THE GLOBAL FUND IMPLEMENTER SERIES

COUNTRY COORDINATING MECHANISMS
PARTNERSHIP AND LEADERSHIP

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

NOVEMBER 2008

List of terms and abbreviations

CCM	Country Coordinating Mechanism
FBO	faith-based organization
LFA	Local Fund Agent
MoH	Ministry of Health
NAC	National AIDS Council (Malawi)
NGO	nongovernmental organization
PLWHA	people living with HIV/AIDS
SWAp	sector-wide approach
PR	Principal Recipient
TB	tuberculosis
TORs	terms of reference

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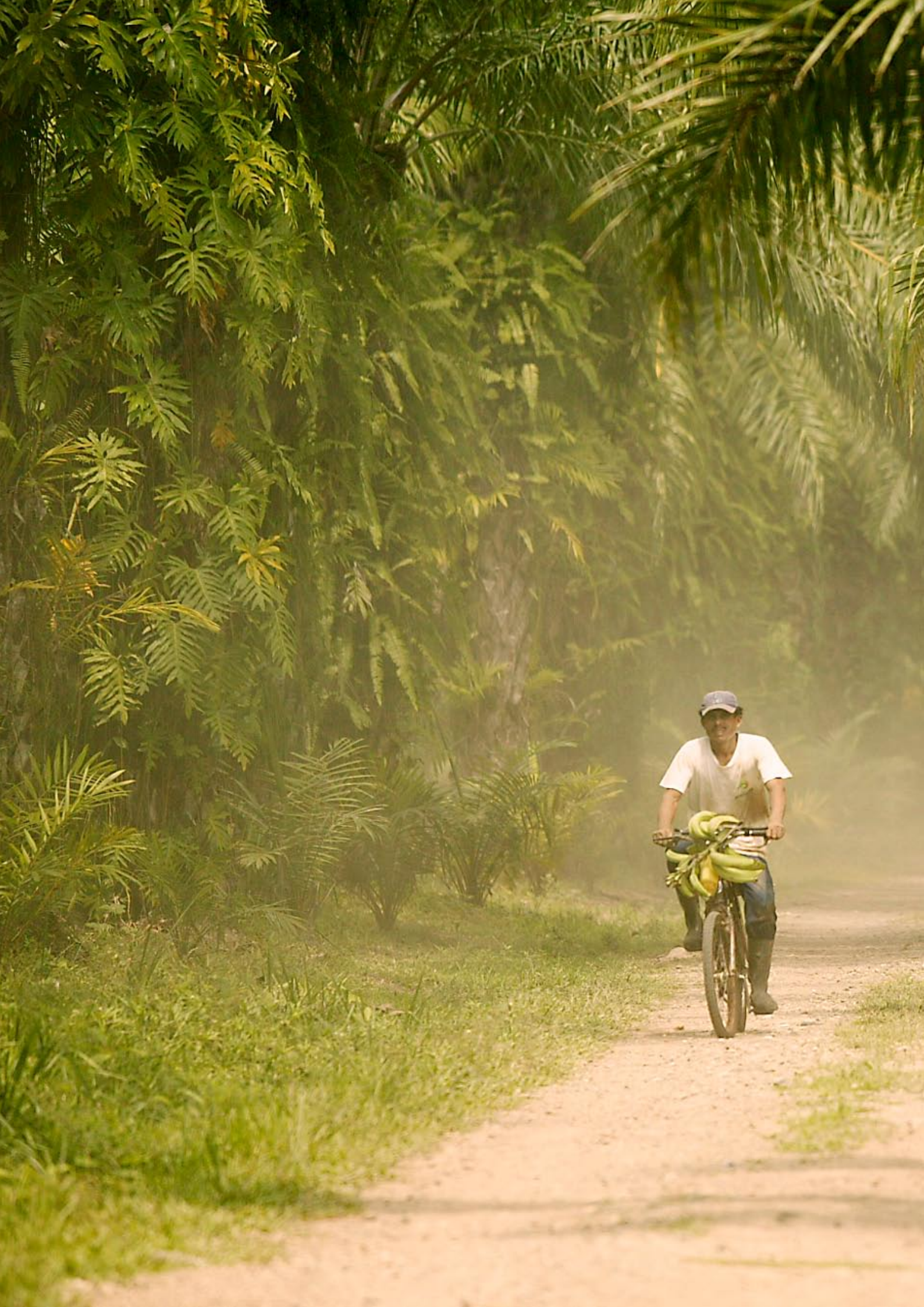


The Country Coordinating Mechanism (CCM) team of the Global Fund to Fight AIDS, Tuberculosis and Malaria recently commissioned case studies across eight thematic areas in 19 countries over six regions. The purpose of the case studies was to draw out cross-cutting themes, lessons learned and, where possible, best practices across regions and across thematic areas. This report is a summary of five country case studies on the theme "Partnerships and Leadership".

These case studies sought to identify the key characteristics of CCM leadership that facilitate good governance, the active involvement of all members in decision-making and provide a balance between CCM processes and leadership and associated challenges. The methodology included a detailed study and analysis of five CCMs (**Malawi**, **Nigeria**, **Zambia**, **Peru** and **Honduras**) and related reports in addition to statistical details sourced from relevant country information available on the Global Fund website.

All of the five case studies emphasized the importance of committed, motivated, democratic and empowered leadership in ensuring the success of the Global Fund's financing of country programs. They also pointed out that effort is needed to promote capacity building within civil society, government and international nongovernmental organizations (NGOs) to enable participants to make well-informed decisions and to advocate for changes that will steer country programs in the right direction.

Partnership building can be challenging because there are so many complex dimensions involved. It is, therefore, imperative that players clarify their roles within a partnership framework, revisit these roles regularly and have a clear conflict of interest policy in place. Although there is no magic formula, each CCM needs to take on the form best suited for its local context and to promote an open, transparent and responsive system of governance.

One interesting finding is that the role of government, especially ministries, has affected how others perceive the CCMs. Interactions between the Local Fund Agent (LFA), the Principal Recipient (PR) and the Global Fund Secretariat also have a bearing on stakeholders' perceptions. Finally, the relative strengths of civil society actors vis-à-vis government has played a large role in stakeholder perceptions. Each of these considerations varies from country to country, given local political and administrative developments.

The five case studies show that the CCM has become an effective forum for people living with HIV/AIDS (PLWHA) to become an active part of funding solutions. The concern remains, however, that participation by people living with tuberculosis (TB) and malaria is less common than by PLWHA. Participation of NGOs representing the TB and malaria sectors is also less common than that of NGOs focused on HIV/AIDS.

The personal qualities of the CCM Chair have a great influence on the functioning of the mechanism. Transparency, openness, good facilitation skills, commitment and a high level of respect were repeatedly cited as necessary traits for a CCM Chair. It was less important whether the Chair was from government or from civil society; his or her personal qualities alone determined effective CCM functioning.

Rationale and Purpose

The CCM team at the Global Fund recently commissioned case studies across eight thematic areas in 19 countries and six regions. The themes were drawn from common issues and challenges faced by most CCMs in executing their roles and responsibilities vis-à-vis proposal development and grant oversight. Study subjects and countries were selected to complement the surveys being undertaken as a part of Study Area 2 of the Global Fund's Five-Year Evaluation.[1]

The country-level case studies on partnership and leadership attempted to document how partnerships within the CCM have functioned and evolved to bring about positive changes towards the scaling-up of the global response to AIDS, TB and malaria. The case studies sought to identify the key characteristics of CCM leadership that facilitate good management, good governance and the active involvement of multiple partners in decision-making processes.

Study Design and Methodology

This consolidated report is based on a detailed analysis of five country case studies on this theme and a briefing on study documentation. The Global Fund website was consulted for background and context on the programs being examined within the case study. The countries where in-depth case studies were conducted were **Malawi**, **Nigeria** and **Zambia** in Africa and **Honduras** and **Peru** in Latin America.

Although the terms of reference (TORs) refer to regional groupings, the small sample size of the five countries has limitations on the regional generalization of these issues and lessons. On the other hand, there are some similarities and concerns that have been addressed at a regional level using a replicable model, as in the case of Latin America, which could point to the need for certain strategic interventions in the case of Africa.

Global Fund Principles

A short introduction addressing Global Fund principles is necessary since they are often tested against the contextual reality in which CCMs operate. For example, country ownership is a core principle critical for a sustainable national response to the three diseases; there are many instances, however, where this principle is compromised at the country level, not only by stakeholder interests and behavior, but also by Global Fund requirements:

- The Global Fund finances national programs through participatory proposal development processes, including multiple stakeholders, processes that complement existing national and/or regional programs, that support national policies and priorities.[2]

- CCMs should build on and link to existing mechanisms for planning at the national level to be consistent with national strategic plans. CCMs could, for example, build on national programs for specific diseases (e.g., national AIDS councils, Roll Back Malaria committees and national steering committees on TB control) in addition to national health strategies. CCMs should also be linked, where possible, to broader national coordination efforts, including poverty reduction strategies and sector-wide approaches (SWAp).

- Membership in the CCM should be broadly representative of a variety of stakeholders, each representing an active constituency with an interest in fighting one or more of the three diseases. Each constituency brings a unique and important perspective, thus increasing the probability of achieving measurable impact against the diseases. Representation of a gender perspective in the CCM is also desirable.

[1] For more information on the Global Fund's Five-Year Evaluation, see www.theglobalfund.org/terg <http://www.theglobalfund.org/terg>

[2] *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria.* p.4. Available at www.theglobalfund.org

Partnership

Partnerships take on various forms depending on the context and challenges at hand. In the case of major public health issues such as HIV/AIDS, TB and malaria, the multisectoral nature of the epidemics and the resulting impact on the national social fabric cannot be ignored. All three pandemics require responses which are, many times, in partnership with parties both within and outside of the health sector. The issue of HIV/AIDS, especially, includes sensitive cultural and behavioral issues at an individual level that form the basis of broader social stigma and denial.

Lessons learned and common sense tell us that leadership capacity and sound partnerships are critical to success in fighting the three diseases. No one constituency (including the public sector) can manage this fight alone. “Partnership” can be defined as a long-term collaboration of organizations based on mutual commitment and interest to achieve commonly defined goals to the benefit of the partners and their constituencies.

Partnerships come with benefits but are also accompanied by competing interests and uneven power relationships. At times, there are also divisive agendas. HIV/AIDS in particular requires a partnership approach, the mobilization of collective strengths and resources, mutual accountability and a sense of common purpose. Platforms or fora that have many partners can either become sites of struggle or create opportunities for joint action. The CCM is one such platform, creating a space for complementary and competing interests to engage.

Leadership

Leadership is also a crucial factor in the success of partnerships. Transparency, accountability, responsiveness, gender sensitivity, energy, the capacity to learn new skills quickly and the ability to lead from the front and forge good working relationships are essential aspects of effective leadership. This is especially so in the context of the health sector in developing countries, where not only millions of lives but also national economies are in danger due to disease, deprivation and poverty. In countries where there is a need for large health-sector interventions — particularly where there is a likelihood of conflict between national and vested interests — leadership must be particularly strong to uphold the cause of the nation, especially the cause of those most vulnerable.

Leaders must have the capacity, authority and respect to direct resources and commitments, to alleviate human suffering and to fine-tune medical and institutional responses in order to save lives. Leaders should be resolved to mediate competing priorities without compromising national interests and should possess the capacity to network and forge good working institutional and interpersonal relationships. These are some of the characteristics of leadership needed for a CCM.

In **Zambia**, the CCM Chair is a professor at the University of Zambia, which is unique among the countries studied. The Chair was democratically elected as a result of a perceived conflict of interest in the case of the former Chair who was also the Principal Secretary in the Ministry of Health (MoH). The election of an academic to the role of CCM Chair caused some anxiety among stakeholders because it was feared that he would not be privy to internal government information and that this would compromise his capacity to provide informed leadership. However, the opposite has proven to be true. The CCM Chair in **Zambia** enjoys enormous respect and acceptance at all levels. His leadership is, in fact, seen as effective and committed.

In **Nigeria**, the CCM functions collectively and decisions are made democratically. Minutes are taken and made available to members before the next meeting. Leadership characteristics that promote partnership within the CCM include the ability and willingness to listen, respecting the views of members, encouraging active participation by all CCM members and responding positively.

Lessons learned

The personal qualities of the CCM Chair have great influence on the functioning of the body. Transparency, openness, good facilitation skills, commitment and a high level of respect were repeatedly cited as necessary traits for a CCM Chair. It was less important whether the Chair was from the government, civil society or NGOs – his or her personal qualities alone determined efficacious CCM functioning.

The Global Fund requires that some sort of CCM be estab-lished to oversee planning, implementation and re-source utiliza-tion of Global Fund support in the fight against HIV/AIDS, TB and malaria. The CCM is a public/private partnership and includes government, private sector and civil society actors represented by NGOs, faith-based organizations (FBOs), bilateral, multilateral and international partners and NGOs, as well as people living with one or more of the three diseases. While government lends political legitimacy to this partnership, NGOs and FBOs incorporate the aspirations of the poor and marginalized and private sector actors contribute a results-oriented work ethic. Development partners bring technical support and financial resources from the international community. The CCM itself is mainly sustained by Global Fund grants and functions despite different and divergent values, principles, cultures, ideologies and work ethics among partner groups.

Interactions between the government, civil society and international actors need to be carefully coordinated and managed to ensure results. One of the primary steps for the effective functioning of any diversely composed organization is open and transparent selection processes, coupled with open and transparent communications and decision-making processes. One important feature to emerge from the five country case studies is that CCMs take on varied roles and functions depending on local context.

In **Malawi**, the CCM is seen as an inclusive space for civil society actors to engage with the government, even though their voice is not particularly strong. In **Peru**, the CCM has seen the development of commissions to deal with unaddressed issues such as medications and communications, in addition to discussions on a proposed ethics commission. The **Nigeria** case study notes that the current CCM is "abundantly endowed with a rich mix of public health, medicine, finance, public policy and project management skills within its membership. If need be, additional expertise and skills can be drawn from a number of non-CCM organizations with observer status and from many other organizations throughout the country." Thus, the CCM is beginning to evolve into a body that is not limited to drafting, facilitating and oversight of Global Fund projects, but is a key player in the national health and development arena.

In **Peru**, the CCM has a number of features not seen elsewhere. The CCM has evolved a layered approach that includes the CCM or the National Health Multisectoral Coordination Mechanism of **Peru** and several sub-groups known as COREMUSAs, which are basically regional level, multisectoral coordination mechanisms for HIV/AIDS and TB. Another innovation documented in the **Peru** case study is the Andean Regional Coordinating Mechanism, which is a body that includes special interests from four neighboring countries: indigenous communities from Venezuela, academic communities from Ecuador and Colombia and a representative of local authorities from **Peru**.

Lessons Learned

The Latin American CCMs have matured considerably in their functioning and have shown innovation in tackling national and regional health challenges. These countries show a higher per capita income, better availability of health-care staff and higher spending on health per capita in comparison with many other countries. In addition, the Latin American countries have a much lower prevalence rate for all three diseases.

The strength of the CCM as a body lies in the diversity of the stakeholders who compose it. As a high-level yet semi-formal governance mechanism, it has great potential to advocate for better local, national, regional and international responses to health challenges — especially the interests of the most vulnerable. Since a country mechanism is a requirement in the Global Fund funding process, there may be cases where it has been perceived to be a donor-imposed mechanism interfering in the country's existing response. Such misconceptions are resolved when the CCM's role in Global Fund processes is fully understood by all stakeholders.

The role of government, especially ministries, has affected how others perceive the CCM. Interactions between the LFA, the PR and the Global Fund Secretariat also have a bearing on stakeholders' perceptions. The relative strengths of civil society actors vis-à-vis government plays a large role in stakeholder perceptions. Each of these considerations varies from country to country, given local political and administrative developments. Although it is sometimes helpful to have leaders who are from government, the chair's personal abilities seem to play a stronger role in affecting the quality of CCM leadership than their professional role.

Desirable Characteristics for Country Coordinating Mechanism Leadership

Some of the desirable qualities of leadership are enumerated below.

Openness and Transparency

Openness, transparency and responsiveness were described as the most important characteristics for a CCM leader, especially the Chair. This is the case regardless of whether the Chair is drawn from the government, civil society, or from international development partners.

In **Nigeria**, for example, the CCM decided to reconstitute itself when grant implementation performance failed to meet targets. The new CCM Chair was seen to be open, transparent and responsive by all case study interviewees. A different situation is documented in **Peru**, where the leadership role of the Ministry of Health (MoH) has varied, providing opportunities for other actors, such as the Vice-Chair, to take on leadership responsibility and the delegation of certain roles to other CCM members.

Responsiveness

In **Peru**, the CCM has gone through three phases:

1) Strong leadership on the part of the MoH who reached out to all sectors and got them actively involved in the CCM in addition to developing a balanced leadership relationship with the PR;
2) Weak leadership on the part of the MoH, resulting in a greatly

expanded leadership role of the PR and reduced involvement by other ministries; and

3) An expanded leadership role played by the executive secretariat of the CCM, led by a strong Chair and executive secretary who represent other CCM members, NGOs, donors/international organizations and affected populations. The Chair and executive secretary took back some responsibilities related to leadership, coordination and oversight that had been left to the PR.

The current **Peru** CCM leadership is trying to blend the advantages of all three phases into a workable, sustainable model. The stakeholders, however, feel that the MoH must play a strong leadership role with multisectoral participation and strong collaboration from the PR in order for the CCM to be sustainable.

Composition of Country Coordinating Mechanisms

One way to promote partnership is to ensure diverse and broad participation in CCMs by multiple stakeholders. CCMs are set up in each country based on the material needs and human resources available to them. The Global Fund and country websites provide details on each CCM (except for **Peru,** where only the Chair and Vice-Chair are listed).

An analysis of CCM composition was completed for each country where the information was available. This analysis shows representation by government, bilateral and multilateral partners, NGOs, academic-sector stakeholders, private-sector stakeholders, FBOs and people living with the diseases. In addition, the CCMs have the recommended (by the Global Fund) combination of representatives from these groups. That being said, these five countries are looking for ways in which they can improve their CCM composition; for example, **Honduras** is looking to expand its public sector representation by adding more people living with TB and more PLWHA.

Historically, the government has been seen as the dominant actor in planning processes. Including other stakeholders is one way to promote stronger partnerships. It also serves to build leadership capacity among CCM members. The **Nigeria** CCM had no official members in the "persons living with the diseases" category, but in many cases the NGO representatives came from HIV-related organizations and networks of PLWHA. Across Africa, participation by government and by NGOs in CCMs is almost equal. Not all countries agree that CCMs are the best place to promote partnership and leadership on these issues. In **Zambia**, for example, it is felt that the CCM is "the wrong governance structure to coordinate the national response", and consequently, "is less influential and authoritative when it comes to prioritization of resource allocations and holding accountable for delivery (especially the government)." Government representatives in CCMs contribute, as their presence infuses resources and political will into driving the program implementation. This is true even when the CCM is not led by the government representatives, as for example in **Nigeria** and **Peru**. The exception is **Zambia**, where the CCM is led by an academic representative and was criticized by some as not being the best mechanism for coordinating the national response to HIV/AIDS, TB and malaria.

CCMs in each country are increasingly seen as important decision-making mechanisms with a unique mix of human, material and technical resources. In addition, CCMs have fostered goodwill between governments and the international community, promoting enhanced the concept of partnership in many countries. Even so, there is a need for improvement in CCM functioning to further strengthen the concept of partnerships.

The five case studies demonstrate that the CCM is an effective forum for PLWHA to be an active part of developing solutions to funding programs. The concern remains, however, that participation by people living with TB and malaria is less than that of PLWHA. Participation by NGOs representing the TB and malaria sectors is also lower common than the participation of NGOs devoted to HIV/AIDS. The challenge is to increase partnerships with people living with the diseases in addition to increasing the participation of NGOs involved in TB and malaria assistance.

Relationships between Country Coordinating Mechanisms and Other Global Fund Elements

CCMs are seen largely as advisory in nature, with little authority to enforce compliance, so partnership with the LFA, PRs and sub-recipients is crucial. The other partners are felt to have more "executive functions" in terms of programming. **Honduras** differs from other countries in that its CCM by-laws stipulate an implementation role as well. In **Honduras**, there is also a stronger working relationship between the LFA and PR than in other countries. In **Malawi**, there are several high-level implementation and reporting mechanisms at the national level. This includes the National AIDS Council (NAC), the SWAp, the National Malaria Control Program, the Health Sector Review Group and others, which have all formed effective partnerships with the **Malawi** CCM. The Director General of NAC confirms that, "there will be one financial report, one narrative report, one monitoring and evaluation report and one audit report. This is not the norm for Global Fund-supported work in the region, and does present challenges both to the Global Fund and to the LFA in attributing success among national initiatives."

In **Peru**, according to one source, "the lack of any relationship and a clearly defined communication channel between the LFA and the CCM has limited the ability of the CCM to play its full leadership role."

In **Nigeria**, on the other hand, despite some difficulty at the outset of Global Fund financing, "communication between the PRs has improved considerably and the CCM is doing everything in its power to improve its communication with the LFA. Initial steps include inviting the LFA to attend CCM meetings with an observer status". The changes implemented by the **Nigeria** CCM have enhanced its leadership ability.

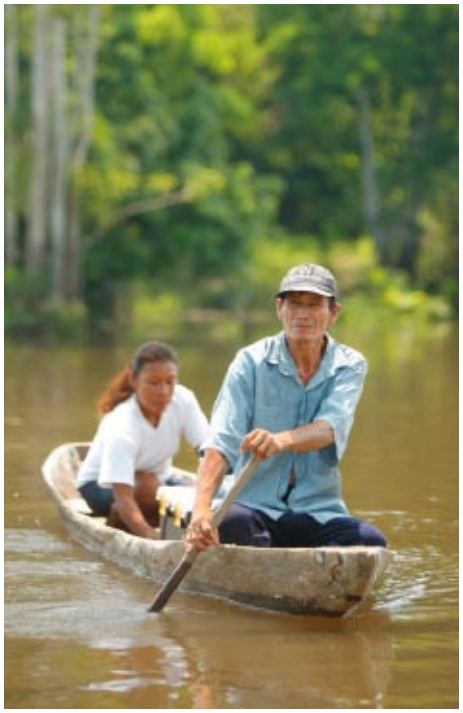
Role of Government

The role of government representatives is critical and their partnership enhances CCM maturity and effectiveness.In the case of **Malawi**, a senior government official from the Treasury was democratically elected as the CCM Chair to replace the previous Chair, who was the Principal Secretary to the MoH. This resolved a conflict of interest because the former Chair, is the PR for the malaria, and TB grants. This change is an indicator of the leadership qualities of the former Chair, who was instrumental in this transition. Similarly, the leadership of the **Nigeria** CCM received broad support, confidence, and goodwill after it took over in June 2006. The new CCM leadership is described as open, transparent, focused, efficient and responsive. This is a complete contrast to the previous CCM leadership. The new Chair represents the NGO constituency, with the first and second Vice-Chairs coming from the government and civil society constituencies, respectively.

The earlier CCM was less successful in its leadership due to a misunderstanding of its roles and responsibilities, a lack of understanding of its oversight functions and a conflict between the CCM and one of the PRs.

Funding the Country Coordinating Mechanism and its Secretariat

Funding plays an important role in CCM effectiveness and is relevant to the long-term sustainability of the CCM itself. In countries where the secretariat is funded and located independently of the government, its role as communication coordinator and facilitator enhances the process of collaboration and partnership. Where the secretariat is funded by and located within government, it is perceived to be less than objective. This is especially true in cases where MoH representatives chair the CCM or are otherwise actively involved in the secretariat. It is difficult for the CCM to form partnerships across a diverse and broad base of stakeholders if there is a perception that it is less than open and transparent or that it is controlled by the government.



All the case studies emphasized the importance of committed, motivated, democratic and empowered leadership in ensuring the success of national programs. Efforts are needed to promote capacity building within civil society, government and NGOs to equip members to take on leadership roles and to advocate for changes that will steer the country in the right direction.

Partnership building can be challenging since there are many complex dimensions involved. It is, therefore, imperative that players clarify their roles within the partnership framework. It is also important to revisit roles from time to time in the form of orientations and refresher training.

Leadership selection has a lasting impact on broader partnership building within national programs. Successful CCMs utilize open and transparent selection processes to appoint leaders. In addition, it is sometimes helpful to have leaders who are not a part of the government. Regardless of what sector the Chair comes from, his or her facilitation skills are a critical factor in the quality of the CCM leadership.

Partnerships must involve all actors. As such, it is essential to have engaged government partners involved in the CCM process. Furthermore, public, private and NGO representatives can effectively take information back to their constituencies and pass their feedback onto the broader CCM. This level of partnership fortifies the commitment and participation of all parties in the CCM process. There is no magic formula; each CCM needs to take on the form best suited for its local context and to promote an open, transparent and responsive pattern of governance.

The five case studies show that the CCM is an effective forum for PLWHA to be active participants in funding solutions. The concern remains, however, that participation by people living with TB and malaria is less common than that by PLWHA. The challenge is to increase partnerships with people living with the diseases in addition to NGOs involved in the TB and malaria fields.

The personal qualities of the CCM Chair have great influence on the functioning of the entire body. Transparency, openness, good facilitation skills, commitment and a high level of respect were repeatedly cited as necessary traits for a CCM Chair. It was less important whether the Chair was from government, civil society or NGOs; his or her personal qualities alone determined efficacious CCM functioning.

The study conducted on the CCMs of these five countries (Honduras, Malawi, Nigeria, Peru and Zambia) resulted in a number of recommendations on how to improve partnership and leadership skills in Country Coordinating Mechanisms:

- Capacity building is required to ensure the long-term sustainability of CCMs as technical, administrative and supportive structures that are well integrated into regional, national and international responses to the three diseases.

- The Global Fund should provide orientation and ongoing training in order to build leadership capacity among CCM members. This should include orientation on CCM member roles and responsibilities. The orientation should also cover the roles of CCM constituencies and other stakeholders.

- CCMs should make materials available before meetings so as to provide members the opportunity to bring issues back to their constituencies and clarify any concerns. (This recommendation is particularly relevant to the constituency of people living with the diseases).[3]

- Ongoing training and collaboration to refine reporting and information exchange between stakeholders improves the quality of working relationships between partners. This enhances transparency, enables the early identification of roadblocks in program implementation and improves corrective action schedules.

[3] For more suggestions relating to CCMs and their constituencies, see *Guidelines on Constituency Processes*, Global Fund, 2008. Available at www.theglobalfund.org <http://www.theglobalfund.org/>

Acknowledgements

There are many individuals responsible for making this report possible, most of whom we can only thank collectively: the interview respondents. We thank all of you for taking the time out of your very busy day to talk with the consultants who conducted these studies. You have provided us with invaluable information on how to improve the functioning of CCMs and the Global Fund is grateful for your input.

The CCM Team would also like to thank the contractors and consultants who worked on this project and drafted the country-specific studies:

Contractors

Sanigest International
University Research Co. LLC
TSF Southern Africa
TSF West and Central Africa

Consultants

Sharon and Peter Claesson
Jack Galloway
Alberto Gonima
Shaun Samuels
Pat Youri

A special word of thanks goes to Sally Wellesley for drafting the theme report.

Many Global Fund Secretariat staff provided input to this report, sometimes to a challenging timeline, and they deserve recognition for their significant contributions.

Country Programs

Fund Portfolio Managers from all the regional units were generous with their time in providing input to the case study methodology, arranging communications and connections between stakeholders, and reviewing many draft reports.

Communications Unit

Jon Lidén, Cheryl Toksoz and Beatrice Bernescut for their professionalism and patience.

And last but not least, the very significant contributions from the Global Fund CCM Team itself deserve enormous recognition. Bonnet Mkhweli, Marion Gleixner, Caroline McArthur, Diane Crawford and Monica Takyi-Appiah who organized and coordinated the myriad elements of the report from start to finish.

On behalf of the CCM Team, thank you everyone for your contributions to this collection of lessons learned. I hope that the lessons will be reviewed, discussed and used wherever possible and appropriate.

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ISBN 92-9224-125-7

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