Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B34/ER12
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B34/EDP16: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B34/EDP17: Decision on the Secretariat's Recommendation on Grant Extensions[2]

[1] Cameroon HIV, The Gambia malaria, Guinea-Bissau TB, Guyana TB, Haiti TB, Indonesia HSS, Madagascar TB, Multicountry Americas OECS TB/HIV, Pakistan HIV, South Africa TB/HIV, Tanzania malaria, Uzbekistan malaria and Uzbekistan TB. Total incremental amount is US$292,046,779 and €11,244,281.
[2] Central African Republic malaria and Egypt HIV. Total incremental amount is €7,416,978

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$292,046,779 and €18,661,259.

Decision Point: GF/B33/EDP16: 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 Section IV to GF/B34/ER12 ("Table 1");*

2. *Acknowledges each country disease component's constituent grants will be implemented by the proposed Principal Recipients listed in Table 1, or any other Principal Recipient(s) deemed appropriate by the Secretariat in accordance with Global Fund policies;*

3. *Affirms the incremental funding approved under this decision (a) increases the upper-ceiling amount that may be available for the relevant implementation period of each country disease component's constituent grants, (b) is subject to the availability of funding, and (c) shall be committed in annual tranches; and*

4. *Delegates to the Secretariat authority to redistribute the overall upper-ceiling of funding available for each country disease component among its constituent grants, provided that the Technical Review Panel (the "TRP") validates any redistribution that constitutes a material change from the program and funding request initially reviewed and recommended by the TRP.*

This decision does not have material budgetary implications for the 2016 Operating Expenses Budget.

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

Decision Point: GF/B34/EDP17: 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 Section IV to GF/B34/ER12.*

This decision does not have material budgetary implications for the 2016 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.

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

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

N	Applicant	Disease Component	Grant Name	Currency	Grant End Date	Total Program Budget	Sources		Recommended Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
							Existing Funding	Incremental Amount for Board Approval			
1	Cameroon[5]	HIV/AIDS	CMR-H-CMF	€	31 December 2017	10,406,343	1,667	10,404,676	10,404,676	11,055,834	HIV: 45,625,870
2	The Gambia	Malaria	GMB-M-MOH	US$	30 June 2018	12,892,796	970,840	11,921,956	11,921,956	1,455,223	4,152,906
			GMB-M-CRS	US$	30 June 2018	4,398,846	4,398,846	0			
3	Guinea-Bissau	TB	GNB-T-MINSAP	€	31 December 2017	3,325,089	2,485,484	839,605	839,605	0	293,519
4	Guyana	TB	GUY-T-MOH	US$	31 March 2019	1,065,099	1,065,099	0	0	0	2.79 million

[5] This grant is complementary to the Ministry of Health grants for TB and HIV service delivery approved by the Board in GF/B34/EDP06.

5	Haiti[6]	TB	HTI-C-PSI	US$	31 December 2017	61,148,404	46,677,176	14,471,228	14,471,228	0	49 million
6	Indonesia	HSS	IDN-S-MOH	US$	30 June 2018	7,962,130	7,962,130	0	0	0	n/a
7	Madagascar	TB	MDG-T-ONN	US$	31 December 2017	7,165,890	1,127,476	6,038,414	6,038,414	0	2.19 million
8	Multicountry Americas - OECS	TB/HIV	QRB-C-OECS	US$	31 March 2019	5,023,999	0	5,023,999	5,023,999	0	n/a
9	Pakistan	HIV/AIDS	PAK-H-NZT	US$	31 December 2017	10,070,876	4,751,105	5,319,771	11,507,239	739,720	23,860,000
			PAK-H-NACP	US$	31 December 2017	9,229,653	3,042,185	6,187,468			

[6] Although Haiti submitted a joint TB/HIV concept note as a country with a high rate of TB/HIV co-infection, the HIV component was reviewed at an earlier date and approved in GF/B33/EDP20 for reasons of timing and alignment with the national planning cycle.

10	South Africa	TB/HIV	ZAF-C-AFSA	US$	31 March 2019	16,383,562	0	16,383,562	208,317,626	22,346,213	5,584,066,735
		TB/HIV	ZAF-C-SCI	US$	31 March 2019	16,886,614	1,602,283	15,284,331			
		TB/HIV	ZAF-C-KHETH	US$	31 March 2019	20,246,415	0	20,246,415			
		TB/HIV	ZAF-C-KZN	US$	31 March 2019	31,676,308	0	31,676,308			
		TB/HIV	ZAF-C-NACOSA	US$	31 March 2019	44,988,165	15,113,950	29,874,215			
		TB/HIV	ZAF-C-NDOH	US$	31 March 2019	129,283,633	59,617,457	69,666,176			
		TB/HIV	ZAF-C-RTC	US$	31 March 2019	36,605,560	14,703,085	21,902,475			
		TB/HIV	ZAF-C-WCDOH	US$	31 March 2019	18,348,320	15,064,176	3,284,144			

11	Tanzania	Malaria	TZA-M-MOF	US$	31 December 2017	162,433,969	131,806,967	30,627,002	30,627,002	20,906,422	Malaria: 11.8 million HSS: 247.9 million
12	Uzbekistan	Malaria	N/A	US$	31 December 2018	400,000	243,774	156,226	156,226	n/a	n/a
13	Uzbekistan	TB	UZB-T-RDC	US$	31 May 2018	17,998,240	14,015,151	3,983,089	3,983,089	0	239.5 million

02 Table 2: Secretariat's Recommendation on Grant Extensions

N	Country	Disease Component	Grant Name	Currency	Period of Extension (Months)	Additional Funding	Rationale
1	Central African Republic	Malaria	CAF-813-G10-M	€	3	7,416,978	To allow the Principal Recipient to scale up essential services while the country finalizes the malaria funding request
2	Egypt	HIV/AIDS	EGY-608-G03-H	US$	9	0	The extension will allow for the provision of services during grant-making to resolve issues related to recoveries, the installation of a fiduciary agent and implementation arrangements

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

The following grants resulting from 13 concept notes have been found to be disbursement-ready by the Global Fund Secretariat following a systematic review process and 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.

Cameroon HIV Grant: Cameroon National Association for Family Welfare (CMR-H-CMF)

1.1 Civil society Principal Recipient. This grant with a civil society Principal Recipient, focused on HIV prevention, is complementary to the Ministry of Health grants for TB and HIV service delivery approved by the Board in GF/B34/EDP06.

1.2 Strategic focus of the Cameroon HIV program. HIV prevalence in Cameroon has fallen in recent years among the general population from 5.5 in 2004 to 4.3 percent in 2011; HIV rates remain higher among key populations, with average prevalence rates among sex workers in 2009 at an average of 36 percent with significant regional variations, and HIV incidence among men who have sex with men ranging between 24.2 (in Yaoundé) to 44.3 (in Douala) percent. Epidemiological data on HIV among people who inject drugs is not available because, to date, no situational analysis of the phenomenon of drug use and HIV has been carried out in Cameroon. The strategic focus of the Cameroon HIV program is to contribute to reducing new HIV-related infections by 50 percent and TB/HIV-related mortality by 2017. The HIV program aims to contribute to achieving:

- An increase in the percentage of people living with HIV known to be on treatment 12 months after initiation of ART from 60.4 in 2014 to 80 in 2018
- Ensuring that at least 80 percent of the key populations adopt less risky behavior by 2017
- A reduction in the estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months from 5.6 in 2014 to 3 in 2018
- Improving program and grant management capacity so as to increase the budget implementation rate to more than 90 percent in 2017

1.3 Implementation challenges. Cameroonian law criminalizes sexual relations between people of the same sex, and sex work is banned; though sex work is still tolerated to a relative degree, the restrictive legal environment in which men who have sex with men live compromises respect for and protection of their right to health, including related rights. Due to the restrictive laws, it is difficult for these groups to obtain legal recognition as associations, which restricts the community contribution to the provision of the package

of prevention and treatment services. To mitigate and address these issues, this grant includes the following relevant activities:

- At the central and regional level, targeted advocacy and risk management meetings related to HIV prevention and other interventions for key populations;
- Legal support for the implementation of activities for key populations as well as training and advocacy of stakeholders, such as judges, officials of the judicial police, traditional authorities, and journalists, on human rights issues and access to health services for key populations;
- Institutional capacity-strengthening of a key population organization for decreasing stigma and increasing key population access to health systems, upon submission of a detailed budget by the Principal Recipient.

1.4 Domestic contributions. Total HIV and TB domestic financial commitments amount to €51,708,730 which represents 36 percent of HIV and 39 percent of TB total resources available in the next implementation period. Cameroon continues to experience economic growth, despite the continued security and humanitarian crisis in the region. However, poor infrastructure and weak governance hamper economic activity, making it difficult to reduce poverty in a sustainable manner and adequately address development needs. Despite these challenges, the Global Fund and partners continue to actively engage with the Government of Cameroon to ensure that the it lives up to its commitments, and to discuss next steps towards transition and sustainable health financing in Cameroon in the medium- to long-term.

The Gambia Malaria Grants: Catholic Relief Services (GMB-M-CRS) and the Ministry of Health (GMB-M-MOH)

1.5 Strategic focus of The Gambia malaria program. The Gambia is located on the West African coast and is classified in the low human development category, at 172 out of 187 in the 2014 Human Development Index. Malaria is a major public health threat in The Gambia, as it is meso-endemic with the whole population at risk of infection. The malaria incidence declined by 43 percent over the past four years, and the 2010 and 2014 Malaria Indicator Surveys show that parasite prevalence has declined across the country in children under the age of five from 4.0 to 0.2 percent. The goals of The Gambia's malaria program are to reduce malaria mortality rates and incidence by 40 percent each between 2013 and 2020. Key achievements of the planned programming include:

- Decreasing the number of confirmed malaria cases via microscopy or rapid diagnostic test per 1,000 population per year from 157 in 2013 to 39 by 2019;
- Increasing the proportion of the population that slept under an insecticide-treated net the previous night from 68.7 percent in 2014 to 80.0 percent by 2019; and
- Maintaining proportion of health facilities without stock-outs of key commodities during the reporting period at 100 percent.

1.6 Operational issues, risks and implementation challenges. This grant includes performance incentives for central government staff, for which a phase-out plan was agreed with the Ministry of Health, with a 70 percent reduction of Global Fund resources for this activity by 2018. The plan stipulates that incentives for relevant positions will be covered by government support from the 2017 budget cycle onwards, with incremental increases and complete takeover of the relevant costs by 2019.

1.7 Domestic contributions. The counterpart financing share of the Government of The Gambia, 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 20 percent. This meets the minimum threshold requirement of 5 percent for a low-income country and represents a 60 percent increase compared to the previous implementation period. The "Health is Wealth" national health policy for 2012 to 2020 is intended to improve quality health services and accelerate growth toward universal coverage. Through a 3 percent levy on tobacco and tobacco products, alcohol and other hazardous products, the Government of The Gambia seeks to increase financing of health care. A resource mobilization plan will be developed by late 2016 to improve the revenues to the health sector, in addition to developing a financial sustainability plan.

Guinea-Bissau TB Grant: The Ministry of Health (GNB-T-MINSAP)

1.8 Strategic focus of the program. While the entire population of Guinea-Bissau is at risk for TB, the most vulnerable groups include people living with HIV, prisoners, contacts of confirmed pulmonary TB patients, children under the age of five years, people living more than 5 kilometers away from a health center and fishermen. Despite the increases in TB mortality, prevalence and incidence rates between 1990 and 2014, ongoing improvements in the case detection rate were observed from 2006 to 2013, with the exception of the period between 2011 and 2013 which was marked by political crisis. Challenges facing the program include inadequate detection, lack of focus on key populations, insufficient patient monitoring resulting in loss to follow up, inadequate central management of drugs and insufficient community involvement. The goal of the Guinea-Bissau TB program is to reduce incidence of TB by 25 percent and mortality by 50 percent between 2015 and 2019. Anticipated impact and outcomes of the program include:

- Reducing per 100,000 population the TB incidence rate from 369 in 2014 to 340 in 2017 and mortality rate from 63 in 2014 to 52 in 2017;
- Increasing the case notification rate of all forms of TB per 100,000 population from 131 in 2014 to 156 in 2017; and
- Increasing the treatment success rate of bacteriologically confirmed multidrug-resistant (MDR-TB) cases from 40 percent in 2013 to 50 percent in 2017.

1.9 Operational issues, risks and implementation challenges. Guinea-Bissau is currently considered a challenging operating environment and is characterized by chronic political instability and a lack of human resources and infrastructure. Grant-making has revealed that payment of salary incentives are currently misaligned across the three active Global Fund grants in Guinea-Bissau. The Secretariat has discussed with the CCM the need to harmonize salary payment levels across all grants under the allocation-based funding model with the aim of eventually phasing them out completely. Moreover, linking incentives with performance will be an essential component. Concrete indicators of performance and a long-term transition plan must be developed. At the Secretariat's request, the CCM submitted in December 2015 a harmonized proposal for salary incentives which would be applied to all Global Fund grants in Guinea-Bissau; the Secretariat is currently reviewing the proposal. As an interim measure, the budget includes a funding ceiling amount of €50,000 (1.5 percent of the grant) for the payment of incentives for 4 staff at the national TB control program staff and 6 Ministry of Health staff in charge of MDR-TB care and prevention activities, who are critical for successful grant implementation and achievement of set programmatic targets. Once the proposal has been agreed with the CCM and incentive levels are aligned for the three grants, the Secretariat foresees that the funding ceiling amount will be reduced and the savings will be reinvested in other program areas. Moving forward, the Secretariat and CCM will be engaging other in-country partners to ensure an aligned approach.

1.10 Domestic contributions. Government commitments for TB represent a 25 percent increase compared to the previous implementation period. However, a shortage of qualified health staff, particularly in rural areas, persists in the country. Given the fragility of Guinea-Bissau and its high dependency on external aid, Guinea-Bissau will need sustained support for years to come to ensure delivery of basic health services and reduce health inequalities. Nonetheless, Guinea-Bissau is making important efforts to increase its mobilization of domestic revenue. Government investments and pledges include reforms and institutional strengthening, as well as support for disease-specific programs.

Guyana TB Grant: The Ministry of Health (GUY-T-MOH)

1.11 Strategic focus of the program. Guyana is classified as a lower-upper-middle income country. The goal of the Global Fund supported TB program is to reduce mortality and TB/HIV related mortality in the country, in alignment with the goals of the national strategic plan for TB for 2013 to 2020 of reducing TB/HIV mortality from 9 per 100,000 population to 3 per 100,000 population. Context-specific strategies and activities to support this goal include:

- Early diagnosis of TB including universal drug-susceptibility testing;
- Improvement of treatment and support of all TB cases including drug-resistant TB;
- Strengthening of collaborative activities between TB/HIV and as well as other risks for co-morbidity;
- Increase screening of TB contacts and high-risk groups.

Expected achievements of the planned programming include:

- Reducing the transmission of TB by increasing case detection, from 75 percent in 2013 to over 90 percent in 2018;
- Reducing the emergence of MDR-TB by improving case detection of over 90 percent of MDR-TB and increasing the successful treatment rate of bacteriologically confirmed drug resistant TB cases from 50 percent in 2012 to 75 percent in 2021
- Reducing the burden of TB through improved management of TB/HIV co-infection.

1.12 Salary incentives. With the exception of three positions under this program, the Government of Guyana will fully support all required human resources by March 2016. Total human resource costs will decrease from US$57,213 in year 1 to US$42,081 in year 3 of the grant and by its last quarter, only one position will still be supported. A complete transition is anticipated by the beginning of the next implementation period.

1.13 Domestic contributions. The Government of Guyana contributed 48 percent of the national TB program funding in 2014 and has indicated an increase in the government funding to TB. In addition, the Government of Guyana is contributing US$2.8 million as a willingness-to-pay financing amount across all three diseases, mainly related to absorption of human resources, the procurement of drugs as well and investments in health information systems. First-line drugs for TB, previously financed by Global Fund grants, are now entirely covered by domestic contributions. Furthermore, this grant includes the gradual transition of financing for second-line drugs to the Government of Guyana as well.

Haiti TB Grant: Population Services International (HTI-C-PSI)

1.14 Joint TB/HIV program. Although Haiti submitted a joint TB/HIV concept note as a country with a high rate of TB/HIV co-infection, the HIV component was reviewed at an earlier date and approved in GF/B33/EDP20 for reasons of timing and alignment with the national planning cycle. The TB component is being recommended for approval through this report and the entire TB/HIV program will be consolidated under a single grant, with the final grant amount extended to cover the added TB modules.

1.15 Strategic focus of the program. Haiti is the country with the highest TB rates in the Americas region with estimated TB prevalence and incidence rates in 2014 of 244 and 200 per 100,000 population, respectively. However, TB-related mortality fell by 50 percent between 1990 and 2014 from 50 to 20 per 100,000 population; case detection rates increased from 32 percent in 1995 to 75 percent in 2014. For 2014, WHO estimates the incidence of multidrug-resistant TB (MDR-TB) is 2.5 percent of new TB cases and 11 percent of re-treatment cases. TB incidence is highest in key populations, such as urban populations residing in slums and other informal settlements, contacts of TB patients and incarcerated populations; in addition, Haiti registers a high rate of TB/HIV co-infection. The goals of the Haiti TB program are to stabilize sero-prevalence among adults, increase the survival rate for adults and children living with HIV on ART and reduce morbidity and mortality linked to TB by 10 and 15 percent, respectively. Aligned with the national strategic plan for 2015 to 2019, planned achievements of the proposed TB-specific programming include:

- Increasing the proportion of MDR-TB cases that are diagnosed and treated from 58 percent in 2012 to 85 percent in 2019 of expected cases
- Maintaining the therapeutic success rate for smear positive and negative pulmonary TB at 85 percent between now and the end of 2019

1.16 Domestic contributions. 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 at the end of 2010 may jeopardize additional commitments to HIV and TB in the next three years as emergencies might force reallocations in the national budget. However, sustainability issues are being address in specific areas of the program, such as the increased investment in

blood safety in close collaboration with the American Red Cross and Haitian Red Cross in developing an income-generating business model. The government has reiterated the commitment to integrate salary costs of added community-level health workers in 2018 and beyond into the national budget. This will be further discussed during the grant-making process for the HSS grant under the responsibility of the Ministry of Finance.

1.17 GAC review and recommendations. The GAC and partners supported the integration of TB programming with that planned jointly with the HIV component presented in late 2015. GAC partners commented on the needs during this implementation period to scale-up TB and MDR-TB interventions and to ensure linkage between TB/HIV programming, particularly at HIV care facilities. The GAC was informed that during grant-making, the national TB program was supportive of the suggested decentralization to extend capacity to scale-up with the support of partners including the Green Light Committee and PAHO. GAC partners requested more information on results-based financing programming, and was informed that the results-based financing program in collaboration with the World Bank program and USAID is separate from this grant. The Secretariat also informed the GAC that it is looking at ways to maintain funding for GeneXpert and the lab network beyond 2017.

Indonesia HSS Grant: The Ministry of Health (IND-S-MOH)

1.18 Strategic focus of the program. The pace and extent of Indonesia's decentralization in the health sector has been remarkably rapid, resulting in a highly decentralized health sector in which districts are well positioned to respond effectively to local level health needs that may have been previously overlooked by national authorities. However, standardization and consistency of health information systems and supply chain management, long-identified as HSS building blocks that are crucial to program performance, are difficult to address in this context. Sufficient and quality-assured drug supply and accurate and timely health information represent two significant challenges that have led to sub-optimal performance of the Indonesia HSS program in the past. To address this, the goals of the program are to build a conclusive and convincing evidence base that will persuade district leaders to invest in national policies, standards and tools for health information systems and supply chain management. This grant will be used to fund an innovative approach to addressing critical bottlenecks to develop more effective solutions for district health information systems and supply chain management systems in 10 districts. Planned achievements of the proposed programming include:

- Developing more flexible and responsive supply chain management systems;
- Making relevant health data readily available, enabling more prudent and informed planning and budgeting across all programs; and
- Increasing awareness of health systems' performance by health managers at facility, district, provincial and central levels.

1.19 Operational issues, risks and implementation challenges. In the context of Indonesia's decentralized health system, making further progress in the fight against HIV, TB and malaria in Indonesia requires an approach to programming and risk management differentiated by district. Program, performance, and financial and fiduciary risks are considered to be adequately managed.

1.20 Domestic contributions. Government commitments across all three diseases represent a 76 percent increase compared to the previous implementation period. The Global Fund concept notes across all diseases take into account the national development plan for 2015 to 2019 and major reforms of social security and health systems are ongoing to reach universal health coverage by 2019. It is estimated that the share of domestic financing in total health expenditure in Indonesia will increase dramatically from about 38 percent in 2013 to 58 percent in 2017 to meet the targets of this national plan. To finance its ambitious programs for infrastructure development, health, and social assistance, the government has taken decisive fiscal policy actions. The energy subsidy bill has been reduced to 5 percent of total government expenditure in 2016 from 19 percent in 2014, opening sizable space in the budget. This has resulted in a 43 percent year over year increase in the central government allocation to health in 2016. To ensure sustainability, those district governments adopting the program being piloted will finance it independently. The Secretariat will continue to engage in conversations with the central Ministry of Health to promote further roll-out of the pilot.

Madagascar TB Component Grant: The Office National de Nutrition (MDG-T-ONN)

1.21 Strategic focus of the program. Madagascar has a high burden of TB, largely attributable to the high rates of poverty and of malnutrition; in 2015, estimated rates per 100,000 population were 235 (207–264) for incidence, 406 (214–659) for prevalence and 51 for TB-related mortality. Estimates of multidrug-resistant TB (MDR-TB) indicate rates of resistance of 0.5 percent among new TB patients and 3.9 percent among retreatment cases in 2014 and TB treatment success rate is 82 percent from 2014's cohort. TB/HIV co-infection rates are very low at 1 percent. Twenty-three percent of TB patients know their HIV status, and 98 percent of known HIV-positive TB patients are on ART. The goals of the Madagascar TB program are to:

- Consolidate treatment success rates for all forms of TB across all regions and strengthen overall TB program management;
- Increase the number of TB case notifications each year at a rate exceeding the annual population growth rate; and
- Maintain low levels of drug-resistant TB and ensure sustainable care and support for TB patients and families.

Projected achievements of the planned programming includes:

- Increasing the number of TB cases (all forms) notified annually by 5 percent in 2016 and 7 percent in 2017, to reach a TB case detection rate of 60 percent of estimated cases by 2017
- Increasing the treatment success rate to 87 percent among bacteriologically-confirmed cases and 85 percent among all forms, by 2017
- Maintaining the prevalence of MDR-TB among previously-treated cases at less than 4 percent
- Increasing the percentage of TB patients receiving an HIV test from 22 percent in 2014 to 60 percent by 2017

1.22 Implementation challenges. Madagascar is one of the poorest countries in the world, with 81.3 percent of population living under US$1.25 a day. As a result of low economic growth, at an average of 1.8 percent per year since 1960, and rapid population growth of 2.9 percent per year, the GDP per capita has halved since 1960. Madagascar remains fragile, having experienced a long history of recurring political instability and significant vulnerabilities, most recently in 2009. Madagascar is also highly vulnerable to climatic and other exogenous shocks, such as cyclones, floods, locust infestations, and health epidemics such as the recent outbreak of bubonic plague.

1.23 Domestic contributions. 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 21 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government contribution is primarily for compensation of human resources and operational overheads of the national TB program. Funding available from the government meets about 8 percent of the funding need for the next implementation period.

1.24 GAC review and recommendations. The GAC commended the Madagascar TB program and requested partners' assistance in identifying prioritized areas for reinvestment of savings to strengthen the program and increase impact. GAC partners noted that case detection, MDR-TB, laboratory infrastructure and network, community TB care, and government-supported incentives for TB patients could be areas of reinvestment. The GAC and partners both noted the importance of supporting technical assistance and cooperation during grant implementation, for which the Secretariat is already engaging the CCM to submit a formal request. The Secretariat informed the GAC that the Principal Recipient put effort into increasing the targets versus what was presented in the concept note, however, the increase was marginal and there remained an opportunity to be more ambitious for this implementation period. To this end, the current grant documents include a condition to ensure the disbursements will not occur until an approved strategy and plan is put forth, including a potential increase in targets, in consultation with technical partners.

Multicountry Americas TB/HIV Grant: Organization of Eastern Caribbean States (QRB-C-OECS)

1.25 Strategic focus of the program. The six countries included in the multicountry Caribbean grant are Antigua and Barbuda, Dominica, Grenada, St Kitts and Nevis, St Lucia and St Vincent, and the Grenadines. All of these countries all classified as small islands developing states and part of the Organization of Eastern Caribbean States (OECS) with an estimated cumulative population of 575,000, as well as common approaches and policies to key sectors, including health, trade and education. The OECS region is still a generally low HIV prevalence region, with estimated adult HIV prevalence rates ranging from 0.57 percent in Grenada to 1.5 percent in Antigua and Barbuda. Higher prevalence rates have been reported among men who have sex with men in some of the countries and a gender imbalance noted among new HIV infections, with 69 percent occurring among males in 2013. With a combined TB incidence of 55.8 per 100,000 population, the six OECS countries have a low TB burden. In general, the distribution of TB burden in the region mirrors that of HIV, with countries with higher HIV prevalence recording more TB cases. The goals of the OECS TB/HIV program are to

- Reduce the incidence of HIV in accordance with the HIV 90-90-90 targets and achieve TB elimination in accordance with the TB elimination framework for low incidence countries; and
- Sustain and strengthen services for HIV, TB and sexually transmitted infections for key populations

Planned achievements of the proposed programming include:

- Increasing adults and children currently receiving ART among all people living with HIV from 28.8 percent in 2015 to 54 percent in 2018
- Increasing the percentage of TB patients who had an HIV test result recorded in the TB register from 63 percent in 2013 to 100 percent in 2018, as well as the percentage of HIV-positive registered TB patients given ART during TB treatment from 94.1 percent in 2013 to 100 percent in 2018
- Increasing registered TB cases, all forms (bacteriologically confirmed plus clinically diagnosed) successfully treated from 63 percent in 2013 to 88 percent in 2018

1.26 Domestic contributions. As a multicounty applicant, OECS is exempt from counterpart financing and willingness-to-pay requirements according to the Eligibility and Counterpart Financing Policy. However, governments are the largest contributor to HIV and TB programs, with 57 percent in 2014 and 82 percent in 2015 of the financing coming from national governments.

Pakistan HIV Grants: Nai Zindagi Trust (PAK-H-NZT) and the National AIDS Control Program (PAK-H-NACP)

1.27 Strategic focus of the program. Since the early to mid-2000s, the HIV epidemic in Pakistan has transitioned from low prevalence and high risk to a concentrated epidemic among key populations, including people who inject drugs, *hijra* (transgender) sex workers, and male and female sex workers. The highest rates of new infections occur among people who inject drugs. Key populations are geographically distributed throughout the country but are mainly in the major urban cities and provincial capitals. The goal of the Pakistan HIV program is to halt new HIV infections and improve the health and quality of life of people living with and affected by HIV in Pakistan. To reach this goal, the planned programing includes context-specific activities and interventions such as:

- A needle and syringe exchange program, advocacy for opiate substitution therapy and provision of condoms to key populations;
- Establishment and strengthening of an ART adherence unit as well as new HIV treatment centers to increase the geographical reach of services; and
- Strengthening the coordination between service delivery sites to improve results across the continuum of care.

Through the coordination of the national HIV program with the Global Fund-financed regional grants multicountry South Asia , APN+ and MENAHRA, support for transgender people and men who have sex with men are being delivered at the regional level. As a result, support for men who have sex with men is not included in this HIV/AIDS grant. Projected outcomes of the planned programming include:

- Increasing ART coverage among people living with HIV from 6 percent in 2015 to 9 percent in 2017

- Reaching 21 percent of people who inject drugs with HIV prevention programs and 45 percent of people who inject drugs reporting the use of sterile injecting equipment the last time they injected in 2016
- Maintaining stable rates of *hijra* and male sex workers living with HIV at 7.2 and 3.1 percent, respectively

1.28 Domestic contributions. 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 55 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments related to this disease represent a 56 percent increase compared to the previous implementation period. The realization of domestic commitments is critical for reducing dependence on the Global Fund, program scale-up and the long-term sustainability of HIV financing in Pakistan. Sustainability of Global Fund supported programs will continue to be a focus of country engagement and the Secretariat is collaborating with partners on the agenda of improving domestic financing for health.

1.29 GAC review and recommendations. The GAC and partners appreciated that Pakistan has now signed the framework agreement, allowing it to move forward into implementation. GAC partners noted that the program has improved its strength in recent years, though the opportunity still exists to improve services for key populations and ART coverage. GAC partners expressed concern regarding the type of services available to people who inject drugs and emphasized the importance of eventually addressing opioid substitution therapy beyond advocacy.

South Africa TB/HIV Grants: Aids Foundation South Africa (ZAF-C-AFSA), Kheth'Impilo AIDS Free Living (ZAF-C-KHETH), Networking HIV, AIDS Community of South Africa NPC (ZAF-C-NACOSA), the Republic of South Africa (ZAF-C-KZN, ZAF-C-NDOH and ZAF-C-WCDOH), Right to Care NPC (ZAF-C-RTC) and Soul City Institute for Health and Development Communication NPC (ZAF-C-SCI)

1.30 Country context. South Africa has an extreme disease burden of both HIV and TB. The country has a generalized HIV epidemic and the largest number of HIV infected individuals globally with a current estimate of 6.4 million. Despite progress and the downward trend in incidence rates, South Africa still reports very high levels of new infections. The highest incidence occurring among young women and girls, sex workers and their clients, transgender people and men who have sex with men. South Africa has the third highest burden of TB globally after India and China, though the estimated incidence of TB has declined per 100,000 population from a peak of 977 in 2008 to 860 in 2013. The estimated prevalence of all forms of TB per 100,000 population also declined from 817 in 2007 to 715 in 2013. Similarly, the estimated TB mortality per 100,000 population, excluding from TB/HIV co-infection, declined from 64 in 2005 to 48 in 2013. South Africa has the highest number of people co-infected with TB and HIV of any country in the world. Due to improvements in ART coverage, there was a decline in mortality related to TB/HIV co-infection per 100,000 population from 330 in 2011 to 121 in 2013. The provision of ART for people co-infected with TB and HIV has also increased over time from 24 percent in 2007 to 66 percent in 2013. With an estimated 6,200 cases of multidrug-resistant TB (MDR-TB) in 2014, South Africa is ranked 10th among high burden MDR-TB countries. The proportion of diagnosed MDR-TB cases started on treatment continues to fluctuate and the treatment success rate of the 2013 MDR-TB cohort was 45 percent compared to the global rate of 48 percent.

1.31 Strategic focus of the South Africa TB/HIV program. The goals of the program are:
- To reduce new HIV infections by at least 50 percent using combination prevention approaches;
- To initiate at least 80 percent of eligible patients on ART, with 70 percent alive and on treatment five years after initiation;
- To reduce the number of new TB infections as well as deaths from TB by 50 percent;
- To ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the national strategic plan; and
- To reduce self-reported stigma related to HIV and TB by at least 50 percent.

To reach these goals, South Africa's HIV and TB response in this program is built around activities focused on key populations and high-impact interventions, with supporting and cross-cutting priorities around critical enablers and improving quality of care. The strategic focus includes
a comprehensive package of integrated services to young women and girls, sex workers, men who have sex with men, transgender people, people who inject drugs, people in prisons, and people who live in peri-mining areas, prison, informal settlements, as well as other vulnerable populations to be identified through a geospatial mapping exercise. This will be done in parallel with addressing structural and environmental vulnerabilities and barriers to access including gender-based violence, stigma, legal and policy context, and education. In addition, the program will focus on strengthening community and health systems to build capacity among civil society, promote treatment adherence and integrate data management and information systems. Key programmatic targets include:

- Enabling 98 percent of people living with HIV, a total of 6.2 million people, to receive ART by 2019, of which the Global Fund will support 128,850 patients;
- Reaching an annual average of over 260,000 young people aged 10-24 years with a comprehensive prevention program, of which about 150,000 will receive an HIV test;
- Engaging a total of 30,000 young women aged 19-24 years with a cash plus care program;
- Reaching over 2.1 million other key and vulnerable populations to be identified through a geospatial mapping exercise with HIV prevention programs and another 3.2 million key and vulnerable populations through a mass media campaign;
- Initiating 90 percent of HIV-positive registered TB patients on ART; and
- Ensuring 100 percent of drug-resistant TB cases identified will have begun second-line treatment.

1.32 Operational issues, risks and implementation challenges. To further strengthen management of operational risks, the GAC recommended that the Secretariat closely monitor the three new Principal Recipients to ensure that minimum requirements are met before grant signing and that systems are functioning at a satisfactory level prior to disbursement. During the first six months of implementation, the Secretariat, LFA and other assurance providers will follow-up to determine if additional actions may be necessary to ensure a robust control environment that is functioning adequately to manage the funds flowing through these three new Principal Recipients.

1.33 Domestic contributions. Total domestic financial commitments amount to US$5,584,066,735, representing 83 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 96 percent for HIV and 92 percent for TB, a 23 percent increase compared to the previous implementation period. Sustainability for HIV and TB funding is an extremely difficult issue to manage in the South African context, due to the magnitude of the epidemics and the demand for treatment. Given the expected growth in the funding gap over the medium to long term, South Africa has commenced the process of introducing sustainable and innovative financing options such as rolling-out the national health insurance scheme, generating additional sources of investment in health through increases to taxes on alcohol and tobacco and introducing a social impact bond for prevention of HIV among sex workers (supported with catalytic investment from the Global Fund grant).

1.34 Special considerations for incentive funding award. In line with the TRP's prioritization of prevention programs for young women and girls in the above allocation request, the GAC has approved the investment of the incentive award of US$49,812,068 and reinvestment of savings in several areas, including an evidence-based cash plus care prevention program to help reach 30,000 young women and girls to reduce incidence of HIV among this key population and to leverage contributions from domestic and other sources through a social impact bond mechanism to complement the Treasury of South Africa investments in prevention programs for sex workers and their clients. Special considerations were taken into account, namely South Africa's exemplary massive domestic investments in HIV and TB programs, as well as the demonstration of effective use of evidence and programmatic data for planning, prioritization and the expression of ambitious demand based on robust investment cases. In recommending investment of incentive funding in piloting these innovative approaches, the TRP stressed that further scale-up is contingent upon adequate operations research to establish effectiveness, document lessons learned and evaluate impact of the proposed innovations relating to the social impact bond and the cash plus care

program. Additionally, South Africa's above allocation request presented a good example of potential for additional quantifiable impact driven by ambitious scale-up through decentralization of the nurse-initiated treatment of MDR-TB program, and evidence-based programming for other key populations including a framework for addressing people who inject drugs and their partners, as well as prevention programs for men who have sex with men and transgender.

1.35 GAC review and recommendations. The GAC and partners expressed their support for the South Africa TB/HIV program moving forward into implementation. The Secretariat highlighted to the GAC the program focus on women and girls, particularly through the innovative "Cash and Care" program for young and vulnerable women, social impact bond program targeting sex workers and a comprehensive prevention program for young women and girls, female sex workers and men who have sex with men. The GAC was notified of the collaboration and integration of TB and HIV interventions, particularly for vulnerable populations, as well as the scale of HIV programming for men who have sex with men, transgender people and people who inject drugs. GAC partners noted that critical gaps still exist in the national HIV prevention program, particularly for key and vulnerable populations and that the strategic focus of the proposed grant has the potential to provide catalytic funding to address these program priorities, to ensure that they are subsequently mainstreamed and financed with domestic contributions. Additionally, GAC partners acknowledged that South Africa acts as a role model for other countries in the region regarding the strong political commitment, scale and share of its domestic financing for health, HIV and TB programs, as well as in relation to the inclusive grant negotiations process. GAC partners welcomed the expansion of the MDR-TB program and expressed their willingness to support this throughout grant implementation. GAC partners' attention was drawn to the decentralized nature of the TB program and the need for support for infection control at the community level. The GAC noted with concern the macroeconomic and fiscal framework that has led to severe pressure on government budgets and asked the Secretariat to monitor closely to ensure that domestic financing commitments are met and that HIV and TB program components are not lost. The GAC was informed that the Secretariat is working very closely with the Ministry of Health to ensure program sustainability in all areas, including the absorption of new program staff (for procurement and supply chain management as well as programming on women and girls) into the domestic budgets. GAC partners commented on the opportunity to improve adherence to HIV and TB treatment during this allocation period. Lastly, the GAC endorsed the reinvestment of funds leftover from previous grants into priority areas of unfunded quality demand, including prevention programming for young women and girls.

Tanzania Malaria Grant (TZA-M-MOF)

1.36 Country and epidemiological context. Tanzania is one of the biggest recipients of Global Fund investment, with US$1.4 billion disbursed to date, and has the third largest population at risk of malaria in Africa. Malaria remains the top outpatient and inpatient diagnosis, with incidence of 161 per 1,000 population in all ages and 379 per 1,000 population in children under the age of five. The country has been successful in demonstrating significant impact in the fight against this disease, with notable improvements in malaria treatment and access to prevention services over the past decade. These have resulted in a dramatic decrease in the mortality rate in children under the age of five, from 148 per 1,000 live births in 1999 to 81 in 2010, and 52 in 2013. It is estimated that at least 50 percent of the decrease in deaths among children under five can be attributed to improved malaria interventions, translating to 60,000 deaths averted each year.

1.37 Strategic focus of the program. The grant is two-fold in its support for both the malaria control program as well as overarching health system strengthening activities. It aims to reduce the average malaria prevalence from 10 percent in 2012 to 5 percent in 2016 and thereafter to less than 1 percent by 2020. The grant also aims to contribute to the overall health sector goal to reach all households with essential health and social welfare services, meeting as much as possible the expectations of the population and objective quality standards by applying evidence-based efficient channels of service delivery in order to:

- Achieve a 20 percent reduction in the maternal mortality ratio and neonatal mortality rate in the five worst-off regions;
- Achieve a balanced distribution of skilled health workers at the primary care level in targeted underserved regions;

- Support 80 percent of primary health facilities to be performance-rated three stars; and
- Ensure 100 percent availability of stock of essential medicines.

Activities to support malaria and HSS program goals include:

- Scaling up and maintaining effective and efficient vector control interventions, including the provision of LLINs to 5.1 million pregnant women and infants, in addition to distributing 2.1 million LLINs through school net programs.
- Promoting universal access to early diagnosis, treatment and provision of preventive therapies to vulnerable groups, including treatment of 25 million diagnosed and presumed malaria cases by the end of 2017.
- Training health facility workers in timely submission of logistics management information systems (LMIS) reports to ensure availability of commodities and to support management of the supply chain.
- Providing student grants to 1,910 students to ensure distribution of health staff to remote areas and recruiting 49 tutors for students in health training institutions.

1.38 Report of the Audit by the Office of the Inspector General (OIG). In August 2015, the OIG conducted an audit of the Tanzania malaria program and the report was published in February 2016. The audit raised important issues affecting malaria and HSS activities: supply chain management weaknesses, presumptive malaria treatment, the private sector co-payment mechanism for ACTs, value for money and weak financial management. The Secretariat and OIG agreed on the management actions in order to address the issues raised in the audit, such as:

- **Review of the systems for storage and distribution of medical commodities**: The Secretariat and key country stakeholders have instituted a review of the medical stores department and the development of an operational plan based on the review findings is in progress. A separate operational plan will be agreed upon between the Secretariat, the Government of Tanzania and partners with a view of improving the overall accountability throughout the supply chain. Additionally, generating quarterly stock status reports aiming to address stock discrepancies between the central and zonal medical stores department warehouses is also in the plan. These reports are expected to reconcile total quantities consumed during the reporting period with the quantity in stock at health facilities and all warehouses, quantities ordered, average monthly consumption and months of stock.

- **Planned scale-up and the improvement of services:** To improve quality of service issues, the Secretariat is working with stakeholders to ensure that the quantification and forecasting of malaria medicines and test kits is revisited before additional investments are made. The Principal Recipient (the Ministry of Finance) is also required to identify a suitable entity to manage the private sector co-payment mechanism for ACTs as well as to prepare a supervision and training plan, specifically addressing the quality of services that are found to be sub-optimal.

- **Effectiveness of HSS**: To help maximize the impact of HSS investments in general, the Secretariat will provide operational guidance on the planning, overseeing and monitoring construction and renovation projects.

- **Management and oversight**: To mitigate delays in program implementation and the flow of funds, the CCM will submit a time-bound action plan showing how implementation arrangements will be streamlined and strengthened regarding Principal Recipient capacity to deliver on its mandate, its delegated authority to sub-recipients, and risk management and assurance framework. Restructuring and reinforcing the two program management units within the Principal Recipient and the Ministry of Health is also expected to accelerate the flow of funds within the accountability framework of the national financial systems. The Secretariat is also supporting the Principal Recipient to upgrade its financial management and reporting under the current funding model.

Lastly, the Secretariat is in the process of reviewing the findings relating to the loss of assets and funds not accounted for and will make proposals to the Recoveries Committee accordingly. Once the recoverable amounts have been finalized, the Secretariat will pursue the recovery of these amounts to the fullest extent.

1.39 Domestic contributions. Total domestic financial commitments include US$11.8 million for malaria and US$247.9 million for HSS, representing 6 percent of the total resources available for malaria

and 74 percent for HSS in the next implementation period. Government commitments across all programs supported by the Global Fund represent a 30 percent increase compared to the previous implementation period. The government has since included health as a priority sector in the subsequent round of the "Big Results Now!" initiative, especially focusing on strengthening human resource capacity and lessening dependence on external resources for medicines and other health commodities. Government financing of commodity procurement is proposed to increase from current levels of around 5 percent to 20 percent by 2020, contributing to mainstreaming of program interventions as well as sustainability. The government is in the process of finalizing a national health financing strategy with the main objective to achieve universal health coverage through increased mobilization of domestic financial resources. The aim is to provide the necessary framework for comprehensive and mutually reinforcing reforms in all areas of health financing, so that an increasing number of Tanzanians will have access to quality health services without facing financial risks related to health care. The Secretariat has conducted extensive discussions with the Ministries of Health and Finance, the Prime Minister's Office, development partners, parliamentarians, civil society representatives and the former First Lady of Tanzania to advocate for and support these efforts. A new grant from the Bill & Melinda Gates Foundation is complementing the Global Fund investments with technical assistance for the health financing strategy and the development of sustainability plans.

1.40 Special conditions for incentive funding. The Tanzania malaria concept note was originally reviewed by the TRP in window 7 in September 2015. The TRP recommended that the allocation request proceed to grant-making at that time, with a caveat that the above allocation request be considered for incentive funding only after further clarifications were submitted in window 8 in November 2015. Following the TRP review window 8, the GAC awarded incentive funding of US$27,713,851 based on updated TRP prioritization and recommendations on the above allocation amount, focused on investments in health information and procurement and supply management systems as well as purchase of additional LLINs which are critical for covering all pregnant women and infants at risk of malaria. In light of the compressed timeframe between the award of incentive funding and presentation of the full grant for GAC review, the Secretariat has included conditions precedent to the use of the incentive funding amount upon delivery by the Principal Recipient of a detailed work plan and budget for the specific ring-fenced activities within the first quarter of 2016.

1.41 GAC review and recommendations. The GAC commended the progress achieved in the Tanzania malaria program and noted the efforts to increase domestic financing for health as well as advancements towards sustainability. While the GAC acknowledged the TRP's recommendation that entomological monitoring be removed from the allocation funding request, GAC partners confirmed that entomological monitoring is crucial and expressed strong support for maintaining surveillance in the above allocation request and added to the country's unfunded quality demand, also taking into account the need to ensure ongoing commitments are carried over from the previous grant. GAC partners expressed support for the re-quantification of malaria commodities undertaken during grant-making and acknowledged that efficiencies identified as a result of re-quantification were reinvested in critical LLIN mass campaign activities committed under the existing grant which had not been included in the concept note. GAC partners further emphasized the need to address issues of overconsumption by ensuring quality of care, and the Secretariat provided assurance that the strategic framework for the private sector supports control of overconsumption through frequent surveys, more active management of the first-line buyers including targeted distribution to high prevalence areas of the country. GAC partners highlighted the opportunity for lessons learned from the roll out of the national health information systems framework in other countries and noted the Secretariat's efforts to ensure a cross-cutting, transparent reporting system is developed in collaboration with partners.

1.42 GAC review and recommendations in relation to OIG management actions. Additionally, the Secretariat affirmed to the GAC that proposed management actions to address OIG findings were developed in close collaboration with the OIG. At the same time, the GAC acknowledged the systemic nature of many of the issues highlighted by the OIG, emphasizing the need to ensure that in addressing the concerns raised in the short-term, progress is also anticipated over the next several years. Furthermore, the GAC noted that, through grant savings as well as incentive funding activities, the country has already prioritized funding to specifically address audit findings over the course of grant implementation.

Uzbekistan Malaria Grant – investments to support technical cooperation and incentive award based upon attainment of malaria elimination certification

1.43 Country context. The Uzbekistan malaria program, with financing from the Global Fund since 2004, has achieved significant impact and the country is currently in the phase of preventing reintroduction of malaria. According to the 2014 WHO Global Malaria Report 100 percent of the targeted population was protected by insecticide-treated nets and 100 percent of the indoor residual spraying of household with insecticide coverage targets was achieved. Additionally, the country pays specific attention to malaria surveillance. Epidemiological investigations of all reported cases of malaria are carried out systematically.

1.44 Strategic focus of the Uzbekistan malaria program. The TRP and GAC acknowledged that in the absence of any locally transmitted malaria cases and deaths, Global Fund support to Uzbekistan will not contribute directly to a reduction in the disease burden nor impact malaria morbidity and mortality. To optimize and ensure effective use of the country's allocation for malaria, the TRP and GAC recommended strategic refocusing of the available funds to be used as a catalytic investment to ensure that resilient and sustainable systems for health are in place to achieve malaria elimination certification and ensure implementation of the national strategic plan for malaria for 2016 to 2020, and that the malaria elimination program establishes robust measures towards the prevention of reintroduction of malaria. In light of the existing grant performance concerns and high proportion of the budget in the concept note that is dedicated to program management costs, the GAC recommended restructuring of malaria investments in Uzbekistan to reach funding levels considered appropriate and sufficient to achieve the objectives of the concept note with part of the grant funding being set aside for technical cooperation to support the country in implementing activities required to attain WHO malaria elimination certification, with the rest of the funding going to an incentive award amount of US$400,000 (drawn from the malaria 2014-2016 allocation) to be paid only upon the country receiving the elimination certification. No other operational or programmatic costs will be funded by the Global Fund, in line with TRP recommendation that only activities that are critical to implementing malaria elimination certification and preventing re-introduction of malaria not currently covered by domestic resources should be funded. The remaining funding amount of US$93,404 of a total allocation of US$838,806 would be made available for reallocation to the HIV and TB programs through revision of the program split during grant-making.

1.45 Domestic contributions. Uzbekistan has committed more than US$3.2 million of funding for 2016-2018, a commitment that represents a 57 percent increase compared to the past malaria spending in 2013-2015. Based on the data available, the counterpart financing share is 82 percent which is above the required minimum.

1.46 GAC recommendations**.** The GAC discussed different options on how to best manage Global Fund malaria investments in Uzbekistan and emphasized the need to ensure programmatic and cost effectiveness and value for money. The GAC recommended an alternative funding mechanism to achieve malaria elimination certification which allows for optimization and leverage of Global Fund investments, substantial simplification and reduction of operational costs, includes funds for technical cooperation to support the country towards this goal and an award to be payable upon attainment of malaria elimination certification. The GAC endorsed the decision to reinvest the remaining amount previously proposed to be used by the malaria program into the TB and HIV components.

Uzbekistan TB Grant: The Republican DOTS Center (UZB-T-RDC)

1.47 Strategic focus of the Uzbekistan TB program. Uzbekistan is classified as a lower lower-middle-income country. Uzbekistan belongs to one of the 18 high priority countries of the WHO European region and one of the 27 countries in the world with the highest multidrug-resistant TB (MDR-TB) burden. In alignment with the national strategic plan, the goals of the proposed TB grant for 2013-2020 are to:

- Reduce the TB incidence rate from 82 to 38 per 100,000 population;
- Reduce the TB related deaths from 9.1 to 2.6 per 100,000 population; and
- Reduce the burden of MDR-TB by 50 percent compared to 2014 levels.

Context-specific strategies and activities to support these goals include but are not limited to:

- TB prevention and adherence for ambulatory treatment for vulnerable populations;
- Sputum smear microscopy investigations;
- Prevention of opportunistic infections in TB/HIV patients with procurement of co-trimoxazole; and
- Testing for rapid identification of drug or multidrug resistance through GeneXpert;

1.48 Domestic contributions. The Government of Uzbekistan has committed US$239,514,960 for the TB program, accounting for 92 percent of total resources available during this allocation period and representing a 24 percent increase compared to the previous implementation period. The government of Uzbekistan fully took over the procurement of first line TB drugs, starting from 2016, and will be gradually taking over procurement of second-line TB drugs during the implementation of the grant.

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 3 below in accordance with the Board decision GF/B31/DP12.

2.1 Simplified application approach. As Morocco is nearing the end of its eligibility for Global Fund financing, the CCM and Secretariat have worked together on a simplified approach, allowing the country's current grants to be extended as the country's eligibility and transition plans will be further clarified under the 2017-2019 allocation period. These extensions will continue activities under previously Board-approved grants while the activities transition to domestic financing.

Table 3: Grant Extensions Approved by the Secretariat

N	Country	Disease Component	Grant Name	Currency	Period of Extension (Months)	Additional Funding
1	Morocco	TB	MOR-011-G05-T	€	6	0
2		HIV	MOR-011-G04-H	€	6	0

01 Updates and Reconciliations to Previous Reports to the Board

The Secretariat hereby notifies the Board of non-material updates and reconciliations to previous GAC reports to the Board, of which the details are shown in Tables 4 and 5 below.

1.1 Background. Prior to July 2015, the total program budget of multiple grants recommended by the GAC to the Board for funding did not reflect planned disbursements of grants from the rounds-based funding model. The budgets of new grants, up until this point, were based on forecasts of costed activities to be implemented during the new grant's implementation period. Therefore, through the information shown below, the Secretariat is presenting for Board information the reconciliation of total program budgets of multiple grants previously approved by the Board. The purpose is to ensure transparent reporting to the Board and alignment of approved program budgets with published grant amounts which have been revised to reflect addition of existing rounds-based funding arising from planned disbursements, liabilities and carry-forward activities covered within the 2014-2016 allocation, but not previously taken into account in the new grants.

2.2 Rationale. Of the 18 grants with revised budgets presented in Table 4 below, 10 result from the lead time for order and disbursement for the Pooled Procurement Mechanism not being effectively factored into the total program budget; in these cases, the disbursement, initially projected to take place prior to the approval by the Board of relevant new grants, took place afterwards instead. In 7 of the cases listed below, activities were not implemented according to their original schedule and activities were carried forward into the respective new grants. In the last remaining case, activities were unable to be carried out in a timely manner due to audit report-related issues. In all these cases, the amount included in the originally-planned disbursements was excluded from the total program budget of related new grants in the allocation-based funding model. However, since the planned disbursements did not take place or the amount disbursed was less than projected prior to signing of the related new grants, the existing available funding was therefore consolidated into the respective new grants, resulting in actual total program budgets for multiple grants published by the Secretariat that were higher than the funding recommendations originally presented to

the Board based on the 2014-16 Allocation. However, as those planned disbursements were part of existing funds and not from the relevant incremental amounts, they have no effect on the Board-approved incremental funding and therefore do not require alteration to the Board's decisions.

2.3 Updated measures. To ensure consistent reporting, the Secretariat has introduced new guidance and measures during quarter 3 of 2015 to reflect these planned disbursements in the calculation of amounts presented to the Board. Furthermore, to ensure that these issues are monitored and reported appropriately, the Secretariat plans to provide the Board with a similar report on reconciliations to GAC-recommended amounts to the Board on an annual basis.

Table 4: Reconciliation of financial recommendations to the Board by the GAC in 2015

Applicant	Currency	Grant Name	GAC Report Reference	Board-Approved Budget	Revised Budget
Armenia	US$	ARM-T-MOH	GF/B33/EDP01	9,243,338	9,531,268
Burkina Faso	€	BFA-C-IPC	GF/B33/EDP07	6,743,006	7,876,000
Congo (Democratic Republic)	US$	COD-H-CORDAID	GF/B33/EDP12	72,046,946	82,173,143
Congo (Democratic Republic)	US$	COD-H-SANRU	GF/B33/EDP12	75,453,105	84,856,359
Congo (Democratic Republic)	US$	COD-M-MOH	GF/B32/EDP01	34,721,717	40,196,213
Congo (Democratic Republic)	US$	COD-M-PSI	GF/B32/EDP01	119,790,157	134,224,102
Congo (Democratic Republic)	US$	COD-T-CARITAS	GF/B33/EDP12	38,870,165	38,964,683
Ghana	US$	GHA-T-MOH	GF/B33/EDP07	22,506,425	24,902,845
Mozambique	US$	MOZ-C-FDC	GF/B33/EDP04	21,646,391	22,026,026
Mozambique	US$	MOZ-H-MOH	GF/B33/EDP04	180,928,522	203,244,616
Mozambique	US$	MOZ-M-WV	GF/B33/EDP04	23,187,703	27,002,115
Mozambique	US$	MOZ-T-MOH	GF/B33/EDP04	38,432,108	40,618,491
Niger	€	NER-H-CISLS	GF/B33/EDP07	14,259,597	14,486,006
Nigeria	US$	NGA-M-NMEP	GF/B32/EDP05	292,995,125	308,577,343
Nigeria	US$	NGA-M-SFH	GF/B32/EDP05	79,944,045	91,676,004

SADC (Regional)	US$	QPA-H-SADC	GF/B32/EDP15	11,373,458	11,932,264
Swaziland	US$	SWZ-H-CANGO	GF/B33/EDP12	5,636,567	6,308,560
Tanzania	US$	TZA-T-MOF	GF/B33/EDP07	21,286,266	21,377,285

1.2 Table 5 below presents a case where there is an increase to the budget amount of Eritrea HIV ERI-H-MOH. Such increase is within the country's 2014-16 allocation and representing a transfer of in-country cash balance to fund previously committed liabilities under the Phase 2 ERI-H-MOH. These were not (and should have been) included in the total budgets when the Board approved program budgets for the Eritrea malaria grant on 30 June 2015 (GF/B33/EDP07). The transfer was part of the Secretariat's efforts to close the said Phase 2 grants and consolidate all funding under the NFM grants to simplify relevant grant management going forward given the Principal Recipient is the continuing one. Since the transfer of cash balance to fund previously committed liabilities were part of the country's existing funding not affecting Eritrea's allocation, it does not affect the incremental funding amount previously approved by the Board, and therefore do not require alteration to the Board's previous decision.

1.3 The funds transferred are planned to be used towards the original commitments, which included predominantly:

- The procurement of health products, notably ARVs;
- Condoms;
- Laboratory equipment;
- Development of commination material for promoting of behavioral change;
- Provision of nutritional support to people living with HIV on ART and for orphans and vulnerable children;
- Monitoring and evaluation; and
- Program management costs.

Table 5 Amendments to Previous Reports on Eritrea

Applicant	Currency	Grant Name	GAC Report Reference	Board-Approved Budget	Revised Budget
Eritrea	US$	ERI-H-MOH	GF/B33/EDP07	19,795,804	23,939,512