THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM

FOURTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Fourth Call for Proposals for grant funding. This Proposal Form should be used to submit proposals to the Global Fund. Please read the accompanying Guidelines for Proposals carefully before starting to fill out the Proposal Form.

Timetable: Fourth Round

Deadline for submission of proposals	April 5, 2004
Board consideration of recommended proposals	June 28 – 30, 2004

Resources available: Fourth Round

As of the date of the Fourth Call for Proposals, US$604 million is available for commitment for the Fourth Call for Proposals (pending any appeals to Third Round decisions). It is likely that more resources will become available before the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website.

Geneva, 10 January 2004

Notes:

How to use this form:

1. Please read ALL questions carefully. Specific instructions for answering the questions are provided.

2. Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try, as much as possible, to respect these indications.

3. To avoid duplication of efforts, we urge you to make maximum use of existing information (e.g., from program documents written for other donors/funding agencies).

4. Proposals may be posted on the Global Fund web site and/or otherwise made public.

Proposal Title	ROLL BACK MALARIA GABON
Country/Countries	GABON

Type of Application:

- [X] Country Coordinating Mechanism
- [ ] Sub-Country Coordinating Mechanism
- [ ] Regional Coordinating Mechanism (including Small Island States)
- [ ] Regional Organization
- [ ] Non-Country Coordinating Mechanism

[Please check one of the boxes, which will categorize your application type. For explanations of categories refer to Guidelines for Proposals section II paragraphs B1 to B4. Please note that Regional CM applications include also proposals from Small Island States.]

Proposal Components:

- [ ] HIV/AIDS
- [ ] Tuberculosis
- [X] Malaria
- [ ] HIV/TB
- [ ] Integrated

[Please check the box or all boxes your proposal targets; for explanations of components refer to Guidelines for Proposals section III paragraph A.]

Table of Contents

1 Eligibility

Country / Countries	GABON

☐ Low Income
☐ Lower-Middle Income
X☐ Upper-Middle Income
☐ High Income

[See the Guidelines for Proposals, Annex 1. For proposals from multiple countries, complete separately for each country.]

1.1 Lower-Middle Income and Upper-Middle Income Country

[Countries classified as "Lower-Middle Income" or "Upper-Middle Income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals section II.A.). Sections 1.1.1 and 1.1.2 are required for this proposal and without them this proposal will not be considered for financing.]

1.1.1 Co-financing and greater reliance on domestic resources

[This proposal is eligible only if it demonstrates that it is significantly co-financed from domestic resources. As a guide, for proposals from Lower-Middle Income countries, this co-financing should cover approximately 20% of the total cost of the program, whereas for proposals from Upper-Middle Income countries, this co-financing should cover approximately 50% of the total cost of the program. Loans should be considered as domestic resources for the purposes of quantifying co-financing. This proposal must also demonstrate that domestic resources are increasingly being relied upon over the five years of the proposal. Please complete the following table to fulfill both of these eligibility requirements. The field "Total requested from the Global Fund" should match the request in Table 5.2.]

Table 1.1 – Co-financing and greater reliance on domestic resources

Financing Sources	**In USD**				
	Year 1	**Year 2**	**Year 3 Estimate**	**Yr 4 Est.**	**Yr 5 Est.**
Domestic resources that will be used to co-finance the proposal	**2451143.125**	**1258671.775**	**1730793.19**		
(a) Government	*1926232.5*	*700000*	*1030793.2*		
(b) Other domestic	*524910.625*	*558671.775*	*699999.99*		
Total requested from the Global Fund	**4902286.25**	**2517343.55**	**2472561.7**		
Domestic co-financing percentage	**50.0 %**	**50.0%**	**70.0 %**		
Reliance on domestic resources (ratio of domestic resources to 1Global Fund financing)	**1**	**1**	**0.7**		

At least 50% of the domestic resources will be mobilized for the first two years to provide co-funding (2005-2006). Beginning in the third year (2007), this co-funding will increase by 20% each year using domestic resources to achieve financial autonomy in the fight against malaria in 2010. This proposal

covers a three-year period (2005-2007), at the end of which a new request for aid will be submitted to the Global Fund that includes consideration of the country's increased participation.

1.1.2 Poor or vulnerable populations

[This proposal is eligible only if it demonstrates that it focuses on poor or vulnerable populations. Describe the poor or vulnerable populations targeted by this proposal (2–3 paragraphs).]

Gabon's population is estimated to be 1 300 000 (UNDP, 2003). Populations vulnerable to malaria are children under 5 and pregnant women. The 0-5 population was 195 000 (WHO, 2002)* in the year 2000. A 2.9% rate of increase per year (UNDP, 2003) was applied, giving a population of 224 963 in 2005, 231 487 in 2006 and 238 200 in 2007. The expected number of pregnancies was estimated at 48750 in 2005.

* WHO Regional Office for Africa- basic indicators 2002, health situation in the WHO African Region

[Describe how these populations have been identified, and how they will be involved in planning and implementing the proposal (2–3 paragraphs).]

We know that in stable malaria transmission areas like Gabon, children under 5 and pregnant women are the most vulnerable groups because of their low immunity. The majority of cases occur in these two groups, the severe cases of malaria affect these populations almost exclusively. To estimate the size of these two target groups, the worldwide report on human development (UNDP, 2003) was used along with the WHO document cited above, which describes baseline indicators in the African Region.
Treatment, prevention and promotional activities, to be developed with the community, will combine the two vulnerable groups, especially in terms of home management of malaria and the use of insecticide-treated materials.

2 Executive Summary

[Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of The Global Fund.

NOTE: THIS SECTION TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED IN]

2.1 Component and Funding Summary

Table 2.1 – Total Funding Summary

	Total funds requested in USD					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Malaria	4902286.25	2517343.55	2472561.7			

2.2 Proposal Evaluation

[Please specify how you would like your proposal to be evaluated:]

☐ The Proposal should be evaluated as a whole
X☐ The Proposal should be evaluated as separate components

2.3 Proposal Summary

[Please include quantitative information where possible (4-6 paragraphs total):

- *Describe the goals, objectives and key service delivery areas per component, including expected results and timeframe for achieving these results. Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them (including target populations and their estimated number).*

- *If there are several components, describe any synergies expected from the combination of different components (By synergies, we mean the added value the different components bring to each other, or how the combination of these components may have broader impact).*

- *Indicate whether the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal.]*

Proposal Summary

The goal of this proposal is to help reduce malarial morbidity and mortality in children under 5 and pregnant women.
There are three coverage goals (results), and these determine the services to be delivered:

1- By 2007, at least 60% of malaria cases in children under 5 and pregnant women will be properly treated within 24 hours of initial symptoms.

Services to be delivered to achieve result 1:

- Prompt effective antimalarial treatment using the new treatment policy
- Surveillance of parasite resistance to drugs
- Management of malarial cases at home

2- By 2007, at least 60% of pregnant women and children under 5 will sleep under insecticide-treated mosquito nets.

Services to be delivered to achieve result 2:

- Proper supply of insecticide-treated nets;
- Promotion of long-lasting insecticide-treated mosquito nets for vulnerable target groups.

3- By 2007, at least 60% of pregnant women will receive Intermittent presumptive treatment (IPT).

Services to be delivered to achieve result 3:

- Promotion of prenatal consultation for pregnant women;
- Supply of Sulfadoxine-Pyrimethamine (SP);
- Capacity building of IPT service deliverers.

By achieving these results we will be able to achieve the impact stated in the goal, that is the reduction of morbidity and mortality.

However, support services are required to achieve and maintain these results:

- Set up a monitoring and evaluation system;
- Build capacity at all levels of the health system.

Various stakeholders (sub-recipients) will be called to help implement these interventions, from the public and private sectors, religious organizations, civil society, and the university, in order to provide comparative advantages.
This proposal will complement and update interventions to combat malaria in the country, using recent developments in treatment policy, especially the use of artemisinin-based combinations to manage vulnerable target groups (children under 5 and pregnant women). Instituting IPT for pregnant women and promoting long-acting insecticide-treated mosquito nets are significant innovations.

3 Type of Application:

Table 3 – Type of Application

Type of Application:	
X☐	Country Coordinating Mechanism (to National CCM section, 3.1)
☐	Sub-Country Coordinating Mechanism (to Sub-National CCM section, 3.2)
☐	Regional Coordinating Mechanism (including Small Island States) (to Regional CM section, 3.3)
☐	Regional (to Regional Organizations section, 3.4)
☐	Non-Country Coordinating Mechanism (to Non-CCM section, 3.5)

3.1 National CCM Section

Table 3.1 – National CCM Basic Information

Name of National CCM	Date of Composition
Multisector Consultative Committee to Fight HIV/AIDS, Tuberculosis and Malaria	August 28, 2002 (Presidential Decree no. 1026b/PR/MSPP, amended May 7, 2003)

3.1.1 Has the National CCM applied previously to the Global Fund? X☐ Yes ☐ No

3.1.2 Has the National CCM composition changed since the last submission? ☐ Yes X☐ No

[If yes, describe the changes (1-2 paragraphs).]

3.1.3 Did the National CCM build upon an existing body or is it a new mechanism? X☐ Existing ☐ New

The current CCM is an extension of the Consultative Committee to Fight HIV/AIDS and sexually transmitted diseases (CNLS/MST).

3.1.4 Describe how the National CCM operates.

[e.g., decision-making mechanisms, constituency consultation processes, structure of sub-committees, frequency of meetings, implementation oversight, etc. (2 paragraphs).
Provide statutes of the organization, organizational diagram, terms of reference as attachments.]

The CCM is composed of a plenary assembly, an office and a permanent secretariat. The CCM meets once each quarter, convened by the chairperson. It can only deliberate once one-half of its members are present. CCM decisions are reported through minutes signed by the chairperson and the session secretary, without giving the positions expressed by members. The minutes are given to all members of the committee, who have one week from the date received to approve them or make comments. The CCM office is made up of the chairperson, two vice-chairpersons and members of the permanent secretariat. The CCM is a small body in charge of preparing and executing the decisions made by the CCM plenary assembly. The permanent secretariat of the CCM (6 members) is in charge of daily management and relations with the Global Fund secretariat.

CCM members are not remunerated, but the costs of running the office and member travel for committee work is paid for out of the government budget.
The Global Fund secretariat receives the minutes of CCM deliberations.

3.1.5 Do you have plans to enhance the role and function of the National CCM? ☐ Yes X☐ No

[If yes please describe plans and ongoing activities, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph).]

3.1.6 National CCM Membership Section

Table 3.1. 6A – National CCM Leadership Information

	National CCM leadership details	
	Chairperson	**Vice Chairperson**
Name	Mr. Faustin BOUKOUBI	Pr. Pierre André KOMBILA
Title	Minister of Health	Director General, Santé
Mailing address	B.P. 50, LIBREVILLE,GABON	B.P. 50, LIBREVILLE,GABON
Telephone	+ 241 722407// 763590	+ 241 764807
Fax	+ 241 748821	+ 241 761060
Email address		
		2eme Vice Chairperson
		Pastor Gaspard Obiang
		Civil Society Representative
		BP 22187 Libreville Email: gas-obiang@caramail.com

[One of the tables below must be completed for each National CCM member.]

Table 3.1.6B – National CCM Member Information

National CCM member details	
Member 1	
Agency/Organization	Ministry of Culture and Public Education
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Educational sector
Name of representative	Mr. NSI NGUEMA Guillaume
Title	Director General, Ministry of Public Education
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support

Member 2	
Agency/Organization	Ministry of Communication
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Communication sector
Name of representative	LEKOGHO Jules César
Title	Technical Counsel to the Minister of Communication
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support for proposal preparation

Member 3	
Agency/Organization	Ministry of Defense
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Military Health
Name of representative	Dr BA OUMAR Paulette
Title	General Physician
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support for proposal preparation

Member 4	
Agency/Organization	Ministry of Finance
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Finance sector
Name of representative	Mrs. BINENI Jeanne
Title	Study Director

Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of proposal budget

Member 5	
Agency/Organization	Ministry of National Education
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Educational sector/Government
Name of representative	Mrs. MEBALEY Blanche-Reine
Title	Coordinator, Committee to Fight AIDS, in the Ministry of National Education (COLUSIMEN)
Email Address	mebaleyb@yahoo.fr
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support for proposal preparation and examination

Member 6	
Agency/Organization	Ministry of Health
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Health sector
Name of representative	Dr TOUNG-MVE Médard
Title	Director, National Program to Fight Tuberculosis
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 7	
Agency/Organization	Ministry of Health

Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Health sector
Name of representative	Dr MABIKA MAMFOUMBI Modeste
Title	Director, National Program to Fight Malaria
Email Address	mabikmamfoubi@yahoo.fr
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 8	
Agency/Organization	Ministry of Health
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Health sector
Name of representative	Dr MALNGOA MOUELET Gabriel
Title	Director, National Program to Fight AIDS
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 9	
Agency/Organization	Ministry of Social Affairs and Solidarity
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Social Affairs
Name of representative	Mr. MINTSAMI NDNGO Jean Pierre
Title	Director General, Wellbeing
Email Address	

Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the component

Member 10	
Agency/Organization	Ministry of Family
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Social Affairs sector
Name of representative	Mr. FOUTTI MAVOUNGOU
Title	Counsel to the Minister
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 11	
Agency/Organization	Ministry of Higher Education
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Education sector
Name of representative	Mr. IDIATA Franck
Title	Technical counsel to the Minister
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 12	
Agency/Organization	Ministry of Work and Employment
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Industrial Medicine sector
Name of representative	Dr WEZET NAMBO Guy
Title	Inspector General, Industrial Medicine
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 13	
Agency/Organization	Ministry of Health
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Health sector
Name of representative	Mrs. MOUGUENGUI Paulette
Title	Director, National Pharmaceutical Office
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support

Member 14	
Agency/Organization	Ministry of Health
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government/Health sector

Name of representative	Dr MABNGOO Adolphe
Title	Director, Drugs
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support

Member 15	
Agency/Organization	Confédération Patronale Gabonaise [*Gabon Business Confederation*]
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Private sector
Name of representative	OYIMA Jean Claude
Title	Chairperson, Confédération Patronale Gabonaise [Gabon Business Confederation]
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 16	
Agency/Organization	UNICEF
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. LAUBJERG Kristian
Title	Representative of UNICEF
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 17	
Agency/Organization	UNDP
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. DIAWARA Hamidou
Title	Resident representative of UNDP
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal development coordinator/Principal beneficiary (PR)

Member 18	
Agency/Organization	EUROPEAN COMMISSION
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. KREBS Jochem
Title	Ambassador
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 19	
Agency/Organization	Economic and Social Council (CES)

Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Community sector
Name of representative	Me MAYILA Louis Gaston
Title	Chairperson of the Economic and Social Council
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support

Member 20	
Agency/Organization	Coopération Française
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral cooperation
Name of representative	Mr. Decamps
Title	Counsel to the Coopération Française
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical support

Member 21	
Agency/Organization	World Health Organization
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Dr BRUN Alain Christopher
Title	Representative of WHO

Email Address	oms.gabon@internetgabon.com
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation/Coordination

Member 22	
Agency/Organization	UNHCR
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. AKINOLA Benedict
Title	Representative of UNHCR
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 23	
Agency/Organization	UNESCO
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. GASSAMA Makkily
Title	Representative of UNESCO
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 24	
Agency/Organization	World Bank
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Multilateral partner
Name of representative	Mr. TEYMOURIN Mehmaz
Title	Resident representative
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 25	
Agency/Organization	Gabon Network of Organizations to Fight AIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Non-governmental organization
Name of representative	Pastor Gaspard OBIANG
Title	Vice-Chairperson of the CCM, Civil Society Representative
Email Address	gasp-obiang@caramail.com
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Preparation/Examination of the proposal

Member 26	
Agency/Organization	Gabon Movement for Family Wellbeing [MGBEF]
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Community sector

Name of representative	Mrs. NGWEVILOT Yvette
Title	Chairperson, MGBEF
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 27	
Agency/Organization	National Network to Promote Reproductive Health, Adolescents and Youth
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Community sector
Name of representative	Mr. M'PAGA Georges
Title	Chairperson of the network
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 28	
Agency/Organization	Association of the Central African Episcopal Conferences against AIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Religious organization
Name of representative	Monseigneur Basile MVE ENGONE
Title	Archbishop of Libreville
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 29	
Agency/Organization	National Network of Churches against AIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Religious organization
Name of representative	Pastor NGOUA Jude
Title	Representative of Evangelical and Pentecostal Churches of Gabon
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 30	
Agency/Organization	High Council of Islamic Affairs
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Religious organization
Name of representative	Mr. NTCHORERE Souleyman
Title	Vice-Chairperson of the Council
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 31	
Agency/Organization	Gabon Assistance and Action Association for people with HIV and AIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS,	Non-governmental organization

tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	
Name of representative	Mrs. SIAKA Sidonie
Title	Chairperson of the Association
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Proposal preparation

Member 32	
Agency/Organization	Outpatient Treatment Centre
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Dr NZAMBA Chantal
Title	Department Head
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 33	
Agency/Organization	Jeanne Ebori Foundation
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Para-public sector
Name of representative	Dr OGANDAGA Emmanuel
Title	Department Head, Internal Medicine
Email Address	

Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 34	
Agency/Organization	Organization of First Ladies of Africa against AIDS ([OPDAS]
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Non-governmental organizations
Name of representative	Dr NDNGO YOUSSOUF Georgette
Title	OPDAS Technical Committee
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

Member 35	
Agency/Organization	University of Health Sciences
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Academic/educational sector
Name of representative	Dr NDJOYI Angélique
Title	Department Head, Microbiology Department, College of Medicine
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Examination of the proposal

3.1.7 National CCM Endorsement of Proposal

PROPOSAL TITLE: ROLL BACK MALARIA IN GABON

"We the undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Table 3.1.8 – National CCM Endorsement

Agency/ Organization	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health	*Faustin BOUKOUBI*	*Minister*		
Ministry of Health	*KOMBILA KOUMBA Pierre*	*Director General, Health*		
Ministry of Health	*Toung-Mvé Médard*	*Director, PNLT*		
Ministry of Health	*Mabika Mamfoumbi Modeste*	*Director, NPFM*		
Ministry of Health	*Malonga Mouelet G.*	*Director, NPFA*		
Ministry of Social Affairs and Solidarity	*MINTSAMI NDNGO Jean Pierre*	*Director General, Well-being*		
Ministry of Family	*FOUTTI MAVOUNGOU Armel*	Counsel to the Minister		
Ministry of Higher Education	*IDIATA Franck*	*Technical counsel to the Minister*		
Ministry of Culture and Public Education	*NSI NGUEMA Guillaume*	*Associate Director General*		
Ministry of Communication	*LEKOGHO Jules César*	*Technical counsel to the Minister*		
Ministry of Defense	*Dr BA OUMAR Paulette*	*General Physician*		
Ministry of Finance	*BINENI Jeanne*	*Study Director*		
Ministry of National Education	*MEBALEY Blanche- Reine*	*Coordinator, COLUSINEM*		
Ministry of Work and Employment	*Dr WEZET NAMBO Guy*	*Inspector General, industrial medicine*		
Ministry of Health	*Paulette Mouguengui*	*Director, OPN**		
Ministry of Health	*Dr MABNGOO Adolphe*	*Director, drugs*		

Confédération Patronale Gabonaise (CPG)	*Mr. Jean-Claude OYIMA*	*Chairperson*		
UNICEF	*M. Kristian LAUBJERG*	*Resident representative*		
UNDP	*M. DIAWARA Hamidou*	*Resident representative*		
European Commission	*M. KREBS Jochen*	*Ambassador*		

"We the undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Agency/ Organization	**Name of representative**	**Title**	**Date**	**Signature**
Economic and Social Council (CES)	*Maître MAYILA Louis Gaston*	*Chairperson*		
Coopération française	*DECAMPS Benoît*	*Counsellor*		
WHO	*BRUN Alain*	*Representative*		
UNHCR	*AKINOLA Benedict*	*Representative*		
UNESCO	*GASSAMA Makkily*	*Representative*		
World Bank	*TEYMOURIAN Mehrnaz*	*Resident Representative*		
Gabon Network of Organizations to Fight AIDS	*Pasteur Gaspard OBIANG*	*Chairperson*		
Gabon Movement for Family Wellbeing	*NGWEVILOT Yvette*	*Chairperson*		
National Network to Promote Reproductive Health, Adolescents and Youth	*M'PAGA Georges*	*Chairperson*		
Association of Central African Episcopal Conferences against AIDS	*Mgr Basile MVE ENGONE*	*Archbishop of Libreville*		
National Network of Churches against AIDS	*Pasteur NGOUA Jude*	*Representative, Evangelical and Pentecostal churches of Gabon*		
High Council of Islamic Affairs	*NTCHORERE Souleyman*	*Vice-chairperson of the council*		
Gabon Assistance and Action Association for people with HIV and AIDS	*SIAKA Sidonie*	*Chairperson des PLWHA*		
National Education Union	*BITOUGAT Christiane*	*Chairperson*		
Outpatient Treatment Centre	*Dr Chantal ZAMBA*	*Chief Physician*		
Jeanne Ebori Foundation	*Dr Emmanuel OGANDAGA*	*Department Head*		
Organization of First Ladies of Africa against AIDS (OPDAS)	*Dr NDNGO Youssouf*	*OPDAS Technical*		

	Georgette	*Committee, Gabon*		
University of Health Sciences	*Dr Angélique NDJOYI*	*Department Head*		
Gabon Assistance and Action Association for people with HIV and AIDS	*BAKOKO Jean Baptiste*	*Vice-Chairperson*		
Minister of Planning	*MASSANDE Saïd-Omar*			
Albert Schweitzer Hospital Foundation	*M MOUGIN*	*Director*		

4 Components Section

[PLEASE NOTE THAT THIS SECTION AND THE NEXT SECTION NEED TO BE COMPLETED BY COMPONENT, so, for example, if the proposal targets three components sections 4 and 5 must be completed three times. The system will automatically generate separate sections for each component.]

4.1 Identify the component addressed in this section

☐ HIV/AIDS
☐ Tuberculosis
X☐ Malaria
☐ HIV/TB
☐ Integrated

4.1.1 Indicate the estimated start time and duration of the component

[Please take note of the timing of proposal approval by Board of the Global Fund (listed on the cover of the Proposal Form), as well as the fact that funds typically will not be released for a minimum of 2 months after Board approval]

Table 4.1.1 – Proposal start time and duration

	From	To
Month and Year:	January 2005	December 2007

4.2 Contact persons for questions regarding this component

[Please provide full contact details for two persons – this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2 – Component Contact Persons

	Primary contact	Secondary contact
Name	Mr. Faustin BOUKOUBI	Mr. Hamidou DIAWARA
Title	Minister of Health	Resident representative
Organization	Government	UNDP
Mailing address	B.P. 50, LIBREVILLE, GABON	B.P. 2183 LIBREVILLE, GABON
Telephone	(241) 76 35 90	(241) 73 88 87
Fax	(241) 74 88 21	(241) 73 88 91
Email address		regestry.ga@undp.org

4.3 National context for this Component

4.3.1 Disease burden

[Please provide 1-2 paragraphs on each of the following]:

4.3.1.1 Latest data on prevalence, incidence and other disease measurements, including data sources used

Magnitude: Recent data show that malaria is the leading cause of doctor visits and hospitalization, Annual average prevalence of plasmodial infection in febrile children between 0 and 10 across the

country varies from 31% to 71% (Analysis of the Malarial Situation in Gabon, 2003) [1]. The annual incidence rate was estimated at 2 148 per 100 000 inhabitants in the general population in 1998 (UNDP, 2003).

In the Libreville Hospital Centre (CHL), statistics show that malaria is the reason for 40% of doctor visits for fever.

Severity: Severe forms of the disease occur in 45% of febrile children hospitalized. Anemia requiring transfusion represents 70% of the severe forms (data gathered at the CHL and the Albert Schweitzer Hospital in Lambaréné, 2002). In the CHL, the malarial mortality rate is 9% (2000-2002).

the situation is aggravated by *Plasmodium falciparum* resistance to antimalarials, which varies from 50% to 100% for chloroquine in some areas (study conducted in 2002: Department of Parasitology-Mycology in the College of Medicine in Libreville, Schweitzer Hospital in Lambaréné, and the International Medical Research Centre in Franceville).

In Libreville, 64% of pregnant women are stricken with malaria, and 71% of them have malaria-related anemia[2].

These data only represent the tip of the iceberg, because they come from public health structures; home deaths are not notified, and no more than 10% of these are reported.

4.3.1.2 Stage and type of epidemic, and most affected population groups

Malaria is holoendemic throughout the country and transmission is continuous. The most vulnerable populations are children under 5 and pregnant women. Gabon's population is estimated at 1 300 000 (UNDP, 2003). The 0-5 population represents 14% of the total population, or 195 000 children.

4.3.2 Describe the political commitment in responding to the disease, including by reference to internationally agreed-to targets (e.g., the commitment by African Heads of State to increase health sector spending to 15% of public expenditure) (1–2 paragraphs)

Gabon's government has agreed to make significant efforts to improve the healthcare situation for the populations. It hopes to provide access to drugs at lower costs to the poorest population, and to define a sector policy to improve health sector management. This strategy determined the priority objectives of public expenditures on health as well as the respective roles of the private and public sectors, consisting mainly of applying the measures set forth in decree 001/95 (Source: EDS 2000).

Regarding the fight against malaria:
- On the international level, Gabon has taken part in all global and regional mechanisms and initiatives in the Fight against Malaria, notably the Ministerial Conference on the Fight Against Malaria in Amsterdam in 1992, the African Initiative to Fight Malaria in Harare in 1997, and the African Summit on the Roll Back Malaria initiative in Abuja in 2000.

- On the national level, the government of the Republic of Gabon has promulgated a law on alleviating and removing taxes and customs duties on mosquito nets and insecticides in order to reach the Abuja objectives more quickly. The antimalarial drug policy was revised in July 2003 for the introduction of artemisinin-based therapeutic combinations and IPT for pregnant women. Products concerned in this new treatment policy are recorded on the list of essential medicines:
  - Artesunate-Amodiaquine
  - Artemether-Lumefantrine (Coartem)
  - Sulfadoxine-Pyrimethamine

1 Report from the National Consensus Workshop on Therapeutic Perspectives of Malaria
2 Marielle K. Bouyou Akotet et al. Prevalence of *Plasmodium falciparum* infection women in Gabon, Malaria Journal 2003.2:18

4.3.3 List the national disease control strategies consulted in the preparation of the proposal, and describe how lessons learned from the implementation of these strategies have been incorporated in this proposal (2–3 paragraphs)

National strategies to combat malaria revolve around case management and prevention. These two main strategies are supported by capacity building and multisector collaboration.

Case management: a national consensus workshop was held from July 1 to 4, 2003, which led to the adoption of artemisinin-based therapeutic combinations as first and second line treatments (artesunate-amodiaquine and artesunate-lumefantrine). However, the steps needed prior to an effective implementation of the new malaria treatment policy have not yet been taken. Home management is still not organized, although it is included as a strategy to fight malaria.

Prevention:
- Intermittent Presumptive Treatment (IPT) for pregnant women was adopted during a national consensus meeting, but there is no implementation plan yet.
- Insecticide-treated mosquito nets are an essential measure for preventing malaria in children and pregnant women, but there is no plan for promoting insecticide-treated nets.

4.3.4 List any broader development initiatives (e.g., Poverty Reduction Strategy Papers, Highly-Indebted Poor Countries initiative) ongoing in << pull country name >>, and describe the links between this proposal and these initiatives (2–3 paragraphs)

Gabon is an upper middle-income country (World Bank, March 2003) with average per capita income of US$4000. This places Gabon in the intermediate-upper level (PRI-TS) of countries, and thus Gabon cannot participate in the HIPC (Highly Indebted Poor Countries) Initiative.
However, although Gabon's high GDP, which places it 78th worldwide, the country has a human development index placing it at 118th place, according to the Global Report on Human Development in 2003, UNDP (Human Development Index: 0.653)
Gabon is in the process of finalizing its poverty reduction strategy paper. This proposal for the malaria component considers both the Millennium Development Objectives and the Poverty Reduction Initiative, which considers combating disease a priority.

Reference: Draft of the poverty reduction strategy paper, IMF mission, March 27 to April 10 2003 – Ministry of the Economy, Finance, Budget and Privatization – Minister of State office.

4.3.5 Describe how the proposal will contribute to broader efforts to reach the Millennium Development Goals (www.un.org/millenniumgoals) (1–2 paragraphs)

This proposal to fight malaria in Gabon will undoubtedly help attain the Millennium Development Goals because it targets two vulnerable groups: children under 5 and pregnant women.
- Protecting pregnant women with insecticide-treated nets and IPT will help reduce malaria incidence and maternal anemia, and consequently maternal death. Protecting pregnant women will also help reduce neonatal mortality related to malaria in children with low birth weights and premature births that are associated with malaria in pregnancy.
- Preventing malaria through the use of insecticide-treated nets and early management with effective drugs will help reduce mortality in children under 5, which is an important element of the Millennium Development Goals (MDG).

4.3.6 Describe the links to international initiatives (e.g., the World Health Organization/UNAIDS "3-by-5" initiative to address the insufficient access to antiretroviral therapy, the Global Plan to Stop TB, and the Roll Back Malaria Partnership) (1–2 paragraphs)

This proposal aligns with the Roll Back Malaria (RBM) initiative, which targets reducing malarial mortality by 50% in 2010 as compared to year 2000 figures. It also is part of achieving the Millennium Development Goals. The interventions chosen are appropriate for use with the RBM initiative strategies and the recommendations from the African Heads of State Conference in Abuja in April 2000, i.e.:

- Early prompt management with effective drugs;
- Protection of children with insecticide-treated nets;
- Protection of pregnant women with insecticide-treated nets and intermittent presumptive treatment;
- Partnership in the fight against malaria;
- Contributions to developing the health system through capacity building and monitoring and evaluation.

4.3.7 Is there a sector-wide approach or other fund-pooling mechanism in place in the health sector? ☐ Yes X☐ No

[If yes, briefly describe how it operates and if you anticipate using it to administer part/all of the Global Fund grant (1–2 paragraphs)]

[For HIV components only:]

4.3.8 Is there a World Bank Multi-Country HIV/AIDS Program? ☐ Yes ☐ No

[If yes, describe how interventions in this proposal complement those financed by the World Bank MAP (2–3 paragraphs)]

Describe how the financial management approach of this proposal relates to that being used by the World Bank MAP (1–2 paragraphs)

4.3.9 Indicate names and types of key agencies providing technical assistance to the national response

Table 4.3.9 - Technical Partners in National Response

Name of Agency	**Type of Agency** (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	**Main technical focus** (e.g., prevention, care and support, treatment, etc.)
World Health Organization	Multilateral	Technical assistance; Planning and Implementation; Monitoring and Evaluation; Developing technical guides
University of Health Sciences	University sector	Malaria case management; Technical assistance, training, basic research; operational research; tests of therapeutic efficacy
Albert Schweitzer Hospital	Not-for-profit private (Foundation)	Malaria case management; basic research; operational research; tests of therapeutic efficacy
Franceville International Research Centre (CIRMF)	Government	Basic research; operational research

4.3.10 Earmarked financial contributions to the national response to this disease

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources.]

Table 4.3.10- Financial Contributions to National Response

	Financial contributions in USD							
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Domestic	2451143	1258671.775	1730793.19	2451143	1258671.775	1730793.19	2451143	1258671.775
External	15000	150000	150000	15000	150000	150000	15000	150000
Total resources available	2466143.13	1408671.78	1880793.19	2466143.13	1408671.78	1880793.19	2466143.13	1408671.78

4.3.11 Total resource needs

[Describe the total resources needed to combat this disease.]

Table 4.3.11- Total resource needs

	In USD				
	2004	**2005**	**2006**	**2007**	**2008**
Total resources available	2466143.13	1408671.78	1880793.19	2466143.13	1408671.78
Total need	4902286.25	2517343.55	2472561.7	4902286.25	2517343.55
Unmet need	2436143.12	1108671.77	591768.51	2436143.12	1108671.77

[Describe the source of the resource needs (e.g., costed national strategies), or, if they were estimated for the proposal, how the estimates were developed (1 paragraph)}

4.3.12 Describe plans to ensure that any Global Fund resources received would be additional to the existing and planned resources (2–3 paragraphs)

[Global Fund financing should be additional to existing and planned resources in the fight against AIDS, tuberculosis and malaria, and so should not replace existing domestic or external resources]

A strategic plan to combat malaria was developed in 2002, and domestic resources from various sources are being used: government, development partners, religious groups, NGOs, not-for-profit private groups, for-profit private groups (drugs).

4.3.13 Analysis of gaps in coverage of key service delivery areas

[Please list any key service delivery areas from Annex B that are included in national strategic plans but which are currently not available at all or not currently available at sufficiently wide scale]

The various areas included in this proposal are part of the 2002-2006 strategic plan to fight malaria. However, strategies have been slow to be realized despite the development of the new strategic plan and adoption of the new treatment policy:

- ITN promotion is not yet effective, lacking a promotion plan and funding;
- ACT use for treatment and IPT for pregnant women are not yet effective.

4.3.14 Does this application focus primarily on scaling up existing interventions, introducing new interventions, or both?

☐ Scaling up
☐ New
X☐ Both

4.3.14.1 If "scaling up" or "both", describe how the interventions addressed in the proposal build upon existing programs (2 – 3 paragraphs)

Malaria:
A strategic plan was drawn up to combat malaria, in collaboration with various partners. The primary interventions that have begun to be implemented are mainly centered around managing malarial cases in health facilities, prevention through the promotion of insecticide-treated mosquito nets, chemoprophylaxis and/or intermittent presumptive treatment in pregnant women.

4.3.14.2 If "scaling up" or "both", describe how the interventions to be scaled up were identified from among other existing interventions (1–2 paragraphs)

The 2001 analysis of the situation identified a number of problems and factors in the fight against malaria:

- poor case management in the community and in health structures;
- low use of insecticide-treated nets despite their being widely available in those areas where they are traditionally used;
- weaknesses in technical and managerial capacities;
- ineffectiveness of chloroquine used to treat cases and chemoprophylaxis for pregnant women;
- weaknesses in the National Health Information System (SNIS).

The interventions were selected in consideration of the problems identified in the situation analysis, of vulnerable target groups, and of recent changes to drug policy.

Because resistance has increased and spread, the drug policy was changed in July 2004 (see the report of the national consensus meeting). This requires health agents to be re-trained, intermittent presumptive treatment for pregnant women to be introduced, and the use of insecticide-treated materials to be scaled up throughout the country.

These needs require capacity building at all levels.

4.3.14.3 If "scaling up" or "both", indicate the major barriers to scaling up the interventions that have been identified as proven and effective have not previously been scaled up

[Check as many as apply, and then briefly (1–2 paragraphs) explain each barrier below.]

☐ Policies, standards and guidelines
X☐ National capacity (health systems, human resources, etc.)
☐ Stigma, discrimination and human rights
☐ Gender-related issues
X☐ Financing
☐ Other (please specify: _____)

The lack of capacity in the NPFM and health system, at all levels, means that we have not been able to implement interventions that are known to be effective in combating malaria even though a strategic plan was drawn up in 2002. The lack of partners to combat malaria means that there have been no joint activities or round tables for mobilizing resources for implementation.

4.3.14.4 If "scaling up" or "both", describe any innovative aspects to scaling up these interventions (2 – 3 paragraphs)

The interventions selected for this proposal bring significant innovations to the fight against malaria in Gabon:

- The effective introduction of artesunate-based therapeutic combinations (ACT), based on the decisions made in the consensus meeting: artesunate-amodiaquine as first-line treatment and artemether-lumefantrine as second-line treatment.
- The implementation of intermittent presumptive treatment with SP for pregnant women, also selected during the consensus meeting.
- The promotion of long-acting insecticide-treated mosquito nets targeting children under 5 and pregnant women.
- Setting up a monitoring and evaluation system, which has not existed until now.

- Capacity building in terms of planning, program management and morbidity management.

4.3.14.5 If "new" or "both", describe how the new interventions addressed in the proposal complement and build upon existing programs (2 – 3 paragraphs)

The interventions selected for this proposal bring significant innovations to the fight against malaria in Gabon:

- The effective introduction of artesunate-based therapeutic combinations (ACT), based on the decisions made in the consensus meeting: artesunate-amodiaquine as first-line treatment and artemether-lumefantrine as second-line treatment.
- The implementation of intermittent presumptive treatment with SP for pregnant women, also selected during the consensus meeting.
- The promotion of long-acting insecticide-treated mosquito nets targeting children under 5 and pregnant women.
- Setting up a monitoring and evaluation system, which has not existed until now.
- Capacity building in terms of planning, program management and morbidity management.

4.3.14.6 If "new" or "both", describe how these interventions were identified (1–2 paragraphs)

The interventions were selected in consideration of the problems identified in the situation analysis, of vulnerable target groups, and of recent changes to drug policy.

4.3.14.7 If "new" or "both", describe why these interventions were not previously in widespread use (1– 2 paragraphs)

Management using ACT and IPT could not be introduced prior to the national consensus meeting.

We had to ensure the availability and cost of long-acting insecticide-treated mosquito nets on the international market in order to promote their use.

4.3.14.8 If "new" or "both", describe any innovative aspects to these interventions (2 – 3 paragraphs)

The innovative aspects are:

- the introduction of ACT for therapeutic management;
- the introduction of long-acting insecticide-treated mosquito nets;
- the supervised administration of SP for IPT for pregnant women
- the combination of distributing treated mosquito nets to pregnant women with prenatal consultation at their first contact with a health structure;
- the combination of distributing treated mosquito nets to children at appointments for vaccinations, nutrition consultations and sick-child doctor visits;
- the use of community networks to distribute ITNs.

4.3.15 Does this application complement earlier grants from The Global Fund? ☐ Yes X☐ No

4.3.15.1 If yes, describe how this application complements earlier grants from the Global Fund (2 – 3 paragraphs)

4.4 Program Strategy

Guide to the Program Strategy Section

Goal, Objectives, Services to be delivered and Main Activities

In this section, the component strategy is described by completing Table 4.4, as well as the questions which follow.

Table 4.4 is designed to help applicants clearly summarize the strategy and logical rationale behind their proposal, and to show how expanded coverage of key services to be supported by the Global Fund relate to a broader national plan for the disease component. Applicants are asked to describe the program goal, objectives, services to be delivered and main activities, as well as key indicators to be used for measuring impact and coverage. See the Guidelines for Proposals, section V.B.2 for more information.

Applicants should also include a detailed action plan for the first 12 months and an indicative action plan for the second year. These should be attached as an annex to the proposal form.

Goals (Code 4A):
These should be broad and overarching and will typically reflect national disease program goals. The results achieved will usually be the result of collective action undertaken by a range of actors. Examples include "Reduced HIV-related mortality," "Reduced burden of tuberculosis," or "Reduced transmission of malaria."

Reduce the malarial mortality and morbidity rates in pregnant women and children under 5.

Impact indicators (Code 4B):
List national behavioral and disease surveillance indicators linked to each goal. Annex A contains globally agreed-to indicators for measuring disease impact. You can also include other indicators and describe them.

Goal:	**Reduce the malarial mortality and morbidity rates in children under 5 and pregnant women.**	
(See Annex II) Impact Indicator	**Baseline:** **Year: 2005**	**Objective in numbers** (last year of the proposal) **Year: 2007**
Reduced mortality for all causes in children under 5	**Baseline data to be collected**	Reduce by 30% from baseline year.
Reduced malaria-specific mortality	**Baseline data to be collected**	Reduce by 30% from baseline year.
Reduced malaria-specific morbidity	**Baseline data to be collected**	Reduce by 30% from baseline year.

Baselines (Code 4C):
If previous surveys have already been implemented, give details of last survey results for the particular indicator described under Code 4B.

We propose conducting a baseline survey

Targets (Code 4D):

Include here the targets to be reached at or toward the end of the proposal. If the means of collecting this information (e.g., survey) only occurs every several years, include the target for year in which the data collection will take place and specify the year.

Baseline data will be collected during 2005 at health structures and in communities, using the usual tools recommended by WHO for collecting baseline data at the national level. The malarial morbidity and mortality rates will be measured again in 2007 to assess the impact of the project.

Objectives (Code 4E):

Describe the objectives. These should describe the intention of the programs for which funding is sought and provide a framework under which services are delivered. Examples linked to the goals listed above include "To improve survival rates in people with advanced HIV infection in four provinces," "To reduce transmission of tuberculosis among prisoners in the ten largest prisons" or "To reduce malaria-related morbidity among pregnant women in seven rural districts."

Specific objectives are:

1- By 2007, at least 60% of malaria cases in children under 5 and pregnant women will be properly treated within 24 hours of initial symptoms;

2- By 2007, at least 60% of pregnant women and children under 5 will sleep under insecticide-treated mosquito nets;

3- By 2007, at least 60% of pregnant women will receive intermittent presumptive treatment (IPT).

Services to be delivered (Code 4F):
To accomplish each objective, the key services to be delivered should be identified. Examples linked to the objectives listed above include "Scaling up of access to antiretroviral therapy," "Expansion of directly-observed therapy, short-course," or "Distribution of insecticide-treated bednets." Describe here the service areas to be delivered. First, select from the lists of services to be delivered in Annex B (Code 4F), and then briefly describe the service to be delivered (Code 4G).

Services to be delivered and activities to be conducted for the objectives are:

Objective 1: By 2007, at least 60% of malaria cases in children under 5 and pregnant women will be properly treated within 24 hours of initial symptoms:

Services to be delivered:
- Prompt effective antimalarial treatment
- Surveillance of parasite drug resistance
- Managing malarial cases at home

Activities:
- Adapt and reproduce the (WHO) training guide on case management in health facilities
- Adapter and distribute the (WHO) guide on home-based management
- Reproduce and distribute community awareness and mobilization media aids
- Re-train care providers (doctors, midwives, nurses, lab technicians)
- Train community intermediary trainers in home-based management
- Train community intermediaries in home-based management
- Create awareness in mothers and guardians of children about home-based management
- Order ACTs: artesunate-amodiaquine and artesunate-lumefantrine
- Test the effectiveness of the ACTs used
- Create awareness in the communities

Objective 2: By 2007, at least 60% of pregnant women and children under 5 will sleep under insecticide-treated mosquito nets:

Services:
- Proper supply of long-lasting mosquito nets
- Promotion of ITNs to vulnerable target groups

-

Activities:

- Train 390 community intermediaries
- Organize a mass treatment campaign (MTC)
- Create 32 community insecticide-treatment units
- Provide the community insecticide-treatment units with kits and insecticides (KO-Tab)
- Order long-acting insecticide-treated mosquito nets
- Test the effectiveness of insecticides

<u>Objective 3:</u> By 2007, at least 60% of pregnant women will receive intermittent presumptive treatment (IPT):

Service to be delivered:

- Promote prenatal consultations for pregnant women
- Supply Sulfadoxine-Pyrimethamine
- Provide service deliverers with capacity building for IPT

Activities:

- Reproduce IPT training and awareness tools
- Train personnel (midwives, doctors, health agents) in IPT
- Provide SP drugs to health structures (PM)
- Create awareness in women on the use of IPT (PM)
- Supervise implementation of IPT (PM
- Distribute Sulfadoxine-Pyrimethamine **free of charge** to pregnant women during prenatal consultations for supervised administration (PM)

Support services:

- Build capacity of the NPFM team and the health system at all levels
- Strengthen monitoring and evaluation
- Build capacity in inventory management and procurement

Activities:

Capacity building

- Train NPFM members, provincial and district teams in planning and implementing activities to combat malaria
- Train NPFM personnel and provide study abroad
- Update the curricula in the training schools to be in line with the national policy to fight malaria (PM)
- Organize technical support missions

Program materials:

Monitoring and evaluation

(see M&E section: Section 4.6)

Coverage indicators (Code 4G)

Describe the indicator/s to be used to measure increased coverage for each service to be delivered. Choose from lists in Annex B and/or use an indicator that is already being used for this service delivery area and describe. Insert baseline and targets for years 1-5. A new initiative is not likely to have a baseline, or will have a baseline of 0. The "year" refers to the year of proposal implementation. The timing of the measurement of these annual targets should, as far as possible, be aligned with existing (e.g., national) data collection and reporting systems (see the Guidelines for Performance Based Funding for further details).

[insert digit only fields for baseline, and for targets years 1, 2, 3, 4, and 5].

[Drop down lists of indicators by service delivery area is in Annex B]

Early home management

- Prompt effective antimalarial treatment:
    - Number of providers trained in the new treatment plan
    - Children under 5 with access to prompt effective treatment

- Monitoring drug resistance:
    - Number of service deliverers trained
    - Number of sentinel sites established to monitor antimalarial drug resistance

- Managing malarial cases at home:
    - Number of service deliverers trained
    - Number of child guardians who recognize the signs and symptoms of malaria
    - Appropriate care-seeking behavior and antimalarial use

Early management in health structures:

- Prompt effective antimalarial treatment:
    - Number of patients with uncomplicated and severe malaria receiving proper treatment after diagnosis
    - Number of health facilities with no reported stockouts of antimalarial drugs
    - Number of malarial deaths in children under 5 in hospitals

- Monitoring drug resistance
    - Number of service deliverers trained
    - Number of sentinel sites established to monitor antimalarial drug resistance

Insecticide-Treated Nets (ITNs):

- Number of service deliverers trained
- Number of mosquito nets, permanent mosquito nets, pretreated mosquito nets or retreatment kits distributed.
- Number of sentinel sites established to monitor insecticide resistance.
- Households owning an insecticide-treated net
- children under 5 using an insecticide-treated net

Information, Education and Communication

- Number of service deliverers trained
- Number of targeted areas with IEC services

Malaria in pregnancy

- Number of pregnant women receiving correct intermittent presumptive treatment

Support environment and cross-cutting aspects:

- Strengthening health systems:
    - Number of staff members trained
    - % of budget spent on health infrastructure
    - % of patients who are accurately referred

- Coordination and partnership development:
    - Number of networks/partnerships involved

- Monitoring and evaluation:
    - Number of service deliverers trained
    - % of budget spent on monitoring and evaluation

- Procurement and supply management capacity building:
    - Number of service deliverers trained
    - % of service delivery points with sufficient drug supplies
    - % reduction in unit costs of drugs and commodities

Main activities (Codes 4 K and L)
****

Early home management:

A guide for managing malarial cases at home (developed by WHO) will be adapted during a national workshop to be organized by the Ministry of Health. Adapting this guide will mobilize all local competencies, especially UNICEF, WHO, the Ministries of Health, Education, Public Education, Family and Information. A series of training sessions will be organized in health regions and departments that target community intermediaries. Posters about treatment orientations and information for the public will be developed and distributed to households to support early management of cases.

Early management in health structures:

A national workshop will be organized to adapt the training guides to the new therapeutic direction established at the July 2003 consensus meeting.
Training sessions will be organized for regional trainers in each of the 10 health regions of the country. Ten sessions in all will be organized.
Next there will be a series of training sessions in health departments led by those trainers who have already been trained.
These training sessions will primarily target doctors, nurses and midwives in charge of disease management activities, and lab technicians for microscopic diagnosis.
In health facilities (dispensaries/nursing centers, medical centers, health centers, medical-social centers, regional hospitals, national hospital) artemisinin-based combinations (ART + amodiaquine) will be used as first-line treatments.
The artemether-luumefantrine (Coartem) combination will be used as a second-line treatment to treat therapeutic failures of first-line treatment.
Quinine will only be used to manage cases of severe malaria, so appropriate guides and algorithms will be made available to healthcare workers in health facilities.

Drug supplies:

Drugs will be supplied in accordance with the revised drug policy. The National Pharmaceutical Office (OPN) will be in charge of making drugs available in health facilities using the new supply process (allotment and delivery). The initial allotment of drugs will cover theoretical needs calculated on the basis of the number of expected malarial cases and the [visit] frequency rate for health facilities for a one-month period. Drugs will then be ordered quarterly.

The drugs cited in this submission are intended for pregnant women and children under 5. Because malaria is endemic in Gabon and transmission occurs throughout the year, drug requirements for the rest of the population will be managed through the traditional activities of public and private health facilities. Similarly, reagents for microscopic diagnosis of malaria will be supplied by the OPN.

Insecticide-treated nets (ITNs):

ITNs will be promoted through marketing, advocacy, communication and social mobilization, in order to improve usage levels in the target population.
Mass treatment campaigns (MTCs) for collective mosquito net treatment will be organized in each department in order to treat existing mosquito nets in the population through insecticide treatment units, which will be created.
The current number of insecticide treatment centers with a formal role will be increased in order to have an insecticide treatment centre in each department. Community intermediaries will be trained in insecticide treatment techniques.

The Maternal and Infant Health Service will distribute new mosquito nets to the target populations (pregnant women and children under 5). Mosquito net orders will be place the first two [years]. Community intermediaries (390) will be used to distribute mosquito nets as part of proper management.

Community distribution circuits for mosquito nets will also include the OPN, religious organizations and NGOs (Alize, Italian).

Information, Education and Communication

A national workshop to adapt awareness tools and gather all of the partners involved in the fight against malaria will be organized by the Ministry of Health. Awareness and community mobilization tools/aids will then be developed and distributed in all departments in the country. These aids will demonstrate good community practices, which should result in behavioral changes to help the fight against malaria.
Community intermediaries will be trained in each department in information and awareness techniques, using modules from the adaptation workshop.

The National Program to Fight Malaria, religious groups and NGOs will supervise the activities conducted at the community level.
Activities to update community intermediaries will be organized every six months, to ensure the quality of services provided to the population. All available communication channels (radio, television) will be used.

Malaria in pregnancy

SP will be used in intermittent presumptive treatment (IPT) for pregnant women. Quinine will be used to treat malaria in pregnant women.

Implementing IPT during pregnancy will help reduce the portion of maternal mortality due to malaria.

A guides for managing malaria in pregnant women and IPT will be developed and distributed to all departments. Training, awareness and supervision tolls will be adapted from the WHO guides.

A regional workshop will be organized to train departmental trainers in IPT. The plan to implement IPT in each department will also be developed during this workshop. Health Department Heads will then train their personnel (midwives, doctors, health agents) in IPT.

All health structures will be supplied with sufficient quantities of SP, in 25 mg sulfadoxine tablets and 750 mg pyrimethamine tablets, to cover the bi-annual needs.

SP administration will be under direct supervision during prenatal consultations.

Support environment and cross-cutting aspects:

Training and re-training sessions will be organized for all agents involved in managing malaria in each department.

Capacity building of personnel working with malaria will involve epidemiology, public health, informatics, etc., and study abroad as part of knowledge sharing. Sub-regional and regional schools and institutes will be asked to contribute. Computer, communication and logistics materials will be made available to the program so that it can efficiently meet its reference terms.

Three computers (2 desktops and 1 laptop) with software, 2 black & white and color printers and one high-capacity photocopier will be provided to the NPFM.

Wheeled equipment will include two all-terrain vehicles for the central region (coordination and supervision), 10 motorcycles (one per health region), 3 pinnace boats, and 100 bicycles (2 per department, with 50 departments).

The boats are justified to reach villages along waterways, as the country has 5 lagoon, coastal and fluvial regions.
The motorcycle and bicycle for these regions is justified to develop data collection activities, and supply drugs and insecticides in isolated areas.

Entomology dissection kits, two field microscopes and binoculars will be supplied by WHO.

Malarial surveillance will be integrated in the National Disease Surveillance System (SNIS). SNIS tools will be used in all health facilities in the country. Five malaria-specific sentinel sites will be established across the country to help support the SNIS. The primary site will be set up in the medical centre, with 2 secondary sites in health centers in the same area.

A health centre will be set up in community sites. There will be 2 sites: one close to medical activities, and one far away. The mandate for all sites will be the monthly collection of malarial data (morbidity and mortality) using previously established aids.

The sentinel sites for the medical centers will be when surveyors conduct their studies on the sensitivity of local strains of *Plasmodium falciparum* to the antimalarials used, and the sensitivity of vectors to the insecticides used in treatments.

Supervision and monitoring of the various activities

Two types of supervision will be initiated. The first will concern the central to intermediate levels, every 6 months. The second will concern the intermediate operational level to the periphery every 4 months. This will be an integrated supervision that will cover all of the activities implemented as part of this component in relation to disease management and prevention. Supervisory training will be applied during each supervision visit.
The integrated supervision guide will serve as an aid to implementing supervision.

Table 4.4 – Program strategy

2							

ACTIVITES PRINCIPALES SUR LA VOIE DES SERVICES A FOURNIR		
Principaux domaines d'actibité prévus qui conduisent aux services à fournir		Sous-bénéficiaires responsables de la mise en oeuvre
1.1	*voir code4 K*	*voir code 4 L*
1.2		
1.3		
2.1		
2.2		
2.3		

Table 4.4 – Program strategy

COUVERTURE

voir code 4 E

Domaines de services à fournir à l'aid des subventions, liés à chaque objectif	
1	
2	
3	

	Indicateurs liés à chaque domaine de services	Base - Couverture	Cibles année 1	Cibles années 2	Cibles année 3	Cibles année 4
1		*voir code 4 H*	*voir code4 I*	*voir code 4 J*		
2						
3						

PROCEDURE

ACTIVITES PRINCIPALES SUR LA VOIE DES SERVICES A FOURNIR		
	Principaux domaines d'actibité prévus qui conduisent aux services à fournir	Sous-bénéficiaires responsables de la mise en oeuvre
1,1	*voir code4 K*	*voir code 4 L*
1,2		
1,3		
2,1		
2,2		
2,3		

Table 4.4 - Program strategy

GRANT PROGRAM: OBJECTIVES AND SERVICES TO BE PROVIDED

Objective 3 : By 2007, at least 60% of pregnant women and children under 5 will sleep under insecticide-treated mosquito nets;

see code 4 E

Services to be provided using grant, by objective

1	
2	

	Indicators for each service area	Baseline - Coverage	Targets Yr 1	Targets Yr 2	Targets Yr 3	Targets Yr 4	Targets Yr 5
1		*voir code 4 H*	*voir code4 I*	*voir code 4 J*			
2							
3							
4							
5							
3							

MAIN ACTIVITIES IN THE SERVICES TO BE DELIVERED AREA

4.4.1 Describe the quality and type of the training to be carried out (e.g., delivery of ART services according to national guidelines, or peer counseling in sexual and reproductive health, according to national youth mobilization guidelines).

Introducing basic treatment with ACTs and IPT will improve the quality of malarial management. Health agents will be trained in this new policy and awareness will be created in communities so that they participate in it. Regarding the use of ITNs, community intermediaries will be trained in insecticide treatment techniques and awareness will be created in communities through mass treatment campaigns.

4.4.2 Describe the broad approach for human resources development, including how adequate human resource capacity will be developed to support program scale up (2–3 paragraphs)

Human resource development is significant for achieving the objectives set forth in this component. It will be accomplished at various levels and in various areas:

- Two weeks of training for the NPFM team, Regional Health Directors (DRS), and chief physicians in departments of the country in program planning and management
- Training at various levels in collecting and managing information for M&E
- Training teams from provinces and districts in planning
- Training service providers in case management and IPT
- Updating health training curricula in the College of Medicine
- Study abroad and knowledge sharing with other countries with endemic malaria
- Participating in international courses
- Organizing a 2-week course in combating malaria for chief physicians in the departments

The various types of training set forth in the proposal will build capacity both in the health sector (at the central, intermediate and peripheral levels) and in the community.

4.4.3 Describe the key risks and assumptions made in preparing this proposal (3–4 paragraphs)

The key risks and assumptions made are the presuppositions necessary to effectively implement the proposal.
Risks:
These include difficulty mobilizing activities to fight malaria, weaknesses in the health system (especially in the area of Health Information System and the drug distribution system), an insufficient budget, and problems in the disbursement of funds allocated to the program from the national budget.

Assumptions:
Growing support from the government and partners, as well as from the community, primarily grouped around the large population centers (Libreville and Port Gentil), more frequent prenatal consultations by pregnant women, especially during their first pregnancy.

4.4.4 Describe gender inequities regarding access to the services to be delivered (1–2 paragraphs)

Gender inequities in malaria are related to risk. Pregnant women are at a higher risk of contracting severe malaria, especially those in their first pregnancy. For this reason, the proposal will make this sector of society a priority target. Grant mosquito nets will be distributed to all pregnant women who visit the Maternal and Infant Health (SMI) service. Particular emphasis will be placed on training mothers and guardians of children in managing malaria at home. Mothers whose children sleep under mosquito nets will be involved in the awareness process in turn, through community intermediaries.

4.4.5 Describe how this proposal will contribute to minimizing these gender inequities (1–2 paragraphs)

In order to deal with the gender-related inequity for risk, pregnant women will benefit from three special measures:

- Free access to IPT during prenatal consultation;
- Free access to ITNs during the first prenatal consultation;
- Free treatment of malaria cases in health structures, in accordance with the policy in effect in the country.

4.4.6 Describe the populations that are particularly vulnerable to this disease (1–2 paragraphs)

Gabon's population is estimated to be 1 300 000 (UNDP, 2003). Populations vulnerable to malaria are children under 5 and pregnant women. The 0-5 population was 195 000 (WHO, 2002)* in the year 2000. A 2.9% rate of increase per year (UNDP, 2003) was applied, giving a population of 224 963 in 2005, 231 487 in 2006 and 238 200 in 2007. The expected number of pregnancies was estimated at 48750 in 2005. Children under 5 average 7 febrile episodes. Therefore the number of febrile episodes

expected in 2005 is 1 574 741, and the number of probable cases of malaria (40%) is 629 897, with 1%[3] (or 6 299 cases) at risk of developing into the severe, potentially lethal, form. In 2006, the expected number of febrile episodes will be 1 620 409, 648 164 of which will be malaria, and in 2007 this number will be 1 667 400, 666 960 of which will be malaria.

On the basis of a birth rate of 37.5 per 1000, the expected number of pregnant women is **48 750** in 2004, **49 969** in 2005 and **51 218** in 2006. Current data on the prevalence of malarial infection in pregnant women shows that 57% of pregnant women are carriers of *Plasmodium falciparum* and thus risk having low birth weight children. Of these women, 71% have associated anemia, which carries an estimated 10% risk of *in utero* death.

Particular emphasis will be placed on these poor/vulnerable populations (according to the World Bank, 60% of the population lives below the relative poverty level with a monthly income below 60 000 CFA francs, and 20% lives below the absolute poverty level with a monthly income of 29 000 CFA francs). Women are most affected by precarious economic situations; a growing number of family heads are women, creating a problem of caring for children. Women represent 50.7% of the total Gabon population. Their social status, precarious economic situation, and poor access to health, schooling and higher-level jobs in both the public and private sector make them vulnerable to sexual violence and HIV infection. Regarding education, a decrease in the level of schooling for girls at the end of the secondary cycle has been reported due to pregnancy and quitting school. In 1993, an analysis of the marital situation showed a high rate, 45%, of single women who were heads of households. In many cases women are responsible for their children alone, without any assistance from the father or the government, which leads to infants and children being abandoned.

4.4.7 Describe how these populations are involved in planning the program and how they will be involved in implementing and monitoring it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

Populations will be involved through community-based interventions:
- Managing cases in the community;
- Distributing and treating mosquito nets;
- Conducting communication activities to change behavior;
- Collecting community-level data for M&E.

Community intermediaries, especially from NGOs and religious organizations that develop community activities deep inside the country, will be trained and involved in all of the priority activities in this component.

4.4.8 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) (1–2 paragraphs)

Services and interventions that target the vulnerable groups, children under 5 and pregnant women, will be provided without discrimination to guarantee equity. At the community level, the target population will be identified by community leaders and representatives of civil society in order to avoid any possible stigma or fraud.

4.4.9 Describe how this proposal will contribute to reducing stigma and discrimination against people living with malaria, and other types of stigma and discrimination, including gender-based, that facilitate the spread of these diseases (1–2 paragraphs)

In this country, malaria is not a disease that requires special precautions for the community. Patients are accepted by their families and cared for within the family until they are well, except in cases requiring hospitalization. This proposal aims to facilitate access to preventive and treatment care to the most vulnerable groups: children under 5 and pregnant women.

[3] Challenges in fighting malaria in Africa, USAID, CDC, 1994, page 4

4.4.10 Describe how the beneficiaries of this proposal (malaria) and/or affected communities are involved in planning the program and how they will be involved in implementing it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

Populations will be involved through community-based interventions:

- Managing cases in the community;
- Distributing and treating mosquito nets;
- Conducting communication activities to change behavior;
- Collecting community-level data for M&E.

Community intermediaries, especially from NGOs and religious organizations that develop community activities deep inside the country, will be trained and involved in all of the priority activities in this component.

Beneficiary collaboration will consist of recognizing malarial signs and early management in families, treating existing mosquito nets in the community with insecticide, and complying with IPT.

4.4.11 Describe how the communities involved in this proposal are involved in planning the program, and how they will be involved in implementing it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

The population will be involved in the fight against malaria from now on, by managing the disease within the community and by taking ownership of the preventative measures available to them at a known cost/effectiveness ratio, such as large-scale use of mosquito nets or other insecticide-treated materials.
Monitoring/evaluation of service coverage will be emphasized.

4.4.12 If the proposal contains anti-malarial drugs or insecticides, include data on drug resistance and/or resistance of vectors in the country or in the target population/area (1–2 paragraphs)

Plasmodium falciparum resistance to chloroquine is currently quite high throughout the country. Studies conducted in recent years have shown the following levels of therapeutic failure:

- Libreville in 1997: 69%
- Ntoum in 2001: 78%
- Oyem in 2001: 91.3%
- Lambaréné in 2001: 100%

Studies of AS-AQ and Artemether-Lumefantrine combinations have shown effectiveness rates greater than 95%.

(Consensus meeting report)

4.5 Program and Financial Management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, Section V.B.3 for more information.]

4.5.1 Will implementation be managed through a single Principal Recipient or multiple PRs? X☐ Single ☐ Multiple

[Every component of your proposal can have one or several Principal Recipients. In table 4.5.1 below, you must nominate the Principal Recipient(s).]

Table 4.5.1- Implementation Responsibility

Responsibility for Implementation			
Nominated Principal Recipient(s)	**Area of Responsibility**	**Contact Person**	**Address, Telephone & Fax, Email address**
UNDP	- Managing funds - Contracting activities - Audits - Centralizing M&E data	M. Hamidou Diawara UNDP Representative in Gabon BP 2183 Libreville	Tel: +241 73 88 87/90 Fax: +241 73 88 91 hamidou.diawara@undp.org

4.5.2 Describe the process by which the CCM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was nominated should be included as an Annex to the proposal]

Administrative and financial management remain a weakness in the country, despite efforts to improve them. Because of these weaknesses, the CCM decided to entrust management of the Global Fund grant to a UN system agency given with known international financial management capacities. Thus the responsibility was entrusted to the United Nations Development Program (UNDP), by consensus. Part of the reference terms for the support to be provided by the UNDP will be the progressive transfer of capacities and responsibilities to the national planning and management mechanisms involved in this proposal.
In addition, since the UNDP is the principal recipient for the HIV/AIDS component, it will be able to use its experience for this component as well.

Nominating the UNDP as the PR will ensure proper, transparent management of the Global Fund grant, especially by:

- developing a manual of administrative, accounting and financial procedures that specify the roles, responsibilities and relationships between the PR, the CCM and the stakeholders;
- using computerized systems that are already in place and adapted to Global Fund procedures, so that analytical accounting, general accounting, contracting activities and the generation of financial statements can be established under proper conditions, facilitating analysis of the program's execution and monitoring.

The UNDP has a great deal of experience in this type of management agreement, and the system in place is adapted to funding multiple activities presented as projects. The selection of this type of agreement was guided by the transparency of fund management, and with concern for achieving a high level of consumption of the funds made available.

4.5.3 Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings these arrangements might have and how they will be addressed (i.e. capacity building, staffing and training requirements, etc.).]

The UNDP has the "Atlas" management system, an integrated management software for managing financial resources, personnel, procurement and projects. It has a VSAT and a high-quality computer network with good connectivity, which will guarantee rapid access and data processing, especially regarding payments to service deliverers, purchases, inventories, etc. UNDP personnel are highly qualified in accounting, financial management, supply management and project management. They have undergone computer training sessions to improve their performance in effective using the "Atlas" management system.

The UNDP uses a results-based management approach that relies on the rigorous planning and budgeting of activities. The "Atlas" management system assists in drawing up action plans and budgets as well as providing budget control. The UNDP's administrative, accounting and financial procedures establish internal control mechanisms that guarantee transparency in financial accounting management, contracting activities and payments.

Government and civil society partners will receive training in the use of various software.

The UNDP will benefit from the confidence of institutional partners, and has developed good working relations with civil society in various areas, using a multisector approach.

4.5.4 Has the nominated PR(s) previously administered a Global Fund grant? X☐ Yes ☐ No

4.5.5 If yes, describe the performance of the nominated PR in administering previous Global Fund grants (1–2 paragraphs)

The arrangements (audit, PR/UNDP) that precede signing the grant agreement with the Global Fund for the HIV/AIDS component are currently under way.

4.5.6 Describe other relevant previous experience(s) that the nominated PR has had:

[Please describe in broad terms the relevant programs, and their objectives, key implementation challenges and results (2–3 paragraphs)]

4.5.7 Describe the proposed management approach.

[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (1–2 paragraphs).]

Partners' role (government implementation structures, civil society, NGOs, Community-Based Organizations):
To develop and submit projects, implement approved projects, monitor projects, propose narrative and financial reports, and provide information and support to the audit and quality control mission.

CCM role:
To develop annual plans and budgets, examine and approve projects submitted by sub-recipients, examine and approve the narrative and financial reports produced by the PR, examine and approve audit reports, participate in monitoring missions, advocate to facilitate implementation of projects;

The UNDP will take on the responsibility of managing the grant allocated by the Global Fund. Its role will consist of:

a. Developing budgets performing accounting for grant management;
b. Establishing sub-contracts with sub-recipients or service deliverers;
c. Organizing all contracting processes;
d. Controlling service quality and making payments;

e. Procuring goods;
f. Contributing to service deliverer training in implementation management modules (“Atlas” software);
g. Supporting the organization and carrying out of audit missions;
h. Supporting the development of technical and financial reports.

The UNDP will disburse funds at the central and peripheral levels after the CCM has examined and approved the action plans submitted by the stakeholders. It will subcontract with other UN system agencies that have comparative advantages in certain areas (UNPF, WHO) and service bodies (UNOPS, IAPSO).

A procedures manual will set forth the roles, responsibilities and relationships between the PR, the CCM and the stakeholders.

The UNDP will present the CCM with an activity report, a financial report and an external audit report every six months. Stakeholders will send progress reports for activities for which they have received funds to the UNDP (intermediate and final reports with reports justifying expenses).

A local Global Fund agent (LFA) will be in charge of monitoring and controlling the PR’s activities. This LFA will be an independent entity, and will be designated by the Global Fund.

4.5.8 Explain the rationale behind the proposed arrangements

[For example, explain why you have opted for that particular management arrangement (1 paragraph)]

The UNDP Office has well-known competencies and infrastructures that allow it to absorb this volume of management. It is also one of the UN system agencies, who have the lowest management costs for external funds and who have fast disbursement systems. The UNDP will benefit from the confidence of institutional partners, and has developed good working relations with civil society in various areas, using a multisector approach.

Nominating the UNDP as the PR will ensure proper, transparent management of the Global Fund grant, especially by:

- developing a manual of administrative, accounting and financial procedures that specify the roles, responsibilities and relationships between the PR, the CCM and the stakeholders;
- using computerized systems that are already in place and adapted to Global Fund procedures, so that analytical accounting, general accounting, contracting activities and the generation of financial statements can be established under proper conditions, facilitating analysis of the program’s execution and monitoring.

In addition, the UNDP Office has the capacity of implementing decentralized, flexible and rapid management, while allowing support to be set up to improve performance in accounting and administration.

4.5.9 Are sub-recipients expected to play a role in the project? X☐ Yes ☐ No

4.5.10 Have the sub-recipients already been identified? X☐ Yes ☐ No

The sub-recipients that have been identified are:

- The National Program to Fight Malaria (NPFM/PNLP):
  Its primary role will be to provide training, activity implementation, coordination, and M&E for the activities of various stakeholders.
- WHO:
  Technical approval of requests, developing human resources and adapting technical tools, supervision and monitoring of activities, building capacity, quality of drug and insecticide effectiveness tests, facilitating purchases and drugs, and M&E.

- UNICEF:
  Providing mosquito nets and insecticides, supplying sulfadoxine-pyrimethamine for the IPT program in prenatal consultations.
- National Pharmaceutical Office (OPN):
  Managing and distributing drugs.
- University:
  The university sector will be involved in research, especially in supporting the implementation of various targeted surveys.
- Religious and faith-based organization NGOs:
  Community mobilization, managing patients and distributing mosquito nets.

4.5.11 Describe the process by which sub-recipients were selected (e.g., open bid, restricted tender, etc.) (2–3 paragraphs)

The selection of sub-recipients was influenced by their experience in the field and by the credit given them by the population. Selection also considered the specific mandates of certain sub-recipients in combating malaria and poverty.

4.5.12 Describe the relevant technical, managerial and financial capabilities of the sub-recipients.

[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (i.e. capacity building, staffing and training requirements, etc.).]

- NPFM: This is the national body in charge of implementing activities to combat malaria. It is the principal contractor for this proposal. Therefore, it is responsible for the specific supervision of all interventions to be developed and at the end of which objectives should be reached in 2007. The NPFM currently has one biologist physician with a degree in public health, one public health physician, one entomologist and support administrative personnel.
- University: The Parasitology Department in the College of Medicine of Libreville is involved in implementing the component and has one unit for managing malarial cases in the Libreville Hospital Centre. The Department has one researcher and several assistants who are active in numerous malaria research activities. This Department also works in collaboration with universities in Europe, especially: the Parasitology Department in the Université François Rabelais College of Medicine in Tours, the Tropical Medicine Institute in the Armed Forces Health Service (IMSSA) in Marseille, the INSERM unit 511 in the Pitié-Salpètrière university hospital centre, and the Parasitology Department of the University of Tubigüen.
- Bilateral agencies (WHO, UNICEF): These will provide the NPFM with technical expertise to build managerial capabilities for implementing the component activities. They will offer technical guidelines adapted to the country, will encourage large-scale implementation of these guidelines and will facilitate information and knowledge exchanges.
- Religious and faith-based organizations and NGOs: Those selected are already involved, although only partially, in implementing interventions in communities. Regarding their technical capacities, we should note that health facilities associated with religious organizations are found throughout the country and have nurses with a great deal of experience managing tropical diseases, including malaria. NGOs have developed a large capacity to mobilize communities over the years. All of the NGOs have administrative profiles of active or retired personnel.
- the National Pharmaceutical Office (OPN): This is the most appropriate national body to manage and distribute drugs. It has significant experience in the areas of distribution and storage. It has operational branches throughout the country.

4.5.13 Describe why sub-recipients were not selected prior to submission of the proposal (1–2 paragraphs)

All of the sub-recipients selected in implementing this component are already collaborating with the National Program to Fight Malaria.

4.5.14 Describe the process that will be used to select sub-recipients if the proposal is approved (1–2 paragraphs)

Meetings of interested parties and stakeholders will be organized to once again specify the authenticity and operational credibility of the various sub-recipients selected. A legal work group will be set up through consensus between the Ministry of Health and sub-recipients to consolidate national solidarity to combat malaria within the framework of implementing this component.

NGOs and religious organizations:
- Recognition by the Gabon government, production of legal documents, production of reports prior to activities demonstrating the development of community-based activities in healthcare

OPN:
- Examination of operations, management and audit reports of the Office

University:
- Examination of operations and management reports of the unit in charge of the Parasitology Department

Multilateral partners:
- Issuing an offer for bids.

4.6 Monitoring and Evaluation (M&E)

In this section of the proposal form, applicants should describe the main elements of the program's monitoring and evaluation plan. This is done primarily through completion of Table 4.6.

Table 4.6A- M&E Table

IMPACT	Baseline	Technical Partners	2-5 year targets	Data source	Freq Data collection
Reduced mortality for all causes in children under 5	88.6 p.1000 (2000)	NPFM,SNIS,IELE, PCIME,PEV	- 30%	Survey Report	5 years
Reduced malaria-specific mortality	ND	NPFM,SNIS,IELE, PCIME,PEV	- 30 %	Survey & Activity reports	5 years
Reduced malaria-specific morbidity	ND	NPFM,SNIS,IELE, PCIME,PEV	- 30 %	Survey & Activity reports	5 years

Coverage Indicators:

	Intended results Indicators	*Baseline Coverage*	*First year target*	*Second year targets*	*Data source*	*Frequency of collection*
1	**Prevention**					
	1.1. Insecticide-Treated Nets (ITNs)					
	Number of service deliverers trained	*ND*	*390*		*Activity reports*	*Annually*
	Number of mosquito nets, permanent mosquito nets, pretreated mosquito nets or retreatment kits distributed	*ND*	*30%*	*60%*	*Surveys and Activity reports*	*Annually*
	Number of Sentinel sites established for monitoring insecticide resistance	*ND*	*2*	*3*	*Activity report*	*Annually*
	Households owning an insecticide-treated net	*<1%*	*30%*	*60%*	*CAP surveys*	*Annually*
	Children under 5 using an insecticide-treated net	*< 1%*	*30%*	*60%*	*Activity reports CAP surveys*	*Annually*
	1.2. Malaria in pregnancy					
	Number of service deliverers trained	*0*	*200*	*200*	*Activity reports*	*Annually*
	Number of pregnant women receiving correct intermittent presumptive treatment	*ND*	*48750*	*49969*	*Surveys and Activity reports*	*Annually*
	Pregnant women using insecticide-treated nets	*< 1%*	*30%*	*60%*	*Activity reports CAP surveys*	*Annually*
	1.3. Information, education and communication (IEC)					
	Number of service deliverers trained	*ND*	*390*		*Activity reports*	*Annually*
	Number of targeted departments with IEC services	*ND*	*20*	*52*	*Activity reports*	*Annually*
2	**Treatment**					
	2.1. Prompt effective antimalarial treatment					
	Number of service deliverers trained	*ND*	*642*	*25*	*Activity reports*	*Annually*
	2.2. Monitoring drug resistance					
	Number of sentinel sites established for monitoring antimalarial drug resistance	*ND*	*5*		*Activity reports*	*Annually*
	2.3. Home based management of malaria					
	Number of service deliverers trained	*0*	*390*		*Activity reports*	*Annually*
3	**Support environment and cross-cutting aspects**					
	3.1.Health systems strengthening					
	Number of staff trained	*ND*	*94*		*Activity reports*	*Annually*
	3.2.Coordination and partnership development					
	Number of partnerships involved	*3*	*10*	*15*	*Activity reports*	*Annually*
	3.3.Monitoring, evaluation					
	Number of service deliverers trained	*ND*	*264*	*400*	*Activity reports*	*Annually*
	3.4. Procurement and supply management capacity building					
	% of service delivery points with sufficient drug supplies	*ND*	*50 %*	*100 %*	*Activity reports*	*Annually*

This table is closely linked to Table 4.4 above. If submitted online, the principal data in common with Table 4.4 will be automatically imported into Table 4.6. As for Table 4.4, Table 4.6 will be automatically reproduced for each main objective and target results will be linked to that objective.

If the form is not filled out online, we recommend you copy the entire table for each goal and start by describing the M&E plan for goal one and the expected results BEFORE describing the next goal and result indicators. Please complete all information for all goals.]

[Instructions for Completing Table 4.6]

(Code 7A-H):

(Code 7I):
The field requires specific information on the source of data for each indicator and the reference baseline. For example, if a demographic and national health study was conducted to measure an indicator, indicate which year of the study is the baseline. For indicators linked to service delivery areas, the data source is usually the agency in charge of implementation at the district/province level, and this agency should be cited as the source of the data. If these data are nationally centralized, indicate the source of the cumulative national data.

(Code 7J):
Indicate the frequency with which data is collected. This will vary considerably depending on the type of data. Data about service coverage (for example, the number of people trained or clients reached) may be collected monthly or quarterly, while impact indicators may only be collected annually or every two, three, or five years.
The Global Fund encourages the development of nationally owned monitoring and evaluation plans and M&E systems, and the use of these systems to report on grant program results.

By answering the questions below, applicants should clarify how and in what way the M&E plan for the grant application relates to existing data collection efforts, and summarize any capacity development needs, to enable applicants to carry out the M&E plan described in Table 7.

4.6.1 Describe how the plan complements or contributes towards existing efforts to strengthen M&E plans and/or relevant health information systems.

There are information-gathering tools at the different levels of the health system that were developed by the Ministry of Health. Unfortunately, however, the health information system is not yet operational at the district level, even though it includes data on malaria. Data is usually collected piecemeal and irregularly.

This component involves strengthening the existing system. We have identified three main areas to accomplish this:

- *Setting up a national system for monitoring data collection* by strengthening the logistics and human resources of the National Health Information System. Building human resources will involve training statistics agents at provincial stations. These agents will be the primary people responsible for collecting data at the peripheral level, processing the information, analyzing them for use at the collection level (peripheral), and creating and submitting monthly reports. These reports may be distributed to the hierarchy and to partners. High-quality tools, computers and Epi-Info software will be made available to the program, and data will be processed in collaboration with the Integrated Disease Surveillance services (IDR).

- *Strengthening support and evaluation activities* (expertise): internal, external and regional. The implementation of activities will be reported on monthly and quarterly, and will be evaluated semi-annually and mid-project in accordance with the schedule of *implementation evaluation recommended by WHO*

- The component *will strengthen personnel capacities at all levels* of the system for collecting, analyzing and exploiting data, as well as for distributing reports.

The M&E plan revolves around: collecting baseline data; collecting data from health structures and communities on a regular basis; creating a composite database; creating an M&E network; establishing sentinel sites for regular monitoring of data in the community and in health structures; semi-annual monitoring of progress made towards reaching the Abuja targets; annual evaluation of results (coverage) and impact; revising the work plans on the basis of results obtained; technical and financial audit; final evaluation at the end of the third year.

- **Collecting baseline data**

A survey of baseline data will be conducted at the start of the project to provide baseline indicators. The system will then be gradually integrated into the system of collecting data monthly in the districts, quarterly in the provinces and semi-annually at the national level. Malaria surveillance indicators will be integrated into the National Health Information System.

In the short term, the database will be collected. This will serve as point of reference to evaluate progress made in results or program impact.

- **Collecting data from health structures and communities on a regular basis**

In the medium term, the system for monitoring and evaluating healthcare delivery in communities and in peripheral health units will be part of regular supervision activities. The “Form for Malaria Data Collection and IMCD in Health Facilities and Communities” will be mainly used in health facilities during exit interviews.

- **Creating a composite database**

All data on morbidity, mortality, socio-economic data and community data relating to malaria will be compiled into a composite database that will be updated regularly by each of the partners.

- **Creating an M&E network**

A monitoring and evaluation network will be established for all available malarial data from the various services and institutions. Data from each partner will feed into the composite database, which will be usable by all.

- Specific surveys will also be conducted, such as surveys of Plasmodium resistance to antimalarials and vector resistance to insecticides. In addition, regular morbidity and mortality reports and results from the surveys will be distributed to the entire hierarchy and partners.

- **Establishing sentinel sites for regular monitoring of data in the community and in health structures**

Sentinel observations sites will be established in five health departments to collect data from health structures and communities on a regular basis:

- o One medical centre and two dispensaries will be selected for health training data
- o Two communities will be selected: one near a dispensary and one far away

These sentinel observatories will provide reports monthly.

-

- **Semi-annual monitoring of progress made towards reaching the Abuja targets**

Semi-annual monitoring will allow finances and activity implementation to be monitored, to allow /sic/

- **Annual evaluation of results (coverage) and impact**

Annual evaluations will allow the three primary results (coverage) indicators to be refined:

- o Proportion of malarial cases correctly managed in the community within 24 hours (using sentinel observatory data)
- o Proportion of malarial cases correctly managed in health facilities
- o Proportion of pregnant women given IPT
- o Proportion of pregnant women using insecticide-treated mosquito nets
- o Proportion of children under 5 sleeping under insecticide-treated mosquito nets.

Data for measuring morbidity and mortality impact indicators will be collected yearly at the sentinel observatories. The 2005 health demographic survey will also provide more representative information on these indicators.

- **Revising the work plans on the basis of results obtained**

All data will be used to redirect and adapt the national plan to fight malaria.

- **Technical and financial audit**

Technical and financial audits of the CCM, the NPFM and various stakeholders will be conducted each year, to ensure the quality of interventions, transparency of fund management, and a good cost/effectiveness ratio for activities.

- **Measuring the program's impact at the end of the period**

A final representative evaluation will be conducted the third year of the project, i.e. 2007, in both health structures and in communities. This process will allow us to assess the activities performed in relation to the millennium objectives.

4.6.2 Describe any capacity building that might be required to implement the M&E plan.

[2–3 paragraphs)]

Capacity building of managerial staff will revolve around:

- Training personnel at the central and intermediate levels (in malaria, epidemiology, informatics, etc.) and study and operations abroad (planning, management, M&E)
- Organizing missions by WHO consultants to support the country
- Study and knowledge sharing trips with other countries
- Setting up the necessary M&E equipment and logistics:
    - Computers: two desktops and one laptop, and two printers
    - One photocopier
    - Two all-terrain vehicles, 10 motorcycles (one for each health region, 3 pinnace boats, 100 bicycles (two per department) for collecting data in inaccessible areas
    - Megaphones (390 megaphones, one for each community intermediary)
    - Two field microscopes, one pair of binoculars and entomological dissection equipment will be purchased for NPFM field activities.

The boat purchase is justified by the 5 lagoon, coastal and fluvial regions; it will be needed to reach villages along the waterways.
The motorcycles and bicycles in the regions are justified by data collection activities, drug and insecticide supply in isolated areas.

4.7 Procurement and Supply Management

[In this section, applicants should describe their arrangements for procurement and supply management of health products, integral to this component's proposed disease interventions, including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention (e.g., condoms), laboratory equipment and support products (e.g., microscopes and reagents).
When completing this section, applicants should refer to the Guidelines for Proposals section V.B.5.]

4.7.1 Will procurement and supply management of health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of health products?

☐ PR only
☐ Sub-recipients only
X☐ Both

4.7.2 Approach to procurement of health products

[Which of the following types of organizations will be involved in the procurement of health products. Check all that apply:

X☐ National medical stores, national tender board or equivalent
☐ Sub-contracted procurement organization(s) (national) (specify which one[s])
☐ Sub-contracted procurement organization(s) (international) (specify which one[s])
☐ Other (specify)
[If more than one of these is checked, describe the relationships between these entities (1 paragraph)]

4.7.3 Approach to supply management of health products

[Which of the following types of organizations will be involved in the supply management of health products:

X☐ National medical stores or equivalent
☐ Sub-contracted procurement organization(s) (national) (specify which one[s])
☐ Sub-contracted procurement organization(s) (international) (specify which one[s])
☐ Other (specify)
[If more than one of these is checked, describe the relationships between these entities (1 paragraph)]

4.7.4 Describe the capacity that exists to ensure compliance with the Global Fund's policies in each of the following areas, and any capacity building and/or technical assistance needs (1 paragraph per topic):

For this we will refer to the procedures and methods for procurement, management, drug and medical equipment distribution at the National Pharmaceutical Office (OPN).

4.7.4.1 Procurement plan development
Drugs will be procured through an open international invitation to tender. OPN specifications conform to guidelines provided during the meeting of African Ministers of Health and associated countries regarding the impact of CFA franc devaluation on drug policy that was held in Abidjan on March 18, 1994. These specifications were created from the national list of essential medicines and medical devices, which includes mosquito nets and insecticides. The invitation to tender notice of the bid tender was published in the press (national daily newspaper "L'Union"). All bids were received by the OPN Secretariat, which assigned a number to each indicating the date and time it was recorded.

4.7.4.2 Procurement systems

The invitation to tender involves the following steps: opening the envelopes, opening the bids, technical and financial analysis of the bids (technical analysis and financial evaluation and comparison), awarding the contract, preparing the purchase order, and issuing the purchase order.

The purchase orders for the products selected are written, signed and sent to suppliers to establish the pro forma invoice to conform to the amounts ordered.

The pro forma invoice is signed by the OPN Director and sent to the *Trésorier payeur général* for payment.

4.7.4.3 Quality assurance and quality control

Quality assurance
All drugs that enter the country must have prior Marketing Authorization (MAA). The MAA is obtained after an application dossier is filed with the pertinent department of the Drug and Pharmacy Service (DMP) and evaluated.
The technical commission for drug registration, whose secretariat is provided by the DMP, rules on the following elements:

For brand-name drugs

- Pharmaceutical dossier
- Pharmacological dossier
- Toxicological dossier
- Clinical dossier

For generic drugs

- Pharmaceutical dossier
- Bioavailability and comparative bioequivalence dossier
- WHO quality assurance certificate
- MAA from the country of origin and/or the MAA from countries where the product is marketed.

Quality control
Gabon does not have a quality control laboratory. However, a small level 1 quality control laboratory is being constructed, and funds for equipment and training will be sought at the appropriate time.
At this time quality control of certain products will be conducted by the WHO collaborative centers, at the DMP's request.

4.7.4.4 National laws and international agreements

National legislation on pharmacy practice in the Republic of Gabon dates to 1961, and has been revised once. The related document that is included in the National Health Policy is in the signature process; disseminating it will definitely require non-negligible financial support. There are also regulatory documents regarding international agreements, notably with the International Office of Narcotics Control (OICS) and Psychotropic Substances based in Vienna, Austria, as well as intellectual property agreements (TRIPS, Bangui Accord, etc.)

4.7.4.5 Distribution and inventory management

The following steps are taken upon receipt: Products are unloaded, counted by boxes received, by compound and by unit, registered under their commercial name and then moved to wholesale outlets. Each product has a given place. Each product must have as many lots as there are expiration dates. The supplier and the purchase order are tracked to compare the amounts received versus the amounts ordered. If differences are found, or if expiration dates do not comply with the standards defined in the specifications, a claim is immediately filed. A standard form is filled out for such an event.

To distribute products, the OPN presents a purchase order that is made available to the health facilities. The purchase order book, written by the OPN, varies depending on the type of health facility (hospital, medical centre and health centers, dispensaries, health stations).

Four private transport companies, approved by the Ministry of Public Health, provide transport. Each transporter delivers to determined provinces.

4.7.4.6 Appropriate use

In the hospitals and health centers, especially the Mother and Child Health services and Pediatric/Maternity services, drugs are administered free of charge to treat both hospitalized patients and outpatients. A prescription is written for each patient to allow him or her free access to the drug in health facilities, depending on availability. This proposal intends to help eliminate stockouts in health facilities, which are the only places where the poor populations have access to healthcare.

4.7.5 Drug donation programs

[Specify participation in any donation programs that are currently supplying health products (or which have been applied for) including the Global TB Drug Facility and drug donation programs by pharmaceutical companies, multilateral agencies, and NGOs relevant to this application (1 paragraph).]

N/A

[For tuberculosis and HIV/TB components only:]

4.7.6 Does the proposal request funding for the treatment of multi-drug resistant TB? ☐ Yes X☐ No

[If yes, be aware that all procurement of medicines to treat multi-drug resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee of the Stop TB Partnership. For a Green Light Committee application form see Annex C.]

5 Component Budget Section

[Please remember that this section is to be completed for each component.
Throughout "year" refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.]

5.1 Full and detailed Budget as an attachment to the Proposal Form

[By way of supporting information for the Summary Budget in Table 5.2, a detailed budget should be provided as an attachment to the Proposal Form. It should reflect and be consistent with the broad budget categories mentioned in Table 5.2 and preferably also reflect the activities of the component. The detailed budget should include assumptions and formulas used to estimate major budget items. It should cover the first and second year of the Proposal and in respect of the first year may be broken down by quarters.]

5.2 Budget Summary

[*Please note that a detailed one-year action plan and an indicative action plan for the second year need to be provided with the detailed budget.*]

[In Table 5.2, summarize the funds requested from the Global Fund. The budget should be by year and budget category. The budget categories are explained below:]

OBJECTIVES		**2005**	**2006**	**2007**	**TOTAL**
1	Building management capacity	1991559	1593734	1706868	5292161
2	Mosquito nets	1597468	539339	374065	2510863
3	Strengthening prevention using IPT	136106		9482	145589
	Support services				
4	Managerial capacity building	515450	30000	30000	575450
5	Monitoring and evaluation	428261	234405	234405	897072
6	Administrative costs	233442	119873	117741	471057
Total requested from GF		4902286.25	2517343.55	2472561.7	9892191.5

Human Resources: *Salaries, wages and related costs (pensions, incentives and other employee benefits, etc.) relating to all staff (including field personnel), consultants (excluding short term consultants included under categories below) and staff recruitment costs*
Infrastructure and Equipment: *Information Technology (IT) and building infrastructure, office equipment, audio visual equipment, vehicles, and related maintenance and repair costs, etc.*
Training: *Workshops, meetings, training publications, training-related travel, etc. Do not include training-related human resources costs which should be included under the Human Resources category above.*
Commodities and Products: *Bednets, condoms, diagnostics, microscopes, syringes, etc.*

Drugs: *Antiretroviral therapy, drugs for opportunistic infections, TB drugs, anti-malarial drugs, etc.*
Planning and Administration: *This category includes;*

(a) Short term technical consulting costs, travel, field visits and other costs relating to program planning, supervision and administration (including in respect of managing sub-recipient relationships, monitoring and evaluation, and procurement and supply management).
(b) Overhead costs such as office rent, utilities, internal communication costs, insurance, legal, accounting and auditing costs, etc
(c) Printed material and communication costs associated with program related campaigns, etc.

In relation to (a), (b) and (c) do not include human resources costs which should be included under the Human Resources category above
Other: *Costs that do not fall within above categories – please specify*

Table 5.2a –Fund Request from the Global Fund

	Funds requested from The Global Fund (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human Resources						
Infrastructure and Equipment	392937.13					392937.13
Training	1006849.9	148425.92	154115.27			1309391.09
Commodities and Products	1445917.97	344620	345565			2136102.97
Drugs	1411124	1451945.88	1493872.56			4356942.44
Planning and administration	645457.25	572351.75	479008.871			1696817.87
Other (please specify)						
Total funds requested from the Global Fund	4902286.25	2517343.55	2472561.7			9892191.5

5.3 Funds requested for functional areas

[Provide the budgets for each of the following three functional areas. In each case, these costs should have already been included in Table 5.2, so the below tables should be subsets of the budget in Table 5.2, not additional to it. For example, the costs for monitoring and evaluation will be included in various of the line items above (e.g., Human Resources, Infrastructure and Equipment, Training, etc.).]

Monitoring and evaluation:
[This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.]

Table 5.3a – Costs for monitoring and evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and evaluation	412015.05	45478.25	361267.84			1225761.14

Procurement and supply management:
[This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance including laboratory testing of samples, and any other costs associated getting sufficient health products of assured quality,

procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion; do not include drug costs].

Table 5.3b – Costs for procurement and supply management

	Funds requested from the Global Fund for procurement and supply management (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and supply management						

Technical assistance:

[This includes: costs of consultant and other human resources that provide technical assistance on any part of the proposal, from the development of initial plans through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation, and procurement and supply management]

Table 5.3c – Costs for technical assistance

	Funds requested from the Global Fund for technical assistance (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Technical assistance	41528	23649	23649			88825.07

5.4 Partner Allocations

[Indicate in table 5.4 below how the requested resources in Table 5.2a will, in percentage terms, be allocated amongst the implementing partners:

Table 5.4 – Partner Allocations

	Fund allocation to implementing partners (in %)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Academic/educational sector	1.52	-	34.03			
Government	34 .1	14.25	15.9			
Non-governmental/ Community-Based Org.	34.1	14.25	14.20			
People living with HIV/AIDS, tuberculosis, and/or malaria	28.8	57.7	60.42			
Private sector	-	-	-			
Religious/faith-based organizations	0.37	0.7	0.73			
Multi-/bilateral development partners	5.60	5.70	5 .72			
Others (please specify)						
Total	100	100	100			

[If there is only one partner, please explain why (1 paragraph).]

5.5 Key Budget Assumptions for Requests from the Global Fund

5.5.1 Specify in the tables below the Drugs and Commodities & Products unit costs, volumes and total costs, for the FIRST AND SECOND YEARS ONLY.

*[Use the treatment categories that follow the tables (organized by disease). Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources. (For example:* Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003 (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); International Drug Price Indicator Guide on finished products of essential drugs, Management Sciences for Health in collaboration with WHO (published annually) (http://www.msh.org); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (http://www.stoptb.org/GDF/drugsupply/drugs.available.html*)) If prices from sources other than those specified above are used, a rationale must be included.*

Table 5.5.1.A – Drugs, Year 1

Year 1			
Treatment category	**Average cost (based on delivery duty unpaid) per person-year or treatment course (in USD)**	**Number of person-years or treatment courses procured**	**Total cost (in USD)**
Artesunate + Amodiaquine	2	629 897	1259 794 USD
Coartem	2	62 990	125 980 USD
Sulfadoxine-pyrimethamine	0.52	48750	25 350 USD
TOTAL			**1 411 124 USD**

Table 5.5.1.A – Drugs, Year 2

Year 2			
Treatment category	**Average cost (based on delivery duty unpaid) per person-year or treatment course (in USD)**	**Number of person-years or treatment courses procured**	**Total cost (in USD)**
Artesunate + Amodiaquine	2	648164	1 296 328 USD
Coartem	2	64817	129 634 USD
Sulfadoxine-pyrimethamine	0.52	49969	25 983.88 USD
TOTAL			**1 451 945.88 USD**

[If prices from sources other than those specified above are used, provide a rationale for using these prices]

HIV/AIDS:

- Antiretroviral therapy (prevention of mother-to-child transmission)
- Antiretroviral therapy (first-line for adult treatment)
- Antiretroviral therapy (second-line for adult treatment)
- Antiretroviral therapy (other including post-exposure prophylaxis)

- Antiretroviral therapy (first-line for pediatric treatment)
- Antiretroviral therapy (first-line for pediatric treatment)
- Prophylaxis of opportunistic infections
- Treatment of opportunistic infections (including home-based and palliative care)
- Treatment of sexually transmitted infections
- Other (please specify)

Tuberculosis:
- Anti-tuberculosis therapy (first-line)
- Anti-tuberculosis therapy (second-line)
- Other (please specify)

Malaria:
- Monotherapy
- Artemisinin-based combination therapy: Artemether–lumefantrine (Coartem®)
- Artemisinin-based combination therapy: other
- Combination therapy: Non-artemisinin-based
- Parental and rectal antimalarials for severe malaria
- Prevention
- Other (please specify)

[Use the commodities and products categories that follow the tables (organized by disease)]

Table 5.5.1B –Commodities & Products Year 1

Year 1				
Commodities and products categories	**Unit (e.g., one mosquito net, one gross of condoms)**	**Unit cost (in USD)**	**Quantity**	**Total cost (in USD)**
K-OTAB	1	1	312 000	312 000
Long-acting ITNs	1	5	224 963	1 124 815
Insecticide-treatment materials	1 lot	284	32	9102.97
TOTAL				**1445917.97**

Table 5.5.1B –Commodities & Products Year 2

Year 2				
Commodities and products categories	**Unit (e.g., one mosquito net, one gross of condoms)**	**Unit cost (in USD)**	**Quantity**	**Total cost (in USD)**
K-OTAB	1	1	31 200	31 200
Long-acting ITNs	1	5	6 524	32 620
TOTAL				**63 820**

HIV/AIDS
- Condoms
- Diagnostic tests for HIV infection (e.g., rapid tests, ELISAs, etc.)
- Diagnostics: CD4+ T cell
- Diagnostics: HIV RNA (viral load)

- Diagnostics: Other
- Sterile injection equipment (e.g., syringes, etc.)
- Universal precautions supplies (e.g., syringes, etc.)
- Other (please specify)

TB
- Laboratory equipment (durable products, such as microscopes, x-ray machines, etc.)
- Laboratory supplies (non-durable products, such as slides, reagents, sputum containers, x-ray films, etc.)
- Other (please specify)

Malaria
- Mosquito nets: Insecticide Treated Nets: Factory pretreated mosquito nets
- Mosquito nets: Insecticide Treated Nets: Untreated mosquito nets
- (Re) treatment supplies
- Long lasting insecticidal mosquito nets
- Insecticides for outdoor and/or indoor spraying
- Spraying equipment
- Diagnostics: Rapid Diagnostic Tests (RDTs)
- Diagnostics: Other
- Other (please specify)

5.5.2 Justification for Drugs and Commodities and Products

[Provide the rationale (e.g., assumptions or formulas used) for the volumes of drugs and commodity/products listed in Table 5.5.1. (2–3 paragraphs)]

The therapeutic combination was chosen because of the therapeutic failure that led to the national consensus meeting on therapeutic perspectives of malaria in Gabon. During this meeting, the artesunate-amodiaquine and artemether-lumefrantrine combinations were selected as first-line and second-line treatments, respectively.
The amount of antimalarial drugs was determined on the basis of theoretical expected cases of malaria in the target population (pregnant women and children under 5) and with consideration of the growth rate of the target population.

The expected population for the period covered by the project (2005, 2006, 2006 /sic/) was calculated using the formula:
$P_x = P_o (1 = r)^d$
in which
P_x is the expected population in year x
r is the growth rate
n is the number of years between the baseline population and the expected population.

The baseline population for children under 5 is estimated to be 195 000 (WHO, 2000), and the baseline population for pregnant women is 1 300 000 (UNDP, 2003). /sic/

The population of Gabon is estimated at 1 300 000 (UNDP 2003). Populations that are vulnerable to malaria are children under 5 and pregnant women. The population of children 0-5 was 195 000 in 2000 (WHO, 2002)*.

5.5.3 Human Resources costs

[In cases where Human Resources is an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent Human Resources spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1–2 paragraph)]

5.5.4 Other key expenditure items

[With respect to other expenditure categories (e.g., Infrastructure and equipment) which form an important share of the budget, explain how these amounts have been budgeted for the first two years (1–2 paragraph)]

Equipment expenditures involve logistical strengthening of the program (vehicles, computer equipment). They have been budgeted on the basis of local data (market cost).

6 Annex A: Impact indicators

Impact indicators (indicators per goal)				
HIV/AIDS	**TB**	**Malaria**	**HIV/TB**	**Integrated**
Reduced adult HIV prevalence (ages 15-49)	Reduced number of smear-positive cases per 100.000 population per year	Reduced all-cause under 5 mortality (endemic areas)	Percentage of people still alive at 6, 12, and 24 months after initiation of antiretroviral treatment	
Reduced percentage of young people aged 15-24 who are HIV-infected	Reduced number of deaths from TB (all forms) per 100.000 population per year	Reduced malaria specific mortality		
Reduced percentage of high risk groups (sex workers, clients of sex workers, men who have sex with men, injecting drug users) who are HIV infected		Reduced malaria specific morbidity		
Reduced percentage of HIV-infected infants born to HIV-infected mothers				
Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner				
Percentage of young people who have had sex before the age of 15				
Percentage of young people who had sex with more than one partner last year				

Percentage of high risk groups which have adopted behaviors that reduce transmission of HIV				
Percentage of adults on treatment who increase their weight by at least 10% 6 months after initiation of antiretroviral treatment				
Percentage of people remaining on treatment at 6, 12, and 24 months				
Percentage of people still alive at 6, 12, and 24 months after initiation of antiretroviral treatment				

7 Annex B: Service delivery areas and coverage indicators

B1: HIV/AIDS

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Mass media	Number of service deliverers trained
		Number of HIV/AIDS radio/television programs/newspapers produced
	Information, Education, Communication	Number of service deliverers trained
		Number of HIV/AIDS prevention brochures/booklets distributed
		Number of peer educators active
	Youth education	Number of service deliverers trained
		Percentage of schools with teachers trained in life-skills based HIV/AIDS education
		Number of young people exposed to HIV/AIDS education in school settings
		Number of young people exposed to HIV/AIDS education out of school
	Condom distribution	Number of service deliverers trained
		Number/percentage of retail outlets and service delivery points with condoms in stock
		Number of condoms sold through public sector
		Number of condoms sold through private outlets
	Programs for specific groups	Number of service deliverers trained
		Number/percentage of sex workers and clients exposed to outreach programs
		Number/percentage of men who have sex with men exposed to outreach programs
		Number/percentage of mobile populations exposed to outreach programs
		Number/percentage of injecting drug users reached by HIV/AIDS prevention services
		Number/percentage of large companies with HIV/AIDS workplace policies and programs
	Voluntary counseling and testing	Number of service deliverers trained

		Number/percentage of districts with VCT services
		Number/percentage of people receiving VCT
	Prevention of mother-to-child transmission of HIV (PMTCT)	Number of service deliverers trained
		Number/percentage of health facilities offering minimum package of PMTCT
		Number/percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
	Sexually transmitted infection diagnosis and treatment	Number of service deliverers trained
		Number/percentage of patients with STI comprehensive case management
	Post-exposure prophylaxis	Number of service deliverers trained
		Number of people who receive post-exposure prophylaxis
	Blood safety, universal precautions	Number of service deliverers trained
		Percentage of transfused blood units screened for HIV
		Percentage of districts with access to donor recruitment and blood transfusion
Care and Support	Palliative care	Number of service deliverers trained
		Number/percentage of health facilities with capacity to deliver basic level counseling and medical services for HIV/AIDS
		Number of chronically ill with external support
	Support for orphans	Number of service deliverers trained
		Number/percentage of orphans and vulnerable children less than 18 years whose households received free basic external support in caring for the child
	HIV/TB	Number of service deliverers trained
		Intensified TB case finding among people living with HIV/AIDS
		Number/percentage given counseling and voluntary testing
		Number/percentage on cotrimoxazole preventive therapy
		Number/percentage provided with antiretroviral therapy
Treatment	Treatment and/or prophylaxis for	Number of service deliverers trained

	opportunistic infections	Number of people on treatment for opportunistic infection
		Number of people on cotrimoxazole preventive therapy
		Number/percentage of health facilities capable of providing advanced interventions for prevention and medical treatment for HIV infected persons
	Antiretroviral treatment and monitoring	Number of service deliverers trained
		Number/percentage of people with advanced HIV infection receiving antiretroviral combination therapy
Supportive environment and cross-cutting aspects	Strengthening of civil society	Number of civil society organizations reached
		Percentage of total HIV/AIDS services delivered by civil society
	Stigma	Number of service deliverers trained
		Number of support groups of people living with HIV/AIDS fighting against discrimination
	Health systems strengthening	Number of staff trained
		Percentage of budget spent on health infrastructure
		Percentage of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	Number of networks/partnerships involved
	Monitoring, evaluation, and operational research	Number of service deliverers trained
		Percentage of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	Number of service deliverers trained
		Percentage of service delivery points with sufficient drug supplies
		Percentage reduction in unit cost(s) of drug(s) and commodities

B2: TB

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Identification of infectious cases	Number of service deliverers trained
		Percentage of all estimated new smear-positive TB cases detected under DOTS
	Prevention of transmission by treating infectious cases	Number of service deliverers trained
		Percentage of new smear-positive cases registered under DOTS who smear-convert at 2 months of treatment
	Prevention of TB in children	Number of service deliverers trained
		Number of children who have been vaccinated with BCG
		Percentage of children who have been vaccinated with BCG
	Prevention of TB among people living with HIV/AIDS	Number of service deliverers trained
		Number of individuals dually infected with TB and HIV who receive isoniazid preventive therapy
		Percentage of individuals dually infected with TB and HIV who receive isoniazid preventive therapy
Care and Support	Supporting patients through direct observation of treatment	Number of service deliverers trained
		Percentage of patients cared for with DOTS during intensive phase
Treatment	Timely detection and quality treatment of cases	Number of service deliverers trained
		Number/percentage of the population covered by DOTS
		Number/percentage of treatment facilities implementing DOTS
		Percentage of smear-positive TB cases registered under DOTS successfully treated
	Control of drug resistance	Number of service deliverers trained
		Percentage of new smear-positive cases registered under DOTS who default or transfer out of treatment
	Systematic monitoring of performance in case management	Number of service deliverers trained
		Number of sites with fully functional recording and reporting system
		Percentage of treatment facilities submitting accurate, timely and complete reports

Supportive environment and cross-cutting aspects	Health systems strengthening	Number of staff trained
		Percentage of health facilities and laboratories involved in DOTS with sufficient capacity for DOTS
		Percentage of budget spent on health infrastructure
		Percentage of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	Number of networks/partnerships involved
	Monitoring, evaluation and operations research	Number of service deliverers trained
		Percentage of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	Number of service deliverers trained
		Percentage of health facilities involved in DOTS with sufficient drug and laboratory supplies
		Percentage reduction in unit cost(s) of drug(s) and commodities

B3: Malaria

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Insecticide-treated nets (ITNs)	Number of service deliverers trained
		Number of mosquito nets, long-lasting mosquito nets, pretreated nets or retreatment kits distributed
		Number of Sentinel sites established for monitoring insecticide resistance
		Number/percentage of households owning an insecticide-treated net
		Number/percentage of children under 5 using an insecticide-treated net
	Malaria in pregnancy	Number of service deliverers trained
		Number of mosquito nets, long-lasting mosquito nets, pretreated nets or retreatment kits distributed
		Number of pregnant women receiving correct intermittent presumptive treatment
		Number/percentage of pregnant women using insecticide treated nets
		Number/percentage of pregnant women receiving intermittent presumptive treatment or chemoprophylaxis
	Prediction and containment of epidemics	Number of service deliverers trained
		Percentage of epidemics detected within two weeks of onset and properly controlled
	Indoor Residual Spraying	Number of service deliverers trained
		Number of homes and areas sprayed with insecticide
	Information, education & communication (IEC)	Number of service deliverers trained
		Numbers of targeted areas with IEC services
Treatment	Prompt effective antimalarial treatment	Number of service deliverers trained
		Number of patients with uncomplicated and severe malaria receiving correct diagnosis and treatment
		Number of health facilities with no reported stockouts of antimalarial drugs
		Number/percentage of children under 5 years of age with access to prompt effective treatment
		Number/percentage of patients with severe malaria receiving correct treatment
		Number/percentage of health facilities with no reported stockouts of antimalarial drugs
	Monitoring of drug resistance	Number of service deliverers trained
		Number of sentinel sites established for monitoring antimalarial drug resistance

	Home based management of malaria	Number of service deliverers trained
		Number of caretakers recognizing signs and symptoms of malaria
		Percentage of persons exhibiting health care seeking behavior and use of appropriate antimalarials
Support environment and cross-cutting aspects	Health systems strengthening	Number of staff trained
		Percentage of budget spent on health infrastructure
		Percentage of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	Number of networks/partnerships involved
	Monitoring, evaluation and operations research	Number of service deliverers trained
		Percentage of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	Number of service deliverers trained
		Percentage of service delivery points with sufficient drug supplies
		Percentage reduction in unit cost(s) of drug(s) and commodities

B4: HIV/TB

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	TB prophylaxis for people living with HIV/AIDS	Number of service deliverers trained
		Health facilities capable of providing basic interventions for prevention and medical treatment for people living with HIV/AIDS
		Number of people living with HIV/AIDS on TB prophylaxis
Care and Support	Cotrimoxazole preventive therapy during TB treatment	Number of service deliverers trained
		Intensified TB case finding (among people living with HIV/AIDS)
		Number/percentage of people on TB treatment accessing voluntary counseling and testing
		Number on cotrimoxazole preventive therapy
Treatment	Antiretroviral treatment and monitoring	Number of service deliverers trained
		Number/percentage of people with advanced HIV infection receiving antiretroviral combination therapy
Supportive environment and cross-cutting aspects	Health systems strengthening	Number of staff trained
		Percentage of budget spent on health infrastructure
		Percentage of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	Number of networks/partnerships involved
	Monitoring, evaluation and operations research	Number of service deliverers trained
		Percentage of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	Number of service deliverers trained
		Percentage of service delivery points with sufficient drug supplies
		Percentage reduction in unit cost(s) of drug(s) and commodities

B5: Integrated

	Service delivery areas	Coverage indicators (per service delivery area)
Supportive environment and cross-cutting aspects	Health systems strengthening	Number of staff trained
		Percentage of budget spent on health infrastructure
		Percentage of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	Number of networks/partnerships involved
	Monitoring, evaluation and operations research	Number of service deliverers trained
		Percentage of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	Number of service deliverers trained
		Percentage of service delivery points with sufficient drug supplies
		Percentage reduction in unit cost(s) of drug(s) and commodities

8 Annex C: Green Light Committee Applications

Annex for the sub-component on Tuberculosis on applications to the *Global Fund to Fight AIDS, Tuberculosis and Malaria*, that include use of second-line anti-TB drugs.

INSTRUCTIONS FOR APPLYING TO THE GREEN LIGHT COMMITTEE FOR ACCESS TO SECOND-LINE ANTI-TUBERCULOSIS DRUGS

Completed applications should be delivered, according to the deadline provided by The Global Fund to Fight AIDS, Tuberculosis & Malaria, to:

World Health Organization
Communicable Diseases
Green Light Committee of the Working Group on DOTS-Plus for Multidrug-Resistant Tuberculosis
20 Avenue Appia
CH-1211
Geneva 27
SWITZERLAND

E-mail: dotsplus@who.ch

World Health Organization

2003

SUMMARY

DOTS-Plus means DOTS first. Potential DOTS-Plus pilot projects that (1) build on the foundation of a solid DOTS-based TB control programme, (2) design their project within the principles put forth in the *Guidelines for Establishing DOTS-Plus Pilot Projects for the Management of Multidrug-Resistant Tuberculosis (MDR-TB)*, and (3) write their application in the format prescribed in these *Instructions For Applying to the Green Light Committee for Access to Second-Line Anti-Tuberculosis Drugs (*herein after referred to as the *Instructions*) have an excellent likelihood of receiving the "green light" from the Green Light Committee (GLC) to participate in the pooled procurement of second-line anti-TB drugs at preferential prices. Moreover, the application process may lead to enhanced communication between the project site and the WHO, the members of the Working Group, and the GLC. This will benefit all parties involved, but most importantly patients with MDR-TB. The feedback and monitoring process for DOTS-Plus pilot projects should provide the clinical and programmatic experience needed to develop global standards for the prevention and control of MDR-TB.

OVERVIEW OF APPLICATION PROCESS

Countries that have included use of second-line anti-TB drugs in their application to The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) must submit an application to WHO Green Light Committee (GLC). The application enables the GLC to understand the structure and performance of the basic TB control programme and the proposed DOTS-Plus pilot project and the capability of the project to prevent misuse of second-line anti-TB drugs.

The GLC may reach one of the following decisions:

1) GLC advices the GFTAM to fund the project;

2) The GLC advices the GFTAM to fund the component of the project incorporating the use of second-line anti-TB drugs conditional to revisions/modifications before the project can participate in the pooled procurement process for preferentially priced second-line anti-TB drugs; or

3) The DOTS-Plus pilot project does not meet at the moment the standards set and the GLC advices the GFTAM not to fund the component of the project incorporating the use of second-line anti-TB drugs.

Approval of project does not guarantee that it will maintain the principles set in the *Guidelines* throughout the duration of the project.. In order to assure that drugs will not be mismanaged, monitoring visits will be made throughout the duration of the project. The objective of these visits are to review the implementation of the DOTS strategy and the DOTS-Plus pilot project at the site, and to provide technical assistance (if needed) on behalf of the GLC.

INSTRUCTIONS FOR APPLICANTS

There is no official application form[4]. The application, in English or translated into English, should conform to the format and include the content described in this document. The application should have three major sections:

1. A cover letter (two pages maximum).
2. The main body of the application (thirty pages maximum).
3. Annexes (no page limit).

Cover Letter

The cover letter should be typed or printed on the applicant organization's original letterhead. It should be addressed to the "Green Light Committee." The cover letter should be signed by the project director and contain the following items in relation to the DOTS-Plus pilot project:

- Location.
- Size of cohort to be treated.
- Anticipated start date and duration.
- Time schedule for inclusion of patients during the pilot project.
- List of all organizations involved.
- Brief justification of the need for a DOTS-Plus pilot project.

Body of the Application

In general, the application should describe in specific terms how the basic TB programme at the pilot project site and the proposed DOTS-Plus pilot project will develop the principles listed in the *Guidelines*. The body of the application should be divided into seven sections:

i. Background;
ii. Relevance of the DOTS-Plus pilot project;
iii. Government commitment;
iv. Organization, management and coordination
v. Laboratory issues;
vi. Treatment and follow-up strategy;
vii. Information systems and data management;
viii. Annexes

The content of each section should be comprised of the topics and issues highlighted in the *Guidelines*. Although all applications should include these sections, other sections may be added if it would explain the project more clearly.

[4] However, the application should be printed or typed on standard A4 or 8.5"x 11" paper, single-spaced, with 2.5 cm (one inch) margins, characters no smaller than twelve points in height and no more than twelve characters per 2.5 cm. This format applies to all parts of the application prepared originally by the applicants; it does not apply to photocopied annex material.

Background

This section should address the reasons for the emergence of MDR-TB in the region and the applicants' assessment of the relative importance of each reason.

8.1.1.1.1.1 Relevance of the DOTS-Plus Pilot Project

This section should provide the justification for a DOTS-Plus pilot project as well as the projected outcomes of the pilot project. This section should state the following:

- All the relevant drug resistance surveillance data for the country as a whole, and/or from the district where the DOTS Plus project will be implemented (to appear in the Application as an Annex).
- Drug resistance profile of the proposed DOTS-Plus treatment cohort.
- Treatment outcome cohort data for the country as a whole, and from the district where the DOTS Plus project will be implemented.
- The expected epidemiological impact of the potential DOTS-Plus pilot project.
- Anticipated long-term strategy to manage MDR-TB in the region.
- Full descriptions of the management programme if the management of MDR-TB cases is already occurring within the TB control programme of the proposed DOTS-Plus pilot project (to appear in the Application as an Annex).

Government Commitment

The governing authorities, leadership of the health department, and the leadership of the TB control programme in the region must be firmly committed to TB control. This section must present credible evidence of such commitment. It should also verify that treatment of MDR-TB is provided free of charge to the patients. This section should include:

- Commitment of the TB control system to regulate and account for the distribution of second line anti-TB drugs according to specific guidelines.
- Original letters of support (to appear in the Application as an Annex) from each of the collaborating institutions to implement the DOTS-Plus pilot project in case these have not been included in the original application to the GFTAM.

Organization, Management and Coordination

The organization and operation of the proposed DOTS-Plus pilot project is crucial, as is the relation of the two to the TB control system in the region. Roles and responsibilities of each participating component of the TB system, including specific individuals, must be delineated to prevent overlap and to ensure all aspects of the pilot project are covered. Local institutions, the general medical services, and the social services system as well as outside donors or collaborators should be integrated into the pilot project. This section should provide a detailed description of:

- Local facilities of the TB control system (including specialized units) that will be involved in the treatment of MDR-TB patients and the roles and responsibilities of each of them.
- Local personnel in the TB control system who will be responsible for the treatment of MDR-TB patients, and their training / experience in the management of MDR-TB and use of second-line anti-TB drugs.

  Local facilities outside the TB control system that will be involved in the management of MDR-TB patients, including roles and responsibilities of each (e.g., prisons, general medical services, social services, psychiatric facilities, alcohol and drug abuse treatment programmes, social services, etc.).

  Local, national and international collaborating agencies and the roles and responsibilities of each of them.

  Plan for implementation of the DOTS-Plus pilot project.

  Management and coordination of the DOTS-Plus pilot project.
- Management system for anti-TB drugs, especially the second-line anti-TB drugs to be procured as a result of this application, including storage, distribution, monitoring, reporting, and accountability.

  Monitoring and supervision of the DOTS-Plus pilot project by both an internal and external body.

  Training programme for all health care personnel, laboratory technicians, and information systems/data management personnel.

Laboratory Issues

This section should clearly identify all laboratories involved in the DOTS-Plus pilot project and the capabilities of each one. Specify the number and types of specimens processed; the techniques used for smear-microscopy, culture and DST; biosafety procedures for laboratory workers; and the structure of the laboratory supervision. This section should provide a list and brief description of:

- Local reference laboratory(s) performing smear-microscopy, culture, and/or DST.
- Quality assurance system and supervisory activities of the local reference laboratory(s), and the results of the most recent quality assurance evaluations.
- Any other laboratories performing culture and DST.
- Laboratory network performing smear-microscopy only.

This section should also provide a more detailed description of:

- Collaboration with an international reference laboratory and the quality assurance system associated with this laboratory.
- Process and infrastructure for specimen collection, transport and referral.

Case-finding Strategies

This section should clearly describe the case-finding strategies to be employed for enrolling the patients in the cohort. Some projects have already identified the MDR TB patients to be included in the cohort. Some other may have also additional plans for enrolling patients which at the time of the application have not being identified yet. This section should provide a list and brief description of:

- Stage in the diagnostic assessment at which the TB patient receives a DST (a flowchart will help).
- Inclusion / exclusion criteria to be employed for selecting, out of the total of MDR TB cases identified by the project, those to be enrolled in the cohort of the DOTS Plus project.
- Health care institutions / bodies in charge of elaborating and applying those inclusion / exclusion criteria.

Treatment and Follow-up Strategy

This section should clearly describe all aspects of the management of patients with the proposed treatment cohort, from case finding and selection through post-treatment follow-up. Key baseline, monitoring, outcome variables, and outcome analyses should be specified according to WHO criteria.[5] This section should include the strategy/plan (with justification) for:

- Treatment regimens for both intensive and continuation phases according to specific drug resistance patterns.
- Transfer of patients and patient information from hospital/dispensary (inpatient) settings to the ambulatory or polyclinic setting, and in the reverse direction if necessary.
- Other transfers of patients and patient information such as transfer between the prison and the civilian sectors, to long-term care or specialized housing facilities, sanatoria, or to other hospitals.
- Monitoring schedule for patients and evaluations/tests to be performed at each point.
- Direct observation of drug ingestion.
- Ensuring complete treatment and follow up of all patients (case management).
- Detailed management of adverse reactions and collection of adverse reaction data.
- Provision of social services and support needed by patients.

Information Systems and Data Management

The Working Group on DOTS-Plus on MDR-TB will facilitate a list of variables and outcome definitions for the collection of data. However, the applicant can include in the application its own plan and forms for collection of data.
The ability to accurately record and report data covering all aspects of case finding, diagnosis, treatment, outcome, and programme performance is crucial to all DOTS-Plus pilot projects. These DOTS-Plus pilot projects are considered pilot projects because sufficient data do not exist to provide definitive evidence-based policy guidelines. The DOTS-Plus pilot project must commit to training all participants and

[5] *Tuberculosis Handbook*. WHO/TB/98.253
Guidelines for the Management of Drug-Resistant Tuberculosis. WHO/TB/96.210
Treatment of Tuberculosis: Guidelines for National Tuberculosis Control Programmes. WHO/TB/97.220

to record the required information accurately and completely, including supervision and quality assurance. The training requirements may be intensive. In addition to the standard data set, this section should specify:

- Case finding and notification system and forms.
- Laboratory data recording and reporting system.
- Format for aggregate quarterly and annual reporting.

Annexes

The annexes of the application should contain all letters of support and relevant data related to the project. Specifically, this section should contain the following items in separate annexes:

1. Drug-resistance surveillance data and standard WHO/IUATLD analysis of this data.
2. Proposed therapeutic protocols and the proposed number of patients in each treatment scheme.
3. Results of quality assurance programmes performed for each laboratory (and each procedure) involved in the DOTS-Plus pilot project.
4. All data collection and reporting forms to be used.
5. Specific procurement request, in six-month intervals and cumulative total, for second-line anti-TB drugs to complete treatment of the proposed cohort including, the generic name, formulation, unit dose, number of unit doses, cumulative weight of each drug, and the timing for delivery (see attached form 'A' for drug procurement request). Changes to the procurement request after GLC approval requires a satisfactory justification to be assessed by the GLC.
6. Examples of aggregate case finding and programme performance reports from the previous two years (if possible) according to the attached form 'B'.
7. If the management of MDR-TB cases is already occurring within the TB control programme of the proposed DOTS-Plus pilot project, then data from the management programme must be included. Information included in the cover letter and body of the application does not need to be repeated in this annex. However, as a minimum, this annex should contain (in reference to the MDR-TB cohort managed under the current TB programme), the following information:

    - number of MDR-TB cases registered per year,
    - number of MDR-TB cases treated under current TB control programme,
    - treatment regimen(s) utilized (stratified by drug-resistance pattern),
    - time to sputum and culture conversion,
    - treatment outcomes, and
    - adverse reactions encountered.

Form A: Drug Procurement Request

Name of Project:
Duration of Project (in years):
Timing for delivery of the first drug request (covering 6 months treatment):
Size of the cohort:

Request	DRUG	Km **1 g vials**	Am **1 g vials**	Cm **1 gr vials**	**Pth 250 mg Tab**	**Eth 250 mg Tab**	**Cip 500 mg Tab**	**Ofl 200 mg Comp**	PAS **4 g sachets**	Cs 250 mg **caps**
Quantity for each treatment course	____									
Total quantity unit doses for first drug request covering first 6 months										
Total drug request for the total cohort										

Form B: TB aggregate case finding & programme performance reports

Country:
National Tuberculosis Program of:

RESULTS OF TREATMENT IN NEW SMEAR POSITIVE PULMONARY TUBERCULOSIS PATIENTS										
	Year or Quarter Number		**Year or Quarter Number**		**Year or Quarter Number**		**Year or Quarter Number**		**Year or Quarter Number**	
Number (N°) of Registered patients										
	N°	%	N°	%	N°	%	N°	%	N°	%
Patients Included in Cohort		100		100		100		100		100
Cured										
Treatment Completed										
Failures										
Defaulters										
Transfer Outs										
Deaths										