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GLOBAL FUND APPROVES $310 MILLION IN RENEWAL AND INTERIM FUNDING

The Board of the Global Fund on 25 April approved renewal and interim funding of up to $310 million. These announcements do not represent additional resources but rather reflect the country allocations announced on 12 March.

Recommendations dating from December 2013 by the Technical Review Panel (TRP) and the Secretariat, including the Grant Approvals Committee (GAC) informed the Board's decision. The essence of the recommendations for each of the countries supports ongoing efforts to encourage applicants to merge their requests for continued funding with concept notes covering all of the funds they were allocated for 2014–2016.

The awards from 25 April will help prevent program disruptions by extending grants that were to be closed by 30 June. They include $247 million in renewal funding (Table 1) and $63 million for interim funding under the NFM transition phase (Table 2).

Table 1: Funding awards for grant renewals, from GAC Report GF-B31-ER04

Country	Component	Grant Number	Ceiling ($US millior
Ethiopia	TB	ETH-T-FMOH	41.

Kenya	HIV	KEN-H-KRC	23.
	HIV	KEN-H-MOF	146.
Morocco	HIV	MOR-011-G04-H	23.
	TB	MOR-011-G05-T	4.
Uganda	TB	UGD-T-MoFPED	8.
TOTAL			247.

Kenyan HIV programs were awarded $170.2 million in renewal funding and $53.0 million in interim NFM funding, for a total $223 million. Kenya's total HIV allocation for 2014-2016 is $337.3 million.

All of the amounts shown in the tables are ceilings; the amounts finally committed could be less.

Table 2: Interim funding awards, from GAC Report GF-B31-ER04

Country	Component	Grant Number	Ceiling ($US millior
Ethiopia	TB	ETH-T-FMOH	9.
Kenya	HIV	KEN-H-KRC	6.
	HIV	KEN-H-MOF	46.
Moldova	HIV	MOL-H-PCIMU	1.
TOTAL			63.

* The award to Moldova was € 731,918, converted to US dollars at a rate of 1.3822.

Recipient-specific details are summarized below.

Ethiopia has the eighth highest TB burden in the world and is also one of the 27 countries with high burdens of multi-drug resistant TB. Although TB incidence, prevalence and mortality rates are estimated to have declined by 33%, 47% and 63% respectively between 1990 and 2012, the TB burden remains high. An estimated 230,000 new TB cases and 160,000 TB-related deaths occur annually. Only 10-15% of the known cases of MDR-TB received second-line anti-TB treatment in 2011-2012.

Ethiopia will use Global Fund money to support its updated National Strategic Plan (NSP) 2014-2020 in

achieving targets including the diagnosis and treatment of nearly 460,000 cases of TB, which would increase case detection from 64% to 85%; a treatment success rate of over 90%; treatment of more than 2,900 cases of MDR-TB; and the provision of both TB drugs and anti-retroviral therapies to nearly 44,000 TB patients living with HIV.

Other programs include boosting laboratory capacity for better smear microscopy and culture and drug sensitivity testing functions and procuring and deploying 30 additional GeneXpert machines. Cross-cutting health system strengthening interventions such as training for health extension workers and the expansion of community-based TB care in health posts (from 44% of health posts to 100% by the end of 2014) are also envisioned.

Ethiopia's country coordination mechanism (CCM) intends to submit a single TB-HIV concept note covering all of its NFM funding for TB and HIV in August 2014.

Kenya has achieved considerable success in addressing HIV. Annual new infections declined by 18% from 2007 to 2012; AIDS-related deaths were down by 40% since 2009; new infections among children declined by 44% between 2009 and 2012; and by June 2013, 619,669 people were receiving ARVs based on 2010 WHO guidelines (a coverage rate of 83%). Nationally, HIV prevalence was down from 7.2% in 2007 to 5.6% in 2012, but prevalence has risen in two regions. There are higher rates among women than among men and the epidemic has disproportionately affected specific key populations, including men who have sex with men (estimated prevalence: 15%), sex workers (29%), people who inject drugs (18%), prisoners (8%) and fishing communities (26%).

Kenya's strategic plan targets both the general population as well as key affected populations and the regions with the highest rates of transmission. Ongoing country dialogue has emphasized the need to focus on combination HIV prevention, including investing in complementary prevention interventions currently not funded by the Global Fund – i.e. voluntary medical male circumcision and condom distribution.

The budget includes $53 million to support Kenya's implementation of the 2013 WHO ARV guidelines, in order to achieve universal access targets by 2017. Kenya will be encouraged to invest more in gender-specific strategies and community system strengthening, in line with GAC recommendations.

Kenya's CCM intends to submit a single TB-HIV concept note covering its NFM funding for TB and HIV in January 2015.

Morocco: HIV prevalence remains low in the general population (0.14%) but a sentinel surveillance survey conducted in 2010-2011 identified an HIV prevalence of 11.4% among people who inject drugs (PWID), 5.1% among men having sex with men (MSM), and 1.9% among female sex workers (FSW). These vulnerable populations, plus clients of sex workers, represent 67% of new infections.

Morocco's National Strategic Plan 2012-2016 includes focused strategies for each vulnerable group, devoting two-thirds of its budget through 2016 to high-impact activities targeting the aforementioned at-risk populations as well as migrants, truck drivers and clients of sex workers, uniformed personnel, prisoners, construction or seasonal workers, and vulnerable women and youth.

Morocco also plans to adopt the 2013 WHO ARV guidelines, which will increase the number of patients eligible for ARVs by 24% by the end of 2016. Treatment costs will be shared equally by the Global Fund and government. Goals are to reach 50% of the national target of 2.4 million people with HIV testing and counseling by 2016. Some $5 million — about 20% of the $23 million available to Morocco — will be allocated to community systems strengthening.

Uganda has one of the world's highest TB burdens. While treatment success has increased from 63% to

77% among patients who began treatment between 2000 and 2011, it remains lower than the global target and does not reach the 82% average success rate for that cohort for Africa. Among people co-infected with TB and HIV, only 59% are on ART.

The next implementation period will aim to reduce TB mortality and morbidity. The budget includes funds for improving diagnostic capacity, community mobilization and TB-HIV collaborative activities. The national TB program aims to increase coverage of ARVs for TB-HIV co-infected patients from 60% in mid-2013 to 75% by end-2014 and 100% by end-2015.

The Uganda CCM should submit a concept note covering its NFM funding by October 2014.

Moldova has an HIV epidemic concentrated mainly among PWID. Using 2010 WHO guidelines, it is estimated that only 35% of people in need of ARVs were receiving them by the end of 2012. Recommendations emerging from country dialogue would devote funds to procurement of ARVs to ensure adequate stock to cover the needs in 2015. This will contribute towards the shift to full responsibility for ARV provision by government; until 2013 all ARV treatment was paid for by the Fund.

The Moldova CCM expects to submit a concept note covering its NFM funding in May 2014.

Grant extensions

The Global Fund Board also approved a 10-month, $13-million extension for an HIV grant in Sudan (SUD-011-G15-H) to avoid a disruption in service between the end of Phase 1 and the January 2015 start of Phase 2. The Sudan CCM should submit a concept note in the next few months covering all of its NFM funding for HIV.

Under authority delegated to it, the Secretariat approved three-month costed extensions for two Senegal malaria grants, for a total $11 million. The funds were needed to procure and distribute long-lasting insecticide-treated nets to permit a smooth transition to funding under the NFM.

The Secretariat also approved un-costed extensions for TB grants in Afghanistan and Central African Republic; for HIV grants in Kyrgyzstan and multi-country southern Africa (SADC); for a malaria grant in Rwanda; and for an HSS grant in Viet Nam.

Information for this article was taken from Board Decisions GF-B31-EDP05, GF-B31-EDP06 and GF-B31-EDP 07 and from GF-B31-ER04, the Report of Secretariat’s Grant Approvals Committee. These documents are not available on the Global Fund website.

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