Electronic Report to the Board

Report of the Secretariat's Grant Approvals Committee

GF/B33/ER03
Board Decision

PURPOSE: This document proposes two decision points as follows:

1. GF/B33/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation[1]
2. GF/B33/EDP05: Decision on the Secretariat's Recommendation on Grant Extensions[2]

This document is part of an internal deliberative process of the Global Fund and as such cannot be made public.

[1] Bhutan Malaria, Ethiopia HSS, Ethiopia Malaria, Gambia HIV, Guinea Malaria, Lao TB, Mozambique Malaria, Mozambique TB/HIV, Papua New Guinea HIV, Philippines HIV, Sao Tome & Principe TB, Senegal HIV, Somalia HIV, Somalia Malaria, South Sudan TB, Tanzania TB/HIV, Uganda HSS, Uganda TB/HIV, Viet Nam TB/HIV, Yemen Malaria. Total incremental amount is US$845,524,917 and EUR 8,555,373.

[2] Malawi HIV, Multi Country Americas REDCA+ HIV. Total incremental US$37,283,718

The Global Fund

I. Decision Points

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

1.1 Set forth below is the Secretariat's recommendation to approve additional funding up to an amount of US$845,524,917 and EUR 8,555,373

<u>Decision Point: GF/B33/EDP04: Decision on the Secretariat's Recommendation on Additional Funding from the 2014 Allocation</u>

The Board:

1. *Approves the incremental funding recommended for each country disease component, and its constituent grants, as listed in Table 1 of Annex 1 to GF/B33/ER03 ("Table 1");*
2. *Acknowledges each country disease component's constituent grants will be implemented by the proposed Principal Recipients listed in Table 1, or any other Principal Recipient(s) deemed appropriate by the Secretariat in accordance with Global Fund policies;*
3. *Affirms the incremental funding approved under this decision (a) increases the upper-ceiling amount that may be available for the relevant implementation period of each country disease component's constituent grants, (b) is subject to the availability of funding, and (c) shall be committed in annual tranches; and*
4. *Delegates to the Secretariat authority to redistribute the overall upper-ceiling of funding available for each country disease component among its constituent grants, provided that the Technical Review Panel (the "TRP") validates any redistribution that constitutes a material change from the program and funding request initially reviewed and recommended by the TRP.*

This decision does not have material budgetary implications for the 2015 Operating Expenses Budget.

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

<u>Decision Point: GF/B33/EDP05: Decision on the Secretariat's Recommendation on Grant Extensions</u>

The Board:

1. *Approves extension of the relevant implementation period for each grant listed in Table 2 of Annex 1 to GF/B33/ER03.*

This decision does not have material budgetary implications for the 2015 Operating Expenses Budget.

II. Relevant Past Decisions

1. Pursuant to the Governance Plan for Impact as approved at the Thirty-Second Board Meeting,[3] the following summary of relevant past decision points is submitted to contextualize the decision points proposed in Section I above.

Relevant Past Decision Point	Summary and Impact
GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period[4]	The Secretariat is exercising operational flexibility with respect to the duration of grants, as outlined in GF/B31/DP09, for the Mozambique TB/HIV, Mozambique Malaria, Tanzania HIV and Uganda TB/HIV grants.
GF/B31/DP12: Extension Policy under the New Funding Model[5]	This decision point establishes the current policy, based on which the extensions described in this Report are granted and reported by the Secretariat or otherwise recommended to the Board for approval.

III. Action Required

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

[3] GF/B32/DP05: Approval of the Governance Plan for Impact as set forth in document GF/B32/08 Revision 2 (http://www.theglobalfund.org/Knowledge/Decisions/GF/B32/DP05/)
[4] GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/)
5 GF/B31/DP12: Extension Policy under the New Funding Model (http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP12/)

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

01 Summary of the deliberations of the Secretariat's Grant Approvals Committee (GAC) on funding recommendations

Bhutan Malaria Grant (BTN-M-MOH)

1. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$1,942,261 for the Bhutan malaria program, which consists of the Ministry of Health grant BTN-M-MOH of the incremental amount of US$1,776,655 for the implementation period 1 July 2015 through 30 June 2018. Bhutan did not submit an above allocation request and does not have registered unfunded quality demand.

2. Epidemiological situation. Bhutan has an estimated population of approximately 740,000. According to the WHO, Bhutan is categorized in the pre-elimination phase and is on track to decrease malaria incidence by over 75 percent for the period 2000-2015, moving the country into the elimination phase. Over the years, the country has made tremendous progress in preventing and controlling malaria, as shown by the reduction of malaria cases from 5,935 in 2000 to 45 in 2013, and an annual parasite incidence reduction from 13.8 per 1,000 population in 2000 to 0.2 per 1,000 population in 2013. In addition, the malaria test positivity rate has declined from 7.8 percent in 2000 to 0.14 percent in 2013, while the annual blood examination rate has decreased from 22 percent in 2000 to 6 percent in 2013. Key populations constitute 33% of the total population of the country (234, 669 people), located in 15 out of the total 20 districts. The groups most-at-risk in Bhutan are farmers, students and migrant workers and the country has recently recorded an increase in imported malaria cases among mobile workers / laborers and border populations.

3. Past program performance. Interventions and achievements of the malaria program in Bhutan coincide with Global Fund funding with a clear decline in morbidity after 2006, when the first mass long lasting insecticidal nets (LLINs) distribution took place. In 2005, the Global Fund signed the first grant with the Ministry of Health's Vector Borne Disease Control Program as Principal Recipient. The Global Fund's investment in malaria prevention and control activities were guided by the national strategic plan for 2012 to 2016. The mid-term review of the malaria program conducted in September 2013 concluded that overall program performance was strong.

4. The goal of this program is to achieve zero indigenous malaria in Bhutan by 2018 and obtain WHO malaria-free certification by 2020. To enable Bhutan to achieve the program goal, the Global Fund will invest in the following strategies: (i) early, effective and complete diagnosis and treatment; (ii) intensification of integrated vector management; (iii) geographical reconnaissance and mapping with micro-stratification by village; (iv) intensification of surveillance and response; (v) quality assured laboratory diagnosis, treatment and follow up; (vi) provision of LLINs and focal indoor residual spraying; (vii) empowerment of communities; and (viii) cross-border collaboration. Expected outcomes include a 28 percent reduction in reported malaria cases, 0.15 confirmed malaria cases per 1,000 persons per year and zero inpatient malaria deaths per 1,000 persons per year.

5. Implementation arrangements. The proposed implementation arrangements in Bhutan build on past experience of the current grant, for which the Ministry of Health's Vector Borne Disease Control Program is the Principal Recipient. The current malaria program has been strongly performing with the program and financial management systems in place deemed sufficient and compliant with the minimum standards. LLINs and rapid diagnostic tests (RDTs) will be procured through the Global Fund's pooled procurement mechanism. By sourcing products through this mechanism, the Principal Recipient has access to quality-assured products at competitive prices.

6. TRP review and recommendations. The TRP considered this concept note to be technically sound, aligned with the revised national strategic plan for 2015-2020 and strategically focused in terms of prioritizing interventions that will help the country achieve its goal of malaria elimination. The TRP noted the need to resolve issues such as the social marketing around LLIN usage and indoor residual spraying, reaching target groups such as mobile/migrant workers and border populations, the linkage between community action groups and malaria programming, the application of geographic

information systems activities to other communicable disease programming, and training workers for cross-cutting programming.

7. GAC review and recommendations. The GAC recommended an upper funding ceiling for grant making of US$2,321,443 based on TRP recommendations. The GAC endorsed the TRP recommendations, and reviewed progress against actions taken during grant-making to address TRP clarifications. During grant-making, US$449,000 in efficiencies were identified as the result of reducing travel, training, administrative, communication material and HR costs. GAC endorsed reinvestment of US$74,000 in the program for a prevalence survey, the provision for an external audit, and costs for geological survey equipment. The remaining savings in the amount of US$382,147 will not be reinvested in the program, and have been made available for re-allocation.

8. Domestic contributions. The Bhutan health system is predominantly financed by the Royal Government of Bhutan from its own resources. About 85 percent of the total health expenditure is financed by general government expenditure. The estimated funding need for the national malaria program of the Royal Government of Bhutan in the next implementation period is US$6,485,060. Total domestic financial commitments amount to US$3,279,456, which represents 52 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 56 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower-income country. Government commitments related to malaria represent a 13 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$275,015. In line with the requirements of sustainability and longer term growth, all recurrent expenditures of the malaria program are exclusively funded by the government both at national and sub-national levels.

Ethiopia HSS Grant (ETH-S-FMOH)

9. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$52,260,169 for the Ethiopia HSS program, which consists of the Ministry of Health grant ETH-S-FMOH of the incremental amount of US$44,627,165 for the implementation period 1 July 2015 through December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$15,774,456 is registered as unfunded quality demand, in line with TRP recommendations.

10. Epidemiological situation. Ethiopia has made significant strides in scaling up and strengthening program interventions achieved through conscious and systematic investments in developing sustainable and reliant health systems to achieve the UN Millennium Development Goals (MDGs). MDG 4 on child health has been achieved; the mortality of children under 5 declined by over 47 percent between 2000 and 2011, and infant mortality by 39 percent. Significant progress has been made on MDG 5 on maternal health; maternal mortality is estimated to have been reduced by 64 percent between 1990 and 2010. Additionally, the country is on track to achieve MDG 6 on combatting HIV/AIDS, malaria and other diseases with nearly 50 percent, 40 percent and 30 percent reductions in HIV, malaria and TB related deaths respectively.

11. Past program performance. Ethiopia is one of the largest recipients of Global Fund resources with an approved maximum funding of US$1.73 billion and a total US$1.6 billion already disbursed. HIV/AIDS accounted for 64 percent of total investments (US$1.08 billion), followed by malaria (29 percent, US$489 million), and TB (6 percent, US$93 million). Over the years, Global Fund grants have supported different components of health systems strengthening (HSS) interventions through disease proposals, and under the cross-cutting HSS components of the round 9 TB proposal. The investments have contributed to massive expansion of health facilities, with a 13-fold increase in health facilities and health posts from around 1,500 in 2000 to over 20,000 in 2014, thereby improving geographic access to health facilities to over 95 percent of the population within a 10km radius. Significant among them is over 10,000 new community health posts were made functional and over 3,000 health centers constructed. The health sector development program got a significant boost in early 2000, not only from increased domestic financing, but complimented by additional external resources from multilateral and bilateral funding mechanisms including the Global Fund, GAVI, PEPFAR, President's Malaria Initiative contributing to the MDG Pooled Funding mechanism in Ethiopia.

12. Program goals. The government of Ethiopia articulates its mission "To promote health and wellbeing of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, curative, palliative and rehabilitative health services via a federalized and democratized health system and empowered community" with a vision "To see healthy, productive, and prosperous Ethiopians". To support this mission, the program goals are to reduce under five mortality to less than 35 per 1000 live births by 2020; reduce neonatal mortality to less than 15 per 1000 live births by 2020; reduce maternal mortality to less than 200 per 100,000 live births; and reduce morbidity and mortality due to HIV, TB and malaria. To realize its health sector goals, the country has adopted a four pillar strategic approach: (i) excellence in health service delivery through promotion of good health practices at individual, family and community level and the provision of equitable preventive, curative, rehabilitative and emergency health services; (ii) excellence in quality assurance by managing quality and safety in health services including laboratory quality; (iii) excellence in leadership and governance by encouraging evidence based policy formulation and planning; implementation; and monitoring and evaluation of the health system; and (iv) excellence in health system capacity through enhancement of resources for health, which includes the human and financial resources, health infrastructure and supply that are accessible to communities.

13. Implementation arrangements. The grant will be implemented by the Federal Ministry of Health of Ethiopia as the grant Principal Recipient. Given that the priority areas requested in the HSS concept note consist of the scale-up and strengthening of national monitoring and evaluation, procurement and supply chain management, financial, and laboratory systems, the Federal Ministry of Health is the natural implementer to ensure sustainability and synergies across activities.

14. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it is linked to a clear strategic plan for the health sector, including for disease specific programs, which has been developed through a close collaboration between the Government of Ethiopia and development partners. The TRP also acknowledged areas in which progress could be made during grant-making, with clarifications requested such as how the country will transition to electronic health systems, how the country plans to address human rights, gender and geographic disparities among underserved rural populations, what indicators will be measured during implementation, plans for refresher trainings and upgrading of health extension workers to avoid disruption of services and ensure quality, and justification for proposed capital investments including in vehicles and PSM / warehousing.

15. GAC review and recommendations. The GAC expressed strong support for the Ethiopia HSS concept note, recognizing that it is a good example of health systems strengthening and addressing critical gaps in health systems for strengthening implementation of HIV, TB and malaria programs. The GAC noted, furthermore, that the concept note builds on past achievements as well as on lessons learned through independent program reviews. The GAC recommended an upper funding ceiling for grant making of US$45,694,020 based on TRP recommendations. GAC emphasized the need to ensure accountability and sustainability through the efficient use of available infrastructure, and requested the CCM to re-align funding away from capital intensive projects towards more optimal use of existing infrastructure as appropriate. The GAC endorsed the TRP recommendations, and reviewed progress against actions taken during grant-making to address TRP clarifications. The country team highlighted achievements such as the consolidation of cross-cutting HSS interventions in this single grant, the plan for expanding electronic information systems, and an improved performance framework that allows the Secretariat to better monitor grant progress and impact. The GAC was supportive of the country's community-centered approach and commitment to provide health services to all residents, noting the country's efforts in making health centers available throughout all rural areas of the country. In addition, the Secretariat confirmed that during grant implementation, disbursements related to PSM capital investments (additional fleet and warehouse) are contingent upon detailed assessment of needs to optimize and maximize existing infrastructure before further expansion, and a costed implementation plan.

16. GAC review and recommendations. In its first review the GAC noted the significant exposure of the grant to fiduciary/financial risk due to the very high cash levels in-country, particularly in respect to cash held in local currency. GAC stressed the need for measures to be included in the Grant Agreement to bring cash balances to within acceptable levels (to be defined during grant making) and to safe-guard Global Fund assets. In its second review the GAC was informed that as part of grant-making, the national programs identified concrete steps to improve capacity, find efficiencies in processes (including optimizing procurement lead times) and strengthen systems to reduce cash

balances and find efficiencies. The GAC was also informed that the country has put a lot of emphasis on strengthening financial management capacity, implementing an integrated financial management information system (IFMIS) to ensure greater transparency of the flow of funds, to be fully aligned with the procurement management system (ERP). The quality and availability of financial and programmatic data was well demonstrated down to the facility level. Ethiopia has been identified as a priority country for HSS case studies this year, focused on the impact of historical HSS investments and on PSM and service delivery. It will be important to collaborate with the World Bank, GAVI, UNICEF and other partners on Ethiopia's case study to generate relevant information to support co-investment and harmonization of programs.

17. Reinvestment of efficiencies: Following grant-making, the total HSS budget was revised upwards to US$52,260,169 due to identified savings and delayed implementation of existing grant activities to be carried forward into the new implementation period. This increase is due to the following factors: (i) the amount of US$562,457 initially planned for health extension workers career development training has been transferred to the grant budget using savings resulting from the malaria grant, (ii) the amount of US$5,503,693 of in-country cash committed to the round 9 grant (ETH-911-G11-S) activities has been carried forward mainly for the installation of solar panels and radio equipment in rural health posts and procurement of lab equipment currently in process; (iii) in July 2014, the HSS grant received funding of US$500,000 through Special Initiatives for a Service Availability Readiness Assessment with data quality review and community health information system strengthening (CHIS). GAC endorsed the proposed reinvestment of identified savings and efficiencies.

18. Results based funding (RBF) model. Considering the OIG recommendation to conduct further system assessments and testing of Ethiopia's internal control environment, the design of the current grant is not established on the RBF model but is currently structured as a standard grant. Following on from the OIG recommendations, the Secretariat aims to undertake an assessment and test of the internal control environment over Q3/Q4 2015 to inform a transition to RBF for the malaria grant in Ethiopia. After completion of the internal control assessment, and based on the findings of the assessments recommended by the OIG, the CCM will submit detailed information and a proposed RBF matrix to the Secretariat for further review by the TRP and GAC, and for consideration towards a phased transition to the RBF model for the HSS grant as well.

19. Domestic contributions. The estimated funding need for the priority areas of cross-cutting HSS for Ethiopia in the next implementation period is US$134.5 million. In the identified health systems strengthening activities to be prioritized, total domestic financial commitments amount to US$19.8 million, which represents 15 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 30 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 20.1 percent increase compared to the previous implementation period.

Ethiopia Malaria Grant (ETH-M-FMOH)

20. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$148,752,983 for the Ethiopia malaria program, which consists of the Ministry of Health grant ETH-M-FMOH of the incremental amount of US$115,512,587 for the implementation period 1 July 2015 through December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$14,154,980 is registered as unfunded quality demand, after adjusting for efficiencies identified during grant-making and in line with TRP recommendations.

21. Epidemiological situation. The diverse ecology in Ethiopia supports a wide range of malaria transmission intensities, ranging from low-hypoendemic transmission in the highlands and semi-arid regions to high-endemic perennial transmission in the lowland regions and valley floors. Based on annual parasite incidence and altitude, four broad strata are identified, which show that the proportion of the population at risk of malaria is 60 percent. As per the 2011 Malaria Indicator Survey, approximately 47 percent of malaria risk areas, which include areas below the altitude of 2,000 meters, were covered with indoor residual spraying (IRS); long lasting insecticidal nets (LLINs) combined with

IRS protected 72 percent of the population living in the malarious areas. In spite of the significant gains, malaria morbidity in Ethiopia continues to be high - accounting for 17 percent of the total outpatient visits and 8 percent of the total admissions in all age groups, with similar percentages in children under the age of five.

22. Past program performance. Ethiopia is one of the largest recipients of Global Fund resources with an approved maximum funding of US$1.73 billion. Ethiopia has made significant strides in expanding coverage of key malaria control and preventive interventions throughout the country. During the period from 2000 to 2012, with contributions from government and external partners, over 38 million rapid diagnostic tests (RDTs), 48 million artemisinin-based combination therapy (ACT) treatments, and 56 million LLINs were procured and distributed. Major scale-up efforts began in 2004/2005 with the introduction of ACT as the first line treatment, expanded use of RDTs as well as stepping up of vector control and prevention through the wide distribution of LLINs backed by targeted IRS of houses. The number of health facilities providing ACTs and diagnosis by RDT or microscopy increased five-fold, from 3,622 to 18,792 facilities; parasitological test confirmation of malaria cases increased from less than 10 percent to 83 percent; and malaria surveillance reporting completeness increased from less than 20 percent to over 80 percent.

23. The goal of this program is to, by 2020 achieve near zero malaria deaths, precisely no more than 1 confirmed malaria death per 100,000 population at risk; reduce malaria cases by 75 percent from the baseline of 2013; and eliminate malaria in selected low transmission areas. To enable Ethiopia to achieve these program goals, the Global Fund will invest in the following strategies: (i) community empowerment and mobilization through engagement of health extension workers and health development army and community networks; (ii) sensitization and mobilization of communities for early diagnosis by making malaria diagnosis accessible at all health posts in malaria endemic areas through expansion and use of multi-species RDT at the community level, and quality-assured microscopy in health facilities; (iii) sustain universal coverage of effective and efficacious treatment as per the national guidelines by supporting integration of malaria interventions as part of integrated community case management; (iv) achieve and maintain universal coverage of vector control strategies including LLINs and IRS as per the updated national stratification; (v) strengthen malaria elimination efforts at sub-national level in identified districts through strengthened surveillance, case notification, case and foci investigation and classification; and (vi) strengthen capacity of surveillance, as well as monitoring and evaluation activities, and undertake routine and periodic data collection and analysis.

24. Implementation arrangements. The Federal Ministry of Health, the Principal Recipient for all previous malaria grants, has been nominated to continue as Principal Recipient. The CCM has indicated that the Federal Ministry of Health meets the minimum standards and, based on current program implementation, has adequate systems to ensure program delivery. The malaria program is implemented through the three-tier public health care delivery system, and health posts manned by health extension workers support the community outreach and integrated community case management component.

25. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound, with proposed interventions that are feasible in the current context, subject to continued strengthening of the health systems. Furthermore, the TRP noted that proposed interventions are in line with the 2014-2020 national strategic plan, which emphasizes the continued strengthening of Ethiopia's network of health extension workers that has been able to effectively support community level health provision. The TRP did request, however, that the country clarify eight issues during grant-making. These issues included the adjustment of indicators for access to antimalarial treatment; prevention of malaria in pregnancy; RBF characteristics, suitability and appropriateness of performance indicators related to the RBF mechanism; data quality; the potential duplication of funding for trainings; the quality of laboratory services and the focus on at-risk groups.

26. GAC review and recommendations. The GAC expressed strong support for the Ethiopia malaria concept note, recognizing that the program seeks to achieve high impact through investment in strategic priorities of the 2014-2020 national strategic plan, including community empowerment and mobilization, LLINs, IRS, case management, malaria elimination and strengthening of monitoring and evaluation. The GAC also noted that the national strategic plan has been developed with robust stakeholder involvement, and is a good example of the type of joint planning and programming that contributes to appropriate prioritization. The GAC endorsed the TRP recommendations and made further recommendations to the country about improving data quality and addressing the issue of underreporting, approach to linking the indicator targets to the RBF disbursement schedule; and asked that the country incorporate OIG recommendations as its review continued during grant-making.

Following grant-making, the GAC reviewed progress against actions taken during grant-making to address TRP clarifications. The GAC commended, in particular, the focus on rural populations through community-based interventions and the complementarity of the health systems strengthening grant to the provision of malaria-specific services.

27. GAC review and recommendations. The GAC recommended an upper funding ceiling for grant-making of US$126,235,129 representing an estimate of available funding by the grant start date. During grant-making, a number of activities originally scheduled for implementation prior to the start date of the current grant were identified under the round 8 grant ETH-809-G10-M. Due to delays those activities are currently planned to be finalized in the first few months of the new grant. These include distribution of bed nets, construction of IRS storage facilities, Health Extension Worker trainings, Malaria Indicator Survey, etc. – amounting to approximately US$10 million in carry forward budget. In addition, due to the urgent timing of Ethiopia's 2015 universal coverage campaign, existing resources from in-country cash and grant undisbursed funds were reprioritized to fund procurement of LLIN's to be delivered and distributed in 2015 amounting to US$ 23 million. Therefore the total budget of the grant has been revised upwards to US$148,752,983 accounting for the above-mentioned activities. During grant-making savings of US$ 22,607,620 were identified resulting from updated global pricing in procurement of ACTs, RDTs and LLINs. The GAC has endorsed the reinvestment of savings in the prioritization of LLINs and to fully cover IRS needs following the concept note strategy of targeted interventions by stratification. These interventions were identified as unfunded quality demand as recommended by the TRP.

28. Results based funding (RBF) model. Considering the OIG recommendation to conduct further system assessments and testing of Ethiopia's internal control environment, the design of the current grant is not established on the RBF model but is currently structured as a standard grant. Following on from the OIG recommendations, the Secretariat aims to undertake an assessment and test of the internal control environment over Q3/Q4 2015 to inform a transition to RBF for the malaria grant in Ethiopia. After completion of the internal control assessment, and based on the findings of the assessments recommended by the OIG, the CCM will submit detailed information and a proposed RBF matrix to the Secretariat for further review by the TRP and GAC, and for consideration towards a phased transition to the RBF model. In this regard, the GAC partners underlined the importance of target setting using lessons learned from other RBF programs.

29. Domestic contributions. The estimated funding need for the national malaria program of Ethiopia in the next implementation period is US$451.8 million. Total domestic financial commitments for malaria amount to US$66.1 million, which represents 14.6 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 26 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 20.1 percent increase compared to the previous implementation period.

The Gambia HIV Grant (GMB-H-NAS and GMB-H-ActionAid)

30. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$14,768,343 for The Gambia HIV program, which consists of the National AIDS Secretariat grant GMB-H-NAS with the budget amount of US$11,079,816 and of the incremental funding of US$9,073,538, and GMB-H-ActionAid grant with the budget amount of US$3,688,527 and the incremental funding of US$3,313,056 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$7,843,704 is registered as unfunded quality demand, in line with TRP recommendations.

31. Epidemiological situation. The Gambia is situated on the West Coast of Africa and is almost completely geographically surrounded by Senegal. With an estimated population of 1.9 million people, the country is classified in the low human development category and ranked 172 out of 187 in the 2014 Health Development Index. HIV remains a public health problem with the prevalence rate among the 15-49 age group at 1.9 percent. The country has a generalized low HIV epidemic with pockets of high HIV prevalence concentrated among key populations. The Gambia's health care services are organized as a three-tier hierarchical system, with village health services providing primary health care, health centers providing secondary health services and hospitals providing health care. HIV-related services

such as antiretroviral treatment (ART), prevention of mother-to-child transmission, and HIV testing and counseling are integrated into the existing healthcare delivery system and are provided across all three tiers. The two key populations referred to by the applicant are female sex workers and "other key populations."

32. Human rights context for key populations: In November 2014, a new law was passed following the legacy of homosexuality being illegal in The Gambia. The new law (known as the Principal Act) criminalized same-sex with a sentence of up to life imprisonment for "aggravated homosexuality" for the repeated offence of homosexuality and if the offender is living with HIV. The enactment of the law was followed by a wave of arrests of LGBT people in The Gambia, raids and detentions, torture of suspected LGBT & MSM, government sponsored anti-homosexuality protests and fear among key populations (with some fleeing to Senegal due to fear of reprisals) and program implementers. The escalation in stigma acts as a barrier to accessing HIV care, testing and prevention services, in addition to the significant risks to the safety and security of beneficiaries and implementers. The HIV prevalence among female sex workers is estimated at 15.9 percent and that other key populations is estimated at 9.8 percent. Due to stigma and discrimination by health workers, 10 percent of female sex workers reported that they were afraid to access health services and so do not continue their referrals. The 2011 integrated biological-behavioral surveillance report further demonstrated that about 33 percent of other key population groups also suffered at least one form of discrimination or abuse of their rights. Stigma and discrimination based on health status is also described as a major obstacle for referral and follow-up of TB/HIV patients.

33. Past program performance. With the support of Global Fund investments, the national response to HIV/AIDS has made significant gains. By the end of June 2014, 4,335 adults and children with advanced HIV infection were currently receiving ART, compared to the baseline of 688 in 2009. With ten ART site services currently operating countrywide, this is a notable increase in the access to ART services. There are 32 prevention of mother-to-child transmission sites countrywide and voluntary counseling and testing among pregnant women has performed well. In 2012, 85 percent of pregnant women were tested, which improved to 95 percent in 2013. In addition, in 2013, 729 seropositive pregnant women completed antiretroviral (ARV) prophylaxis out of the target of 837, reaching a 87 percent achievement, largely as a result of the elimination initiative from UNAIDS, UNICEF and WHO. Condom promotion and distribution among men showed improvements with 67 percent of men reported using a condom at last sex with a non-regular, non-commercial partner in the past 12 months compared to 48.5 percent in the 2010 Behavior Surveillance Survey. Additionally, the same study indicated that 77.8 percent of men reported using a condom at last sex with a commercial partner in the past 12 months compared to 59.3 percent in 2010.

34. The goal of this program is to achieve zero new HIV infections, zero AIDS-related deaths and zero stigma and discrimination in The Gambia. To enable The Gambia to achieve the program goal, the Global Fund will invest in the following strategies: (i) behavior change communication activities reaching general population and key populations and focusing on youth using mass media and outreach awareness campaigns; (ii) test and treat strategy for female sex workers and other key populations as possible; (iii) increase the coverage of treatment services in an effort to improve service delivery and reduce HIV/AIDS-related morbidity and mortality; and (iv) use of key population-friendly health providers to offer health services.

35. Implementation arrangements. The Principal Recipient selection process was conducted through an open, transparent and competitive process. Going forward the program will be implemented through a dual-track financing model by Action Aid International - The Gambia (AAITG) and National AIDS Secretariat (NAS) as co-Principal Recipients where NAS will be implementing the treatment component, and AAITG will be responsible for mass media, community prevention and key population programming. The round 8 grant, implemented by these same Principal Recipients, was rated as having satisfactory program management with good programmatic performance, both grants achieving ratings of A.

36. TRP review and recommendations. The TRP considered this concept note strategically focused and technically sound, linking well to the country's national strategic plan and indicating key national priorities. However, the TRP acknowledged a lack of key population data, insufficient clarity on the proposed interventions for key populations, the need for improving the performance framework and a weak procurement and management supply system. The TRP requested that these issues be addressed during grant-making.

37. Change in country context for key populations. During grant-making the GAC was updated on the amendment to The Gambia Criminal Code following the September 2014 submission of the concept

note (life imprisonment for "aggravated homosexuality"). The country team met with in-country stakeholders and concluded that adjustments were necessary to ensure the physical safety of beneficiaries and implementers, and that discretion in implementation was thus key for the program moving forward, with indicators and timelines adjusted to reflect these changes. Moreover, in light of the changing context, some TRP clarifications were no longer feasible (e.g. IBBSS and Key Population estimates in 2015, proposed indicators and targets) within indicated timelines. Considering the safety situation, the GAC endorsed conducting regional benchmarking/data triangulation in 2015 with an understanding that the IBBSS will be budgeted in 2016 and its feasibility assessed by the Secretariat during grant implementation, in collaboration with technical partners and community groups. The GAC also requested the country team to work with stakeholders to develop an updated work plan for key population activities adapted for the current context (completed), with a possibility for further reprogramming at a later stage. The GAC further acknowledged that in light of the human rights context, there will likely be allegations of human rights violations which may be reported to the OIG. The GAC recommended that the Secretariat reach out to in-country networks and community groups to facilitate reporting of such cases, if they emerge.

38. GAC review and recommendation. The GAC recommended an upper funding ceiling for grant making of US$13,598,585 based on TRP recommendations. Following grant -making, the GAC partners underlined the efforts to evolve programming and planning around the evolution of the political climate in The Gambia, particularly concerning key populations. During grant-making, US$2.8 million were identified in savings from the TRP endorsed budget and the current grant from prevention programs for general populations, prevention of mother-to-child transmission and pipeline commodities. GAC endorsed reinvestment of savings in treatment, procurement and supply chain management, program management, key population programming and progress towards compliance with the 2013 WHO HIV treatment guidelines. The GAC commended the applicant's effort of realigning programming with the volatile legal and social situation and recommended that best practices be shared with others working in similarly sensitive situations. GAC has also been informed that the grant includes investments in salaries and performance-based incentives totaling US$566,899 for government performance and retention, which will be phasing out going forward, as agreed upon with the CCM, government and in-country partners.

39. Domestic contributions. The estimated funding need for the national HIV program of The Gambia in the next implementation period is US$28,606,199. Total domestic financial commitments amount to US$1,896,493, which represents 10% of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 10 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 58 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$11,100,452. In addition, a special condition for the ongoing tracking of increasing future commitments to ensure continued compliance has been included though a relevant provision in the grant agreement.

Guinea Malaria Grant (GIN-M-CRS)

40. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$62,200,411 for the Guinea malaria program, which consists of the Catholic Relief Services grant GIN-M-CRS with the incremental funding amount of US$57,297,731 for the implementation period from 1 July 2015 through 31 December 2017. The above allocation funding request submitted in the concept note was funded through incentive funding, as recommended by the TRP and therefore there are no activities registered as unfunded quality demand for the Guinea Malaria program.

41. Epidemiological situation. Guinea has an estimated 2014 population of 11,767,987 and a low level of health service utilization. In Guinea, malaria is an endemically stable disease with long seasonal outbreaks lasting six to eight months, during which Guinea's entire population is exposed. Malaria is in the control phase, but remains the leading cause of morbidity and mortality in Guinea and represents 31 percent of medical consultation in public health sites for all age groups. The four groups identified as key populations are children under the age of five, pregnant women, people living in rural areas and people who attend private health facilities with limited access to prevention and treatment services. The average malaria prevalence among children aged 6 to 59 months is at 44 percent, with some regional variation. In 2012, the country reported a total of 1,220,574 cases of suspected malaria, from which only

a total of 317,200 cases were confirmed positive by microscopy or rapid diagnostic tests (RDTs). In 2013, the National Malaria Control Program reported 211,257 confirmed malaria cases in the country and the WHO reported high morbidity with 4.4 million cases (2.3 to 6.6 million) and a number of deaths due to malaria estimated at 12,000 (9,400 to 14,000). The Ebola outbreak has further compounded an already challenging and weak health system situation in the country, while diverting much needed resources. Issues include the disruption of malaria control activities in the most affected districts of the Forest region, as highlighted by the refusal of households in some localities to receive community health workers to avoid any risk of contamination. Similarly, some community health workers have been unwilling to take the risk of making household visits due to the same fears.

42. Past program performance. The Global Fund has been a major funder of the malaria program in Guinea since 2004, since which investments in malaria have gradually increased with the scope and quality of interventions also improving over the years. The country only began addressing malaria with any significant financing from 2004 and only with a major scale up from 2011 to date with the co-financing between the Global Fund and the President's Malaria Initiative. The data availability and quality from the routine data system is insufficient to measure the malaria burden and WHO cautions against using reported cases as proxy for assessing trends. Nevertheless, the estimated malaria incidence does not seem to have decreased significantly over the past ten years, while the estimated malaria death rate declined by around 50 percent.

43. The goal of this program is to contribute to reducing malaria morbidity by 75 percent compared with 2000, and reduce mortality to almost zero by 2017. To enable Guinea to achieve the program goal, the Global Fund will invest in the following strategies: (i) protecting at least 80 percent of the target population with effective malaria prevention measures by 2017; (ii) ensuring the early management of at least 90 percent of malaria cases, in accordance with national guidelines, in health care centers and the community; (iii) strengthening the population's level of knowledge on malaria prevention and treatment measures; (iv) strengthening the program's management, partnership and coordination capacities on all levels; (v) strengthening the supply chain management and health management information systems of the country. Expected outcomes of these strategies include 100 percent of households owning at least one insecticide treated bed net by 2016-2017, 80 percent of pregnant women and children under the age of five sleeping under an insecticide treated bed net by 2017, and parasite prevalence decreasing from the baseline of 44 percent to 25 percent in 2017, with increases in suspected, confirmed cases at both the health facility and community levels.

44. Implementation arrangements. Based on the recommendations of the multi-sectorial committee, the CCM chose to maintain Catholic Relief Services as Principal Recipient in order to capitalize on the lessons learned and improvements achieved since the restructuring of the portfolio. Malaria commodities will be managed together with other partners, including the President's Malaria Initiative, with oversight by a national committee to reduce the risk of stock-outs.

45. TRP review and recommendations. The Guinea malaria concept note was submitted originally in window 2 in June 2014. While the country was seeking to build on earlier achievements and was in line with the strategic objectives of the recently revised National Strategic Plan, the TRP cited the remarkably low uptake of malaria related services and lack of planning to ensure future uptake by relevant target groups for maximum impact. Following the TRP recommendation for further iteration, Guinea submitted a revised concept note in window 3 in September 2014. The TRP considered this concept note to be more strategically focused and technically sound and complimented it for highlighting program shortcomings and providing ways to systematically address them. However, the TRP noted that the proposed activities might be ambitious considering the ongoing Ebola outbreak and lack of health services in place. Given the satisfactory responses provided by country to the issues raised by the TRP in July 2014, Guinea's revised concept note was recommended to proceed to grant making with one issue related to inadequate number of RDTs requested by the country to be addressed during grant-making.

46. GAC review and recommendations. The GAC endorsed the TRP's recommendation and awarded an upper funding ceiling of US$60,017,151. GAC awarded incentive funding of US$ 2,078,401 based on TRP prioritization of the above allocation request which fully covers the quality demand as recommended by the TRP. The GAC expressed strong support for the Guinea malaria revised concept note, recognizing that it is more strategically focused, highlights program shortcomings and systematically addresses them. The GAC asked the applicant and country team to revisit several elements of the proposal, including the engagement of key populations, harmonization of product selection and procurement, reinforcement and streamlining of distribution systems, and creating flexible systems to take into account the Ebola outbreak. Savings generated during grant-making were

reinvested in cross-cutting activities to accelerate recovery and strengthen resilience of health systems including health management information systems (HMIS) and the procurement of additional rectangular LLINs to fill the LLIN gap, in line with TRP recommendations. The GAC took note of the country's progress during grant-making in addressing TRP clarifications, such as the number of RDTs ordered. The country team explained that the low request for RDTs took into account those already ordered through the President's Malaria Initiative as well as the decreased demand resulting from the Ebola outbreak. GAC partners expressed support for the proposed way forward and commended the flexibilities and adaptation to the ongoing developments in Guinea underlining that collaboration is essential in helping Guinea rebuild and strengthen its health system.

47. Domestic contributions. The estimated funding needs for the national malaria program of Guinea in the next implementation period is US$113,100,749. Total domestic financial commitments amount to US$10,613,219, which represents 9.6 percent of total resources available for the next implementation period. The counterpart financing share based on current government contribution and on the assumption that the full requested indicative funding in this concept note is approved is 13 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$3,272,576. Government commitments across all three diseases represent a 39 percent increase compared to the previous implementation period.

Lao TB Grant (LAO-T-GFMOH)

48. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$7,239,191 for the Lao TB program, which consists of the Ministry of Health grant LAO-T-GFMOH with the incremental funding amount of US$3,016,044 for the implementation period 1 July 2015 through 31 December 2017. The above allocation funding request submitted in the concept note was funded through incentive funding, as recommended by the TRP, therefore there are no activities registered as unfunded quality demand for the Lao TB program.

49. Epidemiological situation. Lao People's Democratic Republic is a lower-middle income country with a population of 6.6 million, with one third living in urban areas. The prevalence of all forms of TB, as well as TB incidence and mortality, declined significantly between 1990 and 2012, with the latest data showing that Lao has achieved the UN Millennium Development Goal (MDG) target of halving TB prevalence between 1990 and 2015. However the case detection rate of all new and relapse TB cases is only 30 percent and prevalence remains high at 514 per 100,000 population. TB prevalence correlates with increased age and is higher amongst males across all age groups, and one and a half times higher in rural than urban areas. The national TB program has integrated TB services in five central, 16 provincial and 140 district hospitals as well as in 98 percent of health centers, and in 2005 the program achieved full DOTs coverage. TB control is integrated into primary health care, and case finding is conducted by physicians in both hospital and outpatient. The rate of multidrug-resistant TB (MDR-TB) is around 5 percent among new TB cases and 23 percent among retreatment cases. There are significant delays in diagnosis and enrolment of MDR-TB patients, resulting in high death rates before initiating second line drug treatment. Key populations for TB are identified as people living with HIV, household TB contacts, mine workers, prisoners, children and mothers, and the elderly, who have limited access to prevention and care. In order to address TB-HIV co-infection, the national TB and HIV programs have conducted joint planning for TB-HIV collaborative activities in order to increase TB detection among HIV positive patients.

50. Past program performance. The Global Fund has been the main source of funding of the TB program since 2003 through successive grants in rounds 2, 4, 7 and 10. TB case notification increased significantly since 2003 after Global Fund support allowed for full country coverage in all districts in 2005, but stagnated from 2006 onward.

51. The goal of this program is to reduce the burden of TB in Lao and to reach WHO targets through providing universal access to TB diagnosis and treatment, providing free first and second line drugs, improving patient support, strengthening the TB laboratory network, strengthening links between TB programs with other public and private health services, scaling-up of MDR-TB programming, and strengthening TB-HIV program collaboration, among other strategies. Expected outcomes include decreases in the TB mortality rate to 9 per 100,000 population, the prevalence rate to 422 per 100,000 population and incidence rate to 171 per 100,000 population.

52. Implementation arrangements. Going forward the grant will be implemented by the current Principal Recipient- the Department of Disease Control of the Ministry of Health- considering its good performance and longstanding role as Principal Recipient since the first Global Fund grant agreement was signed in Laos, as well as their significant institutional knowledge of the Global Fund processes and requirements.

53. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it follows international guidance, the national strategic plan and a recent external TB review. The TRP noted that it may be difficult for the country to increase the case load targets considering its capacity and requested that the country revisit its plan for distributing GeneXpert machines during grant-making. In addition, the TRP requested clarification regarding development of a comprehensive strategy to manage the increased MDR-TB caseload by the NTP, updating the TB/MDR-TB Management Guidelines and developing a robust plan to build the provincial capacity for the treatment of identified MDR-TB patients especially in light of the planned decentralization of TB care.

54. GAC review and recommendations. The GAC concurred with the TRP and commended the country for making tremendous progress in reducing prevalence and mortality since 1990 and meeting the Millennium Development Goal (MDG) targets. Based on the TRP recommendations on prioritization of the above allocation request, GAC awarded incentive funding of US$1,498,395 with the understanding that this amount will be used to cover (i) TB care and prevention in order to extend the benefits of the grant, such as reduced delays and more ready access to treatment services, to patients living in more remote, inaccessible areas of the country, as well as to currently underserved key populations; and (ii) program management so as to provide new survey evidence to help shape future programming, improve connectivity and data transfer, and, with better transportation, improve supervision frequency and quality. The GAC approved US$7,526,356 as the upper-ceiling funding amount for grant-making, which takes into account the incentive award, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. During grant-making, efficiencies found through reducing the number of vehicles and motorbikes procured were reinvested in the procurement of health products. The GAC also noted that the current grant proposes salary incentives (total budget of US$173,053) with gradual reduction from 100 percent in 2015 to 50 percent in 2017, and recommended the Secretariat to work with partners on a harmonized approach to incentive payments.

55. Domestic contributions. The estimated funding need for the national TB program of Lao in the next implementation period is US$13.8 million. Total domestic financial commitments amount to US$3.5 million which represents 36 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 37 percent, which meets the minimum threshold requirement of 20 percent for a lower-middle-income country. Government commitments for the TB program represent a 37 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap for the TB program is US$4 million.

Mozambique Malaria Grants (MOZ-M-MOH and MOZ-M-WV)

56. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$107,360,243 for the Mozambique malaria program, which consists of the Ministry of Health grants MOZ-M-MOH with the budget amount of US$84,172,540 and the incremental funding of US$43,106,362 for the implementation period from 1 July 2015 through 31 December 2016; and the World Vision grants MOZ-M-WV with the budget amount of US$23,187,703 and the incremental amount of US$11,117,864 for the implementation period 1 July 2015 through 31 March 2017. Based on the above allocation funding request submitted in the concept note, the total amount of US$93,547,916 is registered as unfunded quality demand, in line with TRP recommendations.

57. Epidemiological situation. Mozambique, with a population 25,041,922 in 2014, is located on the east coast of Africa and the entire population is at risk of malaria. Although the 2011 demographic and health survey showed a reduction in malaria prevalence nationally, from 51.5 percent in 2007 to 38.3 percent, the country experienced an increase in the incidence of malaria from 134 to 169/1000 inhabitants from 2012 to 2013. The main reason identified for this increase was reduced delivery of interventions such as long lasting insecticide treated nets (LLINs) that occurred in 2012. Malaria

remains the leading cause of mortality and morbidity in Mozambique, making up approximately 44 percent of all outpatient consultations, 57 percent of all paediatric admissions, and 23 percent of in-hospital deaths. Almost all preventive and curative services are provided through the public health sector, with very limited involvement of the private sector. These public sector services are hampered by a severe shortage of health workers, the cost of providing health care services in hard-to-reach areas, the quality of care offered to patients, the availability of medicines and equipment and the motivation of health workers. Poor quality and inconsistent data in Mozambique further constrain planning, implementation, reporting quality and timeliness.

58. Past program performance. The country has made some progress in rolling out and scaling up malaria prevention and control interventions since the 2007 baseline. Household insecticide treated net ownership has increased from 16 percent to 51 percent in 2011, though overall use among people with access to a net was 80 percent, indicating access is the largest barrier to LLIN use. The percentage of households with indoor residual spraying (IRS) in the last 12 months remains low, with 30.4 percent of urban households and only 13.4 percent of rural households receiving IRS. Rapid diagnostic tests (RDTs) have been rolled out across the country and community-based case diagnosis and treatment is increasing, with about 8 percent of the total malaria cases in 2013 diagnosed and treated at the community level. There has been little progress on scaling up intermittent preventative therapy in pregnancy, with a slight increase from 16.2 percent in 2007 to 18.6 percent in 2011.

59. The goal of this program is to halve the 2009 malaria morbidity and mortality rates by 2016. To enable Mozambique to achieve this program goal, the Global Fund will invest in the following strategies by 2016: (i) develop the capacity to effectively manage malaria control at central, provincial and district level; (ii) provide access to at least one malaria prevention method to 100 percent of the population; (iii) test 100 percent of suspected malaria cases presenting in health facilities and communities and treat according to national guidelines; (iv) reach 100 percent of the population with information on malaria, with at least 60 percent following best practice malaria prevention and treatment behaviours; and (v) strengthen surveillance, monitoring and evaluation systems so 100 percent of districts provide timely reporting on key indicators based on quality data, for decision-making at all levels.

60. Implementation arrangements. The program will be implemented by two Principal Recipients: the Ministry of Health, who will work at national level; and World Vision, an international NGO focusing on LLIN distribution and interventions at community level. The main role of the Ministry of Health is coordination of partner involvement and the procurement of medicines and health products, such as LLIN, insecticides, artemisinin-combination therapy and RDTs, as aligned with the national strategy. The World Vision grant complements the Ministry of Health's national program through community mobilization, training of health workers, and in net distribution.

61. TRP review and recommendations. The TRP considered this request to be technically sound and strategically focused, building on the gains of previous investments in malaria control. The concept note is focused on maintaining the current gains and is aimed at intensifying the scale up effort of proven control strategies in Mozambique. The TRP noted that constraints and weaknesses of Mozambique's health, community, laboratory diagnosis, quality assurance and reporting systems are not unique to the malaria program and requested that the CCM present a consolidated plan for operationalizing and implementing health systems strengthening activities in all Global Fund supported programs, and coordinate efforts to prevent duplication among programs, improve harmonization and coordination, and realize cost savings. The TRP also acknowledged that improvements could be made to planned cross-border activities, the targets for malaria control, data collection systems, and the LLIN distribution plan, as well as the information, education, and communication and behaviour change communication budget.

62. GAC review and recommendations. As an integral part of its endorsement for the concept note to proceed to grant-making, the GAC recommended that the country should work towards addressing the actions identified by the TRP. In addition, the GAC recommended that the applicant comprehensively review the vector control strategy to define the most effective control strategy going forward and rational use of available resources for IRS and LLINs, with the support of partners through technical cooperation. Considering that Mozambique is next to countries that are in the pre-elimination phase, the GAC stressed the need for synergies with regional malaria elimination efforts, and recommended that investments are made to build pre-elimination conditions in Southern Mozambique. GAC partners also stressed the need to ensure that investments for HSS strengthen not only delivery mechanisms for the malaria program, but also benefit all the disease components (HIV, TB and Malaria), ensuring synergies and continuation of cross-cutting elements that have been divided across the concept notes submitted by the country.

63. GAC review and recommendations. Based on the TRP's recommendations on prioritization of the above allocation request the GAC awarded incentive funding of US$5,885,035 to support the costs of vector control in 2016. The GAC recommended an upper funding ceiling for grant making of US$73,240,559 based on TRP recommendations, which takes into account the incentive award as well as adjustments of the available funds for the implementation period based on actual and forecasted disbursements up to the proposed start date of the new grant. For portfolio consistency, GAC confirmed that the 2017 LLIN mass campaign would be considered in line with the shortened grant, and underlined the commitment of $70,615,517 of the unfunded quality demand to be made available in 2016 to ensure that LLIN coverage levels funded by the Global Fund are maintained and malaria control gains achieved are sustained. For all grants with shortened grant durations, the Secretariat will closely monitor implementation and actively reprogram unused funds to extend the duration when appropriate.

64. Reinvestment of efficiencies: During grant-making, a number of activities originally scheduled for implementation prior to the start date of the current grant were identified under the round 9 grants (MOZ-911-G11-M, MOZ-911-G12-M) resulting in an increase of the grant budget by US$19,399,388. In addition, a forecasted pooled procurement mechanism carry-over commitment totalling US$16,135,886 will be included in the Malaria grant managed by the Ministry of Health. Acknowledging the gap for the Mozambique malaria program the GAC has endorsed reinvestment of these funds into the program to ensure implementation of vector control in 2016 and strengthening of health information systems, thus increasing the budget to US$107,360,243. The GAC confirmed that the remaining amount of US$93,547,916 quality demand be registered as such.

65. Domestic contributions. The estimated funding need for the national malaria program of Mozambique in the next implementation period is US$402 million. Total domestic financial commitments for malaria amount to US$38 million which represents 15 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 36 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 136 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap for the malaria program is US$147 million. GAC noted with concern the high dependence on external financing of health, and the high level of risk this poses to sustainability of gains achieved in the fight against HIV, TB and malaria. GAC also expressed concern regarding the decline in government spending on health – (9% of GDP in 2012, from 15% in 2005) and called for strengthening of technical cooperation around initiatives to increase domestic financing, including in the development of a national health financing strategy to address the inadequate funding for health in Mozambique.

Mozambique TB/HIV Grants (MOZ-H-MOH, MOZ-T-MOH, MOZ-C-FDC)

66. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$241,007,021 for the Mozambique TB/HIV program, which consists of the Ministry of Health grants MOZ-H-MOH with the budget amount of US$180,928,522 and incremental amount for Board approval of US$52,002,749 for the implementation period from 1 July 2015 through 31 December 2016; MOZ-T-MOH with the budget amount of US$38,432,108 and the incremental funding for Board approval of US$12,102,950, and MOZ-C-FDC with the budget amount of US$21,646,391 and the incremental funding for Board approval of US$1,293,195 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$231,006,779 is registered as unfunded quality demand, in line with TRP recommendations.

67. Epidemiological situation. Mozambique has a generalized HIV epidemic with elevated rates among key populations, a high TB burden and is categorized by WHO as a TB/HIV priority country. According to 2014 WHO estimates, an estimated 120,000 Mozambicans were newly infected with HIV in 2013, making the country among the top 5 with the highest proportion of new HIV infections globally. UNAIDS estimations show that the number of people living with HIV was 1.4 million out of a population of 24.4 million in 2013. The estimated incidence rate peaked at around 1.8 percent in early 2000's, and has been declining to a low of 0.98 percent in 2013. Due to an accelerated response, HIV prevalence and incidence have stabilized over the past six years at 11.5 percent and 0.98 percent, respectively, and a sharp decline in the number of new infections among children was observed after 2010 as a result of

rapid scale-up of prevention of mother-to-child transmission. HIV infection is the major driver for the increase of TB notifications in Mozambique in recent years. Provider-initiated testing and counselling began in 2003 and is now reaching 96 percent of all TB patients. HIV prevalence among TB patients was 56 percent in 2013 and has been decreasing gradually over the past few years, likely due in part to the effect of antiretroviral therapy (ART) scale-up. However, Mozambique still appears to be off-track in achieving and sustaining a declining trend in estimated TB incidence; the estimated incidence rate gradually increased between 1990 and 2000 from 400 per 100,000 to 552 per 100,000 population in 2013 placing the country sixth among the countries with highest TB incidence rate globally in 2013. The case detection rate in 2013 for all forms of TB was estimated to be only 34 percent. Based on a national drug resistance survey conducted in 2009, multidrug resistant TB (MDR-TB) prevalence is estimated at 3.5 percent among new TB patients and 12 percent among retreatment patients.

68. Past program performance. Mozambique has reported remarkable increases in coverage of key HIV services. The number of individuals receiving HIV testing per year has risen from 3.8 million in 2012 to 4.7 million in a population of 24.4 million in 2013; this represents 19 percent of the population. TB case notification rate per 100,000 population was stable between 2009 and 2011 but has shown an increasing trend from 2012. The treatment success rate of 87 percent for new bacteriologically confirmed cases of TB is encouraging. Current MDR-TB treatment success is poor at 36 percent in 2011 cohort, attributed to lack of knowledge on MDR-TB clinical management. There has been progressive improvement in the collaboration between TB and HIV programs, particularly at implementation at health facility level where one-stop approach to co-infected patients is currently wide-spread.

69. The goal of this program is to reduce by 50 percent the number of new HIV infections by 2017, reduce the mortality from HIV in TB patients through HIV testing and counselling and provision of early ART to all, and reduce the mortality from TB in HIV infected persons through intensified case finding and early TB treatment. To enable Mozambique to achieve the program goals, the Global Fund will invest in the following strategies: (i) increase targeted HIV testing for the general population, pregnant women, and key populations; (ii) increase awareness, distribute and promote consistent use of condoms and lubricants; and (iii) provide outreach to key populations, including female sex workers, migrant populations, men who have sex with men, and youth and adolescents, with comprehensive TB/HIV package of services. Expected outcomes include reduced rates of HIV transmission from mother to child to less than 5 percent by 2017, of TB incidence per 100,000 population from 552 persons in 2013 to 390 by 2016, and of TB/HIV mortality rate per 100,000 population from 148 in 2013 to 131 in 2016.

70. Implementation arrangements. The CCM has nominated the Ministry of Health and the Fundação para o Desenvolvimento da Comunidade (FDC), a national NGO, to continue implementation of the program as Principal Recipients. The process of the selection of a new Principal Recipient for TB has been transparent and inclusive; and the re-selection of the existing HIV and TB Principal Recipients was based on strong consensus within the CCM of their respective competency and capacity. The outcome provides the best opportunity for further strengthening joint TB/HIV planning and implementation of the two programs. The Ministry of Health grants predominantly consists of health commodities (96 percent of HIV budget, 65 percent of TB budget). To improve efficiency, the HIV procurement plan for the grant is done jointly with PEPFAR and CHAI. The FDC grant focuses on prevention and treatment adherence at the community level.

71. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it is based on based on extensive analysis of data (including modelling studies) and understanding of disease epidemiology in the country, identifies the needs of key populations and proposes evidence-based interventions to address these needs. The concept note is based on the National Health Strategy (2014 – 2019), National HIV Strategic Plan – PEN III (2010-2014), National Strategic Plan for TB (2014-2018), the Plan for Elimination of Vertical Transmission of HIV, as well as the National Acceleration Plan for HIV/AIDS (2012-2017) - which provides ambitious targets aimed to rapidly reverse the incidence of HIV and expand treatment to effected populations. In addition, the concept note was developed through a comprehensive and inclusive consultation process, including engagement of key and vulnerable populations, development partners and technical agencies. However, the TRP requested that during grant-making the applicant address shortcomings in the areas of prevention programming for girls and young women 15-24, system barriers to prevention of mother-to-child transmission targets, low targets for men who have sex with men, significant weaknesses in health and community systems, the engagement of care providers through public-private mix approaches, and prevention of TB in health care settings.

72. Accelerating ART scale-up. Furthermore, while the TRP commends the country for the significant efforts to increase the number of eligible people living with HIV on ART and is fully aware of the normative guidance on treatment eligibility based on the 2010 WHO eligibility recommendations, the TRP feels that rapid scale-up of treatment coverage even at the current CD4 count ≤350 cells/mm3 proposed in the concept note, and its programmatic and financial implications, have the potential to come at the expense of much needed broad HIV response, particularly including comprehensive prevention efforts, and limit program sustainability. In this regard, the TRP requested the country to present a clear and costed plan for the operationalization of the proposed scale-up of treatment coverage describing priority populations to be scaled-up first and how ART will be distributed among them over time, as well as annual quantification of ARVs to be procured through Global Fund funding, other partners and domestic funding. In response to TRP clarifications, a multi-sectoral consultation process involving the Ministry of Health (Department of Plan and Cooperation and the Department of Administration and Finance), the National AIDS Council and the Ministry of the Economy and Finance is underway to devise a plan and strategy for resources mobilization and increase efficiency to prevent discontinuation of ART treatment and provision of essential services for patients currently on ART.

73. GAC review and recommendations. Based on TRP recommendations on prioritization of the above allocation request, the GAC awarded incentive funding of US$43,560,000, with specific focus on ART to ensure continuity of services in 2016. The GAC endorsed the TRP recommendations and approved US$103,058,931 as the upper-ceiling funding amount for grant-making, which takes into account the incentive funding award, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. The GAC commended the government of Mozambique for its leadership in the progress made to date and the strategic focus of the concept note. The GAC review of the Mozambique TB/HIV concept note firstly acknowledged that there are sizeable gaps in funding for the ART program in 2016 in Mozambique[6], not covered by the allocation request submitted by the CCM and that the program was facing challenges in sustaining scale-up as noted by the TRP. Noting that Mozambique is one of the top 5 countries most burdened by HIV and most behind in ART scale-up, however, GAC partners expressed concerns about gaps in ART funding for scale-up in the context of resource constraints, and stressed the critical importance of continuing the scale-up for both HIV prevention and treatment for public health impact in Mozambique. GAC partners also expressed particular concern about the likely impact of the resource constraints resulting in unavailability of ART for critical population groups including discordant couples, children, key populations and TB/HIV patients, emphasizing their concern about the effect of the lack of ART on the TB epidemic. In light of the above mentioned resource constraints, GAC requested the Secretariat to work with the CCM and partners to explore opportunities for further geographic refocusing of investments in districts with highest disease burden to maximize impact.

74. Reinvestment of efficiencies. During grant-making, a number of activities originally scheduled for implementation prior to the start date of the current grant identified under the round 7 TB and round 9 HIV grants were delayed and funding carried over to the new grant, resulting in increase of the grant budget by US$60,032,203. In addition, forecasted commitments of health products under the pooled procurement mechanism and a refund from a previous round 6 HIV grant totalling US$84,226,905 will also be included in the HIV grant managed by the Ministry of Health. Acknowledging the significant funding gap for the Mozambique TB/HIV program, GAC endorsed reinvestment of the identified funds into procurement of health products for ART, procurement of TB commodities, M&E and DHIS roll-out, IBBS and TB prevalence surveys - thus increasing the budget from US$103,058,931 to US$241,007,021. Given the additional resources of US$60,032,203 identified during grant making, the GAC was pleased to note that with contributions from the Global Fund and other partners, Mozambique will continue scaling-up ART, maintaining full roll-out of the ART Acceleration Plan and achieving program coverage of 885,164 adults and children expected to be on ART by December 2016 (or 53% of all people living with HIV), as planned in the concept note.

75. Continuity of essential services. The GAC acknowledged that the HIV grant managed by the Ministry of Health will end in December 2016 and confirmed the commitment to ensure that ART coverage levels funded by the Global Fund are maintained in 2017 under the continuity of essential services policy with a commitment to prioritize access to unfunded quality demand at the level of US$87,120,000. Furthermore, the GAC was informed that during grant implementation, the gap of the health product procurement budget could be further reduced by US$59 million by an improved analysis

[6] Mozambique 2016 ART gap is estimated at US$43,560,000, reflecting the Global Fund contribution covering 55 percent of estimated 660,000 patients expected to be on ARV treatment by June 2015 for six months of 2016.

of the commodity gaps. The remaining amount of US$231,006,779 was confirmed by GAC as quality demand to be registered as such.

76. Domestic contributions. The estimated funding need for the national HIV and TB programs of Mozambique in the next implementation period is a total of US$1.7 billion, with US$1,592 million needed for HIV and US$123 million needed for TB. Total domestic financial commitments for HIV amount to US$157 million, which represents 16 percent of total resources available for the program in the next implementation period. Total domestic financial commitments for TB amount to US$10 million, which represents 13 percent of total resources available for the program in the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested indicative funding in this concept note is approved, is 84 percent for HIV and 27 percent for TB, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 136 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$597 million for HIV and $46 million for TB. The GAC noted with concern the high dependence on external financing of health, and the high level of risk this poses to sustainability of gains achieved in the fight against HIV, TB and malaria. The GAC also expressed concern regarding the decline in government spending on health from 15 percent of the GDP in 2005 to 9 percent in 2012 and called for strengthening of technical cooperation around initiatives to increase domestic financing, including in the development of a national health financing strategy to address the inadequate funding for health.

Papua New Guinea HIV Grant (PNG-H-OSHF)

77. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$14,207,542 for the Papua New Guinea HIV program, which consists of the Oil Search Health Foundation grant PNG-H-OSHF with the incremental amount for Board approval of US$7,754,208 for the implementation period 1 July 2015 through 31 December 2017. Papua New Guinea did not submit an above allocation funding request for the HIV program and therefore there are no activities registered as unfunded quality demand under this concept note.

78. Epidemiological situation. Papua New Guinea is a small north-western Pacific country with a mixed HIV epidemic. The current national prevalence of HIV in 2014 was reported to be 0.65 percent with approximately 30,000 people currently living with HIV. Sexual transmission accounts for 75 percent of all transmissions and more populous urban areas carry disproportionately more prevalent HIV infection among key populations, particularly sex workers, men who have sex with men and transgender people. Rural areas are characterized by geographical hotspots which are more likely to be fuelled by high levels of unprotected sexual partner turnover and concurrency. In 2012, 2,822 new HIV cases were reported. Modelling using SPECTRUM estimates 2,172 new HIV infections in 2013 and projects 2,031 new infections by 2021. Factors such as geographic barriers, operational issues within the health system and supply chain, and issues with the management of quality assurance in the health system negatively impact the delivery of HIV services. There is considerable fragmentation of the health system and the ability of National Department of Health to ensure the delivery of quality HIV-related and other health services is limited. There are also significant weaknesses in the national surveillance system; although there are now over 200,000 HIV tests being reported annually, there are no population-based surveys to provide estimates of people who know their HIV status. This lack of sentinel surveillance and generally poor data quality greatly affects the ability to understand the impact of the HIV epidemic on key populations as well as the ability to track progress of the response.

79. Past program performance. Papua New Guinea has been implementing Global Fund-supported HIV grants since September 2005. Funding from a round 4 HIV grant targeted the generalized epidemic and supported the scale-up of HIV testing and counseling, treatment and care for people living with HIV, as well as prevention of mother-to-child transmission interventions. A round 10 HIV grant starting in 2012 aimed to further reduce the transmission of HIV and other sexually transmitted infections (STIs). While achievements have been made, there are still significant constraints in the delivery of HIV services in Papua New Guinea.

80. The goal of this program is to limit the impact of HIV and other STIs and minimize their impact on individuals, families and communities by focusing prevention, healthcare access, and treatment and support efforts on key populations in key geographical areas. To enable Papua New Guinea to achieve the program goal, the Global Fund will invest in the following strategies: (i) support and build on the

Papua New Guinea Government's National HIV Strategic Implementation Plan; (ii) engage partners at all levels, with specific attention to engaging and supporting the voices of key populations; (iii) improve access to prevention interventions to reduce risk of HIV and STI transmission for key populations; (iv) strengthen and improve access to quality HIV testing, treatment, care and support services for key populations; and (v) improve systems and processes to enable better utilization of HIV Strategic Information, particularly related to key populations

81. Implementation arrangements. The current Principal Recipient, a private sector entity named the Oil Search Health Foundation, has been reselected following a fair assessment of candidates. Antiretroviral drugs and rapid diagnostic tests will continue to be procured by the Government of Papua New Guinea through its national budget allocations.

82. TRP review and recommendations. The Papua New Guinea HIV concept note was initially submitted in window 3 September 2014 for TRP review. The TRP recommended the concept note for further iteration, noting the need for better identification of key populations, interventions targeting TB/HIV co-infection, addressing health system capacity gaps and plans to address treatment barriers, among others. The revised concept note resubmitted in window 4 November 2014 was considered technically sound and strategically focused on programs for key populations, adequately addressing the concerns and weaknesses that were identified by the TRP in the first review. The concept note is linked to the national HIV strategic plan and addresses the prevalence of gender-based violence in Papua New Guinea and outlines plans to address it. The TRP requested one clarification, that the CCM provide a clear explanation with a brief description of each national HIV program component and highlight how the complementary activities proposed in the concept note enhance the priorities of the National HIV program.

83. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant making of US$14,564,921 based on TRP recommendations. During grant-making, nearly US$1.4 million in efficiencies were found in savings from delayed start in grant implementation, and reinvested as follows: a long-anticipated integrated bio-behavioral survey (IBBS), interventions for gender-based violence, and HIV prevention interventions for Papua New Guinea's second largest mine. The GAC has also been informed that the applicant took advantage of the time during grant-making to re-establish and strengthen the capacity of the Principal Recipient, build momentum for the integrated bio-behavioral survey, and strengthen the grants' focus on key populations. The GAC and partners acknowledged the challenging context and commended the example of the current grant as one of the best practices of collaboration and alignment between partners achieved during country dialogue.

84. Community Systems Strengthening (CSS) and grant prioritization. The GAC also commended Papua New Guinea and partners for progress made during grant-making, in relation to grant prioritization and CSS. Five provinces were selected based on the estimated burden of disease, linkages to TB-sites and geographic "hot spots". Under the grant, CSS and civil society engagement has been emphasized to achieve greater impact: (i) the Principal Recipient will work with UNAIDS and DFAT to develop an achievable plan of action for CSS, including strengthening Igat Hope, the national PLHIV organisation; (ii) Anglicare, CHASI and Hope Worldwide, faith-based non-government organizations will also benefit from capacity development efforts; (iii) grass-roots civil society organizations Kapul Champions and Friends Frangipani will be providing access to services for their networks as well as technical guidance. In addition, an empowerment-based approach will be used to build the capacity of individual peer leaders and their communities and networks to support the prevention, testing, treatment and care activities, as well as policy and guideline development.

85. Domestic contributions. The estimated funding need for the national HIV program of Papua New Guinea in the next implementation period is a total of US$669 million. For the 2015 to 2017 time period, US$110 million is committed by Papua New Guinea, which is an additional investment in this allocation period of US$48 million. This represent a 78 percent increase in government investment in the three programs, compared to the previous phase. Total domestic financial commitments amount to US$56.1 million which represents 20 percent of total resources available for the next implementation period. The counterpart financing share, based on commitments of government contribution in the next phase, and on the assumption that the full requested indicative funding in this concept note is approved, is 77 percent which meets the minimum threshold requirement of 20 percent for a lower-low-middle income country. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$394.4 million.

Philippines HIV Grant (PHL-H-SC)

86. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$13,920,375 for the Philippines HIV program, which consists of the Save the Children grant PHL-H-SC of the incremental amount for Board approval of US$12,008,333 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$2,010,341 is registered as unfunded quality demand.

87. Epidemiological situation. The HIV epidemic in the Philippines is at a low-level concentrated stage, with a recent surge in new cases among men who have sex with men and people who inject drugs. Whereas the overall HIV prevalence in the general population has remained below 0.1 percent, HIV case surveillance shows a substantial increase in recent years in the Philippines with 4,814 cases reported in 2013 compared to 528 in 2008. The country has been identified in the 2012 United Nations Global Report as one of nine countries to have registered more than 25 percent increase in HIV incidence between 2001 and 2011 despite the declining trend of HIV epidemic in the world. Geographically, new infections are concentrated in several locations: 26 category (A) sites mostly in Greater Metro Manila, Cebu and Davao and 19, category (B) sites –where over half of new infections have been reported.

88. Programmatic context and challenges. While successful at controlling the HIV epidemic in female sex workers, the current HIV prevention programs in men who have sex with men and people who inject drugs do not show impact, given low coverage and limited effectiveness. Furthermore, there are high levels of stigma towards men who have sex with men, transgender people and people who inject drugs. In 2011, only 23 percent of men who have sex with men were reached with prevention interventions, 15 percent had ever had an HIV test, and of those tested, only 5 percent knew their test result, while men who have sex with men report very low condom use during their last anal sex at 36 percent. In 2013, less than one-third of people who inject drugs had access to clean needles from Social Hygienic Clinics or Peer Educators, and 35 percent shared equipment at last injection. Drug use is criminalized and having a clean syringe is sufficient grounds for arrest, posing additional barriers to quality programming. Though transgender persons have been identified as a key population, there is no current surveillance data in the Philippines to show the magnitude of HIV among this population. Serious delays in providing test results are a key barrier to linking people into the continuum of care, for all people living with HIV and at-risk populations. Data on TB/HIV co-infection in the Philippines is limited, as no reporting system is in place to capture co-morbidity cases. In 2011, less than a third of the registered TB cases, precisely 3,917 out of 9,331, were tested for HIV, but no data on TB screening for HIV is presented. According to the AIDS Epidemic Model baseline scenario, if the current level and coverage of interventions is maintained, infections will continue to increase and there will be around 57,236 people living with HIV and AIDS by 2017.

89. Past program performance. The Philippines has received over $32 million from the Global Fund for the fight against HIV in the past 10 years. The Global Fund supported program contributes financing to cover over 50 percent of the national antiretroviral therapy (ART) costs and over 80 percent of interventions among men who have sex with men and people who inject drugs. From December 2012 to June 2014, the grant has been performing adequately, with a rating of B1 on average and evidence that overall the coverage goals for key populations were achieved but the high risk behaviors have not significantly changed. On the treatment side, consistent with an increasingly high proportion of care and treatment in the total HIV spending, ART coverage has been rapidly scaled up and the retention rate has been relatively high. The country is planning to roll out the 2013 WHO treatment guidelines in 2015 to further increase the coverage of ARV treatment. There has also been progress in the prevention activities over the years but the coverage among men who have sex with men and people who inject drugs remains low. The HIV treatment program component has seen rapid expansion with the establishment of 18 treatment hubs and the enrolment of 6,437 people on ART as of April 2014 with high retention rates at 88 percent. However, the linkages to care are weak, as enrollment into care starts late, at an average CD4 count of 165. The current need for treatment is estimated at 18,679 people, three times higher than those currently enrolled.

90. The goal of this program is to maintain a prevalence of less than six HIV cases per 100,000 population by preventing the further spread of HIV infection and reducing the impact of the disease on individuals, families, sectors and communities, by 2017. To maintain this rate, the Global Fund will invest in the following strategies: (i) to improve the coverage and linkage of services from prevention and diagnosis among key populations to treatment and care for people living with HIV through an intensified cascade approach to deliver of quality and evidence-based services; (ii) to raise the

awareness among key populations and the public on HIV and sexually transmitted infection (STI) prevention and care services; (iii) to increase demand and access to available HIV and STI services; (iv) to provide timely and evidence-based information for planning, monitoring, evaluation and quality assurance of HIV and STI programs; and (v) to intensify delivery of quality HIV and STI services through a strengthened support system by addressing barriers, improving linkages and ensuring delivery of critical enablers. Expected outcomes of these strategies include 50 percent coverage of men who have sex with men and transgender populations as well as 75 percent of people who inject drugs with prevention programs and increase condom use among all key populations to 80 percent.

91. Implementation arrangements. Going forward the grant will be implemented by a newly selected Principal Recipient, Save the Children, to address the inefficient management under the government system and improve the connection and involvement of communities and civil society organizations, under the leadership of an international NGO with experience in managing Global Fund grants. Although the country office of Save the Children in Philippines was established recently in August 2011, the organization has a long history of implementing of Global Fund grants and has developed expertise in the areas of advocacy, community mobilization activities and treatment.

92. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused, as it provided a clear strategy to address the key drivers of the epidemic in the context of the recent surge in the epidemic in men who have sex with men, transgender people, and people who inject drugs. The TRP acknowledged that the proposed interventions and new implementation arrangements have the potential to achieve impact and avert new infections. The TRP requested that, during grant-making, the applicant develop a detailed plan for the proposed scale-up to ART initiation at CD4 500 and address issues surrounding key populations, such as the reach of community systems strengthening interventions, access to treatment and counseling, and human rights barriers to access.

93. GAC review and recommendations. The GAC expressed strong support for the Philippines HIV concept note, acknowledging that it focuses on important prevention programs for key populations, procurement and supply chain management, health information systems and monitoring and evaluation, removing legal barriers to access, community systems strengthening, program management, and treatment, care and support. The GAC highlighted concerns about the leakage in service cascade from prevention to test to care and treatment; the potential for the new Principal Recipient to transition smoothly into its role and to collaborate with sub-recipients and government health system in the areas of monitoring and evaluation and procurement and supply chain management, and advocacy strengthening.

94. GAC funding recommendations. Based on the TRP recommendations on prioritization of the above allocation request, GAC awarded incentive funding of US$1,118,947 with the understanding that this amount will be used to cover (i) prevention programs for men who have sex with men and transgender people (ii) prevention programs for people who inject drugs and their partners, and (iii) community systems strengthening. The GAC approved US$13,920,375 as the upper-ceiling funding amount for grant-making, which takes into account incentive funding, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. The GAC also acknowledged that while expansion of ART in the Philippines may not have been prioritized for incentive funding, the request is essential to close the gap to reach the national target (90 percent), as no other donor resources are available. The GAC also noted that should savings be achieved, registration of this intervention as unfunded quality demand would provide the opportunity for the country to re-invest in a high-impact intervention during grant-making and/or implementation. During grant-making, US$313,143 of efficiencies were identified. In line with the TRP and GAC's recommendations, US$100,000 will be reinvested to improve the community systems strengthening component and the remaining US$213,143 is reinvested to procure ART drugs to reduce the gap identified at concept note writing.

95. Domestic contributions. The estimated funding need for the national HIV/AIDS program of Philippines in the next implementation period is US$211 million. Total domestic financial commitments amount to US$175 million, which represents 92 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 87 percent which meets the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across all three diseases represent a 75 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap in HIV program is US$20.5 million.

Sao Tome & Principe Tuberculosis Grant (STP-T-UNDP)

96. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$1,567,681 for the Sao Tome and Principe TB program, which consists of the UNDP grant STP-T-UNDP of the incremental amount for Board approval of US$1,289,053 for the implementation period 1 July 2015 through 31 December 2017. Sao Tome and Principe did not submit an above allocation request for the TB program and therefore there are no activities registered as unfunded quality demand under this concept note.

97. Epidemiological situation. Sao Tome and Principe is an archipelago of two islands, Sao Tome and Principe, in the Gulf of Guinea to the northwest of Gabon. With an estimated population of 183,118 people, the country is classified in the low human development category and ranked 142 out of 187 in the 2012 Health Development Index. According to WHO, the country reports the second highest TB prevalence comparing to other islands with similar characteristics at 159 cases per 100,000 population and about 300 TB patients are expected each year. As of 2012, there was an estimated incidence of 93 new pulmonary tuberculosis per 100,000 population, a detection rate for all forms of tuberculosis at 66 percent and an estimated HIV prevalence among TB at 9.2 percent. The rate of multidrug-resistant TB (MDR-TB) is estimated at 1.8 percent among new cases and 88 percent among previously treated cases. Key populations include contacts of smear-positive and MDR-TB cases, prisoners, and people living with HIV.

98. Past program performance. From 2009 to mid-2014, Global Fund TB investments in Sao Tome and Principe totaling US$1.3 million have contributed to important progress and impact, in particular, the reduction of TB incidence. Incidence has decreased from 135 in 1990 to 93 in 2012 per 100,000 population and prevalence has decreased from 258 in 1990 to 159 in 2012 per 100,000 population. Additionally, TB services have been decentralized and the country has achieved 100 percent coverage of HIV testing and antiretroviral treatment of TB patients. However, significant challenges have also been noted related to case detection and quality of care. Gaps in TB health infrastructure, human resources and the health information system persist.

99. The goals of this program are to increase TB case notification and TB treatment success rate, to provide routine screening of resistance, to provide care and support to more than 95 percent of TB/HIV infected patients, and to improve the managerial capacity of the national TB program. To enable Sao Tome and Principe to achieve the program goals, the Global Fund will invest in the following strategies: (i) identify, within general and at-risk population, as many suspected cases as possible; (ii) treat identified patients while increasing therapeutic success rate beyond 85 percent; (iii) mitigate the endemic and break as much as possible the transmission chain; and (iv) implement active case finding among key populations. The target results of this approach are to increase TB case notification rate from 71 cases in 2012 to 80 cases population in 2017 per 100,000 population and to increase TB treatment success rate to more than 85 percent by putting the emphasis on rigorous directly observed treatment and through community involvement.

100. Implementation arrangements. The United Nations Development Programme (UNDP) was re-selected to be Principal Recipient by the CCM based on criteria established in line with Global Fund policies. UNDP will continue to work with the five existing sub-recipients, including four governmental departments and one non-governmental organization.

101. TRP review and recommendations. The TRP considered this concept note to be technically sound and strategically focused. The concept note is aligned with the National Health Development Plan as well as the 2013-2017 National Tuberculosis Strategic Plan. The TRP endorsed the prioritization of nutritional support for TB patients who are severely malnourished including children, all MDR-TB patients, and those living under the poverty line. The TRP encouraged monitoring of the impact of nutritional support, both intended or unintended, to guide future programming. The TRP asked the applicant to clarify points on the shortage of human resources, the need for active TB case finding and the approach to health systems strengthening. In addition, the TRP recommended a review of the plan to ensure patients, including key populations on both islands, have access to the new diagnostic tools.

Given the size of the population and the expected number of TB patients, the TRP recommended de-prioritization of proposed operational research activities and reinvestment of savings into high impact interventions (e.g. increase of case finding).

102. GAC review and recommendations. The GAC endorsed the TRP recommendations, and recommended an upper funding ceiling for grant making of US$1,534,681 based on TRP recommendations. During grant-making, US$33,000 of efficiencies were found and will be reinvested in capacity building activities for sub-recipients, to be executed by the Principal Recipient / UNDP.

103. Domestic contributions. The estimated funding need for the national TB program of Sao Tome and Principe in the next implementation period is US$2.7 million. Earmarked domestic financial commitments amount to US$296,000 which represents 11 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved, is 19 percent which does not meet the minimum threshold requirement of 20 percent for a low-middle-income country. However, the Secretariat recognizes that this is an underestimate of actual government contribution, as at present there are no institutional mechanisms to reliably track all government spending. The Secretariat notes that government spending pertains only to earmarked allocations to the tuberculosis program, such as drugs and commodities, and does not include all government spending such as recurrent costs integrated within the general budget including human resources on government payroll and facility overheads. Even if a crude apportionment of 1 percent of government health spending for tuberculosis is considered, the country will meet the minimum threshold requirement. In light of this context, the Secretariat considers the requirement as met. With the contributions from the Global Fund and other sources, the estimated total funding gap for the TB program is US$173,523. Moreover, based on a commitment letter from the Ministry of Finance indicating additional investment of US$1.1 million, government commitments across all three diseases (HIV, TB and Malaria) represent a 31 percent increase compared to the previous period. The Secretariat will appropriately engage with the government to ensure that requirements are continually met, and per corporate procedures agreed with UNDP, will notify the Principal Recipient and government of this on-going grant requirement. Additionally, National Health Accounts will be finalized in 2015 and results on government health expenditure will be followed up accordingly.

Senegal HIV Grants (SEN-H-CNLS and SEN-H-ANCS)

104. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of EUR 19,478,252 for the Senegal HIV program, which consists of the grant implemented by Conseil National de Lutte contre le Sida (CNLS) SEN-H-CNLS with the budget amount of EUR 14,385,805 and incremental funding for Board approval of EUR 6,587,352, and the grant implemented by Alliance Nationale de lutte Contre le Sida (ANCS) SEN-H-ANCS with the budget amount of EUR 5,092,447 and incremental funding for Board approval of EUR 1,968,021 for the implementation period 1 July 2015 through 31 December 2017. Senegal did not submit an above allocation request for the HIV program and therefore there are no activities registered as unfunded quality demand under this concept note.

105. Epidemiological situation. Senegal has a concentrated HIV epidemic with a stable prevalence of 0.7 percent within the general population and a high prevalence within key populations: men who have sex with men at 18.5 percent, sex workers at 18.5 percent, and people who inject drugs at 10.2 percent. There are significant disparities in the distribution of the epidemic in the regions: the most affected regions are in the South and South East part of the country: Kolda at 2.4 percent, Kédougou at 1.7 percent, Tambacounda 1.4 percent, Sédhiou 1.1 percent, Kaolack 1.1 percent, and Ziguinchor 1 percent. These regions have specific features which explain their prioritization in the national strategic plan, such as heavy cross-border traffic and the emergence of new economic poles including mining sites and weekly markets that attract seasonal and sex workers. Key challenges include the socio-cultural and religious constraints that perpetuate stigma and discrimination against the men who have sex with men and, to a lesser degree, sex workers in terms of their access to prevention and care services.

106. Past program performance. Senegal, through Global Fund grants, has deployed major efforts in the past nine years to scale-up access to HIV prevention, treatment and support for the population with a focus on key populations. Senegal implemented Global Fund grants though rounds 1, 6 and 9 funding. The level of Global Fund investments in HIV has increased since 2003, thus increasing the scope of

interventions. The prevalence among key populations remains significant but has reduced in recent years: 2013 prevalence rates among men who have sex with men is 18.5 percent compared to 21.8 percent in 2007 and 2013 rates among sex workers in are 18.5 percent compared to 19.8 percent in 2010. Furthermore, according to the SPECTRUM projection, the number of new infections has reduced dramatically between 2001 and 2012, by 58 percent, among adults over the age of 15.

107. The goal of this program is to mitigate new HIV infections; to improve the quality of life of infected and affected populations, improve management and coordination of the national response, strategic information, and strengthening of community-based systems. To enable Senegal to achieve the program goal, the Global Fund will invest in the following strategies: (i) strengthening prevention of HIV/AIDS transmission through behavior change communication activities; (ii) strengthening access to voluntary counseling and testing services; (iii) acceleration of coverage and access to prevention of mother-to-child transmission services; (iv) improving HIV/AIDS comprehensive care through community care and support and care for orphans and vulnerable children; (v) promoting a socioeconomic, political, and ethical environment suitable for leadership development, as well as mitigating stigma and discrimination against people living with HIV and developing partnerships, and capacity building for public sector, private sector, and civil society stakeholders; (vi) strengthening monitoring and evaluation and research through an HIV and sexually transmitted infections epidemiological and behavioral surveillance system; and (vii) promoting operational research. Expected outcomes of these strategies include HIV infected children born to HIV positive mothers reduced to less than 2 percent, sex workers declared using a condom with last client above 95 percent, and people living with HIV/AIDS on treatment after 12 months increased to over 80 percent.

108. Implementation arrangements. Going forward the grant will be implemented through the current dual-track implementation arrangements by the Conseil National de Lutte contre le Sida (CNLS), a branch of the Ministry of Health, and the Alliance Nationale de lutte Contre le Sida (ANCS), a local non-governmental organization, as Principal Recipients. This arrangement has been in place since the round 1 grant and provides an opportunity to further capitalize on existing synergies between the government and civil society in accelerating the reduction of new HIV infections and reduction of HIV-related mortality, as well as increase the protection of human rights.

109. TRP review and recommendations. The TRP commended the applicant for a well-focused and strategic concept note that addresses the current epidemiology, capacity gaps, and the social-cultural context. The TRP noted that since the beginning of the country dialogue process, civil society and representatives of key populations have been involved in the review of the national strategic plan, drafting of the National Strategic Framework, and the preparation of the concept note. The TRP highlighted several clarifications for the applicant to work on with the Secretariat during grant-making, including outreach to key populations to ensure that they include more difficult-to-reach individuals - particularly people who inject drugs, unregistered and under-age sex workers, and engagement with sex workers and MSM who have the dual risk of injection drug use; and reducing lost-to-follow up in the prevention-care continuum. The TRP also highlighted the importance of effective national policies and guidelines on harm reduction including needle and syringe programs and methadone maintenance therapy. The TRP stressed the need for close monitoring of the proposed pilot phase of methadone introduction in Senegal for quality and data for advocacy, and to demonstrate success.

110. GAC review and recommendations. The GAC endorsed the TRP recommendations, and recommended an upper funding ceiling for grant making of EUR 17,883,801 based on TRP recommendations. GAC noted that during grant making, the Secretariat engaged in discussions with the country to gradually phase out the current salary incentive scheme. The result of these discussions is the elimination of salary incentives on non-key positions, and the gradual reduction of salary incentives on key positions by the end of the grant in 2017. Salary incentives represent 4 percent of the budget of the grant, and are mainly investing in programs focusing on key populations. The proposed changes in managing salary incentives will therefore result in an overall reduction of 33 percent in funding allocated to incentives by the end of 2017. Moving forward, the Secretariat will work with the Government of Senegal and relevant stakeholders to devise a sustainable incentive program as part of a broader civil service reform to enhance motivation and retention schemes.

111. Domestic contributions. The estimated funding need for the national HIV program of Senegal in the next implementation period is EUR 92,418,460. Total domestic financial commitments amount to EUR 13,680,590, which represents 15 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next

phase and on the assumption that the full requested allocation funding in this concept note is approved is 39 percent, which meets the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent an 84 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is EUR 42,142,508.

Somalia HIV (SOM-H-UNICEF)

112. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$ 20,614,311 for the Somalia HIV program, which consists of the UNICEF grant SOM-H-UNICEF with the incremental amount for Board approval of US$20,614,311 for the implementation period 1 July 2015 through 31 December 2017. The above allocation funding request submitted in the concept note was funded through incentive funding, as recommended by the TRP.

113. Epidemiological situation. Somalia has a generalized HIV epidemic with variation in prevalence among its three zones: HIV prevalence is highest in North West Zone (Somaliland) at 1.13 percent followed by North East Zone (Puntland) at 0.41 percent and lowest in the South Central Zone at 0.25 percent. Though the South Central Zone has a low prevalence, the burden of disease is highest, with 55 percent of estimated people living with HIV. Very few services have been established to address the needs of sex workers and other marginalized populations. There is limited information available regarding men who have sex with men and people who inject drugs. The constant mobility of populations is an additional challenge in surveillance of key populations and ensuring HIV prevention. A 2014 integrated biological and behavioural survey showed 5.2 percent HIV prevalence among female sex workers in Hargeisa (a major transport route and capital city of Somaliland). In that same survey, only 34.6 percent of sex workers reported condom use at last sex. In a rapid assessment undertaken in Mogadishu, only 5 percent of truckers, 10 percent of fishermen and 7 percent of port workers reported having ever used male condoms.

114. Past program performance. The Global Fund supported HIV program in Somalia is currently implemented through a Round 8 grant. Although coverage of people on antiretroviral treatment (ART), using the 2010 WHO guidelines, increased steadily from 579 to 1,748 by the end of 2013, it still remains low. An estimated 31 percent total of people requiring treatment in Somaliland are on ART, with rates in Puntland at 17 percent and South Central at 6 percent as a result of the insecure environment. By the end of 2012, 34 health facilities, comprised of eight in South Central, six in Puntland and 20 in Somaliland, were providing a full package of prevention of mother-to-child transmission services. At the end of 2013, only 56 of the estimated 1,728 (3.2 percent) in need of prevention of mother-to-child transmission were receiving ART. As a result of the significantly low coverage, the mother to child transmission rate is modelled to be 34 percent for 2014.

115. The goal of this program is to reduce new HIV infections by 30 percent by 2019 and mortality among men, women and children living with HIV by 30 percent by 2019, in alignment with the national strategic plan. To enable Somalia to achieve the program goal, the Global Fund will invest in the following strategies: (i) increase access to and utilization of optimally efficient, effective and integrated treatment, care and support services; (ii) prevent new HIV infections especially among key populations such as sex workers and their clients through combination HIV prevention interventions; (iii) strengthen monitoring and evaluation of the response; (iv) ensure an enabling environment for the response; and (v) strengthen management and coordination of the response. Expected outcomes of these strategies include increased ART coverage of people living with HIV to 20 percent by end of 2017 from 5.6 percent in 2013, 100 percent of TB patients tested for HIV by 2017 from 56.2 percent in 2013, and 73 percent of HIV patients screened for TB by 2017 from 60 percent in 2013.

116. Implementation arrangements. UNICEF has been the Principal Recipient for the HIV grants since the Global Fund began supporting the HIV response in Somalia through Round 4. UNICEF will continue as PR going forward. UNICEF is changing its program management structure to incorporate the unit responsible for the implementation of this grant under the organization's Chief of Health. This will contribute to the streamlining of program implementation and mitigating the risks related to vertical implementation and lack of coordination.

117. TRP review and recommendations. The TRP considered the concept note to be strategically sound and technically appropriate to the epidemic setting. The TRP recognized the challenging environment in which the program is operating and acknowledged that this application has promising components with high potential for impact in reducing the burden of HIV in Somalia, particularly the appropriate focus on key populations. The TRP noted that this request is structured on the newly endorsed national HIV strategic plan for 2015 to 2019 that lays out interventions focused on key populations. The TRP was especially supportive of interventions prioritized in key hotspots as identified by border crossing points, ports, urban centers and transport corridors. The TRP also welcomed the inclusion of interventions that create a more enabling and open environment to discuss and promote HIV prevention, treatment and care and to reducing barriers to health service seeking and preventative behaviours. Strengthening the capacity and role of organizations serving sex workers as well as PLWHIV associations and their members will provide a greater voice of PLWHIV and their families to advocate for change and improve access to treatment, care and support. The main issues for clarification during grant-making are focused around strategic re-prioritization and refocusing of investments to expand coverage and strengthen programs covering treatment and care, HIV counselling and testing, gender-based violence, key populations and PMTCT and Maternal and Child Health. In addition, the TRP recommended review of high program management costs and increases in local capacity as feasible.

118. GAC review and recommendations. Based on the TRP recommendations on prioritization of the above allocation request the GAC awarded incentive funding of US$1,765,506, focused on increasing coverage of ART and opportunistic infections to 100 percent of national targets; increasing integrated prevention, treatment, care and support sites providing ART; and funding behaviour change interventions for uniformed personnel. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant making of US$21,366,834 which takes into account incentive funding, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. The GAC expressed strong support for the Somalia HIV request, recognizing that the country dialogue and concept note development processes were inclusive, and the interventions and targets described in the concept note are aligned with the national strategic plan for 2015 to 2019. During grant-making, efficiencies were found in harmonized unit costs, salaries and technical cooperation rates, and the standardization of office costs. The unit costs and incentives have been assessed as reasonable considering the country context and taking into account that most of these incentives are going to people living with HIV and vulnerable women. GAC has endorsed the reinvestment of savings in prevention of mother-to-child transmission, prevention programs for general and vulnerable populations and increases in ART coverage and surveys.

119. Domestic contributions. As a non-CCM country, Somalia is not required to provide evidence of counterpart financing. However, the GAC has been informed that the Somalia Steering Committee proposed a reduction in Global Fund contribution to salaries paid under the current grant from 100 percent in 2015 to 80 percent in 2017. Based on the most recent draft of the public expenditure review and competing public priorities and needs, the likelihood that the Somalia government(s) is able or willing to contribute to the health sector expenditure is low.

Somalia Malaria (SOM-M-UNICEF)

120. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$33,680,843 for the Somalia malaria program, which consists of the UNICEF grant SOM-M-UNICEF of the incremental amount for Board approval of US$31,559,999 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$7,651,902 is registered as unfunded quality demand, in line with TRP recommendations.

121. Epidemiological situation. The whole population in Somalia faces varying risks of malaria. North West (Somaliland) and North East (Puntland) Zones are at greater risk of epidemics due to unstable and seasonal transmission and irregular rainfall patterns. The South Central Zone experiences stable transmission, particularly in the Juba and Shabelle swamp areas and therefore carries the greatest burden of malaria in Somalia, though the area is less prone to epidemics. The malaria epidemiology of Somalia has recently been established by the first ever malaria indicator survey of the

country in 2014. The survey estimated the overall national malaria prevalence at 1.8 percent. The country estimates having 526,000 cases annually, out of the 12.4 million population.

122. Past program performance. The Global Fund has been the main funding partner for the malaria program in Somalia in the last 12 years. Between 2006 and 2013, 4.1 million nets were distributed across all three Somalia zones, with 2.1 million long lasting insecticidal nets (LLINs) having distributed in 2013 alone. Programme data show that the country achieved over 90 percent indoor residual spraying (IRS) coverage of targeted structures, protecting over 460,000 people in 2012 and 2013. According to a recent malaria burden estimation report, there was a decline in malaria-related morbidity by about 40 percent and mortality by about 50 percent between 2007 and 2010.

123. The goal of this program is to achieve and sustain near zero or less than 1 percent malaria prevalence within areas of historically low transmission by 2017; to achieve and sustain universal coverage resulting in 50 percent reduction of malaria transmission in malarious areas of the country by 2017; and to contribute to an integrated health system in Somalia, which will lead to an overall reduction in all-cause mortality. To enable Somalia to achieve these program goals, the Global Fund will invest in the following strategies: (i) ensure at least 90 percent of the population in malarious areas are covered by LLINs and 80 percent of areas with signs of outbreaks will be covered by IRS; (ii) increase access to effective malaria diagnosis and treatment to at least 80 percent of patients in public health facilities, including primary health units, and 60 percent of patients in targeted private facilities by December 2017; (iii) strengthen national capacity and relevant stakeholders for the management and coordination of the malaria by December 2017; (iv) ensure that at least 70 percent of people living in malarious areas recognize and take proper action to prevent malaria and seek treatment by December 2017; and (v) strengthen health system monitoring and evaluation, and procurement supply chain processes by December 2017.

124. Implementation arrangements. UNICEF has been the Principal Recipient for the malaria grant since the Global Fund began supporting malaria response in Somalia and was selected as such for its role as a leading health organization in Somalia and for its ability to provide the Global Fund with some assurances that the program is being implemented as intended. UNICEF is to continue as Principal Recipient under the next implementation period. UNICEF is changing its program management structure to incorporate the unit responsible for the implementation of this grant under the organization's Chief of Health. This will contribute to the streamlining of program implementation and mitigating the risks related to vertical implementation and lack of coordination.

125. TRP review and recommendations. The TRP initially reviewed the Somalia malaria concept note in July 2014 in window 2, recommending it for iteration. The TRP considered the revised concept note submitted in November 2014 in window 4 to be technically sound and strategically focused, containing extensive revisions that addressed previously raised issues. The TRP noted improved planning based on clear analysis of more recent national epidemiological data (MIS 2014), HMIS and lessons learned from past interventions, and that findings of the malaria program review had been taken into account and reflected in the revised funding request.

126. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant making of US$36,597,167 based on TRP recommendations. During grant-making, US$3,232,944 in efficiencies were found in harmonized unit costs, salaries and technical cooperation rates, and the standardization of office costs, to be reinvested in vector control and procurement and supply chain management systems. The GAC has also been informed that the Somalia Steering Committee proposed a reduction in Global Fund contribution to salaries paid under the current grant from 100 percent in 2015 to 80 percent in 2017. Cash incentives have been assessed as reasonable considering the country context taking into account that most of these incentives are paid for the LLINs distribution and supervision, community educators and mobilizers for the days they are active only.

127. Domestic contributions. As a non-CCM country, Somalia is not required to provide evidence of counterpart financing. The Somalia Steering Committee proposed a reduction in Global Fund contribution to salaries paid under the grant from 100 percent in 2015, 90 percent in 2016 to 80 percent in 2017. Based on the most recent draft of the public expenditure review and competing public priorities and needs, the likelihood that the Somalia government(s) is able or willing to contribute to the health sector expenditure is low.

South Sudan Tuberculosis Grant (SSD-T-UNDP)

128. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$15,512,452 for the South Sudan TB program (SSD-T-UNDP) for the implementation period 1 July 2015 through 31 December 2017. The incremental amount for Board approval is US$11,962,650. Based on the above allocation funding request submitted in the concept note, the amount of US$4,157,812 is registered as unfunded quality demand, in line with TRP recommendations.

129. Epidemiological situation. TB is a major public health problem in South Sudan; according to WHO estimates for the year 2012, the prevalence of TB was 257 per 100,000 population and 16,000 people were newly affected with TB. There is an incidence of 146 new TB cases per 100,000 population and a mortality rate of 30 deaths from TB per 100,000 population. However, TB notification has increased from 2,955 in 2008 to 8,408 in 2012. According to the WHO, the burden of multidrug-resistant TB (MDR-TB) among notified pulmonary TB was 250 MDR-TB cases in 2012 with WHO estimating that the prevalence of MDR-TB among new TB cases is at 1.8 percent and 19 percent among retreatment cases. The occurrence of TB among people living with HIV is still unknown in South Sudan. Data from the national TB program suggests that the prevalence of HIV infection in patients with TB is approximately 15 percent. Also, the cohort analysis of TB/HIV who are treated for TB within the existing national TB program network indicates that death rate was 11 percent in 2012.

130. Past program performance. The Global Fund has been the major source of financing for the three diseases in South Sudan over the last ten years. Since 2004, the CCM has been successful in securing funding for Tuberculosis in rounds 2, 5, 7, and TFM. The program supported by this grant aimed to provide TB case diagnosis and treatment services and to establish TB/HIV collaborative interventions in South Sudan. This included the establishment of a coordinating body for TB/HIV activities, surveillance of HIV prevalence among TB cases, intensifying TB case finding, TB prevention amongst people living with HIV and strengthening monitoring and evaluation efforts. The most recent rating for the grant is B1 and the results of Global Fund, governmental and other partner investments over the past decade have led to significant improvements in the coverage of TB interventions in the country. The number of TB cases, all forms, notified through the nation TB program network increased from 1,260 in 2002 to 8,408 in 2012, resulting in an average increase of 24 percent per year. In addition, the number of smear-positive pulmonary TB patients who were identified increased from 752 in 2002 to 3,120 in 2012 with an average increase of 18 percent per year. Such a significant average increase in TB identification per year suggests that there are many patients with TB within the population that need to be identified and appropriately treated.

131. The goal of this program is to contribute towards the reduction of TB prevalence from 257 to 180 per 100,000 population, a 30 percent decrease, by 2030. To enable South Sudan to achieve the program goal, the Global Fund will invest in the following strategies: (i) expand access to quality assured TB diagnostic services; (ii) intensify TB case finding in hospitals and private clinics; (iii) intensify TB case finding among high risk and hard to reach populations; (iv) address childhood TB in public and private hospitals; (v) scale up community TB care; (vi) reduce stigma in the general population and among health care workers; (vii) strengthen drug-resistant TB diagnostic capacity; (vii) establish treatment of drug-resistant TB patients; and (viii) strengthen human resources' capacity for TB program management at all levels. Expected outcomes of these strategies include improved case notification from 63 in 2013 to 191 in 2017 per 100,000 population and improved treatment success rate of all forms of TB from 52 percent in 2012 to 85 percent in 2017.

132. Implementation arrangements. The United Nations Development Programme (UNDP) will continue implementing the grant as the Principal Recipient. The implementation arrangements are also structured in such a way to develop the capacity of the national TB program. Local NGOs and the national TB program are the main implementing partners, with regular and significant collaboration between UNDP and the national TB program on program design, implementation and budgeting.

133. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused as it addresses the main programmatic gaps of the country. The TRP noted that, among other positive aspects, the concept note describes the epidemiological situation, using the information available to identify geographical variations and key populations. The TRP

requested several clarifications, including the extent of health staff capacity building, providing refugees and internally displaced persons with TB/HIV services, the engagement of partners and the applicants' strategy to increase TB treatment success rates. The TRP also stressed the importance of engagement and coordination across all partners to optimize existing resources at all levels especially given the context of resource scarcity. Synergies among all partners are therefore considered an essential requisite to the implementation of the TB concept note. In addition, the TRP stressed the need for a more complete integration and alignment across the Global Fund portfolio in the country to maximize heath system performance and to achieve the impact intended from each grant, highlighting operational synergy among the interventions in the four South Sudan concept notes in critical areas such as training, deployment and operation of community health workers delivering services in HIV, TB and malaria for greater impact.

134. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant making of US$15,512,452 based on TRP recommendations. GAC awarded incentive funding of US$2,437,815 based on the TRP recommendations on prioritization of the above allocation request, focused on TB care and prevention, MDR-TB, strengthening of monitoring and evaluation, and program management costs. While commending the country for the concept note development process in light of the complex operating environment, the GAC noted that the challenging context remains a risk and encouraged the country to continue working in partnership to strengthen its ability to implement programs and managing evolving risks. The GAC reinforced the TRP's message that coordination among development partners is essential in future program success. Activities were adjusted to address TRP recommendations and to cater for costs not originally part of the submission. Therefore efficiencies and savings identified in the amount of US$1.8 million, generated through adjustments in M&E activities that will not compromise the objectives and scope of the program, have been allocated towards Home Health Promoters at community level.

135. Domestic contributions. The estimated funding need for the national TB program of South Sudan for the next implementation period is US$31 million. Total domestic financial commitments amount to US$3.2 million, which represents 14 percent of total resources available for the next implementation period. The counterpart financing share is 13 percent, which meets the minimum threshold requirement of percent for a low-income country. Government commitments across all three diseases represent a 69 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$11.9 million.

Tanzania TB/HIV Grants (TZA-H-MOF and TZA-T-MOF)

136. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$298,479,894 for the Tanzania TB/HIV program. This funding is for the two Ministry of Finance grants: TZA-H-MOF with the budget amount of US$277,193,628 and incremental funding of US$172,448,214 for the implementation period 1 July 2015 through 31 December 2016; and TZA-T-MOF grant with budget amount of US$21,286,266 and incremental funding of US$17,835,579 for the implementation period 1 July 2015 through 31 December 2017. A third grant to be implemented by Save the Children is currently being negotiated and will be presented for Board approval at a later date. Based on the above allocation funding request submitted in the concept note, the amount of US$195,254,828 is registered as unfunded quality demand, in line with the TRP recommendations.

137. Epidemiological situation. Tanzania has a generalized HIV epidemic with concentrated epidemics among key populations of men who have sex with men, and female sex workers and their clients. HIV prevalence in Tanzania has stabilized within the adult population at around 5.1 percent and the country has an estimated 1.4 million people living with HIV. The 2014 modes of transmission study shows that new HIV infections mainly occur in stable heterosexual relationships at 38.8 percent, casual heterosexual sex at 28.9 percent, clients of sex workers at 8.7 percent, partners of people engaged in casual sex at 7.6 percent and men who have sex with men at 6.8 percent. These five groups account for 91 percent of all new infections. Key populations are more likely to encounter social prejudice, stigma, discrimination, denial of their existence and criminalization. The distribution of tuberculosis and HIV often shows an overlapping pattern across the country. Tanzania is one of the world's 22 high TB burden countries. The preliminary results from the first ever TB prevalence survey in Tanzania, conducted in

2012, revealed a TB burden of 295 cases per 100,000 population among adults. This is a higher prevalence than was previously estimated for the country, with the low case detection rate of 54 percent due to the fact that higher number of expected incident TB cases still remain undetected. HIV continues to be a major driver of the TB epidemic in Tanzania. TB/HIV co-infection rate among patients seen in facilities has ranged between 37 and 39 percent over the last three years.

138. Past program performance and implementation arrangements. Tanzania has been implementing strong and successful TB and HIV programs over the last ten years which the Global Fund has supported through Rounds 3, 4, 6 and 8, complemented by investments from other development partners and the Government. Going forward, the program will be supported by the Ministry of Finance and the Save the Children Tanzania as the two PRs nominated in the concept note. The Ministry of Finance will manage, together with the Ministry of Health and Social Welfare, the shortened HIV grant focusing on prevention in general population, treatment, care and support, TB/HIV joint programming, procurement and supply chain management as well as health system strengthening activities. The Save the Children TB/HIV grant will focus on both TB and HIV interventions at community level.

139. The goal of the HIV program is to achieve universal access to comprehensive HIV prevention, treatment, care and support services in order to significantly minimize the transmission of new HIV infections and reduce HIV-related mortality, stigma and discrimination as well as to reduce TB and leprosy incidence and mortality. To achieve the program goals, the investments for the HIV component will focus on the following strategies: (i) comprehensive Antiretroviral Therapy (ART); (ii) HIV counselling and testing; (iii) elimination of mother to child transmission (eMTCT Option B+ strategy); (iv) comprehensive sexuality, gender, and health education and services; (v) human rights, key populations and gender; (vi) health systems strengthening; (vii) targeted Behaviour Change Communication across the strategic programmes designed to increase the demand for services, enhance knowledge and lead to positive changes in risky behaviours at personal, community and national level; and (viii) community based care and support. In line with the draft National TB and Leprosy Strategic plan (2015-2020), by 2020 the TB program aims to reduce the TB incidence by 25 percent and mortality by 50 percent. Current prevention, treatment and support strategies all aim at achieving the following strategic objectives: (i) to increase case detection by 30 percent by 2020 by strengthening routine case notifications and addressing vulnerable groups of the elderly, prisoners, miners and diabetics; (ii) to increase the percentage of childhood TB cases notified in the country from 10.6 percent to 15 percent by 2020 by integrating TB services into reproductive and child health, community-based therapeutic care and active case finding; (iii) to increase MDR TB cases detected and enrolled for treatment from 17 percent of the estimated total cases among those notified to 84 percent by 2020 by scaling up new diagnostic technologies and decentralizing MDR TB services; and (iv) to expand TB/HIV collaborative activities by ensuring that all TB patients are tested for HIV and those who test HIV positive are put on ART promptly and managed.

140. TRP review and recommendations. The TRP considered this concept note be technically sound, strategically focused, and aligned with the HIV and TB strategic plans. The concept note addresses the identified programmatic gaps for both diseases based on robust situational analysis, using the analysis to guide the selection of interventions in a way that will maximize impact. The TRP highlighted six issues to be addressed during grant making including: development of a clear sustainability strategy for reducing the dependence of the TB/HIV program on external support; strengthening interoperability of HIV and TB data systems; mapping of key populations and CSS; development of a detailed plan for MDR-TB expansion, roll-out of Gene-Xpert and drug susceptibility testing services; ensuring increase in case notification targets for TB and MDR-TB should any savings be found; and review of impact targets for TB prevalence and mortality to ensure feasibility.

141. GAC review and recommendations. The GAC expressed strong support for the Tanzania TB/HIV concept note and recognized Tanzania for conducting a thorough country dialogue, with active involvement of in-country partners in concept note development, and the proposed interventions being based on robust TB and HIV situational analysis. The GAC review of the Tanzania TB/HIV concept note as well as the disbursement ready grants acknowledges that there are sizeable gaps in funding the ART program in 2016 and 2017 which are not covered by the allocation request. Tanzania HIV ART gap for 2016 alone is estimated by the Global Fund at US$78,608,549, reflecting the Global Fund contribution covering 100% of the estimated 656,974 patients on ARV treatment for the remaining six months of 2016 (which is the target number of people on ART at the end of the current HIV grant). GAC partners also expressed a particular concern about the likely impact of the resource constraints resulting in unavailability of ART for critical population groups including pregnant women newly diagnosed with HIV, discordant couples, children, key populations and TB/HIV patients, emphasizing the effect of the lack of ART also on the TB epidemic. The GAC praised the TB modules of the concept note and grant

that have boldly translated the findings of the TB prevalence survey into tailored interventions over the coming period.

142. GAC review and recommendations. Based on TRP prioritization and recommendation on the above allocation request, GAC awarded incentive funding of US$78,608,549, with specific focus on ART to ensure continuity of services throughout 2016. The GAC approved US$308,157,063 as the upper-ceiling funding amount for grant-making, which takes into account the incentive award, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. During grant making, the program identified efficiencies in the amount of US$11,889,679 from in-country cash balances, efficiencies in travel-related costs, as well as savings on 2014/2015 procurement transferred from the round 8 HIV grant. GAC endorsed the reinvestment of identified savings in HIV treatment, care and support and in increasing TB case notification. The GAC also noted the likelihood of the country maintaining continuity of services for existing patients on ART, as well as maintaining levels of coverage for the three key groups - notably HIV positive mothers, HIV positive children and TB/HIV patients - by making provision for the enrolment of new patients within the same grant funding while continuously sourcing additional funds to cover the unfunded quality demand. The GAC confirmed the commitment to ensure that ART coverage levels funded by the Global Fund are maintained in 2017 under the continuity of essential services for 656,000 patients on ART by July 2015; the funding gap for ART in 2017 is estimated at US$157.7 million. For all grants with shortened grant durations, the Secretariat will closely monitor portfolio implementation and actively reprogram unused funds to extend the duration when appropriate. These funding requests will also be prioritized among requests to be funded directly through the Global Fund's available resources or through other sources that the Global Fund will support the country to identify.

143. Government efforts to increase health financing. The GAC noted that 87 percent of the cost of the TB program and 93 percent of the cost of the HIV program are externally funded thus creating significant sustainability risks for the Tanzania TB/HIV program moving forward, as also observed by TRP. The GAC acknowledged the tremendous progress made: The Parliament has approved the establishment of an AIDS Trust Fund which will start this financial year July 2015/2016 with an estimated contribution of the Government per annum at TZS 508,277,034,000 (US$298,986,490). As negotiation with the Government of Tanzania is underway to establish sustainable source of financing the AIDS Trust Fund, this amount is projected to increase annually based on allocation and needs. This is additional to the amount provided through budgetary allocation. The Ministry of Health and Social welfare (MoHSW) is also embarking on a vibrant advocacy campaign to Members of Parliament and decision makers on increasing the allocation from the Government's own contribution towards meeting the signed Abuja Declaration of spending 15 percent of the total government budget on health, currently at 11 percent of the allocation. As the Government budget from the 2015/2016 financial year has included the health sector as one priority area in the Big Result Now (BRN) initiative, the MoHSW will therefore receive significant amount of funds to implement Health Sector Strategic Plan IV. The government through the MoHSW is also scaling up the establishment of complementary health financing mechanisms such as a National Health Insurance Fund, Community Health Fund and User Fees which will contribute resources for health care service provision in the country. Due to inequities in access to health services, measures are under way to establish a health care financing strategy which will ensure significant contribution of resources to the health sector in line with the goal of universal coverage. While there has been some progress in increasing domestic financing, GAC partners remain cautious and emphasized the need for strong collaboration amongst all in-country partners as well as ensuring continued high level political engagement on health financing in Tanzania. In this regard, GAC partners underlined the importance of effective operationalization of the AIDS Trust Fund, and for reasons of sustainability as well as equity, to use the current momentum of the AIDS Trust Fund for effectively linking with financing of broader health systems.

144. Domestic contributions. The estimated funding need for the next implementation period of the national HIV program is US$1,814 million and US$160 million for the national TB program. Total domestic financial commitments amount to US$107 million for HIV and US$6.2 million for TB which represents 9 percent and 13 percent, respectively, of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested allocation funding in this concept note is approved is 30 percent for HIV and 20 percent for TB, which meet the minimum threshold requirement of 5 percent for a low-income country. Government commitments for HIV represent a 26 percent increase and for 90 percent increase for TB compared to the previous

implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$564 million for HIV and US$113 for TB.

Uganda HSS Grants (UGA-S-MoFPED and UGA-S-TASO)

145. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$21,771,916 for the Uganda HSS program, which consists of the Ministry of Finance, Planning and Economic Development grant UGA-S-MoFPED with the budget amount of US$14,608,280 and incremental funding of US$14,035,520 and the TASO grant UGA-S-TASO with the budget amount of US$7,163,636 and incremental funding of US$5,885,007 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$2,004,253 is registered as unfunded quality demand, in line with TRP recommendations.

146. Epidemiological situation. Uganda has a total population of 37.58 million and a per capita income of US$510[7]. Uganda has made progress towards achieving the goals 3, 4, 7, and 8 of the MDGs to promote gender equality and empower women, reduce child mortality, ensure environmental sustainability and to develop a global partnership for development. However, achievements for health-related MDGs overall remain low. Uganda is also off-track on the MDGs related to universal primary education. The main challenges in Uganda's health systems include: fragmented service delivery at both national and sub-national levels with weak coordination of actors leading to parallel service delivery; challenges in the coordination of procurement and supply chain management; inadequate storage capacity at warehouses and facilities; inadequate numbers and inequitable distribution of health work force with significant vacancies in health centers; and inadequate legal assistance to minimize the impact of stigma, discrimination, gender based violence.

147. Past program performance. The Global Fund supported programs in Uganda from round 1. Malaria accounts for 54 percent of total investments at US$427 million, followed by HIV/AIDS with 40 percent at US$313 million, tuberculosis with 4 percent at US$34 million, and HSS with 2 percent US$16 million. Health system outcome indicators shows some progress, including increases in antiretroviral treatment (ART) coverage from 53 percent in 2010 to 75 percent in 2013 and TB directly observed short-course coverage from 47 percent in 2012 to 55 percent in 2013. Global Fund support to health system strengthening has contributed to the achievement of key results including 6.8 percent of HIV-infected infants born to HIV infected mothers as of December 2013, compared to a target of 7 percent; the 100 percent increase in the number of facilities providing early infant diagnosis of HIV; a 25 percent increase in the number of facilities providing pediatric ART; the recruitment of 600 health care workers to improve service delivery at health facility level; and increased availability of laboratory equipment including fridges for reagents, microscopes and safety delivery maternity kits to improve laboratory capacity for facilities providing prevention of mother-to-child transmission services, to name a few.

148. The goal of this program is to strengthen the health and community systems for quality, equitable and timely service delivery. To enable Uganda to achieve the program goal, the Global Fund will invest in the following strategies: (i) strengthen procurement and supply management capacity at national and sub-national levels to sustain the national response to HIV, tuberculosis and malaria; (ii) reinforce the national health information and monitoring and evaluation systems for evidence-based decision making for HIV, tuberculosis and malaria response; and (iii) attain community empowerment and respond to the health needs and ensure social accountability and inclusiveness to achieve desired health outcomes in Uganda. Expected outcomes of these strategies include the reduction of maternal mortality ratio from 139 in 2013 to 127 in 2017 per 100,000 population; an increase in the percentage of births attended by skilled health professional from 44 percent in 2014 to 65 percent in 2017; and an improvement in the general service readiness score for health facilities from 61 percent in 2013 to 75 percent in 2017.

149. Implementation arrangements. The HSS program will be implemented through dual track financing with the Ministry of Finance, Planning and Economic Development supporting the public sector while the civil society Principal Recipient, The AIDS Support Organization (TASO), catering to the private not-for-profit sector for the entire Uganda portfolio.

150. TRP review and recommendations. The TRP considered this concept note to be technically sound and addressing critical areas identified through a thorough heath system analysis. The TRP noted, however, that the strategic focus can be further strengthened if the country can streamline proposed interventions and present them in a more cohesive way with a systems strengthening focus.

[7] World Bank, 2014

151. GAC review and recommendations. The GAC endorsed the TRP recommendations and recommended an upper funding ceiling for grant making of US$21,199,157 based on TRP recommendations. The GAC underlined that coordination among stakeholders involved in the procurement and supply chain management of health products should be optimized and transparency improved in order to further enhance the integrity of logistics management information systems (LMIS) data used for decision making. The GAC further highlighted that out of pocket payments (applicable for about 50 percent of the population) remains a barrier to accessing treatment and care and recommended that Uganda explore options for social health insurance. The GAC strongly recommended that the CCM explore using savings to invest in synergies with the reproductive, maternal, newborn and child health (RMNCH) platforms for service provision, to enhance access to health care for women and children. During grant-making, US$1.8 million in efficiencies were found in aligning unit costs and eliminating duplication in the portfolio. The GAC approved the reinvestment of these funds in interventions to remove legal barriers to access, increase investment in service delivery and cover program management costs. The GAC has also been informed that outstanding amounts indicated in the 2009 OIG Report have been refunded to the Global Fund.

152. Domestic contributions. Total domestic financial commitments for Global Fund supported programs in Uganda in the next implementation period amount to US$214 million, which represents a 19 percent increase compared to the previous implementation period. Based on existing commitments, the counterpart financing share of Global Fund support is 44 percent which meets the minimum threshold requirement of 5 percent for a low-income country. A number of initiatives are currently under active consideration for leveraging additional domestic resources to mitigate the dependence on donors and households for financing the health sector. The Ministry of Health is in the process of developing a national health financing strategy to address the inadequate funding of health. One of the priorities for the health sector indicated in the 'National Budget Framework Paper' FY2014115 is the finalization of the legal framework for the implementation of the long pending National Health Insurance Scheme. Another initiative is the plan for operationalizing an AIDS Trust Fund to leverage domestic resources for the HIV response.

Uganda TB/HIV Grants (UGA-H-MoFPED, UGA-T-MoFPED and UGA-C-TASO)

153. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$230,505,464 for the Uganda TB/HIV program, which consists of the Ministry of Finance, Planning and Economic Development grants UGA-H-MoFPED with the budget amount of US$201,004,571 and the incremental amount for Board approval of US$131,870,252 (1 July 2015 to 30 June 2018) and UGA-T-MoFPED with the budget amount of US$22,695,895 and the incremental funding for Board approval of US$10,843,380 (1 July 2015 to 31 December 2017); and the TASO grant UGA-C-TASO with the budget amount of US$6,804,998 and the incremental funding for Board approval of US$6,341,348 (1 July 2015 through 30 June 2018). Based on the above allocation funding request submitted in the concept note, the amount of US$345,212,047 is registered as unfunded quality demand, in line with TRP recommendations.

154. Epidemiological situation. Uganda has a total population of 37.58 million and a per capita income of around US$510. The 2011 AIDS Indicator Survey shows an increase in HIV prevalence among adults from 6.4 percent in 2004/2005 to 7.3 percent in 2011. The HIV epidemic in Uganda has been generalized for more than two decades, with 140,000 new infections per year although with reduced mortality due to antiretroviral treatment (ART) expansion. Women have higher prevalence than men (8.3 percent versus 6.1 percent) and urban prevalence is somewhat higher than rural (8.7 percent versus 7.0 percent). Several key populations with much higher prevalence have been identified including: TB patients, fishing communities, female sex workers, men who have sex with men, uniformed personnel, prisoners and truckers. Key drivers identified include: higher risk sexual behaviour with low condom use, high rates of sexually transmitted infections, low antenatal care utilization, low uptake of male circumcision, sub-optimal ART scale up, inequitable access to health services, stigma and discrimination and gender based violence. Uganda is amongst the three countries where almost 48 percent of the new HIV infections in the region occurred. TB is a major public health problem, causing unnecessary morbidity and mortality. Uganda's is ranked among the 22 TB highest burden countries, with an estimated 65,000 incident TB cases in 2012 and 4,700 deaths. The available data indicates downward trends in incidence rate, from 624 in 1990 to 427 in 2000, to 166 per 100,000 population in 2013. The estimated prevalence rate is 154 per 100,000 population; mortality stands at 11 per 100,000 population and notification increased from 30,000 cases annually in 2000 to almost 50,000 in 2012 and 47,650 in 2013. Multi-drug resistant TB (MDR-TB) is also an emerging challenge in Uganda.

155. Past program performance. Uganda has had considerable success in reducing the HIV prevalence from 18.5 percent in the early nineties to 6.5 percent in adults in 2009 due to, among others, strong political leadership, early recognition of the epidemic as well as an open approach to addressing it, and a strong decentralized multi-sectoral response. The coverage of HIV testing increased from 2005 to 2011 from 11 percent to 45 percent among men and from 13 percent to 66 percent among women. By December 2014, there were 713,744 people on antiretroviral therapy (ART); the coverage of prevention of mother-to-child transmission for HIV positive pregnant women increased from 25 percent in 2009 to 85 percent in 2014; the estimated number of AIDS deaths reduced from 78,000 in 2005 to 63,000 in 2013. Reductions in TB mortality potentially occurred as a result of the scale-up of directly observed treatment, short-term (DOTS) as well as ART. Notification of TB cases increased from 30,000 cases annually in 2000 to 47,650 in 2013. Treatment success rate among new smear positive TB cases has increased from 63 percent to 77 percent for the cohorts of patients that started treatment between 2000 and 2011, respectively.

156. The goal of this program is to: reach a reduction of 35 percent in TB prevalence by 2020; lower the number of new youth and adult infections by 70 percent and the number of new pediatric HIV infections by 95 percent by 2020; decrease HIV-associated morbidity and mortality by 70 percent through achieving and maintaining 90 percent viral suppression by 2020; reduce vulnerability to HIV/AIDS and mitigation of its impact on vulnerable groups; and establish an effective and sustainable multi-sectoral service delivery system that ensures universal access and coverage of quality, efficient and safe services to the targeted population by 2020. To enable Uganda to achieve the program goals, the Global Fund will invest in the following strategies: (i) scale up coverage and utilization of critical HIV prevention interventions to reduce new HIV infections; (ii) enhance programs for the prevention of mother-to-child transmission of HIV; (iii) scale up and sustain the delivery of ART in the public and private sectors; (iv) ensure universal access and coverage of quality, efficient and safe service to targeted population; (v) strengthen the monitoring and evaluation of HIV/AIDS programs to track the progress of implementation of priority initiatives; (vi) detect 85 percent of estimated TB cases and successfully treat 90 percent of them by 2020; (vii) provide TB/HIV integrated care to co-infected patients; and (viii) strengthen systems for effective management of TB & leprosy services. Expected outcomes of these strategies include reducing AIDS-related mortality from 170 in 2013 to 99 in 2016 per 100,000 population; retaining the percent of people living with HIV known to be on ART 12 months after initiation at 85 to 87 percent in 2016; and improving TB treatment success rate for bacteriologically confirmed TB from 80 percent in 2013 to 84 percent in 2017.

157. Implementation arrangements. The program will be implemented through a dual track financing model by the Ministry of Finance, Planning and Economic Development and The AIDS Support Organization (TASO). It should be noted that 94 percent of the budget will go towards health products and equipment to be purchased through the Global Fund pooled procurement mechanism as a risk mitigation measure. The Secretariat will work closely with the assurance providers to ensure monitoring and use of health products.

158. TRP review and recommendations. The TRP considered the concept note to be technically sound and strategically focused based on appropriate mix of prevention and treatment activities for key populations for both TB and HIV identified through a comprehensive situation analysis. Given the lack of specificity on HIV prevention programs, the TRP requested to review the related clarifications carefully to ensure that serious attention will be given to understanding current weaknesses in prevention efforts and rectifying them in the operational plans. The TRP highlighted seven clarifications to be addressed during grant-making including – ensuring funding for TB and HIV activities through December 2017; effective HIV prevention strategies for key population groups; tailored strategies to address low and failing condom use; appropriate targets to monitor progress on MDR-TB treatment expansion; appropriate targets for TB/HIV co-infected patients on ART; strengthening resilience of health system to ensure quality data management and data use, particularly for routine reporting, and addressing human resource capacity challenges to implement the TB/HIV program in line with the HRH National Strategic Plan 2005-2020.

159. GAC review and recommendations. The GAC endorsed the TRP's recommendations on the allocation amount of US$132,435,502 and adjusted the amount to include the remaining TB phase 2 budget of US$9,150,342 to ensure the management of a single grant as per the new funding model principles, thus increasing the amount within allocation funding to US$ 141,585,733. The GAC awarded incentive funding of US$19,842,776 based on TRP prioritization and recommendation on the above allocation request, to help fund underfunded TB care and prevention, MDR-TB, TB/HIV as well as HIV prevention for general, youth and key populations, prevention of mother-to-child transmission community systems strengthening, and monitoring and evaluation. Consequently, the GAC approved

US$161,428,509 as the upper ceiling funding amount for grant-making, which takes into account incentive funding, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. GAC reviewed actions taken to address TRP clarifications, and noted that the negotiated performance framework contains targets for TB/HIV collaborative activities, MDR-TB enrolment on 2nd line treatment, and key population prevention interventions consistent with TRP recommendations and priorities for the incentive funding award. In light of the low and failing condom use, a condom program review has been undertaken and the findings will inform the national condom programming by the Ministry of Health. GAC stressed the importance of close monitoring of progress of the implementation of priority programs highlighted by the TRP, in collaboration with in-country partners.

160. GAC review and recommendations. GAC noted that a shortened grant duration (until June 2017) was deemed appropriate for the HIV program given funding gaps for the ART program, and noted that the treatment and prevention for general population modules received funding for two years while prevention for key populations received three-year funding. The GAC expressed concern about potential disruption of ART services in the second half of 2017[8]; and stressed the importance for the government of Uganda to initiate dialogue with partners and to enhance sustainability of ART for the period July to December 2017 and for increasing ART coverage beyond 2017. The GAC also noted that results of the TB prevalence survey which are expected in 2016 might result in a reprogramming of the grant. The GAC stressed that should this be the case, the CCM should ensure partners are actively involved in the reprogramming. In this regard, the GAC emphasized that should the annual review of absorption capacity signal underperformance in any of the programs, Uganda in consultation with relevant stakeholders should consider reallocating funds across programs to cover gaps in 2016 and 2017. The GAC commended Uganda for the robust involvement of stakeholders in the country dialogue and concept note development processes. The GAC and partners underlined the importance of community-level interventions in this grant and expressed concern regarding the possible closure of community health centers by the government.

161. Legal barriers and human rights. The GAC highlighted with great concern that the HIV Prevention Act and the political support for re-establishment of the anti-homosexuality law contribute to promoting stigma and therefore act as barriers for people and for key populations in particular to seek and access HIV services. While in April 2014 the Ministry of Health issued a circular to all health care service providers providing guidance not to discriminate against any patient seeking services, the GAC emphasized that given the limiting effects the country context can have on program outcomes, interventions to address barriers to health services for key populations should be further strengthened in the program. The Global Fund Secretariat has proactively engaged key populations to ensure meaningful participation during the Joint AIDS Review, the mid-term assessment of the National Strategic Plan (NSP) and the development of the TB/HIV concept note. In addition, together with partners including UNAIDS, WHO, and the United States Government (USG), the Secretariat organized a two-day consultation meeting (early August 2014) for representatives of sex workers and the LGBT community to discuss challenges, opportunities as well as define a roadmap to ensure that medium and long term priorities are taken into account in national strategies and concept notes. The objective of these efforts is to continuously work with the different stakeholders over the ensuing period to ensure access to services and meaningful dialogue for key populations. The Secretariat has also allocated funding to the Uganda CCM for key populations' engagement during country dialogue and national TB/HIV program development processes. In this regard, the CCM held elections in February 2015 where individuals from key populations groups were selected to ensure their representation on the CCM.

162. Domestic contributions. The estimated funding need is US$1884 million for the national HIV program and US$124.5 million for the TB program in the next implementation period. Total domestic financial commitments amount to US$146 million for HIV and US$11.2 million for TB, which represent 11 percent and 23 percent of total resources available for the next implementation period, respectively. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 54 percent for HIV and 50 percent for TB, which meet the minimum threshold requirement of 5 percent for a low-income country. Government commitments across all three diseases represent a 19 percent increase compared to the previous implementation period. With the contributions from the Global Fund

[8] 246,758 patients are expected to be on ART, using Global Fund funding, by 30 June 2017. US$36 million is required for sustaining the same number of people living with HIV on treatment for the period July to December 2017.

and other sources, the estimated total funding gap for the HIV program is US$610 million and US$76.6 million for the TB program.

Viet Nam TB/HIV Grants (VNM-H-VUSTA, VNM-H-VAAC and VNM-T-NTP)

163. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$104,444,734 for the Viet Nam TB/HIV program, which consists of the VUSTA grants VNM-H-VUSTA for the budget amount of US$6,942,775 and incremental funding for Board approval of US$6,792,775, the VAAC grant VNM-H-VAAC with the budget of US$58,062,321 and the incremental funding for Board approval of US$1,205,153 and the NTP grant VNM-T-NTPA with budget amount of US$39,439,638 and incremental funding for Board approval of US$23,124,495 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of unfunded quality demand of US$21,343,708 is registered for the HIV program and US$18,504,761 for the TB program, in line with TRP recommendations.

164. Epidemiological situation. According to recent HIV estimates and projections, there were 256,000 people living with HIV in Viet Nam in 2014, and HIV prevalence for the median age group of 15-49 years is 0.39 percent. The modeled estimates suggest the HIV incidence peaked in early 2000s, and it has since been declining, with estimated incidence at around 15,603 new infections in 2014. The HIV epidemic in Viet Nam remains concentrated among three key populations: people who inject drugs, men who have sex with men and female sex workers. Vietnam ranks 12th among the 22 TB high burden countries and 14th among the 27 high multidrug resistant TB (MDR-TB) burden countries. In 2012, the TB prevalence, incidence and mortality rates were 218, 147 and 20 per 100,000 population, respectively, showing a decreasing trend. The case detection rate is 76 percent. Based on the 2011 drug resistance survey, the level of MDR-TB is 4 percent among new and 23 percent among previously treated patients, showing an increasing trend.

165. Past program performance. Overall, both the HIV and TB grants have been performing well in the past years. On the treatment side, the number of people on antiretroviral therapy (ART) has been steadily increasing. Outreach to HIV key populations has also increased over the years. Compared to 1990, TB prevalence and mortality in Vietnam have dropped by about 62 percent and 60 percent respectively, demonstrating Vietnam's achievement of Millennium Development Goal. There has also been a steady rise in the number of people treated for TB and HIV co-infection as well as MDR-TB.

166. The goals of this program are to contribute to the goals of the National HIV/AIDS Strategy, to strengthen the roles of civil society and key populations in the HIV/AIDS response, to reduce TB mortality in people living with HIV to 8 percent by 2020 in 30 HIV high and medium provinces to reduce the TB prevalence rate in the community to 131 cases per 100,000 population (from 218 / 100.000 in 2012) by 2020, to reduce the TB mortality rate to less than 10 deaths per 100,000 population (from 20/100,000 in 2012) and to keep MDR TB incidence rate under 5 percent of total new TB cases. To enable Viet Nam to achieve the program goal, the Global Fund will invest in the following strategies: (i) provide prevention programs for key populations in 15 provinces in Vietnam; (ii) strengthen community systems; and (iii) remove legal barriers for access to services for key populations. Expected outcomes of these strategies include reducing the TB/HIV mortality rate with a 20 percent reduction from 2013; retaining 85 percent of people living with HIV known to be on ART 12 months after initiation; increasing TB case detection of all forms to 89 percent; and increasing MDR-TB treatment success to 73 percent.

167. Implementation arrangements. The TB program will be implemented by the National Lung Hospital of the Ministry of Health of Viet Nam. The HIV program will be implemented by Viet Nam Administration of HIV/AIDS Control of the Ministry of Health of Viet Nam (VAAC) and Vietnam Union of Science and Technology Associations (VUSTA). The procurement of all medicines, which represent a sizeable portion of the budget, is done directly through the Global Fund pooled procurement mechanism with the exception of second-line drugs for TB to be procured through IDA Foundation.

168. TRP review and recommendations. The TRP considered this concept note to represent a very strong strategically focused and technically sound request for funding that builds on the gains of previous investments in HIV and TB programming. The TRP acknowledged that it presented a comprehensive overview of the HIV and TB situations in Viet Nam, including a discussion of the geographic distribution of both diseases and the key populations most affected by each. However, the TRP was concerned about several points, including transition of people who inject drugs from detention

centres to civil life ensuring they have immediate access to essential services including ART and methadone maintenance treatment (MMT). Regarding the concept note proposal to introduce a nine-month MDR-TB treatment regimen for simple MDR-TB and a regimen containing bedaquiline for patients with pre-XDR and XDR TB, the TRP believes that these novel interventions should be conducted under research-like conditions and with observation, data capture and close monitoring/management of the potential adverse effects with technical consultation with WHO or the Union.

169. GAC review and recommendations. The Secretariat highlighted that the Global Fund calls for the closure of all compulsory treatment facilities and has committed to no longer funding interventions in such centers, noting that the Global Fund's 2012-16 Strategy includes an objective that aims to ensure that programs it supports do not infringe human rights. The GAC noted that residents of 06-centers (compulsory treatment facilities in Viet Nam) should access treatment outside these centers. Following grant-making, the Secretariat further confirmed that patients are accessing treatment outside of 06-centres in the nearby outpatient clinics which facilitates referral after patients are released from the 06-centers. Moreover, the Prime Minster of Viet Nam issued an Order on 26 December 2014 to gradually close all 06-centers by 2020.

170. GAC review and recommendations. The GAC endorsed the TRP recommendations, reviewed progress against actions taken during grant-making to address TRP clarifications. The GAC awarded incentive funding of US$20,122,532 based on TRP prioritization of and recommendation on the above allocation request, to be focused on the activities of scale up of MDR-TB services in 2015-2017 and for covering the program funding gap in 2017. In light of the additional resources made available through the incentive award, the GAC endorsed the exceptional use of the additional funds towards extension of the program end date to December 2017 in addition to the proposed scale-up of MDR-TB program. GAC recommended an upper funding ceiling of US$106,926,070 for grant-making, which takes into account incentive award, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. During grant-making, efficiencies were identified in the reduction of units ordered, the reduction of meetings and workshops, and reduced monitoring and evaluation and costs. The GAC approved the reinvestment of these funds in prevention for people who inject drugs, men who have sex with men and sex workers as well as TB care and prevention. The GAC and partners expressed concern about the ongoing use by the government of detention centers for drug users, and commended the country team on its collaboration with other partners on the ground. The GAC welcomed the efforts being made to pave the way to sustainability of Global Fund investments including the phasing out of salary supplements in 2015 and application of government costing norms, for example in the training of medical assistants. The GAC encouraged the CCM of Viet Nam to ensure sound assessment of national and donor funding and to improve resource predictability, as well as put in place a contingency plan to ensure that MDR-TB patients are not left without access to treatment.

171. GAC review and recommendations. GAC commended the outcome of grant making as an example of best practice, for the exceptional progress made in enhancing value for the money invested, resulting in significant increase in targets across the Vietnam TB/HIV program compared to concept note stage. For example in the HIV program: ART scale up was coordinated with partners and treatments capped at 50,980 by 2017 (from 38,000 in 2014, 45,000 in 2015 and 47,000 in 2016) under Global Fund funding; MMT scale up will reach out to 23,000 PWIDs in coordination with partners (30,000) and with MOH (27,000) to reach 80,000 by 2017; 73 million syringes (funded by savings and efficiencies) to be distributed through VUSTA to PWIDs which should reduce needle sharing significantly in hot zones of transmission and transmission for both HIV and Hepatitis C (given 60 percent prevalence of Hepatitis C among PWIDs); and Viral Load testing will be extended using efficiencies to cover activities originally budgeted in the above allocation request. In the TB program: a very ambitious MDR-TB scale up program has been planned, with coverage of the needs increasing from 30 percent in 2014 to reach 60 percent in 2017; with shorter and less costly regimens for MDR-TB, coverage should further increase to over 80 percent; furthermore, by reinvesting efficiencies, enrolments of MDR-TB patients proposed in the concept note will be fully covered with (2,200 MDR-TB patients in 2015, 2,500 in 2016 and 2,900 in 2017) with less funding (by US$9.3 million) compared to the concept note budget.

172. Domestic contributions for HIV and TB. The estimated funding need for the prioritized components of the national HIV program of Viet Nam in the next implementation period is US$211.2 million (2015-2017). Total domestic financial commitments amount to US$123.5 million for HIV, of which US$51.5 million contributes to the prioritized components of the HIV/AIDS investment case. While the government has made significant commitments to increase its contribution from US$9

million in 2010 to US$44 million in 2017 (an increase of 134 percent in 2015-17, compared to 2012-14), these increases are not sufficient to offset declines in donor funding. The estimate excludes requirements for supportive interventions such as program management, systems strengthening, human resources, monitoring and evaluation, general population programs and other critical enablers. The estimated funding gap for HIV is US$34.2 million, but this gap pertains only to a set of highly prioritized interventions and does not reflect the actual funding gap for the HIV program in Viet Nam. The prioritization of investments was necessitated by a steep decline in available donor funding, from US$103 million in 2010 to about US$53 million in 2017. The estimated funding need for the national TB program of Viet Nam in the next implementation period is US$330.6 million for TB and total domestic financial commitments for TB amount to US$151.5 million.

173. Counterpart financing for HIV and TB. Total domestic commitments represent 86 percent of the total resources available for TB and 29 percent of the total resources available for HIV for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase, and on the assumption that the full requested allocation funding in this concept note is approved is 87 percent for TB and 68 percent for HIV, which meet the minimum threshold requirement of 20 percent for a lower-lower-middle income country. Government commitments across all three diseases represent a 68 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap for the TB program is US$154.8 million and US$34.2 million for HIV.

174. Domestic contributions for ART. In October 2014 Viet Nam was the first country in Asia to sign the 90-90-90 agreement with UNAIDS. The domestic funding for ARVs remains limited at US$1 million yearly in 2015, though shows an increase from US$850,000 in 2014. However, Deputy Prime Minister Vu Duc Dam ordered in March 2015 the appropriation of emergency funding in the amount of US$3 million to cover ARV treatments in 2015. The amount would cover treatments for 20,000 patients at generic process.

Yemen Malaria (YEM-M-NMCP)

175. Funding recommendation for Board approval. For the approval by the Board, the GAC recommended a total budget amount of US$19,847,283 for the Yemen malaria program, which consists of the National Malaria Control Program grant YEM-M-NMCP of the incremental amount for Board approval of US$15,715,744 for the implementation period 1 July 2015 through 31 December 2017. Based on the above allocation funding request submitted in the concept note, the amount of US$6,839,831 is registered as unfunded quality demand, in line with TRP recommendations.

176. Epidemiological situation. Yemen is a country of approximately 25 million inhabitants, who, over the past four years, have been affected by a complex humanitarian emergency having a major impact on the provision of health services, including malaria interventions. Around 68 percent of the population lives in areas at risk of malaria. In 2012, suspected malaria made up 2.3 percent of total outpatient cases, with presumed or confirmed malaria comprising 0.96 percent of cases. Recent reductions have been recorded in major malaria burden indicators, including outpatient attendance, slides positivity rates, and mortality. Integrated community case management was introduced under Round 7 funding, with 214 community health volunteers trained in the use of rapid drug tests and Artemisinin-based combination therapy in regions considered underserved. Pregnant women, children under the age of 5, refugees and internally displaced persons are the groups most vulnerable to malaria infection.

177. Past program performance. Yemen has been the recipient of two Global Fund grants since 2004. The national malaria control program has successfully scaled up major interventions in the last few years, with future planning based on a national malaria control and elimination strategy covering the period 2014 to 2018, aiming for malaria elimination throughout Yemen by 2020. The Global Fund and other donors such as Gulf Cooperation Council partners of “An Arabian Peninsula free of malaria” have helped the National Malaria Control Program to make progress in reducing the burden of malaria. The most recent grant has been able to: (i) maintain relatively low incidence of malaria during the last decade and also confirmed reduced parasite prevalence in the Tehama region as demonstrated through two Malaria Indicator Surveys (2009 and 2013); (ii) register reported local cases on Socotra Island and contribute to a decline of reported cases in the Hadramout region to 1 percent, with zero cases of mortality; and (iii) expand diagnosis services that has translated into more confirmed cases treated and

less clinically treated cases. Additionally, the child mortality has decreased from 102 per 1000 to 53 per 1000 between 2003 and 2013 according to the draft report of the demographic health survey (2013).

178. Program goals. The investment under this program aims to increase access to malaria diagnosis and treatment to all populations at risk including reaching the underserved key populations through the integrated community case management, coverage with malaria preventive tools (including long lasting insecticidal nets (LLINs) and indoor residual spraying) to the targeted populations in malaria risk areas, and strengthening the malaria information, monitoring and evaluation system. The goals of the program are to reduce malaria morbidity by 75 percent by the end of 2018; to reduce malaria mortality to nearly zero cases by end of 2015; and to make a major impact on transmission and reducing incidence to less than 1 case per 1000 in all areas targeted for elimination.

179. Implementation arrangements. The program will continue to be implemented by the National Malaria Control Program / Ministry of Public Health (NMCP) as Principal Recipient, given the current security situation and ability to reach beneficiaries. This Principal Recipient has been managed under the Additional Safeguards Policy since December 2013 due to the political and security situation in the country coupled with self-reported irregularities and capacity weaknesses of the Principal Recipient. In addition to engaging GIZ to strengthen capacity of the Ministry of Public Health, the Secretariat will consider opportunities that may arise for change during implementation.

180. TRP review and recommendations. The TRP considered this concept note to be strategically focused and technically sound. The TRP commented that the proposal presents well-designed intervention packages and laudable objectives. Furthermore, it takes into account vulnerable populations, and the wider health issues, particularly malnutrition of children, that afflict much of the Yemeni population. The TRP commended the Government of Yemen on its very significant contribution to the total funding for the national malaria control and elimination strategy. The TRP highlighted five clarifications for the applicant to address including i) concerns about the cost of combined deployment of IRS and LLINs in the same geographic areas, given the limited resource envelop; ii) relatively low budget for scale-up of iCCM; iii) the need for clarity of the denominator used for some indicators; and as Yemen moves towards elimination, TRP stressed the need for - iv) strengthening M&E systems; and v) set-aside budget to ensure LLINs and /or IRS stocks are available for rapid outbreak response and establishing such response capacity during planning for implementation.

181. GAC review and recommendations. Based on the TRP recommendations on prioritization of the above allocation request the GAC awarded incentive funding of US$1,900,000, focused on LLIN distribution, therapeutic efficacy monitoring and monitoring and evaluation. Regarding combined deployment of IRS and LLINs, GAC technical partners were of the opinion that the continued use of IRS could be justified, given that the country i) is moving towards malaria elimination, and ii) insecticide resistance has been identified, hence the proposal to alternate between pyrethroid and carbamates based chemicals, although a coherent strategy to address insecticide resistance was missing in the concept note. In this regard, the GAC requested the CCM to work with technical partners in articulating the country's vector control/resistance management plans and how the proposed incentive funding could be invested to maximize synergies, ensure cost savings in the long term and increase value for money to achieve highest impact on program goals. GAC welcomed UNICEF's commitment to fund iCCM activities, which will contribute to expanding iCCM beyond the current pilot. GAC endorsed investing in iCCM expansion as appropriate, and in line with an effective malaria case management strategy in the country, based on availability of resources and feasibility within the country context.

182. GAC review and funding recommendations. The GAC endorsed the TRP's recommendations, reviewed progress against actions taken during grant making to address TRP clarifications and awarded an upper funding ceiling of US$18,854,450 for grant making, which takes into account incentive funding, adjustments of the available funds for the implementation period and actual/forecasted disbursements up to the proposed start date of the new grant. In line with TRP and GAC recommendations, the country developed an Integrated Vector Management Strategic Plan (2015 - 2020) as well as Insecticide Resistance Monitoring and Management Plans. Vector control needs assessment was conducted and forms the basis of the new targets described in the performance framework. In addition, during grant-making efficiencies of US$906,394 were identified resulting from revised unit costs, and a balance of US$462,712 is being refunded from the procurement agent. The GAC has endorsed the reinvestment of these savings into LLINs distribution, thus increasing the country's allocation for its malaria program by 2.4 percent derived from reinvestment of existing funding. The GAC also acknowledged that the PPM order of US$2,075,769 originally scheduled to be finalized prior to start of the current grant has been included in the budget for the new implementation period.

183. Risk management. GAC emphasized the need to ensure that Global Fund investments are secure in the current fragile security situation. Additional Safeguards Policy provisions will be maintained, and the Secretariat will continue to monitor the situation on a daily basis. There is an emergency plan that was endorsed by the health humanitarian cluster on 23 April 2015. In addition, 75 percent of the investment will be going through the Global Fund pooled procurement mechanism (PPM) – with distribution to be managed by the humanitarian agencies' logistics cluster; adequate risk management measures are also in place to manage the remaining 23 percent. In addition, the current Local Fund Agent (LFA) UNOPS is being used to effectively monitor program implementation.

184. Domestic contributions. The estimated funding need for the national malaria program of Yemen in the next implementation period is US$98,372,447. Total domestic financial commitments amount to US$28,325,544, which represents 29 percent of total resources available for the next implementation period. The counterpart financing share based on commitments of government contribution in the next phase and on the assumption that the full requested indicative funding in this concept note is approved is 54 percent, which meets the minimum threshold requirement of 20 percent for a lower-lower middle income country. Government commitments across all three diseases represent a 1 percent increase compared to the previous implementation period. With the contributions from the Global Fund and other sources, the estimated total funding gap is US$22,314,313.

02 Summary of the Deliberations of the Secretariat's Grant Approvals Committee (GAC) on proposed grant extensions

Malawi HIV Grant (MLW-H-NAC)

185. Funding recommendation for Board approval. The GAC endorsed the proposed six-month costed-extension with the total budget of US$59,471,233 and incremental funding of US$37,090,681 for the MLW-H-NAC grant and recommends for Board approval.

186. Summary of rationale for the extension request. The CCM of Malawi is seeking the approval of the Global Fund for the six-month costed extension for the HIV grant (MLW-H-NAC) to facilitate the transition to the new funding model and to allow the initiation of the procurement order for the HIV commodities needed in Malawi for consumption during the first semester of 2016. The proposed grant extension will therefore ensure continuation of essential services while the concept note reviewed during Window 5 TRP meeting, and the resulting TB/HIV grant is being negotiated and signed. Taking into consideration the high volume of commodities needed, the manufacturing planning of the commodities, their lead time and the benefits of a delivery by ocean which is the cheapest option, the procurement order has to be placed by June 2015 at the latest to avoid ART treatment disruption in quarter 1 of 2016. It should also be noted that the TRP has recommended the TB/HIV concept note for grant-making with no objection to the request for this six-months costed-extension included in the concept note.

187. Strategic focus of funding for the extension period. The funds requested for the extension period are meant for the procurement of HIV commodities including ARVs (US$41,204,871), opportunistic infections and sexually transmitted infections drugs (US$7,860,725), HIV and syphilis test kits (US$3,076,380) as well as procurement as supply management costs (US$7,329,256). With this extension the country will continue implementing the 2013 WHO HIV treatment guidelines by scaling up coverage of eligible people living with HIV including CD4 500, Option B+, universal eligibility for children under five and positive HIV and TB patients. The targets for the ART will increase over the extension period by 7 percent to 618,488 patients by 31 December 2015 including 41,430 new enrollments.

188. Grant performance. During the last reporting period (January-June 2014), the programmatic performance has been adequate, achieving a "B1" rating, in line with the overall performance of the implementation period. This rating is mainly due to the fact that the good performance achieved on treatment, PMTCT and training indicators is mitigated by the underperformance on the testing and counselling indicator (1,660,075 tests conducted versus a target of 2,818,199). A number of measures, including the expansion of Provider Initiated Counselling and Testing (PICT), have been proposed in

the TB/HIV concept note to improve achievement on this key indicator to enable the continuous scale-up in coverage proposed. However, the overall performance of the grant was downgraded to "B2" due to weaknesses in financial management systems. The main issues are the weaknesses in sub-recipient (SR) management with delays in SR audits and qualified audit reports and ineligible/unsupported expenditures incurred by SRs as reported by the external auditor of the PR. Going forward, the program will be implemented tough a dual track financing with the Ministry of Health and Action Aid as Principal Recipients, the current Principal Recipient (National AIDS Commission) will be discontinued. To mitigate financial and fiduciary risks, a program implementation unit installed at the Ministry of Health level for the management of the Global Fund grants will be maintained for the grant implementation period. In addition, a second Principal Recipient from civil society will take over the prevention activities at community level thus further reducing the scope of activities and funds managed directly by the Ministry of Health.

189. Risks. Taking into account that the grant extension will only cover procurement of commodities which will be handled by the pooled procurement mechanism, and stored and distributed through the parallel supply chain system, the Secretariat does not foresee major risks related to the proposed investment during the extension period.

Multi Country Americas REDCA+ HIV Grant (MAR-H-SICSA)

190. Funding recommendation for Board approval. The GAC endorsed the proposed nine-month extension with the additional funding of US$193,037 for the MAR-H-SICSA grant and recommends Board approval.

191. Summary of extension request/reasoning. REDCA+ is seeking the approval by the Global Fund of the nine-month costed extension for the HIV grant (MAR-H-SICSA) to allow for continuation of grant activities during the revision of its concept note. REDCA+ has been originally scheduled for the Phase 2 review in 2014 but instead submitted a concept note. The TRP reviewed the concept note and recommended it for further iteration following TRP review. The revised concept note was reviewed by the TRP in window 5 in March 2015. Although the TRP found the concept note to be strategically focused, it noted there was insufficient detail on the activities proposed to assess technical soundness and regional added value and therefore recommended the concept note for further iteration in which REDCA+ is expected to provide further details regarding proposed activities, as well as a fully developed advocacy and sustainability strategy. To ensure a smooth transition of activities and avoid a funding gap while the concept note is revised, reviewed and signed, the Secretariat recommends a nine-month extension to the current grant. The grant has previously been extended by nine months pursuing delegated authority established under GF/B31/DP12 and therefore the current extension requires Board approval.

192. Grant performance. Grant performance throughout the current implementation period has been strong, with a rating of A1 in every reporting period and a consistent budget execution of around 80 percent and therefore the Secretariat doesn't perceive major risks linked to this extension.

193. Funding for extension period. Taking into account the projected unspent amount of US$548,402, this funding will not be sufficient to finance planned activities. The Secretariat therefore recommends an incremental amount of US$193,037.

V. Additional Matters

01 Extensions Approved by the Secretariat Pursuant to Its Delegated Authority

1. The Secretariat hereby notifies the Board that it has approved extensions to the grants listed in Table 4 of Annex 1 to GF/B33/ER03 in accordance with the Board decision GF/B31/DP12.

This document is part of an internal deliberative process of the Global Fund and as such cannot be made public.

Annex 1

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

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	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	Bhutan	Malaria	Ministry of Health (BTN-M-MOH)	US$1,942,261	US$165,606	US$1,776,655	US$1,776,655	N/A		US$3.3 million
2	Ethiopia	HSS	Federal Ministry of Health (ETH-S-FMOH)	US$52,260,169	US$7,633,004	US$44,627,165	US$44,627,165	N/A	US$15,774,456	US$19.8 million
3	Ethiopia	Malaria	Federal Ministry of Health (ETH-M-FMOH)	US$148,752,983	US$33,240,396	US$115,512,587	US$115,512,587	N/A	US$14,154,980	US$66.1 million
4	Gambia	HIV	NAS (GMB-H-NAS)	US$14,768,343	US$2,006,278	US$9,073,538	US$12,386,594	N/A	US$7,843,704	US$1,896,493
			Action Aid (GMB-H-ActionAid)		US$375,471	US$3,313,056				
5	Guinea	Malaria	Catholic Relief Service (GIN-M-CRS)	US$62,200,411	US$4,902,680	US$57,297,731	US$57,297,731	US$2,078,401	N/A	US$10,613,219

<table>
<tr><th rowspan="2">N</th><th rowspan="2">Country</th><th rowspan="2">Disease Component</th><th rowspan="2">Proposed Principal Recipient (Grant name)</th><th rowspan="2">Total Program Budget</th><th colspan="2">Sources</th><th rowspan="2">Recommended Total Incremental Funding</th><th rowspan="2">Incentive Funding included in Total Incremental Funding</th><th rowspan="2">Unfunded Quality Demand</th><th rowspan="2">Domestic Commitment</th></tr>
<tr><th>Existing Funding</th><th>Recommended Incremental Funding</th></tr>
<tr><td>6</td><td>Lao (People Democratic Republic)</td><td>TB</td><td>Ministry of Health (LAO-T-GFMOH)</td><td>US$7,239,191</td><td>US$4,223,147</td><td>US$3,016,044</td><td>US$3,016,044</td><td>US$1,498,395</td><td>N/A</td><td>US$3.5 million</td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Mozambique</td><td rowspan="2">Malaria</td><td>Ministry of Health (MOZ-M-MOH)</td><td rowspan="2">US$107,360,243</td><td>US$41,066,178</td><td>US$43,106,362</td><td rowspan="2">US$54,224,226</td><td rowspan="2">US$5,885,035</td><td rowspan="2">US$93,547,916</td><td rowspan="2">38 million</td></tr>
<tr><td>World Vision (MOZ-M-WV</td><td>US$12,069,839</td><td>US$11,117,864</td></tr>
<tr><td rowspan="3">8</td><td rowspan="3">Mozambique</td><td rowspan="3">TB/HIV</td><td>Ministry of Health(MOZ-H-MOH)</td><td rowspan="3">US$241,007,021</td><td>US$128,925,773</td><td>US$52,002,749</td><td rowspan="3">US$ 65,398,894</td><td rowspan="3">US$43,560,000</td><td rowspan="3">US$231,006,779</td><td rowspan="3">HIV : US$157 million
TB: US$10 million</td></tr>
<tr><td>Ministry of Health(MOZ-T-MOH)</td><td>US$26,329,158</td><td>US$12,102,950</td></tr>
<tr><td>Fundação Para o Desenvolvimento da Comunidade</td><td>US$20,353,196</td><td>US$1,293,195</td></tr>
</table>

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	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				
			(FDC)(MOZ-C-FDC)							
9	Papua New Guinea	HIV	Oil Search Health Foundation (PNG-H-OSHF)	US$14,207,542	US$6,453,334	US$7,754,208	US$7,754,208	N/A	N/A	US$56.1 million
10	Philippines	HIV	Save the Children (PHL-H-SC)	US$13,920,375	US$1,912,042	US$12,008,333	US$12,008,333	US$1,118,947	US$2,010,341	US$175 million
11	Sao Tome & Principe	TB	UNDP (STP-T-UNDP)	US$1,567,681	US$278,628	US$1,289,053	US$1,289,053	N/A	N/A	US$296,000
12	Senegal	HIV	Alliance Nationale de lutte Contre le Sida (SEN-H-ANCS)	EUR19,478,252	EUR 3,124,426	EUR 1,968,021	EUR 8,555,373	N/A	N/A	EUR 13,680,590
			Conseil National de Lutte contre le		EUR 7,798,453	EUR 6,587,352				

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	Total Program Budget	Sources: Existing Funding	Sources: Recommended Incremental Funding	Recommended Total Incremental Funding	Incentive Funding included in Total Incremental Funding	Unfunded Quality Demand	Domestic Commitment
			Sida (SEN-H-CNLS)							
13	Somalia	HIV	UNICEF (SOM-H-UNICEF)	US$20,614,311	0	US$20,614,311	US$20,614,311	US$1,765,506	N/A	N/A
14	Somalia	Malaria	UNICEF (SOM-M-UNICEF)	US$33,680,843	US$ 2,120,844	US$31,559,999	US$31,559,999	N/A	US$7,651,902	N/A
15	South Sudan	TB	UNDP (SSD-T-UNDP)	US$15,512,452	US$3,549,802	US$11,962,650	US$11,962,650	US$2,437,815	US$4,157,812	US$3.2 million
16	Tanzania	TB/HIV	Ministry of Finance (TZA-H-MOF)	US$298,479,894	US$104,745,414	US$172,448,214	US$190,283,793	US$78,608,549	US$195,254,828	HIV: US$107 million TB: US$6.2 million
			Ministry of Finance (TZA-T-MOF)		US$3,450,687	US$17,835,579				
17	Uganda	HSS	MOFPED (UGA-S-MoFPED)	US$ 21,771,916	US$572,761	US$14,035,520	US$19,920,527	N/A	US$2,004,253	US$214 million
			The AIDS Support		US$1,278,629	US$5,885,007				

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	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				
			Organization (UGA-S-TASO)							
18	Uganda	TB/HIV	The AIDS Support Organization (UGA-C-TASO)	US$230,505,464	US$463,650	US$6,341,348	US$149,054,980	US$19,842,776	US$345,212,047	HIV: US$146 million TB: US$11.2 million
			Ministry of Finance (UGA-H-MoFPED)		US$69,134,319	US$131,870,252				
			Ministry of Finance (UGA-T-MoFPED)		US$11,852,515	US$10,843,380				
19	Viet Nam	TB/HIV	National Lung Hospital - Ministry of Health of Vietnam (VNM-H-VAAC)	US$104,444,734	US$56,857,168	US$1,205,153	US$31,122,423	N/A	US$21,343,708	US$123.5 million

N	Country	Disease Component	Proposed Principal Recipient (Grant name)	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				
			Vietnam Administration of HIV/AIDS Control - Ministry of Health of Vietnam(VNM -H-VUSTA)		US$150,000	US$6,792,775			N/A	
			National TB Program (VNM-T-NTP)		US$16,315,143	US$23,124,495		US$20,122,532	US$18,504,761	US$151.5 million
20	Yemen	Malaria	National Malaria Control Program (YEM-M-NMCP)	US$19,847,283	US$4,131,539	US$15,715,744	US$15,715,744	US$1,900,000	US$6,839,831	US$28,325,544

Table 2: Secretariat's Recommendations on Grant Extensions

Country	Grant Name	Period of Extension (Months)	Additional Funding	Rationale
Malawi	MLW-H-NAC	6 months	US$37,090,681	To facilitate the transition to the new funding model and to allow the initiation of the procurement order for the HIV commodities needed in Malawi for consumption during the first semester of 2016 and therefore ensure continuation of essential services while the new HIV grant is being discussed and signed.
Multi Country Americas REDCA+ HIV Grant	MAR-H-SICSA	9 months	US$ 193,037	To allow for continuation of grant activities during the revision of concept note

Table 3: Grant Extensions Approved by the Secretariat

Country	Grant Name(s)	Period of Extension (Months)	Additional Funding Approved	Rationale
Madagascar	MDG-810-G13-T	10 months	US$87,498	To continue implementation of life-saving services while the concept note is being written and reviewed
Multi Country Americas REDCA+ HIV Grant	MAR-H-SICSA	6 months	N/A	To allow for continuation of grant activities during the revision of concept note
Malawi	MLW-708-G05-M	6 months	N/A	To allow for continuation of program activities while concept note is being developed and reviewed
Pakistan	PKS-M-DOMC	3 months	N/A	To allow continuation of grant activities while Framework agreement is being negotiated and signed
Pakistan	PKS-M-SC	3 months	N/A	