Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B34/ER02
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B34/EDP02: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B34/EDP03: 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] Botswana TB/HIV, Chad malaria, Djibouti malaria, Djibouti TB/HIV, Haiti malaria, Indonesia TB/HIV, Mali TB/HIV, Paraguay malaria, Sao Tome and Principe malaria, Senegal HSS, Sierra Leone TB/HIV, Southern Africa Regional Coordinating Mechanism HIV, Sri Lanka HIV, Togo malaria and Tunisia HIV. Total incremental amount is US$239,729,034 and €77,255,709
[2] Yemen HIV. Total incremental amount is US$319,484

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$239,729,034 and €77,255,709

Decision Point: GF/B34/EDP02: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation

The Board:

1. *Approves the incremental funding recommended for each country (or, as the case may be, regional) disease component, and its constituent grants, as listed in Tables 1a and 1b of Section IV to GF/B34/ER02 (collectively, "Table 1");*

2. *Acknowledges each country (or, as the case may be, regional) 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. *Approves the reinvestment of within-allocation efficiencies for the Zanzibar TB/HIV grant and its resultant total program budget, as listed in Table 2 of Section IV to GF/B34/ER02;*

4. *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 (or, as the case may be, regional) disease component's constituent grants, (b) is subject to the availability of funding, and (c) shall be committed in annual tranches; and*

5. *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/B34/EDP03: 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 3 of Section IV to GF/B34/ER02.*

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/B33/EDP20: 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 Zanzibar TB/HIV grant approved by the Board on 14 October 2015. The funding recommendation presented in this report modifies the total budget for the Zanzibar TB/HIV program, as described further in Table 2 in Section IV of this report.

III. Action Required

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

2. Please find here a list of documents provided per disease component to substantiate the Board decision. All relevant documents containing the Secretariat's reason for its recommendations to the Board and the funding requests/comments have been posted on the Governance Extranet available at this link.

    a. Concept Note
    b. Concept Note Review and Recommendation Form
    c. Grant Confirmation
    d. TRP Clarification Form (applicable only if the TRP requested clarifications)

[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

Table 1a: Secretariat's Funding Recommendation on Additional Funding from the 2014 Allocation (Countries)

N	Country	Disease component	Grant name	Grant end date	Currency	Recommended budget (incl. cash & disbursements)	Total program budget	Existing funding	Incremental amount for Board approval	Recommended total incremental funding	Incentive funding included in total incremental funding	Unfunded quality demand	Domestic commitment
1	Botswana	TB/HIV	BWA-C-ACHAP	31 December 2018	US$	16,798,970	27,043,807	0	16,798,970	26,614,280	3,478,787	7,380,889	HIV: 363 million TB: 60.5 million
			BWA-C-BMOH	31 December 2018	US$	10,244,837		429,527	9,815,310				
2	Chad	Malaria	TCD-M-UNDP	30 June 2018	€	59,732,391	59,732,391	4,744,326	54,988,065	54,988,065	2,506,789	0	19,155,904
3	Djibouti	Malaria	DJI-M-UNDP	31 December 2017	US$	7,794,954	7,794,954	0	7,794,954	7,794,954	N/A	0	4 million
4	Djibouti	TB/HIV	DJI-C-UNDP	31 December 2017	US$	9,019,598	9,019,598	405,148	8,614,450	8,614,450	N/A	0	HIV: 3.6 million TB: 2.8 million
5	Haiti	Malaria	HTI-M-PSI	31 December 2017	US$	17,305,284	17,305,284	1,624,049	15,681,235	15,681,235	N/A	7,454,346	8,185,375

6	Indonesia	TB/HIV	IDN-H-MOH	31 December 2017	US$	37,873,918	170,824,718	19,534,896	18,339,022	107,497,461	27,761,979	47,158,874	HIV: 160 million TB: 190 million
			IDN-H-NAC	31 December 2017	US$	20,474,258		6,609,743	13,864,515				
			IDN-H-SPIRITI	31 December 2017	US$	24,287,653		1,087,275	23,200,378				
			IDN-T-MOH	31 December 2017	US$	66,363,204		31,268,111	35,095,093				
			IDN-T-AISYIYA	31 December 2017	US$	21,825,685		4,827,232	16,998,453				
7	Mali[5]	TB/HIV	MLI-H-UNDP	31 December 2017	€	50,270,153	50,270,153	37,414,695	12,855,458	12,855,458	N/A	0	HIV: 11.2 million
8	Paraguay	Malaria	PRY-M-OIM	31 December 2018	US$	2,782,936	2,782,936	0	2,782,936	2,782,936	N/A	0	19.8 million
9	Sao Tome and Principe	Malaria	STP-M-UNDP	31 December 2017	US$	5,851,908	5,851,908	1,460,978	4,390,930	4,390,930	N/A	0	1,907,128
10	Senegal	HSS	SEN-S-MOH	31 December 2017	€	4,386,050	4,386,050	0	4,386,050	4,386,050	N/A	0	135,287,250

[5] Although Mali submitted a joint TB/HIV concept note as a country with a high rate of TB/HIV confection, the grant presented in this report includes only the HIV treatment component. The TB grant, which underwent integrated grant-making with the HIV grants, will be implemented by a different Principal Recipient and will be reviewed by the GAC at a future meeting. Additionally, a civil society Principal Recipient for the HIV grant focusing on prevention will be reviewed by the GAC early next year.

11	Sierra Leone	TB/HIV	SLE-H-NAS	31 December 2017	US$	33,194,380	46,660,421	27,572,736	5,621,644	17,833,256	14,168,943	10,871,123	HIV: 2.25 million TB: 0.68 million
			SLE-H-MOHS	31 December 2017	US$	13,466,041		1,254,429	12,211,612				
12	Sri Lanka	HIV/AIDS	LKA-H-FPA	31 December 2018	US$	5,442,741	10,907,292	902,022	4,540,719	8,396,628	N/A	0	16,375,947
			LKA-H-MOH	31 December 2018	US$	5,464,551		1,608,642	3,855,909				
13	Togo	Malaria	TGO-M-PMT	31 December 2017	€	23,903,520	23,903,520	18,877,384	5,026,136	5,026,136	3,402,117	0	7.04 million
14	Tunisia	HIV/AIDS	TUN-H-ONFP	31 December 2018	US$	11,552,532	11,552,532	1,071,949	10,480,583	10,480,583	N/A	672,553	25,311,154

Table 1b: Secretariat's Funding Recommendation on Additional Funding from the 2014 Allocation (Regional Applicant)

	Country	Disease component	Grant name	Grant end date	Currency	Total program budget	Existing funding	Incremental amount for Board approval	Recommended total incremental funding	Incentive funding included in total incremental funding	Unfunded quality demand	Domestic commitment
1	Southern Africa Regional Coordinating Mechanism	TB	QPA-T-WHC	31 December 2017	US$	29,999,027	356,707	29,642,320	29,642,320	N/A	104,517,892	N/A

Table 2: Reinvestment of Within-allocation Efficiencies for a Previously-approved Program

Applicant	Grant name	Currency	Approved grant budget	Revised budget for Board approval	Existing funding	Revised existing funding	Incremental funding already approved	Additional incremental funding for Board approval	Revised unfunded quality demand
Zanzibar[6]	QNB-C-MOH	US$	10,224,371	10,332,417	1,105,518	1,213,564	9,118,853	0	236,246

Table 3: Secretariat's Recommendation on Grant Extension

Country	Disease component	Grant name	Currency	Period of extension (months)	Additional funding	Rationale
Yemen	HIV/AIDS	YEM-T12-G08-H	US$	6	319,484	To allow for the continuation of essential services during grant-making and finalizing of the country's inclusion in the Secretariat's differentiated approach in the Middle East

[6] The GAC recommends that the Board approve an increase to the budget amount of the Zanzibar TB/HIV grant QNB-C-MOH. The additional amount requested is within the allocation and represents reinvestment of committed funds under the round 10 grant ZAN-T-MOHSW as well as undisbursed and unused cash funds that were not included in the total budget when the Board approved an incremental amount for the Zanzibar TB/HIV grant on 14 October 2015 (GF/B33/EDP20). The CCM requests to reinvest this amount in unfunded quality demand, in line with the current program and TRP recommendations.

01 Summary of the Deliberations of the Secretariat's Grant Approvals Committee (GAC) on Funding Recommendations

The following grants resulting from 15 concept notes, including one regional funding request, have been found overall to be disbursement-ready by the Global Fund Secretariat through a review process in consultation with partners.

The concept note for each country component was submitted for review, reviewed by the TRP and determined to be strategically focused and technically sound. The TRP, upon its review, highlighted issues for the applicant to clarify or address during grant-making.

The GAC considered and endorsed the TRP's recommendations and provided an additional level of review. At the time of its first review, the GAC set the upper-ceiling funding amount for grant-making, awarded incentive funding bearing in mind TRP recommendations on the prioritization of the above allocation request, and identified other issues for the applicant to consider as the grant was prepared to be disbursement-ready.

During grant-making, the applicant refined the grant documentation, addressed issues raised by the TRP and GAC and sought efficiencies where possible. In its second review, the GAC reviewed the final grant documentation for disbursement-readiness and confirmed that the applicant addressed issues requested for clarification by the TRP to its satisfaction. Additionally, the GAC endorsed the reinvestment of efficiencies in one of the following: (i) the areas recommended by the TRP; (ii) in other disease components of the same applicant – in the case that the TRP did not provide such recommendations; or (iii) into the general funding pool.

Each applicant has met the counterpart financing requirements as set forth by the Eligibility and Counterpart Financing Policy.

Botswana TB/HIV Grants: African Comprehensive HIV/AIDS Partnerships (BWA-C-ACHAP) and the Ministry of Health (BWA-C-BMOH)

Recommended budget (including cash & disbursements):

1.1 Strategic focus of the program. Botswana faces a dual TB/HIV epidemic with 2013 rates of HIV prevalence of 18.5 percent among the population aged over 18 months, TB incidence of 414 per 100,000 population, and TB prevalence of all forms of 348 per 100,000 population. The country has made progress in the fight against HIV, achieving universal access targets on ART and prevention of mother-to-child transmission. However, challenges remain, including a significant gender disparity with 19.2 percent of women and 14.1 percent of men living with HIV, as well as insufficient health and community systems. The TB epidemic is largely driven by HIV, and drug-resistant TB is an additional emerging public health threat in the country. The goals of the TB/HIV program in Botswana are to prevent new HIV infections and to reduce morbidity, mortality, psychosocial and economic impact associated with TB by 2017. Context-specific strategies and activities to support these aims include:

- Integrating services, including those for TB/HIV; reproductive, maternal, neonatal and child health; and other co-morbidities
- Improving the ethical and legal environment to support the response to HIV and AIDS, including training and sensitization of policymakers and implementers, such as police and court personnel
- Building the capacity of civil society organizations to deliver HIV and TB services through addressing gaps in areas such as finance and administration, program monitoring and evaluation, and human resources management

The expected impact and outcomes of these measures include:

- Increasing ART initiation for people living with HIV from 75 percent in 2013 to 100 percent in 2018, as well as addressing disparities of these rates between districts

- Increasing the percentage of infants born to HIV-positive mothers receiving a virological test for HIV within two months of birth from 47 percent in 2013 to 80 percent in 2018
- Improving TB contact tracing from an estimated 47 percent in 2013 to 66 percent in 2018
- Improving TB treatment success rates from 82 percent in 2012 to 87 percent 2018
- Improving multidrug resistant-TB treatment success rates from 73 percent in 2012 to 80 percent in 2018

1.2 Implementation arrangements. The government Principal Recipient for the Botswana TB/HIV grant will be changing from the national AIDS coordination agency to the Ministry of Health. This change is due to the decision by the government of Botswana to absorb the agency into the Ministry of Health, a move that is anticipated to improve coordination and financial efficiency across programs.

1.3 Domestic contributions. Domestic resources represent 69 percent of total resources available for the next implementation period and an 87 percent increase across all three diseases from the previous implementation period. The government is the primary financier of both the TB and HIV programs, mainly for treatment and care; care and support for orphans and vulnerable children; first- and second-line drugs for TB; and laboratory reagents and related commodities for TB. Additionally, the Government of Botswana is developing a health financing strategy proposing alternative ways of funding and exploring ways to contain costs in the health delivery services and promote efficiency.

1.4 GAC review and recommendations. GAC partners commended the progress in collaboration between HIV and TB programming in the country, and noted the opportunity to continue this through combined messaging in country. GAC partners asked about the involvement of civil society during implementation and were informed by the Secretariat that, with civil society mapping completed, the government plans to work with and strengthen civil society during the grant implemetnation. Additionally, GAC partners underscored the importance of the "test and treat" approach, given the country's high HIV incidence and concerns around loss to follow-up, as well as the focus on HIV prevention in young women and girls. The Secretariat explained that the Botswana TB/HIV program will be working closely on the area of women and girls, particularly the age of consent, with the Global Fund's two regional grants ARASA-ENDA and HIVOS that focus on human rights and prevention among key populations, respectively. The GAC commented on the country's advancements in prevention of mother-to-child transmission, noting the work on this issue across partners and the planned investment of the program's efficiencies into early infant diagnosis.

Chad Malaria Grant: United Nations Development Programme (TCD-M-UNDP)

1.5 Strategic focus of the program. Chad is a land-locked country where life expectancy at birth is 54 years for women and 47 years for men. Malaria is a major public health problem, the reason for 28.2 percent of consultations at health centers and the leading cause of morbidity in the country. While 97 percent of the country's mainly rural population of 13 million is at risk of malaria transmission, children under the age of five and pregnant women are most affected by the disease. The strategic focus of this program is to consolidate the gains of the past years and contribute to improving the health of the population of Chad. Specifically, the objectives of this program are to:

- Achieve a reduction of 30 percent in both malaria morbidity and mortality by the end of 2016
- Achieve an additional reduction of 20 percent in malaria morbidity and mortality between 2017 and 2018 in comparison with 2013
- Successfully complete 80 percent of malaria control support interventions by the end of 2018

The context-specific key activities to achieve these objectives include:

- Case management and patient care through rapid drug tests (RDT) and artemisinin-combined therapy in health facilities
- Vector control through the distribution of long-lasting insecticidal nets (LLINs), including 4,976,390 LLINs to at-risk populations through a 2017 mass campaign

- Prevention measures such intermittent preventive treatment in pregnancy and seasonal malaria chemoprophylaxis for children between the ages of three and 59 months in selected areas
- Strengthening of reporting and community systems
- Integrated community case management

Impact and outcomes of these measures include:

- Reducing all-cause under-5 mortality rate per 1000 live births from 175 in 2010 to 90 in 2018
- Reduce parasite prevalence among children aged 6-59 months from 35.8 percent in 2010 to 13 percent in 2018
- Reducing confirmed malaria cases (microscopy or RDT) per 1,000 population per year from 54.4 in 2013 to 20 in 2018

1.6 Domestic contributions. Total domestic financial commitments amount to €19,155,904, which represents a 66 percent increase compared to the previous implementation period. The security and socio-economic challenges, including the decline in oil prices and the Boko Haram conflict, have had an impact on the level and availability of state funds to put toward the health sector in 2015 and will likely continue to do so throughout the implementation period. The Secretariat will monitor government commitments through government budget and expenditure reports to be submitted on a quarterly basis and by maintaining ongoing dialogue with the Country Coordinating Mechanism, the National High Coordination Council and a multisectoral counterpart financing committee responsible for the monitoring of government commitments.

1.7 GAC review and recommendations. The GAC noted the challenging operating environment in which the Global Fund and partners' supported programs would be implemented and that the program falls under the Global Fund's Additional Safeguard Policy. The GAC acknowledged the difficulties faced by the government in maintaining health spending in light of the conflict with Boko Haram and the influx of displaced persons in the country; however, the GAC emphasized that commitments must be met in order to effectively address malaria. GAC partners commended the collaborative approach to the LLIN distribution during the mass campaign, particularly between Roll Back Malaria, the US Government's President's Malaria Initiative, the African Leaders Malaria Alliance and the Global Fund. The GAC noted that it is critical that both the Principal and anticipated sub-Recipient continue to work together to ensure a successful LLIN mass campaign.

Djibouti Malaria Grant: United Nations Development Programme (DJI-M-UNDP)

1.8 Strategic focus of the program. The country of Djibouti is at high epidemiological risk due to its unstable and highly seasonal malaria transmission. It had reached a pre-elimination level in 2012 with just 24 confirmed malaria cases, placing it at less than one case per 1,000 population; however, the number of malaria cases reached 1,674 in 2013 and 9,439 in 2014. The outbreak over the past two years has centered in the capital and Dikhil, being largely associated with rapid urbanization of the capital, a high number of refugees from neighboring countries, and nomadic cross-border populations in Dikhil. The present program aims at strengthening the control phase of malaria in order to reach pre-elimination phase by 2020. The program will provide testing and treatment for malaria as well as vector control activities, namely indoor residual spraying in the most affected areas and distribution of long-lasting insecticidal nets (LLINs) to the specific populations of refugees, migrants and nomads. The program also includes an important component on health systems strengthening for monitoring and evaluation, and procurement and supply chain management. Outcomes of the planned programing include:

- Increasing the proportion of children under the age of five sleeping under an LLIN from 19.9 percent in 2008 to 45 percent in 2017
- Increasing the proportion of pregnant women sleeping under an LLIN from 25.2 percent in 2008 to 45 percent in 2017
- Improving the proportion of malaria cases that receive first-line anti-malarial treatment from 82 percent in 2014 to 95 percent in 2017

1.9 Office of the Inspector General (OIG) recoveries. Following an investigation and the publication by the OIG of a report in October 2012, which identified US$8.67 million in fraud and ineligible, unsupported and inadequately supported expenditures incurred by the national Principal Recipient at the time, the Secretariat has been pursuing the recovery of US$4.07 million (related to the fraudulent and ineligible expenditures) from Djibouti. To date, US$1.75 million has been repaid in accordance with the repayment schedule agreed between the Global Fund and Djibouti and full repayment of that amount is expected by the end of 2016. The Secretariat is currently reviewing the findings of an independent audit firm in order to determine how much of the remainder of the expenditures found to be non-compliant by the OIG should be repaid by Djibouti, and the Secretariat will pursue the recovery of an additional amount accordingly.

1.10 Domestic contributions. Total domestic financial commitments to malaria amount to US$4 million, which represents 30 percent of total resources available for the next implementation period. The share of total government spending allocated to health was 14 percent, which is the highest level compared to other countries in the region, with Government of Djibouti contributions toward malaria going to LLINs and the recurrent costs of the malaria program.

Djibouti TB/HIV Grant: United Nations Development Programme (DJI-C-UNDP)

1.11 Strategic focus of the program. Djibouti faces a generalized HIV epidemic, with a prevalence rate at 2.9 percent within the general population in 2002 (DHS) and 15.4 percent within the key population of sex workers (Sentinel surveillance report 2010). Djibouti also has the fifth highest TB incidence rates in the world at 619 per 100,000 population in 2014. Furthermore, the country also has high rates of TB/HIV co-infection as well as multidrug resistant-TB (MDR-TB). The goals of the Djibouti TB/HIV program are to reduce new HIV infections by 50 percent by 2017 and to reduce TB prevalence by 25 percent by 2025. Context-specific activities and interventions to support these goals include key population-focused programs such as condom promotion; distribution, diagnosis and treatment of sexually transmitted infections; and removal of legal barriers to increase and improve access to services. Impact and outcomes of the planned programming include:

- Decreasing the TB prevalence rate per 100,000 population from 906 in 2013 to 838 in 2017
- Reducing the percentage of HIV infections among the children of HIV-positive women who have given birth in the preceding 12 months from 19.2 percent in 2014 to 3.1 percent in 2018, with the number of HIV-positive pregnant women receiving ART to reduce the risk of mother-to-child transmission increasing from 53.4 percent in 2014 to 100 percent in 2017
- Increasing the percentage of TB patients who had an HIV test result recorded in the TB register from 83.4 percent in 2014 to 95 percent in 2017, as well as the percentage of HIV-positive registered TB patients given ART during TB treatment from 77.3 percent in 2014 to 100 percent in 2017

1.12 Office of the Inspector General (OIG) recoveries. As noted in the Djibouti malaria grant description, Following an investigation and the publication by the OIG of a report in October 2012, which identified US$8.67 million in fraud and ineligible, unsupported and inadequately supported expenditures incurred by the national Principal Recipient at the time, the Secretariat has been pursuing the recovery of US$4.07 million (related to the fraudulent and ineligible expenditures) from Djibouti. To date, US$1.75 million has been repaid in accordance with the repayment schedule agreed between the Global Fund and Djibouti and full repayment of that amount is expected by the end of 2016. The Secretariat is currently reviewing the findings of an independent audit firm in order to determine how much of the remainder of the expenditures found to be non-compliant by the OIG should be repaid by Djibouti, and the Secretariat will pursue the recovery of an additional amount accordingly.

1.13 Domestic contributions. Total domestic financial commitments amount to US$6.3 million, which represents 25 percent of total resources available for the next implementation period and a 50 percent increase compared to the previous implementation period. The share of total government spending allocated to health was 14 percent, which is the highest level compared to other countries in the region, with Government of Djibouti contributions toward TB and HIV supporting ART, salaries, laboratory consumables and reagents, and the co-financing of health structures.

Haiti Malaria Grant: Population Services International (HTI-M-PSI)

1.14 Strategic focus of the program. Malaria incidence in Haiti is low relative to historical levels and the country is in the malaria control phase, with the proposed program seeking to reorient itself to eliminate the disease in Haiti before 2022. The annual incidence rate fell consistently between 2010 and 2014, and although the entire population in Haiti is at risk of malaria, the most vulnerable reside in residual foci of transmission. To achieve the goal of elimination, before 2017 the country will:

- Confirm all suspected malaria cases by microscopy or rapid diagnostic test (RDT);
- Correctly treat 100 percent of positive cases diagnosed by microscopy or RDT according to the national protocol;
- Implement an effective system of passive and active surveillance and epidemiological data about malaria in Haiti to enable sound decision-making;
- Identify and appropriately treat all malaria outbreak areas; and
- Implement an effective monitoring and evaluation system to make available epidemiological data and enable a selection of effective, relevant and targeted interventions.

1.15 Domestic contributions. Total domestic financial commitments amount to US$8,185,375, which represents 17 percent of total resources available for the next implementation period. Haiti's public institutions in general and health sector in particular are highly dependent on international aid to provide basic public services to its population. There are no indications in the country's economic perspectives that this will change during the implementation period, nor in the medium- to long-term. Furthermore, recurrent natural disasters as well as the backlashes of the cholera epidemic that started in the end of 2010 may jeopardize additional commitments to all three diseases in the next three years as emergencies might force reallocations in the national budget. However, sustainability efforts for this component are linked with the programs objective of eliminating malaria before the year 2022.

1.16 GAC review and recommendations. The GAC highlighted efforts made toward malaria elimination and underlined that its success is dependent on the enhanced collaboration and partnership with different actors, such as partners of the Malaria Zero initiative (formally HaMEC), Elimination of Malaria in Mesoamerica and the Island of Hispaniola, and the border municipalities from Dominican Republic. Taking into account epidemiological aspects and research into the utility of traditional vector control in this specific setting, GAC partners stressed the importance of targeted coverage of nets. The Secretariat clarified that the current program focuses on net distribution in strata 3 areas, which are those categorized as having the highest ongoing transmission, and extending into strata 2 areas. The GAC also acknowledged progress made during grant-making that resulted in enhanced collaboration with the Malaria Zero initiative, including the establishment of a coordinated plan to strengthen surveillance systems with the broad participation of stakeholders such as the Principal Recipient and Country Coordinating Mechanism. This increased coordination will also allow the application of evidence-based, targeted interventions in different strata based on the results from Malaria Zero pilot programs in different regions.

Indonesia TB/HIV Grants: Aisyiyah (IDN-T-AISYIYA), the Ministry of Health (IDN-H-MOH and IDN-T-MOH), National AIDS Commission of Indonesia (IDN-H-NAC) and Yayasan Spiritia (IDN-H-SPIRITI)

1.17 Strategic focus of the program. Indonesia has a concentrated HIV epidemic with a national prevalence of 0.41 percent, with provincial variability ranging from 0.1 percent or less to over 3 percent in areas with low-level generalized epidemics. HIV prevalence continues to increase, particularly among men who have sex with men. Additionally, Indonesia is classified by WHO as a high TB, high TB/HIV and high multi-drug resistant TB (MDR-TB) burden country with the national prevalence survey from 2013 revealing an unexpectedly high TB prevalence of 0.3 percent of the population (1.6 million cases) and an estimated 100,000 TB deaths annually, a much bigger burden than was previously estimated. The goals of the TB/HIV program are to reduce HIV- and TB-related morbidity and mortality in 34 provinces of Indonesia as well as to strengthen health and community systems in order to improve performance. Accordingly, the grant objectives are to:

- Prevent and reduce the transmission of HIV;

- Rapidly expand access to treatment for HIV and increasing retention among those on treatment;
- Improve the quality of life for people living with HIV;
- Reduce the socio-economic impact of the AIDS epidemic on individuals, families and society;
- Develop TB clinical management to ensure complete case notification and Public Private Mix (PPM) activities, increase the TB case notification rate and improve TB treatment success rates in both public and private providers, and expand TB programs among children;
- Expand programmatic management of MDR-TB services to ensure nationwide coverage, including intensify MDR-TB suspect identification, referral and enrollment; and
- Expand TB/HIV collaborative programming.

Priority interventions for the Global Fund-financed Indonesia TB/HIV program include:

- Strengthening and accelerating the rollout of the existing continuum of care model for HIV- and sexually transmitted infection-related health promotion, prevention and treatment in primary health care facilities and hospitals
- Reinforcing the role of civil society for advocacy, prevention, outreach and treatment adherence
- Complementing the integrated TB and HIV services and program components with the community mobilization approach at the primary health care level to deliver comprehensive care for key populations
- Strengthening linkages between health services under the Ministry of Health and other ministries, most notably with the Ministry of Law and Human Rights for the delivery of HIV and TB coordinated services in prisons

Expected impact and outcomes of this program, across the continuum of HIV and TB care, include:

- 11,647 lives saved and 75,300 infections averted through HIV treatment, care and support
- Decreasing AIDS-related mortality from 23 percent in 2014 to 15.68 percent in 2017
- Increasing the percentage of patients on ART 12 months after treatment initiation from 71 percent in 2014 to 87 percent in 2017
- Reducing TB prevalence by 22 percent per 100,000 population from 660 in 2013 to 515 in 2017
- Reducing TB incidence by 9 percent per 100,000 population from 403 in 2013 to 368 in 2017

1.18 Domestic contributions. Total domestic financial commitments amount to US$160 million for HIV and US$190 million for TB, which represents 69 percent of total resources available for HIV and 70 percent of available resources for TB for the next implementation period, as well as a 76 percent increase compared to the previous implementation period. Extensive discussions took place with the Country Coordinating Mechanism, other donors, Principal Recipients and the former Minister of Health regarding reduced reliance on donor-financed incentives, and this is reflected in the grant agreements. Additionally, the GAC award of incentive funding came with the stipulation that the targets of the national strategic plan be reviewed to further increase national targets as noted in the TRP and GAC recommendations, and to budget for first-line HIV and TB drugs and other domestic contributions accordingly in medium-term development plans. The incentive funding was aligned with TRP prioritization of TB care and prevention; MDR-TB programs; and HIV treatment, care and support. During grant-making, targets of the Global Fund were increased in several areas, such as those for ARV coverage, HIV targets for key populations, TB cases notified, and MDR-TB treatment and cases confirmed. Furthermore, a requirement was added to the grant agreement for the Ministry of Health to update the national strategic plan to further increase targets, commensurately updating the targets and budget for first-line drugs and other domestic contributions in health insurance.

1.19 GAC review and recommendations. The GAC commended the Indonesia TB/HIV program for its ambitious targets and for the increase in scale of the program as a result of expanded geographic coverage. The GAC acknowledged the challenges in addressing the TB and HIV epidemics in the decentralized health care system of Indonesia, which covers 514 districts across approximately 8,000 inhabited islands. Following an extensive and consultative grant-making process, the Secretariat reported to the GAC and partners that US$9 million of Indonesia's upper-funding ceiling remained unprogrammed, of which approximately US$4 million is from the HIV component and the remaining US$5 million is from TB.

Partners suggested several areas in which the funds could be potentially invested, in light of the country's significant disease burdens. The GAC noted that the existing recommended funding amount requires nearly doubling the program's absorption over the upcoming two years, and considering that the ambitious targets have met all TRP and GAC recommendations, the country's capacity has already been set to the upper limit in their complex operating environment. Partners commended the collaborative efforts made during grant-making in areas such as data collection, transition planning, ensuring value for money of programs and provision of technical cooperation. Partners also cited the opportunity to further coordinate efforts in fighting TB in the country. In addition, the partners commended the applicant on progress made in integrating TB/HIV interventions as well as including community drug centers in the implementation plans.

1.20 GAC review and recommendation on outstanding grant-making and remaining allocation. As mentioned in paragraph 1.19, the GAC noted that the Indonesia TB/HIV grants presented in Table 1a above do not exhaust Indonesia's full allocation as US$9 million remained in grant-making. Following further discussions regarding potential areas for investment of these funds, GAC partners highlighted TB as an area in which additional investments could be made for highest impact, given the recent epidemiological data revealing Indonesia's higher-than-expected TB prevalence. In addition, GAC partners expressed concerns about the inequities in different parts of the country, while also noting opportunities to invest in building resilience and sustainability of the health system presented through the World Bank and Australian Government Department of Foreign Affairs and Trade's (DFAT) Multi-Donor Trust Fund. Under the Multi-Donor Trust Fund, the program will provide technical cooperation to Indonesia to strengthen identified elements of the health system, and will also conduct studies and relevant analysis on health financing to look at ways to transition Indonesia from dependence on donor funding for health. Following further consultations, the GAC endorsed US$3 million to be used for technical cooperation via the Multi-Donor Trust Fund, including areas such as strengthening linkages with the private sector for TB case notification through the social insurance program, and other follow-up actions based on the results of the ongoing financial and programmatic sustainability assessments. This investment will better position the country for eventual transition, while not putting additional short-term burden on Principal Recipients to absorb additional resources. The GAC, through a separate report to the Board, will recommend this further funding for Indonesia TB and HIV programs from the country's remaining allocation. The remaining US$6 million will be returned to the general funding pool.

Mali HIV Grant: United Nations Development Programme (MLI-H-UNDP)

1.21 Joint TB/HIV program. Although Mali submitted a joint TB/HIV concept note as a country with a high rate of TB/HIV confection, the grant presented in this report includes only the HIV treatment component. The TB grant, which underwent integrated grant-making with the HIV grants, will be implemented by a different Principal Recipient and will be reviewed by the GAC at a future meeting. Additionally, a civil society Principal Recipient for the HIV grant focusing on prevention will be reviewed by the GAC early next year.

1.22 Strategic focus of the program. Mali is a large, landlocked country with relatively limited natural resources and a total population of 17.3 million. The HIV epidemic in Mali is generalized, with a prevalence among adults 1.1 percent in 2013 and higher rates among key populations. The increasing prevalence rate from 2.4 percent in 2007 to 2.9 percent in 2012 among pregnant women is of great concern. The persistence of high-risk sexual behavior, such as inconsistent condom use, unprotected sex at an early age and other sociocultural factors may increase the risk of HIV transmission. The goals of the Mali HIV program are to reduce new infections, morbidity and mortality rates linked to HIV/AIDS; to protect the rights of people living with HIV and key populations; and to improve universal access to adequate services of prevention, treatment and quality care and support. To achieve these goals, the program will strategically focus on the areas of:

- Prevention of mother-to-child transmission;
- Activities for the benefit of key populations;
- Implementation of task-shifting strategy;
- Establishment of favorable environment to fight the disease;
- Provision of local responses as well as employment of mobile strategies;

- Provision of universal access to prevention, treatment care and support;
- Strengthening global patient management services through decentralization, particularly in the reference and community health centers; and
- TB/HIV integration.

Key outcomes and impact of the planned programming include:

- Scaling up the percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission from 38 percent in 2014 to 65 percent by December 2017
- Decreasing AIDS-related mortality per 100,000 population from 13.53 in 2014 to 8.54 by December 2017
- Increasing the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy from 72 percent in 2014 to 90 percent by December 2017

1.23 Implementation arrangements and operational issues. To complement the UNDP grant recommended for funding here, an HIV prevention grant with Plan Mali as Principal Recipient will be presented to a future GAC for review once grant-making is completed. In addition, the Global Fund finances a large number of human resources in Mali; however, the number of positions funded has been reduced from the previous implementation period. The country will be requested to develop a transition plan in order to further reduce the number of personnel financed by the Global Fund, particularly those in public health facilities.

1.24 Domestic contributions. Total domestic financial commitments amount to €11,219,685, representing 15 percent of the HIV allocation. Health in Mali is mainly financed by the state, with the share of the state budget devoted to the development of health increasing from 5.65 percent in 2003 to 12 percent in 2014. During the next implementation period, contributions from the Government of Mali for HIV will go toward third-line ARVs, medical equipment, laboratory supplies, human resource costs, and operational costs.

1.25 GAC review and recommendations. GAC partners noted the security challenges facing the program as well as opportunities for partners to work collaboratively on management of stock and commodities, sustainability of human resources and risk management. The GAC was assured that grant-making for this part of the program was consultative across a range of stakeholders, including donors, and that interventions for key populations, including for people who inject drugs, would be covered in the HIV prevention grant to be presented to the GAC in early 2016. Partners also expressed support for the dialogue occurring in country and the prioritization of prevention of mother-to-child transmission. The Secretariat emphasized the essential role of partners in supporting technical cooperation during grant implementation, especially in the context of the volatile security situation in the country. GAC partners also commented on opportunities for HIV and TB programmatic integration and the importance of avoiding vertical programming.

Paraguay Malaria Grant: International Organization for Migration (PRY-M-OIM)

1.26 Strategic focus of the program. In the past decades, Paraguay has made substantial progress toward malaria elimination, and since 2014 WHO considers Paraguay a country in the malaria elimination phase with no malaria-related deaths reported since 2000. This is Paraguay's first grant for malaria from the Global Fund. The program goal is to obtain WHO certification as a country free from malaria, and to prevent the reintroduction of malaria to Paraguay with a priority focus on mobile and vulnerable populations.

1.27 Domestic contributions. Total domestic financial commitments amount to US$19.8 million, which represents 79 percent of total resources available for the next implementation period. Program sustainability has been ensured since the concept note stage in order to accelerate malaria elimination and sustain last decade's gains, with the understanding that this may be the only malaria grant that the country is eligible for from the Global Fund.

1.28 GAC review and recommendations on the investment of the allocation amount. The applicant was given an allocation of US$5,355,132 and submitted a concept note requesting the full amount in window 6 in June 2015. In line with TRP recommendations, the GAC set an upper-funding ceiling for grant-making of US$3,000,000, emphasizing that only activities critical to implementing the malaria control strategy and building resilient and sustainable systems for health that are currently not covered by domestic resources be included in the final grant. The GAC's funding recommendation took into consideration that the Global Fund financial support to Paraguay malaria program would not contribute directly to a reduction in malaria disease burden nor impact malaria morbidity and mortality. Given no malaria-related deaths reported since 2000, Global Fund financing would instead be used as a catalytic investment to ensure that the systems for health are in place to achieve malaria elimination certification and ensure the prevention of the reintroduction of malaria in Paraguay. The GAC recommended that this grant be structured in two stages, with the first as the three-year implementation period covered within this funding request, and a second stage in which a possible award contingent upon the attainment of certification of malaria elimination may be considered within the Global Fund's results-based financing policy during the next allocation period. Accordingly, the Secretariat is of the view that Paraguay may be eligible to receive a funding award for successful WHO-certified malaria elimination. However, the possibility is subject to further discussion as per the then-applicable results-based financing and allocation policy requirements of the Global Fund and the availability of relevant funding for such an award. In this regard, the GAC recommended that the remaining allocation of US$2.3 million may be returned to the general funding pool.

Southern Africa Regional Coordinating Mechanism TB Grant: WITS Health Consortium (QPA-T-WHC)

1.29 The strategic focus of the Regional TB in the Mining Sector in Southern Africa program is to contribute toward zero infections, zero stigma and discrimination, and zero deaths resulting from TB, HIV, silicosis and other occupational respiratory diseases in the region and in the mining sector in southern Africa. The program seeks to address TB and related illnesses among mineworkers, ex-mineworkers and their families and communities across ten participating countries of Lesotho, Swaziland, Mozambique, South Africa, Botswana, Namibia, Zambia, Zimbabwe, Tanzania and Malawi. The TB burden in the mining sector is particularly high compared to the general population. The ten countries participating in this program have some of the highest TB incidence rates in the world, averaging 591 per 100,000 population. Mineworkers in the southern Africa region have dramatically higher rates of TB infection, as a result of crowded living and working conditions with inadequate ventilation; high incidence of silicosis, particularly among gold miners; and co-infection with HIV. This regional program will link with the country programs to leverage domestic resources and utilize the national systems and capacities.

1.30 GAC review and recommendations. GAC partners highlighted the unprecedented political commitment demonstrated by Southern Africa Development Community (SADC) Heads of State in signing the "Declaration on TB in the Mining Sector" as a clear indicator of growing momentum and demand to address TB in mining as a regional challenge, and also noted the potential to unlock up to US$ 500 million compensation fund for ex-miner workers. There is strong support from Governments in the region, and the opportunity from TB community and partners to address the problem and support the initiative is very high. GAC partners emphasized the importance of engaging the full range of stakeholders, including ex-miners, in this program and encouraging governments to unlock the funds that would compensate these populations. The Secretariat explained to the GAC that the ministries of health and national TB programs of each of the respective countries included in the program were engaged throughout the grant-making process to align strategies and packages with those at the national level. GAC partners also commented that the program would need strong domestic and multistakeholder support in order ensure its sustainability beyond the current grant end date. The Secretariat informed the GAC that collaboration between the Principal Recipient, Regional Coordinating Mechanism and national TB programs resulted in plans for memorandums of understanding to be issued to the participating countries regarding responsibility for occupational health centers and a health management information system. Additionally, the Secretariat emphasized that the program would not be creating parallel systems to those that already exist, but rather working to ensure dialogue and coordination between the respective programs.

Sao Tome and Principe Malaria Grant: United Nations Development Programme (STP-M-UNDP)

1.31 Strategic focus of the program. The two islands of Sao Tome and Principe have different epidemiological situations. São Tomé island is in the control phase with low transmission. In 2014, malaria incidence ranged per 1,000 population from 3.7 (in the Me-zochi district) to 15.5 (in the Agua Grande district).The island of Príncipe is in pre-elimination phase with zero deaths related to malaria since 2006, and in 2014 the island reported an incidence of non-imported cases of 0.39 per 1,000 population. The strategic focus of the country's malaria program is to, by 2017, reduce the malaria incidence to less than 5 cases per 1,000 population on São Tomé and to less than 1 case per 1,000 inhabitants on Príncipe, thereby progressing toward malaria elimination. Further to these aims, the country intends to employ strategies such as:

- Strengthening the institutional, technical and managerial capacity of the:
  - National malaria program;
  - Epidemiological and entomological surveillance system;
  - National monitoring and evaluation system; and
  - Detection and response system for epidemics
- Detecting 100 percent of malaria infection cases at all levels, with high quality laboratory diagnosis, and treat such cases appropriately
- Ensuring that the general population and 90 percent of the at-risk population has access to at least one malaria prevention method, as well as that at least 80 percent of the general population has access to anti-malarial interventions

1.32 Domestic contributions. Total domestic financial commitments amount to US$1,907,128, which represents a 64 percent increase compared to the previous implementation period. In recognition of the development risks facing the country, the government joined G7+, an association of self-declared "fragile states" that are in transition to the next stage of development, and endorsed a new deal that aims to build strong national economies and end poverty. The government has implemented structural economic reforms that have helped to improve its macroeconomic indicators and to provide a more conducive environment for private investors.

Senegal HSS Grant: The Ministry of Health (SEN-S-MOH)

1.33 The focus of the Senegal HSS program is to sustainably improve the health of the Senegalese populations, through strategies such as:

- Strengthening the integrated delivery of HIV, TB, malaria, maternal, new-born and child health services through a package of integrated services;
- Improving the procurement and the supply chain management in the health sector, thereby improving the availability of quality assured essential medicines with proven effectiveness and safe usage;
- Contributing to improving medicines and health products management at all levels;
- Monitoring of interventions in health districts to improve the availability of health data, the identification of health problems and programmatic performance; and
- Improving the governance of health programs by strengthening the implementation quality of HSS interventions both at the institutional and community levels.

Program objectives and outcomes, which span health systems as well as disease-specific programs, include:

- Protecting 80 percent of pregnant women against malaria using intermittent preventive treatment in accordance with national guidelines
- Treating 100 percent of malaria cases in pregnant women seen in health facilities in accordance with national guidelines
- Diagnosing at least 75 percent of expected TB cases of all forms
- Successfully treating at least 90 percent of new diagnosed TB cases
- By 2017, offering ART to at least 90 percent of pregnant women who are newly tested HIV-positive to reduce HIV transmission to the child

- Reducing blood transmission of HIV, hepatitis B and hepatitis C to zero throughout the entire region
- Appropriately treating at least 60 percent of people with sexually transmitted infections who consult health centers by 2017
- Achieving a 75 percent attendance rate for antenatal consultations

1.34 Domestic contributions. Total domestic financial commitments for HSS amount to €135,287,250, which represent an increase of 871 percent compared to the previous implementation period. Through this grant, for which the Country Coordinating Mechanism strategically selected the Ministry of Health as Principal Recipient, synergies and service integrations across ministry departments will be developed in order to increase the sustainability of Global Fund investments. In addition, this HSS grant will pilot a shared-service approach on financial management with the financial department, which also works with other donors and the government.

Sierra Leone TB/HIV Grants: The Ministry of Health and Sanitation (SLE-T-MOHS) and National HIV/AIDS Secretariat (SLE-H-NAS)

1.35 Simplified approach. The Sierra Leone TB/HIV program submitted its funding request through a simplified approach in order to link with the post-Ebola health sector recovery plan, which was developed in consultation with a full range of stakeholders and reflects extensive country dialogue. In operation, this simplified approach included the consideration by the TRP of the health sector recovery plan as the investment case for the TB/HIV funding request. The TRP considered the allocation request to be technically sound and strategically focused, building on past experiences and focusing on key populations to achieve impact. Additionally, the program underwent accelerated grant-making and, with GAC endorsement, negotiated the grant in advance so that the disbursement-ready grant could be considered by the TRP and GAC at the same time as the above allocation request, and recommended for the Board approval before the expiration of current grants in December 2015.

1.36 Country context. The Sierra Leone TB/HIV program was designed as the country was emerging from the outbreak of the Ebola virus disease, during which 8,400 cases were reported and 3,600 deaths occurred (as of March 2015) making it the country most significantly affected by the Ebola outbreak. Poor early recognition of suspected cases and inadequate infection prevention and control standards led to 296 infections and 221 deaths among health care workers, including 11 specialized physicians. The closure and decreased capacity of health units to treat other medical issues resulted in a 23 percent drop in institutional deliveries, 39 percent drop in children treated for malaria, and 21 percent drop in children receiving basic immunization. This was due to both a loss of confidence in health services as well the focus of the health workforce in responding to Ebola. The outbreak also had a profound impact on the HIV and TB disease programs. All programmatic activities were affected, particularly care and prevention. Significant defaulter rates, loss to follow-up, stock-out of commodities and fear of both health workers and community members to visit the health facilities occurred, resulting in the decline of both TB and HIV achievements during this period.

1.37 Epidemiological context. Sierra Leone has a generalized and heterogeneous HIV epidemic, affecting different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The HIV prevalence is estimated at 1.5 percent among adults aged 15-49 years, though among key populations is significantly higher at 6.7 percent among female sex workers, 14 percent among men who have sex with men, 22.4 percent among male-to-female transgender people, 8.5 percent among people who inject drugs, and 2.2 percent among people in prisons. The burden of HIV is also particularly high among TB patients, with an 11.8 percent co-infection rate in 2014. HIV testing among TB patients was 81 percent, and TB screening among people living with HIV was 62 percent in 2014. In 2013, TB prevalence was 446 per 100,000 population and case detection was low at 63 percent. Despite an 83.7 percent treatment success rate for all forms of TB, there were 2,100 estimated TB deaths (excluding HIV-positive TB cases). The goals of the TB/HIV program are to:

- Reduce the burden of TB in Sierra Leone in line with the national strategic plan and Stop TB Partnership targets

- Prevent and mitigate the socio-economic impact of, as well as provide treatment, care and support for, HIV/AIDS at both national and sub-national levels in Sierra Leone

To support these goals, planned activities and interventions in Sierra Leone include:

- Increasing access to and uptake of prevention of mother-to-child transmission services
- Strengthening strong linkages to care for newly diagnosed HIV-positive individuals
- Improving laboratory capacity through updated technologies
- Establishing culture and drug susceptibility testing to confirm MDR-TB cases
- Active TB case finding within health facilities – including ART sites; reproductive, maternal, neonatal and child health clinics; prevention of mother-to-child transmission sites; and voluntary testing and counseling sites and pediatric wards – as well as systematic screening in prisons and military establishments
- Scaling up community interventions to promote social mobilization using the effective Ebola community approach; community health workers will ensure treatment adherence, defaulter tracing, household contact tracing, and referrals

Impact and outcomes of the planned programming include:

- Reducing HIV prevalence among key populations by 10 percent
- Scaling up the coverage of prevention of mother-to-child transmission through life-long ART for HIV-positive pregnant women from 85 percent in 2014 to 100 percent in 2017, with a 50 percent reduction of new HIV infections among children
- Increasing the percentage of people living with HIV receiving ART from a 20 percent coverage in 2014 to 44 percent by 2017, with the percent retained on treatment after 12 months after initiation from the 71 percent in 2013 to 85 percent in 2017
- Increasing the percentage of HIV-positive registered TB patients given ART from 67.4 percent in 2014 to 95 percent by 2017, with the percentage of HIV-positive patients screened for TB increasing from 62.7 percent in 2014 to 100 percent by 2017
- Scaling up TB case notification of all forms per 100,000 population from 201 in 2014 to 276 by 2017
- Increasing TB treatment success rate from 83.5 percent in 2014 to 85 percent in 2017
- Detecting 20 percent of the expected rifampicin- and multidrug-resistant TB cases by 2017

1.38 Domestic contributions. Total domestic financial commitments are US$2.25 million for HIV and US$0.68 million for TB, representing a 38 percent increase compared to the previous implementation period. The government has made significant commitments to increase budget allocation for health and the medium-term expenditure framework plans for health sector spending by the government to double between 2015 and 2017.

1.39 Investments in Human Resources for Health. Investments in human resources for health in Sierra Leone are essential to successful implementation of Global Fund supported TB/HIV, malaria and other national health programs, considering the critical nature of the TB program targets, the need to retain experienced staff with essential expertise and knowledge of the epidemiological context in Sierra Leone.. Due to the Ebola outbreak and the effects in the health sector, the Ministry of Health and Sanitation is not yet in the position to take over the salaries and performance-based incentives currently supported by the Global Fund. However, the Ministry of Health is currently in the process of rethinking the entire health workforce strategy to be implemented with the health sector recovery plan and will continue discussions with the Secretariat on the eventual progressive reductions of Global Fund funding on salary and performance-based incentives.

1.40 GAC review and recommendations. The GAC expressed strong support for the Sierra Leone TB/HIV funding request and commended Sierra Leone for conducting excellent work and carefully incorporating feedback from the TRP's remote review of the allocation request in October 2015 to strengthen the above allocation request reviewed at the window 8 TRP meeting in November 2015. The GAC strongly supported the focus on MDR-TB and expressed willingness to support an intensified intervention to tackle MDR-TB in Sierra Leone, though partners also noted that there is an opportunity for

the associated targets to be more ambitious. GAC partners also commented on the realistic approach and feasibility of targets set for reaching key populations with HIV prevention programs, lauding the government support for these programs. Furthermore, GAC partners expressed their willingness to provide support as needed, such as through the implementation of a gender assessment tool. While acknowledging that steps have been taken toward submission of a joint funding request as an effort to align the TB and HIV programs, the GAC underlined the need to continue supporting the coordination mechanisms of the HIV and the TB programs to ensure effective integration between the two programs. Additionally, the GAC recognized that Sierra Leone is facing severe human resources challenges, particularly in areas of monitoring and evaluation and laboratory support, and GAC partners encouraged the program to recruit a database manager to support management of the health information system. The GAC emphasized that the investments necessitate increased support from in-country partners to accelerate the implementation of activities and improve the absorption of program funds throughout grant implementation. The GAC commended the country for its submission of the TB/HIV program funding request and disbursement-ready grant, which drew strength from its simplified process and range of in-country stakeholders. GAC partners encouraged Sierra Leone to continue to draw on those synergies during implementation, and to work with the Secretariat to explore opportunities for a single-program approach for TB/HIV and health systems strengthening. The GAC was informed that, based on the GAC's award of incentive funding, the Secretariat has included a requirement in the grant agreement that the incentive funding will be released upon the delivery of a detailed plan and budget for the identified priority interventions by the Principal Recipients, including information on how these funds will be spent and what their effect will be on the program's targets.

Sri Lanka HIV Grants: The Family Planning Association of Sri Lanka (LKA-H-FPA) and the Ministry of Health (LKA-H-MOH)

1.41 Strategic focus of the program. Sri Lanka is an island country situated in the Indian Ocean with a population of 21 million and categorized as having a low-level HIV epidemic. It is one of four countries in the Asia Pacific region that has seen up to a 25 percent increase in new HIV infections in the 2001-2011 period, though this is likely the result increased case detection through intensified HIV testing rather than an actual increase in HIV incidence. The goals of the Sri Lanka HIV program are to prevent new HIV infections in key population and vulnerable groups, as well as to ensure high-quality provision of services across the continuum of care, from prevention to treatment, to all populations in need. Objectives and outcomes of the planned programming include:

- Achieving 80 percent geographic coverage of key populations and other vulnerable groups with targeted prevention programs and outreach
- Improving current detection of estimated people living with HIV by 20 percent through targeted HIV testing strategies
- Reducing to less than 15 percent the loss to follow-up of the entry into pre-ART care of identified people living with HIV
- Provide high quality HIV diagnostic, treatment and care services to 100 percent of people living with HIV registered into HIV care
- Ensure the availability, analysis and use of HIV and sexually transmitted infection strategic information
- Increasing the percentage of people living with HIV currently receiving antiretroviral therapy among all adults and children living with HIV from 19.3 percent in 2014 to 41 percent in 2016, with an increased percentage in 2017 and 2018 as a result of the change of national strategies and guidelines

1.42 Domestic contributions. Total domestic financial commitments amount to US$16,375,947, which represents a 142 percent increase compared to the previous implementation period. Major progress has been made toward sustainability for this implementation period, including:

- Domestic financing for ARVs, which will be 100 percent funded through national resources as of 2016
- One hundred percent domestic financing for CD4 reagents as of 2016

- Increases in domestic financing for key population interventions, including 20 percent of condom procurement for 2017, which will increase to 50 percent from 2018 onward

1.43 Change to the Sri Lanka allocation amount. As a result of an investigation by the Office of the Inspector General and the review of progress update disbursement requests submitted, certain ineligible expenditures were identified. As of the date of this report, while a portion of the ineligible expenditures amounts have been recovered, the Secretariat is still in the process of verifying and determining the final amount to be recovered. Should the final amount be unable to be recovered, the Secretariat intends to withhold an amount to be determined from the country's allocation for this implementation period, in line with management decisions providing for such reductions as an exceptional measure to resolve difficult recoveries cases.

Togo Malaria Grant: Primature de la République Togolaise (TGO-M-PMT)

1.44 Strategic focus of the program. Malaria is endemic to and the leading cause of mortality and morbidity in Togo, with the entire 6.8 million population at risk of transmission. In 2013, it was the reason for 27 percent of hospital admissions, 12 percent of deaths in health facilities and 36 percent of deaths among children under the age of five. Togo is still in the control phase and standard control interventions, as recommended by partners, have been implemented in all districts. To address this, the Togo malaria program aims to, by 2017:

- Ensure the protection of at least 80 percent of the population using effective malaria prevention measures;
- Ensure proper treatment of at least 90 percent of malaria cases at every level, including in the community; and
- Support malaria control by building and maintaining capacities for management, partnership and coordination by 2017.

Impact and outcomes of the planned programming by 2017 include:

- The distribution of 4,770,221 long-lasting insecticide-treated nets through a mass campaign, as well as covering 95 percent of pregnant women and of children under the age of one with continuous distribution
- Covering 70 percent of pregnant women with intermittent preventive treatment and 100 percent of children aged three to 59 months with seasonal malaria chemoprevention
- Treating 100 percent of both suspected and confirmed malaria cases

1.45 Domestic contributions. Total domestic financial commitments amount to €7.04 million, which represents an 843 percent increase compared to 2014-2015. Government of Togo contributions go to staff salaries and functional expenses of the national malaria program. Given that the core components of the malaria program are financed through external resources and significant funding gaps exist in the program, leveraging additional domestic resources through high-level engagement was a clear focus of country dialogue. As a result, the government has taken a significant decision to co-finance 50 percent of the long-lasting insecticide-treated nets and 40 percent of the procurement and supply management costs required for mass distribution campaign for 2017.

1.46 GAC review and recommendations. The GAC noted the importance of partner support throughout the concept note iteration and grant-making process for this program; partners expressed their intention to maintain the established support structures throughout the implementation process. Both the GAC and partners acknowledged the importance of domestic commitments materializing in order for the planned distribution campaign to move forward. Additionally, GAC partners noted the missed opportunity for the country to register unfunded quality demand by not presenting the full expression of demand in the concept note. The GAC endorsed the approach that the €10.4 million in savings in the malaria program identified during grant-making be reinvested in the areas aligned with the TRP recommendations on the concept note.

Tunisia HIV Grant: The National Office for Family and Population (TUN-H-ONFP)

1.47 The strategic focus of the program is to reduce both new HIV infections and mortality of people living with HIV by 50 percent by 2018, within the context of a concentrated HIV epidemic among men who have sex with men, people who inject drugs and sex workers. To achieve these aims, the Tunisia HIV program will employ context-specific strategies such as:

- Intensifying prevention efforts for key populations of sex workers, men who have sex with men, and people who inject drugs, as well as vulnerable populations of people in prisons, migrants, clients or partners of key populations, and vulnerable youth
- Improving access and quality of prevention of mother-to-child transmission as well as general HIV prevention, care and treatment services
- Strengthening the coordination, management and monitoring and evaluation of the national response to HIV/AIDS
- Enhancing community systems strengthening efforts of national stakeholders

Key impact and outcomes of the planned programming are:

- Increasing the number of men who have sex with men reached with prevention programs from 39.3 percent in 2014 to 80 percent in 2018
- Increasing the number of sex workers reached with prevention programs from 55.7 percent in 2014 to 80 percent in 2018
- Increasing the number of people who inject drugs and their partners reached with prevention programs from 9.2 percent in 2014 to 80 percent in 2018
- Increasing the percentage of people living with HIV on ART from 24.2 percent in 2014 to 80 percent in 2018

1.48 Domestic contributions. Total domestic financial commitments amount to US$25,311,154, which represents 66 percent of total resources available for the next implementation period. Discussions around the sustainability of the HIV program took place throughout grant-making between the Country Coordinating Mechanism, the national disease program and the Principal Recipient. The Secretariat will continue to engage with the stakeholders, including the government, to support the country in the development of a sustainability plan. The government of Tunisia's investments go toward HIV care and treatment.

V. Additional Matters

01 Extensions Approved by the Secretariat Pursuant to its Delegated Authority

The Secretariat hereby notifies the Board that it has approved extensions to the grants listed in Table 4 of this report in accordance with the Board decision GF/B31/DP12[7].

Table 4: Grant Extensions Approved by the Secretariat

Country	Disease component	Grant name	Currency	Period of extension (months)	Additional funding
Burundi	HIV/AIDS	BRN-809-G07-H	US$	3	-
Burundi	HIV/AIDS	BRN-813-G11-H	US$	3	-
Gambia	Malaria	GMB-M-CRS	US$	6	162,385
Gambia	Malaria	GMB-M-MOH	US$	6	-
Guinea-Bissau	HIV/AIDS	GNB-708-G05-H	€	9[8]	619,855
Madagascar	Malaria	MDG-M-PSI	US$	9[9]	5,125,126
Multicountry South Asia	HIV/AIDS	MSA-910-G02-H	US$	12	-

02 Corrections to Previous Reports to the Board

The Secretariat hereby notifies the Board of the non-material corrections to previous reports to the Board, of which the details are shown in Table 5 of this report.

Table 5: Amendments to Previous Reports

Applicant	Component	Grant name	GAC report reference	Issue	Original text and source	Correct information
Tajikistan	TB	TJK-T-HOPE TJK-T-RCTC	GF/B33/ER 18	Grant end date	• End date for grant is 31 December 2018 (Table 1 on pg 6)	• Correct end date for grant is 31 March 2018

[7] GF/B31/DP12: Extension Policy under the New Funding Model (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP12/)
[8] The period for which the additional funds requested does not exceed 6 months.
[9] The period for which the additional funds requested does not exceed 6 months.