strategy based on the findings of these studies, and initiated a bed net social marketing strategy. The initiative was implemented through a network of health facilities in the eastern part of the country and was combined with the free distribution of nets during malaria outbreaks.



DISBURSEMENT TO COUNTRY TO DATE

MALARIA

With an estimated malaria prevalence of 937 per 100,000 population (2000 est.), Afghanistan is considered to have the fourth-highest malaria burden worldwide of any country outside Africa and the second-highest in the WHO Eastern Mediterranean region. The disease is highly prevalent in the country's rice-growing regions and in rural areas, where 80 percent of Afghanistan's population lives. According to some estimates, the annual incidence of the infection may be as high as three million cases.

Major risk factors for further spread of the disease include large population movements across the country, augmented by a growing influx of returning refugees. The situation is fur-

ther exacerbated by widespread malnutrition and lack of access to effective treatment in the country.

Afghanistan's malaria grant, managed by the Ministry of Public Health, targets the country's 14 provinces with a high risk of malaria transmission: Takhar, Kunduz, Ningarhar, Kunar, Laghman, Baghlan, Faryab, Badghis, Badakhshan, Herat, Khost, Kandahar, Helmand and Bulkh.

The goal of the program funded by this grant is to scale up Roll Back Malaria's efforts in Afghanistan for the period 2006-2010. The grant aims to reduce malaria morbidity and mortality rates by 50 and 80 percent, respectively, through measures such as having a greater number of children and pregnant women sleep under

ITNs, raising the success rate of diagnosing and treating malaria cases, scaling up efforts to inform and educate people about the disease and drastically increasing the number and percentage of sites reporting no stock-outs of drugs.

Because Afghanistan's malaria grant is relatively recent (it has been in the process of implementation for less than a year), it is not yet possible to evaluate its results.

Social marketing in Afghanistan used three mechanisms – public sector outlets run by the Ministry of Public Health together with NGOs, community-based outlets and mobile teams. The community-based outlets, served by community health workers, not only distributed bed nets but also played an important role in malaria health education. Later, the private sector also became involved in the distribution of nets. A 2006 survey showed that the social marketing approach improved accessibility to bed nets for all social groups, including the poor and vulnerable populations, although the services were highly localized.

Afghanistan received a Global Fund grant that sets a five-year strategic plan to reduce the morbidity from

malaria by 50 percent and malaria mortality by 80 percent. The activities will concentrate on the rapid expansion of services with bed net distribution in 14 high-prevalence provinces. Beginning with six provinces in 2007, the program will reach ten provinces in 2008 and all 14 in 2009. A combined strategy of social marketing and free distribution to vulnerable groups will ensure that all economic groups will be reached, covering up to 60 percent of the target population.

Despite this progress, there is still much to be learned about how to target populations at risk in Afghanistan, where the malaria situation has become mesoendemic.

Bangladesh

COUNTRY INDICATORS

Size of population	153,281,000
Gross national income per capita	US\$ 470
HIV Prevalence	<0.1%
Estimated HIV cases	11,000
TB incidence	321,996
Estimated TB cases	575,391
Reported malaria deaths	574
Reported malaria cases	56,879



SUMMARY OF GRANTS

All grants

Total proposal amount	\$186,880,339
Signed grant amount	\$104,428,078
Total disbursed to date	\$52,372,600

HIV/AIDS

Total proposal amount	\$59,713,481
Signed grant amount	\$33,709,873
Total disbursed to date	\$14,415,802

Tuberculosis

Total proposal amount	\$88,104,272
Signed grant amount	\$52,131,026
Total disbursed to date	\$30,151,574

Malaria

Total proposal amount	\$39,062,586
Signed grant amount	\$18,587,179
Total disbursed to date	\$7,805,224

Principal Recipients The Economic Relations Division,
Ministry of Finance, the Government of
the People's Republic of Bangladesh;
Bangladesh Rural Advancement
Committee

Local Fund Agent Emerging Markets Group, Ltd

ACHIEVEMENTS TO DATE

HIV/AIDS

262,000 young people reached with HIV prevention information

17,245 young people received life skills education (LSE) through youth organizations and clubs

3,754 education facilities integrated HIV/AIDS curriculum

Tuberculosis

27,152 new smear-positive TB cases detected under DOTS; 29,973 smear positive TB cases (registered under DOTS) successfully treated

26,929 medical officers trained in DOTS implementation

687 health facilities have TB diagnostic and treatment facilities

One of the world's most densely populated countries, Bangladesh is also one of the world's poorest: almost half of its population live on less than US\$ 1 a day, and the country ranks 132nd out of 162 states in the Human Development ranking. Despite the numerous social challenges Bangladesh is facing, the country's authorities have put significant effort into improving health and education in the country. The number of grant projects in Bangladesh and their diversity serve as a good demonstration of the government's determination to address health challenges in Bangladesh and diminish their burden.

HIV/AIDS

With 11,000 estimated HIV cases, Bangladesh is considered to be among the few fortunate states in the Asia-Pacific region where the HIV prevalence rate is low (less than 0.1 percent). However, such factors as continuing high-risk behavior among male and female sex workers and their clients, growing number of injecting drug users (IDUs), a high rate of STIs and low condom use make Bangladesh a high-risk country for transmission of HIV/AIDS and contributes to the threat of epidemic in the country. In fact, the country presents the highest documented risk behavior in South Asia, making it extremely vulnerable to

the disease: it has the lowest condom use in all of Asia, widespread misconceptions about HIV/AIDS transmission, a high number of clients of the sex industry, extensive sharing of syringes by drug users and dangerously low knowledge of HIV/AIDS risks.

Although traditionally a conservative society, Bangladesh has seen a growing trend of young people engaging in sex outside of marriage, contracting STIs and using the services of sex workers. Young people account for a third of country's population and they have been particularly heavily exposed to the risks of HIV/AIDS:

in 2001, more than 55 percent of all sampled patients with STIs were

younger than 24. A survey conducted among youths within the Global Fund-supported project indicated that about 22 percent of unmarried males experience premarital sexual relations and the majority of them (55 percent) do not use condoms. Although 70 percent of those surveyed had heard of AIDS, their knowledge regarding transmission and prevention was low (21 percent).

Besides aiming to expand the information and health services available to youth, the HIV prevention priority in the country has been to ensure effective targeted interventions to vulnerable populations – female sex workers, the homosexual community, IDUs, migrants and transport workers.

There are two Global Fund HIV/AIDS grants in the country. The first of them, signed at Round 2, targets Bangladesh youth and aims to provide HIV information, skills and services. The program also aims to collect data necessary for policies and programs designed to prevent the spread of HIV/AIDS within the age group of 15 to 24. Implementation of the program is a collaborative effort between the country's Ministry of Health and Family Welfare and Save the Children USA, an international NGO which oversees a group of 17 local NGOs. Since its launch in 2004, 17,794 persons have been trained to deliver youth education through youth organizations and educational institutions; 3,754 schools,

BANGLADESH HIV/AIDS STRATEGY: EDUCATING THE YOUNG

The Bangladesh HIV/AIDS program has successfully incorporated HIV information into the secondary school curriculum from grades 6 to 12. The initiative, implemented by PIACT Bangladesh, a local NGO, involved key ministries in developing and finalizing the curriculum and required approval by the Ministry of Education. Later, teachers were taught using a "Train the Trainer" program how to develop lesson plans and lead classroom sessions. So far the project has trained more than 36,600 teachers, who in turn have trained about 32,000 subject teachers from 6,375 institutions. An additional 63,750 teachers have participated in orientation sessions on HIV/AIDS.

Manuals and teacher guides have been developed to facilitate implementation of the project.

With the incorporation of HIV/AIDS information into the curriculum, about 12.5 million students will receive information on HIV and AIDS starting in 2007.

Incorporation of HIV/AIDS information into secondary and higher secondary school curriculum is a historic policy change in Bangladesh, making it one of the first Asian countries where political leadership has shown strong determination in developing HIV/AIDS programming and where the government has taken a bold step towards implementing such programs. What has contributed to the success of the program was the collaboration between NGOs, government and the private sector through a public/private partnership involving young people.

Bangladesh

colleges, and technical institutes now have teachers trained in quality classroom teaching of an HIV/AIDS integrated curriculum and training was provided to 194,675 service deliverers (this number also includes parents and religious and community leaders who were sensitized to the problem). The program also succeeded in providing

LSE to 17,245 young people and reaching 150,500 young people with HIV prevention information through local drama shows and musical concerts.

The second HIV/AIDS grant, which has only recently been started, aims to build on previous Global Fund grant

activities and seeks to increase the coverage and quality of HIV prevention interventions for young people in Bangladesh. The program particularly targets HIV prevention among high-risk populations.

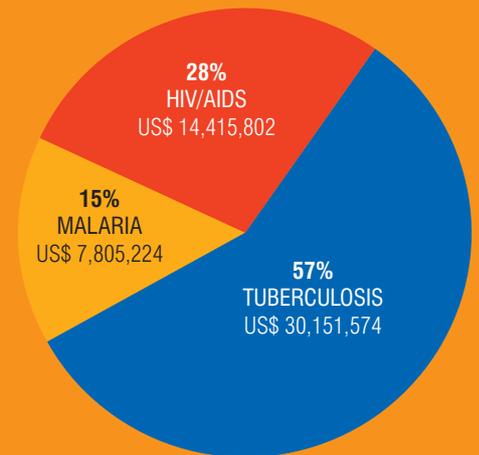
SIGNIFICANT BRANDING: BACHTE HOLEY JANTE HOBE - LIVE TO LEARN!

According to a recent sero-surveillance report conducted in Bangladesh, HIV prevalence in IDUs has reached almost five percent in rural zones and is almost ten percent in the capital. The results of a 2005 HIV/AIDS survey among youth in Bangladesh show that risky sexual behavior is common and that condom use is low. Overall, the young in Bangladesh tend to have poor knowledge and many misconceptions about the disease, which increases their vulnerability and leads to further risky sexual behavior.

With the help of the Global Fund grant directed at prevention of HIV/AIDS among young people, Bangladesh has been able to implement a wide range of behavior change communication (BCC) activities meant to promote awareness and sensitization about HIV and safe sexual behavior among young people. The country's leading advertising agency, Mattra, contributed to these efforts by preparing print and electronic media on the subject and airing TV spots and drama series devoted to HIV prevention.

One of the key achievements of the campaign has been the development of the brand *AIDS Kee? (What is AIDS?)*, and its title *Banchte Holey Jante Hobey (Live to Learn)*. As proof of the program's importance, the 08 July 2007 edition of *The Weekly Economic Times* published a full-page feature on successful brand promotion of various brands in the name of "Brand Zatra". The article covered 15 selective shots from popular television commercials in the HIV/AIDS campaign as an example of significant branding in Bangladesh. The brands were selected through a process that involved independent and voluntary expert panels known as the "Brand Council".

Multimedia campaigns designed with the support of the Global Fund grant encouraged interaction among young people and helped to present the challenges they faced through TV spots, drama, newspapers and local folk media. These powerful communication and illustration tools have played a key role in behavioral change towards HIV/AIDS prevention.



DISBURSEMENT TO COUNTRY TO DATE

DREAM OF A VILLAGE GIRL: LIFE SKILLS EDUCATION IS AN EFFECTIVE TOOL FOR BUILDING CONFIDENCE AMONG YOUNG PEOPLE

A second-year student at Cox's Bazaar Mohila College, Happy comes from a business family, but her dream ever since she was a child was to become a social worker and help people lead a better life.

In December 2007, Happy learned that Prattoy, a local NGO, was looking for young people to work as peer educators in youth clubs facilitating the LSE sessions. After Happy was recruited as a peer educator, she received a five-day training on HIV/AIDS and LSE and started providing LSE training to 40 youths and adolescents in the club. To win support of the community for educating the youth on HIV/AIDS, she now organizes advocacy meetings with parents, teachers, and formal and informal community leaders. She also receives visitors from the government, other NGOs and even other countries (such as the China National Youth Delegation), who come to see the results achieved by Prattoy and share their own experience.

One of Happy's ideas was to provide LSE training to the female madrasa (religious school) students, who usually do not have access to a radio or TV and do not

read magazines and newspapers. Happy took the initiative, discussed the issue with the NGO, and organized an advocacy meeting involving the teachers at the madrasa. In the meeting, she managed to convince them of the importance of providing HIV/AIDS information to students. Later, Happy taught 30 students, openly discussing issues related to sex, sexuality, HIV/AIDS and STIs.

Before starting to work with the NGO as a peer educator, Happy also had lots of misconceptions about reproductive health issues. Now, she has the necessary knowledge on HIV/AIDS and STI transmission and prevention. She also developed skills on how to communicate, motivate, negotiate, solve problems and encourage critical thinking. Happy is now more confident in educating the youths on HIV/AIDS and LSE. Today, she dreams of providing life skills education to her young relatives, friends and neighbors, and becoming a "Champion of Change".

Bangladesh



TUBERCULOSIS

Despite considerable efforts devoted to eliminating tuberculosis in Bangladesh, the disease is still considered a major public health problem. WHO ranks Bangladesh fifth out of the world's 22 high-burden TB countries. Each year, Bangladesh registers 319,000 new cases of tuberculosis, with the disease taking 61,000 lives. Even though effective treatment against TB (DOTS) is available free of charge, each hour eight people in Bangladesh die from tuberculosis.

With the help of the two TB grants received from the Global Fund in Rounds 3 and 5, Bangladesh aims to reduce TB incidence and expand capacity building activities. The first of the two grants committed more than

US\$ 42.4 million to reducing morbidity, mortality, and transmission of TB in the country. The program is managed jointly by the government (represented by the country's Ministry of Health & Family Welfare), and a local NGO, the Bangladesh Rural Advancement Committee, or BRAC. Important results have already been reached: since the start of the program in August 2004, the detection rate of smear-positive cases increased from 29 percent to more than 71 percent (to 87,030 new cases) and the treatment success rate went up to more than 91 percent as compared to 80 percent prior to implementation. In addition, 63,234 persons have been reached by BCC activities.

The second TB grant allowed the program to greatly exceed its targets in terms of number of newly-detected

smear-positive TB cases (51,600 compared to the targeted 43,200) and train health managers, health workers, medical doctors, and health volunteers (both from the government and from NGOs) in DOTS implementation. More than 3,400 pharmacists, village doctors and NGO health staff have been trained on the issue of the public/private mix of measures for addressing the problem of TB and more than 270 social communication events have been held to raise awareness of TB among the population. Additional planned activities include collaboration on HIV/TB countermeasures, treating multidrug-resistant TB (MDR-TB) and intensifying activities within the corporate sector.

MALARIA

Malaria remains a major public health problem in Bangladesh. According to the official estimates, it affects close to 50,000 people in the country. Unofficial estimates place this figure much higher at more than 140,000 cases. Among the country's 64 administrative districts, 13 lie within a highly-endemic area. These districts, which border on India and Myanmar, supply approximately 98 percent of the total annual malaria morbidity and mortality in the country.

In 2005, a total of 48,121 laboratory-confirmed cases were reported from these 13 high endemic districts with 501 people dying from the disease. The data shows that the proportion of male and female cases of malaria in Bangladesh is 54.9 percent and

Like many resource-constrained countries, Bangladesh faced considerable difficulties in providing TB services up until the 1980s. The situation started to change after 1993, with the gradual expansion of country-wide DOTS coverage. That allowed Bangladesh to increase the case detection rate to more than 71 percent in 2006 (as compared to 29 percent in 1993) and the cure rate to over 91 percent (2005 figures) as compared to 80 percent in 1993.

Participatory planning and resource mobilization, health system strengthening and capacity building, community-based service provision, advocacy communication and social mobilization have all

contributed to the current extent of anti-TB progress in the country.

By using a well-established public/private approach, Bangladesh was able to mobilize a significant amount of grant funds in 2004 (Round 3) and 2006 (Round 5) from the Global Fund, which gave momentum to the TB Control program. Participatory planning and resource mobilization, health system strengthening and capacity building, community-based service provision, advocacy communication and social mobilization were all factors in achieving this.



45.1 percent, respectively, with the majority of victims falling within the adult population (people of 15 years of age and older). The high-risk group also includes children and pregnant women.

The spread of the disease within the country has been largely due to the poor and marginalized populations who are particularly susceptible to get infections and die from them. Furthermore, poor families suffer significant income losses due to malaria: when the only earning adult member dies, the family faces economic disaster.

Another major risk factor for malaria propagation in the country has been the high number of seasonal laborers, many of whom arrive from countries and regions highly susceptible to malaria.

The most recent grant in the country's grant portfolio, the malaria grant was signed in March 2007 and was officially launched in June.

Its implementation is split between the government, represented by the Economic Relations Division of the Ministry of Finance, and civil society, represented by BRAC.

The grant's goals include reducing the burden of malaria in the country's 13 highly-endemic districts by the year 2012; providing quality diagnosis and effective treatment to 80 percent of the estimated malaria cases in these districts; promoting use of mosquito nets in 80 percent of the households located in such zones and using selective indoor residual spraying (IRS) for containment of outbreaks. Particular attention is given to

development and reinforcement of partnerships in the health sector in general and malaria control efforts in particular.

Current and planned activities under the national TB control program - working with NGO partners - aim to increase case detection and maintain high cure rates through strengthening DOTS services by involving all health care providers. Other goals include: creating demand for services through comprehensive advocacy, communication and social mobilization, strengthening the procurement and supply system, strengthening supervision, monitoring and evaluation, management of MDR-TB and further development of TB/HIV collaborative activities.

Continued commitment at all levels both from government and civil society, especially NGO partners,

along with sustained funding and increased technical capacity, will help to maintain the current momentum and achieve the Millennium Development Goals set for 2015.

Bhutan

COUNTRY INDICATORS

Size of population	637,000
Gross national income per capita	US\$ 870
HIV Prevalence	<0.1%
Estimated HIV cases	<500
TB incidence	2,219
Estimated TB cases	3,757
Reported malaria deaths	15
Reported malaria cases	3,806



SUMMARY OF GRANTS

All grants

Total proposal amount	\$7,691,038
Signed grant amount	\$2,731,488
Total disbursed to date	\$1,412,970

HIV/AIDS

Total proposal amount	\$3,540,415
Signed grant amount	\$0
Total disbursed to date	\$0

Tuberculosis

Total proposal amount	\$2,413,433
Signed grant amount	\$994,298
Total disbursed to date	\$503,954

Malaria

Total proposal amount	\$1,737,190
Signed grant amount	\$1,737,190
Total disbursed to date	\$909,016

Principal Recipient The Department of Aid and Debt Management of the Ministry of Finance of the Royal Government of Bhutan

Local Fund Agent PricewaterhouseCoopers

ACHIEVEMENTS TO DATE

Tuberculosis

81 percent of new smear-positive TB cases detected (up from 35 percent baseline in 2004)

2,188 health staff trained on DOTS

7,050 DOTS committee members and community influencers trained on DOTS promotion

Malaria

87,897 people covered with indoor residual spraying (IRS)

93,461 long-lasting insecticidal nets (LLINs) distributed

341,902 people reached with BCC activities

The Kingdom of Bhutan, bounded by Tibet in the north and India in the south, has one of the toughest terrains in the world. Nearly 70 percent of the population lives in remote villages. HIV/AIDS is a relatively new threat to the public health, although it is growing. Tuberculosis and malaria, however, have been major health threats for decades. Recently, Bhutan achieved significant success in fighting malaria and tuberculosis, but the extreme poverty of its population, coupled with a lack of domestic medical training programs, makes it more challenging to effectively address these issues. In addition, the constant flow of the malaria-carrying population to the interior parts of the country along with climatic conditions conducive to mosquitogenesis and tough geographical terrain further increase the country's vulnerability to malaria.

HIV/AIDS

Bhutan remains one of the few countries in the world that has a low HIV level and can still hope to stop the epidemic at its roots. According to UNAIDS, the country has approximately 500 HIV-positive people, putting the prevalence of the disease at less than 0.1 percent. However, unlike in other South Asian countries, HIV in Bhutan has a much younger and more feminine face. Of all HIV infection cases reported so far, more than a third were among youth of 15 to 24 years old, and almost half were female.

The key risk factors for the further spread of HIV in Bhutan include increasing trends in injecting drug use, commercial sex work and, more

importantly, widespread casual sex among both men and women. A recent survey revealed that both sexes engage in sexual activity at an early age, have multiple partners, and only 60 percent of the respondents used protection during their last sexual encounter. If left unaddressed, these alarming trends could lead to a large-scale heterosexual epidemic in the general population.

The most recent grant in Bhutan, the HIV/AIDS grant, will address the gaps in the response to the existing HIV/AIDS project funded by the World Bank. Particular attention will be devoted to the problem of HIV/AIDS among the youth in the country. The grant's key objectives range from increasing access to prevention serv-

ices for youth and other vulnerable groups (such as substance abusers, sex workers and mobile populations) to ensuring a continued supply of ARV and opportunistic infection (OI) drugs to sustain the treatment and care of people living with HIV/AIDS. Moreover, the project seeks to provide HIV education for special population groups, and ensure that rural populations have access to HIV counseling and testing.

Bhutan

TUBERCULOSIS

Among the three diseases addressed by the Global Fund, the most prevalent in Bhutan is tuberculosis. There has been a significant breakthrough in scaling down the infection rate due to the establishment of the Bhutan National Tuberculosis Control Program (NTSP) in 1976, yet access to DOTS still fails to reach complete coverage, especially among such population groups as women, youth under the age of 18 and people living in rural areas.

The government is very strongly committed to eradicating the TB threat in the country, directing its efforts at the most vulnerable groups - the poor and remote populations. The NTSP has been pursuing a pro-poor policy by

effectively treating tuberculosis free of charge in 70 percent of Bhutanese patients.

The program has achieved and maintained high treatment success rates, above the global target of 85 percent. The cure rates have also been improving over the years as increasingly more attention is given to follow-up and repeat examinations during the course and at the end of treatment.

The first of the country's two TB grants aims to build the capacity for responding to the disease at national, regional and village levels. The grant, managed by the Department of Aid and Debt Management of the Ministry of Finance of the Royal Government of Bhutan, seeks to intensify advocacy

and awareness activities for TB prevention and increased case detection rates and improve capacity of health staff to detect and treat TB. By the end of 2009, Bhutan aims to increase the TB detection rate from 69 percent to 80 percent; increase the cure rate from 70 percent to 85 percent; improve the quality of TB diagnosis; contain multidrug-resistant tuberculosis (MDR-TB) and improve monitoring and evaluation (M&E) of the program.

The program has already made significant progress on its targets, coming very close to reaching its goals in detecting new smear-positive TB cases and providing patients with DOTS treatment. It launched 96 TV/radio programs about TB, its transmission, diagnosis and treatment.

The second TB grant builds upon the first, but takes its goals and activities further. The project is geared particularly towards providing assistance to women, youth and the more than 70 percent of the country's population living in rural areas. The grant aims to intensify case detection, treatment and follow-up focusing on a special population and patient groups and promote sustainable procurement of second-line drugs and TB vaccines.

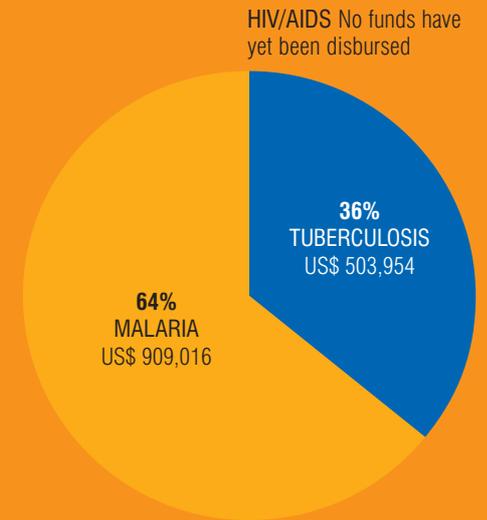
BHUTAN'S GRANT TO FIGHT TB: ACCOMPLISHMENTS

This grant provided the Department of Aid and Debt Management of the Ministry of Finance with over US\$ 994,000 to build capacity at national, regional and village levels to address the disease effectively.

Two years later

- **81 percent of new smear-positive TB cases have been detected**
- **96 TB awareness radio/TV programs have been broadcast**
- **5 health facilities have been fitted with new equipment and**
- **33 laboratory technicians have been trained on sputum microscopy, quality assurance and drug sensitivity.**

The implementing agency has been especially successful in strengthening the health component in the country, achieving or overachieving all of the targets set at the time of the initial proposal in 2005.



DISBURSEMENT TO COUNTRY TO DATE

MALARIA

Malaria is a major public health concern in Bhutan, affecting more than 70 percent of the country's population and putting people in 15 of the country's 20 districts at risk of becoming infected. Five districts – Tsirang, Samchi, Samdrupjongkhar, Sarpang and Zhemgang – are considered endemic, with up to 70 percent of the population directly affected by the disease.

The situation is made worse by the fact that the large majority of the population cannot afford adequate safety nets. A challenging landscape makes it difficult to reach the country's remote areas in the rainy season, which leaves people in malaria-prone

areas without adequate care and treatment. Uncontrolled population movements across the country also contribute to the challenges in identifying and treating the victims of the disease.

The government started addressing the problem of malaria decades ago, and succeeded in greatly cutting down mortality and morbidity from the disease. However, a number of challenges remain, primarily with respect to reaching out to the country's remote rural population (69.1 percent of the total) and increasing the number of specialists trained to take care of the infected, especially in rural zones.

The country's malaria grant – signed in January 2005 – covers a broad

range of interventions in response to the complex epidemiology and burden of malaria in Bhutan. The grant, managed by the country's Department of Aid and Debt Management of the Ministry of Finance, aims to create a link between the country's health sector and the community and involve the malaria-prone populations in identifying specific problems and planning, implementing, monitoring and supervising control activities and decisions on distribution of free and subsidized bed nets.

Over a period of five years (2005-2010) the grant will provide more than US\$ 1.7 million for the needs of increasing both the awareness of malaria and the commitment of the community to preventing the

disease. The grant is designed to benefit primarily the population in high-risk areas in five districts with the highest malaria burden and economically important areas located in the border districts. About 74 percent of the country's population will benefit from quality assured diagnosis and treatment by trained health-care providers. The grant will help minimize the risk of dying from malaria and contribute to increased productivity in the country as a result of reduced morbidity of malaria.

MALARIA CONTROL STRATEGY IN BHUTAN

Until 2005, the malaria control strategy in Bhutan under the Vector-borne Disease Control Program had been defined as prevention through IRS and microscopic diagnosis and treatment with chloroquines and quinine. The Global Fund grant of US\$ 1.7 million for 2005 to 2009 allowed it to strengthen the malaria control strategy. After two years of implementation work, the number of malaria cases reported at health facilities dropped from 3,806 in 2003 to 1,868 in 2006, annual parasite incidence per 1,000 population dropped from 7.2 in 2003 to 3.9 in 2006, and the percentage of households in the perennial transmission districts owning at least one ITN has increased from 20 percent in 2003 to 94.5 percent in 2006.

Despite significant success in reducing malaria-induced morbidity and mortality, a number of challenges remain. Bhutan lacks the human resources necessary for addressing the disease both at the central and at the peripheral level. Additional efforts are needed to ensure that LLINs are used properly and that people come to health facilities promptly to receive early diagnosis and treatment. Even though the present malaria situation in Bhutan is at its lowest level, the constant influx of carrier populations to the interior parts of the country, climatic conditions conducive for mosquitogenesis and the tough geographical terrain may lead the disease to rebound with vengeance. In order to avoid this, control and prevention measures need to be strengthened further. Assistance of the Global Fund in reaching this goal is of crucial importance.

India

COUNTRY INDICATORS

Size of population	1,134,403,000
Gross national income per capita	US\$ 720
HIV Prevalence	0.36%
Estimated HIV cases	2,500,000
TB incidence	1,851,661
Estimated TB cases	3,299,197
Reported malaria deaths	990
Reported malaria cases	1,781,336



SUMMARY OF GRANTS

All grants

Total proposal amount	\$664,506,490
Signed grant amount	\$226,975,083
Total disbursed to date	\$138,050,931

HIV/AIDS

Total proposal amount	\$492,791,693
Signed grant amount	\$140,502,407
Total disbursed to date	\$94,045,630

HIV/TB

Total proposal amount	\$14,819,772
Signed grant amount	\$2,667,346
Total disbursed to date	\$2,185,472

Tuberculosis

Total proposal amount	\$87,850,071
Signed grant amount	\$53,646,497
Total disbursed to date	\$28,400,803

Malaria

Total proposal amount	\$69,044,954
Signed grant amount	\$30,158,833
Total disbursed to date	\$13,419,026

Principal Recipients

The Department of Economic Affairs of the Government of India;
The Population Foundation of India (PFI);
India HIV/AIDS Alliance

LFA

World Bank; UNOPS

ACHIEVEMENTS TO DATE

HIV/AIDS

88,000 PLWHAs receive antiretroviral (ART) in the public sector
5,796 chronically ill people and their families receive care and support
4.1 million people underwent HIV counseling and testing in 2006

HIV/TB

10,523 new cases of TB identified through TB screening in people attending VCT centers
208 health facilities offering both VCT and TB diagnosis and treatment services
4,040 people with advanced HIV infection receive ARV combination therapy after successful completion of TB treatment

Tuberculosis

38,516 patients put on DOTS
101,559 patients put on treatment
10,275 people reached through community meetings

Malaria

1,092,432 ITNs distributed
107,111 cases of severe and complicated malaria treated
3,037,067 community-owned nets treated with insecticide

The second most populous country in the world after China, India is going through an unprecedented economic boom and is rapidly emerging as a major world economic power. And yet, despite its promising political and economic prospects, the country suffers from a heavy burden of poverty and inequality. The precarious living conditions of a large part of India's population have led to major epidemics. The primary threat comes from HIV/AIDS, malaria and tuberculosis, which are responsible for close to 30 percent of all deaths due to infectious and parasitic diseases in the country. India is also one of the high-burden countries for tuberculosis.

HIV/AIDS

The Indian government estimates that approximately 2.45 million people in India were living with HIV as of 2006. Among India's many states, six (Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Nagaland and Manipur, with a combined population of 291 million) have been hit especially hard by the HIV pandemic. In some districts of India, the prevalence of HIV reaches as much as five percent. Close to 66,000 children under the age of 15 are HIV-positive. Alarming, more than 80 percent of those infected do not know that they have contracted the disease.

As in other states, key risk factors for the propagation of the virus include a high rate of STIs, low condom use, high migration, growing drug abuse and high levels of ignorance and unawareness among the youth. In recent years, the Indian government has greatly contributed to fighting the disease by drastically expanding and improving the surveillance system.

The first of India's six HIV grants, managed by the Department of Economic Affairs of the Government of India, allocated US\$ 92 million for the national initiative to scale up care and prevention behavior among pregnant women in India's six states with

high HIV/AIDS prevalence. This includes implementation of a comprehensive HIV/AIDS care package that provides ARV treatment for HIV-positive mothers, their infants and partners, and offering a package of primary prevention, family planning, VCT services and counseling on infant feeding.

The grant has been successful in involving NGOs in providing quality HIV/AIDS care and support services to pregnant women and children and training service providers in HIV/AIDS management.

India's Round 4 HIV/AIDS proposal

was divided between the National AIDS Control Organization (NACO) of the Ministry of Health and the Population Foundation of India (PFI). The PR implements the program through four NGOs in six states that have high HIV prevalence. The Round 6 grant will serve to scale up treatment and VCT in other vulnerable states through the NGOs NACO, PFI and the India HIV/AIDS Alliance.

The key objectives of the grant are to improve survival and quality of life of people living with HIV/AIDS and reduce HIV transmission, to reduce morbidity and mortality by combining care, treatment (including ARVs), pre-

INDIA'S INTEGRATED COUNSELING AND TESTING CENTRES

Though counseling and testing services were started in 1997, less than 20 percent of the people living with HIV/AIDS in India are aware of their HIV status.

Therefore scale-up of counseling and testing services is one of the most important areas of focus in the recently-launched National AIDS Control Program Phase III (NACP-III, 2007-2012). Under NACP III it is envisaged that 22 million people will access counseling and testing annually in the government health sector alone.

The Integrated Counseling and Testing Centres (ICTCs) that offer both VCT and PMTCT are the first interface for people - particularly for high-risk and vulnerable groups - with the HIV/AIDS control and treatment program in the country. Today there are

more than 4,000 ICTCs spread across the length and breadth of India, making it the largest network of its kind in the entire world. In the year 2006 alone, a staggering 4.1 million people accessed counseling and testing services through these centers.

Currently these ICTCs in India are located in the government health system, especially in medical colleges, district hospitals and in community health centers. However, in order to provide better access to the most vulnerable populations, partnerships are needed in order to establish ICTCs in privately-owned clinics, maternity homes and diagnostic laboratories as well as in busy public and commercial areas such as bus terminals, railway junctions, highway hotspots, fairs, markets, etc. For those living in remote and hard-to-reach areas, counseling and testing services in the form of mobile ICTC services are being planned.

India

vention and support. Focusing on India's six high-prevalence states and Delhi, the NGO will be in charge of the prevention program, and NACO will implement treatment activities.

During the five-year lifetime of the project, over 180,000 PLWHA, both adults and children, will be on ARVs, 2.8 million people will receive VCT and 200,000 PLWHA not needing ARVs will be provided care and support through the public sector.

The three most recent grants of India's six HIV grants were approved in Round 6 and aim to scale up availability of treatment, care and support in areas of

India other than the six most-affected states. The specific objective of these three grants is to increase the number of ARV centers and expand access to VCT.

TUBERCULOSIS

Tuberculosis is one of the deadliest and most devastating health burdens India has known over the past decades. An estimated 3.3 million people suffer from the disease, accounting for nearly a third of the global TB burden. Every day more than 20,000 people get infected with the tuberculosis bacillus, more than 5,000 people develop TB disease, and more than 1,000 people die of it.

The direct and indirect cost of tuberculosis to India amounts to an estimated US\$ 3 billion annually. Studies suggest that on average three to four months of work time per patient is lost as a result of TB, resulting in an average lost potential earning of 20 to 30 percent of the annual household income. This leads to increased debt burden, particularly for the poor and marginalized sections of the population.

The TB problem is further compounded by an estimated 2.45 million people in India who are infected with HIV, as TB is the most common OI among HIV-positive individuals. Regardless of the extent of the HIV epidemic, unless

continued urgent and effective action is taken, millions of people in India may die of TB over the next ten years.

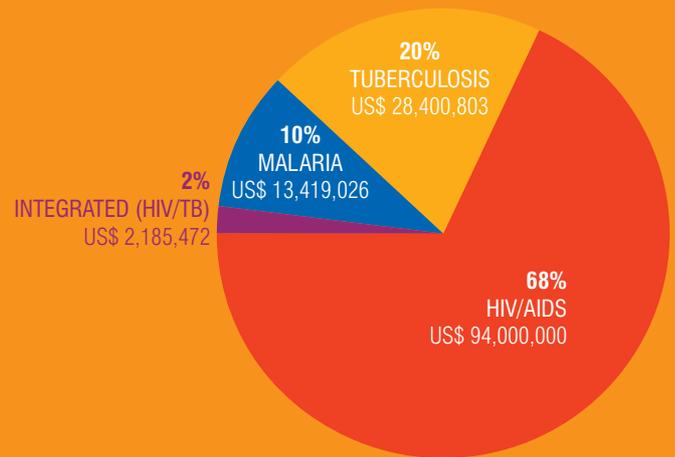
The first of four TB grants for India set out to achieve at least 85 percent treatment success and at least 70 percent detection of new smear-positive cases in order to reduce morbidity, mortality and disability caused by TB. Its other targets include: covering an additional 56 million people that have poor socioeconomic indicators and are largely underserved by the existing health infrastructure, placing 115,000 TB patients on treatment and establishing a model public and private sector integrated TB control program

CONTROLLING TUBERCULOSIS IN INDIA

Having suffered tremendous human and economic loss from tuberculosis, India has been in the forefront of the global efforts to control the disease. The country's Revised National Tuberculosis Control Program (RNTCP), launched in 1997, has proved to be the fastest-expanding TB control program in the history of DOTS, with nationwide coverage achieved by March 2006. It is in line with the Stop TB Partnership strategy for TB control and covers all the activities proposed under the strategy, including pursuing high-quality DOTS expansion and enhancement and addressing TB/HIV. The success of DOTS in India has contributed substantially to the success of TB control in the world.

Under the RNTCP, primary health care facilities have been strengthened to provide standardized TB care through the public health care system established by

the states. Unique innovations under RNTCP include the development of Patient-Wise Boxes, which contain the full course of treatment for one individual patient, decentralized supervision via the sub-district TB Units, with in-built systems for M&E. RNTCP promotes advocacy, political and administrative commitment, as well as community participation. The RNTCP has been found to be highly economical, costing on an average less than Rs 2 (US 5 cents) per capita per year. Currently, the RNTCP program covers the entire population of 1.1 billion in 632 districts of 35 states and Union Territories. It has put 6.7 million TB cases on treatment under the DOTS regime with a success rate of 85 percent that has been maintained consistently since the start of the program.



DISBURSEMENT TO COUNTRY TO DATE

for possible replication and scale-up in the future.

The main objectives of India's Round 2 tuberculosis grant are to expand the Revised National TB Control Program to the "uncovered" population; to achieve at least 85 percent success in treatment amongst registered new smear-positive pulmonary TB cases; and to establish model "Urban TB Control Projects" in four major cities of India by improving the quality and reach of RNTCP to vulnerable populations.

Approved in Round 4, this grant of US \$ 25 million will allow India to pursue the DOTS program in two addi-

tional states, serving a population of 119 million people. A state-level mortality survey and TB infection risk surveys will be conducted in the beginning and the end of the implementation process, allowing the grant to assess reduction in these indicators. Access to DOTS will be made more accessible and 166,600 patients are expected to be initiated on treatment thereby saving 30,000 additional lives.

The most recent of India's four TB grants has as its objectives to consolidate services of the RNTCP and improve their quality; expand and increase the reach of RNTCP; introduce DOTS-Plus in a phased manner;

train and involve private practitioners in RNTCP-DOTS in order to improve the availability and quality of TB control services through a sustainable public/private mix (PPM) approach and contribute towards national efforts in measuring impact of RNTCP in relation to the TB targets outlined in the MDGs. While the bulk of funding will go to government agencies, the program plans to also involve the academic and nongovernmental sectors in implementing its goals.

MALARIA

India contributes almost three-fourths of all cases of malaria in Southeast Asia, with close to two million people infected and a thousand people dying from the disease each year. It has been estimated that India loses up to US\$ 1 billion in lost income as a result of malaria. The problem of malaria has existed in India for centuries. Today, growing industrialization, de-forestation, urbanization and natural disasters such as floods, cyclones, and earthquakes provide a fertile ground for further spread of the disease.

TUBERCULOSIS: FOCUS ON PROVIDERS IN THE FIELD

DOTS providers, the essential backbone of the entire TB program, come from different social backgrounds, professions and communities, but the unifying thread is their concern for patients and their resolve to cure every patient assigned to them, however difficult that may be.

They provide encouragement and support to patients while they take the medication, help them to overcome side effects and ensure that all sputum follow-up examinations are done on time.

One such committed DOTS provider works in a bustling private hospital in Ranchi (Jharkhand). Being the pharmacist of the unit, he is a busy man. But that does not stop him from taking a keen interest in every

TB patient assigned to him. He ensures that they report regularly to the DOTS center. All absentees receive a personal visit, during which DOTS providers try to convince them to return immediately to complete treatment.

When asked about his commitment, the answer of this DOTS provider is simple: "If by just convincing patients to visit the center and take drugs regularly, I can help to cure so many people in our community, then it would be a sin not to put my heart and soul into this mission".

India

Areas of India that are highly endemic for malaria include the north-eastern region and tribal forested and hilly areas of several states including Maharashtra, and selected non-tribal districts. Nearly one quarter of all reported cases are from Orissa State, and 80 percent of reported cases originate from 20 percent of the population. About 1,000 deaths are reported annually, but these figures do not include cases treated in private and not-for-profit health facilities.

The National Malaria Control and Eradication Program was launched as early as 1953. Today, the National Anti-Malaria Program (NAMP) is one of the largest health programs of the Indian government. The National

Health Policy of 2002 reinforced the commitment to malaria control and set as goals the reduction of malaria mortality by 50 percent by 2010 and the efficient control of malaria morbidity. Malaria control in India relies heavily on active case detection: every year nearly 100 million blood smears are taken from identified fever cases, and patients are treated promptly if a diagnosis of malaria is confirmed. Access to prompt diagnosis, treatment and education is further provided through village health workers, drug distribution depots and fever treatment depots.

India's malaria grant provides the country's Department of Economic Affairs with US\$ 69 million to build

the capacities of the provincial health departments in ten states. The population of these ten states represents about ten percent of the country's total, but has 25 percent of malaria cases in the country and 47 percent of malaria deaths.

The main components of the proposed program include training of existing laboratory technicians in the public, private and voluntary sectors to improve access to diagnosis and treatment; use of rapid diagnostic test kits in remote or sparsely-populated areas where laboratory services are not available; supply of anti-malarial drugs and ITNs; provision of artemisinin-based combination therapy (ACT) in drug-resistant areas; promotion and use

of larvivorous fishes; establishment of a community-based drug distribution mechanism; selective insecticidal residual spray; and conducting malaria control awareness and education programs.



Iran (Islamic Republic of)

COUNTRY INDICATORS

Size of population	69,421,000
Gross national income per capita	US\$ 2,770
HIV Prevalence	0.153%
Estimated HIV cases	86,000
TB incidence	16,322
Estimated TB cases	20,963
Reported malaria deaths	2
Reported malaria cases	23,562



SUMMARY OF GRANTS

All grants

Total proposal amount	\$15,922,855
Signed grant amount	\$5,698,000
Total disbursed to date	\$5,455,450

HIV/AIDS

Total proposal amount	\$15,922,855
Signed grant amount	\$5,698,000
Total disbursed to date	\$5,455,450

Tuberculosis

Total proposal amount	N/A
Signed grant amount	N/A
Total disbursed to date	N/A

Malaria

Total proposal amount	N/A
Signed grant amount	N/A
Total disbursed to date	N/A

Principal Recipient The United Nations Development Programme (UNDP)

Local Fund Agent PricewaterhouseCoopers

ACHIEVEMENTS TO DATE

HIV/AIDS

155 VCT sites established

1,741 IDUs exposed to methadone maintenance treatment program, including those in prisons

155,212 people trained by peer education (youth, high-risk groups, prisoners)

In the past 20 years, the Islamic Republic of Iran has seen significant progress in social programs, including health care and social security, but the country continues to face a number of major health challenges, particularly with respect to the growing threat of an HIV/AIDS pandemic fuelled by the major drug routes going through Iran and the proximity to the Newly Independent Countries in Central Asia that experience some of the highest HIV/AIDS growth rates in the world.

HIV/AIDS

The first HIV case in Iran was identified in 1987, and by 2004 more than 7,500 cases had been registered. While this number corresponds to a less than 0.2 percent prevalence, the true extent of the pandemic is likely to be much larger. Experts fear that as many as 86,000 people may have been infected with the virus in Iran, where the traditional Islamic culture attaches a highly negative stigma to the disease and prevents people from getting tested and treated.

More than 95 percent of all identified

HIV cases in Iran occur in men, the majority of whom contracted the virus through drug injection. Given Iran's proximity to Afghanistan, the world's largest narcotics producer, and the busy drug trafficking routes crossing the country, Iran is in danger of a much higher exposure to the virus than the official figures would like to admit.

Iran started to address the problem soon after identifying the first victim of the virus in 1987. A National Committee to Fight HIV/AIDS, set up that year, has been active in promoting preventive measures and helping people who have tested positive.

Today, close to 1.2 million people in Iran are tested for HIV each year. The government distributes free ARVs to those who require treatment.

Iran has one HIV/AIDS grant from the Global Fund. Its goal throughout the past two years has been to provide support to Iranian efforts in controlling the growth of HIV prevalence and incidence in the country. The government's targets include maintaining HIV prevalence among the general population at less than one percent and maintaining HIV prevalence among high-risk groups below 25 percent by the end of 2007.

The project's results have been encouraging. In two years, Iran has trained nearly 62,000 teachers in HIV information and education, with 69 university students receiving training to become trainers for peer education (the target was set at 70). Training among high-risk population groups (youth, prisoners, etc.) falls behind the set targets, but exceeds the mark of 35,000 – a tremendous result for a highly-conservative country where the issues of extramarital relations and drug abuse remain taboo.

ACCOMPLISHMENTS IN PEER EDUCATION AND TEACHER TRAINING

In Round 2, Iran received US\$ 15.9 million in funding from the Global Fund for a five-year project to fight HIV/AIDS. UNDP-Iran was established as the PR of the grant, which further works with three sub-recipients.

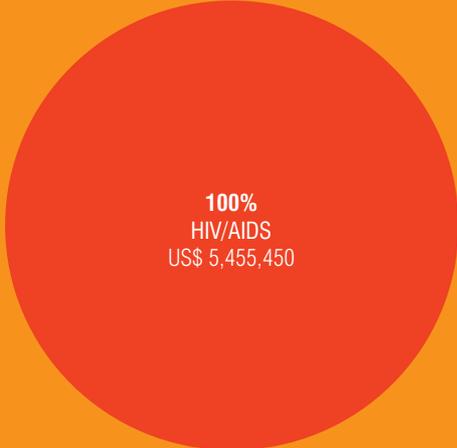
More than two years into the project, there have been several significant accomplishments. The experience of peer education and training of Ministry of Education teachers stand out as the two highly successful cases.

The notion of peer education is not new in Iran, but before the Global Fund project became effective, this technique was only used sporadically in the context of its national HIV/AIDS program. The HIV/AIDS program funded by the Global Fund applied this concept with a great degree of success, planning and implementing it based on the rationale that within the

prison environment, peers could exert more impact than authorities. During the first two years of the program's implementation, more than 130,000 prisoners willingly attended training and the program will target another 200,000 prisoners.

The Welfare Organization, one of the sub-recipients of the grant, used the peer education strategy to educate more than 60,000 people. In addition, another 18,500 university students and youths have been trained through peer education. The second outstanding success in Iran has been teacher training. Using a "Train the Trainer" approach, more than 60,000 school teachers have been trained with another 60,000-plus presently undergoing training. By fall 2007, close to 125,000 school teachers will have benefited from this approach. In the second phase of the project, another 300,000 teachers will undergo the same type of training.

Iran



100%
HIV/AIDS
US\$ 5,455,450

DISBURSEMENT TO COUNTRY TO DATE

Most importantly, the grant monies allowed the program to surpass the target of giving adequate training to health workers, who can further spread information about HIV prevention measures and contribute to bringing down the stigma surrounding this disease. When the grant is completed in 2010, Iran expects to see a significant improvement in the way the HIV/AIDS challenge is addressed and overcome.

MALARIA

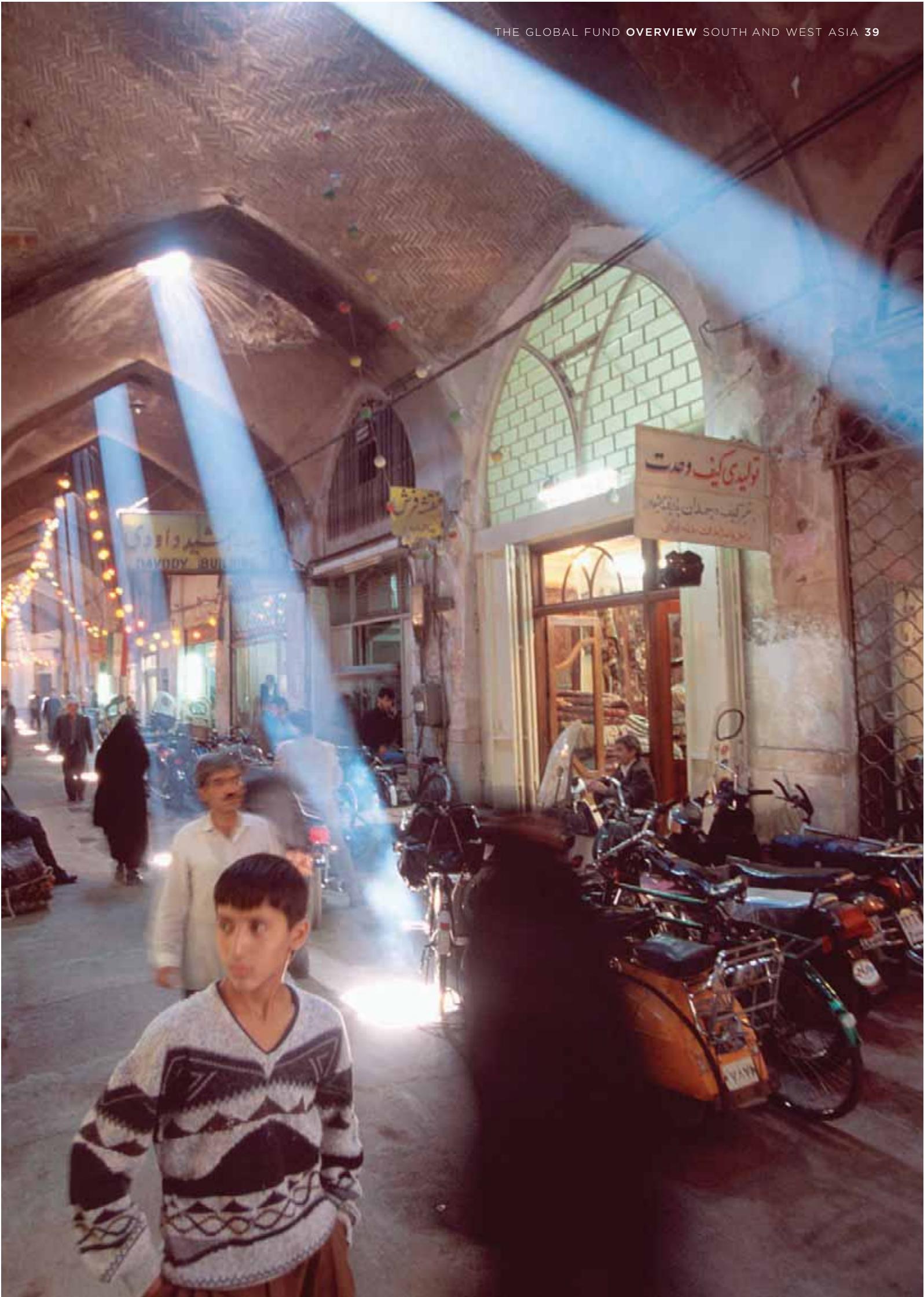
The malaria risk in Iran is not negligible, even if it appears smaller than in other countries in the region. In 2006, a total of 15,909 cases of malaria were reported in Iran, of whom 17 percent were non-Iranians (mostly Pakistani and Afghani immigrants). Moreover, approximately 2.3 million people are at high risk of contracting malaria, and several malaria outbreaks have been reported in recent years. The malaria burden is concentrated in 20 of the country's 327 districts, which are also among the country's poorest and least-developed zones.

Migration of rural populations from the countryside to the peri-urban areas is an important factor in the spread of the disease, with poor housing and living conditions increasing the risk of malaria transmission.

The government's goals include reducing local malaria transmission by 80 percent by 2012 compared to 2006 levels and preventing malaria deaths.

TUBERCULOSIS

The burden of tuberculosis in Iran is much lighter than in many other countries in the region, with approximately 37 cases per 100,000 people (as compared to 333 in Afghanistan and 290 in India). In the past years the TB incidence in Iran has been further decreasing.



Maldives

COUNTRY INDICATORS

Size of population	295,000
Gross national income per capita	US\$ 2,390
HIV Prevalence	N/A
Estimated HIV cases	N/A
TB incidence	155
Estimated TB cases	175
Reported malaria deaths	0
Reported malaria cases	3



SUMMARY OF GRANTS

All grants

Total proposal amount	\$4,865,956
Signed grant amount	\$2,655,685
Total disbursed to date	\$0

HIV/AIDS

Total proposal amount	\$4,865,956
Signed grant amount	\$2,655,685
Total disbursed to date	\$0

Tuberculosis

Total proposal amount	N/A
Signed grant amount	N/A
Total disbursed to date	N/A

Malaria

Total proposal amount	N/A
Signed grant amount	N/A
Total disbursed to date	N/A

Principal Recipient United Nations Development Programme (UNDP)

Local Fund Agent Swiss Tropical Institute

When speaking of the Maldives, most people picture a tropical paradise, a place devoid of all earthly problems and anxieties. But this archipelago of more than 1,200 small islands has faced significant health challenges in the past. Today, the island nation registers cases of TB and may potentially face a considerable HIV/AIDS threat due to increasing high-risk behaviors among some population groups.

HIV/AIDS

The Maldives joined the list of countries affected by HIV/AIDS in 1991 when the first victim of the disease was identified. Since then, 13 cases among the local population and 168 cases among expatriate workers have been reported, all among people 20 to 49 years old.

The spread of HIV/AIDS in the country is still at an early stage, but there are concerns about a potential growth in HIV cases due to a high number of risk factors that exist in the country, including growing drug abuse, a very young population, a highly-developed tourist industry and a large number of expatriate workers. The existing health system in the Maldives is well positioned to sustain a potential increase in HIV/AIDS cases. A number of constraints do remain, however, most notably with respect to a lack of technical skills among medical personnel and a lack of opportunities to develop such skills.

The Maldives' only Global Fund grant allocates US\$ 2.6 million to enforce prevention strategies in order to ensure that the Maldives remains a low HIV-prevalence country. The grant from the Global Fund is meant to help the Maldives address multiple issues (including lack of knowledge, increasing levels of drug use and commercial sex work and a widespread lack of condom use) and find effective methods to prevent the virus from spreading further on the archipelago.

TUBERCULOSIS

Even though in relative terms the Maldives appear to have a much lighter TB burden than most other South Asian countries, TB nevertheless remains one of the most fatal diseases that the Maldives has ever known. Despite numerous efforts to eradicate the disease, it has still not been brought totally under control. However, considerable progress has been made towards decreasing TB prevalence and mortality in the country - in the last thirty years, prevalence has dropped to 0.39 cases per 1,000 and childhood tuberculosis has become almost non-existent.

The National TB Program of the Maldives was the first in the region to achieve the global targets set for 2005. The program has continued to be very successful. The Maldives has maintained a case-detection rate of 100 percent while treatment success rates of more than 90 percent have been consistently achieved over the past five years. As of 1997, no cases of drug resistance have been reported.

MALARIA

Unlike the majority of other South Asian states, malaria has not been a public health problem in the Maldives. In the 1970s, malaria affected up to 1,000 people per year in the Maldives, but there has been no indigenous transmission of the disease since 1984. Only few imported cases (between 10 and 30) are being reported every year.

Nepal

COUNTRY INDICATORS

Size of population	27,094,000
Gross national income per capita	US\$ 270
HIV Prevalence	0.53%
Estimated HIV cases	75,000
TB incidence	48,842
Estimated TB cases	66,158
Reported malaria deaths (2003)	3
Reported malaria cases	9,394



SUMMARY OF GRANTS

All grants

Total proposal amount	\$27,917,308
Signed grant amount	\$21,144,682
Total disbursed to date	\$12,107,379

HIV/AIDS

Total proposal amount	\$10,365,995
Signed grant amount	\$10,365,995
Total disbursed to date	\$6,360,804

Tuberculosis

Total proposal amount	\$10,126,706
Signed grant amount	\$3,354,080
Total disbursed to date	\$1,584,314

Malaria

Total proposal amount	\$7,424,607
Signed grant amount	\$7,424,607
Total disbursed to date	\$4,162,261

Principal Recipients	The Ministry of Health and Population of the Government of Nepal; Population Services International; United Nations Development Programme
Local Fund Agent	PricewaterhouseCoopers

ACHIEVEMENTS TO DATE

HIV/AIDS

708 PLWHA receive ARV treatment
4,770 cases of STIs diagnosed, counseled and treated
284 service deliverers trained in comprehensive HIV/AIDS care and support

Tuberculosis

14,617 new smear-positive cases detected and registered under DOTS
4,731 new smear-positive female TB cases detected

Malaria

113,017 LLINs distributed
814 people with severe malaria successfully treated
194,300 uncomplicated malaria cases diagnosed and treated

TOWARDS UNIVERSAL ACCESS: GETTING ARVs CLOSER TO THOSE IN NEED

Until 2003, most available HIV/AIDS resources in Nepal were spent on targeting high-risk groups with prevention messages. Little attention was given to treatment, care and support interventions. In recent years, however, government and other stakeholders have come to realize that in order to meet the MDG target of halting and beginning to reverse the spread of HIV/AIDS by 2015, prevention and treatment must go hand in hand.

Nepal is implementing its Round 2 grant targeting migrants and youth and focusing on treatment and care services. ARV treatment started in February 2004,

One of the poorest and least accessible countries in the world, Nepal is very susceptible to natural disasters: earthquakes, recurrent floods, landslides, etc. Environmental challenges and widespread poverty (45 percent of the population lives below the poverty line) make the country highly vulnerable to all three of the diseases addressed by the Global Fund. A high number of internally displaced persons (up to 200,000) contribute to the country's vulnerability. Moreover, the decade-long Maoist insurgency has taken a toll of about 13,000 lives and hampered the delivery of basic services, restricted development assistance and caused a breakdown of family and community networks. Its greatest impact has fallen on women and children.

HIV/AIDS

Unless urgent and effective measures are taken, Nepal may soon face the imminent threat of an HIV pandemic. In the absence of such measures, HIV prevalence in Nepal may increase to one to two percent among the 15- to 49-year-olds in less than a decade. Such an increase would represent a ten-fold growth in infection and death rates compared to the present time, potentially making AIDS the leading cause of death among the 15 to 49 year olds.

One of the most threatening prospects of an emerging HIV epidemic in Nepal lies with the country's large male migrant population. An estimated

600,000 to 1.3 million Nepali men migrate to India for seasonal and long-term work, often without their families. Evidence shows that many are using the services of commercial sex workers in areas with high HIV prevalence before bringing the virus back home to Nepal. A recent survey showed that up to 11 percent of all migrants' wives were HIV-positive.

What makes the HIV/AIDS issue in Nepal even more challenging is the lack of VCT services as well as the limited capacity of authorities and health workers to intervene when needed.

The key target of Nepal's HIV/AIDS grant, managed jointly by the

country's Ministry of Health and the United Nations Development Programme (UNDP), is to prevent HIV infection from spreading among migrant laborers and young people and to provide care and support to those already affected.

The program's goal is to initiate prevention and treatment activities in eight districts along the border between Nepal and India in order to reduce transmission of HIV/AIDS among migrant laborers and youth. The program also aims to integrate HIV/AIDS and STI prevention into high school curricula in all 75 districts in Nepal and provide HIV care and treatment in two government hospitals and one university hospital to those

who need it. Successful implementation of the latter goal will allow approximately 2,500 people living with HIV/AIDS to have access to ARV treatment.

Among the recent achievements of the program is its success in providing HIV testing and counseling to 1,658 people. In addition, the program was successful in establishing 10 ARV testing centers and opening eight VCT centers. The program has also been successful in providing training to various population groups, most notably labor migrants, peer educators, and youth.

with two patients in a single treatment center. Within one year two additional sites were established and 50 people were receiving ARVs. As of June 2007, 14 sites are providing ARV treatment to 901 PLWHAs. Nepal's National Action Plan (2006-2008) aims to provide ARV services to 2,500 people by the end of 2008.

Given the late initiation of ARV services in Nepal, the second National HIV/AIDS Strategy (2006-2011) has prioritized infrastructure upgrades along with expansion and scale-up of ARV services throughout the country.

All ARV sites with the exception of one private clinic are in government hospitals, thus ensuring sustainability of the service. Global Fund support includes basic

logistics and equipment support, procurement and supply of ARV drugs, reagents and drugs for OI and STIs and test kits.

SPARSHA, a local NGO, implements the grant and helps people from remote areas to access and initiate ARV treatment. Major challenges it faces include insufficient access of people on ART to other crucial support (psychosocial, nutritional, livelihood) and sustainability of the services provided.

Nepal



TUBERCULOSIS

It is estimated that almost half of the country's population has been affected by tuberculosis in one way or another. Statistical estimates claim that approximately 80,000 suffer from the disease's active form. Tuberculosis in children represents five to ten percent of all cases.

Nepal is a mostly rural country, and the majority of its citizens are illiterate. There is widespread belief in these rural communities that only sinners get the disease. As a result, many infected people hide their condition and deny any signs of the disease. The Nepalese government has been

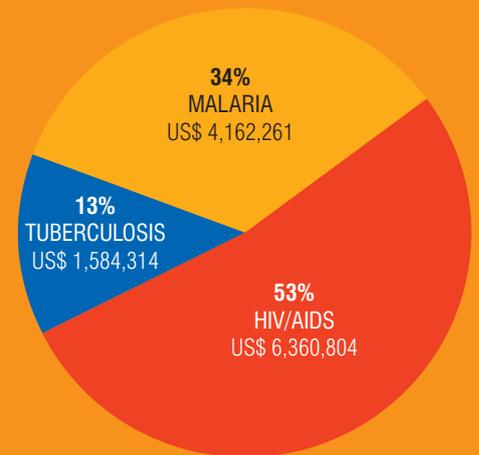
very proactive in trying to educate people in rural areas about prevention and treatment of the disease. Solving the TB problem has become one of the top priorities for the government after it realized what disastrous human, economic, and social losses the disease will bestow on Nepal if the problem is not addressed.

Today, the government's goal is to ensure that there is a DOTS treatment center within the primary health care system for every 100,000 people in Nepal, supported by a microscopy centre for diagnosis and treatment monitoring. It is estimated that almost 25,000 to 30,000 TB deaths could be averted by the DOTS program in Nepal

over the next five years. To achieve its targets, the program aims to increase the case detection rate on a national level to 78 percent and reach treatment success rates of 90 percent by 2010.

Two years after its start, the program still has a long way to go in order to meet all of the targets that have been set in the original proposal. Some success, however, has already been observed, especially with respect to service indicators. The program has been able to meet its targets on the number of centers set up to offer DOTS microscopy service, the number of laboratories participating in the National Network of Laboratories carry-

ing out quality assurance, and the number of DOTS centers participating in trimester review meetings and receiving feedback reports regularly.



DISBURSEMENT TO COUNTRY TO DATE

MALARIA

Out of approximately 27 million people living in Nepal, more than 70 percent (16 million) are at risk of contracting malaria every year, and close to 10,000 clinical malaria cases are reported annually. The true prevalence is believed to be at least twice as high, but the exact number of malaria victims remains unknown due to the low awareness among the local population and poor diagnostic techniques. Only about 40 percent of the population has access to public health service outlets.

Furthermore, over the past decade, the malaria control program has been plagued by periodic epidemics, a

problem of emerging drug resistance and population movement across the border. Combined, these factors lead to increased epidemic potential in malaria-prone districts.

The goal of Nepal's malaria grant, managed jointly by the Ministry of Health and the Population Services International (PSI), is to reduce malaria burden via effective prevention and treatment of the disease with active help from CBOs and other civil society organizations. As of December 2005, PSI is working in partnership with the government of Nepal to develop and implement prevention and public/private training activities in six epidemic-prone districts.

Targeting primarily people living in the country's 12 high-risk districts, the grant attempts to bring forward the government's primary health care system. It is planned that by providing malaria services through this system, existing health service outlets will be able to access populations who face malaria risk for early detection and provide them with prompt and effective treatment at all levels of the health system. This will enable the country to review and update the national malaria drug policy through regular monitoring of malaria drug resistance. Finally, the program will introduce ITNs as a tool for community protection in high-risk and epidemic-prone areas.

SOCIAL MARKETING FOR MALARIA PREVENTION

In a developing country like Nepal where a vast range of public health issues are addressed, the "Social Marketing for the Prevention of Malaria in Nepal" campaign has stood out of the crowd due to its innovative approach. The social marketing campaign strategy used a creative and original project implementation method which capitalized on the core competencies of the government, the private sector, NGOs and civil society.

This strategy involved a comprehensive mix of social marketing and public/private partnership activities which included the sale and distribution of branded LLINs, the development of BCC materials in support of the government's goals and objectives, the design and implementation of target group research, the design of comprehensive LLIN M&E tools and activities that strengthened partnership and coordination between

the government, NGOs, PSI/Nepal and private sector partners. The distribution of the nets was conducted in such a way as to ensure that all nets had been distributed to target households before the monsoon season, when malaria infections are at their peak. In three months, over 100,000 nets were distributed.

The program was implemented in the height of the civil unrest of April and May 2006 and progress was continually hampered by constant stoppages caused by national strikes, curfews, violent protests and general civil unrest. In spite of many obstacles the campaign met all key deliverables and significantly contributed towards the MDG of "halting and beginning to reverse the incidence of malaria" in Nepal. The campaign is now being replicated in another five high-risk malaria districts of Nepal in 2007.

Pakistan

COUNTRY INDICATORS

Size of population	158,081,000
Gross national income per capita	US\$ 690
HIV Prevalence	0.1%
Estimated HIV cases	85,000
TB incidence	286,291
Estimated TB cases	468,400
Reported malaria deaths	29
Reported malaria cases	125,152



SUMMARY OF GRANTS

All grants

Total proposal amount	\$83,365,784
Signed grant amount	\$23,046,969
Total disbursed to date	\$19,744,652

HIV/AIDS

Total proposal amount	\$8,312,200
Signed grant amount	\$8,312,200
Total disbursed to date	\$6,945,016

Tuberculosis

Total proposal amount	\$69,967,146
Signed grant amount	\$9,648,331
Total disbursed to date	\$7,879,050

Malaria

Total proposal amount	\$5,086,438
Signed grant amount	\$5,086,438
Total disbursed to date	\$4,920,586

Principal Recipients The National AIDS Control Programme on Behalf of the Ministry of Health of the Government of Pakistan;
Mercy Corps

Local Fund Agent KPMG

ACHIEVEMENTS TO DATE

HIV/AIDS

42,908 people received counseling and 12,738 underwent testing

41,469 young people exposed to HIV/AIDS education at school

79,731 street children attend drop-in centers

Tuberculosis

10,691 new smear-positive cases detected under DOTS

530,061 people exposed to BCC outreach activities

962 treatment facilities deliver TB DOTS services

Malaria

39,838 patients received correct diagnosis and treatment

600 public sector health providers trained in diagnosis and treatment of malaria

6,096 community representatives trained in BCC

One of the largest countries in South West Asia, Pakistan is becoming an increasingly important economic influence in the region. Yet despite this increasing influence the country faces numerous social challenges. It has one of the highest population growth rates, coupled with widespread poverty, limited access to health care, high child mortality and low levels of disease diagnosis and treatment. Communicable diseases account for up to 40 percent of the total disease burden in Pakistan. UNAIDS estimates that up to 85,000 people in Pakistan are HIV-positive. Pakistan is also one of the 22 high-burden countries for tuberculosis, while malaria also continues to be a major health threat, particularly in rural areas.

HIV/AIDS

WHO/UNAIDS estimates Pakistan to be a low prevalence but high-risk country for HIV propagation. The country is facing a concentrated epidemic among IDUs, with HIV prevalence above five percent in this population. People in the age group of 20 to 44 years old are the most affected by the disease, and men represent more than 80 percent of those infected.

Heterosexual transmission accounts for the majority of reported cases (67 percent). Among other modes of transmission are infection through contaminated blood and blood products (18 percent); homo- or bisexual sexual contacts (6 percent), IDUs (4 percent); and mother-to-child transmission (1.3 percent). The mode of transmission of 35 percent of reported

cases is unknown.

A number of factors make Pakistan particularly vulnerable to the further spread of the disease, the most important of them being high poverty and low literacy levels, especially among women; large proportions of youth with a low level of awareness about HIV and of protective measures; low use of condoms; large refugee and migrant populations and increasing numbers of drug users. The fact that implementation of AIDS programs in a conservative Islamic country has been very difficult makes a successful response to the disease even more challenging.

The goal of the Global Fund HIV/AIDS grant to Pakistan, approved in Round 2, has been to support national efforts to prevent HIV from becoming a

concentrated epidemic in vulnerable populations. In order to achieve its targets, the program counts on using the following strategies: improving knowledge of HIV transmission among out-of-school street children and school children in Karachi and Peshawar; improving screening of blood and blood products; establishing 16 VCT centers in large cities and five ARV treatment and support centers in five major hospitals to increase access to quality counseling and treatment; developing a life skills curriculum for secondary school students; and establishing drop-in centers for at least 10,000 street children.

Implementation is carried out by a number of national NGOs from different cities. Expected outcomes of the program will be to improve knowledge among youths from less than five percent to 60 percent and to triple the percentage of blood products currently screened. During the first two years, the program has reached more than 47,000 young people, trained more than 900 health professionals and established 16 VCT centers and five ARV treatment facilities. Approximately 200 people living with HIV/AIDS are on ARV treatment.

FROM DRUG ADDICT TO PEER EDUCATOR

Eighteen-year-old Farman came to the drop-in center on 10 July 2005. Farman was a drug addict who collected junk during the day and worked as a sweeper at night. Initially, Farman was quite reluctant to come to the center, but with repeated counseling and assurance he became a regular visitor. In the beginning Farman's behavior was quite aggressive, influenced by drug use. Occasionally, he would even become physically violent.

However, with the constant efforts of the staff his behavior was completely transformed. He has become cooperative and has started participating in various much healthier activities. The most positive change occurred when he became a peer educator. Farman is now a completely changed young man. He has given up drugs and is trying his best to improve his life. He was selected by Pakistan Voluntary Health & Nutrition Association to present a testimony at the national launch of "Unite for Children, Unite Against AIDS" in Islamabad.

Pakistan



TUBERCULOSIS

Tuberculosis continues to be a major public health problem in Pakistan, where the burden of the disease is the sixth-highest in the world. In 2005, the estimated prevalence, incidence and mortality of TB per 100,000 people was 297 (down from 359 in 2003), 181 and 37, respectively (WHO Global TB Report 2007). That means that currently close to 500,000 people in Pakistan are suffering from TB.

Pakistan adopted the DOTS strategy in 2000 and achieved 100 percent coverage in the public sector in 2005. Although the case detection rate has increased over the years, it is still low and constitutes a national challenge.

TB primarily affects socially and economically productive age groups (15 to 54 years) of the society, with 75 percent of cases occurring in the economically-active groups and low socioeconomic strata of society. Catastrophic health expenditure for TB treatment has been a serious problem among TB patients and their family members. TB control is therefore considered as one of the important steps in poverty reduction in Pakistan. In 2001, the government of Pakistan declared TB a national emergency.

The first of Pakistan's three TB grants set an ambitious goal of reducing sputum-positive TB cases to 65 per 100,000 population. Unfortunately, however, the program was delayed

by nearly a year due to a number of administrative and coordination difficulties. Despite catching up with some of its targets in 2006, achievements remained low, and it was decided to halt further disbursements. The grant was closed on 31 March 2006.

The goal of the second TB grant allocated to Pakistan by the Global Fund is to support the reduction of TB morbidity and mortality by expanding the TB-DOTS strategy through public health facilities and by enhancing the role of other stakeholders including the private sector.

The two main objectives of the proposal are using a social marketing approach to increase knowledge and

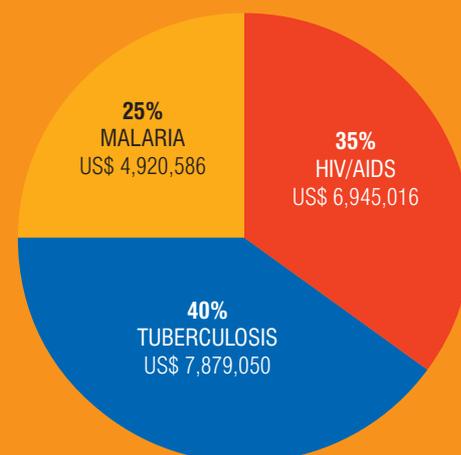
access to high-quality TB information and achieving a 70 percent detection and 85 percent cure rate in partnership with NGOs and CBOs and public sector facilities working on a grassroots level. Overall, the program has demonstrated satisfactory performance with some good results achieved in a number of important areas.

The third TB grant is currently awaiting signature and will start in the fall of 2007.

TB CAPACITY BUILDING IN PAKISTAN

The Pakistan Anti-TB Association (PATA) is an NGO working exclusively for the treatment, rehabilitation and welfare of TB patients throughout the country. PATA is determined to empower people who have tuberculosis and provide help to communities through advocacy, communication and social mobilization strategies which aim to control TB transmission in Pakistan.

Throughout the years of its operations, PATA has grown in size and scope. It has achieved considerable success in training service deliverers and establishing treatment centers. Local PATA stakeholders keep the diagnostic center staff motivated through continuous supportive organizational supervision and prompt responses to their issues. They also carry out community awareness activities such as commemorating World TB Day and conducting health education sessions.



DISBURSEMENT TO COUNTRY TO DATE

MALARIA

Malaria has been a major cause of morbidity in Pakistan and continues to be a key threat to the health of millions who live in malaria-endemic areas, where approximately 95 million of the country's 161 million total population live. Malaria in Pakistan is of unstable pattern and transmission is mainly post-monsoon (from July to November). Seasonal transmission variations, drought, irrigation systems and hydrological changes, population movements, high level anti-malarial drug and insecticide resistance in the parasite and vectors are the major determining factors working behind the high endemicity of malaria-prone zones. Poor access of the population

to early diagnosis, effective treatment and effective prevention measures have further complicated the situation.

Since 2003, Pakistan has been turning to the Global Fund for financial assistance in reaching its goals of cutting malaria incidence in the country. Pakistan is committed to cutting the number of malaria victims by half by the year 2012.

Pakistan received two malaria grants from the Global Fund in Rounds 2 and 3. The goal of the first Global Fund malaria grant has been to accelerate implementation of preventive and curative interventions in Pakistan's 23 high malaria-endemic districts and contribute to the five-year target of

Pakistan's Malaria Control Program of reducing the malaria burden by 50 percent by year 2010. The planned outcome of the project included, among other indicators, training of 4,800 health workers of both public and private sectors in the use of national treatment guidelines and succeeding in having 50 percent of mothers/caretakers of children being able to recognize signs and symptoms of febrile disease in children under the age of five. The Round 3 grant was designed to follow on from the Round 2 program.

Both malaria grants have been facing severe implementation challenges and are currently in the process of being closed.

Sri Lanka

COUNTRY INDICATORS

Size of population	19,121,000
Gross national income per capita	US\$ 1,160
HIV Prevalence	<0.1%
Estimated HIV cases	5,000
TB incidence	12,549
Estimated TB cases	16,571
Reported malaria deaths	2
Reported malaria cases	10,510



SUMMARY OF GRANTS

All grants

Total proposal amount	\$30,409,781
Signed grant amount	\$19,024,431
Total disbursed to date	\$8,437,311

HIV/AIDS

Total proposal amount	\$1,884,360
Signed grant amount	0
Total disbursed to date	0

Tuberculosis

Total proposal amount	\$17,574,471
Signed grant amount	\$9,651,229
Total disbursed to date	\$2,818,903

Malaria

Total proposal amount	\$10,950,950
Signed grant amount	\$9,373,202
Total disbursed to date	\$5,618,408

ACHIEVEMENTS TO DATE

Tuberculosis

3,381 new smear-positive cases detected under DOTS

1,142 new smear-positive TB cases (registered under DOTS) successfully treated

5,539 decision-makers reached by advocacy programs

Malaria

472,613 people screened through malaria mobile clinics

8,572 pregnant women use ITNs

50,753 children screened for malaria

Principal Recipients The Ministry of Healthcare, Nutrition & Uva Wellassa Development; Lanka Jatika Sarvodaya Shramadana Sangamaya

Local Fund Agent PricewaterhouseCoopers

Sri Lanka has been a social success story in the poverty-ridden region due to its long-term emphasis on equity and social justice. The country's 20.7 million inhabitants enjoy comparably high social and health standards, with life expectancy at birth of 73 years - considerably above the world average. Among the three diseases addressed by the Global Fund, only tuberculosis presents a serious challenge, but Sri Lanka's proximity to countries with alarming HIV levels puts it in danger of a potential HIV outbreak on its territory. Successful response to potential health threats in Sri Lanka is hampered by the devastating 20-year long civil war that resulted in the death of more than 60,000 people. The upsurge of violence makes implementation of recovery programs in the country increasingly difficult, especially in areas affected by the tsunami of December 2004.

HIV/AIDS

Sri Lanka currently has a low prevalence of HIV/AIDS (less than 0.1 percent), but like many South Asian countries it presents many factors that make it particularly vulnerable to the spread of infection. These include the growing sex industry, increased population mobility, low use of condoms and a high influx of refugees from countries that suffer serious and growing HIV epidemics (India, Nepal, Cambodia). Widespread poverty, a lack of qualified personnel to raise HIV awareness levels and frequently inadequate access of the poor (especially the plantation workers) to health services all contribute to the threat of HIV situation getting out of hand.

The first case of HIV/AIDS in Sri Lanka was reported in 1987. By June 2006, a total of 785 cumulative HIV infections

have been officially reported to the National STD/AIDS Control Program of the Ministry of Health. Of the reported persons with HIV, 214 have now gone on to develop AIDS. During this period 150 have been reported to die from the disease.

The true burden may be higher than this number as many cases are likely to remain unreported due to stigma, discrimination and limited availability of counseling and testing facilities. Sexual transmission remains the principle channel of disease propagation (96 percent of all cases).

Sri Lanka is still in the beginning stages of an HIV epidemic and successful control will depend on the knowledge, attitudes and practices of the country's adolescents and youth.

Sri Lanka has one HIV/AIDS grant that aims to address weak points in the

national HIV/AIDS control program, most notably the low level of awareness among poor people, especially in plantation zones, and insufficient provision of HIV-related information to in-school adolescents. The proposal includes three sub-components: plantation workers, schoolchildren, and ARV treatment. Each of them presents a range of targets that the program plans to achieve over the five-year period.

As the proposal outlines, plantation workers represent a large part of the country's population and tend to be among the groups most vulnerable to the disease because of their lower social status, high migration levels, and lack of social structures to provide necessary support. The proposed project aims to counter this trend through building up a sufficient human resource base that can reach out to plantation workers and consequently

encourage positive health-seeking behavior.

With respect to in-school adolescents, the program hopes to increase the knowledge on HIV/AIDS transmission and prevention methods by 50 percent by the end of the project period among school children of ten selected districts and maintain a low HIV prevalence in the 15 to 24 year old age group.

Sri Lanka



TUBERCULOSIS

Tuberculosis is a major health problem in Sri Lanka. The estimated number of cases in the country reaches almost 17,000, but only a proportion of these are currently being detected and treated. The majority of TB cases (69 percent) occur in the economically-productive age group of those 15 to 54 years old, putting great pressure on the country's economy. In recent years, there has been an apparent increase in TB cases among young women. Such an increase, however, does not necessarily mean higher exposure of females to the disease. More likely, it is a sign of an increasing number of women turning to health services and getting tested. Similarly, better M&E techniques are likely to be responsible for a recorded increase in the mortality rate of TB patients, as many deaths from TB, especially in

rural areas with limited access to health services, were previously simply not recorded.

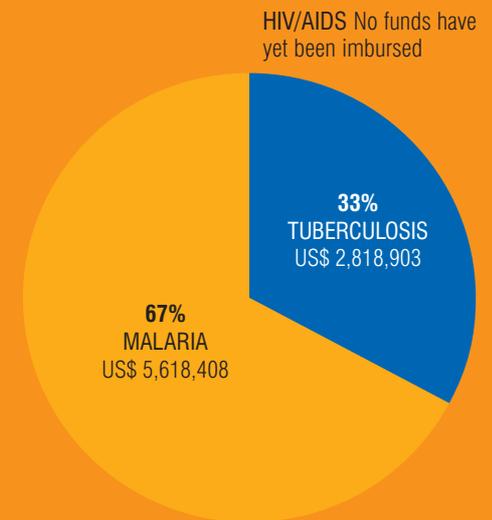
The introduction of DOTS has provided greater access to TB care services to the poor, the women, the rural population and other marginalized populations. Case detection rates and cure rates have since improved. There is, however, a further scope for increasing the case detection rates by strengthening DOTS through the provision of additional resources.

The first of the four Global Fund TB grants to Sri Lanka aims to strengthen the National TB Control Program, resulting in the reduction of the burden of the disease amongst the urban and the rural poor in Sri Lanka. The strategies proposed in this project are strengthening of DOTS programs and peripheral diagnostic services, launching

publicity campaigns, improving the management of information systems and carrying out operational research in relation to tuberculosis control strategies. These are being carried out by the government's National TB Control program in partnership with the NGOs and the private sector.

In a follow-up to the Round 1 TB grant, Sri Lanka's Round 6 tuberculosis grants aim to scale up the activities initiated under the first two grants as well as introduce a range of new methods and channels of responding to tuberculosis in the most effective way. The project plans include promoting a single tuberculosis control program implemented through all health care providers, establishing interventions to address HIV-related TB and multidrug-resistant TB, as well as increasing access to and improving the quality of DOTS services to enhance case find-

ing and treatment success among all TB patients. In addition, the program aims to empower communities to become an inherent part of the TB control efforts. The goal of the latter objective is that TB services would be delivered on a closer-to-home basis in an effective, equitable and more user-friendly manner while at the same time increasing the acceptance of services, reducing stigma and adding to the longer-term sustainability of the program.



DISBURSEMENT TO COUNTRY TO DATE

MALARIA

Although at the present time the country is not experiencing a malaria epidemic, there is sufficient evidence to indicate that a very high malarial potential exists in the country. Population groups that are most vulnerable and most exposed to malaria are the ones who have an enhanced risk because of their occupation. The disease situation, which was especially alarming in the northeast of the country, has been controlled to a large extent and the situation has been steadily improving with reported rates of confirmed malaria cases falling markedly since 1999. However, in several districts it represents the leading cause of death.

The situation has been steadily improving, however, with reported rates of confirmed malaria cases

falling almost ten-fold since 1999. Evidence suggests that to a large extent such success has been due to IRS.

Addressing the disease has been challenging, however, due to a protracted civil conflict that ravages the country and prevents medical personnel from going to certain zones for awareness, counseling and treatment work. With the cessation of hostilities, many of the displaced will return to their homes. That includes approximately 400,000 Sri Lankan refugees in India. Such high migration flows may place substantial demands on the already overburdened health-care system in the country. There is also the risk that returning refugees will introduce strains of drug-resistant malaria to the region.

The first of Sri Lanka's malaria grants

was distributed between the country's Ministry of Health and Lanka Jatika Sarvodaya Shramadana Sangamaya, Sri Lanka's largest NGO. The grant focuses on intensifying the country's malaria control program in the eight districts of the North East Province, putting special emphasis on marginalized populations. In particular, the program aims to establish partnerships with the private sector and CBOs in order to achieve better diagnosis and treatment of malaria. An important goal of the proposed project is to prevent malaria in pregnancy by providing regular malaria prevention education, improving testing and diagnosis and promoting ITNs.

Despite the challenges the country has faced in the past years (including an unstable security situation and the 2004 tsunami disaster), the grant has achieved significant and highly prom-

ising results. Over 12,000 community members have been trained for anti-malaria activities.

A second malaria grant from Round 4 aims to cut the annual parasite incidence by 50 percent by the year 2009 (as compared to the 2003 levels); reduce malaria transmission among vulnerable and mobile populations (especially gem miners and farmers) through early detection and treatment and learn to predict epidemics better.

The implementation of these grants has considerably increased malaria control activities in the country.

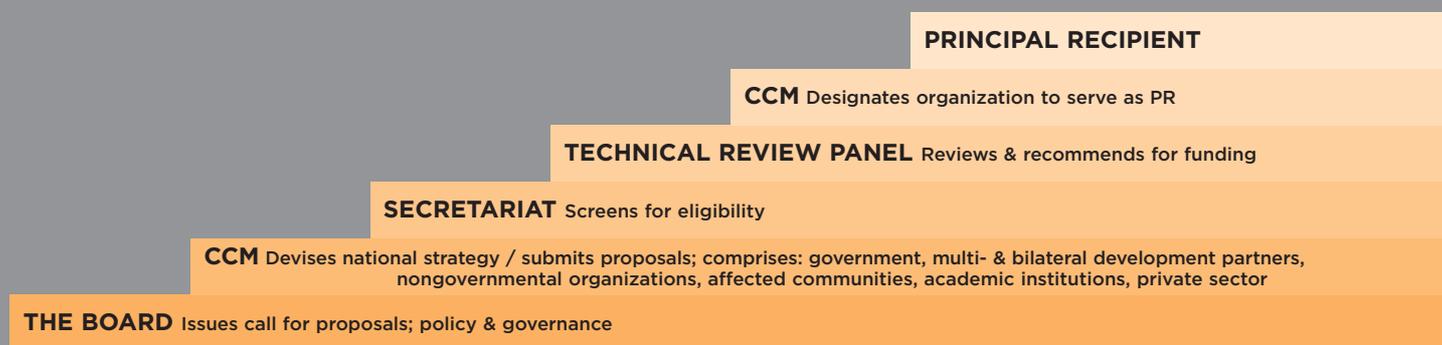
IMPROVEMENT IN MALARIA INCIDENCE IN SRI LANKA

The reported malaria incidence in the country has declined markedly during the recent years from over 200,000 cases (reported annually up to the year 2000) to 10,510 cases in 2003. Several factors have contributed to this positive trend. One of the most important is the 2001 peace agreement between the rebels and the government. Others include a concerted effort to improve the health of rural populations in the country through increased accessibility to quality

healthcare, continued commitment of the government of Sri Lanka to control malaria, the passion and dedication of staff engaged in malaria control and socio-economic improvements in the quality of people's life.

The anti-malaria campaign of the Ministry of Health was assisted in these efforts by the IDA/World Bank, the Global Fund and WHO. Although the program at present has achieved impressive results, maintaining them in a country that lives through an ongoing conflict will be challenging and will require increased commitment of all concerned parties.

Global Fund Proposals Process



The Global Fund awards grants through a system of proposal rounds. Upon decision by the Global Fund Board – typically once a year – a Call for Proposals is issued. In contrast to traditional grant-making organizations, the Global Fund does not have a set amount which it allocates among successful candidates. Rather, once submitted proposals have been evaluated all those which have been recommended are funded, to the limit of the total funds available. To date, the Global Fund has issued seven Calls for Proposals, and all recommended proposals in the first six rounds have been funded (the Seventh Round will be presented to the Board for approval in November 2007).

Low- and lower-middle-income countries are eligible to apply to the Global Fund for grant financing to fight AIDS, TB or malaria. Middle-income countries can apply for grants if they have either a high or a rapidly-growing disease burden and a plan to take over funding when the grant ends. Currently, the Global Fund has investments in all but five low- and lower-middle-income countries and in 23 upper-middle-income countries.

A call for grant proposals is issued by the Board of the Global Fund once per year. Each country establishes a CCM, which is a multi-stakeholder body including representatives of all the sectors involved in the fight against the three diseases (see figure above). (The possibility for a multi-country Regional Coordinating Mechanism or a sub-national Coordinating Mechanism also exists.)

Each CCM typically issues a call to all interested parties in the country to submit proposals for disease education, prevention, treatment and care. The CCM then reviews these proposals and coordinates the production of one consolidated grant proposal. The Global Fund plays no part in the proposal development process. Proposals are expected to support national plans and priorities for

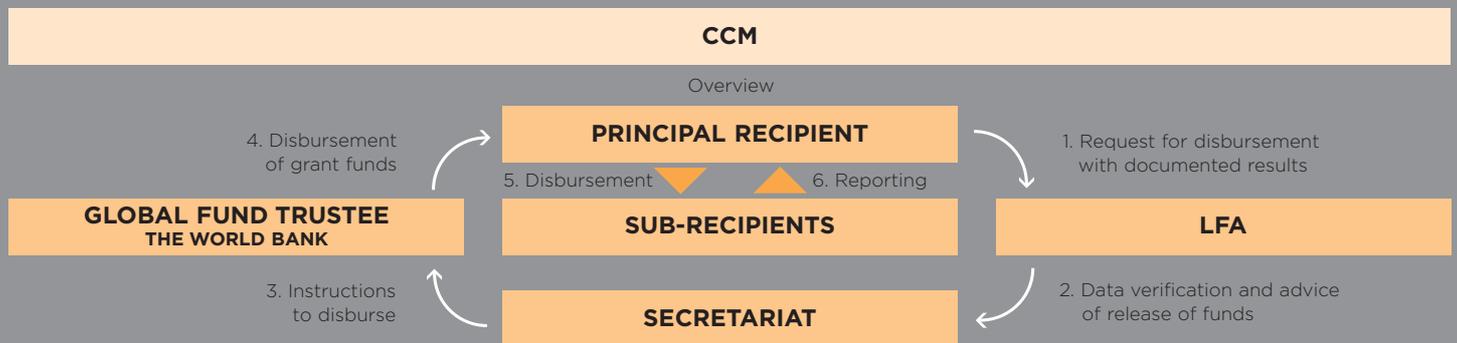
prevention and treatment and fill the country's existing funding gaps. The Global Fund – with extremely rare exceptions – only accepts proposals from CCMs and does not consider proposals from individual organizations or charities.

The Global Fund screens all proposals for eligibility and forwards them to the Technical Review Panel (TRP). The TRP is an independent and internationally-representative body that reviews all proposals and makes recommendations to the Global Fund's Board based on technical quality. Other than a high standard of technical and scientific quality, the Global Fund imposes no other conditions on proposals.

The Board makes the final decision on all grant approvals. Once approved, grants are provided in-principle funding for five years, but only the first two years of financing are approved up front. Based on successful performance after two years, grants are approved for a further three years (referred to as Phase 2 funding).

When a CCM is notified of grant approval, it nominates a PR, which is then approved by the Global Fund. The PR must have the capacity to manage grant financing, supervise grant implementation and coordinate reporting on grant performance. However, the PR is not expected to implement 100 percent of grant-funded programs. This is often done by sub-recipients who implement aspects of the program that are within their area of expertise. These sub-recipients may have submitted proposals to the CCM as part of their country's consolidated Global Fund proposal or they may be selected later as part of a call for implementing partners. Countries are encouraged to select a range of sub-recipients to ensure a comprehensive and multisectoral response to the pandemics. However, the Global Fund does not decide who implements grant-funded programs, requiring only that sub-recipients be technically competent.

Grant Implementation and Performance-based Funding



Once a proposal has been approved, grant agreements are negotiated with the selected PR and include specific, measurable indicators and targets so that grant performance can be assessed periodically. Funding is disbursed incrementally based on performance and in response to disbursement requests submitted by the PR (see figure above). An independent Local Fund Agent (LFA) is appointed in each country to verify the progress and financial reports submitted by the PR. Before disbursing grant funds, the Global Fund portfolio manager ensures that previous disbursements have been spent fully (and on agreed program expenses) and that results are in line with targets set out in the grant agreement. Full disbursement does not occur if previous disbursements have not been spent or if program results are well below target due to implementation delays. This is what is referred to as performance-based funding.

In other words, initial funding is awarded based on technical and scientific merit, but all subsequent funding is made available only on demonstration of proven, documented results by the countries.

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Data in this document is accurate as of June 2007

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