Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B33/ER07
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B33/EDP12: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B33/EDP13: 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] Afghanistan malaria, Botswana malaria, Comoros TB, Congo (Democratic Republic) TB/HIV, Somalia TB and Swaziland HIV. Total incremental amount is US$241,466,827 and €1,817,850
[2] Abidjan-Lagos Corridor Organization HIV, Djibouti HIV, Guinea-Bissau malaria, Kosovo HIV, Nigeria TB, Pakistan malaria and TB. Total incremental amount is US$39,875,625 and €2,335,202

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$241,466,827 and €1,817,850

Decision Point: GF/B33/EDP12: 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/ER07 ("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 the Global Find 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/EDP13: 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/ER07.*

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/B31/DP12: Extension Policy under the New Funding Model[4]	This decision point establishes the current policy, based on which the extensions described in this report are granted and reported by the Secretariat or otherwise recommended to the Board for approval.
GF/B32/EDP15 and GF/B33/EDP07: 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 Pakistan malaria and TB programs approved by the Board on 28 March and on 30 June 2015, respectively
GF/B33/EDP07: 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 Swaziland TB program approved by the Board on 30 June 2015. The CCM of Swaziland submitted a joint TB/HIV concept note. The Secretariat's funding recommendation for the HIV program is set forth in this report.

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

Afghanistan Malaria Grant (AFG-M-UNDP)

1. Funding recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of US$19,627,543 for the Afghanistan malaria program, which consists of the UNDP grant AFG-M-UNDP with incremental funding of US$16,389,068 for the implementation period 1 October 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$357,746 is registered as unfunded quality demand, in line with TRP recommendations.

2. Epidemiological situation. Malaria is widely recognized to be a public health priority in Afghanistan. With an estimated population of 27.5 million, approximately 76 percent of residents of Afghanistan live in rural areas. According to WHO Global Malaria Report 2013, 78 percent (27 percent in high-risk and 51 percent in low-risk areas) of Afghanistan's population live in areas at risk of malaria transmission. The disease is endemic in large areas below 2,000 meters in elevation and is highly prevalent in the river valleys used for rice cultivation, which are common *anopheline* vector breeding grounds. Key populations with limited access to health care include people in insecure areas due to political and continued military conflict; women and girls; ethnic minorities; migrant laborers; returnees; internally displaced persons; and nomads.

3. Program performance. Afghanistan has been implementing a strong national malaria and leishmaniasis control program supported through the Global Fund since 2006, with grants in rounds 5 and 8. The Global Fund is the single largest donor in terms of malaria programs, with a total of US$77.7 million disbursed. Several factors including an armed conflict and natural disasters have affected basic health care services and public health infrastructure in Afghanistan. To resurrect public sector services after three decades of turmoil, since 2003 the Ministry of Public Health, with the strong support of donors and partners, has undertaken a series of bold reforms, including the development of the standardized basic package of health services, which has become the foundation of the Afghan health system and a key instrument in its development. The basic package of health services focuses on delivering a minimum set of essential services in rural areas through the recruitment and training of a cadre of community health workers.

4. The goal of this program is to contribute to the improvement of the health status in Afghanistan through the reduction of morbidity and mortality associated with malaria. To enable Afghanistan to achieve the program goal, the Global Fund will invest in a long-lasting insecticidal net (LLIN) mass campaign complemented by continuous distribution through antenatal care, entomological monitoring, facility-based treatment, integrated community case management, strengthening monitoring and evaluation systems, and grant management, among other interventions. These activities will contribute to achieving the objectives of the national strategic plan for malaria control and elimination to reduce malaria morbidity by 85 percent and reduce malaria mortality to zero by the end of 2017.

5. Implementation arrangements. The Afghanistan portfolio has been restructured and consolidated, and risk management has been strengthened. The activities under this program will be implemented by UNDP, which was selected through a clear and transparent process driven by the CCM.

6. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it is aligned with the national malaria strategic plan for 2013 to 2017 and the prioritization of the interventions proposed is appropriate given the epidemiological context. However, the TRP did request several issues to be clarified, including the rollout of G6PD testing and *P. vivax* treatment protocols; the lack of information in resistance of drug use for *P. falciparum*; inadequate justification of the estimated increasing need of rapid diagnostic tests (RDTs) considering the projected decline of the diseases; the possible duplication in surveillance and health information

systems/epidemic preparedness and response via supervisory visits; and insufficient justification for high program management costs.

7. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended a budget of US$20,210,657 for grant-making, including US$5,110,657 of incentive funding to be invested in an additional 790,104 LLINs, facility trainings, and refresher training for community health care supervisors and workers on rapid diagnostic tests. The GAC expressed support for the Afghanistan malaria concept note and acknowledged that it is based on a comprehensive analysis of the country's malaria epidemiological context, including the current response and future strategy, as well as the implementation of interventions and lessons learned. Moreover, the concept note provides a thoughtful analysis of human rights and gender issues faced in Afghanistan, and aptly identifies key populations. During grant-making, US$2.3 million in efficiencies were identified in the unit cost of RDTs, procurement and distribution of LLINs, training and TV broadcasting costs. The GAC endorsed the reinvestment of these efficiencies in vector control activities, case management as well as program management costs relating to the challenging operating environment. The GAC reviewed actions taken during grant-making toward clarifying issues identified by the TRP, and the GAC was satisfied with the applicant's progress. The GAC commented that Afghanistan was a good example of the allocation-based funding model in action, as time was invested in an iterative country dialogue and the country had sufficient support to submit a concept note and go through grant-making, with the outcome of strategic rationing of the available limited resources. The GAC partners expressed strong support for the Afghanistan malaria program moving forward.

8. Domestic contributions. According to the WHO's Regional Office for the Eastern Mediterranean, about 90 percent of funding for Afghanistan's health system is provided by international (multilateral and bilateral) donors and nongovernmental organizations. Although the financial gap analysis developed during country dialogue indicates that the counterpart financing requirement of 5 percent is being met given overall health expenditure, a detailed calculation per disease area is not possible as there are no national disease accounts in place. Moreover, as most of the funds originate from international pooled funding, the interpretation of this financing as domestic funding is inadequate. The Secretariat's analysis shows that the ongoing security transition will continue to impact the economy and financial status of the country; economic activities are heavily dependent on international assistance with overwhelming dependence on external resources for financing the national budget (up to 66 percent anticipated in 2014 including deficit financing) as well as low share of health in the government budget. To ensure improvement in the government's ability to track health expenditure, the health systems strengthening grant approved by the Board on 27 March 2015 (GF/B32/EDP15) includes investment in the development of national disease accounts in order to more effectively report on counterpart financing and domestic contributions by the next allocation.

Botswana Malaria Grant (BWA-M-BMOH)

9. Funding recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of US$5,128,153 for the Botswana malaria program, which consists of the Ministry of Health grant BWA-M-BMOH with incremental funding of US$5,128,153 for the implementation period 1 October 2015 through 30 September 2018. The applicant did not submit an above allocation request for the Botswana malaria program and therefore there is no unfunded quality demand registered.

10. Epidemiological situation. About 66 percent of Botswana's population lives in areas with a historical risk of malaria, with the highest risk in the north and eastern parts of the country. Malaria transmission occurs almost exclusively in the northern and eastern regions during the rainy seasons, specifically between November and May.

11. Program performance. This is the first malaria grant from the Global Fund to Botswana. Through domestic financing of the national malaria program, the country has significantly reduced morbidity through the implementation of intensified malaria interventions. Specifically, malaria cases have reduced from 8,056 cases (43 per 1,000 population) in 2000 to 456 cases (0.23 per 1,000 population) in 2013, representing a 94 percent decrease in reported malaria cases. Similarly, malaria attributable deaths decreased from 35 to 7 annually, representing an 80 percent reduction. These achievements were made possible through the reintroduction of dichlodipenyltrichloethane (DDT) for intensified indoor residual spraying (IRS); free mass distribution of long-lasting insecticidal nets (LLINs); intensified

community mobilization campaigns on educating the public on IRS and LLINs, as well as early treatment seeking behavior. The adoption of a test, treat and track policy in 2010 resulted in a marked decline in unconfirmed cases reported through the integrated disease surveillance and response system. There has been an intensification of training and re-training of health workers in malaria case management with a consequential effect on improved malaria diagnosis and treatment resulting in a much lower burden of malaria in Botswana.

12. The goal of this program is to achieve zero local malaria transmission by 2018. To enable Botswana to achieve the program goal, the Global Fund will invest in the following strategies: (i) developing a robust information system by 2016 for tracking progress and decision-making; (ii) affecting behavior change by reaching at least 90 percent of the population with appropriate information for malaria elimination by 2017; (iii) detecting all malaria infection through appropriate diagnostic methods and providing effective treatment by 2016; (iv) achieving total coverage of all appropriate vector control interventions in all transmission foci by 2016; and (v) developing the requisite capacity in the program at all levels by 2016 to achieve malaria elimination.

13. Implementation arrangements. This is the first malaria grant from the Global Fund to Botswana. The CCM selected the Ministry of Health as Principal Recipient to implement this program. The Global Fund has signed two grants (one HIV and one TB) to date with the Botswana Ministry of Health, which has performed satisfactorily and has a dedicated program management unit.

14. TRP review and recommendations. The TRP considered this concept not to be strategically focused and technically sound as it clearly identifies how the country will move toward achieving the overall goal of achieving zero local malaria transmission in the country by 2018. The TRP commented on the strong ownership of the program by the government at every level, as demonstrated by government's commitment to grow the health care budget and the country's commendable progress to significantly reduce morbidity and mortality with its own government funding. However, the TRP requested that several issues be clarified: (i) disaggregating interventions by target geographical category; (ii) ensuring that key populations are neither underserved nor under-reported in terms of case numbers; (iii) ensuring the effectiveness of the case-based surveillance system; (iv) reconciling the funding gap between the allocation amount and the funding request; and (v) examining the appropriateness of polymerase chain reaction (loop-medicated isothermal amplification) testing to contribute to the outcomes of this project

15. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended an upper funding ceiling of US$5,128,597 for grant-making. During grant-making, efficiencies were found in the reduction of unit costs and the elimination of some communications interventions. The GAC approved the reinvestment of these funds in information, education and communication interventions; monitoring and evaluation; and trainings. The GAC reviewed actions taken during grant-making toward clarifying issues identified by the TRP and was satisfied with the applicant's progress. The GAC and partners strongly encouraged the applicant to look at joint programming with bordering countries in the region as the country approaches elimination, underlining that only a regional effort toward this goal will eliminate malaria in the region. The GAC commented that partner input on how to prioritize funding for applicants in the malaria elimination phase will be a necessary as more countries reach this stage. GAC partners emphasized the importance of surveillance in Botswana throughout implementation.

16. Regional malaria elimination context. GAC reviewed the Botswana malaria grant and assessed how the program is linked with regional malaria elimination efforts, including investments related to cross-border activities to prevent re-introduction of malaria. GAC acknowledged that malaria elimination in Southern Africa, with special focus on the Elimination 8 (E8)[5] countries, cannot be achieved without strong political engagement and effective investments in vector control in the high transmission countries given the potential regional impact of increased malaria cases in these countries. GAC noted the need to look more carefully at the malaria program spatial targeting approach across countries in Southern Africa, to ensure appropriate interventions even in the low transmission geographical considering that countries with limited resources and health system challenges are likely to prioritize the highest transmission zones. In this regard, GAC recommended that the Botswana malaria program should continue to engage with the E8 regional concept note (recommended for grant making at the March 2015 TRP meeting) during grant making and grant implementation, including

[5] Angola, Botswana, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe

strengthened focus on surveillance and through collaboration with cross-border countries. GAC further stressed the need for Technical Partners to work collaboratively with countries in the region on the best way for the Global Fund to invest in malaria elimination in Southern Africa, recognizing the strategic importance of how individual country programs fit within overall malaria elimination efforts at regional level.

17. Domestic contributions. The estimated total funding need for the Botswana malaria program is US$20.3 million. Total domestic financial commitments for the malaria program amount to US$15.2 million, which represents 75 percent of total resources available for the next implementation period. The Global Fund is the only external funder of the malaria program. The counterpart financing share, based on commitments of government contribution in the next phase, is 75 percent, which meets the minimum threshold requirement of 60 percent for an upper-middle income country. On the assumption that the full requested allocation funding in this concept note is approved, there will be no funding gap for the malaria program.

Comoros TB Grant (COM-T-ASCOBEF)

18. Funding recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of €1,817,850 for the Comoros TB program, which consists of the Association Comorienne pour le Bien-Etre de la Famille grant COM-T-ASCOBEF with incremental funding of €1,817,850 for the implementation period 1 August 2015 through 30 June 2018. The applicant did not submit an above allocation request for the Comoros TB program and therefore there is no unfunded quality demand registered.

19. Epidemiological situation. Comoros, located in the Indian Ocean, consists of four islands, namely Grande Comore, Anjouan, Mohéli and Mayotte, the latter of which is under French administration (and therefore not covered by the national TB program). In 2013, its population was estimated at 743,797 inhabitants, 53 percent of whom are under the age of 20 and 72.1 percent of whom live in rural areas. With a current estimate of TB incidence of 34 per 100,000 population, the TB epidemic in Comoros is low. In 2012, the case detection rate for all forms of TB was 49 percent with geographical variation among the three main islands of the country. Treatment success rates have been high, with 93 percent of new smear-positive TB patients successfully treated in 2013, although some data are missing for previous years. The estimated rate of multidrug-resistant TB (MDR-TB) is 1.8 percent among new TB cases and at 19 percent among previously treated TB cases. Only two cases of MDR-TB were reported in 2008, both of which were imported, and none have been reported since. Comoros also has low prevalence of HIV. The results of surveillance studies conducted to date show that prevalence is less than 0.025 percent, placing the country in a low-level epidemic classification. In 2012, the program reported four cases of TB/HIV co-infection.

20. Program performance. This is the first grant to Comoros from the Global Fund for TB funding and it is fully aligned with the national strategy against TB for 2015 to 2019. The Global Fund has funded grants in Comoros for malaria since round 2 and HIV since round 3.

21. The goal of this program is to reduce morbidity and mortality linked to TB. To enable Comoros to achieve the program goal, the Global Fund will invest in the following strategies: (i) increasing the detection rate of TB from 49 percent to 65 percent; (ii) maintaining a treatment success rate for TB patients of over 90 percent; (iii) providing HIV screening for over 95 percent of TB patients and adequate treatment for at least 95 percent of co-infection cases; (iv) providing case management for 100 percent of expected MDR-TB cases; (v) improving the managerial capacity of the national TB and leprosy program; (vi) strengthening infection control; (vii) contributing to the strengthening of the health system; and (viii) promoting operational research.

22. Implementation arrangements. This is Comoros' first TB grant from the Global Fund. The Principal Recipient selected by the CCM to implement this program is the Association Comorienne pour le Bien-Etre de la Famille (ASCOBEF), a local NGO that has implemented Global Fund programs since 2004. ASCOBEF has been rated as overall a well-performing Principal Recipient.

23. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused on strengthening TB case detection and treatment, building on available epidemiological data and TB case estimates. However, the TRP noted the following concerns to be

clarified: (i) insufficient program targets for case detection; (ii) high program management costs; (iii) the need for enhanced collaboration between disease programs; and (iv) planning for new diagnostic technologies and the expansion of laboratory programs.

24. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended and an upper funding ceiling of €1,817,850 for grant-making. The GAC reviewed actions taken during grant-making toward clarifying issues identified by the TRP and was satisfied with the applicant's progress. The GAC also noted that the grant includes salary incentives totaling €116,066, paid to 31 government employees. Acknowledging that the abrupt reduction in incentives could jeopardize program implementation, the GAC has endorsed the proposed approach of a gradual reduction of salary incentives from 50 percent in the first year to 30 percent in the second year and 20 percent in the third year.

25. Domestic contributions. The estimated total funding need for the Comoros TB program is €2,627,727. Total domestic financial commitments for TB amount to €280,625, which represents 11 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 13 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. The remaining estimated funding gap is €328,483.

Congo (Democratic Republic) TB/HIV Grants (COD-H-CORDAID, COD-H-SANRU, COD-H-MOH, COD-T-CARITAS and COD-T-MOH)

26. Funding Recommendation for Board approval. For approval by the Board, the GAC recommended a total budget amount of US$222,780,062 for the Democratic Republic of Congo TB/HIV program. The program consists of five grants: Stichting Cordaid grant COD-H-CORDAID with an incremental amount of US$59,874,776; the SANRU Rural Health Program of Democratic Republic of Congo grant COD-H-SANRU with the incremental amount of US$53,551,006; the Ministry of Health grant COD-H-MOH with the incremental amount of US$22,577,929; the Caritas Congo ASLB grant COD-T-CARITAS with incremental amount of US$30,959,701; and the Ministry of Health grant COD-T-MOH with incremental amount of US$11,733,569 for the implementation period 1 July 2015 through 31 December 2017. The TRP's recommendations on quality demand within the above allocation funding request were funded entirely through efficiencies found during grant-making.

27. Epidemiological situation. The Democratic Republic of Congo is located in Central Africa and has an estimated population of 70 million. The country faces a generalized HIV epidemic and has maintained a stable HIV prevalence rate among the 15- to 49-year old population at 1.2 percent since 2007. In 2014, the number of adults and children living with HIV were estimated at 392,430, and the number of deaths attributable to AIDS was estimated at 22,980. Mother-to-child transmission continues to contribute significantly to the HIV epidemic with a transmission rate of nearly 30 percent. Key population data are incomplete but, where available, HIV prevalence is shown to be higher among sex workers at 6.9 percent and among men who have sex with men at 17.3 percent. TB is among the first causes of morbidity and mortality in people living with HIV in the country. The Democratic Republic of Congo is ranked 11th among the 22 high-burden TB countries and 14th among the 27 countries that represent 85 percent of the estimated multidrug-resistant TB (MDR-TB) cases worldwide. The treatment success rate of smear-positive cases has consistently been over the 85 percent target recommended by WHO and reached 88 percent in 2012. Case detection rates have shown a decrease from 2010, though, and were at 51 percent in 2012, MDR-TB cases are estimated to represent 2.5 percent of new TB cases and 10 percent of retreatment cases, with the low MDR-TB case detection rate attributable to low diagnostic and laboratory service coverage in the country. In 2012, only 31 percent of TB patients knew their HIV status, 16 percent were co-infected with HIV and 40 percent were enrolled on ART treatment.

28. Past performance and lessons learned. The Democratic Republic of Congo has received over US$380 million to fight TB and HIV over the past ten years from the Global Fund. Global Fund funding contributed to providing testing and counseling to a total of 993,424 people, providing first- and second-line TB treatment across the country and addressing TB/HIV co-infection in geographically stratified health zones. The country continues to face a variety of disease-specific challenges, as well as capacity constraints at the level of the overall health system. Struggles in fighting TB and HIV include

low rates of HIV testing, poor coverage of prevention of mother-to-child transmission programs and insufficiently integrated services for TB/HIV co-infection. Broader issues affecting health systems include inadequate public financing, high out-of-pocket payments, poor distribution of human resources, frequent stock-outs, weak logistics and distribution systems, and an unreliable national health information system.

29. The goal of this program is to contribute to the reduction of HIV-related morbidity and mortality, reduce the negative impact of HIV/AIDS in 354 priority health zones, contribute to a 25 percent reduction of TB-related mortality by 2015 and ensure global care and treatment of all TB/HIV co-infected patients. To enable the country to achieve the program goals, the Global Fund will invest in the following strategies: (i) continuing with the extension and improvement of the DOTS strategy; (ii) improving collaborative TB/HIV activities with a focus on increased HIV testing among TB patients and TB screening of people living with HIV, as well as isoniazid prevention treatment for HIV-positive patients and ART during TB treatment; (iii) fighting MDR-TB through scale-up of case management; (iv) involving members of the community in the fight against TB; and (v) supporting the development of the national supply chain strategy. Outcomes of the proposed programming by 2017 include reducing new infections in infants born to HIV-positive mothers from 28 to 8 percent; increasing ART coverage among adults and children from 24 percent in 2014 (92,561 adults and children on ART) to 41 percent by the end of 2017 (163,928 adults and children on ART); reducing TB/HIV-related mortality in adults from to 9.7 to 6.7 per 100,000 population; enrolling 95 percent of TB/HIV co-infected patients on ART; detecting 387,785 TB cases; and successfully treating 75 percent of MDR-TB patients.

30. Implementation arrangements. The program will be implemented through a dual-track financing arrangement by five Principal Recipients. The three Principal Recipients in charge of the HIV-related activities in the 354 health zones of the country are the Ministry of Health, SANRU, and CORDAID. The Ministry of Health will be in charge of training and monitoring health personnel at all levels of the health system, implementation of a technical cooperation plan, as well as of some research studies. SANRU and CORDAID will focus on prevention and treatment activities and the purchase, transport and delivery of health products across the country. The two Principal Recipients in charge of TB activities in all 516 health zones of the Democratic Republic of Congo are the Ministry of Health, through its national TB control program, and Caritas Congo ASLB. Caritas will support community activities only in 95 health zones. The Ministry of Health will be in charge of all treatment activities, and extensive training and re-training of health personnel at all levels of the health system, while Caritas will focus on advocacy and community support for DOTS as well as the purchase, transport and delivery of health products across the country. TB/HIV collaborative activities will be implemented in the 354 health zones in which the HIV and TB programs converge.

31. TRP review and recommendations. The Global Fund initially reviewed an HIV concept note from the Democratic Republic of Congo's CCM as an early applicant in January 2014. The TRP and GAC sent the proposal back for iteration, requesting that the country present an integrated TB/HIV concept note to foster greater integration of services and collaboration between partners. An integrated TB/HIV concept note was submitted in window 3 in August 2014, which the TRP considered to be technically sound and strategically focused as it builds on gains made in previous investments in HIV and TB control, is based on the national strategic plan, promotes the integration of services and addresses priorities highlighted by TRP and GAC. However, the TRP noted the need to resolve the following outstanding issues: (i) identifying and prioritizing patients with low CD4 cell counts for access to treatment; (ii) adequately covering men who have sex with men and sex workers and procuring condoms and lubricant for these populations; (iii) preventing infection within the general population; (iv) reaching priority TB populations with quality services; (v) setting realistic MDR-TB scale-up targets; (vi) evaluating whether centralized viral load testing is adequate for the prevention of mother-to-child transmission; (vii) addressing coordination gaps between TB and HIV programs and general issues with the health system; (viii) considering possible slow implementation due to a new Principal Recipient; (ix) having the capacity to undertake surveying activities; (x) considering the need for indicators on the quality of TB and HIV programs (xi) addressing bottlenecks and collaboration needs; and (xii) addressing how proposed investments will relieve end users of financial burdens imposed by HIV and TB services.

32. GAC1 review and recommendations. The GAC expressed strong support for the Democratic Republic of Congo TB/HIV concept note and commended the country for conducting a highly participatory and consultative iteration process and for inclusion of a diverse group of stakeholders in the development of the revised concept note, resulting in evidence-based prioritization of interventions

that have high potential for impact. The GAC acknowledged that the revised HIV component of the concept note (previously submitted as an early applicant) responds to TRP concerns and is aligned with the priorities of the National AIDS Control Strategy 2014-2017 and that the joint TB/HIV concept note is also aligned with the national TB strategy. The GAC cited the iterative process as a good example of the Global Fund's funding model playing a catalytic role in enhancing in-country strategic planning and coordination, to direct all available resources to where they can achieve maximum impact. The GAC recommended an upper funding ceiling for grant-making of US$257,468,376 based on TRP recommendations, including the incentive funding award of US$14,495,000 based on the TRP prioritization of and recommendation on the above allocation request, to be focused on TB treatment care and support and HIV prevention programs for sex workers, men who have sex with men, transgender people and the general population. The incentive funding recommendation, however, is contingent upon the country meeting its counterpart financing and willingness-to-pay commitments and the GAC noted with concern past instances of the Democratic Republic of Congo making financial commitments to the Global Fund that ultimately were not funded by the Parliament.

33. GAC2 review and recommendations. The GAC also requested that during grant-making the country focus particular attention on the issues of women and girls and better integration of activities addressing gender-based violence when designing the programs; operational plans to specify programs for key populations including men who have sex with men, transgender people, sex workers and their clients; addressing screening gaps for TB stressing that attention be directed toward increasing case finding beyond 50 percent and putting more people on treatment to close the coverage gap; securing support for appropriate technical cooperation and the need to engage in-country technical partners in light of the work needed to develop operational plans for ART, PMTCT and MDR-TB scale up, and to translate these plans into clear feasible actions; and development of plans to ensure feasibility of completing the proposed surveys and proper risk mitigation measures and tailored responsibilities given current capacity constraints of the proposed Principal Recipients. While GAC Partners welcomed the country's efforts to mainstream gender in the revised concept note and to integrate gender program priorities identified at GAC1 (for example, identification of health care facilities, ante-natal care and community organizations as entry points for programs focusing on women and girls who suffer violence in different forms, and ensuring access to package of services and support) partners stressed that much more needs to be done to ensure effective HIV prevention and treatment programs focusing on adolescent girls and young women, as well as age and sex disaggregated data to report on progress.

34. GAC2 review and recommendations. During grant-making, US$11,800,000 in efficiencies from programmatic management, governmental support and training were identified. The GAC approved reinvestment of efficiencies into programs for drug provision, supply chain and data collection strengthening as well as program management costs including performance-based incentives. Following grant-making, the GAC reviewed progress made toward addressing TRP and GAC recommendations. Several issues were addressed, including the prioritization of patients with low CD4 counts, prevention for the general population, the prioritization of populations at risk for TB and the prevention of mother-to-child transmission, among others. The GAC noted that the TRP issue regarding adequate coverage of condom and lubricant procurement for men who have sex with men and sex workers has been partially addressed, but will be part of a finalized, costed operational plan to be submitted by early 2016. The GAC and partners agreed that the collaborative effort among partners during the iteration process helped build a stronger, more integrated TB/HIV program in the country. However, GAC partners expressed concern regarding TB/HIV collaboration activities being limited to only 354 out of 516 health zones and encouraged the country to scale up to provide both TB and HIV coverage in all 516 health zones. Noting the challenging operating environment, capacity constraints and logistical challenges, the GAC recognized the need for a differentiated and feasible approach to be applied to the country, underlining the potential for impact of the proposed interventions, if implemented effectively and strategically focused, in the prioritized geographical health zones with the highest disease burden.

35. GAC review and recommendations, performance-based funding and incentives. In an innovative and strategic partnership between the Global Fund, World Bank, GAVI, UNICEF and possibly other partners, US$10.5 million from this component will go to performance-based funding for health zones, alongside US$9.5 million included in the malaria grants, in 2016 and 2017. This funding will be awarded to health zones and their employees upon reaching agreed upon targets. The GAC noted this program as having strong potential to leverage Global Fund resources toward improving data quality, service delivery for patients, and procurement and supply chain management, the last of which is one of the greatest area of risk in the country. The GAC was also informed about the ongoing

effort for harmonization of incentives schemes and alignment with other donors in country. The GAC stressed the importance of a united approach with that of other partners and donors in the health sector, taking into account health services overall and not singularly HIV or TB. The GAC endorsed the proposed approach to salaries and incentives (including requesting the country to establish a road map) for the development of a harmonized policy of salary incentives for the Health Sector, and that the transitional financial mechanism for the payment of salaries incentives in 2015 be validated by the Groupe Inter-Bailleurs Santé (the "GIBS").

36. Risks and mitigation measures. The CCM eligibility and performance evaluation as well as an assessment by other implementing partners have shown poor results and a lack of compliance with Global Fund requirements. In order to address the identified issues, the Global Fund and partners, particularly France Expertise International, have supported the CCM in replacing its Secretariat staff and are working toward creating an oversight committee, writing conflict of interest regulations and holding elections for new members. When this technical cooperation is finished, the CCM will be integrated into the Comité National de Pilotage du Secteur de la Santé, a body within the Ministry of Health that acts as a national steering committee for health.

37. Domestic contributions. Total domestic financial commitments for HIV amount to US$20,000,000, which represents 6 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, for HIV is 13 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments related only to this component represent a 130 percent increase compared to the previous implementation period. Total domestic financial commitments for TB amount to US$9,000,000, which represents 11 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 request allocation funding in this concept note is approved, for TB is 15 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments related only to this disease represent a 117 percent increase compared to the previous implementation period. The Global Fund will closely monitor the fulfillment of these commitments throughout implementation, considering the country's past issues in this area.

Somalia TB Reprogramming (SOM-T-WV)

38. Funding recommendation for Board approval. For approval by the Board, the GAC recommends the reprogramming of the Somalia TB program with the total budget of US$25,116,723, for the World Vision International grant SOM-T-WV with incremental funding of US$5,700,000 for the implementation period 1 October 2015 through 31 December 2017. As this is a reprogramming request, the applicant did not submit an above allocation request.

39. Epidemiological situation. TB remains a public health emergency in Somalia. According to the WHO Global Tuberculosis Report 2014, in 2013 the estimated incidence was high at 285 per 100,000 population for TB cases of all forms, while the prevalence was estimated at 548 per 100,000 population. Treatment success rates for all forms of TB, though, are high at just over 87 percent. Somalia has a high burden of MDR-TB with 5.2 percent among new TB cases and 41 percent among previously treated cases. Only about 40 percent of estimated new and about 4 percent of estimated MDR-TB cases were detected and treated in 2013. The long-standing complex emergency state, compounded by natural disasters and chronic malnutrition issues, has negatively affected the TB epidemiology. Although there is an internationally recognized federal government based in the South Central Zone of Somalia, this government has no territorial control over large parts of the zone and the two semi-autonomous northern zones. Essentially, there are three semi-autonomous zonal governments, each with its own health authority, creating significant challenges for health systems.

40. Rationale for reprogramming. The Somalia Global Fund Steering Committee, in place of a CCM as Somalia is a non-CCM country, is seeking the approval of reprogramming of existing funds for the Somalia TB program to avoid disruption in programmatic activities, while taking into account a newly developed national strategic plan. The present reprogramming request includes activities to be performed during the remainder of the Global Fund round 10 grant. The reprogramming request, furthermore, takes full account of the additional activities described in the newly developed national

strategic plan for TB, containing innovative case finding activities, such as the use of female health workers for community screening activities and the intensification of collaboration with the private sector in the scale-up of the response to drug-resistant TB. The reprogramming request also includes strengthening of the national TB program's managerial capacity through the improvement of data management via electronic recording and reporting systems, expanded coverage of the program and the involvement of all levels of health care in the country. Outcomes of the proposed activities include increased case notification and the maintenance of treatment success above 90 percent.

41. GAC review and recommendations. The Somalia TB program implemented by World Vision International was reviewed in January 2014 and there is no evidence indicating significant changes in TB epidemiology or burden since the time of this review. The Secretariat considers the programmatic and financial changes/aspects of the reprogramming request non-material, as there are no major changes to the scope, scale or interventions of the program. The proposed reprogramming will ensure effective and efficient use of the Global Fund investments to support the TB programming and achieve greater impact in the fight against TB, as well as to improve coordination with the HIV and malaria grants to strengthen cross-cutting health and community systems in Somalia.

42. GAC review of program context and operational environment. The main issues highlighted by the GAC relate to the insecurity and inaccessibility of insecure areas due to ongoing conflict, leading to operational and reporting challenges. Expanding the program to areas in need depends on stability and acceptance of the implementing partner by the local authorities. Another significant implementation risk are the human resources supporting the TB programs, which have been pledged to harmonize with the payment rates agreed upon between zonal authorities and partners, as was done for the HIV and malaria support starting on 1 July 2015.

43. Domestic contributions. Somalia is a non-CCM country and the Eligibility and Counterpart Financing Policy exempts non-CCMs from counterpart financing and willingness-to-pay requirements.

Swaziland HIV Grants (SWZ-H-CANGO and SWZ-H-NERCHA)

44. Funding recommendation for Board approval. For approval by the Board, the GAC recommends a total budget amount of US$45,085,465 for the Swaziland HIV program, which consists of the CANGO grant SWZ-H-CANGO with incremental funding of US$5,536,567, and the NERCHA grant SWZ-H-NERCHA with incremental funding of US$29,916,058 for the implementation period 1 October 2015 through 30 September 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.

45. Epidemiological situation. Swaziland is one of the countries with the highest HIV prevalence in the world at 26 percent among the population aged 15 to 49 years and 31 percent among adults aged 18 to 49. Prevalence peaked in the first half of the past decade and started to decline toward the end of the decade. The human toll of HIV and AIDS in Swaziland is a concerning reality, adversely affecting the social and economic gains, including reducing life expectancy from 60 years in 1997 to 33.7 years in 2007. The epidemic is characterized by significant gender disparity, with prevalence higher among women at 38 percent compared to men at 23 percent. Prevalence rates among key populations vary, with prevalence among female sex workers very high at 70 percent and lower among men who have sex with men at 18 percent. The main drivers of HIV in Swaziland include key populations, inconsistent condom use, early sexual debut, intergenerational sex, gender-based violence, low levels of HIV testing and counseling among youth and young people, and the low level of male circumcision. TB/HIV co-infection rates in Swaziland rates among incident TB cases were reported 74 percent in 2013. Eighty percent of TB/HIV co-infected patients received ART in 2013, an improvement from 35 percent in 2010.

46. Program performance. The Global Fund's support to Swaziland dates back to 2003. Swaziland has performed well on counseling and testing, ART programs, and HIV testing as part of prevention of mother-to-child transmission targets. However, key challenges in the past have included weak data collection and reporting systems and sporadic ARV shortages, mainly attributed to procurement management issues.

47. The goal of this program is to sustain high-impact interventions that prevent new HIV infections and save lives. To enable Swaziland to achieve the program goal, the Global Fund will invest

in the following strategies: (i) supporting peer navigation for key populations to essential HIV services; (ii) empowering strengthening awareness and capacity of adolescent girls (in and out of school) to access HIV prevention services; (iii) increasing community awareness and capacity to address gender-based violence; (iv) enhancing community accountability; and (v) strengthening the resilience, adherence and retention in care of people living with HIV. Planned outcomes of these strategies include an increase in people living with HIV receiving ART from 60 percent in 2014 to 91 percent in 2018; a rate of 90 percent maintained on treatment after 12 months by the end of 2017 compared to a baseline of 77 percent in 2013; increased condom use among key populations and youth; and reducing TB/HIV mortality from 400 in 2014 to 336 per 100,000 population by 2017.

48. Implementation arrangements. This request for funding was submitted as an integrated TB/HIV concept note and has been planned for integrated implementation. Due to a changing funding landscape for HIV throughout grant-making, the readiness of the HIV prevention activities and the new Principal Recipient for HIV grant (CANGO), the TB grant was recommended separately for Board approval (GF/B33/EDP07). 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 country has selected two Principal Recipients to support implementation of activities that will enable the realization of this goal. NERCHA is the government Principal Recipient and will be in charge of mainly biomedical prevention interventions and facility-based interventions while CANGO, a civil society Principal Recipient, will be in charge of non-biomedical prevention interventions including interventions focusing on key and vulnerable populations, facilitating linkages with the facility-based interventions, and enhancing the participation of civil society organizations in HIV programming.

49. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it aligns with the national strategic plan and international best practices. Additionally, the TRP commented that it is well prioritized and responds to the epidemiology of the two diseases. The TRP noted several issues to be clarified, including: (i) the limited focus on interventions among sex workers despite high prevalence of HIV; (ii) the over-ambitious plan to roll out HIV viral load testing for all patients on ART; (iii) the lack of size estimates and updated seroprevalence rates of key populations; (iv) the lack of a funding for program management; (v) the funding gap for achieving HIV testing and counseling targets; (vi) the missing justification for the increased cost for nutritional supplements to malnourished ART patients; (vii) the lack of strategy to prevent new infections occurring among children; and (viii) the unclear future of joint planning among HIV- and TB-related stakeholders.

50. GAC review and recommendations. The GAC endorsed the TRP's recommendations and recommended and an upper funding ceiling of US$74,070,746 for grant-making for the TB and HIV components jointly. During grant-making, efficiencies were found in the reduction of unit costs. The GAC approved the reinvestment of these funds, as well as funds from efficiencies found in the malaria and TB programs, in male circumcision interventions. The GAC reviewed actions taken during grant-making toward clarifying issues identified by the TRP and was satisfied with the applicant's progress, particularly in the area of prevention of mother-to-child transmission, in which the country progressed on their plan to roll out lifelong ART treatment for pregnant and lactating women. The GAC noted the effective coordination of resources of investments among partners to direct Global Fund resources currently allocated toward viral load scale-up toward the male circumcision program in the case that further donor contributions are mobilized.

51. HIV prevention programs for adolescent girls and young women. The GAC was informed that, following the high-level discussion and quadrilateral meeting between UNAIDS, PEPFAR, the Global Fund and the Government of the Kingdom of Swaziland, the country has allocated US$735,000 to support a four-arm impact evaluation project on conditional cash transfers (CCTs) for adolescent girls and young women. Furthermore, an additional amount of US$1.4 million is earmarked for further innovative prevention interventions for adolescent girls and young women. These funds may possibly be directed towards another two arms of the CCT impact evaluation for cash-and-care as well as cash-and-pre-exposure-prophylaxis (PrEP) programs. These additional arms will be decided upon after a national PrEP consultation in early August 2014. If the country decides that these further parts of the program are not to be prioritized, then these resources will be directed toward male circumcision where there is still a significant gap. The GAC commended the country's effort to proactively invest in evidence-based HIV prevention programs for adolescent girls and young women, and welcomed the innovation regarding the use of Global Fund resources toward conditional cash transfers.

52. Domestic contributions. The estimated funding need for the national HIV program of Swaziland in the next implementation period is US$351 million. Total domestic financial commitments amount to US$157.6 million, 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 indicative funding in this concept note is approved, is 76 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 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$14 million.

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

Abidjan-Lagos Corridor Organization HIV/AIDS Grant (MAW-607-G01-H)

53. Summary of extension request/reasoning. The GAC endorsed the proposed six-month non-costed extension worth €1,229,002 for the Abidjan-Lagos Corridor Organization (OCAL) grant MAW-607-G01-H and recommends it for Board approval. As this grant has previously been extended by ten months, this extension requires Board approval.

54. Background information. The Regional Coordinating Mechanism for this grant was notified on 28 July 2014 that the GAC had endorsed the recommendation of the TRP for the regional expression of interest submitted by the OCAL in April 2014. Therefore, OCAL submitted a regional concept note on 30 January 2015, for a total funding amount of €14,526,420. The subsequent regional concept note was reviewed by the TRP and the GAC and recommended for grant-making in May 2015.

55. Implementation arrangements. During the most recent reporting period in the second half of last year, the MAW-607-G01-H grant under OCAL as the Principal Recipient achieved a quantitative indicator rating of A2.

56. Programming. The non-costed extension will allow a continuation of essential HIV prevention, care and behavioral change communication services to key and mobile populations of the corridor, who are essentially sex workers, truck drivers, men who have sex with men, people who inject drugs, uniformed personnel, young people and pregnant women. The grant also provides treatment for sexually transmitted infections.

Djibouti HIV Grant (DJB-613-G05-H)

57. Funding recommendation for Board approval. The GAC endorsed the proposed seven-month non-costed extension worth US$603,040 for the UNDP grant DJB-613-G05-H and recommends it for Board approval. As the grant has previously been extended by 12 months, the current extension requires Board approval.

58. Summary of extension request/reasoning. The CCM of Djibouti is seeking the approval of the Global Fund for a seven-month non-costed extension for the HIV grant (DJB-613-G05-H) to facilitate the transition to the new funding model while its concept note recommended for grant-making is being reviewed. The proposed extension will allow for the continuation of essential HIV services before the new grant is signed.

59. Office of the Inspector General findings and recovery. A recovery process is ongoing following the publication of an OIG report in 2012. The country signed a protocol of reimbursement agreement effective as of 24 July 2014 for the uncontested amount, while it was decided that additional documents related to the contested share would be reviewed by an independent audit firm. To date, the country has made the payments in accordance with the schedule provided in the protocol of reimbursement. The process of identifying the additional amount to be reimbursed by the country is currently ongoing. Following OIG findings, the Djibouti portfolio has been implemented through the Additional Safeguard Policy and UNDP has been made Principal Recipient.

60. Programming. During this extension period, funding will be provided to support treatment needs for 1,861 people living with HIV, while activities in relation to prevention of mother-to-child transmission will be focused on 5,860 pregnant women. Other activities include:

- the procurement of medicines, health products and associated procurement and supply chain management costs including the constitution of a buffer stock, geared toward providing support to focus on populations;
- costs related to monitoring and evaluation including planning and administration activities; and

- covering human resource costs, which are high as a result of UNDP being the Principal Recipient

The budget of US$603,040 requested for the seven-month extension will be financed through existing undisbursed grant funds and therefore no incremental funding is required.

Guinea-Bissau Malaria Grant (GNB-M-UNDP)

61. Funding recommendation for Board approval. The GAC endorsed the proposed nine-month costed extension for the UNDP grant GNB-M-UNDP with the incremental amount of €1,230,107 and recommends it for Board approval. As the incremental funding amount exceeds six months of funding, this extension requires Board approval.

62. Summary of extension request/reasoning. The CCM of Guinea-Bissau is seeking the approval of the Global Fund for a nine-month costed extension for the GNB-M-UNDP grant in order to ensure uninterrupted program implementation, while the concept note recommended for grant-making in June 2015 enters the TRP clarifications and grant negotiations phase. The activities to be implemented during extension period are those carried out during the existing grant implementation period and focus on essential services such as: (i) vector control through routine distribution of long-lasting insecticidal nets for pregnant women and children under five, (ii) case management such as testing and treating cases of confirmed malaria, (iii) strengthening data quality through improved supervision and training, (iv) ensuring adherence to national protocol in treatments, (v) community case management, and (vi) health commodities and procurement and supply chain management for program delivery.

63. Implementation arrangements. The program is implemented by UNDP as Principal Recipient with the programmatic performance of the grant rated as B2 during the last period under review (1 July 2014 to 31 December 2014), and an average performance of all indicators of 54 percent and 48 percent for top ten indicators. The low ratings are due to the absence of progress on community case management and supervisions and trainings of health staff. Since the rating review, the Secretariat has worked closely with the Principal Recipient to improve performance by enhancing procurement and supply management processes to ensure kits are available for community health workers to distribute and UNICEF provided technical assistance for the Ministry of Health to elaborate national protocols on integrated community case management. The protocols are now complete and ready for final validation by the Ministry of Health. Therefore, the Secretariat is reassured that going forward the performance will be improved.

Kosovo HIV (KOS-711-G04-H)

64. Funding recommendation for Board approval. The GAC endorsed the proposed 12-month costed extension with incremental funding for Board approval of €1,105,095, for the Community Development Fund grant KOS-711-G04-H and recommends it for Board approval.

65. Summary of extension request and rationale. The CCM of Kosovo is seeking the approval of the Global Fund for a second one-year extension for the KOS-711-G04-H grant in order to ensure uninterrupted program implementation of essential HIV prevention activities, while the clarifications requested by the TRP are addressed and a revised concept note is submitted for review.

66. Programming. The activities and interventions proposed for the extension period have an overall focus on:

- HIV prevention programs (50 percent of budget)
- HIV treatment, care and support
- health information systems as well as monitoring and evaluation
- removing legal barriers to access
- program management costs

67. Human resource costs and program sustainability. Of the proposed extension budget of €1,174,885, 39 percent of funds are dedicated to human resource costs, which are partially planned under various programmatic components. Considering that Kosovo's funding allocation is limited, the Secretariat will undertake further efforts during the extension phase to reduce human resource costs by (i) harmonizing the two program management units under the Principal Recipient and (ii) rationalizing

the headcount at sub-recipient level, with particular attention to administrative and financial functions. At the same time, the Secretariat will review salary levels to ensure that grant-financed salaries are aligned with market rates. The relevant changes will be introduced no later than 1 January 2016.

68. The TRP recommendations will be partially addressed during the extension period by (i) incorporating TRP-requested reviews, including rapid qualitative research on RAE, study on risk behavior of people in prisons, and programmatic mapping of key populations; (ii) changing programmatic approaches to ensure better quality of services, including introducing community outreach, integrating the use of mobile services, and initiating peer-driven interventions; and (iii) taking measures to address gaps in the national information system.

Nigeria TB Grant (NGA-T-IHVN)

69. Funding recommendation for Board approval. The GAC endorsed the proposed six-month costed extension for the Institute of Human Virology Nigeria grant NGA-T-IHVN with the incremental funding of US$18,866,347 and recommends Board approval.

70. Summary of extension request and rationale. The CCM of Nigeria is seeking the approval by the Global Fund of a six-month costed extension for the TB grant NGA-T-IHVN to allow for uninterrupted implementation of activities during grant-making. Nigeria submitted a joint TB/HIV concept note on 15 August 2014, and it was reviewed and recommended for grant-making. The proposed activities for the extension period are in line with the national strategic plan and the concept note. There will be a scale-up in both TB case notification and treatment: (i) the number and percentage of presumptive drug-resistant TB cases receiving testing for drug-resistant TB is to be increased from 47.7 percent (10,410 out of 21,820) in 2013 to 60 percent (21,078 out of 35,130) during the extension period and (ii) 285 bacteriologically confirmed, drug-resistant TB cases will be notified and put on second-line treatment. In addition, to avoid risk of stock-out, the proposed budget includes procurement of second-line drugs through the Global Drug Facility until December 2016, taking into consideration procurement lead times. The Secretariat will work closely with the Principal Recipient to avoid any potential risks and ensure value for money while procuring the laboratory equipment, supplies and consumables budgeted under the extension period. The procurement of these products will also be done through the Global Drug Facility, where clear benefits of price and quality benefits are achievable. More specifically the activities during the extension period include:

- procurement of second-line TB drugs for 285 new multidrug-resistant TB patients and 10 extensively drug-resistant TB patients, US$2,948,660 (15 percent of the total extension budget),
- living support for the patients on treatment, US$2,501,363 (13 percent of the total extension budget),
- procurement of laboratory equipment and consumables, US$7,253,363 (38 percent of the total extension budget),
- monitoring and evaluation and program administrative activities, US$6,488,580 (34 percent of the total extension budget).

71. Program performance and risks. The grant is implemented by the Institute of Human Virology Nigeria (IHVN) as the Principal Recipient, and it has demonstrated a good performance with an A2 rating. Additionally, the Principal Recipient has good capacity in financial management with a high historical absorption rate of 91 percent. The issues identified during the disbursement and progress update reviews have been addressed. There is no ongoing Office of the Inspector General audit. However, to mitigate potential risks, the Secretariat rolled out a fiduciary agent in Nigeria to support principal and sub-recipients. The sub-recipients selected under IHVN include the national TB program. Additionally, financial assurance measures including changes to the structure of internal and external auditors have been introduced.

Pakistan Malaria and TB Grants (PKS-M-DOMC and PKS-T-NTP)

72. Funding recommendation for Board approval. The GAC endorsed the proposed 12-month costed extensions with incremental funding of US$15,648,873 for Pakistan malaria grant PKS-M-DOMC and US$5,360,405 for Pakistan TB grant PKS-T-NTP respectively, and recommends such grant extensions for the Board approval.

73. Summary of extension request and rationale. The CCM of Pakistan is seeking the approval by the Global Fund of 12-month costed extensions to the aforesaid grants. The new funding for the Pakistan malaria and TB programs for this replenishment period was approved by the Board on 28 March 2015 (GF/B32/EDP15) and on 30 June 2015 (GF/BM33/EDP07) respectively. However, the Global Fund and the government of Pakistan are still negotiating the Framework Agreement as of the date of this report[6], and it may take some time before a consensus is reached. Therefore, the grant agreements for the aforesaid grants have not been signed and the implementation cannot commence. Since the allocation funding was originally approved by the Board with a proposal that new funding model grants would be utilized based on the new terms and conditions as reflected in the Global Fund Grant Regulations (2014), the Secretariat through this report is seeking the Board's approval to utilize part of such allocation funding to extend the expired grants, which were governed under the old standard terms and conditions, to avoid program implementation disruption.

74. Programming. During the extension period, the Principal Recipients will follow the workplan and budget from the new grants as already approved by the Board. Apart from the current risks of the grant, described in the previous reports on these grants, the Secretariat does not foresee any additional risks relating to the extension.

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/ER07 in accordance with the Board decision GF/B31/DP12.

[6] More specifically, the issues under discussion relate to privileges and immunities, and human rights.

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	Afghanistan	Malaria	UNDP (AFG-M-UNDP)	US$19,627,543	US$3,238,475	US$16,389,068	US$16,389,068	US$5,110,657	US$357,746	N/A
2	Botswana	Malaria	Ministry of Health (BWA-M-BMOH)	US$5,128,153	US$0	US$5,128,153	US$5,128,153	N/A	N/A	US$15.2 million
3	Comoros	TB	Association Comorienne pour le Bien-Etre de la Famille (COM-T-ASCOBEF)	€1,817,850	€0	€1,817,850	€1,817,850	N/A	N/A	€280,625
4	Congo (Democratic Republic)	TB/HIV	Stichting Cordaid (COD-H-CORDAID)	US$72,046,946	US$12,172,170	US$59,874,776	US$178,696,981	US$14,495,000	US$0	HIV: US$20 million TB: US$9 million
			SANRU Rural Health Program (COD-H-SANRU)	US$75,453,105	US$21,902,099	US$53,551,006				
			Ministry of Health (COD-H-MOH)	US$22,577,929	US$0	US$22,577,929				
			Caritas Internationalis (COD-T-CARITAS)	US$38,870,165	US$7,910,464	US$30,959,701				

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				
			Ministry of Health (COD-H-MCOD-T-MOH	US$13,831,917	US$2,098,348	US$11,733,569				
5	Somalia	TB	World Vision International (SOM-T-WV)	US$25,116,723	US$19,416,723	US$5,700,000	US$5,700,000		N/A	N/A
6	Swaziland	HIV	Coordinating Assembly of Non-governmental Organisations (CANGO) (SWZ-H-CANGO)	US$5,636,567	US$0	US$5,636,567	US$35,552,624		US$16,692,038	US$157.6 million
			National Emergency Response Council on HIV and AIDS (NERCHA) (SWZ-H-NERCHA)	US$39,448,898	US$9,532,841	US$29,916,058				

Table 2: Secretariat's Recommendations on Grant Extensions

Country	Grant Name	Period of Extension (Months)	Additional Funding	Rationale
Abidjan-Lagos Corridor Organization	MAW-607-G01-H	6	-	To allow for continuation of programmatic activities while the regional concept note is being discussed.
Djibouti	DJB-613-G05-H	7	-	To allow for continuation of programmatic activities while the concept note is being developed and discussed.
Guinea-Bissau	GNB-M-UNDP	9	€1,230,107	To allow for continuation of programmatic activities while the concept note is being discussed.
Kosovo	KOS-711-G04-H	12	€1,105,095	To allow for continuation of programmatic activities while the revised concept note is being developed and discussed.
Nigeria	NGA-T-IHVN	6	US$18,866,347	To allow for continuation of programmatic activities while the concept note is being discussed.
Pakistan	PKS-M-DOMC	12	US$15,648,873	To allow for continuation of programmatic activities while Framework Agreement is being negotiated.
Pakistan	PKS-T-NTP	12	US$5,360,405	

Table 3: Grant Extensions Approved by the Secretariat

Country	Grant Name(s)	Period of Extension (Months)	Additional Funding Approved	Rationale
Afghanistan	AFG-809-G09-M	9	-	To allow for continuation of program activities while concept note is being discussed and subsequent steps are completed.
Armenia	ARM-T-MOH	3	-	To allow for continuation of program activities while the Framework Agreement (fully signed) is being ratified by the Armenia parliament.
Bosnia and Herzegovina	BIH-T-UNDP	9	-	To compensate for delays in implementation and transition planning due to circumstances beyond the control of implementers.
Burkina Faso	BUR-M-PADS	3	-	To allow for continuation of program activities while concept note is being discussed and subsequent steps are completed.
Burkina Faso	BUR-810-G10-T	1	-	To allow for continuation of program activities while concept note is being discussed and subsequent steps are completed.
Kazakhstan	KAZ-809-G04-T	6	-	To allow for continuation of program activities while the Board condition concerning recoveries is being met by the country.
Niger	NGR-708-G07-M	6	€1,601,793	To allow for continuation of program activities while concept note is being discussed and subsequent steps are completed.
Sri Lanka	SRL-607-G07-T	3	-	To ensure continuation of essential services while grant-making is being completed and subsequent steps are completed.
Turkmenistan	TKM-910-G01-T	9	US$1,012,425	To allow for continuation of program activities while concept note is being discussed and subsequent steps are completed.