Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B36/ER04
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B36/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B36/EDP05: Decision on the Secretariat's Recommendation on Financing Unfunded Quality Demand from the 2014 – 2016 Allocation Period[2]

[1] Algeria HIV, APH Ukraine TB/HIV, APN+ HIV, Bolivia TB, EMMIE malaria (Early Applicant), ITPC HIV, Myanmar malaria (Early Applicant), MOSASWA malaria, Myanmar TB/HIV (Early Applicant), Nigeria HIV (state-level grant), RAI malaria (Early Applicant), Solomon Islands TB (reinvestment of savings), Zimbabwe malaria (Shortened grant). Total incremental amount is US$ 161,759,736 and €3,631,309.

[2]. Bangladesh TB, Central African Republic TB/HIV, Myanmar TB, Philippines TB, Viet Nam TB. Total incremental amount is US$17,401,992 and €4,325,121.

I. Decision Points

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

1.1 Set forth below is the Secretariat's recommendation to approve additional funding up to an amount of US$ 179,161,728 and € 7,956,430.

Decision Point: GF/B36/EDP04: 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 Tables 1a, 1b and 1c of Section IV to GF/B36/ER04 ("Table 1a", "Table 1b" and "Table 1c");*

2. *Notes the incremental funding approved for APN+, as set forth in Table 1c, is conditioned on the fulfilment of certain time-bound requirements, as described in GF/B36/ER04, and that the Secretariat will inform the Board of the final grant outcome following the relevant deadlines outlined in GF/B36/ER04.*

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

4. *Approves the reinvestment of within-allocation efficiencies for the Solomon Islands TB and South Africa TB/HIV grants and their resultant total program budget, as listed in Table 2 of Section IV to GF/B36/ER04;*

5. *Acknowledges the original grant duration, as expressed by either the implementation or budgeted period, of each country disease component and its constituent grants listed in Table 3 of Section IV ("Table 3") is shortened according to the operational flexibility granted to the Secretariat pursuant to GF/B31/DP09;*

6. *Approves the additional incremental funding and/or implementation period recommended for (a) Iraq TB and (b) Zimbabwe malaria, and each component's constituent grants, as listed in Table 3, based on the available funding that the Finance and Operational Performance Committee (the "FOPC") validated pursuant to GF/FOPC17/DP02;*

7. *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 30 June 2017 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;*

8. *Approves the additional incremental funding and implementation period recommended for disease components (i) EMMIE malaria, (ii) Myanmar malaria, (iii) Myanmar TB/HIV and (iv) RAI malaria, being Early Applicant grants, as listed in Table 3, based on the available funding that the FOPC validated pursuant to GF/FOPC17/DP02;*

9. *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 (or, as the case may be, regional) disease component's constituent grants,*

(b) is subject to the availability of funding, and (c) shall be committed in annual tranches; and

10. *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 additional funding for the unfunded quality demand of certain country disease components.

Decision Point: GF/B36/EDP05: Decision on the Secretariat's Recommendation on Financing Unfunded Quality Demand from the 2014 – 2016 Allocation Period

The Board:

1. *Notes the Secretariat's review of the items on the 2014 – 2016 allocation period's unfunded quality demand ("UQD") register, as described GF/B36/ER04;*

2. *Approves the additional incremental funding recommended for certain UQD of the following country disease components: (i) Bangladesh TB, (ii) Central African Republic TB/HIV, (iii) Myanmar TB, (iv) Philippines TB, and (v) Viet Nam TB, as listed in Table 4 of Section IV to GF/B36/ER04, based on the available funding that the FOPC validated pursuant to GF/FOPC17/DP02;*

3. *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*

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

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

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]
B28/EDP/24: Decision on the Secretariat's Funding Recommendations for Early Applicants	This decision point refers to the funding recommendation with regards to the Myanmar Malaria program approved by the Board on 7 June 2013.
B28/EDP/24: Decision on the Secretariat's Funding Recommendations for Early Applicants	This decision point refers to the funding recommendation with regards to the Myanmar HIV program approved by the Board on 7 June 2013.
B28/EDP/24 and GF/B32/EDP01: Decision on the Secretariat's Funding Recommendations for Early Applicants	This decision point refers to the funding recommendation with regards to the Myanmar TB program approved by the Board on 7 June 2013 and 8 December 2014, respectively.
GF/B30/EDP07: Decision on the Secretariat's Funding Recommendations for Early Applicants	The decision point refers to the funding recommendation with regards to the EMMIE malaria program approved by the Board on 28 Feb 2014.
GF/B30/EDP07, GF/B32/EDP05, and GF/B35/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 Philippines TB program approved by the Board on 5 March 2014, 16 January 2015 and 25 August 2016.

[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] As approved by the FOPC in March 2016, which was the final meeting of the FOPC before the Audit and Finance Committee took over the FOPC's mandate in the new committee structure approved by the Board in January 2016.

Relevant Past Decision Point	Summary and Impact
GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period[5]	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.[6]
GF/B31/DP12: Extension Policy under the New Funding Model[7]	This decision point establishes the current policy, based on which the extensions described in this report are granted and reported by the Secretariat or otherwise recommended to the Board for approval.
GF/B32/EDP01 : Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation	The decision point refers to the funding recommendation with regards to the Zimbabwe malaria program approved by the Board on 8 December 2014.
GF/B32/EDP05 and GF/B34/EDP06: 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 Bangladesh TB program approved by the Board on 16 January 2015 and 18 January 2016, respectively.
GF/B33/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 Iraq TB program approved by the Board on 15 May 2015.
GF/B33/EDP04; Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation	The decision point refers to the funding recommendation with regards to the Viet Nam TB/HIV program approved by the Board on 5 June 2015.
GF/B33/EDP29: Decision on the Secretariat's Recommendation on Policy Exceptions for Processing HIV and TB Funding Applications from Certain Countries in the Middle East Region.	This decision point granted policy exceptions for processing HIV and TB funding applications from these countries to access relevant 2014-2016 funding allocations: (i) waiver of the CCM eligibility requirements; (ii) waiver of the counterpart financing requirement; and (iii) waiver of the "willingness-to-pay" requirement.
GF/B34/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 Nigeria TB/HIV program approved by the Board on 7 December 2015.
GF/B35/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 Central African Republic TB/HIV program approved by the Board on 24 August 2016.

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

[6] 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."

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

III. Action Required

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

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

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

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

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

N	Country	Disease Component	Proposed Principal Recipient (Grant Name)	Currency	Grant end Date	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	Algeria	HIV/AIDS	DZA-H-MOH	US$	31-Dec-19	6,533,577	0	6,533,577	6,533,577	n/a	0	111.8 million
2	Bolivia	TB	BOL-T-UNDP	US$	31-Dec-19	10,710,756	41,775	10,668,981	10,668,981	n/a	1,726,520	21 million
3	Nigeria	HIV/AIDS	NGA-H-LSMOH	US$	31-Dec-17	9,623,390	9,623,390[8]	0	0	0	127,285,250	310.1 million

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

N	Applicant	Disease Component	Proposed Principal Recipient (Grant Name)	Currency	Grant end Date	Total Program Budget	Sources			Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
							Existing Funding	Source of Recommended Incremental Funding	Recommended Incremental Funding				
1	Alliance for Public Health Ukraine	TB/HIV	QMZ-C-APH	US$	31-Dec-19	3,900,000	0	2014-2016 funding for regional applications	3,900,000	3,900,000	0	0	n/a
2	ITPC-West Africa	HIV/AIDS	QPF-H-ITPC	€[9]	31-Dec-19	3,631,309	0	2014-2016 funding for regional applications	3,631,309	3,631,309	0	0	n/a
3	MOSASWA Cross-border Initiative	Malaria	QPA-M-LSDI	US$	31-Dec-19	9,780,000	0	2014-2016 funding for regional applications	5,780,000	9,780,000	0	0	n/a
								Private Sector Donor/ Goodbye Malaria	4,000,000				

[8] Represents reprogramming of existing funds to be transferred from NGA-H-NACA grant and does not increase the total program budget previously approved by the Board for Nigeria TB/HIV (GF/B34/EDP01)

[9] While the concept note submission and TRP and GAC recommendations were made in US$, during grant-making the Secretariat approved revision of the grant currency to EUR.

Table 1c: Secretariat's Funding Recommendation on 'Conditional-Go' for Additional Funding from the 2014 Allocation for APN+ regional grant

N	Applicant	Disease Component	Proposed Principal Recipient (Grant Name)	Currency	GAC 1 Approved Upper-ceiling for Grant-making	Total Program Budget Upper-Ceiling for Board Approval[10]
1	Asian Pacific Network of People Living with HIV/AIDS (APN+)	HIV/AIDS	QSA-H-APN+	US$	3,576,375	3,576,375

Table 2: Secretariat's Funding Recommendation on Reinvestment of within-allocation Efficiencies for Previously-Approved Programs

N	Applicant	Disease Component	Grant Name	Currency	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	Solomon Islands	TB	SLB-T-MHMS	US$	2,758,339	2,974,126	0	215,787	705,660	0	0	HIV: 1,883,417
2	South Africa	TB/HIV	ZAF-C-NDOH	US$	129,283,633	131,126,062	59,617,457	1,842,429	69,666,176	0	0	22,346,213
			ZAF-C-NACOSA		44,988,165	47,926,551[11]	15,113,950	1,288,764	29,874,215	0		

[10] Funding approval is subject to the fulfilment of the conditions set forth in the APN+ grant summary of this report to the Board.
[11] The revised budget reflects the original approved budget amount of US$44,988,165, the signed budget amount of US$43,478,862, the reinvestment of savings of US$1,288,764, and the private sector investment of $3,158,925 recommended by the GAC for Board approval.

Table 3: 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	EMMIE	Malaria	QMG-M-PSI	US$	6	3,200,000[12]	3,867,092	0	0	3,200,000	667,092	667,092	234,716
2	Iraq	TB	IRQ-T-IOM	US$	12[13]	n/a	3,000,000[14]	n/a	0	n/a	3,000,000	3,000,000	n/a
3	Myanmar[15]	Malaria	MYN-M-SCF	US$	12	21,150,079	7,299,581	0	0	21,150,079	5,816,690	30,909,562	35,957,006
			MYN-M-UNOPS		12	51,204,446	31,143,725	0	0	51,204,446	25,092,872		
4		TB/HIV	MYN-H-SCF	US$	12	84,880,620	28,990,083	0	0	84,880,620	25,829,728	68,979,955	12,026,732
			MYN-H-UNOPS		12	76,319,380	42,019,429	0	0	76,319,380	26,329,534		
			MYN-T-SCF		12	18,510,311	7,467,722	14,187,228	0	4,727,000	5,523,157[16]		
			MYN-T-UNOPS		12	89,880,006	46,725,865	66,760,776	0	13,873,000	16,408,019[17]		
5	Regional Artemisinin Initiative (RAI)[18]	Malaria	QMU-M-UNOPS	US$	12	100,000,000	35,762,420	0	0	100,000,000	15,540,864	15,540,864	0
6	Zimbabwe	Malaria	ZWE-M-MOHCC	US$	6	59,460,076	67,663,406	0	0	59,460,076	8,203,330	8,203,330	5,513,563

[12] The Board approved a total program budget of US$10,000,000, of which US$3,200,000 was signed with PSI, while the remaining amount is held for cash on delivery, to be paid directly to countries subject to verification of results achieved.
[13] Figures presented for the Iraq TB request for additional funding correspond to a one-year grant from 1 January 2017 to 31 December 2017 only, as the grant is exceptionally structured as a new one-year implementation period rather than a standard extension, due to the proposed change in PR.
[14] Represents upper-ceiling budget, to be finalized and notified to the Board upon signature of the grant agreement.
[15] Figures presented for the Myanmar Malaria and TB/HIV requests for additional funding and revised UQD correspond to the 2017 year only, as the grants are exceptionally structured as one-year implementation periods rather than a standard extensions. Additionally, the amounts presented as previously approved grant budgets for Myanmar Malaria and HIV reflect only the incremental funding request and do not include remaining cash balance and undisbursed funds, in line with the practice at the time of Board approval (GF/B28/ER18-Revision1).
[16] Additional funding recommended to finance UQD for Myanmar TB of US$5,110,483 has been integrated in part into the MYN-T-SCF budget, as part of the 2017 Myanmar TB/HIV Early Applicant transitional funding request.
[17] Additional funding recommended to finance UQD for Myanmar TB of US$5,110,483 has been integrated in part into the MYN-T-UNOPS budget, as part of the 2017 Myanmar TB/HIV Early Applicant transitional funding request.
[18] Figures presented for the RAI malaria request for additional funding correspond to the 2017 year only, as the grant is exceptionally structured as a one-year implementation period rather than a standard extension.

Table 4: Secretariat's Recommendation on Financing Unfunded Quality Demand

N	Applicant	Disease Component	Grant Name	Currency	Previously Approved Grant Budget	Revised Budget for Board Approval	Source of Recommended Additional Funding	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	Bangladesh	TB	BGD-T-BRAC	US$	44,336,544	46,386,647[19]	Portfolio Optimization and Private Sector Contribution	8,450,796	0	35,885,748	1,859,567	3,999,999	19,210,000
			BGD-T-NTP		36,367,177	38,605,858[20]		6,037,096	0	23,923,904	2,140,432		
2	Central African Republic	TB/HIV	CAF-C-IFRC	€	16,050,093	20,375,214	Portfolio Optimization	5,115,291	0	10,934,802	4,325,121	4,325,121	0
3	Philippines	TB	PHL-T-PBSP	US$	115,562,488[21]	120,853,998	Portfolio Optimization	77,536,167	0	38,026,321	5,291,510	5,291,510	0
4	Viet Nam	TB	VNM-T-NTP	US$	39,439,638	42,757,599[22]	Portfolio Optimization	16,315,143	0	23,124,495	3,000,000	3,000,000	36,848,472
5	Myanmar	TB	MYN-T-SCF	US$	See Table 3.		Portfolio Optimization	See Table 3.			5,110,483[23]	5,110,483	See Table 3.
			MYN-T-UNOPS										

[19] Reflects the revised Board approved budget of US$44,336,544 incorporating reinvestment of savings (GF/B34/ER05), previously signed special initiative funding of US$190,536, and the additional incremental funding amount of US$1,859,567.
[20] Reflects the revised Board approved budget of US$36,367,177 incorporating reinvestment of savings (GF/B34/ER05), previously signed special initiative funding of US$98,249, and the additional incremental funding amount of US$2,140,432.
[21] Reflects program budget amount of US$115,562,488 whereas GF/B35/ER11 made reference to the signed grant amount of US$108,440,114
[22] Reflects the original Board Approved budget of US$39,439,638, the revised approved budget amount of US$39,757,599 incorporating the previously signed special initiative funding of US$323,143, and the additional incremental funding amount of US$3,000,000.
[23] See rows 3 and 4 of Table 3. Additional funding recommended to finance UQD for Myanmar TB of US$5,110,483 has been integrated into the total program budgets for MYN-T-SCF and MYN-T-UNOPS as part of the overall 2017 Myanmar TB/HIV Early Applicant funding request.

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

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

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

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

Each applicant has met the counterpart financing requirements as set forth by the Eligibility and Counterpart Financing Policy. Domestic commitments for disease-specific and health-related spending are subject to local currency value fluctuations against US dollars and Euro.

Algeria HIV grant: The Ministry of Health, Population and Hospital Reform of the Government of the People's Democratic Republic of Algeria (DZA-H-MOH)

1.1 The strategic focus of the program. This is the first Global Fund grant in Algeria since the closure of the Algeria HIV grant in 2008. The HIV epidemic in Algeria is characterized as low, with a prevalence rate below 0.1 percent in the general population, but concentrated in key populations. There are wide data gaps but prevalence in 2014 was estimated at 5.1 percent for sex workers, 6.8 percent for men who have sex with men, and 1.1 percent for people who inject drugs. The program focuses on these most-at-risk groups, as well as vulnerable populations such as people in prisons and mobile populations. The program aims to strengthen community stakeholders in order to mobilize funding and conduct fundraising activities to ensure sustainability of the activities following transition. Context-specific strategies to achieve these goals include:

- Making use of national health care facilities to extend the geographic coverage of HIV testing adapted to suit the needs of the different target groups;
- Developing actions that target prevention and reduction of the risk of sexually transmitted infections and HIV; and
- Developing a system for referring HIV-positive people between referral centers and health care facilities.

Planned achievements of the proposed programming include:

- Increasing the percentage of people living with HIV who have commenced ART with an undetectable viral load after 12 months from 53 percent in 2015 to 77 percent in 2018;
- Increasing the percentage of sex workers taking a HIV test over the reporting period and who know the results from 29.5 percent in 2014 to 40 percent in 2018;
- Increasing the percentage of men who have sex with men taking a HIV test over the reporting period and who know the results from 31 percent in 2015 to 37 percent in 2018; and

- Increasing the percentage of people who inject drugs taking a HIV test over the reporting period and who know the results up to 24 percent in 2018.

1.2 Domestic contributions, transition and sustainability. Total domestic financial commitments amount to US$111,794,085, representing 95 percent of total resources available for the next implementation period. Government HIV commitments represent a 54 percent increase compared to the previous implementation period. The Secretariat will work with local authorities to seek private and domestic funding for key population interventions, prioritizing those essential services currently most reliant on external sources in order to avoid service interruption. The grant includes the development of a sustainability plan within three years. A program management unit is currently being put in place and will include staff of the Ministry of Health.

Alliance for Public Health Ukraine TB/HIV regional grant: International Charitable Foundation "Alliance for Public Health" (QMZ-C-APH)

1.3 Background. The Alliance for Public Health Ukraine initially submitted an Expression of Interest to the Global Fund in TRP Window 6 in June 2015 and was asked to submit a concept note in TRP Window 9 in March 2016. The TRP did not recommend the concept note for funding, as the concept. The GAC noted the TRP's assessment of the Alliance for Public Health Ukraine concept note, recognizing that:

- Strategies build on previous successful regional efforts;
- Linkages to various initiatives, programs and action plans with ambitious targets of international organizations (including UNAIDS 90-90-90 initiative, fast track Healthy Cities program and Zero TB Cities project);
- Proposal for a regional city platform, which is innovative and could serve as a sustainable response in cities with high burden of disease, including municipality commitment; and
- Extensive experience of the Principal Recipient with Global Fund grants.

Following a discussion between the TRP and GAC, the TRP agreed that Alliance for Public Health Ukraine be recommended to continue to grant-making. GAC partners recommended strategic refocusing of investments to develop a pilot program targeting EECA cities with highest disease burden to maximize impact on regional epidemics. Cities would be prioritized for inclusion in the regional program based on ability of municipalities to commit resources (financial or in-kind) and feasibility of effective implementation during the pilot phase. The GAC also requested the applicant to work closely with the Secretariat to address issues of sustainability and responsible transition from Global Fund resources to other sources of sustainable long-term funding, and ensure that clear outcomes and milestones and how these are monitored and evaluated is built into the program. In addition, GAC recommended investment in operational research to establish effectiveness of this pilot program and documentation of lessons learned to inform future strategic investment decisions and scale-up.

1.4 Strategic focus of program. The Eastern Europe and Central Asia region represents one of the few regions globally where there remains a continued increase in the incidence of HIV infection. A constant increase of 58 percent in AIDS mortality has been observed between 2006 and 2012. The region also accounts for 5 percent of the global TB burden, with an estimated 460,000 prevalent TB cases in 2013, and the percentage of HIV among TB cases increased from 3.4 percent in 2008 to 7.8 percent in 2013. The overall coverage of essential HIV prevention services of people who inject drugs, sex workers and men having sex with men in Bulgaria, Georgia, Kazakhstan, Moldova, and Ukraine is around 40 percent. The aim of the Alliance for Public Health Ukraine TB/HIV grant is to develop models of sustainable city responses to HIV and TB for key populations in Eastern Europe and Central Asia that significantly contribute to achieving 90-90-90 HIV/TB targets for key populations. The program will be implemented in five cities selected on the basis of disease burden, the ability of municipalities to commit resources, and the feasibility to effectively implement a pilot project: Almaty, Kazakhstan; Beltsi (Balti), Moldova; Odesa, Ukraine; Sofia, Bulgaria; and Tbilisi, Georgia. The goal is supported by the following objectives:

- To develop and implement a model to reach the '90-90-90' targets for the HIV and TB response for key populations;
- To establish effective partnerships between municipalities and nongovernmental and civil society organizations;

- To ensure sustainable commitments of municipal funding for key population programs;
- To increase knowledge management and popularize city responses on HIV and TB among municipalities in in cities of the Eastern Europe and Central Asia region and globally.

Planned achievements of the proposed programming include:
- Reducing HIV and TB related mortality by 8 and 10 percent, respectively, between 2017 and 2020; and
- Increasing the share increase of funding for TB/HIV activities targeting the key populations from the cities' health budgets by 20 percent between 2017 and 2020.

APN+ HIV grant (conditional recommendation): Asia Pacific Network of People Living with HIV (QSA-H-APN)

1.5 Recommendation by the GAC. The GAC has requested Board approval of the program budget upper-ceiling of US$3,576,375 for the APN+ regional grant conditional upon meeting certain requirements detailed in the "Rationale and Conditions" paragraph below. The Board will be duly notified of the final grant outcome following the deadlines outlined in the conditions below. This conditional recommendation will allow the applicant to complete grant-making following the deadline for Board approval of 31 December 2016 for grants in the 2014-2016 allocation period.

1.6 Background. The regional application submitted by APN+ was recommended for funding by the TRP and the GAC 1 in April 2015. This application builds on the existing APN+ grant, which ended on 30 September 2016 and submitted a six month non-costed extension request from 1 October 2016 to 31 March 2017. The rationale for the non-costed extension is to enable the continuation of current grant implementation period to support the applicant to meet the conditions identified within the specified timelines as part of the GAC recommendation for "Conditional Go", especially in relation to human resource costs of the PMU outlined in paragraph 1.8 below.

1.7 Strategic focus of the program. The program is planned for implementation in nine countries including Bangladesh, Cambodia, Indonesia, Lao, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, and Vietnam. In these countries, HIV epidemics are concentrated in key populations including men who have sex with men, transgender people and people who inject drugs. These groups face stigma, discrimination, human rights abuses, coercion and criminalization, often resulting in limited access, uptake and poor retention in care. Despite the relatively high HIV incidence amongst these key populations, there is limited evidence on which to base advocacy and programs for them. The program seeks to capitalize on the strength of regional networks that have more influence than country-level networks of the targeted key populations, which may not be well positioned to advocate on key legal and regulatory issues. The grant aims to contribute to a reduction of new HIV infections and morbidity among key affected populations, namely men who have sex with men, transgender persons, female sex workers and people who inject drugs. The strategic focus and added value of APN+ are critical in promoting a comprehensive package of services in the region and in improving treatment coverage data among key populations and people living with HIV.

1.8 Rationale and Conditions. The GAC stressed the critical importance of the APN+ regional program in promoting a comprehensive package of services and improving data on treatment coverage for men who have sex with men, transgender people and people who inject drugs in a region where the HIV epidemic is concentrated in key populations. The GAC acknowledged concerns highlighted by the Secretariat including major issues in implementation of the existing APN+ regional grant as well as challenges faced during grant-making, noting unsatisfactory grant documentation, TRP clarifications that have not been sufficiently addressed by the applicant, and concerns regarding country-level implementation arrangements and implementer capacity. The GAC recommended Board approval of the budget upper-ceiling for the APN+ grant conditional upon meeting specific requirements outlined such that if these conditions are not met by specified timelines below and to the satisfaction of the TRP and the Global Fund Secretariat, the grant will not complete grant-making, and the new grant will not be awarded or be signed.

1.9 Acknowledging the continued relevance, strategic focus and potential for impact of the APN+ grant, the GAC recommends Board approval of APN+ conditional upon meeting the following outlined actions within the timelines provided.

- A new program management unit must be hired by 15 March 2017 under the supervision of technical partners and the Global Fund Secretariat through a competitive, open and transparent process. This new program management unit must include: (i) a program manager; (ii) a monitoring and evaluation officer; and (iii) a finance officer dedicated to the grant. Additional program management unit staff may be recruited in consultation with, and upon written approval of, the Global Fund Secretariat. The scope of work of the program management unit staff must correspond to the terms of reference approved by the Global Fund Secretariat.
- The new program management unit team must complete the grant budget negotiations, including the definition of clear milestones, to the satisfaction of the Global Fund Secretariat by no later than 1 April 2017 to ensure that the program will achieve its objectives and produce good outcomes and impact.
- All issues requested for clarification by the TRP must be answered to the satisfaction of the TRP and/or the Global Fund Secretariat, as relevant, by 31 January 2017.

Bolivia (Plurinational State) TB grant: United Nations Development Program (BOL-T-UNDP)

1.10 The strategic focus of the additional investment. Bolivia has an estimated population of 10.5 million inhabitants and has the second highest TB rate in the Latin America and Caribbean region. In 2015, incidence rate for all forms of TB was estimated to be 117 per 100,000 population, with particularly high rates in urban settings. The country reported 7,893 cases in 2015 representing 60.7 percent of the WHO estimate of total cases, and the gap of undiagnosed or unreported cases constitutes one of the main challenges for the country. The drug-resistant TB situation also represents a significant challenge for TB control in Bolivia, as 79 multi-drug resistant TB (MDR-TB) cases were identified out of the 240 total estimated cases for 2015. Only 50 percent of MDR-TB cases and one of the seven extensively drug-resistant TB cases were put on treatment. The goals of the Bolivia TB program are to, by 2020, reduce the incidence of TB by 17 percent and the mortality of TB/HIV co-infection by 15 percent. Context-specific strategies include:

- Offering services for the care, case detection, diagnosis and treatment of all forms of TB;
- Strengthening care services and increasing treatment success rate of MDR-TB; and
- Ensuring the continuity of the cooperation and joint management mechanism between the TB/ HIV programs.

Planned outcomes of the proposed program include:

- Decreasing the TB mortality rate per 100,000 population from 3.1 in 2014 to 2.1 in 2019;
- Increasing the treatment success rate of all forms of TB from 80.1 percent in 2013 to 85 percent in 2019; and
- Reducing the proportion of new TB cases with Rifampicin- or multidrug-resistant TB from 2.5 percent in 2014 to 2.0 percent in 2019.

1.11 Domestic contributions. Total domestic financial commitments amount to US$21 million, representing 54 percent of total resources available for the next implementation period and a counterpart financing share of 82 percent. Domestic financing will mainly cover the needs related to the procurement of second-line drugs, hospital services for MDR-TB patients, and management of adverse reactions to anti-TB drugs.

ITPC-West Africa HIV Regional grant: International Treatment Preparedness Coalition, International Treatment Preparedness Coalition West Africa (QPF-H-ITPC)

1.12 The strategic focus of the program. HIV treatment coverage in West and Central Africa remains at 24 percent compared to 40 percent globally. In some places in the region, fewer than one in five people living with HIV have access to ART. The goal of the program is to increase access to ART for people living with HIV in the Economic Community of West African States region, with a focus on 11 priority countries including Liberia, Ghana, Cote d'Ivoire, Gambia, Senegal, Sierra Leone, Guinea, Guinea-Bissau, Togo, Benin and Mali. Planned activities include:

- Building the capacity of community organizations of people living with HIV on governance, program management, data collection and analysis, and monitoring and evaluation management for networks of people living with HIV; and
- Accelerating development and reach of community treatment observatories by people living with HIV in 11 countries using the methods piloted and demonstrated through other initiatives.

This project is expected to lead to more comprehensive data collection, validation and analysis by community members of people living with HIV at both national and West African regional levels on the:
- Number and type of ART medications available in each district
- Quality of ART delivery facilities against national treatment guidelines;
- Number of and reasons for stock-outs of ARTs and diagnostic kits;
- Average time taken to access ART by people living with HIV; and
- Other factors affecting access, specific issues preventing access to ART for key populations and he knowledge of people living with HIV of HIV diagnostics and treatment.

MOSASWA Cross-border Initiative Malaria Regional grant: Lubombo Spatial Development Initiative (QPA-M-LSDI)

1.13 Background. The Mozambique, South Africa, and Swaziland (MOSASWA) cross-border initiative Expression of Interest to the Global Fund submitted in June 2015 was recommended to proceed to concept note development, and was commended by the TRP and GAC for building on the past success and experience of LSDI1 and for its alignment with the regional malaria elimination strategy. The MOSASWA concept note was submitted in TRP Window 9 in March 2016, and although the TRP acknowledged the potential impact of reducing transmission in in Southern Mozambique on neighboring South Africa and Swaziland, the concept note was not recommended for funding on the basis that the proposed strategic focus of the funding requested as well as the scale and mix of interventions put into question the potential for impact on malaria transmission. The GAC shared the TRP's concerns and noted the TRP's assessment of the MOSASWA concept note. However, recognizing that the epidemiological and programmatic context were well described, the goals and objectives were aligned with the regional plan for malaria elimination and strategies built on previous successful regional efforts, the GAC engaged with the TRP and agreed that MOSASWA be allowed to exceptionally submit an iteration. The TRP and GAC noted that the resubmitted funding request was strategically focused and addressed the key concerns including refocusing of investments on indoor residual spraying and improved collaboration efforts to understand and address cross-border transmission.

1.14 Private sector investment. During grant-making, private sector donor Goodbye Malaria approached the Secretariat with the request to provide the program with additional funding of US$4,000,000, for which an agreement was signed with the donor in November 2016. This amount will be used to expand priority concept note interventions considered strategically focused and technically sound by the TRP, and identified for prioritization should additional funding become available. TRP recommendations were endorsed by GAC and Partners.

1.15 The strategic focus of the program. While South Africa and Swaziland have relatively low malaria case burdens and are well-embarked on the road towards elimination, malaria prevalence in Mozambique reaches up to 55 percent in some areas. Malaria is still the major cause of morbidity and mortality in Mozambique and accounts for 44 percent of all outpatient consultations and 29 percent of hospital deaths. The incidence rate in border districts between these countries varies from less than 0.01 to 500 per 1,000 population. The goal of this program is to work collaboratively to accelerate the malaria response from control to pre-elimination in southern Mozambique and accelerate the transition from pre-elimination to elimination of malaria in Swaziland and South Africa. It aims to achieve zero local transmission in Swaziland, South Africa and Maputo province by 2020 and achieve pre-elimination status elsewhere in southern Mozambique by 2025. Context-specific strategies to reach this goal include:
- Establishing and operationalizing the MOSASWA malaria cross-border initiative to coordinate, harmonize policies, strengthen sub-national capacity and share expertise and strategic information among the three countries.

- Expanding and sustaining access to malaria elimination interventions across the MOSASWA region with particular focus on mobile and migrant populations, malaria risk localities and residents.
- Strengthening capacity for malaria surveillance, operational research and monitoring and evaluation to support elimination efforts, respond to outbreaks and resurgence, and generate evidence for intervention response.

Planned activities of the program include:
- Establishing a regional zone of malaria control between South Africa, Swaziland and Mozambique.
- Setting Maputo Province on the path to malaria elimination through the establishment of a sustainable malaria control program, including the strengthening of the strengthening of entomological surveillance and implementation of the indoor residual program.
- Strengthening monitoring and evaluation in the region through strengthening local health systems and implementing new technologies in data collection and monitoring and evaluation.
- Building a sustainable long-term funding solution for malaria control and elimination efforts in the region by mobilizing private sector support.

1.16 Implementation challenges and risks. To address risks of inadequate coordination and potential duplication between regional and national grants, the Principal Recipient will ensure close coordination with national malaria programs and other regional grants (such as Elimination 8) to avoid overlap of activities during this implementation period, as well as coordinate preparation for the upcoming allocation period. To manage this issue of financial procedure management of the Principal Recipient, the Principal Recipient will produce a general finance policy by 31 January 2017 and the Secretariat will monitor compliance against the policy.

1.17 GAC review and recommendations. The GAC congratulated the program for its persistence throughout grant-making, taking TRP and GAC recommendations into account and enabling effective leveraging of the private sector. The GAC reinforced the need for strong communication between regional and national programs financed by the Global Fund, both on the ground as well as within the Secretariat. Lastly, the GAC reinforced the program's focus on vector control through IRS, case management for epidemic preparedness and response and RSSH systems.

Nigeria HIV grant: Lagos State Ministry of Health (NGA-H-LSMOH)

Introduction

1.18 Progress on OIG, TRP, GAC and Board recommendations and on Nigeria Portfolio Risk Mitigation Measures. Since the approval of the Nigeria TB/HIV grants, the Secretariat has worked to address the concerns arising from the findings and recommendations of the OIG, as well as issues raised by the TRP, GAC and Board over the last year, as they related to the Nigeria portfolio overall as well as in regards to grant-making for a state-level grant for Lagos. The concerns and recommendations alongside mitigating actions taken include:
- Outstanding recoveries. The Recoveries Committee met on 26 May 2016 and determined the recoverable amount of US$5,798,831, which was then approved by the Executive Director. On 7 September, a formal letter was received from the Government of Nigeria stating that all amounts deemed recoverable would be repaid, in two tranches, in 2017.
- Addressing systemic issues. A meeting with President Buhari took place on 28 July 2016, in conjunction with Canada, DFID, EC, GAVI, USG, and the World Bank (BMGF were also consulted during the preparation). The following day, the heads of five national health agencies (including NACA) were removed from their posts. Additionally, prioritized actions were developed and implemented with some ongoing through Implementation through Partnership.
- Health supply chains. To address issues identified, warehousing and distribution services have been moved to a specialized provider and both the NACA and Lagos state grants have increased or begun procurement through the Global Fund's Pooled Procurement Mechanism.
- Fiduciary agent and spot-checks on trainings. The scope of the fiduciary agent team has been expanded and currently includes significant involvement in sub-recipient financial transactions. The plan for spot-checks of planned trainings has been updated and implemented to ensure compliance with Global Fund policy.

- Counterpart financing and willingness-to-pay. Nigeria is in the midst of a fiscal crisis due to prices in oil being below anticipated levels, as this is the dominant driver of federal revenues. Ministry of Health allocations from the federal budget for 2016 and 2017 were less than expected. Advocacy by Senior Management and other Secretariat members, with partners to the Government, from the President downwards, continues.
- Customized comprehensive risk and assurance process. The Nigeria Risk and Assurance Plan has been completed and signed off by Risk owners (October 2016. Periodic revisions will be made to the assurance plan, taking into account the changing context). Portfolio Priorities are being determined and signed off by MEC in June 2016 and being rolled out.
- Data quality and audits. Population-based data for malaria and TB have improved to acceptable levels, while such data for HIV continues to be unsatisfactory. A proportion of the upcoming HIV allocation is likely to be linked to progress in this area. Data issues were identified with one Principal Recipient, who will no longer play a role in managing sub-recipient functions in order to ensure that sub-recipient data is consolidated appropriately and correctly.

Lastly, in April 2016, the Secretariat invoked the Additional Safeguards Policy and two government Principal Recipients were suspended. The Secretariat is currently undergoing grant-making with newly selected Principal Recipients, selected through a request for proposal.

1.19 GAC review and recommendations. The GAC expressed support for the Secretariat's comprehensive and swift approach to tailoring operations for the Nigeria portfolio. The OIG highlighted progress made against Agreed Management Actions, noting that work still needed to be done in reinforcing risk mitigation measures, the fragmentation of anti-fraud controls, and gaps in assurance mechanisms. The change in Principal Recipients was highlighted to the OIG and GAC, which will address some issues raised by the OIG and others.

Nigeria state-level HIV grant in Lagos

1.20 Rationale for Lagos State-level grant. Building on the Nigeria TB/HIV grants approved by the Board through GF/B34/EDP01, including recommendations made by the TRP, GAC and Board, the GAC recommends for Board approval the Nigeria state-level HIV grant for Lagos NGA-H-LSMOH. The GAC recommends for Board approval the first state-level grant in Nigeria with the Lagos Ministry of Health for HIV as part of piloting a decentralized portfolio management approach for Nigeria, which aims to address specific challenges of selected high burden states while increasing impact on the three diseases through greater ownership from the state governments. While the volume of financing represents less than 1% of the overall Nigeria portfolio, entering into a direct grant at the state level is a strategically important approach aimed at reducing risk and improving impact and will provide lessons learned for similar arrangements in the future. The shift to state-level grants is expected to achieve greater impact over time by both tailoring programmatic activities more precisely to state-specific contexts as well as leveraging additional financial resources to address the large funding gap that currently exists in Nigeria.

1.21 Strategic focus of the program. Nigeria has the second largest burdens of both HIV and TB in Africa and is classified as a high TB, HIV and multi-drug resistant TB burden country. The HIV prevalence rate in the general population is 3.4 percent, showing a decrease from 4.1 percent in 2010. In the State of Lagos, an estimated 217,569 people are living with HIV and an overall increase in HIV prevalence rate is observed, reaching four percent in 2014. The grant will contribute to the Lagos State Ministry of Health's ambition to achieve 80 percent ART coverage by 2020 in line with national goals to expand HIV prevention, treatment, care and support. The grant includes clinical HIV services in all facilities in three high burden local government areas, which is complementary to PEPFAR's scale up in eight other local government areas in the State of Lagos. The program introduces provider-initiated testing and counselling and test and start approaches to accelerate scale-up of treatment access. Context-specific strategies include:
- Strategic information and program monitoring including surveys;
- Social mobilization, building community linkages, collaboration and coordination; and
- Institutional capacity building, planning and leadership development in the community sector.

Planned achievements of the proposed programming include:

- Increasing coverage rate from 22 to 55 percent by the end of 2017, and contributing to achieve 80 percent ART coverage in Epe, Ikorodu and Oshodi-Isolo local government areas by 2020;
- Providing people living in the state of Lagos with access to high-quality, patient-centered prevention, diagnosis and treatment services for TB/HIV;
- Reducing new HIV infections and improve the quality of life for infected and affected within the state of Lagos; and
- Decreasing HIV-related mortality per 100,000 population from 116 in 2013 to 70 in 2017.

The state-level program is in line with the national strategic plan and national guidelines, and the state-level program will report into the Nigeria CCM and other relevant national entities to ensure appropriate coordination.

1.22 Domestic contributions. The Lagos State has one of the highest health sector budgetary allocation in Nigeria accounting for 9.7 percent of the State budget in 2016. The government has given priority to health sector spending that targets improved health service delivery to the poor through ensuring universal access to an essential package of care, improving access to health service, increase quality of care and financial access for vulnerable groups. There is a dedicated earmarked budget line from the Ministry of Health showing a 24 percent increase in 2016. In addition, the State of Lagos has committed US$850,000 to support health systems strengthening. US$50,000 will be released for use in 2016 as pre-financing and the remaining US$800,000 is to be used during grant implementation.

1.23 GAC review and recommendations. The GAC congratulated the country in reaching this important milestone. The Secretariat commented that the fiscal agent is one of multiple measures to build financial capacity at the state level and that the State of Lagos has pledged significant domestic commitments to co-finance this program. The important role of partners in working with the state of Lagos was discussed by the GAC, noting that high-level communications were ongoing between technical agencies, the Secretariat and the State government. The collaboration of national-level programs with the state of Lagos was highlighted to the GAC, particularly in relation to services for key populations and private sector health care such as birthing centers.

Solomon Islands TB grant: Solomon Islands Ministry of Health and Medical Services (SLB-T-MHMS)

1.24 Reinvestment of savings in HIV. The GAC recommends that the Board exceptionally approve reinvestment of savings of US$ 215,787 from the grant in closure SLB-810-G01-T to the existing Solomon Islands TB grant SLB-T-MHMS. The GAC endorsed the approach that the HIV component be included in the existing TB grant SLB-T-MHMS to ensure efficiencies. The savings will support the program in carrying out HIV activities through the TB grant as the activities are related to TB/HIV co-infection and to ensure efficient management of funds. Savings will be used to finance priority interventions on the UQD Register as determined by the TRP, including an Integrated Biological and Behavioural Surveillance Survey (IBBSS) and key population size estimation among sex workers and men who have sex with men in order to develop a country specific service delivery model as recommended by the TRP.

South Africa TB/HIV Grants: (ZAF-C-AFSA) (ZAF-C-NACOSA) (ZAF-C-NDOH)

1.25 Re-investment of savings and additional resources from Private Sector. The GAC recommends for Board approval an increase in the final grant amount for the South Africa TB/HIV grants ZAF-C-AFSA and ZAF-C-NACOSA to reinvest savings of US$3.1 million toward the program's unfunded quality demand. These additional amounts would increase the total budget beyond the incremental amount previously approved by the Board on 24 March 2016 (GF/B34/EDP16). The grant savings of US$3.1 million are due to in-country cash balance previously not factored into the funds available for the grant from closed grants SAF-H-NDOH, SAF-H-NACOSA, SAF-H-RTC, and SAF-H-WCDOH, as well as the depreciation of national currency ZAR against the grant currency.

1.26 Strategic focus of reinvested savings. These savings will be reinvested in line with priorities identified by the TRP and GAC and emerging needs as follows:

- ARV procurement and distribution for an additional 14,000 people living with HIV to support implementation of the universal test and treat policy;
- Improving the performance of the PMTCT program and move towards elimination of mother-to-child transmission;
- Developing a hybrid HIV viral load testing model to increase the number of district sites with access to point of care viral load testing to 13 across 6 provinces;
- Providing transition funding to the Sub-recipients to reach an additional 7,560 sex workers with service packages and to conduct an additional 4,292 HIV tests; and
- Conducting a study to identify innovative strategies for young women and girls prevention programs.

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

Introduction

In this report, the Secretariat recommends to the Board additional funding for, and extension of, the second set of grants[24] 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 before 31 December 2017, 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,

[24] 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.

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 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 and October 2016.[25] 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.

EMMIE malaria grant: Population Services International (QMG-M-PSI)

1.27 Rationale for extension. The GAC recommends for Board approval the additional funding and extension of the implementation period for the Elimination of Malaria in Mesoamerica and Hispaniola Island malaria grant QMG-M-PSI, an Early Applicant grant, to continue grant implementation until 31 December 2017 and to cover the evaluation for the second performance period as well as the operational costs to support the regional program for an additional six months. In light of the EMMIE initial submission of a 3.5 year funding request for malaria as an Early Applicant for the 2014-2016 allocation period, this additional funding would allow a continuation of regional coordination, the sharing and alignment of relevant elimination knowledge, and the refinement of conditions for the verification of country results in 2017.

1.28 Background. As an Early Applicant to the allocation-based funding model, the EMMIE concept note was reviewed by the TRP in 2013 and was considered technically sound and strategically focused by the TRP. The TRP recommended the full requested indicative amount of US$10.2 million for funding, which was endorsed by the GAC and approved by the Board for a three-year implementation period ending in June 2017. The initially approved operations budget amount to US$3,200,000. In order to maintain the same level of coverage of interventions from July to December 2017, the total amount of US$667,092 would be needed. The remaining US$ 7 million was set aside as an incentive to accelerate effective and impactful program implementation and award cash on delivery upon demonstration of the country's progress towards its pre-set goals.

1.29 Strategic focus of the program. The goal of the grant is to act as a catalyst fund for countries in the Latin America and Caribbean region to coordinate and expedite their collective and individual progress toward the shared objective of the elimination of malaria. The grant concentrates on improving the surveillance systems to establish baselines, and on decreasing local malaria cases. Proposed activities for the extension period include:

- The coordination with PAHO and WHO for the preparation of the second verification cycle of individual country performance, of which results will be critical to the process to determine the attribution of incentives to countries fulfilling malaria elimination requirements;

[25] As set forth in GF/FOPC17/10, GF/FOPC17/03, GF/AFC01/05, GF/AFC02/07 – Revision 1.

- The development of regional discussions according to the priorities outlined in the EMMIE concept note, experience from individual countries, and recommendations provided by WHO and PAHO after verifications;
- The maintenance of the regional administrative support to formally request data from countries for the verification of 2016 results during the year 2017; and
- The completion the use of remaining "start-up" funding for those countries with implementation reprogramming.

1.30 Performance during the period. The grant uses workplan tracking measures to measure the progress of the nine countries toward the goal of zero malaria cases and improvement of conditions for elimination by 2020. The achievements made since 2014 include:

- 100 percent of EMMIE countries and programs are focusing on elimination have updated malaria guidelines and national strategy to include elimination strategies. EMMIE recognizes the importance of the strategic use of behavior change communication for malaria elimination.
- In-country and regional workshops to develop skills or malaria program and vector control staffs were held to strengthen capacities for malaria elimination.
- Progress was made on the implementation of national microscopy quality assurance systems, and the program also contributed to the improvement of surveillance systems.

1.31 Progress on key issues raised by the TRP and GAC. EMMIE is compliant with TRP and GAC recommendations made at the time of review and approval of the original funding. The actions to address the TRP and GAC comments included:

- Validation of country data: The regional program has developed and implemented a verification protocol, which will be completed early 2017 for the 2016 cycle;
- Operation research agenda: The participant countries have been receiving technical support for specific studies on malaria elimination;
- Reduction of Principal Recipient budget and risk mitigation measures: Reprogramming to reinvest efficiencies was held in 2016, and the country will continuously monitor the progress on these issues; and
- Regional surveillance system: The Principle Recipient reports the data compiled each semester.

1.32 Cash-on-delivery. At the time of Board approval of the EMMIE grant, the Board approved a total program budget of US$10 million, of which US$7 million is to be paid directly to countries subject to achievement of results based on annual epidemiological data related to the number of local malaria cases. The Regional Coordinating Mechanism will reinforce the organization of the regional coordination program to a cash-on-delivery mechanism to keep political support, address identified weaknesses at regional level and support national initiatives for eligible and non-eligible countries. As verification of results is still underway, payments for results reached in 2015 and 2016 will be made only from 2017.

1.33 Sustainability. Major risks have been associated with political processes in the region and the lack of priority given to malaria elimination in comparison to other regional health threats, as reflected in national resources focused on malaria in participant countries. Several activities have been delayed due to long internal approval processes, political instability or natural disasters. Dialogue between stakeholders continues in order to encourage the prioritization of malaria and support the expected targets. Involvement of partners has been an important mitigation measure, and additional actors are becoming partners at both national and regional level to provide complementary funding to cover specific epidemiological studies.

Iraq TB grant: International Organization for Migration (IRQ-T-IOM)

1.34 Rationale for additional funding for one-year grant. The GAC recommends for Board approval an upper-ceiling for additional funding to establish an exceptional one-year grant to extend the Iraq TB program from 1 January 2017 to 31 December 2017. The one-year grant will be implemented by a new Principal Recipient, the International Organization for Migration (IOM), and will ensure the provision of essential services, while enabling Iraq to transition to the 2017-2019 allocation period. The GAC recommendation for Board approval is in line with flexibilities approved by the Secretariat's Executive

Grant Management Committee in application of the Global Fund Challenging Operating Environments (COE) Policy.[26]

1.35 Background. For the 2014-16 allocation period, Iraq received Transition Funding for its existing tuberculosis component, as the country became ineligible in 2013 when it was classified as an upper-middle income country with moderate disease burden. The Iraq TB program was approved by the Board for Transition Funding through GF/B33/EDP01 with a total program budget of US$6,702,885 for 30 September 2015 to 31 December 2016, to allow for a clear transition to other sources of funding (national or otherwise). In April 2016, the Global Fund Board approved the COE Policy that allows for country components with existing grants that would otherwise be ineligible under the current Eligibility Policy, to be considered eligible to continue to receive an allocation, as long as their country remains classified as a challenging operating environment. Thereafter in November 2016, in application of the challenging operating environment policy, the Secretariat confirmed Iraq's continued classification as a COE and exercised the flexibilities provided under the COE Policy to allow Iraq TB to be considered eligible to receive an allocation for the 2017-2019 period. As outlined in the Report submitted to the Board in November 2015 (GF/B33/ER18), Iraq is among the countries whose grants are to be managed under the integrated management platform established as an innovative and differentiated approach to provide essential HIV, TB, and malaria services in the Middle East Region. The Middle East Response (MER) grant, managed by IOM was approved by the Board (GF/B35/EDP20) in November 2016 and will be signed in the coming weeks. At this stage, as previously report to the Board, the MER grant does not include activities for Iraq, given that Iraq was not previously eligible for additional funding. Should Iraq TB receive an allocation amount in the 2017-2019 allocation period, the funding and activities would be managed through the MER grant.

1.36 Funding gap. The current Iraq TB grant was designed prior to the adoption of the COE Policy and did not contemplate the availability of further funding, as could be the case given the flexibilities in the COE Policy referenced above. As such, it ends 31 December 2016, which means the period over which it utilizes its 2014 – 2016 allocation is shorter than the typical period that ends 31 December 2017. Iraq TB was not previously considered as part of the sub-set of the grant portfolio of Shortened Grant and Early Applicant components for which funding gaps for all or part of 2017 have been systematically tracked and for which additional funding was made available for portfolio optimization by the FOPC at its March 2016 meeting. In November 2016, the GAC recognized Iraq TB posed the same considerations and principles when evaluating Shortened Grants and Early Applicants. As such, the funding needs would be covered through remaining funding made available for portfolio optimization, and as validated by the FOPC in March 2016, to enable Iraq to transition into the 2017-2019 allocation period. The Technical Review Panel has reviewed the strategic scope of interventions proposed for the MER grant, which included Iraq as an integral focus country.

1.37 The strategic focus of the program is to ensure the continuity of essential services, including:

- Ensuring that essential TB testing and treatment services are provided in the context of the protracted conflict occurring in Iraq, including the provision of MDR-TB screening and treatment;
- Provision of TB screening and support to 12 Governorates particularly affected by the conflict through activities such as early detection of TB cases and treatment support, particularly among IDPs and the 250,000 Syrian refugees living in the Iraqi Kurdistan region;
- Provision of basic TB screening and laboratory equipment to support the rehabilitation of TB centers in recently liberated areas where facilities were severely destroyed or looted due to the conflict; and
- The one-year grant will also focus on ensuring a smooth transition of the Iraq portfolio to the integrated grant management platform that IOM is setting up at the regional level to oversee the implementation of activities funded in Iraq, which will be implemented through its well established Country Office.

1.38 Performance of the current grant. The current grant, implemented by UNDP as the Principal Recipient, has supported the delivery of integrated TB health care services across the country, including detection, diagnosis, treatment and prevention activities. Achievements include the improvement of the TB case detection rate, a recorded treatment success rate of 91 percent of all forms of TB in 2015.

[26] As set forth in Annex 1 to GF/B35/03 and approved by the Board in April 2016 under decision point GF/B35/DP09.

1.39 Implementation arrangements. Given that the current UNDP-managed TB grant ends on 31 December 2016 and that Iraq will only be added to the scope of the MER at a later stage, the proposed approach is to enter into a new funding agreement with a new Principal Recipient, namely IOM, the Principal Recipient of the MER grant. Iraq is managed under the Additional Safeguards Policy whereby the Secretariat is delegated authority to nominate the Principal Recipient. IOM has an established country presence in Iraq and a standing working relationship with the Iraqi national TB program.

1.40 Flexibilities for GAC review and recommendation. In light of the challenging operating environment context, the adjustments being made to the program, and the very short timelines required to submit the funding request to the Board to allow the grant to be approved before the end of 2016, the Secretariat has exercised a number of flexibilities provided for in the COE Policy in terms of the grant documents to be submitted for Board approval and of the disbursement and grant monitoring modalities to be established under the one-year grant. In this regard, the grant is submitted for Board approval on the basis of GAC endorsement of the summary budget proposal, representing an upper-ceiling budget amount of US$3 million, and a brief grant narrative submitted by IOM. Standard documentation for a new grant, including detailed budget, list of health products and supplies, performance framework, and grant confirmation will be completed by the Principal Recipient and Secretariat prior to grant signature. The Iraq TB program also benefits from the recently conducted capacity assessment of IOM for the MER grant. The Board will be duly notified of the final grant outcome upon the signature of the Grant Agreement.

1.41 Operational issues, risks and implementation challenges. The following main risk mitigation measures will be put in place under this funding agreement:

- Funds will be disbursed to IOM along the same lines as for the MER grant.
- While activities will be implemented by the IOM Iraq Country Office, activities will be under the oversight of the integrated grant management platform established at the regional level in Amman, Jordan for the MER grant.
- The Local Fund Agent for the MER grant will monitor on-going implementation of the grant activities.
- IOM will provide a detailed implementation map for the one-year grant agreement, which will be reviewed by the Secretariat.
- Once the sub-recipients are selected across different countries included in the MER grant, the Secretariat will conduct an analysis of the key risks and challenges encountered and put additional measures in place, if necessary.

1.42 Domestic contributions. Through the policy exceptions granted in GF/B33/EDP29 on 13 November 2015, the Board granted Iraq and other countries included in the MER exemptions to the counterpart financing and willingness-to-pay requirements, in addition to the CCM eligibility requirements.

1.43 GAC review and recommendations. The GAC endorsed the approach to consider Iraq TB in line with the principles of a Shortened Grant to be funded through funds made available for portfolio optimization. GAC members highlighted the need for continued strong collaboration with partners to ensure continuation of essential services in Iraq.

Myanmar malaria and TB/HIV

1.44 Rationale for extension. The GAC recommends for Board approval the additional funding for a one-year implementation period for the Myanmar malaria (MYN-M-UNOPS and MYN-M-SCF) and TB/HIV (MYN-H-UNOPS, MYN-T-UNOPS, MYN-H-SCF and MYN-T-SCF) Early Applicant grants to sustain life-saving services as a bridge to transition the current program and align the portfolio to the 2017 to 2019 allocation period. The requested one-year implementation period, in line with TRP recommendations, will ensure the continuation of TB, HIV and malaria interventions at the existing scope and scale through 31 December 2017 as a bridge to transition the current program and align the portfolio to the 2017-2019 allocation period.

1.45 Background. As an Early Applicant to the allocation-based funding model, the Myanmar malaria concept note was reviewed by the TRP in 2013 and was considered technically sound and strategically

focused. The TRP recommended the full allocation amounts of US$57,504,316 for malaria and US$199,462,456 for TB/HIV for funding, which were approved by the Board for three-year implementation periods ending in December 2016. In order to align with national planning systems, address changes in the epidemiological environment, mitigate the risk of program disruption and to address changes in the epidemiological environment, as well to align with the Global Fund's replenishment cycle, Myanmar submitted four-year concept notes for malaria and TB/HIV that were reviewed by the TRP in July 2016. The four-year concept notes were developed and reviewed based on the budgets for 2016 as the basis for the funding request, as the 2017-2019 allocation amount was not yet determined. The TRP found these concept notes to be strategically focused and technically sound and recommended they proceed to grant-making for the one- year implementation period for 2017 as well as the 2018-2020 upon notification of the allocation amount.

1.46 Operational issues, risks and implementation challenges. The Secretariat has worked with the country to identify a range of issues and is undertaking appropriate mitigating measures across both the malaria and TB/HIV programs, including:

- Services to politically and geographically isolated areas: Since the inception of the grants, the programs have worked toward expanding public services to all areas, including those that are politically and geographically isolated. This will continue to be an area of focus for the programs.
- Decreasing donor attention to health: In the response to the shift of external donors to financing education, democracy and the peace process, domestic commitments to health have increased dramatically.
- Human resources for health: The Secretariat has increasingly encountered requests to support higher budget under human resources and office cost sharing. To allow sub-recipients to maintain essential services, a compromised has been reached to allow some minimum increases in 2017. Sub-recipients were requested to find other alternative funding sources for the next funding cycle (2018-2020).
- Gender and human rights barriers: The current programs have activities to address these barriers. Efficiencies found in the 2017 have been allocated to these areas, such as civil society networks and Ethnic Health Organisations.
- Supply chain limitations: Efficiencies found in 2017 budget have been allocated to supply chain strengthening activities.
- Data issues: Myanmar is still using paper-based reporting and part of the 2017 budget is dedicated to an e-health initiative including, DHIS2 and Master Patient Index.

1.47 Domestic financing and fulfillment of commitments for the 2014-2016 period. Government spending on Global Fund supported programs in 2013- 2016 is 236 percent higher than that committed at the time of accessing funding for the grants under the 2014-2016 allocation. These increases have been on account of progressive increase in government spending on ARVs, MMT, MDR-TB drugs, malaria commodities, program management, human resources and infrastructure. In 2017-20, the government is committed to maintaining and incrementally increasing programmatic investments along with absorbing additional health systems costs for scaling up services. An additional investment of US$86 million is anticipated in 2017-20, which is 22 percent of indicative allocation from Global Fund for the period. Government contributions for malaria in 2017 will finance 11 percent of the malaria funding need and will primarily go toward salaries for the national malaria program at the central, regional and township levels, as well as maintenance of infrastructure, travel expenses, investments in malaria commodities such as insecticides for IRS; and infrastructure, including an entomology insectary. Government contributions for TB/HIV for 2017 will finance 14 percent of HIV and 20 percent of TB needs and will primarily go toward procurement of TB and HIV commodities, program management and health system costs, MDR-TB diagnostics, infection prevention and control, and human resources.

1.48 GAC review and recommendations. The GAC and partners supported the Myanmar malaria program moving forward with a one-year implementation period to align the program with the 2017-2019 allocation period. The GAC and partners further congratulated the Myanmar malaria and TB/HIV programs for impressive progress to date, including scale-up and progress on the UN's Millennium Development Goals. The Secretariat confirmed the benefit of submitting the malaria and TB/HIV funding requests to the TRP at the same time, noting that the unknown allocation amounts provided the opportunity for the country to undertake modeling exercises. Additionally, the concurrent discussions allowed for

technical groups to examine the same issues in conversation with one another, including health information systems strengthening (DHIS2, surveillance, etc) and strengthening of procurement and supply chain management. Partners noted that, while investments are being redirected to the areas mentioned above, they will remain engaged in health issues. GAC partners were concerned about the country's plans to perform a pilot for the shortened MDR-TB regimen, rather than begin implementing the new normative guidance directly. The Secretariat clarified that after extensive discussions with stakeholders, including with the Ministry which was initially reluctant to initiate the regimen even on a pilot scale, the country finally agreed to pilot the regimen for 200 cases. The Secretariat further highlighted that discussions between the Secretariat and the country's TB technical group and WHO would remain ongoing to try and resolve this issue. GAC partners also encouraged the country to examine linkages between TB and HIV programs, particularly as it related to civil society engagement. The Secretariat highlighted the role of civil society in difficult-to-reach areas. The potential funding gap for HIV following 2017 was discussed between the Secretariat and partners, noting that further action could be taken upon the country being notified of the allocation amount in mid-December.

Myanmar malaria grants: United Nations Office of Project Services (MYN-M-UNOPS), Save the Children (MYN-M-SCF)

1.49 Funding gap for malaria. In order to maintain the same level of coverage with diagnosis and treatment services in 2017 as at the end of December 2016, the total amount of US$30,898,757 and US$7,544,549 unsettled commitments from 2016 would be needed to bridge the funding gap until the grants arising from the next allocation period begin. As of November 2016, the estimated cash balances and undisbursed funds for both grants are projected at US$7,533,744, including US$7.5 million unsettled commitments that is carried over to the 2017 budget. As of November 2016, total savings of US$4.3 million were identified for reinvestment, and were reinvested into procurement of LLINs to reduce the coverage gap. There are no remaining savings from the existing grants. Through optimization of use of funds within the disease component, the remaining incremental amount required to fill the 2017 funding gap is US$30,909,562. The GAC recommended additional funding to cover the remaining gap through allocation of funds available from portfolio optimization efforts as validated by the Finance and Operational Performance Committee in March 2016.

1.50 Strategic focus of the malaria program. From 2012 to 2015, Myanmar cut malaria mortality and morbidity rates by more than 50 percent and 90 percent, respectively. The annual incidence of reported malaria cases dropped from 8.09 to 4.16 cases per 1,000 despite increased testing resulting from the recent roll-out of rapid diagnostic tests. The number of severe malaria cases decreased from over 9,000 between 2005 and 2008 to 660 in 2015. The program aims to reduce malaria cases from 4.16 to 0.62 per 1,000 population by 2020 and malaria positivity rate from 6.9 percent to 0.8 percent from 2015 and 2020. Key targets and planned activities for the implementation period include:

- Distribution of LLINs: 1,502,666 LLINs will be distributed through a mass campaign and 1,942,100 through continuous distribution to at-risk groups, in order to maintain 100% coverage in 2017.
- Case management: Total of 2,674,329 suspected case will be tested and 123,149 malaria cases will be treated in public, community and private sector.

Planned achievements of the proposed programming include:

- Increasing the proportion of households with at least one insecticide-treated net from 67 percent in 2015 to 95 percent in 2017.
- Maintaining proportion of population potentially covered by LLINs to 100 percent in 2017.
- Increasing the proportion of health facilities without stock-outs of key commodities during the reporting period from 79 percent in 2015 to 95 percent.

1.51 Progress on key issues raised by the TRP and GAC for the malaria program. Myanmar is compliant with TRP and GAC recommendations made at the time of review and approval of the original funding. The actions to address the TRP and GAC comments included:

- Interventions for vulnerable populations: Vulnerable populations were clarified as included in the program and LLIN forecasts have included targets for priority groups including pregnant women and at-risk populations in conflict areas.

- Procurement and supply chain management: Funding has been invested in upgrading storage and warehouse facilities at various national and subnational levels. The national authorities also work with USAID to strengthen national program's procurement and supply management capacity.
- Developing a clear information, education and communication/behavioral change communication (IEC/BCC) plan: The country is developing national IEC/BCC guidelines for the period 2016 to 2020.
- Improved coordination of all community-focused interventions for HIV, TB and malaria: The role of the volunteers be expanded to cover diarrhea, acute respiratory infections and fever management.

Myanmar TB/HIV grants: United Nations Office of Project Services (MYN-H-UNOPS and MYN-T-UNOPS), Save the Children (MYN-H-SCF and MYN-T-SCF)

1.52 Funding gap for TB/HIV. In order to maintain the same level of coverage with diagnosis and treatment services in 2017 as at the end of December 2016, the total amount of US$93,889,288 plus US$31,313,811 unsettled commitments from 2016 would be needed to bridge the funding gap until the grants arising from the next allocation period begin. This is consistent with the budget level of the final year of the current grant. As of November 2016, the estimated case balances and undisbursed funds for all four grants are projected at US$51,112,661, including US$31,313,811 unsettled commitments that is being carried over to the 2017 budget. The remaining US$20 million are savings, which are being reinvested to finance the 2017 budget. A total savings of US$8 million identified during grant negotiation was reinvested within the disease program. Through optimization of use of funds within the disease component, the remaining incremental amount required to fill the 2017 funding gap is US$74,090,438. The GAC recommended additional funding to cover the remaining gap through allocation of funds available from portfolio optimization efforts as validated by the Finance and Operational Performance Committee in March 2016.

1.53 Additional funding to finance Unfunded Quality Demand from portfolio optimization. Following a rigorous screening and prioritization process to identify highest priority needs on the Register of Unfunded Quality Demand (UQD) (see detailed description of process in Section IV.03), the GAC recommends for Board approval an increase in the final grant amount for the TB grants, MYN-T-UNOPS and MYN-T-SCF to incorporate additional funding toward the program's unfunded quality demand. The additional funds will contribute to:

- The increase of 7,717 additional target for TB cases notified and treated (from 146,628 to 154,345);
- Second line drugs for shorter treatment regimen (200 patients) and other medicines;
- Laboratory investigation fees for multi-drug resistant-TB patients; and
- Strengthening of laboratory network and procurement of health equipment.

1.54 The strategic focus of the TB/HIV program. Myanmar has significantly expanded prevention outreach activities among key population as well as increased availability of counseling and HIV testing and ARV treatment in the country. However, by end of 2015 key service delivery gaps remain and the estimated access rate to testing services among people who inject drugs, men having sex with sex, and sex workers are 27 percent, 20 percent and 34 percent respectively. Additionally, only 51 percent of people living with HIV enrolled on ART. Myanmar is also one of 30 highest burden TB/HIV countries in the world. Sixty-three percent of registered TB patients knew their HIV status in 2014, with only 38 percent of TB/ HIV co-infected patients accessed ART, and 85 percent of people living with HIV received TB screening. The country's TB incidence and mortality rates in 2014 were 369 and 53 per 100,000 population, respectively. In 2015, 2,790 multi-drug resistant TB (MDR-TB) cases were notified and 79 percent of those initiated treatment. The program aims to decrease HIV transmission and related morbidity and mortality, disability and social and economic impact in 14 states and regions in Myanmar, and decrease TB cases to fewer than 10 per 100,000 population by 2035. Both the HIV and TB aims to ensure continuity of essential interventions in 2016, including:

- Prevention program for key populations including provision of prevention outreach package and HIV testing for vulnerable population;
- Anti-retroviral care, treatment and its monitoring;
- Prevention of mother-to-child transmission including testing and ART;

- Intensified TB case finding through public, private and community sector and provision of treatment and expansion of sites for programmatic management of drug-resistant TB for intensified case finding of such cases, including a pilot of 200 patients planned to be enrolled on short-term regimen;
- Expansion of early screening and testing and treatment of co-infected TB/HIV patients, covering all 321 townships; and
- Expansion of district health information software 2 platform, case-based monitoring system and Master Patient Index.

Planned achievements of the proposed programming include:
- Increasing the percentage of people who inject drugs reached with HIV prevention programs from 72 percent in 2015 to 86 percent in 2017;
- Increasing the percentage of HIV-positive pregnant women who received ART during pregnancy from 65.9 percent in 2015 to 87 percent in 2017;
- Increasing number of people living with HIV on ART from 114,283 in 2015 to 136,495 people in 2017;
- Enrolling 100 percent of MDR-TB cases notified (3,297) on second-line treatment;
- Increasing the percentage of TB patients with documented HIV status from 51 percent in 2015 to 70 percent in 2017;
- Increasing the percentage of people living with HIV in care who are screened for TB in HIV care or treatment settings from 86.6 percent in 2015 to 95 percent in 2017; and
- Increasing the percentage of TB/HIV confected populations enrolled on ART from 69 percent in 2015 to 86 percent in 2017.

1.55 Progress on key issues raised by the TRP and GAC for TB/HIV program. Myanmar is compliant with TRP and GAC recommendations made at the time of review and approval of the original funding. The actions to address the TRP and GAC comments included:
- Childhood TB: The country has revised childhood TB guidelines and the associated operational plan. Advocacy meetings have already been conducted engaging pediatricians and child health services personnel.
- MDR-TB: The implementation of short TB regimens is expected to start in 2017 from Yangon and Mandalay, followed by other regions. Additionally, the country will strengthen support to MDR-TB patients during the period between diagnosis and treatment initiation. Lastly, the decentralization of MDR-TB has already been rolled out.
- TB/HIV: A phase-based approach to increase ART coverage to reach the targeted 90 percent by 2020 has been put in place. Further, the expansion of TB/HIV intervention to all prisons will be covered by additional domestic and external resources.
- Sustainability plan to support salaries of health and community staff: Efficiency gains from the program management module have been reallocated to TB care and prevention module. An update of sustainability plan for salaries of health and community workers will be developed following the communication of the 2017-2019 allocation amount.
- ART guidelines: Taking into account WHO normative guidance, the country is undertaking revision of national guidelines, scheduled to be published by the end of December 2016.
- Gender, human rights and HIV interventions for key populations: The Ministry of Health and Sports has confirmed additional domestic resources to achieve higher HIV testing targets for people who inject drugs. Furthermore, efficiencies identified during grant-making has been reinvested into human rights-related interventions, and advocacy and lobbying activities will be continued throughout 2017. Lastly, measures have been put in place to improve the recording system for outreach services provided to key populations.
- Condom distribution: In 2015 USAID doubled its regular condom distribution and increased the oval pool of condoms available for Myanmar, thus reducing the need for Global Fund resources for this intervention. The Principal Recipients will coordinate with social marketing groups and commercial entities to increase the proportion of socially and commercially marketed condoms, thus help to gradually reduce the subsidy applied to condoms while maintaining the high availability and use among key population groups.
- Prioritization of townships: The budget has been adjusted to align with the distribution of burden, adjusting the proportion of budget for low- to medium- and high-burden townships.

Regional Artemisinin-resistance Initiative malaria grant: The United Nations Office for Project Services (QMU-M-UNOPS)

1.56 Rationale for extension. The GAC recommends for Board approval the additional funding for a one-year implementation period for the Regional Artemisinin Resistance Initiative (RAI) malaria grant QMU-M-UNOPS, an Early Applicant grant, to continue grant implementation until 31 December 2017 and to ensure the continuation of malaria interventions at the existing scope and scale as a bridge to transition the current program to the Greater Mekong multi-country approach and align the portfolio to the 2017-2019 allocation period.

1.57 Background. As an Early Applicant to the allocation-based funding model, the RAI concept note was reviewed by the TRP in October 2013 and was considered technically sound and strategically focused by the TRP. The TRP recommended the full allocation amount of US$100,000,000 for funding, which was approved by the Board for a three-year implementation period ending in December 2016. In order to maintain the same level of coverage with malaria services in 2017, the total amount of US$30,422,952 plus US$5,339,468 unsettled commitments from 2016 would be needed to bridge the gap. This is consistent with the budget level of the final year of the current grant. As of November 2016, the estimated cash balance and undisbursed funds at the end of 2016 is projected at US$20,221,556, of which US$15 million are savings and US$5,339,468 are unsettled commitments. This amount of US$15 million will be reinvested and used to finance the 2017 budget.

1.58 The strategic focus of the program. The aim of this extension is to support the same interventions and objectives approved under the current RAI grant. The proposed program objectives include:

- To interrupt transmission of *P. falciparum* by universal coverage and usage of insecticide treated bed nets (either long-lasting nets or treated conventional nets) in all targeted areas;
- To provide universal access to quality diagnosis and treatment for static populations at public and private health facilities and through community malaria workers;
- To halt marketing and sale of oral artemisinin monotherapies; and
- To closely monitor trends in malaria cases, to identify and take action to control outbreaks and to undertake therapeutic efficacy studies in sentinel sites.

In line with the objectives, major proposed activities include case management among static and mobile population, distribution of 1.7 million LLINs to at risk population including mobile and migrant populations and border populations, and support to 23,700 volunteers and malaria posts.

1.59 Performance during the period. The RAI grant has been performing at a B1 level throughout the grant implementation, despite significant delay in implementation start-up of some components. The grant has contributed to:

- Deployment of 23,700 village malaria workers;
- Distribution of 3.5 million additional LLINs in risk areas;
- Testing of 8.5 million people and treatment of 272,000 cases; and
- Investigation of 50 percent of the *P. falciparum* cases in low endemic areas and foci response to 39 percent of identified transmission.

1.60 Progress on key issues raised by the TRP and GAC. RAI is compliant with the TRP, GAC and Board recommendations at the time of review and approval of the original funding. The actions to address the TRP and GAC comments included:

- Single multi-country malaria program: A memo has been put forward to the Secretariat's Executive Grant Management Committee to approve the single multi-country malaria program. A clear strategy to assess the impact of RAI regional approach will be developed and a more holistic and streamlined approach to address risks will be taken. A grant-specific RAI regional monitoring and evaluation plan has also been developed.
- Eligibility requirements to ensure participation of established and effective organizations in the implementation: An open and transparent process was undertaken in selecting implementers RAI projects including those involving cross-border activities.

- Mobile and migrant populations: The Regional Steering Committee will discuss an integrated approach for treatment for other diseases than malaria in difficult to reach or mobile populations. It has been engaging with China and other partners throughout the evolution of the RAI, and inputs have been taken into consideration in devising projects targeting mobile and migrant populations as well as people living near the forest and borders.

1.61 GAC review and recommendations. The GAC and partners congratulated the RAI program, noting that it reinforced the importance of multi-country approaches and contributed many lessons learned, in addition to demonstrating results through decreased infections in the region. GAC partners highlighted the need to collect and analyze data on a granular level, as learned from the response to the polio epidemic, to which the Secretariat responded that granular and integrated data was envisioned as part of the grant from its inception and will continue to be a focus. The Secretariat highlighted that the program had the added benefit of expanding general access to health services in the region, noting the success of the integrated approach. GAC partners requested information on the role of civil society in the grant, and were informed that each country includes some civil society element, though the role of civil society needs to be tailored and strengthened according to each context. The GAC and partners were optimistic about the potential impact of RAI going forward under the Greater Mekong multi-country approach and took account of the consolidated regional program that will be taken in the 2017-2019 allocation period.

Zimbabwe malaria grant: Ministry of Health and Child Care (ZWE-M-MOHCC)

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

1.63 Background of shortened grant duration. Under GF/B32/ER01, the ZWE-M-MOHCC grant for the Zimbabwe malaria program was exceptionally authorized to have a shortened grant duration until 30 June 2017. The TRP reviewed the Zimbabwe malaria concept note in Window 3 September 2014 and was found to be technically sound and strategically focused, building on the gains of previous investments in malaria control in the country. The remaining funding gap of US$13,061,456 was 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, based on the need for indoor residual spraying (IRS) and long lasting insecticide-treated nets in 2017. 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 this regard, as of November 2016, total savings of US$4,858,127 were available to cover the 2017 gap, including:

- Change from conical to rectangular LLINs;
- Switching to less expensive class of insecticides;
- Case management; and
- Health information systems, monitoring and evaluation, and procurement and supply chain management.

1.64 Strategic focus of the program. Over the last 10 years, Zimbabwe has recorded a steady annual decline in malaria morbidity, from 155 cases per 1,000 population in 2003 to 29 cases in 2012. An estimated 50 percent of the population lives in transmission risk areas, and a greater proportion of the disease burden is concentrated in some districts found along the border with Mozambique and Zambia. The goal of the program is to reduce malaria incidence per 1,000 population from 22 in 2012 to 10 in 2017, and malaria deaths to near zero by 2017. To achieve this, the program aims at reaching 93 percent of population with IRS and 100 percent with LLINs during the extension period. The percentage of confirmed cases fully investigated and classified will be brought from 60 percent in June 2017 to 80 percent in December 2017. Planned achievements of the proposed programming include:

- Distributing 293,656 LLINs to fill the uncovered requirements of the continuous distribution channel in July to December 2017;
- Performing IRS to support the target of the annual spray cycle of 2,930,375 rooms; and
- Ensuring case management through the procurement of laboratory commodities and quality assurance of rapid diagnostic tests and artemisinin-combined therapy in the last semester of 2017.

Additionally, with the support of partners, the national malaria program has developed new insecticide resistance management guidelines to inform prioritization, and the program employs ongoing entomological surveillance to provide evidence for rotating deployment of IRS and LLINs.

1.65 Progress on key issues raised by the TRP and GAC. The Principal Recipient is compliant with TRP, GAC and Board recommendations made at the time of review and approval of the original funding request. The actions to address the TRP and GAC comments include:

- The risk of malaria importation from neighboring countries: A baseline scoping assessment was conducted to inform strategic sites for cross-border health posts.
- IRS and LLINS: An estimated US$2 million from the Government of Zimbabwe, private sector partners and savings from the current grant will be used to ensure universal coverage of IRS. Separate deployment of IRS and LLINs ensures coverage of at-risk population in 47 districts.
- Vector control: The Ministry of Health is conducting an impact assessment of past interventions to inform strategic prioritization of investments. The program has recruited a full-time resident entomologist who will assist in timely collection, collation and analysis of entomological data.
- Key populations: Personal protection measures are implemented and information collection on human settlement patterns, housing standards and human behavior was initiated to inform best interventions.
- Sustainability of human resources cost: Activity implementation was integrated within the existing district management structures, so that there is no additional personnel required at district level.

1.66 Audit by the Office of the Inspector General (OIG). The recent OIG audit released in July 2016 highlighted inadequate procurement and supply chain arrangements as a contributing factor for the risk of treatment and service disruptions. Specific risks identified include:

- Irregular supply of anti-malaria medicines to facilities without an effective re-distribution mechanism;
- Inaccurate and/or incomplete record keeping that affects accountability of commodities;
- Storage constraints at the provincial level; and
- Limited capacity of facility staff to request for medicines.

The mitigation actions identified, as part of Agreed Managing Actions ongoing until December 2017, include:

- Intensified supportive supervision for optimal stock management;
- Improved storage capacity through renovation and expansion of storage facilities at high volume health facilities;
- Implementation of harmonization of the distribution system to address multiple parallel distribution system through procurement of six trucks and training;
- Expansion of two regional national pharmaceutical company warehouses; and
- Development of an operational plan to support ongoing rationalization of the distribution systems in the supply chain.

1.67 Operational issues, risks and implementation challenges. The Secretariat's risk review concludes that key operational risks that could affect grant objectives during this period have been identified, prioritized and are being mitigated. These risks and mitigation measures include:

- Disruption of services: This risk is mitigated through the extension, which ensures the continuation of essential malaria services.
- Risk of sequestration of funds due to deteriorating economic situation: This risk is minimized as the Global Fund grants are commodity-driven focus of the grant, where 50 percent of the overall budget is for procurement of malaria commodities conducted by the Global Fund's Pooled Procurement Mechanism. The remaining budget is managed by UNDP, who maintains offshore accounts and provides payments to Principal Recipients only upon receiving adequate assurances over security of cash assets.
- Domestic financing: Zimbabwe has met its willingness-to-pay commitment for the funding cycle 2014-2016 through contributions from AIDS Levy tax.

1.68 GAC review and recommendations. The GAC and partners were supportive of the Zimbabwe malaria program moving forward into implementing programming for 2017. The significant success of

changing the specifications of LLINs conical to rectangular was highlighted by partners, noting the program's significant savings available for reinvestment as a result. Partners also commented on the robust strategy that employs a combination of interventions, and encouraged the program to take into account the prioritization of IRS and LLINs on an ongoing basis in order to achieve targets. Attention was called to the integration of human resources for health into the district management structure, which will promote sustainability and program ownership. Lastly, the Secretariat emphasized that the procurement and supply chain management issues would be closely monitored, including the issue of storage.

03 Summary of the Deliberations of the Secretariat's Grant Approvals Committee (GAC) on Financing Unfunded Quality Demand

Introduction

In this report, the Secretariat recommends to the Board additional funding to finance investments on the Register of Unfunded Quality Demand (UQD). The UQD Register was established with the aim of incentivizing high impact, well-performing programs and the submission of robust, ambitious expressions of demand based on national strategic plans or investment cases (GF/B28/DP4). According to the policy adopted by the SIIC in October 2013, funding requests above the amount that can be funded with country allocations, that are recommended by the Technical Review Panel as technically sound and strategically focused, are added to the UQD Register for a period of three years (GF/SIIC09/DP02). Throughout the 2014-2016 allocation period, the Secretariat worked with applicants to finance interventions listed on the UQD Register through reinvestment of efficiencies from grant-making and grant implementation, as well as mobilization of additional resources.

Of the US$700 million validated by the FOPC at its 17th meeting in March 2016 as available funding for portfolio optimization, US$664 million has been utilized to address full or partial 2017 funding needs and programmatic priorities with respect to Shortened Grants and Early Applicants, including those presented in this report to the Board. As such, the remainder is available to finance UQD identified by the Secretariat.

Items on the UQD register have been prioritized and updated in accordance with the process adopted by the Strategy, Investment and Impact Committee in October 2013[27] and presented to the Strategy Committee in October 2016. The Secretariat reviewed the continued relevance of the interventions on the UQD register given that priorities have evolved since the initial submission and review of concept notes. Additionally, it has prioritized the items on the UQD register based on the review and recommendations of the TRP, and factored in the feasibility of utilizing additional funds in the remaining period of existing grants, considering the trajectory of scale-up and sustainability of funding levels for the country components with the highest priority UQD investments. This has allowed for an evaluation of opportunities where additional funds could have potential for disproportionate impact and comparison of the potential impact of using such funds during the remainder of grants from the 2014 – 2016 allocation.

From this assessment, US$36 million of the highest priority potential UQD investments were identified from the US$2.77 billion of registered UQD remaining on the current register, taking into account the following prioritization factors as part of a two-stage process for screening and prioritization of UQD:

- TRP review and recommendations, and prioritization;
- Continued relevance of the interventions on the UQD Register, acknowledging that priorities have evolved since the initial submission and review of concept notes;
- Opportunities for investment in programs that are performing well with potential for disproportionate impact on the epidemics;
- Disease component is receiving funding levels below notional shares under the allocation formula as well as sustainability of funding levels for country components; and
- Feasibility of utilizing additional funds in the remaining period of existing grants from the 2014-2016 allocation period, using forecasted absorptive capacity of 90 percent threshold as a proxy and taking

[27] As approved by the SIIC under decision point GF/SIIC09/DP02, under authority delegated by the Board in its November 2012 decision to evolve the funding model under decision point GF/B28/DP04.

into account the trajectory of scale-up and sustainability of funding levels for the country components with the highest priority UQD investments.

As many items initially registered as UQD have now been financed through grant-making efficiencies and optimization efforts have addressed other partial or full 2017 funding priorities, US$36 million remains available for financing UQD, subject to Board approval on a case by case basis. In the award of UQD and integrating investments into grants, the following parameters were considered by the GAC as it formulated recommendations for Board approval:

- The request is to fund interventions on the UQD Register considered highest priority by the TRP;
- That the applicant work closely with partners and the Secretariat to validate the ongoing need for the recommended areas of investment as well as feasibility of utilizing the additional funding recommended to finance UQD during the remaining period of existing grants; and
- The request is within the upper ceiling set by the Secretariat.

In this report, the GAC recommends additional funding to finance UQD for US$21 million of interventions for the following country components from the 2014-2016 allocation period based on the assessment described above, as listed by country component in the table below.

Country	Component	Amount (US$ or EUR)
Bangladesh	TB	US$2,000,000
Central African Republic	TB/HIV	EUR4,325,121
Myanmar[28]	TB	US$5,110,483
Philippines	TB	US$5,291,510
Viet Nam	TB/HIV	US$3,000,000
Total additional funding recommended for UQD (US$ equivalent)		US$21,356,827

Bangladesh TB grants: National Tuberculosis Control Program (BGD-T-NTP) and BRAC (BGD-T-BRAC)

1.69 Rationale and investments to finance UQD from portfolio optimization and Private Sector donor. The national TB program grant and the BRAC grants are well performing and have made substantial progress in increasing the number of cases detected and successfully treated each year. However, the gap in undetected TB needs to be closed, for which public-private mix is seen as a critical strategy in the context of Bangladesh context. The GAC recommends for Board approval an investment of additional funding of US$4 million for the Bangladesh TB grants BGD-T-NTP and BGD-T-BRAC to incorporate US$2 million from portfolio optimization and US$2 million from private sector donor Comic Relief toward the program's unfunded quality demand. This additional amount would increase the total program budget beyond the amount previously approved by the Board in GF/B32/EDP05 on 16 January 2015 and in GF/B34/ER05 on 18 January 2016.

1.70 The strategic focus of the additional investment. In 2015, Bangladesh was number six of 22 high-burden TB countries according to the WHO. In 2015, a total 209,438 cases of TB were notified, and the notification rate of all forms of TB was 130 per 100,000 population. A recent TB prevalence survey (although still in draft form) confirms that around 150,000 cases remain undetected each year in the country. Methods of reaching and treating undetected patients need greater emphasis particularly on engaging private practitioners and pharmacies into bringing new patients for screening. The additional investment is proposed to expand public-private mix in Bangladesh focusing on a social enterprise model, which has already been run as a successful pilot in three TB screening centers in Dhaka since 2014 by ICDDR,B and using a similar model to reach new urban settings and leverage BRAC's extensive networks into the community. Importance is given in the model to identifying the undiagnosed and unreported cases. The additional funds will focus on:

[28] Additional funding recommended to finance UQD for Myanmar TB has been integrated into the budget for the Myanmar TB/HIV Early Applicant funding request for 2017. The programmatic focus and additional outcomes expected from financing of UQD for Myanmar TB are described in section IV.02 above.

- Increasing cases detected and treated by 11,162, and strengthening linkage with qualified private providers;
- Maintaining treatment success rates of at least 90 percent; and
- Ensuring regular supervision and monitoring.

1.71 Implementation arrangements and risk. The national TB program will fund the scale-up of the social enterprise model currently being piloted through the grant by ICDDR,B as a sub-recipient. BRAC will start new screening centers using a similar model in 8 new urban areas accessing its extensive network and linkages to private providers. New GeneXpert machines for both Principal Recipients will be purchased through Stop TB's Global Drug Facility under the national TB program grant.

Central African Republic TB/HIV grant: International Federation of Red Cross and Red Crescent Societies (CAF-C-IFRC)

1.72 Rationale and investments to finance UQD. This program performs exceptionally well and has taken measures to address issues that have come to light. Despite the issues facing this challenging operating environment, the country is expected to absorb additional funding considering the continued scale-up of interventions through the additional funding's proportion (71 percent) of procurement and supply chain management costs and the high demand, as demonstrated through the pre-ART waiting list of 25,000 people. Additionally, since December 2014, the Principal Recipient has received dedicated procurement and supply management technical support to fill gaps in the Principal Recipient's capacity. The persistent coordination challenges that generate a stock-out risk of first line ARTs in mid-2016 will be addressed through joint programmatic and procurement and supply management supervision at the health facility level. Recruitment of an in-country international procurement and supply management focal point has recently been launched to ensure high quality and well-coordinated procurement activities. The GAC recommends for Board approval an increase in the final grant amount for the Central African Republic TB/HIV grant CAF-C-IFRC to incorporate an additional funding of €4,325,121 toward the program's unfunded quality demand. This additional amount would increase the total budget beyond the incremental amount previously approved by the Board on 24 August 2016 (GF/B35/ER11).

1.73 The strategic focus of the additional investment. ART coverage rates are very low in Central African Republic, at 24.5 percent of people living with HIV receiving ART in 2015. The HIV prevalence rate in the Central African Republic in 2010 was 4.9 percent, with approximately 25,000 people living with HIV in pre-ART. As of 30 June 2016, 29,808 people living with HIV are on ART exceeding the December 2016 target of 28,680. The country's TB prevalence rates per 100,000 population have decreased from 1,348 to 435 cases between 1990 and 2014. Given this recent scale-up, investment in viral load testing and development of a national strategic laboratory plan is essential. The Global Fund is the sole source of funding for anti-TB drugs and will continue to provide the majority of ARTs. Interventions that will be funded through the additional investment include:

- Expanding ART treatment, including increasing the number of patients on ART from 33,527 to 39,752;
- Strengthening the capacity of the TB and HIV national programs;
- Decentralizing MDR-TB case management through the procurement of GeneXpert machines and training of health and lab workers in three additional sites;
- Rolling out behavior change communication through dissemination of 1,000 leaflets; and
- Scaling up viral load testing.

With additional funds, the following targets will be reached:

- Increasing the percentage of adults and children with HIV to be on treatment 12 months after initiation of ART from 62.7 percent in 2014 to 75.0 percent in 2017; and
- Raising treatment success rate of bacteriologically confirmed TB cases from 68 percent in 2015 to 75 percent in 2017.

1.74 Audit by the Office of the Inspector General (OIG) and outstanding amounts. The Government of the Central African Republic was unable to meet the terms outlined in a Reimbursement Protocol that expired on 30 April 2015 concerning €51,453 of ineligible expenditures identified by the Local Fund Agent

and US$911,265 of ineligible expenditures identified by a 2013 OIG audit of grants previously implemented by the Ministry of Health. The Secretariat is finalizing a renegotiated Reimbursement Protocol, which will be signed by December 2016. The government has committed to repaying €51,453 by the end of December 2016 and the remaining balance of US$911,265 by the end of 2019.

Philippines TB grant: Philippines Business for Social Progress (PHL-T-PBSP)

1.75 Rationale and investments to finance UQD. The grant has constantly performed well in both programmatic and financial terms. The adoption and roll-out of new diagnostic tools and intensified case finding activities have increased MDR-TB cases detected and treated from 2,390 to 4,035 in 2015. Additionally, the grant increased multi drug-resistant TB (MDR-TB) target to 5,624 by the end of 2016 and doubled the community-referred TB cases from 7,200 to 14,760.The GAC recommends for Board approval an increase in the final grant amount for the Philippines TB grant PHL-T-PBSP to incorporate additional funding from portfolio optimization toward the program's unfunded quality demand (UQD).

1.76 The strategic focus of the additional investment. The Philippines is one of the 22 high TB burden countries, according to WHO. During 2016, the grant reinvested savings achieved through further decentralizing activities for programmatic management of drug-resistant TB, scaling up GeneXpert diagnosis service and intensifying case finding and default tracing efforts, as well as starting shorter regimen. Within the approved transitional costed extension, the program aims to enroll 6,600 MDR-TB patients, and the TB notification rate for all forms of TB will increase to 245,318. The additional investment will focus on scaling up coverage of programmatic management of drug-resistant TB, aiming to enroll an additional 1,100 MDR-TB patients in 2017 through transitioning newly enrolled patients to shorter regimen treatment. This will increase MDR-TB enrolment from 6,600 in the current performance framework to 7,700. Activities supported by additional funds include procurement of pharmaceuticals, health products and equipment, living support to patients, and expansion of decentralizing programmatic management of drug-resistant TB

Viet Nam TB grant: Vietnam National Lung Hospital (VNM-T-NTP)

1.77 Rationale and investments to finance UQD. The grant has been consistently performing at high levels and enrolling MDR-TB patients as planned since inception. By 2017, 3,000 patients will be enrolled yearly, representing a 50 percent coverage of the yearly 5,500-6,000 estimated new MDR-TB cases. With the additional investment, in combination with switching the bulk of patients to shorter regimens starting in 2017, the coverage will exceed 75 percent during 2018-2020. The Principal Recipient has the technical capacity to further scale up and absorb the additional funding. The GAC recommends for Board approval an increase in the final grant amount for the Viet Nam TB grant VNM-T-NTP to incorporate an additional investment toward the program's unfunded quality demand (UQD). This additional amount would increase the total budget beyond the incremental amount previously approved by the Board on 5 June 2015 (GF/B33/ER03). The Principal Recipient is currently undertaking a negotiation towards reprogramming of grant VNM-T-NTP, whose revised budget is under review by the Local Fund Agent.

1.78 The strategic focus of the additional investment. Viet Nam ranks 12th among the 22 TB high burden countries and 14th among the 27 high multidrug resistant TB burden countries, and in 2012, TB prevalence, incidence and mortality rates were 218, 147, and 20 per 100,000 population respectively. The additional investment is proposed to fund interventions including:

- Active TB case finding at the community level using X-ray and GeneXpert, especially in high-risk and vulnerable populations;
- Improvement of laboratory capacity for TB diagnosis;
- Testing GeneXpert for all acid-fast bacilli (+) cases for increasing multi-drug resistant TB (MDR-TB) case detection; and
- Strengthening active case finding and routine case detection among vulnerable groups including children, people in prisons, elderly and mentally ill patients.

Accordingly, the additional funds has been allocated for the following:

- Conducting TB active case finding in communities in 24 additional districts in eight provinces;

- The expansion of nine-month regimen for MDR-TB treatment;
- Increasing the percentage of notified cases of bacteriologically confirmed, drug resistant Rifampacin-resistant TB and/or MDR-TB from 20.5 percent in 2013 to 65.6 percent in 2017; and
- Increasing the percentage of HIV-positive registered ART patients undergoing TB treatment from 60.5 percent in 2013 to 90 percent in 2017.

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

Colombia TB grant: International Organization for Migration (COL-910-G06-T)

1.79 Rationale for extension. The GAC endorsed a six-month non-costed extension to 30 June 2017 to facilitate a smooth transition from Global Fund financing for the Colombia national TB program. The TB disease component of the Colombia portfolio did not receive transition funding for the 2014-2016 allocation period and remains ineligible for further Global Fund financing. The extension will help address barriers to a successful transition, and increase the likelihood that the currently Global Fund-financed interventions are maintained after the grant closure. The Secretariat has worked with the country to reinvest savings from the current allocation in transition-related activities to be implemented during the extension period.

1.80 Reinvestment of exchange rate savings. The extension will be financed with grant savings that derived partially from exchange rate differences and the depreciation of the Colombian national currency. The GAC exceptionally authorized the reinvestment of savings from foreign exchange gains within the current grant to fund the non-costed extension, noting that savings are within funding made available under the rounds-based funding model. In addition, a part of the additional savings will be used to finance the closure period.

1.81 The strategic focus of the program. The activities financed during the extension period focus on supporting the country to sustain with its own resources the gains achieved with Global Fund support in the past five years. Through capacity building of community health workers and civil society organizations, as well as implementation of international best practices in the management of HIV co-infection and other activities, the grant has helped support the national TB program to:

- Significantly increase the number of people living with HIV on isoniazid preventive therapy;
- Increase the percentage of TB patients with known HIV status from 78 to 95 percent; and
- Increase the percentage of HIV positive TB patients on ART from 58 to 75 percent.

The proposed core activities during the extension period include:

- Extension of salaries for key staff and auxiliary nurses in four cities to support the implementation of the new national comprehensive model of healthcare and to allow for additional time for local authorities to absorb these functions;
- Provision of technical support to ensure that new national policies effectively implement a patient-centered approach including the role played by civil society, and improve data quality for TB/HIV co-infected patients receiving ART in four cities;
- Strengthening of national TB guidelines on the management of MDR-TB, contracting of civil society organizations to provide promotion and prevention services, and social protection for TB patients; and
- Strengthening an international alliance with a technical assistance provider and development and distribution of an outreach toolkit for service providers.

To assess progress, the extension includes a maintenance of targets for two indicators included in the original performance framework for an additional period, as well as transition-focused work plan tracking measures, including:

- Developing national guidelines to further promote integration of community agents and civil society organizations into service delivery; and
- Transferring lessons learned to all eight territorial entities in order to build capacity and sustainability for the grant interventions in the prevention of TB and TB/HIV.

Kazakhstan HIV grant: Republican AIDS Center on Prevention and Control of AIDS of the Ministry of Healthcare and Social Development (KAZ-H-RAC)

1.82 Rationale for extension. The GAC approved a 12-month non-costed extension for the Kazakhstan HIV program to 31 December 2017 to allow an intensification of the program implementation including harm reduction outreach and use for it the consumables supported by the program. The start of this component in the current implementation period was delayed by a need to engage a procurement agent in response to OIG findings. The grant KAZ-H-RAC is a round-based grant that started on 1 January 2012 with a second implementation period started on 1 January 2014, and is scheduled to end on 31 December 2016. The extension will also further support the work on program sustainability and successful transition. Furthermore, given that Kazakhstan became eligible for HIV again in in 2016, the extension gives the country an opportunity for continuity without program interruption, including ongoing support for operational arrangements needed for a potential new grant application and implementation in the 2017-2019 allocation period.

1.83 The strategic focus of the program. The activities supported by the extension will be in line with objectives and activities of the current grant:

- Outreach to people who inject drugs and prevention programs for men who have sex with men;
- Expansion of opioid substitution therapy program in civil sector and support of prevention activities in the penitentiary sector including opening up two opioid substitution therapy sites;
- Support a scale-up of viral load testing responding to the planned ART coverage scale-up; and
- Expanding work on successful transition of HIV program in Kazakhstan contributing towards alleviating the relevant risks.

SADC HIV grant: South Africa Development Community Secretariat (QPA-H-SADC)

1.84 Rationale for extension. The GAC endorsed a 6-month non-costed extension (from 1 July 2017 to 31 December 2017) in order to enable the SADC Secretariat to complete agreements to operate 32 wellness centers for 12 months before they are transferred to the member states. Following the extension, the grant will enter a close-out period to August 2018.

1.85 The strategic focus of the program. The SADC grant targets cross-border mobile populations who travel across international land borders, and aims to reduce the HIV incidence and morbidity associated with HIV and HIV/TB-co-infection among long-distance truck drivers and sex workers, and mitigate their associated impact in the SADC region. As the grant has only been able to establish 12 of the planned 32 wellness centers, during the proposed extension period, the grant will focus on establishing the remaining 20 wellness sites and handing over all sites to the SADC member states. The grant will also work with authorities to address the issue of human trafficking of sex workers and young girls, identified by one of the wellness centers.

1.86 Sustainability. Member states have demonstrated a high level of commitment to the projects and have agreed to own the cross-border wellness sites once established and running for 12 months. Member states will operate these sites for at least two years after the transfer. The majority of sites will complete the transition by December 2017, and approximately ten sites will be transferred during the first quarter of the close-out period, for which the budget will be finalized in June 2017.

1.87 Operational issues, risks and implementation challenges. The delay in procurement of containers for wellness sites have caused delays in full implementation of the program. However, the containers will be delivered by January 2017 and the risk during the delivery phase is manageable.

Thailand TB/HIV grants: The Department of Disease Control, Ministry of Public Health of the Royal Government of Thailand (THA-C-DDC), Raks Thai Foundation (THA-C-RTF)

1.88 Rationale for extension. The GAC approved a 12-month non-costed extension to 31 December 2017 to continue key interventions by using undisbursed funds and in-country cash balance in order to bridge the gap between the current grant and the next allocation. The current grants end on 31 December 2016. As

Thailand TB and HIV remain eligible for Global Fund financing in the 2017-2019 allocation period, the extension will ensure the continuation of service delivery without interruption and provide sufficient time for the development of a new application request and the signing of new grants under the next funding allocation.

1.89 The strategic focus of the program. The current grants focus on the 38 highest HIV and TB disease burden provinces in Thailand with exclusive focus on key affected populations for HIV and TB. HIV prevention interventions include outreach and HIV testing among key population, and activities for TB include care and prevention, MDR-TB treatment, care and support for uninsured migrants and prisoners. The grants are introducing innovative service delivery models for HIV and TB focusing on community-led services, addressing human rights to ensure friendly and supportive access for KAPs as well as changing nationally the TB diagnosis algorithms to bridge the gap to the 50,000 missing TB cases. These innovations will bring down unit costs for prevention and care leveraging the purchasing power of the Ministry of Public Health. The indicators and targets supported by the Global Fund resources for the Extension period will remain at the same level as of the last period of the current grant to ensure continuation of services currently provided.

1.90 Transition to domestic resources. It is acknowledged that Thailand previously communicated to the Board intentions for an early transition from Global Fund financing to domestic resources by 2016. At the time of Board approval, the TRP and GAC expressed some concerns about the ambitious timeline of the proposed transition, recommending that the Secretariat closely monitor the progress of the transition and noting the opportunity for the Secretariat to apply operational flexibility in the case of delays or set-backs. In the absence of a thorough transition plan agreed upon among all parties, in addition to the operational issues of delayed signing and low absorption, the transition to domestic resources has not materialized according to the proposed timeline, necessitating this extension, which will allow for transition to the next funding cycle.

1.91 GAC review and recommendations. The GAC emphasized the necessity of an efficient partnership between government in civil society, in a collaborative and efficient manner.

Annex 1

Table 5: Grant Extensions Approved by the Secretariat

Applicant	Disease Component	Grant Name	Currency	Period of Extension (Months)	Additional Funding	Rationale
Asian Pacific Network of People Living with HIV/AIDS (APN+)	HIV/AIDS	QSA-H-APN+	US$	6	0	Refer to summary above.
Kazakhstan	HIV/AIDS	KAZ-H-RAC	US$	12	0	Refer to summary above.
Thailand	TB/HIV	THA-C-DDC	US$	12	0	Refer to summary above.
		THA-C-RTF	US$	12	0	
SADC	HIV/AIDS	QPA-H-SADC	US$	6	0	Refer to summary above.
Colombia	TB	COL-011-G06-T	US$	6	0	Refer to summary above.