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APPLICANT SELF-ASSESSMENT TO INFORM PROGRAM CONTINUATION

The Applicant Self-Assessment is the mechanism by which applicants provide their rationale for continuation of existing Global Fund-supported grants to deliver on program objectives and highest impact with the available resources. As part of the assessment for Program Continuation, opportunities for programmatic adjustments should be identified for reprogramming as appropriate, taking into account that the revision of grants can take place at any time throughout the grant cycle to ensure that the program is on track to deliver results and achieve highest impact.

Responses to each question should be brief and should clearly demonstrate how the current investments are in line with the country's need to maximize impact. Reference to supporting documents and evidence is strongly encouraged. This self-assessment must be submitted together with Annex 1 to confirm the inclusiveness of the process.

If the applicant confirms material change for any of the questions below, it is required to explain whether this change will have an immediate impact on the programming (i.e. require a Tailored or Full review) or can be addressed at a later stage (i.e. through reprogramming during grant implementation).

SUMMARY INFORMATION			
Applicant	Country Coordinating Mechanism (CCM) – Côte d'Ivoire (CIV)		
Component(s)	Malaria	**Funding amount as per Program Split**	€111,117,115
Principal Recipient(s)	Ministry of Health and Public Hygiene (MSHP): Principal Recipient (PR), government. Save the Children Federation Inc.: Principal Recipient, civil society		
Envisioned grant(s) start date	January 1, 2018	**Envisioned grant(s) end date**	December 31, 2020
Funding amount requested for Program Continuation	€ 111,117,115	**Prioritized above allocation**	None[1]

1. Epidemiological contextual updates

Are there any relevant changes in the country's epidemiological context as compared to the previous funding request (e.g. important changes in trends in incidence/notification rates or prevalence, key drivers of the epidemics, emerging high risk behaviors, drug/insecticide resistance, or coverage of interventions in the general population or specific key populations based on the latest surveys or other data sources)?	☐ Yes ☒ No

On October 15, 2014, Côte d'Ivoire submitted a concept note to the Global Fund for the financing of the fight against malaria between 2015-2017. Despite the progress recorded with the contribution of this funding **(cf. Table 1 below)**, the epidemiological situation remains unchanged.

Table 1: Development of some impact and outcome indicators

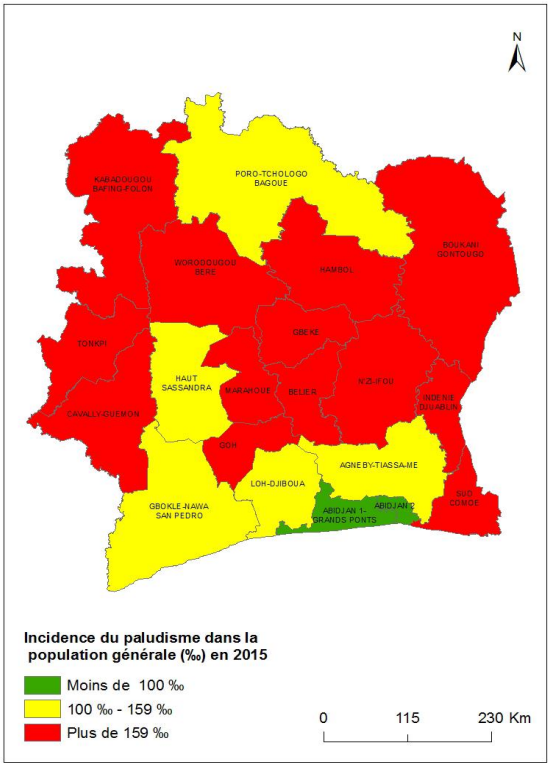
Indicators	Results

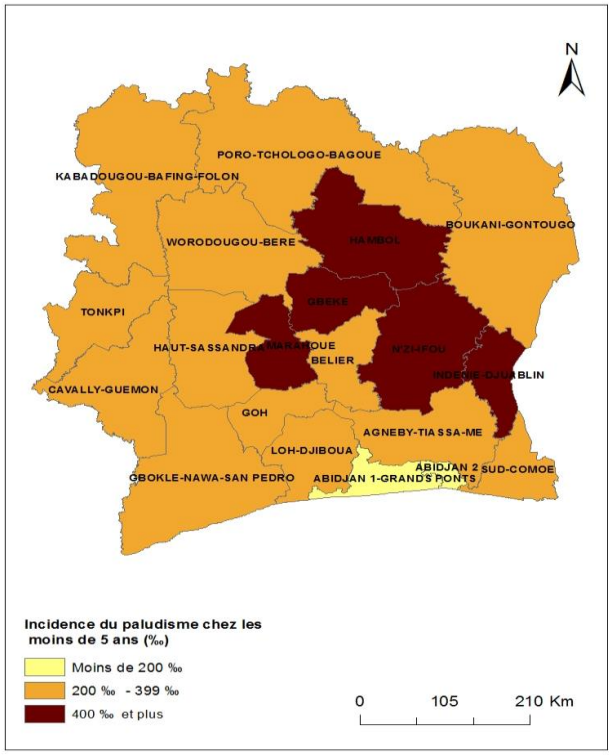
[1] Applicants invited to submit a Program Continuation request are also encouraged to submit a prioritized above allocation request.

	At time of submission of Concept Note on October 15, 2014	At time of submission of current funding request (March 20, 2017)
Mortality rate among children under 5	**108 per 1,000** (EDS-MICS III, 2012, p.126)	**96.2 per 1,000** (MICS 2016, p.18)
Number of deaths linked to malaria	**3,261** in 2013 (WHO Report 2016, p.146)	**2,604** in 2015 (WHO Report 2016, p.146)
Malaria-specific mortality rate in hospitals	**14 per 100,000** (RASS 2013)	**11 per 100,000** (WHO Report 2016, p.146)
Incidence of malaria among the general population	**16.376%** in 2014 (RASS 2014, p.70)	**15.549%** in 2015 (RASS 2015, p.70)
Number of cases of malaria among the general population	**4,708,425 in 2013** (WHO Report 2016)	**3,606,725 in 2015** (WHO Report 2016)
Incidence of malaria among children under 5	**44.69%** in 2014 (RASS 2015, p.15)	**29.2%** in 2015 (RASS 2015, p.15)
Prevalence of parasite among children under 5	**Ranges from 67 to 75%** (Assi et al., 2013 and Hürlimann et al., 2014)	**37%** (EPPA: Malaria and Anemia Prevalence Survey 2016, p.21)
Positivity rate	**70%** (Health Service Survey 2013 p.5)	**67%** (Health Service Survey 2016 p.6)
Rate of use of LLINs among the general population	**32.8%** (EDS-MICS 2012 p.213)	**50.1%** (MICS 2016, p.71) **Rural context: 64.1%** **Urban context: 34.3%**
Rate of use of LLINs among pregnant women	**39.7%** (EDS-MICS 2012 p.217)	**40.1%**[1] (MICS 2016, p.65) **Rural context: 54.2%** **Urban context: 22.9%**
Rate of use of LLINs among children under 5	**37%** (EDS-MICS 2012 p.237)	**59.2%** (MICS 2016, p.62) **Rural context: 69.6%** **Urban context: 43.1%**
Rate of use of insecticide-treated nets (ITN) among general population in households with at least one ITN	**46.2%** (EDS-MICS 2012 p.220)	**62.7%** (MICS 2016 p.63) **Rural context: 74.7%** **Urban context: 46.9%**
Rate of confirmation of malaria cases	**66%** in 2012	**83%** in 2015

	(NMCP Report 2015 p.26)	(NMCP Report 2015 p.26)
Percentage of children under 5 who have received ACT treatment among children who have received an anti-malarial treatment	**11%** (EDS-MICS 2012 p.222) **Rural context: 15.6%** **Urban context: 19.3%**	**63.8%** (MICS 2016 p.67) **Rural context: 63.5%** **Urban context: 64.2%**

Although in regression, the incidence of malaria remains high at the national level.





Transmission remains stable over the year with fresh outbreaks in the rainy seasons.[2] The entire population[3] remains exposed to the risk of malaria. Pregnant women and children under five years of age are the most vulnerable.[4] Certain key populations[5] present high exposure/clinical risks.

The vector situation remains unchanged with: Main vector: *Anopheles gambiae (*95 percent); main causal species: *Plasmodium falciparum (*94.5 percent[6]); rate of inoculation: 400 to 789 pi/h/year;[7] high vector resistance with a relative sensitivity to organophosphates.[8]

The effectiveness of artemisinin-based combination therapy (ACT) is higher than 95 percent after polymerase chain reaction (PCR) correction.

Outside of the coverage in the Intermittent Preventive Treatment (IPTp) and the use of long-

[2] Rainy seasons: April-June; September-October
[3] 24,486,071 inhabitants in 2017
[4] Revised NSP 2012-2015 (Chapter 4.1.4)
[5] People living with HIV, new patients, displaced people, plantation workers
[6] Houngbédji et al. 2016 p.1
[7] Koffi et al. 2009 p.17
[8] Document de lutte anti vectorielle et gestion de la résistance des vecteurs aux insecticides en Côte d'Ivoire p.10

lasting insecticidal nets (LLINs) among pregnant women (in urban settings), the evolution of the other impact and outcome indicators **(cf. Table 1 above)** and coverage **(cf. Table 2 below)** shows significant progress over the course of these grants.

Table 2: Evolution of some coverage rates

Interventions	At time of submission of Concept Note on October 15, 2014	At time of submission of current funding request (March 20, 2017)
LLIN ownership (at least 1 LLIN per household)	**67%** (EDS-MICS 2012 p.229)	**75.1%** (MICS 2016, p.54)
LLIN ownership (1 LLIN per each two persons)	**31.2%** (EDS-MICS 2012 p.209)	**46.9%** (MICS 2016, p.58)
SP2 coverage of pregnant women	**20%** (EDS-MICS 2012 p.229)	**46.7%** [1](MICS 2016, p.66)
SP3 coverage of pregnant women	SP3 was not in force in 2014	**22.6%** (MICS 2016, p.66), after one year of implementation, against an expected target of 20%
RDT rate	**74.7%** (NMCP Report 2013)	**83%** (NMCP Report 2015)
Percentage of cases treated with ACT in the community	**53%** (NMCP Report 2013)	**95%** (NMCP Report 2015)
Community treatment of malaria	**26** of 82 health districts: sparse coverage with 50 CHW/district	**51** of 82 health districts: extensive coverage with on average 70 CHW/district
Treatment of malaria + diarrhea	**Not in operation**	**42** of 82 health districts
Treatment of malaria + diarrhea + acute respiratory infection	**Not in operation**	**9** of 82 health districts
Prevention and treatment in the for-profit private sector	**Not in operation**	**31** of 60 private health facilities
Outreach strategies in localities situated over 5 km from a health center	**46** health districts (232 villages reached)	**46** of 82 health districts (315 villages reached) 70 districts per ANC in mobile consultations
Outreach strategies in shantytowns	**Not in operation**	**2** cities: Abidjan and San Pedro (47 shantytowns reached)

1: Reasons for poor performance: delayed start to active search for pregnant women (community PR began operation one year late); delays in attending antenatal consultations

Despite the improvement in the coverage of interventions achieved with this grant and the contributions by the State, Côte d'Ivoire remains a hyper-endemic country where control actions must continue.

The segmentation[9] of the results of the Multiple Indicator Cluster Surveys (MICS) for 2016 (**Annex1**) confirm that interventions undertaken under this grant have impacted on the disease.

The refocused stratification scheduled for 2018-2020 (**Annex 2)** aims to maintain the current interventions and intensify their focus on the targets and areas with unsatisfactory results.

2. National policies and strategies revisions and updates	
Are there new approaches adopted within the national policy or strategy for the disease program as compared to the previous funding request (e.g. "treat all" guidelines for HIV, short-term regimens for MDR-TB, shift in interventions from malaria control to pre-elimination, expanded role of the private sector)?	☐ Yes ☒ No

The national policy remains unchanged since the submission of the concept note. The National Strategic Plan (NSP) 2012-2015, revised and extended for 2016-17 and used to leverage the New Funding Model (NFM) grant will end on December 31, 2017. The development of a new and more ambitious NSP which will cover the period 2018-2020 commenced in December 2016 under the aegis of WHO, and will be completed in May 2017. To leverage the present grant, stakeholders have decided to extrapolate the revised NSP for 2012-2015 to 2018-2020. This document is aligned with the Global Technical Strategy for Malaria 2016-2030 and the National Health Development Plan (NHDP) 2016-2020. The national standards and guidelines remain valid pending the next NSP.

The goals, objectives, strategies and interventions set out in the revised NSP 2012-2015 have been fully renewed in the extrapolation document. Taking lessons from the NFM, the extrapolation has made it possible to readjust the targets for 2018-2020 using the adjustment variables.[10]

The national strategic directions renewed in the extrapolation document for the period 2018-2020 are set out in **Annex 3**. It also indicates the approach taken to establish the following prioritization: 1 - Universal access to diagnosis and treatment in the public and private sectors; 2 - Universal access to community treatment among children under five; 3 - Universal access to LLINs; 4 - Universal access to IPTp for pregnant women; 5 - Strengthening the Monitoring and Evaluation (M&E) system; 6 - Capacity building for program management and coordination; 7 - Prevention using indoor residual spraying (IRS) and larval control (LAL).

The first six already developed strategies will be renewed with the funding requested in order to intensify the control of malaria between 2018-2020, and to move towards pre-elimination. The interventions in health system strengthening (HSS),[11] community awareness, involvement of local and community organizations, as well as Integrated Community Case Management (ICCM) will be further intensified to bolster the impact on the disease.

3. Investing to maximize impact towards ending the epidemics	
Referring to available evidence and inputs from technical partners and key stakeholders, does the current program continue to be relevant, and is it progressing and generally on track to achieve results and impact? Please provide rationale for the appropriateness of continuation of the goals, strategic objectives and key interventions. As relevant, explain the most important challenges being faced and any mitigation measures that have been put in place.	☒ Yes ☐ No

[9] According to: age, gender, community, income and education
[10] Population growth rate, inflation, the key factors in the success or delay in implementation.
[11] Supply, community, coordination and M&E system.

The evolution of impact, outcome, and coverage indicators **(Tables 1&2)** as well as of program results **(Annex 4)** highlights the advances that evidence the relevance of the current program. The African Leaders Malaria Alliance (ALMA) report for the fourth quarter of 2015[12] confirms the significant results achieved in 2015. The World Health Organization (WHO) Report[13] for 2016 shows that from 2010 to 2015 the country experienced a fall in the incidence rate of over 40 percent, and in mortality of between 20 and 40 percent.

With the achievements obtained between 2014-2016 (**Annex 5**), the current program has shown satisfactory progress toward achieving the established targets. This justifies its renewal with a readjustment of targets in line with the Sustainable Development Goals (SDGs) and the objectives of the global plan for the fight against malaria.

The implementation of the current grants has been marked by a number of difficulties:

- **Treatment**: reluctance among some providers to use artesunate-amodiaquine (ASAQ).
- **PSM**: Lack of traceability in the management of supplies/drugs, frequent stock-outs, insufficient quantity of Rapid Diagnostic Tests (RDTs) provided to hospitals.
- **Prevention**: delays in pregnant women attending antenatal consultation (ANC), delays in routine distribution of LLINs from districts to primary health care facilities.
- **Management**: delay in sending receipts for expenditure incurred in outlying areas, non-adaptability of procedures related to disbursements for the conduct of some studies.
- **Monitoring and evaluation**: monitoring at operational level.
- **Communication/community**: poor level of awareness among the population about the policy of free treatment, lack of motivation of community outreach workers/community health workers (CHWs), late commencement of community PR efforts.

These difficulties have slowed the absorption of supplies/resources, activities to monitor the use of LLINs, active search for pregnant women, and the execution of other activities.

Implementation of the risk management plan[14] will help to anticipate and minimize the difficulties and obstacles during the execution of the requested grant.

The needs covered by this grant are described in **Annex 6**.

4. Alignment with 2017 – 2022 Global Fund Strategy Objectives 2 and 3

Objective 2 to Build Resilient and Sustainable Systems for Health

Does the current grant include an appropriate focus on investments in Resilient and Sustainable Systems for Health (RSSH)? If changes in RSSH investments are needed (in order to maximize reproductive maternal neonatal and child health or other areas) please explain how and when these changes should be addressed.	☒ Yes ☐ No

As a result of the consensus reached during the country dialogue organized on February 14, 2017, stakeholders have decided that each component shall incorporate an HSS element with a view to optimizing the impact on the disease. The catalytic funds (€2,673,300) allocated for HSS will be requested to strengthen the resilience of the system. They will be used to develop a more comprehensive and complementary approach to strengthening the system for the management

[12] ALMA Report 4th quarter 2015 p.1
13 WHO Report 2016 Annex 3-E p. 92
14 NMCP risk mapping

and dissemination of data.

The situational analysis (strengths and weaknesses), challenges, risks and the interventions of the three sub-components of HSS (strengthening of the supply chain; strengthening of the management and M&E system; strengthening of the community system) covered by this grant is presented in **Annex 7**.
In fact, outside of the co-financing funds, significant HSS measures have been developed under the current grant **(Annex 8).** These strengthening measures have contributed to improving the use of health care facilities, usage of which has increased from 27 percent in 2013 to 43 percent[15] in 2016, a jump of 24 points in three years.
Despite these measures, program performance remains hampered by certain shortcomings **(Annex 7)**. During the 2018-2020 period, the following key challenges will receive the full attention of the PRs:

- How to ensure the continuous availability of supplies and drugs at health care facilities?
- How to obtain reliable data on consumption and stock levels in order to take appropriate decisions?
- How to use the NHIS to promptly obtain reliable and complete data incorporating the public, community and private sectors?
- How to effectively implement a harmonized and integrated approach to activities at the community level?

In response to these challenges, the complementary measures for the three abovementioned HSS sub-components will be implemented beginning in 2018 (**Annex 8**).

Objective 3 to Promote and Protect Human Rights and Gender Equality

Is there a need for intensifying efforts to address human rights and gender-related barriers to services and to ensure appropriate focus on interventions that respond to key and vulnerable populations? If changes are needed, please explain how and when they should be best addressed.	☐ Yes ☒ No

With the NFM grant, the counterpart and state co-financing commitments, efforts to promote equality of access to services and the protection of human rights have been intensified. Segmentation of the results of the MICS-2016 **(Annex 1)** reveals a reversal of past inequalities observed in regard to access to services for the poor, the marginalized, rural dwellers, and the least educated.

Health care coverage increased from 64 percent in 2012 to 67 percent in 2015.[16] Free treatment was promulgated for children under five and pregnant women. The Universal Health Coverage policy has been initiated. Services are offered in a manner that is equitable for all.

With the grant requested, interventions that already incorporate equality and gender aspects will be maintained. Minor changes aimed at maximizing impact will be introduced starting in 2018 with a view to strengthening universal access to prevention and treatment services without distinction of gender, community, nationality or economic situation.

This will involve: integrating the treatment of acute respiratory infections in the 42 districts that are already implementing home-based treatment + (HBT (treatment of malaria and diarrhea), taking the number of ICCM districts from nine to 51; intensifying the routine distribution of LLINs to pregnant women and children under one year of age in areas with high incidence and low coverage of LLINs; accelerating community activities aimed at improving IPTp among pregnant

15 RASS, 2015 p.16-17
16 RASS, 2015 p.38

women; intensifying awareness-raising efforts in schools and the community; strengthening outreach strategies in shantytowns/slums; intensifying the activities of mobile outreach consultations in remote/disadvantaged communities; engaging with more women's associations and women CHWs respectively in information education communication (IEC) activities and community treatment.

5. Effectiveness of implementation approaches

Are the current implementation arrangements effective to deliver on the program objectives and anticipated impact (including the Principal Recipient and the main sub-recipients)? If major changes to the implementation arrangements are needed, please explain how and when they should be best addressed.	☒ Yes ☐ No

The modalities and the mapping of implementation of the requested funding will align with those that are currently underway, and that have shown satisfactory performance (**Annex 4**). Based on the consensus arising from the country dialog,[17] the mode of implementation of the current grant (**Annex 4**) will be through dual tracking with renewal of the two current PRs and their sub-recipients (SRs).[18] The arguments in favor of maintaining the PRs was based on the decision to renew the program and their performance, which was judged satisfactory.

A MoU between the two PRs will be renewed. Coordination between the PRs and strategic monitoring of the grant will be carried out by the CCM. A strategic monitoring committee will be put in place before the end of 2017.

The MSHP will remain the government PR and the NMCP the delegated PR.

Coordination of interventions will be through meetings between the SRs and biannual meetings of the Task Force chaired by the General Directorate of Health (DGS). Financial management will be carried out according to the revised procedures manual or specific arrangements approved by the Global Fund.

Save the Children will use the funds according to its Global Fund-approved procedures.

From year 2, the integration and harmonization of community activities (**Annex 7**) will become effective in accordance with the strategic community plan. In this way, community outreach workers will receive progressive capacity building to become CHWs in order to provide the comprehensive package of services set out in the community health strategic plan and validated in February 2017.

The other implementation modalities, including internal and external audits, and the annual inventory of fixed assets and stock, will be maintained. Comprehensive monitoring of activities will also be strengthened. Likewise, the measures to strengthen the three sub-components of the health care system (section 4) will contribute to make implementation of this grant more efficient and effective.

6. Sustainability, transition and co-financing

Are there changes in domestic or international financing (e.g. due to withdrawal of a major donor or significant increase in domestic allocation/funding), resulting in material impact on funding availability for programmatic interventions and sustainability? If yes, describe how these changes impact the country's ability to meet co-financing (previously referred as "willingness-to-pay") commitments for the current grant implementation period and if these changes will impact the country's ability to make and realize future co-financing requirements in	☐ Yes ☒ No

17 Country dialog report for the three diseases.

18 List of SRs by PR and interventions for implementation.

the next implementation phase.	

Thanks to the measures taken by the government to strengthen governance and economic recovery in recent years, Côte d'Ivoire has resumed economic growth. Average GDP rose from -4 percent in 2011 to 9.5 percent in 2015.[19]

The proportion of the state budget allocated to health, although presenting a net increase, remained at 6.1 percent in 2016 (€167,402,741), still below the 15 percent target set by the African Heads of State in the Abuja Declaration in 2001.

With its co-financing commitment, honored in 2016 and 2017 (**Annex 10**) under the terms of the 2014-2016 allocation, the budget allocated directly by the State for the fight against malaria saw an increase from €1,615,959.58 in 2014 to €4,006,791.03 in 2016, and €4,676,251.86 in 2017. In addition to the state counterpart, the co-financing component has been used for the acquisition of supplies and drugs to combat severe malaria, the purchase of hemoglobinometers for the diagnosis of anemia, the strengthening of prevention activities including awareness-raising using truck stages (three regions), sanitation and mosquito control in four communes in Abidjan. The Global Fund remains the main financial partner for the implementation of the NSP. For the period 2015-2017, the Global Fund contribution represents 65 percent of the needs of the NSP. The other partners (WHO, RBM, UNICEF, USAID, private sector) also contribute to the fight at the national level.

Subject to the finalization of the next NSP, the country's needs in the funding of the fight against malaria for the 2018-2020 period are estimated at **€178,661,778.92**.

A funding gap of **€154,675,566** arises when the resources available at the level of the state and of partners other than the Global Fund are taken into account (**Annex 9**). To maintain universal coverage of interventions over the 2018-2020 period, Côte d'Ivoire requests an amount of **€111,117,115** from the Global Fund. Thus, **€43,558,461.23** will need to be mobilized to fill the financial gap.

Before the end of the grant making phase, the competent authorities will submit a written commitment to the Global Fund respecting the minimum co-financing commitment for the 2017-2019 allocation, as was the case with the willingness-to-pay commitment (**Annex 10)**. The co-financing resources will be invested to maximize the universal coverage of the interventions and enhance the HSS. The MSHP will initiate advocacy with the government to request the increase in the state contribution.

With the arrival of USAID/PMI announced for 2018, the funding landscape for the fight against malaria can be strengthened.
The mobilization of additional resources at the national level, especially from the private sector, is envisaged from the perspective of improving the sustainability of the interventions through public-private partnerships and consideration of corporate social responsibility. The Regional Health Departments (RHDs) and Departmental Health Directorates (DHDs) as well as the local communities will receive awareness training so that the experiences gained (use of LLINs, RDTs…) are sustained and the sharing of the costs of certain operational activities (training, supervision, coordination meetings, transport of LLINs…) is gradually introduced, as the financing of certain activities in the fight against malaria is incorporated into local development plans.

[19] *NHDP 2016-2020 p. 15*

Is your country's 2017-2019 Global Fund allocation for the disease component significantly lower as compared to the current grants' spending level? [20] If yes, please provide an explanation on how the scope of the program will be maintained/increased and what are the alternative sources of funding to maintain/increase the current level of coverage.	☐ Yes ☒ No

From 2015 to 2016, the cumulative amount absorbed by the two principal recipients, excluding the expenditure arising from the campaign for the mass distribution of LLINs, is **€30,517,364** (**Annex 9**). This amount is equivalent to an annual average of **€15,258,682**. The projection of this annual average over the three years of the 2015-2017 grant, allows us to estimate expenditure at the end of the NFM grant of **€48,755,577**, excluding the LLIN campaign.

When we include the expenditure related to this campaign, an amount of **€39,061,848**, this gives an estimated total cumulative expenditure over the three years of the NFM of **€87,817,425.**

Comparison of this estimated cumulative total expenditure (**€87,817,425**) with the allocation amount of **€111,117,115** shows a surplus of **€23,299,690** allocated for the 2018-2020 period. Thus, the allocation will certainly make it possible to maintain the current scope of the program, and increase its level of coverage (**Annex 11).**

The absorption capacity of the National Malaria Control Program (NMCP) is further strengthened by the implementation of the Leadership Development Program Plus (LDP+) developed by the Leadership Management and Governance project (LMG) in 2015. This program has strengthened the spirit of team work, presenting a vision of success of the program shared by all. The challenge of improving the resource absorption rate by the directorate of the NMCP is currently being resolved.

The rate of absorption at December 31, 2016 for the public PR is 87 percent.

Despite the late start of activities, the community PR has been able to achieve a rate of 80 percent thanks to the catch-up plan implemented.

The capacity of absorption of the PR Save the Children, will also be strengthened with the increase currently underway in the number of community SRs, for improved efficiency of implementation.

It is important to note that despite taking into account state resources, those of the Global Fund and partners, there remains a gap of **€43,558,461.23** that is required to meet the needs estimated in the extrapolation document for 2018-2020, the total amount of which rises to €**178,661,778.92**

The budgeting for the next NSP, and subsequently taking into account resources to be provided by PMI, will help to better estimate the real gaps for the 2018-2020 period, and to plan a resource mobilization round table.

Projected need for a material change leading to a grant reprogramming

[20] 2017 – 2019 allocation amount stands for 70% or less of the current grants' expenditure level over the last three years calculated by using the last year expenditures multiplied by three.

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Please indicate key timing for program and NSP evaluations/reviews, surveys outcomes, or any other relevant information that may inform the potential need for a material reprogramming from now until the expected end of the new grant(s):[21]

Documents, evaluations, surveys and other relevant information	**Expected availability (month/year)**	**Foresee a need of material reprogramming at that time? (Y/N)**
NSP 2016-2020	*May-Jun 2017*	*Probable*
Expected arrival of funding from PMI	*2018*	*Probable*
Establishment of a Program Coordination Unit (UCP)	*Before the end of 2017*	*Probable*

Note: *All requests for funding and subsidies that result must respect and follow the requirements relating to the targeting of nominations[22] and to the co-financing set out in the policy on sustainability, transition and cofinancing.[23]*

Please complete Annex 1 below to confirm the inclusiveness of engagement with key and vulnerable populations in the process of developing Program Continuation request.

[21] Please refer to the Global Fund Operational Policy Note on Reprogramming during Grant Implementation
[22] Including ensuring interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities for all countries, regardless of income level.
[23] Sustainability, Transition and Co-Financing Policy, GF/B35/04

Annex 1: INCLUSIVENESS OF ENGAGEMENT WITH KEY AND VULNERABLE POPULATIONS[24]

Inclusiveness of engagement with key and vulnerable population in the process of developing the Program Continuation Request (for malaria programs see footnote[25])	
Has the process for developing this request been inclusive, including the views of representatives of key and vulnerable populations, particularly those who are the focus of the program?	☒Yes ☐ No
Were representatives of key and vulnerable populations informed of the amount of allocation available?	☒ Yes ☐ No
In cases of changes in the implementation contexts (i.e. question 1, 2 and 5 above) or increase/decrease in allocation, were representatives of key and vulnerable populations consulted on how risks on the program quality and sustainability can be mitigated?	☒Yes ☐ No
Was feedback from representatives of key and vulnerable populations on the quality, content and delivery of the current program taken into account during the assessment process?	☒ Yes ☐ No

Key populations and vulnerable groups: children under 5 years of age, pregnant women, people living with HIV, prison populations and those living in remote areas have been consulted, have participated and their concerns have been taken into account during the preparation of this funding request.

Three meetings were organized by the CCM in the context of the country dialogue. The first presented the amounts allocated for the three diseases and provided an opportunity to discuss the application procedures for the funding request.[26] The second was devoted to the community dialog,[27] in order to collect opinions and suggestions from the key organizations involved in the fight against malaria with a view to improving the national response. The third meeting permitted a discussion with the stakeholders on the strategic priorities, collecting their views and presenting the phases of the funding request process.[28]

At the focus group,[29] the representatives of vulnerable populations revealed that they have been informed of the seriousness of the disease, means of prevention, the fact that commodities are free of charge and the importance of antenatal consultations for preventive treatment with sulfadoxine-pyrimethamine. They recommended strengthening awareness raising on the use of LLINs, antenatal consultations and the free nature of treatment. They also suggested strengthening awareness raising on environmental sanitation.

The community dialogue suggested key actions in order to improve the national response, in particular strengthening communication activities, operational research, integration of the activities

[24] The Global Fund defines key populations as groups that experience both increased impact from one of the diseases and decreased access to services. It also includes groups that are criminalized or otherwise marginalized. For example, in the context of HIV, key populations include: men who have sex with men, transgender people, sex workers, people who inject drugs, and people living with HIV. The Global Fund also recognizes vulnerable populations, who are those who have increased vulnerabilities in a particular context, i.e. adolescent/women and girls, miners and people with disabilities. For a complete definition, refer to the following link to the Global Fund website.

[25] Malaria programs where malaria-focused civil society and/or community organizations are not represented in the CCM are requested to indicate if civil society and community organizations engaged in responding to malaria have been informed and consulted under the "Applicant rationale" section.

[26] Country dialog report for the three diseases.

[27] Country and community dialog report for Malaria

[28] Country dialog report for Malaria

[29] Two focus group reports

of CHWs and greater involvement of women's groups **(Annex 7).**

During the evaluation process, the key and vulnerable populations expressed their satisfaction with the implementation of the grant and suggested building on the lessons learned and the scaling up of key interventions.