# PROPOSAL FORM – ROUND 7

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Round 7 Call for Proposals for grant funding. This Proposal Form should be used by eligible applicants ('Applicants') to submit proposals to the Global Fund. **Please read the accompanying Round 7 Guidelines for Proposals carefully before completing the Proposal Form**.

| **Applicant Name** | Country Coordinating Mechanism |
|---|---|
| **Country/countries** | Ethiopia |
| **Components included in this Proposal Form** *(Check each applicable box below)* | |
| ☒ HIV/AIDS[1] | |
| ☐ Tuberculosis[1] | |
| ☒ Malaria | |

**Timetable: Round 7**

**Deadline for submission of proposals**: **4 July 2007**

Board consideration of recommended proposals: 14 - 16 November 2007

1 In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; 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/.

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## REQUIRED ATTACHMENTS


**A.** **Targets and Indicators Table** *(Complete a separate table for each component)*

**B.** **Preliminary List of Pharmaceutical and other Health Products** *(Complete a separate table for each component)*

**C.** **Membership details of CCM, Sub-CCM or RCM** *(Complete once only)*

**+** **Detailed Budget** *(Complete a separate detailed budget for each component)*

**+** **Detailed Work plan** *(Complete a separate detailed workplan for each component)*


A checklist of all annexes to be attached to the Proposal Form by an Applicant can be found at the end of sections 3 **and** 5 (per disease component) of the Proposal Form.

## REFERENCE DOCUMENTS FOR APPLICANTS

*(These and other documents are available at http://www.theglobalfund.org/en/apply/call7/documents/)*

| | |
|---|---|
| Country Coordinating Mechanisms: | The Global Fund's 'Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility' (**CCM Guidelines**)<br><br>'Clarifications on CCM Minimum Requirements – Round 7' |
| Monitoring and Evaluation: | Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**)<br><br>'M&E Systems Strengthening Tool', June 2006 |
| Procurement and Supply Management: | The Global Fund's 'Guide to Writing a Procurement and Supply Management Plan', January 2006 |

# How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Round 7 Guidelines for Proposals
   - A complete copy of this Proposal Form
   - A complete copy of Attachments A, B and C to this Proposal Form

2. **Read the accompanying** Round 7 **Guidelines for Proposals** before completing this Proposal Form.

3. Further guidance for completing specific sections is also included in the Proposal Form itself, printed in *blue italics*. Where appropriate, indications are given as to the recommended maximum length of the answer.

4. To **avoid duplication of effort**, we recommend that you make maximum use of existing information (e.g., national health sector development plans, national monitoring and evaluation frameworks, situation analyses of strengths and weaknesses of the existing responses to the disease(s), and documents written to report to the Global Fund on existing grants and/or work supported by other donors/funding agencies).

5. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are submitting a fully complete application.

6. **Attach all documents** requested throughout the Proposal Form **including** a budget, work plan, and all documents you are requested to annex to the proposal.

7. Consult our "Frequently Asked Questions" link:
   *http://www.theglobalfund.org/en/apply/call7/documents*

**Important notes:**

**1. Some or all of the information submitted to the Global Fund by Applicants will be made publicly available on the Global Fund website after the Board funding decision for Round 7.**

**2. The Global Fund Board is currently considering whether to post the evaluation forms prepared by the Technical Review Panel during the proposal review process** ('TRP' Review Forms') **on the Global Fund website.** If this decision is taken, the TRP Review Forms for all Round 7 proposals (both approved **and unapproved**) will be published on the Global Fund website after the Board funding decision for Round 7.

# How to use this form

## WHAT IS DIFFERENT COMPARED TO ROUND 6?

Amendments aimed at improving the ease of completing the Proposal Form include:

1. all **CCM, Sub-CCM and RCM information needs** (including the **eligibility requirements**) **are now** with other 'Applicant Type' information **in section 3A**;

2. **Section 4** has been **re-ordered** to better enable Applicants to describe the overall strategy/country context, how the funding request harmonizes with other in-country actions, and then what will be achieved under this proposal;

3. **Section 4** also requests detailed information **on three key lessons learned arising from the Technical Review Panel's review of Round 6 proposals**. These are:

(a) addressing the **comments of the TRP** from proposals not approved in prior Rounds (section 4.6.1) and **attaching the relevant TRP review form**(s);

(b) explaining a Round 7 request for additional funding for the same key services covered by earlier Global Fund grants, where there are **large undisbursed amounts of money** under those earlier grants, including unsigned Round 6 grants (section 4.6.4(a)); and

(c) describing how bottlenecks in performance experienced by Principal Recipients ('PR') who are again nominated as PR for Round 7 have been addressed in the proposal;

4. **Section 5 requests less complex budget details**, responding to the comments of Applicants and the Technical Review Panel in Round 6;

5. **Attachment A (Targets and Indicators Table)** has been prepared by disease. Applicants may use the pre-filled list of potential indicators where relevant to their proposal, or overwrite the table;

6. **Attachment B (Preliminary List of Pharmaceutical and other Health Products) has been prepared in Microsoft Excel** to assist Applicants to identify key information about products, their pricing and intended suppliers. Again, it has been prepared by disease; and

7. **Contact details and proposal endorsement signatures for CCM, Sub-CCM and RCM Applicants are now located in a new Attachment C**. This is to facilitate an automatic upload of this material into our data base to ensure that we have current contact details accurately displayed on the Global Fund website.

## Health Systems Strengthening – Round 7

As in Round 6, there is no separate health system strengthening (HSS) component in Round 7.

**Applicants should request funding support for HSS on a per disease component basis within the disease specific sections of this proposal** (section 4 and 5). **Applicants are very strongly encouraged to review the Round 7 Guidelines for Proposal** (sections 4.4 and 4.5) **and this Proposal Form** (introduction in section 4.4) **before they complete these sections**.

# 1 Proposal Overview

## 1.1 General information on proposal

| Applicant Type |
|---|

*Please check one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.*

☒ National Country Coordinating Mechanism

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

| Proposal component(s) and title(s) |
|---|

*Please check the appropriate box or boxes below, to indicate component(s) included within your proposal. Also specify the title for each proposal component. For more information, please refer to the Guidelines for Proposals, section 1.1.*

| | Component | Title |
|---|---|---|
| ☒ | HIV/AIDS[2] | Ensuring Quality HIV/AIDS Services by Consolidating and Strengthening Existing HIV/AIDS Prevention, Treatment, Care and Support Programs, |
| ☐ | Tuberculosis[2] | |
| ☒ | Malaria | Concerted Action Against Malaria in Ethiopia to Achieve and Maintain High Impact |

| Currency in which the Proposal is submitted |
|---|

*Please check only **one** box below. **Please note that you must use this same currency throughout the whole Proposal Form** (that is, for all components for which funding is sought). It will be assumed that all financial amounts indicated in your whole proposal are in this **one** currency.*

☒ US$

☐ Euro

2 In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; 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/.

# 1 Proposal Overview

| Summary of Technical Assistance Provided During Proposal Preparation | | |
|---|---|---|
| *Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation* ***of this proposal*** *for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.* | | |
| **Section/Component** | **Name of organization or organizations providing assistance and type of assistance provided** | **Duration of technical assistance** |
| ☐ Sections 1 to 3B | | |
| ☒ HIV/AIDS component, and/or budget | PEPFAR, UNAIDS/AMREF, UNFPA and Action Aid Ethiopia provided financial support for the recruitment of two International Consultants and two local consultants who provided full time technical support in the proposal preparation | 25 April – 4 July 2007 |
| ☐ Tuberculosis component, and/or budget | | |
| ☒ Malaria component, and/or budget | RBM Partnership Secretariat, Geneva, by providing funding for proposal development and by assigning an external consultant and a local consultant | 9 May–4 July 2007 |

## 1.2 Proposal funding summary per component

*Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding budget summary by cost category in table 5.3 for each disease component. The currency in the table below must be the same currency as indicated in section 1.1 above.*

*Table 1.2 – Total funding summary*

| Component | Total funds requested over proposal term | | | | | |
|---|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
| **HIV/AIDS** | 38,887,227 | 26,072,470 | 20,210,181 | 11,322,416 | 9,769,289 | 106261583 |
| **Tuberculosis** | | | | | | |
| **Malaria** | 8,541,159 | 8,430,303 | 21,305,892 | 28,730,278 | 32,565,217 | 99,572,849 |
| **Total all components** | 47,428,386 | 34,502,773 | 41,516,073 | 40,052,694 | 42,334,506 | 205,834,432 |

# 1 Proposal Overview

## 1.3 Contact details for enquiries by the Global Fund

*Please provide full contact details for two persons **who will be available and duly authorized to provide the Global Fund with responses to any questions about the whole Proposal Form after 4 July 2007** (that is, **all of the components** which are applied for and **not** on a disease by disease basis). This is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately **three months** after the submission of the proposal.*

*Table 1.3 – Contact details for enquiries by the Global Fund*

| Contact Details for Enquiries on the Applicant's Proposal after Submission | | |
|---|---|---|
| | **Primary contact** | **Secondary contact** |
| **Name** | Dr Tedros Adhanom Ghebreyesus | Dr. Nejmudin Kedir |
| **Title** | Minister of Health | Department Head, Planning and Programming, |
| **Organization** | Federal Ministry of Health | Federal Ministry of Health |
| **Mailing address** | Ministry of Health, P.O.Box 1234, Addis Ababa, Ethiopia | P. O. Box 1234<br>Addis Ababa<br>Ethiopia |
| **Telephone** | +251 11 551 6378 | + 251 11 553 5938 |
| **Fax** | +251 11 551 9366 | + 251 11 551 2691 |
| **E-mail address** | moh.vmo@ethionet.et | moh@ethionet.et |
| **Alternate e-mail address** | tedrosag@hotmail.com | nejmudink@yahoo.com |

# 1 Proposal Overview

## 1.4 Overview Summary of the Applicant's Proposal

Provide a brief overview of the components included in this proposal and the main focus of the work to be undertaken. Applicants applying for more than one disease component should **briefly** refer to **each component here**, but provide a disease specific 'Executive Summary' in section 4.2 for each component.
*(Maximum length of this section is **one page in total**)*

### HIV/AIDS

There are three requests for funding under Round 7 for HIV/AIDS with three Principal Recipients: HAPCO, the Association of Ethiopians Living with HIV/AIDS [AELWHA] and the Ethiopian Inter-Faith Forum for Development, Dialogue and Action [EIFDDA]. The HAPCO request for funding is for 3 years only and is intended to solely consolidate and strengthen implementation of its Round 4 Phase 2 grant by focusing on filling strategic gaps that include programmatic, systems and staffing. These are critical to the effective implementation of the Round 4 grant. The AELWHA and EIFDDA requests for funding under Round 7 are the first time that civil society in Ethiopia has requested funding from the Global Fund and both are for five years each, and designed to strengthen and expand the scale-up of care and support services.

**The HAPCO 3-year request for additional funding has two main objectives:**

1. To reduce by 50% the number of infants born to HIV-infected mothers who are HIV-infected by 2010. With modest additional support to strengthen the PMTCT program, 80% (72,169) of HIV-positive pregnant women will receive combination ARV prophylaxis for PMTCT by 2010.
2. To improve performance of current Global Fund grants through strengthening human resources and filling gaps in the health system.

Strategies designed to address health system gaps include:1)building storage and distribution capacity of New Pharmid, the new structure that will assume overall responsibility for the procurement of ARVs and HIV test kits from UNICEF starting in 2008, 2)recruiting and training nearly 400 data clerks to strengthen M&E, 3) supporting the establishment of a new, state-of-the-art HIV laboratory equipment maintenance facility at the Ethiopian Health and Nutrition Research Institute (EHNRI), and training 120 biomedical engineers, and 4) conducting a small-scale 2-year pilot study to test a financial incentive program to encourage private for-profit hospitals and clinics in Addis Ababa to care for a larger number of HIV/AIDS patients.

Strategies to address human resource gaps include: 1) expanding “task shifting,” 2) introducing novel retention mechanisms to address staff attrition at ART and PMTCT sites, 3) introducing clinical mentoring and supportive supervision services in hospitals and health centers, 4) introducing telemedicine services to a select number of ART and PMTCT sites, 5) providing sleeping quarters for key staff at ART and PMTCT sites in 10% (50) remote rural health centers, and 6) recruiting and training 1,400 care aides to fill critical staffing gaps at ART and PMTCT sites and improve the quality of HIV/AIDS care.

**The PLWHA/FBO 5-year request for additional funding has five main objectives which include:**

1. To increase coverage and adherence to ART in 40 districts of four major regional states by 2012.
2. To enhance community ownership and response to HIV/AIDS through reaching about 20 million people by 2012 with community conversation and other means, and mobilizing local communities to support over 200,000 OVCs
3. To mitigate the social and economic impact of HIV/AIDS on PLWHAs, and their families through creating job opportunities through IGA for 12,000 PLWHAs and their families by 2012, provision of Food and Nutritional support for 23,000 PLWHA and their families by 2012, and provision of community and home based care services to 61,000 PLWHA by 2012.
4. To increase holistic support for OVCs through providing spiritual and psychological counseling to 354,000 OVCs, providing educational materials twice in a year for to 31,000 OVCs, providing financial supports for food, clothing, health, and other materials to 13,000 OVCs, and training and providing start-up capital to initiate

IGA for 13,000 households caring for OVCs.

5. To strengthen the capacity of AELWHA, EIFDDA, and their members.

PR 1: HAPCO 3-year request for funding is US$49.5 million; PR 2: AELWHA 5-year request for funding is US$24.8 million and PR 3: FBOs (EIFDDA) 5-year request is US$32.0 million. The total country request for the HIV/AIDS component is US$106.3 million, split 53% for civil society (PLWHA and FBOs) and 47% for the public sector (HAPCO).

## Malaria

This proposal will address key malaria prevention and control needs by building upon positive achievements and scaling up activities that have not yet been sufficiently supported. The goal of the proposal is to reduce both malaria morbidity and malaria-related mortality by 65% by the year 2012 as compared to the annual averages of the period 2001-2005 (to be estimated from Health Management Information System [HMIS] data as part of the Malaria Indicator Survey and health facility review to be conducted in 2007). The projected reduction in malaria burden is expected to follow the large-scale anti-malarial interventions that began in 2004.

The major areas of focus will be: procurement and distribution of LLINs; procurement of insecticides and spraying equipment and improving availability of operational funds to scale up indoor residual spraying (IRS) in epidemic-prone areas; intensifying IEC activities through inter-personal channels; improving availability of diagnostic tools; in-service training of district-level malaria focal persons and HEWs; and improving the program monitoring and evaluation activities. There will be four key service delivery areas (SDAs) and two health systems strengthening actions with the following specific objectives.

**SDA 1**. Prevention: Insecticide-treated nets (ITNs), to maintain 100% coverage of LLINs (average of 2 nets per household) in all malarious areas through replacement of worn out nets; **SDA 2**. Prevention: Vector control other than ITNs (IRS), to increase IRS coverage in epidemic-prone areas to 60% from 2010 onwards; **SDA 3**. Prevention: BCC community outreach, to raise awareness of populations in malarious areas and bring about behavioural changes through community outreach IEC/BCC inter-personal channels; **SDA 4**. Treatment: Diagnosis, to ensure universal access to diagnostic services using RDTs at peripheral health facilities lacking microscopy facilities; **SDA 5.** Health systems strengthening **(**HSS): Human resources, to train 2 health workers from each of the 450 malarious districts on basic malariology and 20,000 HEWs in endemic districts on diagnosis and case management, vector control, and BCC/IEC inter-personal channels; and **SDA 6**. HSS: Monitoring and evaluation, to effectively monitor implementation of the proposed activities and evaluate the impact and outcomes of the all SDAs. As sufficient funding has already been secured for the next few years for antimalarial drug requirements, this component will not be addressed in the current proposal.

A total of USD99,572,849 is requested over 5 years, including USD89,630,049 for the key SDAs and USD9,942,800 for the HSS components.

# 1 Proposal Overview

## 1.5 Overview of rationale for multi-country proposal approach

***Only complete this section if your proposal targets more than one country.***

***Importantly, the difference between a 'Regional Coordinating Mechanism'*** *and* ***'Regional Organization' Applicant is explained in the Round 7 Guidelines for Proposals****. Please refer to that material before completing this Proposal Form including, in particular, section 3A.4 (RCM), or 3A.5 (Regional Organization).*

*The Global Fund is very supportive of proposals which respond to cross-border or multi-country issues which are most effectively addressed through a regional/multi-country proposal that has been developed in close consultation with in-country stakeholders from* ***each of the countries included in the proposal****. Preferably, the CCM of each country will have been involved in identification of relevant issues and the development of the multi-country response from an early time so that the CCMs and RCM or RO Applicants can agree which aspects are appropriate for a multi-country approach.*

*In this section, please describe:*

*(a) the common issue for these countries which presents a strong argument for a regional or cross-border approach;*

*(b) why a multi-country proposal will be more effective in responding to the issues presented than if each CCM presented the same activities on a country by country basis; and*

*(c) how the applicant (RCM or RO) worked with the CCM** of each country during the proposal development process to ensure that the funding requested in this proposal does not merely replace existing financing, but contributes additional financing to increase the regions capacity to respond to the disease(s).*

*(**Where there is no CCM for a specific country included in the multi-country proposal because the country is a small island developing state, the applicant should describe how a broad cross-section of stakeholders were transparently and effectively consulted to ensure that there is broad in-country support and understanding of the multi-country approach in such countries).*

| **Overview of rationale for multi-country approach**<br>*(maximum one page)* |
|---|
| |

# 1 Proposal Overview

## 1.6 Previous Global Fund grants/proposals recommended for funding

*For each component applied for in Round 7, please provide **specific details of the amounts disbursed by the Global Fund and also expended under existing Global Fund grants** (by Round) as **at 31 March 2007**. For more detailed information, see the Guidelines for Proposals, section 1.6.*

*Combined HIV/TB grants from Rounds 1, 2 and/or 3, should be included in only the HIV/AIDS table below, or the TB table below.*

*Table 1.6.1 – Previous Global Fund HIV/AIDS financial support*

| HIV/AIDS | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Round 2 | 90,924,911 | 90,772,106 | |
| Round 3 | | | |
| Round 4 | 40,031,469 | 37,545,834 | |
| Round 5 | | | |
| Round 6 | | | |
| Total | 130,956,380 | 128,317,940 | |

*Table 1.6.2 – Previous Global Fund tuberculosis financial support*

| Tuberculosis | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Round 2 | | | |
| Round 3 | | | |
| Round 4 | | | |
| Round 5 | | | |
| Round 6 | | | |
| Total | | | |

# 1 Proposal Overview

*Table 1.6.3 – Previous Global Fund malaria financial support*

| Malaria | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Round 2 | 70,599,857 | 70,599,857 | |
| Round 3 | | | |
| Round 4 | | | |
| Round 5 | 37,389,954 | 33,034,842 | |
| Round 6 | | | |
| Total | 107,989,811 | 103,634,699 | |

*Table 1.6.4 – Previous Global Fund HSS and other financial support*

| HSS or Integrated | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Main disease targeted | | | |
| Round 2 | | | |
| Main disease targeted | | | |
| Round 5 | | | |
| Main disease targeted | | | |
| Total | | | |

# 2 Country Eligibility

**Only those applications that meet all applicable eligibility criteria will be reviewed by the Technical Review Panel.**

**These eligibility criteria are:**

- ➔ **Section 2 – *Country eligibility***
- ➔ ***Section 3A – Applicant Type eligibility***
- ➔ ***Section 3B – Proposal signature and endorsement***

***Country eligibility*** *is a multi-step process that depends on World Bank's classification of the income level of the country (or countries) targeted in the proposal* ***at the time of the call for proposals*** *(not the closing date).*

*Please read through this section carefully and consult the Guidelines for Proposals, section 2, for further guidance on the steps to be followed by each Applicant.*

## 2.1 Income Level

*Please check the appropriate box(es) in the table below for the relevant country (or countries for multi-country proposals only), and include the country name in the relevant box(es).* ***Multi-country applicants*** *(i.e., RCM or Regional Organization Applicants) ➔ see the Guidelines for Proposals, section 2.1 regarding eligibility of your proposal, and complete all relevant sections depending on the income levels for the respective countries.*

| World Bank classification of Income level of countries/ economies included in proposal | **Country/economy name(s)**<br>*(include the name of each country/economy* ***and*** *its relevant income level for multi-country proposals)* | |
|---|---|---|
| ☒ Low-income | Ethiopia | ➔ *Go straight to* ***section 3A****, Applicant Type* |
| ☐ Lower-middle income | | ➔ *Complete* ***both*** *sections 2.2 and 2.3, and then go to section 3A* |
| ☐ Upper-middle income | | ➔ *Complete* ***each of*** *sections 2.2 and 2.3* ***and*** *2.4, and then go to section 3A* |

# 2 Country Eligibility

## 2.2 Counterpart financing and greater reliance on domestic resources

**Complete if <u>any</u> country/economy targeted in this proposal is classified as Lower-middle <u>or</u> Upper-middle income under the World Bank's classification of income level.**

### 2.2.1 CCM and Sub-CCM Applicants

*The table should be completed for <u>each component</u> included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.2.1.*
***Amounts included in line A and line B in the tables below should be in figures not percentages.***

***<u>Important notes</u>:***

1. *The field "Total requested from the Global Fund" in tables 2.2.1(a) to (c) below <u>must equal</u> the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3 for each corresponding component.*

2. *Non-CCM Applicants do not have to fulfill any counterpart financing requirement.*

*Table 2.2.1(a) – Counterpart financing HIV/AIDS*

| Financing sources | HIV/AIDS *(same currency as selected in section 1.1)* | | | | |
|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 estimate | Year 4 estimate | Year 5 estimate |
| Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]** | | | | | |
| Counterpart financing (B) **[linked to the disease control program]** | | | | | |
| **Counterpart financing as a percentage of total financing:** [B/(A+B)] x 100 = % | % | % | % | % | % |

# 2 Country Eligibility

*Table 2.2.1(b) – Counterpart financing tuberculosis*

| Financing sources | Tuberculosis *(same currency as selected in section 1.1)* | | | | |
|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 estimate | Year 4 estimate | Year 5 estimate |
| Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]** | | | | | |
| Counterpart financing (B) **[linked to the disease control program]** | | | | | |
| **Counterpart financing as a percentage of total financing:** [B/(A+B)] x 100 = % | % | % | % | % | % |

*Table 2.2.1(c) – Counterpart financing malaria*

| Financing sources | Malaria *(same currency as selected in section 1.1)* | | | | |
|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 estimate | Year 4 estimate | Year 5 estimate |
| Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]** | | | | | |
| Counterpart financing (B) **[linked to the disease control program]** | | | | | |
| **Counterpart financing as a percentage of total financing:** [B/(A+B)] x 100 = % | % | % | % | % | % |

# 2 Country Eligibility

### 2.2.2 Regional Coordinating Mechanism (RCM) and Regional Organization (RO) Applicants only

RCM and RO Applicants are required to demonstrate compliance with the Global Fund's minimum **counterpart financing** requirements for each Lower-middle income or Upper-middle income country/economy included in the RCM or RO application which is also eligible to apply in Round 7 in its own right. Eligible countries/economies are listed in Attachment 1 to the **Guidelines for Proposals**.

**RCM and RO Applicants may either**:

(a) **Complete table 2.2.2 below** and **ensure that the CCM endorsements *(required under section 3B.1.3 for RCMs, and 3B.2.1 for ROs)*** for **each** country/economy eligible in Round 7 **include information by that country/economy on its counterpart financing levels**;

**If table 2.2.2 is completed, RCM and RO Applicants are reminded that the CCM endorsement letter required under either section 3B.1.3 or 3B.2.1 must also include information validating that country/economy's counterpart financing level for the relevant disease**.

**OR**

(b) **Fully complete the applicable table(s) in section 2.2.1 above** for **each** country/economy listed as eligible in Round 7.

*Table 2.2.2 – RCM or Regional Organization summary of Country/Economy Counterpart financing level*

| Country/Economy | CCM Confirmed Counterpart Financing – first year of proposal term ** | CCM Confirmed Counterpart Financing – last year of proposal term ** |
|---|---|---|
| | % | % |
| | % | % |
| | % | % |
| | % | % |
| | % | % |

**** Note ➔ RCM and Regional Organization** Applicants must show that each of the countries targeted in this proposal are **moving from**:

(a) 10% **to** 20% counterpart financing over the proposal term if a Lower-middle income country; or

(b) 20% **to** 40% counterpart financing over the proposal term if an Upper-middle income country.

# 2 Country Eligibility

## 2.3 Focus on poor or vulnerable populations

**All proposals which target Lower-middle income and/or Upper-middle income countries/economies** (including multi-country proposals which include countries/economies other than Low-income countries/economies) **must demonstrate a focus on poor** or **vulnerable population groups**. *Proposals may focus on both population groups but **must** predominantely focus on at least one of the two groups. Complete this section in respect of each disease component.*

| | |
|---|---|
| 2.3 | Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal. *(Maximum half a page per component)*. |
| | |

## 2.4 Upper-middle income high disease burden minimum thresholds

Proposals from Upper-middle income countries/economies must also demonstrate that they currently face a high national disease burden. Please complete the section(s) below relevant to each disease component included in your proposal. Please note that if the Applicant falls under the 'small island economy' lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Annex 1 to the Guidelines for Proposals).

| | |
|---|---|
| (a) | **HIV/AIDS Current High National Disease Burden**<br>For Round 7, the Global Fund has determined that the only Upper-middle income countries which may apply for funding for HIV/AIDS *(whether a single country proposal, or as part of a multi-country proposal)* are Botswana, Equatorial Guinea and South Africa. *(See the Guidelines for Proposals, section 2.4 for more information.)* |

| | |
|---|---|
| (b) | **Tuberculosis Current High National Disease Burden**<br>Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)* |
| | |

| | |
|---|---|
| (c) | **Malaria Current High National Disease Burden**<br>Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)* |
| | |

# 3A Applicant Type and Eligibility for Funding

*This section requires **all Applicants** to:*

*(a) Describe what type of applicant they are; and*

*(b) Describe how they meet the minimum requirements **to be eligible to submit a proposal**.*

*Throughout this section, Applicants are requested to attach documents to support the information summarized below.*
***At the end of section 3B all Applicants must complete a 'checklist' to ensure that they attach all documents**.*

***All Coordinating Mechanism Applicants** (whether CCM, Sub-CCM or RCM) **and Regional Organizations must also** complete section 3B of this Proposal Form and provide the documented evidence requested.*

***Non-CCM Applicants** do not complete section 3B. These Applicants must complete section 3A.6 of this Proposal Form and attach documentation supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism (whether CCM, Sub-CCM or RCM) structure.*

## Confirmation of Applicant Type

*Table 3A – Applicant Type*

*Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form as indicated on the right hand side of the table as this sets out the road map to fully complete section 3A and 3B.*

| | | |
|---|---|---|
| ☒ | National Country Coordinating Mechanism | ➔ *Complete sections 3A.1 and 3A.4 and 3B.1* |
| ☐ | Sub-national Country Coordinating Mechanism | ➔ *Complete sections 3A.2 and 3A.4 and 3B.1* |
| ☐ | Regional Coordinating Mechanism for multi-country proposals (including small island developing states) | ➔ *Complete sections 3A.3 and 3A.4 and 3B.1* |
| ☐ | Regional Organization for multi-country proposals | ➔ *Complete section 3A.5 and 3B.2* |
| ☐ | Non-CCM Applicants for single country proposals only | ➔ ***Only** complete section 3A.6* |

***Importantly*** ➔

***Each Applicant should only complete one version of the relevant sections set out above** and not a new version for each disease component.*

*Applicants should also **only** complete those sections set out in table 3A above that are indicated as relevant to their application to ensure that they do not expend unnecessary resources on completing sections that do not apply to them.*

# 3A Applicant Type and Eligibility for Funding

## 3A.1 National Country Coordinating Mechanism (CCM) Applicants

*For more information, please refer to the Guidelines for Proposals, section 3A.1, and the CCM Guidelines.*

*Table 3A.1 – National CCM: overview information*

| Name of CCM |
|---|
| Country Coordinating Mechanism, Ethiopia |

### 3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

(a) The extent to which the CCM acts as a functional partnership between government and other key stakeholders, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and

(b) How it coordinates its activities with other national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

*(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.)*

The Central Joint Steering Committee (CJSC), composed of multilateral and bilateral agencies, coordinates the technical and financial support for the implementation of the Health Sector Development Program (HSDP). The committee also oversees the integration of all health-related programs run by government, NGOs, as well as bilateral and multilateral agencies operating in the country. The CJSC represents the highest governing body of the HSDP. The CJSC coordinated establishment of the Country Coordinating Mechanism (CCM) in February 2002 to expedite the GFATM supported activities.

Most members of the CJSC are also members of the CCM to ensure transparency and consistency of activities funded by GFATM with the HSDP and the national policy. Moreover, to ensure the broadest multi-sectoral representation and partnership among different stakeholders, several members have been added to include groups such as the Ethiopian Health and Nutrition Research Institute, the Ethiopian Public Health Association, Ethiopian Association of People Living with HIV/AIDS (PLWHA), and the Ethiopian Employers' Federation. Both the CJSC and CCM are chaired by the Minister of Health signifying the political commitment towards the HSDP and GFATM.

The CCM also ensures the participation of all sectors in the implementation of activities in funded proposals by outsourcing projects. Outsourcing is done through an open advertisement and applications are reviewed by a local technical review panel (TRP) that advises the CCM based on the quality of application and implementation capacity of the applicant. The local TRPs for each of the GFATM target diseases are nominated by the CCM based on their expertise and by insuring wider representation.

The CCM meets every month on a regular basis, except in emergency situations in which case extraordinary meetings can be convened by the chairperson. The agenda and necessary documents organized by the Secretariat are forwarded to CCM members one week before regular meetings. Decisions are made by consensus, and implemented through the Secretariat. The Secretariat submits reports of activities to the CCM chair and members. The CCM has established a technical steering committee and three technical groups that work on the HIV/AIDS, TB and Malaria GFATM proposals.

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

# 3A Applicant Type and Eligibility for Funding

## 3A.2 Sub-national Country Coordinating Mechanism (Sub-CCM) Applicants

*For more information, please refer to the Guidelines for Proposals, section 3A.2, and the CCM Guidelines.*

*Table 3A.2 – Sub-national CCM: overview information*

| Name of Sub-CCM |
|---|
| |

**3A.2.1 Mode of operation**

Describe how the Sub-CCM operates. In particular:

(a) The extent to which the Sub-CCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders in the region in which the Sub-CCM operates, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) The process by which the Sub-CCM developed under the guidance of a functional CCM and how it became to be formally recognized by that CCM *(Note: if there is evidence of a legal framework for the sub-national entity stating its autonomy please provide such evidence)*; and

(c) How the Sub-CCM coordinates its activities with other sub-national and national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as Regional and/or National AIDS Councils, Municipal, State or National Parliamentary Health Commissions, Regional and/or National Monitoring and Evaluation Offices and other key bodies).

*(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide a diagram setting out the interrelationships between all key actors as an annex to this proposal including, in particular, the interrelationships with the National CCM. Please indicate the appropriate annex number in your checklist to sections 1 to 3B before the start of section 4.)*

**3A.2.2 Rationale**

(a) Explain why a Sub-CCM approach represents an effective approach in the circumstances of your country.
*(Maximum of half a page.)*

(b) Describe how this proposal is consistent with and complements the national strategy for responding to the disease and/or the national CCM plans.
*(Maximum of half a page.)*

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

# 3A Applicant Type and Eligibility for Funding

## 3A.3 Regional Coordinating Mechanism Applicants

***(includes small island developing states without national CCMs)***

*For more information, please refer to the Guidelines for Proposals, section 3A.3, and the CCM Guidelines.*

*Table 3A.3 – Regional Coordinating Mechanism: overview information*

| **Name of Regional Coordinating Mechanism (RCM)** |
|---|
| |
| **RCM Secretariat Office Address** |
| |

**3A.3.1 Mode of operation**

Describe how the RCM operates. In particular:

(a) **The extent to which the RCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) **How the RCM coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, national monitoring and evaluation offices, or the national strategies of small island developing states who are not required to have their own national CCM or other national coordinating body); and

(c) **The RCM's governance structure and processes,** and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

*(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc.* ***The recommended length of response is a maximum of one page****. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the RCM, and a diagram setting out the interrelationships between key stakeholders across the included countries as an annex to this proposal. Please indicate the appropriate annex number in your checklist to sections 1 to 3 before the start of section 4.)*

**3A.3.2 Rationale**

(a) Describe how this proposal is consistent with and complements the national strategies of countries included and/or the national CCM plans.
*(Maximum of half a page.)*

| | |
|---|---|
| (b) | Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM.<br>*(Maximum of half a page.)* |
| | |

➔ *After completing this section, **complete BOTH section 3A.4 and section 3B.1**.*

## 3A.4 Functioning of Coordinating Mechanism (CCM, Sub-CCM and RCM Applicants)

**IMPORTANT NOTE FOR APPLICANTS:**

**All CCM, Sub-CCM and RCM Applicants must meet, and continue to meet, the Global Fund's minimum requirements for eligibility for funding. This section asks Applicants to describe the operations of their Coordinating Mechanism, and update information provided in Round 6. You will be asked to re-confirm this in the Checklist at the end of sections 1 to 3B of this Proposal Form.**

*For additional information regarding these requirements, see:*

- *The CCM Guidelines; and*
- *'Clarifications on CCM Minimum Requirements'.*

### 3A.4.1 Round 6 Application History

*Table 3A.4.1 – Applicant's Round 6 Application History*

| *Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table to complete other important questions.* | |
|---|---|
| ☒ Applied in Round 6 **and** determined as having met the minimum requirements for Round 6 | ➔ ***Complete section 3A.4.2 and** each of **Requirements 3(a), 3(b), 4(a) and 5(a)** within sections **3A.4.5 and 3A.4.6**.* |
| ☐ Did not apply in Round 6 **or** determined ineligible in Round 6 | ➔ ***Complete** sections 3A.4.2 to 3A.4.6 **inclusive**.* |

### 3A.4.2 Changes in CCM, Sub-CCM or RCM from Round 6 Application

| |
|---|
| Describe **in detail** any changes in the membership or operations of the Coordinating Mechanism (i.e., CCM, Sub-CCM or RCM) since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted for the selection of members by their own sectors, or to manage conflicts of interest; or oversee the work of implementation partners.<br>*If new processes have been adopted, these must be described, and relevant documents attached as an annex to your Round 7 proposal.* |
| The Ethiopian Chamber of Commerce has been replaced by the Ethiopian Employers' Federation due to long absence. There are no any other changes in the composition of the CCM in terms of represented institutions and the working modalities. |

# 3A Applicant Type and Eligibility for Funding

***Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements – Round 7' at**: http://www.theglobalfund.org/en/apply/call7/documents*

***Applicants are reminded that 'Coordinating Mechanism'** ('CM') **for the purposes of this section means either a CCM, Sub-CCM or RCM Applicant as relevant**.*

| **3A.4.3 Principle of broad and inclusive membership** | |
|---|---|
| **(a)** | **Requirement 1 ➔ Selection of non-governmental sector representatives**<br>Provide evidence of how the CM members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**.<br>*Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for CM representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.* |

| **Documentation relied on to support compliance with Requirement 1** | **Identify which annex to this proposal contains these documents**<br>***Please indicate the applicable annex number** in your checklist to sections 1 to 3B before the start of section 4.* |
|---|---|
| ☒ Selection criteria for each sector developed by each respective sector | Annex 2 |
| ☒ Minutes of meeting(s) at which the sector transparently determined its representative | Annex 2 |
| ☒ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member | Annex 2 |
| ☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process | Annex 2 |
| ☒ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM. | Annex 7 |
| ☒ Other: *(please specify):*<br>Copy of letters of nominated CCM members | Annex 4 |

| **(b)** | **Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1** |
|---|---|
| Non-governmental sectors involved in the prevention and control of HIV/AIDS, TB and Malaria are represented in the CCM by at least one member from their respective institutions. The NGO sector makes up about a third of the CCM membership. The selection is carried out in a transparent manner and all concerned are directly involved. | |

# 3A Applicant Type and Eligibility for Funding

**3A.4.4 Principle of involvement of persons living with and/or affected by the disease(s)**

**Requirement 2 ➔ People living with and/or affected by the disease(s)**

Describe the involvement of people living with and/or affected by the disease(s) in the CM.
*(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section).*

Organizations of people living with HIV/AIDS and non-governmental and civil societies including FBOs are represented in the CCM. The population living in malaria risk area are not directly involved or represented in the CCM. However, their needs are addressed through civil societies represented in the CCM by the Christian Relief and Development Association (CRDA) and other NGOs and governmental agencies whose mission and mandate is to serve the affected population.

**3A.4.5 Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5)**

*As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the CM's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting(s) where the CM decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal. We will also review how, during the program term, the CM will oversee implementation.*

**Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:**

**Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.**

The CCM invites all interested parties to participate in proposal preparations. Invitations are released through official letters and also through advertisements on a national newspaper, namely, *The Ethiopian Herald*. Partners from all sectors (public, private, NGO, Civil Societies and Academic and Research Institutions) interested in participating in proposal preparations thereafter join working sub-groups (copies of the invitation letter and the advertisement are attached; see Annexes 3 and 7).

**Requirement 3(b) ➔ Process to review submissions received by the CM for possible integration into this proposal.**

Each of the participating partners presents their areas of interest, funding needs and justification to the working sub-groups. The areas of focus are identified by the Malaria Control Support Team (MCST) and approved by the CCM. Selection of activities is based on relevance to the HSDP and the Malaria Prevention and Control Strategic Plan developed in consultation with partners. In addition, feasibility and relevance of the proposed activities are also critically considered.

The areas of focus for the HIV component are identified based on their relevance and contribution to the implementation of the Universal Access Plan, the HIV/AIDS Strategic Plan and the Country's second PRSP called - Plan for Accelerated and Sustainable Development to End Poverty (PASDEP).

**Requirement 4(a) ➔ Process to nominate** the Principal Recipient(s) for proposals.

The Principal Recipients (PRs) are nominated and unanimously approved by CCM members. The nomination of institutions/organizations as PRs is mainly based on the mandate, duties and responsibilities vested in the institutions/organizations in the planning, executing, and monitoring of the health, care, and support programs.

# 3A Applicant Type and Eligibility for Funding

**Requirement 4(b)** ➔ **Process to oversee/review** program implementation by the Principal Recipient(s) during the proposal term.

Program implementation pace and status is monitored by the CCM based on regular reports on the implementation of planned activities. Concerned PRs submit a monthly administrative, financial and technical report. The report is also sent regularly to the Local Funding Agent (LFA) and GFATM. Furthermore, direct and indirect supervisory activities are carried out by the Federal Ministry of Health (MOH), concerned stakeholders, and external evaluators from the LFA and the Portfolio Manager.

**Requirement 5(a)** ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in the proposal development process.

As a mechanism to ensure broad range of participation of stakeholders in the proposal preparation, public announcements and official invitations are released with the primary aim of inviting all partners to take part in the process. Through this process, partners that volunteer to participate are given the chance to present their issues and ideas to enrich the proposal. Minutes are taken to document all issues presented, discussed and for which consensus has been reached. Concept notes have been developed for both components, and it was reviewed and endorsed by the CCM. A national consultative meeting has been organized in which regional health bureaus, AELWHA, FBOs/EFIDDA, multilateral and bilateral organizations, NGOs, representatives of professional associations, the private sector, and other partners took part and discussed on details of the proposal and provided important inputs during the development process.

**Requirement 5(b)** ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in grant oversight processes.

The CCM regularly receives status of implementation of planned activities with detailed financial and technical reports. Issues that require special consideration and decision are also dealt with through regular and extraordinary meetings of the CCM. The CCM also provides the necessary support to the LFA in order to facilitate proper auditing of financial and technical activities.

| **3A.4.6** | **Principle of effective management of actual and potential conflicts of interest** | |
|---|---|---|
| | **Requirement 6** ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal? | ☒ Yes<br>☐ No |
| | **If yes**, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**. | |

The CCM has a mechanism and guidelines for the management of conflict of interest for malaria component as the chair of CCM and PR are from the same entity (see Annex 8). The document is approved by all members of the CCM (see Annex 8).

# 3A Applicant Type and Eligibility for Funding

| 3A.4.7 Financial Support for Coordinating Mechanism operations | |
|---|---|
| Does the applicant intend to apply for funding of CCM operations?<br>*Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.* | ☐ Yes<br>*provide details below*<br>☒ No<br>*go to section 3B.1* |
| **If yes**, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals.<br>**Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.** | |
| | |

➔ *After completing this section,* ***go to section 3B.1.***

## 3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

*For more information, please refer to the Guidelines for Proposals, section 3A.5.*

*Table 3A.5 – Regional Organization: overview information*

| Name of Regional Organization | |
|---|---|
| | |
| **Sector represented by the Regional Organization**<br>*(Check the relevant box below)* | |
| ☐ | Academic/educational sector |
| ☐ | Government |
| ☐ | Non-Government Organizations |
| ☐ | People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria |
| ☐ | Private sector |
| ☐ | Religious/faith-based organizations |
| ☐ | Other *(please specify)* |

# 3A Applicant Type and Eligibility for Funding

| 3A.5.1 | Mode of operation |
|---|---|
| | *In addition to answering the questions below, Regional Organizations must provide (as additional annexes to this proposal) documentation describing the organization, such as:*<br>• *Statutes, by-laws of organization (official registration papers); and*<br>• *A summary of the main sources and amounts of funding over the past three years.*<br>**Describe below** how the Regional Organization operates. In particular:<br>The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects;<br>The extent to which people living with and/or affected by the disease(s) targeted in the Regional Organization's proposal were involved in development of your proposal; and<br>**The coverage and past experience** of the Regional Organization's operations, with a particular focus on outcomes relevant to the subject of this proposal<br>*(Maximum of half a page.)* |
| | |

| 3A.5.2 | Rationale |
|---|---|
| (a) | Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved.<br>*(Maximum of half a page.)* |
| | |
| (b) | Explain how the countries targeted in the Regional Organization's proposal represent a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes.<br>*(Maximum of half a page.)* |
| | |

➔ *After completing this section, complete section 3B.2.*

## 3A.6 Non-CCM Applicants

***Non-CCM proposals are only eligible for funding under exceptional circumstances listed in section 3A.6.1 below. For more information, please refer to the Guidelines for Proposals, section 3A.6.***

*In addition to answering the sections below,* ***all Non-CCM proposals should include as annexes additional documentation describing the organization,*** *such as: statutes and by-laws of organization (official registration papers) or other documents evidencing the key governance arrangements of the organization; a summary of the background and history of the organization, scope of work, past and current activities; and a summary of the main sources and amounts of existing funding over the past three years.*

*Table 3A.6 – Non-CCM Applicant: overview information*

| | |
|---|---|
| **Name of Non-CCM Applicant** | |
| **Business address** *(including street, town/state and country)* | |

# 3A Applicant Type and Eligibility for Funding

| | Primary contact | Secondary contact |
|---|---|---|
| **Name** | | |
| **Title** | | |
| **Organization** | | |
| **Mailing address** | | |
| **Telephone** | | |
| **Fax** | | |
| **E-mail address** | | |
| **Alternate e-mail address** | | |

**Indicate the sector represented (check appropriate box):**

- ☐ Academic/educational sector
- ☐ Government
- ☐ Non-government Organization (NGO)/community-based organizations
- ☐ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organizations
- ☐ Other *(please specify)*

| **3A.6.1 Rationale for applying outside of a CCM, Sub-CCM or RCM** |
|---|
| *(a) Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following:*<br>(i) Countries without legitimate governments;<br>(ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or<br>(iii) Countries that suppress, or have not established partnerships with civil society and NGOs.<br>***Describe in detail** which of the **above condition(s)** apply*<br>(Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.1 for further information on how the Global Fund will interpret these criteria.) |
| |

# 3A Applicant Type and Eligibility for Funding

| 3A.6.2 | Attempts to have Non-CCM proposal included in the CCM, Sub-CCM or RCM proposal |
|---|---|
| | (b) Describe **all attempts by your organization to submit this proposal and have it included in the relevant final proposal of a CCM, Sub-CCM or RCM** (as appropriate to the content of your proposal), **providing details of any responses received**.<br>*(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM, Sub-CCM or RCM as an annex to the proposal. Please ensure that your description clearly sets out whether you provided a copy of your proposal for consideration by the CCM**, Sub-CCM** or RCM**,and if not, why not.)*<br>***(** Contact details for CCMs, Sub-CCMs and RCMs are available on the Global Fund website, or by contacting proposals@theglobalfund.org )*** |
| | |
| | (c) If you are aware that a CCM is also submitting a proposal in Round 7 for a country or countries included in your proposal, **provide a detailed explanation of why you believe that your non-CCM proposal merits consideration and recommendation for funding as well as any national CCM proposal**.<br>*(Maximum of one page. In this section, please set out any particular issues which you believe support the submission of a Non-CCM Applicant proposal in circumstances where a CCM has applied.)* |
| | |

*If this Non-CCM proposal originates from a country in which no CCM exists (for example, a small island developing state), please **also** complete section 3A.6.3.*

| 3A.6.3 | *Consistency with national policies* |
|---|---|
| | Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy).<br>*(Maximum of one page. Provide evidence [e.g., letters of support] from relevant national authorities in an annex to the proposal.)* |
| | |

*➔ After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

# 3B Proposal Endorsement

## 3B.1 Coordinating Mechanism Applicants *(CCM, Sub-CCM and RCM)* membership and endorsement

***All national (CCM), sub-national (Sub-CCM) and regional Coordinating Mechanisms (RCM) Applicants must:***

*(a)* ***Fully complete this section****; and*

*(b)* ***Complete and attach*** ***'Attachment C'*** *to list all of the members of the Coordinating Mechanism, their contact details and email addresses. (This excel file is available for completion by downloading it from the Round 7 documents website of the Global Fund.)*

### 3B.1.1 Leadership of the Coordinating Mechanism

*Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information*
*(not applicable to Non-CCM and Regional Organization Applicants)*

| | Chair | Vice Chair |
|---|---|---|
| **Name** | Dr Tedros Adhanom Ghebreyesus | Dr Kebede Asrat |
| **Title** | Minister of Health | Director |
| **Organization** | Ministry of Health | Christian Relief and Development Association (CRDA) |
| **Mailing address** | Ministry of Health, P.O.Box 1234, Addis Ababa, Ethiopia | CRDA, P.O.Box 5674, Addis Ababa, Ethiopia |
| **Telephone** | +251 11 551 6378 | +251 11 439 0322 |
| **Fax** | +251 11 551 9366 | +251 11 439 3502 |
| **E-mail address** | moh.vmo@ethionet.et | kasrat@ethionet.et |
| **Alternate e-mail address** | tedrosag@hotmail.com | crda@ethionet.et |

➔ *Go to section 3B.1.2 (membership information).*

# 3B Proposal Endorsement

## 3B.1.2 Membership information of CCM, Sub-CCM or RCM

*Please note that to be eligible for funding, CCM, Sub-CCM and RCM Applicants must demonstrate evidence of membership of people living with and/or affected by the disease(s). Also, it is recommended that the membership of the CCM, Sub-CCM or RCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1 and the CCM Guidelines.*

*Table 3B.1.2 – Summary of Coordinating Mechanism members*

| Summary of Membership of CCM, Sub-CCM or RCM | |
|---|---|
| The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**.<br>*Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.*<br>***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal.*** | |
| **Sector Representation** | **Number of members representing the sector** |
| ☒ Academic/educational sector | 1 |
| ☒ Government | 5 |
| ☒ Non-Government Organizations (NGOs)/community-based organizations | 1 |
| ☒ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria | 1 |
| ☒ Private sector | 1 |
| ☒ Religious/faith-based organizations | 1 |
| ☒ Multilateral and bilateral development partners in country | 5 |
| ☐ Other *(please specify):* | |
| **Total Number of Members** | 15 |

➔ *Go to section 3B.1.3 (proposal endorsement)*

# 3B Proposal Endorsement

## 3B.1.3 CCM, Sub-CCM and RCM proposal endorsement

***Level 1 Endorsement***

*CCM, Sub-CCM and RCM members must endorse their own proposal for an application to be eligible.*

***This is demonstrated by each member of the Coordinating Mechanism*** (whether CCM, Sub-CCM or RCM) ***signing Attachment C in the final column once all membership information has been completed.***

*Please note that the **original** (not photocopied, scanned or faxed) **signatures of the CCM, Sub-CCM or RCM members** must be provided in **Attachment C**. The minutes of the CCM, Sub-CCM or RCM meeting at which the proposal was considered and endorsed must be attached as an annex to this proposal. The entire proposal, including Attachment C and the minutes, must be received by the Global Fund Secretariat by 4 July 2007.*

| | | |
|---|---|---|
| **Level 1 endorsement** | Check this box **only** if the CCM, Sub-CCM or RCM has completed the membership details and **members have signed Attachment C** to the Proposal Form | ☒ |

***Level 2 Endorsement – Sub-CCM and RCM Applicants only***

***For sub-national (Sub-CCM) and regional Coordinating Mechanism (RCM) Applicants only, the national CCM of the country (or countries for RCM applications) must also endorse the Sub-CCM or RCM proposal.***

*This endorsement must be evidenced by providing the Global Fund with written confirmation of the endorsement from the Chair and/or Vice-Chair of the relevant CCM(s) **together with** a copy of the minutes of the CCM meeting at which the Sub-CCM or RCM proposal was **presented for review by the national CCMs and transparently discussed** and endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.1.3.*

*Table 3B.1.3 – Sub-national or regional (C)CM proposal endorsement by national CCMs*

| **Level 2 endorsement of Sub-CCM or RCM proposal by National CCMs**<br>*List below each of the national CCMs that have agreed to this proposal and **provide documented evidence of this endorsement, including copies of the CCM meetings at which the Sub-CCM or RCM proposal was discussed and endorsed**. For Sub-CCM proposals which only cover one part of a country, only that country should be listed.* | | |
|---|---|---|
| **Country** | **Date of CCM Endorsement** | **Annex number to this proposal** |
| | | |
| | | |
| | | |
| | | |
| | | |

*➔ After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

# 3B Proposal Endorsement

## 3B.2 Regional Organization proposal endorsement

### 3B.2.1 National CCM endorsement of Regional Organization proposal:

*Regional Organizations **must receive** an **endorsement in writing from the CCM for all countries targeted in the proposal** unless the country does not have a CCM (by reason that it is a small island developing state without a CCM, or it is a country which has never been eligible for funding from the Global Fund and does not therefore have a functional CCM). **This endorsement must be evidenced by** written confirmation from the Chair and/or Vice-Chair of all relevant CCMs **and** a copy of the minutes of the CCM meeting at which the Regional Organization's proposal was transparently discussed and, if relevant, endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.2.*

*List below each of the national CCMs that have endorsed this proposal and provide documented evidence of this endorsement. (If no national CCM exists in a country targeted in the proposal, include evidence of support from other relevant national authorities.)*

*Table 3B.2.1 – Regional Organization proposal endorsement by national CCMs*

| Country | Date of CCM Endorsement | Annex number to this proposal |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*➔ After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

# 4 Component Section *Malaria*

*The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers* ***and the precise title of the document*** *on the right hand side of the table.*

| Relevant item on the Proposal Form | Description of the information required in the Annex | Title of the Document and annex number given to each annex |
|---|---|---|
| **Section 3A: Applicant Type and Eligibility for Funding** | | |
| ***Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):*** | | |
| 3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM) | Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors). | Annex 1 |
| **Documentation describing compliance with the minimum Coordinating Mechanism requirements** (sections 3A.4.3 to 3A.4.6 inclusive): | | |
| Minimum Requirement 1 | Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism. | Annex 2 |
| Minimum Requirement 3(a) | - solicit submissions for possible integration into the proposal. | Annex 3 |
| Minimum Requirement 3(b) | - review submissions for possible integration into the proposal. | Annex 3, 5 and 7 |
| Minimum Requirement 4(a) and 4(b) | - select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation. | Annex 6 |
| Minimum Requirement 5(a) and 5(b) | - ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process. | Annex 3 |
| 3A.4.6 – Minimum Requirement 6 | Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism | Annex 8 |
| ***Regional Organization Applicants:*** | | |
| 3A.5.1 | Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding. | Not applicable. |
| ***Non-CCM Applicants:*** | | |
| 3A.6 | Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing | Not applicable. |

# 4 Component Section *Malaria*

| Relevant item on the Proposal Form | Description of the information required in the Annex | Title of the Document and annex number given to each annex |
|---|---|---|
| | the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding. | |
| 3A.6.2 b | Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM. | Not applicable. |
| 3A.6.3 *(if submitted for a country where no CCM exists)* | Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies. | Not applicable. |
| **Section 3B: Proposal Endorsement** | | |
| 3B.1.3 ***Level 1 Proposal Endorsement** (CCMs, Sub-CCMs and RCMs)* | Minutes of the meeting at which the proposal was developed and CCM endorsed.. | **Attachment C to the Proposal Form** Annex 18 |
| 3B.1.3 (***Level 2 Proposal Endorsement** = Sub-CCMs and RCMs only)* | Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal. | Not applicable. |
| 3B.2.1 (***Level 2 Proposal Endorsement** Regional Organizations only)* | Documented evidence that the national CCMs have reviewed and endorsed the proposal. | Not applicable. |
| **Other documents relevant to sections 1 to 3B attached by Applicant:** *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)* | | |
| Section 4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal | Feedback to TRP Round 6 Review and Actions Taken | Annex 15 |

***PLEASE NOTE THAT SECTION 4 and SECTION 5 MUST BE COMPLETED FOR EACH SEPARATE DISEASE COMPONENT**. This section is only for your malaria component, and sections 4 and 5 for HIV/AIDS and tuberculosis occur earlier in this Proposal Form (refer to the section headings to find the section relevant to your proposal).*

*For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.*

## 4.1 Requested proposal term for this disease component

*Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed within 12 months of Board approval.*

# 4 Component Section *Malaria*

**Important note:**

**If your proposal term is less than five years, please first refer to the Global Fund's Round 7 'Frequently Asked Questions' (No. 132)** at:
http://www.theglobalfund.org/en/apply/call7/documents/documentsfaqs/

*Table 4.1.1 – Proposal start time and duration*

| | From | To |
|---|---|---|
| **Month and year:** | January 2008 | December 2012 |

## 4.2 Disease specific component executive summary

### 4.2.1 Executive summary

Describe the overall strategy of the proposal component, by referring to challenges, existing and/or new needs, goals, objectives and planned outcomes and outputs to be achieved through the additional funding requested in this proposal, specifying the main beneficiaries (including target populations and their estimated number). Also specify any institution/facilities that will benefit from any support for health systems strengthening strategic actions.

*(**Maximum of one page in length**, highlighting, in a summary format only, key aspects from information described in your answers to the questions within section 4).*

This proposal entitled *"Concerted Action Against Malaria in Ethiopia to Achieve and Maintain High Impact"* will address key malaria prevention and control needs by building upon positive achievements and scaling up activities that have not yet been sufficiently supported. The goal of the proposal is to reduce both malaria morbidity and malaria-related mortality by 65% by the year 2012 as compared to the annual averages of the period 2001-2005 (yearly average reported malaria episodes during this period was 3,149,741). The projected reduction in malaria burden is expected to follow the large-scale anti-malarial interventions that began in 2004.

The major areas of focus will be: procurement and distribution of LLINs; procurement of insecticides and spraying equipment and improving availability of operational funds to scale up indoor residual spraying (IRS) in epidemic-prone areas; intensifying IEC activities through inter-personal channels; improving availability of diagnostic tools; in-service training of district-level malaria focal persons and Health Extension Workers (HEWs); and improving the program monitoring and evaluation activities.

It is estimated that the annual number of malaria cases in the country is in the order of 11.7 million, with *P. falciparum* accounting for 70% of the infections. Vivax malaria accounts for 30% of the cases. Although Coartem is the first-line antimalarial for the treatment of *P. falciparum*, chloroquine remains effective against *P. vivax*; hence there is need for laboratory confirmation of fever cases to avoid wasting relatively expensive drugs.

Maintaining the high coverage of LLINs achieved in Ethiopia needs a sustained financial support to replace worn-out nets and to distribute new ones in order to keep up with the population increase. In the absence of replacement stocks, the gains of the programme so far can be lost and there is a risk of worsening incidence.

Achieving high utilization rate is a major challenge in Ethiopia due to low mosquito nuisance during the dry seasons, a phenomenon that might discourage the frequent use of nets unless intensive BCC/IEC campaigns are sustained. The expansion of the primary health care has created a unique opportunity for health education through low-cost inter-personal channels by HEWs and community volunteers, including basic health message cards or other health education toolkits in which major health problems can be addressed in an integrated manner.

Many of the long-serving, specialized cadre of vector control and other malaria control staff in Ethiopia have not been replaced at the required pace. The immediate

need is re-training of the general health staff at district levels on essential skills as well as the principles of malariology. In addition, the HEWs who are currently deployed in the rural areas need to be re-trained to keep up with recent changes in guidelines.

There will be four key service delivery areas (SDAs) and two health systems strengthening (HSS) actions: 1. Prevention: Insecticide-treated nets (ITN); 2. Prevention: Vector control other than ITNs (IRS); 3. Prevention: BCC community outreach; 4. Treatment: Diagnosis; 5. HSS: Human resources; and 6. HSS: Monitoring and evaluation. As sufficient funding has already been secured for the next few years for the antimalarial drug requirements, this component will not be addressed in the current proposal. The major objectives and the expected outputs are listed below.

Objective 1. To maintain 100% coverage of LLINs in all malarious areas through replacement of worn out nets (SDA 1). A total of 10,601,603 LLINs will be distributed in malarious areas.

Objective 2. To increase the IRS coverage in epidemic prone areas to 60% from 2010 onwards (SDA 2). The outputs include procurement and distribution of 2,688,077 kg DDT 75% water dispersible powder (WDP) and 4,500 spray pumps with 4,500 spare part kits, and provision of operational funds for the spraying of an average of 958,829 households every year.

Objective 3. To raise awareness of populations in malarious areas to bring about behavioural changes through community outreach IEC/BCC inter-personal channels (SDA 3). A total of 885,597 health education toolkits will be distributed in 11,354 *kebeles* (or localities).

Objective 4. To ensure universal access to diagnostic services, using RDTs for fever cases at peripheral health facilities lacking microscopy facilities (SDA 4). A total 11,216,809 RDTs will be distributed.

Objective 5. To train 2 health workers from each of the 450 malarious districts on basic malariology and all HEWs in the same districts on diagnosis and case management, vector control, and BCC/IEC inter-personal channels (SDA 5). A total of 900 district-level malaria focal persons and 20,000 HEWs will be trained. A total of 450 trainers will be also trained prior to the training of the HEWs.

Objective 6. To effectively monitor implementation of the proposed activities and evaluate the impact and outcomes of all SDAs. A computer database will be established and data collection tools distributed and used for compilation of routine HMIS data relevant to the GF malaria grants and to monitor the activities. Program implementation progress will be closely monitored through supportive supervision and malaria indicator surveys will be carried out twice during the proposal term for program evaluation.

A total of USD99,572,849 is requested over 5 years, including USD89,630,049 for the key SDAs and USD9,942,800 for the HSS components.

## 4.3 National program context for this component

*The information below helps reviewers understand the disease context, what is working well and will be built upon, which problems the proposal will address and the major constraints for the implementation of the proposed component. Please refer to the Guidelines for Proposals, section 4.3.*

### 4.3.1 Indicate whether you have any of the following documents** *(check the appropriate box)*, and if so, please attach them as an annex to your proposal:

☒ National Health Sector Development/Strategic Plan

Annex 9. Ethiopia Health Sector Development Program 2005/6-2010/11 (HSDP III)

☒ National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings**

Annex 10. Five Year Malaria Prevention and Control Strategic Plan for 2006-2010

Annex 11. Five Year Malaria Prevention and Control Indicative Plan for 2011-2015

☒ Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)

Annex 12. Health Commodities Supply System Master Plan (also known as Pharmaceuticals and Logistics Master Plan)

☒ Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal**

Annex 13. Proceedings of the National Annual Review Meeting on Malaria Prevention and Control, 2007

☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)

Annex 14. Implementation of National Health Management Information System (HMIS) and Monitoring and Evaluation (M&E) Reform (2007-2010)

** *Applicants will be asked to refer to these documents, where they exist, throughout this section 4 as further support for the proposal's overall strategy.*

**4.3.2 Epidemiological and disease-specific background**

(a) In table 4.3.2 below: (i) identify the total population of the country/countries; **and** (ii) then provide current estimates of the stage of the disease in the listed population groups. *The 'source of estimate' (final column in the table below) may be from recent published estimates of WHO, but may also be published national estimates or statistics.*

*Table 4.3.2 – Estimated disease prevalence within key population groups*

| Population | Estimated number | Year of estimate | Source of estimate |
|---|---|---|---|
| (i) **Total Population** (all ages) | 77,200,000 | 2007 | Central Statistics Agency population projections based on the 1994 census |
| (ii) **Current estimates on the stage of the disease in the following population groups**: | | | |
| Population at risk for malaria *(all ages)* | 52,500,000 | 2007 | Altitude-based malaria risk map and estimates of population living in areas below 2000 meters (68%) |
| Pregnant women at risk of malaria | 2,600,000 | 2007 | Based on percentage of pregnant women projected by the Central Statistics Agency (the 1994 Census), and assuming population at risk of 68% |
| Children under 5 at risk of malaria | 9,500,000 | 2007 | Based on percent children under five years of age projected by the Central Statistics Agency (the 1994 Census), and assuming population at risk of 68% |

| Population | Estimated number | Year of estimate | Source of estimate |
|---|---|---|---|
| Estimated malaria episodes per year | 11,700,000 | 2007 | Teklehaimanot *et al* (2005), *Coming to Grips with Malaria in the New Millennium*, EarthScan: Sterling |
| Reported malaria episodes per year | 3,100,000 | 2001-05 | Federal Ministry of Health (MOH) (Routine HMIS reports) |
| Malaria deaths per year *(all ages)* | No representative data (Attempts will be made to estimate this during the Malaria Indicator Survey in 2007) | | |
| Malaria deaths per year *(under 5 years)* | 94,000 | 2005 | Child Survival Strategy Document (MOH) |
| Under 5 child mortality (per 1000) | 123 | 2005 | Demographic and Health Survey (EDHS) (2005) |
| Number of bed nets in country | 16.5 million | May 2007 | Federal Ministry of Health Report |
| Proportion of children under 5 protected by bed nets | Data on number of children under five years of age protected by ITN is in process of compilation. One study showed 84.0% (n=1,770) of children under five years of age protected by ITNs | 2006 | Survey Report, Aklilu Lemma Institute of Pathobiology, Addis Ababa University |
| Other: *(identify)* Proportion of households sprayed with residual insecticides | In 2005-06 1.7 million unit structures in 570,000 households were covered with Indoor Residual Spray this constitutes sprayed with 20-30% of households in malarious areas | 2006 | MOH (estimated based on annual reports) |

(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons for their use. Any data on drug resistance should also be included (where relevant). *(Maximum two pages.)*

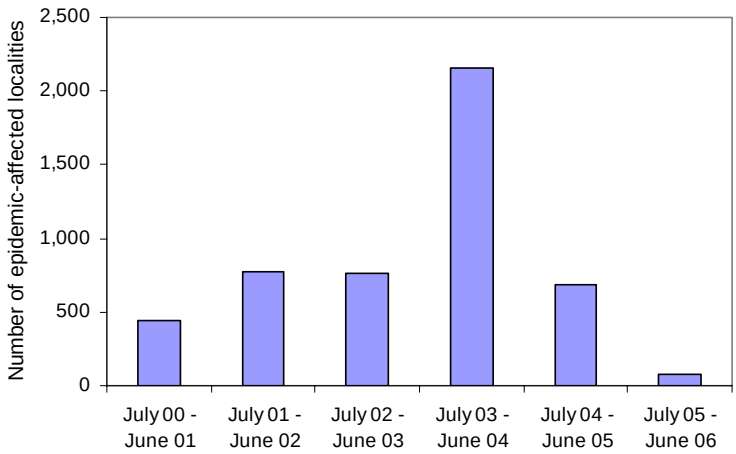
The diverse climatic and geographical features of the country has resulted in unstable transmission in most areas, causing focal and large-scale epidemics in the past.

# 4 Component Section *Malaria*

Prevention of epidemic malaria is still a major challenge in Ethiopia. Many highland fringes and lowlands which are sources of transmission have been sprayed regularly in the past 4-5 decades mostly using government funding but shortage of operational funds, insecticides and spraying equipment has bottlenecked the efforts to cover all areas in need of this essential intervention. Time and again, it has been observed that focal epidemics affecting the largely non-immune populations occur in areas excluded from regular spraying operations due to such shortages.

Almost 68% of the Ethiopian population live in malarious areas covering almost 75% of the land. During the first half of the current decade, the proportion of malaria in outpatient department, admission and in-patient deaths has been increasing and a major epidemic affected the country in 2003 and 2004. During the epidemic more than 2 million cases and around 3,000 deaths were reported. Health facility data indicate that the number of malaria cases, admissions and deaths is on the decline after the epidemic. Since the large scale distribution of ACT drugs and ITNs, and following the increased coverage of indoor residual spraying (IRS), there is some evidence that the frequency of epidemic reports has substantially decreased (Figure 1). Although incidence of admissions and deaths has declined, there is some evidence that the rapid expansion of the primary health services as the result of the training of a large number of HEWs and construction of rural health posts might result in an increased number of reported fever cases served at the peripheral health services.

**Figure 1.** Number of malaria epidemic affected localities in Ethiopia, July 2000 - June 2006.




The intensified antimalarial interventions are expected to significantly reduce overall child mortality and will contribute to a faster decline in the observed general downward trend in line with the Millennium Development Goals. Demographic Health Survey results show that this rate has decreased from 166 per 1000 live births in the year 2000 to 123 per 1000 live births in 2005.

Ownership of ITNs has substantially increased in the last few years, mainly as the result of the support received from the GF and a number of partners. A household survey conducted in 2006 by the Aklilu Lemma Institute of Pathobiology in 17 districts in eight regions indicates that 98% of 3,042 respondents own at least 1 ITN and 46% own at least 2 ITNs. In contrast, only 16% of households owned ITNs in 2001. The survey also found that 84.0% (n=1,770) of children under 5 years of age slept under an ITN the previous night.

Access to treatment with Coartem and distribution of LLINs has substantially increased since 2004 mostly through the GFATM support. In the last two years, 11,035,177 doses of Coartem and 16,270,175 LLINs have been distributed (Federal Ministry of Health data). In terms of ITNs distribution, a full coverage of all endemic areas will be achieved before the end of this year. Rapid diagnostic tests (RDTs) for malaria diagnosis have also been made available in many peripheral health facilities. The GF funds have also been used for training of health workers, production of IEC materials and operational costs.

The whole country has been stratified based on altitude and annual rainfall in terms of the risk of malaria transmission and epidemics. Priority key SDAs planned within this proposal have also been identified for each of the strata (see Table below). A detailed map has been developed to show the epidemiological classification for each district (Figure 2). The composition of each district in terms of the relative proportion of the different strata has been estimated. These proportions will be used to calculate the population size falling under each of the strata for all districts in the country. This information will be useful for prioritising target areas and selectivity of interventions, which will contribute, in the long run, to program

sustainability.

Epidemiological strata in Ethiopia, with areas targeted for the key service delivery areas in this proposal (stratum B has been addressed in previous grants) (Symbols: +++ high priority; ++ moderate priority; + low priority; - normally not recommended.)

| Strata | Altitude (m) | Annual rainfall (mm) | Description | SDA 1 | SDA 2 | SDA 3 | SDA 4 |
|---|---|---|---|---|---|---|---|
| | | | | ITNs | IRS | BCC | RDTs |
| **A** | **>2500** | | **Malaria-free highlands** | **-** | **-** | **-** | **-** |
| **B** | **≥2000 & ≤2500** | | **Highlands affected by occasional epidemics** | **-** | **-** | **+** | **+** |
| **C** | **<1500** | **<500** | **Arid lowlands affected by occasional epidemics; malarious near water** | **++** | **-** | **++** | **++** |
| **D** | **≥1750 & <2000** | | **Highland fringes with low transmission; epidemic-prone** | **+** | **++** | **++** | **+++** |
| **E** | **≥1500 & <1750** | | **Highland fringes with high transmission; epidemic-prone** | **++** | **+++** | **++** | **++** |
| **F** | **<1500 m** | **≥500 and ≥1000** | **Malarious lowlands with seasonal transmission** | **+++** | **++** | **++** | **++** |
| **G** | **<1500** | **≥1000** | **Malarious lowlands, intense seasonal transmission** | **+++** | **+** | **++** | **++ (during low transmission season)** |

Chloroquine was the first line drug for the treatment of *P. falciparum* malaria until 1999, when it was replaced by sulfadoxine-pyrimethamine (SP). However, prior to the 2003 epidemic, *P. falciparum* resistance against SP reached an unacceptable level. A nation-wide study in 2003 confirmed that the mean treatment failure rate of SP was 36% (Jima *et al*. 2005, *East African Medical Journal*, 28: 391-395). On the other hand, the efficacy of artemether-lumefantrine (Coartem) was found to be 99% (Jima *et al*. 2005, *East African Medical Journal*, 28: 387-390). The antimalarial drug policy was then changed in August 2004. Coartem is now the first-line drug for the treatment of uncomplicated *P. falciparum* malaria. Quinine is used as the second-line treatment. For severe malaria, IV quinine is recommended whereas IM artemether, which is currently under a process of registration in Ethiopia, is recommended as a pre-referral treatment. On the other hand, chloroquine is still effective against *P. vivax* malaria and hence remains the first-line treatment for this species. A study conducted in 2003 found that the mean treatment failure against this species was only 2.3% (unpublished data, Federal Ministry of Health).

# 4 Component Section *Malaria*

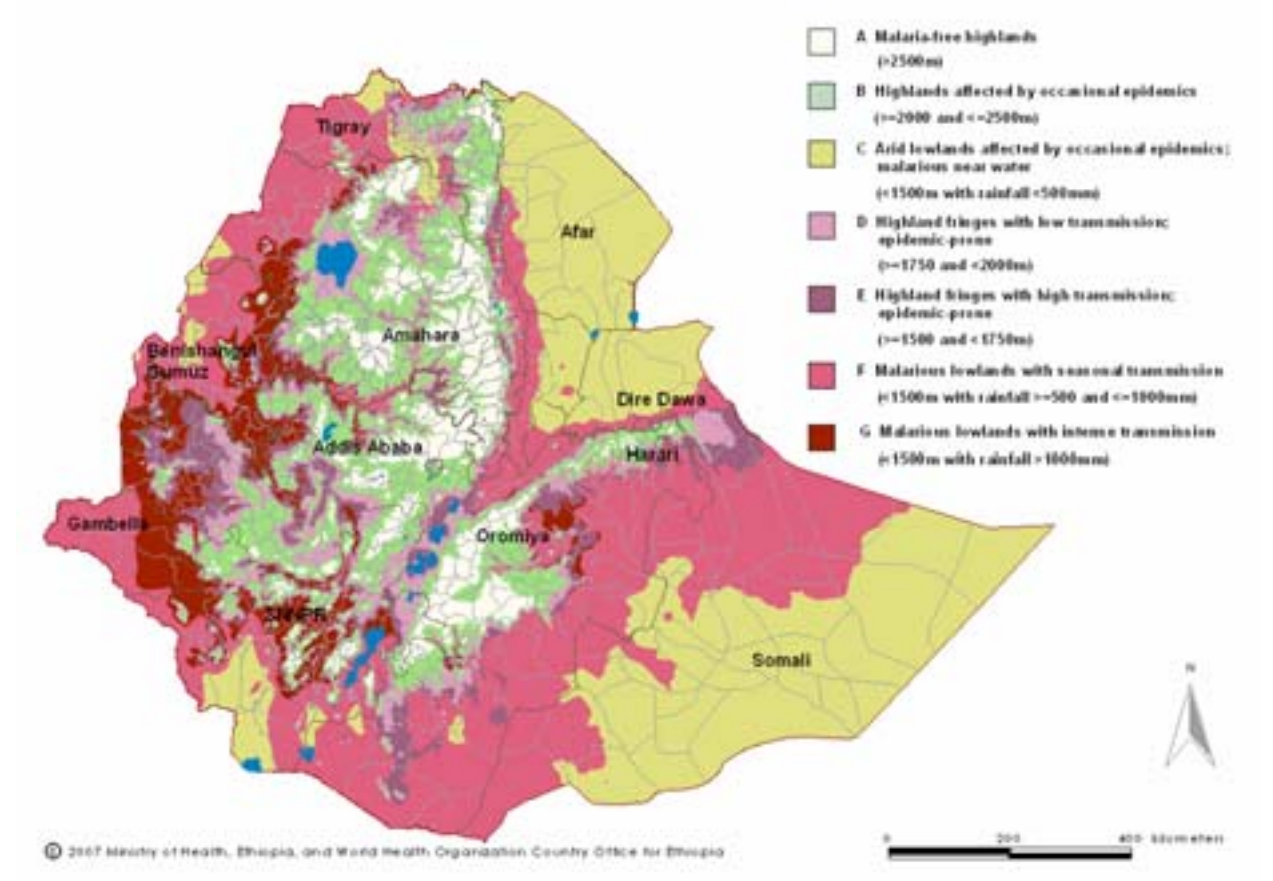



**Figure 2**. Map showing epidemiological strata in Ethiopia, with district and regional boundaries.

### 4.3.3 Disease-prevention and control initiatives and broader development frameworks

*Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.3.3.*

(a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.
*Applicants should ensure that the information provided below takes into account the cumulative outcomes based on all current and planned support from all stakeholders (government, major international initiatives, international donors and partnerships etc).*

The malaria prevention and control program in Ethiopia is guided by a five year strategic plan developed within the context of the third phase of the Health Sector Development Program (HSDP III) of the country. The current five year strategic plan for the period 2006 – 2010 aims to achieve universal coverage for malaria diagnosis and treatment by 2008, 100% coverage of all targeted households to own an average of two ITNs by 2007, and achieve 60% coverage of IRS in epidemic-prone areas by 2010 (see Annex 10).

The main strategies for malaria prevention and control include early diagnosis and prompt treatment of fever/malaria cases, selective vector control (IRS, ITNs and larviciding) and prevention and control of epidemics through routine surveillance, adequate preparedness and timely response. Other supporting strategies include operational research, IEC/BCC, human resource development and program monitoring and evaluation.

**Early diagnosis and prompt treatment**
In line with RBM goals, the objective is to ensure universal access for malaria diagnosis and treatment within 24 hours of onset of fever by 2010. Although laboratory-based diagnostic services (mostly using microscopy) are currently available to an estimated 34% of the population (served at health centers and hospitals), a substantial increase is expected with the expanding health services. RDTs have been in use since 2004/5 in peripheral facilities where microscopy is unavailable and for the rapid investigation of epidemics. In health facilities where RDTs and microscopy are unavailable, treatment is based on clinical diagnosis. Coartem® is being used for the treatment of uncomplicated *P. falciparum* malaria and chloroquine for *P. vivax* malaria. Oral quinine is used for the treatment of *P. falciparum* malaria in infants weighing below five kilograms and in pregnant mothers during the first trimester. Parenteral quinine is used for the treatment of severe and complicated malaria. Intramuscular (IM) artemether is recommended for pre-referral treatment.

**Selective vector control**
IRS and ITNs are the two most important vector control interventions in use in Ethiopia. All areas considered malarious (below 2000m altitude) are targeted for ITN distribution. This intervention primarily targets pregnant mothers and children under five years of age. To date, 16.5 million ITNs have been distributed throughout the malarious districts in the country, using GFATM Rounds 2 and 5 as well as other donor support. Approximately 10 million households will have an average of two ITNs by the second half of 2007. ITNs are distributed free of charge using different channels including the public sector through health facilities, campaigns and Enhanced Outreach Services (EOS).

IRS has been in use in Ethiopia for several decades, but the shortage of insecticides, spraying equipment and operational funds led to under-coverage of areas that are at risk of seasonal and epidemic malaria. Mostly DDT is applied once a year as a pre-emptive intervention prior to the main transmission season (in June and July), although malathion is also used in limited areas. Currently the service covers only 20-30% of the target areas and the plan is to increase coverage to 60% of epidemic-prone areas from 2010 onwards.

Control of mosquito breeding/source reduction and larval control using temephos (Abate®) are sometimes used in areas with manageable breeding sites, usually in small urban centers and resettlement villages.

**Epidemic prevention and control**
The main objective of this strategy is to strengthen routine monitoring of epidemics for early detection and rapid response. The target is to detect and contain epidemics within two weeks from onset in 80% of the districts at risk. Emphasis is placed on building capacity of districts and peripheral health units to ensure preparedness and early response. Meteorological data are monitored (although on a limited scale) for preparedness. The main focus is on early detection through regular monitoring of morbidity cases using epidemic charts at health facilities and weekly reporting to district levels. IRS is sometimes used as a pre-emptive action as well as for the control of on-going epidemics. The primary intervention is, however, mass fever treatment and effective case management in health facilities.

**IEC/BCC**
The goal of IEC/BCC activities is to bring about sustainable behavioral changes for malaria prevention in particular regarding the use of ITNs and IRS, improved health seeking behavior and adherence to prescriptions, participation in prevention and control activities. Social mobilization and sensitization of health workers for malaria prevention and control are also among the components of the strategy. Participatory, interpersonal and traditional communication methods and mass media approaches are all utilized at different levels.

**Monitoring and evaluation (M&E)**
This supporting strategy aims at strengthening the information system in line with the national HMIS and Integrated Disease Surveillance, within the RBM M&E framework. Methods for data collection include routine reports from health facilities, population based surveys and operational research to monitor program performance and to evaluate impact.

**Operational Research**

This is also a supporting strategy to conduct local operational studies with the aim of gathering evidence for decision-making regarding appropriate and effective malaria prevention and control measures. Such research activities are usually carried out in collaboration with academic and research institutions. Assessment of anti-malarial drug efficacy, monitoring insecticide efficacy and other entomological studies, ITN utilization and behavioral studies are some of the research areas receiving special attention.

**Human resources development and capacity building**
This supporting strategy aims at developing the capacity of health workers at all levels of the health care system in planning, implementation and evaluation of malaria prevention and control. The immediate focus is on in-service training of health workers, especially focusing on community level health extension workers, but the long-term objective is to incorporate basic malariology courses into the pre-service training curricula of health workers. The National Malaria Training Center will be renovated and equipped (with support obtained from the US Government's PMI) so as to improve its insectary, laboratory, computing and teaching facilities and transform it into a national center of excellence with a capacity for training needs for malaria and other health programs.

(b) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context**. *(Also include an overview of any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' (e.g., for HIV/TB collaborative activities) or the 'Roll Back Malaria Global Strategic Plan').*

Ethiopia has developed Poverty Reduction Strategic Paper (PRSP) in July 2002, currently known as the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP), on the basis of the Millennium Development Goals (MDG) and the country's socio-economic development needs. The PASDEP's vision is to increase growth of the national economy at an average rate of 5.7% per annum until 2015 in order to achieve poverty reduction by half from the 2002 level. Malaria is the leading health problem in the country and is known to affect the overall socio-economic development, in particular in areas where the disease is endemic. Reduction of the malaria burden, therefore, reduces the direct and indirect economic loss attributed to the disease, and thus will contribute to the overall poverty reduction efforts.

The Highly Indebted Poor Countries (HIPC) initiative, endorsed by 180 governments, lobbies for the approval of debt relief to hasten investment needs of these countries. Debt relief is part of a comprehensive poverty reduction strategy comprising a range of polices aimed at improving social programs, good governance and widely shared economic growth. Under HIPC, Ethiopia received a write-off of USD1.3 billion in 2004 and over USD3 billion in 2006 to support its poverty reduction efforts. As the health sector is a major beneficiary from debt relief initiatives, malaria control efforts will be further strengthened and sustained.

The Millennium Development Goals require countries to work in partnership with their development partners to achieve specific targets by 2015. The MDG priority targets of halting malaria by 2015 and reversing its impact requires a concerted effort to meet investment needs of the program. Accordingly, the HSDP III and the five year strategic plan for the period 2006 – 2010 aims at achieving 100% access to malaria diagnosis and treatment by 2010 and 100% ITN coverage in all targeted households by 2007.

The interventions and services proposed in the Five Year National Strategic Plan for Malaria Prevention and Control (2006 – 2010) are closely linked to international and regional initiatives including the RBM, the Integrated Management of Childhood illnesses (IMCI), and the Child Survival and Making Pregnancy Safer (MPS), through partnership with multilateral agencies (WHO and UNICEF) and bilateral donors.

Establishing an effective and responsive health service is an integral component of Ethiopia's national development policy, which aims at achieving significant economic growth and poverty reduction. In view of this commitment, the government has decided to invest on health and adopted a Sector-wide Approach for the planning and

implementation of health programs to achieve the health development objectives of providing comprehensive, integrated and cost-effective primary care services. The first and second sector wide programs (HSDP I and II) were implemented from 1998 – 2002 and 2003 – 2005, respectively. The HSDP provides the foundation for all health policy in the country and all programs requesting support from the Global Fund. The control of malaria has been benefited and will continue benefiting from the overall health development activities implemented within all the HSDP phases.

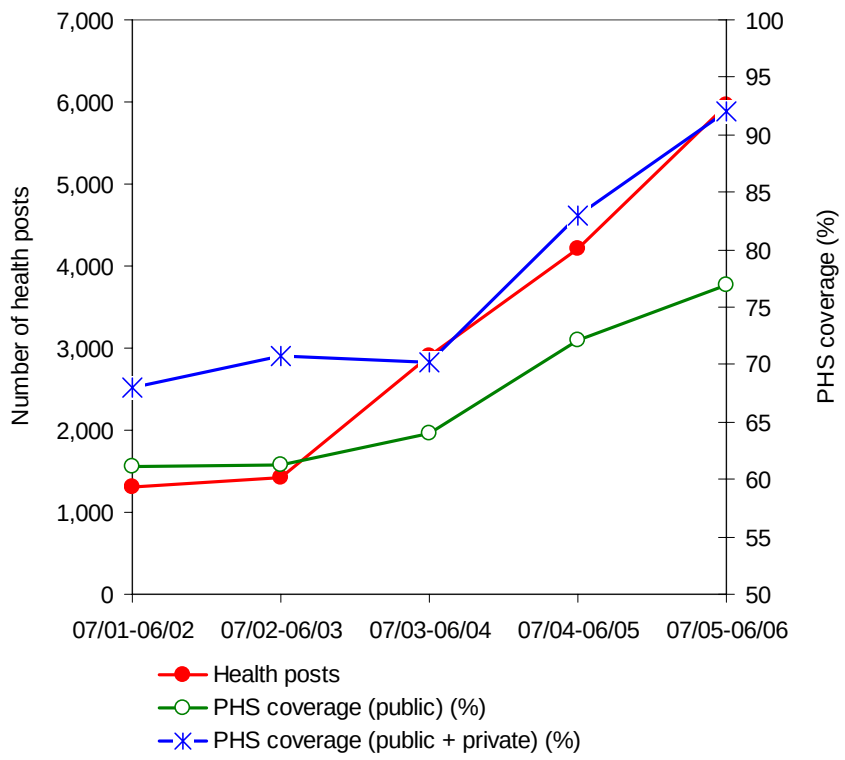



**Figure 3**. Progress of the development of health facilities and the potential health service (PHS) coverage (%) in Ethiopia.

The public health service delivery system is expected to expand in the coming years. In particular, the presence of Health Extension Workers in rural areas will contribute to sustained services in these areas (Figure 3). In the HSDP III, a program of accelerated expansion of the health services will be implemented, aiming to achieve 100% health service coverage by 2010. This goal is expected to be realized through a rapid construction of health facilities and training and deployment of up to 30,000 HEWs.

(c) Describe how this proposal seeks to: (1) use, to the extent that they exist, country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

The HSDP encourages integration of management functions and procedures within the health services and harmonization of resource planning and program monitoring with partners. The CCM, composed of key stakeholders including donors, and its Secretariat, oversee and monitor the proposal development process, budgeting, program implementation, monitoring and evaluation. Regular financial and program monitoring and evaluation reports are received by all partners within a well-established procedure. Furthermore, the National Malaria Control Support Team, comprising representatives of multilateral and bilateral donors and the Malaria Control Program, regularly meet to assess resource needs and to monitor essential activities.

The information system within the MOH needs strengthening. A project entitled "Implementation of the National Health Management Information System (HMIS) and Monitoring and Evaluation (M&E) Reform" has been launched by the MOH in collaboration with partners. Program monitoring and evaluation activities planned within this proposal will benefit from the end products of this reform. The quality and quantity of routine HMIS data will be enhanced and made use of in the proposal.

The procurement and supply management system is also being strengthened, through a newly launched and Pharmaceuticals and Logistics master Plan which currently approved and is at an implementation stage. The government organization called Pharmid will be restructured so as to serve the public sector in procurement of medical supplies and commodities and their efficient distribution to health facilities and districts. The proposal will make us of this new system when it is fully operational although in the meantime, other procurement and distribution mechanisms will be utilized.

The proposal is based on the close working relationship between the Ministry of Health and multilateral and bilateral organizations in terms of procurement of commodities and supply management. For example, the World Health Organization assists in the day-to-day managerial and technical functions of the Malaria Control Program by assigning a full-time staff member. The UNICEF Country Office also has an active involvement in the procurement and distribution of LLINs and antimalarial drugs.

### 4.3.4 National health system

(a) Briefly describe the main health systems constraints related to this component by focusing on the strengths, weaknesses, opportunities and threats of the health system.

**Please consider the list of health systems strengthening strategic actions ('HSS Strategic Actions') outlined in section 4.4.2 of the Guidelines for Proposal when providing this description**.

One of the main **strengths** of the health system is the deployment of 17,400 health extension workers (HEWs) in rural areas that is expected to substantially increase the service coverage. The current health service coverage by the public sector is 77% (and 92% for public and private sectors). Malaria mostly affects rural settings and communities far from health service catchment areas at a disadvantage. The high service coverage already achieved, in particular in terms of ITN distribution and treatment, will facilitate expansion of more services.

There are also some **weaknesses** in the health system that are being addressed by the Government and partners. Shortage of human resources in the public health services is one of them. With regard to malaria, since the Ethiopian Malaria Eradication era in the 1950s, a range of highly-trained and specialized cadre of vector control and other staff have been serving throughout the country. Due to changes in the health service policy and shortage of funds, many of these long-serving staff have not been replaced at the required pace and their skills and experiences are being lost without transfer to the younger generation. On the other hand, there is a need to address health problems in an integrated manner within the decentralised health services. The district health staff who are currently charged with managing their own disease control programs, including planning, implementation and monitoring and evaluation of IRS operations. The immediate need is re-training of the general health staff at district levels on some of the essential specialized skills as well as the principles of malariology, within the context of the HSDP strategies. On the other hand, the HEWs who are currently deployed in the rural areas need to be re-trained on malaria diagnosis, case management, vector control, appropriate use of drugs and health

education methods to keep up with recent changes in the guidelines.

Developing a strong HMIS and program monitoring and evaluation system has been a major challenge. There are needs to improve the quality of routinely collected data, to develop data analysis, and to find ways of translating the output of the information system into evidence-based decision-making. This is clearly stated in the HSDP III document: "challenges faced in relation to HMIS are lack of coordinated effort and leadership, lack of strategy and policy, shortage of skilled human resources and lack of guidelines. The timeliness and completeness of HMIS reporting remain poor, and such delays contribute to the failure (at all levels) to use data as the basis for informed decision-making in planning and management. In addition, parallel reporting mechanisms persist with programmatic and donor-supported initiatives resulting in multiple reporting formats and an increased administrative workload". Therefore, information in the health sector is basically affected by two categories of problems: 1) the inadequate quality, completeness and timeliness of data produced through the routine health recording and reporting procedures based on parallel systems; and 2) the insufficient use of available data for planning, implementation, service management, monitoring and evaluation.

Building a strong and efficient procurement and supplies management system is also a major challenge faced by the health system. The success of the strategies planned within the HSDP will directly depend on the establishment of an effective and efficient health commodities supply system (HCSS). In HSDP III, "weak procurement and management of drugs and medical equipment and supplies" has been identified as one of the strategic areas that impact the likelihood of successful implementation of the program.

There are several new **opportunities** that would encourage a broad-based participation of communities and stakeholders in improving public health in general and malaria prevention and control activities in particular. A strong political commitment and high level of donor support have created a favorable environment for the proper functioning of the health system. The Pharmaceuticals and Logistics Master Plan is in its implementation phase and is expected to significantly improve efficiency of the procurement and supplies management system. Furthermore, many new opportunities to reform HMIS are now emerging. These include a shift of focus from data collection to data analysis and information use, with improved tools and methods for epidemiological surveillance and performance monitoring, and innovations such as information technologies and geographic information systems, all of which have the potential to significantly improve both HMIS coverage and data quality. Important opportunities are also emerging from the process of health system decentralization and accompanying demands for locally relevant and useful health information.

A few factors are thought to **threaten** the health system in general and the malaria control program in particular. In spite of the intensified activities, epidemics might still pose a threat and there is a challenge to strengthen the disease surveillance information system for early detection and response through the use of modern computing technologies. The proposal also assumes that the current donor support will continue to exist at least until the time when local capacity can takeover. Medical staff attrition rates have been unacceptably high in recent years, mainly due to "brain-drain" of physicians to some foreign countries and employment opportunities in the private sector.

(b) Describe the national priorities in addressing these constraints.

**Accelerated Expansion of Primary Health Care Services**

Expansion of health services through the primary health care has been a major national priority in recent years, in line with the principle of the HSDP. The current health service coverage by the public sector is 77% (and 92% for public and private sectors). Important steps have been taken in the decentralization of the health care system. Decision-making processes in the development and implementation of the health system are shared between the Federal Ministry of Health (MOH), the Regional Health Bureaus (RHBs) and the District Health Offices. The MOH and the RHBs are responsible for the development of guidelines and standards, resource mobilization and technical support, while the district health offices are responsible for the planning, implementation and evaluation of health service programs.

Currently, there are 138 hospitals (86 of which are government-owned), 635 health centers (620 of which are government-owned), 5,955 health posts, 1,206 health stations and 2,264 private clinics operating across the country (Planning and Programming Department [2006], *Health and Health Related Indicators 2005-06*, Federal Ministry of Health, Addis Ababa). In addition, there are more than 2,000 pharmacies, drug shops and rural drug vendors mainly owned by the private sector. A total of 6 universities and 21 senior and junior health workers training institutions owned by government and 11 private training institutions currently operate in the country. There The growing size and scope of the private health sector, both for profit and not-for-profit, offers an opportunity to enhance the health service coverage and quality. An increasing number of indigenous and international NGOs are currently involved in various service delivery areas. Training curriculum and certification system of health workers is jointly monitored by the Ministry of Education and Ministry of Health.

The Government is planning to take measures to increase retention of medical staff through attractive incentive systems. There are plans to introduce performance-based reward systems appropriate to the country's realities, including compensation systems for highly qualified staff assigned in remote rural health centers and hospitals. An accelerated training of health officers is also under way to upgrade their skills.

Over the last four years, malaria control in the country benefited from a substantial amount of funding for the first time since the eradication era. Services aimed at strengthening the malaria prevention and control effort through rapid scale-up of interventions, especially in rural areas, is being implemented primarily through support obtained from GFATM and other donor support. Most of the investment has been used for the procurement of anti-malarial medicines, commodities, vehicles, motorcycles, training and operational costs.

**HMIS and M&E Reform**

Other priorities include improving the HMIS and monitoring and evaluation component of the health system, and upgrading the procurement and supplies management system. Implementation of the plans for both of these priorities is currently under way and major steps have been taken to secure funding for the initiatives. The HMIS and M&E reform will focus on four main areas for support: 1. Capacity building, including pre-service and in-service training of health workers on HMIS, as well as their continuous education through refresher courses; 2. Supplies, including printing and distribution of recording and reporting formats as well as guidelines and manuals on HMIS; 3. ICT equipment provision and maintenance, including provision of computers and accessories to District Health Offices and hospitals, and establishment of data warehouse at the national and regional levels; 4. Feed back and supervision, including publication of quarterly feed-back bulletins, annual performance reports and annual statistical booklets, as well as execution of quarterly supervisory visits and HMIS review meetings at all levels. Until the overall HMIS and M&E reform takes off, some special activities have been planned within this proposal to strengthen program monitoring and evaluation through development of a specialized GF database, and systems for compiling routine HMIS data and through mid-term and end-of-program malaria indicator surveys.

**Upgrading Pharmaceuticals and Logistics Supply Services**

The current procurement, storage and distribution capacity of Pharmid will be strengthened though the implementation of the Pharmaceuticals and Logistics Master Plan. The vision of the plan is "a constant and uninterrupted supply of vital and essential health commodities for the end users of all public health facilities." The plan is in its implementation stage and the "New Pharmid" - responsible for procurement, storage and distribution of the supplies - is expected to be fully operational in the coming 1-2 years. The main priorities will be development of the storage capacities by constructing and upgrading regional hubs or warehouses, development of the whole system, and the provision of the start up capitals for procurement of supplies. Until the "New Pharmid" takes over the procurement, storage and distribution of the commodities requested within this proposal, an arrangement will be made with the UNICEF Country Office to carry out the activities.

(c) **Coordination and Synergies**

Briefly describe how disease specific programs are coordinated within the framework of the National Health Sector Development Plan, where one exists. For instance how the proposed component relates to (where appropriate) the national communicable disease strategy and to priorities in the plan.

If the Applicant's proposal covers more than one component, also describe any synergies expected from the combination of different components. For example, linkages between HIV and malaria prevention and control strategies. *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

The health policy aims at strengthening a decentralized system as this system is the most appropriate to reach a vast majority of the rural population, which has limited access to basic health care services. Decision making processes in the development and implementation of the health system are shared between the MOH, the Regional Health Bureaus (RHBs) and the District Health Offices. The role of the MOH and the RHBs focuses more on policy issues and technical support, while the district health offices play the pivotal roles of managing and coordinating the operation of the primary health care services.

At the federal level, there is the Malaria and Other Vector-borne Diseases Control Team, hereinafter referred to as the "Malaria Control Program" (MCP), under the Disease Prevention and Control Department. The MCP coordinates overall malaria prevention and control activities in the regional states. Training and

In the national health policy a Primary Health Care Service is designed to include preventive, promotive and basic curative and rehabilitative services. A four-tier system for health service delivery has been introduced, characterized by a primary health care unit (PHCU), comprising one health center and five satellite health posts, and then the district hospital, zonal hospital and specialized hospital. A PHC-unit has been planned to serve 25,000 people, while a district and a zonal hospital are each expected to serve 250,000 and 1,000,000 people respectively.

The components of the HSDP include health service delivery and quality of care, rehabilitation and expansion of health care facilities, human resource development, strengthening pharmaceutical services, IEC, HMIS/MIS, health care financing, and monitoring and evaluation. HSDP I primarily aimed at expansion of health coverage and equity in access, especially towards the country's under-served rural population. HSDP II focused on the accelerated expansion of the primary health care, complementing the achievements of HSDP I. This involved the recruitment and training of health extension workers and the construction of health posts and health centers. An innovative health service delivery system through the implementation of the Health Service Extension Program (HSEP) has been recently introduced. The HSEP aims to train and deploy Health Extension Workers (HEWs) to serve a population of 5,000 with 2 HEWs. Accelerated Expansion of Primary Health Services strategy has also been endorsed as part of facilitating the implementation of the HSEP. HSDP III plans to train 30,000 HEWs to be assigned in 15,000 rural *Kebeles* (or localities with an approximate population size of 5,000 each) and to achieve universal health service coverage by 2008. To date, a total of 17,400 HEWs have been trained and deployed as regular government employees. HEWs treat fever cases with ACTs, and where available, use RDTs for confirmation. They have a major role in community education and health promotion.

As the full deployment of the required number of HEWs is expected to take up to four years, a bridging strategy is being implemented in 325 drought prone and food insecure districts through the Enhanced Outreach Strategy (EOS). The EOS offers a set of high impact child survival interventions that include measles vaccination, deworming, nutritional assessment, vitamin A and ITN distribution that will reach up to six million children every six months.

The health policy also encourages promoting the participation of the private sector, civil societies and non-governmental institutions in contributing to the delivery of health services. Health services in Ethiopia are financed by four main sources. These are government (both federal and regional); bilateral and multilateral donors (both grants and loans); non-governmental organizations; and private contributions.

| | |
|---|---|
| **4.3.5** | **Common funding mechanisms**<br><br>*This section seeks information on funding requested in this proposal that is **intended to be contributed through a common funding mechanism** (such as Sector-Wide Approaches (SWAp), basket or pooled funding (whether at a national, sub-national or sector level).* |
| (a) | Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism? |
| | ☐ Yes<br>➔ *answer questions below.* |
| | ☒ No<br>➔ *go to section 4.4* |
| (b) | Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach? |
| | |
| (c) | **Describe the common funding mechanism, whether it is already operational and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)* |
| | |
| (d) | Describe the process for independent supervision of the performance of the common funding mechanism.<br>Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**. ***Attach,*** *as an annex to your proposal****, the most recent external assessment of the operations of the common funding mechanism****.* |
| | |
| (e) | Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed.<br>*Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.* |
| | |
| (f) | 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 common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for malaria activities during the proposal term*. |
| | |

# 4 Component Section *Malaria*

## 4.4 Overall Needs Assessment

**The outputs and outcomes planned to be achieved under this proposal** (if approved) **should be based on an analysis of financial and programmatic gaps in national plans/programs to prevent and control the disease**.

**To help Applicants identify these gaps:**

**Step 1** **Section 4.4.1** requests Applicants to identify gaps in the main programmatic areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main gaps only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*;

**Step 2** **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Round 7 Guidelines for Proposal (section 4.4.2). *Section 4.4.2 below also requests information on other current and planned levels of support for these same actions; and*

**Step 3** **Section 4.5** requests Applicants to identify the overall disease specific financial need for the country/countries targeted in this proposal. **This table asks Applicants to identify,** on a national disease specific basis, **the overall financial needs required to prevent and control the disease**. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Thereafter, in section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

***See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.***

### 4.4.1 Programmatic Needs Assessment

**4.4.1 Overall programmatic needs assessment**

(a) **Based on an existing Health Sector Strategic Plan** *(or, if not in existence, an analysis of national/regional goals, together with careful analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies)*, **describe the overall programmatic needs in terms of people in need of these key services**. Please indicate the quantitative needs for three to five main services that are intended to be delivered for this disease component (e.g., long lasting insecticide treated bed nets, and ACTs and other pharmaceuticals for malaria treatment). Also specify clearly how much of this need is currently covered (or will be covered) over the proposal term by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table required under section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.4.1.*

Approximately, 68% of the total population live in areas at risk of malaria transmission. On average, populations not covered with available funds for the identified key service delivery areas per year is estimated to be 20.8 million for ITNs, 17.7 million for IRS, 47.2 million for BCC community outreach and 9.0 million for diagnostic services using RDTs. Approximately 25% of this need is expected to be covered through this proposal (except BCC community outreach which will 100% covered by the proposal). It is expected that government funding will increase during the proposal's term. It is also expected that the partners will maintain their current levels of funding and commitment.

It is estimated that the annual number of malaria cases in the country is in the order of 11.7 million, with *P. falciparum* accounting for 70% of the infections. Unlike most African countries, vivax malaria is also common in Ethiopia and accounts for 30% of the cases. Although Coartem is the first-line antimalarial for the treatment of *P. falciparum*, chloroquine remains effective against *P. vivax* and thus is still the first-line treatment for this species. The main challenge faced by peripheral health units, in particular the health posts lacking microscopy facilities, is the treatment of all fever cases with Coartem, which is much more expensive compared to chloroquine. Furthermore, studies show that only 30-40% of fever cases in Ethiopia are due to malaria. Studies indicate that the use of rapid diagnostic tests (RDTs) before prescription of expensive ACT drugs in routine case management in areas where most febrile cases are not due to *P. falciparum* infections is more cost-effective than a blanket fever treatment. The use of RDTs in most rural areas is essential, especially by HEWs, if the malaria case management using ACTs is to be sustainable. In Ethiopia, treatment without laboratory confirmation is recommended only in epidemic situations or when and where the percentage of malaria cases exceeds approximately 45% of fever cases.

The maintenance of the full coverage achieved in terms of ITN distribution in Ethiopia needs a sustained financial support to replace worn-out nets and to distribute new ones in order to keep up with the population increase. The estimated life of LLINs is about 3-4 years. Unless ITNs are replaced after the end of their effective life, the gains of the programme so far can be easily lost and there might be a risk of worsening of disease incidence.

The diverse climatic and geographical features of the country has resulted in unstable transmission in most areas, causing focal and large-scale epidemics in the past. Prevention of epidemic malaria is still a major challenge. Many highland fringes and lowlands which are sources of transmission have been sprayed regularly in the past 4-5 decades mostly using government funding but shortage of operational funds, insecticides and spraying equipment has bottlenecked the efforts to cover all areas in need of this essential intervention. Time and again, it has been observed that focal epidemics affecting the largely non-immune populations occur in areas excluded from regular spraying operations due to such shortages. Inadequate coverage in IRS was among the major contributing factors.

The use of ITNs is relatively new in the country. Although 100% coverage of LLIN distribution in malarious areas is expected before the end of 2007, achieving high utilization rate is a major challenge due to the relatively longer transmission-free months in most areas where very low mosquito nuisance might discourage the frequent use of the bed nets. The use of inter-personal channels in health education by HEWs has been introduced recently in Ethiopia. Mass media campaigns are useful but they do not reach the majority of the Ethiopian population. Only 5% of Ethiopian households own a television set, and only one in three family have radios. The expansion of the primary health care has created a unique opportunity for health education through low-cost inter-personal channels by HEWs and community volunteers using health education toolkits in which major health problems can be addressed in an integrated manner.

(b) **Complete table 4.4.1**

*Table 4.4.1 is designed to assist Applicants to clearly illustrate overall programmatic needs in terms of people in need of key services. Applicants should note that this gap analysis should be used to guide the completion of the Targets and Indicators Table in Attachment A to the Proposal Form (see section 4.6 of the Guidelines for Proposals).*

**In addition, please specify below** relevant information concerning the groups targeted and any assumptions including target size.

All households in malarious areas will be targeted for the distribution of an average of 2 LLINs per household. Nets are assumed to be replaced every 4 years and new nets are distributed on an annual basis by taking into consideration the population increase (approximately 2.9% per annum). As the distribution will cover nearly all households by the second half of 2007, replacement distribution will be the main focus from 2008 onwards. As part of this proposal, a total of 10,601,603 LLINs will be distributed in malarious areas (In Table 4.4.1, the excess need shown under 2008 for

LLIN has been deducted from the 2009 need in the budget as shown in Annex E).

The current coverage of IRS is 20-30%. This will be increased to 40% in 2009 and to 60% in 2010, which will be maintained until 2012. The outputs of this proposal in terms of scaling up IRS include procurement and distribution of 2,688,077 kg DDT 75% water dispersible powder (WDP) and 4,500 spray pumps with 4,500 spare part kits, and provision of operational funds for the spraying of an average of 958,829 more households every year in addition to the current coverage by government funding and partner support.

The BCC community outreach will target all areas at risk of malaria transmission. A total of 885,597 health education toolkits will be distributed throughout all malarious areas in 11,354 *kebeles* (or localities).

The antimalarial treatment requirements are adequately covered by other sources, including the previous GF Rounds 2 and 5; therefore, this service delivery area has been excluded from this proposal.

Currently RDT is used in peripheral health facilities without microscopy and by health extension workers (HEWs), but the number of tests available each year is still low relative to fever cases reporting to the facilities. The availability of RDTs will be increased to test most of the expected febrile cases. A total of 11,216,809 RDTs will be distributed to peripheral health units that lack microscopy facilities.

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*Please refer to the M&E Toolkit when completing this table for information on key services and service delivery areas.*

**Important Note: For at least three (but not more than five) "key service" areas targeted by this proposal,** list the size of the target group in Part A of table 4.4.1 below, and then complete Parts B, C and D for the same "key service" area. [For example, if the country's planned outcome by 2012 is 3,000,000 children under 5 protected by LLINs (Part A in the table below), and current and planned support, including all existing Global Fund and other donor support, is expected to ensure that 800,000 children protected by 2012 (Part B in the table below), the overall unmet need will be 2,200,000 (Part C in the table below). In Part D of this table, Applicants should then describe the extent of additional coverage for this key service targeted by this proposal.]

### Original Table

*Table 4.4.1 – Overall programmatic needs assessment*

| | | Programmatic Gap Analysis | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | | Anticipated | | | | | |
| | | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| **Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)** | | | | | | | | | |
| Key Service 1 | Insecticide Treated Nets | 49,669,587 | 51,089,476 | 52,509,365 | 53,929,254 | 55,349,143 | 56,769,032 | 58,472,103 | 60,226,266 |
| Key Service 2 | Vector control (other than ITNs) (Indoor residual spraying) | 9,933,917 | 10,217,895 | 10,501,873 | 10,785,851 | 22,139,657 | 34,061,419 | 35,083,262 | 36,135,759 |
| Key Service 3 | BCC community outreach | 49,669,587 | 51,089,476 | 52,509,365 | 53,929,254 | 55,349,143 | 56,769,032 | 58,472,103 | 60,226,266 |
| Key Service 4 | Diagnosis (RDT) | 24,268,560 | 22,535,462 | 20,108,606 | 16,294,235 | 15,254,894 | 12,828,038 | 10,539,545 | 8,137,652 |
| Key Service 5 | | | | | | | | | |
| **Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:** | | | | | | | | | |
| Key Service 1 | Insecticide Treated Nets | 10,446,394 | 40,832,983 | 50,613,146 | 55,486,635 | 53,558,844 | 31,962,303 | 22,182,140 | 17,308,651 |
| Key Service 2 | Vector control (other than ITNs) (Indoor residual spraying) | 12,417,397 | 12,772,369 | 13,127,341 | 8,899,257 | 8,899,257 | 8,899,257 | 7,812,645 | 7,812,645 |
| Key Service 3 | BCC community outreach | 0 | 26,776,220 | 29,076,220 | 16,196,220 | 16,196,220 | 16,196,220 | 0 | 0 |
| Key Service 4 | Diagnosis (RDT) | 0 | 16,031,488 | 12,515,394 | 8,045,582 | 4,303,080 | 5,838,464 | 0 | 0 |

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| | | Programmatic Gap Analysis | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | | Anticipated | | | | | |
| | | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| Key Service 5 | | | | | | | | | |
| **Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 – B^1 = C^1$, $A^2 – B^2 = C^2$ etc.)** | | | | | | | | | |
| Key Service 1 | Insecticide Treated Nets | 39,223,193 | 10,256,493 | 1,896,219 | -1,557,381 | 1,790,299 | 24,806,729 | 36,289,963 | 42,917,615 |
| Key Service 2 | Vector control (other than ITNs) (Indoor residual spraying) | -2,483,479 | -2,554,474 | -2,625,468 | 1,886,594 | 13,240,400 | 25,162,162 | 27,270,616 | 28,323,114 |
| Key Service 3 | BCC community outreach | 49,669,587 | 24,313,256 | 23,433,145 | 37,733,034 | 39,152,923 | 40,572,812 | 58,472,103 | 60,226,266 |
| Key Service 4 | Diagnosis (RDT) | 24,268,560 | 6,503,974 | 7,593,212 | 8,248,653 | 10,951,814 | 6,989,574 | 10,539,545 | 8,137,652 |
| Key Service 5 | | | | | | | | | |
| **Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL** | | | | | | | | | |
| Key Service 1 | Insecticide Treated Nets | *Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.* | | | -389,345 | 447,575 | 6,201,682 | 9,072,491 | 10,729,404 |
| Key Service 2 | Vector control (other than ITNs) (Indoor residual spraying) | | | | 471,648 | 3,310,100 | 6,290,541 | 6,817,654 | 7,080,778 |
| Key Service 3 | BCC community outreach | | | | 37,733,034 | 39,152,923 | 40,572,812 | 58,472,103 | 60,226,266 |
| Key Service 4 | Diagnosis | | | | 2,062,163 | 2,737,954 | 1,747,393 | 2,634,886 | 2,034,413 |
| Key Service 5 | | | | | | | | | |

## 4.4.2 Strategic actions to strengthen health systems

***As explained at the start of section 4.4**, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.*

***The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy**.*

*Before completing this section, Applicants should refer to the Round 7 Guidelines for Proposals, section 4.4.2. where significantly greater detail is provided on HSS Strategic Actions supported in Round 7.*

**4.4.2 Description of HSS Strategic Actions included in this component**

(a) **Complete table 4.4.2 below to describe for up to five actions** *(copy the table as many times as relevant)*:

(i) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this disease component**;

(ii) **how the actions link to the planned work during the program term** and **address** key points arising from the analysis of the health system referred to in your response to question 4.3.4 above; and

(iii) **what other support is currently available or planned for the same actions** to ensure achievement of the planned outputs and outcomes of this proposal.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame *(please also ensure you provide this Plan as an annex to the proposal as requested in section 4.3.1)*.

**To clearly demonstrate the link requested in (ii) above**, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to the information on the revised indicators for HSS in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

***Remember to expand the table for up to five HSS Strategic Actions**.*

*Table 4.4.2A – Summary of essential HSS Strategic Actions requested in Round 7*

**4.4.2A Summary of funding requested for HSS Strategic Actions in Round 7**

In the table below summarize, on a per year basis, the total of the funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed by you in table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**). Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

| Total funds for essential HSS Strategic Actions requested over proposal term | | | | | |
|---|---|---|---|---|---|
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| 3,358,265 | 3,539,165 | 913,040 | 913,040 | 1,219,290 | 9,942,800 |

*Table 4.4.2 – Summary of Strategic Actions essential to this proposal*

| | |
|---|---|
| **Action 1** | *(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)*<br>The HSS Strategic Action component addressed in this proposal includes strengthening the human resources and the HMIS and M&E programs.<br>Training of malaria focal persons at district level and health extension workers stationed at health posts will be given a special attention. All service areas that will be scaled up will be supported by training and re-assigning of relevant staff in the 450 malaria endemic districts.<br>The shortage in human resources will be addressed in the long-term by adequately incorporating basic malariology in pre-service training of health workers, but this activity will not be part of the present proposal. In this proposal, as a short-term measure, 2 malaria focal persons will be trained from each of the 450 malarious districts on basic malariology for 2 months, and 20,000 HEWs from the same districts will be given a short refresher course in line with recent developments and guidelines, especially on malaria diagnosis (both clinical and RDTs), case management including rational use of drugs, vector control and BCC/IEC inter-personal channels. A total of 450 trainers will be also trained prior to the training of the HEWs. |

**Describe below** the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| **In-service training of malaria focal persons:** | | | | |
| 450 | 450 | 0 | 0 | 0 |
| **Training of HEW trainers :** | | | | |
| 450 | 0 | 0 | 0 | 0 |
| **In-service training of HEWs:** | | | | |
| 10,000 | 10,000 | 0 | 0 | 0 |
| Round 7 Funding Request Year 1 | Round 7 Funding Request Year 2 | Round 7 Funding Request Year 3 | Round 7 Funding Request Year 4 | Round 7 Funding Request Year 5 |
| **In-service training of malaria focal persons:** | | | | |
| 900,000 | 900,000 | 0 | 0 | 0 |
| **Training of HEW trainers :** | | | | |
| 110,350 | 0 | 0 | 0 | 0 |
| **In-service training of HEWs:** | | | | |
| 1,419,875 | 1,419,875 | 0 | 0 | 0 |

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

*In the left hand column below, please identify the name of* ***other providers*** *of HSS strategic action support. In the*

*other columns, please provide information on the type of outputs.*

| Name of supporting stakeholder ⬇ | Timeframe of support for HSS action | Level of financial support provided over proposal term *(same currency as this proposal)* | Expected outcomes from existing and planned support |
|---|---|---|---|
| Government | 2008-2012 | 248,275 | 900 health workers trained; cost of their basic salaries during the training covered by Government |
| Other Global Fund Grants (with HSS elements) | 2008-2010 | 459,175 | 300 health workers trained |
| Other: *(identify)* PMI | 2008-2010 | 250,000 | The Nazareth Malaria Training Center building renovated |

| | |
|---|---|
| **Action 2** | *(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)*<br>The HMIS and M&E system is undergoing a reform. Until the system is fully functional, this proposal seeks to strengthen specific activities that will help to effectively monitor and evaluate the proposed program. Specific database will be developed and data collection tools relevant to the proposal's impact, outcome and process indicators will be developed. Malaria Indicator surveys will be carried out in 2009 and 2012 to gather data not captured within the routine HMIS. |

**Describe below** the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| **A computer database developed for program monitoring:** | | | | |
| 1 | 1 | | | |
| **Data collection tools printed:** | | | | |
| 27,000 | 27,000 | | | |
| **Malaria indicator surveys conducted:** | | | | |
| | 1 | | | 1 |
| **Routine HMIS data compiled** | | | | |
| **Supervision conducted** | | | | |
| **Annual review meetings held (national and regional levels):** | | | | |
| 9 | 9 | 9 | 9 | 9 |

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| Round 7 Funding Request Year 1 | Round 7 Funding Request Year 2 | Round 7 Funding Request Year 3 | Round 7 Funding Request Year 4 | Round 7 Funding Request Year 5 |
|---|---|---|---|---|
| **A computer database developed for program monitoring:** | | | | |
| 15,000 | 0 | 0 | 0 | 0 |
| **Data collection tools printed:** | | | | |
| 4,050 | 4,050 | 4,050 | 4,050 | 4,050 |
| **Malaria indicator surveys conducted:** | | | | |
| 0 | 306,250 | 0 | 0 | 306,250 |
| **Routine HMIS data compiled:** | | | | |
| 0 | 0 | 0 | 0 | 0 |
| **Supervision conducted:** | | | | |
| 829,800 | 829,800 | 829,800 | 829,800 | 829,800 |
| **Annual review meetings held (national and regional levels):** | | | | |
| 79,190 | 79,190 | 79,190 | 79,190 | 79,190 |

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

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

| **Name of supporting stakeholder** ↓ | **Timeframe of support for HSS action** | **Level of financial support provided over proposal term** *(same currency as this proposal)* | **Expected outcomes from existing and planned support** |
|---|---|---|---|
| Government | 2008-2012 | 450,000 | Routine supervision at regional and district levels will also be supported through an annual budget of USD90,0000 |
| Other Global Fund Grants (with HSS elements) | 2008-2010 | 100,000 | For routine supervision at regional and district levels |
| Other: *(identify)*<br>WHO<br>The Carter Center | 2008-2010<br>2008-2010 | 151,500<br>107,801 | Establishment of a system for trend monitoring, routine supervision and annual review meetings at national and regional levels |

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| Activity | Fund Requested in GF Round 7 Malaria Proposal (US Dollars) | | | | | |
|---|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
| In-service Training malaria focal persons | 90,000 | 90,000 | - | - | - | 180,000 |
| Training of Health Extension Workers | 110,350 | - | - | - | - | 110,350 |
| In-service Training of Health Extension Workers (HEWs) | 1,419,875 | 1,419,875 | - | - | - | 2,839,750 |
| A computer database developed for program monitoring | 15,000 | - | - | - | - | 15,000 |
| Data collection tools printed | 4,050 | 4,050 | 4,050 | 4,050 | 4,050 | 20,250 |
| Malaria indicator surveys conducted: | - | 306,250 | - | - | - | 306,250 |
| Supervision conducted: | 829,800 | 829,800 | 829,800 | 829,800 | 829,800 | 4,149,000 |
| Annual review meetings held (national and regional levels): | 79,190 | 79,190 | 79,190 | 79,190 | 79,190 | 395,950 |
| Total | 2,548,265 | 2,729,165 | 913,040 | 913,040 | 913,040 | 8,016,550 |

**4.4.2 HSS Strategic Actions continued**
**Risks arising from support for the actions and cross-cutting issues**

*Applicants are strongly encouraged to refer to the Guidelines for Proposals before completing (b) to (g) below.*

(b) Describe your consideration of the broader implications of the proposed strategic actions and their potential impact on the functioning and performance of the health system, key institutions and stakeholders and other health programs (through a SWOT or other similar exercise). Describe, especially, any risk mitigation strategies in response to potential threats to the health system, and proposed options for ensuring long-term sustainability of the strategies built into this proposal.

The in-service training of health workers from malarious districts will result in absence from duty during the training periods. The scheduling of the training program will take into consideration the timing of malaria transmission and other major health programs so that workers would not travel during peak seasons. The two district level staff and two HEWs from health posts will not undergo the training programs both at once, but in turn, so the services they render would not be interrupted.

(c) Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?

☐ Yes
➔ *complete (d) and (e), and then (f)*

☒ No
➔ *go to section 4.4.2(f)*

(d) **If yes to (c)**, provide a short description of which component(s) and how the HSS Strategic Actions in this component will benefit achievement of the outputs and outcomes targeted in the other component(s).

| | |
|---|---|
| (e) | If relevant, provide a detailed justification (*with clear information on direct linkages to this disease component)* for those cross cutting HSS Strategic Actions in this component which you believe should still be funded even if one or both (as relevant) of the other components submitted in Round 7 are not recommended for funding.<br>*(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component). Refer to the Guidelines for Proposals, section 4.4.2(d) for additional guidance.* |
| | |

| | | |
|---|---|---|
| (f) | Are there any cross-cutting HSS Strategic Actions integrated within **another component** in your Round 7 proposal that will benefit this component?<br>*Applicants should ensure that the detailed budget in the other component(s) clearly identify the costs of the HSS Strategic Actions. Applicants must also ensure that there is no duplication of costs included in the various components.* | ☐ Yes, Tuberculosis<br>☐ Yes, Malaria<br>☒ No |

| | |
|---|---|
| (g) | **CCM and RCM Capacity for Health Systems Strengthening Issue identification**.<br>Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6.<br>➔ *Refer to the Guidelines for further information,, section 4.4.2(g)* |

The CCM members and their institutions are involved in many of the stakeholder meetings to identify program priorities through problem analysis and the annual review meetings. Several drafts of the proposals from the different components have been critically reviewed by the CCM members and discussed in details on the regular as well as extraordinary meetings. The CCM members also visit regions to oversee program implementation progress in the field. There are no changes in the relative capacity of the CCM.

## 4.5 Financial Needs Summary

### 4.5.1 Overall Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, describe the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis). As described in step 3 under section 4.4, such analysis should recognize any required investment in the HSS Strategic Actions described in section 4.4.2 above.

**Summarize the overall financial need in table 4.5**.

The overall financial need requested within this proposal is estimated at USD99,572,849 over the 5 years, including budgets for key service areas (USD89,630,049) and health systems strengthening (USD9,942,800). The budget for the key service areas is requested according to the following proportions: Insecticide treated nets (58.6%), vector control other than ITNs (IRS) (21.0%), BCC community outreach (3.2%), and diagnosis (RDT) (7.3%).

The costing for the ITNs was based on a 25% of the gap to replace worn out nets at four-year intervals plus new nets in line with the annual population increase of approximately 2.9%. The cost of each LLIN was estimated at USD5. The procurement and

distribution cost was estimated to be USD0.50 per LLIN. The cost of IRS includes the procurement of DDT 75% WDP, spray pumps and spare part kits, and operational field expenses for the implementation of spraying operations. This cost is also 25% of the actual need. For BCC community outreach, the cost includes development, production and distribution of BCC/IEC toolkits to be distributed to HEWs and community volunteers for interpersonal education. All the required number of toolkits will be provided with the GF Round 7 funding. Of the RDT requirements, 25% will be covered by this proposal. The total expected number of fever cases have been used as the basis, taking into account the health service expansion mainly through the HEWs.

### 4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

**Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B**.

The financial contribution from the Government during the proposal term is estimated to be around USD41.1 million, mostly in the form of salaries and overhead costs. In addition, it is expected that part of the funds obtained through debt-relief initiatives will be used for strengthening the health system in general and malaria control in particular.

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to this component (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

**Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line C.**

The contribution of multilateral and bilateral organizations, namely, the World Bank, UNICEF, WHO, USAID, UNITAID, The Carter Center and PMI, during the first three years is estimated at USD57.2 million. From the GF Rounds 2 and 5, a total of USD82 million is expected to be disbursed between 2008 and 2010.

### 4.5.3 Overview of Financial Gap

**In table 4.5, Line E, provide a calculation of the gap between the estimated overall need** (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal in section 5.*.

### 4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources. Explain plans to ensure that this will continue to be true for the entire proposal term.

The contribution of the Global Fund will be approximately a quarter of the total unmet need. It is expected that government and other bilateral and multi-lateral contributions will continue to be a substantial part of the budget needed for staff

costs and maintaining high coverage of essential interventions.

### 4.5.5 Strategy for achieving sustainability

Describe the strategies and approaches that will be used during the proposal term to ensure that the interventions/activities initiated and/or expanded by this proposal will more likely be sustainable (continue) beyond the proposal term. *(See section 4.5.5 of the Guidelines for Proposals.)*

***Note*** ➔ *Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term. Rather, their description should include how the country/countries targeted in the proposal are addressing their capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-finanical resources to ensure effective prevention and control of the disease(s)..*

The public health service delivery system is expected to expand in the coming years. In particular, the presence of Health Extension Workers in rural areas will contribute to sustained services in these areas. Ethiopia's second five-year National Strategic Plan for the period 2006-2010, has been developed in line with HSDP III and RBM strategies aiming to achieve a 50% reduction in the burden of malaria by 2010. In the HSDP III, a program of accelerated expansion of the health services will be implemented, aiming to achieve 100% health service coverage by 2010. This goal is expected to be realized through a rapid construction of health facilities and training and deployment of up to 30,000 HEWs.

The expansion of laboratory services will contribute to the reduction in consumption of RDTs and improve rational use of anti-malarial medicines. Reliance on RDTs will be eventually reduced as the health units are equipped with basic laboratory facilities. The improved diagnosis and treatment services and the intensified prevention activities will contribute towards a significant reduction in the malaria burden and hence the investment needed to run the program will be affordable. Furthermore, the decreasing prices of ACT drugs might make them relatively more affordable. Furthermore, the intensive interventions to be undertaken within this proposal will more likely lead to a declining malaria incidence.

Government funding of key interventions is also expected to increase in the light of the current economic conditions in the country. In terms of vector control using IRS, the government has been allocating annual budget since the 1950s and it will continue supporting this intervention after the end of the proposal. The main insecticide used (DDT) is also locally formulated in a plant partly owned by the government. There is a plan to expand the insecticide production capacity of this plant for sustained availability and affordability of insecticides. In addition, using a different funding, a geographic information system (GIS) will be used to develop a detailed stratification map of malarious areas including important manmade and natural transmission foci. The GIS data will enable the identification of sources of transmission which will be the focus for a highly selective IRS which will also protect bordering areas.

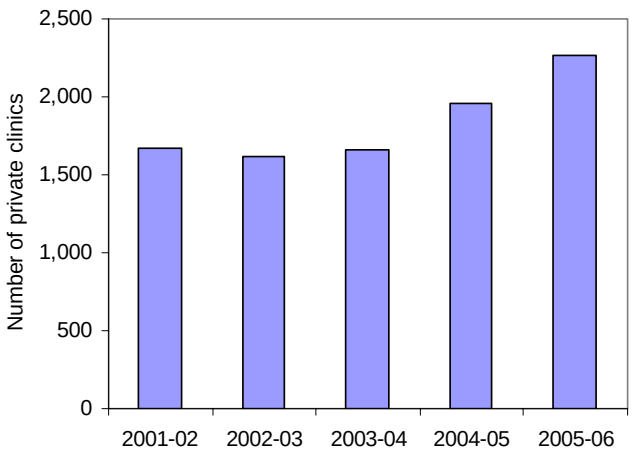


**Figure 4**. Trends in number of private clinics in Ethiopia, 2002-2006.

There are a number of civil societies involved in malaria prevention and control. The major ones include The Anti-Malaria Association and The Ethiopian Malaria Control Professionals Association. The involvement of the private sector is also increasing (Figure 4).

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*Table 4.5 - Financial contributions to national response*

| Financial gap analysis *(same currency as selected in section 1.1)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Refer back to instructions under section 4.4, step 3*** | Actual | | Planned | | Estimated | | | |
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| **Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs** | 182,874,289 | 139,483,968 | 131,787,894 | 103,138,154 | 125,827,092 | 182,947,666 | 202,697,089 | 197,297,049 |
| Domestic source **B1** : Loans and debt relief (*provide donor name*) | 0 | 0 | 0 | 0 | 0 | 0 | - | - |
| Domestic source **B2** : National funding resources | 5,252,564 | 5,252,564 | 5,407,564 | 7,247,346 | 7,369,446 | 7,492,756 | 9,424,848 | 9,548,158 |
| Domestic source **B3:** Private Sector contributions (national) | | | | 0 | 0 | 0 | 0 | 0 |
| **Total of Line B entries ➔ Total current & planned domestic resources** | 5,252,564 | 5,252,564 | 5,407,564 | 7,247,346 | 7,369,446 | 7,492,756 | 9,424,848 | 9,548,158 |
| External source **C1**: All current & planned Global Fund (Rounds 2 and 5) | 37,915,011 | 71,303,462 | 22,401,329 | 19,449,284 | 29,912,721 | 32,700,244 | - | - |
| External source **C2:** (*provide donor name*) WB (PBS) | 0 | 15,128,000 | 13,949,888 | 0 | 0 | 0 | - | - |
| UNICEF | 6,731,763 | 13,775,437 | 3,941,000 | 4,200,000 | 4,200,000 | 4,200,000 | - | - |
| WHO | 353,500 | 353,500 | 479,500 | 308,500 | 308,500 | 308,500 | - | - |
| USAID | 500,000 | 0 | 1,712,207 | 0 | 0 | 0 | - | - |
| UNITAID | 0 | 0 | 6,000,048 | 5,356,021 | 5,562,000 | 5,562,000 | - | - |
| The Carter Center | 0 | 14,639,958 | 119,496 | 184,194 | 83,646 | 109,507 | - | - |
| PMI | 0 | 0 | 0 | 8,925,000 | 8,925,000 | 8,925,000 | - | - |
| External source **C3** (*provide donor name*) | | | | | | | | |
| External source **C4**: Private Sector grants/ contributions (International) | | | | 750,000 | 750,000 | 750,000 | 750,000 | 750,000 |

# 4 Component Section *Malaria*

| Financial gap analysis *(same currency as selected in section 1.1)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Refer back to instructions under section 4.4, step 3*** | **Actual** | | **Planned** | | **Estimated** | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** |
| **Total of Line C entries ➔ Total current & planned external resources** | 45,500,274 | 115,200,357 | 48,603,468 | 39,172,999 | 49,741,867 | 52,555,251 | 750,000 | 750,000 |
| **Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)** | 50,752,838 | 120,452,921 | 54,011,032 | 46,420,345 | 57,111,313 | 60,048,007 | 10,174,848 | 10,298,158 |
| **Line E ➔ Total Unmet need (Line A – Line D) -** | 132,121,451 | 19,031,047 | 77,776,862 | 56,717,809 | 68,715,779 | 122,899,659 | 192,522,241 | 186,998,891 |
| *The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.* | | | | | | | | |

# 4 Component Section *Malaria*

## 4.6 Malaria component/implementation strategy

*This section describes the strategic approach of the proposal, and the activities that are intended to be supported over the proposal term. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance. For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.*

**In support of this section 4.6, all applicants must submit by disease component:**

1. A **Targets and Indicators Table** ➔ This is included as **Attachment A** to the Proposal Form. *When setting targets in this table, **please refer explicitly to the programmatic needs analysis** in section 4.4. All targets should be measurable and identify the current baseline. **Importantly, this table will be utilized to measure performance of the program over the whole proposal term.** For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. Refer to the Guidelines for Proposals, section 4.6.*

**and**

2. A **Work Plan** ➔ which must meet the following criteria. *(Refer to the Guidelines for Proposals, section 4.6):*

   a. *Structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

   b. *Covers the first two years only of the proposal term and is:*
      ***i detailed for year 1, with information broken down by quarters;***
      ***ii indicative for year 2, with information at least half yearly.***

   c. ***Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

***Please note that other documents are also required to be submitted to ensure a complete application for Round 7 funding**. Applicants are strongly encouraged to use the by-disease checklist after section 5 to ensure that all necessary documents are attached to the proposal submitted to the Global Fund.*

**IMPORTANT INFORMATION FOR APPLICANTS RE-SUBMITTING A PREVIOUSLY UNAPPROVED ROUND 5 or ROUND 6 PROPOSAL FOR THIS SAME DISEASE COMPONENT**

### 4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*

In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)*

The Round 6 malaria proposal was not recommended for funding due to a number of drawbacks identified by TRP. Most of the weaknesses identified were mainly related to lack of indicators, programmatic gap analysis, contribution of other partners and detailed budget breakdown. These problems have been fully addressed in the present proposal. Accordingly, indicators have been included with description (Attachment A), the programmatic gap analysis is comprehensive (Table 4.4.1), detailed budget has been worked out (Annex E) and partners' contribution included (4.5). The complete list of feedbacks to the TRP comments is given below.

# 4 Component Section *Malaria*

Feedback to the Technical Review Panel (TRP) Comments on the Global Fund Round 6 Malaria Proposal

Background:

- Fund Requested in Round 6: USD 49,947,701 for five years.
- Outcome: The proposal was rated as category 3 and was not recommended for approval in its present form but encouraged to resubmit after a major revision.

1. Overall TRP Comments:
   1. Strengths: Institutional strengthening of the national malaria training center is planned in order to ensure sustainability and universal access for diagnosis through the training of health workers.
   2. Weaknesses: This proposal has been judged by TRP as showing some important technical weaknesses which raise concerns as to the feasibility of its effective implementation. There are also concerns regarding absorptive capacity, due to the large amount of undisbursed Global Fund grant funds still available to the country.
2. Feedback to specific TRP comments and actions taken:

| No. | TRP Comment (Weaknesses) | Feedback | Action |
|---|---|---|---|
| 1 | The description of the activities that will be implemented within each service delivery area lacks detail. Not clear who will do what, when, how and with what resources. | Comment accepted (The activities lacked sufficient details). | The GF Round 7 malaria proposal includes sufficient details regarding the type of activities and how, when, and by whom they will be implemented, as well as their respective costs. |
| 2 | Activities supported by other recipients are not mentioned. A clear analysis should be included. Other donor funds are placed collectively under domestic costs in the Gap analysis. | An attempt was made to describe activities supported by other, but it may not have been exhaustive. | In the Round 7 proposal this has been given due emphasis and explained in detail (see section 4.6.3 of the Round 7 proposal). Donor contributions have also been indicated separately (see Table 4.5 of the Round 7 proposal). |
| 3 | Not clear how this grant is complementary to previous grants and other funding. There is only one line stating that there is no duplication but no further details are given. | The explanation with regard to the complementarities of the funds requested in Round 6 was not exhaustive. | In Round 7, clear justification has been included to indicate the complementarities of the requested funds. |
| 4 | Round 5 proposal for up to USD 140 million has just started (and Round 2 Grant is still to finish) yet problems identified related to targets being met have already been raised. There is still a significant amount of unspent money. | The approved fund for Round 5 was USD 140 million. However, the amount disbursed was USD 59 million. Nearly 80% of what was disbursed has been expended. Therefore, this comment does not seem to be entirely correct. | There has been a remarkable absorptive capacity of the program. All the necessary efforts will be made to maintain the fund utilization efficiency. |
| 5 | Target groups and social stratification were not adequately described. | Due to the unstable nature of malaria transmission in Ethiopia, all age groups are at risk and incidence is not restricted to a specific age group. In the social stratification, percentages women and those living in rural areas has been indicated, although the percentages for some age groups were incomplete. | In Round 7, effort has been made to provide a full description of the malaria situation and target groups and a new map has been developed to show the various epidemiological strata based on altitude ranges and annual rainfall. The percentages of populations residing in each of the strata have been identified for all districts in the country. Recommended interventions have been proposed for each of the strata. |

| | | | |
|---|---|---|---|
| 6 | Budget lacks detail. Mention is made of the enhancement of 50 health centers at a cost USD 2.8 million but no further details are given. Cost of USD 500,000 quoted for renovation of malaria training center but no further details and no details regarding training costs are given. | Budget for health center upgrading and enhancement of the Nazareth Malaria Training Center was presented as a lump-sum amount. Costing for specific activities was not possible as the cost fluctuation in the construction industry was highly unstable. The overall cost was roughly estimated, leaving the details to be decided through an open competitive bidding. | There is no request for health institution upgrading or enhancement of the Nazareth Malaria Training Center in the Round 7 proposal (the funding for this activity is expected to be provided by PMI/USAID). |
| 7 | Impact indicators are not identified in the attachment. | Only one impact indicator was proposed in Round 6. | In Round 7, 3 impact and 4 outcome indicators have been identified with their baseline values. |

### 4.6.2 Goals and objectives and service delivery areas

Referring to your overall needs assessment in section 4.4.1 above, provide a summary of the proposal's overall goal(s), objectives and service delivery areas. *(The information below should be **no longer than a one page summary**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**).*

**Goal**

To reduce both malaria morbidity and malaria-related mortality by 65% by the year 2012 as compared to the annual averages of the period 2001-2005 (yearly average reported malaria episodes during this period was 3,149,741). The averages will be used as baseline due to the substantial inter-annual variations of malaria transmission in the country.

**Objectives**

*Key service areas:*

**Objective 1**. To maintain 100% coverage of LLINs (average of 2 nets per household) in all malarious areas through replacement of worn out nets (Service Delivery Area 1. ITNs).

**Objective 2**. To increase IRS coverage in epidemic prone areas to 60% from 2010 onwards, including in areas previously excluded from spraying operations due to shortage of resources (Service Delivery Area 2. Vector control other than ITNs [IRS]).

**Objective 3**. To raise awareness of populations in 100% of endemic areas on malaria prevention and control and bring about behavioral changes through community outreach IEC/BCC inter-personal channels (Service Delivery Area 3. BCC community outreach).

**Objective 4**. To ensure universal access to diagnostic services using RDTs for 100% of fever cases seen by peripheral health facilities with no microscopy-based diagnosis (Service Delivery Area 4. Diagnosis).

*Health systems strengthening:*

**Objective 5**. To train 2 health workers from each of the 450 malarious districts on basic malariology and all HEWs in endemic districts on diagnosis and case management, vector control, appropriate use of drugs and BCC/IEC inter-personal channels (Service Delivery Area 5. Human resources).

**Objective 6**. To effectively monitor implementation of the proposed activities and evaluate the impact and outcomes of the SDAs through routine HMIS reports and Malaria Indicator Surveys at mid-term and end of the proposal period (Service Delivery Area 6. Monitoring and evaluation).

| 4.6.3 Specific Interventions, Target Groups and Equity | |
|---|---|
| (a) | **Specific Interventions/Activities supported by this proposal**<br>Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom. *(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)* |

# 4 Component Section *Malaria*

There will be four key service delivery areas (SDAs) and two health systems strengthening (HSS) actions: 1. Prevention: Insecticide-treated nets (ITN); 2. Prevention: Vector control other than ITNs (IRS); 3. Prevention: BCC community outreach; 4. Treatment: Diagnosis; 5. HSS: Human resources; and 6. HSS: Monitoring and evaluation. As sufficient funding has already been secured for the next few years for the antimalarial drug requirements, this component will not be addressed in the current proposal.

A total of 10,601,603 LLINs will be distributed in malarious areas. A total of 2,688,077 kg DDT 75% water dispersible powder (WDP) and 4,500 spray pumps with 4,500 spare part kits will be procured and distributed. Operational funds will be provided for the spraying of an average of 958,829 more households every year in addition to those sprayed by using government funding and support from partners. A total of 885,597 health education toolkits will be distributed in 11,354 *kebeles* (or localities).

A total of 11,216,809 RDTs will be distributed to peripheral health facilities lacking microscopy facilities. A total of 900 district-level malaria focal persons will be trained for two months on basic malariology from 450 malarious districts. From the same districts, 20,000 HEWs will be trained on vector control, diagnosis and case management, including rational use of drugs, and BCC/IEC inter-personal channels. A total of 450 trainers will be also trained prior to the training of the HEWs.

A computer database will be established and data collection tools distributed and used for compilation of routine HMIS data relevant to the GF malaria grants and to monitor the activities. Data clerks at the district and regional levels will be used to compile and report the data. Program implementation progress will be closely monitored through regular supportive supervision at regional, and district and health facility levels, and malaria indicator surveys will be carried out twice during the proposal term for program evaluation. Annual program review meetings will be held at the national and regional levels.

The details of the activities and the responsible bodies for their implementation are given in the table below under each SDA, together with a quarterly timetable covering the whole of the proposal term.

Details of activities (see Attachment D for details of the quarterly work plan).

| | Activities | Responsible bodies | Additional descriptions of activities |
|---|---|---|---|
| **SDA 1. Prevention: ITNs** | | | |
| 1.1 | Procurement of LLINs | PHARMID, UNICEF* | UNICEF is expected to carry out procurement during the first year (and also probably the second year) until the capacity of Pharmid will be adequate to take over this function. Part of the procurement and distribution budget (USD0.50 per LLIN) will be used to upgrade the storage and distribution capacities of Pharmid. |
| 1.2 | Distribution of LLINs | PHARMID, MOH, RHBs, DHOs | To avoid storage problems, consignments will be distributed to regions and districts immediately after arrival, especially during the first and second years. |
| **SDA 2. Prevention: Vector control other than ITNs (IRS)** | | | |
| 2.1 | Procurement of DDT 75% WDP | PHARMID, UNICEF* | DDT is currently formulated in Ethiopia at the Adami Tulu Pesticide Factory. This is a government-owned plant. The management of the factory have close working relationships with the MOH and there are no difficulties anticipated in procurement of the insecticide and distribution to regions (usually RHBs organize their own means of transportation). |
| 2.2 | Procurement of spraying equipment with spare part kits | PHARMID, UNICEF* | 900 spray pumps and 900 spare part kits will be procured every year, first through UNICEF, and then Pharmid. Storage is not necessary and RHBs will be allocated their own quotas which they will be able to transport to regions. |
| 2.3 | Ensuring availability of operational funds to increase IRS coverage | MOH, RHBs, DHOs | The operational funds are allocated for field payments of spray personnel and for fuel. The activities will be coordinated by district health offices. Spray men will be daily labourers from surrounding communities trained prior to the IRS operations. The annual spraying will be completed in all areas in 46 days (including six days of spray men training), before the transmission season. |
| **SDA 3. Prevention: BCC community outreach** | | | |
| 3.1 | Identification of health education needs through KAP surveys | Consultants or sub-recipients, MOH, MCST | Consultants or sub-recipients will be closely working with MOH and the MCST, and develop an appropriate data collection tool for the KAP survey. An adequate sample size will be determined and the survey conducted in different parts of the country to capture the IEC/BCC needs of different communities. |
| 3.2 | Development of messages for inter-personal channels | Consultants or sub-recipients, MOH, MCST | Consultants or sub-recipients will develop messages that should be approved by the MOH in collaboration with the MCST. |
| 3.3 | Preparation of artwork & translation of messages into local languages | Consultants or sub-recipients, MOH, RHBs, MCST | The messages will be translated into the major regional languages and pre-tested for clarity. The artwork is prepared and also tested for appropriateness and clarity. |
| 3.4 | Printing of BCC/IEC toolkits | MOH | Health education toolkits containing the translated messages and artwork will be printed and bound in such a way that they can be carried and demonstrated with ease during house-to-house visits by HEWs and community volunteers. |
| 3.5 | Distribution of the toolkits to all HEWs in malarious areas | MOH, RHBs, DHOs | Approximately 78 toolkits will be distributed to each malaria endemic *Kebele* (or locality) throughout the country. |
| **SDA 4. Treatment: Diagnosis** | | | |
| 4.1 | Procurement of RDTs | PHARMID, UNICEF* | Careful considerations will be made regarding inventory levels before each round of RDT procurement to avoid wastage due to expiry of the kits. |
| 4.2 | Distribution of RDTs | PHARMID, MOH, RHBs, DHOs | RDTs will be distributed to regions and districts on the basis of sound forecasts of usage and needs, rather than on a quota basis. Pharmid warehouse hubs will be used to store the kits for easy transfer between areas according to needs. |
| **SDA 5. HSS: Human resources** | | | |
| 5.1 | Training of 900 district-level health workers from 450 malarious districts for 2 months on basic malariology | MOH, WHO, RHBs, sub-recipients | This activity will be contracted out to sub-recipients but there will be a close follow-up by MOH, WHO and RHBs so as to make sure that the training program will be of the highest possible standard. The focus of the program will be on practical issues expected to be faced by district malaria focal persons, including vector control techniques (in particular IRS operations), malaria diagnosis and case management, epidemiology and surveillance, program monitoring and evaluation and some operational research techniques such as insecticide susceptibility and drug efficacy studies. |
| 5.2 | Development, translation & printing of HEW training manuals | Consultants or sub-recipients, MOH, WHO | HEW training manuals will be developed by consultants or sub-recipients in close collaboration with the MCST. The manuals should take into account the educational levels of HEWs and pedagogical requirements for clarity and effectiveness. The focus will be on diagnosis (on clinical grounds and by using RDTs) and treatment, rational use of drugs, vector control, accurate record keeping and reporting, and inter-personal IEC/BCC techniques. |
| 5.3 | Regional level training of 1 trainer of HEWs per district during Year 1 (5 days) | RHBs | One trainer will be selected from each district and trained by MOH, WHO, and RHB staff. A short training or orientation will be carried out prior to the programs, for the staff to be involved in the training of trainers. |
| 5.4 | Training of 20,000 HEWs from all endemic areas on malaria diagnosis, case management, vector control, | DHOs, RHBs | The HEWs will be trained in their respective districts in two rounds, each time selecting one of the HEWs in each health post in order to avoid interruption of services. The HEW manuals (developed under Activity |

| | | | |
|---|---|---|---|
| | appropriate use of drugs and health education (5 days) | | 5.2) will be used for the training programs. |
| **SDA 6. HSS: Monitoring and evaluation** | | | |
| 6.1 | Development of a computer database for monitoring program activities | Consultants or sub-recipients, MOH | The computer database will be developed for use at district, regional and federal levels for monitoring activities and disease trends. The database should be designed to enable simple data entry and production of summaries of reports relevant to important indicators. |
| 6.2 | Printing data collection tools for distribution of commodities and monitoring program activities | MOH, WHO | The data collection tools will be identical to the data entry forms used in the computer database described under Activity 6.1. Only relevant information needed for program monitoring will be included in the forms to avoid unnecessary efforts gathering data that would not be utilized. |
| 6.3 | Conducting Malaria Indicator Surveys (2009 and 2012) | MOH, WHO, MCST | A baseline malaria indicator survey is planned to be conducted during September-October 2007 using funds from other sources. The contents of the survey and data collection tools are being developed. The survey will be carried out in 125 malarious districts and the same surveys will be conducted in the same districts in 2009 and 2012. |
| 6.4 | Compilation of routine HMIS data relevant to GF malaria indicators | MOH, RHBs, DHOs | Data clerks at district and regional levels will compile HMIS data relevant to the selected impact and outcome indicators. This activity will continue until the HMIS and M&E reform will be fully operational. A system will be designed for monitoring regular reporting of the data to higher levels. |
| 6.5 | Supervision | MOH, RHBs, DHOs, CCM, LFA, MCST, Partners | Regular supervision will be carried out at all levels. Supervisory checklists will be used to monitor critical activities and take corrective actions as necessary. |
| 6.6 | Annual Review Meetings | MOH, RHBs, MCST, Partners | Annual meetings will be held at regional and national levels to review the progress of the implementation of planned activities. All partners will be invited to participate and reports will be examined in relation to annual plans and actions are recommended. |

* UNICEF's involvement in procurement will be a transitional role until the "New Pharmid" is fully operational.

(b) **Target groups**

Provide a description of the target groups (and, where relevant, the rationale for inclusion or exclusion of certain groups). In addition, describe how the target groups were involved during planning, implementation and evaluation of the proposal prior to submission to the Global Fund. Describe the impact that the program will have on these group(s).

The target groups according to service delivery areas:

**SDA 1. ITNs**. All households in malaria endemic areas.

**SDA 2. Vector control other than ITNs (IRS).** About 60% of malarious areas, mostly at risk of seasonal and epidemic malaria. These are usually highlands or highland fringes, but lowland areas will be also targeted until detailed GIS maps are developed for selective/barrier application.

**SDA 3. BCC community outreach.** All populations living in endemic areas (i.e. 68% of the total population).

**SDA 4. Diagnosis**. Fever cases clinically suspected for malaria.

**SDA 5. HSS: Human resources**. 900 health workers from 450 districts that are malaria endemic; 450 trainers of HEWs; and 20,000 HEWs in the same districts.

**SDA 6. HSS: Monitoring and evaluation.** Population in all malarious areas.

The target groups had no direct involvement in proposal development but were represented by regional health bureaus and partners who had substantial inputs in the process through working groups and a national consultative meeting held to enrich the proposal.

It is expected that the successful implementation of the proposal will significantly reduce malaria transmission, incidence of disease and death and occurrence of epidemics. The knowledge and skills of district-level staff and HEWs in malaria prevention and control will be enhanced. Positive behavioral changes relevant to malaria prevention and control as well as treatment-seeking among most populations living in malarious areas are expected as the result of the BCC/IEC activities.

(c) **Equitable access to services**

Describe how principles of equity will be ensured in the selection of clients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs).

The expansion of health services to rural areas through HEWs is based on the principles of equity which will benefit the previously under-served populations.

(d) **Social inequalities targeted in this proposal**

Describe how this proposal addresses the needs of specific marginalized groups in the country/countries targeted in this proposal. *For example, if your proposal targets a gender, age-group or other demographic presently excluded or underrepresented in existing service delivery activities, identify this and describe how the group(s) will be targeted.*

Please ensure that you include appropriate targets and indicators to monitor performance against these strategies in '**Attachment A**' (Targets and Indicators Table).

Malaria prevention and control services, including treatment and LLINs distribution, will be delivered in underprivileged rural communities through health extension workers.

| | |
|---|---|
| (e) | **Stigma and discrimination**<br>Describe how this proposal will contribute to reducing stigma and discrimination against people living with and/or affected by HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases. |
| Not applicable. | |

## Linkages to other programs

| | |
|---|---|
| **4.6.4** | **Performance of and linkages to current Global Fund grant(s)** |
| (a) | If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.<br>*Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.*<br>***Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained.*** |

A large proportion of the funds for the implementation of planned malaria prevention and control activities has been from the GF Rounds 2 and 5 grants during the last four years (2003-2006) and used to significantly scale up key interventions. The main interventions supported were vector control using LLINs, IRS, diagnosis and treatment, IEC/BCC and M&E. The key SDAs that will be requested again in this proposal are ITNs, IRS, BCC community outreach, and diagnosis (RDTs).

With support from GFATM and other partners 100% coverage of all malarious areas with at least two LLINs per household is expected to be achieved before the end of 2007. In this proposal 25% (which is 10.6 million LLINs over five years) of the need is requested for replacement of worn out LLINs and additional nets in accordance with population increase in order to maintain the full coverage.

IRS coverage currently is estimated to be 20-30% of the population living in epidemic prone areas. A total of 1,679 spray pumps and spare part kits have been procured using GF Round 2 funding. However, to increase the coverage to 60% by 2010 additional funding will be required for procurement of additional spraying equipment and insecticide and for operational funds. Again, 25% of the gap is requested in this proposal.

To ensure universal access to malaria diagnostic services, RDTs need to be deployed in malarious areas where peripheral health facilities with no microscopy-based diagnosis. Funding for testing 9 million febrile cases every year has been secured over the last three years from earlier grants and other donors. However, a broad-based primary health service is in the process of expansion in the country. In particular, there is an accelerated growth in the number of health posts. This has resulted in a wider access to essential services of the rural population where most malaria cases are reported. Due to the rapidly expanding Health Service Extension Program (HSEP) at peripheral level 25% of the total requirement is being requested for the next five years.

IEC/BCC activities have also been implemented in the previous years with the support of GF grants and other sources. However, the funding was limited and not sufficient to cover community-level effective methods like personal communication channels. The funding requested through this proposal will be used to develop personal communication kits that can be used by all HEWs and community volunteers. Since the health service delivery is being supported by trained HEWs the planned health education and community mobilization efforts will contribute to improved uptake and appropriate utilization of the services.

| 4.6.5 | Performance of and Linkages to other donor funding for the same disease |
|---|---|
| | Provide an overview of the main achievements (in terms of outcomes and impact on the disease) which are planned over the same term as this proposal through the support of other external donors, whether bilateral or multi-lateral. Also describe if there are any major bottlenecks to implementation in those grants/programs which may be relevant to the implementation strategy for this proposal, and if so, what steps will be taken to mitigate such challenges. |

Funds for antimalarial drug requirements will be covered by current grants and other donor and Government sources and therefore will not be requested in this proposal.

(b) Where there are any linkages in this proposal to planned interventions already supported by Global Fund grants, **describe, by reference to information generated in regard to those existing grants**,** how implementation bottlenecks and lessons learned have been incorporated into the implementation strategy for this proposal to better ensure the overall feasibility of the planned interventions*(maximum one page).*

*(**Applicants should refer to, for example, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1.)*

In the previous GF rounds the program has faced some challenges and bottlenecks. The key implementation challenges were delays in fund disbursement, procurement and delivery of supplies. We addressed and resolved the difficulties by adopting a system for fast approval of funds by working closely with the Local Funding Agent and by negotiating with the GF Secretariat to directly transfer the funds to commodity providers. These new arrangements improved the situation significantly and we were able to procure millions of LLINs, ACTs and other commodities. The other arrangement that was used to resolve the procurement delays was by making arrangements with WHO and UNICEF by contracting out activities as an interim strategy.

As a long term solution the MOH has developed "Health Commodities Supply System Master Plan" (now also known as the "Pharmaceuticals and Logistics Master Plan") to improve the overall procurement and supplies management. Under this plan, quality health commodities are identified, ordered, and made available at the right time, in adequate quantities, and at the lowest possible cost to the system. The old supply system will also be made more efficient by shortening the lengthy bureaucracy and availing health products as down as to the lower level as possible. To do this a 'New Pharmid' equivalent to a central medical store as in many countries has been restructured and reorganized. A number of partners who have a specialty and experience in the field are actively being involved in the process of developing the new system including UNICEF, UNFPA, JSI/Deliver, Management Science for Health/Rational Pharmaceutical Management Plus (MSH/RPM Plus), and the Clinton Foundation. The new system is expected to benefit malaria prevention and control efforts in a number of ways: 1) The "New Pharmid" will deliver malaria commodities directly to District Health Offices and health facilities and hence the supply chain will be reduced and made efficient; 2) Orders are placed from bottom-up by health facilities rather than the current top-down approach and is based on actual needs; 3) There will be more flexibility that will allow the transfer of drugs and RDTs between hubs to respond to malaria epidemics and reduce loss due to expiry.

There are a number of donors that are currently supporting or planning to support the malaria control program to scale up different interventions. Some of the external donors that are recording major achievements in terms of outcome and impact on malaria are: PMI, UNITAID, WB, UNICEF and WHO.

**PMI**

In June 2005, the United States Government announced a new five-year, USD1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in most affected countries in sub-Saharan Africa. The goal of this initiative is to reduce malaria-related mortality by 50% after three years of full implementation in each of the countries.

Ethiopia was selected in December 2006 to start the program from 2008. While overall systems support will benefit the national level and other regions, coverage targets will be for the Oromiya Region, albeit the largest, covering 27 million people, of which 68% are at risk for malaria. By the end of 2010, the PMI will assist the region to achieve the following targets in populations at risk for malaria: 1) >90% of households with a pregnant woman and/or children under five will own at least one ITN; 2) 85% of pregnant women and children under five will have slept under an ITN the previous night or in a house that has been sprayed with IRS in the last 6 months.

The major anticipated bottle neck that may face this large initiative may be the new financial management procedures and capacity of liquidating and reporting on time related with USAID financial obligation. To address this anticipated challenge the MOH and the Oromiya Regional Health Bureau in collaboration with PMI will recruit accountants that are well-versed with USAID financial policies.

**UNITAID**

UNITAID is a global initiative to scale up rapid diagnosis and prompt treatment for people suffering from malaria. For Ethiopia the initiative approved to supply 2.5 million treatment doses of ACT every year during the period 2006-2011. We do not anticipate any major bottleneck in achieving the goal and availing the ACTs at health facility levels.

**UNICEF**

UNICEF provides technical as well as financial support to the program worth USD1.5 million every year in its regular budget during the next five years. Support that will be provided through provision of technical assistance and supplies include: 1) rolling out the distribution of ITNs/LLINs nationwide; 2) promoting correct utilization of ITNs; 3) building capacity at national and sub-national levels for monitoring of LLINs/ITNs coverage and utilization; 4) ensuring prompt care seeking behavior, access to quality treatment at the community/health post level and adequate referral care for severe malaria at the health center level in all malarious districts; 5) assisting the MOH in leveraging funds. UNICEF also assists in the procurement of medical supplies and health commodities. It has also a role in the implementation of the Pharmaceutical and Logistics Master Plan. There are no major bottlenecks anticipated in achieving the aims.

**WHO**

WHO provides technical and financial support to scale-up the implementation of the five-year malaria prevention and control country strategic plan. The WHO Country Office provides mainly technical support in planning, implementation, monitoring and evaluation, surveillance, epidemic preparedness and response and operational studies. To facilitate the implementation of these activities an annual regular budget of USD308,500 is expected to be available. We do not anticipate any constraints in the implementation of WHO-supported programs.

## Private Sector Contributions

### 4.6.6 Private Sector contributions

(a) If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.

➔ *Refer to the 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.*

The contribution of the private sector in malaria prevention and control activities in Ethiopia has been increasing over the last few years. The two most prominent private sector entities are Population Service International (PSI) and AED-NetMark. Both are active members of the Malaria Control Support Team (MCST). PSI is involved social marketing of LLINs in urban centers at subsidized prices. In addition, they have been contributing to the production and broadcasting of health education messages through local mass media and printed materials.

(b) Referring to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution.)

| **Size of population group that is the focus of the Private Sector contribution ➔** | Population Service International (PSI) has received funding from a donation by Vestergard Frandsen PLC to produce IEC/BCC messages broadcasting through local regional radios that cover 2 to 3 million people living in malarious areas. AED NetMark similarly have obtained funding from USAID and local partners (Petram & East African groups PLCs) who are involved in promoting subsidized LLINs distribution through outlet pharmacies and health education dissemination using mass media and mobile IEC teams. |
|---|---|

| **Refer to Guidelines for examples on 'Contribution Description'** *** Add extra rows below to identify each main Private Sector contributor* | | **Contribution Value** *(same currency as selected in section 1.1)* | | | | | |
|---|---|---|---|---|---|---|---|
| **** Private Sector Contributor Name** | **Contribution Description** *(in words)* | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| Vestergard Frandsen | Support for IEC/BCC of malaria for broadcasting of malaria messages through PSI | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 250,000 |
| Petram & East African Group PLC | Support for AED NetMark to promote subsidized LLINs | 700,000 | 700,000 | 700,000 | 700,000 | 700,000 | 3,500,000 |

# 4 Component Section *Malaria*

## 4.7 Principal Recipient information

*In this section, Applicants should describe their proposed implementation arrangements, including the nominated Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information.*

*Where the Applicant is a Regional Organization or a Non-CCM Applicant, the term 'Principal Recipient' should be read as the planned implementing organization.*

*The Applicant may nominate one or several Principal Recipients to lead implementation and undertake reporting to the Global Fund during the proposal term.*

*To be eligible for funding in Round 7, CCM, Sub-CCM and RCM Applicants must ensure that each Principal Recipient has been* ***transparently selected*** *(refer to section 3A.4.5 of this Proposal Form)*

*Table 4.7: Nominated Principal Recipient(s)*

| | | |
|---|---|---|
| Indicate whether implementation will be managed through one or several Principal Recipients. | ☒ | One |
| | ☐ | Several |

| Responsibility for implementation | | | |
|---|---|---|---|
| **Name of Nominated Principal Recipient(s)** | **Sector Represented** | **Name of Contact person** | **Address, telephone, fax numbers and e-mail address of contact person** |
| Federal Ministry of Health | Public | Dr Zerihun Tadesse | P. O. Box 1234,<br>Addis Ababa,<br>Ethiopia<br><br>Tel: + 251 11 515 9682<br>Fax: + 251 11 553 4867<br>Email malaria@ethionet.et |
| | | | |

## 4.8 Program and financial management

### 4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements.
*(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM, Sub-CCM, or RCM where relevant. Maximum one page.)*

**Federal Ministry of Health**. The overall management of the proposal will be mainly the responsibility of the Disease Prevention and Control Department (DPCD) in collaboration with partners. The MOH, in collaboration with the Malaria Control Support Team (MCST) has developed the National Malaria Prevention and Control Strategic Plan upon which this proposal is based. The MOH, as a PR, has also taken the lead in the development of the proposal together with relevant partners within and outside the CCM. Outsourcing of activities and implementation of activities by sub-recipients will be overseen by the MOH in collaboration with the CCM and Regional Health Bureaus. The MOH will also take responsibility of following up the procurement and distribution of commodities. It will also oversee the implementation of planned

activities by Regional Health Bureaus, District Health Offices and sub-contractors and provides guidance when necessary. The MOH also undertakes training of trainers and development of training manuals for use at regional and district levels. The implementation of the program will be closely monitored by the MOH through progress reports from Regions, field visits, LFA reports, financial reports, commodity distribution reports and Annual Review Meetings.

**Regional Health Bureaus**. The RHBs contributed to the development of the proposal through a review meeting organized by the MOH in collaboration with the RBM Secretariat, WHO, and the Malaria Control Support Team. RHBs oversee implementation of planned activities at the regional and district levels. They have a major role in organizing the planned training programs, in particular the training of trainers of HEWs, and distribution of operational funds as well as commodities. Program monitoring and evaluation roles and activities of RHBs include regular supportive supervision, review meetings and follow-up of progress reports and submission of regular reports to MOH.

**District Health Offices.** District Health Offices select target populations and health facilities for the planned interventions. Most activities will be implemented at the district levels. District health offices will distribute commodities and funds, and undertake the training of HEWs. District Health Offices will be involved in regular supervision of activities at health facility levels review meetings.

**CCM**. The CCM will oversee management of the program. It provides guidance during proposal development and makes major decisions regarding the component activities and budget in consultation with technical groups. The CCM also delegates a Technical Review Panel (TRP) to support the program in technical issues and review proposals from sub-recipients regarding their technical merits and feasibilities, and to recommend for approval by the CCM for funding. The CCM also carries out follow-up activities through progress reports and field visits.

**Local Funding Agency**. An organization called KPMG will act as the LFA for this proposal. They will verify action plans according to funded activities and will be responsible for auditing finances and certifying reports. The LFA will also undertake field visits to evaluate implementation status of planned activities and progress in achieving program objectives.

**UNICEF**. UNICEF has contributed to the proposal development process by assigning experts to participate in the working groups within the MCST. The organization also had a crucial role in the development of the Pharmaceuticals and Logistics Master Plan and procurement of commodities in the previous GF grants and will share this experience with the “New Pharmid” and render the necessary technical assistance in procurement and distribution of commodities as necessary. In addition, within their selected group of districts targeted for the Enhanced Outreach Strategy (EOS), UNICEF will also provide technical and financial assistance in ITN distribution.

**WHO**. Two National Program Officers (NPOs) have been assigned by WHO to work closely with the Malaria and other Vector-borne Diseases Control Team, DPCD, MOH. WHO has been providing technical assistance during the development of the National Malaria Prevention and Control Strategic Plan and this proposal as well as their implementation. The NPOs will take part in organizing training programs. They will be also involved in the implementation of other activities in the proposal, including development of guidelines. WHO’s inputs in program monitoring and evaluation will include participating in the planning and implementation of malaria indicator surveys, KAP surveys for the development of IEC/BCC messages, annual review meetings, field supervision and review of progress reports in close collaboration with the MOH.

**PMI/USAID**. The PMI has launched a project in the Oromiya region to support various malaria control activities including vector control through ITNs and IRS, case management, IEC/BCC, information management, and human resource development. The Adama Malaria Control Training Center, which will be used for organizing the malariology course planned within this proposal, will be renovated through the PMI support.

**Malaria Control Support Team**. The MCST includes members representing most organizations involved directly or indirectly in malaria prevention and control in Ethiopia. Working groups have been established within the MCST to develop concept notes specifying program priorities, which were the basis for this proposal. Some member organizations will also be involved in the actual implementation of planned activities in this proposal through their own mandates and through sub-contracting certain activities. Some of the members will contribute to IEC/BCC and advocacy activities. The MCST meets regularly to discuss program progress and constraints.

Other M&E activities include participation in field supervision and annual review meetings.

**New Pharmid**. The procurement of all commodities and storage will be the responsibility of Pharmid which has been re-structured to centrally coordinate and implement supply services. Furthermore, supplies will be distributed to regions through the network of the nationwide Pharmid storage and distribution hubs.

### 4.8.2 Principal Recipient capacities

*Please note that if there are multiple Principal Recipients, section 4.8.2 below* ***must be completed separately for each one****.*

(a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient ('PR'). Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

The Federal Ministry of Health will be the PR for this grant. The PR has been managing previous grants of GFATM: two rounds of malaria (Rounds 2 and 5). Of these, Round 2 has been rated by the GF as "B1" based on performance so far and is expected to obtain an "A" rating. The MOH has also managed two rounds of GFATM TB grants (1 and 6). Technically the ministry in general and the Malaria Control Program in particular has a core of experts who are providing technical support to regional health bureaus and malaria partners within the country. There are 10 regular and other 3 seconded and 5 contract experts working in Malaria Control Program with the following areas of public health specialty: general public health, epidemiology, entomology, vector control, data management and mapping and diagnostics and treatment.

The PR has the capacity to manage large amounts of funds from the Government as well as donors. The MOH has a Finance Department and an Audit Service staffed with experienced financial managers and accountants. In 2005/06 the MOH successfully managed a recurrent budget of more than USD116 million and a capital budget of more than USD81 million. In addition, the Government has set itself uncompromising standards of financial management, with various studies confirming that the basic systems are already in place to ensure adequate control of public funds. In Ethiopia, the accounting system is sufficiently developed to easily track sources of funding to help final users implement planned activities. The Ministry is also required to submit weekly reports on expenditure, and these serve as conditions for further disbursement. Quarterly and annual financial reports are also collated as part of a progress report in the implementation of projects. To the maximum extent possible, these regular financial reports are used as the basis for financial monitoring of the GFATM. However, it is agreed that the standard systems may be supplemented, if necessary, with special reporting arrangements to ensure adequate monitoring.

The Malaria Control Program activities and funds allocated by GFATM will be managed and implemented by the Principal Recipient. Selection of sub-recipients will be based on the quality of proposals submitted to the program. There is already credible experience in outsourcing and sub-contracting certain activities based on comparative advantage of other partners.

| | | |
|---|---|---|
| (b) | Has the nominated PR previously managed a Global Fund grant? | ☒ Yes |
| | | ☐ No |

**If yes to (b)**, explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

The PR was selected due to its successful management of the previous GF and other grants and implementation of planned activities, achieving encouraging results, in particular in achieving very high coverage of key interventions in a short time.

| | | |
|---|---|---|
| (c) | Is the nominated PR currently managing a large program funded by another donor? | ☒ Yes<br>☐ No |

| | |
|---|---|
| (d) | Identify the total budget (current and planned) under management by **each nominated Principal Recipient**. |

The PR currently is managing close to USD300 million from the Government and various donors. This does not include the funds managed by Regional Health Bureaus at Regional levels.

| | |
|---|---|
| (e) | Describe the performance history of the nominated PR in managing these programs/grants.<br>**Specifically**, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes. |

The PR managed with full satisfactory performance two rounds of GF malaria grants and other two rounds of TB grants. The Round 2 Malaria and Round 1 TB grants had a 100% fund utilization. In 2005/06 the Ministry managed a recurrent budget of more than USD116 and capital budget of more than USD81 million, from the government and donors' sources with more than 90% and 80 % expenditure rates, respectively.

| | |
|---|---|
| (f) | Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**. |

Most activities will be implemented by several regional health bureaus and districts, and sub-recipients that will be selected after approval of the proposal. The fund will also be accessible to other stakeholders and partners like research institutions, professional associations and academia, who will be involved in the implementation of some of the activities.

The PR has been managing huge amount of fund from the Government and donor sources as indicated above. Recent evaluation conducted for the Protection of Basic Services (PBS) showed a high absorptive capacity and performance of the health sector. From the PBS grant of USD34.1 million that was allocated for the health sector for one year in 2006, 90% has been utilized. The requirements for the accountability and transparency test performed by the World Bank mid-term review using the standard methodological tests were also rated high.

| **4.8.3** | **Sub-Recipient information** | |
|---|---|---|
| (a) | Are sub-recipients expected to play a role during the term of the proposal? *(Only in the very rarest of cases would the Global Fund expect there to be no sub-recipients.)* | ☒ **Yes**<br>➔ ***complete the rest of 4.8.3***<br>☐ No<br>➔ *go to 4.9* |
| (b) | How many sub-recipients will or are expected to be involved in the implementation? | ☐ 1 – 5<br>☒ 6 – 20<br>☐ 21 – 50<br>☐ more than 50 |

| | | |
|---|---|---|
| (c) | Have the sub-recipients already been identified? | ☐ Yes<br>➔ *complete 4.8.3. (d) –(e) and (f) and then go to 4.9*<br><br>☒ No<br>➔ *go to 4.8.3. (g) – (h)* |
| (d) | Describe:<br>(i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process.<br>(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients *(Also identify significant potential bottlenecks to **transparent strong performance** by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).* | |
| Not applicable. | | |
| (e) | **Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.<br>**Below** please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. *(maximum two pages).* | |
| Not applicable. | | |
| (f) | **Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal**.<br>*(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)* | |
| Sub-recipients are selected based on the soundness and relevance of the proposal they submit. The proposal submission is believed to be appropriate when submitted as soon as funding is ensured. | | |
| (g) | **Where sub-recipients have not been identified prior to proposal submission**, **describe in detail the process that will be used to select sub-recipients** if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved. | |
| There will be official invitation for sub-recipients' proposal on identified activities. Selection of sub-recipients' proposal will be based on soundness, relevance, budget justification and implementation capacity. The selection is made based on review and technical recommendations by the local Technical Review Panel for malaria. | | |

## 4.9 Monitoring and evaluation framework

*The Global Fund encourages the development of nationally owned monitoring and evaluation (M&E) plans and M&E systems, and the use of these systems to report on grant program results in the overall context of country priorities and movement towards reaching the Millennium Development Goals. When completing the section below, applicants should clarify how and in what ways monitoring and evaluating implementation of the work supported by this proposal relates to existing data-collection efforts.*

**Applicants are strongly encouraged to refer to the M&E Toolkit when completing this section**.

### 4.9.1 Monitoring and evaluation plan

Describe how the data relating to performance against planned outputs and outcomes set out in the 'Targets and Indicators Table' *(required to be annexed as 'Attachment A' to your proposal, see section 4.6)* will be accurately collected, collated and reported by implementing partners during the proposal term to the Applicant (if CCM, Sub-CCM or RCM), the Global Fund and the body responsible for national monitoring and evaluation.

Please also identify any surveys which are planned to be supported (in whole or part) by the funding requested in this proposal, the rationale for such surveys, and how the surveys (and their outcomes) support and feed into single national data collection systems.

*(Where a National M&E plan exists, Applicants may attach this to their application as a clearly named and numbered annex.)*

Data collected through the routine Health Management and Information system from health facilities and districts and data collected through program specific studies and surveys will be used for the monitoring and evaluation of program activities. There are two malaria indicator surveys planned in this proposal: one in 2009 (mid-term review) and 2012 (end-of-program review). A similar survey has been already planned using other sources of funding during the 2007 transmission season to serve as a baseline. The surveys will include all the relevant GF and other impact and outcome indicators.

### 4.9.2 M&E Systems Capacity Assessment

Where there is no National M&E plan **or** the work anticipated under this proposal is anticipated to place additional burden on existing national, regional and/or sub-regional M&E systems, **Applicants are strongly encouraged to review the '*M&E Systems Strengthening Tool*' and provide, in only a summary format below, a description of the major gaps identified and how this proposal incorporates a plan to overcome those gaps to support an effective monitoring and evaluation framework in the country.**

*In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5.*

*The Global Fund recommends that between 5 to 10% of the total component budget is utilized to strengthen M&E systems.*

In the effort to strengthen the health management information system, the Federal Ministry of Health has embarked upon a plan for the period 2007-2010. This plan, entitled: "Implementation of the National Health Management Information System (HMIS) and Monitoring and Evaluation (M&E) Reform", will be implemented through a budget of USD13.5 million allocated from other sources. The routine information needs of this proposal will be adequately addressed in the medium term through the system to be set up as part of this reform.

The main activities identified in the national plan include: 1) capacity building; 2) supplies, including printing and distribution of recording and reporting formats as well as guidelines and manuals on HMIS; 3) ICT equipment provision and maintenance; and 4) feedback and supervision. These will be supported through all available means and the outputs utilized for monitoring and evaluation of the planned activities

within this proposal.

All key stakeholders at federal, regional, district and health facility levels are expected to contribute to and use the revised HMIS and M&E. The reform will provide a platform for evidence-based planning, implementation and monitoring towards a more equitable, efficient and effective health care system. The aim is to implement the revised HMIS and M&E system through phased expansion to all districts, within the context of the overall direction provided by the HSDP III.

Inclusion of the essential data collection tools for monitoring and evaluation of malaria prevention and control activities in the HMIS and M&E plan will be ensured through a close collaboration with the Planning and Programming Department within the MOH. Due to the overlap of the reform period with the initial phase of the current proposal, there will be a need to develop interim program-specific information system and M&E plan until the main MOH plan is fully functional. The system will include: 1) Development of a computer database for monitoring GF activities; 2) Printing data collection tools for distribution of commodities and monitoring GF activities; 3) Malaria Indicator Surveys (2009 and 2012); 4) Compilation of routine HMIS data relevant to GF malaria indicators; 5) Supervision; and 6) Annual Review Meetings.

Implementation of all the activities planned under this proposal will be closely monitored through supportive supervision by the PR, regional health bureaus, district health offices, CCM members and partners. Details of the budget with frequencies of such visits have been developed for supportive supervision at all levels (see Annex E for details).

## 4.10 Procurement and supply management of health products

*In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of health products (including medicines). When completing this section, Applicants should refer to the Guidelines for Proposals, section 4.10.*

### 4.10.1 Roles and responsibilities for procurement and supply management of health products

(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.
*If a function is planned to 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 MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).* | In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).* | Indicate if there is need for additional staff or technical assistance |
|---|---|---|---|
| Procurement policies & systems | New Pharmid | PA, SR, SMA* | ☒ Yes<br>☐ No |
| Quality assurance and quality control of pharmaceuticals | Drug Administration and Control Authority | RB | ☐ Yes<br>☒ No |
| International and national laws (patents) | Ethiopian Science and Technology Commission | RB | ☐ Yes<br>☒ No |
| Coordination | Disease Prevention and Control Department | PR | ☒ Yes<br>☐ No |
| Management Information Systems (MIS) | Planning and Programming Department | PR | ☐ Yes<br>☒ No |
| Product selection | Disease Prevention and Control Department | PR | ☐ Yes<br>☒ No |
| Forecasting | Disease Prevention and Control Department | PR | ☐ Yes<br>☒ No |
| Procurement and planning | Disease Prevention and Control Department<br>New Pharmid<br>UNICEF (short-term) | PR<br>PA, SR, SMA<br>MO | ☒ Yes<br>☐ No |
| Storage and Inventory management | New Pharmid | PA, SR, SMA | ☐ Yes<br>☒ No |
| Distribution to other stores and end-users | New Pharmid<br>District Health Offices | PA, SR, SMA<br>IO | ☐ Yes<br>☒ No |
| Ensuring rational use | MOH<br>Drug Administration and Control Authority | PR<br>RB | ☐ Yes<br>☒ No |

* Abbreviations: PA = Procurement agent; SR = Storage agent; SMA = Supply management agent; RB = Regulatory body; PR = Principal recipient; MO = Multilateral organization; IO = Implementation office.

| | |
|---|---|
| (b) | Briefly describe the organizational structure of the unit with overall responsibility under this proposal for procurement and supply management of health products, including medicines. Indicate how it coordinates its activities with other entities such as the National Drug Regulatory Authority, Ministry of Finance (for budgeting and planning), Ministry of Health, drug storage facilities, distributors, etc. |

The Pharmaceutical Supply and Logistics Department (PSLD), Federal Ministry of Health, has teams responsible for procurement, supply management and monitoring. However, Pharmid is in the process of taking over the procurement functions of this department. The roles and responsibilities for procurement and supply management of commodities for malaria prevention and control will fundamentally change during the next 1-2 years with the adoption and implementation of a five-year investment program which calls for the establishment of a new health commodities supply system for the public sector in Ethiopia, including the creation of a "New Pharmid" (working name) and other new structures. Major capital investments will be made to build storage capacity of New Pharmid and strengthen regional distribution.

The organization structure of the New Pharmid has been proposed to enhance the efficiency of health commodities and supplies storage and distribution through the various hubs to be upgraded throughout the country. Supplies can be directly ordered by districts and health facilities from these hubs.

The supply procurement procedures in Ethiopia are set by the Ministry of Finance and Economic Development, and are compliant with national and international laws. Procurement is conducted in an open tender where all interested parties are invited to bid. Analysis of the bid documents (by a tender committee) is based on the capacity of the bidders to deliver the required supply of proven quality, in time and at competitive prices. The bid analysis report is submitted to the State Minister for final approval. The approved bid evaluation is forwarded to Pharmid for contract management. The contract will be signed between the PR and winning bidders after it is reviewed by the Medico Legal Service of the Federal Ministry of Health. Pharmid will be responsible for clearing supplies from port, storage and distribution of the procured supplies. Until Pharmid's full capacity is developed, the involvement of UNICEF may be necessary in procurement, especially during the first year.

The medical supplies and equipment procured for use in the country are subject to registration and quality assurance as stipulated by the independent regulatory body, which is the Drug Administration and Control Authority (DACA).

However, because of limited number of firms producing supplies such as the ACT drug Artemether-Lumefantrine and the Long Lasting Insecticide Treated Nets (LLINs), the Ministry of Finance and Economic Development has given special permit to the Federal Ministry of Health to procure these supplies in collaboration with WHO and UNICEF.

| 4.10.2 Procurement capacity | | |
|---|---|---|
| (a) | Will procurement and supply management of medicines and other health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also conduct procurement and supply management of these products? | ☒ Principal Recipient only<br>☐ Sub-recipients only<br>☐ Both |

(b) For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four organizations will be involved in procurement.*

| Organization Name | Total value of medicines and other health products procured during last financial year *(In same currency as this proposal)* |
|---|---|
| UNICEF (2006) | USD56,078,539 |
| Pharmid (July 2005 – June 2006) | USD24,821,667 |

**4.10.3 Coordination**

(a) For the organizations described in section 4.10.2.(b) above, indicate **in percentage terms, relative to total value**, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.

The procurement through UNICEF was done using resources mobilized from various sources, including: the Global Fund (74%), Canadian CIDA (16%), JICA (6%) and DfID (4%).

Pharmid's source of funding was its own capital and government support.

(b) Specify participation in any donation programs through which medicines or other health products are currently being supplied (or have been applied for), including: the Global Drug Facility for anti-tuberculosis drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

The donation program for antimalarials is obtained from UNITAID. The program will provide on average 2.5 million treatment courses for the period 2006-2011.

**4.10.4 Supply management (storage and distribution)**

| | | |
|---|---|---|
| (a) | Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term? | ☒ Yes ➔ *continue to (b)*<br>☐ No ➔ *go to 4.10.5* |
| (b) | **If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below. | ☒ National medical stores or equivalent (Pharmid)<br>☐ Sub-contracted national organization(s) *(specify which one(s))*<br>☒ Sub-contracted international organization(s) *(specify which one(s))* UNICEF<br>☐ Other *(specify)* |

(c) Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how the increased requirements under this proposal will be transparently and effectively managed.

Pharmid will develop the primary distribution system for drugs and medical supplies for the public sector. The distribution design will emphasize logistics efficiency by using a hub warehouse network system based on population density, geography and routing. The new system will balance warehousing and transport costs, and concentrates logistics capacity in a relatively small number of hubs. To ensure appropriate storage of supplies, the warehouse hubs will need substantial upgrading. The plan calls for building or renovating up to 12 major hub warehouses, each serving a geographic area with a population of 3 to 5 million people (Figure 5).

**Figure 5**. Proposed new Pharmid warehouse hub locations.

For immediate procurement and storage needs, assistance will be sought from UNICEF and special arrangements will be made with regional health bureaus and district health offices for temporary storage of the commodities and immediate distribution as much as possible, as has been the case in the previous GF grants.

It is expected that Pharmid can progressively take over procurement of health products from UNICEF in about 1-2 years. Currently it has a capacity to procure USD50 million of health products, especially if there is an improved cash flow and an extra storage and distribution capacity is provided. As of June 2007, the storage capacity is 14,725 square meters. Approximately 54% of these are based in 10 regional warehouses and the rest in Addis Ababa. An additional storage capacity of 7,937 square meters is needed to upgrade Pharmid's capacity. There is a cold chain storage capacity of 210 square meters but an additional 105 square meters is required. The total construction cost of the additional storage space is estimated at USD8,398,220. It is planned that some of the cost may be covered partly from the procurement charges included in this proposal and partly from the HIV/AIDS proposal.

(d) Describe each organization's **current distribution capacity** for medicines and other related health products and indicate how the increased coverage will be managed, and potential challenges addressed if any. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal, and the extent of incremental increase that is on existing distribution arrangements.

As of June 2007, Pharmid has 5 large trucks with 400 quintal capacity, 3 medium-sized trucks with 100 quintal capacity, 2 small-size trucks with 50 quintal capacity, and 12 delivery vans (mostly with 40 quintal capacity). It is estimated that 40 additional (40 and 5 quintal capacity) vehicles will be needed. The cost towards this need will be partly covered from the budget for distribution of malaria commodities.

The distribution of the warehouse hubs and secondary hubs which is line with the geographic proximity of populations and health facilities is expected to facilitate the distribution system to operate smoothly using “best access” routes. Through this mechanism, district health offices and health facilities can obtain medical supplies from their nearest hubs.

The distribution system will have an efficient (and a partly automated) inventory control system that provides directions for moving supplies to/from storage hubs; provide information to management on receipts, issues, and stock balances; reconcile inventories to automated records; and coordinate physical inventories.

### 4.10.5 Pharmaceutical products selection

Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use.

Yes

In section 5.4.1, Applicants are requested to complete **'Attachment B' to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.

Not applicable.

## 4.11 Technical and Management Assistance and Capacity-Building

*Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including in respect of development of M&E or Procurement Plans, enhancing management or financial skills etc. When completing this section, Applicants should refer to the Guidelines for Proposals, section 4.11.*

### 4.11.1 Capacity building and training

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further strengthen national capacity, capacity of Principal Recipients and sub-recipients, as well as any target group. Ensure that these activities are included in the detailed budget in section 5.

There is an accelerated training of health extension workers and professionals of higher category (e.g. upgrading of health officers). Enhancement of health facilities is also implemented to ensure equitable distribution of basic services. Through a PMI funding, the Adama Malaria Control Training Center will be renovated and its facilities improved.

### 4.11.2 Technical and management assistance

(a) **Needs Assessment**

Describe any needs for technical assistance, including assistance to enhance management capabilities to support the attainment of the planned outputs and outcomes under this proposal. Where relevant, link your response in this section to the potential capacity constraints of the Principal Recipient and/or other implementing partners under this proposal. *(Please note that technical and management assistance should be quantified and reflected in the component budget section, in section 5).* ***In your description, identify the process by which needs were assessed and evaluated****.*

There is no immediate need for special technical assistance apart from the ones being provided by country-level partners such as WHO and UNICEF. To strengthen implementation of the planned activities, locally recruited procurement and finance officers and malaria experts that will provide technical assistance to the Regional Health Bureaus can suffice.

(b) **Planned sources and mechanisms for procurement of services**

Describe how technical and management assistance is planned to be obtained during the proposal term in a transparent and efficient manner. In particular, identify whether local, national and/or international assistance will be obtained, the scheduled timeframe (short term or longer term) and the rationale for this approach. Also describe how the provision of the planned assistance will contribute to long term increased capacity to respond effectively to the disease.

The technical and management assistance is expected to be obtained through bilateral and multilateral support that will be obtained from partners. During implementation of the Pharmaceuticals and Logistics Master Plan, the partners who have expressed their commitment to provide support will mobilize the necessary resources from their respective institutions. Specific timeline for the delivery of the technical and management assistance needs identified is indicated in the master plan and this is expected to build capacity of the New Pharmid in health commodity supply services.

For the immediate procurement needs, UNICEF will be involved at least during the first an second years until the capacities of Pharmid is well developed to take over.

# 5 Component Budget *Malaria*

## 5. Malaria Component Budget - Overview and general guidance

This section 5 is where Applicants detail their funding request which is summarized in table 1.2. **Section 5 must be completed for each disease component included in your proposal**.

**For Round 7, section 5 has been restructured to adopt the following order:**

1. **prepare a detailed component budget** (section 5.1);
2. from that detailed budget, **prepare a summary by objective and service delivery area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. then provide details about **key budget assumptions** (section 5.4).

**Funding to be contributed through a common funding mechanism**
If part or all of the funding requested for this component is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.5)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds within the common funding mechanism; **and**

(b) provide, as an annex to your proposal, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

### 5.1 Detailed Component Budget

**A detailed per-disease component budget covering the proposal period must be attached as an annex to your proposal.**
The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

***The Detailed Component Budget*** *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.1):*

*(a) It should be **structured along the same lines as the Component Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities.*

*(b) It should cover the full term of the proposal, and:*
*(i) be **detailed for year 1 and year 2**, with financial information broken down by **quarters for the first year, and at least half yearly for the second year**;*
*(ii) provide summarized information and assumptions for the balance term of the proposal period (year 3 and beyond).*

*(c) It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

*(d) It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*

*(e) Details on HSS Strategic Actions should be clearly identified.*

*(f) It should be **consistent** with other budget analysis provided elsewhere in the proposal, including those in this section 5.*

# 5 Component Budget *Malaria*

## 5.2 Summary by objective and service delivery area

*Please provide a breakdown of the annual budget by objective service delivery area (SDA) derived from your detailed component budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form).* Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total).

**The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category).**

*Table 5.2: Budget breakdown by service delivery area and objective.*

| | | **Budget breakdown by SDA** *(same currency as in section 1.1 of the Proposal Form)* | | | | | |
|---|---|---|---|---|---|---|---|
| **Objective Number** | **Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)* | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| 1 | Insecticide-treated nets (ITNs) | 0 | 130,279 | 13,875,199 | 20,298,140 | 24,005,198 | **58,308,816** |
| 2 | Vector control other than ITNs (Indoor residual spraying) | 694,899 | 2,981,189 | 5,381,847 | 5,806,421 | 6,018,361 | **20,882,717** |
| 3 | BCC community outreach | 3,147,589 | 0 | 0 | 0 | 0 | **3,147,589** |
| 4 | Diagnosis | 1,340,406 | 1,779,670 | 1,135,806 | 1,712,676 | 1,322,368 | **7,290,926** |
| 5 | Human resources | 2,430,225 | 2,319,875 | 0 | 0 | 0 | **4,750,100** |
| 6 | Monitoring and evaluation | 928,040 | 1,219,290 | 913,040 | 913,040 | 1,219,290 | **5,192,700** |
| **Total of funds requested from the Global Fund:** | | 8,541,159 | 8,430,303 | 21,305,892 | 28,730,278 | 32,565,217 | **99,572,849** |

# 5 Component Budget *Malaria*

## 5.3 Summary by cost category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your detailed component budget (section 5.1)*

(a) Different from Round 6, the cost categories in table 5.3 have been expanded to provide greater clarity between different cost categories.

(b) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(c) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

*(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)*

# 5 Component Budget *Malaria*

*Table 5.3 – Budget breakdown by cost category*

*Use the "MALTable53Line" button in the standard toolbar to insert row at the end of table*

| | **Breakdown by cost category** *(same currency as in section 1.1 of the Proposal Form)* | | | | | |
|---|---|---|---|---|---|---|
| | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| **Human resources** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Technical Assistance (Development of BCC/IEC toolkits)** | 48,000 | 0 | 0 | 0 | 0 | 48,000 |
| **Training** | 2,430,225 | 2,319,875 | 0 | 0 | 0 | 4,750,100 |
| **Health products and Health Equipment (including handling and distribution)** | 1,919,859.40 | 4,080,921.79 | 18,853,110.71 | 26,148,474.81 | 29,612,759.35 | 80,615,126 |
| **Medicines and pharmaceutical products** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Procurement and supply management costs** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Infrastructure and other equipment** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Communication Materials (BCC/IEC toolkits)** | 3,099,589 | 0 | 0 | 0 | 0 | 3,099,589 |
| **Monitoring & Evaluation (7% of the total requested funds)** | 928,040 | 1,219,290 | 913,040 | 913,040 | 1,219,290 | 5,192,700 |
| **Living Support to Clients/Target Populations** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Planning and administration** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Overheads** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Other:** *(To be further defined to meet national budget planning categories)* **Operational funds for IRS** | 115,446 | 810,216 | 1,539,741 | 1,668,763 | 1,733,168 | 5,867,333 |
| **Total funds requested from Global Fund** | 8,541,159 | 8,430,303 | 21,305,892 | 28,730,278 | 32,565,217 | 99,572,849 |

## 5.4 Key budget assumptions

*The detailed component budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for year 1 and year 2 in relation to three key areas.*

### 5.4.1 Pharmaceuticals and other health products and equipment

***Applicants must complete Attachment B to this Proposal Form*** *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1 and 2 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.*** *Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.*

(a) **Provide a list (by generic product name) of artemisinin based combination therapies and other anti-malarial medicines** to be used in years 1 and 2, and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
*(Please complete table B.1 in Attachment B to the Proposal Form.)*

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**.
*(Please complete table B.2 in Attachment B to the Proposal Form.)*

(c) Provide **the total cost** for all other medicines to be used over years 1 and 2. It is not necessary to itemize each product in the category.
*(Please complete table B.2 in Attachment B to the Proposal Form.)*

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
*(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)*

*Information on appropriate unit costs is available at, for example*:

- *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2005, http://www.who.int/medicines/areas/access/med_prices_hiv_aids/en;
- Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Center and WHO (http://www.intracen.org/mas/mns.htm);
- *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org/what_msh_does/cpm/index.html*; and*
- *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility http://www.stoptb.org/gdf/drugsupply/drugs_available.asp.)*

**Provide any additional information on unit costs below**

```
Unit costs of commodities (see Annex E for more details and rationale):


1) LLIN: Unit price USD5.00; procurement cost USD0.25; distribution cost USD0.25.
Total cost 10,601,603 LLINs x USD5.50 = USD58,308,816.

2) DDT 75% WDP: Unit price USD5.00 per kg. Total cost 2,688,077 kg x USD5.00 =
USD13,440,384.

3) Spray pumps: Unit price USD250. Total cost 4,500 units x USD250 = USD1,125,000.

4) Spare part for spray pump: Unit price USD100. Total cost 4,500 units x USD100 =
USD450,000.

5) RDT: Unit price USD0.60 per test; distribution cost USD0.05. Total cost USD0.65 x
11,216,809 tests = USD7,290,926.

6) BCC/IEC toolkit: Printing USD3.00; distribution cost USDUSD0.50. Printing and
```

distribution cost 885,597 toolkits x USD3.50 = USD3,099,589. Development and translation cost USD48,000. Total cost USD3,147,589.

**Human resources costs**

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the client/target population level, and how these salaries will be sustained after the proposal period is over. ***(Maximum of half a page)***.

*(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)*

Not applicable.

### 5.4.3 Other key expenditure items

Explain the rationale for how other expenditure categories which form an important share of the budget (e.g., infrastructure and other equipment; communication materials; or planning and administration), have been budgeted for the first two years. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

1) Training costs:

a) Training of district level malaria focal persons from 450 malarious districts (to be contracted out). USD2,000 per trainee: USD2,000 x 900 trainees = USD1,800,000.

b) Training of 20,000 HEWs from health posts in 450 malarious districts:

Development, translation, printing and distribution of training manuals: USD35,500.

Regional level training of 450 trainers: USD74,850.

District level training of 20,000 HEWs: USD2,839,750.

2) Operational costs for IRS:

Per diem for spraying personnel: The operation lasts 46 days every year before the transmission season. Annually, an average of 958,829 households will be sprayed. An average of 3,995 spray men, 799 squad chiefs, 200 technicians (or team leaders), 50 supervisors, and 200 drivers will take part each year.

Total cost: Per diem USD5,467,322; Fuel USD533,349.

3) Monitoring and evaluation:

a) Computer database: USD15,000.

b) Printing of forms: USD20,250.

c) Malaria indicator surveys twice (in 2009 and 2012) in 125 districts: USD250,000 per survey, total: USD500,000.

d) Supervision costs at all levels: Total cost USD4,149,000 (see Annex E for details).

e) Annual review meetings; Total cost USD395,950.

See Annex E for more details and rationale.

# 5 Component Budget *Malaria*

*The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.*

| **Section 4: Component Strategy – Malaria** | | **Annex Number to your proposal** |
|---|---|---|
| 4.3.1 | Documentation relevant to the national disease program context. | Annexes 9 and 10 |
| 4.3.5(c) *(**only** if common funding mechanism)* | Documentation describing the functioning of the common funding mechanism. | Not applicable. |
| 4.3.5(d) *(**only** if common funding mechanism)* | Most recent assessment of the performance of the common funding mechanism. | Not applicable. |
| 4.6 | **A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**. | **Attachment A – Malaria** |
| 4.6 | **A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year). | Annex D |
| 4.6 | **A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals. | Annex 15 |
| 4.8.3 (c) | List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**) | Not applicable. |
| 4.9.1 | National Monitoring and Evaluation Plan/Strategy (if one exists) | Annex 14 |
| **Section 5: Component Budget – Malaria** | | **Annex Number to your proposal** |
| 5.1 | **Detailed component Budget** | Annex E |
| 5.1 *(if HSS strategic actions are included – see section 4.4.2)* | Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget). | Not applicable. |
| 5.4.1 *(and section 4.10.5)* | Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3) | **Attachment B – Malaria** |
| 5.4.2 | Human resources costs. | Annex E |
| 5.4.3 | Other key expenditure items (Monitoring and | Annex E |

| | | |
|---|---|---|
| | evaluation). | |
| 5.1 - 5.3<br>*(if common funding mechanism)* | Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal. | Not applicable. |
| **Other documents relevant to sections 4-5 attached by Applicant:** | | **Annex Number to your proposal** |
| | | |
| | | |
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