## Electronic Report to the Board

# Report of the Secretariat's Grant Approvals Committee

GF/B35/ER07 Revision 1
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B35/EDP07 Revision 1: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B35/EDP08 Revision 1: Decision on the Secretariat's Recommendation on Grant Extensions[2]



1 Angola malaria, Angola TB/HIV, Central African Republic malaria, Ghana malaria (shortened grant), Haiti HSS, Honduras HIV, Kosovo HIV, Liberia malaria, Madagascar malaria, Mauritania HIV, Mauritania malaria, Mauritania TB, Mozambique HIV (shortened grant) Namibia TB, Peru HIV, Sierra Leone malaria, Tanzania HIV (shortened grant), Uganda malaria (shortened grant) and Zimbabwe HIV (early applicant). Total incremental amount is US$506,503,500 and €11,938,578.
2 Tunisia HIV and Mali HIV. Total incremental amount is US$4,608,959 and €1,456,215.

# I. Decision Points

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

Set forth below is the Secretariat's recommendation to approve additional funding up to an amount of US$511,112,459 and €13,394,793.

***Decision Point: GF/B35/EDP07 Revision 1: 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 1a of Section IV to GF/B35/ER07 ("Table 1a");*

2. *Approves the reinvestment of within-allocation efficiencies for the Iran HIV grant and its resultant total program budget, as listed in Table 1b of Section IV to GF/B35/ER07;*

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

4. *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 ("Table 2") is shortened according to the operational flexibility granted to the Secretariat pursuant to GF/B31/DP09;*

5. *Approves the additional incremental funding and implementation period recommended for (a) Ghana malaria, (b) Mozambique HIV, (c) Tanzania HIV and (d) Uganda malaria disease components, and each component's 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. *Acknowledges the grant duration and related funding originally approved by the Board for those country components that participated in the concept note process in 2013 as part of the transition to the allocation-based funding model authorized under GF/B28/DP05 (the "Early Applicants") will end on or before 31 December 2016 and accordingly will need additional funding to bridge the relevant program implementation until 31 December 2017, the typical end date of grant programs arising from the 2014 - 2016 allocation period;*

7. *Approves the additional incremental funding and implementation period recommended for Zimbabwe HIV disease component, being an Early Applicant grant, as listed in Table 3, based on the available funding that the FOPC validated pursuant to GF/FOPC17/DP02;*

8. *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*

9. *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/B35/EDP08 Revision 1: 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 4 of Section IV to GF/B35/ER07.*

***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 Finance and Operational Policy Committee (FOPC) validated US$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 priority areas arising from the 2014 to 2016 allocation period.[4] |
| **GF/B31/DP12: Extension Policy under the New Funding Model[5]** | 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. |

[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] FOPC DP
[5] GF/B31/DP12: Extension Policy under the New Funding Model (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP12/)

| | |
|---|---|
| **GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period[6]** | 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.[7] |
| **GF/B34/EDP16: 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 Haiti TB/HIV program approved by the Board on 24 March 2016. |
| **GF/B32/EDP13: 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 Iran HIV program approved by the Board on 18 March 2015. |
| **GF/B32/EDP15: 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 Ghana malaria program approved by the Board on 28 March 2015. |
| **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 HIV and Tanzania HIV programs approved by the Board on 5 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 Uganda malaria and Zimbabwe HIV programs approved by the Board on 8 December 2014. |
| **GF/B33/EDP27: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation** | This decision point refers to the funding recommendation to regards to the increase the final grant amount to incorporate (i) incentive funding and (ii) a private sector contribution from Children's Investment Fund Foundation to the Zimbabwe HIV program approved by the Board on 13 November 2015. |

# 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)

[6] GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/)
[7] 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."

# IV. Summary of the deliberations of the Secretariat's Grant Approvals Committee

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

| N | Applicant | 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 | Angola | TB/HIV | AGO-H-UNDP | 30 June 2018 | US$ | 30,002,727 | 1,320,130 | 28,682,597 | 28,682,597 | 3,876,506 | 39,496,587 | 60 million |
| 2 | | Malaria | AGO-M-MOH | 30 June 2018 | US$ | 38,833,100 | 12,539,832 | 18,090,175 | 26,293,268 | 0 | 0 | 52.4 million |
| | | | AGO-M-WVI[8] | 30 June 2018 | | | 0 | 8,203,093 | | | 0 | |
| 3 | Central African Republic | Malaria | CAF-M-IFRC | 31 December 2017 | € | 17,961,025 | 7,369,631 | 10,591,394 | 10,591,394 | 2,106,420 | 0 | n/a |
| 4 | Haiti | HSS | HTI-C-PSI | 31 December 2017 | US$ | 65,248,708 | 61,123,404 | 4,125,304 | 4,125,304 | 1,183,667 | 0 | 669 million |
| 5 | Honduras | HIV | HND-H-CHF | 31 July 2019 | US$ | 15,205,042 | 2,194,093 | 13,010,949 | 13,010,949 | 0 | n/a | 79.5 million |
| 6 | Kosovo | HIV/AIDS | KOS-711-G04-H | 31 December 2017 | € | 1,493,276 | 146,092 | 1,347,184 | 1,347,184 | n/a | 0 | 1.67 million |
| 7 | Liberia | Malaria | LBR-M-MOH | 30 June 2018 | US$ | 39,766,427 | 21,909,262 | 5,689,575 | 14,703,040 | 7,330,340 | 3,009,691 | 6 million |

[8] The Angola Malaria AGO-M-WVI grant includes one module originally proposed within the Angola HSS concept note (Community Workforce module for US$2,751,590). The remaining Angola HSS grant will be presented for GAC review at a subsequent meeting.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | LBR-M-PII | 30 June 2018 | | | 3,154,125 | 9,013,465 | | | | |
| 8 | Madagascar | Malaria | MDG-M-PSI | 30 June 2018 | US$ | 59,611,390 | 39,731,456 | 1,000,000 | 1,000,000 | 0 | 0 | 16.7 million |
| | | | MDG-M-MOH | 30 June 2018 | | | 18,879,934 | 0 | | | | |
| 9 | Mauritania | TB | MRT-T-SECNLS | 31 December 2018 | US$ | 4,838,927 | 0 | 4,838,927 | 4,838,927 | 0 | 0 | 3 million |
| 10 | | HIV/AIDS | MRT-H-SECNLS | 31 December 2018 | US$ | 9,223,633 | 1,651,296 | 7,572,337 | 7,572,337 | 0 | 0 | 4 million |
| 11 | | Malaria | MRT-M-SECNLS | 31 December 2018 | US$ | 15,554,200 | 0 | 15,554,200 | 15,554,200 | 0 | 0 | 7 million |
| 12 | Namibia[9] | TB | NMB-T-MoHSS | 31 December 2017 | US$ | 15,289,132 | 15,289,132 | 0 | 0 | n/a | 0 | 62.5 million |
| 13 | Peru | HIV/AIDS | PER-H-PATH | 30 June 2019 | US$ | 12,487,092 | 5,924,380 | 6,562,712 | 6,562,712 | 0 | 410,477 | 213.9 million |
| 14 | Sierra Leone | Malaria | SLE-Z-MOHS | 30 June 2018 | US$ | 36,049,992 | 14,671,597 | 16,046,587 | 16,046,587 | 2,829,478 | 2,436,645 | 3.5 million |
| | | | SLE-M-CRSSL | 30 June 2018 | | | 5,331,808 | 0 | | | | |

[9] The Namibia malaria grant is a simplified application with no material reprogramming.

## Table 1b: Reinvestment of Within-Allocation Efficiencies for Previously-Approved Programs

| 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 | Iran | HIV/AIDS | IRN-H-UNDP | US$ | n/a | 11,961,295 | 13,131,823 | 3,035,807 | 1,170,528 | 8,925,488 | 0 | 0 | n/a |

## Table 2: Secretariat's Recommendation on Shortened Grants and Early Applicants

| 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 | Ghana | Malaria | GHA-M-AGAMAL | US$ | 12 | 13,325,139 | 23,060,609[10] | 13,325,139 | 4,454,139 | 0 | 0 | 0 | 0 |
| 2 | Mozambique | HIV/AIDS | MOZ-H-MOH | US$ | 12 | 180,928,522 | 280,497,506 | 128,925,773 | 155,886 | 52,002,749 | 76,981,737 | 76,981,737 | 143,886,779 |
| 3 | Tanzania | HIV/AIDS | TZA-H-MOF | US$ | 12 | 277,193,628 | 423,842,884[11] | 104,745,414 | 0 | 172,448,214 | 109,078,557 | 109,078,557 | 307,125,310 |
| 4 | Uganda | Malaria | UGA-M-MoFPED | US$ | 12 | 121,346,277 | 145,743,990 | 13,422,506 | 0 | 107,923,771 | 24,398,252 | 39,383,304 | 41,124,714 |

[10] The revised budget reflects reinvestment of cash balance of US$4,454,139 from closed Round 8 malaria grant GHN-809-G08-M and transfer of US$5,281,331 from GHA-M-MOH.
[11] Represents scenario 1 proposed by the Country Team for GAC endorsement to scale up ART with additional reinvestment of efficiencies. The revised budget reflects the original approved budget amount of US$277,193,628, the revised signed budget amount of US$277,593,629 due to special initiative funding, and the additional incremental funding of US$109,078,557 recommended by the GAC for Board approval.

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | UGA-M-TASO | | 12 | 30,431,393 | 44,606,581 | 2,201,263 | 0 | 28,230,130 | 14,985,052 | | |
| 6 | Zimbabwe | HIV/AIDS | ZIM-H-UNDP | US$ | 12 | 468,705,052 | 611,375,034 | 311,217,127 | 0 | 126,053,782 | 142,669,982 | 142,669,982 | 127,621,036 |

## 01 Table 4: Secretariat's Recommendation on Grant Extensions

| N | Applicant | Disease Component | Grant name | Currency | Period of Extension (Months) | Additional Funding | Rationale |
|---|---|---|---|---|---|---|---|
| 1 | Tunisia | HIV/AIDS | TUN-607-G01-H | US$ | 12 | 4,608,959 | The extension will allow for the provision of services during the Secretariat's continuing discussion with the country regarding the signing of a Framework Agreement. |
| 2 | Mali | HIV/AIDS | MAL-813-G11-H | € | 0 | 1,456,215 | See extension summary in Section 7. |

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

The following grants resulting from 20 funding requests have been found to be disbursement-ready by the Global Fund Secretariat in a thorough review process and in consultation with partners.

The funding request 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. Domestic commitments for disease-specific and health-related spending are subject to local currency value fluctuations against US dollars and Euro.

**Angola HIV, HSS and Malaria Grants: The Ministry of Health (AGO-M-MoH), United Nations Development Programme (AGO-H-UNDP) and World Vision (AGO-M-WVI)**

1.1 Overall context. The TRP initially reviewed the Angola TB/HIV and malaria concept notes in June 2015 and recommended the requests for further iteration, noting that the significant health system barriers that affect quality of services across the country were not addressed in the applications. In November 2015 the revised TB/HIV and malaria concept notes were resubmitted together with a cross-cutting health systems strengthening (HSS) concept note, and following review all three requests were recommended for grant making by the TRP. The TRP presented its recommendations on the concept notes in an integrated review form, emphasizing the importance of joint coordination and planning across the three diseases and HSS during grant making. In March 2016, the TRP and GAC recommended incentive funding of US$3,876,506 for the TB/HIV program following review of the revised above allocation request. To reinforce domestic contributions and catalyze additional co-financing to scale up the critically under-funded national TB and HIV programs, the TRP and GAC conditioned the incentive funding award upon the Government of Angola matching the amount with domestic funding in its 2017 health budget. During the grant-making process Angola contended with a number of challenges, notably a significant increase in malaria transmission, an outbreak of yellow fever, and leadership change at the Ministry of Health accompanied by a reshuffle of senior management staff at the ministry. During grant making, in order to address longstanding challenges with feasibility of grant implementation, the country with support from the Secretariat adopted innovative implementation arrangements including a pilot project approach, focusing investments and service delivery efforts on geographical areas with highest transmission rates (hotspots) and highest potential for scale up.

1.2 Strategic focus of the HIV program. HIV is a generalized epidemic in Angola, with an estimated prevalence of 2.35 percent among adults aged 15-49. HIV incidence is estimated to be increasing in Angola and mother-to-child transmission rates were high at 25.4 percent in 2013. These rates are associated with the low coverage of ART, with 27 percent of people living with HIV receiving ART, and prevention of mother to child transmission services, with 39 percent of HIV-positive pregnant women receiving ART. The goal of

the Angola HIV program, to be implemented by UNDP, is to reduce new HIV infections amongst general population and key populations and to increase coverage of prevention of mother-to-child transmission and ART for children and adults. Planned achievements of the proposed programming include:

- Reducing the estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months from 25 percent in 2013 to 18 percent by June 2018;
- Increasing the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy from 51 percent to 59 percent by June 2018; and
- Increasing the percentage of TB patients who have an HIV test recorded in the TB register to 38 by June 2018 and increasing the percentage of HIV-positive registered TB patients on ART during TB treatment to 85 percent by June 2018

1.3 Strategic focus of the malaria program. Malaria remains a major public health problem in Angola, with year-round transmission, and is a principal cause of morbidity and mortality throughout the country. In 2014, malaria accounted for 35 percent of mortality in children, 25 percent of maternal morbidity, and caused 60 percent of hospital admissions of children under-five years of age and 10 percent of admissions of pregnant women. The goal of the Global Fund-supported malaria program in Angola is to reduce morbidity and mortality of malaria by 60 percent between 2014 and 2020. Planned achievements of the proposed programming include reducing inpatient malaria deaths per 1,000 from 0.23 in 2014 to 0.16 in 2017 and malaria test positivity rate from 43.8 in 2014 to 30.7 in 2017. In line with the TRP recommendation to enhance coordination between disease grants and health systems strengthening where appropriate, the malaria grant to be implemented by World Vision includes the 'community workforce module' from the HSS concept note, given the linkages between this module and integrated case management of malaria to be implemented under the World Vision grant.

1.4 Operational issues, risks and implementation challenges. Grant implementation in Angola faces multiple challenges, including treatment disruptions and stock-out, data quality, fulfillment of government commitments, and financial and governance risks. The Secretariat and country have taken adequate measures to mitigate these issues, including:

- Updating quantification for 2017 with improved data around commodity forecasting, use of an inter-agency committee to oversee procurement commitments made by different stakeholders and timely placement of orders through the Pooled Procurement Mechanism to avoid treatment disruption or stock-outs;
- Tracking measures to monitor co-financing commitments;
- Programmatic strategies to improve data systems such as an electronic HIV/AIDS notification system, strengthening surveillance systems for malaria including the hiring of focal point and surveillance officers, and training health facility and community-level staff in monitoring and evaluation as well as statistical analysis;
- Setting up a new program management unit for the malaria program within the Ministry of Health, with the additional oversight of a fiscal agent to mitigate the risk of inadequate internal controls and Principal Recipient governance.

1.5 Audit by the Office of the Investigator General (OIG). The Global Fund has already recovered close to US$3 million of the total of US$4 million found as ineligible expenditures in an OIG report published in January 2016 as the result of procurement fraud in a malaria grant that took place in 2013. After the procurement fraud was uncovered, new measures for the use of program funds were enforced such as engaging a fiscal agent financed by the Ministry of Health, and Angolan authorities have arrested and indicted the officials involved; criminal proceedings are ongoing.

1.6 Domestic contributions. Total domestic contribution based on earmarked budget allocation for 2016 and commitment to maintain increases in 2017 amount to US$358 million for HIV (including costs of general health services and infrastructure for HIV service delivery) and US$52.4 million for malaria (excluding cost of service delivery and infrastructure borne by the government). Earmarked government commitments in 2016 to 2017 represent a 12 percent increase for HIV and a 64 percent increase for malaria compared to 2014 to 2015. Sustainability of domestic financing of the disease programs was a key issue discussed during grant-making involving both the Ministry of Health and Finance. The Secretariat joined advocacy efforts with our partners throughout 2015 when due to the fiscal crisis (related to the fall in oil

prices) the health budget suffered significant cuts. The 2016 budget, which was only approved in March, showed an increase of 24 percent for health, and in particular a six-fold increase in earmarked allocations for malaria, compared to 2015. In addition, considering that over half of the budgets for the HIV and malaria programs are allocated to health commodities and related costs, particular efforts were made to find out exactly the monetary value allocated by the government for the procurement of health commodities. The original funding requests proposed the Global Fund cover 40 percent of the needs for HIV and 30 percent of the needs for malaria, with the remaining amounts to be covered by the government and other donors. Despite the worsening fiscal crisis that has resulted in a devaluation of the local currency and US currency restrictions, the Secretariat has secured a written commitment by the government to:

- Procure 60 percent of ART needs including funding from a WB soft loan; and
- Procure 1.2 million units of artemesinin-combined therapy, with increased commitments in 2017 as per the original funding request.

These procurements will be closely monitored and reviewed by the Secretariat as well as the inter-agency malaria quantification committee.

1.7 GAC review and recommendations. The GAC and partners expressed support for the Angola malaria and HIV programs, and underscored how critical it is for the government to fulfill its domestic financing commitments. GAC partners emphasized the urgency of beginning implementation in light of the recent increase of malaria transmission and reinforced the importance of collaboration between partners to avoid a full-scale outbreak. GAC partners also noted the potential to provide universal coverage of LLINs in Angola through flexible distribution modes, to which the Secretariat responded that it would welcome the opportunity to work with in-country stakeholders to use resources as effectively as possible. GAC partners requested information on strategies for young women and girls and noted the importance of addressing transactional sex within the HIV program as well as making use of available data. The GAC was informed that the Secretariat is working on strengthening the community-level systems through health workers at that level in order to provide test-and-treat services and that young women and girls is considered a priority by the country. Additionally, the grant includes several trainings for health workers, including plans to train health workers in the provinces where malaria transmission is the highest. In order to address issues flagged by GAC partners on viral load testing for TB patients co-infected with HIV, the program is working with the World Bank on the procurement and use of GeneXpert machines for which the Global Fund-supported program will provide training.

**Central African Republic malaria Grant: The International Federation of Red Cross and Red Crescent Societies (CAF-M-IFRC)**

1.8 Strategic focus of the program. Malaria, endemic to the Central African Republic, represents a major cause of mortality with an estimated 3,800 deaths in 2013. The epidemic is concentrated among children under five accounting for half of 698,298 of confirmed cases. The goal of the Global Fund-supported program, implemented by the International Federation of Red Cross and Red Crescent Societies, is to reduce malaria-related morbidity and mortality in the general population by 50 percent from 2010 to 2017. Context-specific strategies and activities to support this goal include:

- Mass distribution of long lasting insecticide-treated nets in health regions 4,5,6 and 7;
- Strengthening of supervision system for clinical and commodity data reported; and
- Development of a community strategy and roll out of community case management in two districts.

The fragile political context and conflict in Central African Republic has resulted in operational challenges and posed barriers to measuring expected impact and outcomes of the proposed programming, such as limitations in terms of data reporting, completeness, quality and timeliness, data analysis and data use. Therefore, the Secretariat is unable to provide baselines and targets for the program at this point, however, the planned 2016 malaria indicator survey is expected to provide the necessary information to establish a sound epidemiologic basis.

1.9 Operational issues and implementation challenges. As a challenging operating environment, the Central African Republic was placed under the Additional Safeguard Policy in 2014. Security has steadily improved since the last outbreak of violence in September and October 2015, however, the situation

remains uncertain and some grant activities have been delayed as a result. The Principal Recipient drafted emergency contingency plans along with other international and national stakeholders through regular United Nations cluster meetings. The Principal Recipient as well as the Secretariat have identified weaknesses in data quality, including discrepancies between data in health facility reports and central database. Additionally, the program faces challenges in stock management and health products ordering processes. To address this, the Secretariat has agreed with the Principal Recipient on the following risk mitigation measures:

- Implementation of a nationwide malaria indicator survey to improve reporting for 2016 and 2017;
- The inclusion of a nine-month buffer stock based on weaknesses in stock management and the potential risk of commodity waste at the peripheral level.

1.10 Domestic contributions. Government contribution based on historic budget allocated to malaria is €0.9 million representing 5 percent of total resources available for the next implementation period. While the transition plan for the health sector indicates substantive increases in government spending on health, negotiation of specific government commitments for health was not a feasible option in the current environment. The Secretariat will appropriately engage with the authorities once the situation further normalizes to discuss investments in health.

1.11 GAC review and recommendations. The GAC and partners commended the quality of the Central African Republic's malaria program given the challenging operating environment and expressed their hope for other applicants to follow in the country's steps considering its strong performance and extensive coverage of LLINs. The GAC and partners also acknowledged the Secretariat's flexibility in responding to the challenging operating environment as well as the program's good absorptive capacity. The GAC noted that the new Ministry of Health of the Central African Republic faced a challenging task in building up its public health system following the conflict, emphasizing the need to follow up on its efforts on rebuilding the resilience and sustainability of the health system. GAC partners added that, as the country stabilizes, technical assistance may be needed to address outstanding issues, such as the malaria program's lack of an insecticide resistance management plan. The Secretariat informed the GAC and partners that the Global Fund was financing five positions in the monitoring and evaluation unit to improve data collection and management that are critical for health system strengthening, which GAC partners encouraged be monitored to ensure that opportunities for transition are not overlooked. GAC partners also highlighted the importance of reinforcing the national supply management system and were informed by the Secretariat that the country is collaborating with consultants around planning such a reinforcement. The GAC was pleased to note that the Government of the Central African Republic seems to be prioritizing health as it moves toward a more stable situation.

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

1.12 Integrated HSS and TB/HIV program. 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 and approved in GF/B33/EDP20 for reasons of timing and alignment with the national planning cycle and the TB component was reviewed and approved through GF/B34/EDP16, consolidating the program under HTI-C-PSI. The HSS component is being recommended for approval through this report and the entire TB/HIV program will be consolidated under this single grant, with the final grant amount extended to cover the added HSS modules.

1.13 Strategic focus of the program. The health system in Haiti faces substantial challenges, including a shortage of health workers, decaying infrastructure and risk of natural disasters. To support the implementation of disease-specific Global Fund-supported programs, the HSS component within the TB/HIV grant will invest in health information systems, monitoring and evaluation, health and community workforces, and a results-based financing program for health facilities. Planned achievements of the proposed programming include:

- Increasing the percentage of health management information system or other routine reporting units submitting timely reports according to national guidelines;
- The recruitment and training of 415 community health workers to be performing assigned activities within 12 months of recruitment; and

- 50 health facilities achieving their corresponding targets as defined in the Haitian results-based financing program.

1.14 Operational issues and implementation challenges. The CCM, with Secretariat support, has decided to use a consolidated implementation approach, managing the three disease components and HSS under a single Principal Recipient. This approach will facilitate the mitigation of specific challenges of a challenging operating environment and enhance synergies between the programs.

1.15 Domestic contributions. Total domestic commitments for both the HIV and TB programs amount to US$49 million representing 8 percent of total resource needs and 11 percent of total resources available for the next implementation period. Government commitments for HIV and TB represents a 19 percent increase compared to the previous implementation period. Haiti's public institutions in general and health sector in particular are highly dependent on international aid to provide basic public services to its population. Furthermore, recurrent natural disasters as well as the backlashes of the cholera epidemic that started in the end of 2010 may jeopardize additional commitments to HIV and TB in the next three years as emergencies might force reallocations in the national budget.

**Honduras HIV Grant: Cooperative Housing Foundation (HND-H-CHF)**

1.16 Strategic focus of the program. Located in Central America, with an estimated population in 2015 of 8.8 million inhabitants, Honduras has an HIV prevalence rate of 0.4 percent among the general population. The epidemic is primarily concentrated among men who have sex with men, transgender females, female sex workers and the Garifuna indigenous population. The goals of the Global Fund-supported Honduras HIV program, to be implemented by the Cooperative Housing Foundation, are to:

- Reduce the number of new cases of HIV infection by at least 50 percent;
- Reduce the rate of mother-to-child HIV transmission to 0.3 cases or fewer in every 1,000 live births; and
- Reduce TB co-infection among persons diagnosed with HIV by at least 10 percent.

To support these goals, strategies employed include expanding ART coverage providing combined prevention packages to key populations and strengthening the national HIV system. Planned achievements of the proposed programming include:

- Reducing AIDS-related mortality per 100,000 population from 14.4 in 2014 to 10.1 in 2018;
- Percentage of people living with HIV known to be on treatment 12 months after initiation of ART from 83 percent in 2014 to 90 percent in 2018;
- Increasing the percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission from 36.5 percent in 2015 to 75 percent in 2018.

1.17 Audit by the Office of the Investigator General (OIG). A report was released by the OIG in December 2015 on an audit for Honduras, highlighting the key issues of the impact of the Ministry of Health reform and the lack of effective controls over programmatic data, resulting in poor data quality. To address these issues, the following management actions were implemented:

- A national monitoring and evaluation plan for HIV that describes information flow and the role of each level and unit within the Ministry of Health is being finalized, with a national plan for strengthening information systems has been incorporated into the grant.
- Resources have been allocated to ensure the Principal Recipient has sufficient personnel and capacity to carry out oversight and monitoring visits to implement data quality controls and implementation arrangements have been adjusted to reflect a clear picture of the coordination and the flow of information from the Ministry of Health to the Principal Recipient.

1.18 Domestic contributions. Total domestic financial commitments to HIV amount to US$79.5 million, which represents 78 percent of total resources available for the next implementation period. To promote a sustainable HIV response in Honduras, the following actions are being taken:

- A gradual progressive absorption plan for co-financing the amount needed for ARV, RDT, CD4 and viral load with national resources, has been agreed upon with the country to be further revised to align with normative guidance and international targets;
- The development of a sustainability plan for preventative services for key populations will be complete by the end of 2017, as requested by the TRP; and
- Alongside partners, the Secretariat is working to promote the update of the joint HIV approach for Central America to define expected milestones and scenarios for the sustainability of the national response of each country and promote the alignment and harmonization of available technical and financial resources to achieve this objective.

**Kosovo HIV Grant: The Community Development Fund (KOS-711-G04-H)**

1.19 Simplified funding request. The Kosovo HIV program initially submitted a concept note to the TRP in Window 5 in March 2015 and was recommended for further iteration. Considering that Kosovo HIV program had previously been extended twice for the total duration of 24 months to allow for the development of the funding request, less than 40 percent of Kosovo's allocation remained available for the iterated concept note. The Global Fund Secretariat and the Technical Review Panel acknowledged that there is a need to consider a differentiated and simpler application process, in particular for countries receiving limited new funding and those that will be generally continuing activities under the existing programs with some reprogramming. In light of the above, the applicant was allowed to undergo a simplified application process through an extension, with the following conditions:

- The applicant address the issues raised by the TRP or provide plans outlining how the issues would be addressed during implementation; and
- A full request be submitted to the TRP for review during the 2017 to 2019 allocation period.

1.20 Strategic focus of the program. While only 100 cases of HIV infection have been officially registered in Kosovo, a country of 1.8 million, the country is regarded as vulnerable to HIV epidemic due to its high rates of poverty and unemployment; increasing drug use and high-risk sexual behavior, particularly among young Kosovars and other vulnerable groups; high mobility of Kosovars to and from Europe and Balkan countries with higher prevalence rates of HIV; and the presence of large international community, the majority of whom are unaccompanied workers. The goal of the Kosovo HIV program, to be implemented by the Community Development Fund, is to maintain the low prevalence of HIV and improve the quality of life of people living with HIV in Kosovo through:

- Ensuring equitable access to high quality prevention, treatment, care and support with a focus on key populations;
- Strengthening the health and community systems that enable needs-based, sustainable and integrated interventions for key populations most affected by the HIV epidemic; and
- Creating a supportive environment for a sustainable response to HIV and AIDS in Kosovo.

1.21 Performance incentives. Performance-based incentives in the grant are provided for four positions, each of these with the purpose of putting in place a system of HIV case management. The incentives will be phased out following the extension and the associated duties will be integrated into the terms of reference of the relevant individuals. To this end, the incentives are foreseen to decrease from 20 percent to 15 percent of the gross salary by year 2.

1.22 Domestic contributions and sustainability. Total domestic financial commitments to the HIV program amount to €1.67 million, representing a 44 percent counterpart financing commitment. Despite the fact that the HIV program remains low priority for the government due to the low disease burden, sustainability has been a key focus of grant-making and the following strategy will be pursued:

- As part of its willingness-to-pay commitment, the government agreed to take over funding for ART monitoring and procurement of rapid diagnostic tests for the penitentiary system, as well as the procurement of methadone from 2017.
- In order to ensure a gradual transfer of procurement and supply chain management responsibilities from the Principal Recipient to the Ministry of Health, a TB/HIV procurement and supply chain officer will be seconded to the Ministry of Health. A methadone maintenance treatment focal point will also

be recruited to coordinate the program and address various quality issues. The roles and responsibilities of both officers will be gradually absorbed by the Ministry of Health.

- To ensure sustainability of the remaining prevention services, the program will have a strong focus on social mobilization, advocacy, creating an enabling environment for social contracting and strengthening civil society organization capacities, and establishing formal linkages between government (including local government) and civil society. In addition, the program will also support trainings and on-the-job support to address stigma and discrimination.
- Finally, a transition readiness assessment will be conducted in order to support the development of a transition plan, which is planned to be integrated with the national strategic planning exercise.

**Iran HIV Grant: United Nations Development Programme (IRN-H-UNDP)**

1.23 Reinvestment of savings. The GAC recommends for the Board approval an increase of US$1.17 million to the budget amount of the Iran HIV grant IRN-H-UNDP thus bringing total budget to US$13,131,823. The additional amount requested is within the allocation and represents reinvestment of uncommitted cash funds from a Round 8 grant not included in the total budget of the Iran HIV grant in the original approval by the Board on 18 March 2015 in GF/B32/EDP13. The GAC has endorsed the country's request to reinvest this amount for initiating strategic activities such as carrying out key population studies, active case finding and treatment follow-up interventions. Specifically, the proposal includes:

- Conducting Priorities for Local AIDS Control Efforts (PLACE) studies in three priority cities to gather information on the hotspots for neglected populations, and to monitor and improve HIV prevention program coverage in areas where key populations are concentrated;
- Providing rapid diagnostic tests for people who inject drugs, people in prisons, vulnerable men/women and members of positive clubs, consistent with the UNAIDS 90-90-90 and national strategic plan targets; and
- Providing viral load kits for 13 sub-national labs.

This investment would respond directly to the concerns raised by the Board, Secretariat and partners of investments for key populations in the light of Iran's upcoming transition as an upper-middle-income country. The Secretariat, Principal Recipient (UNDP), and the Ministry of Health have made substantial efforts to include the appropriate activities/interventions for vulnerable and neglected population in the National Strategic Plan 2015-2019. The reinvestment of savings from the Global Fund grant can play a catalytic role in supporting and initiating evidence-based interventions for underserved populations and generating strategic information for transition planning.

**Liberia Malaria Grants: The Ministry of Health (LBR-M-MOH) and Plan International, Inc (LBR-M-PII)**

1.24 Simplified approach. The Liberia malaria program, through the CCM, submitted a simplified funding requests in March 2016 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.

1.25 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. 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 malaria disease program, with malaria testing, community-level activities and planned scale-up all suspended throughout the outbreak. However, presumptive malaria treatment and distribution of long-lasting insecticidal nets (LLINs) continued, and there was mass antimalarial drug administration in Monrovia to reduce febrile cases presented as suspected Ebola cases.

1.26 Strategic focus of the program. Liberia has high perennial malaria transmission and the entire population of 4.6 million is at-risk for transmission. According to data from the 2013 health facility survey, malaria accounted for 42 percent of outpatient department attendance and 39 percent of in-patient deaths. It is expected that in 2016 a new malaria indicator survey will be conducted which will allow the country to estimate current malaria prevalence and determine the impact of Ebola on malaria. The goals of the Liberia malaria and HSS program are to:

- By 2020, reduce illness and deaths caused by malaria by 50 percent;
- Ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost; and
- Improve the health status of the Liberian population through building a resilient health system.

The expected impact and outcomes of the malaria and health systems strengthening program includes:

- Reducing under-five mortality rate per 1,000 live births from 94 in 2013 to 69 by 2018;
- Reducing maternal mortality ratio per 100,000 population from 1,072 in 2013 to 712 by 2018;
- Reducing parasite prevalence from 28 percent in 2011 to 20 percent in 2016;
- Increasing the proportion of households with at least one LLIN for every two people from 22 percent in 2013 to 72 percent in 2018.

1.27 Operational issues, risks and implementation challenges. In the post-Ebola context, 3 percent of requested funds will support malaria positions directly working for the malaria program and the supply chain management unit at the Ministry of Health. 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. While 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. The 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 human resources for health plan within 90 days after the adoption of such plan. Additionally, a condition has been included that the Principal Recipient must submit an updated budget to the Global Fund with respect to the transition of salary and incentive to the government payroll by no later than 31 July 2016, reflecting a transition in two tranches by the end of 2017. In addition, to mitigate risks related to procurement and supply chain management, the fiscal agent team in-country may be expanded and further actions will be put in place to strengthen the recording and storage system at central medical store.

1.28 Domestic contributions. Total domestic financial commitments to the malaria program amount to US$6 million and represent 12 percent of total resources available in the next implementation period. Government commitments to the heath sector for fiscal years 2016-2018 represent a 29 percent increase compared to 2013 to 2015. A core focus of Liberia's post-Ebola economic stabilization and recovery plan for 2015 to 2017 is rebuilding and strengthening capacity to deliver health services, with better coverage particularly in the rural areas. Aligned to government's focus on sustainability of core systems, a key outcome of country engagement has been increased absorption of Global Fund's historic support for health personnel. By the 2015 fiscal year, 104 personnel that were previously supported by Global Fund have been fully transitioned to government payroll.

1.29 GAC review and recommendations. The GAC and partners commended the country's strategic focus and technically sound approaches, particularly on HSS. GAC partners emphasized the importance of transitioning salary incentives to the government payroll in the long-term and requested further information on how the HSS grant will fit into existing government systems. The GAC was informed that the Secretariat, government and partners worked together on developing the HSS component, which includes community-level interventions for health information and data. Additionally, the Secretariat explained to the GAC that the initial 104 staff transitioned from Global Fund to government payroll were

completed prior to a clear plan, so remaining staff transitions are anticipated to be further articulated and lead to a more effective process. Lastly, the Secretariat shared that new human resource for health guidelines are being developed with key partners including USAID, the World Bank and WHO to ensure alignment with new strategy guidelines, in addition to Global Fund case studies to spread learnings from human resources for health issues.

**Madagascar Malaria Grants: The Ministry of Health (MDG-M-MOH) and Population Services International (MDG-M-PSI)**

1.30 Strategic focus of the program. Malaria is a major public health issue in Madagascar with 88 percent of the population living in high transmission areas. It is considered endemic in 90 percent of regions and, in 2014, malaria was the fifth biggest cause of death for all age groups and the eighth biggest for children under the age of five, in public health facilities. However, data from health care facilities show that the malaria morbidity rate for all age groups fell from 18.8 percent in 2003 to 5.5 percent in 2014. The goal of the Madagascar malaria program is to reduce malaria-related deaths to zero, and to reduce the test positivity rate to less than 5 percent in all districts by the end of 2017. Planned achievements of the planned programming, to be implemented by the Ministry of Health and Population Services International, include:

- Reducing the malaria test positivity rate from 49.6 percent in 2015 to less than 10 percent in 2018;
- Maintaining the proportion of population that slept under an LLIN the previous night at 80 percent between 2016 and 2018;
- Increase the number of long-lasting insecticidal nets distributed through social marketing from 122,756 in 2015 to 225,000 in 2018 and to targeted risk groups from 118,926 in 2015 to 723,418 in 2018.

1.31 Operational issues, risks and implementation challenges. In the new grants, the number of staff receiving performance incentives has been drastically reduced from rounds-based grants and will use less than 0.03 percent of the total Global Fund malaria grant budget. Incentives will continue for a limited number (11) of strategically selected civil servants heavily involved with the national malaria control program, who play crucial roles in managing the grant and aligning it with national and donor programs. These are to align the salaries of the national malaria control program with salaries for employees directly under Global Fund programs, which are paid at market rates. The incentives are conditioned to the submission of timesheets and performance appraisals by the Principal Recipients. Additionally, to address the outstanding issues of Principal Recipient capacity as well as procurement and supply chain management, the following actions are being taken:

- The Country Coordinating Mechanism, the national technical working group and the Ministry of Health have all agreed to invest grant funds into technical assistance and specifically for a fiscal agent for this grant implementation period so as to ensure efficient program management and build capacity;
- The installation and update of accounting software, as well as training of Principal Recipient accounting specialists, is being undertaken to improve and facilitate reporting;
- Funds have been budgeted for a technical support unit that includes program management, monitoring and evaluation as well as procurement and supply chain management support to the Ministry of Health's program management unit; and
- Through a management action, the Principal Recipient will be submitting stock status reports to the Secretariat for all commodities before new orders are confirmed to avoid over- and under-stocking.

1.32 Domestic contributions. The counterpart financing share based on commitments of government contribution in the next phase is 6 percent, which meets the minimum threshold requirement of 5 percent for a low income country. Government commitments across all three diseases represent a 10.5 percent increase compared to the previous implementation period. Following constitutional elections in 2014, the current government has given priority to raising social and infrastructure spending which has helped bring additional government resources to the health sector. However, the situation still remains fragile with annual growth not exceeding 3 percent after the sharp fall in economic activity in 2009. Madagascar needs to create the necessary budgetary space to support inclusive growth and health spending through revenue mobilization, budget prioritization and public financial management reforms to improve the effectiveness of spending and ensure sustainability.

1.33 GAC review and recommendations. The GAC endorsed the grant end date of 30 June 2018 in order to allow for effective implementation in line with priority malaria strategies as defined in the national strategic plan, taking into account that mechanisms to access new funds would be required prior to this date in order to place orders for LLINs for a mass campaign at the end of 2018. GAC partners suggested this order be placed before the end of 2017, to ensure timely arrival for implementation of the mass campaign from the third quarter of 2018. The Secretariat assured GAC partners that a mechanism would be put in place to facilitate the orders of nets for 2018 mass campaigns, as it will be needed for other countries in the Global Fund portfolio beyond Madagascar. The GAC was informed that technical assistance has already been supplied during the grant-making period to help build capacity of the Principal Recipient, the Ministry of Health, and that partners have provided collaborative support around the central medical store and the distribution of drugs. GAC partners welcomed the changes concerning the building of resilient and sustainable systems for health and anticipated further coordination between partners to avoid duplication between programs.

**Mauritania HIV, Malaria and TB Grants: Secrétariat Exécutif National de la Lutte contre le Sida (MRT-H-SENLS, MRT-M-SENLS and MRT-T-SENLS)**

1.34 Strategic focus of the HIV program. Mauritania has a low HIV burden with a prevalence rate of 0.4 percent in 2012 among the general population. However, HIV prevalence rates seems higher among key populations based on estimates from insufficient sampling, including men who have sex with men (44.4 percent), sex workers (4 percent) and people in prisons (2.9 percent). The goal of the Global Fund-supported program is to reduce new infections by 70 percent by 2018 and to ensure that at least 80 percent of adults living with HIV and 50 percent of children living with HIV receive antiretroviral therapy. Specifically, the objectives of this program are, by 2018, to:

- Ensure that at least 80 percent of each of the populations with the highest risk exposure and the vulnerable populations who benefit from the prevention programs adopt lower risk behavior with regard to HIV infection;
- Ensure that at least 80 percent of the key and vulnerable populations who benefit from prevention programs and 80 percent of people living with HIV will know their serological status.

Expected achievements of the planned programming include:

- Reducing the percentage of men who have sex with men who are living with HIV from 44 percent in 2014 to less than 30 percent in 2018; and
- Reducing the estimated percentage of child HIV infections from HIV-positive women from 16.6 percent in 2014 to 8 percent in 2018.

1.35 Strategic focus of the malaria program. Mauritania has a severe malaria burden with an estimated 70 percent of the population living in areas at risk of transmission and a stable incidence rate per 1,000 population of 250 over the past decade. The goal of the malaria program is to contribute to the reduction of malaria morbidity and mortality within the population for sustainable socio-economic development. Expected achievements of the planned programming include:

- Reducing confirmed malaria cases per 1,000 population from 46 in 2013 to less than 3 in 2018;
- Maintaining inpatient malaria deaths per 1,000 population from 0.73 in 2013 to under 1 in 2018.

1.36 Strategic focus of the TB program. TB incidence, prevalence and related death rates in Mauritania are showing declining trends. However, case detection and treatment success rate remain inadequate at 67 percent and 71 percent in 2014 respectively. The goal of the TB program is to substantially reduce the burden of TB by 2018 in line with the objectives of the global strategy for tuberculosis prevention, care and control after 2015 with the specific objectives of:

- Detecting 12,137 cases of TB by 2018;
- Successfully treating at least 85 percent of new bacteriologically confirmed TB cases by 2018;
- Testing at least 90 percent of notified TB cases for HIV and ensure a treatment success rate of 80 percent of TB/HIV co-infected patients by 2018;
- Diagnosing and treating 181 cases of multidrug- resistant TB (MDR-TB) between 2015 and 2018;

Planned achievements of the proposed programming include:

- Increasing case notification rate of all forms of TB per 100,000 population from 67 in 2014 to 69.5 in 2019;
- Increasing case notification rate of rifampicin- or MDR- TB from 26 percent in 2015 to 60 percent in 2019; and
- Increasing treatment success rate of bacteriologically confirmed TB, rifampicin-resistant and/or MDR-TB cases from 71 and 23 percent in 2013 to 85 and 65 percent in 2019, respectively.

1.37 Investigation by the Office of the Inspector general (OIG). Following an investigation on all grants implemented in Mauritania conducted in 2009, the OIG found that US$4.23 million were misused in the context of the HIV grant implemented by the Secrétariat Exécutif National de la Lutte contre le Sida and that US$2.5 million were misused at the level of the sub-recipients under malaria and TB grants managed by UNDP. The full US$4.23 million was repaid by the Government of Mauritania, however, US$1.3 million remains outstanding from the grants under UNDP. Mauritania was thereafter placed by the Global Fund Secretariat under the Additional Safeguards Policy in November 2010.

1.38 Operational issues and risks. The CCM nominated the Secrétariat Exécutif National de la Lutte contre le Sida as Principal Recipient for all three grants. The Principal Recipient is currently undergoing a restructuring, and with the support of the French 5% Initiative three international staff will support the restructured Principal Recipient to efficiently manage the grants and the selection process of civil society sub-recipients. The Secretariat is currently recruiting a fiduciary agent to provide financial oversight as well as capacity building to the Principal Recipient.

1.39 Investments in building the resilience and sustainability of health systems (RSSH). The Secretariat has identified a delay in the development of the RSSH assessment across the three disease components and measures have been taken to ensure the distribution of harmonized and sustainable interventions for RSSH between the different grants under the leadership of the Ministry of Health. The Secretariat will remain in continuous dialogue with the government, donors and technical partners to coordinate RSSH investments.

1.40 Performance incentives. Salaries at the Principal Recipient level paid by the Global Fund amount to US$ 756,003, US$963,109 and US$239,155 for the HIV, malaria and TB programs respectively, representing 8, 6 and 5 percent of the total budgets. In addition, budgets totaling US$192,487, US$113, 018 and US$288,769 respectively for HIV, malaria and TB programs will be used to pay incentives at the different national programs and at service delivery level over thirty months of grant implementation.

1.41 Domestic contributions. Domestic contributions toward HIV, malaria and TB amount to US$4.2 million, US$7 million and US$3.2 million representing, respectively, 35, 25 and 44 percent of total resources available for the next implementation period. Government commitments related to HIV, malaria and TB represent, respectively, a 16, 34 and 56 percent increase compared to the previous implementation period. For the three programs, government contributions include a budget line for the purchase of pharmaceutical products including drugs.

1.42 GAC review and recommendations. The GAC and partners commended the CCM of Mauritania for completing the application process, noting that the grants demonstrated the collaborative efforts of the CCM with donors and partners through a consultative process. GAC partners noted the difficult context and pledged support for the management unit, the reinforcement of capacity for program management and sub-recipient capacity analysis. GAC partners also welcomed the opportunity for scale-up and acknowledged the alignment with population focused investment strategy. GAC partners highlighted the opportunity for further domestic resources to be committed, taking into account the financing by the government of Mauritania of first line drugs for TB and LLINs. The Secretariat was encouraged to continue the pursuit of balancing program implementation with fiduciary risk and was requested to provide more information on TB/HIV collaboration and the implementation of RSSH interventions. The GAC was informed that studies on TB/HIV within key populations will be completed during implementation and that the country is already moving toward providing “one stop” TB/HIV services. Additionally, the Secretariat explained to the GAC that the RSSH component included the roll-out of DHIS2 and TomPRO financial management software, complementing other donor investments.

**Namibia TB Grant: The Ministry of Health (NMB-T-MoHSS)**

1.43 Strategic focus of the program. In 2014, Namibia had the fifth highest TB incidence rate in the world at 561 per 100,000 population, as well as high estimated TB prevalence at 627 per 100,000 population. The estimated incidence and prevalence of TB in Namibia have been falling at an average rate of 5 percent per year since 2002. TB is the leading cause of death among people who have HIV and HIV poses a major risk factor for TB. The goal of the Namibia TB program, to be implemented by the Ministry of Health, is to reduce TB transmission, morbidity and mortality to such a level that TB is no longer a public health problem. Planned achievements of the proposed programming include

- Reducing the TB death rate (among new smear positive cases) from 5.1 in 2012 to 3.4 of in 2017;
- Increasing treatment success rate (among new smear positive TB) cases from 83 percent in 2012 to 90 percent in 2017;
- Reducing HIV sero-prevalence among TB patients (all forms) from 47 percent in 2012 to 38 percent in 2017; and
- Increasing treatment success rate among MDR-TB cases from 68 percent in 2012 to 75 percent in 2017.

During grant implementation, the Secretariat and country will continue to explore the issue of cross-border TB cases and will take findings into account moving forward.

1.44 Operational issues, risks and implementation challenges. In order to mitigate risks related to the program management unit, the Secretariat will work with the newly established CCM oversight committee to improve financial management through new staffing practices and a capacity-building exercise, and train the unit on using a standardized dashboard for regular reporting and action tracking.

1.45 Audit by the Office of the Investigator General (OIG). There are pending recoveries of US$869,091 for the malaria and TB/HIV grants following an audit by the OIG. The country does not dispute the recoveries decision and has committed to pay in 2016. This amount was not part of the allocation.

1.46 Domestic contributions. Total domestic financial commitments amount to US$62.5 million, which represents 77 percent of total resources available and 79 percent of the counterpart financing share for the next implementation period. Government commitments for TB represent a 96 percent increase compared to the previous implementation period. Namibia faces significant macroeconomic and fiscal challenges in the backdrop of the global economic crisis, lower revenues from the Southern African Customs Union and excess volatility in exchange rates and currencies. Despite these constraints, the budget for the Ministry of Health increased by 17 percent in 2016 and the government's medium-term expenditure framework projects further prioritization of health. Furthermore, the Ministry of Health is conducting a restructuring to improve management through better human resource staffing practices and the implementation of the Global Fund financial management capacity-building exercise.

1.47 GAC review and recommendations. The GAC and partners commented on the encouraging progress made by Namibia in addressing TB/HIV co-infection and investment in community-based TB care. GAC partners expressed concern about the TB treatment success rate, to which the Secretariat responded that funding has been allocated for additional GeneXpert machines and that the Global Fund will assist the program to optimize use of all GeneXpert machines, the number of which have increased to match the planned scale-up of the program. Additionally, the Secretariat highlighted that the government is trying to ensure that all TB patients are able to receive treatment. The GAC was also informed that the Government of Namibia is holding quarterly meetings with Angola to address the issue of cross-border TB cases and share learnings. GAC partners anticipated that the planned prevalence survey (as part of the request for operational research) will have an impact on the case notification rates and also noted the opportunity for the program to look closely at regional mining in relation to TB, as well as synergies with the regional program on TB in mining. GAC partners also noted potential synergies in TB and HIV programming, specifically in the use of mobile units and programs from other partner programs, which the Secretariat assured partners would be looked at before the finalization of the upcoming HIV grant.

**Peru HIV Grant: Pathfinder International (PER-H-PATH)**

1.48 Strategic focus of the program. In 2013, HIV prevalence rate among adults in Peru was estimated to be 0.3 percent. The epidemic is concentrated in key and vulnerable populations, mainly men who have sex with men and transgender women in urban areas. The goal of the Global Fund-supported program, implemented by Pathfinder International, is to contribute to the reduction of new HIV cases in the most affected populations in Peru by bridging the gap in HIV screening, prevention and care. Expected outcomes of the planned programming include:

- Increasing condom use among man who have sex with men and transgender sex workers from 50 percent in 2011 to 70 percent in 2017;
- Increasing the rate of people living with HIV on treatment 12 months after initiation of ART from 31 percent in 2013 to 80 percent in 2019.

1.49 Domestic contributions. Total domestic commitments for the HIV program amounts to US$213.9 million representing 92 percent of total resources available for the next implementation period. Government commitments for HIV represent a 9 percent increase compared to the previous implementation period. The government contribution is anticipated to increase incrementally over the next phase to support the planned scale-up of services.

**Sierra Leone Malaria Grants: The Ministry of Health and Sanitation (SLE-Z-MOHS) and Catholic Relief Services (SLE-M-CRS)**

1.50 Simplified approach. The Sierra Leone malaria program submitted its funding request through a simplified approach in order to link with the post-Ebola health sector recovery plan, which was developed in consultation with a full range of stakeholders and reflects extensive country dialogue. In operation, this simplified approach included the consideration by the TRP of the Health Sector Recovery Plan 2015-2020 as the investment case for the funding request. The TRP considered the allocation request to be technically sound and strategically focused, building on past experiences and focusing on key populations to achieve impact. The funding request also builds on lessons learned from past implementation and the Ebola outbreak, as well as being anchored in the Sierra Leone Malaria Control Strategic Plan 2016-2020.

1.51 Country context. The Sierra Leone malaria program was designed as the country was emerging from the outbreak of the Ebola virus disease, during which 8,400 cases were reported and 3,600 deaths occurred (as of March 2015) making it the country most significantly affected by the Ebola outbreak. Poor early recognition of suspected cases and inadequate infection prevention and control standards led to 296 infections and 221 deaths among health care workers, including 11 specialized physicians. The closure and decreased capacity of health units to treat other medical issues resulted in a 23 percent drop in institutional deliveries, 39 percent drop in children treated for malaria, and 21 percent drop in children receiving basic immunization. This was due to both a loss of confidence in health services as well the focus of the health workforce in responding to Ebola The Ebola outbreak in Sierra Leone also had a direct impact on the malaria program. Gains made in malaria control regressed during the Ebola outbreak with halting of confirmatory testing of suspected malaria cases (based on WHO recommendations), as well as limited continuity and scale-up of malaria key control activities as the country prioritized the response to the Ebola epidemic. The number of antenatal care visits declined by 27 percent and the number of long lasting insecticidal nets (LLINs) distributed in antenatal care clinics declined by 63 percent. However, to try to address malaria in the context of Ebola, mass drug administration with antimalarials was conducted in highly endemic Ebola areas to attempt to reduce febrile cases presenting to Ebola treatment units and provide short-term protection for malaria as per WHO directives.

1.52 Strategic focus of the program. Malaria is endemic in Sierra Leone with the entire population at risk as a result of stable and perennial transmission throughout the country. Malaria is the leading cause of morbidity and mortality amongst children under five years of age and remains a serious public health challenge as well as acting as a major impediment to socio-economic development perpetuating the cycle of poverty. The goal of the Sierra Leone malaria program, to be implemented by The Ministry of Health and Sanitation and Catholic Relief Services, is to reduce malaria morbidity and mortality by at least 40 percent between 2015 and 2020. Planned achievements of the proposed programming include:

- Distributing 4,186,515 LLINs through a mass campaign to achieve universal coverage;
- Reaching LLIN usage rates of 90 percent among pregnant women and malaria cases at every level, including at children under the age of five;
- Building and maintaining capacities for management, partnership and coordination;
- Covering 70 percent of pregnant women and 69 percent of children covered with intermittent preventative treatment; and
- Testing 100 percent of suspected cases and treating 100 percent of confirmed malaria cases.

1.53 Investments in human resources for health. Considering the critical nature of the malaria program and the post-Ebola context, the need to retain experienced staff with essential expertise and knowledge of the epidemiological context in Sierra Leone is crucial in the implementation of Global Fund grants. Therefore, 0.2 percent (US$57,000) of the grant budget will go toward performance incentives for eleven government staff positions that are critical for the implementation of this grant. While the Ministry of Health and Sanitation is not yet in the position to take over these salary incentives due to the Ebola outbreak, the health workforce strategy is being rethought in the wake of the epidemic within the framework of the Health Sector Recovery Plan. During implementation, the Secretariat will participate in discussions with the Ministry of Health and Sanitation and in consultation with in-country partners inform development of strategies and timelines to transition Global Fund funding of salary incentives to domestic resources.

1.54 Domestic contributions. The counterpart financing share based on commitments of government contribution in the next phase is 10 percent, which meets the minimum threshold requirement of 5 percent for a low income country. The medium-term expenditure framework of the government indicates increasing commitment to finance the health sector from government's own revenues. The allocation for health (excluding foreign grants) has increased by 41 percent in 2016, with its share in total budget (excluding foreign grants) increasing from 8.9 percent in 2015 to 10.3 percent in 2016. The increase in allocation is primarily for strengthening health systems and improving public health. In addition, the government is piloting a national health insurance scheme to improve coverage of health care. The 2016 Finance Bill has introduced a national health insurance levy of 0.5 percent on the value of all contracts in support of the proposed scheme. A key outcome of the country engagement has been an agreement to absorb Global Fund's historic budget support for health worker salaries to government payroll by July 2017. Additional resources are anticipated for the health sector with the redemption of pledges made by development partners to the post-Ebola Health Sector Recovery Plan that would respond to the gaps in the health system.

1.55 GAC review and recommendations. The GAC, partners and Secretariat acknowledged the hard work and collaborative effort between the country and partners to prepare this grant for implementation, and lauded the integration of the malaria grant within the country's multi-component grant comprised of HSS, TB and malaria. GAC partners requested information on the joint assessment, capacity building and financing of salary incentives. The Secretariat assured partners that the program management unit joint assessment results would be shared, that technical assistance was included in the grant for capacity-building and that the amount of grant funds to be put toward performance incentives would be realistic for the anticipated phase out. The Secretariat also shared plans for trainings for community health workers, who will have integrated supportive supervision as well, and encouraged partners to provide input on the development of the health workforce strategy.

# 03 Summary of the Deliberations of the Secretariat's Grant Approvals Committee (GAC) on Shortened Grants and Early Applicants

**Introduction**

In this report, the Secretariat recommends to the Board additional funding for, and extension of, the second set of grants[12] with implementation periods ending prior to 31 December 2017 (the "Shortened Grants" or "Early Applicants"). 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). Early Applicants participated in the concept note development and review process in 2013 as part of the transition to the allocation-based funding model, as authorized under GF/B28/DP05. As such, the resultant grant duration and related funding approved by the Board for such country components ended on or before 31 December 2016, prior to the typical end date of grant programs arising from the 2014 to 2016 allocation period.

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 disease treatment needs that resulted in having to use their total allocation during a shorter period than the allocation covered.

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 planned shortened implementation period would be treated as quality demand that could not be funded within the amounts initially allocated to the country components. The 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. In its review of the disbursement-ready extension to the grants, the GAC took into account risk assurance mechanisms, program progress made to date and the fulfillment of TRP and GAC clarifications during implementation.

Shortened Grants and Early Applicants 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, such as mass long-lasting insecticidal net campaigns, and engagement of in-country stakeholders, including 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. As presented to the FOPC, Early Applicants were established prior to the finalization of the allocation methodology for the 2014 to 2016 allocation period, which resulted in such programs having grant end

[12] 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.

dates prior to 31 December 2017. Accordingly, they have been included as priorities from the current allocation period that could receive additional funding from the available funds validated by the FOPC for portfolio optimization. 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 and the Audit and Finance Committee in June 2016.[13] Even as portfolio optimization aims to deal with potential funding needs at a country-disease level, it is based on:

- Regularly monitoring 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.

**Ghana Malaria Shortened Grants (GHA-M-AGAMAL)**

1.56 Rationale for extension of the Ghana malaria grant. The GAC recommends for Board approval the extension of the Ghana malaria shortened grant GHA-M-AGAMAL to continue implementation through 31 December 2017, and to sustain the scope and scale of essential malaria services in 2017.

1.57 Background of the shortened grant duration. Under GF/B32/EDP15, the GHA-M-AGAMAL grant for the Ghana malaria program was exceptionally authorized to have a shortened grant duration until 31 December 2016 while the other malaria program grant, GHA-M-MOH, was approved with an end date of December 2017 but considered shortened because not all prioritized, essential services were funded through end 2017. The Ghana malaria concept note was submitted to the TRP in window 3 in September 2014. The GAC endorsed the TRP recommendations and approved US$24,409,625 of incentive funding in addition to the allocation amount for the malaria component. The remaining funding gap identified by the country, Global Fund and partners for the malaria program, in line with the programmatic assumptions for the shortened grant agreed by the TRP and GAC, was based on the planned geographic expansion of indoor residual spraying (IRS) to three northern regions during 2015 to 2016. However, due to a shortage of funds within the allocation, IRS was reduced from 24 to 11 districts within the grant. As IRS was not scaled-up during this period as originally proposed, the amount needed to maintain the scale and scope of the Ghana malaria program in 2017 was reduced significantly to US$7,943,525. The GAC requested the Secretariat to 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. In this regard, as of May 2016, total savings reinvested to cover the remaining 2017 gaps comprised:

- Savings identified within the malaria portfolio during implementation and budget revisions,
- Cash balance from closed rounds-based malaria grant, and
- Savings of US$5,281,331 to be transferred from GHA-M-MOH to GHA-M-AGAMAL.

While reprogramming of savings identified under the GHA-M-MOH grant is currently ongoing, the total financial need will be filled with savings from within the current grant and no incremental funding is requested to fill the gaps in the Ghana Malaria program. The reinvestment of efficiencies and savings within the grants would reduce the remaining unfunded quality demand to zero.

1.58 Strategic focus of the program. Ghana is one of the countries in sub-Saharan Africa that has made the most pronounced progress in scaling up intervention coverage to control malaria, despite the entire 25 million population being considered at-risk for malaria transmission. Annual deaths from malaria declined from 6,054 in 2000 to 2,985 by 2013, including a decline of deaths of children under the age of five from malaria from 3,952 in 2000 to 1,348 by 2012. The indoor residual spraying activities to be funded under

[13] As set forth in GF/FOPC17/10, GF/FOPC17/03, and GF/AFC01/05.

this extension request were part of the malaria concept note and this extension would allow the Principal Recipient to continue implementation within the scope and scale of the current grant. Key achievements of the planned programming include covering 907,324 people in Ghana with indoor residual spraying, maintaining the current coverage of this intervention at 90 percent of the population under GHA-M-AGAMAL. The two northern regions previously proposed to be covered by expansion of IRS are now covered with LLINs. Additionally, under GHA-M-MOH 74 percent of the population is covered by the provision of long-lasting insecticidal nets and 135,000 children will be covered with seasonal malaria chemoprevention. While the need for a clear transition plan has been highlighted, the national malaria control program has requested the Global Fund to continue funding the ACT co-payment in 2017 to ensure access to affordable ACTs for vulnerable populations. The Secretariat confirms that the ACT co-payment is currently covered within the grant.

1.59 Insecticide resistance. In light of concerns around increasing insecticide resistance, as highlighted by the TRP and GAC, insecticide susceptibility of malaria vectors is being routinely monitored by AGAMAL and the President's Malaria Initiative in response to detection of reduced susceptibility. While a formal national insecticide resistance monitoring and management plan is not yet in place, resistance management decisions based on available data have been discussed and agreed with national and international partners.

1.60 Audit by the Office of the Investigator General (OIG). The OIG conducted an audit of Global Fund investments in Ghana that was published in October 2015. The outcome of this audit was six agreed management actions across all disease programs in Ghana, though none of them relate specifically to the continuation of indoor residual spraying as outlined in this extension.

1.61 Progress on key issues raised by the TRP, GAC and Board. In its review of the Ghana malaria program, the TRP, GAC and Board raised several concerns that were addressed by the applicant:

- Addressing the short-comings of monitoring and evaluation as well as procurement and supply chain management: During grant-making the monitoring and evaluation investment was increased to strengthen technical capacity and logistics for overall malaria control as well as improving the quality assurance system. Subsequently, with support from WHO, comprehensive surveillance and rapid impact assessments took place and the case management registration system was improved. Technical support was also provided for supply chain management and pilots of last mile distribution are underway to be brought to scale by 2017.
- Overconsumption of artemesinin-combined therapy (ACT): A nationwide training on case management with emphasis on the use of rapid diagnostic tests was been conducted in the private and public sectors and, as mentioned above, the case management registration system was revised, allowing proper recording of treatments.
- The development of a national insecticide resistance plan: No formal insecticide resistance monitoring plan is in place yet, as it remains under discussion with stakeholders, however, routine monitoring of insecticide resistance continues to take place.
- Transition plan for private sector co-payment: The national malaria control program did not develop a transition plan but has rather requested Global Fund to continue to fund ACT co-payment up to the end of 2017 in order to ensure access of affordable ACTs to vulnerable populations.

1.62 Domestic contributions. The government's counterpart financing commitments for malaria in the 2015 to 2017 period are US$370 million, an additional investment of US$199 million compared to spending from 2012 to 2014. While government spending on malaria and overall health sector faces considerable macroeconomic constraints, in light of decreasing economic growth, the overall Ministry of Health budget has increased by 25 percent in 2016. Budget allocations to the two major components of government malaria spending – human resources and social health insurance – have increased by 27 and 29 percent respectively in 2016. However, government allocations to "goods and services" have been reduced by 90 percent, severely impacting centralized procurement of drugs and commodities.

1.63 GAC review and recommendations. The GAC and partners commended the country's efforts to cover unfunded quality demand to maintain the scope and scale of the current program within previously approved funds, acknowledging the capacity and capability of the national malaria control program. GAC partners highlighted that the program's progress is a result of continuous country dialogue and Principal

Recipients who seek to achieve long-term goals and are willing to adjust, including the leadership role of the Ministry of Health. The Secretariat noted the need for support from and alignment among partners to accelerate implementation of the supply chain master plan and to push the government to fulfill commitments to malaria and other health programs.

**Mozambique HIV Shortened Grant (MOZ-H-MOH)**

1.64 Rationale for costed extension. The GAC recommends for Board approval the extension of the Mozambique HIV shortened grant to continue implementation through 31 December 2017, and to sustain the scope and scale of essential services in HIV treatment in 2017.

1.65 Background of the shortened grant duration. Under GF/B33/EDP04, the grant for the Mozambique HIV program was exceptionally authorized to have a shortened grant duration until 31 December 2016 for MOZ-H-MOH. The Mozambique joint TB/HIV concept note was submitted to the TRP in window 4 in November 2014. The GAC endorsed the TRP recommendations and approved US$43,560,000 of incentive funding in addition to the allocation amount for the HIV component. As part of the GAC recommendation to the Board, the GAC confirmed that the procurement of ARVs, pre-ART, treatment adherence and treatment monitoring should be prioritized at the level of US$87,120,000 to sustain the Global Fund share of contributions to the treatment program based on the estimated number of people on treatment at the start of the grant in July 2015. The GAC requested the Secretariat to 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. In this regard, as of May 2016, total savings of US$10.29 million within the approved HIV grant were identified for reinvestment within the disease program, including:

- Savings from health product orders including reductions in ARV prices;
- Efficiencies identified during budget negotiations;
- Cash balance from closed rounds-based HIV grant of US$155,886.

The remaining 2017 funding gap is therefore reduced to US$76,981,737. This gap 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$143.89 million.

1.66 Strategic focus of the program. Mozambique has a generalized HIV epidemic with elevated prevalence rates among key populations. The estimated incidence rate peaked at around 1.8 percent in the early 2000's, and has been declining to a low of 0.98 percent in 2013. The 2009 nationwide survey showed a prevalence of 11.5 percent, with high variation between geographic areas. The country has implemented an accelerated response to the HIV epidemic since 2013. The goal of this program is to reduce by 50 percent the number of new HIV infections by 2017, reduce the mortality from HIV in TB patients through HIV testing and counselling and provision of early ART to all, and reduce the mortality from TB in HIV infected persons through intensified case finding and early TB treatment. The activities to be funded during the extension period were part of the above allocation request in the concept note for the period of 2015 to 2017. Achievements of the programming so far include:

- Significant reduction in AIDS related mortality per 100,000 from 269 in 2013 to 143 in 2015, exceeding the target of 170;
- Scale-up of the number of sites certified to enroll ART patients from 316 in 2012 to 937 in 2015, exceeding the national target of 707;
- Increasing the number of people living with HIV receiving ART from 40 percent in 2014 to 50 percent in 2015, exceeding the 45 percent target.

In February 2016, the Mozambique HIV program moved to CD4 500 eligibility among the general population and will begin rolling out a test and start strategy in 30 districts in July 2016 with gradual expansion planned for 2017. Partners have indicated an increase in contributions to HIV products to help close the funding gap associated with the transition of the program to new treatment eligibility criteria.

1.67 Progress on key issues raised by the TRP, GAC and Board. In its review of the Mozambique HIV program, the TRP, GAC and Board raised several concerns that were addressed by the applicant:

- Resource constraints affecting the scale-up of ART, particularly for key populations and TB/HIV joint interventions: While universal access is included in the HIV acceleration plan, a national policy was agreed which provides preferential access to treatment for members of key populations. Additionally, the MOH has worked closely with PEPFAR to revise the national ART eligibility criteria and align plans for increased support to the HIV program, with a geographically focused strategy to provide test and treat first in areas of highest HIV burden.
- Strategy for women and girls: The civil society Principal Recipient, Foundation for Community Development, is implementing specific service packages for women and girls, and is developing an approach to reach girls age 10 to 14 with the support of local partners.
- Importance of community response to HIV: The civil society Principal Recipient, Foundation for Community Development, is implementing a community response targeting key populations, and developing a community approach to support adherence.
- Weaknesses in procurement and supply chain management: These are addressed as cross-cutting issues in all active grants as well as through the extension of the HSS grant until the end of 2017, with additional support provided by PEPFAR and the World Bank, in the implementation of the national logistic improvement plan.
- Declining government spending on health: Despite a tightening financial situation, due to decreasing revenue and high debt services costs in 2016, the government has maintained the 2016 domestic financing level in health at the 2015 level of 10.5 percent. In line with GAC recommendations to mitigate the sustainability risks associated with high dependence on external financing, the Ministry of Health is also developing a Health Financing Strategy, with the support of the health partners group.
- Sustainability plan for ART: The Global Fund and US government have been working closely together to ensure continuity of funding to HIV program through sharing information and regular review of the commodities funding situation.

1.68 Operational issues, risks and implementation challenges. Key risks to the program include government spending cuts, low absorption and fiduciary risks. Measures to address these challenges include:

- Close monitoring of government health spending to adjust implementation in case of drastic changes;
- Focusing grant funds (98 percent) on purchasing commodities through the Pooled Procurement Mechanism and working with the central medical stores and provincial authorities for in-country logistics
- Supply chain strengthening through the HSS grant, the Secretariat's Implementation Through Partnership project, and investments by partners such as PEPFAR;
- Increased assurance mechanisms of funds directed through government systems, including strengthening financial capacity in the program management unit, commissioning expenditure verification by the LFA, and implementing a financial control environment review.

1.69 Domestic contributions. The government of Mozambique's commitment for willingness-to-pay was US$28 million across all diseases in the 2015 fiscal year. Overall government health expenditure in 2015 was 98 percent for recurrent costs and 99 percent for investment costs at central level. Recent reports of previously undisclosed government external debt have led budget support donors to stop funding through government channels, which may pose a risk of shrinking the resource envelope for government health programs. The Secretariat will continue to follow government contributions to the health sector closely through the allocation period.

1.70 GAC review and recommendations. The GAC and partners took note of the increasing size of the treatment program over the allocation period so far, commending the expansion of treatment eligibility criteria to provide key populations with ART regardless of CD4 count. However, GAC partners expressed concerns about adherence, as the retention of patients on ART rate after 12 months has remained largely static at 66 percent, and noted that a study is underway to better understand the true rate of patients lost to follow up. GAC partners stressed the need to put systems in place to provide longitudinal support to the large number of patients on treatment. The Secretariat explained to the GAC that retaining women who start ART during pregnancy has been a significant challenge for the program and that the program will

focus on solutions, including expansion of pioneering community adherence support groups for these women to continue ART. GAC partners expressed further concern that as the focus on treatment has increased, the relative focus on prevention, particularly for adolescent girls and young women, requires a continued and equal attention and called for rethinking approaches to reduce new infections. The GAC was informed that specific service packages for women aged 15 to 19 and 20 to 49 have been developed and are being implemented in 60 districts across the country, with another program being developed with partners for girls aged 10 to 14. GAC partners acknowledged the potential benefits of the expansion of the HIV program on declining TB prevalence and highlighted the need for additional capacity for TB screening among patients on ART. The Secretariat acknowledged the work that still needs to be done to improve the efficiency of TB programming and highlighted that GeneXpert machine capacity is increasing to 54, including 17 from the Global Fund. GAC partners also noted the importance and benefits of coordination between partners in the areas of procurement and supply chain management as well as health management information systems, welcoming the development of a stronger RSSH programming in the upcoming allocation period. Lastly, the GAC and partners highlighted the risks posed by the current fiscal crisis, acknowledging that a united emphasis from partners to help the country address its situation is critical.

**Tanzania HIV Shortened Grant: The Ministry of Finance (TZA-H-MOF)**

1.71 Rationale for costed extension. The GAC recommends for Board approval the extension of the Tanzania HIV shortened grant to continue implementation through 31 December 2017, and to sustain the scope and scale of essential services in HIV treatment in 2017.

1.72 Background of the shortened grant duration. Under GF/B32/EDP15, the grant for the Tanzania HIV program with Ministry of Finance and Planning as the Principal Recipient was exceptionally authorized to have a shortened grant until 31 December 2016 for TZA-H-MOF. The Tanzania joint TB/HIV concept note was submitted to the TRP in November 2014. The GAC endorsed the TRP recommendations and approved US$78,608,549 of incentive funding in addition to the allocation amount for the HIV component. The remaining funding gap identified by the country, Global Fund and partners in 2017, based on the programmatic assumptions agreed by the TRP and GAC, was estimated at US$157,630,560 to maintain the scope and scale of Global Fund contributions to essential HIV/AIDS services for the continuity of essential HIV services ~~for 656,794 patients on ARV treatment at the start of the grant in July 2015.~~. The GAC requested the Secretariat to actively monitor implementation and to proactively reprogram any identified savings towards funding essential services during the period of grant extension, where appropriate, before further scale-up of programs in 2017. In this regard, as of May 2016, total savings of US$36,921,444 were identified through unit cost reductions in HIV commodities while further savings of US$11,381,305 were realized for reinvestment within the disease program from the procurement of ARVs and HIV rapid diagnostic tests through the Pooled Procurement Mechanism. The remaining 2017 funding gap is therefore further reduced to US$109,078,557. This gap 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 in addition to grant savings. The additional funds, as well as the reinvestment of efficiencies within the grants, would reduce the remaining unfunded quality demand to US$307,125,310 million.

1.73 Strategic focus of the program. Tanzania has a generalized HIV epidemic with concentrated epidemics among key populations of men who have sex with men, and female sex workers and their clients. HIV prevalence in Tanzania has stabilized within the adult population at around 5.1 percent and the country has an estimated 1.4 million people living with HIV. Key populations are more likely to encounter social prejudice, stigma, discrimination, denial of their existence and criminalization. The strategic focus of this extension is to maintain the scope and scale of the Global Fund contributions to essential HIV/AIDS services ~~for the 656,794 people on ART at the start of the grant in July 2015~~ through December 2017, taking into account the funding needed in 2016 to implement a change in maximum stock levels from 12 to 15 months and the increase in the proportion of patients shifted from AZT-based regimen to Tenofovir-based regimen. The change in treatment guidelines from CD4 350 to CD4 500 eligibility for ART in January 2016, as well as adoption of the test and start strategy planned for October 2016, have attracted funding contributions from the government and other partners, to fill the programmatic gap in increasing number of patients on ARV treatment.

1.74 Operational issues, risks and implementation challenges. To effectively address the risks faced by the Tanzania HIV program, including the potential for ART disruption; procurement and supply chain management, distribution and storage challenges; and the internal control environment, the following steps have been taken:

- Short-term measures to address the risk of ART disruption include additional funding contributions by the Global Fund and US government, as well as continued dialogue with the Global Fund, the Government of Tanzania and other key partners to identify additional resources to cover the full funding gap.
- Mitigation actions to address issues with procurement and supply chain management include implementation of reforms for the Medical Stores Department and an action plan for the Ministry of Health, Community Development, Gender, Elderly and Children.
- To address the inadequate internal control environment that increases the likelihood of fraud, corruption or theft of assets, a financial development capacity building project is well underway; it aims to enhance the Principal Recipient's oversight function, facilitate improvements in internal controls and foster continued engagement with the Auditor General to ensure more effective audit execution and reporting. In addition, the applicant will move forward with the Agreed Management Actions resulting from the 2015 Audit, as detailed in the paragraph below.

1.75 Audit by the Office of the Investigator General (OIG). In 2015, the OIG undertook a risk-based audit of four active Global Fund grants in Tanzania, assessing the adequacy and effectiveness of implementation arrangements and efficient use of grant funds, access to quality assured health products, and accurate and timely submission of data to support the decision making process. The report (GF-OIG-16-002) was released on 8 February 2016 and six agreed management actions were raised, covering inadequate financial and fiduciary controls, supply chain challenges, treatment scale-up and health system strengthening. The Secretariat is committed to continuing active engagement with all levels of partnership to ensure full compliance in addressing the agreed management actions within the given timeframes. Additionally, the report identified potentially ineligible costs of US$0.6 million and potentially unsupported amounts of US$9.3 million, of which US$8.7 million relating to Medical Stores Department (MSD) have been referred to the OIG investigations. In agreement with the OIG, the Secretariat will continue to work with the Local Fund Agent for expenditure verification to determine the recoverable amounts. Should these allegations be substantiated, the Secretariat will pursue full recovery of these funds.

1.76 Progress on key issues raised by the TRP, GAC and Board. In its review of the Tanzania HIV program, the TRP, GAC and Board raised several concerns that were addressed by the applicant:

- Resource mobilization and sustainability: The budget for health in fiscal year 2016 to 2017 increased, as did the AIDS Trust Fund, and a workshop on investing for health was held for parliamentarians and civil society to better understand health financing. The program will continue to include support for timely and accurate reporting of government expenditures.
- Strengthen interoperability of HIV and TB data systems: The TB grant has been awarded Special Initiative funding to support the purchase and implementation of a TB electronic record and reporting system.
- Key populations and community system strengthening: Size estimation and mapping of key populations, supported both by Global Fund Special Initiative funding and USAID, currently underway, will inform the key population targets.

1.77 Domestic contributions. Domestic financing commitments for HIV, TB, Malaria, and HSS in the 2015 to 2017 allocation period total US$478 million, reflecting an additional investment of US$110 million compared to the 2012 to 2014 funding period. The allocation to the Ministry of Health from domestic resources has increased by 39 percent in the 2016 to 2017 fiscal year, on account of a 372 percent increase in domestic allocation to the development budget for procurement of ARVs and HIV commodities, infrastructure development, and procurement and supply chain management. In addition, a number of initiatives are underway to diversify and expand the sources of funding in order to ensure sustainable financing of the health sector and to reduce dependence on donors, including a donor resource mapping project to support timely and accurate reporting of government expenditure and donor landscape and extensive discussions between the Secretariat, Ministries of Health and Finance, the Prime Minister's Office, development partners, parliamentarians, and civil society representatives. The AIDS Trust Fund Bill

was passed in 2015 resulting in a moderate increase in funding in the 2016-2017 fiscal year and the government is in the process of establishing the National Social Health Insurance.

1.78 GAC review and recommendations. The GAC and partners acknowledged the progress of the Tanzania HIV program so far in adopting new treatment eligibility criteria in line with normative guidance. While acknowledging the programmatic gaps associated with moving towards test and start, as well as savings from the reduction in unit costs for ART, the GAC ~~agreed upon the importance~~in Executive session recommended total incremental funding for Board approval of ~~maintaining the scope and scale of Global Fund contributions to the Tanzania HIV program in line with patient numbers previously agreed by GAC,~~US$ 109,078,557 noting that ~~any~~ further ~~scale-up before the next allocation period would~~ increase in Global Fund liabilities in the ~~next~~current allocation ~~and~~period could threaten the sustainability of future Global Fund contributions to the program during the 2017-2019 allocation period. However, GAC also recognized that additional efficiencies may be found during grant implementation through reduced costs for commodities, improved procurement and supply chain mechanisms and adoption of new service delivery models for ART which continue to bring down the overall unit cost for ART and allow for an increase of ART patient targets. In this regard, GAC encouraged the reprogramming / reinvestment of any efficiencies found during grant implementation as appropriate to support the ~~program.~~country towards the goal of reaching the 90-90-90 targets by 2020. GAC partners stressed the importance of ensuring programmatic quality and ~~ensuring~~ adherence ~~/~~ /maintaining the number of people on treatment as the HIV treatment program expands. GAC partners noted efforts to strengthen the TB program at the community level and encouraged the country to take a similar approach to HIV programming. In particular, GAC partners highlighted the opportunity to examine how treatment and viral load monitoring work together as a package, with a focus on treatment quality as well as prevention and community-level programming. The GAC and partners also highlighted the Government of Tanzania's substantial commitments to HIV commodities in the domestic health budget, and encouraged strong collaboration among all stakeholders to ensure focus on quality service delivery and data for decision-making. In this regard, GAC supports the plan for dialogue between the Government of Tanzania, development and technical partners, and the Global Fund to further discuss and agree on ART targets and explore opportunities to optimize investments so that available resources can be used to increase the program coverage within the approved funding envelope.

**Uganda Malaria Shortened Grants: The AIDS Support Organisation (UGA-M-TASO) and the Ministry of Finance, Planning and Economic Development (UGA-M-MoFPED)**

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

1.80 Background of the shortened grant duration. Under GF/B32/EDP01, the grant for the Uganda malaria program was exceptionally authorized to have a shortened grant duration until 31 December 2016 for UGA-M-TASO and UGA-M-MOFPED. The Uganda malaria concept note was submitted to the TRP in window 1 in June 2014 and was considered technically sound and strategically focused by the TRP. The GAC endorsed the TRP recommendations and approved US$27,426,867 of incentive funding to cover 50 percent of the LLIN mass campaign needs in addition to the allocation amount for the malaria component. As the original concept note did not cover the full three year implementation period, the GAC further recommended that the Secretariat work with the CCM to identify an appropriate approach for the country to present an above allocation request for 2017. During grant-making, the Secretariat worked with the country and partners to quantify resource needs to cover essential services activities in 2017. As part of the GAC recommendation to the Board, the GAC confirmed that the funding gap of US$42,238,483 for medicines, commodities and essential services would be considered in line with the shortened grant. The GAC requested the Secretariat to actively monitor implementation and to proactively reprogram any identified savings towards funding essential services during the implementation period. The remaining 2017 funding gap as of May 2016 has been identified as US$39,383,304. This gap 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 would reduce the remaining unfunded quality demand to US$41,124,714.

1.81 Strategic focus of the Uganda malaria program. Malaria is highly endemic in Uganda with approximately 90 percent of the population at risk. In particular, populations at risk include internally displaced persons and refugees concentrated in the northern part of the country, as well as nomads and difficult-to-reach populations. Malaria is a leading cause of morbidity and mortality in the country, accounting for approximately 30 to 50 percent of outpatient visits at health facilities, 15 to 20 percent of hospital admissions, and up to 20 percent of all hospital deaths. In 2013, 13.5 million suspected malaria cases including 10.3 million presumed and confirmed cases were reported, the largest number reported from an African country. This costed extension will allow the Uganda malaria program to maintain the scope and scale of Global Fund contributions to medicines, commodities and essential services through December 2017. It will primarily accommodate the 2017 essential commodity needs with 85 percent of the requested budget allocated for medicines and other health products and related procurement and supply chain management costs. The extension will contribute to universal coverage of at-risk populations through distribution of 24 million LLINs, including 12.3 million from the Global Fund, during the 2016 to 2017 mass campaign and contribute to achieving the national goal of at least 90 percent of malaria cases in the public and private sectors and community level receiving prompt treatment by 2018. In addition, the requested amount will also help replenish commodities that were depleted in order to help address the unforeseen malaria outbreak in the Northern districts, which may have been triggered by the discontinuation of indoor residual spraying in 2014. In 2016, one round of IRS will be conducted in ten most affected districts as an emergency response to malaria resurgence, in addition to supportive interventions including strengthening HR, distribution of LLINs, increased supply of malaria commodities, and strengthening community case management.

1.82 Operational issues, risks and implementation challenges. There are two key financial risks which include fraud risk, explained by the country's position in the International Transparency Index. This is being addressed by strengthening the integrity and controls within the sub-recipients through enhanced internal controls. The other source of risk is the delayed retirement of advances, which restricts the programs' cash flow for implementation. This also makes the advances susceptible to misuse. This risk is being addressed through the implementation of the re-imbursement agreement with the Principal Recipients related to ineligible expenditures, and the heavy commoditization of the grants. Recent reports in 2016 indicate a malaria outbreak with reported cases already higher than the corresponding period in 2015. This situation would require additional funding to supply life-saving commodities to address the upsurge. Since the current allocation was based on quantification carried out before the 2015 outbreak, there is a risk of treatment disruption due to inadequate funding to address the upsurges. The Secretariat is engaging the Government and Partners on how to best respond to the current outbreak, including mobilization of additional resources from all stakeholders.

1.83 Audit by the Office of the Investigator General (OIG). In November 2015, the OIG undertook a risk-based audit of the Global Fund grants in the Uganda in addition to following up on the previous audit. The report (GF-OIG-16-005) was released on 26 February 2016 and resulted in six agreed management actions covering challenges in financial accountability, supply chain management, and data availability. The reporting timelines for each action will be met as the Secretariat is already engaging with the Principal Recipient and implementation partners to agree on the broader objectives and processes to address the recommendations of the OIG. Of the US$28.18 million identified by the OIG report in unexplained variances in quantities of commodities, US$21.4 million from national medical stores was referred for investigation the scope of which includes assessment of potential variances due to data quality and capacity issues. Should the investigation confirm any recoverable losses, the Secretariat will pursue full recovery of these funds.

1.84 Progress on key issues raised by the TRP, GAC and Board. In its review of the Uganda malaria program, the TRP, GAC and Board raised several concerns that were addressed by the applicant:

- Reprioritization of interventions: Funding for integrated community case management, facility-based artemesinin-combined therapy and rapid diagnostic tests for the public, private not-for-profit and private sectors, and injection artesunate were prioritized in the program prior to implementation.
- Regular updates on actions taken to ensure and monitor internal controls for fiduciary accountability: The CCM provides updates to the Secretariat on a six-month basis on actions being taken to address matters.

- Optimization of resources allocated to case management and monitoring of implementation of integrated community case management: Integrated community case management interventions are being implemented in a staggered manner over the course of grant implementation, in alignment with UNICEF, DFID, PMI and the Malaria Consortium, to avoid duplication.

1.85 Domestic contributions. Domestic financing commitments for HIV, TB, Malaria, and HSS in the 2015 to 2017 allocation period is US$213 million, a US$34 million increase in investment compared to the 2012 to 2014 funding cycle. Domestic commitments pertain to earmarked allocations for procurement of ARVs, TB drugs and artemesinin-combined therapy; to the MOH for implementation of indoor residual spraying and counterpart contribution for coordination of Global Fund grants; and to the National AIDS Commission. The share of health in the domestically financed budget has increased from 6.6 percent in fiscal year 2014 to 2015 to 7.6 percent in 2016 to 2017. In the context of exchange rate depreciation which fueled inflation prospects and prompted monetary tightening, the 2016 to 2017 budget framework focuses on improving efficiency of health investments through implementing the health financing strategy; fast tracking establishment of the national health insurance scheme and provision of a medical credit fund for private health sector players; implementing a transparent resource allocation process; and strengthening financial and commodities tracking systems.

1.86 GAC review and recommendations. The OIG highlighted challenges to effective implementation of the Uganda malaria program and emphasized the need for the investigative process to determine whether the identified variances in stock records are recoverable amounts or due to major issues in record keeping. The GAC was informed that the Ministry of Finance of Uganda takes the allegations of fraud very seriously and is working to ensure that challenges and risks are addressed. GAC partners questioned whether improvements have been seen in the last three months and were assured that a set of activities for improved supply chain management have been agreed with all partners. The Secretariat provided further assurance that the slow rate of disbursements is mostly an artefact of the system of chargebacks on the PPM mechanism, which are realized slowly, and that rates of absorption are over 80 percent where the expenditure on commodities is considered. GAC partners noted that collaboration with the Secretariat is very strong, ensuring that planning, programming and responding to challenges is aligned, particularly in working with partners to fill key gaps to maintain the scope and scale of the malaria program. GAC partners emphasized the seriousness of the current outbreak in the Northern region, which was not predicted when the amount for unfunded quality demand was registered and exemplifies the need for efforts to track programmatic and financial gaps on an ongoing basis. The GAC assured partners that the Secretariat would follow up on the validation of unfunded quality demand to address emerging needs. GAC partners further highlighted the need to consider malaria quantification challenges as part of a broader health systems issue, demanding gradual rather than sudden change. The GAC commended the health workforce training program for diagnostics in febrile children and suggested that integrated community case management be rapidly spread to all districts for increased impact for populations living far from health services. The GAC further emphasized the need for shared responsibility, across the partnership, for the vector control strategy in 2017.

**Zimbabwe HIV Grant: United Nations Development Programme (ZIM-H-UNDP)**

1.87 Rationale. The GAC recommends for Board approval the additional funding and implementation period for the Zimbabwe HIV grant ZIM-H-UNDP, an Early Applicant grant, to continue grant implementation to the beginning of the next allocation period, and to sustain the level of coverage for treatment and prevention services as a bridge to transition the current program and align the portfolio to the 2017-2019 allocation period. In light of Zimbabwe's initial submission of a three-year funding request as an Early Applicant for the 2014 to 2016 allocation period, this additional funding would prevent the risk of program disruption, align with national planning systems and allow time for dialogue between the applicant and partners on transitioning from UNDP as Principal Recipient to more country-owned implementation arrangements in the next funding cycle.

1.88 Background. As an Early Applicant to the allocation-based funding model, the Zimbabwe HIV program initially presented its concept note for review by the TRP in April 2013. The TRP recommended the initial allocation amount of US$311,217,128 for funding, which was approved by the Board in 2013, in

addition to the incremental allocation amount of US$126,055,782 reviewed by the TRP in Window 3 in October 2014, which was in line with the TRP's recommended prioritization of unfunded quality demand in the original above allocation request. As an Early Applicant, the country was not able to compete for incentive funding at the time of submission of the initial concept note and therefore had the unique opportunity to submit a revised above allocation request to compete for incentive funding in Window 6 in June 2015, taking into account lessons learned after the first year of implementation. In November 2015, the Board through GF/B33/EPD27 approved US$25,274,085 of incentive funding and a private sector contribution of US$6,160,057 by the Children's Investment Fund Foundation toward the program's unfunded quality demand. In order to maintain the same level of coverage with treatment and prevention services in 2017 as at the end of December 2016, the total amount of US$179,662,360 would be needed to bridge the funding gap until the next allocation period. As of May 2016, total estimated savings of US$36,992,378 were identified for reinvestment within the current grant resulting from price reductions in the procurement of ARVs. Through optimization of use of funds within the disease component, the remaining amount required to fill the 2017 funding gap is US$142,669,982. The GAC recommended additional funding to cover the remaining gap through allocation of funds made available from portfolio optimization efforts as approved by the Finance and Operational Policy Committee in March 2016.

1.89 Strategic focus of the program. The aim of this extension is to sustain the trajectory of declining HIV infections and increased access to HIV treatment for Zimbabwe to reach the tipping point where the number of new HIV infections per year becomes less than the number of people being initiated on ART. This will be a major contribution to improving health, the economy and human capital in Zimbabwe. The interventions and activities under the extension period are in line with the existing TRP/GAC approved interventions, and no new activities have been introduced. Specifically, the goals of the Zimbabwe HIV program, revised to align with the extended implementation period, are to:

- Reduce HIV related mortality from 29,548 in 2012 to 14,960 for adults and 9,949 in 2012 to 2,674 for children by 2017;
- Reduce new HIV infections in adults aged 15 to 49 years from 1.1 percent in 2012 to 0.56 percent in 2017; and
- Reduce the percent of HIV-positive infants born to HIV-positive women from 18 percent in 2010 to 2 percent by 2017.

1.90 Performance during the 2014-2016 allocation period. The Zimbabwe HIV program has performed well during the 2014 to 2016 allocation period both programmatically and financially. The latest performance assessment in June 2015 rated the grant at a performance level of A2 with a total disbursement volume of 86 percent, with remaining funding to be reprogrammed into the 2017 budget requested in this report as well as for procurement in 2016. Zimbabwe has succeeded in rapidly scaling up ART, meeting 98 percent of its key ART target as well as 85 percent of its prevention of mother-to-child transmission target and 71 percent of the voluntary medical male circumcision target.

1.91 Audit by the Office of the Investigator General (OIG). A draft OIG audit report was shared with the Government of Zimbabwe and Principal Recipients on 24 May 2016 as part of the standard consultative process, with supporting documentation under review. In addition, the final draft report was subsequently shared with the Audit and Finance Committee (AFC) on 29 June 2016, in accordance with the OIG Disclosure Policy. Some of the issues noted in the report relate to quality of care, diagnostic capacity, financial oversight and challenges in the country's supply chain management system. A small amount (representing 0.1 percent of the total funding allocation for Zimbabwe) are under consideration as non-compliant costs. Should these initial findings be substantiated, the Secretariat will pursue full recovery of these funds.

1.92 Additional implementation challenges. Risks and challenges faced by the Zimbabwe HIV program in effective implementation and corresponding mitigation measures include:

- Funding liquidity: The current grant agreement will be amended and accompanied by an intense dialogue with the key partners including the Government of Zimbabwe and PEPFAR aimed at achieving the optimal volume and timing of funding.
- Potential supply chain disruptions and inadequate space to store health products: Technical support is underway for the procurement of an electronic logistics management information system platform and,

in coordination with partners, for the construction of a bigger warehouse for the central medical store, NatPharm. Additionally, support is provided by the Global Fund to build the capacity of NatPharm to conduct the procurement of commodities through a mentorship program, in order to transition responsibility from National AIDS Council.

1.93 Progress on key issues raised by the TRP. In its review of the Zimbabwe HIV program, the TRP raised several concerns that have been addressed by the applicant:

- Roll-out of self-testing: The Principal Recipient received a three-day training using a standardized manual and a national technical working group meets monthly with WHO to monitor the pilot. Lessons learned will be evaluated and used to refine the community-based funding model before the roll-out to other districts.
- Gender-based violence interventions for adolescent girls: In accordance with Zimbabwe's national strategic plan for AIDS (and reinforced by the gender assessment), training was provided to national, provincial and district stakeholders, including government departments, to mainstream these activities.
- Improvements in pediatric case finding and treatment: A bottleneck analysis was conducted in the 44 districts with low pediatric ART coverage and high yield potential. The findings of this analysis were used to develop district implementation plans with specific targets on HIV testing, linkage to care, and ART initiation for infants, children and adolescents.
- Linkages to and retention in care and treatment: An electronic patient monitoring system, use of peers, education through adolescent-friendly and youth centers, use of SMS and social media platforms, and provider-initiated testing and counseling have been integrated into implementation plans in order to improve linkages to and retention in care and treatment.

1.94 Domestic contributions. In April 2013 when the initial concept note for this program was submitted, government commitments for the HIV program for the 2014 to 2016 allocation was US$132 million. This financing is primarily through the "AIDS Levy", which is a 3 percent charge on individuals, companies and trusts on the amount of income tax assessed and accrues to the National AIDS Trust Fund. Funding from this levy increased significantly, from US$5.7 million in 2009 to US$38.6 million in 2014. As this increase was reflected, government commitments for the 2014 to 2016 allocation period were commensurately increased to US$145 million. The HIV program receives earmarked budget allocations from the Ministry of Health that cover ARTs as well as HIV/AIDS awareness and research funding, in addition to funding from other ministries and agencies for HIV mainstreaming. While there has been greater prioritization of health in the national budget, all economic activity is severely constrained by tight liquidity conditions resulting from limited external inflows and lower commodity prices. The persistent large current account deficits, exacerbated by a sharp appreciation of the U.S. dollar, have worsened Zimbabwe's external position and competitiveness. Unemployment is rising, and employment has been shifting to the informal sector, impacting AIDS Levy collections.

1.95 TRP review and recommendations. As part of the bridge mechanism, the TRP and GAC agreed that a remote TRP check-in would be needed for identified Early Applicants, including those whose 2017 transitional costed extension requests exceeds the threshold of US$50m. Overall, the TRP considers this request for a costed extension to be technically sound and strategically focused as it is in line with the objective of maintaining the existing scope and scale of interventions that protect the gains achieved, save lives and are high impact, and represent good value for money. The TRP confirmed its satisfaction with the current progress and believes the requested costed extension will contribute to further reductions in the impact of HIV and AIDS in Zimbabwe. The TRP identified a number of issues and made recommendations that the country should consider during the extension and in the next funding allocation period, related to maintaining adequate levels of condom procurement and promotion as well as the need for a comprehensive condom assessment and routine monitoring to assess service access and utilization; expansion and evaluation of community-based interventions for hard-to-reach adolescents; and implementation of programs for key populations including programs for men who have sex with men, people who inject drugs, and prisoners, as well as work with the government and partners to ensure that support for the nationwide sex worker program is maintained.

1.96 GAC review and recommendations. The GAC commended the Zimbabwe HIV program for its impressive performance during the 2014-2016 allocation cycle. GAC partners noted that the program is grounded in a strong prevention component and is a model for sustainable scale up, with notable efforts towards patient retention and plans to increase its focus on sustainability in the next allocation period, noting the success so far of the government's AIDS Trust Fund. GAC partners also acknowledged work in the country to monitor decreasing incidence in the general population as well as in key populations. GAC partners highlighted the need for district level monitoring and evaluation systems to monitor adherence and track patients over time, as well as the need to strengthen TB testing among HIV patients. The GAC was informed that Zimbabwe has a strong program of differentiated care and will be working with partners to launch different packages for supporting differentiation of care in prevention and key population programs. GAC partners encouraged the country to revisit targets throughout implementation in order to align them with the latest data on treatment enrollment. Though GAC partners commended the AIDS Levy, concerns were expressed regarding its future ability to contribute as a result of the current strain on the economy and the Secretariat was encouraged to closely monitor this situation. Lastly, in reference to the OIG audit, the program was encouraged to continue investigating ways to improve the laboratory system in Zimbabwe.

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

**Mali HIV Grant: Plan International (MAL-813-G11-H)**

1.97 Rationale for extension. The GAC recommends for Board approval an increase of €1,456,215 to the budget amount of the current Mali HIV grant MAL-813-G11-H, from the 2014 to 2016 HIV allocation.

1.98 Background. The MAL-813-G11-H grant in Mali, managed by Plan International, started on 1 November 2013 and will end on 31 October 2016. The focus of this grant is the provision of HIV prevention and treatment services for key populations, in particular for sex workers, their clients, and men who have sex with men. The MAL-813-G11-H grant is part of a dual-track funding arrangement, where a second HIV grant managed by UNDP covers ART, prevention of mother-to-child transmission services and TB/HIV services. While the MAL-H-UNDP grant has been approved by the Board in December 2015 (GF/B34/EDP02) and signed, the grant under the allocation-based funding model to be implemented by Plan is currently in grant-making. Prior to the signature of MAL-H-UNDP, the Secretariat transferred all existing and unused Board-approved funds, currently committed to grants that have ended or will end shortly, to the MAL-H-UNDP to facilitate internal financial reporting, in particular for expenditure tracking and absorption analysis, and to facilitate the closure of older grants. Part of this exercise included the de-commitment of some of the existing funding on the MAL-813-G11-H grant that was expected to remain unspent before the end of the grant due to delays in the implementation. However, after this transfer was completed, the Secretariat discovered that the cash balance previously communicated by the Principal Recipient was incorrect and overestimated due to an error made by the bank and that long-standing Pooled Procurement Mechanism commitments for HIV commodities had not been taken into account in the calculations for the de-commitment. As a consequence, the funds left on the MAL-813-G11-H grant following the de-commitment are insufficient to cover the programmatic needs until the start of the Plan grant under the allocation-based funding model. In order to rectify this situation, it is proposed that €1,456,215.24 from the HIV allocation funding be re-committed to the current MAL-813-G11-H grant to cover programmatic needs until the start of the new grant in October 2016.

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

### Table 5: Grant Extensions Approved by the Secretariat

| N | Applicant | Disease Component | Grant Name | Currency | Period of Extension (Months) | Additional Funding |
|---|---|---|---|---|---|---|
| 1 | Honduras | HIV | HND-H-CHF | US$ | 3 | 0 |
| 2 | Uzbekistan | TB | UZB-809-G05-T | US$ | 1 | 0 |