Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CCM COTE D'IVOIRE		
Country	Republic of Côte d'Ivoire		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	Low income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a re-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Strengthening the national response to HIV in order to scale up prevention to comprehensive care, factoring in gender and key populations at high risk of HIV infection.	Yes	No
Tuberculosis[1]	Preventing multi-resistant tuberculosis by improving comprehensive care of tuberculosis	No	Yes
Malaria	N/A	N/A	N/A

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	X Yes	☐

[1] Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

		No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	x Yes	☐ No

HIV Component: Côte d'Ivoire's proposal in its HIV component is not a new submission of Round 8. This Round 9 submission was prepared as part of a largely participatory process. It included all of the actors involved in the HIV/AID strategy. To do so, it factors in gender in its AIDS-specific measures. Its purpose is to improve available prevention services to reduce new infections in the general population, women, and key populations at high risk of HIV infection; to reduce morbidity and mortality due to AIDS by providing access to care, service quality, and the care continuum, and to strengthen leadership, coordination, and Monitoring & Evaluation of the national response. The main beneficiaries of this proposal are: the general population, women, and Key Populations at high risk of HIV infection.

Tuberculosis Component
The Round 9 tuberculosis component is a new submission of Round 8. It includes the 4 targets of Round 8. However, Targets 3 and 4 have been reworded to be consistent with the Service Delivery Areas that were developed in said targets. The change is as follows:
Old wording

1. Pursue the extension of a high-quality DOTS.
2. Control co-infections of tuberculosis-HIV, multidrug resistant tuberculosis (MDR-TB) and tackle other challenges.
3. Enlist all caregivers
4. Give the ability to act to persons diagnosed with Tuberculosis and to the community.

New wording
1. Pursue the extension of a high-quality DOTS and its upgrade
2. Control TB/HIV co-infection and multi-resistant tuberculosis.
3. Strengthen the public-private partnership
4. Strengthen communication via mass media and community involvement

Currency	☐ USD	or	☒ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: **Membership details of CCMs or Sub-CCMs**

Complete the following sections for each disease included in Round 9:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

*** Only to be included in one disease in Round 9. Refer to the Round 9 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the Round 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available Here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Clarified Section

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	22,498,959	23,567,343	24,430,387	26,965,227	28,491,406	125,953,322
Tuberculosis	6 479 813. 02	3 192 443. 01	7 738 171. 39	7,672,040 .89	8,894,862. .67	33 977 331
Malaria	-	-	-	-	-	-
HSS cross-cutting interventions section 4B and 5B within *[HIV/AIDS]*	22,524,400	21,286,325	19,540,959	18,627,755	15,610,859	97,590,298
					Total Round 9 Funding Request ➔:	257,520,951

1.2. Contact details

	Primary contact	Secondary contact
Name	Prof. Auguste KADIO Dieudonné	Dr Irma AHOBA
Title	Chairperson of the CCM	Chairman of the Drafting Committee for the HIV Component
Organization	CCM COTE D'IVOIRE	Ministry of Health and Public Hygiene
Mailing address	BP V 04 Abidjan	01 BP 5420 Abidjan 01
Telephone	(+225) 20-22-17-43 / 20-22-17-44	(+225) 20 32 28 69
Fax	(+225) 20-22-17-45	(+225) 20 32 29 83
E-mail address	augustekadio@yahoo.com	irmahoba@yahoo.fr
Alternate e-mail address	ccmcotedivoire@yahoo.fr	pnpecinfo@yahoo.fr

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
3TC	Lamivudine
ABC	Abacavir
AES	Blood Exposure Incident
AGR	Revenue Generating Activities
AIBEF	Ivorian Association for Family Well-Being
AIDS	Acquired Immune Deficiency Syndrome
AIDS Ministry-MLS	AIDS Ministry
AIMAS	Ivorian Social Marketing Agency
AMD	District Maintenance Workshop
ANADER	Agence Nationale pour le Développement Rural (National Agency for Rural Development
ANRP	National Drug Regulatory Authority
ARF	Acute Respiratory Failure
ARSIP	Interfaith Alliance for AIDS and other Pandemics
ARVs	Antiretrovirals
ASAPSU	Association for Self-Promotion of Urban Health
ATG	Technical and Management Assistance
ATI	International Technical Assistance
AZT	Zidovudine
BAD	Banque Africaine de Développement (African Development Bank)
BCC	Behavior-Change Communication
BTS	Higher Technician's License
CAT	Anti-Tuberculosis Center
CBO	Community-based organization
CBO	Community-based organization
CC	Community Counselor
CCI-CI	Chamber of Commerce and Industry of Côte d'Ivoire
CCLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Services Committee)
CCM	Country Coordinating Mechanism
CD	Counseling and Testing
CD4	CD4 Lymphocytes
CDIP	Service Provider-Initiated Counseling and Testing
CDLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Committee)
CDT	Centre de Diagnostic et de Traitement (Diagnostic and Treatment Center)
CDV	Counseling and voluntary screening
CECI	Coalition of Côte d'Ivoire Businesses for HIV/AIDS Control
CeDReS	Center for AIDS Diagnostics and Research
CEROS	Think Tank on AIDS Orphans
CESAG	African Center for Advanced Management Studies

CGECI	General Federation of Côte d'Ivoire Business
CHO	Community Health Office
CHS	Specialized Hospital Center
CHS	Specialized Hospital Center
CHU	University hospital center
CHU	Urban Health Center
CHW	Community Health Worker
CIE	Ivorian Electric Company
CIMLS	Comité Interministériel de Lutte contre le SIDA (Interministerial AIDS Committee)
CIRBA	Abidjan Integrated Bioclinical Research Center
CI-TELCOM	Côte d'Ivoire Telecommunications
CM	Prise en charge (Treatment)
CMP	All-Party and Partnership Committee
CNACI	National Antituberculosis Committee of Côte d'Ivoire
CNCA	National Audiovisual Communications Council
CNLS	National AIDS Council
CNM-CI	National Trade Council of Côte d'Ivoire
CNO	Northwest Center
CNPS	Caisse Nationale de Prévoyance Sociale (National Fund for Social Welfare)
CNTS	Centre National de Transfusion Sanguine (National Centre for Blood Transfusions)
COGES	Comité de Gestion (management committee)
COLTMR	Tuberculosis and Respiratory Illness Organizational Collective
COP	Country Operational Plan
COSCI	Council of AIDS Organizations in Côte d'Ivoire
CRIEM	Regional Infrastructure, Equipment and Maintenance Center
CRLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Committee)
CSE	Centre de Surveillance Epidémiologique (Epidemiological Monitoring Centre)
CSHC	City & School Health Center
CSLS	Sectorial AIDS Committee
CTAIL	Technical Support Unit for Local Initiatives
CTX	Co-trimoxazole
CVLS	Village AIDS Committee
DAF-santé	Financial Affairs Division
DBS	Dried Blood Spot
DD	Departmental Director
DDI	Didanosine
DFR	MSHP Training & Research Division
DFR	Training & Research Division
DGS	Directorate-General for Health
DHR	Human Resources Department
DIEM	Infrastructures and Medical Equipment Division

DIPE	Direction de l'Information, de la Planification et de l'Evaluation (Planning Information and Evaluation Department)
DMOSS	Mutuality and Social Agencies in the School Environment Division
DMS	Social Mobilization of MLS Division
DNT	National Treatment Guidelines
DOTS	Direct Observed Therapy strategy
DPM	Pharmacy and Drug Division
DPSE	Planning and M&E Division
DQA	Data Quality Assessment
DR	Direction Régionale (Regional Department)
DREN	National Education – Regional Division
DSRP	Poverty Reduction Strategy Document
DSRP	Poverty Reduction Strategic Document
DST	Drug Susceptibility Testing
ECD	District Management Team
EDS	Demographic Health Survey
EEQ	External Quality Evaluation
EFV	Efavirenz
EIS-CI	Survey on AIDS Indicators in Côte d'Ivoire
ESPC	Intake Health Care Facility
EST	Establishment
ESTHER	Group for In-Network Hospital Treatment Solidarity
EU	European Union
FAD	Development Aid Fund
FGM	Female Genital Mutilation
FHI	Family Health International
FILTISAC	Spinning and Weaving of Bags
FIPME	Ivorian Small and Mid-Sized Business Federation
FNLS	National AIDS Fund
FSU COM	Community-Based City Health Training
FTC	Emtricitabine
FUS	City Health Training
GAVI	Global Alliance for Vaccine Immunization
GBV	Gender-Based Violence
GDF	Global Drug Facility
GDP	Gross domestic product
GF	Global Fund to control AIDS, Tuberculosis and Malaria
GFMU	Global Fund Management Unit
GH	General Hospital
GIP	Public Interest Group
GLC	Green Light Committee
GRSE	Monitoring & Evaluation Reference Group
GSA	Scientific Support Group
GTT	Technical Working Group

GTZ	German Technical Cooperation
HD	Health district
HH	Health Center
HIPC	Highly-Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSS	Health system strengthening
ICAP	International Center for AIDS Care and Treatment Programs
ICCB	International Catholic Child Bureau
ICRC	International Committee of the Red Cross
IDE	State graduate nurses
IEC	Information-Education-Communication
IFRC	International Federation of the Red Cross
IHAA	International HIV/AIDS Alliance
INFAS	National training institute for health representatives
INS	Institut National de la Statistique (National Statistics Institute)
IO	Opportunistic Infection
IOM	International Office of Migration
IPCI	Institut Pasteur de Côte d'Ivoire (Côte d'Ivoire Pasteur Institute)
IUATLD	International Union Against Tuberculosis and Lung Disease
JHU-CCP	Johns Hopkins University- Center for Communication Programs
KAP	Knowledge, Attitudes and Practices
KFW	Kreditanstalt Fur Wiederaufbau (German Development Bank)
LFA	Local Fund Agent
LIPA	Line Probe Assay
LNME	National List of Essential Drugs
LNSP	National public health laboratory
LPV	Lopinavir
M&E	Monitoring and Evaluation
MD	Ministère de la Défense
MDG	Millennium Development Goals
MDS	Mutuelles de Santé
MEF	Ministry of Economy and Finance
MEMSP (Ministry of Health & Population)	Government Ministry: Ministry of Health and Population
MEN	Ministry of national education
MFFAS	Ministry of Women, Family, and Social Affairs
MJDH	Ministry of Justice and Human Rights
MPA	Minimum Packet of Activities
MPD	Ministry of Planning & Development
MRU	Mano River Union
MSHP	Ministry of Health and Public Hygiene
MSM	Men who have Sex with Men

National Nutrition Program (NNP)	National Nutrition Program
NGO	Non-governmental organization
NHIS	National Health Information System
NRC	National Reference Center
NSP	National Strategic Plan
NTCP	National Tuberculosis Control Program
NVP	Nevirapine
OCAL	Organisation du Corridor Abidjan – Lagos
OCHA	Office for the Coordination of Humanitarian Affairs
OHADA	Organization for Harmonization of Business Law in Africa
ONUCI	United Nations Operation in Côte d'Ivoire
OVC	Orphelins et Enfants Vulnérables (Orphans and Vulnerable Children - OVC)
PAA	Priority Action Area
PAPO	Highly Vulnerable Populations Aid Project
PDSSI	Integrated Health Services Development Project
PE	Peer Educators
PECP	Pediatric Treatment
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PF	Family Planning
PHE	Public Health Evaluation
PIAHIV	Persons Infected with/ Affected by HIV
PLWHAs	Persons Living with HIV
PMI	Protection of Mothers and Infants
PMLS	Multi-Sector AIDS Program
PMTCT	Prevention of Mother-to-Child Transmission (of AIDS)
PNC	Pre-natal consultation
PNDS	National Health Development Plan
PNLP	National Malaria Program
PN-OEV	National Treatment Program for Orphans and Children Made Vulnerable by HIV/AIDS
PNPEC	Programme national de prise en charge médicale des PVVIH (National Medical Care Program for PLWHA)
PNSR/PF	National Program for Reproductive Health and Family Planning
PPH	Pulmonary Tuberculosis
PR	Principal Recipient
PS	Sex worker
PSC	Prospective & Strategy Unit
PSI	Population Services International
PSP CI	Public Health Pharmacy of Côte d'Ivoire
PTB-	Microscopy-negative Pulmonary TB
PTB+	Microscopy-positive Pulmonary TB
PUR	Emergency/Rehabilitation Program
PVD	Lost to Follow-Up
PWC	Price Waterhouse Cooper

RAI	Annual Risk of Infection
RASS	Annual Report on Health Situation
RCI	Republic of Côte d'Ivoire
REPMASCI	Network of Media Professionals in the Arts Against AIDS and Other Pandemics in Côte d'Ivoire
RETRO-CI	Retrovirus Côte d'Ivoire
RGPH (General Census of Population & Housing)	General Census of Population and Housing
RHC	Regional Hospital Center
RHC	Rural Health Center
RHS	Human Resources – Health Care
RIP+	Ivorian PLWHA
RTV	Ritonavir
S&E	Monitoring and Evaluation
SASDE	Accelerated Strategy for the Survival and Development of Children
SCB	Banana Culture Society
SCMS	Supply Chain Management System
SDA	Service Delivery Area
SIG	Information and Management System
SIH	Hospital Information Subsystem
SISR	Routine Health Information System
SOTRA	Société de Transport Abidjanais (Abidjan Transport Company)
SR	Sub-recipient
STCO	Technical Secretariat for Operational Coordination
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB-MR	Multi-resistant Tuberculosis
TDF	Tenofovir
TMVA	Average Annual Variation Rate
TRP	Technical Review Panel
TRU	Training and Research Unit – Medical Science
UN	United Nations
UN System	United Nations System
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchasing Facility
UNODC	United Nations Office on Drugs and Crime
VAD	Home-based care
VSAT	Satellite Communications Network
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1. Members and operations

2.1.1. Membership summary

Sector Representation	Number of members
☑ Academic/educational sector	2
☑ Government	6
☑ Non-government organizations (NGOs)/community-based organizations	3
☑ People living with the diseases	1
☑ People representing key affected populations[2]	1
☑ Private sector	3
☑ Faith-based organizations	2
☑ Multilateral and bilateral development partners in country	5
☑ Other *(please specify): syndicates*	2
Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	25

[2] Please use the Round 9 Guidelines definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_AttachmentC_en.xls

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):		
(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

CCM Côte d'Ivoire is made up of members representing the Public and Private Sectors and Civil Society; associations of persons living with and/or affected by HIV/AIDS, tuberculosis, and/or malaria (APASTP) and development partners. CCM, to accomplish its mission appropriately, has established 4 commissions within itself: The proposal drafting commission, the monitoring & evaluation commission, the communications & resource mobilization commission, and the resource harmonization commission (Annex n° 1).

The Proposal Drafting and Monitoring & Evaluation Commissions are made up of people who are able to evaluate the impact of health system problems on projects and programs and their results for the three diseases (HIV/AIDS, Tuberculosis, and Malaria). In line with the By-laws, committees may use Technical Experts having the required capacities and experience.

For example, we can quote the Chairman of the CCM, who is an infectious disease specialist and former head of the infectious disease center at the Treichville University Hospital Center in Abidjan and former dean of the Abidjan School of Medicine). The Permanent Secretary, who is a Public Health Physician, was Director of the National Malaria Program for 13 years and a Community Health Officer, coordinating all 21 of the Ministry of Health and Public Hygiene's programs, and a representative of civil society who is an expert in comprehensive treatment and positive prevention of HIV.

The CCM includes a proposal drafting committee tasked with: (i) coordinating the consensus-building in the sectors involved in controlling the three diseases in order to develop a proposal, (ii) presenting the General Assembly, in cooperation with the harmonization and needs analysis committee, with a summary of strategic and programmatic recommendations issued by the sectors ; confronting it with identified needs and gaps to feed the debate and decision-making in regard to the priority topic(s) for the next proposal, (iii) mobilizing consultants and other technical supports necessary for developing the proposal, (iv) supervising the technical team tasked with participatory development of the proposal. This commission is made up of nine people, taken from all of the sectors. The various members are experts in cross-analysis of system-wide needs and health and planning programs. In their roles, some of the members have already participated in planning and implementing projects in health care. As such, the Permanent Secretary of the CCM and the Chairman of the Council for International AIDS Organizations have taken part in preparing the National Health Development Plan (PNDS 2009-2013) (Annex 22) and the strategy document on poverty reduction (DSRP 2009-2015) (Annex 50). This expertise of CCM members is strengthened by the support of Development Partners (WHO, UNAIDS, UNFPA, European Union, American Cooperation, World Bank, French Cooperation, and UNICEF).

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

Within the CCM are a Representative from the Ministry of Women, Family, and Social Affairs, in charge of "Gender" issues at the national level, and a representative of UNFPA who currently chairs the Gender Theme Group. Representatives of the Strategic Ministries, such as Health, AIDS, and Youth, within CCM are also members of the gender theme group. In terms of representation, civil society, infected and affected persons, and the private sector are represented by 14 members within CCM, and those members also help to factor in the gender approach. In addition, in terms of parity within the CCM, eight of the 25 members are women. They are present both within the office and at the general assembly, and are active participants in decision-making regarding gender equality.

Furthermore, CCM members are stakeholders in the process of preparing the application. Some members, such as the UNFPA and MFFAS representatives, are directing programs on gender advancement on a daily basis, and, as such, have helped complete two studies on gender and three training sessions on gender mainstreaming in development programs.

As this proposal was being developed, a Consultant from the World Bank specialized in gender held several working sessions, including one training session on gender and integrating gender into the development of the Round 9 proposal, with the members of the CCM and the technical development group for this proposal (Annex 3). A National Consultant specialized in gender also participated in the Proposal Drafting Group. CCM members versed in gender issues helped incorporate those issues into the proposal.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.

Within the CCM is, statutorily, a Proposal Development Committee, with planning and development skills for projects covering several sectors, especially health, including tuberculosis and HIV. This committee is composed of at least five (5) members of the Côte d'Ivoire CCM (in addition to the Chairman). Every sector is represented. These members include one representative from the government, two from civil society, and one from the development partners. In addition, the CCM's bylaws allow co-opting by the committee of technical experts endowed with the required capacities and experience.

Note also that, in the quest to intensify the national response to the HIV epidemic, the Ivorian government has been opting for a multi-sector, decentralized approach for several years. That is why the CNLS (National AIDS Council) was created on January 7, 2004. This Council includes members from all development sectors (health, education, hydraulics, agriculture, defense, energy, finance, etc.). Several CNLS members who have actively participated in developing the various multi-sector AIDS plans, specifically the National Strategic Plans and the Operating Plans, sit on the CCM.

Within the CCM, there are project planning and development skills covering several areas, coming from all development sectors (public, private, and civil society). For instance, from the government sector, the representative of the Ministry on AIDS, Director of the STCO of that Ministry, the representative of the WHO for bilateral and multilateral development partners; for civil society and the representatives of

persons living with or affected by HIV/AIDS, the former Executive Director of the Ivorian network of AIDS Services organizations. For the private sector, the Coordinator of the Federation of businesses against AIDS.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☉ Applied for funding in Round 7 and/or Round 8 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

2.2.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*

A wide range of actors, from Civil Society as well as the private sector, at the national, regional, and community level participated in developing the proposal. Indeed, once the call for proposals was made by the Global Fund, the CCM met to decide on the Côte d'Ivoire's candidacy and provide guidelines to guarantee the proposal's success (Annex 2). Technical management for preparing the proposal by component was entrusted to the Coordination Office of the PNPEC (National Service Program for People Living With HIV) for the HIV/AIDS component, and the Coordination Office of the National Program against Tuberculosis for the Tuberculosis component. The proposal for the HSS is being steered by the Office of Information, Planning & Evaluation.

The Joint United Nations Team on HIV provided technical and financial support to development of the application for Global Fund Round 9. This technical support was provided for the recruitment and provision of a general practitioner/consultant who coached and guided the preparation of the HIV and HSS components. Four national and three international consultant were also made use of to support the aspects of generality, gender, and budget by the World Bank, UNFPA, UNAIDS, and MSH. Technical contributions, via the personal participation of Joint Team members, specifically UNAIDS, UNICEF, UNFPA, UNDP, WFP, and the WHO have been made as needed in the different steps of the process. Joint financial support has been provided by UNAIDS, UNICEF, UNDP, and the MSH to the national development workshop and harmonization workshop, which included all stakeholders in an inclusive and highly participatory way.

To gain the involvement of all sectors, as of the beginning of the proposal development process, representatives from the different sectors were included in the groups created. With the various actors in the public (health and non-health), community, confessional, and private sectors, a workshop to finalize analysis of the situation and its gaps was organized at the WHO (enriched by the contribution of the analysis of community gaps by a national consultant at the community level, validated by three meetings). There was also participation of the partners against AIDS (Annex 8). The workshop was an opportunity to identify intervention themes and service delivery areas, and to amend the first draft of Annex A of the proposal's HIV component.

The participants' contribution during that workshop, their representation of the different sectors involved, and their areas of expertise made it possible to finalize the list of participants in the proposal drafting workshop. It lasted 12 days as a closed retreat in Bassam (Annex 8). The contribution of the financial partners, implementation partners, field actors, and recipients made it possible to draft a proposal that factored in the realities in the field and the specific needs of target populations. Both workshops were financed by the joint team of the United Nations system.

The Secretariat of the CCM launched the call for the submission of mini-proposals on the national level for the HIV and Tuberculosis components, as well as the HSS published in the national daily "Fraternité Matin" #13 300 of Thursday, 12 March 2009 (Annex 4). To receive the harmonized mini-proposals, a template was provided to the bidders (Annex 5).

After the submission deadline, the 20 mini-proposals accepted for Round 9 by the Secretariat of the CCM were summarized (Annex 6), then sent to the proposal development commissions with the summaries of the 19 mini-proposals submitted in Round 8. Note that further to the call for proposals by the Global Fund, the CCM met with the proposal drafting teams on several occasions to validate the various steps in the process and bring them up to date. Each of the meetings was an opportunity to better factor in the aspirations of all actors, in the public sector, the private sector, and Civil Society. (Annex 8).

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*

In response to the call for mini-proposals (Annex 4) on HIV, tuberculosis and HSS, the CCM received 20 mini-proposals, i.e.:

- one mini-proposal from GIP ESTHER (French bilateral cooperation initiative, PIG (Public Interest Group) type;
- 15 mini proposals from 15 NGOs;
- 1 mini proposal from the Private Sector;
- 1 mini proposal from an NGO-Foundation;
- 1 mini proposal from a Foundation;
- 1 mini proposal from a United Nations System Agency.

In all, we have received 20 Mini Proposals (Annex 6). Of these, 17 were on the HIV/AIDS component, one on the Tuberculosis component, one for AIDS and HIV/TB Co-Infection, and one was on both AIDS and Tuberculosis. These mini-proposals used the following process for their potential consideration:

1. Presentation of mini-proposals by promoters before the working group created by the CCM.
2. Review of mini-proposals by the proposal development commission; the points reviewed were (i) geographic coverage (ii) the goal, targets, activities, and targets. Criteria for inclusion in the Round 9 national proposal dealt mainly with the relevance of the mini-proposal, concordance of targets with those of the national strategic plan and those resulting from the analysis of financial and program shortages.
3. Transmission of mini-proposals and comments by the CCM's proposal development commission to the working groups created for the formulation of the various national proposals.

It should be noted that the 19 mini-proposals of Round 8 supplemented the proposal.

Moreover, the actors from Civil Society and the private sector were invited to participate in the various working groups tasked with developing the national proposal (Annex 7).

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

The process used to get people other than those from CCM involved was conducted as follows:

- Identifying skills for all selected focus areas: It was conducted by the members of the proposal

development commission. Along with the definition of needs for technical support (national resource persons, national consultants, and international consultants). Then followed the development of reference terms for the formulation of the request for each component;

- An invitation was sent by the chairperson of the CCM to the national bodies (Ministries, private sector, civil society) where the resource persons matching the required profiles were identified for their availability to the national proposal development commission (Annex 7) ;
- A request was sent by the chairperson of the CCM to the development partners seeking the support of resource persons from their United Nations System institutions System des Nations Unites (UNICEF, UNHCR, WHO, WFP, UNAIDS, UNFPA), and from civil society, Rip+. Elsewhere, the proposal development committee received technical support from international and national consultants made available for the HIV component and the HSS by the United Nations System (UNAIDS, WFP, WHO) and bilateral cooperation (PEPFAR/MSH).

The mobilized resource persons and national and international consultants integrated the different working groups, in which they regularly participated in meetings and workshops held as part of the development of the national proposal.

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***Annex 8***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.

The CCM contains a commission for the monitoring & evaluation of subsidies and Principal Recipients, whose responsibility it is to supervise the program's implementation. (Annex n° 1). This committee can call on other skills inside or outside the CCM, depending on the focus and areas of supervision.

From the first proposals accepted by the Global Fund for Côte d'Ivoire, the CCM has regularly monitored the progress and quality of the programs via half-yearly reviews. Since Round 2, the first accepted HIV/AIDS proposal, of which the Principal Recipients were the UNDP for Phase I, then the NGO CARE for Phase II, the CCM has carried out its first supervision missions. These supervisions have involved the NGO CARE for Rounds 2, 3, and 5 for HIV/AIDS, and Rounds 6 and 8 for the community portion of the Malaria Services Program. Likewise, it coached the National Tuberculosis Services Program for Rounds 3 and 6, and the National Malaria Services Program for Rounds 6 and 8.

To supervise implementation of the Round 9 programs, the CCM will organize quarterly supervision missions, to be performed on the basis of terms of reference with a supervision grid prepared for Principal Recipients and Sub-Recipients, in order to improve efficacy and efficiency in implementing the proposals. This data-collection tool will be provided to the actors to be supervised and periodically revised in cooperation with them. Each supervision mission will be followed by the preparation of a supervision report, which will specify, among other things, the progress of program implementation. The supervision report will be presented to all CCM members at a plenary session, and corrective measures will be proposed with feedback to the bodies concerned for consideration of the mission's recommendations.

During these supervision missions, the CCM will review the various areas related to the working plan of the Principal Recipients and Sub-Recipients. They will also cover compliance with scheduling of approved activities in the working plan, the use of procedure manuals, the degree of completion of indicators and technical reports, disbursement procedures and financial report quality, contract awards, supply chain management, management of the partnership with the Sub-Recipients, the Sub-Sub-Recipients, and consideration of the recommendations of the CCM and the Global Fund.

Let us be clear that in 2008, the CCM held 11 general Assemblies (AG) and, as of now, 5 GM in 2009. During some of these meetings, there was a progress report on the implementation of subsidies, and solutions for improvement were adopted.

In 2008, at two workshops organized by the CCM with the support of MSH for improving its members' abilities, the CCM with all its components made two field visits in five different districts: Bonoua, Aboisso, Toumodi, Djekanou, and Yamoussoukro. Tangentially to these workshops, the CCM went on site visits

and toured community-based organizations. During these visits, CCM members and field actors discussed ways to improve methods and strategies of implementing their activities.

In these districts, the emphasis was on HIV/AIDS on a health level and on a community level, and also on malaria on the community level. In the first half of 2009, the CCM's monitoring & evaluation commission visited the Principal Recipients CARE International; Tuberculosis Program; and a Sub-Recipient of Round 6 – the Malaria Program. During the contact meetings of this CCM commission, documents such as the monitoring & evaluation plans of NTCP and CARE (Malaria and AIDS) were made use of. This commission has its 2009 action plan budgeted and currently implemented (Annex n° 12).

(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

As the CCM had learned from the difficulties encountered in supervision of the activities, recipient and sub-recipients at the implementation of the previous Rounds, it did a profound restructuring, specifically by creating an M&E commission (Annex n°1). This commission is supported by the Permanent Secretariat. The current process of supervising the implementation of programs involves other actors who are not CCM members but who have proven expertise (M&E personnel from the Ministry of Health, AIDS Services, and partners).

To this end, the M&E committee analyzes the various supervision areas and identifies the areas in which outside skills are necessary to formulate terms of reference for mobilizing national resource persons and national and international consultants.

An invitation is sent by the CCM Chairperson to the national structures (Ministries, private sector, civil society) where resource persons matching the required profiles have been identified for their availability to the CCM. A request is sent by the CCM Chairman to the development partners for the provision of resource persons or identified national/international consultants. These outside actors come into the CCM team to carry out the supervision mission. A mission report is then submitted for approval to the CCM meeting and feedback is given to the supervised bodies so that the necessary corrective measures may be taken.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*

In its restructuring begun in 2007, the CCM has clarified roles and reviewed the process of designating Principal Recipients(Annex n° 1). The CCM's structure was renewed in February 2008, in keeping with Global Fund directives. The process used to select each Principal Recipient in this proposal, in a transparent and documented manner, was as follows:

- **Stage 1**: Further to its decision to develop a national proposal as part of the submission to the Global Fund's Round 9 for the HIV/AIDS and Tuberculosis components, the Côte d'Ivoire CCM published a call for bidders for the charge of principal recipient of the Fund's grant, in the journal Fraternité Matin #13.300, 12 March 2009 (Annex n° 13).
- **Stage 2**: At its 23 March 2009 meeting, the CCM, in keeping with its bylaws, established a commission for designating the principal recipients of Round 9 (including members of the project development commission, chairpersons of the CCM's various commissions, partners in development, and resource persons) to conduct the process of designating Principal Recipients under the CCM's supervision. This evaluation commission, chaired by its second Vice President , was composed of: 1 WHO representative; 1 UNICEF representative; 1 UNAIDS representative; 1

PEPFAR representative; 2 representatives from the public sector, 2 representatives from the private sector, and 2 representatives from civil society; 1 representative from the MSH office, an office that supports CCM in its reforms and in improving members' skills. The CCM secretariat received 17 applications in response to the call for bidders, and sent them to the Recipient selection committee. (Annex° 18).

- **Stage 3**: On March 27, 2009, the evaluation questionnaire prepared on the basis of the Global Fund's evaluation criteria was sent to all 17 candidates for self-evaluation (Annex n°16). Candidates had until 1 pm on 2 April 2009 to fill out and file the self-evaluation form with the CCM secretariat.
- **Stage 4**: On Thursday, April 2, 2009, the commission, based on the evaluation questionnaire, prepared a rating grid for the self-evaluation forms. Thirteen of the 17 candidates who submitted filed their self-evaluation sheet. The commission set the date for reviewing the self-evaluation forms for Wednesday, April 8, 2009.
- **Stage 5**: On Wednesday, April 8, 2009, from 10 am to 6:30 pm, the commission reviewed the submissions and rated the candidates. This individual rating of candidates made it possible for the commission to eliminate 3 of them and preselect only 10 for an evaluation visit to their main offices. The purpose of the evaluation visit at the main offices of the 10 preselected candidates was to verify the existence of physical proof of a certain number of documents - financial, institutional, programming, monitoring & evaluation, and purchasing & inventory management (GAS), as listed on the self-evaluation form. To this end, a letter including the list of documents to be verified, as well as the date and time of the CCM evaluation team's visit was sent to the 10 preselected candidates. (Annex° 18).
- **Stage 6**: On April 14, 2009 (from 8:30 am to 6 pm) and on April 15, 2009 (from 8:30 am to 1:30 pm), the commission visited and evaluated all 10 candidates. Further to the results obtained in the field, the evaluation team completed a second rating of the candidates. The average of the two scores obtained by each of the candidates (self-evaluation score + post-visit score divided by 2) gave the final classification. (Annex° 18).

Evaluation of the principal recipient candidates was covered in a report presented to CCM at its GM of May 14, 2009 (Annex n° 19). After discussion with the commission, the General Assembly confirmed the evaluation report of said commission and remitted the list of preselected principal recipients to the harmonization workshop of the Ivorian proposal on May 18, 2009 for insertion by the various Côte d'Ivoire proposal finalization groups (Annex n° 21). The principal recipients were invited to fill out the portion of the form about themselves.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	(Annex n° 19)

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
PNPEC/MSHP	HIV	Government
CNPS	HIV	Private sector and Civil Society
NTCP	TB	Government
CARITAS	TB	Private sector and Civil Society
DIPE/MSHP	HSS	Government

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1. of Round 9 Guidelines*

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
N/A

2.2.7. Managing conflicts of interest

(a)	Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	☐ Yes ***provide details below***
		☉ No ➔*go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☐ **Yes** ***[Insert Annex Number]***

2.2.8. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	☑ Yes

2.3. Sub-CCM details

2.3.1. Status of Sub-CCM	
Identify if the sub-national coordinating mechanism:	
(a) Operates under the authority of the CCM and focuses on a particular region or issue.	☐ *Answer s.2.3.2. and s.2.3.3.*
(b) Claims an independent basis to operate without oversight of the CCM	☐ *Answer s.2.3.2. and s.2.3.4.*

2.3.2. Rationale
Why does a Sub-CCM approach represent an effective approach in the circumstances of your country?
ONE PAGE MAXIMUM

2.3.3. CCM Endorsement	
(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal.	***[Insert Annex Number]***
(b) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	***[Insert Annex Number]***

2.3.4. Justification of independence of Sub-CCM
Explain how the Sub-CCM has a right to operate without guidance from the CCM.
ONE PAGE MAXIMUM

2.4. Non-CCM Applicants [delete sections 2.1. to 2.3. and only complete s.2.4 below]

2.4.1. Sector of work

(check one box only):
☐ Academic/educational sector
☐ Government
☐ Non-government organization (NGO)/community-based organizations
☐ People living with the diseases
☐ People representing key affected populations
☐ Private sector
☐ Faith-based organizations
☐ Other: *please specify:*

2.4.2. Status of Non-CCM applicant

(a)	Identify the main justification for submitting a non-CCM proposal *(check one box only)*:	
	(i) Country in conflict, facing a national disaster or in a complex emergency situation	☐ *Go to s.2.4.3.*
	(ii) Country that suppresses, or has not established partnerships, with civil society and non-governmental organizations	☐ *Complete (b) below, and then s.2.4.3.*
	(iii) State without a national government, and not being administered by a recognized interim administration	☐ *Go to s.2.4.3.*

(b) If (ii) applies:

- describe, in date order, all attempts to have activities from the non-CCM proposal included in the CCM's proposal, and the CCM's response; and
- briefly explain why you will be able to do the work and achieve the outputs/outcomes when the CCM has not supported the proposal.

TWO PAGE MAXIMUM

2.4.3. Expected benefit of proposal

Briefly explain how the work included in this proposal (HIV, tuberculosis and/or malaria as relevant) addresses gaps in the existing country efforts.
ONE PAGE MAXIMUM

2.4.4. Non-CCM knowledge and experience in cross-cutting issues

Health Systems Strengthening The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the applicant.
(a) Describe the capacity and experience of the applicant to consider how health system issues impact programs and outcomes for the three diseases.

Gender awareness The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in: • methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and • the factors that make women and girls and sexual minorities vulnerable.
(b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Multi-sectoral planning The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the applicant in multi-sectoral program design.

2.4.5. Principal Recipient(s)

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.*

Name	Disease	Sector**

[use "Tab" key to add extra rows if needed]		

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

2.4.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
ONE PAGE MAXIMUM

2.4.7. Endorsement by Non-CCM Applicant

Position	Printed Full Name	Signature

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	▪ Texts and procedures of the Côte d'Ivoire CCM (Governance Manual, Bylaws)	(Annex° 1)
	▪ Report - determination and adoption of Round 9 development process	(Annex° 2)
	▪ Report - working/training session with Gender Consultant from the World Bank	(Annex° 3)
	▪ Call for mini-proposals for development of Round 9 national proposal	(Annex° 4)
	▪ Template for call for mini-proposals	(Annex° 5)
	▪ Texts and procedures of the Côte d'Ivoire CCM (Governance Manual, Bylaws)	(Annex° 1)
2.2.2(b)	▪ Summary of mini-proposals, then transmission of mini-proposals to development teams	(Annex° 6)
2.2.2(c)	▪ Invitation letter	(Annex° 7)
	▪ PV from development meetings (monitoring workshops and meetings by the CCM) for Round 9 (attendance lists).	(Annex° 8)
2.2.3(a)	▪ Reports from Grd Bassam and Yamoussokro	(Annex° 9)
	▪ Monitoring & Evaluation Commission Report	(Annex° 10)
2.2.3(b)	▪ Grd Bassam and Yamoussokro Report	(Annex° 11)
	▪ CCM Monitoring & Evaluation Commission budgeted action plan	(Annex° 12)
2.2.4(a)	▪ Call for bids for the selection of Principal Beneficiary(ies) (for) Round 9	(Annex° 13)
	▪ Establishment of a PR evaluation committee: PV AG CCM	(Annex° 14)
	▪ Briefing of commission members on evaluation methodology criteria: Report	(Annex° 15)
	▪ Letter to PR candidates + Self-Evaluation File	(Annex° 16)
	▪ Operational meeting on self-evaluation forms: Report	(Annex° 17)
	▪ Evaluation of the capacities of organizations preselected for the position of principal recipients	(Annex° 18)

Proposal checklist - Section 1 and 2

	at the 9th Round of the Global Fund: Mission report	
	▪ Report from the GA of the CCM for the designation of the Principal Beneficiary(ies)	(Annex° 19)
2.2.7	No conflict of interest between the PR, Chairperson, and Vice-Chairpersons	(Annex° 20)
2.2.8	Minutes of the proposal consolidation workshop	(Annex° 21)
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members).	**Attachment C to the Proposal Form**
Sub-CCM applicants only		
2.3.3 (***CCM Endorsement***)	Documented evidence (including minutes of the CCM meetings) that the CCM in the country reviewed and endorsed the proposal (as relevant).	
2.3.4	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM.	
Non-CCM applicants only		
2.4.1	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
2.4.2(a)	Documentary evidence justifying the one of the three exceptional circumstances for submitting a non-CCM proposal	
2.4.2(b)	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM – ROUND 9

Sections 3-4-5-HIV

Strengthening of the national response to HIV to scale up prevention and general care taking into account gender and key populations at high risk of HIV infection

Country Coordinating Mechanism (CCM) COTE D'IVOIRE

June 2009

SÉRIE 9 - VIH

Figure n° 1: ADMINISTRATIVE MAP OF COTE D'IVOIRE

LIST OF ABBREVIATIONS

Acronym/Abbreviation	Definition
3TC	Lamivudine
AAVR	Average Annual Variation Rate
ABC	Abacavir
ADB	African Development Bank
AHR	Annual Health Report
AIBEF	Ivorian Association for Family Well-Being
AIDS	Acquired Immune Deficiency Syndrome
AIMAS	Ivorian Social Marketing Agency
AIS-CI	AIDS Indicator Survey in Côte d'Ivoire
ALCO	Abidjan-Lagos Corridor Organization
ANADER	National Agency for Rural Development
ANRP	National Pharmaceutical Regulatory Authority
ARD	Acute Respiratory Distress
ARI	Annual Risk of Infection
ARSIP	Alliance of religious leaders engaged in the fight against AIDS and other pandemics
ARV	Antiretroviral
ASAPSU	Urban Health Self-Help Support Association
AZT	Zidovudine
BCC	Behavior Change Communication
BEA	Blood Exposure Accident
BTS	Advanced Technician's Certificate
CA	Community Advisor
CAT	Tuberculosis Center
CBO	Community Based Organization
CBO	Community Based Organization
CCI-CI	Côte d'Ivoire Chamber of Commerce and Industry
CCLS	Municipal Committee on AIDS
CCM	Country Coordinating Mecanism
CD4	Lymphocytes CD4
CDLS	Departmental AIDS Committee
CECI	Coalition of Ivorian Businesses against HIV/AIDS
CeDReS	AIDS Research and Diagnosis Center
CEROS	Reflection Group on AIDS orphans
CESAG	African Centre for Higher Management Studies
CGECI	General Confederation of Companies in Côte d'Ivoire
CHO	Community Health Official
CIE	Ivorian Electricity Company
CIMLS	Interdepartmental Committee on AIDS
CIRBA	Integrated Bioclinical Research Center in Abidjan

CI-TELCOM	Côte d'Ivoire Telecommunication
CMP	Multi-party and Partnership Committee
CNACI	National Tuberculosis Committee in Côte d'Ivoire
CNCA	National Council on Audiovisual Communication
CNLS	National AIDS Council
CNM-CI	Côte d'Ivoire National Chamber of Professions
CNPS	National Fund for Social Welfare
CNW	Centre North West
COGES	Steering Committee
COLTMR	Federation of Organizations for controlling Tuberculosis and Lung Disease
COP	Country Operational Plan
COSCI	Group of Organizations in the fight against AIDS in Côte d'Ivoire
CRIEM	Regional Center for Infrastructure, Equipment and Maintenance
CRLS	Regional AIDS Committee
CSLS	Sectoral AIDS Committee
CSU	Urban Health Center
CSUS	Urban and School Health Center
CT	Counselling and Testing
CTAIL	Technical Support Unit for Local Initiatives
CTX	Cotrimoxazole
CVLS	Village AIDS Committee
DAF	Development Aid Fund
DAF-santé	Directorate for Financial Affairs
DBS	Dried Blood Spot
DD	Departmental Director
DDI	Didanosine
DFR	MSHP Research and Training Directorate
DFR	Research and Training Directorate
DGS	General Health Directorate
DIEM	Infrastructure and Medical Equipment Directorate
DIPE	Information Planning and Evaluation Directorate
DMOSS	Mutual Benefit and Social Work Directorate for Schools
DMS	MLS Social Mobilization Directorate
DMW	District Maintenance Workshop
DNT	National Treatment Guidelines
DOTS	Direct Observed Therapy strategy
DPM	Pharmacy and Drugs Directorate
DPSE	Planning and Monitoring and Evaluation Directorate
DQA	Data Quality Assessment
DR	Regional Directorate
DREN	National Education Regional Directorate
DRH	Human Resources Directorate

DSC	Community Health Directorate
DSRP	Poverty Reduction Strategy Document
DSRP	Poverty Reduction Strategy Document
DST	Drug Susceptibility Testing
DTC	Diagnosis and Treatment Center
ECD	District Management Team
EDS	Health Demographic Survey
EFV	Efavirenz
EMC	Epidemiological Monitoring Center
EQE	External Quality Evaluation
ERP	Emergency Rehabilitation Program
ESPC	Primary health care facilities
ESTHER	Together for a Networked Hospital Therapeutic Solidarity Network (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau)
ETS	Establishment
EU	European Union
FGM	Female Genital Mutilations
FHI	Family Health International
FILTISAC	Spinning and weaving of bags
FIPME	Ivorian Federation of Small and Medium-sized Businesses
FNLS	National AIDS Fund (Fonds National de Lutte contre le SIDA)
FP	Family Planning
FSSU	Forward Studies and Strategy Unit
FSU	Urban Health Training
FSU COM	Community-based Urban Health Training
FTC	Emtricitabine
GAVI	Global Alliance for Vaccine Immunization
GBV	Gender-Based Violence
GDF	Global Drug Facility
GDP	Gross Domestic Product
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GFMU	Global Fund Management Unit
GH	General Hospital
GLC	Green Light Committee
GPHC	General Population and Housing Census
GRSE	Monitoring and Evaluation Reference Group
GTZ	German Technical Cooperation
HC	Health Center
HD	Health District
HHR	Health Human Resources
HIPC	Heavily Endebted Poor Countries
HIS	Health Information System
HR	Human Resources
HSS	Health System Strengthening

ICAP	International Center for AIDS Care and Treatment Programs
ICCB	International Catholic Child Bureau
ICRC	International Committee of the Red Cross
IDE	Nurse with State Diploma
IEC	Information-Education-Communication
IFRC	International Federation of the Red Cross
IGA	Income Generating Activities
IHAA	International HIV/AIDS Alliance
IMS	Information and Management System
INFAS	National Health Worker Training Institute
IOM	International Office of Migration
IPCI	Pasteur Institute in Côte d'Ivoire
ITA	International Technical Assistance
JHU-CCP	Johns Hopkins University- Center for Communication Programs
KAP	Knowledge, Attitude and Practice
KFW	Kreditanstalt Fur Wiederaufbau (German Development Bank)
LFA	Local Fund Agent
LIPA	Line Probe Assay
LPV	Lopinavir
M&E	Monitoring and Evaluation
M/E	Monitoring and Evaluation
MAP	Minimum Activity Package
MCP	Mother and Child Protection
MDG	Millenium Development Goals
MDS	Mutual health insurance companies
MEF	Ministry of Economy and Finance
MEMSP	Ministry of State, Ministry of Health and Population
MFFAS	Ministry for Women, Family and Social Affairs
MJDH	Ministry of Justice and Human Rights
MLS	Ministry in the fight against AIDS
MNE	Ministry of National Education
MoD	Ministry of Defence
MPD	Ministry of Planning and Development
MRU	Mano River Union
MSHP	Ministry of Health and Public Hygiene
MSM	Men that have Sex with Men
NBTC	National Blood Transfusion Center
NEDL	National Essential Drug List
NGO	Non-Governmental Organization
NHIS	National Health Information System
NPHL	National Public Health Laboratory
NRC	National Reference Center

NSI	National Statistics Institute
NSP	National Strategic Plan
NVP	Nevirapine
OCHA	Office for the Coordination of Humanitarian Affairs
OHBLA	Organization for the Harmonization of Business Law in Africa
OI	Opportunistic Infection
ONUCI	United Nations Operation in Côte d'Ivoire
OVC	Orphans and Vulnerable Children
PAPO	Assistance Project for Highly Vulnerable Populations
PDSSI	Integrated Health Services Development Project
PE	Peer Educator
PEC	Care
PECP	Paediatric Care
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PFA	Priority Field of Activity
PHE	Public Health Evaluation
PIAHIV	People Infected and Affected by HIV
PICT	Provider-Initiated Counseling and Testing
PIG	Public Interest Group
PLHIV	People living with HIV
PMCT	Prevention of Mother-Child Transmission
PMLS	Multisectoral AIDS Control Program
PNC	Pre-Natal Consultation
PNDS	National Health Development Plan
PNLP	National Malaria Programme
PNLT	National Tuberculosis Programme
PNN	National Nutrition Programme
PN-OEV	National Programme for Orphans and Vulnerable Children
PNPEC	National Care and Treatment Programme of PLHIV
PNSR/PF	National Health Reproduction and Family Planning Programme
PPH	Pneumo Phtysiology
PR	Principal Recipient
PSI	Population Services International
PSP CI	Côte d'Ivoire Public Health Pharmacy
PVD	Patient lost to follow-up
PWC	Price Waterhouse Cooper
RCI	Republic of Côte d'Ivoire
REPMASCI	Network of Arts and Sport Media Professionals engaged in the fight against AIDS and other pandemics in Côte d'Ivoire
RETRO-CI	Retrovirus Côte d'Ivoire
RHC	Regional Hospital Center
RHC	Rural Health Center
RHIS	Routine Health Information System
RIP+	Côte d'Ivoire network of organizations supporting PLWHA

RTV	Ritonavir
SASDE	Accelerated Strategy for Child Survival and Development
SCB	Banana Cultivation Company
SCMS	Supply Chain Management System
SDA	Service Delivery Area
SHC	Specialist Hospital Center
SHC	Specialist Hospital Center
SIH	Hospital Information Sub-system
SOTRA	Abidjan Transport Company
SR	Sub-Recipient
SSG	Scientific Support Group
STCO	Technical Secretariat for Operational Coordination
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TB-MR	Multi-Resistant Tuberculosis
TDF	Tenofovir
TMA	Technical and Managerial Assistance
TPM-	Smear Negative Pulmonary Tuberculosis
TPM+	Smear Positive Pulmonary Tuberculosis
TRP	Technical Review Panel
TWG	Technical Working Group
UFR	Medical Science Training and Research Unit
UHC	University Hospital Center
UICTMR	International Union against Tuberculosis and Lung Disease
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchase Facility
UNODC	United Nations Office on Drugs and Crime
UNS	United Nations System
VAD	Home Visit
VCT	Voluntary Counseling and Testing
VIH	Human Immunodeficiency Virus
VSAT	Satellite Communication Network
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

3. PROPOSAL SUMMARY

3.1. Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	1st July 2010	30 June 2015

3.2. Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 9 HIV proposal?	☐ Yes *(go first to (b) below)* ☒ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 9 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at:*

http://www.theglobalfund.org/documents/rounds/9/CP_PoI_R9_FAQ_GrantConsolidation_en.pdf

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

Funding for Round 2 took place on 31 May 2009 and there is currently no other GF funding. There is therefore a gap which must be filled. The CCM has sent the Global Fund (GF) a service continuation request for former patients being treated in Round 2 for a 12 month period which is in the process of being approved. Such service continuation is different to the proposal submitted in Round 9 and will be taken into consideration when planning the implementation of this Round.

The date was selected by taking into consideration the time required to examine the proposal by the TRP, the various exchanges with the TRP, in accordance with the proposal category, the decision of the Global Fund Board of Directors, the LFA evaluation missions and the timeframes for disbursing funds which could be one year. Taking into account the deadline for filing tenders of 1st June 2009, one year should be given to allow the various signatures to be obtained and implementation to be started. As a result, the period for implementation will be different to the Ivorian tax cycle which starts in January each year and ends in December. The alignment of the proposal with this is not advisable.

3.4. Program-based approach for HIV

3.4.1. Does planning and funding for the country's response to HIV occur through a program-based	☐ Yes. Answer s.3.4.2

approach?	☉ No. ➔ *Go to s.3.5.*
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☐ No. Do not complete s.5.5

3.5. Summary of Round 9 HIV Proposal

Provide a summary of the HIV proposal described in detail in section 4.

The political and military crisis in 2002 led to an increase in poverty for the entire population, particularly in the Centre, North and West regions (CNW). The political situation seems to be getting back to normal but there is still a disparity between the North and the South in terms of the availability and accessibility of prevention, treatment, care and support services. Estimates by UNAIDS in 2008 show an average seroprevalence rate of 3.9% in Côte d'Ivoire (Attachment n° 44) which remains the most affected country in West Africa. The epidemiological context is marked by the feminization of the epidemic (6.4% for women compared to 2.9% for men (Attachment n° 46) and an increase in post conflict sexual violence. An extremely high prevalence rate is also noted in the 3 key populations at high risk of HIV infection: Sex Workers (SW) (44%), MSM (43%) and the prison population (28%) (Attachment n° 56). In response to this situation, the PSN 2006-2010 (Attachment n° 25) has defined some priorities aimed at universal access to prevention, treatment, care and support services which target vulnerable populations. The achievement of the results in the PSN has been slowed down by financial and organizational constraints, the inability to access BCC intervention throughout the entire territory and the poor quality of general care services for PLHIV and OVC. Consequently, in order to achieve the national objectives, the Côte d'Ivoire proposal ***"Strengthening of the national response to HIV to scale up prevention and general care talking into account gender and the key populations at high risk of HIV infection"*** aims to prevent new infections, to treat and to provide care and support for key populations at high risk of HIV infection and for vulnerable populations through gender-specific intervention. It includes 3 goals:

1. To improve the offer of prevention services in order to reduce new infections in the general population, in women and in key populations at high risk of HIV infection;
2. To reduce AIDS-related morbidity and mortality by providing access to care, service quality and care continuum;
3. To strengthen the leadership, coordination and monitoring and evaluation of the national response.

These 3 goals can be broken down into 7 objectives and 18 Service Delivery Areas (SDA). This proposal responds to two urgent concerns which are to continue the action and the results achieved in Rounds 2, 3 and 5 of the GF and to direct the activities towards the target populations which so far have received little support. It places emphasis on (i) the integration of Gender-specific intervention taking into account age, level of education, geographical situation, prevalence rate and the general population's level of vulnerability and (ii) the key populations at high risk of HIV infection such as Sex Workers (SW), the prison population and Men that have Sex with Men (MSM). The main results aimed at are as follows: (i) BCC activities for 797,063 young people, 57,825 SW; 27,972 prisoners and 7,097 MSM. (ii) the testing of 1,412,595 people, (iii) prophylaxis for 19,716 HIV positive pregnant women and their children, (iv) the treatment of 29,595 PLHIV, (v) the provision of equipment in 19 laboratories (vi) the operation of 10 CTAIL and (vii) the strengthening of operational coordination. With regard to the public sector, the implementation of this proposal will cover 29 Health Districts (HD) including 20 HD from Round 2 and 9 new HD which have no HIV intervention. With regard to the Private, Faith-based and Community-based sectors, the intervention will cover the entire territory.

In order to achieve the objectives in this proposal, an effective health system based on a good health information system is a prerequisite. Consequently, the aim of a Health System Strengthening Project (HSS) brought about by HIV, in addition to the national proposal, is to improve the state of health and the well-being of the population including vulnerable groups. It mainly aims to strengthen the national health information system through the following 5 methods of intervention: (i) strengthening of the institutional framework and the governance of the health system in 51 HD, (ii) improvement of the accessibility to health services for populations in 50 ESPC, (iii) increase in the care offer and high-quality health services in 37 HD, (iv) increase in the availability and safety of drugs and strategic inputs and (v) availability of a minimum package of performance indicators to manage services in 83 HD. The main results are: (i) 58 health development plans implemented and the operational civil society platform; (ii)50 COGES redynamized and 25 health insurance companies operational (iii)documents of standards and procedures available and technical capacity of 43 reference hospitals strengthened (iv) 37 district pharmacies equipped and operational, drug monitoring system operational, NPHL strengthened with regard to drug quality control; (v) institutional and technical capacities of the players involved strengthened, strategic information available and used for decision-making. The PNPEC/MSHP, the DIPE/MSHP and the CNPS are the principal recipients that have been respectively appointed on behalf of the Public Sector, HIV

section, for HSS and for Civil Society and the Private Sector HIV section. These 3 structures have proven experience in the management of similar programs and considerable funds.

4. PROGRAM DESCRIPTION

4.1. National prevention, treatment, care, and support strategies

(a) Briefly summarize:

- the current HIV national prevention, treatment, and care and support strategies;
- how these strategies respond comprehensively to current epidemiological situation in the country; and
- the improved HIV outcomes expected from implementation of these strategies.

Côte d'Ivoire has a National Health Development Plan (PNDS) 2009-2013 (Attachment n° 22) and a multisectoral and multi-disciplinary National Strategic Plan (PSN) 2006-2010 (Attachment n° 25) and a National Aids Plan 2008-2009 which has been used as a basis for the costing of the proposal for Round 9 (Attachment n° 26). The 15 priorities targeted in the PSN are: Children (0-15 years old), OVC (0-18 years old), Young people (15-24 years old), Women and young girls, the armed forces and fighters, Sex workers, Migrants and lorry drivers, Teachers, PLHIV, Drug users, Men that have sex with men, Conflicting couples, Workers (public and private sectors), Rural population, Prison population.

The strategies in the PSN 2006-2010 which aim to strengthen prevention in order to reduce the prevalence of HIV/AIDS from 4.7% in 2005 to 3.5 in 2010 and to improve the general care of people infected with and affected by HIV are:

1. Prevention and strategies

Prevention is developed through 10 PFA: BCC, VCT, PMCT, prevention through condoms, the fight against STI, blood transfusion safety, the prevention of blood exposure accidents and biological liquid accidents, the fight against stigmatization and discrimination in relation to HIV/Aids, Prevention in PLHIV and the fight against HIV/AIDS through drug use.

The strategies used are mass or local raising awareness activities via the channel of community shift workers, pleas to authorities and decision-makers with regard to behavior change. Such changes will be expressed through (i) an increase in the attendance of VCT, (ii) a reduction in the transmission of HIV from mother to child, (iii) an increase in the systematic use of condoms by young people, women and key populations at high risk of HIV infection, (iv) a reduction in the incidence rate of STI and the treatment of STI cases, (v) a reduction in HIV prevalence in new blood donors, (vi) the elimination of discriminatory practices towards PLHIV

2. Medical and community care and their strategies

The commitment by the government and by the various players involved in the fight against HIV/AIDS is expressed by the strengthening of the offer of care facilities and the improvement of access to ARV and OI treatment. The county has 215 care sites, to which ARV are delivered free of charge (Attachment n° 72a) and new treatment schemes have been implemented since June 2008 (Attachment n° 74 and 75).

Community care enables patient follow-up and facilitates care continuity as well as reducing the number of patients lost to follow-up. It relies on Civil Society organizations. Nutritional, dietary, legal and socio-economic support aims to provide support for people infected with and affected by HIV in order to improve their quality of life.

The care of OVC is coordinated by the National Programme to care for OVC (PN-OEV) and reduces the dislocation of the family unit.

3. Coordination

The Government has set up a national, decentralized coordination system through the following bodies: the CNLS, the CIMLS, the Forum of Partners, Decentralized Committees and Sectoral Committees. The CNLS created in 2004 (Attachment n° 82) is the single body for national coordination presided by the President of the Republic: its technical secretariat is carried out by the Ministry for AIDS (MLS). The Interministerial AIDS Committee (CIMLS), presided by the Prime Minister, is responsible for monitoring the direction and the coordination of all multisectoral activities. Sectoral AIDS committees have been set

up in 34 Ministries and steering committees in the private sector. Regional, departmental, communal and village committees involved in the fight against Aids are in the process of being gradually set up at decentralized level.

4. Funding

The general objective of funding is to mobilize the resources needed to implement the national strategic plan with a view to sustainability. The strategies consist of drawing up a funding plan and of pleas to local authorities. Within this context, the National AIDS Fund has been set up. The total cost of the PSN 2006-2010 is estimated to be €452,956,520.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7 or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

	Document	Proposal Annex Number	Page References
☑	National Health Sector Development/Strategic Plan	(Attachment n°22)	1-155 pages
☑	National HIV Control Strategy or Plan	(Attachment n° 25)	1-155 pages
☑	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	(Attachment n° 24) (Attachment n° 53) (Attachment n° 67) (Attachment n° 69) (Attachment n° 75)	1-55 pages 1-92 pages 1-112 pages 1-71 pages 1-41 pages
☑	Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal	(Attachment n° 32) (Attachment n° 33) (Attachment n° 34) (Attachment n° 69) (Attachment n° 108d)	1-78 pages 1-63 pages 1-39 pages 1-75 pages 1-11 pages
☑	National Monitoring and Evaluation Plan (health sector, disease specific or other)	(Attachment n° 28)	1-99 pages
☑	National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need of services	(Attachment n° 77) (Attachment n° 87) (Attachment n° 88) (Attachment n° 89) (Attachment n° 90)	1-15 pages 1-59 pages 1-177 pages 1-42 pages 1-65 pages

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal		
(a) Do the activities target:		
☐ Whole country	☒ Specific Region(s) ***If so, insert a map to show where*	☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

** (Attachment n° 27).

Figure N° 2: Distribution of HIV prevalence in 19 regions in Côte d'Ivoire

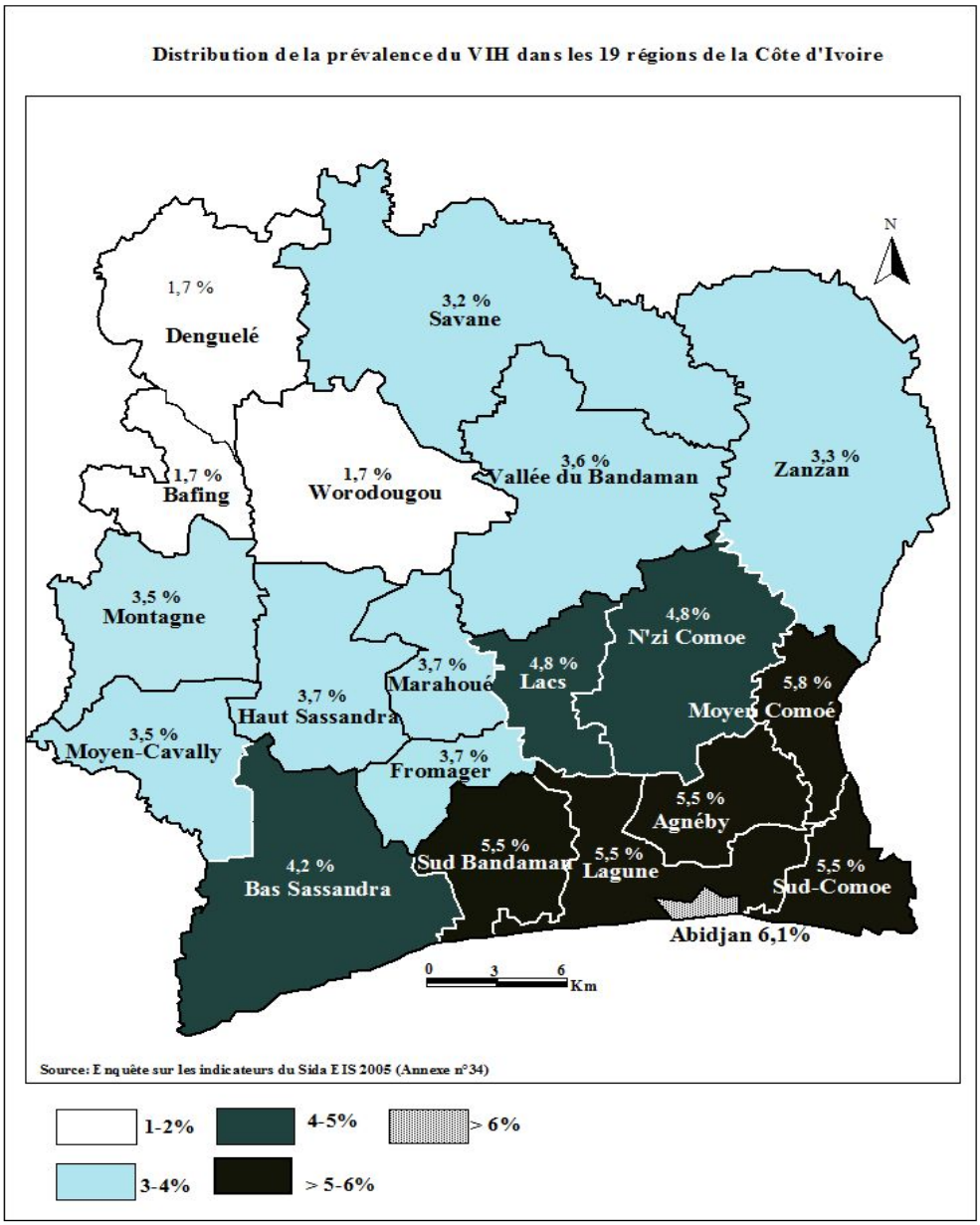
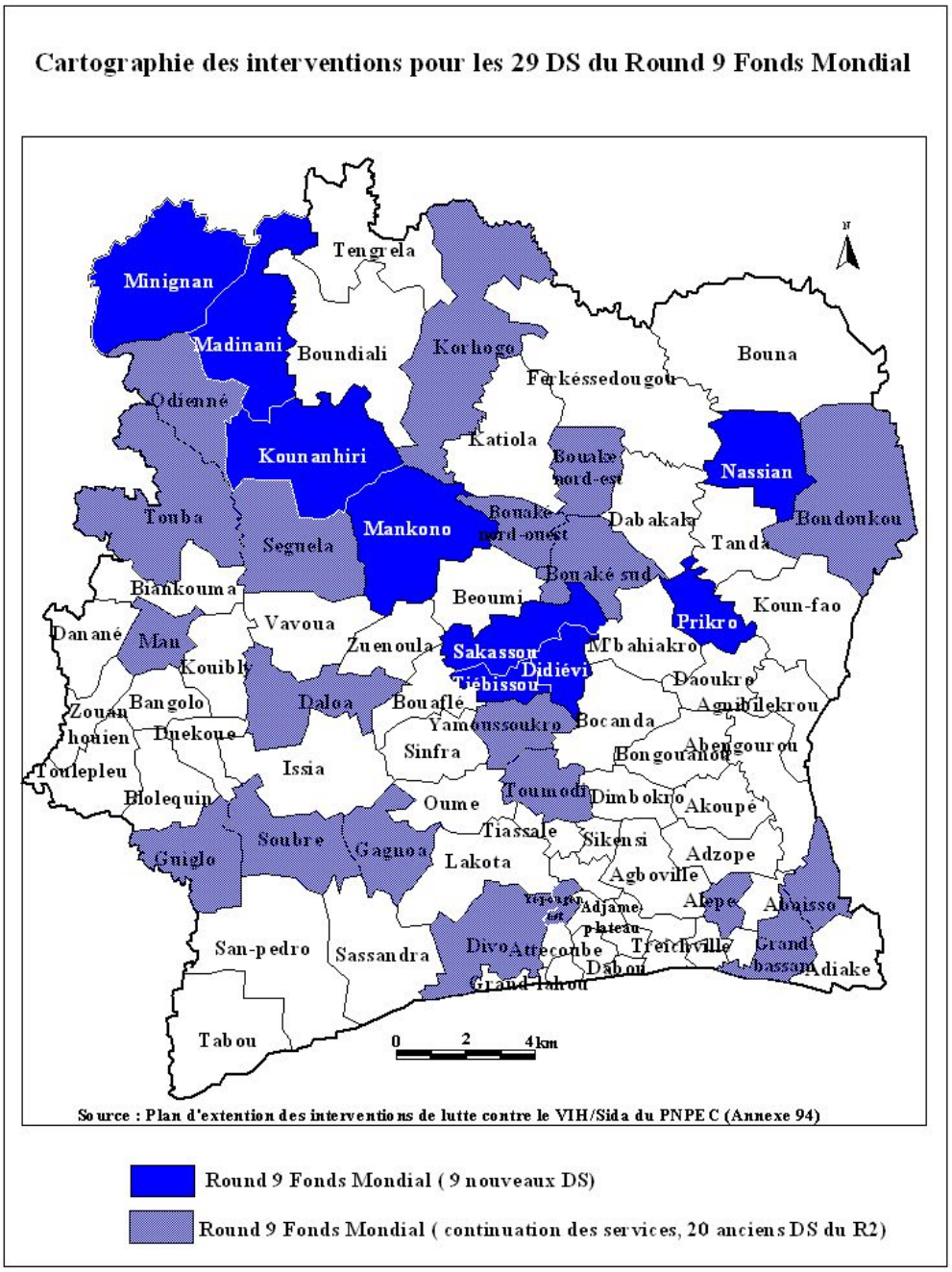


Figure n° 3: map of the intervention in Round 9



Round 9 Fonds mondial (9 nouveaux DS)	Global Fund Round 9 (9 new HD)
Round 9 Fonds mondial (continuation des services, 20 anciens DS du R2)	Global Fund Round 9 (service continuation, 20 HD from previous R2)

(b) **Size of population group(s)**

(If national data is disaggregated differently then type over the categories proposed)

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	20,227,876	Estimate by the NSI	2007
Women > 25 years	3,673,385	Estimate by the NSI	2007
Women 19 – 24 years	1,126 ,156	Estimate by the NSI	2007
Women 15 – 18 years	2,026,333	Estimate by the NSI	2007
Men > 25 years	3,895,825	Estimate by the NSI	2007
Men 19 – 24 years	1,190,954	Estimate by the NSI	2007
Men 15 – 18 years	2,020,809	Estimate by the NSI	2007
Girls 0 – 14 years	4,043,988	Estimate by the NSI	2007
Boys 0 – 14 years	4,100,120	Estimate by the NSI	2007
Other **: Prison population ***Refer to the Round 9 Guidelines for other possible groups*	11,493	ESTHER CI report	2009
Sex workers Other **:	78,191	Estimate by the NSI and proportion of SW (Estimate from the study by VANDEPITE J, and Col)	2008
Other **: Men who have sex with men a Men who have sex with men	11,892	Estimate by the NSI and estimate from the Clinique de Confiance and Ruban rouge report	2008
Other **: Orphans and other vulnerable children Orphans and other vulnerable children (OVC)	1,400,000	UNICEF/WHO estimates	2008

4.2.2. HIV epidemiology of target population(s)

(If national data is disaggregated differently then type other the categories suggested)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV *(all ages)*	480,000	Estimates by UNAIDS	2007
Women living with HIV > 25 years	143,262	Estimates by UNAIDS	2007
Women living with HIV 19 – 24 years	43,920	Estimates by UNAIDS	2007
Women living with HIV 15 – 18 years	79,027	Estimates by UNAIDS	2007
Pregnant women living with HIV	51,408	Estimates by UNAIDS	2007

4.2.2. HIV epidemiology of target population(s)

(If national data is disaggregated differently then type other the categories suggested)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Men living with HIV > 25 years	151,937	Estimates by UNAIDS	2007
Men living with HIV 19 – 24 years	46,447	Estimates by UNAIDS	2007
Men living with HIV 15 – 18 years	82,763	Estimates by UNAIDS	2007
Girls (0 – 14 years) living with HIV	20,569	Estimates by Spectrum	2007
Boys (0 – 14 years) living with HIV	20,793	Estimates by Spectrum	2007
Other**: Sex workers infected with HIV	34,404	Estimate by the NSI and Prevalence according to the PAPO FHI draft study	2009
Other**: Prison population infected with HIV	3,218	Social management chart estimates by the NSI and UNODC report	2009
Other**: Men who have sex with men infected with HIV	3,568	Estimate by the NSI and Prevalence estimated	2008
Other**: Orphans and other Vulnerable Children (OVC) infected with HIV	54,600	UNICEF/WHO estimates applying the national prevalence rate	2008

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[1] who may have disproportionately low access to HIV prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. HIV program

Describe:

- the main weaknesses in the implementation of current HIV strategies;
- how these weaknesses affect achievement of planned national HIV outcomes; and
- existing gaps in the delivery of services to target populations.

The response to the epidemic has faced several problems and the various obstacles which hinder the implementation of the strategies are as follows:

- The insufficient scope of BCC on behavior as a result of insufficient resources and inadequate communication channels and the fact that the messages are not very specific to the targets. This furthers the spread of the HIV infection
- The fact that Gender is not really taken into consideration in the intervention does not solve the vulnerability facing HIV in vulnerable populations and key populations at high risk of HIV infection
- The decentralization of the various areas of intervention is not effective. The “per site approach” intervention strategy used has not given the results expected. As district management teams have not taken over the intervention, intervention is not sustainable and stops as soon as it hits the first hurdle
- Poor service quality is curbing the attendance of prevention and care structures. This weakness

[1] Please refer back to the definition in s.2 and found in the *Round 9 Guidelines*.

is due to the lack of motivation of medical and paramedical staff, insufficient infrastructures and a lack of equipment.

- The financial inaccessibility of PLHIV to other drugs for treating OI and to CTX as a curative treatment is a deficit with regard to general care and compromises the quality of life of PLHIV
- Inadequate health information literacy characterized by the low availability of data and its use in decision-making. As a result, planning and decision-making is not based on the facts and does not use the resources efficiently
- The weakness observed in the coordination of field activities does not enable intervention to be directed and does not provide good visibility of the activities of the various players in the field. This is at the source of duplicate intervention and the inadequate use of resources
- Inadequate community care for PLHIV which only exists in certain large towns. The fact that Community Advisors have no legal status and the lack of intervention synergy between the community section and the medical section do not enable the follow-up of PLHIV to be improved and are the source of the high number of patients lost to follow-up which was estimated to be 20,000 in 2008.
- The response by the private sector to AIDS is still poor as witnessed by the insufficient access to prevention services for workers, their families and coastal populations. Numerous steering committees are no longer operational which consequently reduces the service offer

The poor offer of care and support to OVC jeopardizes their blossoming as well as the respect of their fundamental rights.

4.3.2. Health System

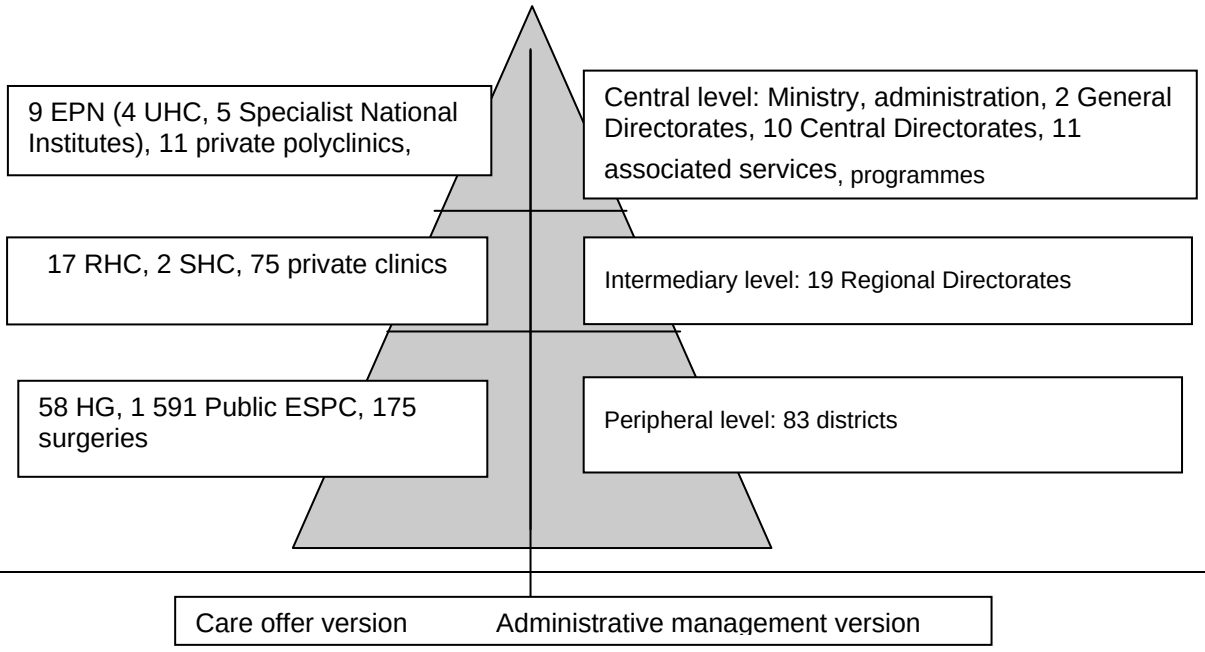
Describe the main weaknesses of and/or gaps in the health system that affect HIV outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and HIV outcomes (e.g.: PMTCT services), but perhaps not also malaria and tuberculosis programming and service delivery.*

The Côte d'Ivoire helath policy is defined in the National Health Development Plan (PNDS, 2009-2013). In 2007, the Ivorian health system included 19 health regions, 83 Health Districts (HD) and 1,677 public care institutions including 1591 primary health institutions (Attachment n° 22). The health system is in the shape of a pyramid and includes 3 levels:

Figure n° 4: Health Pyramid



In 2007, coverage in care institutions was estimated to be 1 ESPC for 13,831 inhabitants, 1 maternity ward for 14,000 women of reproductive age, 1 hospital bed for 2,890 inhabitants (Attachment n° 22).

The country has 19,784 officials distributed in the 3 levels of the pyramid including 60% concentrated in the region of Lagunes and its surrounding areas (Attachment n° 24). The ratios are 1 doctor for 5695 inhabitants, 1 nurse for 2331 inhabitants, 1 midwife for 3717 women of reproductive age and 1 senior health technician for 13,157 inhabitants.

The private sector has 653 pharmacies, 813 nursing care offices, 175 centres and surgeries, 37 community-based health institutions, 75 clinics, 11 polyclinics and 21 laboratories.

The faith-based sector has 250 health centres and hospitals, including approximately 60 for the Catholic Church and 4 for Methodist and evangelical churches for HIV related activities. The information in relation to this sector is scattered. The main priority is cartographic and statistical information.

The community sector has approximately 50 active NGOs in general care management. There is not currently any complete data on NGO intervention for the entire territory.

Table I: Distribution of health staff in 2007

	Catégorie de personnels	Effectifs		%
Personnel médical	Médecins	2746	3433	17
	Pharmaciens	413		
	Chirurgiens dentistes	274		
Personnel paramédical	Infirmiers	6973	9799	50
	Sages femmes	2258		
	Aides soignants	568		
Personnel technique	Techniciens supérieurs santé	1419	1419	7
Personnel administratif et social	Personnel administratif et social	2561	2561	13
Personnel journalier	Journaliers	2572	2572	13
	Total	**19 784**	**19 784**	**100**

Source : DRH-Santé

Personel médical	**Medical staff**
Personel paramédical	**Paramedical staff**
Personel technique	**Technical staff**
Personel administratif et social	**Administrative and social staff**
Personel journalier	**Day labourers**
Médecins	**Doctors**
Pharmaciens	**Pharmacists**
Chirurgiens dentistes	**Dental surgeons**
Infirmiers	**Nurses**
Sages femmes	**Midwives**
Aides soignants	**Nursing auxiliaries**

Techniciens supérieurs de santé	**Senior health technicians**
Personels administratifs et social	**Administrative and social staff**
Journaliers	**Day labourers**

The inadequacies of the health system are as follows:

1. The inadequate number of HHR and the significant difference in geographical distribution in favour of the Lagunes region and its surroundings with predominance in towns. In fact, this region alone has 60% of HHR. The 2002 social and political crisis has led to a massive number of health staff in CNW areas fleeing to the southern area for safety reasons. The health system in these areas has completely collapsed, following the destruction and/or looting of health infrastructures and medical equipment. This situation concerns 10 regions out of 19: Regions in the vallée du Bandaman, Zanzan, Lacs, Worodougou, Denguéle, Bafing, Savanes, Montagnes, Haut-Sassandra and Marahoué.
2. The decrease in quality of the service offered and the attendance of services for certain population types such as rural populations, populations in inaccessible areas and the poor. The health system has gradually been redeployed but it is functioning on a minimum, given that the security situation is still precarious. UNICEF has set up the emergency projects PUR 1 & 2, the main aim of which is to revive the Health Districts affected by the crisis. This involves a total of 41 HD which could re-open their doors to the populations in these areas spurred on by such projects.
3. The loss of health staff's motivation is emphasised by the lack of financial resources. The main cause is the under-funding of the sector since less than 5% of the State budget is allocated to the Ministry of Health.
4. The weakness of the health information system characterized by the continued, permanent fall in the spped and completeness of the data and statistical reports sent. There is also insufficient Human Resources and equipment.
5. PMCT is still poor as a result of geographical coverage: 69 HD out of 83 have at least one PMCT site, but only 316 sites are operational out of the 716 sites offering PNC. In addition, there is an insufficient number of trained staff, the insufficient promotion of PMCT and poor coordination. Furthermore, HIV is not actually included in the district MAP.
6. The scaling up of general care is not effective due to the low geographical coverage of health structures offering care facilities. Persistent weaknesses are the inadequate number of trained staff and the inaccessibility to OI drugs for PLHIV. Biological follow-up has also experienced problems in relation to the frequent break-down of equipment as a result of inadequate biomedical maintenance.
7. The inadequate coordination of activities implemented at central and decentralized level as well as the inadequate coordination of intervention by national and international partners is slowing down the achievement of the objectives in the PSN

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect HIV outcomes.

Serious effort has been made by Côte d'Ivoire to improve the response to the epidemic. Such effort has strengthened prevention, improved the accessibility of PLHIV to treatment and strengthened coordination and the information system.

1. To make up for the insufficient number of health staff and the unequal geographical distribution, the government exceptionally recruited 1,287 staff in 2006 and 2007. Some staff that had deserted the crisis areas has been redeployed. Supported by the various partners, staff members have received training covering the various areas of HIV: PMCT, VCT and care. A strategic human resources plan (Attachment n° 24) has been drawn up by the MSHP with the support of

Abt Associates.

2. The quality of the service offered has been improved through the restoration and the provision of equipment for health structures in CNW areas.
3. To strengthen the quality of service facilities and to continue to revitalize HD, measures to increase the salaries of doctors and other health officials by the government are underway. However, such measures are inadequate due to high living costs.
4. In relation to the improvement of the speed and completeness of data, measures have been taken both by the State and by partners to support the DIPE.
5. To strengthen PMCT and to improve geographical coverage, a scaling-up plan 2008-2011 has been drawn up and is in the process of being implemented. This plan provides for the installation of 572 PMCT sites in 2011 through their integration in PNC services and for staff training. The offer of PMCT services is promoted through mass and local awareness-raising activities.
6. The plan to extend care provides for the improvement of geographical coverage and the access of PLHIV to treatment. At least one care site will be opened in all 83 health districts and 98 care sites will be provided with laboratories for biological monitoring. Medical staff members have been trained in diagnosis and treatment and paramedical staff members have been trained on patient follow-up.
7. To improve decentralisation, the country has committed to reform to strengthen the district approach and to strengthen the responsibility of District Management Teams. Such actions will operationalize HIV activities through health districts which represent the operational units of the health system. With a view to effectively including community advisors, a guide to defining the package of activities carried out by such advisors has been drawn up.

4.4. Round 9 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current HIV epidemiology and identified weaknesses and gaps from s.4.2.2 and s.4.3.

Note: All health systems strengthening needs that are most effectively responded to on an HIV disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No: 1	Strengthening of the quality and accessibility to PMCT	Historical		Current		Country targets			
Indicator name	Number of HIV positive pregnant women receiving complete antiretroviral prophylaxis to reduce the risk of mother-child transmission	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		50,570	52,018	53,488	54,978	56,486	58,007	59,540	61,091
B: Extent of need already planned to be met under other programs		4,817	6,909	11,800	11,800	11,800	11,800	11,800	11,800
C: Expected annual gap in achieving plans		45,753	45,109	41,688	43,178	44,686	46,207	47,740	49,291
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			1,289	3,589	6,089	9,089	19,716

Priority No: 2	Improvement of the quality and accessibility of CT services	Historical		Current		Country targets			
Indicator name	Number of people receiving counseling and testing with test results sent	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		5,056,969	5,201,805	5,348,800	5,497,793	5,648,560	5,800,719	5,953,970	6,109,074
B: Extent of need already planned to be met under other programs		84,733	311,145	630,000	630,000	630,000	630,000	630,000	630,000
C: Expected annual gap in achieving plans		4,972,236	4,890,660	4,718,800	4,867,793	5,018,560	5,170,719	5,323,970	5,479,074
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			122,599	280,051	527,277	952,685	1,412,595

ROUND 9 – HIV

Priority No: 3	Improvement of the quality and accessibility to medical care through ARV and biological follow-up	Historical		Current		Country targets			
Indicator name	*Number of people with the advanced HIV infection receiving treatment based on a combination of antiretrovirals*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		111,308	115,271	119,124	122,946	126,685	130,289	133,703	137,807
B: Extent of need already planned to be met under other programs		38,221	51,833	60,333	68,833	77,333	85,833	93,833	100,833
C: Expected annual gap in achieving plans		73,087	63,438	58,791	54,113	49,352	44 456	39,870	36,974
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			14,757	16,385	20,841	25,443	29,595

Priority No: 4	Strengthening of the psychosocial care of PLHIV, OVC and key populations at high risk of HIV infection	Historical		Current		Country targets			
Indicator name	*Number of OVC that have received care*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		408,306	420,000	431,868	443,898	456,071	468,357	480,731	493,254
B: Extent of need already planned to be met under other programs		84,947	84,947	80,000	80,000	80,000	80,000	80,000	80,000
C: Expected annual gap in achieving plans		323,359	335,053	351,868	363,898	376,071	388,357	400,731	413,254
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			3,000	10,000	25,000	35,000	45,000

Priority No: 5	Strengthening of the fight against HIV in the workplace	Historical		Current		Country targets			
Indicator name	*Number of steering committees implementing programs which focus on the HIV infection*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		1,617	1,587	1,556	1,525	1,673	1,740	1,840	2,008
B: Extent of need already planned to be met under other programs		162	258	258	308	358	408	408	408
C: Expected annual gap in achieving plans		1,455	1,329	1,298	1,217	1,315	1,332	1,432	1,600
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			100	300	450	600	600

Priority No: 6	Improvement of the leadership, coordination and monitoring and evaluation of the national response	Historical		Current		Country targets			
Indicator name	*Number of operational technical committees to support local initiatives*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		19	19	19	19	19	19	19	19
B: Extent of need already planned to be met under other programs		0	7	7	7	7	7	7	7
C: Expected annual gap in achieving plans		19	12	12	12	12	12	12	12
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			5	12	12	12	12

The 6 priorities in the proposal have been selected following an analysis of the situation based on the PSN 2006 2010 *(Attachment n° 25)*.

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 9 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA), activities and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*

Where there are planned activities that benefit the health system that can easily be included in the HIV program description (because they predominantly contribute to HIV outcomes), include them in this section only of the Round 9 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 9. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 9 Guidelines (s.4.5.1.) for information on this choice.*

The proposal submitted by Côte d'Ivoire includes 3 goals, 7 objectives and 18 SDA. It particularly focuses on the inclusion of Gender in all the objectives and specific activities proposed. The 3 vulnerable groups targeted are women, young people and OVC. The 3 key Populations at high risk of HIV infection that are targeted are SW, MSM and the prison population.

GOAL 1: To improve the offer of prevention services to reduce new infections in the general population, in women and in key populations at high risk of HIV infection taking into account gender

Objective 1: To strengthen social mobilization and communication in the fight against HIV for women, young girls and key populations at high risk of HIV infection

SDA 1.1: BCC – Mass media: Since the 1st case of AIDS was notified in 1985, numerous local and mass IEC/BCC activities have been conducted by a large number of players. In spite of this, the level of behavior change remains low; it is currently 12% (Attachment n° 45). The communication channels regularly used are aimed at individuals, families, certain specific target groups and the community. In reality, BCC is not achieving all its targets via the mass media channel: access to information via the media is poor, particularly for women in rural areas (Attachment n° 46 and 50). In addition, young people aged between 15 and 24 are rarely exposed to such media. Insufficient access to audiovisual material (television and radio), the low rate of literacy and the low use of local languages in the messages are restricting access to information. In addition, the messages distributed are not particularly specific to certain populations.

This proposal includes reaching vulnerable groups such as PLHIV, women, young people and the general population. Significant effort will be made in relation to key populations at high risk of HIV infection which are SW, the prison population and sexual minorities (MSM). To strengthen BCC (Attachment n° 52) through mass media, intervention will be carried out on the various requirements of the target populations in relation to gender, age, education, geographical situation as well as the level of vulnerability and the risk of contamination. It will use the 2 national radio stations and 80 local radio stations in particular to relay messages in local languages, the 2 television channels and 30 printed newspapers. The raising of awareness will be carried out via 3,267 peer educators (PE) in 61 local languages for PLHIV, leaders, celebrities, artists and the 80 community associations targeted. Consequently, 20 prevention spots, 1,300 programmes and 500 press releases will be distributed.

Action will be implemented by specialist communication bodies in the fight against HIV through 80 Community-based Associations and 10 social networks committed to the fight against HIV. The action for the 3 key populations at high risk of HIV infection is specified in SDA 1.3.

Main activities in relation to SDA 1.1

- Creation and broadcasting of 20 prevention spots
- Broadcasting of 1,150 radio programs and 150 television programs
- Production of 500 press releases in 30 newspapers
- Organization of 76 public information and education campaigns on HIV, gender-based violence and human rights

Indicator

- Number of radio and television programs broadcast

Expected results

- 1,300 radio and television programs broadcast by 2014.

Target population

- 13,820,757 people over 15 years old in the general population including 4,670,364 women, 4,972,285 men, 2,138,804 young girls (15-24 years old) and 2,039,304 young boys (15-24 years old)

Implementation manager

- PNPEC/MSHP

SDA 1.2: BCC Community shift workers and schools: According to the PSN 2006-2010, an increase in activities has been noted with regard to mass raising awareness. However, the increase is insufficient particularly in rural environments and with regard to certain target groups: educated and uneducated young people and teachers (Attachment n° 25). The inadequacy of BCC intervention is also noted which takes into account the requirements of target populations in relation to gender, age, education, geographical situation, as well as the prevalence rate and the level of vulnerability. This is expressed by persistent risky behavior, mainly in women and young people. According to the AIS CI, 18% of young women and 27.6% of young men are fully aware of HIV whereas knowledge of all the methods of transmission varies between 9.0% and 13.4% according to the study (Attachment n° 46). Finally, the level of knowledge is poor and must be improved.

The education rate is 56.1% according to the DSRP (Attachment n° 50). The Aids sectoral committee in the Ministry for National Education (MEN) which comes under the Mutual Benefit and Social Work Directorate for schools (DMOSS) is supported by Health clubs which exist in each school to carry out prevention activities and to include “life Skills/Aids” in school curriculums (Attachment n° 54). In 1997, a study showed that 7 teachers died per week as a result of Aids (Attachment n°55). As a result, at least 71,655 children aged between 6 and 11 could not be educated during the study period.

The proposal affects 793,063 young people including 392,205 young girls and 400,858 young men who are both educated and uneducated, which represents 50% of the gap. The activities will be carried out through local action to raise awareness and through participative communication (set of 3 themes, set of risks, questions to be discussed and code set). This strategy relies on education by 400 PE pupils, teachers and uneducated people. With regard to schools, it will support the MEN sectoral plan through health clubs and action targeted at 7,000 members of teaching staff. Particular attention will be given to activities that target educated and uneducated young girls as they are exposed to unwanted pregnancies and sexual and physical violence more than boys (Attachment n° 46). Specific local BCC intervention will be carried out for uneducated young girls and boys, street children and young people in small jobs through clubs and associations at their place of business, griots and religious and community leaders. Sports and culture celebrities will be involved in carrying out certain intervention.

Main activities in relation to SDA 1.2

- 16 training workshops for 400 peer educators including 50 teachers
- Support for 70,000 BCC activities for 400 peer educators
- Support for 30,000 local BCC activities to reach educated and uneducated young girls in rural and urban areas
- Organization of 20 football, basketball and handball tournaments for girls and boys during which messages to raise awareness will be circulated
- 200 mass campaigns in districts
- 200 awareness-raising campaigns in schools (pupils and teachers)

Indicator

- Number of people having received local education by peers for prevention within the scope of BCC

Expected results

- 793,063 young people, i.e. 444,115 educated and 348,948 uneducated will benefit from BCC activities
- 7,000 teachers taking part in BCC activities, including 3,390 female teachers and 3,610 male teachers

Target population

- 4,178,108 young people between 15-24 years old including 2,138,804 young women and 2,039,304 young men

Implementation manager

- CNPS

SDA 1.3: BCC-Community shift workers and key populations at high risk of HIV infection:

- **Sex Workers**

Few targeted actions have been carried out with regard to BCC and care which are directed at Sex Workers. The FHI Capture/Recapture study (Attachment n° 56) estimates the number of SW to be 34,777 of which 15-30% attend STI/HIV/Aids prevention and care services. The seroprevalence rate found by "Centre Espérance de San Pédro" in 2008 is 44% (Attachment n° 56) in SW. In reality, the number of SW has been underestimated as the figures do not take into account more frequent occasional, in particular prostitution related to the socio-political crisis in 2002. With regard to BCC, the services offered are still inadequate (Attachment n° 58). The messages distributed which are directed at SW do not take into account the specificity of the target, sex, level of education or language as more than 50% of SW are illiterate and 22% speak English. (Attachment n° 59). The number of peer educators trained on male and female SW is insufficient. Coverage for preventive and curative care is also insufficient: 13 centers to care for SW for the entire country. Abidjan and its surrounding areas as well as San Pédro are served by 2 mobile testing units.

The proposal will take into account BCC activities conducted via 75 peer educators and 25 CA aimed at male and female SW, their customers and their sexual partners at their workplace (brothels, hotels, bars, busy streets) which will place particular emphasis on the use of condoms. The addition of 5 mobile teams who will travel to prostitution sites twice per week will enable STI testing and prevention services to be offered. The production of 5 messages and communication media against stigmatization and violence towards PLHIV in this target will take into account English, local languages and the level of education. Such intervention will reach 57,825 SW, i.e. 64.3% of the gap. Action will be carried out by SW associations and community associations.

Main activities

- Organization of 520 outreach activities per mobile unit
- Organization of 39,000 outreach activities by PE
- 4 training workshops for CA and PE on BCC, gender, gender-based violence, HIV and human rights
- 1 training workshop for CA on CT, gender, gender-based violence, HIV and human rights

Indicator

- Number of sex workers having benefited from the HIV prevention program

Expected results

- 57,825 SW will benefit from the HIV prevention program by 2014, i.e. 50,000 female SW and 7,825 male SW.

Target population

- 96,778 Sex workers

Implementation manager

- CNPS

- **Prison population**

Out of 33 prisons, 22 are operational and 11 are in the process of being restored in the Center, North and West areas with a capacity to accommodate approximately 2,500 prisoners in theory (Attachment n° (56 and 61). There are 11,655 prisoners including 221 women i.e. 2.5% of the total number supervised by 1065 supervisors (Attachment n° 60). The seroprevalence rate is estimated to be 28% in this population according to the UNODC report (Attachment n° 56). The insufficient number of nursing auxiliaries has been noted: 3 doctors, 1 midwife, 26 IDE, 1 pharmacist management assistant. Consultation premises are reduced, unsuitable and dilapidated. Prisoners receive, on average, one meal per day which does not cover their energy requirements and puts them at risk of malnutrition. Even though sexual relations and, as a result, the use of condoms are prohibited in prisons, the Togbé T. study attests that 20% of prisoners held for 6 to 12 months affirm that they have had sexual relations in prison (Attachment n° 56). HIV care is supported in 2 detention and correction centres using ESTHER and CARE/Global Fund funding for Abidjan (Attachment n° 62) and ICAP/PEPFAR funding for Bouaflé.

BCC will be carried out by 162 male and female PE, prisoners and supervisors on prevention, promotion of care and stigmatization during group talks in cells, learning workshops and in religious communities. Peer educators will facilitate the prisoners' access to infirmaries which will be supported by 30 CA for testing. ARV will be prescribed by resident physicians or physicians from referral hospitals and will be

dispensed in accordance with the DOTS strategy. Prisoners whose tests are HIV positive will be cared for within the prison health structure. The awareness of supervisors will be raised through HIV committees. Operational research will enable Aids indicators to be filled in for prisons

This proposal targets 27 prisons and takes into account gender in the prison population in relation to age, sex, education, geographical situation and the type of detention. BCC activities will be directed in a diverse manner at groups of men, women, adolescent(s) and their families. It targets 27,972 prisoners by taking into consideration the prison accommodation capacity in CNW areas and the renewal of the prison population. The activities will be conducted by GIP ESTHER and Civil Society associations. The prison project is managed by one team consisting of 1 program manager, 1 accountant, 1 logistician and 1 driver.

Main activities
- o 27 BCC and gender training workshops for 6 peer educators in each of the 27 prisons every 2 years
- o 1 training workshop for Community Advisors on CT
- o 1,085 shifts for doctors and nurses for the testing and the general care of PLHIV per year

Indicator
- Number of prisoners that have received outreach education by peers on prevention within the scope of Behavior Change Communication

Expected results
- 27,972 prisoners have benefited from outreach education by peers on prevention by 2014, i.e. 560 female prisoners and 27,412 male prisoners, i.e. 75% of the gap
- The awareness of 1,065 supervisors raised through 27 HIV committees in prisons.

Target population
- 37,297 prisoners and 1,065 penitentiary guards

Implementation manager
- CNPS

- **Sexual minorities**

Besides SW and the prison population, sexual minorities (MSM, Transvestites and Transsexuals) have benefited from very little action which targets them specifically (Attachment n° 63). The number of MSM is unknown, but is estimated to be between 3,000 and 5,000 in Abidjan. In 2008, 350 MSM were monitored by the Confidence Clinic in Abidjan and the awareness of 322 was raised by the NGO Ruban Rouge. According to the report, from the participation survey to identify the requirements for the prevention and care of STI and HIV in MSM, 43% of them are HIV positive, 45.1% do not regularly use condoms, 46.2% are bisexual and 42.7% have been tested (Attachment n° 57).

Interpersonal communication, the raising of awareness in small groups and mobilisation for testing will be carried out for MSM, Transvestites, Transsexuals and their sexual partners. Such action will be carried out by 20 CA and 30 PE who will place particular emphasis on the use of condoms. A counselling and documentation centre will provide psychological assistance where necessary. The Confidence Clinic and Centre Plus of the NGO Ruban Rouge and specialist associations will carry out awareness raising activities for health service providers and social services in order to facilitate access to care and to reduce stigmatization.

Main activities
- o Support for 240 self-help sessions
- o Support for the operation and provision of equipment for a counselling and documentation centre
- o Drawing up a health guide specifically for sexual minorities
- o 2 training workshops for CA and PE on BCC, gender, HIV and human rights
- o 6 training workshops for sexual minorities on life skills by NGOs

Indicator
- Number of MSM that have benefited from an HIV prevention program

Expected results
- 7,097 MSM will benefit from the HIV prevention program, i.e. 50% of the gap

Target population
- 13,647 MSM

Implementation manager
- CNPS

- **Drug users**

There is very few statistical data on drug users in Côte d'Ivoire. However, the entire range of drug use methods can be found in this country, both injectable methods or otherwise, with the use of inexpensive crack taking first place. The scourge affects all layers of society and for some years, the education sector has also been affected. According to the 2007-2008 DMOSS report on activities (Attachment n° 54) 196 cases of drug addiction including 10.20% for secondary school staff and 89.80% for pupils have been recorded by the Regional Directorate for National Education in Abidjan 2.There is no specialist structure for the therapeutic care of drug addicts; consequently, structures such as the National Public Health Institute or the psychiatric hospital in Bingerville take over where necessary. To get a better idea of this high risk population, the proposal envisages carrying out a national survey and initiating a reflection workshop and a plea with political, legal and medical authorities to draw up a policy and strategies on prevention and care for drug users.

Main activities

o Reflection workshop and plea

Implementation manager

- CNPS

SDA 1.4 Diagnosis and treatment of Sexually Transmitted Infections (STI): STI which have not been diagnosed and are incorrectly treated are a portal for the HIV infection. Behavioral studies have established that young people commence sexual relations at a very early age and even though they have information on the methods of contracting STI and HIV, they do not regularly use condoms. They are therefore at risk of HIV in addition to unwanted pregnancies for young girls. The syndromic approach for diagnosis and treatment in accordance with WHO guidelines has been adopted (Attachment n° 64). The incidence rate of STI is 7‰. The improvement of care for STI is likely to significantly slow down the spread of the HIV infection. However, the care of STI is faced with numerous problems: the insufficient training and retraining of health staff, the inadequate management of treatment kits, insufficient laboratories and the high cost of diagnosis tests. Sexual violence is also at the source of STI. According to a study (Attachment n° 89) carried out in 2008, 846 cases of sexual violence were recorded in 58 health structures visited and only 8% of the victims benefited from full medical analysis.

The proposal will manage 43,132 STI cases out of the 67,745 expected cases, i.e. 75% of the gap. It will support activities which aim to respond to the various requirements of target populations in relation to gender, age, education, geographical situation, poverty status as well as the prevalence rate, the level of vulnerability and the risk of contamination. Particular attention will be given to the preconceived ideas which compel men, women and young children to not seek treatment for STI. BCC messages will be designed to put a stop to such stereotypes. These activities will be carried out by health professionals who will be trained on gender and gender based violence issues.

Main activities in relation to SDA 1.4

o 8 training workshops for health professionals on the syndromic approach to STI
o 8 training workshops for health professionals on gender and gender based violence
o 700 sessions to raise awareness on STI including 200 targeted at SW and MSM (talks)
o Supply of 56,072 kits for the syndromic care of STI

Indicator

- Number of STI cases in health institutions which have been correctly diagnosed, treated and advice has been given

Expected results

- 43,132 STI cases correctly diagnosed and treated out of the 67,745 expected cases by 2014

Target population

- The population of 9,677,820 sexually active adults, including 4,730,011 women and 4,947,809 men,

Implementation manager

- PNPEC

SDA 1.5: Condoms: according to the AIS 2005, Aids indicators show that the number of women using condoms is less than the number of men. In fact, 33.6% of women between 15 and 24 years old compared to 51.6% of men use condoms during high-risk sexual relations. (Attachment n° 46). The Ivorian Social Marketing Agency (AIMAS), which was created in 2001, manages the supply, with 4 distributors registered for the social marketing of condoms to 505 wholesalers, 1,510 semi wholesalers and 16,580 points of sale throughout the entire territory. Insufficient availability has been noted in rural areas. In addition to being sold, condoms are distributed free of charge during activities to raise

awareness.

The proposal envisages a marked increase in social marketing as well as the free distribution of 10% of female condoms and 5% of male condoms during local and mass awareness raising activities. In total, 33,923,486 condoms will be purchased, i.e. 33,673,486 male condoms and 250,000 female condoms. This represents 5% of the gap of 865,631,400 condoms by 2014. The promotion of condoms will be strengthened by placing emphasis on the use of the female condom. Distribution points will be created in 15 university cities, 50 large schools, 500 markets and in places frequented by key high-risk populations. Activities to put a stop to stereotypes, stigmatization and social barriers which prevent the use of female and male condoms will be conducted towards women, young girls and men. Condoms will be distributed and sold by AIMAS in collaboration with community associations which are mainly for women and young people.

Main activities in relation to SDA 1.5:

- Purchase of 1,683,674 male condoms for free distribution to associations
- Purchase of 25,000 female condoms for free distribution to associations
- Purchase of 31,989,112 male condoms for social marketing
- Purchase of 225,000 female condoms for social marketing
- Support for the promotion of the condom for AIMAS including specific action to target prejudices on the use of condoms

Indicator

- Number of condoms sold and distributed

Expected results

- 33,673,486 male condoms and 250,000 female condoms sold by social marketing by 2014

Target population

- The population of sexually active young people

Implementation manager

- CNPS

SDA 1.6: Strengthening of Civil Society and institutional capacities: the advent of AIDS has led to the creation of numerous community associations. They target several sub-populations: women, religious people, young people and key populations at high risk of HIV infection. Some associations have developed into community support organizations varying from prevention to medical care. However, there are not enough of them in relation to the needs of PLHIV. In general, most community associations are located in geographically limited areas with little supervision and inadequate data management. (Attachment n 65). They have few qualified human resources available and are weakened by a lack of equipment and management capacities. The coordination of associations has been set up through 10 communities, faith-based and private sector networks, the task of which is to coordinate, supervise and train NGO members (Attachment n 66). The networks are also faced with problems in relation to insufficient human, material and financial resources.

The proposal envisages strengthening the capacities of 10 networks and 80 community organizations which are active in the various areas of intervention. Strengthening will focus on administrative, financial and technical capacities, restoration, equipment, operational support and monitoring and evaluation. “Education on gender and HIV” integrated activities for groups of women in poor rural areas will lift certain structural social constraints on behaviour change.

Main activities in relation to SDA 1.6

- 4 training workshops on planning and project management which include a section on “education on gender and HIV”
- 4 training workshops on management and leadership
- Operational support for 80 community associations
- Participation in the payment of managers in 80 community associations
- Technical Support for the strengthening of the Community System

Indicator

- Number of community based associations that have benefited from the strengthening of capacities

Expected results

- 80 community organizations are strengthened by 2014

Target population

- 80 NGO and 10 national networks

Implementation manager

- CNPS

Objective 2: Improve accessibility and service quality of Counselling and Testing

SDA 2.1: Testing and counselling: There are 287 operational CT sites throughout the national territory with an objective of 460 sites in 2010 in the PSN (Attachment n 25). In addition, 69 out of 83 HD have at least one CT site. In spite of this, testing results are still very low, with only 16% of the target achieved in 2008, i.e. 311,145 people tested out of the 1,882,616 provided for. The reasons for such low attendance are linked to the inadequate promotion of CT, the insufficient number of social staff on sites and the insufficient training of peer educators for effective social mobilization. In addition to this, there is the fact that the private sector is hardly involved, the fear of stigmatization and the customer's fear of receiving a positive result.

The proposal provides for the opening of 120 CT which will be integrated in health structures and 10 communities CT and will provide continuous support for 41 CT from Rounds 2 and 5. The extension of CT concerns 29 HD for health structures in the public sector (20 previous HD from Round 2 and 9 new HD) throughout the entire territory for the private, faith-based and community sector. It will reach 1,412,595 people, i.e. 726,812 men and 685,783 women in the general population in both urban and rural areas. Activities to raise awareness will be directed at women, placing particular emphasis on testing during PNC, key populations at high risk of HIV infection and rural populations by using adapted fixed and mobile intervention strategies. In addition, action to improve service quality such as the revision of CT guidelines which include gender issues will be carried out. On the whole, testing will be systematically offered to SW and MSM during all prenatal consultations and family planning consultations, medical consultations, upon going to prison and during the raising of awareness.

Main activities in relation to SDA 2.1

- Revision of guidelines on counselling and testing to include gender issues
- Implementation of 120 integrated CT and 10 community CT
- 4 training workshops on gender and on psycho-social care of GBV cases
- Purchase of inputs and tests for 1,412,595 people to be tested
- Organization of 12 monthly testing sessions per mobile unit

Indicator

- Number of people benefiting from counselling and testing with test results sent

Expected results

- 1,412,595 people, i.e. 725,462 men and 755,073 women counselled and tested with test results sent, i.e. 50% of the gap

Target population

- 3,455,189 tests of the general population, young people, women, key populations at high risk of HIV infection (PSN target)

Implementation manager

- PNPEC/MSHP

Objective 3: To strengthen the accessibility and the quality of prevention of the transmission of the HIV infection from mother to child

SDA 3.1: PMCT: PMCT services are currently only available in 44% of health structures which offer PNC (316 out of 716). These 316 sites are distributed in 69 of the 83 HD. The number of expected pregnancies expected in 2014 is estimated to be 1,221,815 (Attachment n° 29). In 2008, 179,000 pregnant women benefited from counseling and testing, i.e. only 17% of expected pregnancies. In addition, only 6,909 (77.2%) of pregnant women who tested positive had access to ARV for PMCT. The low rate of access to PMCT services is explained by low human and financial resources and the vertical approach to the service offer in particular.

The 2007-2011 scaling-up plan (Attachment n° 69) takes the 4 components of PMCT into consideration: primary prevention, the prevention of unwanted pregnancies in women living with HIV, the prevention of the infection passing from infected mothers to their children and care, treatment and support for women living with HIV, their children and their families.

The proposal includes the following intervention: (1) Testing and counselling initiated by PNC and maternity providers, (2) prophylactic combinations, (3) access for HIV positive pregnant women to clinical and immunological evaluations (CD4) (4) Cotrimoxazole prophylaxis for HIV positive pregnant women and children born to HIV+ mothers (5) early virological diagnosis of children born to HIV+ mothers

through the PCR technique on DBS (6) the stepping up of primary prevention towards women of reproductive age (7) access for HIV positive women to family planning (8) the improvement of the nutritional status of HIV positive pregnant women living in households with food insecurity and child feeding (9) the strengthening of health workers' and communities' capacities (10) the implementation of monitoring and coordination bodies for scaling-up. The proposal will improve the availability and the quality of key services on 90 sites in the 20 HD from Round 2 and in 9 new HD which do not have any coverage for the public sector and throughout the entire territory for the private, faith-based and community sector. It will also improve the quality of services in 54 former sites from Round 2. Full antiretroviral prophylaxis will be given to 19,716 HIV positive pregnant women who are not eligible for treatment and to their children. Support and the link between PMCT and care will be provided by 60 CA who will provide counselling, VAD, and PDV research. In addition, special attention will be given to measures which improve service quality through mechanisms to motivate high-performance sites and through the involvement of districts in implementing and monitoring intervention. The revision of guidelines on PMCT will include the gender dimension in order to improve the management of intervention for women that have tested positive. The low prevalence of HIV, the poor attendance of health structures and social-cultural factors in targeted areas justify the 40% proportion of the gap covered by the proposal which is realistic in light of previous results.

Main activities in relation to SDA 3.1

- Revision of standards and guidelines on PMCT to include gender aspects
- Motivation of staff in 50 sites to improve the quality of PMCT services
- Implementation of 2 regional laboratories for early detection
- Implementation of 250 information sessions on incorrect ideas in relation to PMCT by 25 NGO
- Distribution of family food rations for 6 months to 3,943 families of pregnant women with food insecurity
- Short-term International Technical Support for PMCT

Indicator

- Number of HIV positive pregnant women receiving full antiretroviral prophylaxis to reduce the risk of mother to child transmission

Expected results

- 492,907 pregnant women and 3,000 spouses receive HIV counselling and testing
- 19,716 HIV positive pregnant women receive full antiretroviral prophylaxis and benefit from counseling and support in relation to diet

Target population

- 1,221,815 expected pregnant women by 2014

Implementation manager

- PNPEC/MSHP

Objective 4: To strengthen the fight against Aids in the workplace

SDA 4.1: Private sector: in 2000, the National Policy document to fight against Aids in the workplace estimated the rate of employee deaths as a result of Aids to be 5.6% (Attachment n° 70). The response by the private sector is still low. With regard to prevention in 2008, 258 Aids committees were set up out of the 1,587 steering committees provided for. As Round 2 ended on 31 May 2009, 80% of these committees are no longer operational. Out of the 49 companies which offer general care services to their infected employees and their families, 42 do so by concluding contracts with the Infectious Disease Department and the CIRBA. The testing rate is less than 3% in the population of workers in the private sector which delays case management in the workplace.

The strategies will induce the testing of 50% of workers for early care management which will allow companies to preserve their staff and to safeguard their productivity. The following methods will be used: (1) mass and local awareness-raising activities in the workplace; (2) the promotion of voluntary testing of workers during annual health check-ups; (3) the involvement of the private sector in national voluntary testing days and (4) the medical care of PLHIV and their families. Discrimination towards PLHIV is high in companies. Pleas will be made to company managers to promote and distribute the national Aids charter in the workplace (Attachment n° 71)

The private sector envisages making 600 Aids committees operational, including 150 in small and medium sized companies which are members of the FIPME to step up prevention. The role of these committees will be to manage activities in the fight against Aids in companies. The care and support services offered will be improved for 175,076 workers and their families in 30 private sector health centers

which will be supported by 15 CA. The minimum package of these 30 health centers will be: CT, PMCT and the therapeutic care of workers and their families. Neighbouring populations to companies in rural areas will benefit from care services in 83 HD. The strengthening of capacities will concern 6 private sector organizations (CECI, CGECI, FIPME, CCI-CI, CNM-CI and the Unions) for the coordination and sustainability of actions to fight against Aids in companies. The project will recruit: 1 coordinator, 1 program manager, 1 accounting assistant and 1 driver. 50% of the salaries for these staff will be funded by the project and 50% by the CECI/CGECI and employer organizations.

Main activities in relation to SDA 4.1

- o Completion of a survey on the access of workers in companies to ARV
- o 96 training workshops for 2,400 PE members of steering committees
- o Organization of 30 inter-company football, basketball and volleyball tournaments
- o 2 training workshops for facilitators to support the integration of non-discriminatory codes of conduct towards PLHIV in company internal rules and procedures
- o Medium-term International Technical Support for the private sector.

Indicator

- Number of steering committees implementing programs which focus on the HIV infection

Expected results

- 600 steering committees implementing programs which focus on the HIV infection, which corresponds to 37.5% of the gap

Target population

- 175,076 workers, infected staff, their families and rural population, coordinated by 600 steering committees

Implementation manager

- CNPS

GOAL 2: To reduce Aids related morbidity and mortality by providing access to care, service quality and care continuum

Objective 5: To improve the accessibility and the quality of medical care through ARV, the prevention and treatment of OI and biological follow-up

SDA 5.1: Antiretroviral treatment (ARV) and follow-up: Care through ARV is carried out in 215 sites in 69 HD out of 83. In 2008, 51,833 PLHIV including 3,100 children are undergoing ARV treatment. With regard to universal access to prevention, treatment, care and support services, Côte d'Ivoire opted to make ARV free of charge in August 2008 (Attachment n° 72a). A Technical Committee to monitor the stock of ARV, consumables and inputs is responsible for the quantification of national requirements for ARV and inputs (Attachment n° 105). Out of patients that have received ARV at least once, the number of patients lost to follow-up represent 27.8%. In fact, out of 71,833 PLHIV that have started ARV treatment, 51,833 are still undergoing ARV treatment, i.e. 20,000 patients lost to follow-up. Pediatric care which was carried out in 175 of the 215 care sites experienced problems due to the shortage of trained care providers, the insufficient early detection of cases and the high number of patients lost to follow-up.

The Global Fund Round 9 proposal will carry out activities in the 29 HD mentioned above for the Public Sector and throughout the entire territory for the Private, Faith-based and Community Sector. There are 29,595 patients to be managed in 35 previous sites and 90 new sites within 5 years by 2014. This figure includes 11,232 PLHIV in Round 2 and the new patients included in Round 9, i.e. 18,363 PLHIV. Any patient testing positive will receive an initial biological check-up following which patients eligible for ARV treatment in accordance with national standards are put on treatment plans by a prescribing physician. All positive patients, eligible or otherwise, will benefit from biological follow-up in accordance with national guidelines. With regard to technical resources, 19 laboratories will be upgraded to complete the balance. The strengthening of service provider capacities will enable care for children who will be referred from the various testing portals (PMCT site, paediatric consultation, social centers). HIV positive patients suffer from nutritional deficiencies due to their reduced food intake and the poor absorption of nutrients. Their daily requirements are increased by 10 to 50%. Nutritional assistance will be provided to malnourished PLHIV in the form of 1,480 nutritional and dietary kits. This strategy will also improve adherence to ARV treatment. The creation of nutritional restoration and development centers will enable the nutritional status of PLHIV to be monitored.

The patients cared for by the Global Fund in 2014 represent 80% of the gap. With regard to community care, particular emphasis is placed on patient compliance for treatment success. To ensure care continuum, a network of community players will be deployed around the health structures which offer

MAP for PLHIV. (Attachment n° 73). Action in relation to medical care which takes into account post-exposure prophylaxis will be directed at victims of sexual violence.

Main activities in relation to SDA 5.1

- Purchase of ARV for 29,595 PLHIV, including 2,368 children,
- Purchase of inputs and reagents for the biological follow-up of 29,595 PLHIV undergoing treatment and 29,595 PLHIV who are not eligible for treatment according to the plan
- Provision of equipment for 19 biological laboratories
- 5 quantification workshops
- 4 training workshops for physicians on gender and the psycho-social and medical care of Gender-based violence cases
- 4 training workshops for service-providers on PECP

Indicator

- Number of people with the advanced HIV infection receiving treatment based on a combination of antiretrovirals

Expected results

- 29,595 PLHIV, including 2,368 children receive treatment based on a combination of antiretrovirals, i.e. 80% of the gap
- 19 biological laboratories provided with equipment

Target population

- 137,807 PLHIV eligible for treatment based on a combination of antiretrovirals

Implementation manager

- PNPEC/MSHP

SDA 5.2: Prophylaxis and treatment for Opportunistic Infections: the OI care guide recommends prescribing Cotrimoxazole prophylaxis for immunosuppression fixed at 350 CD4. Diarrhoea represents 20% of OI; this incidence rate has been significantly reduced due to the wide-scale use of Cotrimoxazole. On average, candidiasis affects 60% of PLHIV with a CD4 rate between 200 and 500/mm3; The most frequently encountered OI are in relation to pulmonary tuberculosis as well as digestive, neurological and timorous impairment. In spite of ARV and biological follow-up being free of charge, care for Opportunistic Infections excluding Tuberculosis is problematic. The methods of diagnosis (toxoplasmosis) and care (cryptoccocal meningitis, Kaposi's disease) are limiting factors. Problems in relation to the geographical and financial accessibility of PLHIV to drugs and additional examinations have been noted. The introduction of Cotrimoxazole in the treatment of OI has reduced HIV related morbidity and mortality.

TB is the 1st cause of mortality in PLHIV and the HIV/TB co-infection complicates any specific care (Attachment n° 76). 40% of TB cases can be attributed to HIV. There is a care guide for the HIV/TB co-infection. All HIV positive patients diagnosed with tuberculosis are automatically referred to the Tuberculosis Centre which monitors Tuberculosis and HIV. Tuberculosis treatment is free of charge in Côte d'Ivoire and is provided in CAT and VCT through the PNLT. ARV treatment for tuberculosis patients in CAT is entirely managed by the PEPFAR.

The proposal envisages drawing up administrative laws on OI, the prevention of OI through Cotrimoxazole, the strengthening of the capacities of care providers for the diagnosis and care of 124,713 cases of OI, and the availability of treatment which is suitable for various OI.

With regard to the management of Tuberculosis, active research is systematically recommended before initiating treatment and during the follow-up of PLHIV. The proposal will only carry out activities to raise the awareness of medical staff for the early detection of Tuberculosis with a view to referring these to CAT where a biological and clinical diagnosis will be carried out. A module for the early diagnosis of Tuberculosis will be introduced into the training of health staff and community shiftworkers involved in care.

Main activities in relation to SDA 5.2

- 2 Consultations to draw up administrative laws on OI
- Allocation of drugs for OI through molecules for 124,713 episodes
- 4 training workshops for care providers on the care of OI
- 7 training workshops on the early diagnosis of tuberculosis

Indicator

- Number of PLHIV diagnosed and treated for Opportunistic Infections

Expected results

- 124,713 morbid episodes diagnosed and managed

Target population

- 498,854 PLHIV

Implementation manager

- PNPEC/MSHP

Objective 6: To strengthen the community care of PLHIV, women, OVC and key populations at high risk of HIV infection

SDA 6.1: Care and support for chronically ill patients: The support for PLHIV and vulnerable groups is one of the priorities in the 2006-2010 PSN (Attachment n° 25). To ensure the general management of HIV, the rights of PLHIV must be strengthened (Attachment n° 77) and care continuum must be provided to enable PLHIV to rely on the services available in the public and the community sector. Community based associations act as an intermediary within communities for the services initiated by the public sector and support PLHIV in their care path. The follow-up of PLHIV improves treatment compliance to reduce, on the one hand, the number of "patients lost to follow-up" and on the other hand, to avoid the development of resistance to treatment. The efficient use of the referral and counter-referral system is part of this strategy. However, to date, such care continuum has only been carried out in part due to the lack of development of community management throughout the entire territory, the inadequate follow-up of PLHIV undergoing ARV treatment by NGOs and reluctance in relation to home visits due to stigmatization. In addition, community officials do not have sufficient training and the financial resources for community care are inadequate for populations at high risk of the HIV infection who are stigmatized. All this problems observed in the field explain the significant number of patients lost to follow-up and the lack of treatment compliance. With regard to the 20,000 patients lost to follow-up, there is no data on deaths, movement, treatment abandonment or change in care center.

The strategy proposed to reduce the number of patients lost to follow-up relies on CA who support the PLHIV from the care center to his home environment. Each care center will be partnered with an NGO, the members of which are recruited and trained in psychosocial monitoring. The CA are responsible for organizing self-help groups, VAD, some home care and compliance with the schedule of RDV in care centers. Patients lost to follow-up who have evaded follow-up are actively researched through telephone calls or VAD. The aim is to manage 44,206 PLHIV. In addition, to improve care continuum, the proposal la proposition for Round 9 envisages setting up 5 "transit homes" to welcome, accommodate and support infected and affected people who come from afar for follow-up in health organizations. Management covers medical, psychosocial, nutritional and economical aspects such as IGA and direct assistance for vulnerable populations. Medical care will be provided in 22 community health centers for the support of PLHIV. The restoration of 10 community health centers is provided for in addition to the 12 existing centers. These community health centers are managed by associations which are competent in the care of PLHIV. The proposal submitted provides for 22,987 home care and 88,412 home visits. The activities will be carried out by 100 Community Advisors trained for this purpose in working with both the medical sector and the community sector. The proposal envisages improving the nutritional status of patients undergoing ARV treatment with food insecurity by distributing family rations for 6 months to 5,919 PLHIV. Self-help groups, time for sharing and fundamental exchanges in psycho-social support, will be facilitated by the production of community meals.

Main activities in relation to SDA 6.1

- o Recruitment of 100 community advisors
- o Completion of 22,987 home care visits and purchase of 22,987 home care kits
- o Production of 600 community meals
- o Development of 50 collective IGA for associations of PLHIV
- o Distribution of family food rations for 6 months to 5,919 PLHIV with food insecurity where one patient is undergoing ARV treatment

Indicator

- Number of PLHIV that have received community care

Expected results

- 44,206 PLHIV will receive community care

Target population

- 498,854 PLHIV and their families

Implementation manager

- CNPS

SDA 6.2: Care and support for key populations at high risk of HIV infection: the support for SW, the

prison population and MSM is inadequate. Few health structures offer care which is adapted to these targets. In addition, few IGA and not much intervention have been carried out to enable the empowerment of SW and MSM.

For 8000 SW, the proposal provides for the strengthening of medical care centers, the support of SW associations, the development of activities which aim to empower SW and to reduce their vulnerability, the provision of 50 grants for professional training, the development of 150 targeted, managed IGA for 500 SW who would like to get out of prostitution

With regard to the prison population, psychological and social support is provided by 30 Community Advisors from associations. They will prepare prisoners for getting out of prisons and their referral to Centers which are responsible for locating homes for prisoners. Nutritional care and support will be provided with a view to the nutritional restoration of 2,880 malnourished prisoners.

The proposal aims to carry out actions in health centers in collaboration with associations which have specific activities aimed at MSM to enable the community care of 7,097 MSM as well as support action to improve consultation and their empowerment.

Main activities in relation to SDA 6.2

- Elimination of illiteracy for 1,500 SW
- Support for the implementation of 150 collective IGA for SW
- 50 professional training grants for SW
- Distribution of 13,560 “Food for work” or hygiene kits (motivation) to peer educators, prisoners and supervisors.
- Provision of 25 professional training grants to MSM

Indicator

- Number of sex workers having benefited from community care

Expected results

- 8,000 sex workers will benefit from community care

Target population

- SW, the prison population, MSM

Implementation manager

- CNPS

SDA 6.3: Care and Support for Orphans and other Vulnerable Children: the 2008 WHO/UNICEF report estimates the number of OVC due to whatever reason to be 1,400,000 including 1,600 OVC in conflict with the law (Attachment n° 78). In 2008, UNAIDS estimated the number of OVC as a result of HIV to be 420,000 (Attachment n° 44). OVC are faced with several problems which damage their fundamental rights: education, health, social welfare, nutrition and access to inheritance. The National Program for Orphans and other Vulnerable Children (PN-OEV) coordinates the intervention aimed at OVC that have lost at least one parent. The PN-OEV has drawn up a national policy document (Attachment n° 79), national guidelines (Attachment n° 80), the 2007-2010 Strategic Plan (Attachment n° 81). The creation of 16 platforms for collaboration, which include 118 private, community and public organizations (social centers and educational institutions), which further the action synergy of all the players involved.

However, the care of OVC has its limits. Barely 10% of OVC benefit from care as a result of the breakdown of the family unit and the malfunction of the traditional care channel. Children continue to have their inheritance rights infringed and very few children are declared to the Registrar of Births, Marriages and Deaths. Access to basic social services is poor as in 2008, only 1753 OVC benefited from educational support, 84,947 benefited from psychosocial support and a tiny proportion of families benefited from support for implementation. Nurseries, SOS villages and orphanages only cover 2.15% of social assistance organizations. In spite of the increasing number of associations involved in the care of OVC, their action is limited due to low technical and material capacities, insufficient human resources, the unavailability and the lack of ownership of national policy documents and data collection tools.

The proposal aims to strengthen the capacities of families to protect OVC, by providing them with economical and psychosocial support. It will facilitate access to basic social services by providing them with medical, educational, legal, dietary and psychosocial care. The distribution of family food rations for 6 months to 9,000 households with food insecurity will enable OVC to have the food they need to grow and to continue their education. Community mobilization and the training of community associations will be strengthened. These strategies will allow for the care of 45,000 OVC out of the 413,254 OVC targeted by

the PSN. The insufficient number of specialist associations and the low absorption rate at local level explains the 10.9% objective which is realistic in view of the work previously carried out. Coordination will be carried by the Ministry for family, women and social affairs through the PN-OEV. Implementation will be carried out together with OBC platform members.

Main activities in relation to SDA 6.3

- Support for psychosocial care through VAD for 45,000 OVC
- Support for educational care (primary and secondary) for 36,000 OVC
- Support for legal care for 20,000 OVC
- Support for medical care for 9,000 OVC
- Support for the strengthening of PN-OEV and 30 Social Centers
- Distribution of family food rations for 6 months to 9,000 families with food insecurity looking after an OVC

Indicator

- Number of OVC having benefited from care

Expected results

- 45,000 OVC will benefit from care by 2014, i.e. 10.9% of the gap

Target population

- 413,254 OVC

Implementation manager

- CNPS

GOAL 3: To strengthen the leadership, the coordination and the Monitoring and Evaluation of the national response

Objective 7: To improve the leadership, the coordination and the Monitoring and Evaluation of the national response

SDA 7.1: Leadership, decentralization and multi-sectorality: the National Aids Council (CNLS), created by a decree in 2004 (Attachment n° 82) ensures the national leadership of multi-sectoral coordination, presided by the Head of State. It is represented at decentralized level and at sectoral level by regional, departmental, communal and village committees as well as by sectoral Aids committees. To date, 16 out of 19 CRLS, 38 out of 58 CDLS, 52 out of 197 CCLS and 723 out of 3000 CVLS have been set up.

The CNLS Secretariat is carried out by the Ministry for Aids which is represented at decentralized level by technical committees to support local initiatives (CTAIL) and supported by the use of decentralized committees (Attachment n° 84). At sectoral level, each of the 34 Ministries coordinates their sector internally, and inter-sectoral coordination is carried out by the Interministerial Aids Committee (CIMLS) which is presided by the Prime Minister. A Partnership Forum which is co-presided by the Ministry for Aids and the Ministry of Health has been set up (Attachment n° 25). A Technical Secretariat for Operational Coordination (STCO) is responsible for national coordination whilst the CTAIL are responsible for regional coordination.

In relation to this priority, the support from the Global Fund (Round 2) has strengthened the capacities of 5 CTAIL (South-Comoé, Fromager, Vallée du Bandama, Savanes, Montagnes). The support from PEPFAR will focus on 11 CDLS by 2010. The PUMLS covers 4 regions (Lagunes, South Comoé, Savanes and Montagnes) including 20 departments and 5 sectors (Defense, Interior, Health, Education and Youth).

The problems noted are inadequate coordination and supervision at decentralized level and insufficient consultation between the MLS and networks of Civil Society associations.

The proposal envisages supporting CTAIL in 10 regions (Bafing, Worodougou, Denguelé, Agneby, Haut Sassandra, Moyen Cavally, Marahoué, Sud Bandama, N'zi Comoé and Lacs) and the strengthening of the STCO. The intervention in relation to this SDA is carried out by the CNLS Secretariat, the CTAIL, sectoral committees, decentralized committees, Civil Society networks and the Private Sector.

Main activities in relation to SDA 7.1

- 8 training workshops for people at central and decentralized level from all sectors on Planning, Monitoring and Evaluation, Program/project management, knowledge of the Epidemic and response and gender
- Annual participation of 10 players from the various sectors in 2 international conferences on HIV

- Support for 20 consultation sessions for Civil Society networks with the MLS
- Provision of equipment for 10 CTAIL
- International technical assistance with Governance and Partnerships for the STCO for 2 years

Indicator

- Number of operational technical committees to support local initiatives (CTAIL)

Expected results

- 10 CTAIL in 10 regions will be operational

Target population

- The population in 10 regions

Implementation manager

- PNPEC/MSHP

SDA 7.2: Operational coordination of the Health Sector: The strengthening of the sectoral coordination of HIV intervention in the health sector is one of the priorities of the PSN (Attachment n° 25). The Ministry of Health ensures the coordination of HIV intervention within the health sector. Such coordination is carried out through the National Program for the Medical Care of PLHIV (PNPEC) which was set up in 2001 and the organization of which was changed in 2008 (Attachment n° 85a). The function of the PNPEC is to organize the management of HIV in Côte d'Ivoire. On the one hand, this consists of drawing up policies, strategies, standards and guidelines on the care of PLHIV and ensuring that these are applied. On the other hand, the PNPEC is responsible for planning for intervention to be extended within the sector, coordinating all the care activities, supervising the implementation of activities and promoting the various interventions.

Since it was set up, the PNPEC has drawn up policy documents, standards and guidelines on the various areas of care and has developed communication and data collection tools. Exchange frameworks on intervention have been established coordination is still inadequate as a result of the diversity of the parties involved. The take-over of intervention by the HD, which is the operational unit of the health system, is inadequate due to insufficient knowledge and insufficient sharing of national guidelines. The high mobility of staff has also been noted who tend to migrate to organizations offering better working conditions. The PNPEC is faced with insufficient logistics resources for ensuring the effective implementation of guidelines.

The proposal furthers consultation frameworks, draws up/reviews and distributes national guidelines, strengthens the PNPEC in its role as coordinator of HIV intervention within the health sector and stabilizes its staff and strengthens the take-over of intervention by the HD.

Main activities in relation to SDA 7.2

- Drawing up a strategic plan on HIV intervention in the health sector which includes gender
- Drawing up a national operational plan for the health sector based on district micro-plans
- Drawing-up of documents, standards, guidelines and policies on the general care of PLHIV
- Organization of 20 quarterly coordination meetings for the players involved
- Recruitment of a biologist
- Organization of 8 training sessions for DD and DR on the supervision of CT, PMCT and care activities

Indicator

- Number of monthly coordination meetings held

Expected results

- 60 monthly coordination meetings held by 2014

Target population

- The general population in 19 regions

Implementation manager

- PNPEC/MSHP

SDA 7.3: Monitoring and Evaluation and operational research: the national system for the monitoring and evaluation of the national response to Aids includes the health sector component and the non-health sector component. The MSHP fills in all the indicators in relation to the medical care of PLHIV through the information and management system (IMS) managed by the DIPE. Information on intervention at community and sectoral level is collected and analyzed by the MLS through the DPSE. All this information is centralized at the DPSE in order to produce and distribute annual reports for decision-making. Notable progress has been made with regard to monitoring and evaluation. In particular various surveys have been conducted such as sentinel sero-surveillance since 1997, the AIS in 2005 and behavioral surveys to provide data on HIV, the availability of an electronic tool which is harmonized at national level for the

longitudinal monitoring of PLHIV has already been rolled out to 17 care sites.

However, the following has been noted (Attachment n° 32) (i) the failure to take over the national M/E framework, (ii) the low speed and completeness of data leading to certain players setting up parallel reporting systems, (iii) the failure to systematically share information gathered on HIV activities, (iv) insufficient information literacy expressed by the low interest in the data reporting activity and the insufficient transmission of data from operational level to central level, (v) the lack of reports on activities by sectoral and decentralized committees for community and private sector data sent to central level, (vi) insufficient material resources leading to the non-availability of HIV tools which are standardized at all levels (17% disruption in supplies), (vii) the poor use (44%) of data produced at all levels, (viii) the failure to regularly audit the quality of data, (xi) the poor feedback from central level to the 19 regions and the 83 HD.

This proposal contributes to the strengthening of the national system for the monitoring and evaluation of HIV intervention. It will involve improving the quality of the HIV data collected and furthering the use of data for decision-making in relation to the fight against Aids. The program will ensure the availability of paper copies and electronic tools for HIV data. 400 field staff will be trained in Monitoring and Evaluation. The 5 annual reports on the health sector will be sent electronically by relying on the recent extension of the internet connection in the country. Annual reports will be produced at national level and will be distributed to further their use. To avoid double counting among the various care centers, a unique code system will be set up for the entire territory. The proposal submitted plans for 9 operational research activities.

Main activities in relation to SDA 7.3

- Reproduction of data collection tools for each area
- Organization of a quarterly meeting with players in the field
- Mid-term and final project evaluation
- Completion of 2 annual audits on the quality of community data for the public and private sectors
- Implementation of a unique code for patient identification
- International Technical Assistance on monitoring and evaluation and HIV Epidemiological Surveillance

A series of surveys will be conducted which include gender in collection tools and analysis plans (Attachment n°37).

1. Survey on the quality of CT services
2. Study on the impact of Aids in the private sector and on the contribution of the private sector
3. Study on the impact of intervention in relation to the Prevention of HIV Transmission from Mother to Child
4. Survey on the determinants of patients lost to follow-up with regard to medical care
5. Survey on the survival of patients undergoing ARV treatment at 12, 24, 36 and 60 months
6. Survey on the seroprevalence of HIV in SW in the 29 HD
7. CAP survey of prison populations in 27 prisons
8. Survey on seroprevalence in injecting drug users

Indicator

- Number of health districts that have sent monthly HIV reports to the DIPE within the required time frames

Expected results

- 29 health districts send monthly HIV reports to the DIPE within the required time frames

Target population

- Managers in 83 health districts

Implementation manager

- PNPEC/MSHP

SDA 7.4: Program administration and management cost: the CCM has identified 3 Principal Recipients (PR): the National Program for the Medical Care of PLHIV (PNPEC/MSHP) for the Public sector, HIV section, the DIPE/MSHP for HSS and the National Fund for Social Welfare (CNPS) for Civil Society and the Private Sector, HIV section.

The PNPEC, the body for coordinating the medical care of people living with HIV within the Ministry of Health has a great deal of experience in relation to coordinating the fight against Aids. It has a pluridisciplinary staff consisting of approximately forty people with experience in the area of HIV. The

program also has experience in the management of national and international funding and a financial and program reporting system. However, the evaluation committee has found the need to strengthen the financial and institutional management system.

Main activities

- Recruitment of staff consisting of 22 people (1 project coordinator, 1 assistant coordinator, 1 financial manager, 1 accountant, 1 internal management auditor, 1 Monitoring and Evaluation manager, 1 administrative bilingual assistant, 4 regional coordinators, 4 regional monitoring and evaluation managers, 4 regional financial and administrative assistants)
- Allowances based on performance for public sector human resources engaged in the implementation of the project at central and peripheral level
- IT and communication equipment (5 IT kits, 15 laptops, 2 overhead projectors, 1 group antivirus licence, 1 photocopier, 5 fax, 5 scanners, 22 mobile telephones)
- Rolling stock equipment (3 x 4X4 vehicles, 5 motorcycles)
- Strengthening the capacities of human resources
- Project team coordination meeting every two months
- Assignment to supervise regional players
- Drawing up of quarterly reports
- Production of monthly information on the project
- Annual report meeting with all the players in the project

The CNPS is a private company with ISO 9001 certification. Its mission is to recover social security contributions and the payment of benefits relating to such schemes. The CNPS has a great deal of experience in financial management and the management of reports of funds of social security schemes. Financial and accounting transactions are systematically traced by an automated accounts management system which uses ORACLE software. The financial department has 109 staff members. They all have a BTS in accountancy or a postgraduate degree in finance and accountancy. The CNPS has 21 branches represented in 14 regions. They all have financial autonomy and are interfaced with the information system plan which provides all accounting, financial and statistical data in real time. Through the management of its health centers and its Aids control unit, the CNPS has experience in controlling Aids in the workplace and programme management.

Main activities

- Recruitment of a team consisting of 17 people: 1 coordinator, 1 bilingual secretary, 1 private sector programme manager, 1 community programme manager, 1 monitoring and evaluation manager, 1 administrative and financial manager, 1 subgrant manager, 3 monitoring and evaluation assistants and 3 administrative and financial assistants, 3 drivers
- Provision of IT hardware and communication equipment (8 IT kits, 5 laptops, 4 scanners, 3 overhead projectors, 1 group antivirus licence, 1 large capacity photocopier, 4 fax machines, 20 mobile telephones)
- Rolling stock equipment: 3 x 4X4 vehicles
- Design of manuals on procedures for the management unit
- Strengthening of human resources capacities in management, programme management and management of GF procedures
- Annual report meeting on project monitoring
- Bi-annual supervision of regional offices

Indicator

- Number of high-performance PR

Implementation manager

PNPEC/MSHP, CNPS

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

The RCI CCM is not submitting the original proposal from Round 8 which is not recommended by the

TRP. It has repeated the participative process in relation to the situation analysis for the Round 9 proposal. However, any adjustments have been made based on implementation plans and activities to take into account each "weakness" identified in the "TRP examination form" for rounds 7 and 8 (Attachment n° 30, 31). Substantial effort has been made to avoid any duplication with other lenders and with the Global Fund since Round 2 ended on 31 May 2009, taking into account the areas with no HIV intervention and targeting the population groups which do not receive any substantial intervention (Attachment n° 27).

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

The lessons learned during the implementation of previous programmes avoid the same mistakes from being repeated. An exhaustive study of the intervention, parties involved and lenders in relation to Aids has been carried out previously to avoid the same programmes from being repeated on the same sites and partial overlaps of programmes supported by the different lenders. As a result, the proposal has selected as a priority populations which are inadequately or are not supported by other programmes. It also includes the continuation from Round 2 and proposes to extend the same activities to HD which are not covered.

The proposal has been adapted to the specific post-crisis context, taking into account the more pronounced general impoverishment in CNW areas and starting off with the greater vulnerability of young girls and women to the risk of HIV infection. The proposal also includes more significant requirements in relation to staff training and the restoration and provision of equipment to facilities in these areas. Even though most HD have at least one general care site (prescription and follow-up of ARV, PMCT, CT, community monitoring) populations still have very unequal access to these facilities. The proposal satisfies this concern by expanding the coverage of care facilities through the addition of MAP to HIV care in 80 operational Health Centres.

The community sector is experiencing problems with coordination and its action is often spread out which leads to a loss of efficiency. The proposal places particular emphasis on strengthening this sector, its coordination, leadership, good governance and the concept of personal responsibility. In order to carry out its role fully, the community sector needs to be recognized by the other players involved, particularly health staff, as an essential player in care and care continuum. In the same way, social mobilization for PMCT and CT is allotted to the community sector to improve the attendance of these facilities.

The problems in relation to the supply and the disruption of supplies of ARV have led the PSP to suggest the formation of a communal basket of ARV to which each lender (Global Fund, PEPFAR, UNITAID) may contribute in accordance with its planning. This measure will be maintained in Round 9.

The “Health District” approach with the strengthening of the leadership of the district director is the approach adopted by Côte d’Ivoire. This strategy brings together the quality managers of the services and the supervisors of peripheral health facilities and improves the performance of such facilities. Similarly, the strengthening of the district M/E unit enables the more fluid circulation of the data collected. In view of this finding, Rounds 5 and 2 have supported the districts in the areas of intervention of these proposals. This strategy will be continued to improve performance and monitoring.

Finally, some procedures in relation to recruitment, management, disbursements to sub-recipients and the validation of expenses are complex and risk slowing down the execution of the programme. The anticipation of procedures and a detailed plan which is strictly complied with should reduce any delays in the execution of the programme.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available HIV prevention, treatment and/or care and support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the*

response between these key population groups).

Côte d'Ivoire has ratified laws on sex equality. In the Ministry for women, family and social affairs, there is a department for equality and gender. This structure has raised the awareness of all the other Ministries, including the MSHP to set up sectoral committees on gender. The members of these sectoral committees are trained on gender and training is extended to other staff members. With regard to the care offered, access to the various health centres is free and open to men and women, both rich and poor.

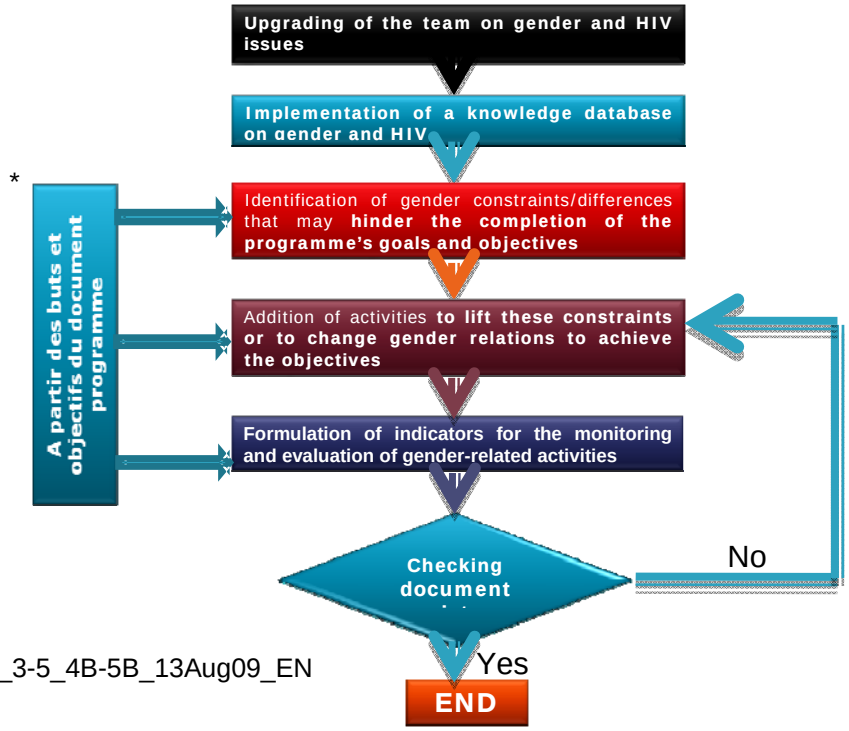
With regard to HIV, the feminisation of the epidemic has been noted since 2005 (two women infected for every one man). In addition, women represent more than 50% of poor people in society. The majority of women are dependant upon their spouse, particularly with regard to health. Some population groups are more exposed t the risk of HIV infection, particularly women (Attachment n° 87 and 88), sex workers (SW), men that have sex with men (MSM) and prisoners. They make up a marginal population. Not much HIV intervention is carried out in their favour and the care facilities for these populations are all in Abidjan. In order to comply with equal access to the various facilities, target groups (PLHIV, OVC) key populations (women, SW, MSM, prisoners) have been identified for this proposal. In addition, a national programme specifically for caring for populations at high risk of HIV infection has been set up with a view to addressing discrimination and stigmatization among other things.

In Côte d'Ivoire, ARV have been free of charge for the entire population since 2008. However, some health districts do not have any care facilities or PMCT facilities. However, the care of opportunistic diseases is not free of charge which significantly slows down the general care of PLHIV. This proposal will ensure the free supply of ARV and will enable the care of opportunistic diseases. Health districts which are not covered will be included and strategies will be developed for key populations at high risk of exposure.

The strengthening of the PMCT program, which has been identified as a main priority, shows that women are at the centre of this proposal. To improve family protection, action has been carried out to involve spouses who will benefit from testing and care.

PLHIV, OVC and target populations, who are stigmatized and discriminated against, are among the principal recipients of the proposal. Their care will be free of charge for ARV and for opportunistic diseases. Prevention programmes will be developed for PLHIV. Associations for people living with HIV, which are significantly involved in this proposal, will benefit from a strengthening of their capacities to help reduce stigmatization and discrimination. Finally, the total coverage of 83 HD through this proposal will enable rural areas to be reached where the poorest populations with no access to HIV intervention are situated.

Figure n° 5: CONCEPTUAL FRAMEWORK FOR INCLUDING GENDER IN THE ROUND 9 PROPOSAL



*A partir des buts et objectifs du document programme	From the goals and objectives in the programme document

Table n° II: Gender-related activities in the Round 9 proposal

Objectives and SDA	Obstacles relating to gender relations and other social constraints that may hinder the achievement of the goals and objectives	Activities to lift these constraints to change gender relations to achieve the objectives
SDA 1.2	- The exposure rates to mass media are very low for women in rural areas (AIS) - Poor social mobilisation to change the behaviour of young people - The rate of school attendance by the general population is very low in CI - A large proportion of young people are outside the academic education system - Secondly, the net rate of education of girls is only 26.6%	- Completion of 36,000 talks for social mobilisation for CA of young girls and boys aged between 15 and 24 - Completion of 18,000 local BCC campaigns for women in rural areas - Training of 75 teachers and 20 NGO which are active in the educational sector on BCC activities - Organization of local BCC activities to reach young girls, mothers and uneducated young people - Organization of 25 tournaments for young girls and young boys
SDA 1.3	- Fear of revealing their HIV positive status to partners who are not customers - Low self-esteem	- 4 training workshops for CA and PE on BCC, gender, gender-based violence, HIV and human rights
SDA 1.4	- Very poor social mobilization	- Support for the mobilization of NGO - Support for the training of prisoners on life skills by NGO
SDA 1.5	Very poor social mobilization	- 2 training workshops for CA and PE on BCC, gender and HIV - Support for the training of sexual minorities on life skills by NGO
SDA 1.6	- Young boys do not use any means of prevention - Young boys often express their masculinity violently (fact that women do not manage to negotiate sexual relations with their partners)	- 8 training workshops for health professionals on the syndromic approach to STI and the strengthening of capacities on gender and HIV/STI - 500 sessions to raise awareness on STI, gender-based violence and its impact on STI and HIV
SDA 1.7	- Social and cultural barriers with regard to the use of condoms - Problems in relation to women wearing female condoms and negotiating the use of male condoms	- Support for the organization of community-based BCC activities which are specifically directed at prejudices in relation to the use of condoms
SDA 1.8	- Lack of qualification and experience on communication to eliminate GBV, FGM, etc.	- Training of NGO on gender and HIV issues
SDA 2.1	- No counseling protocol which includes gender - Fear of women of the reaction of their spouse having tested positive - Abandonment of family and friends, particularly for women that have tested positive - Feeling of humiliation for men whose wives have tested positive	- Raising the awareness of communities on stigmatization and discrimination which involves men in implementation - Strengthening the capacities of 100 CA on gender and the care of gender-based violence - Support for NGO for legal pleas on HIV
SDA 3.1	- The woman is often the first to be informed - Stigmatization and unequal relations in decision-making with regard to the household and family	- Revision of standards and guidelines on PMCT to include gender considerations - Organization of community education programmes on PMCT through NGO

SDA 4.1	- Significant discrimination and stigmatization in companies - Job recovery, particularly for men	- Plea and support for drawing up or including a non-discriminatory code of conduct towards PLHIV in corporate internal rules and regulations
SDA 5.1	- Unequal access to rare resources - Stigmatization and frustration at access create patients lost to follow-up, particularly women	- Support for the implementation of continuous funding strategies and for the elimination of unequal access between men and women, particularly in rural areas
SDA 6.1	- The burden of care in families rests on women and makes them more fragile - Quality of psychosocial and emotional support by community advisors - Lack of activities which address social and structural issues	- Recruitment of 100 CA and training on care related gender issues - Support for the restoration of means of subsistence for patients and the women looking after them - Support for the development of microprojects for men and women in poor rural areas including activities which include "education on gender and HIV" components
SDA 7.1	- Coordination mechanism between MSHP, MLS and MFFAS - Training of technical staff in these facilities on gender issues and HIV	- Implementation of a coordination mechanism between the MLS, the MSHP and the MFFAS - Support for the training of technical staff in these ministries on gender and HIV issues
SDA 7.2	- Gender not included in strategic intervention plans	- Drawing up a strategic plan on HIV intervention in the health sector which includes gender
SDA 7.3	- National knowledge database on gender issues and HIV practically non-existent	- Conduct a survey which takes gender issues into consideration in data collection tools and analysis plans

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

The national response to the HIV epidemic is multisectoral and encourages the participation of the 34 ministries in the country. The intervention proposed within this context is part of the country's general development policy. All the areas in the response have been selected and are priorities. Development partners select their activities in addition to the guidelines in the 2006-2010 PSN (Attachment n° 25). However, to respond to the weaknesses in the health system with a view to achieving the objectives, the proposal will give bonuses to service providers who are involved in some activities which are essential for optimum impact. This approach could unintentionally cause an imbalance in staff in health facilities and lead to unintentional consequences. To this effect, instead of giving individual incentives, we are providing for collective incentives for the facilities involved based on their performance in the 29 HD covered by the proposal.

The salaries of the staff members to be recruited may create an imbalance in health facilities. To remedy this, the salaries provided for are index-linked based on the salary grids in effect in the country.

In addition, the selection of certain target groups (vulnerable groups) as well as of key populations at high risk of HIV infection (SW, MSM and prison population) may be unfavourable to other recipients in the general population. To this effect, additional funds will be mobilized to develop activities towards other groups that are not included in this proposal. In addition, other lenders such as PEPFAR, the World Bank and UNICEF are already in the field and the map of Round 9 intervention shows the complete lack of duplication of activities (Appendix n° 27). This proposal is additional funding for actions focusing either on targets which until now have not been included or on areas with inadequate care facilities.

The PMCT facilities offered to 19,716 HIV positive pregnant women will significantly reduce the number of children infected. Our objective is to reduce the rate of mother to child transmission from 12% to 7% by 2014. The knowledge of a woman being HIV positive generally created conflict within families and other

social problems such as stigmatization, discrimination and domestic violence within the family. To remedy this, 60 community advisors will be recruited to strengthen the links between the community and care facilities (PMCT sites). The inclusion of gender will take into account social and gender issues which create obstacles to the access to care (Attachment n° 89 and 90).

Decentralisation and the lack of a charge for the ARV dispensed may be the cause of the poor use of medical products. To this effect, collective prescription committees will be set up in 29 HD and will be led with the technical support of the PNPEC. In addition, a mentoring system will enable regular, systematic monitoring at central level to improve the general care of the 29,595 PLHIV targeted by this proposal.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 or Round 8 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

Côte d'Ivoire has received support from the Global Fund for several HIV Rounds (2, 3, 5, 7). Rounds 3 and 5 have been completed, Round 2 ends on 31 May 2009, and a request for service continuation is in progress to care for the 11,232 PLHIV undergoing ARV treatment. Round 7 is in the process of being implemented

Round 2: "Strengthening the national response to HIV/Aids" (Attachment n° 92a).

Round 2 was the 1st grant awarded by the GF to Côte d'Ivoire in 2003. It concerned a proposal to strengthen the national response to HIV in all its components and throughout the entire territory. The areas concerned are the strengthening of prevention activities and the involvement of the community; access and the quality of voluntary testing and counseling; the prevention of the transmission of HIV from mother to child; the quality and access to the general care of PLHIV. The proposal was agreed to by the GF for a period of 5 years which ran from 1st March 2003 to 31 May 2009. The initial PR: UNDP; 2nd PR: NGO CARE International and grant total: 46,139,046 USD.

During the 1st phase of the programme coordinated by UNDP, satisfactory results were obtained, the Global Fund programme was deployed in 19 health regions, particularly in the southern area of the country and in the capital Abidjan. As there were apparent problems, the GF suspended its disbursements for one year, then in July 2007 signed a 2nd programme grant agreement with the NGO CARE International as the PR to ensure the continuation of corporate activities by the previous PR. The suspension of disbursements led to the stoppage of GF activities and PEPFAR took over in facilities in the south of the country, the north functioned on a minimum with no support. A 2nd programme grant agreement for 23,220,715 USD was signed with the 2nd PR CARE International on 30/06/07.

The 3 main constraints in phase 2 explain the relatively poor results at the end of the programme: (1) the stoppage of activities for one year with significant loss of motivation in facilities in the centre and in the north (2) the incomplete takeover of intervention sites from phase 1 (the sites in Abidjan which include 70% of PLHIV undergoing ARV treatment are supported by PEPFAR since the first phase stopped) However, a protocol agreement was discussed with this lender, which includes the rather significant financial participation of the GF in the purchase of ARV. (3) numerous conditions precedent imposed by the GF as a result of the delay in closing the UNDP programme. The results achieved on 31 December 2008:

- 106 steering committees and 84 religious organizations carry out activities to fight against Aids
- 8,296,319 condoms have been distributed and/or sold
- 41 operational VCT have advised and tested 94,225 people
- 54 PMCT facilities have advised and tested 43,134 women, including 2,150 who received ARV

prophylaxis and 379 are under ARV protocol
- 10,106 PLHIV make up the regular queue in 35 care facilities for ARV
- 16 NGO involved in community care, the monitoring of PLHIV undergoing ARV treatment and palliative care has monitored 9,466 PLHIV and 9,953 OVC.

A proposal for **service continuation** is underway to provide care to PLHIV undergoing ARV treatment at the end of the programme for one year. It will involve 11,232 people on 31/05/09. In total, 20 districts are affected by the request for service continuation: Odienné, Touba, Séguéla, Soubré (Buyo), Daloa, Guiglo, Gagnoa, Yamoussoukro, Toumodi, Bouaké NE, Bouaké NO, Bouaké Sud, Man, Korhogo, Yopougon Est, Alépé, Aboisso, Grand Bassam (Bonoua), Bondoukou, Divo. At the end of the service continuation, no other GF funding will be underway in Côte d'Ivoire (Attachment n° 92b).

Round 3: **"Prevention of the expansion of the HIV/AIDS epidemic within the context of the acute political and military crisis".**

Proposal submitted to the Global Fund excluding the CCM, with the support of the OCHA and the WFP, as a result of the particular circumstances of the serious political-military crisis in Côte d'Ivoire. As the Côte d'Ivoire government has no longer controlled the Centre, North and West (CNW) areas occupied by rebels for more than one year, it has been proposed that this emergency should be responded to through an international NGO (CARE) intervening in collaboration with and through local NGO. The GF has agreed to the proposal. The areas of intervention: CNW – Duration: 21 months, from 01/04/04 until 31/12/05 and grant total: 1,023,534 USD. The general objective: to reduce the spread and the effects of HIV in the areas occupied by rebels as well as in the refuge next to the front lines through the revitalization of active NGO in the fight against HIV and the resumption of prevention activities. The results achieved on 31/12/05:

- 85 NGO/CBO/OI strengthened and regularly distributing condoms.
- 5,645,019 condoms distributed and/or sold
- 100% of districts in CNW areas (20 districts) covered in relation to HIV prevention activities
- 119 military barracks, 33 schools covered in relation to prevention activities
- 35 health facilities strengthened and supplied with cotrimoxazole and STI kits.

Round 5: "Prevention and care of HIV/AIDS in the post-conflict situation" (Attachment n° 93 and 94).

As the social and political situation is not yet stable, a second proposal has been submitted to the Global Fund via the Côte d'Ivoire CCM to consolidate the assets from round 3 and to complete such intervention by extending the service delivery areas to voluntary counseling and testing and to the medical and psycho-social care of PLHIV, mainly in communities. The proposal agreed to by the GF in category 2 A. The PR: NGO CARE International. The areas of intervention: CNW – Duration: 27 months, from 25/07/06 until 31/10/08 and the grant total: €2,919,770. The results achieved on 31/10/08:

- 273,379 young people aged between 15 and 24 affected by local activities to raise awareness
- 9,227,677 condoms distributed and/or sold
- 14,318 people advised and tested and who have received their results
- 5,000 STI cases and 16,748 cases of Ios treated

ALCO project (24 months) (Attachment n° 95).

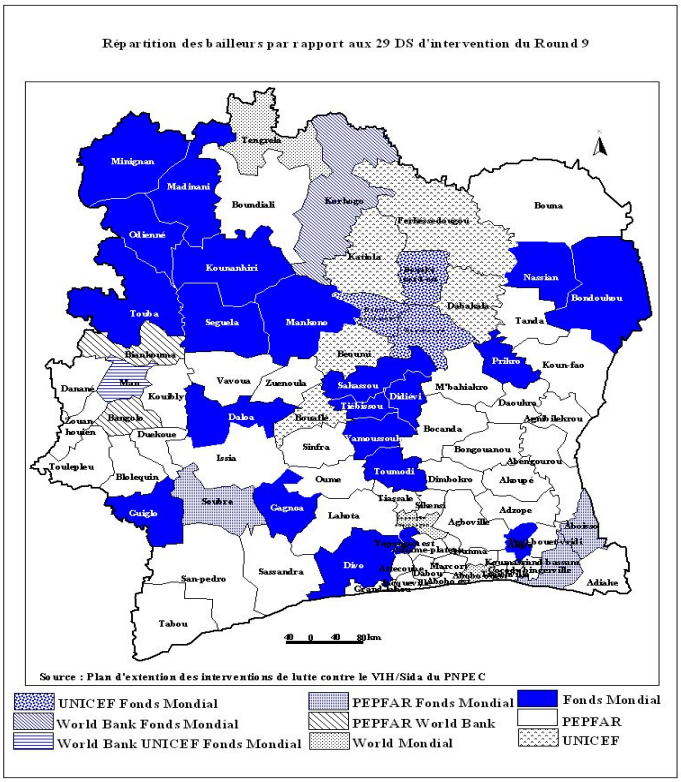
The Corridor project to step up HIV intervention targeting mobile populations, the consolidation and extension of the regional project to fight STI/HIV/Aids in Abidjan and Lagos: covers 5 countries which are Côte d'Ivoire, Ghana, Togo, Benin and Niger. The goals of the project are to control the spread of HIV and to reduce HIV-related morbidity and mortality in mobile populations along the Abidjan Lagos corridor. The objectives of the project are to increase the regular use of condoms in sex workers and lorry drivers. The project will last for 5 years from September 2007 to August 2012 for a total amount of €11,854,310. During the first year, the project enabled the distribution of 4,904,439 condoms, the testing of 217,893 people, 498 PLHIV to undergo treatment and the training of 4,337 peer educators.

4.6.2. Links to non-Global Fund sourced support

Describe <u>any</u> link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

Figure n°6: Distribution of lenders in relation to the 29 districts in round 9



The above map shows the links between the Round 9 proposal and the partners other than the Global Fund. **The PEPFAR** (€26,807,334 in 2008) has provided support in the fight against Aids since 2003 through all the areas and mainly in public sector health facilities for health intervention. PMCT activities have included 3,000 pregnant women in this programme. The care objective aims to put 77,000 PLHIV on ARV treatment in 2009 and 80,000 OVC are cared for each year.

With regard to prevention, the main partners are the **PEPFAR,** the **World Bank**, **UNICEF**, the **WHO** and bilateral cooperation agencies such as **German (**€2,695,743 in 2008), **French** (€49,170 in 2008) and **Swiss cooperation**. The **UNFPA** (€1,164,386 in 2008) has intervention focusing on VCT and PMCT in 11 VCT/PMCT centres and 12 Youth Counselling Centres; as well as STI/HIV/Aids prevention in displaced populations, sex workers, men in uniform and ex-fighters in the CNW areas and care and support for 329 PLHIV and support for 250 OVC (Attachment n° 98). **UNICEF** (€755,072 in 2008) provides support with the implementation of PMCT/PECP in 16 HD and 77 sites offer PMCT facilities. In 2008, 35,371 pregnant women (91.5%) benefited from PMCT facilities. 167 victims of sexual violence received PEP kits.

With regard to medical care, **the PEPFAR** is the main lender for all sectors.

With regard to care and support, the **WHO** (€278,190 in 2008) intervenes in the strengthening of testing, counseling, strategic information, speeding up universal access to essential drugs and other quality inputs. The **UNDP** (€296,104 in 2008) funds the nutritional care of infected children, the strengthening of the capacities of players in the coordination of the MLS with logistics support in Bouaké and in Korhogo and the provision of radiology equipment for the “Espoir” Centre in Adjouffou. It is also funding a programme for 4,000 ex-fighters. The **FAO** (€97,652 in 2008) and the **WFP** (€3,913,043 in 2008) intervenes in nutritional support and food security. **ESTHER** (€534,141 in 2008) supports hospital facilities and the MACA in Abidjan.

With regard to coordination and monitoring and evaluation, the support from PEPFAR must be noted. **UNAIDS** (€268,822 in 2008) supported the drawing up of the Commitment report (UNGASS 2008), the 2008 national action plan and 19 regional operational plans, coordination (implementation of the partners’ forum) and the strengthening of the capacities of the MLS and Civil Society.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 9 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

Within the scope of this project, the Côte d'Ivoire private sector (CECI, CGECI, FIPME, CCI-CI, CNM-CI and the Unions) favour the co-funding system. The public/private sector partnership has given a financial contribution for the implementation of Round 9 for a total of €10,682,405. The 6 elements of this participation are as follows:

- The involvement of medical staff in 50 corporate health facilities, i.e. 50 physicians, 45 IDE, 30 mid wives and 15 Social Assistants, is estimated to amount to 40% of their working hours dedicated to the project. Within the scope of HSS, private sector health centres will be strengthened to offer medical care in areas where there are no State health facilities.
- The contribution of each company involved in the project is €3,050 for the provision of equipment for their committee (1 premise, 1 desk, 1 computer, 1 printer, 1 Internet line).
- The involvement of 2,400 peer educators, i.e. 4 PE in each of the 600 companies targeted to manage Aids programmes and to lead BCC sessions, is estimated to amount to 10% of their working hours dedicated to the project. In return, private sector facilities will enter into contracts with Civil Society organizations, particularly with the RIP+ to intervene in surrounding communities and in families of workers offering them prevention services and high-quality community-based care and support
- The travel expenses of committee members paid for by the company (vehicle mileage costs) involved in the project.
- 50% of the salaries of the 4 people recruited to the coordination unit (1 coordinator, 1 programme manager, 1 accountant and one driver). This contribution which preceeds any intervention will improve results in the long-term. Therefore, within the scope of this project, the private sector will carry out an organizational procedure to set up a steering committee in the CECI to meet requirements in relation to transparency and good governance. In addition to site visits for supervision in the field through quarterly and bi-annual assignments, the private sector foresees holding monthly and quarterly coordination meetings in Abidjan and in each of the 16 regions.

The main impact of the private sector's involvement in the fight against Aids will be the contribution to the sustainable funding of activities. For this reason, the project provides for a study of the physical and human determinants in the fight against Aids in the private sector, the result of which will be to enable the implementation of effective, sustainable programmes within companies.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?)* ➔	175,076 workers and their families

Contribution value (in EURO)

Refer to the Round 9 Guidelines for examples

Organization Name	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**

CECI/CGECI	Medical staff in 30 corporate HC	300,751	300,751	300,751	300,751	300,751	1,503,755
CECI/CGECI	Provision of equipment for 600 committees	786,900	305,000	457,500	280,600	0	1,830,000
CECI/CGECI	2 400 Peer educators	943,964	365,878	548,816	336,607	2,195,266	4,390,531
CECI/CGECI	Vehicle mileage costs	594,698	230,503	345,754	212,063	1,383,017	2,766,035
CECI/CGECI	50% of staff salaries in the unit	29,270	29,270	29,270	29,270	29,270	146,350
CECI/CGECI	50% of the total amount for the study on the private sector's physical and human determinants	45,734					45,734
Total		2,701,317	1,231,402	1,682,091	1,159,291	3,908,304	10,682,405

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved HIV outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach prevention, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

The proposal helps to improve the public sector, Civil Society and the private sector by favouring the strengthening of capacities, the strengthening of the usual partnerships in institutional exchanges and the requirement to preferably provide sustainable funding.

- **The strengthening of the capacities** of community organizations mainly concerns organizations for women, PLHIV and key populations at high risk of HIV infection. In effect, the absorption capacities of community organizations have been reduced in general. This concerns helping 80 organizations to face up to the use and the provision of equipment for their organization. Such capacity strengthening will facilitate scaling-up by increasing their absorption capacities.
- **The networking and the coordination** of community organizations at central and peripheral level to harmonize practices and general planning will be the 2nd stage of strengthening. This concerns ensuring technical cooperation between the various types of players involved in care. By strengthening community care and its structuring with the public health system, exchanges are created which, in the long-term, increase the absorption capacities of both systems.
- **The development of strategic planning for drugs** is operational at central level and will be strengthened at district level. The system to supply and stock ARV and reagents will rely on the Public Health Pharmacy (PSP) and will be supported by development partners.
- **The strengthening of Internet communication** facilitates data collection and promotes international exchanges at time of globalization.
- **Sustainable funding**: by making the decision to make ARV and biological check-ups free of charge (Decision N°213 /CAB/MSPH/ of 20 August 2008 on free antiretroviral treatment in public health establishments) the government has affirmed its political intention to improve access for

PLHIV to medical care. It will be responsible for 10% of the total funding of ARV for the entire duration of the proposal. The intervention/activities provided for by this proposal may then be sustained as a result of continuous leadership at the highest level. In addition, with regard to human resources, the strengthening of the capacities of health staff and community officials involved in the implementation of the selected activities will lead to the takeover of intervention by the local community and key sectors in regions.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

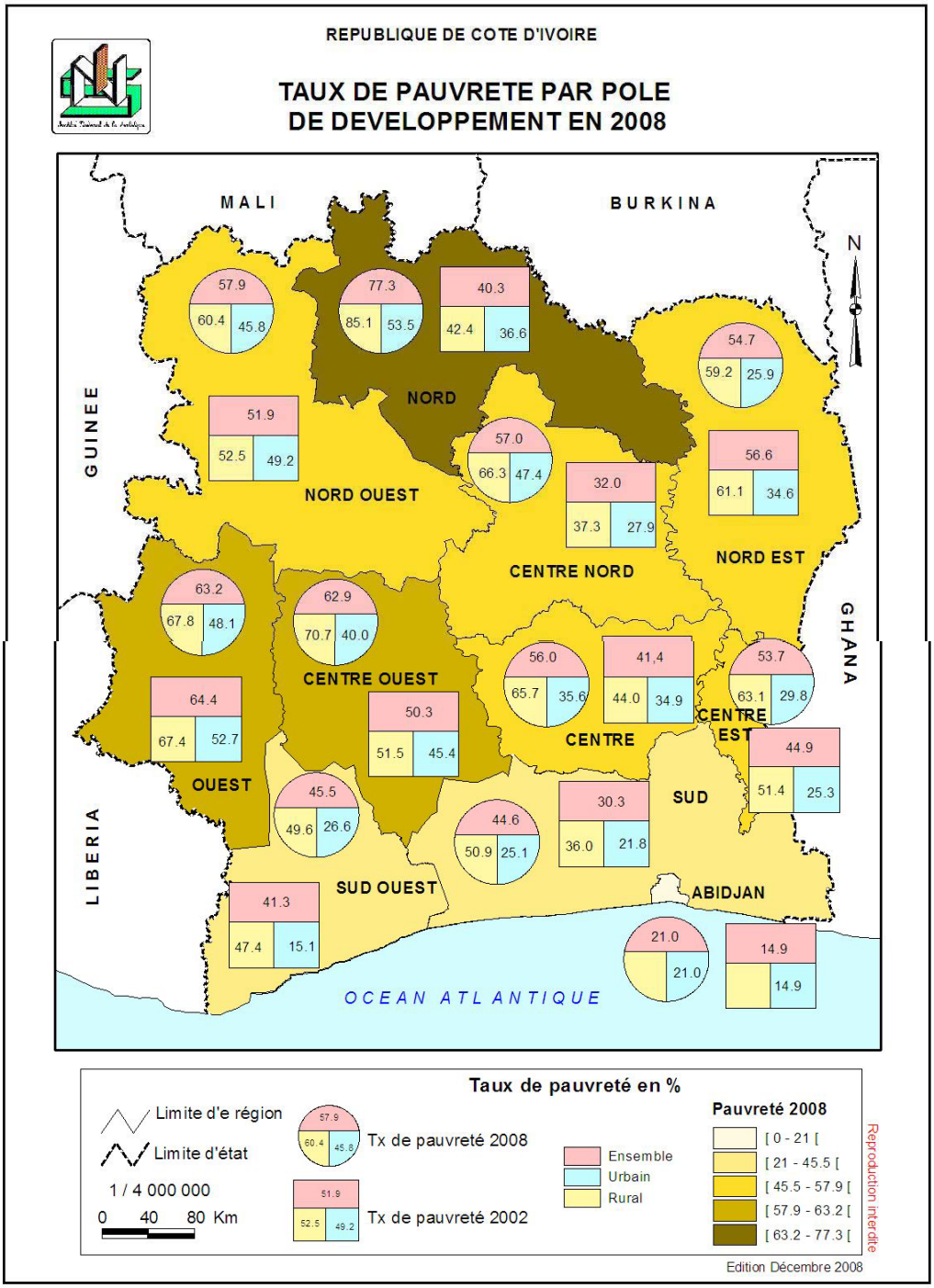
This proposal includes the various development frameworks drawn up by Côte d'Ivoire and development partners. It concerns the Poverty Reduction Strategies Document (DSRP), UNDAF Common Country Assessment Document 2009-2013, the Millenium Declaration on the achievement of the Millenium Development Goals (MDG) and the STOP TB strategy to fight against tuberculosis. These are included along with the objectives, strategies and targets drawn up in national and international reference documents with a view to achieving the MDG.

The improvement of the health of populations is one of the Government's economic and social objectives for development and to reduce poverty. To this effect, the following strategic objectives have been adopted to ensure the completion of the MDG (Attachment n° 49) in relation to health by 2015. It involves: i) strengthening the national health system; ii) placing the health of mother and child at the centre of the concerns; iii) furthering universal access to Aids prevention, treatment and care and support services; iv) strengthening the fight against Malaria, Tuberculosis and other current diseases.

In addition, the application of the STOP TB strategy furthers universal and fair access to high-quality diagnosis and treatment of tuberculosis (Attachment n° 51). At global level, the partnership objective for 2015 is to reduce prevalence and mortality rates in relation to the 1990 benchmark values by 50%. In Côte d'Ivoire, the objectives will probably not be achieved in 2015 as TB-MR and the HIV/TB co-infection pose particular problems which have been included in the TB Component in the Round 9 proposal.

The state of poverty is measured in the DSRP (Attachment n° 50), through monetary standing which is based on the indicator of well-being and the poverty threshold. In 2008, this approach identified as poor, any person with a consumption expenditure of approximately €1 per day, i.e. €367.80 per annum. Currently, one person out of two is poor compared to one person out of 10 in 1985. Poverty has therefore experienced a trend increase going from 10.0% in 1985 to 36.8% in 1995 and to 33.6% in 1998 before rising to 38.4% in 2002 then to 48.9% in 2008, due to the subsequent sociopolitical and military crises. Poverty is more pronounced in rural areas than in urban areas. The poverty rate has gone from 49% in 2002 to 62.45% in 2008 in rural areas compared to 24.5% and 29.45% over the same period in urban areas. The increase in poverty is more significant in the town of Abidjan, with an approximate 50% increase compared to 20% in other towns. Finally, the number of poor people has multiplied by 10 in the space of a generation. The poverty rate has gone from 10% in 1985 to 48.9% in 2008, which corresponds to an estimated number of poor people of 974,000 in 1985 and of 10,174,000 in 2008.

Figure n°7: Poverty rate per development pole in 2008



Limite de région	Regional boundary
Limite d'état	State boundary
Tx de pauvreté 2008	2008 poverty rate
Tx de pauvreté 2002	2002 poverty rate
Ensemble	Total
Urbain	Urban
Rural	Rural

Pauvreté 2008	Poverty 2008

Within the scope of reform by the United Nations, the 2009-2013 United Nations Development Assistance Framework (UNDAF) (Attachment n° 97) is considered to be a multi-annual strategic planning instrument for the entire United Nations System. It will enable development partners to fully commit to the implementation of the DSRP through coordinated, consistent support. United Nations' offices estimate the commitment needed to fund this strategy over 5 years to be €327,762,308. The funding for this Framework will be reassessed, and if necessary, fund mobilization strategies will be supported by the UNDP Resident Coordinator. The cost of direct intervention required to achieve the MDG Health section in Côte d'Ivoire between 2006 and 2015 is much higher than this amount.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national HIV outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

The national system for the monitoring and evaluation of the national response to Aids includes 2 components: the health sector component and the non-health sector component. The MSHP in accordance with the PNSE, (Attachment n° 28) enters the indicators in relation to the medical care of PLHIV through the health Information System (HIS) managed by the Directorate for Information, Planning and Evaluation (DIPE). Through the Directorate for Planning and Monitoring and Evaluation (DPSE), the MLS is responsible for collecting, analyzing and processing information on intervention at community and sectoral levels. All this information is centralized in the DPSE to produce and distribute reports for decision-making. Health data is compiled on HC in a monthly report which is sent to the HD. The HD compiles the reports for its health area and after an initial analysis sends them every month to the health region, which, in turn, sends them to central level. The software Simple1 and the computer application SIGVISION are used by districts to manage data.

The NHIS national policy document (Attachment n° 86) shows that information is fed back to HD and the DR during management team meetings and to central level during distribution workshops. It gives clear guidelines on the management of health information. Community and sectoral data is collected by peripheral players in the various sectors and is sent to the regional committee. In addition to the routine data which is collected regularly, additional information on the management of activities is collected through sero-surveillance surveys, surveys on services and behavioural surveys. In spite of all these mechanisms, the various evaluations note the strengths and weaknesses of the Health Information System (HIS).

The strengths of the HIS

The 4 strengths of the HIS are as follows:

1. The roles are well shared out since organization is set up with tasks divided between the MLS and the MSHP. In fact, the national Monitoring and Evaluation Plan is operational and measures the progress made in relation to the 2006-2010 PSN. The MLS has an Information and Communication Directorate which has a documentation centre and site which helps to distribute information.
2. Human resources have benefited from the strengthening of capacities by the Atlanta CDC. Numerous senior managers have been given training in the USA and in Europe on epidemiology and on monitoring and evaluation. Staff mobility from public organizations to private organizations is very high which leads to insufficient capitalization on experience in the field.
3. The MSHP, with the support of development partners, has conducted national sero-surveillance surveys and 5 HIV sentinel surveillance surveys since 1997. The Technical Surveillance Group has been working to set up 2nd generation surveillance for more than one year to improve the knowledge of vulnerable groups and of sub-populations for strategies to raise awareness. In addition, studies on resistance to ARV and on the HIV/TB co-infection are proposed in this

proposal. The 2005 AIS and the results of the EDS include an HIV module available for planning the proposal. Finally, the country is participating in three multi-centre studies (CT, PMCT and ARV) which proves the dynamism of the M&E system and the reliability of the data collected. The results of these studies will provide information for the implementation of the programme

4. A single electronic tool will harmonize, at national level, the longitudinal follow-up of 51,833 PLHIV undergoing treatment and is already being deployed in approximately fifty sites. This tool will be used in all medical care sites funded by the grant.

The 6 weaknesses of the HIS

The weaknesses of the HIS fall within the scope of the MEASURE assessment in 2008 of the information channel (Attachment n° 32). The inadequacies found are as follows:

1. The failure to take over M&E by certain players has led to the implementation of parallel reporting systems. Since 2004, with the arrival of massive flows of funds, the monitoring of activities has suffered from the concern by each partner to have data in real time. This difficult situation is made complicated through the unequal distribution of contributions in the country's 83 HD. National problems in relation to making data fully available in good time have led partners to set up their own parallel data collection channel. The result is data discrepancies on the same subject and on the same health organization. Finally, the data collection system at community level is behind in relation to the data collection system at health level. Round 9 funding will lift this constraint by 2014.
2. Inadequate information literacy is expressed by the low interest in relation to data reporting activities. In effect, the lack of reports from 34 sectoral committees and 19 decentralized committees on monitoring and evaluation and the low use of data produced at all levels have led to the poor quality of the information collected. The decisions arising from this are not appropriate.
3. Insufficient material resources leading to the non-availability of standardized tools at all levels. The frequent breakages of basic tools lead to lack of staff motivation and frequent delays in the analysis and the processing of data at local level. Even though all HD are concerned by this inadequacy, we have noted a greater problem in the 39 HD in the CNW area due to the recent social and political situation.
4. The insufficient number of 31 managers in Epidemiological surveillance centres (EMC) in organizations (health and non-health) is obvious mainly in the 39 HD in the CNW area. This is due to the mobilization problem and to the low redeployment of staff. The reluctance of health professionals is mainly linked to the difficult material conditions encountered in the field with regard to housing and the feeling of individual insecurity.
5. Poor coordination and supervision at all levels explains the low number of reports sent between the various levels in the pyramid (peripheral, intermediary and central). The 83 DD and the 19 DR are not sufficiently involved in carrying out M&E activities. The lack of funding often put forward should be compared with the poor supervision at central level. The lack of regular audits on data quality does not further involvement at local level.

Insufficient financial resources for the implementation of 2nd generation studies for certain key populations at high risk of HIV infection (SW, MSM and prison population) does not allow for suitable, recognized strategies for the general care of these groups.

4.8.2. Avoiding parallel reporting

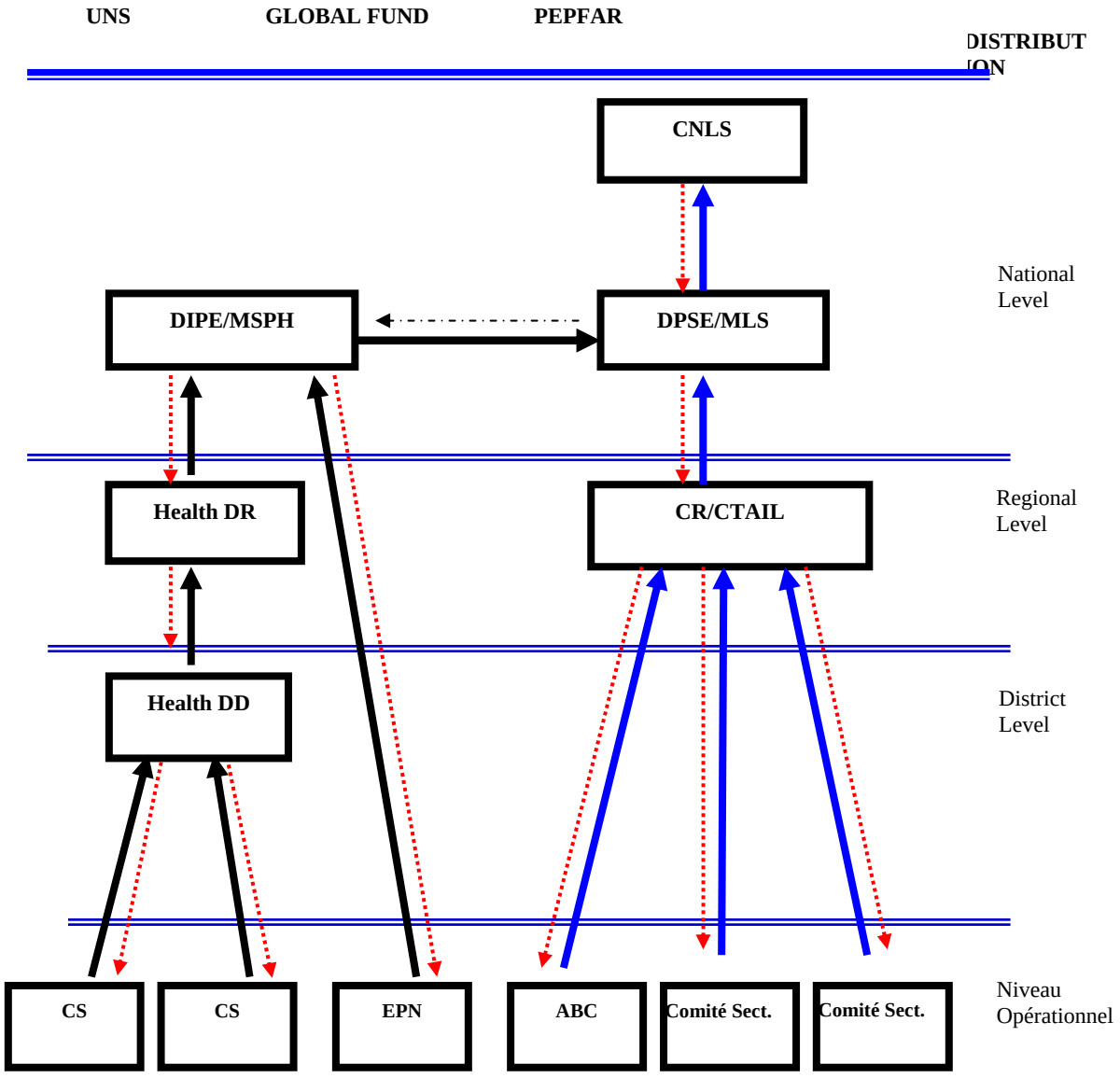
To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

The institutional framework for the multisectoral fight for the coordination and implementation of actions to control HIV is based on the 3 “three one’s” principles, mainly the implementation of a single framework for monitoring and evaluation. This framework defines the information channel according to whether health data or non-health data is involved. The MSPH is responsible for the collection of health data through the health information system. Non-health data is collected by the MLS (Attachment n°28).

In order to avoid parallel reporting channels, data collection on the implementation of this proposal will be secured on the health sector channel which already has an operational system. This programme relies on this existing framework and will help to strengthen it. The operational level is represented by the 1,591 Health Centres and the 1,150 NGO. These organizations draw up monthly activity reports which are sent to districts with regard to health and to regional committees with regard to non-health data. At regional level for non-health data, information is aggregated, processed, analyzed and used in decision-making. However, reports from districts are sent directly to central level and copied to regional directorates. Monitoring and Evaluation is carried out by the players involved in National Programmes to fight against Tuberculosis, Malaria and Aids, the 2 Principal Recipients (PNPEC and CNPS) and their Sub-Recipients at all levels. Several measures have proved necessary to participate in implementation:

- At national level, the DIPE for the health sector will analyze and process the data received and will then send it to the MLS DPSE so that the national database can be updated. The DPSE compiles both health and non-health data to produce annual activity reports for clearer decision-making.
- Data collection and reporting tools for the Principal Recipients, Sub-Recipients and the players in the field will be reviewed and standardized. The various reports are sent to the DIPE and to the DPSE which in turn distributes them to all the players involved in the fight against Aids.
- The monitoring and evaluation managers of sub-recipients will be trained on the use of the tools and the importance of high-quality reports. The data and information produced during implementation by the players involved will be validated at all levels in the pyramid before being sent to a higher level.
- The Principal Recipients will hold quarterly meetings at central level with the sub-recipients to ensure the technical and financial monitoring of the grant. Every quarter, the Principal Recipients will send a copy of the report to the CCM, the DIPE and the DPSE to ensure centralization in a single database.
- The Monitoring and Evaluation Reference Group of the CNLS-STI will validate all the survey protocols and the results of such surveys.
- An annual review of the implementation of the project will be conducted which involves all the implementation partners.

Figure n° 8: Health information channel in Côte d’Ivoire



4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

The Monitoring and Evaluation Reference Group (GRSE) managed by the MLS includes all the monitoring and evaluation managers in Aids organizations in Côte d'Ivoire. This group forms an exchange platform on monitoring and evaluation issues within the scope of implementing the National Strategic Plan on HIV. The results of the IMS (Attachment n° 32) have shown that there are not enough resources dedicated to strengthening the IMS. Round 9 is an opportunity to correct the following inadequacies:

1. Data discrepancies on the same theme and for the same health organization will be reduced. This involves improving decision-making information based on actual fact. The following

measures will get round this inadequacy:

- The strengthening of the capacities of 87 health officials in 29 HD and of 29 monitoring and evaluation managers in CTAIL with regard to the collection, management, processing and use of HIV data for decision-making.
- The set-up of an internet connection in Epidemiological Surveillance Centres and in 29 general hospitals in 29 HD and 29 CTAIL. These measures will facilitate the sending of data in real time from peripheral level to central level and the feedback of information.
- The number of data collection and reporting tools at community and health level will be sufficiently reproduced and their route to care providers and CBO will be ensured.

2. Inadequate information literacy is expressed by the low use of data and a lack of analysis at local level. In addition, basic software such as Epi info, SIGVISION and SIGVIH is not used enough by data managers. Such inadequacies will be reduced by the following measures:
   - The promotion of correct data reporting in 29 HD, 34 sectoral committees and 19 decentralized committees in the fight against Aids has not been sufficiently developed by managers at central level. This activity will be carried out by setting up incentives such as a prize for the best official to produce monthly activity reports and send them within the required timeframes.
   - The data produced is not generally used in decision-making. To remedy this situation, 5 workshops to distribute the results will be organized at national level and 10 workshops at regional level to help the 29 HD and 6 RD. These workshops will take over the results and use them in decision-making as well as to draw up regional plans to fight against Aids.
   - The motivation of the staff involved in the management of HIV data through the availability of computer equipment. In effect, the proposal provides for the purchase of 30 desktop computers and 10 laptops. IT equipment and data-sending equipment will be maintained for 5 years.
3. The insufficient number of human resources in the 29 districts is included in the HSS section of Round 9 in order to improve the response to expectations in relation to the implementation of grants from the Global Fund to fight HIV, Tuberculosis and Malaria.
4. Poor coordination and supervision at all levels explains the low number of reports sent between the various levels of the pyramid (peripheral, intermediary and central). Joint supervision by the MSHP and decentralized committees will get round this weakness.

The lack of regular audits on data quality does not further involvement at local level. The funding in this proposal will facilitate the execution of quarterly audits of data in health districts and decentralized committees in the fight against Aids.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1 HIV	National Programme on the Medical Care of people living with HIV (PNPEC)
Address	Immeuble le général, 6ème étage, Avenue Botreau Roussel, Plateau; 01 BP 5420 Abidjan 01; Tel + 225 20 32 28 69; Fax + 225 20 32 29 83; Email: pnpecinfo@yahoo.fr
The National Programme on the Medical Care of people living with HIV is the body in the Ministry of Health which is responsible for coordinating intervention which falls within the Health section of the fight	

against HIV.
Created by decision No 411 of 23 December 2001 which was amended in 2008 (Attachment n° 85a), the PNPEC is organized into six services, Care Service (PEC), Counselling and Testing service, Prevention of Mother to Child Transmission service (PMCT), Sexually Transmitted Infection service (STI), Monitoring and Evaluation Service (ME) and the Administrative and Financial Service. These services address the various areas of intervention including PMCT, CT, STI care through ARV, Ios, palliative care and blood exposure accidents.
The PNPEC is managed by a Coordinator Manager who is assisted by four technical advisors recruited following an open invitation to tender in 2008, with the financial support of PEPFAR, for the areas of prevention, care and strategic information.
The PNPEC currently coordinates 215 care centres, 316 PMCT sites and 287 CT sites which are distributed throughout the entire territory, according to an approach to include HIV in health centres. The PNPEC relies on districts which form the operational unit for implementing intervention to care for HIV.
The programme has a great deal of experience in the management of HIV projects. It works in collaboration with various partners, lenders, national and international NGO and networks for people living with HIV.
This experience and these assets will be adapted and transferred to sub-recipients for the management of grants made available to them

The PNPEC has a multi-disciplinary, high-quality team, with significant experience in public health, particularly in the area of HIV. In effect, it includes physicians with more than 8 year's experience, health economists with an average of 4 year's experience and pharmacists with an average of two year's experience. In addition, it includes midwives, a statistician and a social assistant whose skills have been strengthened in the areas of the general care of PLHIV.
In addition to all the skills raised above, the PNPEC is constantly asked by other organizations to upgrade their staff members, some of its managers are also asked individually. These staff members benefit from computer equipment consisting of 20 desktop computers and 4 laptops which were purchased in 2008 are all linked on a local network.

The general resources of the PNPEC include funding by the State budget which amounts to approximately 100,000,000 FCFA per annum. With regard to financial support from partners, the MSHP has set up a fiduciary unit which supports the PNPEC with financial management. More recently in the PUMLS/ World Bank project, the PNPEC will receive funding to conduct a project to extend intervention in relation to the medical care of PLHIV in the regions of Savanes, Montagnes and Lagunes.

The PNPEC produces quarterly programmatic and financial reports for these projects. The purchase of financial management software is underway for 2009. This highly appraised gift will be adapted to the requirements of the Global Fund. Manuals on procedures exist and may be adapted to the requirements of the Global Fund

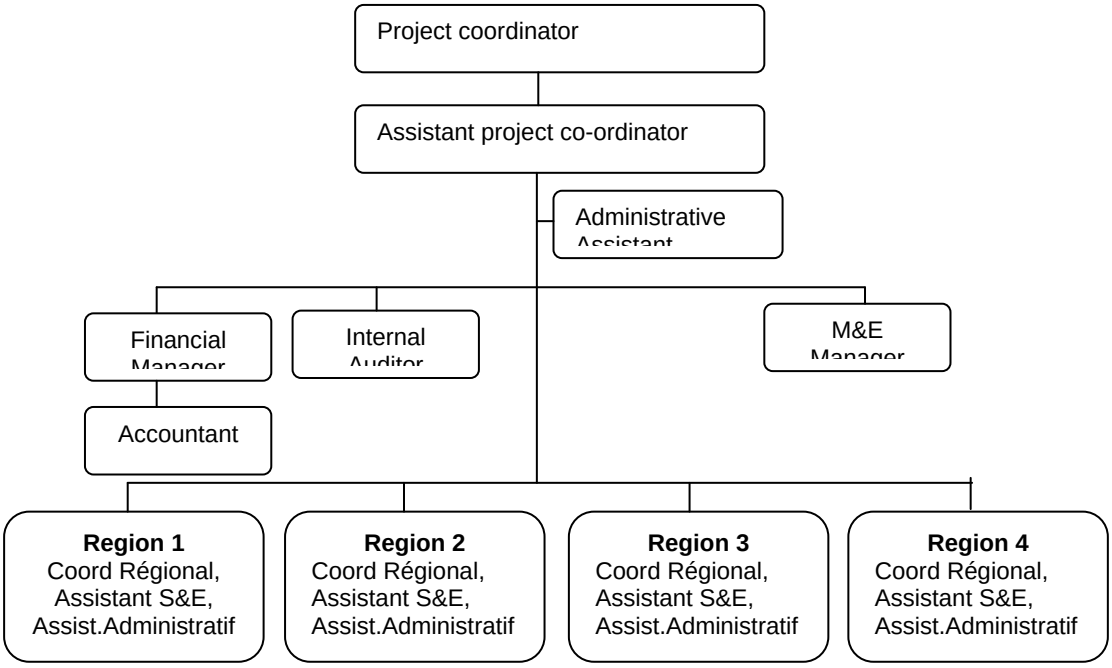
The purchase of goods and services for the PNPEC comply with international standards. The programme is exempt from duties and taxes for GF and PEPFAR projects. This also applies to Round 9
.
To effectively manage R9 of the GF proposal and to familiarize PNPEC staff with the GF management requirements, strengthening the capacities of the PNPEC appears to be necessary in the following areas:

- ***Human Resources***
    - At central level
        - 1 project coordinator
        - 1 assistant coordinator
        - 1 financial manager
        - 1 accountant
        - 1 internal management auditor
        - 1 monitoring and evaluation manager
        - 1 bilingual administrative assistant
        - 3 drivers
    - At regional level
        - 4 regional coordinators
        - 4 monitoring and evaluation managers
        - 4 administrative and financial assistants

- ***IT Equipment***
  - Strengthening of computer equipment (5 IT kits (desktop computers, printers, uninterruptible power supply) + 15 laptops
  - 5 overhead projectors + 1 photocopier + 5 scanners
  - Purchase of a group antivirus licence
  - Communication equipment (5 Fax machines + 22 mobile telephones)

- ***Rolling stock***
  - 3 x 4X4 vehicles
  - 5 motorcycles

Figure n° 9: PR 1 Flowchart



PR 2: HSS	Information, Planning and Evaluation Directorate (DIPE/MSHP)
Address	Avenue Lamblin, près de la nouvelle Mosquée du Plateau 04 BP 341 Abidjan 04 Telephone: (225) 20.32.33.17 - Fax: 20.32.34.40 Email: dipemshp@yahoo.fr

With regard to technical capacity

The Information, Planning and Evaluation Directorate (DIPE/MSHP) is a central directorate in the Ministry of Health and Public Hygiene (MSHP). The decree n° 2007-507 of 13 June 2007 on the organization of the Ministry of Health and Public Hygiene determines its duties.

The DIPE/MSHP is managed by a director who is appointed by a Council of Ministers decree upon the suggestion of the Ministry of Health. A public health physician and researcher, specializing in programme management, with 13 years of experience in management, monitoring and evaluation and operational research, first in a health district, then at the National Institute of Public Health, then at the head of the DIPE, he is assisted by four sub-directors. They all specialize in public health and project management, with a good knowledge of the health system and experience varying between 6 and 13 years.

The DIPE/MSHP also has 30 officials including 8 senior health managers with experience varying between 2 and 13 years in the Ivorian health system. The administrative and financial department is led by three officials including one specialist in accounting and financial management, with between 10 and 13 year's experience. They also have considerable experience in the management of projects and

partnership agreements.

The DIPE is the organization in the MSHP responsible for health information. In accordance with the4 health policy, it has an institutionalized network for collecting and sending data throughout the entire national territory. Within the scope of its mission, it has developed database software (SIGVISION and SIGVIH) which is available to all levels in the health pyramid to improve the processing of information. Its computer equipment currently consists of 8 desktop computers and 3 laptops.

With regard to managerial capacity

The mission of the DIPE/MSHP is to: (i) collect, process and distribute health information and to draw up the annual report on the health situation, (ii) to draw up and to update the health map and the directory of health institutions on an annual basis; (iii) to set up a database and to ensure the electronic archiving of any information in relation to the health system; (iv) to carry out studies, to plan and schedule the development of the health system in collaboration with the unit for prospects and strategy in the Ministry of Health and Public Hygiene; (v) to keep health statistics up-to-date; (vi) to draw up and to promote the epidemiological evaluation system by liaising with the facilities in question.

The organization of the DIPE includes one Directorate, four sub-directorates (SD) and two associated departments: (i) the Health Information SD, (ii) the Epidemiological Surveillance SD, (iii) the SD for Evaluation and Health Action and (iv) the Health Map and Planning SD, (v) the administrative and financial department, (vi) the information and documentation department.

The activities are implemented and monitored for each programme area corresponding to the activities in each sub-directorate. Statutory technical meetings are held on a weekly basis by each sub-directorate and department and a meeting to monitor all the activities by the DIPE is organized once per week excluding management meetings. Meeting and activity reports are distributed and retained in accordance with an established procedure. The activities are evaluated at least once per annum which is then used as a basis to draw up the action plan for the following year.

The DIPE/MSHP is responsible for the monitoring and evaluation of health action in the Ministry of Health and Public Hygiene. In this respect, it produces specific reports, particularly the annual report on the national health situation (RASS), HIV reports, HIV sentinel sero-surveillance reports, directories of health statistics and activity reports, resulting from the implementation of its missions, reports on the execution of projects and partnership agreements. It has conducted or participated in several surveys and evaluations, the most recent of which is the AIS 2005, the current EDS III, the evaluation of the measles campaign, the evaluation of the IMS in 2008 and the evaluation of the NHIS through the HMN tool in 2009. These various reports are subject to a rigorous validation process which involves the people forming the resources of the ministry and development partners. It has set up a document archiving and retention system to ensure the traceability of its action.

With regard to financial management capacity

The State budget is managed in accordance with national procedures. Any funds outside the budget made available to the DIPE are managed in accordance with three methods: (i) opening of a private account managed by the accounting department, (ii) management by the MSHP fiduciary unit, (iii) managed by an administrator appointed by the Ministry of the Economy and Finance and supported by the DIPE accounting department.

In 2008, the DIPE/MSHP had to manage €7,257,083 from various funds including the State budget (€56,404), the CARE/DIPE agreement (€121,954), the grant HMN grant (€19,231), the WHO grant for the evaluation of the measles campaign (€29,908) and the GAVI Alliance grant for HSS (€5,792,798 including €1,236,789 disbursed in 2008).

The DIPE has a framework to prepare financial tables, experience acquired through the management of projects executed through a partnership with various lenders. the administrative and financial department regularly produces financial reports which are distributed (State budget, MSHP/CARE/DIPE agreement, MSHP/PEPFAR agreement, GAVI HSS).

Unlike the implementation of expenditure in the State budget recorded by the SIGFIP, any accounting and financial transaction outside the budget is systematically recorded. Such recording will be facilitated by the use of software which will be available in 2009 and will enable automated management to trace financial and accounting transactions. Book-keeping complies with the rules in the OHBLA treaty. Any

transactions made during the day are recorded in the general ledger.

With regards to payment, the procedures impose that supporting documents must be gathered before any funds are disbursed. The disbursement time frames are 24 hours for cash and a maximum of 72 hours for cheques and transfers which require 2 signatures, the signature of the Director of the DIPE and the Director of Financial Affairs in the MSHP. All funds are granted following the proof of expenditure. The purchase of goods and services complies with national and international standards. The legal department in the Ministry of Health and Hygiene assists the DIPE with drawing up and examining draft agreements with partners.

Even though the DIPE/MSHP has expertise enabling it to manage and supervise the implementation of the programme, it needs to be strengthened to guarantee the optimum management of the project. Therefore, its staff members need to be strengthened with regard to Leadership, Management and Governance, Logistics management, Monitoring and evaluation and documentation management. It also needs to recruit qualified staff to manage the project, in particular: A project management assistant, 2 bilingual management assistants, 1 finance manager, 1 budgetary monitoring manager, 4 programme managers (Manager of intervention programme 1 and 2, Manager of intervention programme 3 and 4, Manager of intervention programme 5, monitoring and evaluation manager, 1 legal monitoring manager, 1 manager for the community section and 1 logistician.

The project will be coordinated by a committee which includes the PR and the SR. It is presided by the PR. The day-to-day management of the project will be carried out by a management unit consisting of a project manager, an administrative and financial management team and a technical management team. With regard to technical management, four (4) programme managers and a monitoring and evaluation manager will be recruited. An accountant, an internal auditor and a legal monitoring manager will be responsible for the administrative and financial management of the project. Two bilingual management assistants and five support staff members will also be recruited.

The premises of the DIPE/MSHP should also be restored and provided with computer equipment, furniture, communication methods and additional rolling stock.

➔ ***Copy and paste tables above if more than three Principal Recipients***

PR 3: HIV	**National Fund for Social Welfare (CNPS)**
Address	**24, Avenue Lamblin, Plateau; BP 317 Abidjan 01; Tel + 225 20 252 100; Fax + 225 20 327 994; Website: www.cnps.ci; Email:info@cnps.ci**

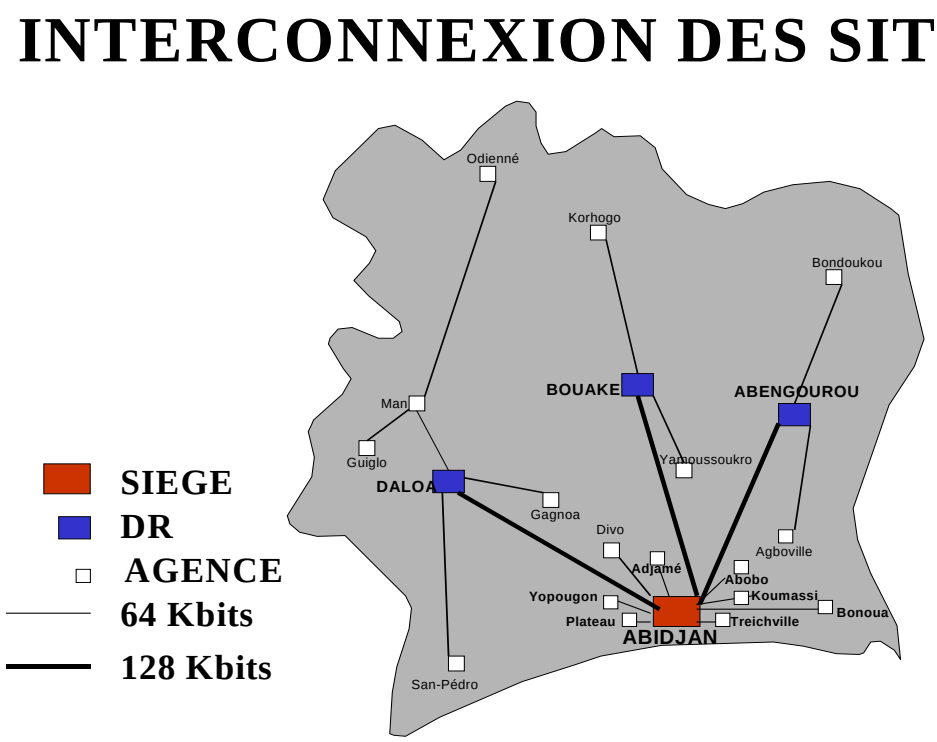
Created in 1960, the National Fund for Social Welfare (CNPS) was a semi-public institution which was assigned the main task of managing the compulsory social welfare scheme for salaried and similar workers. Further to reform in 1999, it has become by decree n° 2000-487 of 12 July 2000 (Attachment n° 85b), a social welfare institution (CNPS), i.e. a private company (with no share capital), with the status of legal entity and financially autonomous. In accordance with its mission, the CNPS ensures the recovery of social security contributions and provides the benefits service in relation to these schemes. It is also involved in the area of prevention of occupational hazards and health and social action for its policyholders. It has 830 officials.

The CNPS is managed by a Board of Directors (CA) consisting of 12 members. It is managed on a day-to-day basis by a Managing Director appointed by the CA who is assisted by 2 deputy managing directors and a technical advisor. In addition to general management, the flowchart of the CNPS includes a general inspectorate, 6 central directorates and 8 units responsible for various management aspects. Since 1983, a training institute referred to as the Institute for social security occupations (IMSS) trains social security managers in all the member countries of the CIPRES which includes 6 French-speaking African countries.

The CNPS covers the entire Ivorian territory through 21 braches in 14 regions.
Each branch has management autonomy enabling it to provide its services to customers in real time (accountancy, finance, collection, benefits). In addition, the CNPS has a high-performance computer network. In fact, all its organizations are linked through a private telecommunications network. Each site has a local network which is linked to the head office network via a specialist link (256 kb/s within the country and 10 Mb/s for Abidjan). The CNPS' computer equipment currently consists of 830 computers

and 40 servers. Computer data at the CNPS is systematically backed up at the end of the day and archived outside the institution.

Figure n° 10: Interconnection of sites



Siège	Head office
DR	DR
Agence	Branch

Within the scope of its general operation, the CNPS has developed expertise which has been proven for decades in the following areas: The identification of social insurance policyholders and contributions and the management of their individual accounts; The collection and management of funds in kind; The management of the beneficiaries of the various social services (retirement pensions, widows pensions, daily allowances, family allowance) both nationally and internationally; The implementation of the health and social action programme through medical and social centres in particular; The development of action to prevent occupational hazards in companies. To effectively carry out these activities, the CNPS has developed a supervision and audit culture. It has committed to quality procedures based on international reference systems (ISO 9001). The CNPS has a manual of procedures for all its operations (purchasing and stock management, financial and accounting management).

On average, the total resources of the institution amount to €152,449,017 per annum. It has term deposits (DAT) in several banks for a total amount of €18,293,882. The financial department of the CNPS has 109 staff members.

All financial and accounting transactions are systematically recorded. Financial and accounting transactions are traced in an automated management system which uses ORACLE software. Book-keeping at the CNPS complies with the rules in the OHBLA treaty and the CIPRES (private general accounting) treaty. Any transactions made during the day are entered in the general ledger.

With regard to payments, the procedures impose that any supporting documents must be collected before the funds can be disbursed. Disbursement timeframes are 24 hours for cash and 48 hours for cheques and transfers which require 2 signatures; the signature of the Managing Director and the signature of the Financial and Accounting Director.

At the end of each quarter, the CNPS produces financial reports (balance sheet, profit and loss statement, ancillary expenses). At the end of the year, the financial reports are consolidated and approved by the Board of Directors. This expertise will be adapted and passed on to sub-recipients to manage the grants available to them.

The CNPS has a manual of administrative, accounting, financial, purchasing and stock management procedures. These procedures may be adapted to the requirements of the Global Fund.

The CNPS is developing a health and social action programme for salaried workers and their families as well as for non-salaried populations. For this purpose, it has six health centres (Treichville, Yopougon, Bouaké, San-Pédro, Korhogo and Divo) including two which are for technical capacities which is the same as a general hospital. During 2008, the health centre in Yopougon attracted 29,163 patients, 70 % of which are malaria cases. In addition, the CNPS has an occupational risk prevention department and a department for the Aids programme .

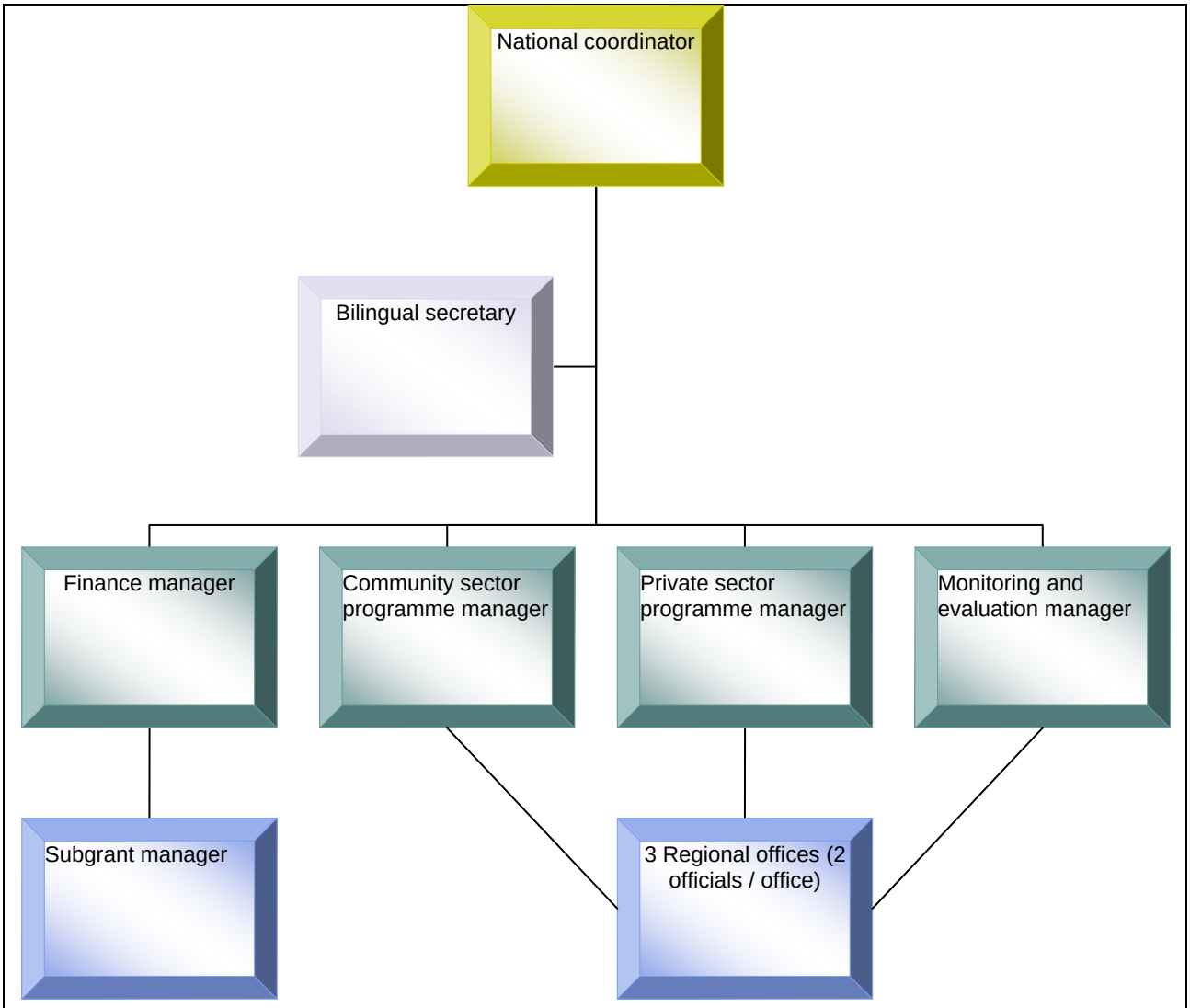
The purchase of goods and services for the CNPS complies with international standards. The CNPS has a committee for tenders and bids. It also has automated stock management software called Logest-Vision.

For the effective and efficient management of this proposal which strictly complies with GF standards, in addition to strengthening the capacities of the CNPS in monitoring and evaluation which is required, the CNPS will also be strengthened in the following areas:

- ***Human Resources***
    - o At central level
        - One project coordinator,
        - Two programme managers (community and private)
        - One Monitoring and Evaluation manager
        - One administrative and financial manager
        - One subgrant manager
        - One bilingual administrative assistant
        - One cleaning operative
    - o At regional level
        - Three monitoring and evaluation assistants
        - Three administrative and financial assistants
        - Three drivers

- ***IT equipment***
    - 8 IT kits
    - 5 laptops
    - 4 scanners
    - 3 overhead projectors
    - 1 group antivirus licence
    - 1 large capacity photocopier
    - 1 telephone / fax line
    - 1 landline
    - 20 mobile telephones
- ***Rolling stock***
    - 3 x 4X4 vehicles

Figure n° 11: PR 3 flowchart



Coordonnateur national	National coordinator
Secrétaire bilingue	Bilingual secretary
Chargé des finances	Finance manager
Chargé de programme secteur communautaire	Community sector programme manager
Chargé de programme secteur privé	Private sector programme manager
Chargé du suivi évaluation	Monitoring and evaluation manager
Responsable subgrant	Subgrant manager
3 Bureaux régionaux (2 agents/ bureau)	3 Regional offices (2 officials / office)

4.9.2 Sub-Recipients

(a) Will sub-recipients be involved in program implementation?	☐ Yes
	☐ No
(b) **If no**, why not?	

N/A	
(c) **If yes**, how many sub-recipients will be involved?	☐ 1 – 6
	☐ 7 – 20
	☐ 21 – 50
	☐ more than 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	☒ Yes *[Annex n° 38 and 39: SR list of PR 1 and 3]*
	☐ No **Answer s.4.9.4. to explain**
(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.	

Out of a concern to be the most representative possible, the Côte d'Ivoire proposal will be implemented by 3 PR representing the public sector for HIV, the HSS section, and the Private Sector and Civil Society for HIV. The Ministry of Health and Public Hygiene, through the PNPEC/MSHP and the DIPE/MSHP, represents the public sector (HIV section and HSS section), the CNPS, the private sector and Civil Society.

The PNPEC/MSHP: governmental PR

The PNPEC/MSHP has identified the public sector sub-recipients (SR) which are the PSP, the DGS, the DIPE, the DPSE, the STCO, the PNPEC and the DR. These SR sign a service delivery agreement with the PNPEC/MSHP for the services which fall within their specific mission as a public organization.

The PSP intervenes in relation to the management of drugs and inputs, the DGS intervenes in the coordination of central directorates, health programmes and regional and district directorates. The DIPE and the DPSE manage the monitoring and evaluation of health data and non-health data. The STCO is concerned with the coordination of the fight against Aids and leadership aspects. The PNPEC intervenes in the national coordination of HIV intervention in the health sector and the DR intervenes in coordination at regional level.

With regard to certain areas such as BCC mass media, a request for the proposals of sub-recipients for organizations specializing in communication will be made which will be selected in accordance with rules on transparency.

The CNPS: Private Sector and Civil Society PR

The private sector sub-recipients are the CECI, the CGECI, the FIPME, the CCI-CI, the CNM-CI and the unions which are partners to the CNPS within the scope of taking out contracts to complete activities on prevention and general care for workers and their families in the workplace. The Sub-Recipients previously identified by the CNPS sign a service delivery agreement with the latter to complete activities on Behaviour Change Communication (BCC). This concerns furthering universal access to condoms for all workers and their families. Sub-Recipients that have entered into contracts with the CNPS identify within member companies, the people who are trained by the CNPS as peer educators to lead activities to raise awareness.

There is not much information on the HIV situation in private companies in Côte d'Ivoire. The involvement

of companies in the national response to HIV in Côte d'Ivoire is low and is mainly a one-off through campaigns to raise awareness which aim to prevent the risks of HIV infection in the workplace. Consequently, some companies have set up Aids units and have drawn up prevention strategies for their staff. In the proposal, the CNPS is responsible for boosting the activities in this sector for 600 companies.

Civil Society, through its Sub-Recipients is significantly involved in the implementation of the programme. In general, community care is entrusted to community organizations which do not necessarily include PLHIV. Civil Society sub-recipients are made up of NGO, faith-based associations and associations for PLHIV involved in carrying out activities in the areas of care (PLHIV and OVC) and prevention (CT, BCC and PMCT). Their intervention in the community and the link that they form with health organizations ensure care continuum.

Their contribution as a result of their individual specificity enables a targeted approach, particularly in key populations at high risk of infection which are SW, MSM and the prison population. Community health organizations offer general care including psychosocial support which is essential for PLHIV and recommended by national policy. Home visits and care, nutritional support, support for OVC and moral support are all activities which are carried out by these organizations. Some NGO for women affected and infected by HIV provide a specific approach to young girls and are essential for the proper conduct of PMCT.

With regard to prevention, Civil Society sub-recipients will act as a backbone in the implementation of the programme in urban and rural areas, for educated young people and for uneducated young people. With regard to the care of certain key populations at high risk of infection such as SW and MSM, effort will be made to improve access to care. The experience of community organizations caring for these key populations will contribute to achieving such access.

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

The sub-recipients have acquired experience in carrying out activities in the areas of IEC/BCC Prevention, the care of PLHIV and OVC, CT, PMCT, the care of key populations at high risk of HIV infection and coordination. Some of them have more than 5 year's experience in these areas. Some have worked in high-risk areas, ex-rebel CNW areas, and with highly vulnerable targets such as prisoners, lorry drivers, migrants, SW, MSM and men in uniform. Their members have been trained in the management and monitoring of technical, administrative and financial projects. Consequently, a project is implemented according to well-defined phases: study of the situation, determination of relevant activities which are appropriate to the target and the area of intervention, drawing up of an action plan, execution of the identified, planned activities, formative supervision, sessions to strengthen capacities to carry out the activities, design and distribution of support, project evaluation, knowledge-building workshops and implementation of plans to end projects. Procedures for managing lenders are included and observed.

Pre-identified sub-recipients have already worked in the implementation of several projects and programmes (Mano river, Corridor, promotion of the health of adolescents and young people, support for the Health Sectoral Plan, Integrated Health Services Development Project (PDSSI), Global Fund Phase 2 Round 2, Round 3 and Round 5, PEPFAR/CARA. The problems likely to affect performance are in the management of financial and logistics resources. With regard to financial management problems, managers have been recruited and strengthened from previous programmes. They will contribute to the support of each sub-recipient. With regard to logistics: logistics resources have been acquired from previous programmes, which will be available to sub-recipients following the agreement of the GF. In the same way, the PR will contribute its available logistics resources. These logistics will be made available based on a rigorous plan for sub-recipients to ration the use of rolling stock. Any gaps in the logistics plan will be offset by the purchases budgeted for in the proposal.

The SR of the HSS section have not been pre-identified.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

The SR for the HIV section are currently identified based on an analysis of the project ideas submitted following the tender launched by the CCM. The previous experience of some organizations in carrying out activities to fight against Aids at national level has also been taken into consideration. Finally, sub-recipients that have successfully executed Global Fund projects in Côte d'Ivoire have been selected. However, as the programme has national coverage, some areas do not have organizations with sufficient experience or recognition. Likewise, some organizations do not have enough time to draw up project ideas to submit to the CCM. For this reason, another method of selecting sub-recipients for the HIV section and for the HSS section has been provided for which takes into account all the measures with regard to transparency in the selection process:

- Call for tenders with a wide circulation through official journals and information channels for international and national networks and bodies, e mail, etc
- Formation of a selection committee validated by the CCM
- Analysis of the proposals received
- Identification of potential recipients
- Analysis of their financial and technical capacities
- Provisional selection of sub-recipients
- Evaluation of their financial and technical capacities in the field
- Validation of the selection
- Training of sub-recipients
- Allocation of sub-grants

On average, this process will last 2 months. It has the advantage of facilitating the selection of sub-recipients in areas which are hard to access.

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and

- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

The PNPEC/MSHP, the DIPE/MSHP and the CNPS will work in partnership under the management of the National Aids Committee (CNLS) meaning from the entire Ivorian nation. The skills of the CNPS with regard to monitoring and evaluation and of the PNPEC/MSHP with regard to financial management will be upgraded to comply with the requirements of the lender. The various sub-recipients will have management manuals.

The transfer of skills to the Sub-Recipient is essential to achieve the same strict management. For example, it is important that sub-recipients have a manual of procedures which is adapted to improve the management of activities. The training of the Principal Recipient and of Sub-Recipients on Global Fund procedures is a key element for the success of the activities and the achievement of the objectives. This requires management assistance and technical assistance.

The activities of the Sub-Recipients will be coordinated by the Principal Recipient. It will organize meetings every 2 months with the parties in question to monitor the progress of the activities implemented

and to help them to prepare the various reports requested. The PR will have to identify training requirements and/or requirements in relation to the technical support of the main sub-recipients for which adequate solutions will be provided, whether in terms of training, or in terms of support by experts who will be identified for this purpose.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfil its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

- **For HIV**

The activities planned in this proposal are part of the general framework of the national response to HIV. The volume and complexity of some of these activities require additional work in terms of programme coordination and management, governance and partnerships, HIV epidemiological surveillance, the strengthening of the community system, private sector, PMCT. Technical and Management Assistance (TMA) covers all 7 objectives in the proposal. Depending on the type of activity and the availability of national skills, assistance will be local or international. It takes the form of national and international consultancy, and support by ITA over a long period. Particular emphasis will be placed on transversal gender throughout the entire proposal.

The implementation of these activities therefore requires the strengthening of capacities for the MSHP, the MLS, and Civil Society organizations, as well as the organizational development of these organizations to make them more efficient. TMA provides support with defining tools to enable the effective implementation of the project and ensures that such tools meet the requirements of the GFATM and the challenges raised by the project. The selection of the various areas of technical assistance is linked to all the inadequacies raised in the gap analysis. For this reason, international and/or national consultants will be recruited based on tenders to support the drawing-up of these documents, the completion of studies and evaluations and the implementation of the various procedures.

The identification of the requirements within the various sectors

The process of drawing up the proposal has included an analysis of the general situation and the specific context of the various players. Based on the activities provided for and the skills which may be mobilized by each player, a statement of requirements has been drawn up by all the stakeholders, with technical support from UNAIDS and WHO.

Identified problem justifying the proposed TMA

The 6 themes which justify TMA are as follows:

1. **Program coordination and management**: senior TMA to coordinate and manage the program
2. **Governance and partnerships**
3. **PMCT**: only 15% of the requirements were covered during 2008 with a very low spate of PMCT in terms of HIV positive pregnant women that received a combination of antiretrovirals to reduce transmission from mother to child. senior PMCT TMA in the short term

4. **Monitoring, Evaluation and HIV epidemiological Surveillance:** Senior International Technical Assistant for HIV epidemiological surveillance
5. **The community system**: Senior ITA to strengthen the community system
6. **The private sector**: Senior ITA for the private sector in the medium-term

The type of assistance required for each of the 6 themes targeted

1. One ITA for the **Coordination and management of the program**.
2. One ITA **for Governance and partnerships**
3. One ITA **for PMCT**
4. One ITA for **Monitoring, Evaluation and epidemiological Surveillance**
5. One ITA for **the strengthening of the community system**
6. One ITA to support the **private sector**

- **With regard to HSS**

  With regard to the implementation of the project, the following assistance is envisaged:

  - 2 technical assistants for financial management including one international and one national
  - 2 technical assistants for the strengthening of community systems including one international and one national
  - 2 technical assistants for program management including one international and one national
  - 2 technical assistants for monitoring and evaluation including one international and one national
  - 2 technical assistants for care quality including one international and one national

The procedure for identifying the requirements within the various sectors:

Requirements will be identified through technical exchange meetings, report analyses and visits and supervision in the field.

- **The procedure for obtaining TMA**

National and international technical assistance will be obtained through open tenders, in accordance with the regulations in effect public contracts in Côte d'Ivoire. The rules specify the roles and the responsibilities of the various players in the various stages in the award of a contract, the content of the TDR, the members and the duties of the contracts committee, the content of the reports to be filed, etc. The various stages in the award of a contract are clearly explained for this type of service. In general, with regard to technical assistance, the principle is to share, as much as possible, the national human resources of the Ministry of Health and Civil Society organizations and to ensure the transfer of skills. The effectiveness of technical assistance will be assessed based on the resolution of the inadequacies identified and on the achievement of the project objectives. Finally, the conclusion of a contract with the technical/management assistant will be based on the concept of "Performance-Based Financing (PBF" and on an incentive framework based on results, which is the idea that has also been retained for consultants.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ ***Go to s.4B if relevant, or direct to s.5.***
	☒ **Yes** ➔ ***Continue on to answer s.4.10.2.***

Clarified Section

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Supply systems and policies	MSHP/Public Health Pharmacy	Sub-recipient responsible for supplies, receipt, storage, distribution and the monitoring and evaluation of the management of pharmaceutical products to peripheral areas	☒ Yes
Intellectual property rights	MSHP/ Pharmacy and Drugs Directorate (DPM) Ministry for Industry and Commerce	The DPM is responsible (Attachment n°104): -for drawing up and applying regulatory laws in relation to drug monitoring -for data collection, declarations and reports with a view to forming a national database on drug monitoring -for the distribution of any information in relation to drugs -for carrying out the surveys prescribed by the Ministry of Public Health; -for research and data analysis on the monitoring of a drug or product intended for human use which needs approval -for coordination and the fight against the illegal trafficking of drugs	☒ Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	MSHP/PSP/PNPEC	PSP/sub-recipient responsible for stock management and	☒ Yes

		monitoring, coordination, monitoring the execution of the national supply plan	☐ No
Product selection	MSHP/ national committee for the quantification of HIV products	Validation of quantification data Choice of molecules from national guidelines Quantification of the national requirements Drawing up of the national supply plan	☉ Yes ☐ No
Management Information Systems (MIS)	MSHP/ DIPE/PSP	PSP/sub-recipients responsible for the logistics management information of HIV products (PSP) DIPE/central directorate responsible for health information,	☉ Yes ☐ No
Forecasting	MSHP/ public health pharmacy/national committee for quantification	Annual workshop on national quantification using the software QUANTIMED	☉ Yes ☐ No
Procurement and planning	MSHP/ public health pharmacy/ national committee for quantification	Annual workshop on quantification and monitoring supply schedules using the software Pipeline.	☉ Yes ☐ No
Storage and inventory management *More details required in s.4.10.4*	MSHP/ PSP	Two stock management software packages which are interfaced with each other: SAGE 1000 (management of stock movements, financial management of tenders and transit,) MACS (warehouse management with selection of batches)	☐ Yes ☉ No
Distribution to other stores and end-users *More details required in s.4.10.4*	MSHP/ PSP	Bi-annual plan on pre-determined distribution Monthly delivery throughout the whole of Côte d'Ivoire from monthly order reports sent by centres	☉ Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance)	MSHP/ PSP	Sub-recipient responsible for drug monitoring	☉ Yes ☐ No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
Public Health Pharmacy (PSP) /supply, storage, distribution, supervision of the distribution of medical products	Sub-recipient	€24,416,235
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

This proposal relies on existing systems to manage supplies and stock. The Public Health Pharmacy (PSP) manages this. (Attachment n° 102 and 106)

Any requirements are assessed by the national selection and quantification committee (Attachment n° 105) using quantification software (QUANTIMED). Evaluation is carried out in accordance with the National Essential Drug List (NEDL) and National Treatment Guidelines (DNT).

The supply requirements recorded in a plan are divided between the various lenders and each party places its order according to its own procedures.

The PSP is responsible for supplies out of the funding from the national section. The PSP uses two acquisition methods according to the conditions determined by the code on public contracts. These involve open international invitations to tender in accordance with the decree N° 92-08 of 08 January 1992 and the negotiated tender (where the tender is declared to be unsuccessful). With regard to ARV, the PSP only purchases pre-qualified products by the WHO, taking into account the lender's requirements. The administrative procedures for issuing products are carried out by the PSP transit department from the documents sent by the supplier. For this tender, the suppliers will be paid by the PSP from a special account created to manage products, which is held at a private bank.

The products received by the PSP are systematically assessed to ensure that they comply with the order (Attachment n° 107). In addition to WHO pre-qualification, the PSP ensures the quality control of ARV products through systematic samples taken from all the batches of drugs received for analysis by the National Public Health Laboratory. Given that the NPHL does not have enough tools to control ARV, the capacities of the NHLP should be strengthened in this proposal.

Stock management support is computerized and manual. Management software (SAGE 1000 linked to MACS) includes the management of supplies, stock, sales and warehouses. For each product, a stock form is filled in manually. Products are subject to weekly rotating, random inventories and to a general bi-annual inventory.

Distribution is carried out from a plan and a pre-determined bi-annual timing chart. All 215 centres approved for HIV activities receive supplies once per month for sites within the country and twice per month for sites in Abidjan. Distribution is carried out according to the district approach for centres within the country; the district is therefore responsible for distributing ARV to health centres. The insufficient number of logistics should also be noted. As a result, the execution of Round 9 of the Global Fund requires logistics support for 29 HD by increasing the volume of storage through the restoration of 29 district pharmacies.

With regard to monitoring and evaluation, a logistics management and information system has been set up to monitor the management and rational use of drugs. An operational procedure manual on management and monitoring tools have been developed and distributed to all care sites (Attachment n° 107). The 464 managers trained on the use of these tools will feed back information on drugs management (consumption, available stock, losses and adjustments) on a monthly basis from peripheral level to central level. Quarterly supervision at central level will check the quality and the reliability of the information sent.

Drug monitoring system carried out by the Pharmacy and Drugs Directorate (DPM) in the Ministry of Health (Attachment n° 104)

Drug monitoring is carried out by the DPM with regard to the rational use of drugs and consumer safety. In light of the significant requirements in terms of rolling stock (1 vehicle for every DPM), the implementation of the programme funded by the Global Fund will require logistics support.

4.10.5. Storage and distribution systems

(a)	Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	☑ National medical stores or equivalent
		☐ Sub-contracted national organization(s) *(specify)*
		☐ Sub-contracted international organization(s) *(specify)*
		☐ Other: *(specify)*

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Only the Public Health Pharmacy (PSP) provides the actual storage of pharmaceutical products. The PSP currently has 5 warehouses with a total capacity of 18,846m² which may be extended. A plan to strengthen capacities and storage conditions is currently being implemented with the support of PEPFAR. To date, the equipment of the warehouses with the assembly of racks to store pallets and the implementation of a system to monitor temperature in the warehouses with a provision for air extraction is being carried out. This plan provides for the equipment of new warehouses to store ARV products, the strengthening of the IT system to manage warehouses and the strengthening of tools and equipment for handling.

The Global Fund Round 2 is currently funding a project to build a coldstore in the PSP. In addition, the PSP has received handling equipment. The plans cited above do not include the strengthening of storage capacities in district pharmacies. This tender provides for the strengthening of storage capacities and conditions at peripheral level (districts) in the HSS section.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Only the PSP carries out distribution. The Public Health Pharmacy has good logistics adapted to deliveries and to supervision. 27 delivery vehicles, including 11 x 10 tonnes, 7 x 5 tonnes and 9 x 2.8 and 1.5 tonnes and 24 supervision vehicles including 6 x 4x4.

The Public Health Pharmacy distributes drugs to approximately 850 customers each month throughout the entire national territory according to a bi-annual distribution plan which is pre-determined and distributed.

Health products are distributed according to the district approach, i.e. the Public Health Pharmacy

delivers to districts which in turn deliver to health centres. However, all GH, RHC, UHC and health institutions in Abidjan are supplied directly by the PSP.

The execution of Round 9 of the Global Fund will require logistics support for the 29 HD in question. This will consist of the restoration of 29 district pharmacies to improve the storage conditions of pharmaceutical and medical products.

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-HIV' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-HIV' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

The HIV form Attachment B is completed with the CHAI unit costs for the Clinton Foundation. We have increased these costs by 20% to meet the transport and insurance costs to route them to Côte d'Ivoire. The services of the PSP in relation to the management and supply of stock are 8% including BIVAC mandatory taxes, for controlling quality and distribution.

Antiretroviral treatment in Côte d'Ivoire is provided according to National Guidelines which are drawn up by the PNPEC (Attachment n° 74 and 75) based on the 2006 recommendations by the WHO. The molecules listed in attachment B correspond to primary and secondary treatment in adults as well as in children. This treatment includes cases of the HIV/TB and HIV/Hepatitis B co-infection. As treatment compliance is one of the priorities in the care through ARV, 95% of triple combination therapies will be purchased in fixed form and 5% in separated form.

With regard to opportunistic infections, biological diagnosis and care are still paid for by patients who encounter enormous problems facing up to these. In this proposal, we are asking to purchase Cotrimoxazole which is prescribed to prevent these infections and drugs to care for certain recurrent Opportunistic Infections.

With regard to reports on the initiation and monitoring of antiretroviral treatment, the national guidelines currently in effect recommend the completion of additional examinations such as research on Ag HBs, proteinuria on strips, urine test for pregnancy, lipid tests and viral load. In addition to medical equipment and reagents for completing these examinations, sustainability for equipment maintenance, continuous training and support for the quality procedures should be included.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?	☐ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☉ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9, and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria programme outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the diseases (possibly with other health impacts);*
- *Section 4B is not also included in the tuberculosis or malaria proposal.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions.

Section 4B can be downloaded from the Global Fund website. Applicants are asked to click here if they intend to include "health system strengthening cross-cutting interventions" ("HSS cross-cutting interventions") **in their proposal.**

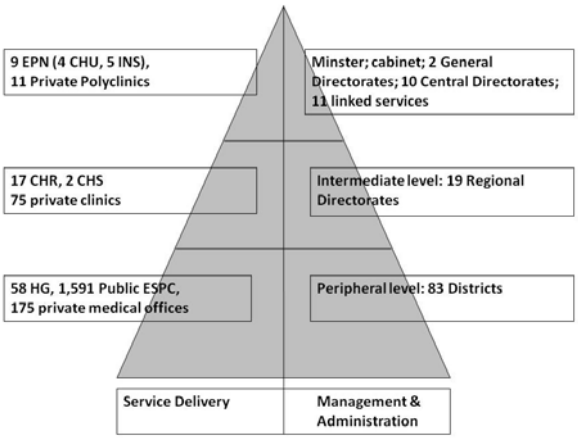
4B.1 Description of 'HSS cross-cutting intervention' ➔ ***Refer to the Round 9 Guidelines for information completing this section.***	
Title: Intervention 1 *(Change number for each separate/main intervention)*	*Strengthen Management and leadership of the health system in 51 Health Districts*
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*HIV/AIDS, Tuberculosis, Malaria and other diseases*
Identify the HSS SDA from your "HSS Performance Framework"	*SDA 1.HSS - Leadership and Governance*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

Côte d'Ivoire's public health system is organized in the shape of a pyramid with the administrative system mirroring the service delivery system, as shown in figure 1. The health district is the functional unit of the system and is charged with making national health policy operational. In 2007, the public health sector in Côte d'Ivoire consisted of 1,591 primary health care facilities (ESPC), which includes 1,119 Rural Health Centers (CHR), 317 Urban Health Centers (CSU), 122 Specialized Urban Health Centers (CSUS), and 31 Urban Training Centers (FSU). There were 77 reference hospitals - 58 General Hospitals (HG), 17 Regional Hospitals (CHR) and 2 Specialty Hospitals (CHS); and 9 Tertiary facilities comprised of 4 University teaching hospitals (CHU) and 5 specialized institutes. The ratio of 1 facility for 13.831 inhabitants is inadequate and is worse in rural areas. Moreover, physical access is a problem with only 44% of the population living within 5 km of a health facility. 27% of the population live between 5 and 15 km while 29% live more than more than 15 km from any facility. (Annex 1)

The political and economic crisis during the current decade has had a profound effect on the overall health system. The majority of public health facilities are in a poor state of repair, service quality is poor and the health system is underperforming (Annex 1). Efforts to rebuild the system are underway with the support of development partners, but the government still has difficulty in meeting its financial commitments.

Figure 1 National Health Pyramid for Cote d'Ivoire



The public sector is supported by the faith-based sector with 50 hospitals; and the private sector with 653 pharmacies, 813 infirmaries, 37 community health centers, 75 private clinics, 11 polyclinics, 21 laboratories and 113 dentist's offices. The for-profit private sector has been growing rapidly in urban centers (Annex 1)

The goal of this proposal is to improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.

Five interventions are proposed to achieve this goal.

1. Strengthen Management and leadership of the health system in 51 health districts;
2. Improve access to health services in 50 health facilities in 8 health districts in Worodougou and Montagnes Regions;
3. Improve access to, and quality of care in 37 health districts;
4. Improve drug security and the availability medicines and essential supplies in 37 health districts;
5. Make available, in a timely fashion, a minimum package of package of management and service delivery indicators for all 83 districts.

The target regions and districts were selected according to the following criteria: Intervention #1 strengthens the 51 health districts that are not currently receiving management and leadership support from the GAVI Alliance. Intervention #2 addresses the needs of the two poorest regions in the country to address financial barriers to access as identified in the PRSP. Interventions #3 & #4 target 37 health districts that have not yet received any support to rehabilitate facilities, improve the quality of care, and also a general target of integrating the three target diseases into the national minimum package of services. Finally Intervention #5 addresses the nationwide need for real-time health and management indicators.

In this first intervention we have identified one SDA – Leadership and Governance

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 1: Strengthen Management and leadership of the health system in 51 health districts		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	**Organizations Responsible**	**Target Populations**
1. Leadership & Governance	S.R. 1 & 2	1. Central, Regional, and District directors in the public sector, and private sector and community leaders. 2. Structures at all three levels of the health pyramid
INDICATORS: 1. Number of Individuals targeted for training who actually receive training in Management and Leadership 2. Percentage of those trained who practice the principles of management and leadership in their routine work		

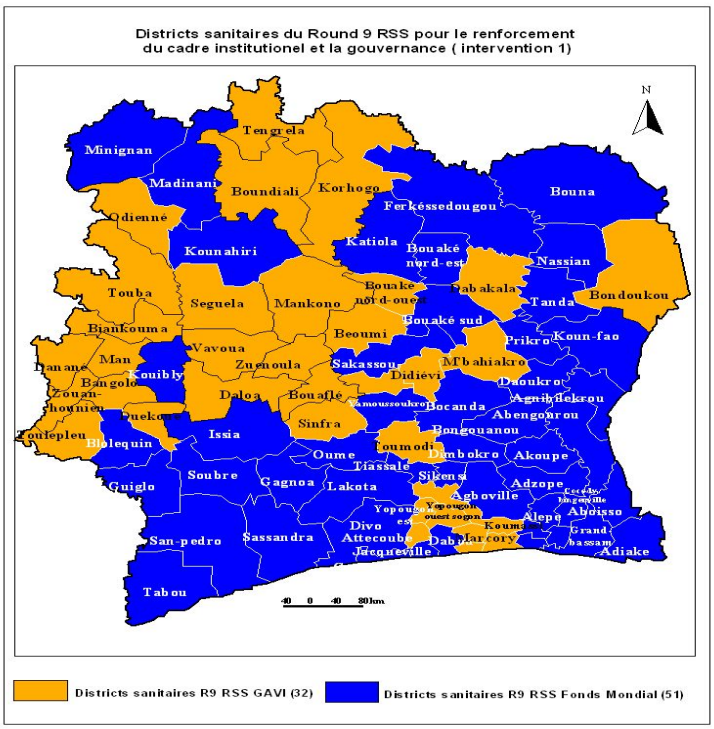
The situation analysis shows that planning, monitoring and coordination of activities throughout the system is weak: monitoring and supervision of the 19 regions and 83 districts is irregular; (Annex 2 & 3), there is a lack of synergy between the governmental and non-governmental sectors – for example public-private-community partnerships are not effective at the district level; oversight of management systems is erratic; and, leadership capacity is extremely weak. A clear symptom of these weaknesses is the fact that many of the 19 regions and 83 districts have not created their multi-year development plans. The root causes for these problems have been assessed to be the lack of a regulatory framework and the lack of technical capacity in those charged with leadership and management in the public and private sectors. Civil Society is also limited in both the scale and range of activities that they are able to conduct because of the lack of resources and qualified managers (Annex 4) and there is little capacity for training of community leaders in governance, leadership, supervision or coordination.

In order to improve the capacity to plan, manage, coordinate, monitor, and evaluate HIV, TB, and Malaria services we propose to provide assistance to the 51 districts and 7 regions not being supported by GAVI, to strengthen the capacity in health systems management, improve system efficiency and effectiveness and ultimately result in more accessible services of better quality. Specifically we will strengthen the regulatory framework for services, improve the working conditions for system managers, and build the capacity of individuals in leadership and management. (Annex 5)

Strategy 1: Strengthening the health system's regulatory framework

This strategy will involve the development of a framework document that will define the relationships and interactions between the different actors in the health system including public, private, and community sectors. It will establish performance-based partnerships with an emphasis on decentralization at the district (the functional unit of the health system). An international consultant will facilitate the development. After being validated and distributed to all partners the framework will guide the interactions within the health system and with other sectors. The application of the framework will be led by the Directorate General of Health (DGS) with support from the Department of Community Health (DSC). The DGS will organize workshops in every region to introduce the framework and build understanding and ownership. These workshops will be followed up by annual supervisory visits to reinforce the application of the framework. An evaluation of the effectiveness and possible revision of the framework is planned in year 3.

Figure 2 Target Health Districts for Leadership and Governance Interventions



Strategy 2: Strengthening management capacity

This strategy is focused on strengthening management capacity of 224 managers at all levels of the health pyramid. In this context the 203 leaders of public sector institutions and 21 from Civil Society will receive theoretical and practical training in leadership, governance, and managing for results. This training will be undertaken by a specialized training group selected in accordance with Global Fund procedures. Following the initial training the 7 target regions and 51 districts will receive on-site support in developing implementation plans for the current National Health Development Plan (PNDS) and will later develop the 58 health, HIV, TB, and Malaria plans which will contribute to the PNDS for 2014 – 2018. In support of the strengthened planning process, regular planning review and monitoring meetings will take place quarterly in the district, biannually in the region, and annually at national level.

Strategy 3: Strengthening community-based systems

To improve the capacity of civil society organizations, a “platform” will be established which will provide support to community based organizations (CBO) in strategic and operational planning, while providing assistance in coordination, leadership and capacity development for 17 civil society networks. A local consultant and 2 facilitators will elaborate the statues and legal framework for the Platform; a local headquarters will be identified and rehabilitated; and a staff of six will be recruited to manage the Platform. Equipment, including IT, communications, and a 4x4 vehicle will be provided to enable supervision of the individual networks; routine functioning costs will be supported; and a web-site will be developed. The Platform’s staff will receive specialized training in life-skills, community networking and management, and will bring the networks together for joint learning, exchange and planning on an annual basis. In addition to equipping the Platform, each of the 17 networks will be equipped with a laptop computer and a 4x4 vehicle to conduct supervisory activities and will receive a subsidy for their operation.

A detailed description of the activities for this SDA is in the attached workplan
Proposed budget: € 13,423,491 (see the detailed budget Annex 5.B.2 & 5.B.3)

(b) **Indicate below the planned outputs/outcomes/impact** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
Regulatory Framework Available and distributed	All health sector actors introduced to the framework and trained in its use		Evaluation and revision of the framework	
Establishment of the Platform capacity building of the staff, and 6 NGO networks functional	11 NGO networks functional within the Platform	17 NGO networks functional within the Platform	Platform continues to support 16 networks and a sustainability plan is developed	Platform continues to support 16 networks and sustainability plan implemented
6 NGO networks equipped and leaders trained in community leadership	5 NGO networks equipped and leaders trained in community leadership	6 NGO networks equipped and leaders trained in community leadership		
75 Leaders competent in leadership, management and governance	75 Leaders trained and competent in leadership, management and governance	74 Leaders trained and competent in leadership, management and governance		
	75 leaders trained and competent in management for results	75 leaders trained and competent in management for results	74 leaders trained and competent in management for results	
		75 health facilities use results-based management	150 health facilities use results-based management	224 health facilities use results-based management
			PNDS 2014-2018 published	

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇		**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government		2010 - 2015	178,491,323	Institutional support and overall management and leadership of the health system
Other Global Fund	R 2 HIV:	2007-2009	148,233,463	Institutional support and overall management and leadership of the health system

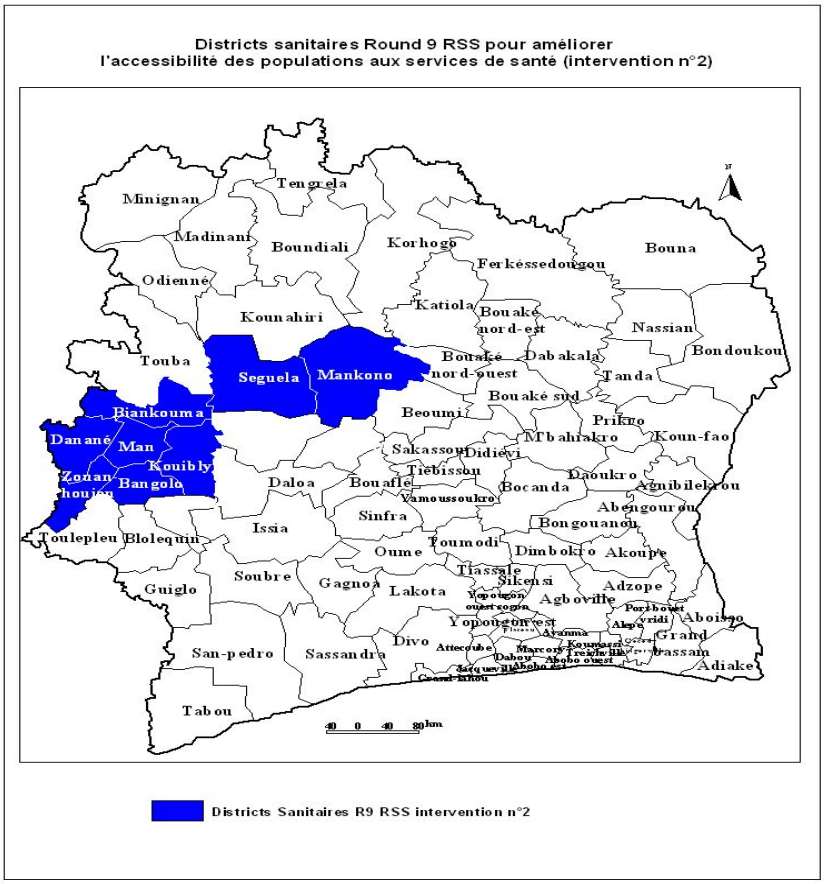
Grants (with HSS elements	R 5 HIV	2006-2008	0	
	R6 TB	2008 – 2010	283,395	Institutional support and overall management and leadership of the health system
	R6 MALARIA	2007 – 2008	6,555,138	Institutional support and overall management and leadership of the health system
	OCAL	2008 – 2009	34 76	Institutional support and overall management and leadership of the health system
Other: *(PEPFAR)*		2007-2014	510,948	Institutional support and overall management and leadership of the health system
Other: *(GAVI)*		2008-2012	448,860	Institutional support and overall management and leadership of the health system
Other: *(OMS)*		2009-2013	1,086,957	Strengthening of preventive, promotional and curative service capacity
Other: *(UNICEF)*		2009-2013	1,456,522	Strengthening of preventive, promotional and curative service capacity
Other: *(BIT)*		2009-2013	115 942	Strengthening of preventive, promotional and curative service capacity

4B.1 Description of 'HSS cross-cutting intervention' ➔ *Refer to the Round 9 Guidelines for information completing this section.*	
Title: Intervention 2 *(Change number for each separate/main intervention)*	*Improve access to health services in 50 health facilities in 8 health districts in Worodougou and Montagnes Regions*
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*HIV/AIDS, Tuberculosis, Malaria and other diseases*
Identify the HSS SDA from your "HSS Performance Framework"	*SDA 2. HSS - Financing*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

The Government contribution to the health sector only represented 7.2% of total government expenditures in 2006 instead of the 15% targeted by the African heads of state during the 2001 Abuja Summit (Annex 6). During the same period of time international partners contributed an average of 7,053 billion CFA francs per year (approximately 8.7% of the MSHP's total budget). (Annex 1) In addition the largest proportion of the MHSP's budget is allocated to tertiary-level facilities (11,5 billion CFA francs), while the entire primary health care sector receives 4.5 billion CFA francs. This creates a situation where the primary health care system is greatly underfinanced and enormous inequities in accessibility and availability of services exist.

Figure 3 Target Regions and Districts for Financing Interventions



Districts sanitaires Round 9 RSS pour améliorer l'accessibilité des populations aux services de santé (interventions n°2)	R9 HSS Health district to improve access to health services for populations (intervention n°2)
Districts sanitaires R9 RSS Interventions n°2	R9 HSS Health district Intervention n°2

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 2: Improve access to health services in 50 health facilities in 8 health districts in Worodougou and Montagnes Regions		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	**Organizations Responsible**	**Target Populations**
2. Financing	S.R. 3	1. Health Facility Management Committees 2. Members of Mutuelles 3. Health professionals
INDICATORS: 1. Number of Mutual Associations created 2. Percentage of target population of Mutuelles who become members of the mutual		

The poverty rate in Côte d'Ivoire's is estimated to be 44%, with certain regions (such as Montagnes) reaching levels of 77%. (Annex 7) This limits the financial access of the population to services. In addition, 85 – 90% of the population is not covered by any form of social assistance. At the same time, the household contribution to the overall health budget has been rising steadily and is currently 28.7 billion CGA francs (35.4% of the MHSP budget). (Annex 1) The overall utilization rate of health services is low 13.5% of the population access formal health services, with primary health care being slightly higher at 17% (Annex 8) These figures are considerably worse in the poorest regions such as Worodougou and

Montagnes where the health service utilization rate is 8.95% and 6.93% respectively (Annex 8).

In addition to the above, the health sector personnel are poorly motivated for many reasons – the most obvious being low salaries compared to other professionals; a lack of appreciation of their work within the system; and, very difficult working conditions (especially in the rural areas). (Annex 9).

This intervention is designed to respond to the financial barriers to access which contribute to the low utilization rates of services, and at the same time improve the quality of services being offered to make them more responsive to the demands of the population.

Strategy 1: Revitalization of Health Facility Management Committees (COGES)

Health Facility Management Committees were created as part of the Bamako Initiative but have since become inactive. Many lessons were learned during their existence, and in order to support the development of health Mutuelles (strategy 2), it is important that a formal management partnership be re-established between health care providers and community at the facility level. In order to achieve this, we will to revise the governing framework for COGES and train members of 50 COGES in organization and management. The COGES will be used to sensitize communities about the availability of services and provide feedback to services about community demand and perceptions of quality. To support their role each COGES will be have a space renovated at the health facility and will be provided with office and IT equipment. The project will also provide support for monthly meetings of the COGES with the community at large. To support taking the initiative to scale, a cadre of specialist trainers will be developed to provide financial management training, supervision and oversight from the 8 District and 2 Regional levels.

Strategy 2: Establishment of Mutual Health Assurance Associations (MdS)

In support of the development of a national MdS program, the Project will pilot the establishment of 50 MdS in the same 50 communities supported in strategy 1. The regions of Worodougou and Montagnes were chosen because these have the highest poverty rate and the lowest utilization rates in the country. 25 MdS are proposed for each of the 2 regions. Prior to beginning work, two study tours will take place to look at successful models of Mutuelles elsewhere in Africa, by a team consisting of 2 government representatives and 2 civil society representatives.

The first year will start with a national awareness and information gathering campaign, with an intense focus on the two target regions. As the results of this become clear, the focus will be the development of the overall program, the legal framework, procedures, strategic approach, and implementation tools. An oversight and management team will be established to steer the process following the study tours with an office in each region and a 4x4 vehicle provided in each to access the districts and communities. A range of community-based partners from both governmental and non-governmental sectors will be invited to participate in the process. The first target communities will be chosen in the second year of the project and will be those who are in proximity to primary health care facilities (ESPC) and who self-select after the initial awareness campaign. As the MdS are formed, a room will be made available (and renovated if necessary) within the health facility, and the staff of the MdS trained. Essential office and IT equipment will be provided to manage the finances and register the population and a motorcycle will be provided for communication purposes with the community. The MdS will receive monthly supervisory visits by a joint MSHP/Civil Society team. A special fund will be created and managed by the MdS to provide membership fees for those who are deemed unable to pay (strict criteria will be developed).

As the program rolls out in the third and fourth years a multi-sectoral task force will monitor the process and conduct an evaluation in the final year making recommendations for taking the program to scale nationally.

Strategy 3: Extending access to care for MdS members to the reference hospital

To ensure access to care for MdS members who are referred to hospitals, a grant will be given to 8 general hospitals to take into account the fact that they will need to provide free services. This grant will take the form of a monthly supply of medicines. The Project will hold a consensus workshop to develop a mechanism for identification of appropriate medicines, management and accounting for these medicines, and for identifying and accounting for care given to MdS members. Oversight of the program will be assured by the same team that oversees the MdS.

Strategy 4: Establish a performance-based financing mechanism to improve quality of care.

Côte d'Ivoire is currently engaged in a pilot program of performance-based financing (PBF) with financial support from PEPFAR and technical assistance from Abt. Associates. This program is aimed at improving the motivation and retention of staff in 6 health facilities including 4 urban health centers, 1 rural health center, and one district hospital in the Ferkessédougou district (Annex 10). This Project will build on the Ferkessédougou pilot (following the upcoming evaluation), expanding it to all the health facilities in the 8 focus districts and in Worodougou and Montagnes. Building on the experience of other countries (notably Rwanda) the project will incorporate specific quality of care performance measures for financing with the intent of systematically improving quality of care. Districts will be successively recruited over the first three years. After an initial evaluation of current performance, technical assistance will be provided to set targets and build capacity, and performance contracts will be developed. All quality measures will be developed according to national norms and standards.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1)
Proposed budget: € 17,788,432 (see the detailed budget Annex 5B.2 & 5B.3)

(b) **Indicate below the planned outputs/outcomes/impact** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
Revision of the regulatory framework for the COGES	COGES functioning	COGES functioning	COGES functioning	COGES functioning
Development of the MdS program	Pre-testing of MdS in 5 ESPC	Extension of MdS to an additional 20 ESPC	Extension of the MdS to all 50 target ESPC	Evaluation of MdS program
Development of the PBF program with a focus on quality of care	Establish Pilot PBF in 2 health districts	Extend PBF to 2 additional districts (total 4)	Extend PBF to 2 additional districts (total 6)	Extend PBF to 2 additional districts (total 8)

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇		**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government		2010 - 2014	2,515,409	Contribution to improving access of populations to health services
Other Global Fund Grants (with HSS	R 2 HIV:	2007-2009	0	
	R 5 HIV	2006-2008	0	
	R6 TB	2008 – 2010	0	
	R6 MALARIA	2007 – 2008	0	

elements	OCAL	2008 – 2009	0	
Other: *(iPEPFAR)*		2009 - 2010	323,308.27	Performance Based Financing
Other: *(identify)*				
Other: *(identify)*				
Other: *(identify)*				

4B.1 Description of 'HSS cross-cutting intervention'

➔ ***Refer to the Round 9 Guidelines for information completing this section.***

Title: Intervention 3 *(Change number for each separate/main intervention)*	*Improve access to, and quality of care in 37 districts*
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*HIV/AIDS, Tuberculosis, Malaria and other diseases*
Identify the HSS SDA from your "HSS Performance Framework"	*SDA 3.1 HSS – Service Delivery* *SDA 3.2 HSS – Human Resource Development*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

The PNDS 2009 – 2013 (Annex 1) envisions growth in the availability and the quality services in the next five years which will result in increased confidence in health services and a greater utilization rate of the 1,591 health facilities. There are significant barriers to obtaining these goals: run-down and obsolete facilities; inappropriate infrastructure; poor standards of care; failure to adhere to national norms and standards; and a lack of state of the art knowledge all remain significant challenges.

Faced with these challenges, Côte d'Ivoire has just approved a Human Resources for Health strategic plan (2009 – 2013) (Annex 9), which is aimed at improving service delivery at all levels of care.

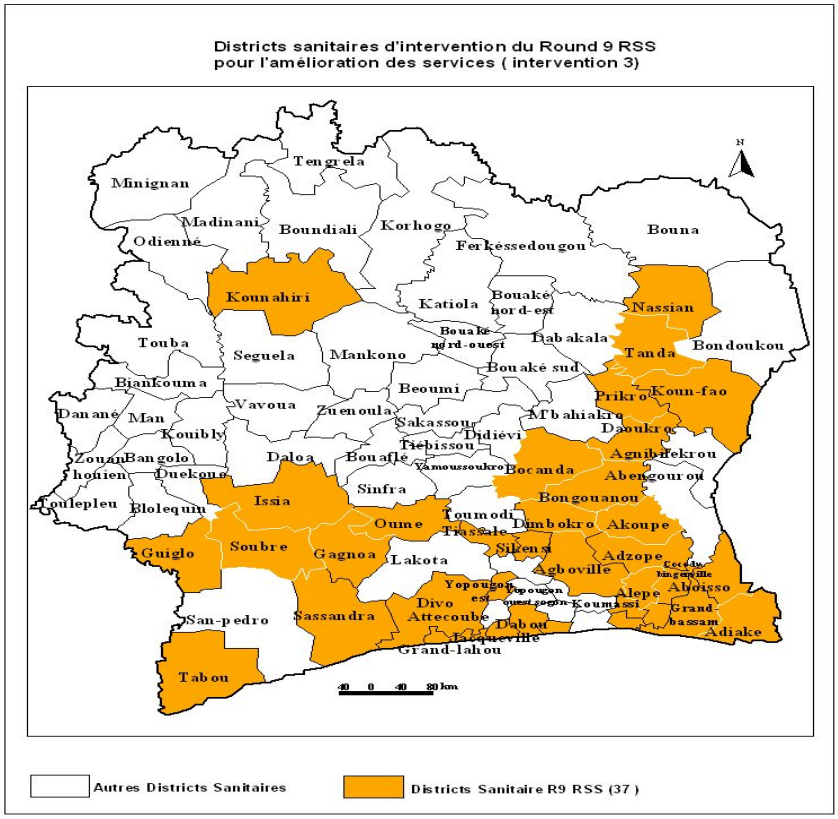
Many partners have contributed to assisting Côte d'Ivoire in renovating its health infrastructure. For example, with the support of the European Union and UNICEF, 62% of primary health centers in the Central, North, and Western zones have been renovated between 2003 and 2008, and an additional 61 facilities will be assisted between 2009 and 2013 (Annex 11). In addition, funding from GAVI is targeted to renovate 8 regional hospitals, 24 general hospitals, and 326 primary health care centers between 2009 and 2015 (Annex 4). To date however, in the 37 target regions for this intervention, 648 health facilities have received only summary support and remain in the government's plans for future renovations.

Intervention 3 is designed to bring the Global Fund's support in a synergistic fashion with other donors to improve service delivery in the 37 districts that are not receiving targeted assistance to improve service delivery.

We will improve service delivery and raise standards of care, improve management of medical waste, improve service quality, and improve the skill base of health professionals in the 37 districts. To do this we propose two SDA. 3.1 Health Services. 3.2 Human Resources for Health

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 3: Improve access to, and quality of care in 37 districts		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	Organizations Responsible	Target Populations
3.1 Service Delivery	S.R: 4	1. 6 regional hospitals, 27 general hospitals, 508 primary centers, 2 regional and 3 district maintenance depots 2. 150 TSL
INDICATOR: 1. Percentage of health facilities supervised according to national norms and standards.		

Figure 4 Target Health Districts for systems, human resource and medicines interventions



Autres districts sanitaires	Other health districts
Districts sanitaires R9 RSS (37)	HSS R9 health districts (37)

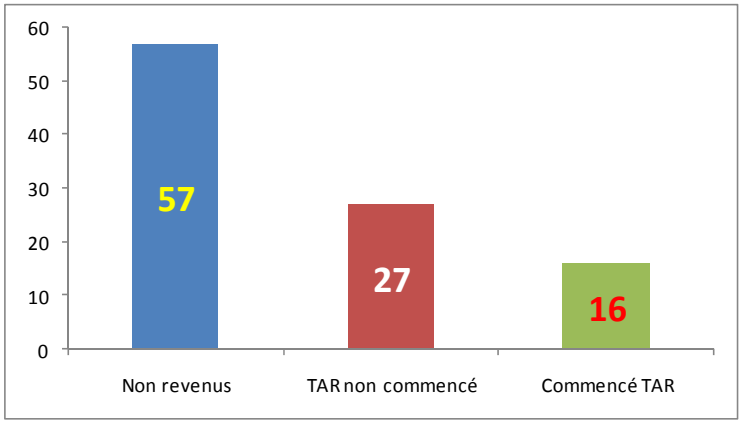
Overall quality of care is compromised by the lack of capacity to maintain essential equipment at both health facilities and in laboratories (a recent survey identified the fact that only 20 percent of laboratories have the equipment necessary to meet their terms of reference). This situation has been caused in-part since the district and regional maintenance depots founded by GTZ in 2002 have ceased to function (Annex 12).

With particular reference to HIV, blood-borne diseases, and other infectious disease, the health system in the 37 health districts is unable to deal with biomedical waste safely. A survey (Annex 13) showed that the majority of facilities do not even have waste bins, and the same survey indicated that 63% of all health districts in the country no-longer have a functioning incinerator. With the lack of equipment, staff have ceased to practice safe waste disposal or procedures (Annex 14)

A national minimum package of activities has been defined for the primary health care level (Annex 15), but these norms have not been distributed, are not known by most staff, and are not adhered to by health personnel. This leads to diminishing quality of care being delivered. A survey conducted in 2006 showed that 50% of people questioned were not satisfied with the care they received (Annex 16). The 2008 evaluation of HIV services which was conducted in both public and private sector facilities indicated that 57% of patients were lost to follow-up, suggesting that there are significant numbers of treatment failures and a great waste of resources (Annex 17). The situation in the private sector has not been adequately studied, but anecdotal evidence suggests that overall availability of services is better than in the public sector, but it is also known that private practitioners rarely adhere to national norms and standards for care. Until now, all significant interventions aimed at improving quality of care have been aimed at improving HIV services, and these have only focused on 42 of the 83 districts in the country.

Laboratory diagnosis for HIV, TB, and Malaria has been integrated into 70% of health facility laboratories, but external quality evaluations are only conducted for HIV (Annex 18).

Figure 5 Follow-up of HIV patients with CD4 < 200



To address these specific weaknesses the following strategies are proposed:

Strategy 1: Strengthening the service delivery framework

Four documents will be developed, validated, and distributed. 1) Human resource performance norms for each level of the health pyramid (including private and community sectors); 2) Norms for the management of hospital equipment at all levels of the health pyramid (for all sectors); 3) Maintenance manual for hospital equipment; and 4) maintenance manual for laboratory equipment. To facilitate these activities an international consultant and five local consultants will be engaged to work with technicians in the public and private sectors. 75 technicians will be trained in preventive maintenance of laboratory equipment. Lastly, the minimum package of activities for the general hospital will be revised to integrate state of the art approaches to the management of HIV, TB, and Malaria.

Strategy 2: Strengthening standards of care

In order to improve standards of care it is important to improve waste management and the ability to maintain the equipment in the 551 health facilities and 43 laboratories in the 37 districts and 6 regions. This will include providing medium capacity incinerators for the 43 district and regional hospitals, and providing the equipment necessary for the disposal of biomedical waste at all 551 health facilities. The six regional and 3 district maintenance depots will be equipped with maintenance and tool kits, and the provision of a 4x4 vehicle and 9 motorcycles will ensure that regular maintenance can be assured at all facilities.

All 43 laboratories will be provided with freezers (-20°C) and refrigerators (+4°C), and will also receive microscopes and maintenance kits comprising 10 spare bulbs, reagents, and cleaning materials.

Strategy 3: Strengthening quality of care through the creation of quality teams

These activities will address the 43 reference hospitals and 508 primary health care centers in the public sector, and 15 in the non-governmental sector (5 private, 5 community, and 5 religious). 20 supervisory trainers will be trained (including 5 laboratory specialists). Using an evaluation framework developed to reflect the minimum package of activities and the management and administration norms for the health facilities, the trainers will conduct assessments at each facility. Using the results of the assessment, a quality management team will be established at the health facility (the terms of reference will be developed according to the type of facility and the level of the pyramid). The exercise will begin at the hospitals, and the quality management team will receive intensive coaching over a period of a month to establish its competence and mode of operation, including the development and monitoring of quality plans, and the use of standard quality assurance and quality improvement tools.

The Regional Hospital teams will be responsible for introduction of the approach at the district hospitals (in collaboration with the trainers), and the district hospital teams will ultimately introduce the approach to the primary health care centers. Once the system is functional, supervisory teams will visit every two months using a formative approach to improve the quality of care.

In addition, the 50 laboratories in the target regions (government and non-governmental) will receive biannual external quality evaluations on the quality of microscopy for TB and Malaria.

Strategy 4: Strengthening the capacity for action at health facilities

As noted above, the quality teams at the health facility will benefit from routine formative supervision. Formative supervision will build on capacity at the facility, assist with problem identification and solving, develop competences, facilitate relationships with the community, and mentor and train staff at all levels. At present supervisory activities are not taking place with any regularity (in 2008 only 10% of health facilities received supervision according to national norms). The central level will supervise the regions biannually; regions will supervise districts quarterly; and districts will supervise primary health care centers every two months. There will be an annual meeting of supervisors at each level of the system to share experiences and lessons learned.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1
Proposed budget: € 8,744,716 (see the detailed budget Annex 5B.2 & 5B.3)

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 3: Improve access to, and quality of care in 37 districts		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	**Organizations Responsible**	**Target Populations**
3.2 Human Resources for Health	SR 4	1. All health workers at the regional and district levels 2. Medical, paramedical, and nursing training schools
INDICATOR: 1. Percentage of health districts that maintain HRM files up-to-date		

With 19,784 health workers, (Annex 19) Cote d'Ivoire would seem to have a sufficient number of personnel, but there are serious problems with the human resource capacity: there is a calculated shortage of 1475 nurses and 753 midwives; many facilities continue with low staff to patient ratios – 1 doctor for 5,695 population, 1 nurse for 2,331 population, 1 midwife for 3,717 women of reproductive age, and one senior medical officer for 13,157 population. (Annex 19) The lack of a functioning human resource management system has resulted in geographical inequities in distribution of staff – 60% of health professionals work in the Lagunes region, which contains only 24% of the population. (Annex 20). The problem has been exacerbated by the crisis that began in 2002 which resulted in a large scale migration of people from the central, north, and west regions to the south of the country. As noted elsewhere, staff morale is a significant problem because of low pay and poor working conditions.

In medical and nursing schools, management is not included in the curriculum, with the result that health professionals graduate without the basic skills to manage the facilities that they are put in charge of.

This proposal will strengthen basic training schools and assist in the implementation of the new national strategic plan for human resources development

Strategy 1: Strengthening basic medical and nursing training

Three peripheral branches of the National Health Training Institute (INFAS) will be provided with audiovisual and IT equipment (Bouaké, Korhogo et Aboisso). In addition, specialized training in planning, information systems, and data for decision-making will be developed. Curricula at the national university's faculty of medical sciences will be revised to integrate modules in management, leadership, planning, information management, and data for decision-making and the statistics department will receive material and technical support. Working closely with current faculty, existing curricula will be examined and faculty will be involved in every step to ensure their acceptance and understanding new didactic material being introduced. Finally 20 professors and teachers will receive specialized training in how to teach the new modules.

Strategy 2: Strengthening the management of human resources for health

As a part of the new strategic plan for human resources the HR management software will be revised to enable the integration of the private, faith-based, and community sectors. The software will then be introduced at the district level to enable a more effective decentralized management of human resources. 37 districts will be equipped with dedicated IT material to manage human resource. Training of staff in the use of this software and human resource management will include 134 central level staff; 6 regional directors; 2 staff from each district; and, 60 private sector and community representatives.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1)
Proposed budget: € 698,058 (see the detailed budget Annex 5B.2 & 5B.3)

(b) **Indicate below the planned outputs/outcomes/impact** (through a key phrase and not a detailed description) that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information*.

Year 1	Year 2	Year 3	Year 4	Year 5
2 Maintenance manuals produced	Norms and standards for human resources and manual for management of hospital equipment produced	Revised reference hospital manual produced		
100% of facilities have capacity to manage biomedical waste				
20 supervisory trainers in place and quality management program piloted in 6 hospitals	Quality program evaluated and expanded to 58 hospitals	Annual evaluation of quality management program	Annual evaluation of quality management program	Annual evaluation of quality management program
15% of health facilities supervised routinely	40% of health facilities supervised routinely	60% of health facilities supervised routinely	75% of health facilities supervised routinely	80% of health facilities supervised routinely
2 External Quality Evaluations conducted of laboratories	2 External Quality Evaluations conducted of laboratories	2 External Quality Evaluations conducted of laboratories	2 External Quality Evaluations conducted of laboratories	2 External Quality Evaluations conducted of laboratories

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇		**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government		2010 - 2014	512,614,009	Support to improving accessibility and quality of care
Other Global	R 2 HIV:	2007-2009	95,438,089	Contribution to renovation of three hospitals

Fund Grants (with HSS elements	R 5 HIV	2006-2008	13,720	Support to improving accessibility and quality of care
	R6 TB	2008 – 2010	1,462,766	Strengthening National Malaria program
	R6 MALARIA	2007 – 2008	1,359,470	Contribution to renovation of three hospitals
	OCAL	2008 – 2009	0	
Other: *(PEPFAR)*		2007-2014	5,109,475	Support to improving accessibility and quality of care
Other: *(GAVI)*		2008-2012	3,221, 349	Support to improving accessibility and quality of care
Other: *(OMS)*		2009-2013	5,362,319	Support to improving accessibility and quality of care
Other: *(UNICEF)*		2009-2013	11,413,043	Supporting preventive, promotional and curative care
Other: *(UNHCR)*		2009-2013	21,739	Supporting preventive, promotional and curative care
Other: (*PAM)*		2009-2013	1,811,594	Supporting preventive, promotional and curative care
Other: *(ONUSIDA)*		2009-2013	54,348	Supporting preventive, promotional and curative care
Other: *(UNFPA)*		2009-2013	18,840,580	Supporting preventive, promotional and curative care

4B.1 Description of 'HSS cross-cutting intervention'	
➔ *Refer to the Round 9 Guidelines for information completing this section.*	
Title: Intervention 4 *(Change number for each separate/main intervention)*	*Improve drug security and the availability medicines and essential supplies in 37 health districts*
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*HIV/AIDS, Tuberculosis, Malaria and other diseases*
Identify the HSS SDA from your "HSS Performance Framework"	*SDA 4.1 HSS – Medicines and Technology*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

This intervention targets two public health structures – the Pharmacy directorate (DPM) and the National pharmacy (PSP)

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 4: Improve access to, and quality of care in 37 districts		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	**Organizations Responsible**	**Target Populations**
4 Medicines and Technology	SR: 5	1. 37 DS 2. At-risk population 3. Total population of 37 districts
INDICATOR: 1. The number and percentage of health facilities that have all tracer medications available on the day of the visit		

The national pharmacy (PSP) is the lead agency in implementing the national essential medicines policy (Annex 21), and has an extensive supply network throughout the country (Annex 22). The PSP is a para-statal organization with financial autonomy, and receives support from external funding agencies including the European Union, PEPFAR, the Global Fund, and the Clinton Foundation. These partners provide free drugs and supplies for the treatment of HIV, TB, and Malaria, and the PSP is responsible for the warehousing and distribution of the drugs and supplies. Despite all this assistance, the drug supply system functions very poorly and is getting worse. Stock-outs are common for all drugs – a study showed that between 2005 and 2008 the rate of stock-outs at the central level rose from 17% to 35% (Annex 23). Figures for stockout rates at the peripheral level are not collected routinely, but are estimated to be at least 50%. Elements that contribute to this appalling situation are the absence of regional depots, a lack of drug management competence, and inadequate drug management procedures in peripheral

pharmacies. In addition, the cold chain is rarely functional because of a lack of refrigerators, materials and maintenance equipment. PEPFAR is providing assistance through the SCMS project with the introduction of “Simple one” and “Simple two” software, which provides information on ARV stocks, but TB and malaria medications are not included.

The pharmacy directorate (DPM) is responsible for pharmocovigilence. Adverse reaction forms have been developed and with financing from the Global Fund round 6 grant 19 health districts were trained in reporting and actions. However, the remaining districts of the country have not had the process introduced and reports are not received at the national level.

To improve the supply of essential drugs and supplies and the safety of medicines the following strategies are proposed:

Strategy 1: Support to the National policy task force to make recommendations for improving national drug policy

The national policy task force will receive additional support to add a review of the current policy environment concerning essential drugs, access to drugs, financing, and management. They will be charged with making recommendations for policy change that will reduce legal and policy bottlenecks and improve the accessibility of drugs and reduce stockouts. This activity will be under the leadership of the Ministry of Health.

Strategy 2: Strengthening drug management capacity at the peripheral level

37 district and 2 zonal depots will be supported in this intervention. (Zones cover several regions). Two zonal depots will be established by renovating and equipping facilities in existing regional hospitals and a refrigerated lorry will be purchased to ensure the supply of the zones from the central level. In addition, each of the 37 district pharmacies will be assessed, renovated, and supplied with basic equipment for drug and supply maintenance – IT equipment, air-conditioning, refrigerator, freezer, office equipment, and shelving. Existing software for ARV management will be updated to include the management of TB and malaria medicines and the pharmacist and pharmacy managers from each of the 37 districts will be trained in the software’s use. In addition, two pharmacy managers from each district will be trained in stock management. Monthly supervisory visits will be introduced to maintain competence, identify and resolve problems in stock management.

Strategy 3: Support to the National Pharmacy Regulatory Board (ANRP)

This assistance will support the development of treatment guidelines for HIV, TB, and Malaria, and a new adverse reaction reporting system for the three target illnesses. Using lessons learned from the existing Global Fund Malaria program, the various tools for collecting adverse reactions will be outlined, integrated into the existing adverse reaction reporting system, and the new tools introduced. Each district will have 2 pharcomovigilence focal points (the district pharmacist and the district statistician). These individuals will be trained in the management of the program, and 11 care providers from each district will be trained in adverse reaction reporting and will then be responsible for reporting to the focal points. The DPM will have IT equipment supplied and dedicated to adverse drug reactions and monitoring, and will have a 4x4 vehicle supplied for supervision and responding to reports that need urgent investigation.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1)
Proposed budget: € 3,158,116 (see the detailed budget Annex 5B.2 & 5B.3)

(b) **Indicate below the planned outputs/outcomes/impact** (through a key phrase and not a detailed description) that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5

Report of the Policy committee available	Implementation of the policy committee's recommendations			
5 district pharmacies rehabilitated and equipped	20 district pharmacies rehabilitated and equipped	12 district pharmacies rehabilitated and equipped		
Drug treatment guidelines developed	Development and validation of pharmaco-vigilence tools	Implementation of the national pharmaco-vigilence system		

(c) **Describe below** other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇		**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government		2010 – 2014	25,359 ,132	Support to improve the availability of drugs and maintain drug security
Other Global Fund Grants (with HSS elements	R 2 HIV:	2007-2009	397,709	Support for the cold chain
	R 5 HIV	2006-2008	0	Support for warehousing and distribution of ARVs
	R6 TB	2008 – 2010	508,965	Supply of drugs and supplies to health facilities for TB
	R6 MALARIA	2007 – 2008	99,332	Supply and management of ACTs in sites under the responsibility of CARE
	OCAL	2008 – 2009	1,398,308	Supply of drugs and supplies in Gonzagueville – Noé
Other: *(PEPFAR)*		2007-2014	4,087,581	Support to improve the availability of drugs and maintain drug security
Other: *(GAVI)*		2008-2012	804,988	Support to improve the availability of drugs and maintain drug security
Other: *(OMS)*		2009-2013	869,565	Support to preventive, promotive, and treatment services.
Other: *(UNICEF)*		2009-2013	30,434,783	Support to preventive, promotive, and treatment services
Other: *(EU)*		2009-2013	1,255,197	Supply of essential medicines to facilities in the EU project zone
Other: *(JICA)*		2009-2013	954,670	Support to improve the availability of drugs and

			maintain drug security

4B.1 Description of 'HSS cross-cutting intervention'	
➔ ***Refer to the Round 9 Guidelines for information completing this section.***	
Title: Intervention 5 *(Change number for each separate/main intervention)*	*Make available, in a timely fashion, a minimum package of package of management and service delivery indicators for all 83 districts.*
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*HIV/AIDS, Tuberculosis, Malaria and other diseases*
Identify the HSS SDA from your "HSS Performance Framework"	*SDA 5.1: HSS – Information Systems*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

An effective health information system is essential to monitoring the success of districts in achieving their mission. Monitoring and evaluation ensures that outcomes correspond to goals. In Côte d'Ivoire the health information system collects and manages information through four mechanisms: the routine health information system; GIS; epidemiologic surveillance; and periodic studies. Currently Côte d'Ivoire is not able to provide timely information on the functioning of the health system, and this intervention is designed to make reliable information available on the three priority diseases at all levels of the pyramid

GOAL: Improve the health and well-being of the Ivorian population including vulnerable groups from 2010 to 2015.		
INTERVENTION 5: Make available, in a timely fashion, a minimum package of package of management and service delivery indicators for all 83 districts		
PRINCIPAL RECIPIENT: DIPE/MSHP		
SDA	**Organizations Responsible**	**Target Populations**
5.1 Information	PR/SR: DIPE	1. Children < 5 years 2. Pregnant women 3. Entire population
INDICATOR: Number and percentage of regions and districts that submit monthly reports on time		

Côte d'Ivoire's information system is organized according to the principles of the "Three Ones", and the key actor is the epidemiologic surveillance officer (CSE) who is responsible for managing and integrating information at the local level, and is supervised by the regional and district director.

A detailed analysis of the weaknesses of the information system is presented in the health statistics directory 2001-2008 (Annex 8) and in the information system evaluation from 2008 (Annex 24). Individual units responsible for information management demonstrate common weaknesses: inadequate facilities resulting in poor working conditions; out of date equipment; a lack of data security; a lack of technical support; and, a non-functioning logistics system. The same evaluation showed that only 2 districts in the whole country met the minimum requirements, while the Direction for Information, Planning and Evaluation (DIPE) was unable to fulfil its role because of a lack of equipment and technical capacity.

There is an early effort to develop a community sub-system through the support of UNICEF's SASDE project. At the same time reference hospitals are in the process of developing internal information systems and electronic patient records. Neither of the preceding efforts are integrated into the national information system, nor are the human resources, pharmacy, pharmacovigilence, and laboratory databases which are also incomplete and inadequate. Data collection tools have been developed but are not routinely available which makes the collection and transmission of information difficult. PEPFAR has agreed to support the printing and distribution of tools for 2009, will finance 50% of the costs in 2010, and 10% of the costs in 2011. There are no norms and standards for health information management, and supervision to monitor data quality takes place infrequently - 29% of health facilities and 40% of districts

received any form of supervision between 2001 and 2006 (Annex 8). Feedback happens, but is slow and incomplete (for example the statistical directory for 2001 – 2006 was not produced until 2009.

A lack of training in information management, and loss of qualified staff has resulted in a human resource crisis in the information system and makes it impossible to implement either the short or medium term plans. Only 51% of districts and 30% of health facilities have staff trained in information management.

Finally, the lack of capacity to conduct routine studies as part of the information system has held back the ability to make adjustments to the health system in the face of changing circumstances.

To address these difficulties we propose 9 strategies:

Strategy 1: Strengthen institutional capacity in information management

This strategy responds to the breakdown of the information system backbone and the lack of physical and human capacity to manage they system. It consists of three parts: renovation and restoration of existing equipment and facilities; replacement of out-of-date and non-functional equipment; and responding to the human resource crisis. 81 epidemiologic surveillance centers (CSE) at the district level, 19 at the regional level, and one at the national level will be renovated. Each will be provided with IT equipment. 16 districts, 3 regions, and the DIPE will receive 4x4 vehicles for supervision and liaison, and 49 motorcycles will be provided to the districts.

A new, integrated information network will be established to operationalize the “three ones”. The network will link the DIPE, all districts and regions, the Malaria, TB, and HIV programs, the five central directorates, and the NGO platform. Using VSAT technology, servers and transmission mechanisms will be established. Data security issues will be addressed, and a new web-based information interface developed (through a public-private partnership). All the sub-systems of the information system will be integrated into the system (community, drugs, laboratory, human resources, etc), and national health indicators and tools will be re-examined and revised.

In order to address the human resource crisis, 19 medical information specialists and 19 statisticians will be recruited for the regions, and an information specialist in HIV, TB, and Malaria based at the DIPE.

Strategy 2: Strengthening technical capacity and human resources

The project will take over the production of paper data collection tools as the assistance of PEPFAR phases out (starting in 2010 and continuing through the end of the project). In addition a mobile telephone network will be established to deal with epidemiologic alerts, and to facilitate the roll-out of the new system. Training in data management will take place for 292 people (242 peripheral and 50 central), and specialized training will also be conducted in electronic management of documents and the production of electronic bulletins. Each year 10 public sector and 2 civil society actors will receive short-term training in routine information management at CESAG in Dakar. A total of 48 people (40 public and 8 civil society) will be trained in applied statistics, and 25 will be trained in Geographic Information Systems. Two study tours are also envisioned for 4 members of the MSHP and one civil society member to view the experiences of successful information systems in other countries.

Finally, in order to target unseen bottlenecks and ensure the effective implementation of this project, a detailed technical assistance plan will be developed during the first year after consultation with all sectors at all levels

Strategy 3: Improving information feedback and publication of information

A series of technical meetings, workshops and information sharing days will be used to build a “culture of information” within the health system. Routine monthly meetings at the regional level for the information teams from districts will allow an analysis and validation of information, and a national information day will be organized in collaboration with private and civil society organizations. In addition an annual report and a quarterly epidemiological bulletin will be produced.

Strategy 4: Strengthening monitoring and evaluation

A national monitoring and evaluation plan will be developed integrating public, private, and community sectors. An information database of national studies will be created and made available. Every year an evaluation of data quality will be conducted and the results published.

Strategy 5: Development of a staff retention program based on performance

According to the 2008 evaluation there is a constant drain of experienced staff form the information

system. We propose to establish a variety of mechanisms to offer performance-based incentives to remain in the system. This will include scholarships for those who exceed performance expectations; prizes for performing CSEs, and other innovations developed with the assistance of an external agency specialized in performance incentives.

Strategy 6: Development of the community information sub-system

The current activities of UNICEF will be evaluated and will be the starting point for the development of an integrated community system which will be piloted in two districts. The system will enable community actors to have up-to-date information to facilitate their decision-making and also enable the national system to take count of community activities. It will greatly strengthen the NGO Platform in their role with civil society networks.

Strategy 7: Development of the hospital information sub-system

This system will be developed as part of a public-private partnership between the DIPE and a specialized firm in hospital IT systems. The project will pilot the hospital system in 4 primary care facilities, two general hospitals, one regional hospital, and one university hospital.

Strategy 8: Improving the availability of indicators

The next demographic and health survey is planned for 2009, and will provide updated information for the baseline of this project. During the course of the project, we plan to conduct two mini-DHS studies to measure specific population based indicators and impact indicators related to the overall project which will serve as important guides to national health programming.

Strategy 9: Improving the quality of health services

Three national studies on quality of care will be conducted as a supplement to the information system to gather information that cannot be collected through the routine system. These will be on quality of care service at the health facility; client satisfaction; and the impact of training and behavior change approaches on health provider activities.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1)
Proposed budget: € 45,172,440 (see the detailed budget Annex 5B.2 & 5B.3)

Project Management

- The Direction of Information, Planning, and Evaluation (DIPE) is one of the directorates within the Ministry of Health. The DIPE's role is to ensure that health information is available to all actors in the health system for prompt decision-making. The DIPE was selected through a competitive process to be the Principal Recipient for the HSS project. It has all the strengths necessary to manage this project, with a strong network of CSEs in every district and region that enables data aggregation, analysis and action. At the central level the DIPE has good management capabilities and the ability to manage information. However, as previously noted, the DIPE suffers from an overall human resource shortage and its buildings are inadequate to support a project of this size. In addition, the CCM, charged with the monitoring of all Global Fund activities does not have the necessary resources to conduct supervisory visits and coordination meetings. To ensure that the DIPE is able to carry out its role at Principal Recipient, three strategies are proposed:

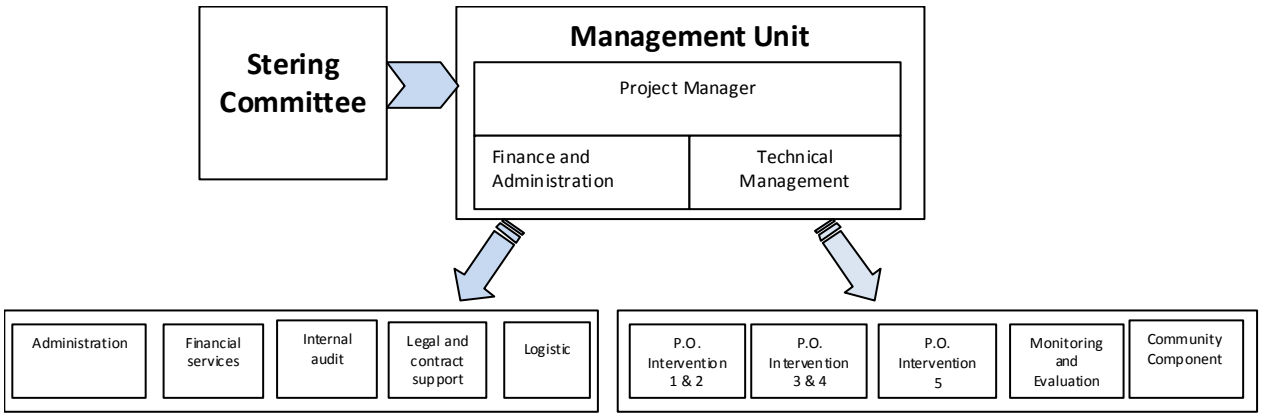
Strategy 1: Improving management of the HSS project

The project will be coordinated by a management unit overseen by the PR and engaging all the SRs. The Unit will be assisted by individual staff from the DIPE who will provide technical and financial support. Technical assistants will be recruited to support each member of the DIPE staff. Currently empty posts – 2 bilingual assistant directors, a budgeter, a contracting officer, a M&E officer, and a driver will all be recruited using approved recruiting procedures. (See the attached organizational chart). In addition a designated liaison will be identified and supported in each SR, and the necessary renovations will be carried out at the DIPE to ensure that the project can be adequately managed.

During the implementation of the project, the DIPE will call on the support of 10 national and international consultants to provide assistance in strengthening community health systems, financial management, operations management, planning, and quality management, and monitoring and evaluation

Strategy 2: Support to the management of sub-recipients

Sub recipients will benefit from training in financial, administrative and technical training. They will also receive appropriate equipment, office supplies and fuel subsidies.



P.O.: Program Officer

Strategy 3: Support the coordination of the management unit

It will organize quarterly meetings of the various monitoring programs between the PR, SRs and CCM.

A detailed description of the activities for this SDA is in the attached workplan (Annex 5B.1)
Proposed budget: € 8,605,045 (see the detailed budget Annex 5B.2 & 5B.3)

(b) **Indicate below the planned outputs/outcomes/impact** (through a key phrase and not a detailed description) that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5

25 CSE renovated and equipped	75 CSE renovated and equipped			
30 districts, 10 regions and the DIPE connected to the information network	53 districts, 9 regions and 5 Directorates connected to the network			
			National data collection tools revised	Data collected through the new tools and system
Community sub-system established	Community data incorporated into the information system	Evaluation of lessons learned from the pilot to go to scale		
	Hospital sub-system established	Hospital data incorporated into the information system	Evaluation of lessons learned from the pilot to go to scale	

(c) **Describe below** other current and planned support for this action over the proposal term

In the left hand column below, please identify the name of other providers of HSS strategic action support. In the other columns, please provide information on the type of outputs.

Name of supporting stakeholder ⬇		**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government		2010 - 2014	8,776,871	Support to monitoring and evaluation
Other Global Fund Grants (with HSS elements	R 2 HIV:	2007 - 2009	74,437,640	Support to monitoring and evaluation
	R 5 HIV	2006 - 2008	4,391	Supervision in four Districts
	R6 TB	2008 - 2009	152,222	Support to monitoring and evaluation
	R6 MALARIA	2007 - 2008	521,259	Support to monitoring and evaluation
	OCAL	2008 – 2009	0	
Other: *(PEPFAR)*		2007 - 2014	510,948	Support to monitoring and evaluation
Other: *(GAVI)*		2008 - 2012	1,556,035	Improving information management at all levels of the health system
Other: *(OMS)*		2009-2013	1,086,957	Support to preventive, promotive, and treatment services
Other: *(UNICEF)*		2009-2013	36,232	Support to preventive, promotive, and treatment services
Other: *(ONUSIDA)*		2009-2013	36,232	Support to preventive, promotive, and treatment services

Other: *(PEPFAR)*	2007-2014	510,948	Support to monitoring and evaluation

4B.2 Engagement of HSS Key Stakeholders in Proposal Development	
(a) Briefly describe **which** important HSS stakeholders (e.g., *ministries of planning, finance etc*, non-*government* sectors) have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 9 proposal. Explain why these stakeholders were selected. Why are they the most relevant to a comprehensive assessment of health system weaknesses and responses in the particular country context?	
These interventions were developed using a consensus-building and participatory process. They use the priorities outlined in the health sector development plan 2009 – 1013 (PNDS) (Annex 1) as the starting point, and the process used the same methodology that was used in developing the PNDS. The process involved several meetings with the different stakeholders to conduct a situational analysis, set priorities, identify strategies, and to ensure coherence with the objectives, strategies, and activities. The different stakeholders were identified according to their different technical profiles, their role in making services accessible to the population, and their experience in managing health systems. We believe that this has led to a truly consensus proposal. All directorates and services in the MSHP were involved - Direction Générale de la Santé (DGS); la Direction de la Santé Communautaire (DSC); la Direction de l'Information, de la Planification et de l'Evaluation (DIPE); la Direction des Affaires Financières (DAF-santé); la Direction de la Formation et de Recherche (DFR); la Direction des Infrastructures et de l'Equipement (DIEM); la Direction Générale de l'Hygiène Publique; la Direction des Ressources Humaines (DRH); and the Direction du Médicament et de la Pharmacie (DPM). In addition specific units with the MSHP associated with the three priority diseases were also involved – National Public Health Laboratory (LNSP) the National Pharmacy (PSP); and the Planning and Strategy Cell. Each helped identify weaknesses in the system and propose possible solutions with a specific focus on partnership with the private sector and civil society; the role of the MSHP; financial analysis; decentralization and district management; community and household behaviors and contributions to the health system; and the role of development partners. The same groups also contributed significantly in hosting meetings and providing support to budget the project (Annex 11) Other Ministries were also engaged – the Ministère de l'Enseignement Supérieur et de la Recherche Scientifique (MEN), the Ministère de la Lutte contre le sida (MLS), the Ministère du Plan et du Développement (MPD), and Ministère de l'Economie et de Finances (MEF). These ministries were engaged from the situational analysis through the identification of problems and strategies to resolve them. Development partners who were involved include the United Nations (UNICEF, UNDP, WHO, UNFPA, UNAIDS, and WFP), multisectoral partners (African Development Bank and the World Bank, and bilateral donors (GAVI, PEPFAR, JICA, EU, CARE International. They participated in the situational analysis, identified possible solutions, helped prevent duplication of financing and consolidate activities to improve the overall coherence of the program.	
(b) Has the applicant ensured that: (i) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under any of the specific disease components (section 4.5.1 of each disease)?; and	☑ Yes

(ii) the detailed work plan**** and the** 'Performance Framework'****** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal? *** Applicants may prepare a separate **work plan** for the HSS cross-cutting interventions and a separate **'Performance Framework'** (Attachment A) if they prefer.*	☑ Yes

4B.3 Strategy to mitigate initial unintended consequences

Unintended Consequences	Factors considered when deciding to proceed with the request for the financial support in any event	Strategies for mitigating these potential disruptive consequences
Service interruptions while staff are engaged in training or away from their post for Project work	We considered that the individual training must be sufficiently important that it provides a benefit greater than the loss of service provision	▪ Reorganization of staff tasks to take account of absences. ▪ Use short-course training ▪ On-site training ▪ Distance training.
Loss of staff trained by the project to other districts, services or to the private sector	The capacities in management, leadership, and systems strengthening are important for the country no matter which sector or service the individual ends up in.	▪ Selecting staff who are committed to the sector or area in which they work ▪ Create service contracts for those who receive long-term training ▪ Supervise regularly to keep staff engaged and motivated
Creating parallel networks in the public, private, and faith-based sectors by giving them competences they did not have before	It is important that every partner is able to deliver the best quality services and this requires strong health systems for each sector	The creation of a coordination mechanism between the NGO Platform, and the private sector, with individuals assigned responsibility to make it work
Overloading staff in the districts by adding new roles, tasks, and activities from the project	When we looked at the current workload, we noted that many tasks are not prioritized and feel that with good prioritization some current tasks can be given lower emphasis than those deemed essential for god systems functioning	▪ Conduct a thorough activity prioritization exercise ▪ Facilitate prioritization and activities for district staff by identifying those activities that lead to better care and those that have little or no influence
The government's absorptive capacity is exceeded in attempting to implement this program	This is one of the most significant weaknesses identified in the government's ability to manage the health system, and to not address it will merely result in continued failure of the health system to function.	▪ Hire staff on a contractual basis in the short term to make up for gaps in government capacity ▪ Engage local and international partners to strengthen individual and organizational capacity.
Creation of a parallel market for drugs	We feel that the likelihood of parallel markets are higher when there are no drugs available through the public sector (as now), than the risk of leakage into the parallel market when they	▪ Conduct awareness campaigns on the dangers of drugs sold in the parallel markets. ▪ Strengthen enforcement activities against the black

	become available.	market in collaboration with the police.

5. FUNDING REQUEST

5.1. Financial gap analysis - HIV

➔ *Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.*

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	74,620,745	91,109,631	108,283,012	122,651,332	147,181,599	176,617,919	211,941,502	211,941,502
Line A.1 ➔ Total need over length of Round 9 Funding Request				*(combined total need over Round 9 proposal term)*				403,576,451
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)								
Domestic source **B2:** National funding resources	4,474,245	4,474,245	4,474,245	4,474,245	4,474,245	4,474,245	4,474,245	4,474,245
Domestic source **B3:** Private Sector contributions (national)				1,294,319	1,092,201	1,322,128	1,563,213	1,563,213
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	4,474,245	4,474,245	4,474,245	5,768,564	5,566,446	5,796,373	6,037,458	6,037,458
External source **C1** *PEPFAR*	26,807,334	26,807,334	77,178,716	77,178,716	77,178,716	77,178,716	77,178,716	77,178,716
External source **C2** *EU*	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C3** *FA0*	0	97,652	500,000	500,000	500,000	500,000	500,000	500,000
External source **C4** *UNFPA*	1,666,392	1,684,386	1,575,639	1,575,639	1,575,639	1,575,639	1,575,639	1,575,639
External source **C5** *UNICEF*	1,497,764	755,072	2,685,507	2,088,986	2,088,986	2,088,986	2,088,986	2,088,986
External source **C6** *HCR*	0	182,734	182,734	182,734	182,734	182,734	182,734	182,734
External source **C7** *WHO*	278,190	278,190	10,200	10,200	10,200	10,200	10,200	10,200
External source **C8** *ONUCI*	56,706	50,736	50,736	50,736	50,736	50,736	50,736	50,736
External source **C9** *UNAIDS*	368,300	268,822	673,438	673,438	673,438	673,438	673,438	673,438
External source **C10** *FAO*	97,652	97,652	97,652	97,652	97,652	97,652	97,652	97,652
External source **C11** *UNDP*	658,384	296,104	79,710	72,464	181,159	108,696	108,696	108,696
External source **C12** *World Bank*	0	0	2,173,913	5,072,464	5,072,464	2,173,913	2,173,913	2,173,913
External source **C13** *GIP ESTHER, French Cooperation*	0	534,141	355,426	355,426	355,426	355,426	355,426	355,426
External source **C14** *Clinton Foundation*	0	0	81,961	0	0	0	0	0
External source **C16** *French Cooperation*	49,170	49,170	0	0	0	0	0	0

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C17** *German Cooperation*	2,695,743	2,695,743	0	0	0	0	0	0
Domestic source **B3:** Private Sector contributions (national)				0	0	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	34,675,636	34,297,738	86,145,633	88,358,455	88,467151	85,496,136	85,496,136	85,496,136
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Global Fund Grant D1: (*Round 2*)	3,846,602	3,374,629	6,251,830	0	0	0	0	0
Global Fund Grant D2: (*Round 5*)	848 336	1 471 896	0	0	0	0	0	0
Global Fund Grant D3: (*ALCO Round 6*)	1,431,040	3,123,250	3,062,930	2,541,890	1,695,200			
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	6,125,978	7,969,775	9,314,760	2,541,890	1,695,200	0	0	0
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	45,275,859	46,741,758	99,934,638	96,668,909	95,728,797	91,292,509	91,533,594	91,533,594
Calculation of gap in financial resources and summary of total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	29,344,886	44,367,873	8,348,374	25,982,423	51,452,802	85,325,410	120,407,908	120,407,908

Financial gap analysis *(same currency as identified on proposal coversheet)*

Note ➔ Adjust headings (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**

	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Line G = Round 9 HIV funding request *(same amount as requested in table 5.3 for this disease)*				22,498,959	23,567,343	24,430,387	26,965,227	28,491,406

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 9, the total maximum funding request for HIV in Line G is:

*(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*

*(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*

Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2010-2014 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

20,84%

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensures that government, non-government and community needs were included to ensure fully implementation of country's HIV program strategies.

The National Strategic Plan (PSN) to fight against HIV 2006-2010 shows, further to analysis, that the figures are much less than the requirements. In fact, Cote d'Ivoire is increasingly affected by the pandemic in sub-regions. Over the duration of the request for funding which runs from June 2010 to May 2015 (calculated for 5 years, therefore 2010-2014), the annual totals have been calculated and budgeted for based on the amounts retained in the national strategic plan 2006-2010, the average rate of change of the requirements over 5 years has been calculated (Attachment n° 109). The total cost of the PSN 2006-2010 is estimated to be €452,956,520. The table below represents the PSN per intervention area.

Table III: Distribution of the annual funding for the PSN 2006-2010

AREA OF INTERVENTION	FUNDING REQUEST (in €)						PROPORTION (%)
	2006	2007	2008	2009	2010	TOTAL	
Prevention	20,083,634	20,374,811	20,649,219	22,881,073	23,701,249	107,688 461	23.77%
Care	24,745,524	36,715,821	53,070,552	66,068,355	76,241,278	256,840,006	56.70%
Coordination	2,494,066	3,309,668	4,364,615	5,210,707	6,091,863	21,472,444	4.74%
Strengthening of capacities	4,889,040	8,502,082	7,271,818	7,489,820	7,753,557	35,907,842	7.93%
Monitoring - Evaluation	2,719,690	3,911,842	3,373,697	3,789,883	5,538,473	19,333,584	4.27%
Research	1,359,845	1,804,996	2,381,254	2,843,174	3,323,389	11,712,658	2.59%
GENERAL TOTAL	**56,291,800**	**74,620,745**	**91,109,631**	**108,283,012**	**122,651,332**	**452,956,520**	**100.00%**

The annual analysis of the funding for each strategy highlights the decreasing coverage of the requirements over time. This coverage was 104.26% in 2008, gradually decreasing to 79.68% in 2009 to reach 65.97% in 2010. This decrease is increasingly linked to a lack of information on the funding potentially offered over time. In fact, numerous partners do not have sufficient information on their budget forecasts as of 2008.

The period provided for the implementation of this proposal runs for 4 years which is the period covered by the National Strategic Framework to fight against STI/HIV/AIDS. To this effect, an estimate of the requirements has been made for 2010 and was used as a basis to calculate the other years in the planning of Round 9. Consequently, the estimate of the financial requirements for 2010-2014 which covers this proposal is €870,333,854 including announced funding of €466,757,403 i.e. requirements that are not covered amounting to €403,576,451. The analysis of the financial gaps for 2010-2014 shows an extremely high requirement which is not covered amounting to €120,407,908 in 2014. However, the respective amounts for requirements that are not covered in 2010 and 2011 are €25,982,423 and €51,452,802. It should be noted that the totals stated for 2010-2014 have been given for information only by the various partners, particularly in the United Nations System.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

- prioritize domestic financial contributions to the national HIV program *(including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

Côte d'Ivoire is a heavily indebted poor country and is on the decision point of the HIPC initiative. In this respect, this line is not included in row B of table 5.1 **(**Attachment n° 50). This situation is explained by the fact that the country is in a post-conflict situation and must face up to the significant poverty of the population which affects urban areas more than rural areas.

State resources are guaranteed since there is a budgetary line of €1,905,613 for the purchase of ARV. This funding does not face up to the disruption in the supply of drugs in view of the large number of PLHIV undergoing treatment but shows the intention to research the sustainability of the general care of patients.

Finally, national resources are used according to advice, transparently and fairly, to implement prevention, treatment and care and support strategies at national, regional and community levels with the sponsorship from development partners.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time)*. Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

In Cote d'Ivoire, external funding comes from PEPFAR, the United Nations System, development and bilateral and multilateral cooperation institutions (World Bank, French Development Agency, Swiss Cooperation, GTZ and KFW).

The PEPFAR has funding which will last until 2014. In addition, funding cycles from certain partners such as BAD for the Mano River Union programme (Cote d'Ivoire, Liberia, Sierra Leone and Guinea) and the European Union are coming to an end. There is an obvious risk of a deficit which must be taken into consideration in future years. The 3 main changes to the forecast contributions to intervention for the duration of the proposal are:

- The end of the Round 2 grant on 31 May 2009: this is driving Côte d'Ivoire into an area of uncertainty since PEPFAR funds are not able to care for PLHIV without any funding.
- The end of the 12 month service continuation programme which ends in May 2010 when Round 9 takes over;
- The end of DAF/ADB funding in June 2009 is included in the Round 9 grant request for the Mano River Union project;
- The end of Global Fund ALCO funding (Round 7) in July 2012.

External funding is estimated after 2010. It is therefore difficult to currently forecast all the changes to contributions for the remainder of the proposal term. Finally, the basic assumption is that the level of funding will at least remain at the current level until 2014.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/rounds/9/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 9. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/ccm/

5.3. Summary of detailed budget by objective and service delivery area

Clarified Section

Objective n°	Service Delivery Area	Année 1	Année 2	Année 3	Année 4	Année 5	Total
1	1.1. CCC - Mass media	486 598	359 570	543 843	326 870	221 889	1 938 770
	1.2. CCC – Community and school areas	463 521	496 874	496 793	496 793	496 412	2 450 393
	1.3. CCC – Community outreach and Populations at High Risk of HIV Infection	736 519	481 638	518 560	585 811	556 358	2 878 886
	1.4 Diagnosis and treatment of STI (sexually transmitted infections)	311 475	50 449	67 711	54 523	57 569	541 727
	1.5 Condom	392 294	288 917	231 585	230 363	309 781	1 452 940
	1. 6 Reinforcement of the civil society and institutional capacities	974 223	1 205 492	1 260 373	1 260 373	1 260 373	5 960 834
	TOTAL OBJECTIVE 1	**3 364 630**	**2 882 940**	**3 118 865**	**2 954 733**	**2 902 382**	**15 223 550**
2	2.1 Testing and advice	1 652 073	2 054 028	2 456 776	3 133 087	3 307 701	12 603 665
	TOTAL OBJECTIVE 2	**1 652 073**	**2 054 028**	**2 456 776**	**3 133 087**	**3 307 701**	**12 603 665**
3	3.1 PMTCT	***1 246 156***	***1 897 476***	***1 524 618***	***1 393 591***	***1 564 304***	***7 626 145***
	TOTAL OBJECTIVE 3	**1 246 156**	**1 897 476**	**1 524 618**	**1 393 591**	**1 564 304**	**7 626 145**
4	4.1 Private Sector	***534 044***	***735 941***	***553 119***	***684 157***	***681 558***	***3 188 819***

	TOTAL OBJECTIVE 4	**534 044**	**735 941**	**553 119**	**684 157**	**681 558**	**3 188 819**
5	5.1 Antiretroviral treatment (ARV) and monitoring	6 967 817,0	6 160 616,0	7 968 948,0	9 955 215,0	12 051 052,0	**43 103 648,0**
	5.2 Prophylaxis and treatment for opportunistic infections	1 020 640,0	1 105 482,0	1 067 603,0	1 117 032,0	1 196 083,0	**5 506 840,0**
	TOTAL OBJECTIVE 5	**7 988 457**	**7 266 098**	**9 036 551**	**11 072 247**	**13 247 135**	**48 610 488**
6	6.1 Care and support for chronic diseases	1 904 130,0	1 541 945,0	1 763 993,0	1 824 846,0	811 914,0	**7 846 828,0**
	6.2 Care and Support for populations at a high risk of HIV	98 299,0	131 563,0	98 299,0	98 299,0	98 299,0	**524 759,0**
	6.3 Support for orphans and vulnerable children	2 675 326,0	2 669 768,0	2 455 502,0	2 455 502,0	2 455 502,0	**12 711 600,0**
	TOTAL OBJECTIVE 6	**4 677 755**	**4 343 276**	**4 317 794**	**4 378 647**	**3 365 715**	**21 083 187**
7	7.1 Leadership, Decentralization and Multisectoral Collaboration	421 062,0	740 943,0	243 498,0	249 596,0	246 945,0	**1 902 044,0**
	7.2 Operational Coordination for Health Sector	409 874,0	503 475,0	448 960,0	276 948,0	268 991,0	**1 908 248,0**
	7.3 Monitering Evaluation and Operational Research	599 242,0	860 801,0	365 084,0	350 855,0	388 873,0	**2 564 855,0**
	7.4 Program Management and Administration Costs	1 605 666,0	2 282 365,0	2 365 122,0	2 471 366,0	2 517 802,0	**11 242 321,0**
	TOTAL OBJECTIVE 7	**3 035 844**	**4 387 584**	**3 422 664**	**3 348 765**	**3 422 611**	**17 617 468**
Total Request for Funding from The Global Fund for HIV Round 9:		**22 498 959**	**23 567 343**	**24 430 387**	**26 965 227**	**28 491 406**	**125 953 322**

5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

Avoid using the "other" category unless necessary – read the Round 9 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	1,681,094	2,476,535	2,494,829	2,514,952	2,514,952	**11,682,362**
Technical and Management Assistance	326,286	525,640	136,823	79,870	98,177	**1,166,796**
Training	2,675,190	765,238	151,575	80,971	54,811	**3,727,785**
Health products and health equipment	4,200,876	3,503,371	4,337,247	6,041,487	6,513,089	**24,596,070**
Pharmaceutical products (medicines)	4,186,780	5,149,936	6,286,507	7,444,416	8,554,155	**31,621,794**
Procurement and supply management costs	610,123	329,457	380,540	481,004	545,661	**2,346,785**
Infrastructure and other equipment	1,820,008	1,523,621	959,386	541,509	541,509	**5,386,033**
Communication Materials	797,105	690,245	874,518	657,545	548,890	**3,568,303**
Monitoring & Evaluation	1,881,919	2,634,239	2,373,369	2,325,723	2,345,947	**11,561,197**
Living Support to Clients/Target Populations	3,041,069	3,417,563	3,607,815	3,763,540	3,707,289	**17,537,276**
Planning and administration	745,340	1,475,902	1,720,824	1,801,970	1,801,970	**7,546,006**
Overheads	504,203	1,028,641	1,062,743	1,188,029	1,220,745	**5,004,361**
Other: *(Use to meet national budget planning categories, if required)*	28,966	46,955	44,211	44,211	44,211	**208,554**
Round 9 HIV funding request (*Should be the same annual totals as table 5.2)*	**22,498,959**	**23,567,343**	**24,430,387**	**26,965,227**	**28,491,406**	**125,953,322**

5.4.1. Overall budget context

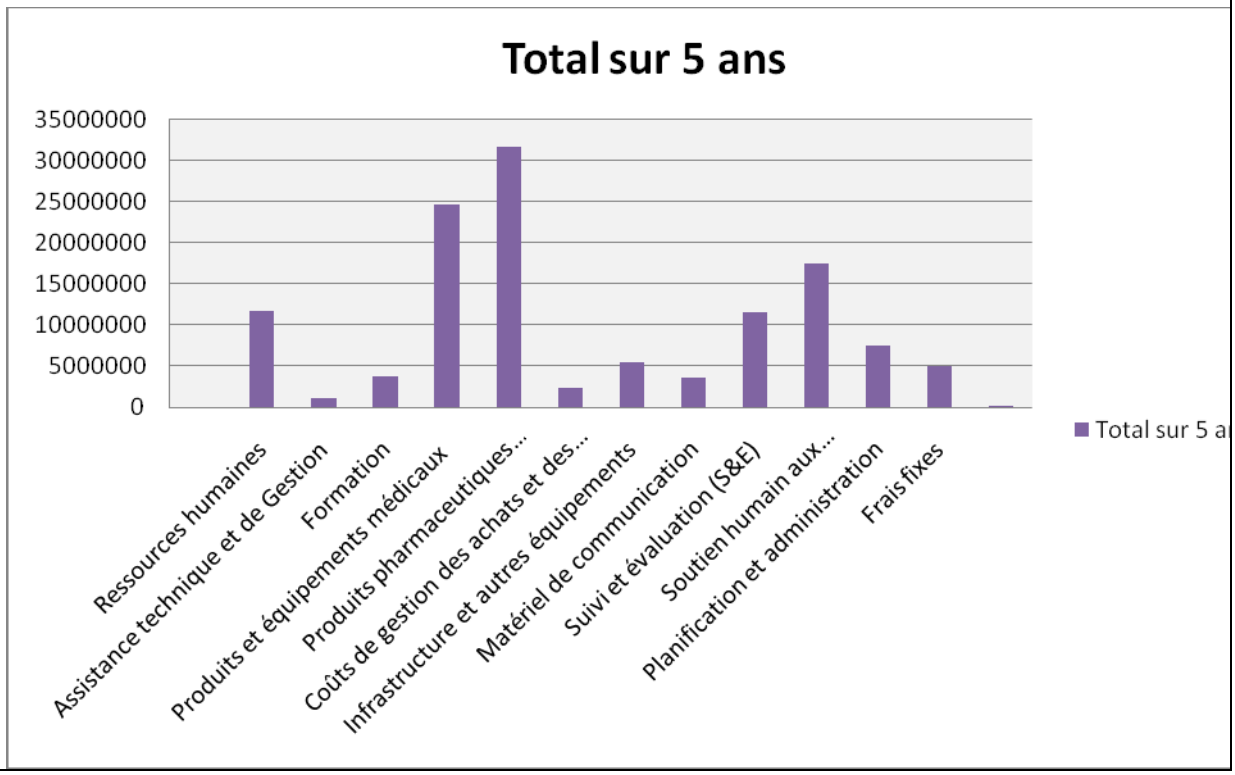
Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

The budget structure shows that approximately 37% are affected in the first 2 years. This is explained by the intention to guarantee optimum conditions for the implementation of the Round 9 proposal. In fact, essential investments needed to implement activities such as infrastructure/equipment, the drawing up and the production of essential activity guides, training and international technical assistance are provided for in the first two years.

In terms of cost categories, pharmaceutical products represent 25% of the total budget and have experienced a real increase between the first and the last year. The high demand for therapeutic care underpinned by the fact that ARV are free of charge explains this increase in the cost of drugs.

Medical products and equipment represent 20% of the total budget: scaling-up requires the strengthening and the improvement of the existing technical capacities and the availability of medical products at regional and decentralized level.

Figure n°12: Budget per cost category over 5 years



5.4.2. Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

Human support for patients and target populations represents 14% of the overall total of the proposal. This is explained by the fact that prison populations, OVC, PLHIV with food insecurity receive food rations for themselves and their families.

Human resources represent 9% of the proposal budget. They include 400 Community Advisors, 3,267 peer educators, 3 managers for each association for 80 associations and staff for the PR.

The assumptions for International Consultants are detailed in the table below.

Table IV: Cost assumptions for international consultants

Detailed assumptions: Details of technical assistance in the short-term (1 month)	Quantity	episode	Unit cost	Total cost	Cost in €	Cost in USD
Fee	30	1	250,000	**7,500,000**	**11,434**	15,000
Perdiem	30	1	120,000	**3,600,000**	**5,488**	7,200
Return plane ticket	1	1	850,000	**850,000**	**1,296**	1,700
TOTAL				**11,950,000**	**18,218**	**23,900**
Average cost in man-days	**398,333**	**CFA**	**607.26**	€	**0,00**	**USD**

The cost of International Technical Assistance is based on the costs used by the United Nations System.

With regard to OVC, some budget calculation bases

Table V: Cost assumptions for the care of OVC

Detailed assumptions: Details of technical assistance in the short-term (1 month)	Quantity	episode	Unit cost	Total cost	Cost in €	Cost in USD
School uniform	2	1	**15,000**	**30,000**	**46**	60
Enrolment	1	1	**20,000**	**20,000**	**30**	40
100 page exercise books	10	1	**500**	**5,000**	**8**	10
Bags	1	1	**3,000**	**3,000**	**5**	6
Pencils	4	1	**100**	**400**	**1**	1
Rubbers	4	1	**100**	**400**	**1**	1
Red and blue biros	10	1	**200**	**2,000**	**3**	4
School uniform	1	1	**3,000**	**3,000**	**5**	6
Other school supplies (books)	1	1	**30,000**	**30,000**	**46**	60
				93,800	**143**	**188**
Average cost in man-days	**93,800**	**CFA**	**143,00**	€	**187,60**	**USD**

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national HIV program.

➔ *Attach supporting information as a clearly named and numbered annex*

Figure n°13: Distribution of goal 1 by SDA

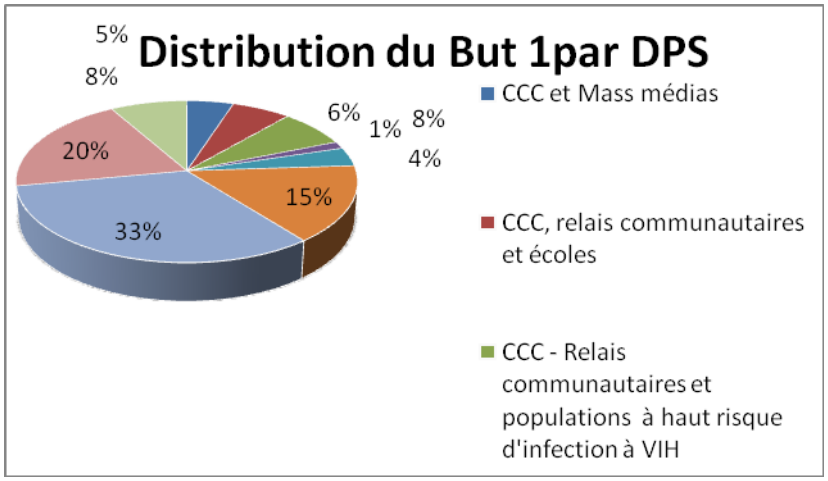


Figure n°14: Distribution of goal 2 by SDA

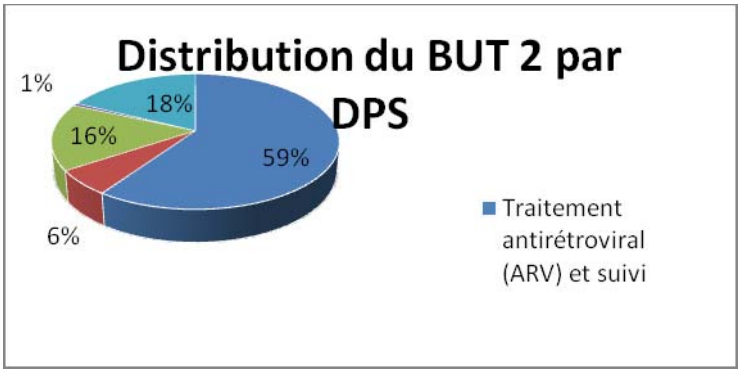
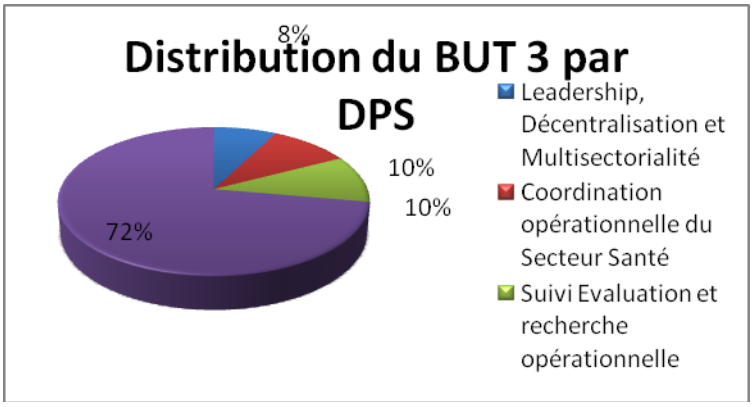


Figure n°15: Distribution of goal 3 by SDA



5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
N/A
5.5.2. Measuring performance How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
N/A
5.5.3 Additionality of Global Fund request Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the HIV program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on HIV outcomes during the proposal term*.
N/A

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Requests for funding for HSS cross-cutting interventions are optional in Round 9

*SECTION 5B CAN ONLY BE INCLUDED IN **ONE DISEASE** IN ROUND 9 and only if this disease includes in section 4B. the applicant's programme description with respect to the HSS cross-cutting interventions.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions.

Section 5B can be downloaded from the Global Fund website. Applicants are asked to click here if they intend to include "health system strengthening cross-cutting interventions ("HSS cross-cutting interventions") ***in Round 9 and if they have completed section 4B and have included it in the HIV sections of their proposal***

5B.1 Detailed Budget

Steps in budget completion:

1. **Submit a detailed budget of the HSS cross-cutting interventions *in Microsoft Excel format*** using the same numbering for budget line items as in the description of HSS cross-cutting interventions in section 4B.1.

   - **The detailed budget must be submitted as a clearly numbered annex**. *The HSS cross-cutting interventions may be prepared as a separate Excel worksheet of the disease budget, or a separate file (Excel workbook) at the applicant's election.*

   - **For guidance on the level of detail required** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the detailed budget guidance in section 5.1 of the** Round 9 Guidelines *(i.e., same instructions as for the disease budget preparation)*

2. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (section 5B.2).
   (*Note – 'SDAs' for the purpose of HSS cross-cutting interventions are **not** the same as the SDAs for the diseases. Refer to s.5B.2 of the* Round 9 Guidelines *for more information).*

3. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (section 5B.3); and

4. **Ensure the** detailed budget **is consistent with** the detailed workplan for HSS cross-cutting interventions, **and the** 'Performance Framework' for HSS cross-cutting interventions *(Attachment A).*

➔ ***READ THE* ROUND 9 GUIDELINES *FOR MORE INFORMATION***

5B.2 Summary of detailed budget for HSS cross-cutting interventions by objective and service delivery area

Table 5B.2 – Summary of detailed budget by objective and service delivery area

		Budget breakdown by SDA					
Objective Number	**Service delivery area** *(Use the same numbering as the detailed work plan for HSS cross-cutting interventions)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1	HSS - Leadership, Management, and Governance	3,311,504	2,478,049	2,385,306	2,941,928	2,306,704	13,423,491
2	HSS - Financing	1,697,972	3,862,731	4,959,488	4,691,228	2,577,013	17,788,432
3	HSS - Health Services	1,966,871	2,034,022	1,712,813	1,476,203	1,554,807	8,744,716
3	HSS - Human resources for health	239,504	453,755	1,553	1,599	1,647	698,058
4	HSS - Medicines and Technology	1,046,787	883,479	422,386	396,780	408,684	3,158,116
5	HSS - Information Systems	12,169,968	10,017,445	8,455,867	7,468,363	7,060,797	45,172,440
5	Management and Administration of the Program	2,091,794	1,556,844	1,603,546	1,651,654	1,701,207	8,605,045
Total funds requested from Global Fund for HSS cross-cutting interventions *(i.e., total for all the interventions described on a programmatic basis in s.4B.1, where included in Round 9)*		22,524,400	21,286,325	19,540,959	18,627,755	15,610,859	97,590,298

5B.3 Summary of detailed budget by cost category

Summary information provided in the table below should be supplemented with additional detail in section 5B.4 below.

Table 5B.3 – Summary of detailed budget by cost category

Avoid using the "other" category unless necessary – read the Round 9 Guidelines.	**Breakdown by cost category** *(same currency as selected by Applicant on face sheet of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	1,767,532	2,300,670	3,705,735	3,816,908	2,041,534	13,632,379
Technical and Management Assistance	1,431,189	1,128,129	1,180,732	1,267,962	1,144,373	6,152,385
Training	5,104,227	4,006,388	3,531,196	4,516,666	3,457,914	20,616,391
Health products and health equipment	359,902	368,124	-	-	-	728,026
Pharmaceutical products (medicines)	-	35,330	90,975	187,408	193,031	506,744
Procurement and supply management costs	-	-	-	-	-	-
Infrastructure and other equipment	8,033,410	4,680,122	1,195,822	414,380	50,188	14,373,922
Communication Materials	165,652	1,224,202	953,354	981,955	1,011,414	4,336,577
Monitoring & Evaluation	3,694,431	4,356,805	5,486,577	3,958,175	4,138,673	21,634,661
Living Support to Clients/Target Populations	-	78,511,	80,867	83,293	85,791	328,462
Planning and administration	866,664	1,521,006	1,644,660	1,721,486	1,758,033	7,511,849
Overheads	1,101,393	1,587,038,	1,671,041	1,679,522	1,729,908	7,768,902
Other: *(To be further defined to meet applicant's budget planning categories)*	-	-	-	-	-	-
Total funds requested from Global Fund for HSS cross-cutting interventions (s.4B.1)	**22,524,400**	**21,286,325**	**19,540,959**	**18,627,755**	**15,610,859**	**97,590,298**

5B.4.1 Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

- In general, significant variations have been observed at most costs categories and the reasons are the following:
- Human Resources: The increase of resources from the taking into account of the annual remuneration of the technical team's management and the indemnities and then the premium motivation of some health staff since the first year of implementation.
- At the level of the Technical and the Management Assistance: The decline of resources from the second year shows that the bulk of this section is much more concentrated in year 1. It is most of the cases based on the national and international expertise for the support various areas of interventions.
- Concerning the Training: the increase of resources over the period shows the importance attached to the training, the matter is to allow to the different participants to have necessary competences at their disposal for the implementation of their activities.
- Concerning the medical products and equipments: The wide variation in the decline is responsible to the chosen option which is to equip only the PSP, the CHR and HG.
- At the level of the Pharmaceutical products: The high fall of this category is related to the chosen option by Cote d'Ivoire to equip with pharmaceuticals products the general hospitals of the two poorest regions in order to improve Medical fully paid expenses (mutual health project).
- At the level of the Infrastructures and other equipments: The increase of the resources (endowments) in years 1 and 2 shows that most of the activities are devoted to the start of the implementation of the process in order to allow to the different structures to come up to expectations of the populations
- Monitoring and evaluation: the increase of resources shows the importance attached by Côte d'Ivoire to strengthen its existing system. That's why, all sectors have been taken into account in the information system for this purpose, through the introduction of new tools and the improvement of existing ones.
- At the level of the Planning and administration: the variation to the increased resources shows the emphasis devoted to the activities coordination between on the one hand the different levels of the health pyramid (central, regional and departmental level) and the other between the primary and secondary beneficiaries of the Global Fund proposal.

5B.4.2 Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) how these amounts have been budgeted in respect of the first two years; and (ii) to what extent human resources spending will strengthen health systems' capacity at the client/target population level.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach such information as a numbered annex to the proposal, and indicate the annex number in the checklist at the end of this section.*

The part of human resources in the budget that is 14% remains important. From this fact it turns up to CCM, to assume completely its responsibility towards this situation and the specificity of this proposal, focused on the payment or the motivation of the participants (technical team of management, health workers) in the implementation of the activities.

Indeed, examining the volume of activities and financial resources to implement in the framework of the proposal, it has therefore been necessary to implement a system of motivation based on the performance of the concerned participants; which will allow in a high proportion to achieve the expected results.

5B.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation

of the national disease program. ➔ *Attach supporting information as clearly named and numbered annex.*
Other expenditure items don't represent a significant part in the budget.

Proposal checklist – Section 3 to 5 HIV

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	(Attachment n° 22) (Attachment n° 23) (Attachment n° 24) (Attachment n° 25) (Attachment n° 26)
4.2.1	Map if proposal targets specific region/population group	(Attachment n° 27)
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	(Attachment n° 22)
4.4	Document(s) that explain basis for coverage targets	(Attachment n° 22) (Attachment n° 23) (Attachment n° 28) (Attachment n° 29)
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	**Work plan**
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	(Attachment n° 30) (Attachment n° 31)
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	(Attachment n° 32) (Attachment n° 33) (Attachment n° 34)
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	(Attachment n° 35) (Attachment n° 36)
4.9.1 *(for non-CCM applicants)*	**Document describing the organization such as: official registration papers, summary of recent history of organization, management team information**	N/A
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	(Attachment n° 38) (Attachment n° 39)

Proposal checklist – Section 3 to 5 HIV

4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**List Annex Name and Number**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)*** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first two years and annual information for years 3, 4 and 5).	**Work plan**
Section 5: Financial Information		**List Annex Name and Number**
5.2	**A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)**	**Detailed Budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	(Attachment n° 40)
5.4.3	Information on basis of costing for 'large cost category' items	(Attachment n° 41)
5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	N/A
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	N/A
Section 5B: HSS Cross-cutting financial information		**List Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).* Quarterly information for the first two years and annual information for years 3, 4 and 5).**	**Detailed Budget**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	(Attachment n° 42)
5B.4.3	Information on basis of costing for 'large cost category' items	(Attachment n° 43)

Proposal checklist – Section 3 to 5 HIV

Other documents relevant to sections 3, 4 and 5 attached by Applicant:		List Annex Name and Number
4.5.1	Survey on Aids impact indicators in Côte d'Ivoire	(Attachment n° 33)
4.5.1	Operational research form	(Attachment n° 37)
4.5.1	UNAIDS estimates	(Attachment n° 44)
4.5.1	UNGASS Survey	(Attachment n° 45)
4.5.1	AIS 2005	(Attachment n° 46)
4.5.1	National RCI report on the MDG	(Attachment n° 47)
4.5.1	Evaluation of MDG	(Attachment n° 48)
4.5.1	National Development Strategy based on the MDG	(Attachment n° 49)
4.5.1	2008 Poverty Reduction Strategy (DSRP)	(Attachment n° 50)
4.5.1	The STOP TB Strategy	(Attachment n° 51)
4.5.1 (SDA 1.1)	National Strategies for BCC	(Attachment n° 52)
4.5.1 (SDA 1.1)	Strategic plan to prevent HIV, Aids and STI in the young population aged between 15 and 24	(Attachment n° 53)
4.5.1 (SDA 1.2)	Ministry of National Education Sectoral Plan 2007-2010	(Attachment n° 54)
4.5.1 (SDA 1.2)	HIV and teaching staff report on the impact on the Ivorian educational system	(Attachment n° 55)
4.5.1 (SDA 1.3)	National Data and Strategies on the implementation of HIV programmes aimed at highly vulnerable populations	(Attachment n° 56)
4.5.1 (SDA 1.3)	Report on the participative survey to identify the requirements to prevent and care for STI and HIV/Aids in MSM	(Attachment n° 57)
4.5.1 (SDA 1.3)	Situation analysis of the coverage of intervention in favour of SW in Côte d'Ivoire	(Attachment n° 58)
4.5.1 (SDA 1.3)	Behaviour, attitude and practices of sex workers with regard to STI	(Attachment n° 59)
4.5.1 (SDA 1.3)	Prison statistics in RCI	(Attachment n° 60)
4.5.1 (SDA 1.3)	Report on the penitentiary situation in CI	(Attachment n° 61)
4.5.1 (SDA 1.3)	Report on activities to strengthen the care of HIV at the MACA	(Attachment n° 62)

Proposal checklist – Section 3 to 5 HIV

4.5.1 (SDA 1.3)	Testimony by a MSM from the NGO Arc-en-ciel	(Attachment n° 63)
4.5.1 (SDA 1.4)	STI care algorithm in CI	(Attachment n° 64)
4.5.1 (SDA 1.6)	Map of the organizations to fight HIV / AIDS in RCI	(Attachment n° 65)
4.5.1 (SDA 1.6)	Report on the training of peer educators on positive prevention	(Attachment n° 66)
4.5.1 (SDA 3.1)	Manual of PMCT technical procedures 2007	(Attachment n° 67)
4.5.1 (SDA 3.1)	PMCT joint mission report	(Attachment n° 68)
4.5.1 (SDA 3.1)	PMCT scaling-up plan	(Attachment n° 69)
4.5.1 (SDA 4.1)	National policy to fight against HIV and Aids in the workplace in RCI	(Attachment n° 70)
4.5.1 (SDA 4.1)	Top performance Programme to fight against HIV/Aids in the workplace in RCI	(Attachment n° 71)
4.5.1 (SDA 5.1)	Decision on the free cost of antiretroviral treatment	(Attachment n° 72a)
4.5.1 (SDA 5.1)	Monthly report on ARV and OI drugs	(Attachment n° 72b)
4.5.1 (SDA 5.1)	Guide to harmonize Community Advisors	(Attachment n° 73)
4.5.1 (SDA 5.1)	Decision on a new ARV scheme	(Attachment n° 74)
4.5.1 (SDA 5.1)	Report on the technical workshop to revise ARV treatment strategies in CI	(Attachment n° 75)
4.5.1 (SDA 5.2)	PNLT 2007 activity report	(Attachment n° 76)
4.5.1 (SDA 6.1)	Bill on the protection of PLHIV	(Attachment n° 77)
4.5.1 (SDA 6.3)	OVC report, UNICEF, 2008	(Attachment n° 78)
4.5.1 (SDA 6.3)	Policy Document	(Attachment n° 79)
4.5.1 (SDA 6.3)	National guidelines on the services to be offered to OVC as a result of HIV/Aids in Côte d'Ivoire	(Attachment n° 80)
4.5.1 (SDA 6.3)	2007-2008 Strategic Plan on the Care of OVC	(Attachment n° 81)
4.5.1 (SDA 7.1)	Decree on the creation of the CNLS	(Attachment n° 82)
4.5.1 (SDA 7.1)	Decree on the organization of the MLS	(Attachment n° 83)
4.5.1 (SDA 7.2)	PNPEC plan to extend HIV/Aids intervention	(Attachment n° 84)

Proposal checklist – Section 3 to 5 HIV

4.5.1 (SDA 7.2)	Decision on the organization of the PNPEC	(Attachment n° 85a)
4..5.1 (SDA 7.2)	Decision on the changes to the CNPS	(Attachment n° 85b)
4.5.1 (SDA 7.3)	National Health Information System, Policy Document	(Attachment n° 86)
4.5.4	Analysis of gender-based violence in the department of Abidjan	(Attachment n° 87)
4.5.4	Crisis and gender-based violence in Côte d'Ivoire-Study results and main challenges	(Attachment n° 88)
4.5.4	National Policy Document on Gender	(Attachment n° 89)
4.5.4	Status of Mainstreaming Gender in the Cote d'Ivoire National HIV Response	(Attachment n° 90)
4.5.4	TRP Briefing on Gender	(Attachment n° 91)
4.6.1	Report on Round 2 phase 3rd quarter	(Attachment n° 92a)
4.6.1	Overview of the links between the proposals for intervention and pre-existing grants	(Attachment n° 92b)
4.6.1	PREMA Quarter 2 project report	(Attachment n° 93)
4.6.1	PREMA phase 2 round 5 project report	(Attachment n° 94)
4.6.1	ALCO activities report health section on 30 November 2008	(Attachment n° 95)
4.6.1	PEPFAR-CARE protocol agreement	(Attachment n° 96)
4.6.2	UNS Development Aid Framework Project	(Attachment n° 97)
4.6.2	Final evaluation of the 2003-2007 CI-UNFPA cooperation programme	(Attachment n° 98)
4.6.2	RCI-UNFPA country programme action plan	(Attachment n° 99)
4.9	PR CARE subgrant management manual	(Attachment n° 100)
4.9	Manual on the supply and management policies of CARE stock	(Attachment n° 101)
4.10	Decree on the creation and organization of the PSP-CI	(Attachment n° 102)
4.10	Decree on the creation of the NPHL	(Attachment n° 103)
4.10	Decree on DPM organization	(Attachment n° 104)
4.10	Decision to create the committee to monitor ARV stock and consumables	(Attachment n° 105)

Proposal checklist – Section 3 to 5 HIV

4.10	Overview of the PSP	(Attachment n° 106)
4.10	PSP Procedure Manual	(Attachment n° 107)
4.10	Average Laboratory Cost	(Attachment n° 108a)
4.10	Summary table on the contributions of lenders to the laboratory	(Attachment n° 108b)
4.10	Quantitative laboratory results on new and previous guidelines	(Attachment n° 108c)
4.10	WHO Mission report, WHO supplies	(Attachment n° 108d)
5.1	2006-2010 PSN costs and funding document	(Attachment n° 109)
	HSS Appendix	
4B 1 (SDA 1.1)	Rapport on the meeting to monitor Regional Directorates and Departmental Directorates	(Attachment n° 110)
4B 1 (SDA 1.1)	National Plan to Manage Health Waste	(Attachment n° 111)
4B 1 (SDA 1.1)	Report on the supervision of Regional Directorates by SHP	(Attachment n° 112)
4B 1 (SDA 1.1)	CI_GAVI Health System Strengthening	(Attachment n° 113)
4B 1 (SDA 2.1)	Health funding in Africa	(Attachment n° 114)
4B 1 (SDA 2.1)	2001-2006 Directory of Health Statistics	(Attachment n° 115)
4B 1 (SDA 2.1)	Strengthening the health system in CI, GAVI HSS proposal, CI	(Attachment n° 116)
4B 1 (SDA 3.1)	Abt Associates	(Attachment n° 117)
4B 1 (SDA 3.1)	French Coop Unicef 2009-2013 Country Programme Action Plan	(Attachment n° 118)
4B 1 (SDA 3.1)	Technical and financial support programme on DIEM Maintenance	(Attachment n° 119)
4B 1 (SDA 3.1)	2009-2011 National Plan on the Management of Medical Waste	(Attachment n° 120)
4B 1 (SDA 3.1)	National Plan on the Management of Health Waste	(Attachment n° 121)
4B 1 (SDA 3.1)	VIDE Manual on PAM reference guidelines in Health Districts	(Attachment n° 122)
4B 1 (SDA 3.1)	Situational analysis report HHR_CI_November_06	(Attachment n° 123)
4B 1 (SDA 3.1)	Evaluation of the quality of HIV/AIDS services in Cote d'Ivoire	(Attachment n° 124)
4B 1 (SDA 3.1)	Laboratories Evaluation Report_ APHL	(Attachment n° 125)
4B 1 (SDA 3.2)	Staff requirements point_HHR_2008	(Attachment n° 126)

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4B 1 (SDA 3.2)	2009_DIPE population data	(Attachment n° 127)

Attachment A - HIV Performance Framework

Program Details

Country:	Republic of Côte d'Ivoire
Disease:	HIV/AIDS
Proposal ID:	Strengthening the national response to HIV so as to scale up prevention and overall case management, taking account of gender and the key high-risk groups for HIV

Program Goal, impact and outcome indicators

	Goals
1	Improve the offer of prevention services to reduce new infections among the general population, among women, and among key groups at high risk of becoming infected with HIV in view of the gender aspect
2	Reduce AIDS-related morbidity and mortality rates by providing access to care, quality of services, and continuity of care
3	Strengthen the leadership, coordination, and monitoring & evaluation of the national response
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
Impact	Number and % of infants born to mothers who are carriers of HIV and who are in turn carriers of the virus	ND		Health Facility survey			0		0	The survey for Year 2009 is underway. New ones are planned for Years 3 and 5.
Impact	Number and % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	72%	2008	Health Facility survey		1			1	A survey takes place in 2009, and the next ones will occur in Years 2 and 5.
outcome	Number and percentage of sex workers (M&F) who say they used a condom with their last customer	ND	2008	AIS (AIDS Indicator Survey)	1		1		1	A behavioral survey will take place in 2010, and the next ones will occur in Years 3 and 5.
outcome	Number and percentage of men who say they used a condom the last time they had anal sex with another man	ND		Specific surveys and research (specify)	50%		1		1	The behavioral survey is planned for Years 1, 3, and 5.

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Strengthen social mobilisation and communication to combat HIV among women, young girls and key high-risk groups for HIV	
2	Improve accessibility and the quality of services for Counseling and Screening	
3	Strengthen accessibility and the quality of Prevention of Mother-to-Child Transmission of HIV	
4	Strengthen efforts against HIV at the workplace	
5	Improve accessibility and quality of medical treatment with ARV, prevention and treatment of OI, and biological monitoring	
6	Strengthen the community treatment of PLWHA, women, OVC, and key groups at high risk of becoming infected with HIV	
7	Improve the leadership, coordination, and monitoring & evaluation of the national response	

Attachment A - HIV Performance Framework

Program Details

Country:	Republic of Côte d'Ivoire
Disease:	HIV/AIDS
Proposal ID:	Strengthening the national response to HIV so as to scale up prevention and overall case management, taking account of gender and the key high-risk groups for HIV

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	BCC - Mass media	Number of radio and television shows broadcasted	ND		REPMASCI reports	50	100	150	200	500	1,000	1,300	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	This activity will be carried out jointly with National Committee on Aid Co-ordination (CNCA) and REPMASCI (the CI Network of Media Professionals and Artists); monthly, by counting
1.2	BCC - community outreach and schools	Number of people receiving community and peer education about prevention as part of BCC	ND		Report from the National AIDS Control Committee (CNLS)	20,000	138,462	213,065	287,668	447,160	615,918	793,063	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Reports on activities, raising awareness; monthly
1.3	BCC - Community outreach and Key high-risk groups for HIV	Number of sex workers (M&F) who have benefited from HIV prevention programmes	13,000	2008	Reports from Family Health International's (FHI) PAPO Project	3,161	10,537	13,698	16,200	27,602	45,021	57,825	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Reports on activities, raising awareness; monthly
		Number of detainees receiving outreach and peer education about prevention as part of Behavior Change Communication	ND		Reports from ESTHER GIP (public interest grouping)	800	1,714	2,825	3,935	7,930	14,917	27,972	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	The monthly turnover rate of prison detainees is 5%; 27 prisons; monthly
		Number of MSM who have benefited from HIV prevention programmes	575	2008	Reports from Clinique de Confiance and Ruban Rouge	500	1,212	1,920	2,628	3,994	5,556	7,097	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Report from "Clinique Confiances" and other specialist organizations; monthly, by counting
1.4	Diagnosis and treatment of sexually transmissible infections (STI)	Number of STI cases who were correctly diagnosed, treated, and counseled in health facilities	84,813	2008	Reports from the Information, Planning and Research Unit of the Ministry of Health (DIPE)	3,000	7,581	11,635	15,689	24,293	33,350	43,132	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	Report on activities of healthcare organizations; monthly, by counting
1.5	Condom	Number of condoms distributed and sold.	26,850,179	2008	Reports from AIMAS	4,000,000	11,725,149	14,980,500	18,235,851	22,066,923	26,190,739	33,923,486	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	WHO standards: 1 couple using 144 condoms is protected for one year; monthly
1.6	Strengthening of civil society and institutional capacity building	Number of community-based associations benefiting from capacity-strengthening	ND		Report from the National AIDS Control Committee (CNLS)	40	60	80	80	80	80	80	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	The community-based associations are picked to provide case management for OVCs, PLWHA, Key population groups; monthly
2.1	Testing and Counseling	Number of people receiving counseling and screening with transmission of screening results	311,145	2008	Reports from Programme national de la prise en charge (PNPEC - National Case Management Program)	60,000	122,599	200,378	280,051	527,277	952,685	1,412,595	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	All screening strategies will be used, CDIP (patient initiated testing) and VCT both at healthcare centres and in the community; monthly
3.1	PMTCT	Number of seropositive pregnant women who receive full ARV prophylaxis to reduce the risk of Mother-to-Child Transmission	6,909	2008	Reports from Programme national de la prise en charge (PNPEC - National Case Management Program)	1,000	2,500	4,500	6,500	11,000	15,000	19,716	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	These samples are taken during ANCs (antenatal consultations, CPN) in all the healthcare organizations; monthly
4.1	Private sector	Number of work committees implementing programs related to HIV infection	258	2008	Reports from Coalition of Ivoirian Businesses against HIV/AIDS (CECI)	0	100	200	300	450	600	600	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Employees' awareness is raised by means of works committees; monthly
5.1	Antiretroviral treatment (ARV) and monitoring	Number of people afflicted with an advanced HIV infection who receive antiretroviral combination therapy	51,833	2008	National report from PSP-CI	11,732	13,257	14,757	16,385	20,841	25,443	29,595	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	Global Fund quarterly report on activities December 2008; the 11,232 patients in March 2009; 80.04% of the gap has been taken into account up to 2014
5.2	Prophylaxis and treatment for opportunistic infections	Number of PLWHA diagnosed and treated for opportunistic infections	ND		Report from the Information, Planning and Research Unit of the Ministry of Health (DIPE)	10,000	22,254	34,057	45,861	70,748	96,802	124,713	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	routine activities of healthcare centres; monthly
6.1	Care and support for the chronically ill	Number of PLWHA that benefited from community-based treatment	13,751	2008	Report from the National AIDS Control Committee (CNLS)	1,000	3,835	#VALUE!	11,948	20,623	34,071	44,206	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Global Fund quarterly report on activities December 2008
6.2	Care and support for key populations at high risk of HIV infection	Number of sex workers (M&F) who have received care in the community	260	2008	Reports from Clinique de Confiance	140.00	740	2,240	3,740	5,240	6,240	8,000	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	Community Report; monthly, by counting
6.3	Support for Orphans and other Vulnerable Children	Number of OVC receiving treatment	84,947	2008	Reports from National OVC Program (PNOEV)	800	3,000	7,500	10,000	25,000	35,000	45,000	Y	N	Y - over program term	National Social Insurance Fund (CNPS), civil society and private sector PRs	OVC National Plan (PNOEV) December 2008, Monthly
7.1	Leadership, Decentralization, and Multisectorial Collaboration	Number of technical support units for local initiatives that are operational	7	2008	Report from the National AIDS Control Committee (CNLS)	1	5	7	12	12	12	12	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	MLS (AIDS Ministry) Report; monthly
7.2	Operational coordination for the health sector	Number of monthly coordination meetings held	ND		Reports from Programme national de la prise en charge (PNPEC - National Case Management Program)	6	12	18	24	36	48	60	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	Meetings held by the PNPEC; monthly
7.3	Monitoring , Evaluation, and Operations Research	Number of Health Districts which have sent their monthly HIV reports to the DIPE on time	ND		Reports from the Information, Planning and Research Unit of the Ministry of Health (DIPE)	5	8	10	15	20	25	29	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR	Report on activities; monthly
7.4	Programme running and administration cost	Number of Performing PRs			Please select…	2	2	2	2	2	2	2	Y	N	Y - over program term	National HIV/Aids Care &Treatment Programme (PNPEC)/MSHP, governmental PR CNPS/Civil society and private sector PRs	Report on activities; monthly