

**PRINCIPAL RECIPIENT  
GRANT IMPLEMENTATION UPDATE**

**Period Covered: 1 January to 30 March 2011**

**HIV AND TUBERCULOSIS – ROUND 7 GRANTS  
MALARIA – ROUND 5 ‘ROLLING CONTINUATION CHANNEL’ PHASE**

**A. Round 7 HIV Grant**

**PR Coordinator: Albert Angelo Concepcion**

**What’s working well?**

***Blood Safety and Universal Precautions***

The shift from a training indicator to one that measures impact on blood supply ‘allowed’ the national societies in four PICTs (Cook Islands, FSM, Kiribati and Samoa) to ‘reach out’ to non-family member blood donors and collaborate more closely with national laboratories/blood banks in data collection and reporting. Performance in the prior period indicated IFRC’s proactive engagement with the national programs and improved data collection by M&E officers at the laboratory level.

***(HIV and STI) Counselling and Testing***

Overall, the ‘regional’ counselling and testing program implemented across 12 PICTs (including Solomon Islands) have shown remarkable performance, an indication that resources invested in Phase 1 are making some impact –

- Accredited counselling and testing sites continue to provide HIV and/or STI counselling and testing services according to the “Pacific minimum standards” (a.k.a. essential standards);
- Increasing number of people being screened for HIV in the 12 PICTs, with one-third of that receiving counselling and testing services as per the “Pacific minimum standards”. This is a reflection of improved recording and reporting by national HIV and STI programs, especially for Kiribati where reporting has increased by 46% as compared to prior periods;
- Improved quality, increased coverage and consistency of STI testing services in majority of the 8 national laboratories (excluding Kiribati, Nauru, Niue and Tuvalu) providing *in situ* testing services for Chlamydia with no reported breaks lasting more than 14 days; and
- Increasing number of ANC women being tested for STI in the 11 PICTs (excluding Niue), either through the use of nucleic acid assay testing (NAAT) available *in situ*, or through overseas referral.

***Treatment of Sexually Transmissible Infections***

Similar to HIV and STI counselling and testing, overall grant program performance on STI treatment continue to show positive results –

- Health care workers in the region continue to receive capacity building inputs on comprehensive STI case management (three provinces in Solomon Islands) and enhancement training on the new STI control strategy for Phase 2 (Nauru, Tuvalu and Vanuatu);

- Majority of the pre-determined treatment sites, at the national and provincial levels, remain fully equipped and supplied for HIV and STI treatment, ensuring no stock outs of ARVs and/or STI drugs as per the national/regional treatment guidelines; however, stock outs were noted in a number of treatment sites in FSM, Nauru, Samoa and Solomon Islands; and
- More ANC women continue to receive treatment for Chlamydia, with regional performance calculated at 73%. Four PICTs showed 100% treatment coverage for ANC women – Nauru, Palau, RMI and Tuvalu.

### ***Reducing Stigma in All Settings***

In order to address HIV-related stigma and discrimination, PIAF has worked across multiple stakeholders in a number of countries and was successful in setting up two support networks in Kiribati and Vanuatu. These support networks provide human rights information and other services to PLWH and the community. As part of the process, legal literacy training were conducted in the two PICTs, followed by partnership building between PIAF and local partners and strengthening of linkages with PLWH and the local community.

### **What needs significant focus?**

#### ***Condom Distribution***

In order to address reports of low level access to condoms in some PICTs over the 2008 and 2009 calendar year, the grant program moved from a procurement approach to a confirmation of condoms distributed to service points. It appeared that this shift proved challenging to UNFPA and the national programs in terms of data collection from a number of PICTs on the number of condoms that were actually distributed and therefore ‘available for use’. There is a need for UNFPA to ensure that data are better collected and reported in the coming periods.

#### ***ARV Treatment and Monitoring***

In relation to ARV treatment and monitoring –

- Regular access to ART continues to improve, with ‘new cases’ (PLWH eligible for ART based on the new WHO guideline for initiating ART) receiving treatment in accordance with the regionally approved treatment protocol. However, the quality of in-PICT case management, which includes patient monitoring, continues to be a challenge – with 4 deaths recorded from Kiribati, RMI, Solomon Islands and Tuvalu, and 2 drop-outs reported from Kiribati and RMI. To date, 39 PLWH eligible for ART are receiving this lifelong, life-saving treatment.
- Plans are underway to ‘set up’ a regional framework for HIV care in the region, with the planned regional workshop on “Patient Monitoring for HIV Care and ART” to be held in July 2011. This workshop will strengthen the capacity of PICTs to provide and sustain long-term HIV care and support and to establish an effective patient monitoring system integrated with prevention, care and treatment at HIV care sites.

#### ***Information System***

In Phase 2, the importance of M&E was reinforced with the objectives of (1) establishing cross-cutting national HIV and STI M&E teams that would be responsible for timely and high quality data collection and reporting, and (2) ensuring that national HIV and STI programs would be implementing routine, high quality M&E activities according to the national strategic plan and how

they link to PRSIP II outputs, outcomes and objectives. Challenges experienced in the recruitment of the regional M&E officers (at SPC level) unfavourably impacted on this area. This would be addressed by SPC in Period 6, once the regional M&E officers come on board.

**What are the strategic challenges?**

***(HIV and STI) Counselling and Testing***

The PR has commissioned two technical consultants to undertake an independent, external review of PCSS' (a) implementation of the counselling training program in 12 PICTs including the assessment of protocols and tools used to accredit counselling and testing sites based on the Pacific minimum standards; and (b) grant management performance. There is a potential to revise parts of the counselling training program and improve the training approach based on the findings from three PICTs visited (Kiribati, Tonga and Vanuatu) and recommendations from the report. The Task Force on Counselling and Testing will take the lead in the planned changes in content and approach.

As regards the assessment of counselling and testing sites, a number of PICTs expressed their intentions to provide quality counselling and testing services following the increase in the number of health workers trained in counselling and testing. PCSS has added an additional step in the whole assessment and accreditation process, to involve the national programs to undertake their own in-country assessments prior to the formal accreditation by PCSS.

***Continued Funding for HIV and STI in the Region***

With the new and enhanced HIV and STI control strategy being largely dependent on the Round 7 HIV grant, a strategy for external and continued funding will have to be developed well in advance of the end of Phase 2.

To date, the rollout of new HIV strategies for CD4 testing and the HIV confirmatory testing algorithm has been completed in majority of the 12 PICTs supported by the grant. As regards the rollout of the enhanced STI control strategy, epidemiologic treatment for six out of the seven PICTs (Cook Islands, FSM, RMI, Nauru, Tuvalu and Vanuatu, with the exception of Samoa) with high prevalence of Chlamydia is planned to start in July and August 2011.

***Performance of SRs***

The gap between performing and underperforming SRs has widened. Technical assistance or support provided by SPC and other partners has not been successful in addressing the systemic challenges faced by RMI, Samoa and Tuvalu. There is a need for intensified support in these PICTs and a strong focus by SRs on grant program implementation.

**B. Round 7 Tuberculosis Grant**

**PR Coordinator: Interim Coordinator (Victor Paul Bagtas) to commence 06 June 2011**

*What's working well?*

*Ownership of work plans and Master Training Plans*

The Sub-Recipients seem to have a greater sense of ownership of their work plans and their Master Training Plans. In addition they seem more confident to make decisions about minor programmatic and financial changes to the work plan and seem to better understand when a decision requires approval, and at what level. The necessity for Master Training Plans has crystallised thinking about national and regional trainings, and it is anticipated that the quality of training documentation will improve as a result of the increased focus on training. At the Principal Recipient level, an increased focus on planning for training, and subsequently monitoring training activities will complement the national efforts to provide more comprehensive training documentation.

*Screening of vulnerable groups (i.e. prisoners, immigrants and TB contacts)*

The Sub-Recipients have accelerated progress against some of the screening indicators in the TB grant. Screening prisoners for TB has taken place in five Pacific Island countries and territories and newly arriving immigrants were screened for TB in Niue. Not only is there a higher number of prisoners being reported as screened, but a higher number of countries are reporting screening activities. Niue's screening of three immigrants, while small in numbers, indicates that their newly developed disease screening protocol is in effect and operational. In addition, a large number of contacts were screened in the last period and the reported result was almost double the target. TB contact tracing was carried out in five Pacific Island countries and territories. Moving forward into the remainder of Phase 2 it may be important to evaluate the yield of such activities in order to determine the effectiveness of screening efforts.

*TB/ HIV collaborative activities*

In period 5, TB/HIV collaborative activities were accelerated, in particular HIV screening of TB patients. In period 5, 50% of eligible TB patients were screened for HIV, and this was above the target of 30%. Seven Pacific Island countries and territories implemented HIV testing of TB patients in period 5 and Kiribati is planning to scale up HIV testing of TB patients moving forward into period 6.

*Development of revised national TB guidelines consistent with WHO/ SPC policy recommendations*

National TB guidelines were revised in four Pacific Island countries and territories with the aim of providing countries with the most up to date information on the clinical and programmatic management of TB in their settings. The guidelines are consistent with international policy recommendations on TB control, most notably the *Treatment of Tuberculosis guidelines; fourth edition* (WHO/HTM/TB/2009.420). In addition, the recording and reporting tools have been revised to be consistent with international recommendations and the countries needs. Some countries are planning dedicated workshops to launch the new TB guidelines and it will be important that staff are trained on the new technical recommendations in the guidelines as well the revised recommendations for treating and managing TB patients.

***What needs significant focus?***

*Data quality, including quality of supporting documentation*

As outlined below, the quality and timeliness of supporting documentation and data requires significant attention moving forward into period 6. This is the single most important area of focus as the Sub-Recipients move into periods 6 and 7 of the grant. Sub-Recipients will need to provide higher quality supporting documentation in the next periods and all data will need to undergo a quality check before being sent to the Principal Recipient. For example, it will be important that all supporting documentation is provided on a Ministry letterhead with clear documentation about what the data definitions are, dates of collection, source of the data etc. Sub-Recipients could take a more proactive approach to monitoring their TB grants by verifying data at regular intervals and rectifying any errors before it is sent to the Principal Recipient. While it is acknowledged that no dataset is perfect, additional focus on data definitions, data counts and data tools are required. In November, 2011 it is anticipated that WHO and SPC will hold a joint training for Sub-Recipients on the programmatic management of TB, and recording and reporting will be a major focus of this training.

*Better recording and reporting of training activities*

All Sub-Recipients who attended the *4th Regional Workshop on Programmatic and Financial Reporting* in Nadi in February, 2011 understand the rationale for the Global Fund's new emphasis on planning and monitoring training activities. Following on from this meeting all Sub-Recipients developed "Master Training Plans" which were submitted to the Global Fund for approval. In parallel, the Principal Recipient has developed tools to better monitor training activities and these tools will be effective from May 2011 Sub-Recipients will need to provide high quality documentation for all trainings and this will then be provided as supporting documentation for reporting to the Principal Recipient. If countries require technical assistance on better monitoring training activities, it will be provided by the Grant Co-ordinators, Grant Management Unit.

***What are the strategic challenges?***

*Quality and timeliness of supporting documentation*

Supporting documentation relating to the performance indicators was less standardised and of a lower quality in period 5, compared to period 4. Pharmacy reports generally appeared more ad hoc, fewer reports were provided on official letterhead, limited qualitative analysis was provided in relation to training outcomes and patient level records required significantly more interpretation and deciphering in period 5 compared to period 4. There were some notable exceptions. Vanuatu had prepared a thorough report with good quality supporting documentation. SPC's surveillance data was consistent and accurate and could be used to report results against several critical higher level indicators.

*Data quality and consistency*

With a few exceptions, the quality and state of completion of the first draft period 5 reports was unexpectedly poor for the Round 7 TB grant. A deterioration in quality had taken place compared to the first draft reports provided for period 4. Emphasis had been given to reporting at a lower, activity status level, with the bulk of supporting documentation serving only to demonstrate that expenditure had taken place against a milestone, and that input level events had occurred. Additional explanation was required in relation to key activities and achievement against outputs and outcomes.

*Catching up on Phase 2 implementation*

Implementation of Phase 2 activities will continue to challenge some Sub-Recipients despite the fact that the work plans have been simplified and consolidated moving into Phase 2. While some Sub-Recipients/ National TB Program staff are implementing confidently and efficiently against their work plans, others are struggling to implement the range of activities as described in their work plans. While there are a number of contextual factors for this, some Sub-Recipients will need to continue to accelerate implementation against their work plans moving into periods 6 and 7. In addition, the Principal Recipient notes the increasing complexity of core TB program activities in the TB grant. In parallel, in the Phase 2 Performance Framework there are a number of new indicators which carry with them a range of previously unfamiliar activities. While some Sub-Recipients are very capably rising to the challenge in implementing these activities, others will need to undertake an assessment of the challenges in implementation at the national level and try to address any gaps in implementation.

*Human resource issues*

The outgoing TB Grant Co-ordinator, Mark Lambert left SPC in April, 2011. Following his departure, the HIV Grant Co-ordinator, Albert Concepcion, has been providing grant management support for the TB grant. Recently, the Principal Recipient recruited a TB Grant Co-ordinator consultant to oversee the two Global Fund TB grants until a permanent replacement for Mark is found. The consultant has significant experience working at the Principal Recipient level and will commence work with SPC in early June.

In addition, the senior technical staff member (Dr Janet O'Connor) left SPC in April, 2011 following completion of her contract. Currently Ms Kerri Viney is acting in the position. Kerri's substantive position is that of TB Technical Officer. Ongoing work is taking place within SPC to recruit another technical staff member once funding has been identified.

**C. RCC Malaria grant – Implementation Phase**

**PR Coordinator: Lilian Sauni**

*What's working well?*

*Management of sub-recipient work plans*

There has been a huge improvement in the way that the sub-recipient countries are managing their programmes. This year, both country programmes have included provincial malaria managers and supervisors in the micro-planning and more focus has been put on making sure that all provinces are aware of their targets and what is involved in achieving them. This has been recognised as the reason why plans have not been working well in the past and why there has always been a struggle towards the later part of the year in making sure targets are reached. Feedback from this process has been very positive as provincial staff feel that they have involvement and participation in the micro-planning and can bring up issues that they face in implementing activities.

*Understanding of Performance-based funding*

Countries have now understood what performance based funding means and the need to achieve results for the continuation of funding to flow. This shift in attitude has taken some time to happen and is very positive given that in the past the Malaria programmes have been receiving more assistance in funding from donor partners than any other programme in the Ministry of Health. Programme staff at provincial levels are now all aware of the need to achieve results and this drive has made it easier for the headquarter staff in making sure that targets are achieved.

*Protection of Population from Malaria*

Long lasting insecticide treated nets and spraying has been rolled out in 2010 to cover most of high Malaria risk areas. Coverage has been very high in these areas as these were the priority areas identified for both programmes in 2010. Assessment done during this quarter showed that both programmes has achieved very good coverage in protecting people at risk and through active monitoring and case management, malaria risk is in control.

*What needs significant focus?*

*Monitoring and Evaluation:*

- The delivery of timely, high quality programmatic reporting from the two countries is still an ongoing issue, and especially the lack of verified data with sufficient supporting documents. Although there has been a marked improvement in the reporting, there is still a great need in making sure that data is verified before submission to the PR. There is great need to build capacity of the local programme staff to ensure that the quality of the reporting is acceptable.
- Accurate, reliable and timely information produced from Health Information System (HIS) and Malaria Information System (MIS) is needed in both countries. This has been a continuing issue with the current information that is available from these sources which greatly affects the capacity of quality reporting from the countries. Urgent attention and action are needed to make sure that the HIS is strengthened so that the Malaria programme is able to use the data for reporting. Currently a stand-alone and vertical system approach by use of the MIS is the only way that both countries are able to report on progress for the targets sets in the performance framework.

***What are the strategic challenges?***

*Community Outreach and Mass Media:*

Community mobilisation and awareness has been identified as ‘gaps’ in both countries Malaria Programme strategy and there is a need to strengthen capacity to be able to report performance on this are. As both countries have capacity in the Ministry’s Health promotion unit, there needs to be a coordinated effort to work together to achieve the results needed to show progress. This is particularly more important given that community awareness is crucial to the effectiveness of Malaria control efforts and making sure that people use LLINs and let their houses to be sprayed with insecticide.

*Programme Management Capacity*

There are still ongoing issues in both countries with regards to making sure that there is effective management capacity to ensure that the programmes are working in line with approved strategies and objectives. Although country Malaria Steering Committees and Technical working groups provide continued support for decision making and technical advice, the overall management capacity of country managers is still an area that needs more support. Training and advisory support with focus on capacity building would greatly assist the managers.

***Malaria RCC Phase 2 Request for Continued Funding Application Progress***

During this past quarter, the PR has been working very actively with both sub-recipients in the preparatory work needed for the Phase 2 application. This work had started well ahead of the 31<sup>st</sup> March date receipt of the formal invitation to the PIRMCCM for application for Phase 2 funding. The process begun with consultations within each country by consultants brought in by the PR and WHO. Informal discussions and workshops were carried out in making sure that effective consultation is made with all stakeholders and especially the country programmes on what is needed in Phase 2. A review of the Phase 1 implementation was also carried out and positive feedback has been received on progress and the approach needed for the Phase 2. Both country Malaria programmes were actively involved and guided the discussion process and were well supported by the donor partners.

**D. Procurement and Supply Management**

**PR Coordinator: Elizabeth Wrench**

*What's working well?*

*Procurement Processes at the PR Level*

The procurement calendar setting out key procurement activities including stock takes from countries and order preparation is in use. All orders are tracked using the PSM Monitoring Table form order placement through to confirmation of receipt and payment. A PSM Budget Forecast is updated and shared with the team each week. All these innovations make placement of rolling or routine orders much simpler. The long term agreements in place are continuing to streamline routine orders and enable Suppliers to plan which improves the expiry dates of stock, and on-time supply.

*Procurement Undertaken and Planned*

This quarter has seen the procurement and distribution of the items as listed in the table below:

*List of major procurement completed or committed by PR from 1st January to 31 March 2011*

<b>Disease</b>	<b>Products</b>	<b>For countries</b>	<b>Amount in USD</b>
HIV	STI testing supplies	Region	6,358.89
HIV	ARVs and STI drugs	Region	6,149.65
HIV	HIV test kits	Region	27,099.00
Malaria	Laboratory Supplies	VU	49,583.11
Malaria	Microscopy Repair and Maitenance equipment	SB	4,430.53
Malaria	LLINs	VU & SB	270,000.00
<b>Total</b>			<b>363,621.18</b>

The following table details planned procurements to the end of June 2011:

*Procurement to be conducted by PR forecast from 1st April to 30 June 2011*

<b>Disease</b>	<b>Products</b>	<b>Time frame</b>	<b>For countries</b>	<b>Budget in USD</b>
HIV	STI testing supplies	June	Region	450,000.00
HIV	HIV test kits (screening & confirmation)	June	Region	30,000.00
HIV	CD4 consumables	May	Region	1,050.00
HIV	ARVs & STI drugs	May	Region	30,000.00
HIV	QC Testing ARVs	May	Region	3,000.00
HIV	QC Maintenance of ProbeTec	June	SB VU RMI FSM	25,000.00
HIV	Viral Load	June	Region	2,000.00
Malaria	Monitoring Kits Insecticide Suceptibility	June	SB	1,000.00
Malaria	LLINs	May	SB	210,000.00
Malaria	EARL lights or similar	June	SB	35,000.00
Malaria	Laboratory supplies for microsocopy	June	VU	1,500.00
Malaria	Microscopes	June	SB	46,000.00
Malaria	IRS insecticide and equipment	June	SB	300,000.00
Malaria	QC Testing LLINs	April	SB & VU	4,000.00
Malaria	RDT	May	VU	27,000.00
<b>Total</b>				<b>1,165,550.00</b>

We note that we are trying to complete a lot of Malaria procurement by the end of May to reduce the cash balance before the submission of the Phase Request for Continued Funding.

*Regional Pharmacist Office*

The Regional Pharmacist Office has been greatly strengthened by the 18 month input of Mr Jason Bower as Capacity Building Pharmacist Consultant, however it was recognised that after his departure in December 2010, the Regional Office would require an extra person. Mr Imran Khan joined the office in January 2011 as Inventory Control Assistant who will be providing day to day operational and administrative support to Ms Sujita Narayan. Imran has been undergoing intensive training in the operations of the office under the supervision of Sujita Narayan, and we welcome him to the team. Part of his induction was the preparation of the February bi-annual distribution to PICTs. This distribution now includes routine supply of CD4 testing supplies for those countries using the PIMA CD4 analyser, and both screening and confirmatory test kits for the detection of HIV.

*Quality Assurance and Quality Control*

The Global Fund's online Price and Quality Reporting Mechanism is up to date for the quarter (including the previously overlooked procurement and supply of condoms which is outsourced to UNFPA), and these entries are ready for verification by the LFA.

The PR's pharmaceutical testing policy was approved by the LFA, and an accredited laboratory, Vimta Labs in India, was selected. Our first batch of 7 lines was sent in January, and results are expected in April.

Quality control testing was performed on ICON insecticide for the Malaria Program in Solomon Islands that was past its expiry which is nominally "2 years from date of manufacture". The samples were shown to still be within specifications so the expiry date has been extended to April 2012.

The LLINs for Solomon Islands underwent and passed comprehensive physical, mechanical, and chemical testing prior to being shipped from the manufacturing site. The PR would like to see tests being done on LLINs from the field to ensure insecticide levels are still within specifications.

***What needs significant focus?***

*In-country Distribution of Condoms*

Under the Round 7 HIV grant, UNFPA is sub-contracted to procure and supply male and female condoms, and lubricant to PICTs. The indicator in the grant, however, is "*Number of condoms (disaggregated by male and female condoms, and those provided through government versus NGO systems) that are available for use in PICTs during the last 12 months*". So obviously recording the quantity of condoms procured and supplied by UNFPA is important, but it would be better to be able to show how many condoms have been distributed by National Medical Stores to access points as these are then truly "available for use".

Reporting against this indicator in Period 5 was poor, with reports received from only 2 PICTs. The PR understands UNFPA is working along with their colleagues in Reproductive Health Commodity Security programs to better collect this data in Period 6.

***What are the strategic challenges?***

*Forecasting*

Forecasting refers to quantifying future needs for pharmaceuticals and health products, and is in general done poorly. There are several methods, but the simplest is to review consumption on a monthly basis, consider stock on hand, and make projections for monthly requirements in the future.

Generally consumption data for pharmaceuticals is available, but less so for RDTs and lab supplies so sometimes a regular stock take is the only way to deduce usage.

The PR is prepared to continue with forecasting for the region, but requests that lab managers, pharmacists, and medical store personnel provide accurate and timely information when requested. If

there are factors that are likely to affect usage, such as a large testing campaign, or a decision to screen a certain population group, this should be communicated to the PR in advance so we can cater for an increased need.

*Human Resources*

The departure of the PSM Officer, Ms Sophie Vuvant at the end of January was a challenge for the PSM Team who was then reduced to one. Thanks to the outstanding organizational skills of Sophie, and an excellent handover, functions were not too badly affected. The PSM Coordinator recruited a replacement who is unable to commence until April 2011.

**E. Finance**

**PR Financial Controller: Semisi Fukofuka**

**Financial Update**

The table below shows financial activity for all grants at the PR level, and shows in particular what percentage of total funds the PR has received from Geneva, and what percentage of these funds have been spent or disbursed to SRs.

The financial results summarised in the table below include the results for Round 7 Phase 1.

**SECRETARIAT OF THE PACIFIC COMMUNITIES**

**PR Summary Financial Results**

Amount in US\$

Reporting Period	From	To
	01/07/03	31/03/11
Reconciled to bank statement as at:		10/05/11

	Malaria (RCC)	HIV R7	TB R7	PIRMCCM	TB R8	COMBINED
	Actual USD	Actual USD	Actual USD	Actual USD	Actual USD	Actual USD
<b>Approved Funding &amp; Budgets</b>						
Total Approved Upper Ceiling budget	19,598,643	21,470,746	11,235,235	170,304	3,962,489	56,437,416
Cummulative Budget to Date	19,598,643	15,981,649	8,240,549	170,304	1,727,493	45,718,638
Funds Received from GF	14,980,483	13,190,424	6,814,387	170,304	1,513,808	36,669,405
Undisbursed Fund from GF	4,618,160	8,280,323	4,420,848	0	2,448,681	19,768,011
<b>Expenditure Statement</b>						
Total Disbursements to Sub-Recipients	5,860,255	7,959,102	4,717,098		1,435,475	19,971,930
Centralised Procurement	3,570,574	2,047,206	176,395		0	5,794,176
Project Management	1,184,071	1,448,780	1,180,025	231,247	27,271	4,071,394
<b>Total Expenses</b>	<b>10,614,901</b>	<b>11,455,088</b>	<b>6,073,518</b>	<b>231,247</b>	<b>1,462,746</b>	<b>29,837,500</b>
<b>Balance in Bank</b>	<b>4,561,665</b>	<b>1,751,948</b>	<b>801,490</b>	<b>(60,943)</b>	<b>51,062</b>	<b>7,105,222</b>
Fund Received as % of Phase 1 Budget	76.44%	61.43%	60.65%	100.00%	38.20%	64.97%
Cash-Burn Rate (Funds Spent as % of Funds Received)	70.86%	86.84%	89.13%	135.78%	96.63%	81.37%

At the end of March 2011 the PR had in its grant bank account US\$7.1M of which 64.4% is the Malaria RCC grant. As noted in the last quarterly update the high bank balance at this stage of implementation represents a challenge to everyone involved in implementing the Round 7 and the RCC grants.

**PIRMCCM Grant**

The PIRMCCM grant is in deficit by US\$63,883 as no funding is yet available for the operations of the PIRMCCM for 2010. The new grant covering the period January 2011 to December 2012 has been approved and the first disbursement is pending. The lengthy delays in achieving grant approval are due to many factors. These include:

- The Global Fund introduced a new form for PIRMCCM funding applications which resulted in a lot more work for the Secretariat. In addition to the new requirements built into the new form, the instructions were not clear resulting in many budget iterations due the numerous queries and request for update from the Global Fund. The Secretariat now has a better

understand of the new funding application process and it does not expect to experience the problems in future applications.

- The process of establishing a Joint Secretariat to support the various oversight committees responsible for public health projects starting with the PIRMCCM and the RFC required additional work on the budget to ensure that the Joint Secretariat is resourced appropriately both in terms of HR and financial resources. This necessitated changing the original budget submission for the PIRCCM. The Secretariat requested additional time from the GF in order to finalise the new budget ensuring adequate resources are available to provide high quality professional services to all the committees that it will support.

### *What's working well?*

#### *Resource Mobilisation*

The PIRMCCM was successful in its applications for the Round 7 Phase 2 funding achieving a very good result for the Multi-Country Western Pacific member countries and development partners.

The total approved work plan budgets funded by The Global Funds for Phase 2 are:

- US\$13.9M for HIV and;
- US\$7.4M for TB

<i>Summary of Approved Funds and Financing Decision</i>	HIV US\$	TB US\$
<b>Approved Phase 2 Work Plan Budgets</b>	<b>13,869,484</b>	<b>7,363,542</b>
<b>This is financed by</b>		
Phase 1 undisbursed amount from The GF	955,382	1,085,098
Phase 1 cash balance as at 30 June 2010 at both PR and SRs level	2,163,347	687,184
Approved new incremental funding	10,750,755	5,591,260
<b>Total Funding for Phase 2</b>	<b>13,869,484</b>	<b>7,363,542</b>

### *What needs significant focus?*

#### *Ramp-up of Phase 2 implementation activities*

The PR encourages everyone involved with grant implementation to ensure accelerated implementing activities during Period 6 and for the remainder of the Round 7. Implementation activities were affected by the Phase 2 reapplication and the delays in signing the Phase 2 grants. Now there is an urgent need to re-focus attention on accelerating implementation activities again.

- Phase 1 suffered from significant delays at the beginning, which the grants never really recovered from. We need to ensure that the Region will maximise the benefits it will receive from the Round 7 Phase 2.
- The Global Fund has committed US\$21.3M to help the MWP members fight HIV and TB over the next three year it is now up to us to make sure that the Phase 2 grants will achieve what we plan to achieve.
- All grants have been performing well programmatically but continue to struggle with absorptive capacity. SRs need to ensure that funding allocated for health system strengthening activities and activities that are indirectly link to the performance framework are fully utilised. These are important strategically in building up in-country future capacities.

**What are the strategic challenges?**

*Low Cash burn rate*

- One of the main areas of concern for the PR is the low cash-burn rate or the low rate of cash utilisation at **SR** level. The table below shows summary of cash utilization by disease. Overall cash-burn rate to end of December 2010 was 73% with Tuberculosis at 83%, HIV at 88% and Malaria at 49%.

Cash Burn Summary to 31 Dec 2010	Budget	Disbursements	Expenditures	Spending Rate	Cashburn Rate
HIV	10,530,329.00	11,058,023.00	9,773,903.00	93%	88%
TB	5,873,161.00	5,178,947.00	4,280,976.00	73%	83%
MRCC	13,600,758.00	8,971,023.00	4,420,009.00	32%	49%
<b>Total</b>	<b>30,004,248.00</b>	<b>25,207,993.00</b>	<b>18,474,888.00</b>	<b>62%</b>	<b>73%</b>
Spending Rate is Expenditure as percentage of Budget					
Cashburn Rate is expenditure as percentage of fund disbursed					

- The main reasons for the low cash-burn rate during Phase 1 included the following:
  - Slow start to Round 7 Phase 1 due to impact of the Round 2 grant closure activities
  - Unrealistic timing of activities for Phase 1 activities did not take into account factors such as country capacities and internal recruitment processes
  - Impact of factors outside the control of the PR and PIRMCCM such as the H1N1 Outbreak, the global financial crisis, and the Tsunami which impacted Samoa and Tonga
  - Impact of SR specific issues such as:
    - the special legislation required by the RMI parliament to govern the administration and management of the Round 7 grants in RMI
    - delayed start to significant clinic refurbishments planned for Kiribati and Samoa due to time taken to meet the condition precedents set by the Global Fund
  - Significant delays in the signing of the Malaria RCC grant resulted in the delayed release of funds. The Grant agreement was not signed until September 2009 with a grant start date of 1 January 2009, with funds only released in October 2009.

*Timely identification and resolution of implementation bottlenecks*

- The Round 7 grants are now entering Phase 2 and the Malaria RCC grant in its second year of implementation, the issues mentioned above are now behind us with most of the new staff funded from Round 7 and Malaria RCC now in place.
- A key to maintaining the cash-burn rate at the higher end of the scale is the timely identification and resolution of implementation bottlenecks. The PR in this quarterly report process will provide updates on SR cash-burn rate for each quarter. This will enable the PIRMCCM to make timely decisions on intervention measures where problems are identified.
- Unless solutions are identified to address the low cash burn rate, it is likely that the Phase 2 funds will be significantly underutilised resulting in significant lost opportunities for the region.

*Appendix 1*

**Financial Graphs – Financial Results to 31 March 2011**

