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WHERE WE BEGAN  In the early 2000s, after public health experts identified highly effective interventions to treat and prevent HIV and AIDS, international leaders came together to establish the Global Fund to Fight AIDS, Tuberculosis and Malaria, the world’s largest public health financier. This “war chest,” as UN Secretary-General Kofi Annan described it, provided the world with unprecedented resources to battle the devastation caused by AIDS, as well as the other two deadly pandemics. Shortly afterward, the United States launched bilateral programs to help address AIDS and malaria: the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI).

The combined resources of the Global Fund and bilateral donors such as PEPFAR and PMI have helped save millions of lives in the past decade. This investment has helped yield incredible results: HIV incidence has been reduced by more than 20 percent, tuberculosis deaths by more than 40 percent, and malaria cases by 26 percent.

But there is much more work to do to defeat the diseases. Ensuring they no longer pose a worldwide public health threat requires moving toward a more sustainable, broadly financed and collective approach.

A STORY OF PROGRESS  With improved epidemiology, we are now better poised to target resources for maximum impact. Experts believe that, with the right level of resources, we can turn the three pandemics into low-level epidemics, controlling malaria and tuberculosis and putting the goal of a generation with no new HIV infections firmly within reach.

But, given the current global financial crisis, hitting these targets necessitates partnership and collaboration in the broadest sense. As described by the Executive Director of the Global Fund, Dr. Mark Dybul, defeating the three diseases will require a diverse approach to funding, including resources from traditional government donors, the private sector, emerging economies and domestic investment.

Because the Global Fund was founded on the principle of country ownership—country-led development and implementation of programs, as well as domestic investments—Friends of the Global Fight Against AIDS, Tuberculosis and Malaria has chosen to take a deeper look at one of these areas in particular: domestic contributions. What we found is that there are stories of real advancement, collaboration and progress.

This series of snapshots—compiled through interviews with Global Fund staff, officials at other aid organizations, and domestic leaders in the featured countries—are intended to highlight some of the strides that low- and middle-income countries throughout the world are making with respect to domestic investments in HIV/AIDS, tuberculosis and malaria programs.

The set of countries we have included in this compendium —cutting across each of the three diseases as well as various regions of the world—tell a story of progress toward a healthier, more sustainable future. Though each is unique, these countries are taking steps toward shared responsibility and increased accountability for the health of their people.

WHAT DOES PROGRESS LOOK LIKE?
Progress comes in a variety of shapes, depending on what is feasible and what works most effectively in a particular country. Financial co-investment for care and treatment is certainly one measure. But this is not the only way to assess progress. Countries are also demonstrating strong political will, building capacity and increasing technical expertise. Regardless of the particular form progress takes, these countries are making strides in their own national responses to AIDS, tuberculosis and malaria.
THE SITUATION  Indonesia, despite an economic crisis in 1997, has experienced ongoing improvement in socioeconomic indicators in recent years. The health status of Indonesians has also consistently improved, with life expectancy increasing steadily since 1993. However, the country still struggles with unemployment, poverty and a high disease burden—particularly for tuberculosis.

Despite this burden, Indonesia’s program to fight the disease is an undeniable achievement. Tuberculosis mortality has been declining approximately 4.1 percent each year since 1990. As a result, Indonesia is now ranked fourth, down from third, on the list of 22 high-burden countries, and mortality from the disease has decreased by 47 percent since 1990.

This success did not happen overnight. Over the years, Indonesia has made a strong commitment, both politically and financially, to improving its health systems, placing special emphasis on the fight against tuberculosis.

THE TURNING POINT  In 2012, 66 percent of all funding for the National Tuberculosis Program came from the Global Fund. Because of Indonesia’s status as a high-burden country, the Global Fund views continued investment as necessary and has included the country in its High-Impact Asia portfolio, a grouping of countries where the Global Fund and its partners can have the greatest impact. Indonesia’s desire and commitment to meet its own public health needs is strong, but, for now, the country still relies on external financing.

Since taking office in 2004, President Susilo Bambang Yudhoyono has been a strong supporter of the Millennium Development Goals, the globally agreed-upon blueprint designed to meet the needs of the world’s poorest people.

Yudhoyono has also shown leadership on health and development by establishing national health plans and supporting domestic co-investment. The Indonesian government now purchases all first-line anti-tuberculosis drugs to treat drug-sensitive tuberculosis—as well as malaria and HIV/AIDS drugs—and is contributing to the procurement of second-line treatment for multidrug-resistant tuberculosis (MDR-TB). Between 2011 and 2012 alone, the central government’s budget for the National Tuberculosis Program increased by 19 percent.
Foreign aid may still be requisite in Indonesia, and the incidence of tuberculosis may still be high, but the country’s strong political leadership and steady progress is irrefutable. Indonesia is well positioned to achieve results and increasingly take over financial responsibility for its own health programs.

WHAT’S NEXT  Recognizing that the Global Fund should not be a long-term solution, the Indonesian Ministry of Health is developing an “exit strategy” to transition from Global Fund financing. This will be done gradually and strategically, with an eye toward maintaining the same level of health coverage in the country.

This exit strategy relies on a holistic approach that reaches across sectors to tap into financing. From insurance, corporate social responsibility initiatives, government funding, and efficient allocation and use of existing funding, Indonesia is in the early stage of laying out a detailed plan that maps how these elements will fund the National Tuberculosis Program—and other national health priorities—in the near future. In fact, the country plans to implement universal health coverage in 2014, with the goal of reaching 100 percent coverage by 2019.

This approach will dovetail with the Global Fund’s new funding model, which focuses on complementing and strengthening existing national health strategies. Through this type of collaboration, multilateral aid will help strengthen the overall performance of Indonesia’s essential health services—like those for tuberculosis—and will help the country’s government identify where it should increase its own health budgets.

The Burden of MDR-TB in Indonesia

As a lower-middle-income country, Indonesia will continue to be eligible for Global Fund grant financing, despite its growing economy. MDR-TB remains a problem in Indonesia, making it particularly important that the country continue to receive support. A statement by USAID indicates that “MDR-TB [in Indonesia] is a growing threat with more than 2,100 suspected MDR-TB cases diagnosed, 453 [patients] receiving treatment, and 51 have been cured after two years of successful treatment.” Further, according to the Stop TB Alliance, “treatment for drug-resistant TB can take up to two years, and is so complex, expensive, and toxic that a third of all MDR-TB patients die.”

While the government procures all of the first-line medicines required for drug-sensitive tuberculosis in the country, second-line MDR-TB drugs are a significant financial burden on growing economies. As a result, the Global Fund has shifted financing to procure most of these second-line MDR-TB drugs. The government of Indonesia is slowly increasing its budget for these drugs, with a goal of eventually covering the cost of all medications and diagnostics required for its citizens.
THE SITUATION  On the heels of Namibia’s independence in 1990, HIV/AIDS took a devastating toll on the nation, overwhelming its young government institutions. The then-untreatable infection ripped through the general population. It was exacerbated by stark inequality, high unemployment, and a largely rural, migratory population with limited access to services. Prevalence peaked in 2002, when nearly a quarter of the adult population was HIV-positive.

Beginning in the early 2000s, Global Fund, PEPFAR and other external donor resources poured into Namibia. Outside support fortified the fledgling health system, financing treatment, prevention and institutional capacity needs.

Namibia has now made once-unimaginable gains against HIV/AIDS. More than 80 percent of people with HIV have access to lifesaving antiretroviral therapy, more than 90 percent of pregnant women are tested and treated, and AIDS-related deaths and HIV incidence have both fallen by more than half. While donor contributions remain integral to the country’s health programs, Namibians are taking evermore control of their own health and the tools to improve it.

THE TURNING POINT  Despite its high disease burden, as an upper-middle-income country Namibia has already absorbed many of its own health costs. Namibia has also laid out a National Strategic Framework to accelerate recent progress. This framework is the product of a broad, participatory process that brought together government, civil society, local communities and international partners, much like the “country dialogue” process the Global Fund helps foster. While the country had previously developed shorter-term strategies to navigate the worst years of the crisis, this framework, established in 2010, was the first to take a long view. The ambitious plan lays out accomplishments, areas for improvement, and a roadmap for a healthier future. Among a long list of goals, it prioritizes and sets targets for prevention, treatment, behavior change and support for marginalized populations.

International donors are still heavily invested, but the nature of those investments is changing, and today they account for less than half of the total resources for the HIV response. Most day-to-day treatment and service delivery costs are now covered by the government. Recent years have also seen a steady transition of health worker positions from the Global Fund and PEPFAR payrolls to the public system. Meanwhile, external aid has been freed up to focus on specific strategic investments such as scaling up voluntary male circumcision, eliminating mother-to-child transmission of HIV, building capacity among civil society groups, and using the nation’s successful antiretroviral delivery program as a model for strengthening the broader health system.

WHAT’S NEXT  Namibia now faces the critical question of how to sustain—and build on—the gains it has made. Progress in HIV/AIDS will depend on the collective effort of the government, civil society, and the private sector, alongside traditional donors, and it will also require identifying gaps, targeting the most at-risk populations and using science for greater impact. To that end, in 2013 these key players are gathering for a midterm review of the strategic framework, a chance to identify obstacles and press toward the plan’s goals. With the initial emergency under control, Namibia is able to focus on what it will take to defeat AIDS within its borders.

In his introduction to the National Strategic Framework, Namibia’s President H.E Hifikepunye Pohamba said, “There is a saying: ‘If you want to walk fast, walk alone, but if you want to walk far, walk with others.’ We want to go beyond that with our new [framework]: we want to walk both far and fast.” With Namibians in the lead and all stakeholders working together, the country is on track to do just that.
**South Africa**

Political Will Drives Dramatic Turnaround in AIDS Response

**THE SITUATION** South Africa has the largest HIV epidemic in the world, with a prevalence rate of 17.3 percent. The country also suffers from a high incidence of tuberculosis, largely due to cases of co-infection; 60 percent of tuberculosis patients in the country suffer from HIV as well.

Prior to 2008, the South African government, led by President Thabo Mbeki, seemed to be in a state of denial—questioning the causes of the disease in ways that were, at best, unproductive and, at worst, dangerous.

Between 2002 and 2008, the Global Fund and PEPFAR provided substantial resources to address the crisis, allocating support to critical interventions that the country’s government was not willing or ready to address. Given the state of emergency, much of the work was focused on getting people on treatment as fast as possible, often not in clinical settings. By necessity, external aid organizations worked outside of the public health system. Though there were provinces that refused to adhere to national policy, instead providing treatment to those in need, it was at far too small a scale.

Despite the best efforts of these external groups, including the Global Fund, little progress was made against the epidemic.

**THE TURNING POINT** The situation changed in 2008 with incoming President Jacob Zuma and his Minister of Health, Aaron Motsoaledi. Within a year—highlighted by a powerful speech on World AIDS Day 2009—a series of reforms designed to prevent HIV and tuberculosis infections were announced.

This leadership team worked aggressively to gather the epidemiological and behavioral data necessary to clearly illustrate the toll AIDS had taken on South Africa. In addition, it fostered an open dialogue about HIV/AIDS, tuberculosis and sexually transmitted infections. By the end of 2011, the country also unveiled a National Strategic Plan for these diseases.

South Africa’s commitment to fighting HIV/AIDS and tuberculosis in the past several years has led to sizeable results—AIDS-related mortality has gone from 257,000 deaths in 2005 to 194,000 in 2010. The financial

“South Africa is expanding its own investments in the care and treatment of HIV and TB. With the South African government in the lead—coordinating planning and alignment of implementation with PEPFAR, the Global Fund, and other development partners—we will see reduced costs and increased access to health and social services.”

"In this country, it’s not because of a lack of research and knowledge that a wrong policy was followed."

— H.E. Aaron Motsoaledi, South African Minister of Health

Responsibility has also shifted, with the South African government now covering more than 70 percent of the national HIV/AIDS expenditures. And this transition happened remarkably quickly, a clear illustration of what can happen when political will is firmly in place.

**What’s Next**

The fight is certainly not over in South Africa. However, the government has set very aggressive short- and long-term targets. There is commitment at the highest levels to achieving a 20-year vision of zero new HIV and tuberculosis infections, zero preventable deaths and zero discrimination associated with the diseases.

For the foreseeable future, meeting this goal will continue to require some level of external support. Continued Global Fund investments will allow South Africa to further scale up its own response while maintaining the same quality of care, and it will also help ensure key populations are reached, including women and girls, men who have sex with men, intravenous drug users and sex workers.

The robust discussion and a national strategic health plan allow for even closer coordination between South Africa and the Global Fund. In particular, the country dialogue—a critical component to the Global Fund’s new funding model—is a channel to identify needs, assess available resources to meet those needs and determine where external funding may be able to fill in remaining gaps.

It is the country’s government, though, with its strong commitment and increasing level of domestic financing—combined with the strategic use of external aid—that is paving the way for an AIDS-free generation in South Africa.

**Fast Facts on Progress in South Africa**

- The scale-up of antiretroviral therapy (ART) programs has helped to reduce AIDS-related mortality from 257,000 deaths in 2005 to 194,000 in 2010. Additionally, antiretroviral coverage has increased to 80 percent, and the transmission of HIV from mother to child has been reduced to less than 2 percent.
- Multiple effective platforms have been developed for partnership and planning, including the South African National AIDS Commission, the Country Coordinating Mechanism and the Development Partners Forum.
- Prior to 2011, U.S.-supported NGOs provided 80 percent of all HIV/AIDS drugs. Today, the South African government covers more than 70 percent of the national HIV/AIDS expenditures.
- The country is reengineering its primary health care to be more effective, strengthening its district health system, establishing school-based care and deploying community-based health worker teams.
- Today, South Africa has the largest GeneXpert program—a rapid TB diagnostic test—in the world with nearly 500,000 tests performed since July 2012. In addition, it has become a world leader in HIV/TB co-infection research with a world-class institute of dedicated to the study of the syndemic, the KwaZulu-Natal Research Institute for Tuberculosis and HIV.
The poorest country in Central America, Nicaragua is still recovering from 1998’s Hurricane Mitch. Worsening the damage caused by civil war in the 1980s, the hurricane devastated the country’s infrastructure and economy.

Nicaragua used this natural disaster as an opportunity to step up its fight to control malaria. Because the disease is native and endemic, the influx of hurricane-related funding was directed by country leaders toward rebuilding its malaria control program. Out of a tragedy came an opportunity; the number of malaria cases started to fall. The number of confirmed cases in 1996 was 70,000; in 2008, that number was 762.

In 2004, Nicaragua began implementing a grant from the Global Fund to maintain its hard-won decrease in malaria cases. These resources were focused on reducing transmission in 36 high-risk municipalities. In the years since, Nicaragua has been approved for three malaria grants from the Global Fund worth more than $15 million to push the country toward control and elimination of the disease. Malaria incidence—22 per 100,000 in 2011—has continued to decrease.

From a high of more than 70,000 in 1996, the number of confirmed cases dropped to 762 in 2008. That corresponds to an incidence rate of only 0.13 per 10,000 inhabitants, a number just above the criterion required for designation as pre-elimination.

Nicaragua now has made significant progress in the fight against malaria, already achieving the Millennium Development Goal target of 75 percent reduction in malaria.

With the support of the Global Fund and other partners, Nicaragua has been able to maintain control of malaria at the national level. The Global Fund helped to develop capacity for a national monitoring and evaluation system that has since been integrated into the national health systems, facilitating long-term sustainability.
The government of Nicaragua is also working to ensure behavior is permanently adapted to help interrupt transmission of malaria. Disease awareness has been integrated into the national education system through the country’s Healthy Living campaign. As part of this initiative, for example, the Ministry of Education uses a Monopoly-style board game to teach children how to protect themselves and their families against malaria. This program brings together individuals, families and communities in a concentrated effort against the disease. It also promotes behavior change by enlisting the younger generation to influence their elders.

**WHAT’S NEXT**

Despite Nicaragua’s status as a lower-middle-income country, the government is doing what it can to take over some of the costs of its own health programs. For example, though Global Fund financing is currently used to purchase rapid diagnostic tests and cover the costs of procuring and distributing long-lasting insecticide-treated nets, the Nicaraguan government now covers the cost of all malaria medications.

Additionally, increased government efforts in detection, treatment and prevention of malaria have led to a significant reduction in the number of cases. In fact, some areas of Nicaragua are now entering the pre-elimination phase. Recently, the country was awarded a monitoring and evaluation grant from USAID to ensure that there is a strong case follow-up system in place and to help move the country as a whole into the malaria pre-elimination phase.

The Global Fund’s Regional Malaria Elimination Initiative in Mesoamerica & Hispaniola

Mosquitoes that carry the malaria parasite can easily cross borders, making it far more effective for countries in proximity to work together to defeat the disease. To that end, in 2011 the Pan American Health Organization, together with donors, technical experts and other stakeholders, laid out a multiyear plan for malaria control in the Americas.

The Global Fund is encouraging the development of a Mesoamerica and Hispaniola plan to fight the disease. In early 2013, the multilateral organization provided catalytic funding to help build on the drive to end malaria across the region. The Global Fund’s regional malaria grant is intended to stimulate the coordination between countries, accelerating existing efforts to eliminate malaria in the region.

In June 2013, all 10 countries in Mesoamerica and Hispaniola gathered to craft the concept note for this initiative. This document is intended to be the roadmap for malaria elimination, looking at what is needed from a political, technical and country coordination perspective. The Ministers of Health of the region then met to sign a declaration, committing to get to zero cases by 2020 and certified elimination by 2025.
THE SITUATION  The Caribbean region is second only to sub-Saharan Africa in HIV prevalence among adults. In the Dominican Republic alone, there are approximately 44,000 people living with the disease in an area smaller than West Virginia.

Even prior to the AIDS epidemic, the Dominican government lacked the resources to fully fund the health needs of its people. For the past decade, outside financing from the Global Fund, PEPFAR, the World Bank and others has played a titanic role in the country’s fight against HIV/AIDS, as well as many other diseases. The devastating 2010 earthquake in neighboring Haiti further strained the Dominican Republic’s health system, with an uptick in immigration and growing threats from tuberculosis, malaria and cholera.

THE TURNING POINT  The epidemic in the Dominican Republic began stabilizing in 2005, but prevalence remained high, particularly among marginalized groups. Amidst ongoing work to strengthen the Dominican health system, a national law passed in 2011 reshaped an old government agency into what is now the National Council for HIV and AIDS (CONAVIHSIDA). This revitalized group brought civil society and affected communities together with government agencies, donors and the private sector to tackle HIV/AIDS.

CONAVIHSIDA is now stepping up the fight against the epidemic, emboldened by a wider mandate, stronger leadership and more autonomy. The council is tasked with coordinating day-to-day service delivery and strategy, but it is also fighting for a more sustainable approach to the disease.

WHAT’S NEXT  While the full impact of the broader changes remains to be seen, recent progress in the AIDS response gives reason for hope. Historically, 100 percent of HIV treatment costs in the country were covered by the Global Fund. But in 2012, CONAVIHSIDA worked with the multilateral organization to help secure $2 million in domestic co-financing, as well as additional country support for human resources. That contribution covers only a fraction of the total cost, but it is an important step toward joint responsibility. Conversations are under way about increasing the local share further in coming years.

CONAVIHSIDA management is also looking to add antiretroviral drugs to the Dominican Republic’s basic social security package. If approved, this would integrate the lifesaving treatment into existing government systems, better ensuring its long-term availability.

The Global Fund, CONAVIHSIDA and other stakeholders continue to work closely to make sure foreign investments reinforce domestic investments, rather than replace them. There is undoubtedly still a long way to go, but the steps of the past few years provide hope for a healthier, more sustainable future.
The island of Sri Lanka is prone to endemic malaria because of its tropical climate, monsoons and a civil war that wreaked havoc on the health system. With local dedication and international support, however, the country’s fight against the disease has proved to be a great success.

In 1999, the nation faced more than 250,000 diagnosed malaria cases. Since then, it has rallied political and financial resources, both internally and from international donors like the Global Fund, to beat back the deadly mosquito-borne disease. By 2012, the number of indigenous malaria cases had fallen to just 23—a staggering reduction of 99.9 percent in just 13 years. Today, Sri Lanka is on the verge of malaria elimination.

This is not a fait accompli, though. Sri Lanka has reached this critical moment before; in 1963, with the use of DDT and other mosquito control methods, the country was similarly nearing elimination. But resources and attention were then turned to other immediate health threats, only to result in a major malaria resurgence five years later. It has taken half a century to regain that chance at elimination. Today, Sri Lanka’s leadership is determined not to repeat the mistakes of the past.

For nearly three decades, Sri Lanka’s internal armed conflict prevented the full rollout of any national health strategy. The war displaced hundreds of thousands of people and decimated much of the health infrastructure in the North and East.

Despite the difficulty imposed by the war, the Ministry of Health and its non-governmental partners worked hand-in-hand throughout the 2000s across much of the island, scaling up testing, treatment and prevention with the Global Fund’s financial support. With a mix of education, screening, distribution of insecticide-treated nets, entomological surveillance and other control techniques, the country made swift progress against malaria.

When the conflict ended in 2009, an overwhelming number of remaining malaria cases were among soldiers, refugees and others on the move in conflict zones. The Global Fund and other donors are now helping rebuild facilities, train health workers, and improve data collection for malaria and other diseases. With new infrastructure and a skilled workforce, Sri Lanka is folding the former conflict area into its national successes.

Sri Lanka will likely reach elimination soon—but that doesn’t mean the fight is over. Imported cases from neighboring India and elsewhere have the potential to spread quickly given the climate and high mosquito population.

The same monitoring and testing strategies that helped in the fight against malaria will also help guard against resurgence. Teams from the government’s Anti-Malaria Campaign continue to crisscross the country, collecting and analyzing mosquito specimens. In addition, mobile malaria clinics conduct spot-screenings in the most high-risk areas. And a combination of civil society and health ministry staff are mobilizing communities, scientists and health care providers to make sure the disease doesn’t return.

Sri Lankan leadership is strategizing for its next Global Fund grant and the next stage of its battle, when maintenance—rather than reduction—is the chief concern. Well aware of the risk of backsliding, and armed with the technical know-how and the right systems, Sri Lanka stands ready to make sure malaria goes into the history books and stays there for good.
Political will and strong leadership, cross-cutting coordination, engaged stakeholders and the development of a solid strategic plan are just a few of the complicated factors at play as low- and middle-income countries transition toward taking more responsibility for the health of their populations.

As evidenced in our country snapshots, there is no one-size-fits-all solution to reaching sustainability. But despite unique, and often adverse, circumstances, each country represented in this compendium is moving toward self-reliance and sustainability and recognizes that those qualities will be critical to controlling AIDS, tuberculosis and malaria once and for all.

Methodology

To develop this compendium of country snapshots, Friends conducted interviews with experts directly involved in the programs. We identified the countries according to a variety of criteria including:

- Economic growth over the past decade
- Stable political environments
- Discussions with individuals at the Global Fund, PEPFAR and USAID

The information was gathered via phone and email exchanges with Global Fund Portfolio Managers, officials at U.S. bilateral aid organizations such as PEPFAR and USAID, individuals within a particular country’s Ministry of Health and/or representatives from a Country Coordinating Mechanism. In all, more than 20 subject matter experts were consulted in the development of this piece.

The Fund Portfolio Managers, in particular, were asked to describe the health situation in the countries prior to external aid. In addition, they were asked about Global Fund (or joint Global Fund/U.S. bilateral) support that contributed to any major scale-up of health services or coverage. Finally, they were asked how the country has taken ownership of the project since the scale-up and what the future plans are to continue to build capacity and sustainability. Questions were open-ended to ensure comprehensive and frank answers.

Global Fund experts also reviewed this paper and offered input to assure that characterizations of the relationship and various activities were accurate. To support the qualitative information, Friends also utilized the open source data available (listed in APPENDIX: References).
Appendix: REFERENCES


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