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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CCM - GABON		
Country	GABON		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Upper middle income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 8 Proposal Element(s):		
Disease	**Title**	**HSS cross-cutting interventions section** ***(include in one disease only)***
X HIV[1]	Support for the Gabonese initiative to fight AIDS	☐
☐ Tuberculosis[1]		☐
X Malaria	Roll back malaria in Gabon	☒

Currency	USD	or	X EURO

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

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)
+ Attachment C: **Membership details of CCMs or Sub-CCMs**

Complete the following sections for each disease included in Round 8:
3. Proposal Summary

4. Program Description
4B. HSS cross-cutting interventions strategy **

5. Funding Request
5B. HSS cross-cutting funding details **

*** Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

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

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

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

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

IMPORTANT NOTE:

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

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

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

ROUND 8 – Malaria

1 FUNDING SUMMARY AND CONTACT DETAILS

1.1 Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	3 255 046	3 623 983	3 448 342	3 244 972	3 429 919	**17 001 462**
Tuberculosis						
Malaria	3,070,771	1,959,548	3,438,952	2,112,036	3,270,576	13,851,883
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 8 Funding Request ➔:	30,853,345

1.2 Contact details

	Primary contact	Secondary contact
Name	Dr. Emmanuel OGANDAGA	Dr André NDIKUYEZE
Title	Chairman	Vice Chairman
Organization	*Conseil National de l'Ordre des Médecins* (National Medical Association)	Gabon Multi-sectoral Coordinating Committee
Mailing address	BP 12075 – Libreville, Gabon	BP.820 Libreville (Gabon)
Telephone	+ 241 05 32 62 45 + 241 06 97 80 92	+ 241 06 22 44 03
Fax		
E-mail address	awelo250@yahoo.fr	ndikuyezea@ga.afro.who.int
Alternate e-mail address		

1.3 List of Abbreviations and Acronyms used by the Applicant

1.3.1. AIDS Component Acronyms/Abbreviations List	
Acronym/Abbreviation	Meaning
ACCESS	Increase PLWHA access to care in Gabon
AOI	International tender
IGA	Income Generating Activities
ARV	Anti-retrovirals
CALS	Provincial AIDS Control Committees
KAP	Knowledge, Attitude, and Practices
CCSIDA	AIDS Advisory Committee
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
VCT	Voluntary Counselling and Testing
LHC	Libreville Hospital Centre
COSP	Public Health Monitoring Unit
CNLS/MST	National committee to fight AIDS and STDs
CNSS	National Social Security Fund
PD	Prenatal Diagnosis
PD1	First Prenatal Diagnosis
OTC	Outpatient Treatment Centre
VL	Viral Load
DGPIE	General Planning, Investment and Equipment Department
DIS	Health Information Department
SDA	Service Delivery Area
DMP	MSHPFPF Drug and Pharmaceutical Department
RHD	Regional Health Department
EPP	Estimation and Projection Package
ESTHER	Network for Therapeutic Solidarity in Hospitals
MSM	Men who have sex with men
STI	Sexually Transmitted Infections
MSHPFPF	Ministry of Health and Public Hygiene, in charge of the family and the promotion of women
MASSPVOLS	Ministry of Social Affairs, Solidarity, the Protection of Widows and Orphans, and the Fight against HIV
MGBEF	Gabonese Movement for Family Well-being
OVC	Orphans and Vulnerable Children
WHO	World Health Organization

UNAIDS	Joint United Nations Program on HIV/AIDS
OPN	National Pharmaceutical Office
PEC	Care
PC	Pediatric Care
PICM	Communication and Marketing Integrated Program
NHDP	National Health Development Plan
PNLS/MST	National Program to fight AIDS and STDs
PLIST	STI/HIV/AIDS Program
UNDP	United Nations Development Program
PEP	Post-Exposure Prophylaxis
SW	Sex workers
NSP	National Strategic Plan to fight HIV/AIDS
PMTCT	Prevention of mother-to-child HIV transmission
PLWHA	People Living with HIV/AIDS
REGAP+	Gabonese network of people living with HIV
REGOSIDA	Gabonese AIDS Organizations Network
RENAPS/AJ	National network for the promotion of adolescent and youth sexual health and reproduction
RENASES	National network of churches fighting AIDS
PR	Principal Recipient
RUSID	License for the use of the customs IT system
SE/CNLS (DGLS)	Permanent Secretariat of the National AIDS Control Committee
SEEG	Gabonese Energy and Water Authority
AIDS	Acquired Immunodeficiency Syndrome
MCH	Mother and Child Health
M&E	Monitoring and Evaluation
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
HIV	Human Immunodeficiency Virus

1.3.2. List of Acronyms/Abbreviations of the malaria component	
Acronym/Abbreviation	Meaning
AS + AQ	Artemisinin + Amodiaquine
PR	Principal Recipient
CCM	Country Coordinating Mechanism
ACT	Artemisinin-based combination therapies
PD	Prenatal Diagnosis
BAP	Behaviours, Attitude, and Practices
BCC	Behaviour Change Communication
COSP	Public Health Monitoring Unit
IPC	Interpersonal Communication
ISD	Information and Statistics Department
DPD	Drug and Pharmacy Department
RHD	Regional Health Department
DSCRP	Growth and Poverty Reduction Strategy Paper
STG	Standard Treatment Guidelines
EDSG	Health Demographic Survey in Gabon
EGEP	Gabonese Survey on Enrichment and Poverty
RBM	Roll Back Malaria
IEC	Information Education Communication
IELE	Institute of Epidemiology and Endemics
IHPA	Public Hygiene and Sanitation Institute
EDL	Essential Drugs List
ITN	Insecticide-Treated Nets and other materials
LLIN	Long-Lasting Insecticidal Nets
MINAPYGA	National Pygmy Minority of Gabon
NIT	New Information Technologies
CBO	Community-based Organization
MDG	Millennium Development Goals
WHO	World Health Organization
NGO	Non-Governmental Organization
OPN	National Pharmaceutical Office
PCIME	Integrated Care of Children's Diseases
EPI	Expanded Program on Immunization
PLIST	Program to fight sexually-transmitted infections
NHDP	National Health Development Plan
NMCP	National program for the fight against malaria

UNDP	United Nations Development Program
MPP	Prevention of malaria during pregnancy.
RBM	Roll Back Malaria
RGPH	General Census of the Population and Habitat
HIS	Health Information System
SP	Sulfadoxine Pyrimethamine
PHC	Primary Health Care
RDT	Rapid Diagnostic Tests
DOT	Directly Observed Treatment
IPT	Intermittent Preventive Treatment
UNPF	United Nations Population Fund
UNICEF	United Nations Children's Fund
UHS	University of Health Sciences

2 APPLICANT SUMMARY (including eligibility)

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

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

2.1 Members and operations

2.1.1 Membership summary

Sector Representation	Number of members
X Academic/educational sector	2
X Government	10
X Non-government organizations (NGOs)/community-based organizations	7
X People living with the diseases	2
People representing key affected populations[2]	
X Private sector	2
X Faith-based organizations	3
X Multilateral and bilateral development partners in country	6
Other *(please specify)*:	
Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	32

[2] Please use the *Round 8 Guidelines* definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/8/AttachmentC_en.xls

2.1.2 Broad and inclusive membership

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

2.1.3 Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

In evaluating the impact of health system problems on the programs and outcomes for the three diseases, as well as its experience in this matter, the CCM will admit as a resource person, any individual or corporation that it deems necessary in light of his/her competences or action in the furtherance of CCM goals. The General Department for Planning, Investment and Equipment (DGPIE), the Health Information Department (HID), and the Public Health Observation Cell (COSP) will be specifically requested by the CCM to deal with all health system issues and the outcomes of the three diseases. The Ministry of Health, through its three departments, conducted a participative evaluation of the health system, which resulted in the development of the 2007-2011 National Health Development Plan.

Gender awareness

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

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

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

In the management of gender issues, the CCM will call on the expertise of resource persons, as described in Article 6 of its Decree. The CCM will be based on the UNFPA, UNICEF, and the General Department for the Promotion of Women of the Ministry of Health and Public Hygiene, overseeing the family and promotion of women, which is responsible for preparing the national gender policy. In addition, among the CCM members, five government representatives and 4 members of associations have experience with gender issues.

Of the 32 members of the CCM, 12 are women (37.5%).

Multi-sectoral planning

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

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

The CCM uses a participative approach for the preparation of multi-sectoral projects. The call for applications for the development of projects is made according to targets and priority areas in accordance with the AIDS and malaria strategic plans. This allows the CCM to organize the ad hoc analysis and project selection commissions through the Permanent Secretariat.

2.2 Eligibility

2.1.1 Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
Applied for funding in Round 6 and/or Round 7 and was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
X Last time applied for funding was before Round 6 or was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.1.2 Transparent proposal development processes

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

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

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*	
See Annex D	
(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*	
See Annex D	
(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*	
See Annex D	
(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***[Insert Annex Number]***

2.1.3 Processes to oversee program implementation

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

2.1.4 Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles. .*

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*	
See Annex D	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***[Insert Annex Number]***

2.1.5 Principal Recipient(s)

Name	Disease	Sector**
Health and Public Health Ministry, in charge of the family and the promotion of women	AIDS	Government
Health and Public Health Ministry, in charge of the family and the promotion of women	Malaria	Government
[use "Tab" key to add extra rows if needed]		

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

2.1.6 Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
The absence of a designation of at least one PR of the governmental and non-governmental sectors for each disease covered by this proposal is due to the fact that the civil society actors who applied for financing lack sufficient structural capacity to generate and lead the monitoring of a Global Fund grant.

2.1.7 Managing conflicts of interest

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

2.1.8 Proposal endorsement by members

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

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	**Planned Start Date**	**To**
Month and year: *(up to 5 years)*	May 2009	April 2013

3.2 Consolidation of grants (a) Does the CCM (or Sub-CCM) wish to consolidate any existing malaria Global Fund grant(s) with the Round 8 malaria proposal?	☐ Yes *(go first to (b) below)* x No *(go to s.3.3. below)*
***'Consolidation'** refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.* ➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/en/apply/call8/other/#5*	
(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval? *(List the relevant grant number(s))*	

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

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

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

Proposal implementation is **set to begin May 2009**, which corresponds to the beginning of the 12th quarter of Round 5. The choice of this date is explained by two important factors:

- The State's budget cycle, which goes from January 1 to December 31, providing for an analysis of financial gaps, taking into account Government expenses for the previous years' execution and forecasts for the five next years.
- The action plan and reporting cycle of the Round 5 grant in the process of execution, which were aligned with the current one to facilitate implementation.

3.4 Program-based approach for Malaria

3.4.1. Does planning and funding for the country's response to malaria occur through a program-based approach?	☐ Yes Answer s.3.4.2 X No. ➔ *Go to s.3.5.*

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

3.5 Summary of Round 8 malaria Proposal

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

Prepare after completing s.4.

This proposal, taken from the national malaria control strategic plan, aims to ensure increased coverage in the key interventions from now through 2010 and to sustain them until 2013, particularly among children under 5 years and pregnant women, in a context of universal access. This aligns with plans advocated by the WHO and the RBM World Plan, to which African Heads of State committed themselves during the Abuja Summit in 2006. The selection of these groups is based on their particular vulnerability to the disease. The actions planned will supplement those of Rounds 4 and 5, as well as of the Government and other partners.

Coverage goals determining the services to be provided from now through 2013 include:

1. To ensure access to long-lasting insecticide-treated mosquito nets to at least 80% of children under 5 years and pregnant women.

To achieve this goal, the service delivery areas selected include supplying long-lasting insecticide-treated mosquito nets to at least **80% of families** and intensifying Behavior Change Communication through the mass media and community agents and monitoring resistance to insecticides.

2. To ensure access to quick diagnosis and effective treatment to at least 80% of children under 5 years and pregnant women

The Round 5 grant provided for the introduction of ACTs into the treatment of simple malaria among target populations (children under 5 years and pregnant women) in the health care facilities.

The following SDAs have been selected: rapid and effective anti-malaria treatment in health facilities (public and private), malaria home care through community agents, improvement of the quality of biological diagnosis (microscopy and RDT), monitoring of pharmacoresistance and pharmacovigilance.

3. Institutional capacity-building of the National Malaria Program and the monitoring and evaluation system

Implementation of the interventions of the fight against malaria and measurement of the expected outcomes and impact require an efficient management and monitoring/evaluation system. The SDAs selected are the information system, partnership and coordination, management, and governance.

The budget planned for Round 8 amounts to 13,851,883 Euros; added to the balance remaining from Round 5 (10,176,004), it amounts to 24,027,887 Euros, that is, 23.7% of the country's total financing needs of the 2009-2013 strategic plan (101,376,958.88 Euros).

All activities of the project will be performed in partnerships involving the health sector (public and private), related ministries, the civil society, and bi- and multilateral partners.

The CCM and malaria thematic group are in charge of coordinating and monitoring implementation.

4 PROGRAM DESCRIPTION

4.1 National prevention, treatment, care, and support strategies

(a) Briefly summarize:

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

Gabon has a strategic plan (2009-2013) based on the strategies recommended by the WHO through the RBM partnership:

- prevention through the promotion of insecticide-treated mosquito nets and ITP of pregnant women;
- treatment of cases in health care facilities and homes, according to the level of health system contact.

The implementation of these strategies is sustained by:

- operational research based on KAP surveys and evaluation of the therapeutic efficacy of antimalarial drugs and of the vector sensitivity to insecticides;
- social mobilization and Behavior Change Communication (BCC);
- Monitoring and Evaluation ;
- Partnerships.

The recommended prevention strategies (antivectorial fight through insecticide-treated nets and intermittent preventive treatment) allow for the reduction of morbidity and mortality related to malaria, particularly among the target populations. They are easily accessible to the populations and the costs are relatively affordable.

The selection of these strategies is based on the fact that Gabon is an equatorial country with permanent transmission of malaria, in which it is difficult to control the vector.

The Long-Lasting Insecticide-Treated Mosquito Net (LLITN) is physico-chemical barrier between humans and the vector. It is one of the best aids in the antivectorial fight, the least costly, and the most accessible by populations. Its correct, wide-scale use facilitates a 38% reduction in incidence rates of malaria parasitemia, 47% in malaria-related anemia, and 28% in the rate of low-weight births (American Journal of Tropical Medicine and Hygiene (1998):59(5):813-822).

The administration of IPT to pregnant women reduced mother and neonatal morbidity and mortality. Its implementation is facilitated, in Gabon, by the high antenatal consultation services attendance rate (84% EDS 2000).

The permanent availability of the drug in public and private health care facilities provides for **a correct and rapid management of cases** and motivates health care facility attendance. The training of health care providers, community agents, and mothers and guardians of children and the supply of drugs will contribute to increasing access to services and to improving the quality of care of cases in health care facilities and homes.

The implementation **of support strategies** will allow for a better use of services, a better focus on the interventions, improvements in quality and the mobilization of partners and communities in favor of the fight against malaria.

The implementation of all these strategies, thanks to financing from the Government and its partners, especially the Global Fund, will allow the country to obtain significant outcomes:

- Mass distribution of LLITN to target populations during vaccination campaigns and in health care facilities. Six hundred and twenty-three thousand three hundred **(623,300)** LLITNs were distributed over the three last years;
- Implementation of the IPT among pregnant women, with coverage that rose from 30% in 2005 to 52% in 2006 (2006 WHO monitoring);
- Distribution of ACTs in the care of simple malaria cases among children under 5 in health care facilities, with **218,411** children treated out of **227,240** expected, that is, **96%** at the end of 2007, according to the principal recipient's Round 5 report of GFATM (UNDP).

The evaluation in progress of the Round 4 grant and of the first phase of Round 5, with support provided by the WHO, will make it possible to specify the outcomes and impact of the implementation of the strategies of the fight.

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

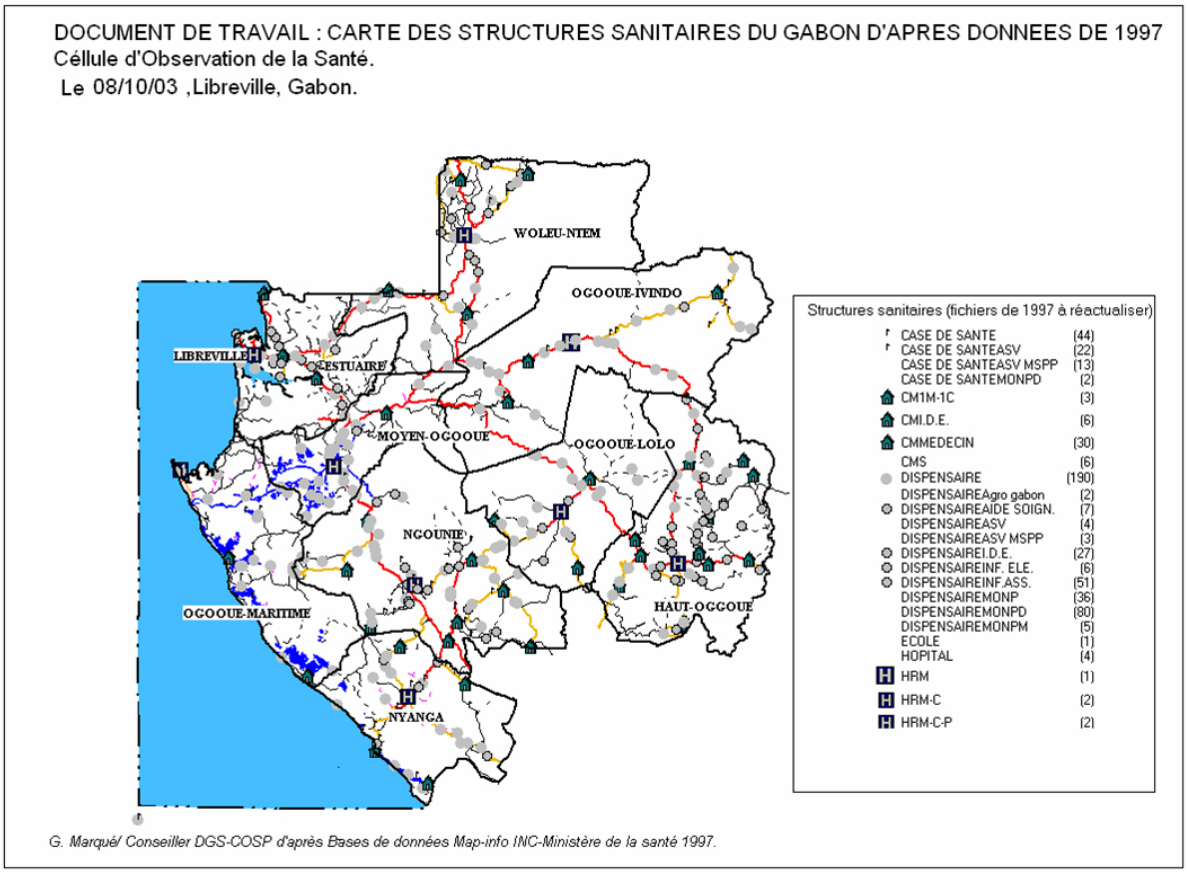
Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
☐ National Health Sector Development/Strategic Plan	NHDP DSCRP	10-25 53 ; 57 ; 67 ; 69 122-128
☐ National Malaria Control Strategy or Plan	National Strategic Malaria Control Plan	Attached
☐ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	National Guidelines in terms of care, LLIN, and IPT. National Health Action Plan	7-16 16 ; 37-38 ; 46-47 Annexes 1, 2, and 3
☐ Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal	SNIS (National Health Information System) Evaluation Report WHO monitoring report DHS	Attached Attached 129 ; 146 ; 147 ; 154
☐ National Monitoring and Evaluation Plan (health sector, malaria specific or other)	Laboratory evaluation report NMCP institutional audit report	Attached Attached
☐ National policies to achieve gender equality in regard to the	Ordinance 01/95	Article 17

provision of malaria prevention, treatment, and care and support services to all people in need of services	Decision 003/CC Decree 00104/PR/MSP	Articles 3, 4, 5, 7, and 12 Articles 4 to 9

4.2 Epidemiological Background

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



(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
*Total country population (all ages)	1,717,121	Decision No. 003/CC of February 17, 2005 referring to the provisory outcomes of the 2003 RGPH (growth rate of 2.5%)	2008
**Women > 54 years	96,529	MSHPFPF (EPP/SPECTRUM National Projection)	2008
**Women 15 – 54 years	418,098	MSHPFPF (EPP/SPECTRUM National Projection)	2008
***Women with a pregnancy in last 12 months	63,907	MSHPFPF (EPP/SPECTRUM National Projection)	2008
**Men > 54 years	75,222	MSHPFPF (EPP/SPECTRUM National Projection)	2008
**Men 15 - 54 years	423,127	MSHPFPF (EPP/SPECTRUM National Projection)	2008
Girls 5 -14 years	223,329	MSHPFPF (EPP/SPECTRUM National Projection)	2008
Boys 5 – 14 years	220,235	MSHPFPF (EPP/SPECTRUM National Projection)	2008
Girls 0 – 4 years	130,341	MSHPFPF (EPP/SPECTRUM National Projection)	2008
Boys 0 – 4 years	130,240	MSHPFPF (EPP/SPECTRUM National Projection)	2008
**** T	396,460	MSHPFPF (EPP/SPECTRUM National Projection)	2008
Other **:			
Other **:			[*use "Tab" key to add extra rows if needed*]

**Estimate of the population from the results of Decision 003*
***the population is composed of 51% women and 49% men*
****pregnant women represent 3.6% of the total population*
*****reproductive-age women represent 22% of the total population*

4.2.2. Malaria epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Episodes of malaria in past 12 months (*all population, all ages)*	197,287*	Statistical data report of the NMCP's Epidemiological	2007

4.2.2. Malaria epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
		Department	
Episodes of malaria in past 12 months: Women > 54 years	7,862*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Women 15 - 54 years	25,453*	Statistical data report of the NMCP's Epidemiological Department	2007
Pregnant women infected with malaria in the past 12 months	3,631*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Men > 54 years	6,892*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Men 15 - 54 years	23,641*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Girls 5 – 14 years	17,828*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Boys 5 – 14 years	17,477*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Girls 0 – 4 years	26,868*	Statistical data report of the NMCP's Epidemiological Department	2007
Episodes of malaria in past 12 months: Boys 0 – 4 years	29,910*	Statistical data report of the NMCP's Epidemiological Department	2007
Other**: ***Refer to the* Round 8 Guidelines *for other possible groups*			
Other**:			
Other**:			[*use "Tab" key to add extra rows if needed*]

*These figures are underestimated due to the incomplete data relate to only part of the public structures (30%).

4.3. Major constraints and gaps

(*For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations*[4] *who may have disproportionately low access to malaria prevention, treatment, and care and support services, including women, girls, and sexual minorities.)*

4.3.1. Malaria program

Describe:

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

Despite the fight efforts made by the Government and its partners, malaria is still a major public health problem in Gabon, marked by high morbidity and mortality. The monitoring by the WHO in 2006 found a prevalence of 61% of fever/malaria among children under 5 years and a mortality of 1.3% for the same age range.

Strengths, weaknesses, opportunities, and threats were analyzed as part of the review of the national strategic malaria control plan in the country. The main weaknesses identified are described below by strategy.

Prevention through insecticide-treated mosquito nets

Poor use of insecticide-treated mosquito nets is observed (19.8% among pregnant women, 18% among children 0-5 years, 2006 WHO Monitoring Review) due to several factors:

- Poor availability of LLITNs: of an estimated need of 1,065,113 LLITNs in 2008 to cover 100% of families (3 mosquito nets), only 623,300, or 58.5%;
- Insufficient resources allocated to the purchase of insecticide-treated mosquito nets in the State budget;
- Inadequate storage capacity and distribution of LLITNs at the basic departmental and community levels;
- Insufficient involvement of NGOs, community agents, and the private sector in the distribution of mosquito nets and in social mobilization;
- Weak implementation of the scaling-up plan of community-based interventions (2005-2007);
- Lack of inclusion of insecticide-treated mosquito nets in the national list of essential drugs.

Prevention among pregnant women (IPT)

In spite of the relatively high rate of IPT coverage (66%, 2006 WHO monitoring), **poor coverage in IPT 2** (42%, 2006 WHO monitoring) can be observed. The reasons for these weak results can be summarized as follows:

- Insufficient involvement of the private sector in the IPT: nonparticipation in training sessions organized by the NMCP, nonobservance of the guidelines in the prescription, nonparticipation in reporting;
- Insufficiency of personnel trained in refocused Antenatal/Postnatal Consultation (ANC) (333 trained persons, but a need of 662) and concentration of ANC service providers in large cities;
- Poor observance of the guidelines (Directly Observed Therapy) by service providers.

Management of health care facility cases

The 2006 WHO monitoring report shows that only 41% of children with a fever received an antimalarial treatment, only 30.5% within 24 hours. The percentage having received antimalarial treatment

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

recommended by the national guidelines is 10.6%. These figures reveal inadequate care in health care facilities. The weaknesses identified based on these results include:

- Unsatisfactory procurement and inventory management: insufficiency of distribution resources from the regional level to departments, health care facilities, and communities, as well as inadequacy of inventory management. These various problems led to supply shortages in certain places and surplus inventory in others;

- Poor geographic accessibility (distance from health facilities and difficulties with transportation) and financial challenges regarding health care (non-compliance with governmental measures regarding free access to care of malaria cases);

- The 2006 WHO monitoring report shows that 47% of ill children self-medicate, and only 43% search out a health care facility;

- Poor quality of care of serious cases with a performance score of 15.3% (2006 WHO Monitoring). This is partly due to frequent shortages of drugs and other inputs for the care of serious malaria cases (quinine, diazepam, syringes, needles, glucose serums, oxygenators, cathlons etc.);

- Insufficiency of personnel training in the care of cases: 573 trained during Round 4 of 4,130 planned by Round 4 and 5;

- Insufficiency of supervision at all levels (47% of facilities supervised, the three last months, 2006 Monitoring);

- Lack of updating of school training CVs regarding the new guidelines for malaria care;

- In spite of the implementation of ACTs, the pharmacovigilance system is still not operational.

Diagnosis

An accounting of the laboratory situation of the civil public health sector performed in February-March 2008 by the UHS, with the financing of the Global Fund (Round 5) showed: **deficient malaria biological diagnosis capacity:**

- only 9 of the 42 laboratories surveyed (21%) had the capacity to perform the malaria parasitological diagnosis;
- 15 laboratories evaluated (37.5%) provide correct assistance to the doctor for the care of malaria;
- 25 of the 42 laboratories visited, or 62.5%, reported errors in results : 12 false negatives, 10 false positives, and 3 false positives and false negatives at the same time;
- Of 171 laboratory technicians counted in the 42 surveyed laboratories, 44%, or 75, were trained in malaria biological diagnosis.

These unsatisfactory results demonstrate an insufficiency of personnel training, supervision, and quality control and an insufficiency and obsolescence of equipment, materials, and reagents. It is also the result of a weak implementation of the minimum package of activities of the laboratories determined in the **National Health Action Plan.**

In addition, insufficient information about the operation of laboratories of the public, military, parapublic and private sectors is available.

Despite the introduction of ACTs, the establishment of RDTs planned in Round 5 has been postponed until the second phase, which starts in the second half of 2008.

Home care of malaria cases

The 2006 Monitoring Report showed that **47% of the children with a fever self-medicate as a first response,** which confirms the need for bringing treatment closer to the patient.

Deficiencies in the training of community agents for the home care of cases can be observed. Thus, Round 5 already financed the training of 235 of the 538 mothers and guardians of children planned. In addition, training modules used were not in compliance with the national care guidelines, including community IMCI. Also, the trained community agents were not supplied with drugs (ACT) and they are insufficient to scale up the strategy.

The lack of supervision and a community-based information system does not assure the provision of quality care and acquisition of reliable data to evaluate outcomes.

The weak outcomes observed in the management of cases in the health care facilities (2006 WHO monitoring report) also hold back implementation of home treatment, all the more so because health agents will have to ensure training and supervision of community agents.

Operational research

All 5 sentinel sites set up by the NMCP are involved in operational research activities related to the monitoring of the resistance of parasites to antimalarials and resistance of the vector to insecticides. Coverage surveys have been planned in the Round 5 action plan through 2010. There are no resources to continue this activity until 2013.

There is also a deficit of reliable data about morbidity and mortality related to malaria, the impact of IPT, and morbidity and mortality of the target populations in question (pregnant women and newborns). The same applies to CAP surveys and multiple indicator surveys.

Social mobilization

In addition to monitoring performed with the support of the WHO in 2006, which did not take social mobilization aspects into account, there is a marked **lack of surveys to evaluate knowledge, attitude and practices (KAP) among populations regarding malaria control strategies (ITN, IPT, case management) with a view to guiding BCC/social mobilization activities**. For this reason, the situation was analyzed based on a consultation process with the stakeholders, supervision reports, and activity reports. This consultation process demonstrated a lack of awareness among populations regarding malaria control strategies. The factors behind this situation include:

- Absence of an integrated communication plan, hence the lack of coordination of social mobilization activities among the different programs;
- Inadequate involvement of NGOs, CBOs, and the private sector, whose capacities need to be strengthened in the implementation of social mobilization activities;
- Insufficient mobilization capacity at the regional and departmental levels;
- Insufficient monitoring of 950 community agents trained in awareness-raising techniques by Round 4;
- Insufficient number of community agents trained in awareness-raising techniques (950, whereas a need of 2,000 community agents was identified);
- Insufficient community communication media;
- Lack of motivation among community agents;
- Poor access to prevention, care, and support services for minority and underprivileged groups (pygmies), as well as in isolated rural areas.

Monitoring/Evaluation and information system

The monitoring/evaluation system of the country today depends on the weak performance of the national health information system for data collection and distribution of results.
The lack of an integrated monitoring/evaluation plan for malaria control that follows the “Three Ones” concept is a major performance monitoring weakness.

Thus, the following problems can be identified:

- a low completion rate (30%, 2005 Ministry of Health's statistics) of the routine data and insufficient feedback;
- inadequate capacity of the monitoring/evaluation unit of the NMCP coordination (insufficient personnel trained in monitoring/evaluation and lack of a database);
- lack of a monitoring/evaluation system of the community-based interventions (collection tools, personnel training, supervision)
- insufficient supervision: 47% of the supervised health care facilities in 2006, according to the 2006 WHO monitoring report, 4 regions of 10 funded for supervision in 2007 (funds available, but not disbursed due to ignorance of fund disbursement procedures);
- lack of review meetings.

Partnerships

Regarding partnerships, there is **insufficient coordination of the interventions among the malaria control partner**. This situation is explained by the weak operationality of the permanent secretariat of the CCM and the malaria thematic group (Task Force). The involvement of a limited number of NGOs/CBOs and private facilities in the malaria control at all levels can also be noted.

The weak involvement of NGOs and the private sector is a limiting factor to accessibility to high-quality preventive and curative services of populations, especially in peripheral and underprivileged rural areas.

Management and governance

The organizational consultation process carried out in January 2007 by the EVAO CONSEIL office identified the main weaknesses in the operation of the NMCP. It consists, especially, of the lack of a formal division of labor among the departments, a deficit in coordination, the lack of a management system (lack of a procedures manual).

In spite of the availability of personnel, there is insufficient training in the areas of planning/management, monitoring/evaluation, and data management.

4.3.2. Health System

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

The description can include discussion of:

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

The analysis of the situation within the NHDP shows that, to date, **the national health system has not offered an appropriate response to the acute demand for care from the population**, particularly from the vulnerable target populations, namely mothers, children, and the elderly. The weaknesses identified include, in particular:

- Insufficient personnel (the total deficit estimated at present is 2,000 agents), unevenly distributed personnel (one third of the personnel is in major cities), and unmotivated personnel (working

conditions are sometimes poor and they face career problems);
- Insufficient and outdated basic health care infrastructure and equipment;
- Poor quality of treatments due to the lack of a national quality standard, insufficient control of health care facilities, and inadequate training programs;
- Lack of a formal collaboration framework among the various components of the health system (military public sector, profit or non-profit private sector), which exacerbates the deficits in treatments offered;
- Poor appropriation of the primary health care, which results in a failure in the operationality of the health department;
- Limited financial accessibility to treatments for underprivileged population groups, especially due to the failure to implement health insurance;
- Lack of updating of the available health map negatively affects the planning and implementation of malaria control activities.

The poor performance of the health system limits implementation of the malaria control strategies, especially at the operational level.

4.3.3. Efforts to resolve health system weaknesses and gaps

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

Vital efforts were made by the Government, partners (WHO, Global Fund, UNICEF, UN Foundation, etc.) to respond to the weaknesses affecting the results in terms of malaria control. These efforts include:

1. **In the area of prevention through insecticide-treated mosquito nets:**

- Distribution of 623,300 mosquito nets from 2006 to 2008, especially during the integrated campaign (more than 300,000) organized in 2007 in all the health regions, thanks to financing from the Government, the Global Fund, and the UN Foundation;
- Insecticide treatment of 9,180 mosquito nets through community agents, of which 2,563 were treated during the mass insecticide treatment campaign in the province of Moyen-Ogooué.

In 2006, the coverage rate was 18% among children under 5 years and 20% among pregnant women (2006 WHO monitoring report). These rates definitely increased thanks to the distribution mentioned above. The evaluation in progress (June 2008) of Round 4 and first phase of Round 5 will provide updated information about current coverage percentages.

2. **In the area of Prevention of Malaria during Pregnancy (PMP)**

The intensification of ANC activities facilitated improvement in IPT 2 rates from 30% in 2005 to 42% in 2006 (2006 WHO monitoring report). The financing received from the Global Fund and WHO support allowed the NMCP and NGOs to provide more than 30,000 pregnant women with IPT between 2006 and 2007 (UNDP report of December 2007). The evaluation in progress (June 2008), with the support of the WHO, will aid in obtaining reliable information about current coverage levels.

3. **In the area of case management in health care facilities**

With the financing of the Government and the Global Fund, Gabon introduced care through ACT in public, parapublic, and private health care facilities (profit or non-profit). According to the Principal Recipient's report, 218,411 cases had been treated by the end of 2007.

During the same period, 573 care providers from the public (civil and military), parapublic, and private sectors and 75 malaria biological diagnosis technicians were trained; antimalarials were supplied to health care facilities of the public sector; and 11 of the 52 laboratories planned were equipped with microscopes.

4. **In the area of home care of cases**

This strategy has not yet been implemented in Gabon. The training of **1,408** community agents by the Ministry of Social Affairs and the Association of Midwives of Gabon (ASFG) has focused on awareness-

raising techniques regarding malaria control and has not addressed home care according to the new national guidelines.

5. In the area of the strengthening of the health system

Several actions were taken by the Government and partners to strengthen the effectiveness of the health system:

5. 1. Strengthening of the NMCP

- Purchase of 8 vehicles thanks to funds received from the Global Fund and 1 vehicle funded by the Government for the coordination of the NMCP;
- Equipping with computer supplies;
- Internet installation;
- Allocation of additional personnel.

5.2. Strengthening of the health system

5.2.1. Human resources

- With financing from the Government, capacity-building of approximately 160 health care personnel in charge of drug management throughout the country;
- Recruitment of personnel by the State every year, including *coopérants* (military national service) for specialties not covered by nationals.
- With financing from the Global Fund, training of 262 agents in data management.

5.2.2. Infrastructure, equipment, and logistics

- Construction and equipping by the Government of five (05) NPO regional branches and eight (08) regional hospital centers, three (03) of which are new;
- Purchase of two vehicles for malaria control by TOTAL GABON for the health regions of Libreville-Owendo and Maritime (UNICEF-TOTAL GABON Project); provision by the Government of vehicles to all departments of the health regions (10), regional health inspections (10), and epidemiological centers (9/10), and 10 ambulances to regional hospital centers and health centers;
- With financing from the Global Fund: equipping of 52 health departments with computer supplies (64 computers, 52 printers, 60 Celtel kits for Internet connection).

5.2.3. Improvement of access to care

- Process in progress to make medical insurance effective, with a view to improving access to care of populations, particularly, mothers, children, and the elderly;
- The Government provided **600,000,000** Francs (or **914,634** Euros) to the Hospital Center of Libreville, in order to ensure free access to childbirth delivery, including cesarians, pediatric consultations, and first aid in emergency facilities. The commitment of the Government has resulted in effective free access to ANCs, vaccines, antimalarial drugs, and LLITNs in favor of the high-priority target populations.
- Implementation of the strategy of primary health care in one department (Lambaréné) by the Albert Schweitzer Foundation.

Partnerships

- Implementation of the CCM reforms to make it functional and compliant with the Global Fund norms;
- Capacity building of 10 NGOs through financing received from the Global Fund.

4.4. Round 8 Priorities

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

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

Priority No 1:	T	Historical		Current		Country targets			
Intervention	T	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		485,930	631,027	247,488	293,763	274,361	493,007	67,528	321,979
B: Extent of need already planned to be met under other programs		117,150	466,150	40,000	253,817	211,671	88,491	60,000	160,000
C: Expected annual gap in achieving plans		368,780	164,877	207,488	39,946	62,690	204,516	7,528	161,979
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			39,946	62,690	204,516	7,528	161,979

*Needs were calculated based on the family approach (average size of family = 5 persons, three mosquito nets per family) and a renewal of stock every 4 years (estimated shelf life of a mosquito net: 3 years).

Priority No 2:	Care of malaria cases	Historical		Current		Country targets			
Intervention	Provision of antimalarials (AS+AQ+A-L)	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		324,091	498,997	698,316	1,037,366	1,375,806	956,631	956,631	1,416,828
B: Extent of need already planned to be met under other programs		181,916	187,163	167,778	1,042,935	1,324,124	1,118,714	404,716	893,883
C: Expected annual gap in achieving plans		142,175	311,834	530,538	35,341	78,505	-142,467	551,915	522,945
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	0	0	414 532	418 356

Calculation basis: number of expected episodes (children under 5 years: 4 episodes per year; children over 5 years and adults: 2 per year) and average drop of 10% in morbidity per year (50% for the 5), attendance rate, and coverage expected for the intervention.

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Priority No 3:	T	Historical		Current		Country targets			
Intervention	T	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		33,341	34,224	43,850	118,748	243,645	235,910	371,752	361,041
B: Extent of need already planned to be met under other programs		0	0	0	33,539	41,925	58,693	0	0
C: Expected annual gap in achieving plans		33,341	34,224	43,850	85,209	201,720	177,217	371,752	361,041
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**85,209**	**201,720**	**177,217**	**371,752**	**361,041**

The needs were calculated based on a progressive introduction of RDTs of 10% of the cases in the first year with a progression of 5% per year to achieve 25% in the fifth year. This calculation excludes children under 5 years and pregnant women, to which the national guidelines plan a syndromic-approach to care.

Priority No 4:	T	Historical		Current		Country targets			
Intervention	T	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*					**340**	**768**	**892**		
B: Extent of need already planned to be met under other programs					0	0	0		
C: Expected annual gap in achieving plans					340	768	892		
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			340	768	892		

Calculation hypothesis: 4 community agents for 1 clinic; there are 500 clinics, therefore, 2,000 agents to be trained in 3 years. Community agents were trained through previous financing for the prevention of malaria. These were not counted because the training did not take the new guidelines and the IMCI approach into account.

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

4.5. Implementation strategy

4.5.1. Round 8 interventions

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

Where there are planned activities that benefit the health system that can easily be included in the malaria program description (because they predominantly contribute to malaria outcomes), include them in this section only of the Round 8 proposal.

Note: *If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B* ***in one disease proposal*** *in Round 8. The applicant will need to decide which disease to include s.4B (but only once).* ➔ *Refer to the* Round 8 Guidelines *(s.4.5.1.) for information on this choice.*

GOAL

The present proposal has the goal of contributing to the reduction of morbidity and mortality linked to malaria among pregnant women and children under 5 in Gabon, according to the commitments made by the African Heads of State during the 2006 Abuja meeting and to the World Action Plan of the Roll Back Malaria Partnership.

To achieve this goal, the 2009-2013 strategic plan of Gabon has set the goal of having 80% coverage of the population in the interventions selected for the fight against malaria (LLITN, IPT, care). Round 8 will contribute to the achievement of this goal, by complementing available funds and managing the coverage of high-priority target groups, that is, 0- to 5-year-old children and pregnant women.

The coverage goals that determine the services to be provided include:

1. To ensure access to long-lasting insecticide-treated mosquito nets to at least 80% of children under 5 years and pregnant women.

2. To ensure access to quick diagnosis and effective treatment to at least 80% of the children under 5 years and pregnant women.

3. To build institutional capacity of the National Malaria Control Program and the monitoring and evaluation system.

The actions planned for Round 8 will complete those of Round 5 and of other partners (integrated campaigns for the distribution of mosquito nets financed by UNICEF, UN FOUNDATION, WHO, TOTAL GABON, the Government etc.), in order to achieve universal access to the malaria control interventions.

Goal 1. To ensure access to long-lasting insecticide-treated mosquito nets to at least 80% of the children under 5 years and pregnant women

1.1. SDA: Insecticide-treated mosquito nets

For this SDA, the following activities will be performed:

1.1.1. Purchase **476,659** long-lasting insecticide-treated mosquito nets;
1.1.2. Ensure the transit, handling, and storage of LLITNs;
1.1.3. Distribute mosquito nets from the central NPO stores to regional warehouses (regional NPO branch);

1.1.4. Ship mosquito nets from the regional warehouses to health departments, clinics, and community agents;
1.1.5. Adapt and validate the operational plan of community-based interventions;
1.1.6. Train **5** trainers of community agents per health department, for a total of **270**;
1.1.7. Train **592** community agents;
1.1.8. Incorporate home care retraining of **1,408** community agents trained in awareness-raising techniques and techniques for the treatment of mosquito nets, with the funds received from Round 5;
1.1.9. Support community agents with means of transportation (**1,000 bikes**);
1.1.10. Ensure the distribution of mosquito nets to the populations through health care facilities and community agents;
1.1.11. Organize an integrated campaign for the distribution of mosquito nets.

The antivectorial fight will consist, essentially, of community-wide scaling up of the utilization of insecticide-treated mosquito nets. For that, it will be necessary to purchase new effective long-lasting mosquito nets, in order to round out the supplies acquired (or planned by Round 5 and other partners) to achieve universal access.

In scaling up for universal access, needs were calculated, based on family approach (5 persons per family and three mosquito nets per family). That figure was multiplied by the expected coverage rate expected to come up with the number of mosquito nets necessary per year, based on a net replacement rate of 4 years (shelf-life of a mosquito net: 3 years). So as to maximize results and to account for possible theft, the needs calculated were multiplied by 1.2 (calculation of 100% of the needs for a coverage of 80%). See Annex 2 (table of estimated mosquito nets needed).

The purchase, transit, maintenance, storage, and transportation of insecticide-treated mosquito nets up to the departmental level will be ensured by the National Pharmaceutical Office (NPO). A contract for the management of purchases will be established between the NPO and the Principal Recipient.

For the transportation of insecticide-treated mosquito nets, the private sector will be called upon through contracts signed with the NPO.

The health departments will ensure the shipment of the mosquito nets to clinics and community agents. They will be provided with a grant for performing this activity with the participation of the private sector.

In order to facilitate the coordination, implementation, and monitoring/evaluation of the scaling-up activities at the community level, the operational plan of the community-based interventions prepared with the WHO will be adapted and validated during a workshop with the support of a consultant. This plan will involve all the stakeholders (Ministry of Health, NGOs, the private sector, and development partners).

So as to maximize impact and coordinate the community-based interventions, the activities will be planned, performed, and monitored within an integrated framework, involving all the relevant health programs.

The community-based interventions will be introduced progressively, in collaboration with the community IMCI Project, supported by UNICEF, with the intent of covering the whole country by the end of the third year. Community agent trainers will be trained by the NMCP at the rate of **60** in the first year, **130** in the second, and **80** in the third. Training will be provided at the health regions' central units.

The following table indicates the number of agents to be trained/retrained, to be supplied with drugs, and to be supervised per year per health region.

	Number of Clinics	Year 1	Year 2	Year 3	Year 4	Year 5
Libreville-Owendo	28	112				
T	24	96				
T	33	132				
T	80			320		
T	94			376		
T	49			196		
T	34		136			
T	60		240			
T	34		136			
T	64		256			
T	**500**	**340**	**768**	**892**		
T		**340**	**1,108**	**2,000**	**2,000**	**2,000**

As the table above shows, the need for trained agents is estimated at **2,000**, of that number, **592** are to be trained and **1,408** to be retrained.

This training will involve all malaria control strategies (utilization of mosquito nets, home care of cases, IPT, and social mobilization). They will be performed by the sub-recipients, which will be selected according to the criteria established by the CCM or the principal recipient (related Ministries, NGOs and religious associations, and the private sector) with the involvement of basic health facilities.

In order to facilitate their transfer to their intervention areas and to improve their motivation level, **1,000** bikes will be supplied to community agents. Priority in the allocation of these bikes will be given to community agents covering village groups and isolated areas. The remaining community agents will be supplied by other programs having community interventions with financing from the Gabonese State (2009 budget) and other partners.

In 2007, Gabon organized an integrated campaign for the distribution of mosquito nets to children under 5 years of age. With the intent of consolidating achievements, the distribution of mosquito nets to target populations (pregnant women and children under 5 years) will be continued through the Mother and Child Health service (vaccination, ANC, maternity), pediatric curative consultation services, pre-school services, and community agents, so as to reach 80% coverage by 2010. Another campaign will be undertaken in 2011 to replace the mosquito nets, which will have reached the end of their usable life, to maintain and strengthen a high level of coverage. The budget relating to this campaign is included in the costs shared by the NMCP and the PEV; the other part of the costs will be borne by the Government and other partners.

1 2. SDA: BCC mass media

Promotion of the fight against malaria will be made through a marketing, advocacy, communication, and social mobilization policy to improve the utilization rate of the interventions by the populations, particularly of the target populations (children under 5 years and pregnant women) and underprivileged populations (isolated rural areas, pygmies, and peripheral areas).

Activities:

1.2.1. To organize a KAP survey about the malaria control strategies;
1.2.2. To organize a workshop for the preparation of an integrated communication plan (with consultant support);
1.2.3. To organize a meeting for the validation of the integrated communication plan;

1.2.4. To prepare and validate a manual for training agents from the media;
1.2.5. To organize two training weeks for **50** agents of **25** private and public media entities about malaria control strategies;
1.2.6. To organize a workshop for the preparation of messages and the identification of communication media;
1.2.7. To broadcast **1,600** messages on 20 radio stations per year;
1.2.8. To broadcast **720** messages on 9 TV channels per year;
1.2.9. To organize World Malaria Day (2012 and 2013).

Due to the lack of data about the KAP of the populations regarding malaria control strategies, it seems essential to conduct a survey in order to better target social mobilization activities.

Based on the results of this survey, the NMCP, in collaboration with the National Service for Health Education, NGOs, other Ministries, public and private media entities, with support from partners (WHO, UNICEF etc.), will organize a workshop for the preparation of an integrated communication plan. This plan will be validated by the Ministry of Health during a meeting. A consultant will be recruited to assist in the process.

The NMCP and the National Service for Health Education will be in charge of preparing the manual for training agents from the media. This manual will be used to organize two (2) training seminars so as to strengthen the skills of journalists, performers, and producers of the media (audiovisual and written) in the treatment of information and the broadcasting of the messages related to the fight against malaria.

This training will be followed by a workshop for the preparation of messages about malaria control strategies, which will be broadcast by public and private media, as established by the integrated communication plan.

The principal recipient will sign an agreement with the media, which will establish the roles and responsibilities of each partner in the implementation of the integrated communication plan. Plans are to broadcast from **20** radio stations during **10** days every three months, with **2** messages per day, or **1,600** broadcasts per year. Nine TV channels will also be selected to broadcast **2** messages per day during **10** days every three months, or **720** broadcasts per year. These broadcasting activities were planned for the three last years of Round 5. Round 8 will ensure continuity beginning in the fourth year.

Every April 25, the Government sponsors World Malaria Day. The financing of this activity has been ensured by Round 5 until 2011. Round 8 will take over beginning 2012.

1. 3. SDA: BCC community agents

Activities:

1.3.1. To create and reproduce **2,044** image board for the community agents in charge of home care;
1.3.2. To raise awareness within communities regarding the malaria control strategies by community agents;
1.3.3. To organize, in partnership with NGOs MINAPYGA and PROMOSANTE, community-based interventions for improving access to prevention, treatment, and support services of pygmies. This activity will be performed in several phases:
1.3.3.1. Organization of a KAP survey in the pygmy community;
1.3.3.2. Organization of a training course for **44** pygmy community agents;
1.3.3.3. Development of BCC activities;
1.3.3.4. Supervision of trained community agents.

1.3.4. To equip the sub-recipients in charge of awareness-raising with audiovisual materials, namely **04** cameras, **10** megaphones, and **10** recorders.

The sub-recipients in charge of performing BCC activities are NGOs/CBOs, religious associations, other

Ministries, and health care facilities.

Strengthening the skills of community agents regarding social mobilization in favor of the fight against malaria is taken into account in the SDA of insecticide-treated mosquito nets, as it consists of integrated training that is part of malaria control strategies.

The NMCP and the Service for Health Education will ensure the creation and reproduction of 2,000 image boards and their distribution to community agents, according to the estimates of the integrated communication plan. These aids will complement those planned for Round 5 (posters, folders, and social mobilization guides).

These aids will serve to guide the communication actions for behavior change (educational talks, IPC, advocacy, etc.) by community agents, health agents, NGOs, etc.

The planned awareness-raising actions will have priority in underprivileged/isolated rural communities (villages, camps, and peripheral areas), health care facilities, barracks, schools, companies, etc.

Ten (10) civil society organizations will be supplied with audiovisual materials for the implementation of BCC activities, as a complement to the computer supplies provided by Round 5.

As part of the improvement in access to services by underprivileged minorities, the PR will work with the NGOs MINAPYGA and PROMOSANTE and with pygmy community leaders in the implementation of community-based interventions favoring this community. The interventions to be performed and their cost were identified and evaluated in collaboration with the NGOs cited.

1.4. SDA: Monitoring of the resistance to insecticides

1.4.1. To evaluate the resistance of vectors to the insecticides used in the treatment of insecticide-treated mosquito nets.

Studies on the efficacy of the insecticides were carried out by the NMCP thanks to Round 4 funding (for 4 sites) and Round 5 (for 6 sites). Phase 2 of Round 5 includes plans to perform three tests in the first quarter of the fourth year (July, August, and September of 2009). Considering that the studies are performed every two years, Round 8 will finance this activity in 2011 and 2013.

Goal 2 – To ensure access to quick diagnosis and effective treatment to at least 80% of children under 5 years and pregnant women

The Round 4 and Round 5 grants made possible the introduction of ACTs in the care of simple malaria in the health care facilities. In the framework of universal access, Round 8, complementing the resources planned in Phase 2 of Round 5, will facilitate the strengthening of the interventions performed in health care facilities and the progressive introduction of the home care of cases.

For this purpose, the SDAs below were identified as high-priority.

2.1 SDA: Rapid and effective antimalarial treatment in health care facilities

In this SDA, the following activities will be performed:

2.1.1. Purchase antimalarial drugs **(832,888 doses of ACT in the fourth and fifth years)**, including for the community level;
2.1.2. Ensure transit, maintenance, and storage of the drugs;
2.1.3. Distribute the drugs from the central NPO stores to regional warehouses (regional NPO branch);
2.1.4. Ship the drugs from the regional warehouses to health departments, clinics, and community agents;
2.1.5. Adapt training manuals to the IMCI approach;
2.1.6. Produce and distribute **400** training manuals, **400** sets of guidelines, and **400** algorithms;

2.1.7 Train 330 health care providers.

Just as in Round 5, the procurement of drugs will be made by the NPO, which will ensure their transit, storage, and distribution to regional warehouses and departmental warehouses. Drugs will be supplied to basic health care facilities by health departments. As with the mosquito nets, a grant will be allocated to the departments, which will draw on the private sector for the transportation of the drugs. The clinics will be in charge of supplying community agents of their coverage areas.

Antimalarial drug needs were estimated based on the number of episodes expected by the type of target population (children under 5 years: 4 episodes per year; pregnant women: 2 episodes per year), the attendance rate, the expected coverage per year, and the positivity rate of biological exams (microscopy and RDT). Considering the 50% drop in morbidity expected from today through 2012, the estimate also counted on an average fall in morbidity of 10% per year (see table of estimated drug needs, Annex No. 3).

The amounts to be purchased take forecasts into account (see analysis of the priority gaps No. 2). In this way, needs will be covered by the Government, the private sector, and the Round 5 grant through 2011 and Round 8 will take over for the years 2012 and 2013. In terms of cost-sharing and targeting of the most affected populations, **Round 8 will take over the identified needs to provide coverage for children under 5 years and pregnant women**. The difference that will make 80% coverage of the populations possible will be financed by the Government and the private pharmaceutical sector.

Training manuals for malaria care will be updated to incorporate the IMCI approach as a strengthening strategy, according to international recommendations.

The NMCP will need to reproduce **400** provider training manuals, **400** sets of national guidelines, and **400** algorithms of malaria care, updated and produced during Round 5. These documents will be made available in all public, parapublic, and private health care facilities.

The number of care providers trained during Round 4 and Round 5 will need to be supplemented in order to cover all public, parapublic, and private health care facilities of the country for the achievement of universal access. A cascade training approach will be followed. Relevant health care facilities will be the pediatric, medicine, and gynecological services of hospitals and medical centers, health centers, MCH, clinics, and public, parapublic and private clinics.

This strategy will be implemented in close collaboration between the NMCP and those responsible for IMCI.

2.2 SDA: Diagnosis

Performing the activities planned for this SDA will contribute to improving the biological diagnosis of malaria in the health facilities. They supplement those performed and planned in previous rounds and by other partners.

The NMCP will need to:

2.2.1 Equip **24** public laboratories, **10** private laboratories, and **6** parapublic laboratories with microscopes;
2.2.2 Supply **51** laboratories of the public, parapublic, and private sectors with reagents and materials;
2.2.3 Supply peripheral health care facilities with RDTs (**1,116,934**);
2.2.4 Train **33** laboratory technicians of the public, parapublic, and private sectors in the biological diagnosis of malaria;
2.2.5. Ensure the quality control of laboratories;
2.2.6. Draw up an account of accomplishments of the laboratories of the health facilities of the public, military, parapublic and private sectors.

The NPO, with the support of the Drug and Pharmacy Department (DPD) and of the parasitology department of the University of Sciences and Health (USS), will be responsible for equipping **40**

laboratories of the public, parapublic and private sectors. The provision of reagents and laboratory materials will include the **11** laboratories equipped during Round 5 and **40** additional labs. This equipment supplements coverage of the needs of all laboratories of the country, which amount to **119**. The GAP will be the responsibility of the Government, other programs, and partners.

An agreement will be signed between the Principal Recipient and the parapublic and private sectors to implement strategies (for example, through the download revision) and to ensure access for populations to the services provided due to the equipment and materials acquired through the project.

Round 5 plans are to purchase 187,500 **RDTs**. Round 8 will fulfill needs through the purchase of [missing text in source document ?]
to meet needs estimated at **1,116,934**. The RDTs will be used, preferably, in health facilities that do not have laboratories capable of performing the parasitological diagnosis of malaria. RDTs will be supplied according to the same system used for drugs. Procurement plans include the purchase of RDTs according to the following schedule: Year 1: 53, 639; Year 2: 131,892; Year 3: 161,806; Year 4: 389,434; and Year 5: 380,162 (Quantities and pace by department and health facility will be determined by the appropriate plan. The need for laboratory technicians is estimated at **204** for the various health sectors (**154** for the public sector and **50** for the private sector). The funds received from Round 4 and Round 5 facilitated training for seventy-five (**75**) technicians with plans to train **96** more during Phase 2 of Round 5. This submission will meet needs through the training of **33** new technicians in the fourth year. These training courses will be ensured by the USS and the National Public Health Laboratory, under the coordination of the NMCP.

The University of Sciences and Health and the National Laboratory will ensure quality control of public and private laboratories. This activity will be performed through the transportation of slides from peripheral laboratories to reference laboratories and through the exchange of slides between laboratories, as well as during supervision visits.

Round 5 financed the evaluation of laboratories of the public health sector. Round 8 will complete the collection of information about the operation of laboratories of the other sectors (public military, parapublic, and private).

2.3. SDA: Home based care of malaria

The planned activities include:

2.3.1. To organize a workshop for the adaptation of training modules of community agents and the trainer's manual;
2.3.2. To reproduce **2,300** training modules for community agents, trainers, and health care facilities;
2.3.3. To reproduce **2,300** algorithms for community agents.
The community-based interventions plan developed in SDA 1.1, Activity 1.1.5, will take into account the activities of home care of malaria cases.

Training 592 and retraining **1,408**, or a total of **2,000** community agents described in Activities 1.1.7 and 1.1.8 of SDA 1.1 will also include home care (integrated module).

The NMCP will ensure the adaptation of the module, by addressing the Community IMCI during a workshop with the support of the WHO and UNICEF. Two thousand three hundred (**2,300**) modules and two thousand three hundred (**2,300**) algorithms will be reproduced and used for training the community agents.

To facilitate the use of the drug at the community level, negotiations will be made with the supplier to adapt packaging.

As described in the distribution system in SDA 2.1, Activity 2.1.4, the clinics will be responsible for supplying the community agents in their coverage areas.

2.4. SDA: Monitoring of drug resistance

2.4.1. To evaluate the efficacy of the antimalarials used in the national guidelines

Studies regarding the efficacy of antimalarials in sentinel sites planned by Round 5 will be carried out every two years (2008 and 2010). R8 will take over by carrying out a study in 2013.

2.5. SDA: Monitoring of the pharmacovigilance

In support of the Drug and Pharmacy Department (DPD), two activities will be performed:

2.5.1. To reproduce and distribute **2,500** pharmacovigilance data collection tools;
2.5.2. To educate **25** trainers in pharmacovigilance (5 central and 20 regional, or 2 per region);
2.5.3. To train **400** personnel in the notification, analysis, and utilization of pharmacovigilance data (2 personnel per facility for 2 facilities per health region) (with consultant support);
2.5.4 To recruit a consultant for the implementation of pharmacovigilance.

The monitoring of the pharmacovigilance is ensured by the Drug and Pharmacy Department, which has an implementation plan for this activity. The principal recipient needs to provide support for the reproduction and distribution of data collection tools already created and the training of personnel on notification, analysis, and utilization of the pharmacovigilance data. Trainers will be trained in one session, in Libreville; personnel will be trained regionally in **16** sessions with **25** participants each.

Goal 3: To build institutional capacity of the National Malaria Control Program and the monitoring and evaluation system

3.1. SDA: Information system

3.1.1. To organize a workshop for the evaluation of the monitoring/evaluation system (Global Fund tools and consultant);;
3.1.2. To organize a workshop for the preparation of a monitoring/evaluation plan;
3.1.3. To reproduce and distribute **2,100** registers for the data collection of the community interventions;
3.1.4. To retrain, in 2010, one hundred and thirty-one (**131**) agents trained on data collection and analysis and another **131** in 2011;
3.1.5. To ensure maintenance of the computer equipment;
3.1.6. To set up a malaria database (with WHO support);
3.1.7. To provide twice-yearly central supervision of the regional level;
3.1.8. To support supervision of the departments by the RHDs (once every three months);
3.1.9. To support the supervision of clinics by health departments every three months;
3.1.10. To support the supervision of community agents once a month through clinics ;
3.1.11. To supply **54** departments and **76** clinics with motorcycles, that is, **130** motorcycles;
3.1.12. To perform annual audits of the management accounts of the principal recipient;
3.1.13. To conduct two surveys (third and fifth years) about the quality of care of patients in health care facilities;
3.1.14. To make a partial evaluation;
3.1.15. To make a final evaluation.

The Principal Recipient will use the Global Fund's tool for strengthening the monitoring/evaluation system to identify strengths and weaknesses in the system and to plan strengthening measures. Two workshops will be organized for this purpose with the help of a consultant: one for the evaluation of the system (**100** participants) and one for the preparation of the monitoring/evaluation plan (**34** participants). The participants of these workshops will come from all the sectors of the health system involved in the fight against the three diseases: malaria, AIDS and tuberculosis.

Reproduction of health care facilities data collection tools was performed during Round 5. Round 8 will ensure their production at the community level, for 2,100 registers. These tools will be prepared by the NMCP in collaboration with the SNIS and the programs having community-based interventions (IMCI,

PEV, PLIST-HIV etc.), as well as manuals for training community agents with the support of the WHO and UNICEF (cf. SDA 2.3, Activity 2.3.1).

The **262** agents trained in 2006 and 2007 on data management will be retrained beginning in 2010 (that is, 131 in 2010 and other 131 in 2011).

The Public Health Monitoring Unit (COSP), in collaboration with the NMCP and the Information and Statistics Department (DIS) will provide support to health regions and departments in the integrated supervision of decentralized facilities and community agents.

Supervision will take a cascading approach: twice yearly from the central to regional levels; from the regions to the departments every three months; from the departments to the clinics every three months; and from the clinics to the community agents every month. Supervision will be integrated with the other programs (PEV, PLIST, and IMCI, among others).

In order to facilitate supervision implementation, Round 5 supplied vehicles for the central level and boats for waterways. The Government equipped 10 health regions with vehicles for the supervision of departments. Round 8 will supplement the supply in order to allow supervision at the departmental (**54** motorcycles) and community levels (**76** motorcycles for clinics). The rest of the vehicles will be supplied by the other programs and partners.

Computer maintenance, ensured up to the third year of Round 5, will be continued in Round 8 during the two last years of the project.

An audit is planned of the principal recipient's statements by an approved auditor, who will be selected through a bidding process. Two surveys about the quality of care in the health care facilities will be conducted in the third and fifth years, so as to evaluate results and the impact of the interventions.

At the end of Phase 1 and the fifth year of the project, evaluations will be made by the principal recipient with the support from partners, especially the WHO.

3.2. SDA: Partnership and coordination development

3.2.1. To set up a thematic group (NMCP, UNS-related ministries, implementation partners) to support the NMCP;

3.2.2. To organize one review of the malaria control activities per health region every six months;

3.2.3. To organize one review of the malaria control activities per department every six months;

3.2.4. To organize four meetings of the malaria thematic group per year.

In order to support the NMCP in the planning, implementation and monitoring/evaluation of the control activities, the creation of thematic groups including the participants below has been planned: external partners, related ministries and programs, NGOs, and the private sector. This group will meet every three months.

Reviews will be organized every six months within the departments and regions, in order to coordinate implementation of the activities, evaluating the evolution of the indicators, identifying weaknesses, and taking corrective measures. The Principal Recipient will use these meetings to collect data about the monitoring/evaluation indicators.

3.3. SDA: Strengthening Management and Governance of the PR and the NMCP

Based on the gaps identified by the 2007 independent audit of the NMCP's operation, technical and management capacity-building activities of the national coordination of the NMCP were introduced in this submission:

3.3.1. Training of two teams in program management;
3.3.2. Training of two teams in monitoring/evaluation of health programs;
3.3.3. Training of one team in data management;
3.3.4. Organization of a local malarial diseases course for **25** personnel.

Plans are for the training courses to be held in the institutions identified by the PR with the support of the WHO. The selection criteria of the personnel to be trained will be created by the PR and approved by the CCM.

A course on malarial diseases will be organized locally with the support of the WHO in order to strengthen the skills of the teams involved in malaria control, particularly at the regional and departmental levels.

3.4 SDA: Program management and administration costs

For the sound management of Round 8 funds, the PR set up a management unit, which will need technical and financial support.

3.4.1. To ensure the salaries of the personnel working at the management unit
3.4.2. To ensure the salaries of the personnel working at the management unit;
3.4.3. Administrative expenses

Regarding transfer of management of the grant from the Global Fund to the Ministry of Health, management unit/support financing of the PR will be ensured by Round 5 for the first three years. Round 8 will take over beginning in the fourth year.

4.5.4. Enhancing social and gender equality

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

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

The services and interventions targeting vulnerable groups (children under 5 years, pregnant women, people living with HIV, the elderly, and minorities, such as the Pygmies) will be provided without discrimination, so as to ensure equality and universal access.

Several actions have been planned for these population groups to benefit from priority access to treatments in home care of malaria cases and in health care facilities. Thus the Government, in order to solve problems of access inequality related to poverty, decided to make insecticide-treated mosquito nets, ANCs, and antimalarial drugs available free of charge.

At the community level, the recipients of the interventions will be identified in association with community leaders and representatives of the civil society, in order to allow for cases of indigence and to avoid exclusion. Actions will be taken in collaboration with representatives of the Pygmies (NGO MINAPYGA) to improve access to services for this minority group.

Likewise, the organization of awareness-raising campaigns and the implementation of the community approach will bring services closer to the most underprivileged populations, especially those living in rural and peripheral areas.

The implementation stakeholders will be NGOs/CBOs, religious associations, and related ministries (Social Affairs, National Defense, etc.).

4.5.5 Strategy to mitigate initial unintended consequences

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

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

An analysis of weaknesses identified problems in the health system that could affect malaria control. The activities planned for Round 8 allow for these weaknesses in order to minimize their impact on the implementation of the control strategies. Particular emphasis is given to the strengthening of monitoring/evaluation and partnerships.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

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

As part of the national plan implementation, this proposal will strengthen achievement of Round 4 and Round 5 goals, which focused on high-priority target groups, and will allow, in this way, for scaling up, the goals of universal access can be attained, according to the commitments made by the Heads of State and the Government in 2006 in Abuja.

The links between this project and previous Rounds consist of the following elements:

1st – Regarding prevention:

- The number of mosquito nets purchased or planned in the previous grants facilitates coverage of the high-priority target groups (children under 5 years and pregnant women). This grant will finance additional needs, so as to achieve universal access;
- Regarding IPT, the previous Rounds are responsible for the purchase of drugs and personnel training. For this Round, this activity is only taken into account in the framework of social mobilization and monitoring/evaluation.
- The lack of planning in the transportation of long-lasting insecticide-treated mosquito nets from regional NPO warehouses to the departments and communities made distribution difficult. This obstacle will be addressed by Round 8, with a view to ensuring their transportation to distribution sites, especially among departments and community agents.

2nd – Concerning the care of cases:

- In this proposal, additional funds have been requested for the management of malaria cases, according to the annual targets planned for all the populations, since Round 5 did not include children under 5 years.
- Regarding universal access to an effective treatment, Round 8 will strengthen the achievements of the previous Rounds concerning the care of cases in health care facilities (public and private) through the expansion of the management sites (training, supervision, and supply) and will progressively introduce home care (training of agents and supply).
- In the area of diagnosis, Round 5 provided training for 75 laboratory technicians and the equipping of 11 laboratories with microscopes and other materials (11 incubators, 11 glucometers, 11 centrifuge, 11 chronometers, 11 Softclix, 11 calculators, etc.) This strengthening will continue through the training of 33 additional technicians and the equipping of 51 new laboratories and their provisioning with materials and reagents.
- The introduction of RDTs, planned for Round 5, is not yet effective. Round 8, according to the recommendations of the efficacy study in progress by the USS, will be responsible for meeting needs, training personnel, and supplying facilities.

3rd – Regarding social mobilization

The previous Rounds financed awareness-raising with the involvement of new partners such as the related Ministries, religious associations, NGOs, and mass media. Phase 2 of Round 5 includes plans to continue this activity by the same stakeholders. These interventions will continue and intensify with the involvement of new stakeholders, namely NGOs/CBOs networked with the support of Round 5. In this social mobilization, high-priority actions will be performed aimed at minority and underprivileged groups (Pygmies and isolated and peripheral areas).

4th – In the areas of monitoring/evaluation and operational research

The previous Rounds financed, among other areas, the training of 262 data managers, computer equipment, and the reproduction of data collection tools. Round 8 includes plans to retrain this personnel in 2010 and 2011 and set up a community-based information system. It will also strengthen the supervision of activities, by providing logistic means (motorcycles) to departments and clinics.

The monitoring of antimalarial efficacy and sensitivity of the vectors will be continued by this grant as soon as Round 5 ends. The system will be strengthened by consideration 8 of quality control of the laboratories and pharmacovigilance, which were not included in previous Rounds.

5th – Partnerships

The previous Rounds provided support for the NGOs/CBOs participating in the implementation of activities, by providing computer equipment and supplies. This strengthening will be continued with the extension of the sub-recipients to other entities for the implementation of community-based interventions and social mobilization.

Special attention is given to the strengthening of partnerships through the restructuring of the CCM and the establishment of a malaria thematic group, which will be responsible for supporting the PR in monitoring implementation and coordination of the activities.

Regarding the five years of the project, the following table illustrates the links between the needs covered by previous funding or those planned and the present request for the primary interventions.

Interventions	Country`s needs	Covered by previous Rounds and others	Request in Round 8
Purchase of mosquito nets	1,498,861	503,979	**476,659**
ACTs	7,142,469	5,110,039	**752,872**
IPT/SP	498,166	498,166 covered by Round 5 and the Government	**0**

4.6.2. Links to non-Global Fund sourced support

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

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

Gabon`s goal is the scaling up of interventions selected in its malaria control strategic plan. This approach requires the mobilization of important resources and the contribution of several partners and programs in order to meet national needs. With this purpose, the resources coming from other partners will intersect those of the Global Fund to avoid overlaps and, thus, allow for sound use through an operational action plan that will demonstrate the visibility and geographic distribution of the different stakeholders.

In this framework, it can be observed that the Biennium of WHO cooperation (2008-2009) has set a goal for scaling up and supporting the implementation of monitoring/evaluation of Round 5. These outcomes will be taken into account during planning.

- The project designated "Port Gentil-Libreville malaria fight and strengthening of routine vaccination," financed by Total-Gabon and amounting to 400,000 USD (or 266,667 €) planned to achieve coverage in ITNs, IPT, and care of at least 60% of pregnant women and children under 5 years by the end of 2007. Its continuity is planned for two additional years. Achievements and forecasts have been considered for the planning.
- The 2007-2011 UNDP "Country Program for Gabon," in the aspect of malaria control has been established as an outcome to benefit the IPT and ITCs for pregnant women and children under 5 years (50,000 USD, or 33,334 €) in four provinces, and the improvement of epidemiological surveillance and information management (100,000 USD, or € 66,668, with HIV/AIDS).
- The budget that the Government allocated to the malaria fight is responsible for the provisioning of health care facilities with drugs, personnel salaries, office supplies, fuel, document printing, purchase of mosquito nets, and building maintenance. These funds have been included in the analysis of gaps (programmatic and financial) and the activities planning.

4.6.3. Partnerships with the private sector

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

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

N/A

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

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

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	Contribution Description *(in words)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved malaria outcomes

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

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

The analysis of the implementation of the activities of Round 4 and Round 5 proposals, financed by the Global Fund, shows:

A need for capacity building of agents providing care services through retraining, in order to improve the quality of care of malaria cases in health care facilities.

Community agents have been established, but currently their skills are limited to BCC and mosquito net treatment.

Round 8 funding will provide for improvement of their skills in the home care of malaria cases through retraining of the agents and formative supervision.

In the area of diagnosis, the retraining of laboratory technicians on biological malaria diagnosis techniques has been initiated.

Regarding monitoring/evaluation, health agents in charge of data management were trained and computer materials were distributed to all health regions. In addition, five sentinel sites were created and partially equipped.

With a view to improving supervision activities, the Government provided all regional departments and epidemiological bases with vehicles.

The interventions selected for this proposal address the obstacles/opportunities identified during the implementation of Round 4 and Round 5 activities. The gaps not covered by Round 4 and Round 5, particularly targeting pregnant women and children under 5 years, have been considered for this proposal, based on the analysis of the health system situation and the conclusions of the 2006 WHO monitoring report.

The implementation of Round 8 activities will allow for capacity building of the stakeholders from the different health sectors, particularly those that participate directly in malaria control. The community agents' role will be increased, so as to facilitate implementation of the interventions that aim at reducing morbidity and mortality linked to malaria.

4.7.2. Alignment with broader developmental frameworks

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

Gabon is an upper-middle income country (World Bank). Thus, it does not have access to the opportunities provided in the framework of the Initiative of Highly Indebted Poor Countries (HIPC). However, in spite of its high GDP (6,000 USD), with its place of 78th in world ranking, the country is characterized by a Human Development Index (HDI) of **0.653**, which puts it in **122th** place, according to the 2007 UNDP Human Development World Report.

Gabon's strategic malaria control plan is part of the attempt to achieve the Millennium Development Goals (**MDG**).

The proposal, drawn from this plan, is in compliance with the National Poverty Reduction and Growth Strategy (**DSCRP**), which makes malaria control one of its high-priority focuses. It is also in accordance with the Roll Back Malaria Initiative (**RBM**), which aims at reaching 80% coverage of the high-priority interventions of the malaria control by 2010.

The interventions selected are in perfect accordance with the recommendations of the Conference of

African Heads of State, held in Abuja in 2006, which emphasized universal access to prevention, care, and support services, namely :

- Prevention through effective long-lasting insecticide-treated mosquito nets (LLITN);
- Prevention among pregnant women through IPT;
- Rapid care of cases through effective drugs, especially ACTs;
- The implementation of support strategies:
  - Epidemiological surveillance and monitoring/evaluation
  - Operational research
  - Institutional and management capacity building
  - Partnerships and integration with other initiatives
  - Advocacy/social mobilization/behavior change communication.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

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

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

The information provided by the National Health Development Plan (2005), the health information system evaluation report prepared in 2005 by the CREDES (Center for health economy research, study, and documentation) and the 2006 WHO monitoring report of the Global Fund "Roll Back Malaria" project allow for the identification of the strengths and weaknesses of the monitoring/evaluation system and for the consideration of achievements planned in the present proposal.

Strengths:

The Ministry of Health, with the support of the partners, created a guiding scheme of epidemiological surveillance and data collection tools for routine surveillance, which are used at all levels of the health system. Malaria information management uses the circuit and structures defined by the national health information system, already described in Round 5. To make this system operational, the Government supplied all the regional health departments with vehicles (10), as well as all the Epidemiological Bases (10), in order to support supervision activities. Three research units participate in the malaria data collection: The clinical malaria research unit of the HCL, the CIRMF (International Medical Research Center of Franceville), and the Medical Research Unit of Albert SCHWEITZER Hospital of Lambaréné.
The funds obtained from the Global Fund for Round 5 provided nationwide training for 262 health agents from public health care facilities on data collection for equipping health departments with computer tools (62 microcomputers and 52 printers). Three of the six (3/6) health regions that include nearly inaccessible river areas were equipped with fishing vessels. Additional vehicles were purchased for the national coordination of the NMCP, and five sentinel sites were created and equipped.
In addition, a strong political initiative to continue the efforts aimed at fixing problems of the system is evident.

Weaknesses:

In spite of these strengths, the national monitoring/evaluation system has several weaknesses, which include: the health information system still does not work very well at the departmental level, even including malaria information; data are insufficient in terms of completeness and readiness; a database at the level of the NMCP is lacking; there is little collaboration between the NMCP, the DIS (Health Information Department) - , and the IELE (Institute of Epidemiology and Endemics); and the low rate of supervision visits (**47%**).
The funds mobilized for Round 8 will facilitate the strengthening of the national monitoring/evaluation system through several activities that will complement Round 5, through the support of partners. The necessary actions include, in particular, a review of the current system, the preparation of a monitoring/evaluation plan, the establishment of an NMCP database, the completion of surveys and of a financial audit, the organization of mid-course evaluation meetings and a final evaluation meeting to measure the impact of the project.

4.8.2. Avoiding parallel reporting

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

(including reporting channels and cycles, and/or indicator selection)?

The reporting system for monitoring/evaluation of the Round 8 activities will draw on the information made available by the Ministry of Health (SNIS, sentinel sites).

It will not be necessary to develop a parallel reporting system. However, the Ministry of Health will use the evaluation tools of the Global Fund's monitoring/evaluation systems to evaluate the capacities of the existing system, with a view to its strengthening.

The indicators selected for monitoring/evaluation of this proposal have been drawn from the national strategic malaria control plan and the multi-agency monitoring/evaluation guide.

The research units involved in malaria control (USS, CIRMF, Schweitzer, National Public Health Laboratory, IELE, IHPA (Institute of Health and Public Hygiene)) will be responsible for conducting the monitoring/evaluation surveys that are planned, with the support from technical partners (WHO).

The 262 health agents trained in data management will be primarily in charge of data collection at the peripheral level (health facilities and communities), as well as the submission of reports to the intermediary and central levels.

4.8.3. Strengthening monitoring and evaluation systems

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

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

Improvements in the monitoring/evaluation system planned in Round 8 will complete those implemented or planned by previous Rounds and those made by others partners (WHO) and the Government.

It will be especially necessary to:

- strengthen the data collection system by making available collection tools and computer materials to health services;
- retrain agents trained in data management and ensure their supervision;
- establish a community-based information system through the training of agents, the making available of collection tools, and supervision;
- carry out surveys about the efficacy of antimalarial drugs and sensitivity of vectors to insecticides;
- strengthen the pharmacovigilance system of antimalarials (ACTs, SP, quinine etc.).

All these activities will be included in a monitoring/evaluation plan, which will be implemented in collaboration with the different stakeholders and the support of partners. The implementation of this plan will be monitored by the NMCP with the support of the malaria thematic group.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

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

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

PR 1	[Ministry of Health and Public Hygiene, in charge of the family and promotion of women]
Address	[PR: 50 Libreville – GABON]

The Ministry of Health was selected as principal recipient as a result of a selection made after the call for

applications launched by the CCM. This department has the necessary skills for the management and supervision of implementation of the activities in the fight against malaria and HIV/AIDS. In order to ensure effective management of the Global Fund grants, the new principal recipient established a project management unit designated CEP. Decree 000521/MSHPFPF/CAB of April 11, 2008 determined the organization and operation of this structure. It includes five (**05**) units:

- Main Administration or Project Coordination;
- Accounting/Management;
- Procurement, Supply, and Contracting;
- Monitoring/Evaluation;
- Logistics and Maintenance.

The reference terms and level of skills required will be determined by the PR and approved by the CCM and the Global Fund. The personnel necessary will be recruited through a bidding process.

Human resources

The Ministry has the following skills:

- Public health specialists;
- Pharmacists;
- Epidemiologists;
- Health promoters;
- Planners;
- Existing NGOs.

Resources in terms of structure

The Ministry has:

- Pharmaceutical Office with national drug and mosquito net storage capacity;
- Regional NPO branches;
- Regional medical centers at the departmental level.

The Ministry was selected as Principal Recipient after an analytical study of its file, which has been proven to be satisfactory in terms of:

- Flowchart;
- Planning and monitoring/evaluation system;
- Procurement, management, and supply;
- Reporting mechanisms;
- Implementation of public grants;
- Financial procedures.

PR 2	[Name]
Address	[street address]
[Description]	

PR 3	[Name]
Address	[street address]
[Description]	

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

4.9.2 Sub-Recipients

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

In this phase of the proposal, only sub-recipients of the public sector have been identified (see list). The civil society and the private sector, considered for the implementation of certain SDAs (home based management, social mobilization, and community BCC) have not yet been identified. The table below shows the corresponding part of work for sub-recipients of the public sector (cf. Annex).

Sub-recipient of the public sector:

- Ministry of Social Affairs (General Welfare Department);
- Ministry in charge of health (NMCP, NPO, COPS);
- Ministry of National Defense (General Military Health Department);
- Ministry of Higher Education (USS).

Sub-recipients of the civil society :

- Gabon Midwives Association;
- REGOPALU;
- RENALPALU.

REGOPALU and RENALPALY are NGO networks participating in the fight against malaria.

4.9.3. Pre-identified sub-recipients

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

Certain entities of the Ministry of Health are key sub-recipients in the implementation of the SDAs. They include the NMCP, the National Pharmaceutical Office (NPO), the Drug and Pharmacy Department, the Information and Statistics Department (ISD), the Mother and Child Health Department (DSMI), Education for Health (EPS), and the Public Health Monitoring Unit. The same applies for certain related Ministries, such as the Higher Education Ministry through the USS, the Ministry of Social Affairs, and the Ministry of National Defense.

- **NMCP**

This is the national authority in charge of implementation of malaria control activities. In the framework of the proposal, it is the master builder. Thus, it is responsible for the specific supervision of all the interventions to be developed, whose target is the achievement of program goals by 2010. The National Program today has **35** agents distributed as follows: 3 physicians, 2 of which have been trained in malaria diseases and 1 in public health; 1 health administrator; 1 health administration agent; 2 health administration assistants; 1 biological engineer trained in public health and IEC; 7 technicians specializing in public health (1 of which is a master, 3 are highly specialized technicians in epidemiology, and 2 are highly specialized technicians in entomology/medical malacology); 3 midwives with a State diploma, of which 1 are IPT trainers; 1 technical health and public hygiene engineering agent; 3 nurses with a State diploma, of which 1 has been trained in communication; 4 statistics technical assistants; 1 administrative secretary; 2 health secretaries; and support personnel (8 drivers).

All this personnel is distributed among **07** departments or units: administration and finances, antivectorial fight, IEC, IPT, care, epidemiology/monitoring/evaluation, and secretariat.

Logistics includes **8** vehicles, **7** of which were obtained through the Global Fund financing, and computer and administrative equipment.

The insufficiency of management and administrative skills of the national coordination could affect performance of the fight against malaria.

- **NPO**

National Pharmaceutical Office (NPO): is the national structure most appropriate for the management of purchases, storage, and distribution of drugs in the public health sector. Human resources at the central level include **55** agents, of which 3 are pharmacists, 2 are high Pharmacy technicians, 17 are technical Pharmacy agents, 2 are health administrators, 7 are technical health administration agents, 4 are health secretaries, 17 are temporary workers (3 drivers, 3 unskilled workers, 3 warehouse keepers, 1 surface technician, 2 entry operators), 1 customs agent, 1 office clerk, and 1 filing assistant. It has substantial experience in the areas of distribution, storage, and bids. Its operational branches cover the entire territory. Its capacities are described in the item “Procurement and Supply Management.”

The NPO faces the following challenges: limited storage capacity; distribution circuit limited to the departmental level, not reaching communities; insufficient control over the consumption of drugs in medical outposts.

- **DPD**

The DPD, DSMI and EPS are services of the Ministry of Health in charge of the implementation of the country’s policy in terms of drugs and Pharmacy, mother and child health in the PMTCT, and production of social mobilization materials.

The pharmacovigilance system reveals several insufficiencies in terms of human, material and financial aspects.

- **USS**

The Parasitology Department of the Medical College of the USS, which participated in the implementation

of the component, has a unit for the care of malaria cases in the Libreville Hospital Center. This department performed several activities that contributed to malaria control: therapeutic efficacy studies, RDT evaluation, training of laboratory technicians for the biological diagnosis of malaria, and evaluation of the laboratories participating in malaria care. The Department relies on a master and assistants, who are responsible for several malaria research activities. This Department also works in collaboration with northern universities, especially the Parasitology Service of the François Rabelais Medicine University, in Tours; the Institute of Tropical Medicine of the Military Health Service (IMSSA), in Marseille; the INSERM 511 Unit of the Academic Hospital of Pitié-Salpêtrière; and the Parasitology Department of the University of Tübingen, in Germany.

The results of the research initiated are out of step with the decisions that the NMCP should make.

- **Ministry of Social Affairs**

The Ministry of Social Affairs, Solidarity, the Protection of Widows and Orphans, and the Fight against AIDS counts on functional facilities (social centers and services) throughout the national territory. During the implementation of Rounds 4 and 5, the Ministry of Social Affairs organized the training of community agents on awareness-raising techniques and social mobilization, in the framework of the fight against malaria. These community agents, in turn, made communities aware of the means of prevention of malaria in their intervention areas.

There was a noticeable inadequacy of guideline training modules nationally and a lack of supervision of trained agents linked to a lack of financing.

- **National Defense**

The Ministry of Defense counts on operational health facilities and logistical means throughout the territory. These facilities are used by populations living in neighboring areas.

Difficult to access river areas, which should be covered by these services, are not reached.
The partial execution of the work plan could delay reaching target populations living in isolated areas.

- **NGO**

The NGOs are knowledgeable about the subject and have the capacity to conduct social mobilization activities.

Their numbers are still insufficient, as are their management and administrative capacities.

The implementation capacity of all these stakeholders will be strengthened so as to adapt to the scaling up requirements of malaria control both in medical outposts and homes.

4.9.4. Sub-recipients to be identified

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

As the CCM is going through a restructuring process, the selection of sub-recipients of the nongovernmental sector has not yet been made. If this proposal is selected for funding, these sub-recipients will be selected before the signature of the grant agreement, based on the following criteria:

- - To be legally recognized and to have headquarters and an account in a local bank;
- - To have a management structure with bylaws, internal regulations, and proven skills in administrative and financial management;
- - To have proven skills (documented) and relevant experience in the area of the requested intervention;
- - To be represented in identified intervention areas;

- - To have the human, material, and financial resources necessary for implementation;
- To have terms of reference specific for the area in question.

4.9.5. Coordination between implementers

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

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)***; and**
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)***.**

The procedures manual of the Principal Recipient (PR) will include a sub-recipient management component, which will specify the norms for selection, monitoring, and evaluation of the implementation entities. Technical assistance will be necessary to prepare this manual and to build capacities of the PR and sub-recipients in its use.

An agreement between the PRs and sub-recipients will specify the roles and responsibilities as well as expected outcomes of each entity.

Coordination between the PR and the principal sub-recipients will be done through the contribution of the CCM and malaria thematic group (Task Force), which will meet every three months.

Supervision by the PR and the CCM will allow for the evaluation of implementation and for the correction, if necessary, of the gaps identified. Coordination reviews at variable frequencies will be planned at all levels (regions, departments) with the participation of community leaders.

The WHO and RBM will be asked to give technical support to the PR.

4.9.6. Strengthening implementation capacity

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

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

(a) the assistance that is planned;**

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

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

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

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

The development of the program interventions throughout the territory needs implementation capacity building at all levels. It is necessary to make up for insufficiencies in certain areas, with a view to having qualified and adapted human resources at different execution levels. The high-priority areas targeted include: the management system, supply, the health information system, monitoring and evaluation, pharmacovigilance, and social mobilization.

The needs for technical assistance of the different sectors were identified based on the

implementation reports of the NMCP activities and of other sub-recipients of previous Rounds, the analysis of training guides that will be used for the strengthening of players' skills, the evaluation of the PR's capacities made in the framework of Round 5, the evaluation of the health information system by the CREDES, the WHO's monitoring report of the Roll Back Malaria interventions in Gabon, the official report of the lack of skills for the establishment of a pharmacovigilance system and of the lack of an integrated monitoring/evaluation plan.

c) In order to comply with competition and transparency rules, calls for applications determining the nature of the assistance, profiles, and acquisition conditions, published by the media, will be used to select technical assistants. A commission will be set up by the PR, with the participation of the partners, for the sorting of proposals and the recruitment of consultants. Considering their expertise in the area of malaria control, the technical partners (WHO and RBM) will be equally requested for choices of technical assistance. Criteria and modalities for selection will be determined in the PR's manual of procedures.

Procedure employed to evaluate the efficacy of this assistance and to implement the necessary adjustments to the sustainability of a high level of support.

d) The assistance of the WHO will be requested to establish criteria assessing the efficacy of the technical assistance. These criteria will be based on the availability and quality of the documents produced, the implementation level of the recommendations, the transfer of skills to the nationals, and the level of improvement of the activities implementation quality expected by the assistance. Relevant indicators will be introduced into the monitoring/evaluation plan for this purpose.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ *Go to s.4B if relevant, or direct to s.5.*
	X Yes ➔ *Continue on to answer s.4.10.2.*

4.10.2. Table of roles and responsibilities

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Ministry of Health/National Pharmaceutical Office	The NPO is the sub-recipient in charge of managing procurement, supply, storage and distribution of essential generic medicines, reagents and medical consumables in medical outposts of the public sector.	X Yes. ☐ No
Intellectual property rights	Ministry of Trade and Industry/DPD	Deliver patents and licenses and ensure stakeholders' rights. The DPD delivers marketing authorizations.	☐ Yes x No
Quality assurance and quality control	Ministry of Health/DPD/Inspection/NPO/WHO	Define and implement the quality assurance policy with the WHO's support. The NPO ensures the quality control of drugs upon delivery	X Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	Ministry of Health/NPO/Inspection/NMCP	The Ministry of Health, through the DPD, revises the national list of essential drugs every two years; for that, a multi-disciplinary commission including all the national experts meets. The NPO ensures coordination and management of drug supplies in the public sector The DPD coordinates the regulatory aspects linked to drug management	☐ Yes x No
Product selection	NPO/DPD/NMCP/WHO	The NMCP, in collaboration with the NPO and the DPD and with the support of the WHO, selects drugs and medical products recommended for malaria control.	X Yes ☐ No
Management Information Systems (MIS)	NPO/NMCP	The NPO manages the management information system of drugs and medical products For this purpose, it uses the management SAGE tool Version 100 and makes management tools available in	☐ Yes ☒ No

		every medical outpost. The NMCP, RHDs and DCDs are responsible for monitoring the management of antimalarial drugs and products.	
Forecasting	NMCP/NPO	Drugs and medical product needs are estimated by the NMCP in collaboration with the NPO, based on consumption and epidemiological situation.	X Yes ☐ No
Procurement and planning	NPO/NMCP	Supplies are ensured by the NPO, based on a Procurement and Inventory Management (PIM) and on a distribution plan developed in collaboration with the NMCP	☐ Yes ☒ No
Storage and inventory management *More details required in s.4.10.4*	NPO/health-care facilities	The NPO and its regional branches, as well as the health-care facilities, ensure the inventory management of pharmaceutical products stored in their warehouses. The SAGE Version 100 software is used by the NPO for inventory management purposes. Suitable tools (order forms, consumption forms, inventory forms, daily and monthly consumption forms and booklets) are in place in health-care facilities	☐ Yes ☒ No
Distribution to other stores and end-users *More details required in s.4.10.4*	NPO/RHD/Private	Based on a distribution plan, the NPO makes drugs available to regional branches and departments. Private operators will ensure the delivery of products to clinics. Users from other sectors are included in the distribution plans at different levels.	☐ Yes ☒ No
Ensuring rational use and patient safety (pharmacovigilance)	DPD/Pharmacovigilance Committee/NMCP	The DPD, in collaboration with the NMPC and with the support of partners, is responsible for the establishment and monitoring of a pharmacovigilance system.	X Yes ☐ No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
NPO	Sub-recipient	Gabonese State and the Global Fund: 2,896,341 euros
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

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

This proposal will draw on existing national systems to manage the additional procurement of drugs and other medical products, to manage inventory, and to ensure pharmacovigilance.

The structures in charge of these actions include:

- The NPO will be responsible for procurement, storage, and distribution. It takes over from the UNDP regarding procurement financed by the Global Fund and will continue to ensure the inventory management and distribution of pharmaceutical products;
- The NMCP will ensure the selection of drugs and medical products, the estimation of needs, distribution monitoring, and inventory management;
- The DPD and Pharmacy Inspection will be responsible for the implementation of pharmacovigilance and compliance with regulations. For this purpose, it will set up a pharmacovigilance unit, which will be responsible for analysing the information collected by basic health facilities and for giving feedback;
- Under the responsibility of the RHDs and head physicians, core teams of regions and departments will ensure inventory supervision and monitoring for a good management of the drugs;
- The private operators will be used to ensure the transportation of drugs and medical products, including to the level of departments and communities.

4.10.5. Storage and distribution systems

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

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

The NPO has several warehouses at the central level (2,000 square meters) and in the 9 health regions (400 square meters per region, or a total of 3,600 square meters) for storage of drugs and other pharmaceutical products used in malaria control.

This proposal includes plans for the purchase of antimalarial drugs (**885,011 treatments**) and mosquito nets (**476,659**).

In order to minimize possible storage problems, the distribution plan will implement sequential deliveries according to the needs. Also, supplies will be shipped directly to health regions and departments, so as to

avoid the accumulation of supplies at the entral NPO's warehouses.

The warehouses of the General Planning and Equipment Department, with a capacity of 400 square meters, will be used for the storage of mosquito nets.

In addition, the logistical capacities of the military health service (storage and distribution) can be requested, if necessary.

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

The NPO organizes a call for applications every two years for the recruitment of private drivers that will ensure the distribution of inputs.

The distribution plan plans a supply every six months in each health region.

If necessary, an additional supply is made based on the needs indicated by health outposts and validated by the RHDs.

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The distribution of the products purchased in the framework of this proposal leads to an increase in volume to be transported, which also leads to an increase in the number of drivers. Additional funds have been planned in the proposal for this purpose.

The integration of the distribution of the products purchased with the GF funds, which used to be made at the NPO's distribution system, in certain measures reduces costs and facilitates better distribution organization.

4.10.6. Pharmaceutical and health products for initial two years

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

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

The pharmaceutical and medical products planned in this proposal are part of the list of essential drugs, in the national guidelines for case management, the use of ITNs, reproductive health care norms, and procedures and/or norms and procedures of the biomedical laboratory. These different documents have been prepared by the Ministry of Health with the technical support of the WHO.

The information on amount, unit costs, and total costs can be found in Annex B of this proposal.

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

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

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

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

ROUND 8 – Malaria

5. FUNDING REQUEST

5.1. Financial gap analysis - Malaria

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

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Malaria program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**ND**	**7450580***	**8500444***	10073160*	9277480*	14948405***	5218224**	4765382**
Line A.1 ➔ Total need over length of Round 8 Funding Request *(combined total need over Round 8 proposal term)*								**60,233,675**
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	ND	461271****	461271	461271	461271	461271	461271	461271
Domestic source **B2** National funding resources	ND	7627	7627	8770[1]	10087[2]	11600[2]	13339[2]	15340[2]
Domestic source **B3** Private Sector contributions (national)				ND[3]	ND[3]	ND[3]	ND[3]	ND[3]
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	ND	468898	468898	470041	471358	472871	474610	476696
External source **C 1: WHO** (*provide source name*)	ND	33333	33333[4]	33333	33333	33333	33333	33333
External source **C2:UNDP** (*provide source name*)	ND	762686	762696[5]	762696	762696	762696	762696	762696

ROUND 8 – Malaria

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
External source **C3** Private Sector contributions (International)	[redacted]			1644000[6]	0	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	ND	796029	796029	796029	796029	796029	796029	796029
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	4219465	2842413	1882405	1438191	1714225	NA	NA	NA
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	NA	4107340	3147332	4348261	2981612	1268900	1270639	1272640
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	NA	3343240	5353112	5724899	6295868	13679505	3947585	3492742
Line G = Round 8 malaria funding request *(same amount as requested in table 5.3 for this disease)*				5724899	6295868	13679505	3947585	3492742

ROUND 8 – Malaria

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants	
In Round 8, the total maximum funding request for malaria in Line G is: *(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and* *(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*	
Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund **Cost sharing = (Total of Line D entries over 2009-2013 period + Line G Total) X 100 / Line A.1**	**23.7** %

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

Explain how the annual amounts were:

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

Line A of Table 1 represents the result of the cost assessment of the different strategies selected in Gabon's 2009-2013 malaria control strategic plan. This process was conducted during the review of the strategic plan together with all the stakeholders participating in the fight: the Ministry of Health (NMCP, technical departments, and other programs), related Ministries (Finances, Social Affairs, National Defense, Communication, etc.), NGOs/CBOs, and the private sector with the technical support of the WHO.

The budget takes into account all the country's needs and all the sectors involved that are necessary for the scaling up of the interventions, in order to reach the goals of universal coverage of ITNs, IPT, and prompt and effective care of cases.

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

Explain the processes used in country to:

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

Considering its designation as an upper-middle income country, Gabon does not benefit from debt-cancellation and is not eligible for the HIPC Initiative. However, in order to reach the goals that have been set, the State committed to making substantial resources available for the purchase of antimalarials (drugs and mosquito nets), as well as for the financing of the implementation of the activities.

The private sector, via oil companies, and the pharmaceutical sector contribute to the financing of the strategic plan.

The CCM was restructured to ensure an efficient use of the resources and transparency in management and to avoid conflicts of interest. The malaria thematic group will also be responsible for strengthening the NMCP and the PR in the management, monitoring, and coordination of the activities.

Quarterly reviews by the LFA, annual audits, CCM or PR supervision, and various planned evaluations will permit management control of the different stakeholders and to ensure that the resources be used in benefitting the populations.

The implementation of the community-based interventions and the participation of NGOs/CBOs are also favorable factors in the use of resources to benefit the underprivileged target groups.

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

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

In order to ensure the availability of the resources as planned by the Government, the CCM, with the support of the Ministry of Health and development partners, will perform advocacy and lobbying actions with the Government, the National Assembly, and the Senate.

The contributions of the private sector could be subject to change or to disbursement delays. The State will make sure to introduce mechanisms to address these situations in grant agreements.

5.2. Detailed Budget

Suggested steps in budget completion:

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

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

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

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

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

6. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	BCC – Mass media	267,021	93,664	178,829	173,837	173,837	887,188
1	BCC – Community agents	259,470	223,551	386,733	386,733	386,733	1,643,220
3	Management and administration costs of the program	107,888	93,312	221,255	294,744	338,939	1,056,138
3	Coordination and development of partnerships (national, community, public-private)	112,212	112,212	112,212	112,212	112,212	561,060
2	Diagnosis	1,181,770	693,281	705,366	294,404	581,327	3,456,148
3	HSS (strengthening of health systems) Management and governance	59,214	0	0	0	0	59,214
3	HSS (strengthening of health systems) Information system	602,023	110,428	230,106	304,014	416,575	1,663,146
1	Insecticide-treated mosquito nets (ITN)	389,667	633,100	1,604,451	194,569	1,058,733	3,880,520
2	Home based management of malaria	17,507	0	0	0	0	17,507
2	Monitoring of the pharmacoresistance	0	0	0	0	33,075	33,075
2	Monitoring of the pharmacovigilance	62,025	0	0	0	0	62,025
1	Monitoring of the resistance to insecticides	0	0	0	74,734	0	74,734
2	Prompt effective antimalarial treatment	11,974	0	0	276,789	169,145	457,908

ROUND 8 – Malaria

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	[use "Add Extra Row Below" from "Table" menu in Microsoft Word menu bar to add as many additional rows as required]						
Round 8 malaria funding request:		**3,070,771**	**1,959,548**	**3,438,952**	**2,112,036**	**3,270,576**	**13,851,883**

ROUND 8 – Malaria

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

Avoid using the "other" category unless necessary – read the Round 8 Guidelines .	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	0	0	35,063	84,152	84,152	**203,367**
Technical and Management Assistance	6,098	0	0	0	0	**6,098**
Training	288,584	128,654	105,217	126,241	0	**648,696**
Health products and health equipment	1,330,598	959,906	1,620,844	291,368	1,302,200	**5,504,916**
Pharmaceutical products (medicines)	0	0	0	155,815	157,023	**312,838**
Procurement and supply management costs	40,748	63,949	208,620	19,707	177,351	**510,375**
Infrastructure and other equipment	365,116	100,616	0	50,000	50,000	**565,732**
Communication Materials	257,395	93,664	173,837	173,837	173,837	**872,570**
Monitoring & Evaluation	292,056	101,362	219,920	351,065	421,967	**1,386,370**
Living Support to Clients/Target Populations	0	0	0	0	0	**0**
Planning and administration	390,841	216,195	309,075	333,475	377,670	**1,627,256**
Overheads	0	0	0	0	0	**0**
Other: *(Use to meet national budget planning categories, if required)*	99,335	295,202	766,376	526,376	526,376	**2,213,665**
Round 8 malaria funding request (*Should be the same annual totals as table 5.2)*	**3,070,771**	**1,959,548**	**3,438,952**	**2,112,036**	**3,270,576**	**13,851,883**

5.4.1. Overall budget context
Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.
To improve the quality of the care of patients suffering from malaria who will visit medical outposts, laboratory equipment is necessary. With the intention of ensuring optimal operation of these laboratories, the NMCP, in collaboration with the NPO, will make sure that reagents and consumables are regularly supplied during the five years covered by the project. This explains the significant variation of costs of medical equipment. Monitoring/evaluation costs may seem excessive, but they represent only 10% of the grant. Supervision of health departments and community, which was not covered by Round 5, has been strengthened in this project, so as to obtain the expected outcomes.

5.4.2. Human resources
In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery. *(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.* ➔ *Attach supporting information as a clearly named and numbered annex*
HALF PAGE MAXIMUM
5.4.3. Other large expenditure items
If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national malaria program. ➔ *Attach supporting information as a clearly named and numbered annex*
HALF PAGE MAXIMUM

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

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

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

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
N/A
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether

program performance influences financial contributions to the common fund.
5.5.3 Additionality of Global Fund request Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the malaria program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on malaria outcomes during the proposal term.*
N/A

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

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

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

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

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

Malaria Proposal checklist

Section	Document description	Annex Number
	[use the "Tab" key to add extra rows if needed]	