Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B33/ER05 – Revision 1
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B33/EDP07: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B33/EDP08: Decision on the Secretariat's Recommendation on Grant Extensions[2]

This document is part of an internal deliberative process of the Global Fund and as such cannot be made public.

[1].Bhutan HIV, Bulgaria TB, Burkina Faso TB/HIV, Cambodia malaria, Cape Verde malaria, Côte d'Ivoire malaria, Eritrea HIV and TB, Ethiopia TB/HIV, Fiji TB, Ghana TB/HIV , Mauritius HIV, Multicountry Western Pacific TB/HIV and malaria, Nicaragua HIV, Niger HIV, Pakistan TB, Russian Federation HIV, Rwanda TB/HIV, Solomon Islands malaria and TB, Sudan HIV, Swaziland TB, Tanzania TB/HIV. Total incremental amount is US$ 658,872,048and EUR 100,333,862.

2 Guatemala TB, Haiti HIV, India TB, Lao (PDR) malaria, Nepal HIV and malaria, Syria TB, Zanzibar TB. Total incremental US$52,320,462

I. Decision Points

1. Based on the rationale described in Section IV below, the following electronic decision points are recommended to the Board:

1.1 Set forth below is the Secretariat's recommendation to approve additional funding up to an amount of US$658,872,048 and EUR 100,333,862.

Decision Point: GF/B33/EDP07: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation

The Board:

1. *Approves the incremental funding recommended for each country disease component and its constituent grants, as listed in Table 1 of Annex 1 to GF/B33/ER05 – Revision 1 ("Table 1");*
2. *Acknowledges each country disease component's constituent grants will be implemented by the proposed Principal Recipients listed in Table 1, or any other Principal Recipient(s) deemed appropriate by the Secretariat in accordance with Global Fund policies;*
3. *Affirms the incremental funding approved under this decision (a) increases the upper-ceiling amount that may be available for the relevant implementation period of each country disease component's constituent grants, (b) is subject to the availability of funding, and (c) shall be committed in annual tranches; and*
4. *Delegates to the Secretariat authority to redistribute the overall upper-ceiling of funding available for each country disease component among its constituent grants, provided that the Technical Review Panel (the "TRP") validates any redistribution that constitutes a material change from the program and funding request initially reviewed and recommended by the TRP.*

This decision does not have material budgetary implications for the 2015 Operating Expenses Budget.

1.2 Set forth below is the Secretariat's recommendation to approve grant extensions.

Decision Point: GF/B33/EDP08: Decision on the Secretariat's Recommendation on Grant Extensions

The Board:

1. *Approves extension of the relevant implementation period for each grant listed in Table 2 of Annex 1 to GF/B33/ER05 – Revision 1.*

This decision does not have material budgetary implications for the 2015 Operating Expenses Budget.

II. Relevant Past Decisions

1. Pursuant to the Governance Plan for Impact, as approved at the Thirty-Second Board Meeting,[3] the following summary of relevant past decision points is submitted to contextualize the decision points proposed in Section I above.

Relevant Past Decision Point	Summary and Impact
GF/B30/EDP2 : Decision on the Secretariat's Funding Recommendations for Grant Renewals	This decision point refers to the funding recommendation with regards to the renewals of Eritrea HIV and TB grants approved by the Board on 22 November 2013.
GF/B30/DP5: The Global Fund Eligibility and Counterpart Financing Policy	This decision point establishes the current policy, including the principles of the "NGO Rule" in relation to the funding recommendation for the Russian Federation set forth in this report.
GF/B31/DP12: Extension Policy under the New Funding Model[4]	This decision point establishes the current policy, based on which extensions described in this Report are granted and reported by the Secretariat or otherwise recommended to the Board for approval.
GF/B33/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation	This decision point refers to the funding recommendation with regards to the Tanzania TB/HIV grant approved by the Board on 5 June 2015.

III. Action Required

1. The Board is requested to consider and approve the decision points recommended in Section I above.

[3] GF/B32/DP05: Approval of the Governance Plan for Impact as set forth in document GF/B32/08 Revision 2 (http://www.theglobalfund.org/Knowledge/Decisions/GF/B32/DP05/)
4 GF/B31/DP12: Extension Policy under the New Funding Model (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP12/)

IV. Summary of the Deliberations of the Secretariat's Grant Approvals Committee

01 Summary of the deliberations of the Secretariat's Grant Approvals Committee (GAC) on funding recommendations

Bhutan HIV Grant (BTN-H-MOH)

1. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$2,001,227 for the Bhutan HIV program, which consists of the Bhutan Ministry of Health grant BTN-H-MOH with incremental funding for Board approval of US$1,918,559 for the implementation period 1 July 2015 through 30 June 2018. The applicant did not submit an above allocation request for the Bhutan HIV program and therefore there is no unfunded quality demand registered.

2. Epidemiological situation and past program performance. HIV prevalence in Bhutan is low, with an estimated rate among adults of below 0.1 percent. As of November 2014, there were 403 officially reported cases of HIV, and of these, 77 people have died. The epidemic is concentrated among young people, with one-third of people living with HIV aged 15 to 24 years. Almost 5 percent of those diagnosed are children below the age of five. The estimated number of people on ART as of January 2015 was 167. From the year 2000 onwards, there was a discernible increase in the number of reported new HIV cases, with between 35 and 50 new cases being reported annually since then. The Global Fund has supported the Bhutan National HIV Program since 2008, with total approved funding amounting to US$3.3 million. Global Fund support in the past two years has been through the transitional funding mechanism and the focus was mainly on procurement, the distribution of ART and prevention activities for key and vulnerable populations. The program has demonstrated strong performance in the provision of treatment to adults, and prevention programs focusing on migrant workers, truckers, taxi drivers and people who use drugs. Low coverage of prevention services for men who have sex with men and female sex workers remains a challenge for the program, as these populations are not formally organized and are hard to reach.

3. Program goals and implementation arrangements. The goal of the Bhutan HIV Program is to reduce new HIV infections and provide a continuum of care to people living with and affected by HIV. To enable Bhutan to achieve this goal, the Global Fund will fund the following strategies: (i) scaling-up HIV treatment, care and support in line with 2013 WHO guidelines in order to reduce mortality and morbidity and leverage the prevention effects of early treatment; (ii) providing defined comprehensive HIV service packages to vulnerable populations; (iii) strengthening health and community systems to deliver an equitable, gender-sensitive and sustainable response; (iv) strengthening strategic information and surveillance for an evidence-based national HIV/AIDS response; and (v) reviewing legal frameworks with the aim of ensuring that the human rights of key populations are respected and reflected into domestic law. The HIV program will also carry out an integrated bio-behavioral survey that will inform baselines and targets at impact and outcome levels as well as operational research aimed at mapping key populations including men who have sex with men and people who use injectable and other drugs. Expected outcomes include scaling-up ART coverage from 14.5 percent to 43 percent according to 2013 WHO guidelines; reaching 70 percent of high-risk transport workers, 70 percent of female sex workers, 50 percent of men who have sex with men, 75 percent of migrant workers and cross border populations, 60 percent of uniformed services, 70 percent of prisoners and 70 percent of drug users with HIV prevention services; and achieving 100 percent reporting from all reporting units.

4. TRP review and recommendations. The Bhutan HIV concept note was initially submitted in window 4 in November 2014. The TRP noted substantial issues such as the lack of prioritization of needs of key populations, lack of interventions for men who have sex with men, transgender groups, research and surveillance activities and inadequate activities focusing on removal of structural and legal barriers. A revised concept note was submitted in window 5 in March 2015 and was considered by the TRP to be strategically focused and technically sound, as all issues raised by the TRP in the first review of the Bhutan funding request were addressed. The TRP requested clarifications on missing budget lines for some proposed interventions activities; the role of key populations in integrated bio-behavioral survey and other studies; and the role of other partners and agencies in addressing structural and legal barriers.

5. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant-making of US$2,241,261 based on TRP recommendations. During grant-making, the program identified efficiencies in the amount of US$340,000 from decreases in travel-related costs, reduction of unit costs of pharmaceutical and health products and equipment, reduction of external professional services, as well as reduction of communication materials. The GAC endorsed the reinvestment US$100,000 of identified savings to increase the funds for planned surveys, include external audits and national data quality audits. The remaining savings in the amount of US$240,000 will not be reinvested in the program and have been made available for re-allocation. The GAC reviewed actions taken to address clarifications requested by the TRP during grant-making and found the applicant's responses to be satisfactory.

6. Domestic contributions. The estimated funding need for the National HIV Program of Bhutan in the next implementation period is US$5,091,754. Total domestic financial commitments amount to US$2,494,872, which represents 49 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 44 percent, which meets the minimum threshold requirement of 20 percent for a lower lower-middle-income country. Government commitments related only to this disease represent a 42.5 percent increase compared to the previous implementation period.

Bulgaria TB Grant (BGR-T-MOH)

7. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of EUR 5,822,822 for the Republic of Bulgaria's TB program, which consists of the Ministry of Health grant BGR-T-MOH with the incremental amount for Board approval of EUR 5,283,663 for the implementation period 1 October 2015 through 30 September 2018. The applicant did not submit an above allocation request for the Bulgaria TB program, therefore there is no unfunded quality demand registered. The grant was developed and negotiated under the assumption that Bulgaria is not expected to receive additional funding from the Global Fund following this allocation and that the necessary measures for a successful transition to domestic funding are adopted during the program implementation.

8. Epidemiological situation and past program performance. Bulgaria is one of the 18 TB high priority countries in the WHO European region and one of the six countries in the European Union reporting more than 20 TB cases per 100,000 population. The TB case notification rate was 27 per 100,000 population. For the 2012 cohort, the treatment success rate for new pulmonary smear/or culture positive was 86 percent, for extra-pulmonary 90 percent and for retreatment pulmonary cases 52 percent. A national drug resistance survey in 2010 showed that multidrug resistant TB (MDR-TB) was detected in 2.1 percent of the new TB cases and 11.1 percent of previously treated TB cases. Treatment success rate for MDR-TB cases was 67 percent for 2011 Green Light Committee (GLC) cohort. HIV-associated TB is not a major public health concern in Bulgaria and in 2013, 72 percent of notified cases were tested for HIV, with results showing a rate among TB patients at less than 1 percent. All patients with HIV-TB co-infection receive free-of-charge HIV and TB treatment covered by the Ministry of Health. The Global Fund has been supporting Bulgaria's TB program through the Ministry of Health since 2008. Achievements from Global Fund investments include significant improvements in the surveillance of the TB epidemiological situation, including the establishment of the national TB register, active screening of TB among key population groups through regional DOTS teams, NGO outreach teams and prison medical centers, full roll-out of an external quality assurance system for laboratory diagnosis and the implementation of the first drug resistance surveillance survey in the country in cooperation with the WHO supranational laboratory, among others. Furthermore, the national TB program has demonstrated excellent results on treatment outcomes reaching more than 85 percent for smear positive during the last six years.

9. Program goals and implementation arrangements. The goal of this program is to reduce the TB incidence by 40 percent by 2025 as compared to 2015. To enable Bulgaria to achieve this goal, the Global Fund will invest in the following strategies: (i) scaling-up high quality integrated patient-centered TB care and prevention nationwide and responding to priority challenges to TB control; (ii) promoting the use of new diagnostic tools, interventions, strategies and enhancing operational research and innovation; (iii) reducing the TB transmission among key populations, including people who inject drugs, prisoners, TB contacts, homeless children, refugees and asylum seekers, diabetics and people living with HIV; and (iv) improving TB case detection and treatment success among the Roma population. The current Principal Recipient, the Ministry of Health, has been re-selected by the CCM.

The program will be implemented in collaboration with a large network of NGOs providing outreach services to support access to health care and the provision of quality services for key populations. Issues related to the absorption of funds and decision-making are anticipated due to frequent changes of government experienced over the past few years and the program continues to explore ways to ensure minimal disruption. Some recommendations in this regard have been included in the grant documentation.

10. TRP review and recommendations. The TRP considered this concept note to be technically sound, strategically focused and effective in addressing the epidemiology of the disease in Bulgaria, including among the key populations of Roma communities, refugees, prisoners, migrants, diabetics and street children. The TRP acknowledged the substantial progress made in regards to increased case detection and achievement of a high cure rate among newly identified cases. The TRP noted the need to resolve issues such as the sub-optimal case detection and cure rates for MDR-TB cases as well as high mortality and death rates.

11. GAC review and recommendations. The GAC endorsed the TRP recommendations and approved an upper funding ceiling for grant-making of EUR 5,633,966 based on TRP recommendations. Following grant-making, the total program budget has been revised upwards to EUR 5,822,822 due to savings identified from undisbursed funding in 2014 under the current grant. During grant-making, EUR 519,000 in efficiencies were identified as the result of streamlining program management costs, revisions in the quantification and unit costs of second line MDR-TB drugs, travel, human resources costs for the health information system, and savings identified in the round 8 grant. The GAC endorsed reinvestment of this amount in the TB care and prevention module, in particular for case detection and diagnosis interventions. The GAC reviewed progress against actions taken during grant-making to address TRP clarifications. The applicant took steps in partnership with WHO to speed up the process of procurement of GeneXpert, increased the involvement of NGOs to ensure the engagement of key populations and clarified the integration of health management information systems across diseases as well as the program sustainability plan. The GAC noted and supported the TRP recommendation that the applicant develops a robust plan for the transition during the life of the grant. The CCM is aware that the grant funds will not be available after September 2018. Therefore, the applicant is committed to finalize the transition strategy by the end of 2016 and proceed with required actions for its implementation during grant implementation. Technical assistance from WHO can be made available to support the development of the Program Sustainability Plan upon request from the Ministry of Health, this could include the development of mechanisms for reinvestment of savings deriving from the decrease of hospitalization rates to the reinforcement of ambulatory care for TB patients.

12. Domestic contributions. The estimated funding need for the national TB program of Bulgaria in the next implementation period is EUR 36.3 million. Total domestic financial commitments amount to EUR 29.9 million, which represents 82 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 86 percent, which meets the minimum threshold requirement of 60 percent for an upper middle-income country. Government commitments for TB represent a 59.5 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is EUR 6.32 million.

Burkina Faso TB/HIV Grants (BFA-C-IPC, BFA-T-PADS and BFA-H-SPCNLS)

13. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of EUR 38,452,687 for the Burkina Faso TB/HIV program, which consists of the Initiative Privée et Communautaire contre le VIH/SIDA au Burkina Faso (IPC) grant BFA-C-IPC with incremental funding of EUR 5,962,157; Programme d'appui au développement sanitaire (PADS) grant BFA-T-PADS grant with no incremental funding; and National Council for the Struggle against HIV/AIDS and STI (SPCNLS-IST) grant BFA-H-SPCNLS with the incremental funding of EUR 20,628,914, for the implementation period 1 July 2015 through 31 December 2017. The applicant did not submit an above allocation request for the Burkina Faso TB/HIV program, and therefore has no unfunded quality demand registered. In this regard, the GAC expressed concern that Burkina Faso, among other countries with large funding gaps and substantial disease burdens, is not submitting its full expression of demand.

14. Epidemiological situation. Burkina Faso has a mixed epidemic with an HIV prevalence of 1 percent among the general population at the end of 2012 and high prevalence among key populations notably sex workers at 16.1 percent, men who have sex with men at 3.6 percent and prisoners at 5 percent. The

burden of HIV is also particularly high among infants at a prevalence rate of 5.1 percent and TB patients at 13 percent with the estimated incidence of co-infection at 9.5 cases per 100,000 population and the expected number of new co-infected cases was estimated to be 1,646 in 2013. The country also has high TB burden and is categorized by WHO as one the TB/HIV priority countries. Antiretroviral therapy (ART) coverage is very low, estimated at 42 percent and only 17 percent for children in 2013. In 2013 new infections were estimated at 6,100 according to Spectrum (including 1,006 children aged 0-14) and is expected to decrease to 4,445 by 2020 (1,316 children). TB remains a worrying public health problem in Burkina Faso, with 5,326 TB cases detected in 2013 and 531 deaths in 2012 with four of the 13 regions in the country reporting the highest cases: Sahel, Haut-Bassins, Centre and Sud Ouest, due to the overcrowding and/or precarious dwellings in these regions. Key populations affected by TB are people living with HIV, children, prisoners, gold miners and other populations living in precarious and crowded dwellings. Between 2000 and 2013 significant progress was made in case notification rate, rising from 21 to 31 cases per 100,000 population. TB incidence, prevalence and mortality have shown decreases over time, progressing towards the 2015 Millennium Development Goals aimed at halving prevalence and mortality (compared to 1990 levels). The number of cases screened and treated for multi-drug resistant TB (MDR-TB) has risen from 12 in 2007 to 56 in 2013 and the MDR-TB treatment success rate has risen from 47.3 percent in 2009 to 70.4 percent in 2011. The death rate among MDR-TB patients remains high at 18.5 percent in 2011 compared to 26.3 percent in 2009.

15. Past program performance. The Global Fund has supported programming for TB and HIV interventions in Burkina Faso since 2003 investing close to US$175 million over the past 11 years through grants in rounds 2, 4, 6, 8, 9 and 10. Despite persistent challenges, the HIV epidemic has been on a downward trend over the past 15 years. The country has made progress in the implementation of the national HIV and TB response. Results of HIV/TB collaboration programs include: 95.9 percent of TB patients benefited from HIV screening in 2013; 73.4 percent of co-infected patients received ART; the HIV prevalence among TB patients fell from 23 percent in 2007 to 12.7 percent in 2013; active testing for TB was carried out on 37.3 percent of people living with HIV in 2013 and TB was detected in 1.3 percent of cases.

16. Program goals. In line with the country's epidemiology, its national strategic plans for HIV for 2015 to 2017 and TB for 2013 2017, and a harmonized community health strategy, the goals of the program are (i) to reduce HIV prevalence from 1.0 percent to 0.83 percent by end of 2017; (ii) to reduce the rate of mother-to-child HIV transmission to less than 5 percent by end of 2017; (iii) to reduce new infections by 21 percent between 2014 and 2017; (iv) to increase the coverage of ART among children and adults living with HIV from 41 percent in 2014 to 58 percent by end of 2017; (v) to reduce TB prevalence from 80 cases per 100,000 population in 2013 to 72 cases per 100,000 population by the end 2017; (vi) to increase treatment success rate of MDR-TB cases from 57.7 percent (2012 cohort) to at least 75 percent by end of 2017 (2016 cohort); (vii) to increase treatment success rate of TB cases of all forms from 79.8 percent (2013 cohort) to at least 90 percent by end of 2017 (2016 cohort); (viii) to decrease mortality rate among TB/HIV co-infected patients from 19.6 percent (2013 cohort) to less than 5 percent by the end of 2017 (2016 cohort); and (ix) to improve program management and availability, quality and use of strategic information.

17. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound, based on a solid analysis of epidemiological context and a strong understanding of the epidemic, appropriately aligned with the national HIV and TB strategic plans and focused on the key populations that are most affected by the epidemic. The TRP requested that nine clarifications be addressed during grant making, including: (i) geographical targeting of interventions for HIV key populations, (ii) clarity on strategies to increase condom use among key populations, (iii) clarity on treatment delivery model for MDR-TB, (iv) support prevention and management of HIV and sexually transmitted infections and TB within prisons, (v) potential overstretching of the health system linked to planned shift to 2013 WHO protocol and Option B+ for prevention of mother-to-child transmission, (vi) lack of current coverage figures for prevention programs, (vii) details about plans to conduct operational research and investigational study to improve diagnosis and treatment are lacking, (viii) prevention and treatment services for men who have sex with men, and (ix) find efficiencies in the budget to fund existing programmatic gaps.

18. GAC review and recommendation. The GAC endorsed the TRP recommendations and noted with concern that although Burkina Faso TB/HIV disease components are eligible for incentive funding, the country decided not to submit the above allocation request. While most of the national strategic plan targets for core indicators were met, the GAC stressed the importance of technical cooperation in

supporting the country during the development of the next national strategic plan and to ensure more ambitious target-setting for effective program coverage and greater impact, highlighting the unmet needs in TB/HIV programming identified during concept note review. During its first review, the GAC was informed that the amount of EUR 10 million of undisbursed funds not taken into account during concept note development was available for the grant-making; GAC recommended the use of these funds to contribute towards addressing priority gaps identified by the TRP. Considering the above, the GAC approved EUR 40,658,970 as the total upper-ceiling funding amount for grant-making, which takes into account adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant.

19. GAC review and recommendations. The GAC reviewed progress against actions taken confirming that TRP clarifications were resolved during grant-making. GAC partners welcomed the robustness and inclusiveness of the country dialogue process. While noting that most key population programs and human rights barriers seem to have been addressed in the concept note, GAC partners expressed concern around the lack of interventions for people who use injectable and non-injectable drugs and stressed the importance of the country's readiness to better monitor, document and develop HIV programs for people who use drugs, particularly given the potential risk amongst sex workers and men who have sex with men. GAC partners also noted the multitude of antiretroviral drug regimens used by the national ART program (operating with 12 first-line and 8 second-line regimens) and underlined the need to rapidly rationalize and simplify the country's ART treatment regimen, develop ART treatment guidelines aligned with normative guidance and to develop a more efficient and cost-effective procurement system for anti-retroviral drugs. Following grant-making the GAC has been informed that the country has been working with technical partners in view of simplification and harmonization of ART regimens. While recognizing the quality of the TB program in Burkina Faso, with relatively good treatment retention and outcomes, GAC partners emphasized the need for more ambitious TB targets, the importance of developing clear scale-up plans and recommended against over-reliance on smear microscopy. Although the number of TB testing and treatment centres per population remains low, with one testing center and two GeneXpert machines available for a population of 18 million, GAC partners underlined the need to use a proper algorithm for the GeneXperts to ensure their effective use and achieve maximum impact.

20. GAC review and recommendations. Following grant-making, the GAC approved proposed investment of undisbursed funds identified following TRP review towards increasing program targets in line with TRP recommendations resulting in: 5,639 additional adults living with HIV put on ART, 202 additional TB patients put on ART, 1,421 additional pregnant women on ART, 1,164 additional new TB cases notified, 130 additional MDR-TB cases notified and treated, as well as increasing coverage of prevention activities among key populations, including sex workers, men who have sex with men, and prisoners, over the two and a half year course of the grant. The program has also made investments in diagnostic and biological monitoring technologies including 25 CD4 count machines, complementary equipment for five viral loading machines and 12 GeneXpert machines. Recognizing the critical nature of the HIV and TB program targets, the need to retain experienced staff with essential expertise and knowledge of the socio-political context in Burkina Faso for the successful implementation of Global Fund grants, the GAC also endorsed the payment of salary incentives for the total amount of EUR 94,190 for the total duration of the program. The GAC decision is based on the understanding that retention of salary incentives is in line with the national decree and therefore aligned with other donors in country and Global Fund contributions toward these will be gradually decreased over the lifetime of the grant, starting with a 25 percent decrease in 2015 and eventually followed by a 75 percent decrease in 2017. The Ministry of Health acknowledged the transition plan proposed by the Secretariat and committed through a letter to progressively take over from the Global Fund funding for staff salary and related incentives as part of its sustainability strategy.

21. OIG investigations. GAC has also noted that the OIG investigations are currently on going in the country since 2011 with the report yet to be released. Risk mitigation measures have been put in place by the Secretariat since 2012 including monitoring of tenders to ensure competitiveness and openness of selection processes, introduction of fiscal agents for all grants and restricted cash policy at sub-recipients level. These mitigation measures will be reviewed and strengthened following the roll-out of the combined assurance exercise.

22. Lessons learned. Burkina Faso opted for a simultaneous application for three disease components and health system strengthening concept notes. Such integrated conceptualization of investments in diseases and health systems provides opportunities for both increasing the allocative efficiency of

investments and maximizing health impact to reach beyond HIV, TB and malaria. Analysis of these experiences is useful for exploring the feasibility of scaling-up integrated concept note submission during the next funding cycle. The GAC highlighted the value added by this approach and recommended that other countries build on lessons learned by Burkina Faso to achieve the same kinds of synergies that resulted from the broad country dialogue involving multiple actors, improving the overall visibility of resources available across the health sector to avoid duplication with other donors, comprehensive analysis of country needs, streamlining community and health system strengthening for example health information systems / M&E across the three diseases, facilitating efficiencies in program management and an integrated approach to investing more strategically. Other main areas of success include the strengthening of district-level capacity for quality data collection and the use of programmatic data for decision making, strengthening community capacity to address key populations and the extension of service delivery integration.

23. Domestic contributions. The estimated funding need for the national HIV and TB programs of Burkina Faso in the next implementation period is EUR 196 million. Total domestic financial commitments amount to EUR 46 million, which represents 48 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase meets the minimum threshold requirement of 5 percent for a low income country. Government commitments across HIV and TB represent a 2.5 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is EUR 97 million.

Cambodia Malaria Grant (KHM-M-UNOPS)

24. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$35,533,343 for the Cambodia malaria program, which consists of the UNOPS grant KHM-M-UNOPS with an incremental funding amount of US$7,867,675 for Board approval for the implementation period 1 July 2015 through 31 December 2017. The applicant did not submit an above allocation request for the Cambodia malaria program, and therefore has no unfunded quality demand registered.

25. Epidemiological situation. The overall course of malaria in Cambodia has been one of mixed geographic success. Five years ago, the region of concern was the northeast, along the border with Thailand. Thanks to creative and sustained efforts, the epidemic was brought under control in that region, only to return in the north-western part of the country. There has been, however, steady progress. The total number of malaria cases treated based on microscopic or rapid diagnostic test (RDT) confirmation declined from 115,614 in 2001 to 74,166 in 2012, with a further reduction to 44,203 in 2013. At the end of 2013, the national malaria incidence was 2.94 per 1,000 and reported deaths had dropped to 12 from 45 the previous year. The most affected population is adult males, who make up two-thirds of all cases, and within this group, men who work in the forests are most at-risk. Artemisinin-resistance has been confirmed in nine provinces (out of 25) and the country is considered to be among the countries with highest rates of artemisinin drug resistance.

26. Past program performance. The Global Fund has been the main donor for the national malaria program since Round 2 with grants from Rounds 2, 4, 6, 9 and the Single Stream of Funding (SSF) as well as through the Regional Artemisinin Resistance Initiative (RAI) grant. Global Fund investments for the malaria program in Cambodia total US$ 140 million. This support to the national malaria program has played a crucial role in significantly reducing malaria morbidity and mortality in Cambodia. Key achievements, according to the WHO 2013 Global Malaria Report, include a 78 percent reduction in the reported number of presumed and confirmed cases from 203,164 in 2000 to 44,748 in 2013, the reduction in malaria parasite prevalence by 75 percent and a drop in deaths from malaria from 608 in 2000 to 45 in 2012, 12 in 2013 and 18 in 2014. Thus, the Millennium Development Goals for both malaria prevalence as well as morbidity and mortality have both been reached. Given the concentration of the disease near international boundaries, the program has aggressively pursued cross-border collaboration, despite political obstacles, through NGOs and, where feasible, direct inter-governmental efforts.

27. The goals of this program are to eliminate artemisinin-resistant parasites of P. falciparum malaria by 2015, to eliminate malaria with an initial focus on Plasmodium falciparum, to ensure zero deaths from malaria by 2020 and to eliminate all forms of malaria in the Kingdom of Cambodia by 2025. The

Cambodia malaria concept note is based on: i) a strong national strategic plan to fight malaria which formed the basis of the successful RAI proposal; and ii) an Elimination Action Framework for Malaria 2015 – 2019 ("Elimination Framework") which reflects the response to the emergence and changing landscape of artemisinin resistance, changed epidemiology and newly defined key population groups at highest risk. While the over-arching objective of the national strategy and Elimination Framework is to eliminate malaria by 2025, the current programmatic approach still centers largely on control activities. The widespread distribution of resistant parasites beyond the Cambodian border since 2011 has meant that malaria interventions focus on scaling up in forested areas, providing sustained vector control and response to outbreaks of malaria cases. Core activities thus remain the universal coverage of diagnosis and treatment of malaria predominantly through the village / community level, management of this also through the private sector and increased coverage and utilization of LLINs for prevention and long-term sustainability of community workforce. The program will focus primarily on populations living in malaria endemic districts (Tiers 1 and 2); long-term forest workers, construction/mining workers, security personnel (military and police), seasonal workers (plantation workers), and indigenous population groups, women and children under the age of five. Expected outcomes of the proposed strategies include reducing malaria incidence to 1.65 per 100,000 population and malaria deaths to 0.05 per 100,000 population, as well as increasing household ownership of at least one insecticidal net to 95 percent and the proportion of population sleeping under an insecticidal net to 70 percent.

28. Implementation arrangements. The Principal Recipient under the current grant is UNOPS, who will continue in this role in the coming implementation period. There was a change in PR between Phase 1 and Phase 2 from the National Malaria Program (CNM) to UNOPS after a 2012 OIG investigation. In the currently proposed grant, CNM continues as the primary sub-recipient and principal implementing partner. The implementation arrangements include funding for a fiscal agent to be embedded in the CNM to ensure fiscal controls and to build financial capacity, with the long term vision that CNM will resume its role as Principal Recipient and a return to national ownership of the malaria program. An additional concern is the long-term sustainability of the financing of management staff and health staff. A plan outlining increased government commitment to assume human resources costs by the end of 2017 is required.

29. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound, as it is in line with Cambodia's malaria elimination framework and builds on prior investments by the Global Fund and other partners. The TRP requested that eight clarifications be addressed during grant making, including: (i) more developed information on the country's multi-sectoral partnership strategy; (ii) using efficiencies in grant-making to fund long lasting insecticidal nets (LLINs) for 2017 and 2018; (iii) ensuring an appropriate surveillance strategy; (iv) developing a case referral strategy; (v) updating the information, education and communication/behavior change communication strategy; (vi) updating the procurement and supply chain management plan; (vii) developing a capacity building strategy; and (viii) providing disaggregated information as part of an updated monitoring and evaluation plan.

30. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended and upper funding ceiling of US$35,319,087. The GAC recognized the country for making steady progress in tackling the malaria epidemic in different regions of the country, but underscored the importance of addressing a harmonized approach to community-level health workers, a common approach to sustainability of human resources financing, the development of a logistics management information system and an increase in fiscal controls at the government level. During grant-making, a total of US$6.8 million in efficiencies was found including from in-country cash balance of US$5,928,950 not taken into account during concept note development, the removal of duplication between grants and the reduction of costs related to travel and human resources. The GAC approved the reinvestment of these efficiencies in procurement of LLINs for the planned mass distribution in 2018, as well as capacity building measures for CNM, including monitoring and evaluation technical cooperation and an embedded fiscal agent. The GAC reviewed actions taken during grant-making to address the clarifications requested by the TRP. The GAC partners were supportive of the capacity building measures for CNM, noting that these measures contribute greatly to the sustainability of the program and address concerns expressed at previous GAC meetings.

31. Domestic contributions. The estimated funding need for the National Malaria Program of Cambodia in the next implementation period is US$72.5 million. Total domestic financial commitments amount to US$13 million, which represents 20 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government

contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 27 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments related only to this disease represent a 33 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$8 million.

Cape Verde Malaria Grant (CPV-M-CCSSIDA)

32. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of EUR 931,251 for the Cape Verde malaria program, which consists of the Comissão de Coordenação do Combate à Sida (CCSSIDA) grant CPV-M-CCSSIDA with an incremental funding amount of EUR 775,754 for Board approval for the implementation period 1 July 2015 through 31 December 2017. The applicant did not submit an above allocation request for the Cape Verde malaria program and therefore has no unfunded quality demand registered.

33. Epidemiological situation and past program performance. The Republic of Cabo Verde is an upper middle-income archipelago of nine inhabited islands with a total population of about 520,000 and unstable malaria transmissions. Cape Verde is considered to be hypo-endemic, with seasonal malaria transmission that is highly-dependent on rainfall and marked by occasional epidemic outbreaks. The country is divided into three epidemiological strata, as follows: i) islands where the vector and local transmission are present , ii) islands where the vector is present but there is no local transmission, and iii) islands with no malaria vector and no local transmission. Transmission peaks are observed during the rainy season, which is generally between August and October. There were a total of 277 cases of malaria between 2008 and 2013, of which 163 were imported and 114 indigenous. The incidence of malaria has remained below 0.1 per 1,000 population for the past 6 years. In 2013, the program recorded zero malaria deaths.

34. The goal of this program is to maintain the incidence of malaria at less than 1 indigenous case per 1,000 inhabitants per year across the country until the end of 2017 and to contribute to consolidating the pre-elimination process. To enable Cape Verde to reach these goals, the Global Fund will invest in the following strategies: (i) protecting 100 percent of at-risk populations transmission hotspots; (ii) ensuring 100 percent of cases are correctly screened and treated; (iii) building on existing human resources and technical and logistical capacities of the epidemiological monitoring system for the elimination of malaria; (iv) building on the existing institutional, technical and management capacities of the national malaria program at all levels to implement interventions; and (v) increasing the populations' level of awareness on prevention and treatment measures.

35. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound, noting that it builds on the achievements realized from previous Global Fund grants that have enabled the country to maintain a significantly low incidence of malaria for the past six years. The TRP requested that the country address seven clarifications, including: (i) reconsidering the vector control approach, particularly the larvicidal interventions; (ii) the establishment of a quality assurance mechanism for microscopy; (iii) planning for a malaria indicator survey; (iv) providing more attention to migrants and the importation of malaria cases; (v) managing the deficiency of G6PD; (vi) providing further details on the planned interventions for health and information management; and (vii) considering the reduction of the number of indoor residual spraying rounds done per year in line with the local malaria vector and transmission context.

36. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling of EUR 931,252 for grant-making. During grant-making, the applicant took steps to improve their monitoring and evaluation system, planned how to increase the detection of malaria cases imported into the country by migrants in partnership with transportation network authorities and migrant organizations, and provided details on cross-cutting interventions, in line with the clarifications requested by the TRP.

37. Domestic contributions. The estimated funding need for the National Malaria Program of Cape Verde in the next implementation period is EUR 3.7 million. Total domestic financial commitments amount to EUR 1.7 million, which represents 49 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and, on the assumption that the full requested allocation funding in this

concept note is approved, is 63 percent, which meets the minimum threshold requirement of 40 percent for an upper lower-middle-income country. Government commitments related only to malaria represent an 82 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is EUR 445,968.

Cote d'Ivoire Malaria Grant (CIV-M-PLNP)

38. Funding Recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of EUR 72,596,079 for the CIV-M-PLNP grant with an incremental funding amount of EUR 57,692,611 to support the Côte d'Ivoire malaria program for the implementation period 1 January 2015 through to 31 December 2017. An additional grant with a civil society Principal Recipient will be presented to a future GAC for approval once grant-making is completed. Based on the above allocation funding request submitted in the concept note, the amount of EUR 20,107,595 is registered as unfunded quality demand, in line with TRP recommendations, noting that this will be updated once grant-making with the second Principal Recipient is concluded.

39. Epidemiological situation. Côte d'Ivoire's has experienced a decade of fragile sociopolitical context, with increasing stability since the end of the 2011 political crisis. Malaria is endemic in Cote d'Ivoire and constitutes a key public health problem, by its frequency, its gravity and its socio-economic importance. Malaria occurs mainly in the rainy season with peaks between May and July and October and November. The country's entire 25 million population is considered at-risk and the disease is the primary driver of medical consultations, accounting for 41 percent of all consultations in health facilities in 2012. Rapid diagnostic tests (RDTs) were introduced in 2011, with 75 percent use recorded in 2013, with a 68 percent positivity rate. Ninety-one percent of positive cases are treated with artemisinin-based combination therapy (ACTs). Intermittent preventive treatment in pregnancy (IPTp) is implemented but a minority of women receive more than 1 dose. Long lasting insecticidal nets (LLINs) are distributed to pregnant women and children under the age of one at immunization. Sixty-eight percent of people with access to an LLIN were reported to use them in 2014.

40. Past performance and lessons learned. Côte d'Ivoire has achieved notable progress in a number of important areas in the fight against malaria. More than 23 million LLINs were distributed between 2009 and 2015 through mass distributions and the number of households having one insecticide treated net per household rose from 10 percent in 2006 to 67 percent in 2011. Gains have also been made in case management with 91 percent of confirmed outpatient malaria cases being treated with ACTs at the health facility level. Overall, the mortality rate of children under the age of five has reduced from 125 per 1,000 population in 2006 to 108 per 1,000 population in 2012. While many successes have been made in tackling malaria, the program continues to integrate learning and identify new areas for action. Past challenges to performance have been frequent stock-outs of LLINs and weak utilization rate of antenatal care services. To respond to these challenges, out-sourced transportation providers were contracted in the first quarter of 2014 to improve the availability of LLINs at health facilities. The latest consolidated results for pregnant women and infants receiving LLINs show a performance of 37 percent, improving from the 2013 result of 34 percent.

41. The goals of this program are to contribute to the reduction of malaria-related mortality to a rate of below 1 death per 100,000 population by the end of 2015 and to contribute to a 75 percent reduction of the total number of malaria cases from 2008 rates by the end of 2015. To enable the country to reach these goals, the Global Fund will invest in the following strategies: (i) providing all the country's households with at least two LLINs per household by the end of 2017 by means of a mass distribution campaign in order to maintain universal coverage; (ii) providing routine distribution to children under one year at prenatal consultations and in vaccination visits and IPTp for all pregnant women at such consultations; (iii) ensuring proper care of confirmed cases of malaria at health facilities; (iv) executing capacity-building for the community based organizations involved in malaria control activities; and (v) health systems strengthening in support of malaria control. Expected outcomes of these strategies include the distribution of 4,573,884 LLINs, reaching 80 percent confirmation of diagnosis and supporting community health workers in 52 districts.

42. Implementation arrangements. The current government Principal Recipient, the Ministry of Health, has been selected by the CCM to continue in its role, in order to benefit from past program experience and continue building capacity. An amount of EUR 64,241 has been identified as ineligible

expenditures under the previous grant. The Ministry of Health of Côte D'Ivoire has agreed to submit, before grant signing, a formal letter confirming the timeline for the reimbursement.

43. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused, as it includes the key interventions required to control and reduce malaria and addresses current gaps and short-comings of the program, including expansion of services to rural and disadvantaged populations at highest risk. However, the TRP also noted that the budget requested for health system strengthening as well as procurement and supply chain management may include some duplication of activities.

44. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended EUR 85,958,747 as the upper funding ceiling for grant-making, which takes into account the incentive award of EUR 29,756,332 for the 2017 LLIN mass campaign and associated costs based on TRP prioritization and recommendation on the above allocation request. During grant-making efficiencies totaling of EUR 2,587,280 were identified in the budgets for training, workshops and meetings as well as adjusting budgets in line with TRP recommendations. The GAC approved reinvestment of these in the 2017 LLIN mass campaign. GAC partners noted the remaining funding gap of EUR 20 million for the 2017 LLIN mass campaign including 2.9 million LLINs and supported the high priority attached to resource mobilization to this end, from both partner and domestic sources of financing. GAC endorsed the payment of performance-based and retention incentives amounting EUR 274,311 for key central level Principal Recipient civil servant staff to be granted on performance evaluation, as the basis for retention of competent personnel, compensation for the additional efforts related to the management of Global Fund grants and improvement of performance and delivery of program objectives. GAC also welcomed CCM efforts to develop a harmonized national performance incentive scheme during program implementation.

45. Domestic contributions. The estimated funding need for the national malaria program for Côte d'Ivoire in the next implementation period is EUR 187,650234. Total domestic financial commitments amount to EUR 65,916,636 which represents 50 percent of total resources available for the next implementation period, exceeding the minimum threshold of 20 percent for a lower lower-middle-income country. Government commitments to malaria represent a 10 percent increase compared to their previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is EUR 56,481,735. GAC welcomed the country's efforts to ensure financial sustainability and noted that the reported initiatives have the potential to increase revenues for the health sector including the Universal Health Insurance bill passed in March 2014 and innovative financing mechanisms introduced (for example, tax on tobacco and air travel and Debt2Health).

Eritrea HIV Grant (ERI-H-MOH)

46. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total amount of US$19,795,804 with an incremental amount for Board approval of US$3,800,920 for the reprogramming of the Eritrea HIV program, which consists of the Ministry of Health grant ERI-H-MOH for the implementation period 1 July 2015 through 31 December 2017. As this is a reprogramming request, Eritrea did not submit an above allocation request.

47. Epidemiological situation. Eritrea has an estimated population of approximately 6.3 million. Data from 2010 show an HIV prevalence of 0.93 percent among adults between the age of 15 and 49, with women twice as much more likely to be HIV positive than men. Findings from the 2012 integrated bio-behavior surveys indicate that the HIV epidemic may be transitioning from a generalized to a concentrated epidemic among key populations, including sex workers with a reported HIV prevalence higher than 5 percent and long-distance truck drivers with an HIV prevalence of 2 percent. Health care in Eritrea is provided to all populations free of charge or at a very nominal fee, through public and private health facilities to ensure universal health care and specifically access to HIV, TB and malaria services. The goals of this program are to reduce HIV transmission, illness, mortality and impact through improved access to quality services with comprehensive programs that will support at least 85 percent of those who need to be on antiretroviral therapy (ART) by 2017 and to improve the quality of life and mitigate the socio-economic impact for people who are infected with and affected by HIV.

48. Rationale for reprogramming. The Eritrea CCM is seeking the approval of reprogramming of existing funds and an incremental amount of US$4,295,254 for the Eritrea HIV program ERI-H-MOH

to avoid disruption in programmatic activities until the next allocation period. The grant will also be extended through 31 December 2017, pursuing original proposal goals with no material changes. In the Request for Reprogramming, the CCM has adequately identified programmatic gaps and aligned grant support objectives with those of the Eritrea National Strategic Plan on HIV and AIDS (ENASP 2015-2017). The national strategic plan (ENASP 2015 - 2017) was developed to align the disease strategy with the next Eritrean National Health Sector Strategic Development Plan 2017-2021, whose development process commences in 2016. The objectives include antiretroviral treatment, PMTCT coverage, counselling and testing, prevention packages towards key population and training of human resources for health. In light of evidence suggesting that the HIV may be transitioning from a generalized to a concentrated epidemic, the strategic focus of the reprogramming request has been placed on key populations including sex workers, those working in places of higher exposure to sexual encounters, truck and taxi drivers, prisoners and populations in urban areas. With UNAIDS support, the national program is in the last stages of modes transmission study that will further inform the response.

49. GAC Review and recommendations. The Eritrea HIV program implemented by the Ministry of Health has undergone a periodic review in October 2013[1] and evidence shows some early signs of epidemic transition, although there are no significant changes in HIV burden since the time of the review. Building on lessons learned from TRP review under the funding model, and acknowledging the need to optimize the value of TRP review, the GAC, in discussion with the TRP, recommends applying operational flexibility to allow a simplified / differentiated application process in line with current polices on non-material reprogramming. The main program risks include financial sustainability and inadequate human resources for health and turnover of available health workers. The Ministry of Health and higher training institutions will continue training more cadres of health workers to alleviate these shortages. In this reprogramming request, the program will continue to pursue the training of health workers in comprehensive HIV care as well as midwives and TB DOTS workers in basic HIV counselling skills in order to ease the effect of the turnover.

50. GAC review of program context and operational environment. The main issues discussed by the GAC relate to ensuring human rights protections in Eritrea, sustainability of the program and inadequate human resources for health resulting from a challenging operating environment. The GAC recommended that concerns about funding sustainability, staff mobility and attrition could be mitigated by the CCM engaging new partners and donors to leverage more government support, as well as strengthening human resources for health through partnerships with established academic institutions. Regarding the need for increasing government commitment through the development of a long-term sustainability plan, in 2013, there was a high level mission to Eritrea that engaged the Presidency, the cabinet and partners. Sustainability of Global Fund supported programs was the key topic of discussion. Most recently, during grant-making the Eritrea Country Team engaged the Ministry of Finance and the Treasury as a follow-up action from the high level mission to kick start the process of establishing a sustainability framework. There are a number of options being considered but all are linked to the process of establishing the next health sector strategic development plan (HSSDP 2017 – 2021). The Ministry of Health together with stakeholders are reviewing the current HSSDP. The exploration of revenue generation mechanisms for the health sector features prominently in future plans. The Secretariat will continue to actively engage the stakeholders involved during this process.

51. Domestic contributions. The counterpart financing share based on commitments of government contribution in the next phase meets the minimum threshold requirement of 5 percent for a low-income country as previously assessed in October 2013 and during concept note review for the malaria grant. Government commitments related to the three disease programs represent a 52 percent increase compared to the previous implementation period. With the contribution of the Global Fund and other sources, the estimated total funding gap is US$ 17,791,306. While the country does not have specific information on disease-specific budgets, details on planned budgets, disbursements and health expenditure utilized over the last three years are available and have been validated.

Eritrea TB Grant (ERI-T-MOH)

52. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$4,415,916 for the Eritrea TB program, which consists of the Ministry of Health grant ERI-T-MOH with no incremental amount for the implementation period 1 July

[1] GF_B30_EDP2: Decision on the Secretariat's Funding Recommendations for Grant Renewals.

2015 through 31 December 2017. As this is a reprogramming request, Eritrea did not submit an above allocation request.

53. Epidemiological situation. The WHO estimated that TB incidence in Eritrea in 2012 was 97 per 100,000 population with a prevalence of 151 per 100,000 population, and mortality (excluding HIV) of 4.7 per 100,000 population. The estimated prevalence of multidrug-resistant TB (MDR-TB) in 2011 was 1.8 percent among new cases and 19 percent among re-treatment cases. According to the 2010-2014 national strategic plan, TB services are free of charge and cover the entire population; however, more effort is required to access key affected populations, which include people living with HIV/AIDS, prisoners and miners. Despite the low prevalence of HIV in Eritrea, TB and HIV remain linked as HIV prevalence among TB patients is 6 percent compared to the 0.93 percent rate among the general population. For people living with HIV, however, there has been a marked improvement in terms of screening for TB as TB/HIV guidelines have recently been developed and training conducted. Eritrea has a countrywide DOTS coverage of 100 percent and treatment success rate of 85 percent though the country has not achieved the WHO Stop TB targets of case detection rate of 70 percent.

54. The goal of this program is to significantly reduce the burden and the transmission of TB in line with the Millennium Development Goals and the STOP TB partnership targets so that TB no longer remains a public health problem in Eritrea. The Eritrea CCM is seeking the approval of reprogramming of existing funds of US$4,415,916 for the Eritrea TB program ERI-T-MOH to avoid disruption in programmatic activities until the next allocation. The grant will also be extended through 31 December 2017 pursuing original proposal goals with no substantive changes made to the indicators in the revised performance framework. Although the proposed activities under the reprogrammed period are not significantly different from those being carried out under the existing grant, there will be greater focus on high disease burden areas and key populations to improve access to TB services and TB case notification.

55. GAC review and recommendations. The Eritrea TB program implemented by the Ministry of Health has undergone periodic review in October 2013[1] and there was no evidence indicating significant changes in TB epidemiology or burden since the time of the review. The request for reprogramming adequately identifies programmatic gaps. In the Request for Reprogramming, the CCM and Principal Recipient have adequately identified programmatic gaps and aligned the grant objectives with those of the National TB Control Strategic Plan (NSP 2015-2017). The national strategic plan (NSP 2015-2017) was developed to align the disease strategy with the Eritrean National Health Sector Strategic Development Plan 2017-2021. The GAC, in discussion with the TRP, endorsed proposed strategic focus of the reprogramming request as it does not present any material changes.

56. GAC review of program context and operational environment. As for the HIV reprogramming request, the main issues highlighted by the GAC relate to ensuring human rights protections in Eritrea, sustainability of the program and inadequate human resources for health resulting from a challenging operating environment. The GAC recommended that concerns about funding sustainability, staff mobility and attrition could be mitigated by the CCM engaging new partners and donors to leverage more government support, as well as strengthening human resources for health through partnerships with established academic institutions. Regarding the need for increasing government commitment through the development of a long-term sustainability plan, in 2013, there was a high level mission to Eritrea that engaged the Presidency, the cabinet and partners. Sustainability of Global Fund supported programs was the key topic of discussion. Most recently, during grant-making the Eritrea Country Team engaged the Ministry of Finance and the Treasury as a follow-up action from the high level mission to kick start the process of establishing a sustainability framework. There are a number of options being considered but all are linked to the process of establishing the next health sector strategic development plan (HSSDP 2017 – 2021). The Ministry of Health together with stakeholders are reviewing the current HSSDP. The exploration of revenue generation mechanisms for the health sector features prominently in future plans. The Secretariat will continue to actively engage the stakeholders involved during this process.

57. Domestic contributions. The counterpart financing share based on commitments of government contribution in the next phase meets the minimum threshold requirement of 5 percent for a low-income country as previously assessed in October 2013 and during Concept Note review for the malaria grant. Government commitments related to the three disease programs represent a 52 percent increase

[1] GF/B30/EDP2: Decision on the Secretariat's Funding Recommendations for Grant Renewals

compared to the previous implementation period. With the contribution of the Global Fund and other sources, the estimated total funding gap is US$3,401,862. While the country does not have specific information on disease-specific budgets, details on planned budgets, disbursements and health expenditure utilized over the last three years are available and have been validated.

Ethiopia TB/HIV Grants (ETH-H-HAPCO and ETH-T-FMOH)

58. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$350,592,881 for the Ethiopia TB/HIV program, which consists of the Federal HIV/AIDS Prevention and Control Office (HAPCO) grant ETH-H-HAPCO with incremental funding for Board approval of US$184,890,710 and the Federal Ministry of Health of the Federal Democratic Republic of Ethiopia (FMOH) grant ETH-T-FMOH with incremental funding for Board approval of US$13,196,499 for the implementation period 1 July 2015 through December 2017. Based on the above allocation funding request submitted in the Ethiopia TB/HIV concept note, the amount of US$18,555,612 is registered as unfunded quality demand, in line with TRP recommendations.

59. Epidemiological situation. The HIV epidemic in Ethiopia follows a low-level generalized pattern, varying with age, sex, marital status and geographic location, predominantly in urban and peri-urban areas, with higher prevalence among women than men (1.9 percent vs 0.9 percent) and far greater prevalence among female sex workers (23 percent), truck drivers (4.9 percent) and prison population (4.3 percent). Between 2003 and 2013, the estimated HIV prevalence among adults 15 to 49 years in Ethiopia declined from 3.3 percent to 1.2 percent and the number of estimated people living with HIV declined from 1.3 million to 0.8 million. The number of AIDS-related deaths declined by over 60 percent between 2004 and 2013, exceeding the 50 percent target reduction by 2015. In spite of the significant progress, the HIV burden remains high with over 790,000 estimated to be living with HIV, over 21,000 new infections, 45,000 deaths, and 900,000 AIDS orphans. Over 10,000 of newly notified TB cases are TB/HIV co-infected. Ethiopia is the ninth highest TB burden country in the world with an estimated 210,000 new TB cases occurring annually (224 per 100,000 population in 2013). The country is also one of the twenty-seven high multi-drug resistant TB (MDR-TB) burden countries, with an estimated MDR-TB rate of 2.3 percent in new cases and 17.8 percent among retreatment cases, translating into an estimated 2,100 MDR-TB cases among the notified TB cases (1,600 in new and 480 in retreatment). The country has a TB/HIV co-infection rate of approximately 10 percent among the notified TB cases with known HIV status. In spite of significant progress, the TB burden in Ethiopia continues to be high with TB accounting for over 30,000 deaths annually.

60. Past program performance. The Global Fund has supported the Ethiopia national HIV/AIDS response since 2003 under round 2, and the country has overall received an approved maximum funding amount of US$1.73 billion from the Global Fund. The program has made significant progress in improving access to HIV prevention and control interventions; with fewer than 700 health facilities providing HIV testing and counseling in 2004, currently nearly 3,500 facilities provide HIV counselling and testing, making it universally accessible across all health centers and hospitals. ART is available in over 1,000 centers and prevention of mother to child transmission (PMTCT) has been expanded to nearly 2,500 centers. The large-scale expansion has supported increasing antiretroviral therapy (ART) coverage to over 333,000 people currently on ART (45 percent of people in need as per 2013 WHO treatment guidelines) and PMTCT coverage over 65 percent. The Global Fund has supported the national TB control program since 2003, under rounds 1, 6 and 10. The TB case notification rate (new and relapse) has steadily increased from a low of 46 per 100,000 population in 1995 to a high of 178 per 100,000 population in 2010 and the program is on track to meet TB-related Millennium Development Goals. Closer review of the treatment outcome data by regions, however, suggests inconsistencies in reporting and data quality issues. Over the last 3 years, the program has seen a decline in TB case notification, currently standing at 140 per 100,000 population, with an estimated case detection rate of 62 percent. The observed decline has been attributed to both under-reporting and the plausible effects of programmatic complacency, suggesting the need for strengthened program management, oversight and the expansion of community engagement. Overall progress recorded in the last decade can be attributed to strong political commitment and leadership in Ethiopia, one of the first countries to undertake a TB prevalence survey, rapid expansion of access to diagnosis and treatment with scale-up of health infrastructure and external financing to support implementation of program activities. Community engagement to support DOTS through community health extension workers has further strengthened the reach and impact of the program.

61. The goal of this program is to, by 2020, prevent 70,000 to 80,000 new HIV infections; save 500,000 to 550,000 lives threatened by HIV/AIDS; and reduce the TB prevalence rate by 35 percent, the TB incidence rate by 30 percent and the TB mortality rate by 45 percent from 2013 levels by 2020. To enable Ethiopia to achieve the program goals, the Global Fund will invest in high impact and targeted prevention programs, intensified HIV testing and counselling, elimination of mother to child transmission and quality care and treatment as well as in expanding and sustaining TB, TB/HIV and MDR-TB interventions in Ethiopia. Specifically, the program aims to implement the following strategies to achieve program goals: (i) targeted prevention programs for female sex workers and clients and laborers and migrant workers; (ii) HIV testing and counseling for the general population with improved targeting; (iii) programming for orphans and vulnerable children; (iv) ART treatment, care and support; (v) scale-up and sustain quality assured TB and MDR-TB diagnosis and treatment, include GeneXpert; (vi) expand community TB care; (vii) outreach to hard to reach pastoralists, prisons and migrants; (viii) strengthen TB/HIV collaboration including expansion of screening, co-trimoxazole preventive therapy, isoniazid preventive therapy and treatment of co-infected patients.

62. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it builds on a successful program, with an appropriate consideration of interventions in relation to epidemiology of the HIV and TB epidemic in Ethiopia, and sensible synergies with projects funded through other sources. The TRP also acknowledged areas in which progress could be made and requested the country to clarify six issues during grant-making. These issues included the generation of evidence and inclusion of activities to address the needs of men who have sex with men and people who inject drugs; gaps in HIV prevention focused on key populations; prioritization of ART treatment for those in greatest need; plans for pediatric ART scale-up; proposed the use of the GeneXpert test as a follow-up test in smear positive pulmonary TB; and possible missed opportunity of providing comprehensive health services through mobile TB/HIV clinics. The TRP cleared the two issues related to evidence generation and focus of prevention programs for key populations but expressed concern that the country's response did not sufficiently address the lack of data collection, programming and services for men who have sex with men and people who inject drugs in Ethiopia and requested GAC attention and engagement on these issues.

63. GAC review and recommendations. GAC endorsed TRP recommendations and approved an upper funding ceiling of US$264,325,031 for grant-making (US$50,250,410 for TB grant and US$ 214,074,622 for HIV grant), including incentive funding of US$10,187,974 based on TRP prioritization of the above allocation request to support TB care and prevention, expanding MDR-TB coverage and mobile case finding for pastoral communities. The GAC made further recommendations to the country about transparency and inclusiveness of country dialogue; TB and HIV coordination; strategic refocusing of investments; sustaining ART financing; and portfolio and cash management.

64. GAC review and recommendations. The GAC reviewed progress against actions taken during grant-making to address issues for TRP clarification related to key populations. The GAC noted the challenges in the socio-cultural and political context in Ethiopia and expressed support for the Ministry's commitment to ensure stigma reduction for key populations and access to health care services for all people regardless of sexual orientation. GAC acknowledged the high-level meeting that took place with the Minister of Health during the Partnership Forum in Addis Ababa, as well as the commitments made during the March Global Fund Board meeting, and welcomed the ongoing engagement and efforts by development partners to find pragmatic solutions. The GAC emphasized the importance of ensuring continued progress in addressing issues for men who have sex with men and people who inject drugs in Ethiopia, with coordinated support from development partners and technical partners and including focusing on male-oriented health programs as a pragmatic solution. The GAC further acknowledged efforts to improve HIV and TB coordination through common indicators in the performance framework on TB/HIV collaborative activities and joint program reviews; improved targeting and prioritization key to achieving intended program targets; monitoring testing for key populations; enhanced cash and portfolio management through submission of an implementation plan by the Principal Recipients and roll out of an integrated financial management information system; and scale-up of community health systems strengthening through health extension workers which have demonstrated concrete achievements in TB case detection. Strengthening the resilience and sustainability of health systems was discussed, and GAC was informed that complementary investments and interventions were covered under the HSS grant.

65. Final program budget and reinvestment of efficiencies. Following grant-making, the total program budget has been revised upwards to US$350,592,881, with the amount of US$73,879,065 for the TB

program and the amount of US$276,713,816 for the HIV program, due to undisbursed funds and carry forward activities from current grants which are in progress and expected to be finalized within the first few months of the new grants. This increase is due to the following factors: (i) the disbursement amount of US$7.3 million initially planned under current TB grant was withheld due to a cash balance identified in country and therefore transferred to the new grant, (ii) the amount of US$16.1 million from current TB grant activities has been carried forward, mainly for the procurement of first line drugs, microscopes and lab reagents, renovation of MDR-TB center, training and sample transportation ; (iii) undisbursed funding of US$38 million earmarked for ARV procurement under a current HIV grant has been transferred to the new grant due to delays in implementation, (v) the amount of US$22 million related to carry forward activities for procurement of rapid tests drugs, opportunistic infection kits and lab equipment, etc. The GAC also noted that US$3.6 million in efficiencies were identified during grant-making through changes in unit cost assumptions for program interventions, program management and training related costs. In line with TRP and GAC recommendations, these funds were reinvested into targeted prevention programs for female sex workers and clients, isoniazid preventive therapy, strengthening MDR-TB sample transportation and TB molecular testing.

66. Results based financing (RBF) model. Considering the OIG recommendation to conduct further system assessments and testing of Ethiopia's internal control environment, the design of the current grant is not established based on the RBF model but is currently structured as a standard grant. Following the OIG recommendations, the Secretariat aims to undertake a phased approach to transitioning the Ethiopia portfolio, which will initially focus on the malaria and HSS grants. The HSS investments provide an opportunity to strengthen system components in preparation for an RBF transition. The Millennium Development Goals pooled fund also presents a strong partner collaboration opportunity with the potential to conduct a joint assessment with other donors.

67. Domestic contributions. The estimated funding needs for the national HIV and TB programs of Ethiopia in the next implementation period are US$806 million and US$248 million respectively for a combined total of US$1,054 million. Total domestic financial commitments amount to US$59 million for HIV and US$28 million for TB, which represents 7 percent and 25 percent of total resources available, respectively, (or 7 percent and 11 percent of funding need) for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 39 percent for TB and 14 percent for HIV, which meets the minimum threshold requirement of 5 percent for a low income country. Government commitments across all three diseases represent a 21 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$14.3 million for HIV and US$125 million for TB.

Fiji TB Grant (FJI-T-MHMS)

68. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$4,445,477 for the Fiji TB program, which consists of the Ministry of Health and Medical Services (MHMS) grant FJI-T-MHMS with the incremental funding for Board approval of US$3,903,340 for the implementation period 1 July 2015 through 31 December 2017. The applicant did not submit an above allocation request for the Fiji TB program and therefore has no unfunded quality demand registered.

69. Epidemiological situation and past program performance. The Republic of Fiji is an island nation in the South Pacific Ocean with 332 islands, of which 110 are inhabited, with a total population of 882,860. Fiji has been part of multi-country grants from the Pacific region since 2003 until successfully submitting a proposal as a single country applicant for a round 10 TB grant. Fiji has one of the most developed economies in the Pacific islands and is defined as an upper-middle income country by the World Bank. Fiji is listed among countries with moderate incidence for TB in the Pacific region and the latest available estimates from the WHO indicate that TB incidence in 2013 was 57 per 100,000 population, prevalence at 100 per 100,000 population and mortality at 4.2 per 100,000 population. Key populations for TB in Fiji include children, particularly those in direct contact with newly diagnosed TB adults, as well as persons living in hot spot areas, populations facing significant challenges in accessing TB services due to geographical or social barriers, diabetes, migrant populations and people over the age of 65. Treatment of TB has been mainly hospital-based until recently; since hospital-based treatment for drug-sensitive TB patients is not recommended by normative guidance, the national TB program is now shifting to outpatient treatment.

70. The goal of this program is to achieve elimination of TB and reduced deaths from TB through universal and equitable access to quality diagnosis and appropriate treatment of latent TB infection, TB, drug resistant TB, TB/HIV co-infection, TB-diabetes co-infection and other high risk groups and hard to reach populations. The strategy is aligned with three pillars: (i) integrated, patient-centered care and prevention for wellness; (ii) bold policies and supportive systems for universal access; and (iii) intensified research and innovation.

71. TRP review and recommendations. The Fiji TB concept note was originally submitted in window 4 on 15 October 2014 and was recommended for iteration by the TRP. While this concept note provided a clear description of the epidemiology and drew from the national strategic plan for TB, the TRP also noted several concerns. The main issue related to the transition strategy, which needed further strengthening by the country is to provide assurance that the transition from Global Fund would not hinder technical progress. In line with the transition strategy, the TRP recommended that the applicant reconsider funding staff salaries and utilize the Global Fund resources to instead support case detection and treatment outcomes at the primary care level, for key populations and in TB hot spot areas. A revised concept note was submitted in window 5 in January 2015 and was considered by the TRP to be technically sound and strategically focused as it had fully addressed all the concerns that the TRP expressed during the previous review. The TRP requested two clarifications be addressed during grant-making, including further development of the human resource transition plan and TB-associated health risks.

72. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant-making of US$4,095,824. During grant-making US$635,225 in efficiencies were found in savings from unit and operational costs as well as adjustments in disbursements. The GAC approved the reinvestment of these funds in the promotion of case detection through sputum collection, transportation to hard-to-reach populations and the establishment of a TB patient advocacy network. In addition, recognizing the importance of community health workers for the success of the program, the GAC also endorsed investment of savings (US$81,728) in the payment of salary incentives for community-based volunteers to identify and refer suspected TB cases as well as increase awareness at the community level. Fiji also took the chance to strengthen the links between the TB program and those for associated health risks as well as to set a timeline for the government to submit a final transition plan.

73. Domestic contributions. The estimated funding need for the national TB program of Fiji in the next implementation period is US$16,996,190. Total domestic financial commitments amount to US$12,241,215, which represents 73 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 63 percent, which meets the minimum threshold requirement of 60 percent for an upper middle-income country. Government commitments related only to this disease represent a 65 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$309,408.

Ghana TB/HIV Grants (GHA-T-MOH, GHA-H-MOH, GHA-H-ADRA, GHA-H-PPAG, GHA-H-GAC)

74. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$120,430,166 for the Ghana TB/HIV program, which consists of the Ministry of Health grants GHA-T-MOH with incremental funding for Board approval of US$22,084,151 and GHA-H-MOH with incremental funding for Board approval of US$60,939,446; the Adventist Development and Relief Agency of Ghana grant GHA-H-ADRA with incremental funding for Board approval of US$3,266,580; the Planned Parenthood Association of Ghana grant GHA-H-PPAG with incremental funding for Board approval of US$1,537,406; and the Ghana AIDS Commission grant GHA-H-GAC with incremental funding for Board approval of US$12,615,524, for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$6,375,348 is registered as unfunded quality demand, in line with TRP recommendations.

75. Epidemiological situation. Ghana has a generalized HIV epidemic with pockets of high prevalence among key populations, notably female sex workers and men who have sex with men. The country also has a high TB burden and is categorized by WHO as a TB/HIV priority country. The national HIV Prevalence and AIDS Estimates (for 2013-2020) show that HIV prevalence in the general population in 2013 was 1.3 percent; and, the country had an estimated 224,488 persons living with HIV, of whom 85 percent are adults. There are considerable geographic variations in HIV prevalence, ranging

from above 3 percent in the Eastern and Ashanti regions to less than 1 percent in the Upper West and Northern regions. HIV prevalence among the general population has steadily dropped to current levels from about 1.8 percent in 2007, and both prevalence and incidence are projected to drop gradually from 1.3 percent to 0.99 percent and 0.04 percent to 0.01 percent, respectively, in 2020 (National HIV Prevalence and AIDS Estimates for 2013-2020). Following the first TB prevalence survey to be conducted in 57 years, TB prevalence is estimated to be three times higher than previously thought at 264 per 100,000 population. Ghanaian males are particularly affected, with an estimated prevalence of 334 per 100,000 population. The TB epidemic is generalized, with geographic variation in case notification linked to better access to health facilities. Treatment success has improved, but detection and treatment of multidrug resistant TB (MDR-TB) patients remains a challenge. The HIV co-infection rate for registered TB cases was 24 percent in 2013.

76. Past program performance. To date, the Global Fund has invested a total of US$255,739,831 in HIV grants for Ghana, through rounds 1, 5, 8, the Transitional Funding Mechanism and interim transitional financing, while investing US$67,762,012 in TB grants for Ghana, through rounds 1, 5 and 10. Notable successes in the fight against HIV and TB in Ghana include enabling the scale up of TB interventions, antiretroviral treatment (ART), prevention of mother-to-child transmission (PMTCT) and prevention services for key populations. While national data suggests steadily declining HIV incidence, prevalence and AIDS deaths, ART retention remains a challenge at 72 percent at 12 months, early infant diagnosis, condom use and HIV data quality restrain further progress. Detecting and treating MDR-TB patients continues to prove challenging, and the results of the TB prevalence survey suggest that TB case detection has not always been adequate. ART coverage for certain groups, for instance, TB patients, children and pregnant women continues to be lower than acceptable levels.

77. The goal of this program is to reduce new HIV infections and deaths among men, women, children and infants, as well as to reduce TB prevalence and deaths in the next three years. To enable Ghana to achieve the program goals, the Global Fund will invest in the following strategies: (i) scale up HIV care and prevention efforts, specifically in four high priority regions in which HIV prevalence is more than twice the national figure; (ii) increase coordination and implementation of TB and HIV collaborative activities; (iii) increase focus on TB case detection in 90 high burden districts; (iv) early detection and enrollment of 100 percent of confirmed MDR-TB cases; (v) strengthen data quality assurance at facility, district and regional levels; and (vi) community systems strengthening. Expected outcomes include increased ART coverage for adults and children from 66 percent in 2014 to 83 percent by 2017 (for patients with CD4 levels of 350 and other eligible), reduced rates of HIV transmission from mother to child from 8.3 percent in 2013 to 2.4 percent by 2017, reduced HIV prevalence among men who have sex with men and female sex workers to 10 percent (from a baseline of 17.5 percent in 2011) and 4 percent (from a baseline of 11 percent in 2011), respectively by 2017, as well as reduced TB prevalence rate per 100,000 population from 264 in 2013 to 238 by 2017 and increased TB case notification from 60 per 100,000 population in 2013 to 103 per 100,000 by 2017.

78. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it is strongly evidence based, responds to the epidemiology of the HIV and TB epidemics in Ghana and is clearly prioritized with a focus on key populations and geographic regions with highest disease burden. The concept note is in line with the goals and strategic objectives of the National HIV Strategic Plan for 2011 to 2015 and the National Strategic Plan for TB for 2015 to 2020. The TRP also acknowledged areas in which progress could be made during grant-making, with clarifications requested including the allocation of resources to strengthen supply chain management; securing sufficient funding for the HIV program; scaling up HIV testing within the general population as well as amongst men and discordant couples; increasing domestic funding for TB; sustainability of enablers for TB; coverage of MDR-TB second-line treatment; addressing declining condom use; operational plan for regional prioritization; and verification of data and interventions for people who inject drugs. Furthermore, while the TRP acknowledged Ghana's ambition to adopt the 2013 WHO treatment guidelines, in light of the low level of ART coverage based on CD4 threshold of 350, the TRP strongly recommended that the country prioritize coverage of treatment at this level before considering increasing the treatment threshold.

79. GAC review and recommendations. The GAC endorsed the TRP recommendations and approved US$118,877,272 as the upper-ceiling funding amount for grant-making, which takes into account adjustments of the available funds for the implementation period. The GAC reviewed progress against actions taken during grant-making to address issues for clarification, acknowledging efforts to close the gap between MDR-TB case notification and treatment. The GAC endorsed the prioritization of ART for those with CD4 350 or less cells/mm3, discordant couples, pregnant women, TB/HIV co-infected patients and all infected children under five years, who will be eligible for ART under the 2013

WHO ART guidelines. GAC partners also expressed support for the plan to phase out zidovudine (AZT) in line with normative treatment guidance and recommended development of phase out plan in collaboration with WHO. GAC partners affirmed that given the TB prevalence survey results and resource constraints, the TB program targets are ambitious but feasible, and highlighted the critical importance of prioritizing proactive case finding efforts and operationalizing a shift in the diagnostic algorithm used in the 90 priority districts. While the GAC endorsed payment of salary incentives (approximately US$170,000) included in the budget of grants implemented by the Ministry of Health, approval was based on the understanding that salary incentives would be phased out as of September 2015, to facilitate moving towards program sustainability.

80. Final program budget and reinvestment of efficiencies. Following grant-making, the total program budget has been revised upwards to US$120,430,166 due to savings identified from undisbursed funding in 2014. The GAC noted that US$11,277,310 inefficiencies were found during grant-making. In line with TRP and GAC recommendations, savings will be reinvested into procurement of second line drugs to reach 100 percent treatment coverage for MDR-TB cases, maintenance of laboratory equipment, improvement of reliability of data collection at ART facilities, DHIS2 data system roll out and towards more in-depth analysis of the TB prevalence survey results. The GAC also highlighted the need to focus on TB case finding as a top priority should efficiencies be identified during grant implementation.

81. GAC review of domestic contributions for TB and HIV. The GAC expressed concern about the low levels of domestic financing for TB and emphasized the need for commitment from the Government and a wide range of stakeholders to address the current financial gaps especially in light of the TB prevalence survey results showing estimates to be three times higher than previously thought. The GAC also expressed concern about the levels of domestic financing for HIV and lack of consistent follow through with committed resources in previous years. The GAC endorsed risk mitigation measures proposed by the Secretariat to secure domestic contribution for HIV including (i) clarifying expectations / financial liabilities, the resolution of inconsistencies in the Government of Ghana contribution and underfunding for ART cohort prior to commencing grant-making; (ii) ensuring Government disbursement for ART during program implementation; and (iii) development of a multi-year financing strategy with government agencies and ministries. The GAC acknowledged that the government has secured funding to support its 2015 cohort of 21,842 ART patients and stressed the importance of upholding government commitments to maintain and scale up the ART cohort in 2016 and 2017. Furthermore, US$6,999,958 of savings from undisbursed funding will be earmarked for ART procurement and not released until the Government of Ghana's budget for ART coverage in 2016 is confirmed.

82. Domestic contributions. The estimated funding need for the national HIV and TB program of Ghana in the next implementation period is US$670,365,119. Total domestic financial commitments for HIV and TB amount to US$264,696,895, which represents 54 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 75 percent for HIV and 67 percent for TB, which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across all three diseases represent an 86 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$184,149,332.

Mauritius HIV Grants (MUS-H-NAS and MUS-H-PILS)

83. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$3,663,430 for the Mauritius HIV program, which consists of the National AIDS Secretariat (NAS) grant MUS-H-NAS of the incremental amount of US$1,472,582 and the Prévention Information Lutte contre le Sida (PILS) grant MUS-H-PILS of the incremental amount of US$1,744,000 for the implementation period from 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the Mauritius HIV concept note, the amount of US$2,213,307 is registered as unfunded quality demand, in line with TRP recommendations.

84. Epidemiological situation and past program performance. The Republic of Mauritius is an island state with a population of 1.3 million inhabitants. It is estimated that there are 9,200 people living with HIV with a prevalence rate of 1.02 percent among adults in the general population, and high prevalence among key populations, as follows: 44.3 percent among people who inject drugs, 22.3 percent among female sex workers, 20 percent among men who have sex with men, and 19 percent among prison

inmates. Injection drug use is the key driver of the epidemic according to the modes of transmission study done in 2013. Key populations are often marginalized and stigmatized with very low access to HIV prevention, treatment and care interventions, and gender inequities result in female sex workers and females who inject drugs being especially vulnerable. The Global Fund has provided support to Mauritius' national HIV and AIDS program since 2010. Mauritius has successfully managed within a period of a few years to set up a response to its specific epidemiological situation and cater to key populations, especially through its harm reduction and prevention of mother-to child transmission programs. Mauritius has also reduced the number of new infections among people who inject drugs, with HIV infection rates dropping from 73 percent in 2010 to 68.1 percent in 2011, 47.2 percent in 2012 and 38.1 percent in 2013, according to government figures.

85. The goal of this program is to stabilize HIV prevalence among people who inject drugs, men who have sex with men, transgendered people and female sex workers as well as reduce AIDS-related mortality. Expected outcomes of the proposed interventions by 2017 include reducing the percentage of sex workers and men who have sex with men who are living with HIV to 20 percent, reducing the percentage of people who inject drugs who are living with HIV to 43 percent, reducing the percentage of HIV-positive infants born to HIV-infected mothers to 4 percent, and increasing the percentage of adults and children with HIV known to be on treatment 12 months after initiation on ARV to 90 percent. To support these goals, the CCM has chosen to continue an existing dual-track implementation arrangement, with the NAS, a government Principal Recipient, and PILS, a civil society Principal Recipient. The performance of both Principal Recipients is satisfactory as demonstrated by A-rated programmatic performance and healthy absorptive capacity with an expenditure rate of above 90 percent. Furthermore, both Principal Recipients have dedicated program management units with effective accountability systems in place.

86. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused as it clearly identifies the key drivers of the HIV epidemic in Mauritius as being key populations and utilizes evidence such as integrated biological behavioral surveillance, modes of transmission and mapping studies to measure HIV prevalence within these key populations. This evidence is also used to identify hotspots within the country where high risk activity for HIV transmission takes place. The TRP requested three items be addressed during grant-making, including a transition plan for interventions targeting key populations, the plan for treatment as prevention and the planned use of pre-exposure prophylaxis.

87. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant-making of US$3,240,152. Following grant-making, the total program budget has been revised upwards to US$3,663,430 due to savings identified from undisbursed funding in 2014. During grant-making, US$254,522 in efficiencies were identified in the in-country cash balance. The GAC approved the reinvestment of these efficiencies to cover quality demand activities in line with the TRP recommendation.

88. Domestic contributions. The estimated funding need for the national HIV program of Mauritius in the next implementation period is US$27.8 million. Total domestic financial commitments amount to US$21.5 million, which represents 84 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 87 percent, which meets the minimum threshold requirement of 60 percent for an upper middle-income country. Government commitments related only to this disease represent a 28 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$2.3 million

Multicountry Western Pacific (Vanuatu) Malaria Grant (QMJ-M-UNDP)

89. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$2,657,874 for the multi-country Western Pacific (Vanuatu) malaria program, which consists of the UNDP grant QMJ-M-UNDP requesting approval to reprogram existing funds for the implementation period form 1 July 2015 through 31 December 2017. The applicant did not submit an above allocation request for the multi-country malaria program and therefore has no unfunded quality demand registered.

90. Multicountry Western Pacific applicant information. The multi-country Western Pacific malaria program received a single allocation, as it had included two countries in the past, the Solomon Islands and Vanuatu. However, as the Solomon Islands decided to submit a separate concept note during this allocation period the multi-country Western Pacific malaria grant now includes the nation of Vanuatu as the only recipient country of this multi-country application with a malaria burden. In line with the Global Fund's Eligibility and Counterpart Financing Policy[5], regional, multi-country and non-CCM proposals are not required to meet counterpart financing requirements.

91. Epidemiological situation and past program performance. Vanuatu is an archipelago in the South Pacific with an estimated population of 251,784 on 65 inhabited islands. Malaria has historically been one of the leading health issues in Vanuatu and the whole population of the country is considered to be at risk of infection, except for the islands of Aneityum and Futuna, which are malaria-free. The malaria burden in Vanuatu has fallen dramatically in recent years, with annual parasitic incidence falling from 33 per 1,000 in 2010 to just 9 per 1,000 population in 2013; since 2012 there have been no confirmed deaths due to malaria in Vanuatu. Significant progress has been made in the fight against malaria in Vanuatu, as highlighted by the fall of the annual parasite incidence from 74 per 1,000 in 2003 to 13.2 per 1,000 population in 2012, and the virtual disappearance of confirmed malaria-related deaths since 2012.

92. The goal of this program is to maintain universal coverage with long-lasting insecticidal nets (LLINs) for the whole population of Vanuatu, ensuring that households are equipped with at least one LLIN, all children under the age of five of age sleep under LLINs and that all pregnant women sleep under an LLIN. To enable the applicant to achieve these program goals, the Global Fund will invest in the following strategies: (i) increasing malaria prevention through LLIN distribution for universal coverage; (ii) innovating in the areas of community mobilization and education; and (iii) strengthening monitoring and evaluation system and its link to malaria control. To oversee the implementation of these strategies, UNDP has been selected as the Principal Recipient, due to its experience implementing Global Fund grants as well as its overall capacity.

93. TRP and GAC review and recommendations. The TRP considers reprogramming request to be technically sound and strategically focused, commenting that it was well formulated and supported by appropriate documentation. The TRP requested that the high program costs resulting from a large amount of personnel and the monitoring and evaluation indicators be clarified during grant-making. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling of US$2,936,384. During grant-making, efficiencies were found in LLIN unit costs. The GAC approved the reinvestment of this amount into malaria indicator survey costs that were initially underestimated, external audit fees for the Principal Recipient and sub-recipients, and Principal Recipient program administration costs.

Multicountry Western Pacific TB/HIV Grant (QMJ-C-UNDP)

94. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$14,214,351 for the multi-country Western Pacific program, which consists of the UNDP grant QMJ-C-UNDP with an incremental funding amount for Board approval of US$10,714,592 for the implementation period 1 July through 31 December 2017. Based on the above allocation funding request submitted in the multi-country Western Pacific TB/HIV concept notes, the amount of US$2,801,000 is registered as unfunded quality demand, in line with TRP recommendations.

95. Epidemiological situation - HIV. The multi-country Western Pacific TB/HIV grant supports programming in 11 island countries and territories, including the Marshall Islands, Micronesia, Kiribati, Vanuatu, Tuvalu, Samoa, Tonga, the Cook Islands, Nauru, Niue and Palau. Among these islands and territories, HIV prevalence continues to be very low, despite contexts of relatively high HIV vulnerability. These areas are characterized by the presence of potential drivers of a future HIV epidemic, such as widespread migration and mobility, dense sexual networks, a large caseload of untreated sexually transmitted infections, low knowledge about HIV and sexually transmitted infections, high levels of transactional sex and significant levels of intimate partner violence. The estimated HIV prevalence among adults aged between 15 and 49 years in the eight countries with data available was less than 0.1 percent in 2012. Data are mainly based on testing among pregnant women

[5] GF/B23/14: Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals from the Global Fund.

and at voluntary counselling and testing centers; systematic HIV testing has not been done until fairly recently, as the capacity to conduct in-country confirmatory tests and HIV testing was developed only over the past seven years. No systematic testing has been done among HIV key populations, which include sex workers and their clients, men who have sex with men and transgender persons. Hence, it is likely that the majority of HIV cases have not yet been identified and that the actual number is considerably higher.

96. Epidemiological situation – TB. The estimated TB incidence rate of these 11 countries and territories is 172 per 100,000 population, higher than the global and regional averages. There is a large diversity between the different countries and territories, however, with some sustaining relatively high TB burdens and others with zero or few patients. The number of people diagnosed with TB has increased by 86 percent among these countries and nations since 2000, accompanied by a combined TB case notification rate from 146.1 to 217.0 per 100,000, which can likely be attributed to improved TB case finding. Identified key populations for TB include household contacts of TB patients, people living with HIV and prisoners. Multidrug-resistant TB (MDR-TB) and TB/HIV are not yet spreading epidemics among the multi-country Western Pacific applicant's islands. The Global Fund has supported both the TB and HIV programs for the multi-country Western Pacific applicant since 2003.

97. The goals of this program are to halt the spread of HIV among the population of the Western Pacific and maintain HIV incidence rates below 0.1 percent annually in the 2015-2017 period; to reduce AIDS-related mortality by strengthening HIV case finding and case management; to reduce the prevalence, incidence and mortality from all forms of TB in the 11 Pacific Island countries and territories, thereby contributing to the post-2015 global TB strategy; and to promote universal and equitable access to quality diagnosis and appropriate treatment of TB, MDR-TB, TB/diabetes co-infected and TB/HIV co-infected patients across the 11 Pacific Island countries and territories. To enable the multicountry Western Pacific applicant to achieve these goals, the Global Fund will invest in the following strategies: (i) scaling up and strengthening prevention of mother-to-child transmission outreach and coverage; (ii) strengthening monitoring and evaluation systems and routine reporting mechanisms; (iii) increasing coverage of a defined minimum package of prevention services for key populations, including men who have sex with men as well as sex workers and their clients; (iv) creating an enabling environment through advocacy efforts to remove legal barriers, and promoting community engagement and empowerment; (v) increasing case notification rates of all forms of TB; (vi) increasing TB treatment success rates; and (vii) increasing HIV testing and counselling for TB patients. The UNDP will continue in its role as Principal Recipient for the TB and HIV programs, as selected by the multicountry Western Pacific regional coordinating mechanism, and have supported the consolidation of these programs into a single grant to foster synergies.

98. TRP review and recommendations. The TB and HIV programs were submitted for TRP review separately, with the TB program reviewed in window 3 in September 2014 and the HIV grant reviewed in window 5 of March 2015. They were both considered to be technically sound and strategically focused, thought TRP did request seven clarifications for the HIV program and four for TB. The TRP's concerns included the opportunity for synergies in program management, legal barriers for service delivery to HIV key populations, a detailed plan for antiretroviral treatment scale-up, the prioritization of HIV population studies, the need for regionally-diverse TB programming and the mobilization of domestic resources for TB.

99. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling for grant-making of US$7,684,011 for the TB program and US$7,667,503 for the HIV program, making the cumulative upper ceiling for both grants US$15,351,514. During grant-making, US$1,268,928 in efficiencies were found in reduced unit costs, undisbursed funds from previous grants, and smaller budgets than forecasted at the concept note stage. The GAC approved the reinvestment of this amount into prevention activities for key populations, inter-country monitoring and evaluation, a TB program review, a regional telemedicine helpdesk and supervision, and program management. The GAC reviewed the proposal to consolidate the separately submitted TB and HIV programs as well as actions taken during grant-making to address the clarifications requested by the TRP and found the results to be satisfactory.

Nicaragua HIV Grant (NIC-H-INSS)

100. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$12,996,303 for the Nicaragua HIV program, which consists of the Instituto Nicaragüense de Seguridad Social grant NIC-H-INSS of the incremental amount of US$9,283,068 for the implementation period 1 July 2015 through 31 December 2017. The applicant did

not submit an above allocation request for the Nicaragua HIV program and therefore has no unfunded quality demand registered.

101. Epidemiological situation and past program performance. Nicaragua is a lower lower-middle income country located in Central America with a concentrated HIV epidemic among the key populations of men who have sex with men, transgender people and sex workers. The prevalence among the general population is 0.15 to 0.26 percent and a 2012 study on modes of transmission reported that 45 percent of new infections were among men who have sex with men, 21 percent among casual heterosexual relationships, 17 percent among stable heterosexual relationships, 4 percent among transgender women, 2 percent among clients of female sex workers, 1 percent among female sex workers and the remainder among lower-risk partners of these various key population groups. Of 218 deaths related to HIV in 2013, 82.5 percent occurred in people aged 15 to 49 years. Main barriers to care among people living with HIV include: stigma and discrimination; low educational levels; limited decentralization of access to HIV treatment; and limited follow-up with people living with HIV. The Global Fund has been supporting HIV programming in Nicaragua since 2004. Through this programming, approximately 6.9 million condoms were distributed, 56,000 people were reached with prevention activities, more than 410,000 high schools students were reached with information on HIV, more than 39,000 people were trained on the law about HIV and 1,796 health workers were trained on HIV integral care. However, between 2000 and 2013, incidence still rose from 0.005 percent to 0.029 percent.

102. Program goals and implementation arrangements. The goal of this program is to maintain HIV prevalence of men who have sex with men at 9.7 percent, of the transgender population at 18.6 percent and of female sex workers at 2.3 percent, as well as reduce new pediatric HIV infections via mother-to-child transmission to less than 0.5 percent by 2020. To serve as Principal Recipient in supporting these goals, the Instituto Nicaraguense de Seguridad Social (INSS), a governmental entity in charge of social security, has been reselected. INSS has successfully implemented grants in Nicaragua since 2009 for the TB and HIV components and has staff familiar with Global Fund policies and procedures. The procurement of health products is done through the Global Fund pooled procurement mechanism in order to ensure quality standards.

103. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused, as it is based on a comprehensive analysis of the situation of the epidemic, and proposes strategic activities with an appropriate focus on key populations. The TRP requested six clarifications to be addressed during grant-making, including: (i) providing a detailed description on prevention activities for youth; (ii) planning strategically for the scale-up to the initiation of treatment threshold at CD4 500 for HIV; (iii) addressing procurement and supply chain systemic issues; (iv) clarifying the activities for people who inject drugs; (v) justifying activities for uniformed personnel within the module for men who have sex with men; and (vi) explaining how health systems strengthening interventions will support TB and malaria programming.

104. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended and upper ceiling of US$12,085,426 for grant-making. During grant-making, US$120,574 in efficiencies were found. The GAC approved the reinvestment of this amount in technical cooperation and equipment for sub-recipients as a result of the recommendations following the capacity assessment. The GAC reviewed actions taken during grant-making to address the clarifications requested by the TRP and found them to be satisfactory.

105. Domestic contributions. The estimated funding need for the national HIV program of Nicaragua in the next implementation period is US$102.1 million. Total domestic financial commitments amount to US$37.5 million, which represents 37 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 71 percent, which meets the minimum threshold requirement of 20 percent for a lower lower-middle income country. Government commitments across all three diseases represent a 15 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$43.4 million.

Niger HIV Grant (NER-H-CISLS)

106. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of EUR 14,259,597 for the Niger HIV program, which consists of the Coordination Intersectorielle de Lutte contre le Sida (CISLS) grant NER-H-CISLS with incremental funding for Board approval of EUR 9,990,764 for the implementation period 1 July 2015 to 31 December 2017. The TRP did not consider the above allocation request submitted under the Niger HIV concept note to be quality demand and therefore there is no amount registered as unfunded quality demand.

107. Epidemiological situation. HIV prevalence in Niger is reported to be falling among the general population, though there is growing concentration of the HIV epidemic, notably among sex workers with a prevalence rate of 17.3 percent and prisoners with a prevalence rate of 3 percent. Despite the low testing rate of pregnant women, as only 53.4 percent of pregnant women seen in 2012 were tested, HIV prevalence among this group fell from 1.7 percent in 2009 to 0.9 percent in 2012. The number of people on antiretroviral treatment increased from 1,261 patients in 2007 to 12,071 in 2013, which represents a coverage level of 26 percent as of December 2013. The country faces a number of challenges to program implementation, including weak health systems. In addition, HIV transmission is criminalized, soliciting for sex on the street is illegal, the law prohibits "unnatural acts" with a person of the same sex who is under age 21, and there is no legislation protecting women from sexual violence.

108. Past performance and lessons learned. As the largest donor for HIV and TB in Niger, Global Fund investments have contributed to the establishment of 44 antiretroviral treatment (ART) sites, 749 sites providing prevention of mother-to-child transmission services, and 762 voluntary counseling and testing sites. ART scale-up has been made possible by the increase in ART centers from five in 2004 to the current 44 in Niger. The country has made notable progress in addressing TB/HIV co-infection and the number of HIV infected TB patients on ART doubled from 2012 to 2013, from 16 percent to 39 percent respectively. The 12-month treatment retention rate remains low at 70.2 percent as of 2013, though it is a marked improvement from previous performance, with rates as low as 46.6 percent in 2007. Since 2009 there have been no ART stock-outs.

109. The goals of this program are to reduce new infections by 50 percent by 2017; improve the quality of life of at least 80 percent of people living with HIV enrolled in HIV care and at least 20 percent of orphans and other vulnerable children identified by 2017; and to ensure efficient governance of the national response against HIV/AIDS. To enable the Niger HIV program to reach these goals, the Global Fund will invest funds to achieve the following objectives: (i) ensure mother to child transmission of HIV is reduced by at least 5 percent by 2017 among children born from HIV positive mothers; (ii) reach at least 80 percent of each of the identified most at risk populations, including sex workers, men who have sex with men, migrant workers and prisoners, to encourage the adoption of reduced-risk behaviors by 2017; (iii) ensure that at least 80 percent of children and adults living with HIV are alive 12 months after initiation of ART by 2017; (iv) effectively protect the human rights of at least 80 percent of people living with HIV enrolled for care and treatment by 2017; (v) ensure participation of community organizations in the national response against HIV/AIDS; and (vi) produce strategic, high quality information regarding sexually transmitted diseases and HIV/AIDS, which are available and used in the national response against HIV/AIDS. Expected outcomes by 2017 include an increase from 70 percent to 80 percent of people living with HIV on treatment after 12 months, a decrease in new child HIV infections via mother-to-child transmission from 23 to 5 percent, reduced prevalence among men who have sex with men from 12 percent to less than 10 percent and reduced prevalence among sex workers from 17 percent to 15 percent.

110. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused, as it is based on a sound epidemiological analysis, aligned with the national strategic plan, identifies priority populations and geographic hot spots, and builds on experiences from past Global Fund investments. The TRP requested that the applicant develop a concrete plan to strengthen and scale-up targeted services for sex workers, provide an operational plan that elaborates on strategies and steps to be taken to estimate the population size of men who have sex with men and map prevention service needs; provide a detailed ART scale-up plan while prioritizing ART coverage in children; and develop a realistic operational plan for scaling up prevention of mother-to-child transmission services as well as HIV services for TB patients. Furthermore, the TRP requested that the applicant develop a plan for improving referral linkages among services in order to support continuum of care for people living with HIV, and to consider the implementation of national guidelines for task

shifting as well as incorporating staff training and recruitment into a comprehensive human resources for health development plan.

111. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling for grant-making of EUR 13,218,067. During grant-making, EUR 1.04 million in efficiencies were found in in-country cash balance, the reduction of salary incentives, the cancellation of a vehicle purchase, the reduction of fiduciary agent service fees, and the reduction of the budget for accounting software. The GAC approved the reinvestment of these efficiencies in procurement of drugs through the Global Fund's pooled procurement mechanism during the program implementation period, thus revising the grant budget upwards to EUR 14,259,597. The GAC reviewed progress against actions taken during grant-making to address TRP clarifications. The GAC noted that HIV transmission remains criminalized and GAC partners commented that though the development of the grant has been constructive, there is concern that targets are still high in view of the legal environment for key populations including sex workers and men who have sex with men.

112. Domestic contributions. The estimated funding need for the national HIV program of Niger in the next implementation period is EUR 50,993,315. Total domestic financial commitments amount to EUR 16,629,516 (inclusive of private sector) which represents 50 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 55 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments for HIV represent a 64 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the HIV estimated total funding gap for HIV is EUR 18,097,527.

Pakistan TB Grants (PAK-T-NTP and PAK-T-MC)

113. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$138,779,283 for the Pakistan TB program, which consists of the National TB Control Program (NTP) grant PAK-T-NTP with an incremental funding for Board approval of US$93,457,352, and the Mercy Corps grant PAK-T-MC with an incremental funding for Board approval of US$9,470,914 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the Pakistan TB concept note, the amount of unfunded quality demand of US$20,205,105 is registered for the TB program, in line with TRP recommendations.

114. Epidemiological situation. Pakistan is a country of 192 million inhabitants and politically fragile, with high rates of both TB and multidrug-resistant TB (MDR-TB). According to WHO, Pakistan ranks five out of 22 in the global high TB burden countries, five out of 27 in global MDR-TB high-burden countries and is responsible for 60 percent of the TB burden in the East and Mediterranean region. This high burden of TB and MDR-TB faces a problematic political, administrative, cultural and geographic environment, resulting in under diagnosis, and despite excellent treatment success, there is an increasing epidemic particularly of MDR-TB. The most recent surveys show that TB prevalence is at 348 per 100,000 population, incidence at 176 per 100,000 population and mortality at 34 per 100,000. The notification rate dramatically increased between 2001 and 2009, but has remained stable since 2009 at 164 per 100,000. According to WHO, Pakistan is not on track to achieving a 50 percent decline in prevalence by 2015. Case detection in Pakistan is largely passive; active case finding and contact screening has not been systematic. However, treatment success rate is reported to be more than 91 percent. MDR-TB is found among 4.3 percent of new cases and 19.4 percent of retreatment cases. Pakistan's TB program is significantly underfunded and it is heavily reliant on Global Fund funding.

115. Past performance and lessons learned. Pakistan has received Global Fund funding to fight TB since 2004 with a round 2 grant, with subsequent investments under rounds 3, 6, 8 and 9. The Global Fund's programs have resulted in enhanced case notification, as demonstrated by the 2013 total of 298,981 TB cases of all forms notified, a 14-fold increase since 2001. Improvements in programming for MDR-TB have also been demonstrated, such as the closed gap between MDR-TB detected and enrolled on treatment in 2013 as well as providing treatment for patients on the MDR-TB waiting list. Eighteen MDR-TB management centers have been established. The program established 16 TB culture and seven DST laboratories, and 43 sites offering GeneXpert testing.

116. The goals of the TB program are to contribute to reducing TB prevalence by 50 percent among the general population by 2020 compared to 2011 rates, and to contribute to reducing the prevalence of MDR-TB among TB patients who have never received any TB treatment by at least 5 percent per year from 2020 onwards. Expected outcomes of the proposed programming include: (i) an increase in TB notification of all forms from 61 percent of estimated cases in 2013 to 71 percent by 2017, while maintaining the treatment success rate at 91 percent; (ii) to enhance MDR-TB enrollment from 18 percent of estimated cases in 2013 to 32 percent by 2017; (iii) to increase the number of TB patients screened for HIV from 3 percent in 2013 to 10 percent by 2017 and the proportion of people living with HIV on antiretroviral treatment who are screened for TB from 60 percent in 2013 to 90 percent in 2017; and (iii) to strengthen and sustain the programmatic and operational management capacity of the TB control program, while enhancing public sector support for TB control.

117. TRP review and recommendations. The Pakistan TB concept note was initially submitted to the TRP in window 3 in September 2014 and recommended for further iteration. The main issues highlighted by the TRP related to poor strategic focus, suboptimal organization of the concept note and the need to better address the low access of women to health services. An iteration was submitted to the TRP in for review in window 4 in November 2015. The TRP considered the revised concept note to be technically sound and strategically focused, as the changes made to it addressed the concerns from the version previously submitted. The TRP requested one issue to be cleared by the Secretariat, regarding the need to develop a TB/HIV co-infection strategy to strengthen TB/HIV collaborative activities and ensure that all TB/HIV co-infected patients are identified promptly and provided with appropriate care.

118. GAC review and recommendations. The GAC endorsed the TRP's recommendations and approved an upper funding ceiling of US$127,155,179 for grant-making, including an incentive funding award of US$10,892,798 to be focused on MDR-TB programming and the improvement of procurement and

supply chain management. The GAC noted that grant-making would be an opportunity for Pakistan to strengthen MDR-TB programs and procurement challenges, as well as to engage partners and key populations. The GAC subsequently reviewed actions taken during grant-making to address the clarification requested by the TRP. GAC partners acknowledged the country's work on detailed planning for MDR-TB and TB/HIV programming during grant-making in line with TRP recommendations. The GAC also noted that STOP TB Partnership is prepared to work on a gender assessment for Pakistan, which will allow the country to target programming appropriately and address issues of gender equality and access in Pakistan. GAC partners suggested that any additional efficiencies identified during grant implementation should be reinvested in increasing MDR-TB detection and treatment through a public-private mix model.

119. Reinvestment of efficiencies. Following grant-making, the total program budget has been revised upwards to US$138,779,283 due to undisbursed funding in 2014 and carry over activities from previous grants. During grant-making, efficiencies amounting to US$2,016,478 were identified by reducing staff costs and correcting errors in quantification and forecasting. In line with TRP and Partners' recommendations, the GAC approved the reinvestment of this amount in MDR-TB drugs, diagnostics and related procurement and supply chain management costs, treatment enablers to support improvement of treatment outcomes for MDR-TB patients, and covering 300 additional MDR-TB patients.

120. Domestic contributions. The estimated funding need for the national TB program of Pakistan in the next implementation period is US$425,735,291. Total domestic financial commitments amount to US$109,659,535, which represents 47 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 46 percent, which meets the minimum threshold requirement of 20 percent for a lower lower-middle-income country. Government commitments for TB represent an 11.4 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$193,200,000.

Russian Federation HIV Grant (RUS-H-OHI)

121. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$11,270,738 for the Russia HIV program which consists of the RUS-H-OHI grant with an incremental amount for Board approval of US$10,869,216 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the Russian Federation HIV concept note, the amount of US$100,380,999 is registered as unfunded quality demand, in line with TRP recommendations.

122. Epidemiological situation. The Russian Federation is experiencing a concentrated HIV epidemic among members of key populations, which is expanding on a significant scale. The cumulative number of Russian citizens formally registered as living with HIV was 907,607 at the end of 2014. The HIV epidemic information is mostly based on state reported data by the Ministry of Health of the Russian Federation statistical compendium (2013). The total number of registered new HIV cases in 2014 was 85,252, which is 6.9% higher than in 2013. According to official statistics 57.3 percent of HIV positive people detected in 2014 had an identified risk factor - injecting drug use (54.9% percent in 2013; 58.3% in 2009). Heterosexual transmission was reported among 40,3 percent of new cases in 2014; sexual transmission among men who have sex with men was reported among 1.2 percent of new cases in 2014, which is probably underreported due to high stigma and discrimination (1% in 2013 and 1.4% in 2009). Sex work is illegal in the country and hence no data are collected or reported for this group.

123. Eligibility and "NGO rule". As of 2012, the Russian Federation is eligible to access Global Fund funding to support HIV interventions only under the "NGO Rule[6]", stipulating that the application

[6] GF/B30/DP5. NGO Rule for HIV/AIDS: UMICs not listed on the OECD's DAC list of ODA recipients are eligible to apply for HIV and AIDS funding only if the following conditions are met: such country has a reported disease burden of 'High', 'Severe' or 'Extreme'; the application is submitted and the program will be managed by a non-governmental organization (NGO) within the country in which activities would be implemented; the government of such country shall not directly receive any funding; requests are submitted as a non-CCM or other valid application; such funding requests must meet the focus of application requirements set forth in Paragraph 17 of this Policy and must demonstrate that they target key services, as supported by evidence and the country's epidemiology; and applicants must provide confirmation that the services requested in the application are not being provided due to political barriers.

should be submitted and the program will be managed by a non-governmental organization (NGO) within the country in which activities would be implemented; the government of such country shall not directly receive any funding; and requests are submitted as a non-CCM or other valid application. Based on the above, the country is also exempt of the fulfillment of willingness-to-pay and counterpart financing requirements. Based on income classifications published by the World Bank in July 2013, the Russian Federation is classified as a high-income country.

124. Past program performance. The Global Fund has been supporting HIV programs in Russia since 2003 through round 3, 4 and 5 grants, which have strongly contributed to development and capacity building of NGOs and HIV prevention services among key populations. Across these three HIV grants to the Russian Federation, about 30 percent of investment has been made into HIV prevention activities among key populations, 45 percent of investment has been made in antiretroviral treatment (ART), post-exposure prophylaxis, prevention mother-to-child transmission (PMTCT) and care and support components. Global Fund grants have also supported ARV treatment activities in Russia. Cumulatively, across the three grants, 8 percent of investment has been made into community systems strengthening, advocacy and policy development activities.

125. Program goal. The concept note sets forth strategic priorities for funding during the grace period granted to the Russian Federation in terms of its eligibility to receive Global Fund support under the "NGO rule". The program will continue the activities initiated under the two previous HIV grants in Russia and aims to create an environment for the integration of evidence-based prevention programs into the national HIV strategy in order to promote further sustainability. The main program focus is to fill the significant programmatic and financial gaps in the current national response to the HIV epidemic in the country, due to the absence of state prevention services for the key populations, namely people who inject drugs, sex workers, and men who have sex with men. The current grant puts an emphasis on community systems strengthening, advocacy by communities affected by HIV and TB/HIV as soft tools for longer-term advocacy with the Russian authorities, potentially leading to the desired result of seeing the local policies change to increase domestic financing for HIV prevention among key populations. The program will be implemented by the Open Health Institute Foundation, which was selected as Principal Recipient though a transparent and open process.

126. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused, proposing implementation of evidence-based interventions that are appropriate to the country context, with a prioritization of key populations. The TRP acknowledged that the concept note aims to improve the enabling environment for prevention interventions among key populations through intensive advocacy efforts and strengthening of community systems. The TRP highlighted six recommendations around the support for prevention interventions for key populations, community systems strengthening for people living with HIV, a strategy to build on the expertise and institutional strength of the network of harm reduction organizations, and an advocacy strategy and plan to include activities specifically geared to local and regional governments. In addition, the TRP recommended the applicant to refocus the above allocation request on maintaining coverage of existing prevention interventions for people who inject drugs and on scaling up coverage of existing prevention interventions.

127. GAC review and recommendations. The GAC endorsed the TRP recommendations and the GAC recommended an upper funding ceiling for grant making of US$12,095,198 based on TRP recommendations. During grant-making, efficiencies of US$361,650 were identified in the revision of costs for health products and human resources. The GAC endorsed the reinvestment of these efficiencies into the forex rate applied to the budget, as well as into increased visits to the project regions and health product storage. The GAC reviewed progress in resolving TRP clarifications during grant-making. GAC partners commended the efforts and progress made by the HIV program in Russia since 2004 and underlined its importance for the region, including the significant effect of Russian epidemics on neighboring countries. Considering the high TB/HIV co-infection rate for incarcerated populations and people who inject drugs, the GAC partners also expressed concern that TB/HIV co-infections might also be neglected among key populations. Partners also noted that until opioid substitution therapy is introduced in the country and harm reduction services are made widely available for people who use drugs, the ability of the program to demonstrate desired impact may be challenged. GAC partners further highlighted concerns related to data availability affecting the measurement of success of HIV preventions. In this regard, in order to mitigate issues with the data reliability and accuracy the Secretariat clarified that the current grant plans to conduct bio behavioral surveys and size (IBBS) estimation exercises for all key populations in the regions where projects are implemented. Results from IBBS and size estimation exercises will be reflected in the targets for the impact and outcome indicators as well as denominators for the coverage indicators for the prevention activities.

Rwanda TB/HIV Grants (RWA-T-MOH and RWA-H-MOH)

128. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$169,806,321 for the Rwanda TB/HIV program, which consists of the Ministry of Health grants RWA-T-MOH with an incremental amount for Board approval of US$15,842,168 and RWA-H-MOH with an incremental amount for Board approval of US$148,528,188 for the implementation period June 2015 through December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$173,682,357 is registered as unfunded quality demand, in line with TRP recommendations.

129. Epidemiological situation. Rwanda has made excellent progress in its efforts against HIV and TB. Overall, HIV incidence has been on a decline since 2000, with the annual estimated number of new HIV infections falling from 13,000 in 2005 to 5,600 in 2013. There is significant geographic variation of prevalence, though, and HIV prevalence stands at 7.3 percent in the city of Kigali and ranges from 2.1 percent to 2.7 percent in the other four provinces. While the HIV epidemic is generalized, with a prevalence rate of 3 percent among the general population, there are more substantial HIV burdens among key populations with prevalence rates of 51 percent among female sex workers and 13 percent among men who have sex with men. HIV prevalence among pregnant women declined from 2.6 percent in 2010 to 1.9 percent in 2011, and the mother-to-child transmission rate at 18 months after birth is 1.8 percent. Good progress has also been made in TB treatment success rate, which is at 89 percent for smear-positive patients and 94 percent for patients supported by community health workers. The TB notification rate has fallen from 92 per 100,000 population in 2006 to 59 per 100,000 population in 2012, following improvements in treatment success rates, ARVs for people living with HIV, community DOTS, TB/HIV integration and infection control. Furthermore, the availability of MDR-TB diagnostic capacity, including culture and drug susceptibility testing, molecular tests and GeneXpert have contributed to a treatment success rate for MDR-TB patients of 87 percent.

130. Past performance and lessons learned. The Global Fund has invested in the Rwanda national HIV program since 2004 and TB program since 2005. The investments in TB have supported high quality DOTS expansion and enhancement; improvement of TB case finding, including active screening for TB among high-risk groups; procurement of first-line and second-line TB drugs; MDR-TB control; interventions addressing TB/HIV co-infection; training of health care providers; and enhancement of TB surveillance. Owing to these efforts, TB incidence, prevalence and mortality are decreasing and Rwanda is on track to achieve the Millennium Development Goal target of a declining trend in TB incidence by 2015 from 291 new and relapse cases per 100,000 population in 1990 to 86 TB new and relapse cases per 100,000 population in 2012. While TB control has made substantial progress over the last decade, there are still significant challenges to be addressed, particularly late diagnosis and treatment initiation. Over recent years, the Rwanda national program has taken HIV services to the level of near universal access. The percentage of health facilities offering voluntary counselling and testing services has risen to 99 percent, compared to only 43 percent in 2009, and prevention of mother-to-child transmission (PMTCT) services are available at 96 percent of health facilities. Apart from prevention, care and treatment services for the general population, targeted services have been developed to reach key populations. Moreover, collaborative activities to address TB/HIV co-infection have been implemented successfully, such that 95 percent of newly enrolled people living with HIV are screened for TB. Maintaining these achievements within a reduced funding envelope, implementing the new WHO HIV treatment guidelines, scaling up voluntary medical male circumcision, and lack of reliable data on the HIV prevalence trend among the key populations constituted key challenges for the program.

131. The goals of the TB/HIV program of Rwanda are, by 2018, to reduce the TB incidence rate by 23 percent, reduce the TB mortality rate by 37 percent, reduce new HIV infections from 6,000 to 2,000, reduce HIV-related deaths from 5,000 to 2,500 and mitigate the impact of HIV by ensuring that people infected and/or affected by HIV have the same opportunities as the general population. The Rwanda TB program during the next implementation period will focus on: (i) increasing the capacity to rapidly diagnose HIV-associated TB, rifampicin-resistant TB, extra-pulmonary forms of TB and TB among high risk groups, such as contacts, prisoners, elderly, children; (ii) ensuring continuous availability of high-quality health care delivery, extend the practical approach to lung health to improve clinical investigation of people with respiratory disease, and strengthen interventions aimed at reducing TB mortality; (iii) enhancing surveillance of TB among health care providers, enhancing isoniazid preventive therapy for TB contacts aged less than five years, and empowering TB patients and communities; (iv) addressing TB/HIV, MDR-TB and other challenges; and (v) supporting an enabling

environment and promoting research. The HIV program will focus on: (i) preventing HIV through: HIV counselling and testing and minimum package of services to key populations, implementation of effective prevention of mother-to-child transmission strategies, voluntary medical male circumcision, and strengthening diagnostic capacity for TB/HIV; (ii) improving the referral system, maintaining treatment retention at a high level, strengthening involvement of community health workers, and scaling up early ART provision nationwide; (iii) providing a minimum package of orphan and vulnerable children services at all levels, sensitization against stigma and discrimination, and implementation of interventions to address harmful gender norms and gender based violence; and (iv) ensuring efficient procurement and distribution of essential drugs and medical products, integration of service delivery, reinforcing monitoring and evaluation systems and ensuring coordination.

132. Implementation arrangements and national strategy financing model. Rwanda is one of the countries selected by the Global Fund for implementation of a results based financing model known as the national strategy financing (NSF) model, given the country's robust, evidence-based, costed and prioritized national strategic plans for the diseases, previous participation in the national strategy financing model, and demonstrated ability to use donor and domestic financing to control HIV and TB. The TB and HIV grants will be implemented by the Ministry of Health of Rwanda as the grant Principal Recipient. The coordination role and experience of the Ministry of Health is central to effective implementation of the national strategy financing model, and also ensures sustainability and synergies across activities. The national strategy financing model offers Rwanda strong incentives for high performance, flexibility in programming and reduces bottlenecks.

133. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused as it presented a robust prioritization of high impact interventions that adequately address outstanding program gaps. The TRP commended the strong engagement of the community in the program and the proposal to further strengthen TB/HIV collaboration. The TRP highlighted some clarifications to be addressed during grant-making and grant implementation including the appropriateness of indicators to evaluate program outcomes under the previous national strategy model, clarification of reliable and geographically comprehensive size estimates for key populations including sex workers and men who have sex with men, TB interventions in prison and TB surveillance amongst health care workers and the need to prioritize HIV programming for key populations and young people, especially girls aged 15-24 years within the allocation funding so that these indicators can still be reported on.

134. GAC review and recommendations. The GAC endorsed the TRP's comments and approved an upper funding ceiling of US$169,806,321 for grant-making. The GAC stressed that the collaboration between the TB and HIV programs should be integrated and strengthened across the proposed program interventions. The GAC highlighted the importance of government and partner collaboration to develop a financial sustainability plan for the Rwanda TB/HIV program. The GAC reviewed actions taken to address TRP clarifications and while nearly all issues highlighted had been addressed during grant-making, GAC noted with concern that the Performance Framework no longer contained key population specific operational indicators for men who have sex with men and sex workers. GAC partners stressed the strategic importance of ensuring comprehensive HIV prevention programming that addresses the specific needs of all key populations and cautioned that the exclusion of key population indicators may pose the potential risk of their marginalization. GAC technical partners also added that as the Global Fund pilot NSF model, the Rwanda TB/HIV program would be scrutinized for learnings and a follow-up survey on key populations during program implementation was critical to measure progress. In this regard, the GAC recommended that the Secretariat reach out to the country to reconsider the integration of the key population indicators including targets in the Performance Framework, as reviewed and recommended by the TRP. In addition, based on the guidance from technical partners regarding the importance of repeating IBBS periodically, the GAC also recommended that the Secretariat explore accessing potential additional funding sources, including from the Global Fund's Special Initiatives Fund, in order to support Rwanda in conducting the IBBS in 2017, the results of which should be reported during the grant implementation period.

135. GAC review and recommendations. Based on follow-up discussions with the country, the GAC noted that the key population indicators will be maintained in the Performance Framework with the provision to include targets for 2017 when the IBBS 2015 results are finalized and that the Global Fund will identify resources to support the IBBS in 2017. The GAC further acknowledged that Rwanda has taken measures to implement evidence-based interventions focusing on key populations. Data to inform development of baselines for these populations will be available upon completion of the ongoing IBSS

and will inform Rwanda's future strategies towards HIV epidemic control. The GAC also acknowledged that key population activities and indicators are captured in the Rwanda national M&E plan and will be reported upon as part of the Rwanda National HIV Annual Report.

136. Domestic contributions. The estimated funding needs for the national HIV and TB programs of Rwanda in the next implementation period are US$42.1 million for TB and US$643.4 million for HIV. Total domestic financial commitments amount to US$9.5 million for TB and US$69.3 million for HIV which represent 23 percent and 11 percent respectively of total resources available for the next implementation period. Based on commitments of government contribution in the next phase, and on the assumption that the full requested indicative funding contained in the concept note is approved, the counterpart financing share is 28 percent for the TB program and 26 percent for the HIV program, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 32 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$234.2 million for HIV and US$8.9 million for the TB program.

Solomon Islands Malaria Grant (SLB-M-MHMS)

137. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$5,579,078 with an incremental amount for Board approval of US$1,592,266 for the Solomon Islands malaria program which consists of the Ministry of Health and Medical Services grant SLB-M-MHMS for the implementation period 1 July 2015 through 31 December 2017. The Solomon Islands did not submit an above allocation request for this component and therefore does not have any unfunded quality demand registered.

138. Epidemiological situation. The Solomon Islands remains one of the highly malaria endemic countries in the Western Pacific region. Malaria transmission in Solomon Islands is quite variable with some areas classified as non-endemic and others classified as hyper-endemic, but over 98 percent of the population is at risk of malaria. During the last decade, the impact from the investments in the malaria program has been significant. The annual parasite incidence (API) rate has been drastically reduced from a peak of 422 cases per 1,000 people in 1993 to 45 cases per 1,000 population in 2013 and despite the high reported clinical incidences, malaria rarely results in death in Solomon Islands. In 2013, there were 3.2 malaria-related deaths per 100,000 population, a reduction of 80 per cent from 17 per 100,000 population in 2007.

139. The overall goal of this program is to reduce the API from 45 per 1,000 population in 2013 to less than 25 per 1000 by 2020 with the following priority objectives: (i) to maintain high long lasting insecticidal net (LLIN) coverage, increase usage and target supplementary vector control measures based on epidemiological need; (ii) to maximize access to and utilization of early laboratory confirmed diagnostic and appropriate effective treatment for malaria; (iii) to support the Ministry of Health in strengthening health systems nationwide; (iv) to maximize program impact through partnership and improved program management; and (v) to continue to move towards malaria elimination by 2035.

140. Results based financing - cash on delivery model (CoD). The Global Fund investments in Solomon Islands to date have been made through a regional coordinating mechanism, the Pacific Islands Regional Multi-Country Coordination Mechanism, and the country was previously part of the multi-country Western Pacific portfolio. In 2014-2016 allocation period the country decided to submit a single country allocation piloted under the cash on delivery financing model. The CoD model is structured around the following aims: (i) pre-financing by the country of all local activities reduces exposure to risk for Global Fund investments, which allows for substantial simplification of grant management processes and reduces operational costs, allowing greater proportion of grant funds to be spent on achieving impact; (ii) sustainability and full country ownership of programs is ensured when the government pre-finances the programs from the very beginning by using and improving national systems; and (iii) increased focus on impact, greatly incentivized by the reward mechanism, will further galvanize the national response to the epidemics. The grant will be implemented by the Ministry of Health and Medical Services (MHMS), a former sub-recipient of past Global Fund grants, who will therefore pre-finance all local activities and implement them jointly with its in-country partners. Procurement of health products and pharmaceuticals will be conducted through the Global Fund's pooled procurement mechanism with the funding being advanced by the Global Fund directly to the supplier. A large proportion of grant funds will be used for capacity building through international

technical assistance, which will be paid in advance by the Global Fund and managed in its entirety by WHO.

141. Results verification. After each year of implementation the MHMS will submit a report that details their achievements against a single impact indicator, the Annual Parasite Incidence. Based on this report, an independent data quality and programmatic assessment is to be conducted, which will inform the Global Fund about the level of achievement against targets for the indicator. Achievement against targets of the impact indicator would guide the Global Fund's disbursement of the award funding and its level. For the country to be eligible for reward funding after year 1 of the grant, the following conditions incentivizing rapid improvement of reporting systems will be have to be met: (i) the malaria information system and the health information system are to be fully aligned by the end of 2015; (ii) data from all tertiary care centers is included in the reporting; (iii) reporting levels from health facilities are maintained; (iv) the proportion of the population covered with the reporting at the end of 2015 is clearly shown; and (v) a plan is developed and implemented for continued improvement in number of facilities reporting on malaria on a regular basis. Additionally and based on lessons learned from the recent past, support from DFAT has created additional layers of financial controls within the Ministry of Health and Medical Services, Ministry of Finance and provinces.

142. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused, as it is aligned with the national strategic plan covering the period from 2015 to 2020 and proposes interventions that are feasible within the context of the country. However, the TRP also raised certain concerns, including worry that the plan is overly ambitious and requires long-term commitment, strong implementation and secure funding, as well as that the inherent health system weaknesses identified in the concept note may affect the achievement of set targets, if not addressed. These health system weaknesses include the shortage of staff, the lack of continuous professional development for health system staff, the quality assurance and supervision mechanisms, and supply chain issues resulting in stock-outs of artemisinin-based combination therapy (ACTs), rapid diagnostic tests (RDTs) and primaquine.

143. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling of US$5,470,000 for grant-making. During grant-making, a total of US$646,010 of efficiencies were identified in the reduced unit costs for health products. The GAC approved the reinvestment of these efficiencies in the procurement of an additional 57,000 bed nets, 264,000 RDTs and 80,000 ACTs. GAC partners highlighted the limitations of focusing on a single impact indicator for determination of results for reward funding, the Annual Parasite Incidence, as it is influenced by both program factors (diagnostic testing rate and reporting rate etc.) and non-program factors (environmental factors and random fluctuations etc.), which could potentially compromise its validity for measuring program progress on a yearly basis. During grant making, this risk was mitigated by the development of a range for Annual Parasite Incidence targets defined in consultation with partners and the implementation of an independent data quality and programmatic assessment that will take into account the overall programmatic context in its determination of the program performance. The GAC also noted that the use of a single impact indicator for funding decisions strongly incentivizes the achievement of the intended impact, encourages evidence-based innovation, streamlines performance measurement and verification and simplifies grant management through reduced reporting requirements. The GAC reinforced that the primary purpose for implementing the cash on delivery model in Solomon Islands is the need to maximize the impact of the limited Global Fund resources by increasing the flexibility and simplicity of grant management processes through country ownership and to encourage the country and key partners in the region to focus on impact. GAC noted that the baseline range for the API targets will be revised at the end of the first year and remain fixed from that point. The GAC also acknowledged that the Principal Recipient should ensure that the national human resource development plan is regularly updated in coordination with all stakeholders. It was also noted that the applicant will be required to ensure meaningful involvement of communities and key affected populations in the implementation of the grant.

144. Domestic contributions. The estimated funding need for the national malaria program of Solomon Islands in the next implementation period is US$33,000,000. Total domestic financial commitments for malaria amount to US$4,857,000, which represents 14.7 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 32 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across

malaria and TB programs represent a 38 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$1,534,495.

Solomon Islands TB Grant (SLB-T-MHMS)

145. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$2,758,339 with an incremental amount for Board approval of US$705,660 for the Solomon Islands TB program which consist of the Solomon Islands Ministry of Health and Medical Services grant SLB-T-MHMS for the implementation period 1 January 2015 through 31 December 2017. The Solomon Islands did not submit an above allocation request for this component and therefore does not have any unfunded quality demand registered.

146. Epidemiological situation. The Solomon Islands has the second highest number of TB cases in the Western Pacific region, though they continue to make progress towards achieving the Millennium Development Goals and the Stop TB Partnership targets for 2015. TB is a major public health challenge in this country - around 400 TB patients are registered every year. Most of these cases are young adults and around 20 percent are children, indicating high levels of transmission. Solomon Islands is an important country in the Pacific region's TB landscape due to its high TB burden at 142 per 100,000 population, incidence rate at 92 per 100,000 population and mortality rate at 14 per 100,000 population. Between 1990 and 2013, TB prevalence, incidence and mortality have fallen and there have been no multidrug resistant TB (MDR-TB) cases. One challenge the country faces is low laboratory capacity, therefore drug susceptibility testing and culture are done in supranational laboratories. In 2013 a total of 360 TB cases of all forms, new and relapse, were notified to the national TB and leprosy program. Overall, the TB case detection rate is 67 percent.

147. The goal of the program is to reduce the burden of TB and TB/HIV co-infection in Solomon Islands and to increase case detection while maintaining the treatment success rate at 90 percent with a cure rate of 80 percent or more. To enable the Solomon Islands to achieve these goals, the Global Fund will invest in the following strategies: (i) ensure universal access to TB and MDR-TB care and prevention interventions; (ii) maintain or improve the quality of TB case detection and diagnosis and treatment and prevention of MDR-TB in the already covered areas and populations; (iii) increase the reach of TB prevention and control services in hard-to-reach areas and among high-risk and key affected populations; (iv) address human rights and gender issues; and (v) foster synergies between the TB and HIV programs and increased uptake of TB/HIV services.

148. Results-based financing, cash on delivery model (CoD). The TB cash on delivery grant will be implemented against achievement of two outcome/coverage indicators in line with TRP and partner guidance: the treatment success rate of all forms of TB and the number of notified cases of all forms of TB cases, including bacteriologically-confirmed, new and relapse cases. Based on the Ministry of Health annual performance report, an independent data quality and programmatic assessment is to be conducted, which will inform the Global Fund about the level of achievement against targets for the indicators. Achievement against targets of the impact indicator will guide the Global Fund's disbursement of the award funding and its level. The primary purpose of proposing this model in Solomon Islands is to address the pressing need for maximizing impact from the limited Global Fund resources by increasing the flexibility and simplicity of grant management processes. Additionally and based on lessons learned from the recent past, DFAT has provided additional support to enhance financial controls within the Ministry of Health and Medical Services,, Ministry of Finance and provinces.

149. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound, commenting that the concept note is tailored to the national and local epidemiology taking into account the peculiarities of the country situation, including the high TB burden, high prevalence of diabetes and implications for cross-border infection from Papua New Guinea. However, the TRP raised some concerns such as the current TB case notification rate and the cure rate for bacteriologically confirmed TB cases, which are below the WHO targets; the lack of information about the performance of TB laboratory services; and the very high turnover of the health staff with no significant initiative proposed to address this major issue, putting the sustainability of TB program at risk. However, given the particular context of the Solomon Islands the TRP acknowledged that sustainability is extremely challenging and self-reliance in the near future may be questionable.

150. GAC review and recommendations. The GAC endorsed the TRP's recommendations and approved an upper funding ceiling of US$2,758,339 for grant-making. During grant-making, efficiencies totaling US$353,248 were found in reduced unit and technical cooperation costs. The GAC approved the reinvestment of these efficiencies in the financing model as Cash on Delivery funding, independent data quality and programmatic assessment and Green Light Committee fees for MDR-TB. The GAC reviewed actions taken during grant-making to address the clarifications requested by the TRP. GAC partners noted that the use of the number of all forms of TB cases notified as a measure of program success come with certain risks, particularly as rates of reported cases have fluctuated yearly over the last ten years, prompting the Secretariat to build greater flexibility toward this indicator into the grant. The GAC also acknowledged that the Principal Recipient should ensure that the national human resource development plan is regularly updated in coordination with all stakeholders. It was also noted that the applicant will be required to ensure meaningful involvement of communities and key affected populations in the implementation of the grant.

151. Domestic contributions. The estimated funding need for the national TB program of Solomon Islands in the next implementation period is US$5,347,677. Total domestic financial commitments amount to US$1,293,501, for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 32 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across malaria and TB programs represent a 38 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$1,534,495.

Sudan HIV Grant (SDN-H-UNDP)

152. Funding Recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of US$20,870,921 for the grant SDN-H-UNDP to support the Government of Sudan HIV program with an incremental funding amount for Board approval of US$16,968,147 for the implementation period 1 January 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$26,787,657 is registered as unfunded quality demand, in line with TRP recommendations.

153. Epidemiological situation. Sudan has a concentrated HIV epidemic with prevalence among the general population estimated at between 0.31 percent and 0.42 percent. Overall the national epidemic is believed to be growing slowly with projections of the number of people living with HIV rising from 49,000 in 2013 to 56,000 in 2017. A 2013 modes of transmission analysis attributes 75 percent of this growth to infections resulting from sexual transmission in sex work and men who have sex with men. There has been limited reach to these groups with a minimum package of services in 2012 and 2013. Condom use remains exceedingly low with just 11 percent consistent use among female sex workers and 19 percent among men who have sex with men according to the 2011 integrated bio-behavioral survey. The antiretroviral therapy (ART) program presently covers about 9 percent of estimated population need, despite the expansion of the number of sites from 21 to 33 between 2007 and 2013.

154. Past performance and lessons learned. Since 2005, the Global Fund has committed over US$125,250,486 to support the national response to HIV and AIDS in Sudan through grants in rounds 3, 5 and 10. Sudan has achieved some positive results as under-five mortality has declined from 123 1990 to 93 per 1000 live births in 2012 and maternal mortality has declined from 537 in 1990 to 216 per 100,000 population in 2012. However, the program has faced many challenges, including a weak health system and past political instability.

155. Program goals and what impact is expected. The goals of Sudan's HIV program are to halt further spread of HIV among the Sudanese population and maintain HIV prevalence rates below 2.5 percent among all most-at-risk populations and below 0.3 percent among the general population by 2017 and to improve the quality of life, health and wellbeing of people living with HIV by providing universal access to comprehensive quality HIV treatment, care and support services. The program seeks to reach between 25,000 and 51,000 female sex workers with HIV prevention services and between 10,000 and 22,000 female sex workers with HIV testing by 2017. Among men who have sex with men and transgender people, the program seeks to reach between 19,000 and 45,000 men who have sex with men with prevention services each year and between 8,000 and 19,000 men who have sex with

men with HIV testing on an annual basis by 2017. Among the general population, the program seeks to reach between 50,000 and 150,000 people with prevention services each year by 2017. Expected outcomes of the proposed programming include increasing the retention rate of people living with HIV on ART to 85 percent after 12 months from 67 percent in 2013 and increasing condom use to 75 percent by female sex workers and men who have sex with men from 2011 rates of 21 percent and 19 percent, respectively.

156. Operational issues and implementation arrangements. UNDP has been selected to continue in its role as Principal Recipient. In order to ensure the long-term sustainability of the program, the payment of performance-based incentives for staff at different management and service delivery levels will be developed into a clear incentive funding scheme within six months of grant signing. The results of the 2014 OIG audit centered on capacity issues and non-financial risks, resulting in two Sudan-specific management actions due 30 September and 31 December 2015. In the first instance, the Global Fund Secretariat will work with UNDP, the Federal Ministry of Health, GAVI and other partners to develop adequate grant management capacity of relevant national institutions, including assessing the current capacity of the Federal Ministry of Health to become a Principal Recipient, establishing corresponding minimum criteria, developing a comprehensive capacity building plan to address gaps and establishing clear performance indicators, targets, milestones and timelines and monitoring the implementation of the comprehensive plan. In the second instance, the Secretariat will ensure adequate risk mitigation and assurance measures are fully in place and reflected in grant-specific QUARTs updated in 2015. Any residual risks will be articulated and approved by the Operational Risk Committee.

157. TRP review and recommendations. The Sudan integrated HIV, TB, malaria and health systems strengthening concept note was initially submitted in window 3 in October 2014. The TRP noted substantial issues that needed to be addressed, including the need for prioritized interventions for key populations according to region, the overall program ambition considering the limited resources, low coverage rates of key populations and joint TB/HIV programming. An iteration was submitted in window 4 in November 2014 and the TRP considered this concept note to be technically sound and strategically focused, as it addressed most of the concerns raised by the TRP in its initial review. Some issues were requested by the TRP to be clarified including adjusting targets to reflect geographic prioritization within a number of program areas, obtaining further clarity on prevention of mother-to-child transmission targets, ensuring that Sudan takes the opportunity to mobilize additional resources, examining the possibility of expansion of primary health care to increase prevention of mother-to-child transmission and HIV testing and counseling coverage, addressing the quality of HIV prevention programs and reprioritizing programming for sexually transmitted infections.

158. GAC review and recommendations. The GAC endorsed the TRP recommendations and approved US$21,956,866 as the upper-ceiling funding amount for grant-making. During grant-making, an in-country cash balance of US$3,735,374 was confirmed. In view of the integrated concept note being submitted, the GAC determined that that the Secretariat collaborate closely with in country stakeholders to identify the utilization that will achieve maximum programmatic impact. The GAC noted the significance of the Sudan Integrated concept note as an ambitious attempt to combine HIV, TB, malaria and health systems strengthening support into one coherent framework. The GAC noted actions taken to address TRP comments during grant-making, including increasing funding to monitoring and evaluation. The GAC acknowledged that a capacity development plan is essential and emphasized that a mid-term review of the national strategic plan including epidemiological analysis, is required for effective program planning and implementation, encouraging the country to use savings and efficiencies during grant implementation to support these items. The GAC also noted that the Secretariat should work with partners and in-country stakeholders to ensure that the country's ART regimens are in line with international best practices and the latest WHO guidance. The Global Fund will continue to work closely with partners in country for the effective and timely implementation of the Global Fund grants and to ensure greatest value for money and impact, noting the relatively high human resource and administrative costs of the grant can also be traced to its focus on labor- and logistics-intensive outreach programming with key populations. The GAC underscored the value of undertaking joint annual assessments across diseases to review and document the implementation of the integrated grant approach as well as any synergies arising from this approach.

159. Domestic contributions. The estimated funding need for the national HIV program of Sudan in the next implementation period is US$73.3 million. Total domestic financial commitments amount to US$8.3 million which represents 26 percent of total resources available for the next implementation

period. The counterpart financing share based on HIV commitments of government contribution in the next phase, and on the assumption that the full requested indicative funding in this concept note is approved, is 26 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across all three diseases and health systems strengthening represent a 171 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total HIV funding gap is US$41.6 million.

Swaziland TB Grant (SWZ-T-NERCHA)

160. Funding Recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$21,189,356 for the Swaziland TB program, which consists of the National Emergency Response Council on HIV and AIDS (NERCHA) grant number SWZ-T-NERCHA with an incremental amount of US$9,143,959 for Board approval for the implementation period 1 July 2015 through 31 March 2018. Based on the above allocation funding request submitted in the concept note, the amount of US$16,692,038 is registered as unfunded quality demand, in line with TRP recommendations.

161. Epidemiological situation. Swaziland has an estimated population of 1.1 million people and the highest TB/HIV co-infection rate in the world, with current estimates of TB prevalence of 945 per 100,000 population. The estimated TB-related mortality, excluding HIV, is at 91 per 100,000 population over the last decade and while there have been substantial improvements in the TB treatment success rate from 68 percent in 2009 to 72 percent in 2013, Swaziland is still below the WHO target of 85 percent. The trends in notification rates over the last five years suggest a huge gap in TB case detection, as the detection rate is estimated at 38 percent. This is contributed to by insufficient active case finding among key populations such as prisoners, mine workers, children and patients with co-morbid conditions such as diabetes. Furthermore, the TB epidemic has been exacerbated by the high rate of HIV prevalence among the general population and the risk of acquiring TB is between 20 and 37 times greater among people living with HIV. The TB/HIV co-infection rate among incident TB cases has remained above 70 percent. Over 70 percent of TB patients are HIV-positive and TB is responsible for more than a quarter of deaths among people living with HIV. However, significant progress has been made in the response to the HIV and TB epidemics, with 80 percent TB/HIV co-infected patients receiving antiretroviral treatment (ART) in 2013, a great improvement from 35 percent in 2010. Additionally, HIV treatment and counselling update among TB patients has increased from 86 percent in 2010 to 91 percent in 2013. Equally challenging for Swaziland in combatting TB is the increasing burden of drug resistant TB cases. A 2009 national drug resistance survey showed a multidrug resistant TB (MDR-TB) prevalence of 7.7 percent among new TB cases, and 33.7 percent among previously treated TB patients, however the country might also be missing many MDR-TB cases due to limited diagnostic capacity. Contributing factors to overall low treatment outcomes for TB are largely a result of a highly centralized system that faces challenges such as inadequate qualified health personnel and weak second line drug susceptibility diagnostic capacity.

162. Past performance and lessons learned. The Global Fund has been supporting Swaziland's HIV program since 2003 and the TB program since 2005. Global Fund supported HIV activities have been aimed at reducing the incidence of HIV and AIDS, mitigating the impact of the disease on infected and affected individuals, supporting orphans and vulnerable children and creating a supportive environment for the provision of services that have been implemented. The Global Fund's investments in TB in Swaziland have supported the expansion of access of basic microscopy, the decentralization of integrated TB/HIV co-management, the improvement of infection control and the strengthening of community based directly observed treatment, short-course. The TB program has performed strongly in the area of TB/HIV with 95 percent of TB patients having their HIV status recorded on the TB register and 78 percent of TB/HIV co-infected persons receiving ART. Challenges remain in the area of case notification and due to a disruption in drug susceptibility testing enrolment of MDR-TB patients, the program suffered a decline in performance.

163. The goal of this program is to contribute to the reduction of the TB, TB/HIV, MDR-TB and extensively drug resistant TB burdens in Swaziland, in line with the national and global TB targets. To enable the Swaziland to achieve the program goal, the Global Fund will invest in the following strategies: (i) enhancing and expanding case finding and successful treatment of TB; (ii) addressing TB/HIV co-infection; (iii) detecting and treating MDR-TB; (iv) contributing to health systems strengthening; (v) engaging all health care providers; (vi) empowering patients and communities to participate in TB

control; and (vii) enabling and promoting program-based operational research. Expected outcomes of these strategies include a reduced TB mortality rate per 100,000 population from 91 in 2013 to 84 in 2018, an increased case notification rate of all forms of TB per 100,000 population from 505 in 2014 to 1,024 in 2018, a reduced TB/HIV mortality rate per 100,000 population from 400 in 2013 to 319 in 2018 and a reduced prevalence of MDR-TB prevalence among new TB patients from 7.7 percent in 2009 to 5 percent in 2017.

164. Implementation arrangements. While the request for funding has been submitted as an integrated TB/HIV concept note and has been planned for integrated implementation, due to a changing funding landscape for HIV post concept note submission and review, the readiness of the HIV prevention activities and the introduction of new Principal Recipient (CANGO) for HIV grant, at this time only the TB grant is being recommended for Board approval. However, the Secretariat would like to emphasize the unified nature of the TB/HIV programming in Swaziland and assure the Board that the interventions outlined will be executed in a coordinated manner. The current Principal Recipient, the National Emergency Response Council on HIV and AIDS (NERCHA) has been reselected for implementation of TB program following an open and transparent assessment of candidates. All first line TB drugs will be procured by the government and the absorption of key positions of health personnel currently supported by donor funds is planned to occur during implementation.

165. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused and aligned with the national strategic plans for HIV/AIDS and TB as well as with international best practices, in addition to being responsive to the epidemiology of the two diseases. The concept note included a well-integrated plan for the implementation of TB, HIV and health systems strengthening activities, an adequate programmatic gap analysis of the priority health system needs and clearly described the rationale behind the Global Fund which is supported by well documented contributions and intentions. The TRP acknowledged an inclusive process of concept note development with the participation of a broad range of stakeholders. The TRP also noted the need to resolve issues such as the lack of budget for program management; the mention (but lack of budget) in the above allocation request for HSS modules; the limited focus of interventions among sex workers; the lack of size estimates and updated sero-prevalence rates for key populations; a plan to roll out HIV viral load testing for 100 percent of patients on ART; the funding gap for HIV testing and counselling targets; the increased cost of nutritional supplements for ART patients; the need for inclusion of WHO recommended best practices for follow-up of mother-baby pairs; concerns regarding the lack of mentorship envisaged for community health workers; and the lack of clear plan for future continued collaboration between HIV and TB stakeholders.

166. GAC review and recommendations. The GAC recommended an upper funding ceiling for grant-making of US$74,070,746 based on TRP recommendations. The GAC endorsed the TRP recommendations related to TB and reviewed progress against actions taken during grant-making to address the TB-related TRP clarifications. During grant-making, US$1,704,013 in efficiencies were identified as the result of the review of unit costs for health products and commodities and the consolidation of training activities. The GAC endorsed the reinvestment of these funds in GeneXpert cartridges and laboratory reagents for second line drug susceptibility testing as well as reinvesting the remaining savings into the HIV component to fill under-resourced activities in that program. The CCM therefore requested and approved a revision to Swaziland's disease split. The GAC reviewed actions taken during grant-making to address the clarifications requested by the TRP and found the response to be satisfactory.

167. Domestic contributions. The estimated funding need for the national TB program of Swaziland in the next implementation period is US$91.6 million. Total domestic financial commitments amount to US$29.8 million, which represents 33 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested indicative funding in this concept note is approved, is 43 percent, which meets the minimum threshold requirement of 40 percent for an upper-lower-middle income country. Government commitments to only this disease represent a 22 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$14.7 million.

Tanzania TB/HIV Grant (TZA-C-STC)

168. Funding recommendation for Board approval. For the approval by the Board, the GAC recommends a total budget amount of US$13,059,126 for the Tanzania TB/HIV grant implemented by the Save the Children (TZA-C-STC) with the incremental amount for Board approval of US$13,059,126 for the implementation period 1 July 2015 through 31 December 2017.

169. Implementation arrangements. The TB/HIV program in Tanzania is implemented though a dual track financing model by the Ministry of Finance and Save the Children Tanzania as the two Principal Recipients nominated in the concept note. The Ministry of Finance will manage, together with the Ministry of Health and Social Welfare, the shortened HIV grant focusing on prevention in general population, treatment, care and support, TB/HIV joint programming, procurement and supply chain management as well as health system strengthening activities. The Save the Children TB/HIV grant will focus on both TB and HIV interventions at community level. Grants implemented by the Ministry of Health have already been reviewed and approved by the Board[7] on 5 June 2015 and therefore through current report the GAC makes recommendation to the Board with relation to the grant implemented by Save the Children.

170. Programming. This Principal Recipient will be implementing the civil society component of the grant, including prevention interventions such as condom distribution, HIV testing and counseling and sexually transmitted infection services for men who have sex with men, transgender people and sex workers in selected regions with higher prevalence. Additionally, Save the Children will work closely with the Ministry of Health on prevention of mother-to-child transmission programming and community-level interventions for improved case detection and MDR-TB implementation for TB.

[7] GF/B33/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation

02 Summary of the deliberations of the Secretariat's Grant Approvals Committee (GAC) on proposed grant extensions

Guatemala TB Grant (GUA-610-G04-T)

171. Funding recommendation for Board approval. The GAC endorsed the proposed nine-month non-costed extension worth US$ 359,368 for the GUA-610-G04-T grant and recommends it for Board approval.

172. Summary of extension request/reasoning. The CCM of Guatemala is seeking the approval of the Global Fund for a nine-month non-costed extension for the TB grant (GUA-610-G04-T) to facilitate the transition to the new funding model while concept note recommended for grant-making is being reviewed. The proposed grant extension will therefore allow for continuation of essential services before the new TB grant is signed.

173. Programming. The activities to be implemented over this nine-month non-costed extension are a continuation of current activities, and are in alignment with the activities proposed in the concept note submitted in April 2015 and will ensure that essential services are uninterrupted. These activities include:

- procurement of second line drugs for 40 new multidrug resistant TB (MDR-TB) patients (US$ 75,786 or 21 percent of total extension budget),
- treatment-related adherence support for 60 MDR-TB patients (US$ 40,435 or 11 percent of total extension budget),
- improving diagnosis, including strengthening the laboratory network (US$ 46,626 or 13 percent of total extension budget), and
- human resources (US$ 160,212 or 45 percent of total extension budget).

The budget of US$ 359,368 requested for the nine-month extension will be financed through existing undisbursed grant funds and therefore no incremental funding is required.

174. Grant performance. During the current implementation period, the grant's performance at the output level has generally been good with an average of an A2 rating. Financial execution has been acceptable with a cumulative execution of 99 percent, as of 31 December 2014. The key management issues over the past two years relate to weaknesses in case detection, the national information and reporting system, and appropriate TB/HIV collaboration.

175. Risks and mitigation measures. Due to the fact that in Guatemala, all external funding going to the MoH requires Congressional approval, the Secretariat notes that there is a risk that Congress will not approve these funds during this period. The Secretariat is engaging the government and with bilateral and multilateral partners to facilitate this approval of funding. In order to provide assurance over Global Fund resources, the Secretariat will not disburse any additional funds associated with this extension until this Congressional approval has been granted.

Haiti HIV Grant (HTI-102-G09-H)

176. Funding recommendation for Board approval. The GAC endorsed the proposed six-month extension of the Haiti TB/HIV grant HTI-102-G09-H with a total budget of US$8,016,310 with US$4,408,872 of incremental funding and recommends it for Board approval.

177. Summary of extension request/reasoning. The CCM of Haiti is seeking the approval of the Global Fund for the six-month costed extension for the HIV grant (HTI-102-G09-H) to facilitate the transition to the allocation-based funding model and to allow continuation of grant activities while the new TB grant is in the grant-making process and to ensure alignment of implementation cycles between TB and HIV programs. The extension seeks to ensure continuity of treatment activities through the current grant's implementation arrangements while new arrangements and key strategic planning are finalized by the Principal Recipient and stakeholders. Furthermore, in order to ensure the coordinated response between all relevant actors in the country, avoid overlaps and enhance value-for-money the Secretariat is working with PEPFAR one of the major donors in Haiti, and will adjust the grant-making and refine operations based on their refocused Country Operational Plan expected the last week of June. The

planning of the start-up of the new prevention activities is ongoing with the newly appointed Principal Recipient and will launch upon the finalization of the work plan. Moreover, to avoid delays the GAC has endorsed the signing of the new grant independently of the end of the current grant implemented by UNDP.

178. Implementation arrangements. The grant is implemented by the UNDP as Principal Recipient. During the last reporting period (July -December 2014) the performance of the grant has been strong, with an "A2" rating which confirms the excellent trend in both programmatic and financial execution following previous periods and linked to strong efforts put in place by the Principal Recipient to catch up on execution of critical planned activities and address identified implementation challenges since 2011.

179. Programming. The activities to be implemented during the extension will be limited to ensuring continuity of treatment and care for current patients (national results are 62,000 as of December 2014 and the extension will support the increasing to 76,000 patients at the end of 2015) taking into account an expected linear increase in new patients being enrolled due to the country's adoption of WHO 2013 recommendations, adopted in mid-2013 (based on past trends, approximately +6000 more individuals per semester). Moreover, de-prioritization of activities in the extension period was done to ensure a gradual phase-out of activities that have been excluded in the concept note or that will undergo substantial changes in the new grant. Focus is put on diagnostic and treatment services. Activity categories include: HIV testing and sexually transmitted infections (STI) screening services (including for key populations), care and treatment for both HIV and STIs, adherence and retention activities for HIV, routine grant programmatic and data monitoring, prevention of mother to child transmission services, and blood transfusion safety.

India TB Grant (IDA-T-CTD)

180. Funding recommendation for Board approval. The GAC endorsed the proposed three-month costed-extension with the total budget of US$30,400,000 and incremental funding of US$ 28,537,483 for the IDA-T-CTD grant and recommends for Board approval.

181. Summary of rationale for the extension request. The CCM of India is seeking the approval of the Global Fund for the three-month costed extension for the TB grant (IDA-T-CTD) to facilitate the transition to the allocation-based funding model and to allow the initiation of the procurement order for TB drugs before the beginning of the new TB grant and in consideration of the procurement lead times of 6-9 months. The proposed grant extension will therefore ensure continuation of essential services while the new TB grant is in the grant-making process.

182. Strategic focus of funding for the extension period. The requested funds are meant solely for the procurement of: second line drugs to ensure 49,800 multidrug resistant TB and 3000 extensively drug resistant TB patients receive treatment; and 200 GenXpert machines to expand the diagnostic capacity; and to ensure timely laboratory/diagnostic readiness before the start of the new TB grant. The current program is implemented by Central TB Division (CTD) under the Ministry of Health, as the executing Ministry on behalf of the Ministry of Finance which has been confirmed as the Principal Recipient going forward. During last reporting period, the program achieved a “B1”rating, in line with the overall performance of the implementation period.

The requested budget amount of US$ 30.4 million will be used for the following activities:

- Procurement of second line drugs through GDF - US$ 25 million;
- Procurement of GenXperts by CTD- US$ 3.6 million
- Laboratory preparation by FIND-US$ 1.8 million.

183. Funding request. Taking into account the existing funding (undisbursed amount) under the IDA-T-CTD of US$1,862,517, the incremental funding of US$28,537,483 will be required to finance the proposed activities.

184. Risks. Taking into account that the requested amount will mainly cover the procurement of second line TB drugs which will be handled by the Global Drug Facility, and stored and distributed through the national supply chain system, the Secretariat does not foresee major risks related to the proposed investment.

Lao (Peoples Democratic Republic) Malaria (LAO-708-G09-M)

185. Funding recommendation for Board approval. The GAC endorsed the proposed six-month extension of the Lao malaria grant LAO-708-G09-M with a total budget of US$4,142,496 with US$4,142,469 of incremental funding and recommends it for Board approval.

186. Summary of extension request. The CCM of Lao is seeking the approval of the Global Fund for the six-month costed extension for the malaria grant (LAO-708-G09-M) to facilitate the transition to the allocation-based funding model. The Lao malaria program is currently in the final implementation period of a transitional funding model grant due to end on 30 June 2015. The malaria program originally submitted the malaria concept note for TRP review in window 4 in November 2014. As the concept note was recommended for iteration, the country made significant changes to the proposal and submitted a new concept note for TRP review in window 5 in March 2015. The Lao malaria concept note was subsequently endorsed by the GAC to proceed to grant-making. However, due to the complexity and number of deliverables required to prepare the grant for Board signing, the Secretariat requests a six-month costed extension in order to mitigate the risk of disruption of services.

187. Implementation arrangements. As of the last reporting period under the malaria grant, the program demonstrated an A2 performance, with an average performance of all indicators at 85 percent. The program continues to perform well with regards to distribution of long lasting insecticidal nets to the at-risk general population, as well as testing suspected malaria cases and treating confirmed cases. However, the program still faces issues with stock management of rapid diagnostic tests and artemesinin-combined therapy, with only 64 percent of health facilities reporting no-stock outs of key commodities.

188. Programming. The activities included in this costed extension have been negotiated and rationalized to align with those activities proposed in the concept note currently in grant-making. The extension provides for timely procurement of bed nets and other necessary commodities through the Global Fund pooled procurement mechanism.

Nepal HIV and Malaria Grants (NEP-H-SCF and NEP-M-SCF)

189. Funding recommendation for Board approval. The GAC endorsed the proposed 12-month extension of the Nepal HIV grant NEP-H-SCF with a total budget of US$11,776,804 and incremental funding of US$11,776,804; the proposed 12-month extension of the Nepal malaria grant NEP-M-SCF with a total budget of US$3,454,834 and incremental funding of US$3,454,834 and recommends for Board approval.

190. Summary of extension request. The CCM of Nepal is seeking the approval of the Global Fund for the 12-month costed extension for the HIV grant (NEP-H-SCF) and malaria grant (NEP-M-SCF) to facilitate the transition to the allocation-based funding model. The applicant is planning to submit concept notes for all HIV, malaria and TB in September 2015. However, given the challenges the country experienced and in light of the recent sequence of earthquakes in Nepal, the Secretariat foresees that this submission will not be possible, and would like to ensure uninterrupted continuation of programs during this allocation period. The Country Team did not seek CCM endorsement for this extension request. The CCM was reelected after 31 March 2015; however, the election process and new CCM membership did not meet the requirements of the Global Fund. Given the context of natural disaster in Nepal, as of May 2015 the grants in country will be managed under a non-CCM model.

191. Implementation arrangements. The GAC noted that due to significant problems with performance in all aspects of the grant management by government Principal Recipients, the previous CCM made a decision to transfer the position of Principal Recipient of the malaria (NEP-M-EDCD) and HIV (NEP-H-NCASC) grants to the Save the Children Federation. The Secretariat will finalize this transition.

192. HIV programming. For the extension period, a moderate increase in the number of enrolled patients under opioid substitution therapy, antiretroviral treatment and prevention of mother-to-child transmission is provisioned. This is in line with the HIV investment case endorsed by the Ministry of Health and Population with support of UNAIDS. In May 2015 the HIV grant received additional financing of US$2.1 million through the Emergency Fund Special Initiative to support disaster relief operations. Activities are planned for a period of six months and are targeted at people living with HIV affected by the earthquake.

193. Malaria programming. As a result in the transfer of Principal Recipient status to the Save the Children Federation, the performance of this grant is expected to improve rapidly although the

earthquakes and its destructions represent challenges. The proposed 12-month extension will focus on vector control through active case finding led by female community health volunteers. The activities include diagnosis, treatment, surveillance and distribution of long lasting insecticidal nets.

194. Performance. The GAC recommends that Nepal's grants not be rated for the period of the extension to take into account the challenge posed by the earthquakes destructions. Reporting will continue under usual arrangements; however, the disbursements will not be tied to programmatic performance. There are significant risks to the implementation due to the recent earthquakes and currently the Secretariat cannot assess the impact on the grant's operations.

Syria TB Grant (SYR-607-G01-T)

195. Funding recommendation for Board approval. The GAC endorsed the proposed 13-month extension of the Syria TB grant SYR-607-G01-T with a total budget of US$862,463 with no incremental funding and recommends it for Board approval.

196. Summary of extension request. The CCM of Syria is seeking the approval of the Global Fund for the 13-month costed extension for the TB grant (SYR-607-G01-T) to facilitate the transition to the allocation-based funding model and to extension to ensure the continuation of life-saving services while the country transitions to the next replenishment period. The Syria CCM intended to submit a concept note in window 5 in March 2015 but was unable to the ongoing armed conflict and the complex emergency situation in Syria, and does not anticipate being able to do so within this allocation period.

197. Programming. Activities of original grant will continue, including the identification and management of TB patients, maintenance of appropriate multidrug resistant TB (MDR-TB), case management service and infection control measures, TB laboratory activities and the improvement of managerial skills of the TB control program. An output indicator was added to the applicant's performance framework, namely the number of individuals screened for TB among internally displaced persons in shelters and hard-to-reach areas with quarterly target of 1,500. The indicator data will be collected from the reports of agencies working with internally displaced persons and therefore does increase the budget. An additional activity has also been added, which is supporting the rehabilitation of the central warehouse in Damascus, in urgent need of repair, with a budget of US$58,830 (7 percent of the extension budget), which was partially renovated with UNICEF funding.

198. Implementation arrangements. Grant implementation occurs in a context of protracted emergency due to the ongoing armed conflict. The grant is managed under the Additional Safeguard Policy with UNDP as PR and the Syrian Arab Red Crescent (SARC) and national TB program as sub-recipients. The main programmatic risks are associated with lack of program coverage in opposition-controlled areas and a potential risk of treatment disruption. Further, due to limited access monitoring activities are restricted to the government controlled areas.

199. Salary incentives. Salary incentives for treatment supporters, mostly doctors at the Ministry of Health, will continue to be paid at the rate of US$150 for MDR-TB treatment and US$50 for TB treatment per person per quarter. At this time, it is impossible to engage community health workers to perform such services due to the security situation in Syria, and therefore only doctors can follow-up with the patients. The total amount for this activity included in the extension is US$59,367 which represents 7 percent of the total extension budget.

Zanzibar TB Grant (ZAN-T-MOHSW)

200. Funding recommendation for Board approval. The GAC endorsed the proposed 3-month extension of the Zanzibar TB grant ZAN-T-MOHSW with a total budget of US$63,190 with no incremental funding and recommends it for Board approval.

201. Summary of extension request. The CCM of Zanzibar is seeking the approval of the Global Fund for the 3-month costed extension for the TB grant (ZAN-T-MOHSW) to facilitate the transition to the allocation-based funding model and to extension to ensure the continuation of life-saving services while the new TB grant is being negotiated during the grant-making process. Taking into account that the current grant has previously been extended by 12 month in total, the current request for extension is presented for the Board approval.

V. Additional Matters

01 Extensions Approved by the Secretariat Pursuant to Its Delegated Authority

1. The Secretariat hereby notifies the Board that it has approved extensions to the grants listed in Table 3 of Annex 1 to GF/B33/ER05 – Revision 1 in accordance with the Board decision GF/B31/DP12.

Annex 1

Table 1: Secretariat's Funding Recommendation on Additional Funding from the 2014 Allocation

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
1	Bhutan	HIV	Ministry of Health (BTN-H-MOH)	US$2,001,227	US$82,668	US$1,918,559	US$1,918,559	N/A	N/A	US$2.5 million
2	Bulgaria	TB	Ministry of Health (BGR-T-MOH)	EUR 5,822,822	EUR 539,159	EUR 5,283,663	EUR 5,283,663	N/A	N/A	EUR 29.9 million
3	Burkina Faso	TB/HIV	Programme d'appui au développement sanitaire (BFA-T-PADS)	EUR 3,320,630	EUR 3,320,630	-	EUR 26,591,071	N/A	N/A	EUR 46 million
			National Council for the Struggle against HIV/AIDS and STI (BFA-H-SPCNLS)	EUR 28,389,051	EUR 7,760,137	EUR 20,628,914				
			Initiative Privée et Communautaire contre le VIH/SIDA (BFA-C-IPC)	EUR 6,743,006	EUR 780,849	EUR 5,962,157				
4	Cambodia	Malaria	United Nations Office for Project Services	US$35,533,343	US$27,665,658	US$7,867,675	US$7,867,675	N/A	N/A	US$13 million

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
			(KHM-M-UNOPS)							
5	Cape Verde	Malaria	Comissão de Coordenação do Combate à Sida (CPV-M-CCSSIDA)	EUR 931,251	EUR 155,497	EUR775,754	EUR775,754	N/A	N/A	EUR 1.7 million
6	Côte d'Ivoire	Malaria	Ministry of Health (CIV-M-PNLP	EUR 72,596,079	EUR 14,903,468	EUR 57,692,611	EUR 57,692,611	EUR 29,756,332	EUR 20,107,595	EUR 65.9 million
7	Eritrea	TB	Ministry of Health (ERI-T-MOH)	US$4,415,916	US$4,415,916	-	-	N/A	N/A	
8	Eritrea	HIV	Ministry of Health (ERI-H-MOH)	US$19,795,804	US$15,994,884	US$3,800,920	US$3,800,920	N/A	N/A	
9	Ethiopia	TB/HIV	Federal HIV/AIDS Prevention and Control Office (ETH-H-HAPCO)	US$276,713,816	US$91,823,106	US$184,890,710	US$198,087,209	US$10,187,974	US$18,555,612	HIV: 59 million TB:28 million
			Ministry of Health (ETH-T-FMOH)	US$73,879,065	US$60,682,566	US$13,196,499				
10	Fiji	TB	Ministry of Health and Medical Services (FJI-T-MHMS)	US$4,445,477	US$542,137	US$3,903,340	US$3,903,340	N/A	N/A	US$12.2 million

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
11	Ghana	TB/HIV	Adventist Development and Relief Agency of Ghana grant (GHA-H-ADRA)	US$3,300,664	US$34,084	US$3,266,580	US$ 100,443,108	N/A	US$6,375,348	US$264.7 million
			Planned Parenthood Association of Ghana grant (GHA-H-PPAG)	US$1,621,833	US$84,427	US$1,537,406				
			Ministry of Health (GHA-H-MOH)	US$80,095,790	US$19,156,344	US$60,939,446				
			Ghana AIDS Commission (GHA-H-GAC)	US$ 12,905,545	US$289,960	US$12,615,524.				
			Ministry of Health (GHA-T-MOH)	US$22,506,425	US$422,274	US$22,084,151				
12	Mauritius	HIV	National AIDS Secretariat (MUS-H-NAS)	US$1,864,381	US$391,799	US$1,472,582	US$1,472,582			
			Prévention Information Lutte contre le	US$1,799,049	US$55,049	US$1,744,000	US$1,744,000	N/A	US$2,213,307	US$4.7 million

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
			Sida (MUS-H-PILS)							
13	Multicountry Western Pacific	TB/HIV	United Nations Development Programme (QMJ-C-UNDP)	US$14,214,351	US$3,499,759	US$10,714,592	US$10,714,592	N/A	N/A	N/A
14	Multicountry Western Pacific	Malaria	United Nations Development Programme (QMJ-M-UNDP)	US$2,657,874	US$2,657,874	-	-	N/A	N/A	N/A
15	Nicaragua	HIV	Instituto Nicaragüense de Seguridad Social (NIC-H-INSS)	US$12,996,303	US$3,713,235	US$9,283,068	US$9,283,068	N/A	N/A	US$37.5 million
16	Niger	HIV	Coordination Intersectorielle de Lutte contre le Sida (NER-H-CISLS)	EUR 14,259,597	EUR 4,268,833	EUR 9,990,764	EUR 9,990,764	N/A	N/A	EUR 16.6 million
17	Pakistan	TB	National TB Control Program (PAK-T-NTP)	US$127,351,666	US$33,894,314	US$93,457,352	US$102,928,266	US$10,892,798	US$20,205,105	US$109.7 million
			Mercy Corps (PAK-T-MC)	US$11,427,617	US$1,956,703	US$9,470,914				

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
18	Russian Federation	HIV	Open Health Institute Foundation (RUS-H-OHI)	US$11,270,738	US$401,522	US$10,869,216	US$10,869,216	N/A	US$100,380,999	N/A
19	Rwanda	TB/HIV	Ministry of Health (RWA-T-MOH)	US$21,278,134	US$5,435,966	US$15,842,168	US$15,842,168	N/A	US$3,864,318	US$42.1 million
			Ministry of Health (RWA-H-MOH)	US$148,528,188	-	US$148,528,188	US$148,528,188	N/A	US$169,818,039	US$643.4 million
20	Solomon Islands	Malaria	Ministry of Health and Medical Services (SLB-M-MHMS)	US$5,579,078	US$3,986,812	US$1,592,266	US$1,592,266	N/A	N/A	US$4,857,000
21	Solomon Islands	TB	Ministry of Health and Medical Services (SLB-T-MHMS)	US$2,758,339	US$2,052,679	US$705,660	US$705,660	N/A	N/A	US$1,293,501
22	Sudan	HIV	United Nations Development Programme (SDN-H-UNDP)	US$20,870,921	US$3,902,774	US$16,968,147	US$16,968,147	N/A	US $26,787,657	US $8.3 million
23	Swaziland	TB	National Emergency Response Council on HIV and AIDS	US$21,189,356	US$12,045,397	US$9,143,959	US$9,143,959	N/A	US$16,692,038	US$29.8 million

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
					Existing Funding	Recommended Incremental Funding				
			(SWZ-T-NERCHA)							
24	Tanzania	TB/HIV	Save the Children (TZA-C-STC)	US$13,059,126	-	US$13,059,126	US$13,059,126	N/A	N/A	HIV: US$1,814 million TB: US$160 million

Table 2: Secretariat's Recommendations on Grant Extensions

Country	Grant Name	Period of Extension (Months)	Additional Funding	Rationale
Guatemala	GUA-610-G04-T	9	N/A	To allow for continuation of program activities while concept note is being negotiated.
Haiti	HTI-102-G09-H	6	US$4,408,872	To allow for continuation of program activities while concept note is being negotiated.
India	IDA-T-CTD	3	US$28,537,483	To allow for continuation of program activities and initiate the procurement of second-line drugs.
Lao (PDR)	LAO-708-G09-M	6	US$4,142,469	To allow for continuation of program activities while concept note is being negotiated
Nepal	NEP-H-SCF	12	US$11,776,804	To allow for continuation of program activities while concept note is being developed and reviewed.
Nepal	NEP-M-SCF	12	US$3,454,834	
Syria	SYR-607-G01-T	13	N/A	To ensure the continuation of life-saving services while the concept note is being developed.
Zanzibar	ZAN-T-MOHSW	3	N/A	To allow for continuation of program activities while concept note is being negotiated

Table 3: Grant Extensions Approved by the Secretariat

Country	Grant Name(s)	Period of Extension (Months)	Additional Funding Approved	Rationale
Abidjan Lagos Corridor	MAW-607-G01-H	6	N/A	To ensure the continuation of essential services for key and mobile populations while the RCM completes grant-making
Benin	BEN-708-G07-M	6	US$641,516	To ensure the continuation of essential services at the community level while the concept note is assessed
Bolivia	BOL-910-G09-H	12	US$1,354,253	To ensure the continuation of essential services at the community level while the concept note is written and assessed

Chad	TCD-M-UNDP	6	EUR 2,906,143	To ensure the continuation of essential services during grant-making
Dominican Republic	DMR-202-G01-H-00	7	N/A	To ensure an orderly closure of activities that will not be continued and the continuation of essential activities during grant-making
	DMR-202-G02-H-00	7	N/A	
Madagascar	MDG-809-G11-H	3	N/A	To ensure the continuation of essential services during concept note writing
	MDG-809-G12-H	3	N/A	
	MDG-810-G14-T	9	N/A	
Nepal	NEP-T-NTC	12	N/A	To ensure the continuation of essential services during the transition to the new funding model in the aftermath of a natural disaster
Sri Lanka	SRL-809-G10-M	6	N/A	To ensure the continuation of essential services during grant-making
Togo	TGO-T12-G12-T	3	N/A	To ensure continuation of activities during grant-making