STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE:* *This template and its associated key tables are subject to minor modifications pending decisions to be taken in early 2014.

Applicants should refer to the Standard Concept Note Instructions to complete this template.

SUMMARY INFORMATION			
Applicant Information			
Country	**Côte d'Ivoire**	**Component**	**Malaria**
Funding Request Start Date	**1 January 2015**	**Funding Request End Date**	**31 December 2017**
Principal Recipient(s)	Government PR or public PR (NMCP) Civil society PR or community PR (APROSAM)		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

1. Current epidemiology

Malaria is rife in Côte d'Ivoire; it is endemic throughout the country, with renewed outbreaks during the rainy season. The rains occur in line with a subequatorial climate between May and July for the main season and between October and November for the secondary season, and with a tropical climate from March to May. The degree to which malaria is endemic varies throughout the country.

Plasmodium falciparum (98 to 99 percent of cases) is the strain that causes most of the uncomplicated and severe cases found, followed by *Plasmodium malariae* (3 to 4 percent). Total parasitic prevalence for all strains varies from 64 to 75 percent (Assi et al., 2013 and Hürlimann et al., 2014_ Annex 7).

The main vectors identified are *Anopheles gambiae* and *An. funestus* (Betsi et al., 2012; Adja et al., 2011_ Annex 8). The resistance level of the major vector, *Anopheles gambiae*, to the insecticides used to impregnate mosquito nets varies depending on the study area from 5 to 60 percent for permethrin, 3 to 26 percent for deltamethrin and 18 to 50 percent for alpha-cypermethrin (Koffi et al., 2009_Annex 9).

Malaria remains the main reason for visits to the country's health care facilities, accounting for 41 percent of consultations in 2012 (NMCP annual report 2013_Annex 10).

The revised treatment plan adopted in 2013 recommends the use of artesunate-amodiaquine or artemether-lumefantrine as a first-line treatment for cases of uncomplicated malaria, followed by quinine tablets if this fails. The preferred treatment for severe malaria is injectable artesunate.

The various treatment efficacy and parasitological studies have shown that the recommended ACTs are over 95 percent effective against *Plasmodium falciparum* (Menan et al., 2012; Touré et al., 2013_Annex 11)

The map showing malaria incidence amongst children under the age of five shows a variable distribution by district. It should be noted that 58 of the country's 82 districts, or 71 percent, have a high level of endemicity of 300 to 450 cases per 1,000 (Figure 1: Red and orange shading)

Figure 1:Cartographie de la morbidité des enfants de moins de 5ans en 2013 par District Sanitaire

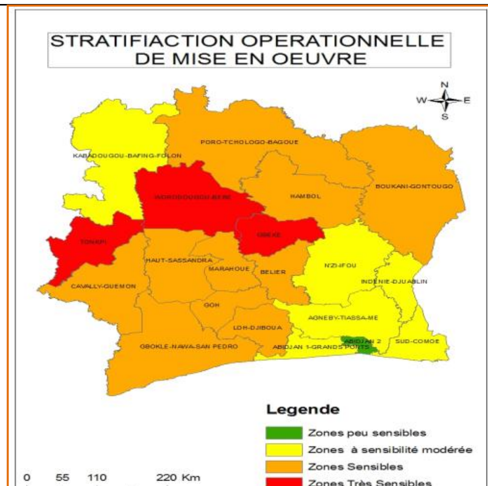


Figure 2: Operational stratification of implementation

Mapping of malaria risk in Côte d'Ivoire finalized by RBM with the support of DFID; operational stratification has been defined on the basis of the incidence of malaria recorded between 2012 and 2013, the level of use of services and the size of the population. Although the disease is endemic throughout the country, priority interventions will be strengthened based on the stratification to maximize the impact of control activities.

Since the introduction and scaling up of Rapid Diagnostic Tests (RDT) in all *Etablissements Sanitaires de Premier Contact* [Primary Healthcare Facilities] (ESPC) in the second half of 2011, the rate of tests carried out has increased from 66.3 percent in 2012 to 74.7 percent in 2013, with a total positivity rate (RDT and TS) increasing from 65 percent in 2012 to 68 percent in 2013 (NMCP annual report 2013_Annex 10).

The number of cases of severe forms of malaria in 2012 was 156,019 in the general population, 50 percent of whom were children under five and 6 percent pregnant women. In 2013, 176,222 cases of severe malaria were notified, 55 percent of whom were children under five and 6 percent pregnant women.

Data on malaria-related deaths amongst the general population and key populations (children and pregnant women) are not available because of the inadequate operation of sentinel sites and the poor quality of the data collected. According to the DHS-MICS 2011-2012, the infant and child mortality rate recorded between 2007 and 2012 was 108 per 1,000 and the maternal mortality rate was estimated at 614 deaths per 100,000 live births over the seven-year period preceding the study (2005-2011).

Improving collection of malaria-related mortality data is a major challenge for the period 2015-2017.

2. Key populations (children under the age of five and pregnant women) can face major difficulties in terms of access to services

An analysis of determining factors for these key populations (DHS-MICS 2011-2012) shows that:

- Children in rural environments, children whose mothers are less well-educated and children from poor families are more exposed and vulnerable to malaria;
- Pregnant, young and the poorest and least well-educated women and those living in rural areas are the most exposed and vulnerable to malaria.

3. Human rights and inequality principles

Côte d'Ivoire has taken account of human rights and social inequalities in implementing its malaria control activities through (i) routine distribution of LLINs amongst pregnant women and children under the age of one and organizing a mass campaign targeting all of the general population in all 82 health districts; (ii) extending home-based care of uncomplicated cases of malaria amongst children

under five from six to 26 of the 82 health districts, including two supported by the IRC; (iii) organizing consultations as part of an advanced strategy targeted at people living more than five kilometers away from a health centre; (iv) introducing a policy of targeted free care for pregnant women, children under five and emergency cases to facilitate access to high-quality care.

In spite of these interventions, efforts still need to be made over the course of the next three years to scale up and strengthen actions aimed at other populations, in particular: (i) prison populations; (ii) agricultural populations, particularly women and their children who are displaced to work in the fields; (iii) people living with HIV; (iv) the school population, for whom malaria is a major cause of absenteeism; (v) people living in disadvantaged neighborhoods and shanty towns in the major conurbations, particularly Abidjan and San Pédro; (vi) through incorporating malaria treatment and prevention guidelines in the training curricula for teachers, schoolchildren and people taking literacy classes.

This grant aims to provide solutions for these gaps and increase the chances of fair access to high-quality services for all.

4. Health systems and community systems context

4.1 Health systems context

The health system in Côte d'Ivoire operates on the basis of the six pillars below, as defined by WHO: i- Infrastructure, equipment and drugs; ii- Human resources; iii- Funding; iv- Governance and leadership; v- Service provision and vi- Health information.

At a national level, the health system includes both the private and public health sectors. The community sector helps to support the public sector, however it does not yet have valid institutional and organizational frameworks. The status of health workers/community outreach workers, who are its main operational actors, has yet to be defined.

i. Infrastructure, equipment and drugs

The health system in Côte d'Ivoire comprises an administrative element and a care element, which are interdependent. Each has three levels, which play specific roles in malaria control.

- Central level

This comprises the Cabinet, two General Directorates, nine Central Directorates, 14 *Établissements Publics Nationaux* [National Public Institutes] (EPN) and the Coordination Departments for the national health programs, including the NMCP. This level is responsible for defining health policy, general coordination of the healthcare system, resource mobilization, monitoring and evaluation and operational research.

In terms of care services, the system is made up of the *Centres Hospitaliers Universitaires*: [University Hospitals] (CHU) (four), the specialist institutes (five) and other National Public Institutes (four) and the emergency services. These provide not only treatment for severe malaria cases but also Intermittent Preventive Treatment for malaria amongst pregnant women and routine distribution of LLINs.

- Intermediate level

This is represented by 20 Regional Health Departments (DRS). In accordance with order no. 399 MHSP/CAB of 18 December 2007, the Regional Health Department covers several health districts. Amongst its responsibilities are coordination of the implementation of the national health policy and monitoring and evaluation of health activities, including malaria control interventions. It comprises 18 Regional Hospitals, which also provide treatment for both uncomplicated and severe malaria cases, Intermittent Preventive Treatment for malaria amongst pregnant women and routine distribution of LLINs.

- Peripheral level

This consists of 82 Departmental Health Departments (DDS) or Health Districts. The Departmental Health Department is responsible for all the public and private health services within the area it covers. Each DDS is administered by an *Équipe Cadre de District* [District Management Team] (ECD) led by the Departmental Director. The ECDs are responsible for operational implementation of the national health policy. They monitor and supervise service providers' application of malaria

control guidelines and are responsible for collecting and submitting health data on malaria to the central level.

Two major challenges need to be tackled by the public health system over the next three years, namely: (i) providing peripheral health centers with the hemoglobinometers and reagents needed for rapid diagnosis of anemia, which is often linked to *Plasmodium* infection, (ii) strengthening the system used to procure, manage and provide appropriate monitoring of input consumption to avoid frequent stock shortages of anti-malarial commodities.

The private health sector consists of 2,036 institutions, including 13 private hospitals, 136 clinics, 964 private sanatoriums, 114 doctor's and gynecology/obstetrics surgeries and 463 company health centers. These provide a range of services including treatment of malaria (Carte sanitaires _Annex 12).

In the absence of malaria data on the private sector, an estimate of the level of use of these services has been produced on the basis of a null hypothesis, according to which a proportion of the population affected by malaria does not use either public-sector services or community health workers. This is estimated at 18.5 percent in each of the private sectors, both for profit and non-profit. A survey will be carried out in this sector during the first year of implementing the project to adjust the estimates for the following year.

In the last two years, the NMCP has started to involve the non-for-profit private health sector (health care services in companies and denominational facilities) in case management. Most service providers in these facilities have taken advantage of training organized either by the districts or by the NMCP. Private-sector facilities are supplied with anti-malaria drugs and RDTs for treating cases of malaria. The 2014 LLIN mass distribution campaign, which is currently underway, will involve the not-for-profit private sector through the Coalition des *Entreprises de Côte d'Ivoire*[Côte d'Ivoire Business Coalition] (CECI) through a public-private partnership for the inclusion of population living in workers' housing owned by agro-industrial enterprises.

As regards the for-profit private sector, the absence of a policy on contractual requirements, poor organization and a late start to dialogue between the public and private sectors has meant that the NMCP has not so far been able to establish a solid partnership with this sector. Involving private for-profit health care facilities affiliated to the *Association des Cliniques Privées de la Côte d'Ivoire* [Côte d'Ivoire Association of Private Clinics] (ACPCI) in malaria control is one of the strategic priorities in the NMCP's revised PSN [National Strategic Plan] for 2012-2015. Disseminating guidelines in malaria treatment and raising awareness amongst service providers in for-profit private facilities will be a priority in the NMCP's next round of interventions. Incorporating data from the private sector in national malaria data will be another of the challenges in the next three years of grant implementation.

ii. Human resources

Malaria control activities are implemented by healthcare workers at different levels of the healthcare pyramid.

Based on Côte d'Ivoire's total population in 2012 of an estimated 23,712,942 inhabitants according to the INS [National Statistical Institute], the ratio of public-sector healthcare workers to the population is as follows: one ESPC per 14,486 inhabitants; one doctor per 12,025 inhabitants and one nurse per 5,232 inhabitants. Compared with the national targets set for the end of 2015 in the National Health Development Plan (PNDS), namely one ESPC per 10,000 inhabitants; one doctor per 5,000 inhabitants and one nurse per 2,000 inhabitants, these ratios reveal the necessity of maintaining consistent efforts in terms of recruiting healthcare workers and building ESPCs. These workers provide routine malaria control activities; capacity was increased in 85 percent of cases following the application of the national guidelines for malaria treatment and prevention (*Rapport d'évaluation de la gouvernance du secteur santé, 2013_ Annex 13*).

Each health region and health district has an *Equipe Régionale de Santé* [Regional Health Team] (ERS) or District Management Team (ECD) respectively, which serve as decentralized structures for coordinating, monitoring and evaluating all program activities, including those of the NMCP. The ECD consists of 11 people, including the manager of the *Centre de Surveillance Epidémiologique* [Epidemiological Surveillance Centre] (CSE), which is responsible for managing morbidity data for all health areas in the district, and the pharmacist, who manages drugs and commodities, including those for malaria.

In 2007, the number of human resources in the private sector was estimated at 790 doctors, 1,173 nurses and 184 midwives. In most cases, healthcare workers lack refresher training on the national guidelines for malaria treatment because of the inadequate partnerships with this sector. The advocacy work carried out by the NMCP with socioeconomic organizations involved in regulating the private healthcare sector, notably the *Association des Cliniques Privées de la Côte d'Ivoire* (ACPCI), has paved the way to increased cooperation as part of a public-private partnership on malaria control.

iii. Financial resources for malaria control

The change in financial resources mobilized for implementing malaria control activities since 2010 is shown in the table: *Etat de financement de la lutte contre le paludisme_ Annex 14*.

Before the introduction of the free health care policy, an estimated 17 percent of the national budget was allocated to the health sector, compared with 70 and 13 percent respectively of household and development partners' budgets in 2008 (*Rapport comptes nationaux de la santé, 2009_Annex 15*). The proportion of the national budget allocated annually to the Ministry of Health increased from 4 percent in 2010 to 4.62 percent in 2012 (*Evaluation gouvernance secteur santé 2014_Annex 13*).

Since 2012, malaria control has benefited from a budget allocation of approximately €3,048,980.34 which covered the acquisition of LLINs in 2012 in the general state budget. The financial contribution from the Global Fund for malaria control in 2012, 2013, 2014 was 74.2%; 95.5%, and 74% compared with state contributions of 24.2%; 4.1%; and 25.1%.

State projections for malaria funding for the next three years (2015-2016-2017) are respectively: Year 1 = €20,698,328; Year 2 = €22,222,818 and Year 3 = €22,995,490, i.e. a total of €65,916,636. These forecasts include the state budget for malaria control and the salaries of healthcare workers involved in treating malaria.

iv. Governance (evaluation of the health sector in Côte d'Ivoire 2014)

According to WHO, the health system covers all activities aimed at promoting, protecting and restoring health. Its governance implies notions of transparency, accountability and community participation. Governance of the health sector in Côte d'Ivoire shows inadequate transparency in management, conflicts of interest and shortcomings in accountability obligations.

v. Service provision

The services provided by the NMCP include: distribution of LLINs, administration of sulfadoxine-pyrimethamine, carrying out RDT and thick smear tests, dispensing ACT [artemisinin-based combination therapy] for treatment of uncomplicated malaria and compounds such as quinine or injectable artemisinin for severe forms. Treatments for severe forms are covered by the state and are free of charge for vulnerable groups, namely pregnant women and children under five, as well as emergency cases. All other commodities are dispensed free of charge, in particular to pregnant women and children under five, as a result of funding from the Global Fund. Consultation fees, health record booklets and thermometers, however, still have to be paid for by patients. This represents an obstacle to access to care for the poorest people living in vulnerable neighborhoods in Abidjan and San Pédro, and in remote rural areas.

vi. Management of health care information

The national information and data management system in Côte d'Ivoire remains poor because of an inadequate reporting culture, poor integration of all data collection systems, a shortage of data management logistics, limited harmonization and integration of collection tools, etc. The NMCP's data collection and management mechanism is integrated with the national information and management system. The monitoring and evaluation plan for the strategic plan will be revised to include targets for the period 2015 to 2017. In 2008, the NMCP introduced a quarterly validation of morbidity data, including active collection at health region level, which helped bring about a significant improvement in the quality, completeness and timeliness of malaria data. A number of inadequacies remain, however, at all levels of the health pyramid. These are: (i) limited availability of primary tools on site; (ii) poor completion of primary tools; (iii) inadequate archiving of registers and reports; (iv) data transcription errors.

In order to mitigate some of these inadequacies, the *Direction de l'Information, de la Planification et de l'Evaluation* [Department of Information, Planning and Evaluation] (DIPE) has implemented the following actions with support from its partners: (i) introduction of new data management software

(DHIS2), which is currently being trialled. This will later be rolled out to health regions and districts and will help to improve data management; (ii) review of primary data collection tools to bring them in line with indicators; (iii) implementation of a three-year plan to strengthen the health information system based on funding from the Global Fund, which represents an opportunity for the NMCP.

As regards results indicators, the NMCP has planned a MIS survey in 2015 not only to cover the results of the 2014 LLIN mass distribution campaign, which is currently underway, but also to measure all key impact and effect indicators for malaria control.

4.2 Community systems context

The community system in relation to malaria control in Côte d'Ivoire has developed around two strategic priorities: prevention and case management.

With regard to prevention, note that the implementation of the 2012-2015 Strategic Plan, with financial support from the Global Fund, has ensured that malaria control activities have been scaled up. Thanks to community organizations and community outreach workers, over eight million LLINs were distributed during the mass campaign in 2011 and 1.8 million in the pilot phase of the 2014 distribution campaign. IEC/BCC activities via local radio stations and community outreach workers have contributed to ensuring that 68 percent of people with access to LLINs actually use them (Hannah Koenker and Albert Kilian, 2014_Annex 16).

According to the results of the 2013 TRaC survey, however, a number of challenges remain, namely: prejudice amongst the population about LLINs, insufficient understanding of how to install LLINs in most households and limited involvement amongst men in monitoring household use of LLINs. Operational implementation of the communications plan for the 2014 campaign will help to address these by strengthening local communications on using LLINs and developing communications strategies based on the regional disparities highlighted by the TRaC survey (*Rapport Enquête TRaC_ Annex 17*).

Implementation of post-campaign activities, such as assisting households with installing LLINs and home visits, will help to improve the level of use of LLINs, particularly amongst vulnerable groups.

With regard to treatment, strengthening community activities in line with the strategic guidelines is necessary to improve access to care for disadvantaged populations.

PECADOM [home-based care] activities (RDTs and malaria treatment for children under five using ACTs) are currently limited to 26 districts. From 2012 to 2013, a total of 1,200 CHWs were trained in 24 health districts with poor health-service coverage outside the two districts supported by the IRC, and were equipped with care kits (a bag, tunic, bicycle, data collection tools, RDTs and ACTs). Twelve (12) other districts will be covered by the end of 2014 to bring the figure up to 38, including the two districts supported by the IRC. In addition, activities to promote *Pratiques Familiales Essentielles* [Essential Family Practices] (PFE) are being developed by CHWs in around ten health districts. However, there are no regulatory provisions for including CHWs in the treatment system. The absence of a formal framework for involving CHWs makes it difficult to implement integrated management of child illnesses. A framework document on implementing community activities has been instigated by the Ministry. Questions around the status and motivation of CHWs are still under discussion.

Based on the 2013 WHO data, which show that diarrhea (12 percent), pneumonia (15 percent) and malaria (38 percent) are the three infections responsible for 65 percent of deaths amongst children under five (IVC data WHO country profile: CERG, WHO, UNICEF published by Liu et al. in The Lancet 2012_Annex 18), this concept note proposes to ensure gradual implementation of integrated case management of malaria, diarrhea and pneumonia over the next three years.

1.2 National Disease Strategic Plans

With clear references to the current national disease strategic plan(s) and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests,[1]describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

First, it should be noted that the NMCP-IC has revised its PSN 2012-2015 but that because of the non-existence of a *Politique Nationale de Développement Sanitaire* [National Health Development Plan] (PNDS) for the period after 2015, an agreement has been reached with regional WHO experts to keep the title of the PSN 2012-2015, amended as follows: PSN 2012-2015, revised with additional planning for 2015 to 2017

a. Key aims, objectives and priority areas for the revised PSN

According to the revised PSN 2012-2015 (*PSN 2012-2015 révisé_ Annex 19*), the program's aim, objectives and priority areas are:

❑ *Aims*

- Reduce malaria-related mortality to below one death per 100,000 inhabitants by the end of 2015 and maintain it at this level until 2017;
- Reduce the number of malaria cases by 75 percent by the end of 2015 compared with 2008 and maintain it at this level until 2017.

❑ *Objectives*

- Increase the proportion of the population (specifically children and pregnant women) sleeping under a long-lasting insecticidal net from 33 percent in 2012 (DHS-MICS 2011-2012) to 80 percent by the end of 2015 and maintain it at this level until 2017;
- Increase the proportion of pregnant women taking at least two doses of SP from 40 percent in 2012 (SNIS) to 80 percent by the end of 2015 and maintain it at this level until 2017;
- Ensure that 80 percent of malaria cases are confirmed and treated in accordance with national guidelines in public- and private-sector health care facilities and in the community by the end of 2015 and maintain it at this level until 2017.

❑ *Priority areas:*

The country's strategic directions and priorities for malaria control as expressed in the revised PSN 2012-2015 are: (i) Achieve and maintain universal coverage of malaria prevention measures and their use, in particular vector control (LLINs) amongst the general population and Intermittent Preventive Treatment amongst pregnant women; (ii) Achieve universal coverage for biological confirmation of suspected cases of malaria seen in public-sector health care facilities; (iii) Achieve universal coverage for biological confirmation of suspected cases of malaria at a community level amongst children under five; (iv) Achieve universal coverage for correct treatment of cases seen in integrated public-sector and not-for-profit private health care facilities; (v) Aim for universal coverage for correct treatment of cases of uncomplicated malaria in the community amongst children under five; (vi) Strengthen social mobilization and communications on measures to prevent and treat malaria; (vii) Strengthen the monitoring and evaluation system, including pharmacovigilance and operational research; (viii) Strengthen the program's management, coordination and leadership

[1]Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

capacities at all levels; (ix) Develop an effective mechanism to mobilize resources for control activities.

The revised strategic plan introduces a number of new key interventions, as follows:

- an integrated approach to community interventions (malaria, pneumonia and diarrhea) for a greater impact on mortality amongst children under five;
- intensification of advanced-strategy consultations where there are vulnerable populations (pregnant women and children under five) in places located more than 5 km from a health center and disadvantaged or poor populations living in vulnerable neighborhoods and shanty towns;
- a more participative and inclusive role for the private sector in combating malaria, in particular in preventing malaria through introducing the distribution of LLINs and free dispensing of SP in private for-profit and not-for-profit private health care facilities, as well as collecting and incorporating data from this sector into the program data;
- greater involvement of faith-based organizations and women's associations, community leaders and local administrative authorities in advocacy and behavior-change communications;
- assistance in respect of malaria prevention and treatment amongst populations in an emergency or disaster situation;
- extension and functionality of sentinel sites in order to establish a proper surveillance system for cases and deaths;
- creation of a stock of anti-malarial supplies to assist populations in emergency and disaster situations.

Implementation of the revised PSN will be based on five operational areas of intervention, covering districts with a high population density, which will implement a package of activities for treating malaria and diarrhea, districts with a full ICCM package and vulnerable neighborhoods situated on the outskirts of major cities. Activities will be implemented at an operational level based on contributions from all stakeholders, in particular women's and young people's associations, community-based organizations, religious leaders, the private sector, local authorities and civil society. In addition to these groups, the advocacy framework will involve parliamentarians and the highest state authorities.

b. Progress on implementing malaria control, main outcomes and impact achieved

❑ Progress on implementation

❑ <u>Diagnosis and treatment in health care facilities:</u>
The national guidelines recommended to healthcare workers advocate systematic confirmation of all suspected cases through the use of RDTs in ESPCs or TS (Thick Smear) tests in major facilities. Current results reveal that public health care facilities achieved case confirmation rates of 66.3 percent in 2012 and 74.7 percent in 2013. The current national strategy aims to increase the rate of case confirmation to 100 percent by 2015 and maintain it at this level until 2017.
Use of injectable artesunate as a first-line treatment for severe malaria will be adopted and rolled out to all major facilities in accordance with the latest WHO guidelines. As a result, procurement of injectable artesunate will increase from 40 percent in 2015 to 50 percent in 2016 and 60 percent in 2017, as a substitute for quantities of injectable artemether and injectable quinine, which will remain as second-line treatments for severe malaria.

Quinine is the only recommended treatment for pregnant women, regardless of the type of malaria or stage of the pregnancy (*Protocole thérapeutique nationale, 2013_Annex 20*).

<u>Diagnosis and treatment in the community:</u>
This activity will cover 38 health districts by the end of 2014. It is run in conjunction with UNICEF, the SR of the governmental PR. Supervision of CHW activities is carried out by health area managers, in this case nurses.
In total, the 1,200 CHWs trained in home-based care have carried out 20,314 RDTs and 17,373 cases of uncomplicated malaria have been notified and treated in six health districts. The CHWs trained in 20 other districts had not started to reportthe data of their activities.

❑ <u>Vector control</u>

- *Prevention using LLINs:*

This involves free distribution of LLINs in a mass campaign to the whole of the population in 2014, with the aim of covering 100 percent of households on the basis of one mosquito net for 1.8 people. As LLINs only last for three years, another campaign will be planned in 2017 in order to maintain coverage.
The joint efforts of various key actors in maternal and child health, combined with reasonable performance with regard to malaria control activities, have contributed to an improvement in indicators, in particular the proportion of people who possess insecticidal mosquito nets, which increased from 10 percent in 2006 to 67 percent in 2012, with an increase in the level of use from 3 percent in 2006 to 33 percent in 2012 (DHS-MICS 201102012_Annex 22).

- *Prevention using Indoor Residual Spraying (IRS) and Larval Source Management (LSM)*

These are the preventive control strategies recommended by WHO as part of an integrated vector-control system and are included in the PSN 2012-2015, but have not been developed because of a lack of funding.

❑ Intermittent Preventive Treatment (IPT) amongst pregnant women

Malaria prevention in pregnant women is based on free administration of at least two doses of Sulfadoxine Pyrimethamine (SP).
According to the DHS-MICS 2011-2012_Annex 22, 18 percent of pregnant women received at least two doses of SP as an IPT at antenatal consultations during their most recent pregnancy.
According to the service survey carried out in 2013, 41 percent of pregnant women who attended consultations received at least two doses of SP as an IPT during their most recent pregnancy. This result is based on data from the public health sector only; results from the private for-profit sector are not currently recorded in the health information system.

❑ Advocacy, information, education, communications and social mobilization

Up until now, two major strategies have been used to ensure effective involvement of all stakeholders in malaria control through behavior-change communications. These are:
- behavior change communications, which are geared to local communications in the community
- social mobilization and community participation, geared to implementation of a consultation platform with stakeholders (representatives of various technical ministries, members of civil society, the community and healthcare workers) and mass communications through the media (radio and television) at both a community and national level.

❑ Surveillance, monitoring, evaluation and operational research

Surveillance is carried out through the *Système National de Gestion et d'Informations Sanitaires* [National Health Management and Information System] (SNIS), which collects routine malaria data, and through the studies and surveys conducted. The current passive collection system for routine data and studies at the six existing sentinel sites are struggling to provide appropriate notification of data on malaria-related mortality.

❑ Emergency and disaster management

One of the new features in the revised PSN 2012-2015 is the inclusion of malaria prevention and treatment in emergency situations (war, local violence or natural disasters).

❑ Table 2: main outcomes and impact following the evaluation of the PSN 2012-2015

Sources	2006 MICS	DHS-IC 2012	RASS 2012	Service survey 2013
Impact and outcome indicators				
Mortality rate amongst children under 5	125/1,000	108/1,000		
Incidence of malaria in the general population			105/1,000	
Incidence of malaria amongst children under 5			295/1,000	

% of suspected patients undergoing an RDT or TS for malaria diagnosis in public health care facilities			36%	68.2% (74.7% SNIS, 2013)
Positivity rate for malaria tests (microscopy and/or RDT)		42%	62%	69.80%
Proportion of uncomplicated malaria cases among people over 5 years treated in line with the national protocol				59%
% of households with at least one ITN/LLIN	10.30%	67%		
% of people sleeping under an ITN/LLIN in the general population	10%	33%		
% children aged under 5 years sleeping under an ITN/LLIN	3%	37%		
% of pregnant women sleeping under an ITN/LLIN		40%		
% of the population who used an LLIN the previous night of those with access to an LLIN		68%		
% of pregnant women receiving at least two doses of SP as an IPT during their last pregnancy		20%	50%	48%

a. Limitations on implementation of the PSN and lessons learned to improve future results (Details in table *Limites de la mise en œuvre du PSN_ Annex 24*)

The results of the program performance review revealed a number of limitations and obstacles to optimal implementation of malaria control activities. In particular, these were:

- limited involvement of public-sector and civil-society actors in malaria control, which has restricted efforts to achieve a good level of LLIN use;
- limited involvement of local authorities in vector control, resulting in continued insalubrity and environmental damage;
- inadequate awareness-raising amongst the population of care services in general and malaria control activities in particular, resulting in limited use of services;
- limited use of healthcare services by malaria patients in public health care facilities (27 percent on average, RASS-2010-2012, Annex 23);
- limited healthcare coverage for the population (64 percent in 2008, source: annuaire des statistiques sanitaries, Annex 25) and disparities in distribution of healthcare workers (strong concentration of high-quality staff in urban environments and major cities to the detriment of rural areas), resulting in inadequate care provision;
- a shortage of management tools at an operational level, leading to a lack of timeliness and completeness;
- shortcomings in the application of management procedures for peripheral stocks, resulting in poor stock management and frequent shortages of drugs and commodities at health care facilities;
- limited coverage, at a district level, of integrated home-based treatment of malaria and other major childhood infections;
- non-integration of private-sector and community data in the SNIS.

The following solutions are proposed to remedy these issues over the next three years:

- **Diagnosis and treatment in the community:**

Activities implemented at the community level over the next three years will consist of: (i) integrating treatment for life-threatening diseases in children under five and gradually scaling this up to a national level. This will involve integrating case management of uncomplicated malaria and diarrhea (minimum package) or case management of uncomplicated malaria, diarrhea and pneumonia (ICCM or full package) in 42 and nine health districts respectively; (ii) retaining UNICEF as the SR for integrated community case management; going forward, this will be implemented in partnership with the *Programme de la santé de la mère et de l'enfant* [Mother and Child Health Program] (PSME). Referral of severe cases to the closest health care facilities by community health workers will be intensified and monitored more closely.

- **Prevention using LLINs:**

The national strategy provides for routine distribution to at-risk populations, particularly pregnant women and children under the age of one (01) year in order to maintain universal coverage specifically for these key populations. It also aims for 100 percent coverage. The routine distribution currently taking place in public health care facilities will be extended over the next three years to denominational health care facilities, the for-profit or not-for-profit private sectors and the community during advanced-strategy consultations in areas that are difficult to access and vulnerable neighborhoods. Public awareness-raising (mass and local) will be strengthened in order to optimize effective use of LLINs, particularly in vulnerable neighborhoods and shanty towns in urban areas.
Routine distribution will be supported by mass campaigns aimed at the entire population in 2014 and 2017, given the three-year life of LLINs.

- **Intermittent Preventive Treatment for pregnant women**

The strategy for the period covered by this allocation will consist of (i) increasing the number of SP doses dispensed to pregnant women free of charge to three; (ii) extending IPT into health care facilities in the for-profit private sector and then developing advanced strategies in disadvantaged areas such as vulnerable neighborhoods and shanty towns. Community organizations such as women's associations and civil-society organizations will still be asked to contribute by identifying pregnant women who should be having IPT but have been lost from the system and referring them to antenatal consultation services.

- **Advocacy, information, education, communications and social mobilization**

Up until now, two major strategies have been used to ensure effective involvement of all stakeholders.
The new funding will help build a partnership with state decision-makers and non-state actors (religious authorities, civil society, private businesses and development partners) with the aim of involving them more closely in IEC/BCC to increase the public's use of LLINs and healthcare services. Particular emphasis will be placed on mass and local awareness-raising by leaders, in order to strengthen use of antenatal consultation services and the use of LLINs. Mass and local awareness-raising will also take place in both public- and private-sector health care facilities, with active efforts to find women who have been lost from the system of antenatal consultations by community actors, in particular CHWs, CBOs and FBOs.

- **Surveillance, monitoring, evaluation and operational research**

The current strategy provides for introducing surveillance of cases and deaths at 12 sentinel sites, including the six that already exist but are not operational. Six other sentinel sites will therefore be identified on the basis of epidemiological data. All 12 sites will serve as a framework for efficacy studies for ACTs and the Malaria Indicator Survey (MIS).

Monitoring of the implementation of interventions through coordination meetings at all levels of the pyramid, quarterly supervision of service providers and periodic monitoring of activities will be maintained or increased.

b. Main areas of linkage to the national malaria control strategy

The universal access to care that guides the national health policy is reflected in the revised PSN 2012-2015, which targets universal coverage for the priority control areas, namely case management and prevention.
Implementation of the strategy may have beneficial repercussions on malaria control if these constraints are removed. Indeed, whilst the results for malaria control achieved in 2013 and presented in the previous tables reveal a degree of progress, performance remains inadequate in respect of the strategic objectives set related to the achievement of the MDGs.

c. Standard funding requests: Not applicable

d. Review and revision process for the revised PSN

Following the first two years' implementation of the third-generation strategic plan 2012-2015 for

malaria control the *Ministère de la Santé et de la Lutte contre le Sida* [Ministry of Health and AIDS Prevention] (MSLS) carried out a mid-term review of the plan with all actors and partners, in January 2014. The review provided an opportunity to identify the progress made and reveal any inadequacies and bottlenecks in implementation in order to propose effective strategies for achieving impact objectives. The results of the review were used to revise the plan and extend its targets to 2017. The revised strategic plan has been evaluated using the JANS tool. The evaluation was carried out by an independent consultant provided by RBM and focused on a situational analysis, the development process (including participation of all stakeholders), implementation, monitoring, budgeting and funding for the plan.
The strategic plan 2012-2015 was revised in both form and substance, taking into account on the one hand, the recommendations made following the analysis of the five JANS attributes and on the other, the contributions and proposals arising from meetings with the private sector, civil-society organizations and focus groups of pregnant women. The main changes are intended to strengthen interventions at a community level and in the private sector in order to increase coverage of malaria-related services and reach at least 80 percent of the population not currently covered. The document was reviewed and examined to harmonize it and identify any programmatic or funding gaps. The sessions involved some 40 people in six pools from civil society, the private sector, NGOs and CBOs, control partners including CARE, UNICEF and WHO, and technical support from the MSH/PMI. These various steps resulted in a revised PSN, which covers the period 2015-2017.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (Government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

Funding requirements for the revised National Strategic Plan (PSN) 2012-2015 are €165,986,473 for the three years of implementation (2015, 2016 and 2017). The budget has been reorganized compared with the presentation in the PSN to take account of the modules recommended by the concept note. The table below shows a summary of the breakdown of the overall cost of the PSN. The most significant proportions relate to vector control, case management, and procurement and supply management, accounting for 42 percent, 34 percent and 11 percent of the total budget of the revised PSN 2012-2015 respectively.

Interventions	Budget 2015	Budget 2016	Budget 2017	Budget 2015-2017	%
Vector control	8,623,859	6,354,076	54,084,635	69,062,570	42%
Case management	20,320,242	17,374,558	18,259,062	55,953,862	34%
Specific prevention interventions	406,942	431,314	445,088	1,283,344	1%
Procurement and supply management	3,638,521	3,708,765	10,775,437	18,122,724	11%

Monitoring and evaluation	2,822,319	1,502,740	1,501,116	5,826,175	4%
Health and community workers	1,171,836	382,721	381,122	1,935,679	1%
Financial management	19,910	19,910	19,910	59,731	0%
Community Systems Strengthening	3,390,149	2,824,928	2,824,928	9,040,005	5%
Program management	1,863,509	1,344,893	1,493,980	4,702,383	3%
TOTAL	42,257,287	33,943,905	89,785,278	165,986,473	100%

a. Availability of funds for each program area and the source of such funding

The resources already mobilized outside Global Fund resources for implementation of the revised PSN 2012-2015 during the period 2015-2017 are estimated at €35,432,508. 84.65 percent of this funding will be allocated to case management, 13.48 percent to LLINs and 1.04 percent to program management.

Planned funding (98.43 percent) will come primarily from the state. UNICEF will contribute 1.55 percent and WHO 0.02 percent.

The table below shows the breakdown of available resources from 2015 to 2017 by area and source of funding

AVAILABLE (euros)	YEAR	LLIN	CASE MANAGEMENT	IEC_BCC	M&E AND EPI. SURV.	PROG_MGT	TOTAL
GOVERNMENT	2015	1,541,615	9,613,503	3,741	-	122,823	11,281,682
	2016	1,591,548	9,901,908	3,741	-	122,823	11,620,021
	2017	1,642,979	10,198,965	3,741	-	122,823	11,968,509
	TOTAL GOVERNMENT	4,776,143	29,714,376	11,224	-	368,470	34,870,212
UNICEF	2015	-	121,959	121,959	-	-	243,918
	2016	-	91,469	91,469	-	-	182,939
	2017	-	60,980	60,980	-	-	121,959
	TOTAL UNICEF	-	274,408	274,408	-	-	548,816
WHO	2015	-	-	1,822	4,736	6,922	13,479
	TOTAL WHO	-	-	1,822	4,736	6,922	13,479
TOTAL AVAILABLE		4,776,143	29,988,784	287,454	4,736	375,392	35,432,508
%		13.48%	84.65%	0.81%	0.01%	1.04%	

Funding deficit

The total funding deficit for the PSN is €130,553,966 or a gap of 79 percent of the total budget for the revised PSN 2012-2015.

The funding gap is 100 percent for the following areas: Specific interventions associated with IPT, procurement and supply management, health and community workers, monitoring and evaluation, financial management and community systems strengthening. The gap is 93 percent for vector control, 46 percent for case management and 92 percent for program management.

The deficit will be funded primarily by the Global Fund and the government, providing the allocated amount and counterpart financing and willingness-to-pay by the Government of Côte d'Ivoire respectively. Funding for certain interventions, in particular the LLIN mass distribution campaign, will be sought under incentive funding for this concept note.

The funding gaps for each intervention for the next three years are presented in the table below.

MODULE	REQUIREMENTS (PSN)	RESOURCES MOBILIZED	GAPS	PERCENTAGE
CASE MANAGEMENT MODULE	55,953,862	29,988,784	25,965,078	46%
VECTOR CONTROL MODULE	69,062,570	5,063,597	63,998,973	93%
SPECIFIC PREVENTION INTERVENTION MODULE	1,283,344		1,283,344	100%
PROCUREMENT AND SUPPLY MANAGEMENT MODULE	18,122,724		18,122,724	100%
HEALTH AND COMMUNITY WORKERS MODULE	1,935,679		1,935,679	100%
MONITORING AND EVALUATION MODULE	5,826,175	4,736	5,821,439	100%
FINANCIAL MANAGEMENT MODULE	59,731		59,731	100%

COMMUNITY SYSTEMS STRENGTHENING MODULE	9,040,005		9,040,005	100%
PROGRAM MANAGEMENT MODULE	4,702,383	375,392	4,326,991	92%
TOTAL	**165,986,473**	**35,432,509**	**130,553,964**	**79%**

b. How the proposed Global Fund investment has leveraged other donor resources

Funding from the Global Fund provides a guarantee that reassures the state and other partners. With its counterpart and willingness-to-pay requirements, funding from the Global Fund has prompted the state of Côte d'Ivoire to invest more in public health generally and in malaria control specifically. The sums allocated by the Global Fund under the NFM significantly reduce the funding gaps for implementing all interventions under the revised PSN 2012-2015. The NMCP will find it easier to mobilize new partners to fill the gap, with a view to achieving the objectives of the revised PSN 2012-2015. The resources allocated by the Global Fund will not only help to strengthen the health system to some extent (procurement and stock management, M&E system, etc.) but also to fill certain gaps in leadership, management and governance, which hamper the achievement of the program's results and limit the commitment of certain partners. Particular support is planned for two of the country's health regions, covering seven health districts. Partners will be more motivated to help the country fill the funding gap with a view to maximizing the impact of interventions in order to achieve the goal set out in the revised PSN 2012-2015.

The sum sought from the Global Fund is €64,689,567 and for the amount over the allocation amount the mass campaign planned for 2017, in the sum of €52,451,207.

c. Actions planned to address funding gaps in program areas

Funding gaps have been identified for the following interventions: Preventive treatment for pregnant women; Case management; Community strengthening; M&E and epidemiological surveillance; capacity building, LLINs, IEC/BCC and Program management.

Planned actions

- Organization of a round table or symposium to mobilize resources from partners once funding has been secured from the Global Fund under the NFM.
- With regard to mobilizing additional funding, the current plan provides for several activities related to (i) advocacy with local and international partners, (ii) advocacy meetings with local political leaders to encourage greater involvement in control activities.

Organizing meetings with all partners will also provide an opportunity to present the planned interventions and conduct reviews to reassure donors that resources are being used efficiently.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Counterpart Financing Requirements	Counterpart Financing Requirements
i. Availability of reliable data to assess	☒Yes☐ No	

compliance		Not applicable.
ii. Minimum threshold of government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒Yes☐No	The state's counterpart threshold is 48 percent of the allocation amount, which is higher than the minimum threshold of 20 percent
iii. Increasing government contribution to disease program	☒Yes☐ No	Willingness-to-pay over the next three years – 2015, 2016 and 2017 – is €6,097,961. This will be split so that it increases each year, as follows: Year 1 = €762,245; Year 2 = €2,286,735 and Year 3 = €3,048,980

b. Compared to previous years, what additional government investments are committed to the national programs (TB and HIV) in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

❑ State counterpart

State counterpart financing has been calculated taking into account the budget allocated to the program, salaries for health care staff involved in treating malaria in the ESPCs, general hospitals and regional hospitals and on the basis of spending on malaria control and the significance of the disease.

Methodology used for salary breakdown for health care staff:

According to the final report on the health map produced by the *Bureau National d'Etudes Techniques et de Développement* [National Office of Technical and Development Research] (BNETD) in conjunction with the DIPE in May 2013, there are 2,091 public health care facilities throughout the country. The results of the study can be broken down based on the following classification of health care facilities:

- 1,945 level 1 facilities called ESPC, or 93 percent of all health care facilities;
- 108 level 2 facilities; the General Hospitals (HG) and Regional Hospitals (CHR), representing 5 percent;
- 38 level 3 facilities; the University Hospitals (CHU) and Psychiatric Hospital (CHP), representing 2 percent of all health care facilities.

Basic care services are provided in the ESPCs. These are the population's first point of contact with the system. Most malaria-related activities are carried out by the ESPCs.

According to the Annual NMCP Report of 2013, malaria accounts for approximately 40 percent of appointments in 2012 at health care facilities.

As a result, it is reasonable to say that care staff devote approximately 40 percent of their working hours to managing malaria.

This figure will be used in the rest of our work on evaluating the proportion of care workers' pay devoted to malaria. The following hypotheses have been used:

- Assumption 1: only doctors, nurses and midwives will be included in the ESPCs.
- Assumption 2: There is one (01) nurse and/or one (01) midwife in Regional Health Centers, rural and urban dispensaries, infirmaries and maternity units. In other ESPCs (urban health centers (CSU), urban health facilities (FSU), etc.) there is one (01) doctor as well as the

nurse and midwife.

- Assumption 3: This sample of key staff (doctors, nurses and midwives) responsible for managing malaria in the ESPCs remains unchanged over the period 2012, 2013 and 2014.

There are 1,638 functional facilities out of a total of 1,945. It is important to take account of functional facilities in evaluating salaries as part of this process. The *Centres Anti Tuberculeux* [Anti-Tuberculosis Centers] (CAT) will also be excluded from our sample as they do not treat malaria cases. This reduces the sample to 1,621 functional facilities to be used for evaluating salaries.

Based on the information from the *Direction de la Solde* [part of the Ministry of Finance responsible for budget monitoring], doctors receive an average monthly salary of €762.25. Nurses and midwives receive an average monthly salary of €381.12.

No.	Type of human resources	Number of staff	Monthly salary per member of staff	Monthly salary	Number of months	Annual salary	Proportion of salary allocated to malaria case management (euros)
						100%	40%
1	TOTAL DOCTORS	1,746	762.25	1,330,888	12	15,970,559	6,388,224
2	TOTAL NURSES	3,964	381.12	1,510,760	12	18,129,237	7,251,695
3	TOTAL MIDWIVES	2,337	381.12	890,688	12	10,688,201	4,275,280
TOTAL ESPC, HG, CHR, CHU and CHP		8,047				44,787,997	17,915,199

Spending on health care staff salaries across all three levels is €17,915,199.
This state counterpart is estimated at 48 percent, which is well above the 20 percent required by the Global Fund.
The counterpart enables the country to take advantage of 85 percent of the amount requested, with the remaining 15 percent dependent on willingness-to-pay.

Willingness-to-pay

In addition to salaries, average state spending on malaria control is valued at €5,765,580.
The budget allocation for Côte d'Ivoire planned by the Global Fund is €86,229,689; 15 percent of this amount is €12,934,454.
The willingness-to-pay technical committee co-chaired by the Director-General for Health and the Special Adviser to the Budget Minister has decided to offer half of the 15 percent (i.e. 7.5 percent) in respect of willingness-to-pay for the next three years (2015-2017). This equates to €6,097,961 split over three years.

Interventions or activities earmarked for funding as a result of additional public spending

ACTIVITIES	Y1	Y2	Y3	TOTAL
Purchase of anti-malarial drugs for severe malaria	406,932	417,512	428,367	1,252,811
Purchase of hemoglobinometers and microcuvettes for anemia diagnosis during malaria	112,500	1,007,547	1,246,788	2,366,835
Purchase of anti-malarial drugs and other commodities for disaster response	99,227	209,406	278,061	586,694
Urgent actions and interventions	134,460	134,460	134,460	403,380
Purchase of commodities and implementation of mosquito eradication		518,597	969,644	1,488,241
ToTAL	753,119	2,287,522	3,057,320	6,097,961

Planned state funding will be spent in accordance with the *Système Intégré de Gestion des Finances Publiques* [Public Finance Integrated Management System] (SIGFIP). This is used to track state spending and will be the source of verification.

Spending is monitored using the SIGFIP database, which tracks all public expenditure. The public

accounts office makes the payment once the service has been delivered.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

Our analysis of the programmatic gaps covered six unquantifiable priority modules, as follows: 1- Procurement and supply chain management; 2- Community health personnel; 3- Monitoring and evaluation system; 4- Financial management; 5- community system strengthening; 6- Program management

These modules were chosen on the basis that the implementation under Round 8 of the interventions associated with these modules experienced a number of problems, which hindered the completion of activities and achieving the expected results. The analysis below shows the gaps identified and activities planned to compensate for them.

1. **Procurement and supply chain management**

An commodities coordination and monitoring mechanism was introduced for Round 8 between the NMCP and the *Nouvelle Pharmacie de la Santé Publique* [New Public Health Pharmacy] (NPSP), which is the SR responsible for managing pharmaceutical and medical products. A procurement and stock management plan for the period 2012-2014 has also been developed. The plan outlines quantities of anti-malarial commodities, delivery and distribution plans and management and monitoring tools.

The procurement and supply-chain management system for the grant currently being implemented has been essentially characterized by frequent stock shortages at health care facilities of ACTs and other commodities associated with: (i) poor anticipation in relation to stock management; (ii) inadequate monitoring at all levels of the supply chain; (iii) poor logistics data; (iv) inadequate resources for transporting commodities from the center to the districts; (v) inadequacies in the operational mechanism for transporting and distributing commodities from the districts to the ESPCs; (vi) the limited level of information in order reports; (vii) inadequate monitoring of average monthly consumption at all levels; (viii) the infrequency of validation meetings for consumption data at a regional level and (viii) the lack of staff motivation because of the fact that commodities are free of charge.

Since 2013, pharmacists have been assigned to regional departments and districts to strengthen the PSM system. The latter are increasingly involved in implementing activities (supervision and

half-yearly validation) aimed at improving the management of drugs and other commodities at a decentralized level. The NMCP has just equipped the NPSP with two additional 16-tonne vehicles purchased with funding from Round 8 to transport commodities to the health districts. For Round 8, 68 containers have just been refurbished to build storage capacity in health districts. Contractual arrangements have been instigated with the private sector to transport LLINs for routine distribution. The NMCP has recently benefited from technical support from GMS to quantify commodities for 2014-2017.

The measures implemented by the NMCP have not so far resulted in a significant improvement in the procurement and stock management system, particularly on the issue of stock shortages in the ESPCs. The inadequacies in the supply chain are systemic insofar as they are clearly linked to the weakness of the health system; this is why other partners are also being mobilized to contribute to improving the procurement and stock management system through establishing regional pharmacies. A plan to strengthen the supply chain for the National Program for the Development of Pharmaceutical Activities (PNDAP) and a technical support project with USAID/PEPFAR through SCMS are currently being implemented in this regard.

In order to minimize the risks of inadequate or non-transparent procedures, purchases of ACT and RDT will continue to be processed through VPP; acquisitions of equipment and SP and purchases of LLINs for the 2017 mass campaign will be entrusted to UNICEF, which will act as a procurement agent for the NMCP.

The challenges for the next three years will revolve around permanent availability of drugs and commodities at the ESPCs and the availability of consumption data.
This concept note, whilst taking into account the strategies and improvement plans currently being implemented through funding from other donors, includes appropriate and pertinent measures aimed at helping to strengthen the supply chain and stock management. These are: (i) strengthening coordination between the NMCP and new PSP through quarterly monitoring and strategic decision-making meetings; (ii) strengthening the NPSP and the NMCP with a technical assistant from MSH to improve procurement and stock management; (iii) entering into contractual arrangements with ESPC managers to supply them with drugs and commodities; (iv) integrated quarterly validation of morbidity and consumption data at a regional level, involving district and regional pharmacies; (v) a continuation of contractual arrangements by the NMCP with private transport companies to ensure timely deliveries of LLINs for routine distribution from the health districts to the ESPCs; (vi) strengthening of half-yearly supervision of pharmacists at an operational level; (vii) reproduction of management tools for drugs and other commodities; (viii) introduction of a *Système d'Information, de gestion et Logistique* [Information, Management and Logistics System] (SIGL) for anti-malarial drugs and other commodities and (ix) quality control for drugs and commodities at all levels.

2. Health and community workers

At a community level, trained CHWs provide treatment for diseases (malaria and diarrhea), whilst community outreach workers carry out awareness-raising activities.

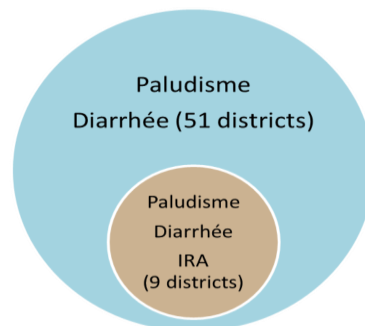
For Round 8, 1,200 CHWs were trained in treating malaria and raising awareness amongst households; 4,100 community outreach workers carry out awareness-raising in households on malaria prevention. Thanks to support from partners, notably UNICEF, 1,350 CHWs have been trained in treating diarrhea and essential family practices. A total of 6,650 community health personnel (CHWs and community outreach workers) provide treatment and awareness-raising activities at a community level. The training programs for community health personnel are not harmonized and skills vary from one health district to another. Furthermore, the ratio of CHWs per district varies from 50 to 100, depending on the program.

Future challenges will mean having a harmonized implementation framework for interventions at a community level.

As a result, the following key actions have been planned for the next three years, in order to fill existing gaps and maximize the impact of integrated case management of children's fatal diseases. These are as follows:

- validation of the strategic plan for community activities;

- harmonization of tools for the three diseases (malaria, diarrhea and acute respiratory infections), integrated training for CHWs and supervision;
- harmonization of training modules and community activity management tools.
- revision of decision-making processes to include management of malaria, diarrhea and pneumonia, including identification of warning signs;
- integrated training of CHWs (Year 1 - 3098, Year 2 = 514) for implementation of interventions in 51 health districts. Nine of the 51 districts where the minimum package (Malaria + Diarrhea) will be implemented will also provide case management of acute respiratory infections (ICCM or the full package: Malaria + Diarrhea + Acute respiratory infections);
- capacity building for 4,100 community outreach workers to implement IEC/BCC activities, including promotion of Essential Family Practices;
- strengthening of awareness-raising activities and community mobilization involving opinion leaders, religious leaders and women's village associations;
- providing CHWs with kits (tunic, bag, bicycle, thermometer, etc.) for integrated case management.



<u>Diagram showing implementation of the community approach</u>

Districts were chosen on the basis of the size of the population and the incidence of malaria. The IEC/BCC aspect of this module will be devolved to the civil society PR, whilst treatment for children under five will be provided by UNICEF in conjunction with the PNSI under the responsibility of the government PR.

3. <u>Monitoring and evaluation system:</u>

The situational analysis of the health information system identified the following inadequacies:
- inadequacy of data collection on malaria-related mortality in public health care facilities associated with an inadequate data-reporting culture by healthcare providers;
- inadequate availability of primary tools (register of appointments, register of antenatal consultations, monthly summary of reports) in ESPCs;
- inadequacy of surveillance data collection associated with non-operation of sentinel sites;
- poor integration of community and private sector data associated with inadequate anchoring to the public health sector;
- lack of timeliness in passive feedback of health system and community data linked to inadequate reporting;
- limited involvement of regional and district management teams in data validation;
- limited monitoring of data on consumption of anti-malaria commodities because of inadequacy of stock management tools;
- poor level of completion of supervisory activities, notably from health districts to ESPCs;
- lack of coherence of data collected by certain health facilities linked to inadequate understanding of the definition of certain indicators.

SNIS data collection tools for Round 8 are currently being revised and will make it possible to collect a full range of useful information on malaria in the public, private and community sectors. Furthermore, the DHIS2 currently being developed will be gradually rolled out and will help support the management of malaria control data. Implementation of the three-year plan on funding from the Global Fund for the HIV component and other partners (PEPFAR, GAVI and UNFPA) to strengthen the health information system 2014 – 2016, including the roll-out of DHIS2, amongst other things and revision of all national indicators (including integration of community indicators); regular provision of collection and reporting tools to ESPCs; and capacity building for monitoring and

evaluation through training and formative supervision will help to address most of the inadequacies referred to above.

The challenges for the next three years are as follows: strengthen the M&E system in order to ensure high-quality data, including data from the community and private sectors at all levels, are available in a timely manner.

As a result, certain interventions in the three-year plan that did not have funding have been included in this Concept Note in order to contribute to addressing the challenge of a functional information system. These are:

- strengthening the system for reporting and disseminating consumption (drugs and commodities), morbidity and mortality data in health care facilities (public and private) and at a community level. To achieve this, primary tools (records of cases and deaths, stock monitoring and consumption data management tools) will be reproduced and made available on a regular basis to healthcare facilities (public, private for-profit and not-for-profit, denominational and company); staff will be trained in using these tools and in data analysis.
- increasing the number of sentinel sites from six to 12 for monitoring maternal and child deaths;
- improving the quality of NMCP/DIPE supervisions;
- organizing data quality-control exercises;
- organizing the usual studies and surveys (MIS, ACT efficacy study, resistance to insecticides survey, LLIN efficacy survey, service survey) to measure progress and take strategic decisions.

These activities will be carried out in conjunction with the sub-recipient DIPE in accordance with the three-year plan approved by the Global Fund.

4. Financial management

The analysis of the situation in terms of financial management reveals some management difficulties to be aware of: (i) insufficience of the manual of procedures; (ii) Partial or late justification of the advances received; (iii) insufficient quality of certain supporting documents by the actors on the peripheral level; (iv) insufficiency of the implementation by the NMCP of the recommendations made by the internal and external audit missions.

Since August 2013, the Global Fund has put in place an international fiduciary agent who supports the 3 governmental PRs. This agency brings technical support in the assembly of bidding documents, the approval of budgets activities, and in the monitoring of the procurement process. This support has helped limit the shortcomings with respect to the procedures having been the subject of questionable costs. The availability of an administrative and financial procedures manual that is common to the three national PRs facilitates the harmonization of the financial management practices between the PRs. The existence of an internal audit unit is an asset to the NMCP but the exercises or control missions are not yet systematic.

The NMCP's challenges for the next three years will be the provision of a management mechanism without the questionable costs, ineligible expenditures, and assuring a level of resource consumption beyond 90% with or without the acquisition costs of commodities. The planned priority actions will include: the revision of the procedures manual at the start of the implementation of this grant to integrate the transmission time of the audit report and a mechanism for monitoring the implementation of the recommendations made in external audit reports; the conducting of regular and at the right dates, the internal and external audit missions; the integration and monitoring of the status of the implementation of the recommendations of the reports of the audits in the terms of reference of the malaria committee of the CCM. This monitoring will be done during the workshop presentations of the Dashboard to the CCM.

5. Community systems strengthening

Community-based management of cases of uncomplicated malaria and other diseases amongst children and pregnant women is still limited, in spite of the efforts made in recent years through the Round 8 grant. In 2006, around 36 percent of the population is located more than 5 km from a health center (annuaire des statistiques sanitaires 2007-2008, Annex 25, pg 26) and people close to a health facility are limited by financial and cultural constraints. Thirty-six percent of the total population located more than 5 km away have access to community care according to the DHS-MICS 2011-2012. Various studies show that the three main diseases responsible for the deaths of

children aged 0-5 years are malaria, pneumonia and diarrhea. Community activities are intended to: (i) essentially promote rapid recourse to care for children presenting with one of these three diseases and increase the use of services from 27 percent to 30 percent by the end of 2017; (ii) increase understanding of prevention methods and case management amongst the population, in particular mothers and child minders, to promote the four Essential Family Practices.

The current community system is characterized by the following inadequacies: (i) the lack of official recognition of the status of CHWs, (ii) the absence of an advocacy framework to implement a formal community system and mobilize resources for community activities, (iii) inadequate integrated communication on management of childhood diseases and (iv) the absence of a reporting system for communications data.

The interventions planned under this concept note will therefore include:

- creation of a formal status for recognition of CHWs through a ministerial order;
- strengthening the partnership framework for resource mobilization and implementing community activities;
- formal contractual arrangements with local radio stations;
- validation of community health policy documents and a framework for implementation;
- establishment of a partnership agreement with women's groups and associations of traditional leaders at a district level;
- provision of PFE promotion tools to CHWs and women's groups;
- development and implementation of an advocacy and communications plan;*
- implementation of an integrated strategy for case management of malaria, diarrhea and acute respiratory infections.

6. Program management:

- Program planning and activities and budget monitoring remain areas that need to be strengthened over the course of the coming years. Activities are often implemented under urgent conditions because timetables overlap with the Ministry of Health's other activities and in particular, because of delays in the contract award process. These shortcomings are linked to excessive workloads due to a lack of personnel in the finance department (arising from delays in recruiting an administration and finance manager and accountants). There have been repeated delays in the purchase of non-medical products (equipment, vehicles, consultants for studies, etc.), which are often linked not only to the long process of approving contract-award documents (such as the procurement plan and tender documentation) but also the absence of a specialist in awarding contracts within the NMCP and the limited support for the procedures manual by staff. Delays in the delivery of equipment, goods and services, which hinder adequate implementation of interventions, create emergency situations and result in activity implementation rates that could be further improved (from 78 percent in 2013) and an acceptable resource absorption rate (70 percent in June 2014 according to the Grant Performance Report). Therate is explained by the inclusion of purchases of anti-malarial commodities through VPP. Further efforts could be made in respect of consumption based on operational activities.

- Coordination with partners: The absence of a single functional framework for meeting partners and thematic groups.

For the last few years, the NMCP has played an active role in the quarterly coordination meetings for health program activities organized by the Community Health Department. The NMCP also places importance on half-yearly coordination or task-force meetings under Round 8 funding, bringing together operational actors and partners. For the NMCP, these meetings now constitute opportunities for joint planning and monitoring of the implementation of activities. Since January 2014, the NMCP has benefited from technical assistance for two years from the MSH LMG project on funding for the PMI in order to improve grant management, in particular in the areas of planning, program management and monitoring/evaluation. As of the last quarter of 2014, the LMG plans to build capacity amongst NMCP executives in respect of leadership, management and governance through a series of mentored training courses on leadership and program development to achieve a higher impact from funding on public health, particularly amongst children and pregnant women.

Satisfactory mid-term results from the MSH LMG project in the Indénié-Djuablin and N'Zi Ifou regions have prompted the Ministry of Health and AIDS Prevention to use the allocation amount to extend the activities of this project to two other regions in the context of health-systems strengthening.

The challenge for the next three years will be to develop a program to control malaria with activity

implementation and resource consumption rates higher than 90 percent.

The interventions planned in this concept note are intended to fill gaps and address shortcomings in program management. These are:

- establishment of a partners' forum for malaria control to ensure continued mobilization of financial resources and monitoring of activities;
- formal contractual arrangements for results with public-sector actors. There is a future planning and strategies department at the Ministry of Health, which is preparing to implement formal contractual arrangements for results in 14 pilot health districts with funding from the World Bank. The NMCP plans to include this funding in this concept note through a contribution based on formal contractual arrangements for the results of certain key malaria indicators;
- outsourcing of contract-awarding activities through formal contractual arrangements with a private firm in accordance with procedures approved by the Global Fund;
- development and implementation of a plan to strengthen human resources involved in malaria control;
- planning of technical assistance (international and national) based on specific program requirements;
- continuation of half-yearly task-force meetings with the Ministry's other programs and decentralized structures;
- planning of half-yearly meetings with stakeholders;
- acquisition of vehicles and computer equipment;
- remuneration of human resources recruited to the project.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

The mid-term review of the 2012-2015 strategic plan noted progress in a number of areas (increase in coverage of RDT, ACT, etc.) of malaria control but these are still insufficient in light of the targets set.
This section of the concept note therefore outlines the priority modules selected by stakeholders in the national dialogue and the interventions proposed for funding from the allocation amount or the amount above this to fill gaps and maximize the impact of control activities. Specific development work has been carried out to strengthen the health system; this remains a cross-disciplinary module addressed in the second part of this section.

I. STRATEGIC PRESENTATION OF FUNDING REQUEST FOR PRIORITY MODULES

Section 3.3 below shows the approach to prioritization adopted for the nine modules below in order of priority: 1- case management; 2- vector control; 3- specific prevention interventions; 4- procurement and supply chain management; 5- health and community workers, 6- monitoring and evaluation; 7- financial management; 8- community systems strengthening and 9- program management.

1. Case management

Five priority interventions have been selected for this module: hospital treatment (health facilities and advanced strategies); integrated case management in communities; case management in the private sector (others); IEC/BCC and monitoring of therapeutic efficacy.

i. Hospital treatment (public health facilities and advanced strategies)

Management of malaria in the context of this funding will apply only to uncomplicated cases. Case management of severe malaria, which represents 7 percent of positive cases, will be funded on the willingness-to-pay component. Two aspects of case management will be funded from the allocation amount. These are diagnosis (microscopy + RDT) of suspected cases of malaria and treatment using artemisinin-based combination therapy (ACT). This will be implemented in the 2,091 public health facilities identified (source: Health Map 2013) and as an advanced strategy in

places located more than 5 km away from a health center. The new funding will allow advanced-strategy case management to be targeted at shanty towns and vulnerable neighborhoods in Abidjan and San Pédro and at prisons in Abidjan. An advanced strategy per quarter will be organized in conjunction with other programs (EPI, PSME, National Nutrition Program (PNN), etc.).

The national target expected in health care facilities and advanced strategies over the three years of the grant is to test 15,585,991 suspected cases. As at 31 December 2014, there will be a remaining stock of 2,851,825 RDTs purchased with funding from Round 8. This will be carried over to year 1 (2015). This leaves a gap of 11,942,055 suspected cases to be diagnosed with RDTs or microscopy from the allocation amount. RDTs will be used in 80 percent of cases compared with 20 percent for TS. Purchasing these commodities would help increase the current level of RDT and TS coverage from 74.7 percent (SNIS 2013) to 95 percent by 2017. As regards treatment, an estimated 9,665,107 positive cases of uncomplicated malaria are expected across all age groups. The availability of ACTs from Round 8 as at 31 December 2014 is 3,444,068 treatments. The gap is therefore 6,221,039 positive cases of uncomplicated malaria, for which ACTs will be purchased from the allocation amount. This will increase the current level of coverage from 91 to 93 percent.

ii. Community-level integrated case management

Community case management will target only children under five. It will be implemented by the government PR via the sub-recipient UNICEF, which will work in partnership with the PSME and the NMCP. Diagnosis and treatment of cases of uncomplicated malaria will be provided by 3,612 CHWs over three years. Fifty-one of the 82 health districts targeted in the revised PSN for implementation of community-level integrated case management will be covered from the allocation amount. Integrated case management will include malaria and diarrhea designated as “PECADOM Plus” in 51 districts, including nine districts implementing ICCM.

All suspected cases will be diagnosed systematically by CHWs using RDTs. Routine CHW activities will also include raising mothers’ awareness of the four Essential Family Practices selected by stakeholders in relation to this grant: (i) promotion of the use of LLINs by pregnant women and children under five; (ii) promotion of antenatal consultations with a focus on adherence to the frequency of consultations by pregnant women; (iii) promotion of breastfeeding; (iv) promotion of early use of home-based care (PECADOM) for the three diseases referred to above.
Patients with no warning signs will be treated with ACTs free of charge. CHW activities will be run with the support of health area managers and under their supervision.
Purchases of commodities (ACTs and RDTs) for management of malaria will be funded from the allocation, whilst commodities for diarrhea and acute respiratory infections will be provided by UNICEF and other partners. CHWs will be provided with community kits (tunic, bicycle, bag, etc.).
The targets for integrated management in the 51 health districts are:

- RDT: National targets = 2,278,011 suspected cases to diagnose and for which funding is required: 1,855,402. The total RDT requirements for the 51 health districts concerned, and community case-management activities will be funded from the allocation amount.
- ACT: national targets = 1,440,613positive cases of malaria to treat. As at 31 December 2014, the availability of ACTs is 429,343 treatments. The gap to fill is 820,652 ACTs, purchased from the allocation amount.
- ORS: 891,489 boxes will be purchased by UNICEF and partners
- Zinc: 891,489 boxes will be purchased by UNICEF and partners
- Amoxicillin: 78,601 bottles will be purchased by UNICEF and partners
- Timers for counting respiration rate: 312 will be purchased by UNICEF and partners

iii. Case management in the private sector:

In partnership with the *Coalition des Entreprises de Cote d’Ivoire* (CECI) 60 private, not-for-profit health care facilities (company dispensaries) will be involved in free diagnoses using RDTs and treatment with ACTs. These health care facilities will be regularly equipped with commodities and management tools.
A partnership with the *Association des Cliniques Privées de la Côte d’Ivoire* (ACPCI) will provide training for 320 health care workers in the private sector on new guidelines for management of malaria. The training costs for these workers will be borne jointly by the PR and ACPCI. For the moment, there is no provision of RDTs and ACTs for the for-profit private sector.

In total, 4,347,255 suspected cases of malaria and 2,749,203 positive cases are expected in

private facilities. The availability of ACTs from Round 8 is 412,587 treatments. No RDTs are available. As a result, 100 percent of RDT requirements and 85 percent (2,028,613) of ACT requirements will be funded from the allocation amount. Expected levels of coverage for RDTs and ACTs in the not-for-profit private sector by 2017 are 100 percent and 93 percent respectively.

iv. IEC/BCC. Comments in the module; specific interventions

IEC activities will be integrated and implemented by the government PR through four NGOs selected by the CCM, split across the 20 regions.

v. *Monitoring of therapeutic efficacy* is planned under the new funding

Planned priority actions for the case management module from the allocation amount are: purchase and regular supplies of commodities for the ESPCs (RDTs, reagents and ACTs) for diagnosis and case management; organization of treatment campaigns; refresher training for 6,173 public-sector health care workers on the new guidelines; training and provision of kits for CHWs; awareness-raising in businesses; support for training for service providers in the public sector; coordination and supervision of control activities in the private sector.

The costs of the case management module for the next three years (2015-2017) is €18,004,238 from the allocation amount and represents 32 percent of the funding gap for the PSN 2012-2017.

2. Vector control

Four priority interventions have been selected for this module. In order of priority, these are: i- Long-lasting insecticidal nets: regular distribution; ii- IEC/BCC; iii- Entomological surveillance; iv- Long-lasting insecticidal nets: large-scale campaign.
Household availability of LLINs is 66 percent and the proportion of the population using LLINs was 68 percent in 2012 (DHS-MICS 2011-2012) for people who have access to them. Although encouraging, these results are still well below national targets, namely 100 percent (universal) coverage and 80 percent use amongst the population, including children and pregnant women.

i. Long-lasting insecticidal nets: regular distribution

Free distribution of LLINs will be implemented in the 2,091 public health facilities identified and as an advanced strategy. It will be extended to 160 private health care facilities, of which 100 are for-profit and 60 not-for-profit. Routine distribution of LLINs will target the most vulnerable groups, namely pregnant women seen during antenatal consultations and children under one year seen when they have their immunizations. National requirements for routine distribution are 6,439,605 LLINs over three years. Apart from the stock of the ORSEC plan, the available stock of LLINs is 1,801,962, of which 1,201,962 purchased from Round 8 will be carried forward to year 1 of the new grant and 600,000 will be purchased through counterpart financing. This leaves a shortfall of 4 573 884 LLINs for the routine, which will be purchased and distributed using the allocation amount.

ii. IEC/BCC. Comments on the module; specific interventions

iii. Entomological surveillance:

Four main entomological surveillance activities have been planned for implementation from the allocation amount. These are: a study on the residual efficacy of LLINs; an evaluation of vector transmission; a study on insecticide resistance and mapping of malaria risk in Côte d'Ivoire. These activities are aimed at monitoring the sensitivity of vectors to insecticides and vector behavior, and developing control actions based on a stratification of malaria risk.

iv. Long-lasting insecticidal nets: large-scale distribution

Given that LLINs last for three years, a new, free campaign of mass distribution of 14,698,357 LLINs (one LLIN for 1.8 people) is planned for 2017. This will provide replacements for the 13,992,750 LLINs that will be distributed by the end of the 2014 national mass campaign. Funding for all LLIN requirements and organization of the mass campaign (micro-planning, counting households, distribution, supervision, implementation of the communications plan, support for installation of LLINs and an early post-campaign survey) will be requested from the amount above the allocation.

Priority actions for the vector-control module are: implementation of activities from the communications plan and strengthening of the LLIN distribution chain to sites where the population collect them. Inadequacies in the supply and distribution chain, which undermined the performance of routine LLIN distribution activities during Round 8, will be addressed by recruiting a private organization for transporting LLINs from the districts to the health center.

The cost of the vector control module for the period 2015-2017 is €69,865,210, of which 20 percent (€14,060,208) will be requested from the allocation amount and €45,389,750 – for the 2017 national campaign – from the amount above.

3. Specific prevention interventions (IPT)

Two interventions have been selected for this module in order of priority. These are: i. Intermittent preventive treatment: pregnant women and ii. IEC/BCC

i. Intermittent preventive treatment: pregnant women

The usage rates of antenatal consultations in the public sector are: Antenatal consultation 1 = 79 percent; antenatal consultation 2 = 63 percent; antenatal consultation 3 = 47 percent. The current level of coverage for IPT 2 is 41 percent (SNIS) and 20 percent according to the DHS-MICS 2011-2012. These results are still low compared with the national target of 80 percent.
Free provision of sulfadoxine-pyrimethamine to pregnant women will continue in the 2,091 public health care facilities identified and on this occasion will be extended to 160 health care facilities in the private sector (100 for-profit and 60 not-for-profit) and to the advanced strategy, not only in places that are more than 5 km from ESPCs but also in vulnerable neighborhoods and shanty towns in the cities of Abidjan and San Pédro. In partnership with the managers of antenatal consultation services, home visits will be organized by the 4,100 CHWs (four visits / month / CHW) with the aim of actively identifying pregnant women lost to follow-up. CHWs and community outreach workers managed by the four NGOs (sub-recipients) will monitor compliance with antenatal consultation schedules by pregnant women in their health records.

Another form of integrating activities is also envisaged by the NMCP. This will involve offering LLINs to HIV-positive pregnant women via the partnership with the national AIDS control program via PMTCT sites. Community mobilization by the alliance is an opportunity to improve the expected results if raising awareness about the use of health care service is included and if the community is more closely involved in health promotion.

Local and mass awareness-raising sessions are conducted by the CHWs as part of the community response to HIV on the use of HIV prevention and treatment services. These sessions will be used to raise awareness amongst pregnant women and their spouses on the use of antenatal consultations so that they can benefit from the prevention services offered in relation to malaria control.

The total target of pregnant women expected over the three years of the grant in different sites is:
- for IPT2: 2,969,406 pregnant women (Year 1= 879,660; Year 2 = 1,031,464; Year 3 = 1,058,282). The remaining stock of commodities purchased during Round 8 will contribute to covering IPT1 requirements for year 1. More stock available for covering IPT2 requirements for pregnant women. In the absence of other funding sources, 100 percent of IPT2 requirements for 2,969,406 pregnant women will be covered by the allocation amount
- for IPT3 the figure is 843,220 pregnant women (Year 1 = 188,498; Year 2 = 257,866; Year 3= 396,856). In the absence of available stock and funding to cover these targets, 100 percent of IPT3 requirements for these targets will be subject to the allocation amount

Administrative materials required for implementation of this intervention, in addition to the SP, will be purchased from the allocation amount.

ii. IEC/BCC

IEC/BCC and community mobilization are support activities for all malaria control interventions. The situational analysis revealed: a service usage rate of 27 percent (SNIS, 2012) and an LLIN usage rate of 68 percent (Hannah Koenker et al) for people with access to them. IPT2 coverage of 41 percent (Enquête de service 2013).
The objective is to have 80 percent of the population using health care services and adopting

preventive and case-management measures.
The IEC/BCC activities developed by CHWs and community outreach workers will help to increase coverage of IPTs, use of public- and private-sector antenatal consultations services and implementation of advanced strategies. IEC/BCC activities will help to reach a total of 5,313,600 people and home visits will help to identify 174,000 pregnant women lost to follow-up for the second dose, at least during the three years of the grant.

Priority actions for the specific prevention Interventions module are: purchase of commodities (SP) and IPT supervised administration kits; strengthening of local and mass communications for access to IPT; and identifying lost to follow-up women.

The total cost of the specific interventions module is €1,230,266 that being 100 percent to be covered by the allocation amount.

4. **Procurement and supply-chain management**

The only priority intervention selected is implementing the procurement and supply management system. Its current operational status, deficits, constraints and priority actions are described in section 3.1 above.
The cost of the procurement and supply-chain management module for the next three years is €18,122,724. The amount of €6 732 518 representing 37 percent of the requirements in the revised PSN 2012-2015 will be requested from the allocation amount and €7,061,457 will be requested on the above allocation amount..

5. **Health and community workers**

Two interventions have been selected for this module. These are: Capacity building for community health workers, retaining their loyalty and increasing their distribution. The situational analysis for the implementation of these interventions, challenges and actions are described in section 3.1 above.
The cost of the health and community workers module for 2015-2017 is €1,935,679. This amount represents 100 percent of the requirements in the revised PSN 2012-2015 and will be requested from the allocation amount.

6. **Monitoring and evaluation**

Three priority interventions have been selected for this module. These are: regular communication of information; analysis, examination and transparency, and survey.
Current execution of this module, an assessment of gaps and challenges and planning for corrective actions for a greater impact on malaria control are presented in section 3.1 above.
The cost of the M&E module in the revised PSN is €5,826,175. This amount represents 100 percent of the requirements in the revised PSN 2012-2015 and will be requested from the allocation amount.

7. **Financial management**

A single intervention (Performance, transparency and accountability obligations of the public financial management systems in the health sector) has been selected for this module, as described in section 3.1 above.
The cost of the financial management module in the revised PSN is €59,731. This amount represents 100 percent of the requirements in the revised PSN 2012-2015 and will be requested from the allocation amount.

8. **Community systems strengthening**

The following three interventions have been selected for this module: (i) monitoring of community accountability obligations; (ii) social mobilization, strengthening community links, collaboration and coordination; and (iii) strengthening institutional capacity, planning and leadership in the community sector.
The cost of the community systems strengthening module for the next three years is €9,040,005. This does not include the costs of additional commodities and drugs for ICCM, which will be provided by UNICEF and other partners with responsibility for implementing this module. No funding available for this module. All of it will therefore be funded from the allocation amount.

9. Program management

9.1 Priority interventions with regards to program management

The three priority interventions chosen for this module are: Policy, planning, coordination and management; Grant management; Support for procurement and supply management systems.
The cost of these interventions for the period 2015-2017 in the revised PSN is €4,702,383. The totality of these needs will be funded from the allocation amount.

9.2 Priority activities with regards to HSS

Stakeholders in the country dialogue undertaken by the CCM agreed unanimously that health systems strengthening should be included as a priority activity in each component (Malaria, TB, HIV) in order to maximize the impact of Global Fund investments on improving public health, particularly amongst women and children.
An analysis of the current situation of the health system (section 1.1), requirements and funding gaps was carried out. The evaluation showed that weaknesses in the health system had hindered not only adequate execution of interventions under the malaria control program but also the performance of grant implementation to date by the PRs of Rounds 6 and 8.
The analysis of the health system identified key inadequacies (Sections 1.1, 3.1 and 3.2), which can be grouped into six main areas, namely:

1. Procurement and supply management
2. Health information system
3. Number of workers in the health sector and communities
4. Service provision
5. Financial management
6. Leadership and management

Given the capacity-building measures planned under the TB grant and grants from other partners (USAID, National Program of Pharmaceutical Activities Development (PNDAP) , etc.), the following additional actions have been planned for the allocation amount to strengthen the health system and improve the program's effectiveness and efficiency. This involves:

❑ *Procurement and supply management (PSM)*

- Development of a PSM plan;
- Increased coordination between the NMCP and the NPSP by establishing periodic discussion forums;
- Capacity-building for people authorized to manage stocks at a district level, using stock data-management software;
- Provision of technical assistance for procurement and supply management with funding from PMI/USAID;
- Increased quality control and assurance for anti-malarial commodities;
- Maintenance of fair, free availability of anti-malarial commodities at service provision sites;
- Improvement in the logistics management information system;
  Introduction of supply management software (SIGL);
- Organization of quarterly data validation workshops at a regional level with pharmacists from the health districts and regions

❑ *Health information system*

- Capacity-building for M&E personnel;
- Development, printing and provision of materials for training in data-management tools;
- Strengthening the coordination mechanism through creation of a technical working group or decentralized coordination;
- Publication of periodic reviews on malaria control;
- Review and evaluation of the strategic plan;
- Organization of data validation workshops with epidemiological surveillance managers in health districts;
- Increased operational research;
- Conduct of studies and surveys: entomological, effectiveness of commodities, vector sensitivity, etc.
- Implementation of a surveillance mechanism for cases and deaths.

❑ *Number of workers in the health sector and communities*

- Increased number of community health workers involved in managing childhood diseases;
- Advocacy work on introducing malaria-control strategies and interventions in the training manual (teachers, children and literacy);

❑ *Service provision*

- Inclusion of service activities not only in health care facilities but also for CHWs, who will now provide integrated case management of malaria, diarrhea and acute respiratory infections;
- Formalization of the case referral system;
- Increased supervision activities at all levels;
- Establishment of a surveillance system for improving quality of care: supervision, service surveys, etc.
- Improvements in laboratory equipment (hemoglobinometers) for anemia diagnosis, particularly amongst children, to ensure early treatment;
- Provision of 10 coordination and supervision vehicles.

❑ *Financial management*

- Capacity-building for NMCP personnel on the administrative and financial management manual;
- Strengthening the role of the NMCP's internal auditor;
- Completion of external audit;
- Increasing use of electronic payment mechanisms;
- Close monitoring of accountants in regions and health districts to equip them with the tools necessary for management of financial information

❑ *Leadership and management*

- Joint NMCP/Partners improvement and planning of *Plan d'Action Opérationnel* [Operational Action Plan] (PAO) activities;
- Development of an LDP program within the NMCP and in two regions in line with the approach adopted in the Indénié-Djuabin and N'Zi-Ifou regions.

All these actions will contribute to a flexible and robust management system for health products that supports procurement and supply management and facilitates effective, high-quality procurement, storage and distribution of anti-malarial commodities.

The total cost of the health systems strengthening activities is €3,098,364. No funding is available for this activity; it will therefore be funded in its entirety from the Global Fund's allocation amount.

In total, the cost of the program management module for the period of 2015-2017 in the revised NSP comes to: **€** 7,800,747. No funding is available for this module, meaning that the entirety of the need will therefore be requested within the allocated amount.

To summarize, all nine of these priority modules and the specific health systems strengthening module described above will have a more significant impact on malaria control, provided they are funded and implemented.

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

a. Rationale for the selection and prioritization of modules and interventions

The modules and interventions pre-defined in the modular template were prioritized on the basis of the aims, objectives and strategies set out in the revised PSN 2012-2015, in accordance with the steps outlined above and presented in the annex "*Priorisation module et interventions_ Annex 21"*

- Selection of goals and objectives targeted by this grant request: the review of pre-defined interventions in the modular template prompted the selection of two aims and three objectives from the revised PSN.
  - Goals: (i) Reduce malaria-related mortality to below one death per 100,000 cases by the end of 2015 and maintain it at this level until 2017; (ii) Reduce the number of malaria cases by 75 percent by the end of 2015 compared with 2008 and maintain it at this level until 2017.
  - Objectives: (i) Increase the proportion of the population sleeping under a long-lasting insecticidal net from 33 percent to 80 percent by the end of 2015 and maintain it at this level until 2017; (ii) Increase the proportion of pregnant women taking at least two doses of SP from 40 percent to 80 percent by the end of 2015 and maintain it at this level until 2017.

- Selection of modules and interventions to be funded by the Global Fund grant: a survey of all the modules and interventions pre-defined in the modular template was carried out to determine the selection. A cross-check of these modules and interventions with the interventions in the revised PSN enabled the stakeholders involved in producing this concept note to eliminate the modules and interventions that will not be funded by the grant. As a result, the indicative funding allocated by the Global Fund will be used to fill the funding gaps in the nine selected modules below.

- Prioritization of modules and interventions to be funded from the grant requested: Four prioritization criteria were defined and scores assigned to each sub-criterion in order to establish the order of priority of modules and interventions

Priority evaluation criterion	Ranking information for priority modules	Scores
Quantitative programmatic gaps	Gap > 50 percent	4
	Gap between 25 and 50 percent	3
	Gap between 10 and 25 percent	2
	Gap < 10 percent	1
Qualitative programmatic gaps Are the services or interventions: 1- relevant or realistic; 2- achievable 3- scale or extent; 4- measurable (against the intended objective)	4 criteria present	4
	3 out of 4 criteria present	3
	2 out of 4 criteria present	2
	1 out of 4 criteria present	1
Funding gaps	No funding available	4
	Less than 50 percent funding available	3
	More than 50 percent funding available	2
	100 percent funding available	1
Impact on the disease	High-impact interventions	4
	Moderate-impact interventions	3

	Low-impact interventions	2
	Very low-impact interventions	1

A module-by-module evaluation based on these priority criteria was carried out by the stakeholders involved in this concept note. Scores were attributed to each criterion and the total score calculated for each module. Modules were ranked in decreasing order of priority based on the total number of points scored. Modules that were ranked equal were reclassified using a weighting based on the severity of the consequences on the beneficiaries of possible elimination of the activities associated with each one.
At the end of the exercise, the nine priority modules below were selected in decreasing order of priority. The same approach was applied to ranking the modules and interventions to be funded.
As a result, the following interventions were selected in conjunction with the priority modules listed in the file "*Priorisation module et interventions_ Annex 21"*
A total of nine modules and 24 interventions were selected for indicative allocated funding and incentive funding under this concept note. The only intervention put forward for funding under the amount above the allocation amount is "Long-lasting insecticidal nets: mass campaign".

b. Expected impact and outcomes

Impact, effect or outcome indicators to be measured in 2017	Expected impact, effect or outcome
Impact indicators	
Mortality rate amongst children under five, all causes combined	Contribute to the reduction from 108 per 1,000 (2012, DHS III) to 93 per 1,000 by 2017
Number of deaths of patients hospitalized for malaria	Reduce the baseline value obtained by the measure planned for year 1 of the grant by 50 percent
Parasite prevalence amongst children aged 6 to 59 months	Target to be defined after the 2015 MIS
Positivity rate for malaria tests	Reduce from 68 percent (SNIS 2013) to 38 percent by 2017
Effect indicators	
Proportion of suspected malaria cases that receive a parasitological test in public-sector health care facilities (microscopy or RDT)	Diagnose at least 95 percent (14,793,880) of suspected malaria cases admitted to public health care facilities in 2015-2017 using RDT or TS
Proportion of suspected malaria cases that receive a parasitological test in the community (RDT)	Diagnose at least 81 percent (1,855,402) of suspected malaria cases admitted within the community in 2015-2017 using RDT
Proportion of suspected malaria cases that receive a parasitological test in private-sector not-for-profit health care facilities (RDT)	Diagnose 100 percent (4,347,255) of suspected malaria cases admitted to private health care facilities in 2015-2017 using RDT
Proportion of confirmed malaria cases treated with ACT in accordance with national policy in public health care facilities	Treat 9,665,107 cases of uncomplicated malaria cases with ACTs, representing 93 percent of positive cases recorded in 2015-2017 (more severe cases represent 7 percent)
Proportion of confirmed malaria cases treated with ACTs in accordance with national policy within the community	Treat 1 440 613 cases of simple malaria with ACTs in 2015
Proportion of confirmed malaria cases treated with ACT in accordance with national policy in private not-for-profit health care facilities	Treat 2 749 203 cases of uncomplicated malaria cases with ACTs in 2015-2017
Outcome indicators	
Number of LLINs distributed to the public during the mass distribution campaign	A total of 14,698,357 LLINs will be distributed to the population in 2017
Number of LLINs distributed to pregnant women and children under the age of five	A total of 6,418,893 LLINs will be distributed to 100 percent of new pregnant women and children under one registered from 2015-2017
Percentage of pregnant women seen in antenatal consultations who have received at least three doses of Intermittent Preventive Treatment (SP)	Reach at least 30 percent of women for IPT3 by the end of 2017, i.e. 843,220 pregnant women should receive IPT3 from 2015 to 2017.
Percentage of pregnant women seen in antenatal consultations who have received at least two doses of Intermittent Preventive Treatment (SP)	Reach at least 80 percent of women for IPT2 by the end of 2017, i.e. 2,969,406 pregnant women should receive IPT2 from 2015 to 2017.

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is not applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.

b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

As a lower-middle-income country, Côte d'Ivoire comes under "a".

This proposal provides for interventions aimed at two sets of vulnerable groups, namely pregnant women and children under five, and people living in vulnerable neighborhoods or more than 5 km away from a health center, along with interventions with a significant impact.
The intention is to cover the requirements for case management of uncomplicated malaria in a hospital setting and amongst vulnerable groups through purchasing ACTs and RDTs, routine distribution of LLINs and dispensing of SP (€13,885,018).
As regards vulnerable populations, the intention is to implement case management activities and awareness-raising of advanced strategies periodically for people living more than 5 km from a health center or in vulnerable neighborhoods (€2,352,179).
At a community level, PECADOM and ICCM will enable ongoing management of children under five in villages that face problems of geographical and financial accessibility (€5,762,215).
Activities with a real impact will help to support all interventions targeted at vulnerable and disadvantaged populations. These are communications (€2,899,846) and community systems strengthening activities (€9,040,040).
These costs do not include PSM expenses associated with procuring supplies.
The combined cost of these interventions is €33,939,263 or 52 percent of the funding requested (see table below).

Areas	**Interventions**	Amount (euros)
ACT, LLIN, RDT, and SP for pregnant women (PW) and children under five in health care facilities	Routine distribution of LLINs for PW and children under 1 year	11,976,268
	ACT for children under 5 years	1,156,189
	RDT for PW and children under 5 years	324,936
	SP for PW	427,625
Sub-total 1		13,885,018
PECADOM and ICCM	Training for CHWs, drugs, equipment, loyalty-retention materials	5,762,215
ADVANCED STRATEGY	A half-yearly strategy per district and in vulnerable neighborhoods	2,352,179
COMMUNICATIONS ACTIVITIES	Involvement of CBOs and FBOs in training and awareness activities	2,899,846
COMMUNITY SYSTEMS STRENGTHENING	Advocacy, social mobilization, identification of lost to follow-up women (SP) and management costs of sub-recipient	9,040,005
Sub-total 2		20,054,245
TOTAL (euros)		33,939,263

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).
b. If more than one Principal Recipient is nominated, how coordination will occur between principal recipients.
c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

a- The funding method selected by stakeholders involved in the country dialogue for the implementation of this grant over the next three years is dual-track financing, with one government or public PR and one civil society or community sub-recipient.

Coordination will be secured through MoU between the two PRs); quarterly coordination meetings between the two PRs will be held.

b- The sub-recipients selected by the CCM will be managed and supervised by the PRs. Should the PR nonetheless disqualify an sub-recipient, it must document the reasons for its refusal.

The sub-recipients were selected following a transparent process that is clearly defined in the terms of reference. This was a seven-stage process, as follows:

- Establishment of a selection committee in accordance with the ToR
- Development, finalization and validation of selection tools
- Call to tenders
- Receipt and opening of tenders and analysis of application files
- Evaluation and selection of sub-recipients
- Approval of shortlisted applicants by the CCM assembly
- List of applicants selected sent to the Global Fund

c- The PR must provide refresher training for the sub-recipients on the basis of a capacity-building plan developed following the evaluation of the sub-recipients by the CCM selection committee. The capacity-building plan will be implemented during the first half of the first year.

Coordination between the PR and sub-recipients will be achieved through capacity-building, supervision, monitoring and quarterly coordination meetings.

d- There are coordination networks of NGOs (ROLPCI), CBOs for women (Association des femmes dans le secteur des vivriers) and parents of children under the age of five and FBOs (faith-based organizations: Alliance des religieux contre le SIDA et le Paludisme), which will be called on to contribute to implementing this funding request.

These organizations will be involved in the following areas:

- Advocacy: seeking commitments from administrative, political and health authorities, and opinion and community leaders (village chiefs, religious leaders and managers of community organizations)
- IEC/BCC: educational talks, individual interviews, home visits (VAD) (to identify women who have disappeared from view for antenatal consultations) and promotion of PFE (Essential Family Practices): use of LLINs, visits to health care facilities, antenatal consultations, etc.

- Community mobilization: information on the disease, visits to health care facilities, debates, presentations, preaching in places of worship, health information kiosk in places of worship, community radio.
- Cleaning up the environment: community mobilization for cleaning courtyards and removing larval sources (tires, puddles, coconuts, tinned food, uncovered barrels, etc.).

These organizations will be given institutional and organizational support to help them achieve the grant objectives:

- Provision of means of transport (vehicle), office equipment and consumables and support for network operation
- Provision of means of transport (motorbike, bicycle), office equipment and consumables and support for operation of NGOs, CBOs and FBOs.
- Training in LMG (leadership, management and governance) for networks
- Training in project management for NGOs, CBOs and FBOs.
- Training in management of operational risks

COLLABORATIVE FRAMEWORK FOR MANAGEMENT OF THE GLOBAL FUND GRANT

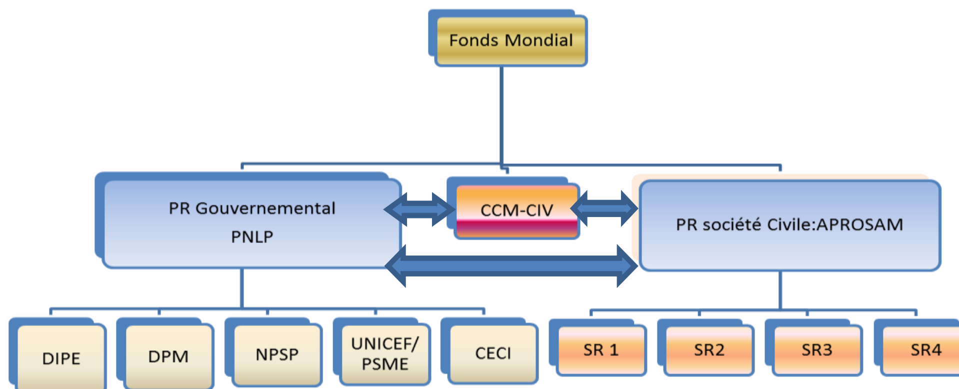


Figure 111 ORGANIZATIONAL DIAGRAM FOR GRANT IMPLEMENTATION

- The CCM will play a leading role in grant coordination and monitoring through its General Assemblies, quarterly review of the PR dashboard, supervision of PRs with a focus on shortcomings and recommendations set out in management letters, visits to sub-recipient sites and review of programmatic and financial progress report (PUDRs) with the Local Fund Agent (LFA).
- PRs will enter into formal contractual arrangements with the sub-recipients selected by the CCM. They will disburse funds to the sub-recipients for operational implementation of activities and will provide coordination and monitoring for implementation in accordance with the MoU to be produced by the PR and sub-recipients, along with organizing quarterly coordination meetings.
- The sub-recipients will be responsible for implementation and will be accountable to the PRs.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

Côte d'Ivoire has shown its commitment to controlling malaria, tuberculosis and HIV through its health programs. Since 2002, Côte d'Ivoire has secured nine Global Fund grants to control these three diseases. The country benefited under Round 2 (September 2003), Round 3 (March 2004-CARE-IC), Round 5 (May 2006 – CARE France) and Round 9 (July 2010) for HIV, Round 3 (March 2004), Round 6 (October 2007) and Round 9 (July 2010) for tuberculosis and Round 6 (October 2007) and Round 8 (October 2008) for malaria. In general terms, all these grants have helped to improve the state of health of people living with the three diseases and to strengthen the health system in Côte d'Ivoire.

Grants for malaria have made it possible to scale up malaria-control interventions in Côte d'Ivoire. As a result of these grants, Côte d'Ivoire has implemented satisfactory diagnostic methods (RDT) free of charge, provided appropriate treatment (ACT) for taking care of patients, introduced intermittent preventive treatment for pregnant women and supplied LLINs, notably the organization of the first national distribution campaign of LLINs in 2011. In addition, the grants have helped to strengthen the health system through the support they have provided to the DIPE (reprographics for all data collection tools) and the PSP (refurbishment of the warehouse used to store LLINs and of a drugs storage warehouse).

Furthermore, the NMCP has benefited from technical support from the PMI for grant management, particularly in the areas of program management and monitoring/evaluation. The international consultant recruited to provide this support took up his post in January 2014 for a two-year period. Another assistant for PSM is currently being recruited.

This funding request for malaria control is designed to take over from the current grant, which comes to an end in December 2014, and will support continued disease control efforts.

As part of its ongoing strategic monitoring of Global Fund grants, the CCM will pay particular attention to the following areas in order to avoid duplication.

- Health systems strengthening (surgical equipment, logistics, IT kit and human resources): the CCM will use the results of the situational analysis (inventory report) from the DIEM to propose a breakdown of health systems strengthening activities by program.
- Community systems strengthening (capacity-building for coordination networks, NGOs, CBOs and FBOs): the CCM will use the map (list, zones and areas of intervention and donors) for these organizations, validated by the Ministry of Health, in order to avoid duplication.
- Coordination / supervision / monitoring and evaluation: the support provided by the programs to operational structures will be incorporated into coordination, supervision and monitoring activities.

Capacity building for human resources (cross-disciplinary modules: advocacy, communications, management, monitoring and evaluation, and risk management): establishment of a list for each qualification (basic training, specialization, capacity-building and area of specialization) and job, based on databases for each program and comparison with district data

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1	**NATIONAL MALARIA CONTROL PROGRAM (NMCP)**	**Sector**	**Public**
1. **Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?**	☒**Yes** ☐**No**		
2. **Minimum Standards**	**CCM assessment**		
3. **The Principal Recipient demonstrates effective management structures and planning**	Yes, the PR selected has effective management structures and planning (Details_Critères minimaux PRs_ Annex 24)		
4. **The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)**	Yes, the NMCP has a sub-recipient for Round 8, namely UNICEF. (Details_Critères minimaux PRs_ Annex 24)		
5. **The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud**	Yes, the internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud. (Details_Critères minimaux PRs_ Annex 24)		
6. **The financial management system of the Principal Recipient is effective and accurate**	Yes, the financial management system of the Principal Recipient is effective and accurate as evidenced by the following: - Existence of a procedures manual for the Global Fund grant. - Existence of an internal auditor and management fiduciary agency - Existence of accounting software (TOMPRO) for budget monitoring; existence of an archiving mechanism for all accounting documents. - Existence of qualified personnel in the accounts department (Details_Critères minimaux PRs_ Annex 24)		
7. **Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products.**	The NPSP is responsible for storage of health products for malaria at a national level. (Details_Critères minimaux PRs_ Annex 24)		
8. **The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions.**	The distribution system and transportation arrangements implemented by the NPSP are efficient through to a district level, given that it has appropriate logistical resources and qualified personnel. However, there are difficulties in ensuring supplies to the ESPCs (Details_Critères minimaux PRs_ Annex 24).		
9. **Data-collection capacity and tools are in place to monitor program performance**	Yes, data-collection capacity and tools are in place to monitor program performance (Details_Critères minimaux PRs_ Annex 24).		
10. **A functional routine reporting system with reasonable coverage is in place to report**	Yes, a functional routine reporting system is in place (Details_Critères minimaux PRs_ Annex 24).		

program performance timely and accurately	
11. **Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain.**	Côte d'Ivoire has a national, ISO 1702-certified laboratory. This is the sole quality-control laboratory for all pharmaceutical and medical products arriving in the country. (Details_Critères minimaux PRs_ Annex 24)

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
Name of PR 2	**APROSAM**	**Sector**	**Community**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☐Yes ☑ No	
Minimum Standards		**CCM assessment**	

12. **The Principal Recipient demonstrates effective management structures and planning**	Yes, APROSAM has effective management structures and planning (Details_Critères minimaux PRs_ Annexe 24).
13. **The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)**	Yes, APROSAM has the capacity and systems for effective management and oversight of sub-recipients. APROSAM works in the areas of HIV/AIDS, reproductive health, malaria, tuberculosis, fistulas, nutrition and GBV. It uses two intervention approaches, namely: a direct approach (running activities on the ground using its own personnel) and an indirect approach (through NGOs, CBOs and FBOs). (Details_Critères minimaux PRs_ Annex 24)
14. **The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud**	Yes, APROSAM has an effective internal control system. The system uses several internal control mechanisms (Details_Critères minimaux PRs_ Annex 24).
15. **The financial management system of the Principal Recipient is effective and accurate**	Yes, APROSAM has an effective and accurate financial management system. The system uses several mechanisms (Details_Critères minimaux PRs_ Annex 24).
16. **Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products.**	Yes, APROSAM has a pharmacy at its headquarters for storing commodities and drugs (Details_Critères minimaux PRs_ Annex 24).
17. **The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions.**	Yes, the distribution systems and transportation arrangements are efficient and ensure continued and secured supply of health products (Details_Critères minimaux PRs_ Annex 24).
18. **Data-collection capacity and tools are in place to monitor program performance**	Yes, APROSAM has a monitoring and evaluation unit made up of eight (08) monitoring and evaluation officials and assistants, including one monitoring and evaluation manager. (Details_Critères minimaux PRs_ Annex 24)
19. **A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately**	Yes, a reporting system is in place, based on the national reporting system used by departmental and regional directorates for sharing activity reports

	(Details_Critères minimaux PRs_ Annex 24).
20. **Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain.**	Where quality control is necessary, APROSAM uses the RETROCI project laboratory (Details_Critères minimaux PRs_ Annex 24).

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity. Also describe past and present performance issues.

b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

a) **Major risks in the country and implementation environment, including external risks**:

Some of the risks identified are described below, however details of the risk analysis for grants carried out by the CCM with support from an independent consultant provided by the MSH LMG project are contained in the file "'Grant risk assessment_ CCM_IC'' attached to this grant request.

- **Risk of sociopolitical disturbances that could hinder or prevent normal grant implementation:** The socio-political crisis in 2010, and the current and future socio-political climate in Côte d'Ivoire need particular attention insofar as:

  - National reconciliation is not yet fully complete. Residual ethnic frustrations continue to be observed in certain locations. This justifies popular support in certain regions for boycotting the national household and population census launched by the opposition.

  - A consensus on electoral reform has not only not been achieved, but is not universally accepted. The opposition refuses to join the Independent Electoral Commission. The next presidential and parliamentary elections foreseen for the second semester of 2015 will be decisive in continuing to embed ongoing peace and social cohesion. Any political disturbance will threaten appropriate implementation of the grant, with risks for the management of goods and equipment.

  There is political will for continuing to engage in dialogue to bring all stakeholders together as part of a process of national reconciliation through the following actions:

  - Political dialogue, bringing together those in power and the opposition parties
  - The CDVR [Dialogue, Truth and Reconciliation Commission], which is continuing with identifying and listening to victims and witnesses, repairing wrongs and promoting reconciliation.
  - The national social cohesion program, led by the Ministry of Planning and Development
  - The solidarity and social cohesion watchdog, led by the Ministry of Solidarity, Women, the Family and Children.

Prior to any risk occurring, all parties receiving funds must take out comprehensive insurance for premises and equipment.

Should the risk occur, the CCM will call a halt to activities and secure the funds and equipment of the CCM, PR, SRs and SSRs by taking the following actions:

  - Freezing bank accounts
  - Drawing up financial statements for CCM, PR, SR and SSR funds
  - Providing these statements to the CCM
  - Gathering all equipment in a previously identified secure place.

- **Risk of natural disasters:** Natural disasters, such as floods, which displace people and lead to an increase in mosquito numbers and swarms, could result in a rise in malaria-related morbidity and shortages of commodities (LLINs) and drugs because of a lack of access to the districts.

  To mitigate this risk, PRs should position commodities in the regions before the rainy season

and coordinate their actions with the ORSEC emergency plan implemented by the National Civil Protection Office to ensure that commodities for malaria control are included in the plan.

- **Risk of corruption** According to Transparency International's Corruption Perceptions Index 2013, Côte d'Ivoire ranks 136th of the 177 most corrupt countries in the world.
  The low pay levels of state and sub-recipient personnel compared with the high cost of living could suggest risks of the use of forgeries, embezzlement and misappropriation of grants, particularly at an operational level.
  Côte d'Ivoire is committed to an active anti-corruption and awareness-raising policy amongst government executives and the population, through an extensive media campaign (posters and TV ads) to increase awareness of the negative effects of corruption. The government supports and monitors a "zero tolerance" approach to corruption.
  The existing control mechanism with regard to the Global Fund grant helps to mitigate a lack of transparency and poor practices in respect of grant management (corruption, misappropriation of grants, etc.).
  The presence and actions of the fiduciary agency (GFA) and the PRs' internal auditor on the one hand, and periodic reviews by the LFA and the annual external audit on the other, are both mechanisms with the capacity to mitigate these risks significantly.

- **Risk of a lack of human resources for implementing activities:** The quality of human resources in Côte d'Ivoire is not a problem. In qualitative terms, the MSLS has appropriate human resources to manage and monitor the resources allocated for implementing this grant. At an operational level, unevenness in the distribution of human resources across the country, more specifically between rural and urban environments, may limit timely implementation of certain activities that require the involvement of service providers at health centers (advanced strategy, supervision of CHWs, supervision of integrated management of malaria, pneumonia and diarrhea, etc.).
  This risk factor will be taken into account in the new reforms in the health sector, which are designed to establish a non-financial system of incentives and improvements in working conditions to ensure that qualified, specialized health care workers remain in rural environments to guarantee fair, high-quality care to the whole population. Efforts to ensure a fair distribution of Human Resources at a national level and choosing a community PR that uses CHWs could help to mitigate this risk.

- **Risk of failing to deliver expected performance or non-achievement of grant contractual objectives:** The performance or achievement of grant objectives may be threatened by: Fear of using Global Fund grants following previous repayments of poorly managed resources by certain district directors. This situation can sometimes entail a refusal to use checks issued by the NMCP for implementing certain interventions (supervision, pre-positioning of LLINs, etc.).
  The task-force meetings organized by the two PRs are opportunities for awareness-raising and support for departmental directors in managing the resources allocated to them for malaria-control activities.

- **Risk of shortages of commodities (medical products and drugs)**: Implementation of a monitoring mechanism for the supply plan, monitoring consumption data and managing stocks in peripheral centers should help anticipate or control the occurrence of this risk.

- **Risk of inappropriate use or misappropriation of equipment and materials acquired through Global Fund grants:** Physical inventories of program materials and equipment have not often been carried out because of a lack of appropriate monitoring software. The first inventory was carried out by the internal auditor in 2013. Materials acquired under funding from Round 6 are not well monitored. The biannual inventory of materials and equipment at the CCM, PRs and SRs will help to manage this risk.

- **Risk of duplication or substitution of resources and activities:** The absence of a map of financial support for each partner's sites and the non-existence of a consolidated action plan including financial support from all partners for supervision activities represent a risk of duplication of funding with partners intervening on other diseases. The absence of a database for satisfactory monitoring of trained people runs the risk of duplication of training for participants.
  The CCM will commission the production of a map of financial support from all partners working

on the three diseases and a management system for people trained and/or training received by area.

- **Risk of incomplete, untimely or unreliable data:** Formalizing and strengthening the data validation mechanism within health regions and at SRs by the PRs will help to mitigate the risk of a lack of data quality. The Rapid Data Quality Audit (RDQAs) planned under this grant will also help to mitigate this risk.

- **Risk of paralysis of activities monitoring on the ground:** The PRs' vehicle fleet is inadequate, resulting in overuse and the risk of early ageing of vehicles as a result of frequent breakdowns.
  Strengthening the CCM's and PRs' vehicle fleet and providing civil-society coordination networks with vehicles will help to manage the risk of paralysis of activities monitoring on the ground.

- **Risk of non-transparent selection of service providers for studies:** Research organizations running studies will be asked to work as a consortium or in competition with each other to avoid the risk of non-transparent selection.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

☐Table 1: Financial Gap Analysis and Counterpart Financing Table
☐Table 2: Programmatic Gap Table(s)
☐Table 3: Modular Template
☐Table 4: List of Abbreviations and Annexes
☐CCM Eligibility Requirements
☐CCM Endorsement of concept note