PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CÔTE D'IVOIRE CCM
Country	CÔTE D'IVOIRE
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Low income
Applicant Type	☉ CCM ○ Sub-CCM ○ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☑	HIV[1]	Contribution to accelerated scaling up of interventions to prevent and manage HIV infection in Côte d'Ivoire	☉
☑	Tuberculosis[1]	Prevention of multi-resistant tuberculosis by improving tuberculosis case management	○
☑	Malaria	Scaling up of interventions to combat malaria in Côte d'Ivoire in the context of national reconstruction	○

Currency ○ USD or ☉ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. 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/

ROUND 8 – Malaria

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 8:
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 8. Refer to the Round 8 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 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

ROUND 8 – Malaria

1 FUNDING SUMMARY AND CONTACT DETAILS

1.1 Funding summary

Clarified table 1.1.

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	22,464,472	32,701,687	26,975,667	28,865,533	31,130,678	142,138,037
Tuberculosis	3,201,207.74	3,951,560.72	1,896,250.93	4,275,635.88	4,562,247.72	17,886,902.99
Malaria	118,050,103	21,315,766	12,644,024	15,450,794	12,837,629	180,298,316
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*	587,945	4,800	4,800	4,800	4,800	607,145
					Total Round 8 Funding Request ➔:	340'930'400

1.2 Contact details

	Primary contact	Secondary contact
Name	Pr Auguste KADIO	Pr Coulibaly Gahoussou
Title	CCM Chairman	Technical adviser at the Ministry for AIDS/Training and Medical Sciences Research Unit at the University of Cocody, Abidjan
Organization	Federation of Côte d'Ivoire Independent Trades Unions	Ministry for AIDS
Mailing address	08 BP 388 Abidjan 08	08 BP 2333 Abidjan 08
Telephone	(225) 20 22 17 43/20 22 17 44 Mob: 225 07 07 42 16/02 03 63 08	(225) 22 42 23 83 Mob: 225 08 32 57 65
Fax	(225) 20 22 17 45	(225) 20 22 17 45
E-mail address	Kadioauguste@yahoo.fr	coulgahoussou@yahoo.fr
Alternate e-mail address	ccmcotedivoire@yahoo.fr	minisida@yahoo.fr

1.3 List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
Cross-cutting	
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CGECI	General Confederation of Côte d'Ivoire Companies (Confédération Générale des Entreprises de Côte d'Ivoire)
CHW	Community Healthcare Worker
CNW	Centre, North and West
DD	Health District Directorate
DIPE	Information, Planning and Evaluation Directorate
DMT	District Management Team
ESPC	Primary health care facilities (Etablissements Sanitaires de Premier Contact)
FBO	Faith-Based Organization
FIPME	Côte d'Ivoire federation of SMEs (Fédération Ivoirienne des Petites et Moyennes Entreprises)
GF	Global Fund
GH	General Hospital
HD	Health District
HIS	Health Information System
IEC	Information Education and Communication
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MSHP	Ministry of Health and Public Hygiene (Ministère de la Santé et de l'Hygiène Publique)
NGO	Non-Governmental Organization
NNP	National Nutrition Program
PEC	Case management (Prise En Charge)
PECP	Pediatric case management (Prise En Charge Pédiatrique)
PNDS	National Health Development Plan (Plan National de Développement Sanitaire)
PR	Principal Recipient
PR	Principal Recipient
PSM	Procurement and Supply Management
PSP	Public Health Pharmacy (Pharmacie de la Santé Publique)
RHC	Regional Hospital Center
RHD	Regional Health Directorate
SDA	Service Delivery Areas

SR	Sub-Recipient
UHC	University Hospital Center
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization
HIV/AIDS	
AIDS	Acquired Immune Deficiency Syndrome
AIS-CI	AIDS Indicator Survey in Côte d'Ivoire
ARV	Antiretroviral
CECI	Côte d'Ivoire Businesses Coalition against AIDS (Coalition des Entreprises de Côte d'Ivoire contre le SIDA)
CEDRES	AIDS Study, Diagnosis and Research Center (Centre d'Etude, de Diagnostic et de Recherche sur le SIDA)
CNPS	National Fund for Social Welfare (Caisse National de Prévoyance Sociale)
COSCI	Federation of NGOs fighting AIDS in Côte d'Ivoire (Conseil des Organisations de Lutte contre le sida en Côte d'Ivoire)
FHI	Family Health International
GIPA	Greater involvement of people living with or affected by HIV/AIDS (GIPA)
HIV	Human Immunodeficiency Virus
INS	National Institute for Statistics (Institut National de Statistique)
MFFAS	Ministry for Family, Women and Social Affairs (Ministère de la Famille de la Femme et des Affaires Sociales)
MLS	Ministry for AIDS (Ministère de la Lutte contre le SIDA)
MSM	Men who have Sex with Men
NAC	National AIDS Committee
ND	Not available (Non Disponible)
OASIS	Organization promoting synergy in interventions to control AIDS (Organisation des Actions pour la Synergie des Interventions de lutte contre le Sida)
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PIAVIH	People Infected with and Affected by HIV (Personnes Infectées et Affectées par le VIH)
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PNPEC	National Care Program for PLWHA (Programme National de Prise en Charge des PVVIH)
PREMA	Prevention and Management of HIV infection and AIDS in conflict situation
RIP+	Côte d'Ivoire network of organizations supporting PLWHA (Réseau Ivoirien des Personnes vivant avec le VIH/SIDA)
RSC	Community systems strengthening (Renforcement du Système Communautaire)
STI	Sexually Transmissible Infection
SW	Sex Worker(s)
UNS	United Nations System

VCT	Voluntary Counseling and Testing
Tuberculosis	
CAT	Anti-tuberculosis center (Centre Anti-Tuberculeux)
CCI-CI	Côte d'Ivoire Chamber of Commerce and Industry (Chambre de Commerce et d'Industrie de Côte d'Ivoire)
CDT	Treatment Center (Centre De Traitement)
CNA	National Chamber of Agriculture (Chambre Nationale d'Agriculture)
CNA-CI	Côte d'Ivoire National TB Committee (Comité National Antituberculeux de Côte d'Ivoire)
CNM-CI	Côte d'Ivoire National chamber of Professions (Chambre Nationale des Métiers de Côte d'Ivoire)
COLTMR-CI	Côte d'Ivoire federation of organizations controlling TB and lung disease (Collectif des Organisations de Lutte contre la Tuberculose et les Maladies Respiratoires de Côte d'Ivoire)
CPT	Cotrimoxazole chemoprophylaxis (Chimioprophylaxie au Cotrimoxazole)
CSE	Epidemiological surveillance center (Centre de Surveillance Epidémiologique)
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment, Short-course
DPM	Pharmacy and Medications Office (Direction de la Pharmacie et du Médicament)
EGPAF	Elisabeth Glaser Pediatric AIDS Foundation
EML	Essential Medicines List
FSUCOM	Community urban healthcare facility / training (Formation Sanitaire Urbaine à base Communautaire)
GDF	Global Drug Facility
GLC	Green Light Committee
GSA	Scientific support group (Groupe Scientifique d'Appui)
HCR	High Commissioner for Refugees
HHR	Human Healthcare Resources
HIPC	Heavily Indebted Poor Country
ICRC	International Committee of the Red Cross
INFAS	National training Institute for Health Workers (Institut National de Formation des Agents de la Santé)
IUATLD	International Union Against Tuberculosis and Lung Disease
JMT	World Tuberculosis / TB Day (Journée Mondiale de lutte contre la Tuberculose)
JSI	John Snow, Inc.
LNSP	National Public Health Laboratory (Laboratoire National de la Santé Publique)
MDR	Multi-Drug Resistant
MDR-TB	Multi-Drug Resistant Tuberculosis
MSF	Doctors Without Borders (*Médecins Sans Frontières*)
NA	Not Applicable
NHIS	National Health Information System

NRC	National Reference Center
NRL	National Reference Laboratory
NTCP	National Tuberculosis Control Program
PAL	Practical Approach to Lung health
PNSSU	National program for school and university healthcare (Programme National de Santé Scolaire et Universitaire)
PPH	Pneumo-phthisiology (Pneumo-phtysiologie Humaine)
PUR	(European Union) Emergency and Rehabilitation Program (Programme d'Urgence et de Réhabilitation - Union Européenne)
$R_{(3,6,8)}$	Global Fund Round (3, 6, 8)
RDV	Meeting (Rendez-Vous)
RSB	*Renaissance Santé Bouaké*
SCB	Society for the study and development of banana cultivation (Société de Culture Bananière)
SIGFIP	Integrated public finance management system (Système Intégré de Gestion des Finances Publiques)
SOGB	Grand-Bérébi company (Société de Grand-Bérébi)
SOTRA	Abidjan public transport system company (Société de Transport Abidjanaise)
STG	Standard Treatment Guidelines
TPM+	Smear positive pulmonary tuberculosis (Tuberculose Pulmonaire à Microscopie positive)
Malaria	
ACSD	Accelerated Child Survival and Development
ACT	Artemisinin-based Combination Therapy
AIS-CI	AIDS Indicator Survey in Côte d'Ivoire
CSE	Person responsible for epidemiological surveillance (Chargé de Surveillance Epidémiologique)
DEPS	Health Institutions and Professions Directorate (Direction des Etablissements et professions Sanitaires)
DHS	Demographic and Health Survey
DPM	Pharmacy and Medications Office (Direction de la Pharmacie et du Médicament)
EPI	Expanded Program on Immunization
EPN	National public entities (Etablissements Publics Nationaux)
FS	Healthcare facility / training (Formation Sanitaire)
GAVI	Global Alliance for Vaccines and Immunization
HIPC	Heavily Indebted Poor Countries
HSS	Health Systems Strengthening
ICP	Integrated Communication Plan
INHP	National Institute of Public Hygiene (Institut National de l'Hygiène Publique)
INS	National Institute for Statistics (Institut National de Statistique)

IPR	Pierre Richet Institute (Institut Pierre Richet)
IPT	Intermittent Preventive Treatment
KAP	Knowledge, Attitudes and Practices
LLIMN	Long-Lasting Insecticide-Treated Mosquito Net
LNSP	National Public Health Laboratory (Laboratoire National de la Santé Publique)
MIS	Management Information System
ND	Not available (Non Disponible)
NMCP	National Malaria Control Program
PFE	Key family practices (Pratiques Familiales Essentielles)
PNC	Pre-Natal Consultation
PRSD	Poverty Reduction Strategy Document
PSI	*Population Service International*
RASS	Annual health situation report (Rapport Annuel sur la Situation Sanitaire)
RDT	Rapid Diagnosis Test
RH/FP	Reproductive Health and Family Planning
RSC	Community systems strengthening (Renforcement du Système Communautaire)
SP	Sulfadoxin pyrimethamine
SUFI	Scale Up For Impact
TBS	Thick Blood Smear
UFR	Training and research unit (Unité de Formation et de Recherche)

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 now 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
x	Academic/educational sector	02
x	Government	06
x	Non-government organizations (NGOs)/community-based organizations	03
x	People living with the diseases	02
	People representing key affected populations[2]	-
x	Private sector	03
x	Faith-based organizations	02
x	Multilateral and bilateral development partners in country	05
x	Other *(please specify):* *Trades Unions*	02
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	25

[2] Please use the *Round 8 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/8/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.

The process of restructuring the composition of the CCM which was started in 2007 was completed on 27 February 2008 with the election of committee members. To achieve its objective effectively, the CCM set up 4 committees, namely the proposal drafting committee, the monitoring and evaluation committee, the communication and resources committee and the resources harmonization committee. The proposal drafting and monitoring and evaluation committees are tasked with evaluating the impact of health system problems on the various projects and programs and their results across the three diseases.

Furthermore, members of the CCM drawn from the Ministry of Health and Public Hygiene, the Ministry for AIDS, the Ministry for Women, Family and Social Affairs and from universities are experts in the field of health systems. In addition, the CCM chairman and other members drawn from civil society and the private sector and with expertise in health systems have been involved at national and international level in examinations of health systems.

Such expertise among CCM members is further strengthened by the support of development partners (WHO, UNFPA, UNICEF, UNAIDS, German Cooperation, WFP, European Union, American Cooperation, World Bank).

Lastly, several CCM members helped to draw up the PNDS (National Health Development Program) which describes the health system, its strengths and weaknesses and strategies to strengthen the said system. These members are also involved in the national proposal drafting process for Round 8.

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.

The CCM includes a Ministry for Women, the Family and Social Affairs representative responsible for gender-related matters at national level, and a UNFPA representative who currently chairs the Gender-related Thematic Group. This Group, which also includes other Ministries such as Health, AIDS and Youth, is responsible for ensuring that gender-related concerns are recognised in the country's policies and development programs. The members are stakeholders in the process of drawing up the application. Some members of the Thematic Group, also represented on the CCM, had to take part in carrying out studies on gender and in training on the mainstreaming of gender-related matters in development programs. Furthermore, in terms of representation within the CCM, out of the 25 members, 8 are women, representing 32% of CCM membership. The committee has two women and three men.

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.

CCM members possess skills in project planning and development across several sectors, especially the health sector, including malaria, tuberculosis and HIV/AIDS. These people are drawn from all development sectors, in particular, the public and private sectors and civil society.

In its concern to intensify the national response to fight the HIV/AIDS epidemic, the Côte d'Ivoire government decided several years ago to pursue a multi-sector and decentralised approach. It is as part of this approach that the National AIDS Committee (NAC) was set up on 7 January 2004. This Committee includes members from all development sectors (health, education, hydrology, agriculture, defence, energy, finance, etc). Several NAC members, who played an active role in drawing up the various multi-sector plans to fight AIDS, in particular, the National Strategic and Operational Plans, sit on the CCM, where they contribute their expertise and experience in multi-sector planning.

It is also worth noting that some CCM members participated in drafting projects for the three components in preceding Rounds, in particular Rounds 2, 3 and 6.

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 6 and/or Round 7 **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 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below***.

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.)*

As soon as the Global Fund announced its call for proposals, the CCM met to define the various stages for a better recognition of all those involved from the public and private sectors and civil society. The proposal drafting committee set up a working group for each component (HIV/AIDS, tuberculosis and malaria)

The committee prepared for and launched the call for submission of mini-proposals at national level through the CCM secretariat. This call was published in the national daily newspaper, the « Fraternité Matin » N° 13 010 on Tuesday 25 march 2008 (See annex n°2). The CCM secretariat also sent out a call for proposals by e-mail. To ensure that the mini-proposals were easily comparable, applicants were issued with a standard format to complete.

To stimulate the involvement of the private sector and community-based organizations, it was agreed at a CCM meeting that they should draw up mini-proposals with a view to their being incorporated into the national proposal (see general meeting and committee minutes, annex n°2).

After a three week deadline, the mini-proposals received by the CCM secretariat were sent to the

proposal drafting committee.

(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 applicants, the CCM received a total of 3 mini-proposals from the private sector and 14 from civil society. Among these 17 mini-proposals, 12 related to the HIV/AIDS component, 3 to the malaria component and 2 to the tuberculosis component. These mini-proposals were examined in the following way:

- Applicants presented mini-proposals to the working group
- Examination of mini-proposals by the proposal drafting committee; the aspects examined concerned (i) geographical coverage, and (ii) the aims, objectives, activities and targets. The criteria for incorporating mini-proposals into the Round 8 national proposal were mainly concerned with the relevance of the mini-proposal, the extent to which the objectives tied in with those of the national strategic plan and those arising from the examination of financial and programmatic gaps.
- Transmission of mini-proposals and the comments of the proposal drafting committee to the working groups set up for preparing the national proposal.

In addition, representatives from civil society and the private sector participated in the various working groups responsible for drawing up the national proposal.

(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 for involving people other than CCM members was conducted as follows:

- The proposal drafting committee members identified the skills required for all the themes accepted. Next, terms of reference for formulating the application for each component and the definition of technical support requirements (national human resources, national consultants, international consultants) were drawn up;
- The CCM chairman contacted national structures (Ministries, the private sector, civil society) where people with the required profiles had been identified, inviting them to make them available to the national proposal drafting committee (Annex 4);
- The CCM chairman sent a request to the development partners to request the support of people from their United Nations System institutions (UNICEF, UNHCR, WHO) and from civil society (CARE International Côte d'Ivoire, Côte d'Ivoire Alliance). In addition, the proposal drafting committee received technical assistance from international consultants made available for the HIV/AIDS component by the United Nations System (UNAIDS, WFP), bilateral cooperation partners (PEPFAR/Ministry of Health and Hygiene) (Annex 4), for the tuberculosis component (WHO, International Union against Tuberculosis and Lung Disease) and for the malaria component (WHO, Roll Back Malaria, UNICEF, CARE).
- The human resources and national and international consultants engaged were incorporated into the various working groups set up by the CCM, and within these they took part regularly in meetings and workshops held as part of the process of drawing up 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 n°5*

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 has a grants and Principal Recipient monitoring and evaluation committee which is responsible for supervising program implementation. This committee can call on other CCM and non-CCM skills depending on the themes and fields to which the supervision relates.

To supervise Round 8 program implementation, the CCM will organize quarterly supervisory inspection based on terms of reference, with a supervision criteria grid designed for Principal Recipients and Sub-Recipients to improve the effectiveness and efficiency of proposal implementation,. This data collection tool will be made available for supervisors and revised periodically in consultation with the latter. Each supervisory inspection will be followed by a supervision report which will, among others, detail the progress of program implementation. The supervision report will be presented to CCM members during a plenary session and any corrective measures required will be suggested, with feedback to the structures concerned so that the recommendations can be taken on board.

During supervision meetings, the CCM will examine the various elements in the Principal Recipients' and Sub-Recipients' work plan. They will be concerned with compliance with the programming of activities approved in the work plan, the use of procedural manuals, the level of achievement in respect of indicators and technical reports, the disbursement procedures and the quality of financial reports, procedures for drawing up contracts and the management of the supply chain, the management of partnerships with the Sub-Recipients and the Sub-Sub-Recipients and the taking on board of CCM and Global Fund recommendations.

(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.

In the implementation of previous rounds, the supervision of activities and Recipients and Sub-Recipients was based essentially on reports from the Principal Recipient. Having drawn lessons from the difficulties encountered, the CCM undertook a thorough restructuring, involving in particular the setting up of a monitoring and evaluation committee. This committee will be supported by staff from the permanent secretariat, which will itself be strengthened by the recruitment of a monitoring and evaluation specialist.

The process of supervising program implementation will involve other non-CCM members with acknowledged expertise (monitoring and evaluation staff from the Ministry of Health and AIDS and partners).

For this purpose, the monitoring and evaluation committee will examine the various areas to be supervised and identify those where external skills are required, and will draw up terms of reference for mobilizing national human resources, and national or international consultants.

The CCM chairman will contact national structures (Ministries, the private sector, civil society) where people with the required profiles had been identified, inviting them to make them available to the national proposal drafting committee. The CCM chairman will request development partners to make available the human resources or national/international consultants identified. These external participants will be incorporated into the CCM team to carry out the supervisory role. A report will be presented for the approval of the CCM and feedback will be given to the structures that were supervised so that any corrective measures required 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 8 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.)*

Côte d'Ivoire restructured the CCM in order to clarify roles and responsibilities and to review the process for appointing Principal Recipients.

The composition of the CCM was therefore restructured in February 2008, in compliance with Global Fund guidelines. In accordance with its by-laws and regarding the appointment of Principal Recipients, the CCM gave the proposal drafting committee the responsibility of appointing Principal Recipients under the supervision of the CCM.

At its meeting on 23 June 2008 to determine the various stages in drafting the proposal, the CCM discussed the minimum conditions required and the twin channel funding for Principal Recipients. The proposal drafting committee set up for the three components, HIV/AIDS, tuberculosis and malaria, prepared and issued two calls for applicants at national level through the CCM secretariat, published in the national daily newspaper « Fraternité Matin » N° 13 010 on 25 March 2008, open for a two week period (see annex n°7). The first call for applicants concerned the selection of a consultancy to perform an evaluation based on the minimum programmatic, financial and transparency management criteria with capabilities in procurement and drawing up of contracts for structures wishing to act as Principal Recipients. This process came to nothing due to budgetary constraints which meant that the CCM could not cover the consultancy fees.

Evaluation of the 10 Principal Recipient applicants was the subject of a report presented to the CCM. This evaluation was carried out using a grid covering elements such as the programmatic system, the institutional system, the financial management system and the applicant monitoring and evaluation system.

Applicants were interviewed and checks were carried out to ascertain their capabilities wherever and whenever necessary. Classification ranged from A (high capability) to C (low capability). The results were presented at the CCM general meeting held on 23 June 2008 for selection and approval (MSH report and CCM minutes in annex 8). The criteria and basic means used (questionnaire) were shared with the CCM, and a discussion on actual capabilities ensued before proceeding to the selection and appointment of Principal Recipients for each component.

(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°9*

2.2.5 Principal Recipient(s)

Name	Disease	Sector**
National Care Program of PLWHA (PNPEC)	HIV	Government
CARE INTERNATIONAL	HIV	Non governmental organisation (NGO) ; community and private sector
National Tuberculosis Control Program (NTP)	Tuberculosis	Government
Côte d'Ivoire Business Coalition against AIDS (CECI)	Tuberculosis	Non governmental organisation (NGO) ; community and private sector
National Malaria Control Program (NMCP)	Malaria	Government
CARE INTERNATIONAL	Malaria	Non governmental organisation (NGO); community and private sector

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

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.

NOT APPLICABLE

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

ROUND 8 – Malaria

Section	Document description	Annex Number
2.2.2.	Governance manual	Annex 1
2.2.2.	By-laws	Annex 3A.1.1.2. Round 7
2.2.2.a	* Minutes of general meetings and CCM office meetings * Time chart for drawing up the proposal * Call for submission of mini proposals for drawing up the Round 8 national proposal * Standard form for submission of mini proposals	Annex 2
2.2.2.b	Call for submission of mini proposals for drawing up the Round 8 national proposal: Attendance and pay form	Annex 3
2.2.2.c	Requests to national structures, UNS and bilateral and multilateral cooperations for consultants and human resources.	Annex 4
2.2.2.d	Workshop and proposal writing group reports	Annex 5
2.2.3.a	Correspondence between the Global Fund and the Côte d'Ivoire CCM regarding the appointment of the Principal Recipient for Round 2 HIV and Round 6 Malaria and Tuberculosis	Annex 6
2.2.3.a	* Call for submissions regarding the selection of Round 8 Principal Recipient(s) * Call for the recruitment of a consultancy or independent consultant(s) * Call for the recruitment of a consultancy or independent consultant(s): Discharge form	Annex 7
2.2.3.a	Evaluation of the capabilities of pre-selected organizations for the position of Global Fund Round 8 Principal Recipients, evaluation report	Annex 8
2.2.3.a	Minutes of the appointment of Principal Recipient(s)	Annex 9

PROPOSAL SUMMARY

Clarified table 3.1.

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	1st July 2009	30th June 2014

3.2 Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing malaria ☒ Yes *(go first to (b) below)*

Global Fund grant(s) with the Round 8 malaria proposal?

☐ 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 8 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/en/apply/call8/other/#5*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval? *(List the relevant grant number(s))* Round 6 grant CIV 607G06M

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.

The proposal's planned start date is in July 2009, which corresponds to the start of the health services' planning for the budget year beginning in January 2010. That date would correspond to six months' execution of the project; the second half-year should begin with the new fiscal year.

So far as consolidation with Round 6 is concerned, the start of the present proposal will coincide with the start of the reporting cycle for Round 6, Year 3, Half-year 2. The two consolidated Rounds would thus have their reporting cycles brought together and mutually corroborated.

3.4 Program-based approach for Malaria

3.4.1. Does planning and funding for the country's response to malaria occur through a program-based approach?

☐ Yes. Answer s.3.4.2

◉ 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 8 malaria Proposal

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

Prepare after completing s.4.

The present proposal, which covers the period 2009 – 2013, is for scaling up the impact of control measures against malaria in the country's 72 districts.

Though morbidity and mortality rates are little documented by the national M&E system, there are still patchy indications that they are rising. Malaria is the foremost cause of morbidity (50.17%, Situation Analysis for 2008), and of mortality in hospital (33%, NMCP database, 2004). It is pregnant women and children under five who pay the heaviest price. These figures may be underestimates, because of the weakness of the healthcare information system.

Moreover, the basic Situation Analysis carried out as part of the implementation of Round 6 has revealed unsatisfactory coverage of the population: LLIMN among children under five: 4.7%; LLIMN among pregnant women: 4.8%; Children correctly treated: 20.9%, IPT among pregnant women: 27%.

In these circumstances Côte d'Ivoire has relaunched its malaria control activities in 19 of the country's districts under Round 6 (2007 – 2011), concentrating on children under five and pregnant women. On the basis of the expected initial results, and given the country's determination to scale up for impact (SUFI), the CCM of Côte d'Ivoire has decided to submit a bid for Malaria funding under Round 8.

Assessment of the country's needs with the Needs Assessment tool developed in 2008 by RBM has shown that over the next five years there will be a shortfall of 18,387,101 LLIMN, 11,730,371 doses of SP, 96,301,129 treatments and 36,387,099 diagnostic tests (microscope examination and RDT) if the actions chosen in the Strategic Plan are to be scaled up. The current proposal for €180,298,316 aims to make good this shortfall so as to halve the rate of morbidity and mortality, bringing the mortality rate of children under five down from 12.5 per thousand in 2008 to 6.25 per thousand in 2013.

A number of strategies have accordingly been chosen to reach these objectives:

1. Coverage of all the country's households with at least 3 LLIMN per household by means of a mass distribution campaign, routine distribution at prenatal consultations (PNC) and in vaccination visits, and community distribution;
2. IPT for all pregnant women at prenatal consultations;
3. Treatment of cases of malaria among pregnant women;
4. Proper care of confirmed cases of malaria at health facilities;
5. Community treatment of cases of fever in children under five;
6. Proper care of severe cases of malaria at health facilities;
7. Capacity-building for the community-based organizations involved in malaria control activities.

The project's recipients will be of two kinds:

1. Direct recipients:
   i. children under five: 3,697,282
   ii. pregnant women: 1,029,089
   iii. the population at large: 21,200,968

2. Indirect recipients: community-based organizations, of which there are 20,000 (2 CBOs per village).

4 PROGRAM DESCRIPTION

PROPOSAL TITLE

PROJECT TO SCALE UP MALARIA CONTROL IN COTE D'IVOIRE IN THE CONTEXT OF NATIONAL RECONSTRUCTION

4.1 National prevention, treatment, care, and support strategies

(a) Briefly summarize:

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

Côte d'Ivoire is a country where malaria is endemic, with constant transmission and surges during the rainy season. Malaria is the foremost cause of morbidity (50.17%, Situation Analysis for 2008) and of mortality in hospital (33% - NMCP database, 2004). It is pregnant women and children under five who pay the heaviest price.

Côte d'Ivoire has a Strategic National Plan for the period 2006-2010 based on the RBM and Abuja recommendations. Two main priorities have been identified:

(i) *The swift and proper care of malaria cases in health institutions and in the community*. This strategy aims to improve people's access to effective treatment through capacity-building and the raising of skills in public, private and community organizations so as to reduce the number of malaria-related complications and deaths. The national policy for treatment is based on the use of Artemisinin-based Combination Therapy (ACT) for cases of uncomplicated malaria and of quinine for severe cases (Order of 12 January 2007). In all these cases, biological confirmation of the diagnosis by RDT or microscope examination (according to the level in the healthcare pyramid) is required before the treatment.

(ii) *The prevention of malaria, by the following means:*

- *drug-based prevention among pregnant women.* This strategy helps diminish anemia in pregnant women and low birth weight in babies. It is carried out in public and private health facilities in the course of PNCs by offering intermittent preventive treatment (IPT) using sulfadoxine pyrimethamine (SP).
- *vector control; a two-pronged attack:*

Distribution of long-lasting insecticide treated mosquito nets (LLIMN) aims to cut malaria transmission by providing these nets to the population at large. Distribution limited to vulnerable groups – pregnant women and children under five – would not adequately protect those groups or break the chain of transmission unless at least 80% of the remaining population is protected. This new approach has led to an upward revision of coverage targets to 100% of the population, with an expected uptake of at least 80%.

Indoor residual spraying (IRS) has been identified as a prevention strategy in the national policy but will not be used under this proposal, firstly because of the large scale LLIMN target, and secondly because of the complexity of implementing IRS.

Supporting activities have been identified to follow up these three main strategies. These are: the promotion of IEC/BCC and community-based campaigns, operation research and partnership development.

(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 proposal when the document was last submitted, and the Global Fund will obtain this document from our Round 7 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
X	National Health Sector Development/Strategic Plan	7	12 and 18
☐	National Malaria Control Strategy or Plan		
☐	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*		
X	Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal	10	25
X	National Monitoring and Evaluation Plan (health sector, malaria specific or other)	13	
☐	National policies to achieve gender equality in regard to the provision of malaria prevention, treatment, and care and support services to all people in need of services		

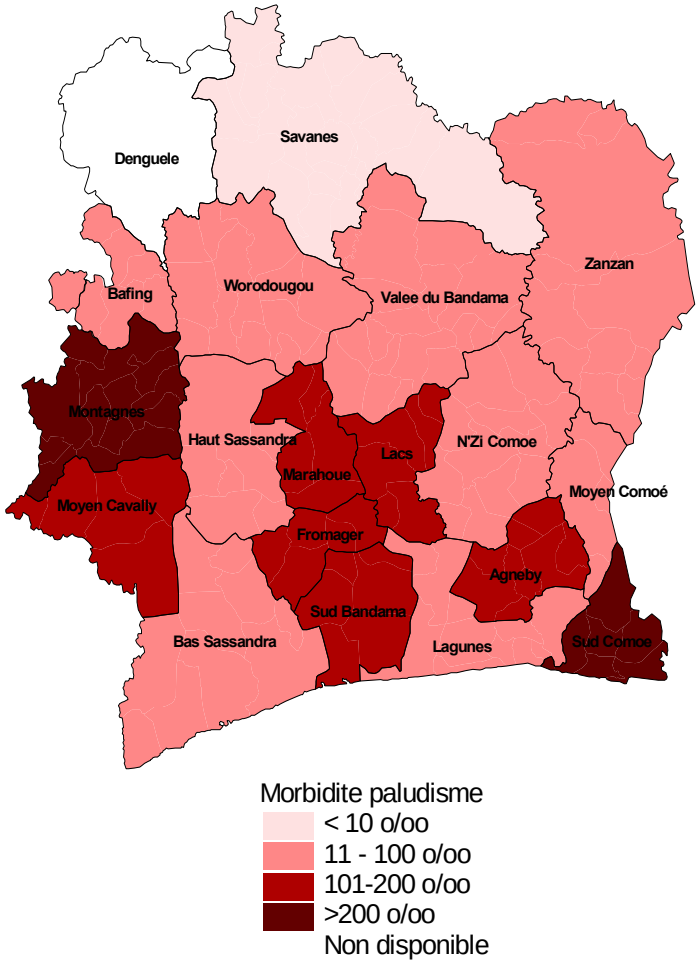
4.2 Epidemiological Background

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*

***** Paste map here if relevant***



Morbidité paludisme	Malaria morbidity
Non disponible	Not available

This proposal is intended to cover all the country's 72 districts. In the 19 districts already covered by Round 6 of the Global Fund (See map), the actions whose target was limited in that Round to pregnant women and children under five will be scaled up.

(b) **Size of population group(s) targeted in Round 8**			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Total country population (all ages)	21,260,968	RBM/MC needs assessment tool estimate based on the 1998 population census	2008
Women with a pregnancy in last 12 months	1,029,089	RBM/MC needs assessment tool estimate based on the	2008

(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
		1998 population census	
Other: 0 – 11 months	641,769	RBM/MC needs assessment tool estimate based on the 1998 population census	2008
Other: 0 – 4 years	3,697,282	RBM/MC needs assessment tool estimate based on the 1998 population census	2008
Other: 5 years and more	17,563,686	RBM/MC needs assessment tool estimate based on the 1998 population census	2008

4.2.2. Malaria epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Episodes of malaria in past 12 months (*all population, all ages)*	NOT AVAILABLE		
Episodes of malaria in past 12 months: Children 0 – 4 years	NOT AVAILABLE		
Other**: ***Refer to the Round 8 Guidelines for other possible groups*			
Other**:			
Other**:			[*use "Tab" key to add extra rows if needed]*

This proposal plans to set up a system for monitoring healthcare units' morbidity and mortality, at sentinel sites. The data gathered in the first year will be available as a basis for the ongoing project.

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[4] who may have disproportionately low access to malaria prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Malaria program

Describe:

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

The main weaknesses in the implementation of current malaria strategies have been identified in the following areas:

PREVENTION

The choice of pregnant women and children under five as sole targets for the free distribution of LLIMN meant covering 20% of the general population at most; this will not reach the RBM and Abuja targets. Furthermore, UNICEF only began providing support for the free distribution of LLIMN in 2006. That distribution only covers 30% of children under twelve months and pregnant women in the country's Center-North-West zone (CNW).

Intermittent preventive treatment (IPT) based on the use of sulfadoxine/pyrimethamine has been adopted for the prevention of malaria among pregnant women. Staff in only 19 health districts out of the country's 72 have been trained in the use of IPT. Access to IPT is also limited by the co-payment charges applied to SPs.

CARE OF CASES

The new treatment protocol based on the use of artemisinin-based combination therapies (ACT) has been adopted since 2005, but promotion and training of care providers for optimal implementation have only taken place in 19 health districts out of the 72. Furthermore, stocks of ACT have often run short due to an inadequate charging system.

The drug monitoring system is currently at the development stage, and not yet in a position to monitor undesirable side-effects reported by patients to the providers.

Moreover there is limited opportunity for confirmation of the parasitological diagnosis of malaria in the peripheral health facilities, which have no resources for biological diagnosis. In the reference hospitals this situation is due to the low number of biotechnicians and equipment (RDT, microscopes, laboratory inputs). This situation makes it impossible to provide swift and proper care to malaria patients in all districts in accordance with the RBM and Abuja recommendations.

PROMOTION OF IEC/BCC AND COMMUNITY-BASED ACTIONS

The population in general knows little about the way malaria is transmitted and could be prevented, and little about the right way to manage cases of fever. These people self-medicate or go to informal sector practitioners, and only seek treatment at healthcare facilities as a last resort.

Community-based activities are carried on by some NGOs and community organizations in projects of limited scope which only affect the 19 districts supported by Round 6 funding. Private enterprise initiatives, on the other hand, go no further than nursing care.

CO-ORDINATION, M&E

So far, co-ordination of actions at national level is mainly limited to the activities of public sector organizations, in particular those involved in implementing Round 6 in the 19 districts. Interaction among the various players within a sector or between sectors is not vigorous. This situation helps

[4] Please refer back to the definition in s.2 and found in the Round 8 Guidelines

to perpetuate the duplication of activities, and to reduce the value added that could be expected from complementarity within and between sectors.

4.3.2. Health System

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

The description can include discussion of:

- *issues that are common to malaria, tuberculosis and HIV programming and service delivery; and*
- *issues that are relevant to the health system and malaria outcomes (e.g.: delivery of ITNs or IRS, or provision of intermittent preventive treatment to pregnant women (IPTp)), but perhaps not also HIV and tuberculosis programming and service delivery.*

Gaps in the healthcare system have been identified that could affect the scaling up of actions to combat malaria. The main ones are as follows:

- organizational inadequacies in the system for managing co-payment money, because State funds are not ring-fenced. This situation hinders the re-use of funds within the health sector alone, which would provide for regular re-stocking.
- poor performance by the biological confirmation laboratories: with reference to the scaling up of ACT, there are few first-line reference facilities (General hospitals, urban health centers) which currently have the microscopes needed for confirmation in cases of fever. Such confirmation is essential for the proper administration of ACTs.
- Insufficient storage for LLIMN in the districts. The main problem the system faces in distributing LLIMN is practical storage capacity: almost all the districts lack adequate infrastructure for storing LLIMNs planned for the 2010 campaign.
- poor coordinating capability at regional level. In the current system for monitoring malaria control activities, the districts send their reports direct to central level, which weakens the regional level's capacity to put things together and provide analysis and feedback. Rolling out ACT and LLIMN at community level will generate a great deal of information to be collected, and its monitoring will have to be strengthened at regional level.
- inadequacy in the system for monitoring indicators of morbidity and of mortality at health facilities such as general and regional hospitals. These institutions do not regularly send information to the national M&E system, nor do they receive feedback. In the case of the UHCs and National Institutes, it is more a matter of a mis-match between the data gathering tools there and the ones used nationally.
- failure to take account of community and private sector data in the program's M&E system. One of the major gaps in M&E is the continuing unavailability of information on these two sectors. The tools in place at community level are not yet being used because those involved have not been trained; and as to information from the private sector, this is not gathered by the national system.

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 malaria outcomes.

- The PSP (Public Health Pharmacy) has set up (since the start of 2008) a separate account for co-payment money recovered in connection with Global Fund activities (Round 6) and other projects where it supplies the medical products and equipment. This will make it possible to remedy the re-stocking issues.
- Round 6 provided for the equipping of 16 general hospitals with microscopes and laboratory inputs, and refresher training for 38 biotechnicians.
- The development partners (UNICEF/EU) have undertaken the rehabilitation of storage sites for drugs and LLIMN in the 38 districts of the CNW zone. The Global Fund made provision through Round 6 for the rehabilitation of 19 district LLIMN storage sites.
- Standing Orders for the organization and functioning of the Regional and District Health Directorates were revised in 2007 to strengthen these Directorates' leadership in the co-ordination, technical support and supervision of the services attached to each (Order No. 212 /MSHP/ CAB of 11 July 2007). To facilitate the handling of Health District and Health Region data, Measure Evaluation/JSI provided equipment in 2006 for five Regional Directorates and nine District Directorates. Under Round 6 CARE CI has equipped 19 other districts with computers for handling data in 2008. By means of the European Union's support projects, UNICEF has equipped 11 Regional Directorates and 26 health districts with computers for handling data.
- Since 2004, PEPFAR has made it possible to revise and update the list of national health indicators by Measure Evaluation/JSI. National tools incorporating these indicators have been prepared. In 2007 the state contributed to the reproduction of these tools, and support for rolling out the tools across 31 districts has been provided by UNICEF through its national reconstruction support project. This capacity-building effort has not included the UHCs and National Institutes.
- The inclusion of community level data in the M&E system in the 19 districts is envisaged under Round 6, but not that of private sector data.

4.4. Round 8 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 malaria epidemiology and identified weaknesses and gaps from s.4.3.

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

Priority No: 1	**Prevention**	**Historical**		**Current**		**Country targets**			
Intervention 1	**Insecticide treated mosquito nets**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		1,444,510	1,492,164	1,482,000	1,482,000	1,263,900	2,497,667	2,549,667	2,603,667
B: Extent of need already planned to be met under other programs		326,000	374,000	953,426	505,000	263,900	263,900	-	-
C: Expected annual gap in achieving plans		1,118,510	1,118,164	528,574	977,000	1,000,000	2,233,767	2,549,667	2,603,667
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			-	1,000,000	2,233,767	2,549,667	2,603,667

The requirements for prenatal consultation and vaccination coverage in 2008 and 2009 were taken into account by Round 6 of the Global Fund. These targets essentially concern pregnant women and children under five. Country-wide LLIMN availability from 2008 is being paid for by contributions from the Global Fund (Round 6), UNICEF and the Methodist Church, which has undertaken to donate 500,000 LLIMN in 2008.

A mass distribution campaign to the whole population is planned for 2010 (three mosquito nets per average household of 5.4 members) in order to attain universal coverage.

From 2011 onward the plan is to provide replacement mosquito nets at community level to maintain coverage levels, assuming one mosquito net in four will need replacing each year (2011, 2012, 2013). Various reasons have been identified for the loss of mosquito nets: nets may be smuggled out to other countries, torn, or worn with age, &c.). Alongside this community distribution there will continue to be a routine distribution to pregnant women and children under five at healthcare facilities.

Three distribution strategies, then, have been selected: (1) Distribution through mass campaigns (11,000,000 LLIMN); (2) Routine distribution at health centers and (3) Distribution through the community (7,387,101 LLIMN).

The mass campaign distribution will take place in 2010 after preparation, an invitation to tender and purchases in late 2009 or early 2010. This will reach all households in the country (three LLIMN per household). At national level this activity will be the job of an Organizing Committee coordinated by the Sub-Recipient responsible for buying and distributing LLIMNs. LLIMNs will be pre-positioned in districts and distributed by the health service staff and community activists supervised by the Area Sub-Recipients.

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The routine distribution will continue at the health facilities for the target groups – pregnant women and children under five – so as to maintain attendance at health facilities. The Principal Recipient will regularly re-supply the districts, with the support of the Area Sub-Recipients. LLIMNs will be distributed free of charge to pregnant women at prenatal consultations (PNC), and for children under five at their vaccination sessions.

As to distribution through the community, this will be done after the 2010 campaign with the aim of maintaining the coverage of three LLIMN per household until the end of the project. The estimates have been made on the basis of replacing one LLIMN in four each year. LLIMNs will be pre-positioned in the health facilities and will be delivered to the community-based organizations (CBO) and to the Community Healthcare Workers (CHW) under the supervision of the Area Sub-Recipients.

Priority No: 1	**Prevention**	**Historical**		**Current**		**Country targets**			
Intervention 2	**Intermittent Preventive Treatment with SP**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		866,706	895,299	2,126,097	2,196,258	2,268,735	2,343,603	2,420,942	2,500,833
B: Extent of need already planned to be met under other programs		866,706	895,299	-	-	-	-	-	-
C: Expected annual gap in achieving plans		-	-	2,126,097	2,196,258	2,268,735	2,343,603	2,420,942	2,500,833
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			2,196,258	2,268,735	2,343,603	2,420,942	2,500,833

IPT is administered in all the country's health facilities, and the above estimate of treatment doses has been made on the basis of 100% of pregnant women nationwide (two doses per pregnant woman). Uptake will be closely connected with the rate of attendance at PNC services, currently 93% for PNC1 and 80% for PNC2. No SP is available for IPT free of charge. The activities currently under way take account of the co-payment policy of the PSP (Public Health Pharmacy).

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Priority No: 2	Care in health facilities	Historical		Current		Country targets			
Intervention 3	Diagnosis using RDT and microscope examination	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*									
RDT		-	-	433,135	2,880 139	5,210 983	4,910 864	5,011 965	128,527
microscope examination		-	-	1,364,041	2,842 093	4,164 924	3,832 517	3,898 321	9,075 798
TOTAL		-	-	1,797,176	5,722 232	9,375 907	8,743 381	8,910 286	9,204 325
B: Extent of need already planned to be met under other programs									
RDT		-	-	-	-	-	-	-	-
microscope examination		-	-	231,161	238,789	470,039	441,204	-	-
TOTAL		-	-	231,161	238,789	470,039	441,204	-	-
C: Expected annual gap in achieving plans									
RDT		-	-	433,135	2,880 139	5,210 983	4,910 864	5,011 965	128,527
microscope examination		-	-	1,132,880	2,603 304	3,694 885	3,391 313	3,898 321	9,075 798
TOTAL		-	-	1,566,015	5,483 443	8,905 868	3,883 177	8,910 286	9,204 325
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*							
RDT					2,880 139	5,210 983	4,910 864	5,011 965	128,527
microscope examination					2,603 304	3,694 885	3,391 313	3,898 321	9,075 798
TOTAL					**5,483 443**	**8,905 868**	**3,883 177**	**8,910 286**	**9,204 325**

The intention is to diagnose 92% of those over five years old presenting at health facilities with fever; of these, 32% would be diagnosed by microscope examination and 60% with RDT. In the case of children under five, the intention is to diagnose only 30% of children who present with fever but do not meet the criteria for immediate treatment. This diagnosis makes it easier to distinguish the proportion of all fevers in children under five that are due to malaria. The aim is to equip all the hospital centers with microscopes. RDT will be used at Rural as well as Urban Health Centers; they are not currently available country-wide. Microscope examinations are undertaken in the University Hospital Centers, Regional Hospital Centers and General Hospitals. 231,162

examinations are to be undertaken by the State in 2008.

Priority No: 2	Care in health facilities	Historical		Current		Country targets			
Intervention 4	**Artesunate + Amodiaquine**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**
A: Country target *(from annual plans where these exist)*	<1 year	225,343	232,778	354,873	323,815	290,322	299,903	309,799	320,023
	1-6 years	3,241,480	3,348,415	5,392,528	4,723,461	3,652,674	2,864,979	2,842,248	2,936,042
	7-13 years	-	-	2,109,369	1,456,463	636,226	342,305	312,937	323,264
	14 years and over	-	-	4,413,469	2,738,776	835,918	572,120	553,375	571,636
	TOTAL	**3,466,823**	**3,581,193**	**12,270,240**	**9,242,516**	**5,415,140**	**4,079,306**	**4,018,359**	**4,150,965**
B: Extent of need already planned to be met under other programs	<1 year	4,771	40,331	456,896	477,324	477,324	477,324	100,000	100,000
	1-6 years	68,635	580,145	1,874,726	1,909,297	1,909,297	1,909,296	400,000	400,000
	7-13 years	-	-	200,000	250,000	250,000	250,000	250,000	250,000
	14 years and over	-	-	200,000	250,000	250,000	250,000	250,000	250,000
	TOTAL	**73,406**	**620,476**	**2,731,622**	**2,886,621**	**2,886,621**	**2,886,620**	**1,000,000**	**1,000,000**
C: Expected annual gap in achieving plans	<1 year	220,572	192,447	-	-	-	-	209,799	220,023
	1-6 years	3,172,845	2,768,270	3,517,802	2,814,164	1,743,377	955,683	2,442,248	2,536,042
	7-13 years	-	-	1,909,369	1,206,463	386,226	92,305	62 937	73,264
	14 years and over	-	-	4,213,469	2,488,776	585,918	322,120	303,375	321,636

ROUND 8 – Malaria

	TOTAL	**3,393,417**	**2,960,717**	**9,640,640**	**6,509,403**	**2,715,521**	**1,370,108**	**3,018,359**	**3,150,965**
D: Round 8 proposal contribution to total need	<1 year	*(i.e., can be equal to or less than full gap)*			-	-	-	209 799	220 023
	1-6 years				2,814,164	1,743,377	955,683	2,442,248	2,536,042
	7-13 years				1,206,463	386,226	92,305	62,937	73,264
	14 years and over				2,488,776	585,918	322,120	303,375	321,636
	TOTAL				**6,509,403**	**2,715,521**	**1,370,108**	**3,018,359**	**3,150,965**

The initial estimate by age group given above was made on the basis of cases presenting with fever at health facilities, assuming a 48% recourse to the health services. Later estimates of the quantity of ACT are based on numbers of confirmed cases of malaria.

The intention is to treat cases of fever among children under five at the community level. This requires a new estimate to deal with the 52% of cases of fever among children under five not seen at health facilities.

The number of cases of fever seen by the private sector has not been taken into account, because of the lack of figures.

For the period 2008 to 2011 there is more ACT available than required for children under twelve months. For this age group the gaps are therefore estimated at zero. After that, these gaps are 209,799 and 220,023 for 2012 and 2013 respectively. So far as the other age groups are concerned, the availability of medication is still below requirements, and handled by the State through the co-payment policy of the PSP (Public Health Pharmacy).

Priority No: 3	Care at community level	**Historical**		**Current**		**Country targets**			
Intervention 5	**Artesunate + Amodiaquine**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**
A: Country target *(from annual plans where these exist)*	<1 year	-	-	37,748	133,339	215,868	189,021	190,872	197,770
	1-5 years	-	-	501,505	1,771,510	2,867,960	2,511,273	2,535,867	2,619,551
	TOTAL	-	-	**539,253**	**1,904,850**	**3,083,828**	**2,700,293**	**2,726,739**	**2,816,721**
B: Extent of need	<1 year	-	-	-	-	-	-	-	-

already planned to be met under other programs	1-5 years	-	-	-	-	-	-	-	-
	TOTAL	-	-	**-**	**-**	**-**	**-**	**-**	**-**
C: Expected annual gap in achieving plans	<1 year	-	-	37,748	133,339	215,868	189,021	190,872	197,770
	1-5 years	-	-	501,505	1,771,510	2,867,960	2,511,273	2,535,867	2,619,551
	TOTAL	-	-	**539,253**	**1,904,850**	**3,083,828**	**2,700,293**	**2,726,739**	**2,816,721**
D: Round 8 proposal contribution to total need	<1 year	*(i.e., can be equal to or less than full gap)*			37,748	133,339	215,868	189,021	190,872
	1-5 years				501,505	1,771,510	2,867,960	2,511,273	2,535,867
	TOTAL				**539,253**	**1,904,850**	**3,083,828**	**2,700,293**	**2,726,739**

Only children under five will be treated at community level. The estimate below covers the 52% of cases of fever among children under five not seen at healthcare facilities. Children under twelve months are estimated to be approximately 7% of this group. For the moment there are no forecasts of ACT at community level for children under five.

It is thought that the CBOs/CHWs will be able to treat up to 80% of fever in children under five seen at community level between now and 2013, which gives a total number for treatment of 13,771,684, of which 964,011 would be children under twelve months.

Intervention 6: Treatment of severe cases; Second Line treatment

The amount needed for the treatment of cases of severe malaria, for cases of malaria in pregnant women and for Second-Line treatment is estimated at 5% of the total cost of treatment of uncomplicated malaria. Two thirds of this amount will be earmarked for the treatment of severe malaria and malaria among pregnant women.

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

4.5. Implementation strategy

4.5.1. Round 8 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, program work area (or, "service delivery area (SDA)"), 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 malaria program description (because they predominantly contribute to malaria outcomes), include them in this section only of the Round 8 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 8. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 8 Guidelines (s.4.5.1.) for information on this choice.*

The object of this proposal is to reduce malaria-related morbidity and mortality in Côte d'Ivoire to half its 2000 level by 2013.

The following specific targets have been selected as instrumental in reducing malaria-related morbidity and mortality between now and 2013:

1. Arrange by 2013 for at least 80% of the population to sleep under long-lasting insecticide-treated mosquito nets (LLIMN)
2. Arrange by 2013 for at least 80% of pregnant women to have two doses of SP as Intermittent Preventive Treatment (IPT) between now and 2013
3. Provide care according to the national protocol for at least 80% of cases of malaria, by 2013;
4. Arrange for at least 80% of contracted CBOs to carry out malaria control activities at community level in accordance with their service agreements
5. Build co-ordination and M&E capacity between now and 2013 among the project's Principal Recipients and Sub-Recipients.

To reach these specific targets, Service Delivery Areas (SDAs) have been chosen for each target.

OBJECTIVE 1: Reduce malaria-related morbidity and mortality in Côte d'Ivoire to half its 2000 level by 2013.		
***Objective 1:* Arrange by 2013 for at least 80% of the population to sleep under long-lasting insecticide-treated mosquito nets (LLIMN)**		
Principal Recipients: CARECI and NMCP (National Malaria Control Program)		
SDA	***Implementing body***	***Target groups***
Long-lasting insecticide-treated mosquito nets (LLIMN)	S/PR: PSI, 5 Area Sub-Recipients, private enterprises	Target 1: children under five Target 2: pregnant women Target 3: population at large
The mean rate of LLIMN coverage for the high-risk target groups falls well short of the results expected for 2010 (60%) in the 19 Round 6 districts. It is 4.80% among pregnant women and 4.70% among		

children under five years (KAP Survey 2008). These low percentages give reason to suspect a similar coverage for the same groups country-wide. Round 8 is meant to cover the population at large according to the RBM universal coverage targets.

Activity 1: Purchase, storage and dispatch to regions and districts

In line with the procurement plan and identified needs (18,387,101 LLIMN), PSI will see to the purchase and dispatch of LLIMN to the districts, and will be allowed to transfer ownership of the containers to the consignee health districts in order to reduce excessive storage costs. Before distribution, the NMCP will ensure that the mosquito nets bought are of proper quality.

A mass distribution campaign will be conducted in 2010. PSI will see to making LLIMN available to the health districts in the right quantities for distribution to households (at the rate of three LLIMN per household). Within each district LLIMN will be transported to the distribution points using the normal resupply arrangements.

For the routine distribution, PSI will make quarterly deliveries of LLIMN to the districts, to be handed out free of charge in the course of PNC activities and routine vaccinations, and quarterly deliveries also to the area's Sub-Recipients, who will distribute them at a subsidized price during various actions by CBOs.

Activity 2: Distribution to the beneficiaries

A mass LLIMN distribution campaign will be carried out at the start of the project. To make sure that all the players on the ground are mobilized and involved from start of the distribution, and to plan the quantities to be given in each geographical zone on the basis of real needs, "microplans" will be prepared by the local organizations. The National Plan will be a synthesis of the Health Regions' microplans. This campaign, run by the NMCP, may if necessary be combined with other mass actions such as additional vaccination activities (AVS), parasite riddance and micronutrient supplement distribution, on the basis of 3 LLIMN per household (mean household size in Côte d'Ivoire: 5.4 people; INS - National Institute for Statistics). Distribution will be carried out by field teams composed of public and private sector healthcare workers and community contact persons.

Routine distribution free of charge in the course of PNC and EPI activities will make it possible to improve service delivery in health facilities and to encourage people to attend facilities. Replacement LLIMN will be sold at a subsidized price by the Area Sub-Recipients through the community network, so as to maintain the level of coverage achieved in the campaign.
These routine distributions (at health centers and at community level) will mean 2,233,767 LLIMN can be made available in 2011, 2,549,667 in 2012 and 2,603,667 LLIMN in 2013.
This strategy will ensure that levels of LLIMN coverage are maintained by making the items available to households which missed out during the mass campaign or have lost (burned, torn, mislaid) their nets.

Activity 3: Promoting LLIMN use

Communication about LLIMN will form part of an integrated communication plan (ICP) to be developed by the NMCP for all its strategies. Behavior surveys will be conducted, and on the basis of their results PSI will be responsible for developing the part promoting LLIMN use. This plan will set out communication strategies for changing behavior using mass media and also word of mouth communication through CBOs, and will include the specific messages to be disseminated.

To implement the communication campaign, PSI will use media with high penetration and retention rates (television, radio, big billboards) and also local media (posters and leaflets for population groups that may be illiterate), focusing on the benefits of proper LLIMN use; the main target group will be pregnant woman and those with children under five, and the secondary target will be the population at large.

At community level, the Area Sub-Recipients will be responsible for implementing communication activities in their own geographical areas. NGO and CBO members will receive training about malaria and its prevention, including LLIMN use. Using special communication tools (a picture box, for example), they will conduct small awareness-raising group meetings at home or at work, using a participatory approach to encourage these population groups to keep using LLIMN as an effective and indispensable weapon for preventing malaria. Mass awareness-raising activities by NGOs and CBOs in co-operation with Community Healthcare Workers (playlets or quizzes) will be used to motivate the

target groups to use LLIMN.

Activity 4: M&E of activities

The NMCP will ask the INHP (National Institute of Public Hygiene) to carry out quality checks on LLIMNs before distribution: the request for the necessary funds will be accompanied by appropriate terms of reference.

At the seven sentinel sites, the Pierre Richet Institut (IPR) will monitor LLIMN effectiveness following use, watching for any emerging chemical resistance. This will be done by means of an effectiveness study to be carried out every other year at each sentinel site.

The vectors' insecticide resistance will be monitored by the IPR at these sites once a year.

The survey of LLIMN coverage indicators will be included in the overall survey measuring the project's annual indicators.

See detailed description of activities in Appendix N° 4

Budget summary: €96,518,869 (see detailed budget, Budget Appendices N° 3)

Objective 2: Arrange by 2013 for at least 80% of pregnant women to take two doses of SP in Intermittent Preventive Treatment (IPT)

Principal Recipients: CARECI and NMCP

SDA	*Implementing body*	*Target groups*
Malaria prevention by using drugs during pregnancy	S/PR: PSP (Public Health Pharmacy)	Target: pregnant women

IPT coverage still depends on attendance at health facilities; so for better coverage of pregnant women by this strategy it is necessary to promote attendance at prenatal consultations and to give health providers training in applying the treatment guidelines. This proposal has a target of raising the 26.6% IPT coverage in 2008 (KAP Survey) to 80% overall in 2013.

Activity 1: Purchase, storage, quality control and dispatch of Sulfadoxine-Pyrimethamine (SP)

SP will be purchased by the Principal Recipient according to Global Fund procedures and the project's procurement plan. 11,730,371 doses of SP (1 dose = 2 × 3 tablets) will be bought to cover the country's needs. Quality checks will be provided by the LNSP (National Public Health Laboratory). The drugs will be stored and distributed by the Public Health Pharmacy (PSP) of the MSHP (Ministry of Health and Public Hygiene). An order will be issued by the MSHP that will make SP available free of charge in both the public and private sectors.

The districts will be supplied monthly by the PSP (Public Health Pharmacy) using normal channels to distribute SP among the public ESPCs (Primary Healthcare Facilities). Private enterprises will draw supplies direct from the PSP (Public Health Pharmacy).

Activity 2: Training of care providers

The intention is to give proper training to all care providers who have not yet had IPT training. This will be done in the project's first year by a pool of trainers at district level. Under the chosen training policy, the NMCP will commission a training organization to train and supervise the training of this pool of district trainers, who will then conduct training sessions for the public and private healthcare providers in the 53 districts. Newly hired public and private sector care providers in the 19 Round 6 districts will also get this training. Refresher sessions will be organized in the project's third year. Training will involve the Reproductive Health and Family Planning (RH/FP). WHO-validated training modules with the national adaptations made under GF Round 6 will be used for this.

Activity 3: Dispensing SP

SP will be administered free of charge by PNC care providers according to the Directly Observed

Treatment strategy (DOT). Suitable medication equipment will be made available to them for this.

Activity 4: Promotion of IPT using SP

The strategy for promoting the use of SP will be part of the integrated communication plan to be developed by the NMCP and its partners (RH/FP, UNICEF, etc.).

Pregnant women will be given information and have their awareness raised during PNC in all healthcare facilities by the district healthcare workers. There will be communication aids to illustrate this word of mouth communication. Staff will stress the importance of the two doses of SP to be taken during pregnancy.

At community level, there will be local and mass media campaigns to raise awareness of the importance of using PNC services and of malaria prevention by using drugs in pregnancy. Messages will target women and their partners, traditional leaders, traditional practitioners and older women.

Following an invitation to tender, a properly qualified communication organization will be commissioned to conduct the activities promoting SP use.

Activity 5: Monitoring/Evaluating activities

Providers will be inspected every two months by the District Management Teams to assess the availability of services and ensure that the national protocol is being applied correctly.

A survey of community coverage of pregnant and recently-delivered women will be carried out each year to evaluate SP use. The organization responsible for the survey will be selected by competitive tender.

See detailed description of SDA activities in Appendix N°4

Budget summary: €3,955,454 (see detailed budget, Budget Appendices N°3)

Objective 3: Provide care according to the national protocol for at least 80% of malaria cases between now and 2013

Principal Recipients: CARECI and NMCP

SDA	*Implementing body*	*Target groups*
SDA 1: Biological diagnosis	S/PR: PSP (Public Health Pharmacy)	Target: Population groups attending healthcare facilities

Unlike mortality, whose trends can be followed through the health services' hospitalization facilities, the number of cases of fever treated as malaria could remain unchanged in the absence of biological confirmation. The Thick and Thin Blood Smear test can only be done in the laboratories of reference facilities (1 or 2 in each district); confirmation of malaria needs to be decentralized using RDT.

Activity 1: Capacity building: laboratory equipment

The laboratories of those public reference hospitals that have not been equipped under Round 6 will now be equipped with microscopes for the parasitological diagnosis of malaria (Thick and Thin Blood Smear test). These laboratories will be regularly supplied by the PSP (Public Health Pharmacy) with inputs for the microscope-based diagnosis of malaria.

The country's Rural Health Centers and the 400 private-enterprise health facilities falling into the same category will be supplied with RDTs through the same channels as described for SP (Public Health Pharmacy or PSP).

In the particular case of private profit-making medical practices, negotiations will be conducted with the MSHP (Ministry of Health and Public Hygiene) through the DEPS (Health Institutions and Professions Directorate) to involve these organizations in confirming diagnoses of malaria made through RDT. The customer will be asked to pay a modest contribution to reward the provider for bearing a share of the costs connected with these confirmations. This will be a standard amount across the country.

Activity 2: Training in biological diagnosis

Under the training policy the NMCP will commission all biological diagnosis training activities (microscope examination and RDT) from the parasitology laboratory of the Medical Science UFR (Training and Research Unit) of the University of Cocody – Abidjan. Two biotechnicians will be trained at each reference hospital in the 53 districts not targeted in Round 6. The budget for this training is taken into account under Cross-cutting HSS. Staff in urban and rural health centers and in the private sector will be trained in the use of RDTs during the project's first year.

Activity 3: M&E of activities

Staff engaged in microscope-based diagnosis in the reference hospitals will be inspected every six months by the Medical Science UFR (Training and Research Unit). Sample slides will be subjected to quarterly quality checks by the same unit.

Every two months, the trained district biotechnicians will inspect the healthcare workers who use RDTs. Quarterly RDT quality checks will be carried out by the parasitology laboratory of the Medical Science UFR (Training and Research Unit).

See detailed description of SDA activities in Appendix N°4

Budget summary: €9,747,624 (see detailed budget, Budget Appendices N°3)

SDA	*Implementing body*	*Target groups*
SDA 2: Swift and proper care of cases of uncomplicated malaria	S/PR: PSP (Public Health Pharmacy)	Target 1: children under five Target 2: population at large

This proposal aims to extend the Round 6 actions so as to attain the RBM goals. The treatment of cases with ACT, which is correct in 20.9% of children under five years (2008 Situation Analysis), will accordingly be improved in the country's healthcare facilities and extended to the community level, and in particular to the CBOs/ CHWs, so as to achieve wider access to treatment and a considerable reduction in mortality.

Activity 1: Supplies of ACT and oral quinine

Healthcare facilities in the 72 districts will be supplied with ACT and oral quinine by the PSP (Public Health Pharmacy) using the same channels as for SP. ACT requirements for children under five have been quantified taking into account the amounts available in the 19 districts under Round 6. Peripheral health centers will supply the CBOs/CHWs belonging to their health areas according to their consumption and on the basis of their uptake rates.

The co-payment funds generated by charging for ACT (are sold at the same price as the malaria drugs bought out of the State budget) will be returned to an "ACT account" jointly managed by the PR and the PSP (Public Health Pharmacy). This principle has already been accepted, and is being applied in Round 6. These funds will be reinvested in the treatment of cases, on the basis of an expenditure plan which must be approved by the CCM beforehand.

Activity 2: Training of care providers

The activity of training in the provision of care will be coordinated by the NMCP, which will commission a training organization to train and supervise this pool of district trainers under the same arrangements as described for SP.

Activity 3: Training community activists

The Area Sub-Recipient is responsible for implementation and co-ordination in its area. The community activists will be trained by the District Management Teams (DMT) and local NGOs. An algorithm will be developed for treatment of cases of fever in the community. CBOs/CHWs will be trained, district by district, in the treatment of cases of fever.

Activity 4: Promotion of ACTs and biological diagnosis

Information will be given to healthcare providers in all healthcare facilities (in the public and private sectors and at community level), and their awareness will be raised in the course of the training sessions and inspections. The information will concern the effectiveness and tolerance of ACTs, the channels of distribution, and the importance of confirming diagnoses for rational use of these products. This word of mouth communication will be illustrated with suitable aids.

At community level, there will be local and mass media campaigns to raise awareness of the importance of early attendance at healthcare facilities and of using ACT. Messages targeting community leaders and traditional practitioners will be developed and disseminated.

For local awareness-raising, community activists will mainly use the CHW's handbook as a communication aid designed for PFE (Key Family Practices) by the MSHP (Ministry of Health and Public Hygiene).

These community activists will include the promotion of ACTs in the course of home or workplace visits.

The ICP of the NMCP 2007-2009 will be revised jointly with all partners, as described in the sections on LLIMN and SP. Following an invitation to tender, a properly qualified communication organization will be commissioned to conduct the activities promoting the use of ACTs and biological diagnosis.

Activity 5: M&E of activities

Care providers will be inspected every two months by the DMT. Community activists will be inspected by heads of health centers every two months. The district staff will be inspected every six months by the Regional Health Teams, with support from the central level and the Area Sub-Recipient

Quality control of ACTs will be carried out by the National Public Health Laboratory. Therapeutic effectiveness tests will be carried out at sentinel sites by the Abidjan Medical Science UFR (Training and Research Unit).

Drug monitoring activities currently taking place under Round 6 will be extended to the 53 districts not currently covered, and will be the responsibility of the National Drug Monitoring Center. These drug monitoring activities will be extended to community level in all 72 districts. The necessary capacity-building of the National Drug Monitoring Center is provided for in the Cross-cutting HSS.

See detailed description of SDA activities in Appendix N°4

Budget summary: €24,249,978 (see detailed budget, Budget Appendices N°3)

SDA 3: Proper treatment of cases of severe malaria	S/PR: PSP (Public Health Pharmacy)	Target: population at large

Lowering deaths at health facilities depends on proper care of severe malaria cases. Such care necessarily requires properly functioning services staffed by qualified personnel.

Activity 1: Supplies of artemether for intramuscular injection, injectable quinine and accessories for parenteral administration.

The main healthcare facilities of the 72 districts will be supplied with injectable quinine, injectable artemether and accessories by the PSP (Public Health Pharmacy) using the same channels as described for ACTs. At the CSRs (rural health centers), artemether for intramuscular injection and artemisinin derivatives in suppository form will be made available for treatment before transfer to the reference center. Quinine-based emergency packs will be made up, depending on the level of skill available in the health facility.

Activity 2: Training of care providers

Care provider training will follow the same principle as described above in the section on the treatment of uncomplicated malaria, since the training is combined and includes both modules.

Activity 3: M&E of activities

Care providers will be inspected every two months by the DMT, and CBOs/CHWs by heads of health centers and local NGOs every two months. The DMTs will be inspected every six months by the Regional Health Teams with support from the central level.

As for drug monitoring activities, the system set up for ACTs will also deal with these two drugs.

See detailed description of SDA activities in Appendix N°4

Summary budget for SDA3: €732,321 (see detailed budget, Budget Appendices N°3)

Budget summary, Objective 3: €34,729,923 (see detailed budget, Budget Appendices N°3)

Objective 4: Arrange for at least 80% of contracted CBOs to carry out malaria control activities at community level in accordance with their service agreements

Principal Recipients: CARECI and NMCP

SDA	*Implementing body*	*Target groups*
SDA 1: Institutional and organizational capacity building of CBOs/CHWs	S/PR: Area Sub-Recipients	Target 1: CBOs and CHWs Target 2: population at large

The scaling up of malaria control activities will rely on community-based actions as the obvious strategy for achieving the goal of universal access to services. The project will assign primary importance to capacity-building at community level so that people participate fully in the fight against malaria.

Activity 1: Organizational capacity-building of CBOs/CHWs

The Area Sub-Recipients will have the task of supporting the Districts and the local NGOs in identifying CBOs on the basis of properly specified criteria. The intention is to commission two CBOs/CHWs per village, which would mean approximately 20,000 CBOs/CHWs country-wide.

In places where no formal CBOs have been set up, the Area Sub-Recipients will support their establishment by institutionalizing organizations. Once such a framework has been recognized by the local authority the local NGOs will be able to commission these CBOs. The CBOs invited to participate in malaria control activities will have to be ones recognized by their own community. Ideally the CHWs will be asked to organize themselves into CBOs wherever possible.

Activity 2: Managerial capacity-building of CBOs/CHWs

A management training module will be prepared by the PR and validated at a one-day workshop for 15 participants including the Area Sub-Recipients, who will then have the task of training 144 NGOs in five three-day sessions, each with 30 participants. The 19 NGOs already identified during Round 6 will also benefit from this capacity-building. Each NGO will have the task of training two for each CBO/CHW in its area of action. In all, 20,000 members of CBOs/CHWs should be trained in 667 three-day sessions.

Activity 3: Capacity building in equipment and funding

Capacity-building in equipment will involve the five Area Sub-Recipients, and the 144 NGOs in the 72 districts.

A lump-sum budget will be allotted to each NGO and each CBO/CHW for its functioning and equipment.

See detailed description of SDA activities in Appendix N°4

Summary budget for SDA1: €836,400 (see detailed budget, Budget Appendices N°3)

SDA	*Implementing body*	*Target groups*
SDA 2: HR capacity building	S/PR: Area Sub-Recipients	Target 1: CBOs and CHWs

		Target 2: population at large

The community activists, who are going to be the key link in implementing the actions at community level, need certain capabilities if they are to deliver good services locally to the target groups. It is therefore necessary to build up this HR capacity, in quality and quantity.

Activity 1: Training community activists

Training aids will be prepared and validated under the responsibility of the NMCP, in co-operation with the Area Sub-Recipients and other partners such as PSI, UNICEF, etc. CBO members will be given training in enable them to carry out outreach activities with target groups in their area of responsibility for the fight against malaria. The idea will be to train trainers in local NGOs and districts, so that these in turn can train CBO members.

Activity 2: Implementation of activities

A minimum package of activities including dispensing of ACTs among feverish children under five, distributing LLIMN, raising awareness about malaria through home visits, meetings and educational chats, will be commissioned from the CBO/CHW by the local NGOs.

The implementation of these activities by the CBOs/CHWs will be supervised by the local NGOs and the districts, which will continue to strengthen their capacity on the ground. Furthermore, a periodic assessment will provide measurements of each CBO/CHW's level of performance so that the necessary remedial measures can be taken.

See detailed description of SDA activities in Appendix N°4

Summary budget for SDA2: €699,567 (see detailed budget, Budget Appendices N°3)

Budget summary, Objective 4: €12,975,047 (see detailed budget, Budget Appendices N°3)

Objective 5: Build co-ordination and M&E capacity among the project's Principal Recipients and Sub-Recipients between now and 2013.

Principal Recipients: CARECI and NMCP

SDA	*Implementing body*	*Target groups*
SDA 1: Strengthen co-ordination	S/PR: Area Sub-Recipients Others: Directorate-General of Health, Regional Directorates, District Directorates	Target 1: Sub-Recipients and Sub-Sub-Recipients Target 2: Districts and CBOs/CHWs

The implementation of this project involves two major imperatives: first, the co-ordination of all players' actions at all levels, and, second, M&E of implementation so as to achieve results. One of the project's priorities will be strengthening the co-ordination mechanisms on the basis of the good practices acquired in carrying out Round 6.

Activity 1: Consolidating the co-ordination of activities

The co-ordination of activities is part of the duties of the NMCP Co-ordination Directorate.

At national level, the coordinating committee known as "Task Force", which was first set up under Round 6, will be reappointed. This is composed of representatives of the development partners (bilateral and multilateral cooperation), the Directorate-General of Health, the PSP (Public Health Pharmacy), the DPM (Pharmacy and Medications Office), the DIPE (Information, Planning and Evaluation Directorate), the Regional Directorates, the Principal Recipients, the Area Sub-Recipients and the NMCP; it will be enlarged to include other government departments, the private sector and any other body whose contribution is considered useful.

This committee will be chaired by the Directorate-General of Health, and the NMCP will provide the secretariat.

It will meet quarterly to review activities and exchange experience and models of good practice.

At regional level a management committee chaired by the Regional Directorates will bring together the District Directors and the Area Sub-Recipients. The quarterly meetings of this committee will enable the Regional Directorates and Area Sub-Recipients to have the information they need before the meetings of the National Committee, and to provide the necessary support for implementing the activities. The meeting will be chaired by the Regional Directorate, and the District of the regional capital will provide the secretariat.

At District level, the usual monthly meeting of the District Management Team (DMT) and its partners, chaired by the District Director (DD), will be enlarged to include those involved in implementing malaria control activities. These meetings will enable the district to review the project's state of progress.

Activity 2: Strengthen the National Malaria Control Program

The NMCP is the body that co-ordinates all the project's activities, and will need strengthening both in human resources and equipment/logistics so as to perform its task more effectively.

For implementing Round 6, the NMCP's staff capacity has been strengthened in the areas of M&E, administration and finance. Nevertheless additional staff support is clearly needed for the better co-ordination of the activities to be implemented under Round 8. Operational functioning of the program must be strengthened, for instance, by additional staff in the NMCP's Care, M&E, Prevention, Research and Communication Departments which were set up by Ministerial Order n°311 MSHP/ CAB dated 4 October 2007 on the organization and functioning of the NMCP. This capacity-building must also be done in the area of financial management, management control, purchasing and stock management.

This HR capacity-building must be accompanied by the introduction of logistics and equipment management aids.
The intention is to equip the NMCP Co-ordination Directorate with 3 vehicles for inspections, and the Regional Directorate with 2 vehicles, likewise for the inspections.

Activity 3: Strengthening the Area Sub-Recipients

With a view to facilitating the implementation of interventions, the country will be divided into five Intervention Areas, each covering four Health Regions on average.

To function properly, the five Area Sub-Recipients will be given their own equipment and operating budgets.

To implement the various activities in accordance with their terms of reference, these Area Sub-Recipients will prepare a program of work which will then be validated by the Principal Recipient. A copy of this program will be available to the NMCP and the Regional Health Directorates.

SDA 2: M&E of project activities	S/PR: DIPE (Information, Planning and Evaluation Directorate), Regional Directorates, District Directorates, PSI, Area Sub-Recipients	Target 1: Sub-Recipients, Sub-Sub-Recipients Target 2: Districts and CBOs/CHWs Target 3: Population at large

The M&E of all the Round 8 interventions will make it possible to follow changes in the project's various indicators and monitor the delivery of high-quality services in all the areas where targets have been set.

Activity 1: Strengthening the monitoring system

The present proposal envisages strengthening the national monitoring system in the following ways:

1. the development of a model for data gathering tools in public and private health facilities; this model would be made available to the Sub-Recipients, which would then have the task of

reproducing it.
2. the training of healthcare workers of the public, private and community sectors, and of leaders of NGOs and CBOs/CHWs in the use of the data gathering tools; this would be combined with the various care courses that are planned
3. the development of a computerized database.
4. capacity-building in IT resources, and the establishment of an Intranet for transmitting data from the regional to the central level.
5. monthly inspections of Community Healthcare Workers by the Health Centers, two-monthly inspections of care providers by the District Management Team, half-yearly inspections of the District by the Region, and inspection of the Regions by the central level twice a year.
6. monthly inspection of the activities of CBOs/CHWs by the local NGOs, and two-monthly inspections of the local NGOs by the Area Sub-Recipients.
7. routine internal data quality audits will be carried out during these inspections at all levels.
8. external quality audits of the data gathered will be carried out each quarter. This activity will be outsourced by the Principal Recipients.
9. assessment of vector insecticide resistance.
10. assessment of transmission,
11. monitoring of the parasites' resistance to malaria drugs.
12. product quality control (impregnated mosquito nets, ACT, SP, RDT)
13. surveillance of malaria drugs' undesirable side-effects (drug monitoring)

Activity 2: Strengthening the project evaluation system

The project's results will be measured by means of indicators of the impact on mortality and morbidity at health facilities and on death rates in the hospitalization services, half-way through and at the end of the project. These indicators will be updated by reference to an initial situation analysis at the start of the project. At the end of the project an MIS (Malaria Indicators Survey) will be carried out. The organization commissioned to conduct these surveys will be chosen by competitive tender.

On the basis of the contracts signed with the various Sub-Recipients and Sub-Sub-Recipients, assessment matrices will be prepared and validated by the Principal Recipients and the CCM. These matrices will be used for the assessment of the Sub-Recipients, Regional Directorates, Districts, NGOs and CBOs/CHWs.

See detailed description of SDA activities in Appendix N°6

Budget summary of the Co-ordination, Monitoring and Evaluation action plan: €18,382,308 (see detailed budget, Budget Appendices N°5)

4.5.2. Re-submission of Round 7 (or Round 6) 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 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

Not applicable to the Côte d'Ivoire proposal, so far as the Malaria component is concerned

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 implementation of Round 6 has enabled the country to develop a certain number of modules which will be used for implementing certain activities described in Round 8, such as:

1. training in the care of malaria
2. training in the implementation of IPT

3. training in the use of data gathering tools
4. training in the biological diagnosis of malaria

The PSM Plan developed in Round 6 has served as a basis for preparing the Procurement and Distribution Plan for Round 8. The key players identified in Round 6 have been re-appointed for the Round 8 plan (CARECI, PSI, NMCP).

A M&E Plan has been developed for the 2005-2010 Strategic National Plan, and provides the basis for all the M&E activities in this proposal.

The administrative procedures which, after discussion, led to the signing of a contract between the Principal Recipient of Round 6 and the MSHP (Ministry of Health and Public Hygiene) will make it possible to facilitate the implementation of the activities with that Ministry's co-ordination service as identified for Round 8.

Under the training strategy used in the course of Round 6 a pool of national trainers has been set up which will be drawn on for implementation of the training plan under Round 8.

The Round 6 situation analysis (in 19 districts) documents some of the indicators chosen for Round 8, such as the incidence of malaria in health facilities' consultations, the rate of use of health facilities, and the percentage of children under five correctly treated.

The national co-ordination body known as the "Task Force", which was set up in the course of Round 6, has been re-appointed and strengthened for Round 8.

Moreover the implementation of Round 6 has shown up inadequacies of human resources, equipment and logistics in the coordinating body. This has made it possible to address the NMCP's capacity-building needs more precisely.

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 malaria 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).*

Social and gender inequalities take virtually the same form in Côte d'Ivoire as elsewhere in Africa, but there are differences depending on whether the zone under consideration is rural, semi-urban or urban. It is accepted that rural or semi-urban areas are disadvantaged in terms of access to health services. The current project intends to achieve the same level of product and input availability in semi-urban and rural areas as in urban ones.

Children and pregnant women – the most vulnerable minorities in our population – will be given priority in the services provided at health facilities (LLIMN and SP). At community level the ACTs for children under five are heavily subsidized.

The CBOs, which are organizations set up within local populations, will be given organizational and institutional capacity-building so as to improve their approach to serving their communities. In the choice of CBOs as Sub-Recipients, applications by women's associations will be strongly encouraged.

Despite the small amount people are asked to pay as a contribution to the cost of ACTs, there is still a marginal group too poor to access this service. In this situation a mechanism will be established to identify and treat such social cases. This mechanism will be funded from the money recovered on ACTs.

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 need to confirm cases of malaria (using RDT and microscope examination) could produce another form of behavior to which health policy has no answer yet: improved ability to diagnose cases presenting with fever will make it possible to limit the use of malaria drugs to plasmodium infections only; and that is liable to lead to an increase in the systematic prescribing of antibiotics in all cases of high temperature, which would formerly, according to the treatment algorithms used in Côte d'Ivoire, have been treated as malaria in the first instance. There will consequently be an emphasis on supervision so as to steer healthcare workers towards the best use of treatment algorithms.

The introduction of these time-saving and easy-to-use RDTs can lead to a neglect of microscope examination in facilities where both methods are established. There is consequently a need for an algorithm governing the use of these two methods; this must be prepared and included in the national guidelines.

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 ACT 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 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.

Round 6 began in November 2007 and is due to end in October 2011. Round 8 will cover the period 2009 - 2013. These two grants will overlap for three years in 19 of the country's districts. Round 8 will scale up (to 80% of the population at large) the distribution of LLIMNs in the 19 districts covered by Round 6; it will also extend the distribution of ACTs at community level. SP, which has so far been charged for in IPT, will be free of charge under Round 8 in all the healthcare facilities of these 19 districts, including private sector ones. So far as community-based actions are concerned, Round 8 will enhance the involvement of local NGOs in the fight against malaria, for the intention is to commission these NGOs to organize the work of the CBOs.

The ACT component of Round 6 provides for biological confirmation of malaria cases by means of microscope examination in the reference hospitals of the 19 districts. Round 8 will strengthen these hospitals' diagnostic capacities, and will extend them to the urban and rural health centers by introducing RDT.

The drug monitoring begun under Round 6 for ACT surveillance will be extended to community level under Round 8.

The implementation of Round 6 saw a few initial blockages due to a number of factors, including:

1. the inexperience of the Principal Recipient and Sub-Recipients in the managing money from the GF.
2. the absence of any existing framework for co-operation between the Principal Recipient and the Sub-Recipients
3. internal procedures within the PR which hampered the implementation of the activities.

Administrative procedures have been adopted to mitigate these problems; these should lead to the signing of an agreement between the PR and the MSHP (Ministry of Health and Public Hygiene). The

experience acquired in negotiating this agreement will enable Round 8 to avoid the delays observed in Round 6.

4.6.2. Links to non-Global Fund sourced support

Describe any 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.

Support from UNICEF

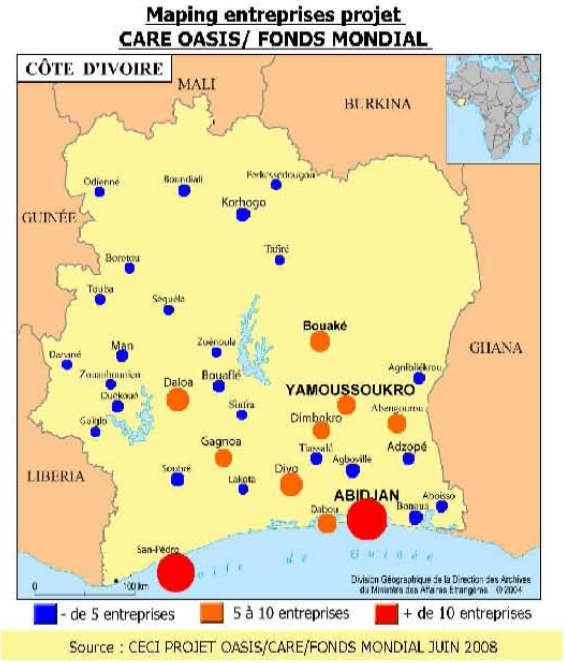
UNICEF plays a part in LLIMN distribution. In 2009 it will supply 250,000 LLIMNs for distribution free of charge to pregnant women and children under twelve months in 37 districts. This aid will only cover 30% of the target groups in of these districts. Round 8 will supplement this to raise the coverage to 100% in all 72 of the country's districts.

UNICEF is also playing a part in the supply of SP for IPT, providing 5,798,121 doses for distribution free of charge to pregnant women in all 72 of the country's districts in 2009.

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 8 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.)*



- de 5 entreprises	Under 5 firms
5 – 10 entreprises	5 – 10 firms
+ de 10 entreprises	Over 10 firms

The private enterprise sector consists of an organization covering 400 firms engaged in various lines of business. These firms are distributed over ten of the country's regions (Savanes, La Vallée Bandama, Haut Sassandra, Bas Sassandra, l'Agneby, Lagunes, Lacs, Marahoué, Sud Bandama, Montagnes, Sud Comoé, Moyen Comoé, Fromager and Bafing). Each firm has healthcare staff to monitor its employees, their families, and the neighboring population.

The population groups covered by these organizations are estimated to number some 1,500,000 people in total, or approximately 7.5% of the present project's target population. These enterprises' healthcare facilities, which already provide consultations for and treatment of malaria, will be used to extend the malaria prevention, consultation and biological diagnosis services to the population groups mentioned above.

Under the present proposal these organizations will be asked to distribute LLIMNs, dispense IPT using SP at prenatal consultations, and carry out the biological diagnosis of malaria cases, treatment of cases of uncomplicated malaria with ACT, IEC/BCC, data gathering and inspections. The healthcare providers within these organizations will have their capacity for these activities enhanced, and assistance will be provided to help them reach more of the targeted population groups. The intention is to make a Private Sector Coordinating Medical Officer available for this project, to co-ordinate all the M&E activities. 50% of this doctor's time will be paid for by the project.

(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)?*) ➔	**7.5% of the population covered: children under five, pregnant women and population at large**

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	**Contribution Description** (*in words*)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
General Business Confederation of Côte d'Ivoire (CGECI)	Costs connected with the dispensing of healthcare services (distribution of LLIMN, ACT, IPT, IEC/BCC, supervision, &c.)	307,337	307,337	307,337	307,337	307,337	1,536,686
	Costs connected with the use of medical facilities	249,712	249,712	249,712	249,712	249,712	1,248,558
Total		**795,784**	**557,049**	**557,049**	**557,049**	**557,049**	**557,049**

This estimate of the contribution from the private sector covers the following:

- services of healthcare workers (LLIMN, IPT, ACT treatment, IEC/BCC, Data gathering and inspections within their organization). These staff number 616, of whom 144 are doctors and 472 nurses.
- One Coordinating Medical Officer will be recruited specially for the project and 50% paid by the private sector. This doctor will work full-time on co-ordination and M&E of the project's activities in private firms.
- The running and maintenance costs of the health service premises.

The time allotted to the project per day per provider in these 400 health facilities is estimated at 1/8 of a working day. The project's use of healthcare premises is also estimated at 1/8 of the running and maintenance costs of those premises.

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved malaria 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, etc.).

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

Strengthening the government sector

1. Institutional capacity-building in the NMCP
The NMCP's institutional capacity will be strengthened, especially in human resources and logistics, so that it can provide optimally effective co-ordination of the activities at all levels of the healthcare pyramid. This capacity-building concerns: (1) improving the capabilities of the staff (technical skills, financial management, stock management), (2) improving capacities in terms of equipment and logistics.

2. Strengthening the organization responsible for epidemiological surveillance
The capacity of the parasitology laboratory of the Medical Science UFR (Training and Research Unit) of the University of Cocody will be enhanced in terms of technical (molecular biology) equipment for monitoring therapeutic effectiveness and resistance development.

3. Strengthening the organization responsible for quality control
The National Public Health Laboratory (LNSP) will be provided with more equipment and laboratory consumables for quality control of drugs and medical products.

4. Strengthening the organization responsible for M&E
Under the present proposal, the IT equipment of the DIPE (Information, Planning and Evaluation Directorate) will be upgraded.

Strengthening the non governmental sector

1. Strengthening the Sub-Recipient NGOs
All Sub-Recipients' capacity will be strengthened in terms of staff and of equipment/logistics. Each organization is to recruit a coordinator and an M&E Officer. Where necessary they may also have an Administration Officer, a Finance Officer or an Area Supervisor.

2. Capacity building at community level
The Round 8 proposal also plans to strengthen community groups, mainly by improving their management, planning and M&E capabilities as well as their technical capacity to combat malaria. Their equipment and financial capacities will also be enhanced.

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 Heavily-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Roll Back Malaria Strategic Plan 2006-2015' for malaria collaborative activities.

Côte d'Ivoire is one of the few West African countries which has not benefited from the Heavily Indebted Poor Countries (HIPC) debt reduction plan, even though more than a third of the population is living below the poverty threshold. This precarious financial background makes malaria and its economic repercussions part of the continuing vicious circle of poverty.

To combat this poverty, Côte d'Ivoire has prepared a Poverty Reduction Strategy Document (PRSD,

1998- 2005) based on the Millennium Development Goals. Côte d'Ivoire aims to reduce the proportion of the population living below the poverty threshold by 11%, bringing the Poverty Index down from 33.6% in 1998 to 30% in 2005. To help in these efforts, Round 8 has set the goal of halving malaria mortality by scaling up its malaria control activities.

In the health sector, the country has recently applied for and obtained GAVI funding to improve access to and the quality of vaccination services by strengthening the healthcare system. This capacity-building should help achieve the health policy objectives set out in the Healthcare Development Plan (2005 – 2010), which is currently being prepared. These are: (1) reduction in infant mortality; (2) the improvement of maternal health; and (3) the fight against HIV/AIDS, TB and malaria. The present proposal, prepared on the basis of the 2006-2010 Strategic Plan to Combat Malaria and the new RBM (SUFI) strategies for universal coverage, should contribute to the attainment of these objectives.

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 malaria outcomes and measuring impact.

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

Description of the existing M&E Plan

The Malaria control activities M&E Plan derives from the NMCP Strategic Plan. It was developed on the basis of the evaluation tool in the Global Fund M&E systems. The indicators chosen for this plan are supplied on the one hand from the MIS (Information and Management System) managed by the DIPE (Information, Planning and Evaluation Directorate) and on the other from specific surveys conducted under the malaria surveillance program. The MIS relies on a network of CSEs based in each Health District and Region. It gathers, processes and analyses the information from all the country's public healthcare establishments. On the basis of the information gathered, the MIS (which has been operating since January 1995) prepares M&E indicators for healthcare activities. Each month the healthcare establishments (Primary Healthcare Facilities and General Hospitals) prepare their reports on paper and then send a copy to the District. The reports are checked, input and processed by the Head of CSE (Epidemiological Surveillance Center) or a deputy based in the district. An electronic copy of the file is sent direct to the DIPE and sometimes also to the Regional Directorate. The DIPE combines the files received into the national MIS database, and produces the RASS (Annual Health Situation Report).
The indicators concerning activities among the population at large are supplied from the periodic surveys conducted as part of the MIS, DHS, KAP or coverage surveys in co-operation with other partners. Some of the data are collected by means of the form completed by Community Healthcare Workers (CHWs) as part of UNICEF's Accelerated Child Survival and Development (ACSD) program. There is a need to develop a tool for standardized data gathering at community level nationwide. CHWs send their reports to the health professionals at the healthcare unit to which they are attached, who compile all these reports from CHWs and attach them to their own report on activities; the data gathered at community level then follow the usual channels of the information and management system.
The drug monitoring system set up under Round 6 is based on gathering information with the use of a form developed and validated at national level. These drug monitoring forms are centralized at district level by the Malaria Unit, and then forwarded to the pharmacology laboratory of the Medical Science UFR (Training and Research Unit) of the University of Cocody. The laboratory processes and analyses the forms and then gives the results to the Districts which have reported reactions following medication; a copy of the report is sent to the DPM (Pharmacy and Medications Office).
Data from the private sector organizations in the various districts are gathered using the national tools by the organizations' data handlers and then forwarded to the district CSE (Epidemiological Surveillance Center). These data then follow the MIS channel (Information and Management System).

Strengths and weaknesses

The MIS (Information and Management System) produced satisfactory results from the monitoring of these indicators during the years 1995 – 1999. This meant that: (1) standardized national data gathering tools had been set up in all public healthcare facilities; (2) health data management software was present; (3) suitable data gathering channels had been defined within the healthcare pyramid, and (4) qualified staff were available at the CSE (Epidemiological Surveillance Center), trained in the operational handling

of such data. Moreover, the DIPE had been restructured so as to manage health data better at national level, and for better co-ordination of monitoring activities.

These achievements were compromised following the social and economic crisis which the country went through between 2002 and 2007. Various weaknesses are now to be noted as a result, and these hamper the proper working of the system that had been set up:

1. Poor availability of data management aids in the healthcare establishments and at community level;
2. Inadequate information-handling culture among health providers;
3. Inadequate data gathering at community level;
4. Failure to integrate data from the public and private sector health establishments within the MIS (Information and Management System);
5. A lack of CSE (Epidemiological Surveillance Center) staff trained in handling data, at the District level and even more so in the Regional Health Directorates (only 3 of the 19 regions have a CSE);
6. Delays in forwarding data to the next level up
7. Incomplete data
8. Inadequate supervision of gathering and handling of the data;
9. Insufficient analysis and application of the information at district and regional levels;
10. Insufficient operational and central feedback. In fact the latest RASS (Annual Health Situation Report) dates from 2000;
11. Inadequate data security. The data processing rooms are poorly equipped and unsuitable;
12. Lack of an IT equipment maintenance strategy.

Apart from the MIS (Information and Management System), the DHS which provide measurements of the social and demographic indicators are conducted irregularly. Since the 1998 DHS, there has been only one AIDS Indicator Survey (AIS) providing an update on certain social, demographic and health indicators, in 2005.

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)?

All the present proposal's M&E activities are included in the M&E system described above.

The community level data will be collected by the staff responsible for monitoring CBOs/CHWs, and will be included in the health services' reports. Those reports will bring together all the data related to the project's implementation and generated by the health facilities. These reports will subsequently be forwarded to the national level via the district CSEs.

The survey data planned under this project will not be duplicating other surveys that might be carried out in the country during the period of the project. For instance, the MIS 2011 survey to be carried out at the end of the [Round 6] project will at the same time document the indicators for the project being planned this year.

The Round 6 reporting system planned for the 19 districts will be used to document the data for Round 8 from those districts. The same goes for the UNICEF reporting system, which will be available for providing information on the indicators measured in the areas covered by UNICEF.

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 present proposal makes the following provision for strengthening the national M&E system:

1. financial support for carrying out the inspections planned at all levels,
2. the purchase of two vehicles to supplement each region's present fleet, and a further two vehicles for the NMCP's coordinating body,
3. the purchase of one vehicle for each of the five Area Sub-Recipients to facilitate supervision of community activists,
4. support for the establishment of a computerized database and a network for transmission of the information from regional to central level,
5. support for the establishment of a quality control system for the data up to central level.

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	**Programme National de Lutte contre le Paludisme (PNLP)** [**National Malaria Control Program - NMCP**]
Address	**PR V 4 Abidjan, Ivory Coast** Tel.: (+225) 20 371407/ 20 371737; Fax: 20 371737; e-mail: PNLP_rci@ yahoo.fr

The National Malaria Control Program is an organization set up within the Ministry of Health and Public Hygiene by Order No. 311 MSHP/CAB/ dated 4 October 2007.
Its mission is to contribute to the reduction of malaria-related morbidity and mortality through promotional, preventive, curative and research activities, and to co-ordinate the fight against malaria.

The NMCP is headed by a Coordinating Director and an Assistant Coordinating Director, who are supported in their work by six officers in charge of the following departments: (1) the Treatment Department, with the task of preparing and promulgating the Treatment Guidelines for malaria, and promoting its use. A plan for training those involved has been set up with the aid of the Scientific Support Group composed of academics; (2) the Prevention Department, whose job is to develop vector control and promote malaria prevention among the population at large; (3) the Communication and Partnership Department, whose tasks include coordinating a plan for communication about malaria and developing partnerships; (4) the Research Department, which co-ordinates and promotes research into malaria; (5) the Department of Administrative and Financial Affairs, which co-ordinates and manages the budget and financial support made available to the NMCP; and (6) the Epidemiology, Monitoring and Evaluation Department tasked with coordinating M&E for all activities.

The NMCP prepares and implements an annual action plan on the basis of a five-year strategic plan.

As concerns monitoring:

The Epidemiology, Monitoring and Evaluation Department establishes an M&E Plan for all actions under the plan. Half-yearly NMCP inspections of the districts are scheduled in co-operation with the other departments and the central Directorates concerned (DIPE - Information, Planning and Evaluation Directorate), PSP (Public Health Pharmacy), &c.) A report on activities is prepared quarterly and sent to the General Health Directorate (DGS) via the Community Health Directorate (DSC).

Regional meetings attended by the CSEs, the District Directors (DD) and the Regional Directors (RD) are provided for under Round 6, to review and validate the data sent by the districts.

As concerns financial management

The NMCP is responsible for managing the operating budget made available by the Economy and Finance Ministry. The budget is managed under normal State procedures. The NMCP is also responsible

for managing other funds provided by partners such as UNICEF, which are made available in a special account on the basis of an annual action plan. Under Round 6 the NMCP is responsible for managing the funds dedicated to the public sector's activities. During fiscal 2008 the NMCP had to manage a total portfolio of US$2,072,193.48.

PR 2 **CARE International en Côte d'Ivoire (CARE CI)**

Address **05 BP 3141 Abidjan 05**

CARE International set up in Côte d'Ivoire in July 2000 to work against HIV/AIDS. When the military, social and political conflict began in 2002, CARE CI decided to concentrate its activities in the areas where government services were lacking, and undertook projects on urban public health, community rehabilitation and HIV/AIDS prevention and treatment.

Since 2006 CARE CI has been deploying a major program to combat malaria, with support from the Global Fund and the European Union, combining prevention and treatment of groups at community level. So far CARE CI has contributed to actions for the rehabilitation of health facilities, the training of healthcare providers, the international procurement of stocks of mosquito nets and drugs, and the establishment of M&E and stock management plans for all the projects it manages for the Global Fund.

CARE has acquired considerable experience as Principal Recipient of many Global Fund projects in Côte d'Ivoire. The Global Fund has already signed four funding agreements with CARE CI as Principal Recipient (PR): (1) in January 2004, for a 18-month HIV/AIDS emergency program in the areas under Forces Nouvelles control, (Round 3), (2) in May 2006, for a fuller supplementary HIV/AIDS program in the same areas, (Round 5), (3) in July 2007, for Phase II of the Stronger National Response to HIV/AIDS program, (Round 2) and (4) in November 2007, for the national program to combat malaria. (Round 6).

The four assessments made by the Global Fund's LFA in Côte d'Ivoire (PWC) have shown that CARE CI has the minimum systems required and the management and implementation capacities needed to take responsibility for the Round 8 proposal. PWC's assessments concerned (1) the systems for financial management, (2) institutional and planning systems, (3) procurement and stock management systems and (4) M&E systems. These assessments are official, and mean that the activities of the Global Fund National Program to Combat HIV/AIDS and Malaria could start immediately.

The successful outcome of these programs, achieved under dangerous and difficult conditions, have won CARE CI the confidence and support of its funding providers, and enabled it to finance many new projects set up in the course of 2007. CARE CI's portfolio for 2008 amounts to US $38 million.

CARE has considerable program-management capacity, but in this project will be requesting support for the development of national tools for M&E of community-based campaigns. Many tools exist at present and need harmonizing if the information on community-based campaigns is to be gathered effectively. These tools will be developed in close co-operation with the ROLPCI (Côte d'Ivoire Network of Malaria Control Organizations), the community implementation organizations and the NMCP, so as to ensure that all are agreed on these tools at the end of the process.

PR 3 [Name]

Address [street address]

[Description]

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

4.9.2 Sub-Recipients

(a) Will sub-recipients be involved in program implementation? ☒ Yes ☐ No

(b) **If no**, why not?

(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
  [Insert Annex Number for list]
- ☐ 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.

Seven (07) Sub-Recipients will be engaged in implementing the actions, six of which (06) have already been identified. These are:

(1) **Public Health Pharmacy (PSP)**: Responsible for the management, procurement and distribution to districts of the products and drugs to be bought for the project (ACT, SP, Quinine, Artemether and materials/equipment for the treatment of severe malaria, RDT and laboratory inputs).

(2) **PSI: (Population Services International)** has been identified as a Sub-Recipient on two accounts. It will be responsible for the purchase, distribution to districts and nationwide promotion of impregnated mosquito nets. It has also been chosen as the one of the five (05) Area Sub-Recipients, and will accordingly conduct and co-ordinate implementation activities at community level within its area (Lacs, Marahoué and Haut Sassandra Regions). PSI will work with a set of contracted NGOs and CBOs. It will also be responsible for their capacity-building, and for the M&E of their activities. PSI was chosen following its submission of a mini project.

(3) **APROSAM:** APROSAM will be responsible for the co-ordination and implementation of activities commissioned from it in its area (Bas Sassandra, Haut Sassandra and Fromager Regions). It will work with a set of contracted NGOs and CBOs, and will also be responsible for their capacity-building, and for the M&E of their activities. This NGO was chosen following its submission of a mini project.

(4) **The Private Enterprise Sector** will involve 400 firms (members of the Côte d'Ivoire Business Coalition to Fight AIDS, TB and Malaria) in the implementation of this project as Sub-Recipient to extend service delivery. The intention is to use these private firms' health services to increase the various actions' coverage of the population. This organization was chosen following its submission of a mini project. The players will be responsible for the delivery of ACTs in consultations, of LLIMNs for children under five in consultations, and of LLIMNs for pregnant women in PNC. In centers providing prenatal consultation services, SP will be dispensed for IPT.

(5) **The National Malaria Control Program (NMCP**) has been identified as an Area Sub-Recipient, to conduct and co-ordinate implementation activities at community level in its area (Sud Comoé, Moyen Comoé, Nzi Comoé and Zanzan Regions). The NMCP will work with a set of contracted NGOs and

CBOs. It will also be responsible for their capacity-building, and for the M&E of their activities. The NMCP was chosen following its submission of a mini project.

(6) **CARE International in Côte d'Ivoire (CARE CI)** will continue its actions in Zone A, and will conduct and co-ordinate implementation activities at community level in its area (Worodougou, Montagnes, Bafing-Denguélé, Savanes and Vallée du Bandama Regions). CARE International will work with a set of contracted NGOs and CBOs. It will also be responsible for their capacity-building, and for the M&E of their activities.

CARE CI was chosen following its submission of a mini project.

The Sub-Recipients not yet identified will be chosen by competitive tender for those areas not yet covered by Area Sub-Recipients.

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 PSP (Public Health Pharmacy)

The PSP (Public Health Pharmacy), an EPIC (public industrial/commercial establishment) is the central procurement agency of the MSHP (Ministry of Health and Public Hygiene), and has strong expertise in the distribution of medical products nationwide.
Its areas of capability are the centralization, scheduling and supplying of medical products needed for the functioning of the public and quasi-public health facilities throughout the country.

It has great experience in joint management of projects, including those financed by partners such as the GF (Round 2 HIV and Round 6 Malaria), PEPFAR, and the European Union.
To improve its distribution service, the PSP plans shortly to open a regional office in the country's capital (Yamoussoukro).

Total purchases in 2007 amounted to €27,557,904, and planned purchases for 2008 are €19,499,754.

The PSP is committed to ISO 9001 certification and ready to provide high-quality services once its drugs storage and conservation system has been improved.

NMCP (National Malaria Control Program)

The NMCP co-ordinates all malaria control activities in Côte d'Ivoire. It manages a UNICEF project to co-ordinate and monitor the distribution of LLIMN and SP to children under five and pregnant women in the CNW zone. Under Round 6, the NMCP is the Sub-Recipient responsible for implementing activities in the public sector.

Under Round 6, the NMCP's staff was strengthened in the areas of M&E and financial management so as to improve its performance as Sub-Recipient in charge of activities connected with the public sector. For this an agreement has been signed with the MSHP (Ministry of Health and Public Hygiene), authorizing the NMCP to set up a mechanism of a kind similar to the private sector, providing among other things for the opening of an bank account for the Round 6 project, the conducting of an annual financial audit and a period of mentorship by the PR in the course of the initial phase.

Scaling up under Round 8 requires good co-ordination of all activities, and the NMCP proposes to commission a trust agency for its financial management in the present project. The NMCP itself will sign off all expenditures.

Moreover, capacity needs to be strengthened in the area of procurement and stock management so as to cope with the requirements under the present proposal as well as other initiatives: funding for this has been requested directly from the program.

The NMCP's communication department covers all the NGOs in ROLPCI (Côte d'Ivoire Network of Malaria Control Organizations). This service works closely with other organizations such as the Red Cross, the ICRC and UNICEF on organization and capacity-building for CHWs.

CARE

CARE International set up in Côte d'Ivoire in July 2000, where since 2002 CARE Côte d'Ivoire has been working in troubled political and social circumstances. Internal migrations continue following the social and political difficulties, problems of food and drinking water supplies in some regions, and major public health problems in the North and West, where government facilities have worsened. CARE CI concentrates its activities in the areas where government services are lacking, and undertakes projects on urban public health, community rehabilitation and HIV/AIDS prevention and treatment, funded by the European Union, the United States government and the Global Fund.

With finance from the Global Fund, CARE CI has developed a major program to combat malaria, combining prevention and treatment of the most vulnerable population groups, including pregnant women and children under five.

The successful outcome of these programs, achieved under dangerous and difficult conditions, have won CARE CI the confidence and support of its funding providers, and enabled it to finance many new projects set up in the course of 2007. CARE CI's projected portfolio for 2008 is US $ 18 million.

PSI

PSI (Population Services International) is a leading international "social market" NGO, with a presence in 62 countries. In 2007, PSI conducted purchases totaling €40,800,000, including more than 17 million LLIMN for its programs funded by a number of development partners (including the GF) either as PR or as Sub-Recipient.

Using GF Round 6 funds, PSI has already set up a distribution and communication system for the distribution of LLIMNs.

Technical support is available for malaria work (distribution and procurement), based in Washington and Nairobi.

APROSAM

APROSAM is an EU-based nonprofit health and development NGO.

It was set up on 9 March 1999 with a social mission to promote community health (IEC/BCC, community mobilization, information, education, training, local awareness-raising and care).Its HQ is in San Pedro.

APROSAM (Association for the Promotion of Mother, Child and Family Health) has been working in the field since 2000 with a strategy involving fixed and mobile services. It is an essential player in the areas of reproductive health, malaria and the fight against HIV/AIDS, and the organization plays an important role in the management of community-based campaigns under the GF's Round 2 HIV project.

APROSAM covers the Bas Sassandra, Haut Sassandra, Fromager and Moyen Cavalry Regions.

CGECI (General Business Confederation of Côte d'Ivoire)

With financial support from the Global Fund/UNDP, CGECI has set up 162 AIDS Committees in private sector firms as part of the execution of Phase 1 of the Global Fund's Round 2, distributed 72,000 male condoms to their workers and organized an advocacy ceremony for 500 Company bosses.

With finance from the FDFP (Occupational Training Development Fund), it trained 49 AIDS activists in 52 private sector firms in 2007.

The experience acquired in the fight against HIV/AIDS will enable this organization to develop and implement actions to combat malaria.

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.

Two Sub-Recipients had not yet been chosen when the proposal was being prepared: one Area Sub-Recipient, and a Sub-Recipient for Communication/IEC/CC (the intention is to set up and implement a communication plan covering all the activities promoting malaria strategies).

The three organizations which presented mini projects to the CCM have been judged capable of implementing malaria control activities in their area.

Sub-Recipients not yet identified will be chosen by competitive tender coordinated by the Principal Recipients, who will set up a selection committee during the first three months of the project. The same procedure has already been used under Global Fund Round 6 for the selection of Sub-Recipients.

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)*.

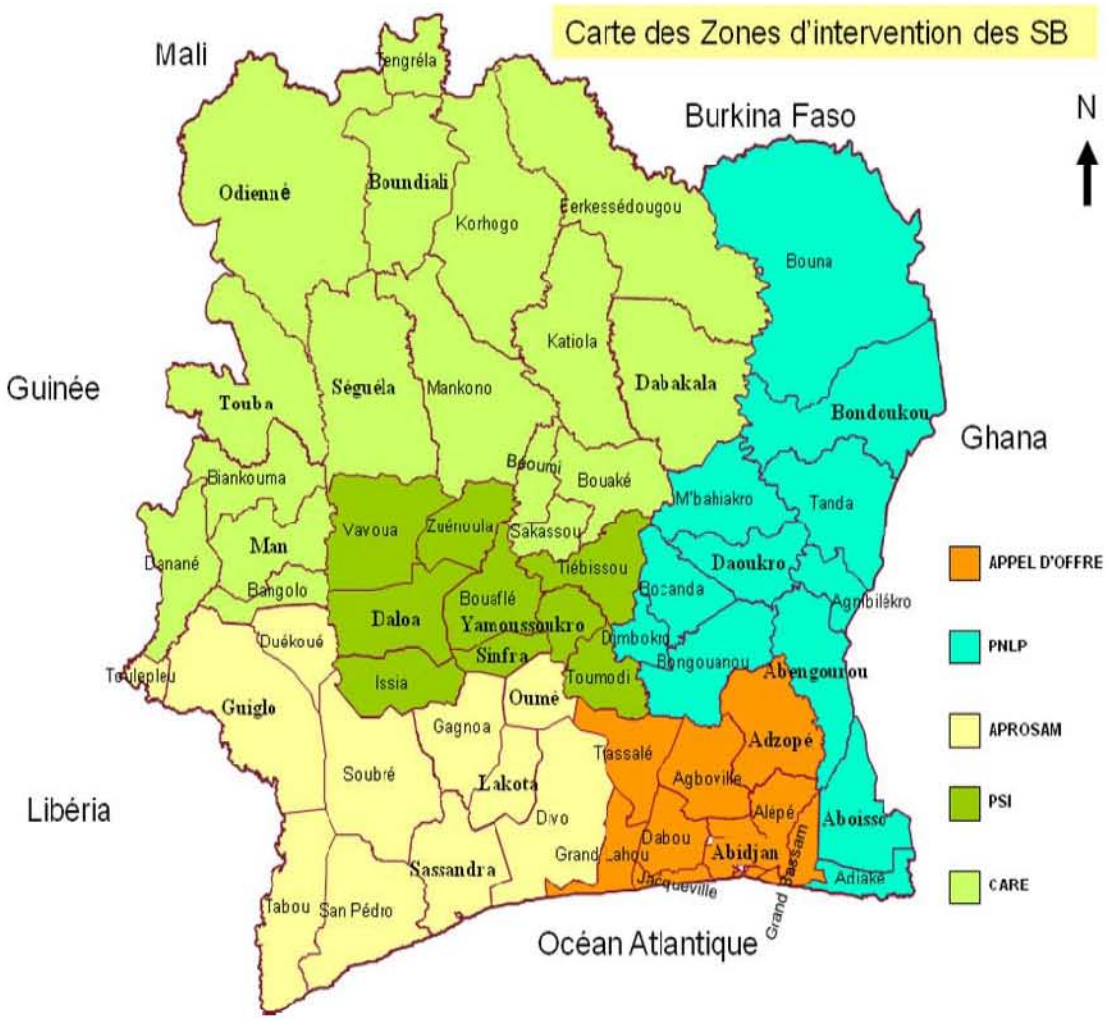
CARE will be responsible for the administrative and financial activities of the NGO Sub-Recipients, and those of the governmental Sub-Recipients will come under the NMCP.

The technical co-ordination of the activities' implementation will be the task of the NMCP, which will also be responsible for M&E.

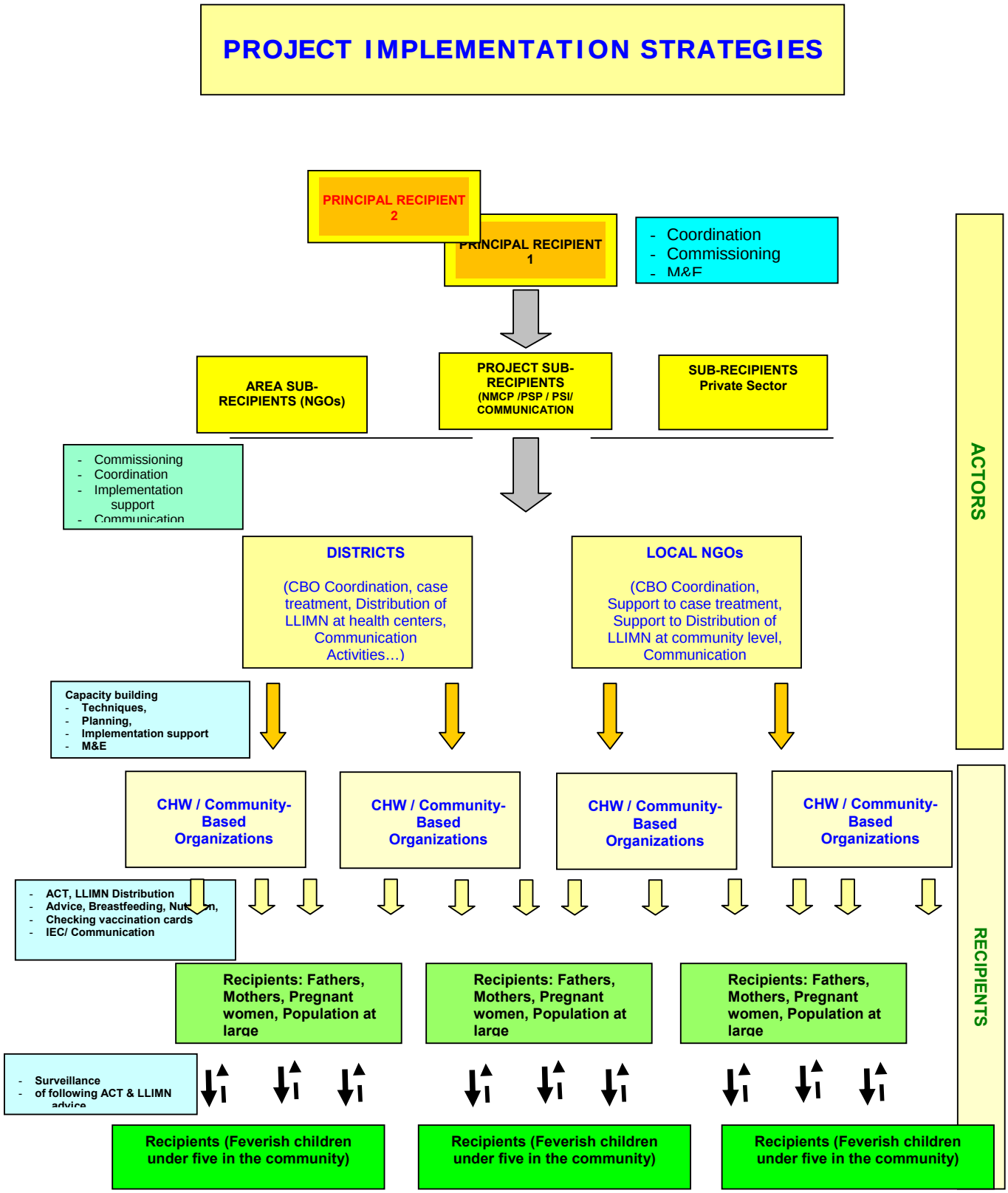
At national level, the Principal Recipients and Sub-Recipients will meet monthly to plan the project and monitor and assess its implementation. These technical meetings should also provide a setting in which the various actors can exchange best practice.

In the Areas, the coordinating committee composed of Regional Directors, District Directors and the Area Sub-Recipients will organize quarterly meetings for planning and monitoring their activities.

At district level, the usual monthly meeting of the District Management Team (DMT) and its partners, chaired by the DD, will be enlarged to include the local NGOs which look after the CBOs. These meetings will allow district monitoring and small-scale planning.



Carte des Zones d'intervention des SR	Map of SR Areas
Apple doffer	To be selected by tender
Guinea	Guinea
Ocean At antique	Atlantic Ocean


PROJECT IMPLEMENTATION STRATEGIES
PRINCIPAL RECIPIENT 2
PRINCIPAL RECIPIENT 1
- Coordination
- Commissioning
- M&E
AREA SUB-RECIPIENTS (NGOs)
PROJECT SUB-RECIPIENTS (NMCP /PSP / PSI/ COMMUNICATION
SUB-RECIPIENTS Private Sector
- Commissioning
- Coordination
- Implementation support
- Communication
DISTRICTS
(CBO Coordination, case treatment, Distribution of LLIMN at health centers, Communication Activities…)
LOCAL NGOs
(CBO Coordination, Support to case treatment, Support to Distribution of LLIMN at community level, Communication
ACTORS
Capacity building
- Techniques,
- Planning,
- Implementation support
- M&E
CHW / Community-Based Organizations
CHW / Community-Based Organizations
CHW / Community-Based Organizations
CHW / Community-Based Organizations
- ACT, LLIMN Distribution
- Advice, Breastfeeding, Nutrition,
- Checking vaccination cards
- IEC/ Communication
Recipients: Fathers, Mothers, Pregnant women, Population at large
Recipients: Fathers, Mothers, Pregnant women, Population at large
Recipients: Fathers, Mothers, Pregnant women, Population at large
- Surveillance
- of following ACT & LLIMN advice
Recipients (Feverish children under five in the community)
Recipients (Feverish children under five in the community)
Recipients (Feverish children under five in the community)
RECIPIENTS

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 fulfill 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.)*

As Principal Recipient for the public sector, the NMCP needs ongoing technical support in project management. Support will in fact be given each quarter by an international implementation consultant.

To achieve the program's goals, it is intended that full time staff (one Project Leader and one M&E Officer) will be recruited for the project by each Area Sub-Recipient.

So far as the NMCP is concerned, there will be a Project Leader, a PSM Officer, an IT technician to run the data transmission network, and an administrative assistant.

A project coordinator will be recruited for the private sector, 50% paid by the project.

All these technical assistants will be selected from applications in response to invitations to apply, coordinated by the Principal Recipients, who will set up a selection committee for each type of activity in accordance with the action plan.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 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.***

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
Procurement policies & systems	CARE, PSP (Public Health Pharmacy), PSI, NMCP	PR, SR with procurement and stock management duties	☒ Yes ☐ No
Intellectual property rights	DPM (Pharmacy and Medications Office)	SR Inspector	☐ Yes ☒ No
Quality assurance and quality control	LNSP (National Public Health Laboratory), INHP (National Institute of Public Hygiene), IPR (Pierre Richet Institute)	SR staff inspectors	☒ Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	CARE, PSP (Public Health Pharmacy), PSI, NMCP	PR, SR	☒ Yes ☐ No
Product selection	National Therapy Committee	Regulator	☒ Yes ☐ No
Management Information Systems (MIS)	DIPE (Information, Planning and Evaluation Department), NMCP, PSP (Public Health Pharmacy)	SR	☒ Yes ☐ No
Forecasting	CARE, PSP (Public Health Pharmacy), PSI	PR, SR	☐ Yes

			☐ No
Procurement and planning	CARE, PSP (Public Health Pharmacy), PSI	PR, SR	☒ Yes ☐ No
Storage and inventory management *More details required in s.4.10.4*	PSP (Public Health Pharmacy), PSI, Districts	SR, SSR	☒ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	PSP (Public Health Pharmacy), PSI, Districts, NGO, CBO	SR, SSR	☒ Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance)	NMCP, Regional Directorates, Districts	SR, SSR	☒ 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)*
PSP COTE D'IVOIRE (Public Health Pharmacy)	Sub-Recipient	27 557 904
PSI INTERNATIONAL	Sub-Recipient	40 572 000

[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.

In the first place the proposal will rely on the NMCP, as the organization which co-ordinates malaria control in Côte d'Ivoire. NB: this central organization results from Côte d'Ivoire's chosen health policy, and in this instance its primary healthcare policy.

Next, this program relies greatly on the higher healthcare echelons from the civil service; to scale up the fight against malaria, the program will need to recruit other civil service officers.

Moreover, the inputs will be distributed by the Public Health Pharmacy (PSP), which is the national public institution whose sole task is the supply of essential drugs, vaccines and consumables, and their stock management and distribution to all healthcare facilities at all levels of the healthcare pyramid.

Lastly, for implementing most of its activities (Care, prevention, drug monitoring) the proposal will rely on official healthcare staff at all levels, and on Community Healthcare Workers for some activities.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

- X National medical stores or equivalent
- ☐ Sub-contracted national organization(s) *(specify)*
- X 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.

The PSP (Public Health Pharmacy) has a storage capacity of 26,000 m^3 for medical products other than LLIMNs. This is sufficient for storing the pharmaceutical and medical products to be procured under Round 8.

PSI will use its two central stores in Abidjan with an overall capacity of 1,200 m^3 for the periodic re-supplying of health districts under routine distribution (health services and community section).

In view of the large quantity of LLIMN planned for the campaign, the intention is to transport these direct to the districts from the port (in containers).

(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.

The PSP (Public Health Pharmacy) is a wholesale distributor of medical products and will supply the districts and reference hospitals (public and quasi-public) according to a well established delivery timetable using its fleet of 23 vehicles (11 ten-tonne, 7 five-tonne and five 2.8 tonne trucks).

For routine distribution, PSI intends as in Round 6 to select a carrier to transport LLIMNs to the Districts by competitive tender;

In the initial campaign the LLIMN supplier will be required to hand over the containers of LLIMNs directly at district level

Clarified table 4.10.6.

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-Malaria' 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-Malaria' 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.

Within the 8th Round of the Malaria section and taking into account WHO recommendations and the national policy on the fight against malaria, the following medical products have been selected. They are described in the table below :

MEDICAL PRODUCTS		INDICATIONS
PHARMACEUTICAL PRODUCTS (MEDICINES)	Artemisinine - based therapeutic combination (**ACT**) i.e. the association of **Artesunate and Amodiaquine (50 + 153 mg)**	First response treatment for of uncomplicated malaria
	Artemisinine - based therapeutic combination (**ACT**) i.e. the association of **Artemether + Lumefantrine (20/120 mg)**	Second response treatment for of uncomplicated malaria
	Quinine Sulfate 300mg *oral*	- Treatment of malaria in pregnant women - Relay treatment of severe malaria by injectable Quinine
	Quinine Hydrochloride (250 mg and 300 mg) *injectable + accessories for parenteral route* *	Treatment of severe malaria
	Artemether 40mg injectable + accessories pour parenteral route*	Treatment of severe malaria anaemia
	Sulfadoxine Pyrimethamine association **(500/25 mg)**	Malaria prevention in pregnant women
MEDICAL PRODUCTS AND EQUIPMENTS	**L**ong-**L**asting **I**nsecticide-treated **M**osquito **N**et (**LLIMN**)	Prevention of malaria transmission
	Rapid **D**iagnosis **T**est (RDT)	Indirect detection of Plasmodium antibodies
	Microscope	Direct laboratory diagnosis of malaria
	Material and laboratory reagents for microscopy*	

* Refer to Annex 4 for composition of emergency kit and laboratory kit

	Product category	Year 1 (EURO)	Year 2 (EURO)	Total 2 years (EURO)	
1	Pharmaceutical products	**8,417,325.97**	**4,897,688**	**13,315,013.97**	
2	Medical products and commodities (excluding pharmaceutical products)	**52,317,672.28**	**2,709,711.16**	**55,027,383.44**	
3	Medical equipment (X-rays, laboratory material, etc.)	**1,027,535.34**	**1,218,082.76**	**2,245,618.1**	
4	Services (related to PSM, for ex., AQ, SGI, URM, etc.)	**30,000**	**10,000**	**40,000**	
5	Non - medical products and services (for ex., vehicles, computers, constructions, financial advice, etc.)				
Total					
Total amount of the grant (EURO)					
Procurement total in % of the grant					

5. FUNDING REQUEST

5.1. Financial gap analysis - Malaria

➔ *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 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Malaria program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**€29,474,500**	**€30,358,720**	**€56,057,093**	**€55,092,646**	**€87,993,996**	**€44,264,95**	**€48,764,715**	**€47,256,049**
Line A.1 ➔ Total need over length of Round 8 Funding Request *(combined total need over Round 8 proposal term)*								
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*) **Non Eligible**								
Domestic source **B2** National funding resources	**€1,725,945**	**€4,076,737**	**€5,299,758**	**€6,889,686**	**€8,956,591**	**€11,643,569**	**€15,136,639**	**€19,677,631**
Domestic source **B3** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	**€1,725,945**	**€4,076,737**	**€5,299,758**	**€6,889,686**	**€8,956,591**	**€11,643,569**	**€15,136,639**	**€19,677,631**
External source **C 1** OMS	**€247,530**	**€247,530**	**€247,531**	**€247,532**	**€247,533**	**€247,534**	**€247,535**	**€247,536**
External source **C2** UNICEF	**€2,048,053**	**€2,048,053**	**€2,048,053**	**€2,048,053**	**€2,048,053**	**€2,048,053**	**€2,048,053**	**€2,048,053**

ROUND 8 – Malaria

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 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
External source **C3** Private Sector contributions METHODIST CHURCH	- €	- €	€6,000,000	- €	- €	- €	- €	- €
External source **C4** Private Sector contributions (international)	[redacted]			- €	- €	- €	- €	- €
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	€2,295,583	€2,295,583	€8,295,584	€2,295,585	€2,295,586	€2,295,587	€2,295,588	€2,295,589
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	- €	- €	5 239 495	1 929 806	5 013 433	1 726 930	- €	- €
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	4,021,528	6,372,320	18,834,837	11,115,076	16,265,610	15,666,086	17,432,227	21,973,220
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	€25,452,972	€23,986,400	€37,222,256	€43,977,569	€71,728,386	€28,598,869	€31,332,488	€25,282,829
Line G = Round 8 malaria funding request *(same amount as requested in table 5.3 for this disease)*				€118,050,103	€21,315,766	€12,644,024	€15,450,794	€12,837,629

ROUND 8 – Malaria

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

In Round 8, the total maximum funding request for malaria 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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2009-2013 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

%

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 ensues that government, non-government and community needs were included to ensure fully implementation of country's malaria program strategies.

The program's overall requirements have been estimated financially on the basis of the "Needs Assessment" (Appendix N° 7), which sets the following coverage targets:

- 100% for the long-lasting insecticide-treated mosquito nets (approximately 03 LLIMN per household of 5.4 individuals)
- 100% IPT coverage of pregnant women countrywide
- 80% for ACT treatment in health facilities (with 48% clinic attendance)
- 80% for ACT treatment of children under five in the community (47% of requirements)
- 80% for ACT treatment in the private sector (5% of the country's requirements)
- 92% of RDT and microscope examination requirements by 2013 for the individuals aged over five years; 32% of microscope examination requirements
- 30% of diagnosis by microscope examination among children under five

So far as cross-cutting actions are concerned (timetable management, procurement, the handling of emergencies, advocacy/BCC/Communication, healthcare system capacity-building, and M&E), needs have been assessed on the basis of the Strategic Plan estimates, revised to take account of the new universal coverage targets in the "Needs Assessment".

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 Malaria Control 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.

Domestic funding has been estimated without taking account of HIPC funds, for which Côte d'Ivoire is not eligible. As to Line B, the State contribution in the form of the NMCP budget and the co-payment by the population groups concerned have been taken into account. Co-payments for drugs supplied by the PSP (Public Health Pharmacy) to the health services have been regarded as the population groups' contribution to the fight against malaria, and taken into account accordingly as part of the domestic contribution.

The State budget for the fight against malaria has been drawn up following budget negotiations, and is published. Implementation of this budget is the task of the Program Director. All the Director's expenditure requests must be validated by the Ministry's Administration and Finance Director, which ensures that the funds are properly used and accounted for.

The contribution of the population groups concerned to the healthcare effort consists for the most part of the co-payments recovered by the PSP (Public Health Pharmacy), which used to pay the proceeds into the general Public Treasury. This procedure prevented the total reuse of these funds for healthcare alone. Since 2008 the PSP (Public Health Pharmacy) has set up an independent account for the Global Fund Round 6 project, so that these people's contributions can now be reinvested in

full.

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)).

Alongside the State, three (03) major partners provide malaria funding; their contributions have been taken into account under Line C. They are:

- the WHO, whose contribution to the fight against malaria in the country diminishes year by year. This contribution has not yet been scheduled for the years 2011, 2012 and 2013
- UNICEF: the same goes for UNICEF, whose contributions are not yet established beyond 2010
- the Methodist Church, with a one-off contribution planned in 2008 could become an ongoing partner in the fight against malaria in Côte d'Ivoire. No agreement for such a partnership has yet been signed, nor its duration specified.

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/apply/call8/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.)

6. Do not include any CCM or Sub-CCM operating costs in Round 8. 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/apply/mechanisms/guidelines/

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Long-lasting insecticide treated mosquito nets	92,670,565	2,255,000	469,370	549,142	574,792	96,518,869
2	Malaria prevention by using drugs during pregnancy	2,275,329	348,818	445,785	391,136	494,386	3,955,454
3	Diagnosis	1,483,847	2,751,816	2,658,162	2,780,708	73,091	9,747,624
3	Swift and proper care of cases of uncomplicated malaria	8,168,364	4,210,669	3,155,339	4,532,682	4,144,471	24,211,525
3	Swift and proper care of cases of uncomplicated malaria in pregnant women	13,679	7,428	5,645	5,683	6,018	38,453
3	Proper treatment of cases of severe malaria	260,511	141,447	107,508	108,242	114,613	732,321
4	Institutional and organizational capacity building for CBOs	750,000	21,600	21,600	21,600	21,600	836,400
4	HR capacity building at community level	2,249,430	6,657,888	1,050,625	1,076,891	1,103,813	12,138,647
5	Institutional and organizational capacity building	597,989	101,578	0	0	0	699,567
5	Monitoring and Evaluation of project activities	7,166,917	2,261,151	2,107,659	3,296,822	3,549,759	18,382,308
5	Strengthening co-ordination of activities	2,413,472	2,558,371	2,622,331	2,687,888	2,755,086	13,037,148
Round 8 malaria funding request:		**118,050,103**	**21,315,766**	**12,644,024**	**15,450,794**	**12,837,629**	**180,298,316**

ROUND 8 – Malaria

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 8 Guidelines .	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	629,060	878,794	881,853	1,604,401	1,619,298	**5,613,406**
Technical and Management Assistance	2,060,000	2,111,500	2,164,288	2,218,394	2,273,855	**10,828,037**
Training	4,932,811	1,645,587	318,607	73	0	**6,897,078**
Health products and health equipment	89,077,897	2,838,162	3,018,004	2,846,786	427,346	**98,208,195**
Pharmaceutical products (medicines)	6,337,594	3,406,695	3,074,395	4,199,912	4,430,002	**21,448,598**
Procurement and supply management costs	6,440	2,255,000	469,370	549,142	574,792	**3,854,744**
Infrastructure and other equipment	1,178,254	110,700	113,468	116,304	149,365	**1,668,091**
Communication Materials	4,449,648	24,600	25,215	114,368	26,492	**4,640,323**
Monitoring & Evaluation	288,894	365,591	296,208	307,952	360,224	**1,618,869**
Living Support to Clients/Target Populations	0	0	0	0	0	**0**
Planning and administration	1,688,777	280,015	281,996	792,505	286,106	**3,329,399**
Overheads	5,647,964	1,064,622	684,434	1,430,226	1,307,332	**10,134,578**
Other: Strengthen Community-based organizations	1,752,764	6,334,500	1,316,186	1,270,731	1,382,817	**12,056,998**
Round 8 malaria funding request (*Should be the same annual totals as table 5.2*)	**118,050,103**	**21,315,766**	**12,644,024**	**15,450,794**	**12,837,629**	**180,298,316**

5.4.1. Overall budget context

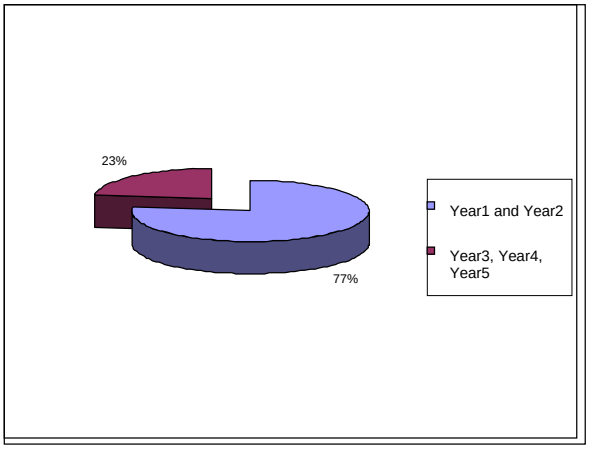
Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

HALF PAGE MAXIMUM

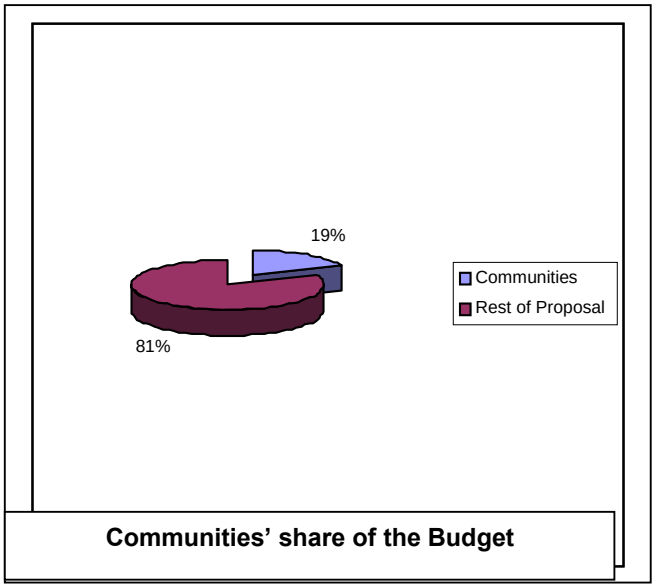
77% of the budget is planned for the two first years with a view to the bulk of the purchases, including the mosquito nets and ACTs. It is also during this first phase that the contracts with the Area SRs come into effect.

Years 3, 4 and 5 of the project will mainly involve the operating budget for implementing and monitoring the project.

The communities' involvement in the fight against malaria amounts to 19% of the total budget.



Budget breakdown by year



Communities' share of the Budget

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*

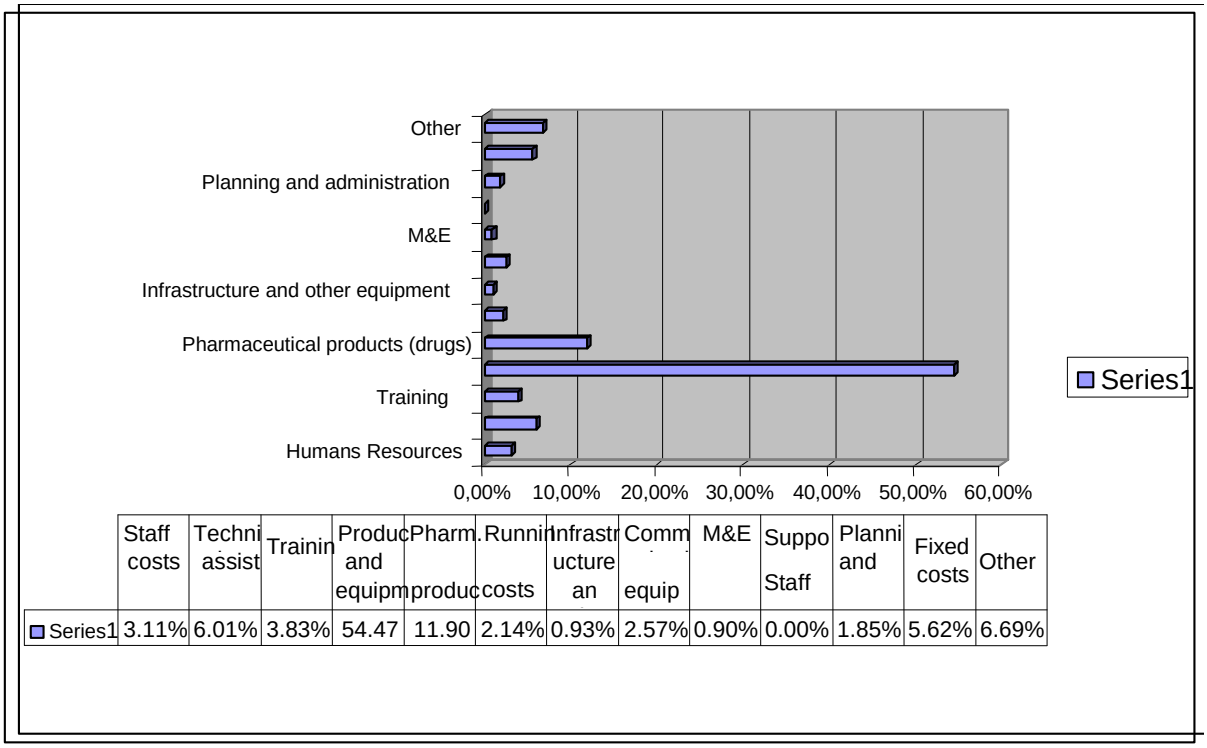
Staff costs do not form a large part of the Budget. They come to 3% of the total budget

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 Malaria Control Program.

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

54% of the budget consists of the purchase of articles and drugs



	Staff costs	Techni assist	Trainin	Produc and equipm	Pharm. produc	Runnin costs	Infrastr ucture an	Comm equip	M&E	Suppo Staff	Planni and	Fixed costs	Other
Series1	3.11%	6.01%	3.83%	54.47	11.90	2.14%	0.93%	2.57%	0.90%	0.00%	1.85%	5.62%	6.69%

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.*
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.
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 malaria program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on malaria outcomes during the proposal term.*

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 8

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 8 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions

Down load 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 8 and has completed section 4B and included that section in the Malaria proposal sections.***

Malaria Proposal checklist

Appendices **Malaria Project**

Section	Document description	Annex Number
Appendix A	Attachment A: Project performance measurement framework	1
Appendix B	Attachment B: Management and Procurement Plan	2
Appendix C	Detailed budget and detailed action plan	3
Appendix D	Detailed description of activities	4
Appendix E	Strategic and Financial Gap Analysis	5
Appendix F	Needs Assessment Calculation Tools	6
Appendix G	PNDS (National Health Development Plan) 2008 - 2012	7
Appendix H	Strategic Plan, Roll Back Malaria in Côte d'Ivoire 2006 – 2010	8
Appendix I	M&E Plan for the 2006 -2010 Strategic Plan of the National Malaria Control Program in Côte d'Ivoire	9
Appendix J	M&E tools (information and management system: primary care establishment monthly report; information and management system: General Hospital monthly report; information and management system: Regional Hospital Center monthly report; community level management aids; drug monitoring, side effects notification form; monitoring the management of inputs to combined preventive activities	10
Appendix K	NMCP Integrated Communication Plan	11
Appendix L	Treatment Guidelines for Cases of Malaria	12
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Appendix O	Survey of Knowledge, Attitudes and Practices on malaria in 19 Health Districts in Côte d'Ivoire	15
Appendix P	Report of the Situational Analysis of the 19 target districts of the project for intensifying the fight against malaria in the post-crisis situation among pregnant women and children under five in 19 target districts of Côte d'Ivoire"	16
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Malaria Proposal checklist

Appendix T	Strengthening the Healthcare System of Côte d'Ivoire (Funding application to the Global Alliance for Vaccines and Immunization - GAVI)	20

Attachment A - Malaria Performance Framework

Program Details

Country:	Côte d'Ivoire
Disease:	Malaria
Proposal ID:	

Program Goal, impact and outcome indicators

	Goals
1	Reduce malaria-related morbidity and mortality in Côte d'Ivoire by 50% compared with the 2000 level between now and 2013
2	
3	
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	Infant mortality rate (children under five), all causes	12,5	2000	DHS/DHS+ (Demographic and Health Survey)					6,25	According to the AIS 2005 data, the mortality rate is 12.5 per 1000. We estimate that this rate has not altered between 2000 and 2005, because of the inadequate implementation of activities during this period. The rate basic for 2000 may therefore be estimated as having been 12.5 per 1000. We intend to measure these indicators in the course of an MIS survey at the end of the project.
impact	Infant mortality rate (children under five), all causes	NA		Health Facility Survey	100%	80%	70%	60%	50%	The basic rate of analysis will be taken as 100% of cases. It is expected that this will fall to 50% by Year 5
please select…	Please Select…			please select…						
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please select…	Please Select…			please select…						

* 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	Arrange for at least 80% of the population to sleep under long-lasting insecticide-treated mosquito nets (LLIMN) between now and 2013	
2	Arrange for at least 80% of pregnant women to take two doses of SP in Intermittent Preventive Treatment (IPT) between now and 2013	
3	Provide treatment according to the national protocol for at least 80% of malaria cases between now and 2013	
4	Arrange for at least 80% of the CBOs to fight malaria at the community level in accordance with their service agreement	
5	Build capacity for co-ordination and M&E among the project's Principal Recipients and Sub-Recipients between now and 2013.	
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

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	Insecticide-treated nets (ITNs)	Percentage of households with at least three LLIMN	NA	2008	Households survey			90%		90%	90%	90%	Y	N	Y - over program term	PR	A household survey will measure the level of the indicator each year; the first assessment will be after 18 months
1.2	Insecticide-treated nets (ITNs)	Percentage of pregnant women who slept under LLIMN last night	4.80%	2008	Households survey			60%		80%	80%	80%	Y	Y	Y - over program term	PR	A KAP Survey was conducted in 2008 under GF Round 6. A household survey will measure the level of the indicator each year; the first assessment will be after 18 months
1.3	Insecticide-treated nets (ITNs)	Percentage of children under five who slept under LLIMN last night	4.70%	2008	Households survey			60%		80%	80%	80%	Y	Y	Y - over program term	PR	A KAP Survey was conducted in 2008 under GF Round 6. A household survey will measure the level of the indicator each year; the first assessment will be after 18 months
1.4	Insecticide-treated nets (ITNs)	Percentage of the population at large who slept under LLIMN last night	NA		please select…			60%		80%	80%	80%	Y	N	Y - over program term	PR	A household survey will measure the level of the indicator each year; the first assessment will be after 18 months

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					
2.1	Malaria prevention during pregnancy	Percentage of pregnant women who have received two doses of SP under DOT during PNC	27%	2008	Households survey			60%		80%	80%	80%	Y	N	Y - over program term	PR	A KAP Survey was conducted in 2008 under GF Round 6. A household survey will measure the level of the indicator each year; the first assessment will be after 18 months
3.1	Prompt, effective anti-malarial treatment	Percentage of cases of uncomplicated malaria among children under five correctly treated in health facilities according to the national protocol	21%	2008	Health Facility survey			60%		80%	80%	80%	Y	N	Y - over program term	PR	A survey will be conducted at health facilities after 18 months and annually thereafter until the end of the project
3.2	Prompt, effective anti-malarial treatment	Percentage of fever cases correctly treated within 24 hours at community level	NA		please select…			20%		50%	70%	80%	Y	N	Y - over program term	PR	A KAP Survey was conducted in 2008 under GF Round 6. A household survey will measure the level of the indicator each year; the first assessment will be after 18 months
3.3	Prompt, effective anti-malarial treatment	Percentage of cases of severe malaria correctly treated according to the national protocol in referral units	NA		please select…			60%		80%	90%	100%	Y	N	Y - over program term	PR	A survey will be conducted at health facilities after 18 months and annually thereafter until the end of the project
3.4	Prompt, effective anti-malarial treatment	Percentage of the reference hospitals (UHC, RHC, GH) equipped for the laboratory diagnosis of malaria	NA		please select…		50%	75%	100%	100%	100%	100%	Y	N	Y - over program term	PR	A survey will be conducted at health facilities after 18 months and annually thereafter until the end of the project
3.5	Prompt, effective anti-malarial treatment	Percentage of healthcare facilities which have not run out of malaria drugs for more than a week in the course of the last three months	NA		please select…		80%	90%	90%	90%	90%	90%	Y	N	Y - over program term	PR	A survey will be conducted at health facilities after 18 months and annually thereafter until the end of the project
4.2	BCC - community outreach	Percentage of CBOs carrying out activities in accordance with their service agreement	NA		please select…		100%	100%	100%	100%	100%	100%	Y	N	Y - over program term	PR	This indicator will be measured after 18 months and annually thereafter until the end of the project after the Reports on Activities from Area Sub-Recipients have been analyzed
5.1	Coordination and partnership development (national, community, public-private)	Percentage of Task Force co-ordination meetings held	NA		please select…	50%	100%	50%	100%	100%	100%	100%	Y	N	N - not cumulative	PR	This indicator will be measured annually on the basis of the Minutes of the various co-ordination committees
	Coordination and partnership development (national, community, public-private)	Percentage of co-ordination meetings held at Regional level	NA		please select…	50%	100%	50%	100%	100%	100%	100%	Y	N	N - not cumulative	PR	This indicator will be measured annually on the basis of the Minutes of the various co-ordination committees
	Coordination and partnership development (national, community, public-private)	Percentage of co-ordination meetings held at District level	NA		please select…	50%	100%	50%	100%	100%	100%	100%	Y	N	N - not cumulative	PR	This indicator will be measured annually on the basis of the Minutes of the various co-ordination committees