Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B34/ER14
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B34/EDP19: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B34/EDP20: 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] Congo (Democratic Republic) malaria, Liberia TB/HIV, and Mozambique malaria. Total incremental amount is US$71,009,453.
[2] Mozambique HSS. Total incremental amount is US$0.

The Global Fund

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$71,009,453.

Decision Point: GF/B34/EDP19: 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/ER14 ("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. *Acknowledges the original grant duration, manifested in the form of either the implementation or budgeted period, of each country disease component and its constituent grants listed in Table 2 of Section IV to GF/B34/ER14 ("Table 2") is shortened according to the operational flexibility granted to the Secretariat pursuant to GF/B31/DP09.*
4. *Approves the reinvestment of within-allocation efficiencies for the Congo (Democratic Republic) malaria grant and its resultant total program budget, as listed in Table 2;*
5. *Approves the additional incremental funding and implementation period recommended for Mozambique malaria disease component and its constituent grants, as listed in Table 2, based on the available funding that the Finance and Operational Performance Committee (the "FOPC") validated pursuant to GF/FOPC17/DP02;*
6. *Affirms the (additional) 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*
7. *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/EDP20: Decision on the Secretariat's Recommendation on Grant Extensions

The Board:

Approves extension of the relevant implementation period for each grant listed in Table 3 of Section IV to GF/B34/ER14.

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/FOPC17/DP02: Validation of Available Funding for Portfolio Optimization	Based on its review and discussion of the Secretariat's risk-adjusted analysis of sources and uses of funds, as presented in GF/FOPC17/10 (i.e., the updated Mid-Term Plan), the FOPC validated USD 700 million as the amount of available funding for portfolio optimization. This amount of available funding will serve as the source of funds to finance the funding recommendations for Mozambique malaria, Mozambique TB/HIV, and Uganda TB/HIV, which are among the priority areas arising from the 2014 – 2016 allocation period due to grant durations that have been shortened to end prior to 31 December 2017.
GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period[4]	This decision point granted operational flexibility to the Secretariat, which has resulted in shortening the duration over which certain grant programs may utilize their 2014 total allocation so that grant terms end prior to 31 December 2017.[5]
GF/B33/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation	This decision point refers to the funding recommendation with regards to the Mozambique malaria program approved by the Board on 8 June 2015.
GF/B32/EDP01: 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 Congo (Democratic Republic) malaria program approved by the Board on 9 December 2014. The funding recommendation presented in this report modifies the total budget for the Congo (Democratic Republic) malaria program, as described further in Table 2 in Section IV of this report.
GF/B31/DP12: Extension Policy under the New Funding Model[6]	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/B26/EDP06: Approval for the Re-launch of the Mozambique Round 8 Health Systems Strengthening (HSS) Grant (MOZ-809-G08-S)	This decision point refers to the re-launch of the Mozambique HSS grant with additional funding and one additional year of implementation approved by the Board on 24 June 2012.

[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/DP09: Transition from the Third to the Fourth Replenishment Period (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/)
[5] The said decision point states: "While each disease component's portion of the Total Allocation will typically cover a period of four years starting from 1 January 2014, the Secretariat, working together with countries and/or regions, has the operational flexibility to structure longer or shorter grant implementation periods while applying the principles of the allocation model (GF/B28/DP4) to guide funding levels towards the amounts derived from the allocation formula."
[6] GF/B31/DP12: Extension Policy under the New Funding Model (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP12/)

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)

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

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

N	Country	Disease Component	Proposed Principal Recipient (Grant Name)	Grant End Date	Currency	Total Program Budget	Sources		Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
							Existing Funding	Recommended Incremental Funding				
1	Liberia	TB/HIV	LBR-C-MOH	31 December 2017	US$	37,612,921	28,028,831	0	9,584,090	n/a	0	TB: 0.69 million HIV: 12.67 million
			LBR-H-PSI	31 December 2017	US$		0	9,584,090				

Table 2: Secretariat's Recommendation on Shortened Grants

N	Applicant	Disease Component	Grant Name	Currency	Period of Extension (Months)	Previously Approved Grant Budget	Revised Budget for Board Approval	Original Existing Funding	Additional Existing Funding	Incremental Funding Already Approved	Additional Incremental Funding for Board Approval	Total Additional Incremental Funding for Board Approval	Revised Unfunded Quality Demand
1	Congo (Democratic Republic)	Malaria	COD-M-PSI	US$	N/A[7]	119,790,157	174,052,981[8]	11,471,707	23,885,446	108,318,450	0	0	0
2	Mozambique	Malaria	MOZ-M-MOH	US$	12	84,172,540	124,427,280[9]	41,066,178	0	43,106,362	43,546,381	61,425,363	21,389,359
			MOZ-M-WV		9	23,187,703	44,881,096[10]	12,069,839	0	11,117,864	17,878,982		

Table 3: Secretariat's Recommendation on Grant Extensions

N	Country	Disease Component	Grant Name	Currency	Period of Extension (Months)	Additional Funding	Rationale
1	Mozambique	HSS	MOZ-809-G08-S	US$	19	0	Please see below Section IV.03: Summary of the deliberations of the GAC on proposed grant extensions.

[7] The original budgeted period is 2 years (1 January 2015 to 31 December 2016) while the implementation period previously approved by the Board is 3 years (until 31 December 2017). Hence, no time extension is requested.
[8] The revised budget reflects the original approved budget amount of US$119,790,157, the revised signed budget amount previously notified to the Board of US$134,224,102 (GF/B34/ER12), the proposed transfer of anticipated savings from COD-M-SANRU of US$15,943,433 and the reinvestment of cash balances of US$23,885,446 from closed Round 10 Single Stream of Funding malaria grants (ZAR-M-PSI, ZAR-M-SANRU, ZAR-M-MOH) recommended by the GAC for Board approval.
[9] The revised budget reflects the original approved budget amount of US$84,172,540, the revised signed budget amount of US$80,880,899 which was reduced as a result of planned disbursements at the time of grant signing, and the additional incremental funding of US$43,546,381 recommended by the GAC for Board approval.
[10] The revised budget reflects the original approved budget amount of US$23,187,703, the revised signed budget amount previously notified to the Board of US$27,002,115 (GF/B34/ER12), and the additional incremental funding of US$17,878,982 recommended by the GAC for Board approval.

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

The following grants resulting from a simplified funding request with no material changes to the program, has been found to be disbursement-ready by the Global Fund Secretariat in a thorough review process and in consultation with partners.

The GAC technical partners provided an additional level of review, and identified issues for the applicant to consider as the grants were prepared to be disbursement-ready. During grant-making, the applicant refined the grant documentation, addressed issues raised by the GAC partners and sought efficiencies where possible. In its second review, the GAC reviewed the final grant documentation for disbursement-readiness and confirmed recommendations to reinvest US$8.1 million of savings identified during grant making.

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

Liberia TB/HIV Grants: Ministry of Health (LBR-C-MOH) and Population Services International (LBR-H-PSI)

1.1 Simplified approach. The Liberia TB/HIV program, through the CCM, submitted TB and HIV simplified funding requests in October and November 2015, respectively, based on the Investment Plan for Building a Resilient Health System in Liberia 2015-2021, which was written in response to the Ebola virus disease outbreak of 2014-2015. The funding requests were subsequently consolidated following discussions with the Ministry of Health in December 2015.

1.2 Country context. The current grant covering the years 2016 and 2017 was developed as the country was emerging from the Ebola virus disease outbreak, from which 10,672 cases and 4,808 deaths were reported by November 2015. Poor early recognition of suspected cases of Ebola by inadequate infection prevention and control standards led to a disproportionate infection rate among health care workers. Ebola had a devastating impact on the already fragile health system and severely affected the Global Fund-supported programs. Health service provision declined severely with facility closures, the refusal of health workers to provide routine health services in the absence of protective equipment and fear in the community to attend health services. Communities turned to private, traditional and informal health providers, with the number of outpatient visits in the public sector dropping by 61 percent. Women and children were most affected: antenatal care provision declined by 43 percent, institutional deliveries by 38 percent, and a significant decline in immunization coverage has also been reported. Reporting through routine channels such as logistics or health management information systems was also severely disrupted. By the time Liberia was first declared Ebola-free in May 2015, it was estimated only 30 percent of facilities were functioning adequately and previous achievements against TB and HIV retrogressed. By March 2016, the ministry successfully fulfilled its aim of reopening 100 percent of health facilities closed during the Ebola outbreak. The Ebola outbreak had a profound impact on the TB and HIV disease programs, with programmatic activities affected.

1.3 Strategic focus of the program. HIV prevalence in Liberia increased from 1.6 percent in 2007 to 2.1 percent in 2013. Significant variations in HIV prevalence exist among regions, with HIV prevalence concentrated among urban areas as well as among key populations. The HIV prevalence is 19.8 percent among men who have sex with men and 9.8 percent among female sex workers. TB/HIV co-infection reached 15 percent in 2014. In 2014, HIV testing among TB patients was at 73 percent, and TB screening among people living with HIV was 100 percent. TB incidence, including HIV-positive individuals, was estimated at 308 (273-346) per 100,000 population, with a low case detection rate of all forms of TB estimated at 57 percent. Through active integration and a "one-stop-shop" approach to service delivery, the program aims to improve access to HIV prevention care and treatment services for TB patients. The goals of the TB/HIV program of Liberia are to:

- Reduce TB prevalence and incidence by 2018;
- Stop new HIV infections;

- Keep people living with HIV alive and healthy; and
- Mitigate socio-economic impact on people infected and affected by HIV and AIDS in Liberia.

The HIV program focuses on both the general population and key populations through prevention interventions, through which 682,614 people will be tested in 2016 and 2017, and 70 percent of key populations will be reached. With the rollout of life-long treatment for HIV-positive pregnant women, the program aims to scale up from a baseline coverage of prevention of mother-to-child transmission from 64 percent in 2014 to 95 percent by 2017 of pregnant HIV-positive women receiving life-long ART. The TB program aims to increase treatment success rate of all forms of TB from 77 percent in 2014 to 80 percent in 2017 and community interventions will be scaled up through community referrals. Through scale-up of diagnosis and treatment of Rifampicin- and other multidrug-resistant forms of TB, the program aims to diagnose and treat 60 percent of the estimated number of these drug-resistant TB cases by 2017. TB/HIV collaborative activities will also be strengthened, with the percentage of HIV-positive-registered TB patients given ART increasing from a baseline of 28 percent in 2014 to 88 percent by 2017.

1.4 Operational issues, risks and implementation challenges. In the post-Ebola context, 4.8 percent of requested funds will support HIV positions directly working for the TB/HIV programs. A condition relating to the alignment of salary scales as well as the gradual transition of Global Fund-supported salary incentive payments to the government payroll was included in the previous rounds-based grants. However, progress has been delayed due to the Ebola situation. The Investment Plan for Building a Resilient Health System includes the strengthening of human resource systems as part of a comprehensive health systems strengthening strategy for the country. The current grant includes a condition that the Principal Recipient submit an updated budget to the Global Fund to reflect the updated salary scale and incentives to be paid to health personnel in the public sector of Liberia in accordance with the adopted human resources for health plan within 90 days after the adoption of such plan. Additionally, a condition has been included that the Principal Recipient submit an updated budget to the Global Fund with respect to the gradual transition of salary incentive payments and performance incentives currently paid by the Global Fund to the government payroll by no later than 31 July 2016, reflecting a transition in two tranches by the end of 2017.

1.5 Domestic contributions. The estimated funding need for the national HIV and TB programs of Liberia in the next implementation period (2016-2017) is US$74.1 million. Total domestic financial commitments for the HIV and TB programs is US$13.36 million, with domestic resources representing 18 percent of the combined resources available for these programs in the next implementation period and a 29 percent increase in health sector spending compared to 2013-2015.

1.6 Reinvestment of savings. The CCM of Liberia identified US$8.1 million of savings, found in the TB/HIV program in large part through more effective quantification of HIV drugs and health products and decided to reinvest US$3.8 million within the TB/HIV program to strengthen the program coordinating unit, provide nutritional support for people living with HIV and procure TB health products for year 1 of grant implementation not previously covered in the budget. The remaining amount of US$4.3 million will be reinvested into the malaria program, through a revision of the program split, to fill the LLIN gap for the 2018 mass campaign. The planned use of these savings will be further detailed during the grant-making process for the Liberia malaria funding request, the outcomes of which will be presented as part of the funding recommendation for the Board's approval.

1.7 GAC review and recommendations. The GAC commended the Liberia TB/HIV program for completing its funding request despite the challenging operating environment. The GAC also noted lessons learned should be captured on the program's integrated approach, which included investing in resilient and sustainable systems for health. GAC partners pledged their support for helping the Liberia health system recover and noted the inclusive planning of this program, commenting positively on the Global Fund's simplified approach in this context. GAC partners requested information on the potential of applying more widely the strengthened contact tracing and community outreach programs developed to respond to Ebola, toward improving TB and HIV outcomes. The GAC was informed that lessons learned from the Ebola response, especially on the contact tracing and community engagement, have been applied to TB and HIV program strategies – specifically toward TB case finding and the use of community outreach to promote adherence, and to find lost-to-follow up cases for HIV. GAC partners noted some discrepancies in the

baseline data being used to measure program indicators and the opportunity to strengthen monitoring and evaluation, among other faculties, during this implementation period. The GAC was informed that this funding request was drafted before the release of updated data, including on the impact of Ebola by WHO, with whom the Secretariat will continue to have discussions as more information is gathered. The Secretariat commended and emphasized the need to maintain during grant implementation the success of partnership arrangements in Liberia, including with WHO, that have enabled the TB and HIV programs to adapt quickly and effectively in the post-Ebola context.

02 Summary of the Deliberations of the Secretariat's Grant Approvals Committee (GAC) on Shortened Grants

Introduction

In this report, the Secretariat recommends to the Board additional funding for and extension of the first set of grants[11] with implementation periods ending prior to 31 December 2017 (the "Shortened Grants"). As reported to the FOPC and the Board, Shortened Grants are a sub-set of the grant portfolio where the Secretariat has applied operational flexibility provided by the Board to shorten (or lengthen) the duration of certain grants (GF/B31/DP09). The result of exercising this flexibility, together with countries that were early applicants during the 2013 transition to the allocation-based funding model, is that several grants have end dates before 31 December 2017, which marks the end date of the typical four-year period over which the total funds allocated in March 2014 were to be utilized (GF/B31/DP09).

The Secretariat applied the operational flexibility for Shortened Grants based on an evaluation of the need to maintain the scope and scale of certain disease component programs. These considerations factored in coverage levels of essential programmatic interventions previously funded by the Global Fund, including gains achieved in controlling or reversing the epidemics, and recognized that certain countries had mass campaign cycles that resulted in having to use their total allocation to cover two mass bed-net campaigns.

Once disease components were prioritized as Shortened Grants, the TRP reviewed the relevant concept notes based on the understanding that technically sound and strategically focused elements of the request for funding beyond 31 December 2016 would be treated as quality demand that could not be funded within the amounts initially allocated to the country components. The Secretariat's Grant Approvals Committee (GAC) approved the final grant amounts for funding recommendation to the Board based on a systematic and robust process of validating programmatic assumptions and funding gaps as submitted in the concept notes and confirmed by the TRP. Shortened Grants are submitted to the Board for approval on a case-by-case basis. This is determined by the timing of when additional funding would be needed, by quarter and month, in line with estimated delivery lead times for commodities, timing of implementation of key programmatic activities (e.g. mass long-lasting insecticidal net campaigns), and engagement of in-country stakeholders (CCMs, Principal Recipients and in-country technical partners). This is to ensure program budgets and availability of funds for 2017 are aligned with the most up-to-date programmatic information.

The additional resources for investment in Shortened Grants, requested for approval by the Board, are derived from the amount of available funding validated by the FOPC at its 17th meeting in March 2016. This available funding has been managed within the limits of the 2014-2016 allocation, based on the operational mechanism put in place to leverage forecasted unspent funds across the portfolio through portfolio optimization, as most recently presented to the FOPC in March 2016[12]. Even as portfolio optimization aims to deal with potential funding needs at a country-disease level, it is based on regularly monitoring

[11] Disease components with Shortened Grant implementation periods include the following: Kenya Malaria, Mozambique Malaria, Mozambique HIV, Sudan Malaria, Tanzania HIV, Uganda Malaria, Uganda HIV, Zimbabwe Malaria, Congo (Democratic Republic) Malaria, Nigeria Malaria, and Ghana Malaria. These will be presented for approval by the Board for additional funding or grant extension over the coming months, the timing of which will be aligned to programmatic and funding needs, on a case-by-case basis.

[12] As set forth in GF/FOPC17/10. GF/FOPC17/03

implementation and dynamic management of a grant's upper ceiling of funds, effectively and efficiently, after taking into consideration reprogramming of activities within the grant; reprogramming of activities across all the grants for a disease component within the same country; and reinvestment of identified savings and efficiencies for maximum impact. Also taken into account are collaborative efforts to ensure effective programmatic implementation and absorption of committed funds aimed at demonstrating impact before the next replenishment, including strategies resulting from the Implementation through Partnership project.

Congo (Democratic Republic) Malaria Grant: Population Services International (COD-M-PSI)

1.8 Increase in program budget (COD-M-PSI). The GAC recommends the Board approve an increase to the budget amount of the Democratic Republic of Congo (DRC) malaria grant COD-M-PSI. The increase in the budget, resulting from optimization of use of funds within the country's malaria disease component, was not included in the Board approved budget for COD-M-PSI on 9 December 2014 (GF/B32/EDP01). The additional amount requested is within the allocation and:

- Represents existing funds from cash balances from previous single stream of funding grants that were not taken into account during grant-making, as well as anticipated savings from grants currently in implementation;
- Does not affect the incremental amount previously approved by the Board; and
- Allows for this grant to continue implementation through to the planned grant end date of 31 December 2017, sustaining the scope and scale of essential services in vector control in 2017.

The unfunded quality demand previously registered will be fully covered and therefore reduced to US$0 accordingly.

1.9 Epidemiological summary. The DRC has the second highest malaria burden in the world, with at least 10 million cases in 2014, equivalent to 8 percent of the global malaria burden. Malaria is the number one cause of morbidity and mortality, and is a significant cause of poverty in DRC. It accounts for 40 percent of all outpatient consultations, 19 percent of deaths in children under the age of 5, and 54 percent of hospitalization in pregnant women. Between 2007 and 2013, the number of malaria deaths increased from 14,372 to 30,918 – an increase of nearly 54 percent. The increase in malaria cases and deaths reported in this period may be explained in part by improvements in reporting, confirmed by the significant decrease of overall child mortality per 1,000 population from 213 in 2001 to 158 in 2010 according to the malaria indicator surveys.

1.10 Rationale for reinvestment. Under GF/B32/EDP01, COD-M-PSI was exceptionally authorized to budget for two years of implementation within a three-year program. The DRC malaria concept note was submitted to the TRP in window 2 in July 2014. The TRP considered the full allocation request of US$304,970,021 and the US$121,116,221 above allocation request as quality demand. The GAC endorsed the TRP recommendations and approved US$36.5 million in incentive funding for, among other activities, mass campaigns of long-lasting insecticidal nets (LLINs), contingent upon DRC meeting its counterpart financing requirements and the willingness-to-pay condition. The GAC endorsed the TRP's recommendation that the remaining critical programmatic and finding gap for the DRC malaria control program, for the mass campaign of LLINs in 2017 (US$63.5 million) be considered unfunded quality demand. In this regard, the GAC recommended that the Global Fund resources cover up to 50 percent of unfunded quality demand based on the principle of maintaining the scope and scale of essential services, equivalent to approximately US$30 million, to catalyze financial contributions from other donors and domestic sources and to mitigate the risk of the creating unrealistic expectations regarding future funding and Global Fund liabilities. The GAC requested the Secretariat actively monitor implementation and proactively reprogram any identified savings toward funding essential services during the period of grant extensions, where appropriate, before further scale-up of programs in 2016. As of March 2016, savings reinvested to cover the remaining gaps for the 2017 LLIN mass campaign, comprised:

- Aggregate cash balances from the closed round 10 single stream funding grants totaling US$23.9 million; and

- Estimated anticipated savings totaling US$22.7 million, of which US$15.9 million from COD-M-SANRU will be transferred to COD-M-PSI and US$6.7 million is made available within COD-M-PSI.

Due to changing market dynamics and unit price fluctuations for LLINs, the amount of unfunded quality demand to cover the 2017 LLIN gap increased from US$63.5 million in July 2014 to US$74.8 million in March 2016. To cover this amount, the Secretariat has proposed to use US$23.8 million from the cash balance left from the single stream funding grants (32 percent) and anticipated savings from COD-M-PSI and COD-M-SANRU totaling US$22.7 million (30 percent). The remaining US$28.3 million (38 percent) will be covered with a contribution from the President's Malaria Initiative. In light of the changing LLIN funding landscape at country level, this increases the proportion of Global Fund financing to cover this gap from the initially intended 50 percent to 62 percent. However, as the funds proposed to be used are within the DRC allocation, this does not require any additional commitment by the Global Fund.

1.11 The strategic focus of the program. The 2013 to 2014 district health survey revealed an increase in LLIN ownership, with 46 percent of people having access to LLINs. Among pregnant women and children in a household with at least one net, use was as high as 83 percent and 76 percent, respectively. The proposed programming would help to further increase LLIN access and use, contributing to the reduction in the under-5 mortality rate, which reduced from 158 deaths per 1,000 live births in 2004 to 104 deaths per 1,000 live births in 2011. The reinvestment of savings would be used to procure and distribute over 9.4 million LLINs in five provinces, while the remaining three provinces would be covered by the President's Malaria Initiative contribution. These campaigns would complement those of 2015 and 2016 and lead to DRC reaching 100 percent coverage of all provinces during a three-year cycle for the first time, with the distribution of more than 34 million nets during this allocation period. To ensure the LLINs are procured and arrive in country in a timely manner, procurement should start in quarter 2 of 2016 through Population Services International.

1.12 Domestic contributions. The government of DRC's commitment for counterpart financing and willingness-to-pay was US$59.2 million, of which US$12.2 million has been disbursed to date. The Secretariat will work closely with the government to ensure commitments are realized, including taking actions through official letters to authorities and holding meetings in country with relevant governmental ministries.

1.13 GAC review and recommendations. The GAC commended the coordinated efforts of the country and the Secretariat. Those efforts ensure gains achieved in optimizing the DRC malaria grants maintain the scope and scale of services through the full implementation period. The GAC noted the need for the Secretariat to work further on effectively tracking domestic commitments against milestones in a timely way, noting the risk that national governance systems in DRC can override planned commitments and would need to be closely monitored and effective risk mitigation strategies implemented. The GAC acknowledged the immense accomplishment it would be for DRC to achieve universal coverage of LLINs during a single allocation period, particularly considering the country's share of the global malaria burden and malaria's place as the primary cause of mortality in children under the age of 5. The GAC noted that it would be essential to work with all in-country stakeholders, including partners, to reach this goal and continue to sustain the program's gains in coming years. In this regard, acknowledging the previous guidance for the Global Fund contributions to the 2017 LLIN mass campaign to not exceed previous funding levels of 50 percent as reported to the Board in GF/B32/EDP01, the GAC endorsed the recommendation to seize the opportunity of investing identified savings into the 2017 campaign in order for the DRC to achieve universal coverage.

Mozambique Malaria Grants: Ministry of Health (MOZ-M-MOH) and World Vision (MOZ-M-WV)

1.14 Rationale for costed extension. The GAC recommends for Board approval the extension of Mozambique's malaria shortened grants to continue implementation through 31 December 2017, and to sustain the scope and scale of essential services in malaria vector control in 2017.

1.15 Epidemiological situation. The entire population of Mozambique, 25 million in 2014, is at risk of malaria. It is the leading cause of mortality and morbidity, making up approximately 44 percent of all outpatient consultations, 57 percent of all pediatric admissions, and 23 percent of in-hospital deaths. Although the 2011 demographic and health survey showed a reduction in malaria prevalence nationally, from 51.5 percent in 2007 to 38.3 percent, the country experienced an increase in the incidence of malaria per 1,000 population from 134 in 2012 to 169 in 2013. The main reason identified for this increase was the reduced delivery of interventions, such as long-lasting insecticidal nets (LLINs), that occurred in 2012.

1.16 Background. Under GF/B33/EDP04, the grants for the Mozambique malaria program were exceptionally authorized to have a shortened grant duration of 18 months for MOZ-M-MOH (until 31 December 2016) and 21 months for MOZ-M-WV (until 31 March 2017). The Mozambique malaria concept note was submitted to the TRP in window 4 in November 2014, and its full US$65,618,603 allocation request and US$103,947,949 above allocation request were considered quality demand by the TRP. The GAC endorsed the TRP recommendations and approved US$5,885,035 of incentive funding in addition to the allocation amount. The total amount of signed malaria grants was $107,883,013. The amount was higher than the GAC-approved ceiling for grant-making of US$73,240,559, as disbursements to the Principal Recipients and Pooled Procurement Mechanism totaling US$34,642,454 planned for before 1 July 2015 were delayed and included in the grant budgets. As part of the GAC recommendation to the Board, the GAC confirmed that the 2017 LLIN mass campaign would be considered in line with the shortened grant duration mechanism to ensure that LLIN coverage levels previously funded by the Global Fund are maintained and malaria control gains achieved are sustained. The GAC requested the Secretariat actively monitor implementation and to proactively reprogram any identified savings towards funding essential services during the period of grant extensions, where appropriate, before further scale-up of programs in 2016. Based on the programmatic assumptions agreed by the TRP and GAC, and in line with the criteria for shortened grants, the total funding gap to sustain the scope and scale of Global Fund contributions to essential services through the end of 2017 was estimated at US$70,615,517 in April 2015. As of March 2016, total savings of US$9,190,154 were identified for reinvestment within the disease program, comprised:

- Savings from LLIN unit cost reduction from US$3.10 to US$2.70 and LLIN distribution cost reduction from US$1.34 to US$1.32. These unit costs have resulted in overall savings despite an increase from the original number of nets planned.
- Savings from commodity orders already placed; and
- Efficiencies found during extension budget negotiations.

Through optimization of use of funds within the disease component, the remaining amount required to fill the 2017 funding gap is US$61,425,363. This is to be funded through the allocation of funds from the overall amount validated by the FOPC as available for portfolio optimization at its March 2016 meeting. The additional funds, as well as the reinvestment of efficiencies within the grants, would reduce the remaining unfunded quality demand to US$21,389,359.

1.17 The strategic focus of the program and its extension. The concept note for the Mozambique malaria program was based on the national malaria strategy for 2012 to 2016, and focused on vector control, malaria case management and health systems strengthening. The grants under the current funding model were signed in June 2015 and started on 1 July 2015. For the years 2016 and 2017, the existing grants cover case management and indoor residual spraying funding needs. They also include funds for procuring and distributing 2.8 million LLINs as part of the universal campaign in one province. Programmatically, the extension activities represent a continuation of the coordinated implementation activities that both Principal Recipients have been performing in vector control over the last four years with improved coordination over time. As per the GAC recommendation, the national campaign is considered a continuation of essential services for vector control with LLINs and has been fully funded by the Global

Fund since 2013. The extension funding request for these grants will allow the country to complete the first universal national LLIN campaign in the remaining 10 provinces in 2017, with 13.5 million nets required. Existing grant funds will cover case management, including procurement of artemisinin-based combination therapy and rapid diagnostic tests, as well as indoor residual spraying funding needs in 2017. The 2017 campaign is planned to start in quarter 1 of 2017, in order to cover all the remaining 10 provinces before the high malaria transmission season starts in November 2017. To ensure the nets arrive in country by January 2017, the procurement of 13,157,944 nets will be made through the Pooled Procurement Mechanism using the Global Fund's online purchasing platform Wambo.org. The planned impact of the proposed programming will contribute to the decline of inpatient malaria deaths per 100,000 population from 13 in 2014 to 7 in 2017.

1.18 Implementation plans. The Principal Recipients are compliant with all TRP and GAC recommendations in the implementation of the grants, including the development of a new vector control strategy, maximizing synergies with regional malaria elimination efforts, and ensuring cross-cutting health systems strengthening investments across the three diseases. The Principal Recipients are engaged with partners in country (President's Malaria Initiative, World Health Organization, and Clinton Health Access Initiative) to ensure programmatic performance and have both performed at the B1 level for the period ending 30 June 2015.

1.19 Operational issues, risks and implementation challenges. The risk of limited program relevance due to partial coverage of the 2017 universal LLIN campaign is mitigated by the investment of additional funding to cover the gap of 13.5 million LLINs as part of the largest campaign the country has ever implemented. Additional risk of delays in implementation have been mitigated by early and comprehensive planning with the heavy involvement of both Principal Recipients since 2014, as well as technical cooperation facilitated by The Alliance for Malaria Prevention (AMP) and malaria partners in country. The risk of low absorption is mitigated by the large proportion of funding budgeted toward procurement of health products through the Pooled Procurement Mechanism and LLIN distribution costs. Further, Mozambique is one of 20 focused countries for the Implementation through Partnership project, focused on improving absorptive capacity and coordination with partners, under which a key activity is support for the vector control strategy with support from the U.S. government and World Health Organization.

1.20 Domestic contributions. The government of Mozambique's commitment for willingness-to-pay was US$28 million across all diseases in the 2015 fiscal year, for which the reporting of expenditures is not yet finalized. Overall government health expenditure in 2015 was 95 percent for recurrent costs and 99 percent for investment costs at central level. The Secretariat will work closely with the government to operationalize the fiscal tracking measures recently put in place and ensure that the domestic commitments are met.

1.21 GAC review and recommendations. The GAC commended the coordinated efforts of the country and the Secretariat to ensure gains achieved in the Mozambique malaria control program are sustained by maintaining the scope and scale of services through the full implementation period. The GAC noted the need for the Secretariat to work further on effectively tracking domestic commitments against milestones in a timely way.

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

Mozambique HSS Grant: Ministry of Health (MOZ-809-G08-S)

1.22 Rationale for extension. The Principal Recipient of the Mozambique malaria grant, the Ministry of Health, is seeking the approval of the Board of a 19-month, non-costed extension for the Mozambique round 8 HSS grant MOZ-809-G08-S, which was re-launched for the three-year implementation period 1 June 2013 to 31 May 2016 under GF/B26/EDP06. The extension will support the Ministry of Health in fully implementing critical supply chain system strengthening activities to enable scale-up of the national disease programs with a budget for the extension period of US$14.3 million, and will bring the grant

implementation period in alignment with disease-specific grants up to the 31 December 2017 end date. Continuation of the health systems strengthening investments in the grant was endorsed by the Principal Recipient as part of the agreed program split for the 2014-2016 allocation. The Secretariat acknowledges the high risk of slow absorption, and requires quarterly monitoring and updating of the procurement plan from the Principal Recipient, to ensure funds are absorbed by the end of the extension period. To ensure implementation of critical infrastructure improvements as planned, the Principal Recipient has undertaken assurance measures, including preparation of a detailed work plan for activities related to the Strategic Plan for Pharmaceutical Logistics, creation of a project department unit, contracting a project manager, and committing to monthly grant progress reporting to the Permanent Secretary. The Secretariat will further maintain enhanced controls on procurement processes and financial transactions, which are in place with the support of the Local Fund Agent. This represents efforts to tighten fiduciary and financial controls, in order to allow the Principal Recipient to improve the financial performance of the grant and the absorption rate.

1.23 GAC review and recommendations. The GAC highlighted the strong need for investments in resilient and sustainable systems for health, in the context of capacity issues in Mozambique. The GAC emphasized the importance of the Implementation through Partnership project and stressed the need for the country to improve absorption during the extension period. The GAC anticipates the impact of the grant will be magnified through accelerated implementation of all Global Fund-supported programs.

V. Additional Matters

01 Extensions Approved by the Secretariat Pursuant to Its Delegated Authority

The Secretariat hereby notifies the Board it has approved extensions to the grants listed in Table 4 below in accordance with the Board decision GF/B31/DP12.

Table 4: Grant Extensions Approved by the Secretariat

N	Country	Disease Component	Grant Name	Currency	Period of Extension (Months)	Additional Funding
1	Lesotho	TB	LSO-810-G08-T	US$	3	0