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

PROPOSAL FORM
ROLLING CONTINUATION CHANNEL
(CCM AND SUB-CCM APPLICANTS)

Applicant Name	**COUNTRY COORDINATING MECANISM S. TOME AND PRINCIPE**		
Country	**Sao Tome and Principe (STP)**		
Applicant Type	**CCM**		
Income Level	**Low Income**		
Disease	**Malaria**		
Expiring Grant Number	**STP-405-G01-M**	**Round**	**4**
Other same disease grants that have links to this proposal:	**Round 7**		

Currency	☒ USD	or	☐ EURO

Deadline for submission of proposal: **1st June 2010**

How to complete this form

INDEX OF SECTIONS AND KEY ATTACHMENTS FOR PROPOSALS **Page**

1. **Funding Summary and Contact Details 2**
2. **Applicant Summary (including eligibility) 3**
   + Attachment C: Membership details of CCM or Sub-CCM
3. **Proposal Summary 8**
4. **Program Description 10**
5. **Funding Request 25**

+ Attachment A: Performance Framework (Indicators and targets)

+ Attachment B: Preliminary List of Pharmaceutical and other Health Products

+ Detailed Proposal Budget: Quarterly for years 1 and 2 and annual details for years 3 to 6

+ Detailed Work plan: Quarterly for years 1 and 2 and annual details for years 3 to 6

IMPORTANT NOTE:

A number of recent Global Fund Board decisions have been reflected in the Proposal Form for the Rolling Continuation Channel. Information on these decisions is available at: http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

The ***Guidelines for Proposals*** *for the Rolling Continuation Channel (the 'Guidelines for Proposals')* contain the **majority of instructions** and examples to assist applicants to complete the Proposal Form. **Applicants are therefore strongly encouraged to read these *Guidelines for Proposals* fully before completing a proposal and continue to refer to them whilst completing this form.**

A check list of all annexes to be attached to the Proposal Form is provided at the end of section 5 of this Proposal Form

1 Funding Summary & Contact Details

1.1 Proposal title

Malaria Control in São Tomé & Príncipe, toward elimination ".

1.2 Funding summary

IMPORTANT NOTE : *(*Decision draft from Council GF/B18/DP13)*

The maximum funding able to be requested in total for the first three years arises 140% of Phase 2 budget, aproved by the Council for the expiring grant.

For this Proposal, this ceiling (including all request for HSS cross-cutting interventions 4B) is calculated as following :

Amount of Phase 2 : 1,543,500 USD **x 140 %** = 2,160,900 USD

(Note. The same ceiling is applied to the global detail budget submited with to theRCC proposal and all the financial tables must be coherent with the same figure).

Disease	Year 1 to 3 *(Check the table below about the maximum possible amount in this period)*	Years 3 to 6	Total
Malaria	$1,185,356	$5,766,767	$6,952,123
HSS cross-cutting interventions (cf. 4B) **	0	0	0
Total :	$1,185,356	$5,766,767	$6,952,123

******* Only if this proposal requests support for health systems strengthening cross-cutting interventions in s.4B (**read the Guidelines for Proposals**). However, if the HSS support that is requested is easily included as part of the disease program strategy in s.4.6.4, do not include s.4B in this proposal.*

1.3 Contact details

	Primary contact	Secondary contact
Name	Dr Arlindo Vicente de A. Carvalho	Dr. Herodes Rompao
Title	Charman CCM S. Tome and Principe	CNE Coordinator
Organization	Ministry of Health	Ministry of Health
Mailing address	S. Tome	St Antonio – S. Tome
Telephone	+239 2 241 200/ 201	+ 239 2 241 650
Fax	+239 2 221 306	+239 2 221 227
E-mail address	avacarvalho@hotmail.com	sacramentosousa@yahoo.com.br
Alternate email Address	gilislandcores@hotmail.com	sacramentosousa@yahoo.com.br

1 Funding Summary & Contact Details

1.4 List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
ACT	Artimisin Combination Therapy
AIDS	Acquired Imuno-Deficiency Syndrome
BCC	Behavior Communication Changing
CCM	Country Coordinating Mechanism
CD	Capacity Developement
CNE	National Center for Endemic diseases
CNES	National Health Education Center
CPN	Antenatal care
CPS	Primary Health Care
DDT	Dichloro-diphenyl-trichlorethan
FENAPA	National Federation of Agricultural associations
FNM	National Drugs Fund
FONG	National Federation of NGOs
GF	Global Fund
GFATM	Global Fund for AIDS Tuberculosis and Malaria
GIEPA	Fisherman Group of economic Goal (small fishermen organization)
GMS	General Management Solution
GPS	Global Position System
HIS	Health Information System
ICDF	International Community Development Fund (Taiwan)
IEC	Information Education Communication
IRS	Indoor Residual Spray
ISVSM	Health Institute (health training school)
KAP	Knowledge Actitude Practice (survey)
LFA	Local Fund Agent
LLINs	Long Lasting Insecticide Nets
NGO	Non Governmental Organization
OMD	Milenium Development Goal
PR	Principal Recipient
PNLS	National Program against AIDS
RCC	Rolling Continuation Channel
RDT	Rapid Diagnosis Test
STP	S. Tome and Principe
TRP	Technical Review Panel

1 Funding Summary & Contact Details

UNDP	United Nation Development Program
UNFPA	United Nation Population Fund
USAID	**United States Agencies for International Development**
WB	**World Bank**

2 Applicant Summary (including eligibility)

Note to applicants:
CCM applicants: Complete sections 2.1 and 2.2 and DELETE section 2.3.
Sub-CCM applicants: Complete all of sections 2.1 to 2.3.

2.1 Members and operations

2.1.1 Membership summary

Clarification email 29 June

Membership summary		Number of members
☒	Academic/educational sector	**0**
☒	Governement	**9**
☒	Non-government organizations (NGOs)/community-based organizations	**7**
☒	People living with the diseases	**2**
☒	People representing key affected populations ***1**	**1**
☒	Private sector	**2**
☒	Faith-based organizations	**1**
☒	Multilateral and bilateral development partners in country	**13**
☐	Other *(please specify):*	
Total Number of Members: *(Number must equal number of members in 'Attachment C')*		**35**

2.1.2 Member knowledge and experience in cross-cutting issues

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

a) Describe the capacity and experience of the applicant to consider how health system issues impact programs and outcomes for the three diseases.

Among the CCM members, some of them have experience in managing health services from different components. In evaluating the impact of health system problems on the programs and outcomes for the three diseases, as well as its experience in this matter, the CCM will admit as a resource person, any individual or corporation that it deems necessary in light of his/her competences or action in the furtherance of CCM goals. The National Health Information System Department (HIS), and UNDP, PR unit will be specifically requested by the CCM to deal with all health system issues and the outcomes of the three diseases.

Representative from the reference pharmaceutics Sector, warehouse, Human Resources, IEC, Health Ministry information System, Monitoring- evaluation Sector of the National Endemic Center were present at the process, they participated in the analysis of situation (strengths, weaknesses and opportunities) and identified priorities toward elaboration of this National RCC Proposal of round 4.

For elaboration of the present RCC proposal, CCM counted with technical assistance of experts on health system and Procurment Supply Management, all from Roll back malaria central Africa network.

2 Applicant Summary (including eligibility)

1 The recommendation to include representation of ***key affected populations*** arose from changes introduced at the 16th Board meeting. The Global Fund adopts the UNAIDS definition as follows: *women and girls, youth, men who have sex with men, injecting drug users, sex workers, people living in poverty, prisoners, migrants and migrant laborers, people in conflict and post-conflict situations, refugees and displaced persons.*

Gender awareness

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

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

b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Furthermore, among the CCM members, there are Experts on gender equality subjects, for instance the UNFPA representative. On the other side, a big number of these members have participated in two training sessions on gender equality, organized at national level.

CCM members are invited to comment their aptitudes and global experiences on gender issues ; taking in account the gender issues while analyzing the program's weaknesses and gaps, and how to improve this proposal by integrating gender equality concerns

The anti-malarial interventions (prevention or management) aim, irrespectively, both men and women, boys and girls. In fact, they emphasize the women by the intermittent preventive treatment for pregnant women and long lasting bednet coverage. They plan a coverage of 100% of children under 5 years old, the drugs coverage for all the malaria detected cases and focalized IRS in specific target areas.

With the purpose of malaria elimination, the current proposal claims indeed to cover the entire population, without distinction, with the anti-malarial intervention, in the highest coverage rate. For attaining this goal the human resource strengthening is necessary, in which the gender will be under consideration as training/recruitment and recruitment.

Multi-sectoral planning

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

(c) D Describe the capacity and experience of the applicant in multi-sectoral program design.

Multi-sectorial approach is used at national level for analyzing problems and elaboration of strategic plan of fighting against malaria, AIDS and Tuberculosis. CCM members are always represented by their colleagues in different exercises of analysis and Monitoring-Evaluation planning.

Besides, STP CCM took responsibility on GF R4 on course, in accordance with a multisectorial approach, involving governmental departments, private sector and several civil society organizations. This is related to Malaria R4 and R7, HIV R5 and Tuberculosis R8.

Within the IRS plan adopted by the country in 2004, a multisectorial experience has been improved and continuing up to now, involving the communities, civil society and several governmental departments (Ministry of Health, Ministry of Social Communication and local authorities…).

With regard to the distribution of LLINs, The Ministry of Education and other partners have been also involved.

2 Applicant Summary (including eligibility)

2.2 Eligibility

2.2.1 Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☒ Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of s.2.2.2 to s.2.2.8 below***
☐ Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***Complete 2.2.3-2.2.8 below and also complete 'Annex 1' to this Proposal Form.***

2.2.2 Broad and inclusive membership

Since the last time you applied to the Global Fund and were determined compliant with the minimum requirements:		
(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases?	☐ No	☒ Yes
If there are significant changes to these processes, or 'no' applies to either situation, the CCM (or Sub-CCM) should complete all of the questions in Annex 1 to this Proposal Form in addition to sections 2.2.3 to 2.2.8 below.		

2.2.3 Processes to select Principal Recipients for program implementation during the Rolling Continuation Channel term

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation.

➔ *Refer to the **Guidelines for Proposals** for further explanation of this recommendation.*

(a) Describe the process used to transparently select each of the Principal Recipient(s) nominated in this proposal.	
CCM decided to re-elect UNDP as principal recipient for this RCC. UNDP has been recomended to keep strengthning the capacity of CNE so that it can, after, become the PR. The later, according to LFA has still shown some weakness which must be overtaken. Within this proposal it's expected that CNE becomes Co PR during the second phase (the three latest years) with regard to IRS and M&E with administrative, programmatic and financial management of these two interventions. After the conclusion of 1st phase of this RCC implementation, an evaluation will be done to check whether CNE is ready to become the Co PR.	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) decided on the Principal Recipient(s) for this proposal.	***[Annex 2]***

2 Applicant Summary (including eligibility)

2.2.4 Principal Recipients

Name	Sector **
UNDP (During all proposal running)	Multilateral development partners in country
CNE (Phase 2 : Three latest years)	Secteur Gouvernemental
(Use "Tab" button on key board to add extra rows if required)	

*** Identify the 'sector' from the list of sectors that are provided in the table in section 2.1.1 above.*

2.2.5 Non implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for program implementation in this proposal. *(Note: if the same Principal Recipient is selected as the expiring grant, provide a detailed explanation of the country's own assessment of performance, and criteria for that selection [that is, not relying only on Global Fund 'Grant Performance Report' materials]).*
N.A

2.2.6 Transparent proposal development processes

***Scale up** and **scope change** are described in the Guidelines for Proposals in detail. Applicants are encouraged to refer to this material before making decisions about the proposal development process.*

A If this proposal continues/scales-up the interventions from the expiring grant, describe in detail the transparent process used by the CCM (or Sub-CCM) to ensure that: (a) a broad group of stakeholders (including CCM, or Sub-CCM, members and non-members) were involved in evaluating the appropriateness of continuing the interventions; and (b) the decision to continue relevant interventions was made after discussion among the stakeholders
CCM has launched an announcement for application, by media (radio and press), since July 2009, for interest demonstration, so that all the civil society organization and other groups can contribute on the RCC devellopment proposal, by anti-malarial sub-plans. In addition, letter has been sent to the health sector intervenient partners, appealing for their interest and their orientations. Finaly, a meeting has been organized on Friday, 24th July 2009 in which the CNE/PNLP has introduced the RCC general guidelines. That have been accepted, by means of including their contributions, specially, concerning IEC actions : teachers and media professional trainings. For the re-submission of the proposal, the procedure has been employed and several mini-proposals were received, especially from the Ministry of Education, NGO Zatona ADIL and Army Health Service. These mini-proposals have been included in the present proposal.

(c) **Attach** documents that show the transparent, broadly inclusive processes used to decide whether to continue (and if so, most probably, scale-up) some or all of the interventions from the expiring grant.	***[Annex 2]***

And/or:

2 Applicant Summary (including eligibility)

B If this proposal proposes a scope change/<u>new interventions</u> (or does not continue some of the existing interventions), describe the transparent processes that the CCM or Sub-CCM followed to ensure that: (a) a broad group of stakeholders (including CCM, or Sub-CCM members and non-members) were involved in an open and inclusive process to solicit submissions and review these for possible integration into this proposal; and (b) the decision of whether to include new interventions was made after these submissions were received, transparently evaluated and discussed by the CCM (or Sub-CCM).
CCM has also decided to strengthen the weaknesses in the R4 implementation, noticed by the TRP. This way, the new and reinforcing interventions were proposed and adopted by CCM in the meeting carried out in February 2010. These new interventions are: IRS, strengthening of druds supply management system, epidemiological vigilance and M&E. Based on this, CNE made an invitation to the partners interested in carring out the realization of these interventions.

(c) **Attach** documents that show the transparent, broadly inclusive processes used to decide which new interventions to include in the proposal to expand the activities of the expiring grant (or replace some of them).	***[Annex 3]***

2.2.7 Managing conflicts of interest

(a) Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as <u>any</u> of the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No ➔*go to section 2.2.8*
(b) **If yes, attach** the plan for the management of actual and potential conflicts of Interest	***[Insert Annex Number]***

2.2.8 Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has '<u>Attachment C</u>'** been completed with the numbers of all members of the CCM (or Sub-CCM)	☒ Yes

2 Applicant Summary (including eligibility)

2.3 Sub-CCMs

2.3.1 CCM Endorsement

(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal..	**N.A**
(c) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	**N.A**

3 Proposal Summary

3.1 Duration of proposal

Please fill in the proposal term start date based on the former grant's expected expiration date.

	Planned start date	To
Month and year: *(up to 6 years)*	January 2011	December 2016

3.2 Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing same disease Global Fund grant(s) with part or all of this Rolling Continuation Channel proposal?	☒ Yes *(go first to (b) below)*
	☐ No *(go to 3.3 below)*

***'Consolidation'** refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the RCC proposal.*

(b) If yes, which grants? *(List the relevant grant number(s))*	Round 7

3.3 Alignment of planning and fiscal cycles

Describe how the start date:
(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or
(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

The fiscal cycle of S. Tome and Principe coincide with the civil (calendar) year, from 1st January to 31st December.

The current program is settled in the same logic was considered in the implementation of Malaria R4 and HIV R5 at present time on the implementation of Malaria R7 that has just started.

The implementation and activities report chronogram take into acccal cycle. In this way, the planing outcomes (results) will be (presented) available per quarters : the activities previewed to be supported by the government and other partners will start on 1st January, as well as those which belongs to the current proposal will start on January 2011.

3.4 Program-based approach?

3.4.1 Does planning and funding for the country's response to the disease occur through a program-based approach?	☒ Yes ➔ Answer s.3.4.2
	☐ No ➔ Go to s.3.5
3.4.2 If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approac?	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism AND provide information at the level of the common funding mechanism in s.4 as appropriate.***
	☒ Non ➔ Go to s.3.5

3 Proposal Summary

3.4.1 Summary of Rolling Continuation Channel proposal

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

Prepare after competing s.4.

Intensifying and updating antimalaria interventions in the small island state of S. Tome and Príncipe (STP) offers a novel opportunity in the fight against malaria. The small size and isolation of STP makes malaria more vulnerable to interventions than nearly any other place in the world where malaria is highly endemic.

Prior, interrupted intervention programs have demonstrated the unusual sensitivity of malaria transmission to intervention in STP, temporarily reducing malaria-related mortality to nearly zero in the early 1980s. This experience also revealed the dangers of interventions not sustained, causing an epidemic in a population in which immunity to malaria was depressed by prior interventions.

The results obtained by malaria component R4 are very encouraging. The national anti-malarial strategy/vision aims to eliminate malaria in STP. Considering this objective, the R7 Proposal expects to increase the intervention coverages to the maximum level. The current proposal has in view to build on the experiences gained in R4, and reinforce the weaknesses noticed in its implementation. This proposal also plans to sustain the coverages that will be reached by R7.

STP plans to attack malaria by scaling up and sustained existing anti-malarial interventions.

Programs to be scaled up and made sustainable include the free distribution of Insecticide-treated Nets (ITNs), IRS (as a new component of R4), diagnosis and correct case management, active research, case management at community level, malaria BCC in the community, including the qualitative study in order to better target the message. General IRS until 2016.

In complement of those based community interventions, this proposal includes also a strong strategy of Epidemiological surveillance in order to implement a system of precocious detection, rapid recognition and appropriate response of the disease.

A surveillance on first-line-drugs effectiveness is planed and entomological surveillance. In order to ensure that efforts can be implemented effectively, the overall capacity of the health infrastructure and its human resources will be strengthened through a comprehensive program of health worker and manager training and through the provision and maintenance of essential equipment.

A special attention will be also made to strengthening the supply management system, which is really weakly structured, monitoring & evaluation system.

These activities are estimated in 18 992 611 USD of whith 9 583 014 USD is already available in the country, covering essentialy the first phase of the proposal. Most part of this awailability is ensured by the Government, GF and Taiwan cooperation. Tha's why the present submission budget is over $6,952,123 of which $1,185,356 in phase 1 and $5,766,767 in phase 2. Also the Country absorption capacity was also considered.

The elaboration of this proposal will invite national governmental institutions such as Ministry of Health (CNE, family planning services), Ministry of Education, National statistic institute, Army health service, etc. This elaboration also invites the civil society sector, NGOs (Red Cross, ZatonaADIL) and national association groups (farmer associations, saleswomen associations and fishermen associations).

Above all, it's crucial to notice that this proposal is significantly indispensable for STP, because if the weaknesses identified in R4 implementation are not corrected, the R4 results and the R7 objectives will be compromised.

4 Program Description

4.1. Key changes in the stage or dynamics of the disease

Summarize the main changes in the **stage or dynamics** of the disease, including any changes in the most **affected population group(s)** between when the original proposal for the expiring grant was submitted, and now.
Applicants are requested to specifically comment on current trends in mortality and morbidity impact indicators within the populations targeted in this proposal, and the assessed contribution of the expiring grant towards more favorable trends in those indicators.

The last evaluation of 2008 has shown a malaria incidence of 17/1000 inhabitants that is actually the impact of integrated anti-malaria measures carried out during 5 years. The Global Fund R4 grant has contributed to reach this impact.

The same way, the rate of proportional mortality (all age group) has decreased from 11% (2005) to 2,5% (2009) and case fatality rate is stable around 1,3% to 1,5% between 2005 and 2009.

These references are essentially owing to the anti-malaria measures carried out:

- In fact, 64984 long-lasting bed nets were distributed to children under 5 years old, corresponding to 100% of targets attained and 17989 children under 5 years old was provided with prompt and recommended treatment. From this distribution, the coverage on children under five years old has reached 61,3% and 61,1% on pregnant women, thanks to the contribution of R4 Global Fond grant.
- The IRS coverage has reached 83,5% of the households in 2006 ; (75,5% et 85,6% between 2007 and 2009).
- The correct management of malaria cases improved because of diagnosis improvement by the introduction of Rapid Diagnosis Test and also by the use of the effective ACT.
- These principals activities has been supported and followed by supervisions, training, leadership and adequate coordination of Heath Ministry, CNE/PNLP.

4.2. National prevention, treatment, care, and support strategies

Describe how the country's disease specific planning frameworks have evolved since submission of the original proposal for the expiring grant to:

• Respond to changes in the stage and dynamics of the disease described in 4.1 above; and
• Focus on ensuring a scale-up in the reach of services to key affected populations beyond early estimates that may not have represented the full range of people needing prevention, treatment, care and/or support services.

Where such plans exist and they are directly relevant to the interventions in this proposal, they should be attached to the proposal (with clear references in the text of this proposal and in the 'Checklist' at the end of s.5) to assist proposal review

The changing's noticed in the country epidemiological situation were confirmed by the evaluation of strategic plan in 2008, of which the report constituted the basis for development of the new strategic plan 2010 – 2015. (**annex 4**)

This new strategic plan permitted to develop a new action plan that took in account the new guidelines and needs related to the new epidemiological status. These needs are summarized as following:

- Some preventive needs (such as LLINs) will remain universal across the entire population of STP as long as a significant threat of malaria transmission persist. Some programmatic needs will remain cyclical for the near future as regular replacement cycles for preventive commodities such as LLINs take effect every four years ;

- The entire programmatic need of the IRS operation was covered by the ICDF, a bilateral partner from Taiwan. But is entering a period of transition that may require alternative support which is

currently covered by GFATM R7. The current proposal aim to continue the activities of spray in emergency focus region, after the end of R7. Other interventions will continue and will be sustainable in continuation of R7 until achieving the goal ;

- Other needs (routine ACTs) will be in direct proportion to the reductions in morbidity that have occurred and will continue to occur as this control program proceeds. However, an emergency supply of ACTs will need to be maintained during consolidation for occasional mass pre-emptive treatment of entire communities when surveillance indicates a significant presence of malaria transmission cycles ;

- Until malaria is eliminated, it is assumed that the entire population of STP is at risk, however some of the activities proposed for the later stages of elimination will be focal responses that will provide services and commodities to an unspecified number of people depending on the specific, temporary need indicated by surveillance ;

- This situation is similar for the reinforcement of epidemiological surveillance that wasn't previewed by R4 of which actions for rapid detection, precocious recognition and rapid epidemics response will be also considered within this proposal.

The programmatic needs of 4 key services are summarized below:

ACTs (from Routine treatment to Mass Presumptive Treatment in Emergencies)

The programmatic needs of ACTs continue to be in flux, and will continue to change as the program proceeds. It is anticipated, however, that the pace of reduction in malaria cases will slow and stabilize temporarily as the program enters a period of low morbidity and mortality.

On the other hand, we could notice more need of ACT due to the refractory nature of the sources of transmission remaining with possible outbreak of new cases.

Thus, based on the most recent annual case rates, the current need for ACTs continuing to decrease in case rates that are expected in the years to follow. It will be prudent to include an extra percentage as safety margin in order to allow for conditions that lead to a greater number of cases than expected. Because ACTs can have a limited shelf-life, care must be taken not to overestimate the product be ordered.

A shift in strategy will occur, however, after universal coverage of LLINs is obtained, that may temporarily increase the need for ACTs in certain locations dramatically, despite the continued reduction of malaria case rates. Mass, presumptive ACT treatment, designed to assist the elimination of malaria will involve treatment of entire communities where malaria transmission has been detected by surveillance. Thus, there will be a time when both routine treatment of actual malaria cases will be consuming ACTs, and a less predictable quantity will be consumed concurrently through emergency actions triggered by specific surveillance observations.

The need of ACT was covered by R7 funding, the current proposal will covered and sustain the gap from 2014.

LLINs (universal coverage)

Universal coverage with LLINs for all residents of STP will continue to be necessary for the duration of the malaria control program, in order to ensure that a basic level of protection is available to all residents of STP, whether or not universal IRS is being performed. Since malaria elimination requires intensive anti-vector measures, the plan is to distribute about 3 nets per household. This universal coverage, once achieved, and with a replacement cycle of every few years, will be sustained until it can be verified that the elimination of malaria has occurred.

The National Strategic Plan, does not yet consider what the policy regarding LLINs should be once the elimination of malaria transmission is achieved, although it may be prudent to continue coverage for several years afterward, at least. Coverage and Use of LLINs Rate in STP now exceeds respectively 60%

and 50%, thus a program of scaling up will continue for the near future (and this is planed in R7). The objective in this R7 is to reach 100% of LLIN coverage. The current proposal has in view to hold this coverage from 2014. To do this, a particular attention will be given to BCC, to change the behaviour for a maximum use of LLIN. The effectiveness of the insecticide used in LLIN will be evaluated, and the entomologic study will be carried out for vector vigilance. The bed net will be distributed through campaign, with continue distribution in through reproductive health program.

IRS (Universal Coverage)
The annual, universal IRS program currently underway provides this service for all households on STP, under the supervision and funding of a bilateral donor (ICDF, Taiwan). The National Strategic Plan recognizes the necessity of continuing this universal IRS coverage through 2009, regardless of whether the present donor maintains their current arrangement, until universal LLIN coverage is attained. After LLIN coverage becomes universal (with >90% utilization), however, a shift in IRS strategy is recommended in which capacity and operations will be decentralized to the district level, and spraying will no longer be provided in regular cycles on a calendar basis, but as an emergency action in response to specific, focal surveillance indicators provided by a program of intensified and integrated clinical and entomological surveillance.

Although, it is not possible to predict precisely what the programmatic needs of a rapid response, surveillance-triggered IRS program are likely to be, the round 7 funding makes assumptions that allow for sufficient coverage for most realistic contingencies. The long, stable shelf life of residual insecticides poses no penalty for overestimation of such needs and the extended storage that may result. This proposal plans to extend this action beyond 2014 in continuation of R7.

The passing (passage) to focalized pulverization will be implemented afterwards the evaluation of entomological and epidemiological indicators for becoming focalized from the nest to the potential epidemic.

Epidemiological Surveillance (Precocious detection, recognition and rapid response to the epidemic)

The drastic diminution of malaria cases makes the country vulnerable to malaria epidemics, because of the immunity decrease. Considering the particularly dangerous characteristics of malaria, a planning of anti-malarial program implementation must be inserted within an epidemiological analysis and within the realization of appropriated interventions, in accordance to the country real situation

The retrospective analysis of data (epidemiological, entomological, environmental, climatological, geographical, and demographical) in collaboration with national institutions's support, will permit to identify factors of risk and vulnerability of malaria epidemics and also determine the indicators of risk to be followed, and establish maps of areas with malaria epidemics risk. It will be settled a collaboration between health department and other sectors (meteorology, environment, geography, agriculture, fishery, cattle raising, National Statistics Institute and demography) in order to ensure the monitoring of epidemics risk indicators.

For epidemics prevention, an important attention will be given to the routine anti-malarial activities inside areas of epidemics risk: keep high coverage of LLINs, active research of cases, focalized IRS within the transmission foci identified, social mobilization (BCC) and diagnosis of all cases detected during the research, etc.

Transversal activities : In completion to this four main axles of combat against the disease within the elimination purpose, there will be an effort in human resource and institutional strengthening, the development of the monitoring & evaluation system, drugs supply management system as well as the operational research and communication in order to sustain the key interventions.

4.3. Population and Epidemiological Background to proposal

4.3.1 Geographic reach of this proposal

4 Program Description

Will activities be implemented: (*'check' one box only*)		
☒ across the whole country	☐ in specific Region(s) *If so, insert a map immediately below this table to show where*	☐ with a focus on specific population groups but not country wide *If so, insert a map immediately belowto show where these groups are if they are in a specific area of the country*

Paste map here if relevant

4.3.2 Size of population group(s) covered by this proposal

Population Groups *(if different age groups apply for your country, change the age groupings below.)*	**Population Size**	**Source of Data**	**Year of Estimate**
Total population (all ages)	160820	INE National Population projection 2002 - 2009	2009
Women > 25 years	29293	INE National Population projection 2002	2009
Women 19 – 24 years	7922	INE National Population projection 2002	2009
Women 15 – 18 years	9687	INE National Population projection 2002	2009
Men > 25 years	26168	INE National Population projection 2002	2009
Men 19 – 24 years	7771	INE National Population projection 2002	2009
Man 15 - 18 years	9760	INE National Population projection 2002	2009
Girls 6 - 14 years	22598	INE National Population projection 2002	2009
Boys 6 - 14 years	23036	INE National Population projection 2002	2009
Girls 0 – 5 years	12292	INE National Population projection 2002	2009
Boys 0 – 5 years	12293	INE National Population projection 2002	2009
Other ** : *(HIV and Tuberculosis proposals. For malaria proposals, divide age groupings < 5 years, and 6 – 14 years)*			***Use "Tab" key to add extra rows if needed***

4 Program Description

4.3.3 Epidemiology of population group(s) covered by this proposal

(Data notified by the program in 2009)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with the disease *(all ages)*	5407	Epidemiological Report CNE	2009
Number of uncomplicated cases, children under 5 years old	712	Epidemiological Report CNE	2009
Number of severe cases, children under 5 years old	615	Epidemiological Report CNE	2009
Number of uncomplicated cases,people over 5 years old	3114	Epidemiological Report CNE	2009
Number of severe cases, people over 5 years old	823	Epidemiological Report CNE	2009
Number of uncomplicated cases in pregnant women	67	Epidemiological Report CNE	2009
Number of severe cases in Pregnant women	76	Epidemiological Report CNE	2009

4.4. Major ongoing weaknesses and gaps that affect outcomes

4.4.1 National disease program

Describe:

- the main weaknesses of the current disease program and how these weaknesses affect achievement of planned national program outcomes;
- existing gaps in the delivery of services to target populations; and
- main weaknesses of and/or gaps in the health system that affect disease program outcomes.

If the implementation of the program since 2005 has shown good results relating to hit the target (that contributed to the impact) as revealed by the evaluation of 2007, some gaps are still remaining mainly related to **The use of LLIN** comparing to the planning prevision. In fact, the LLIN coverage in children under 5 years old has just reached 61,3% instead of expected 65%, for pregnant women it has just reached 61,1% instead of expected target of 67%. However some weaknesses were noticed during the implémentation of the programme between 2005 and 2009. These weaknesses are summarized below :

- ***Malaria diagnosis QA and QC***: There exists a malaria diagnosis quality assurance system. Samples of slides from districts are taken and examined. However districts do not always send the sample slides for quality assurance. Consequently, the NMCP currently undertake direct active case search when they visit the districts for supervision and take blood samples from fever cases.

- ***Quality of laboratory staff***: Diagnostic technicians are not performing optimally. One study based on active surveillance showed that the sensitivity of blood films (microscopy) was only 45% when compared with PCR findings, implying a false negative rate of 55%. This may indicate a skills gap

among laboratory technicians.

- ***TPI***: STP adopted an IPTp policy and included this in treatment guidelines. All the 7 districts of STP are implementing IPTp. There is however no data to estimate the IPTp1, 2 and 3 coverage. However, the coverage is said to be high among those who attend ante-natal care.
- ***Pharmaco*-vigilance:** PV system designed, reporting forms available in all health units and pharmacies. Only one district knew that a PV system was in existence in the country and none had sent any report to the national level. This is however understandable since the reporting system is from the health facilities to the national level. However no reports have been received at the national level**.**
- **Drugs supply and pharmaceutical products managing system.**
- **Weakness on the institutional capacity of the anti-malarial coordinating sector in STP (CNE/PNLP)**

The current proposal claims not only to strengthen the R4 experience (and considering the planning done in R7), but also to make development specially about training in drugs supply and anti-malarial products management for health personnels, organization of a supply monitoring system , purchase system, correct transportation and storage, and quality control of supply (drugs and long lasting insecticide net), including materials and other anti-malarial products.

4.4.2 Health system

(a) Describe the main weaknesses of and/or gaps in the health system that affect outcomes for the disease.
The description should, in addition to explaining health system issues that impact outcomes for this disease, also include a discussion of issues that impact outcomes for other diseases where the weaknesses/gaps are common.

Weaknesses

Policy
Standard case definitions for most of the priority infectious diseases, particularly malaria, are not well defined or applied throughout the health system. Correction of this deficiency will be critical for the success of the malaria elimination program because the current situation will lead to inconsistencies in the patterns of reporting and treatment between facilities.

Human ressources
There are weaknesses with the quality, quantity and distribution of human resource and health service logistics capacity at all levels of the health system. Because of this, some locations and facilities are unable to operate at an adequate level of efficiency. Generally, health system remains weak in terms of staffing, training (initial and refresher), the availability of adequate facilities and equipment, financial resources and community participation. Inadequate availability and capacity of technical specialists to support the health system. There are not enough skilled and qualified epidemiologists, statisticians, entomologists and entomology technicians at all levels of the health system. Moreover, there is no refreshing training in certain critical fields, including epidemiology or Health Information Systems.

Mangement Capacity

There is a lack of management capacity at certain levels of the health system in the areas of planning, supervision and financial management that has affected the progress of scaling-up of malaria control efforts, including the procurement and distribution of LLINs. Planners and supervisors lack skills in data analysis and the interpretation and use of information for management decision making, which provides an obstacle in the deployment and effective utilization of an integrated Health Information System.

There are also deficiencies in communications, coordination and organinal capacity with regard to integrating malaria activities between different sectors, which has adversely affected collaborations within partners and other stakeholders.

Community leaders are not engaged as much as would be desirable in local level planning, implementation and evaluation.

Surveillance
The disease surveillance system and information system are currently very inefficient and inconsistent. Delays in the transfer of the small amount of information currently being collected prevent the use of surveillance information for responding to emergency situations at the district level. There problems are party due to the lack of consistent reporting protocols and formats for conveying health surveillance information.

Community-based activities
There is no ongoing community-based malaria control interventions and the capacity of NGOs and civil society associations still remains weak for following these activities. There is no documentation of best practices due to lack of skills.

Essential health and supply technologies
In addition, some of the central and district health systems are not equipped with the necessary equipment such as computers and basic standardized office equipment and facilities which could facilitate the timely detection and communication of disease threat and efficient monitoring of programme interventions. Low quality laboratory services still pervade the health systems hospitals and district health centers where the necessary training, equipment, supplies and facilties are not always available.

There remains a lack of some of the necessary entomological facilities to support some of the basic operational research required to support the decision-making and function of the interventions programs. In particular, the lack of an insectary and a molecular laboratory limit the extent in which operational research can be employed, resulting in deficiencies in evidence-based formulation and evaluation of interventions, lack of adequate quality assurance for intervention methodology, no early detection of genetic resistance, and no ability to determine the origin of outbreaks by genetic typing of parasites. These functions will be particularly critical for achieving the goal of elimination.

Communications between national, district and local health system levels are extremely limited and inefficient. Many health facilities lack basic functional communication equipments such as telephone, fax e-mail, or internet, nor do they have the financial and human resources to acquire, maintain or utilize them.

This situation is also similar for the supply system of drug and pharmaceutical products that is considerably weak in all level of health system.

Emegency response
District and central level health services lack the personnel and means of transportation in order to arrive quickly to the site of focal outbreaks or epidemics in order to conduct timely investigations or responses. No dedicated system exists to support such emergency efforts. The availability and accessability of transportation varies greatly by location and is not always dependable.

(b) Describe what is already being done, and by whom [not what is planned in this proposal], to respond to health system weaknesses and gaps that affect outcomes for this disease.

Contribution of the Government to address the HS weakness
One of the main stated priorities of the Ministry of Health has been to develop the resources and strategies necessary to strengthen the overall health system including improvement of human resources, training, facilities and equipment. The national health policy has identified health system strengthening as a major initiative that will be given particular attention.

Meanwhile, a certain number of trainings have started among the stuff of Ministry of Health, mainly in relation to laboratory and pharmacy. Since 2000, it has been start out specializations of nurses, with

collaboration of country external partners. Even doctors and other health technicians are included.

GF's Contribution to address the HS weakness (R4 & R7)

Some capacity has been restored through the actions of the 4th Round GFATM project, but many inconsistencies and deficiencies remain. A malaria elimination programme will require a strong surveillance system supported by high quality laboratory services in order to provide a precise diagnosis of malarial illness so that timely responses can be deployed appropriately.

With these two Rounds, a reinforcement of capacity of superior stuff has been made, by recruiting an epidemiologist, a statistician, an entomologist and middle staff, in order to ameliorate data collection.

Several trainings have also been realized between 2005 and 2007 (Malariology and Management). Concerning to refreshing training, districts and central hospital personnels have been retrained in cases management, inside these grants.

Between 2009 and 2010, training in epidemiological vigilance and adequate response has joined more then 80 district agents. Equaly an initiation to entomology has been organized among the district personnels.

During the same period, a series of formative supervisons was also carried out by Central level and districts, in order to ameliorate the quality of interventions.

Concerning to the reinforcement of managing capacity, the GF's contribution permitted to train Sub-recipients and PNLP in management and in GF grants' procedure.

Others's partners Contribution to address the HS weakness (R4 & R7)

The contribution of other partners permitted among others:

- To develop the capacity of health agents in malaria data-base management (WHO), Anti-malarial programs management (WHO), in BCC (Brazil and USAID), in Leadership (GMS);
- To develop the capacity of epidemiological vigilance implementation: Tele-surveillance (GPS, sending of online data) (Brazil and GF/PNUD);
- To improve the condition of the logistic and equipments (vehicles, computers, motorcycles) for actions of pulverization and adequate response (WB, FG/PNDUD, USAID, Taïwan, Brazil).

4 Program Description

4.5. Main program areas of this proposal

4.5.1 *Continuing interventions (including expanding and scaling-up program coverage)*

Complete the tables below for three to six areas identified as the main program priorities for this proposal. Ensure that the choice of priorities is consistent with the current epidemiology and identified program gaps. ***Note****: activities that target health systems weaknesses that are specific only to this disease should be included as disease specific program areas (and described in s.4.6.4). However, if the activities respond to health systems weaknesses on a cross-disease basis (e.g., HIV, tuberculosis and malaria), and are not easily included in the disease specific description, they can be included in the optional s.4B for HSS cross-cutting interventions (and are not therefore also listed in the tables below).*

➔ *Refer to the* ***Guidelines for Proposals*** *for more detailed information on the choice between including interventions as 'disease specific responses' and 'cross-cutting responses*.

Priority No. 1 – continuing / Mise à Echelle, Changement de Cible	**Actual**		**Targeted**								
Indicator name Management of malaria cases (Treatment)	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
A : Country target *(from annual plans where these exist)* Population at risk (All age) with uncomplicated malaria correctly managed at health facilities	9166	3306	2696	5407	2900	2378	1950	1599	1439	1295	1217
B : Extent of need already planned to be met through existing or known future funding (R4, R7) *(This figure* ***must include*** *all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*	9166	3306	2696	5407	2900	2378	1950	1599	0	0	0
C: Expected annual gap in achieving plans	0	0	0	0	0	0	0	0	1439	1295	1217
D : Extent of need covered by	*(i.e., can be equal to or less than full gap))*		0	0	0	0	0	0	1439	1295	1217

4 Program Description

this proposal										

Priority No. 2 – continuing / Mise à Echelle, Changement de Cible)	**Actual**		**Targeted**								
Indicator name Coverage of ITNs	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
A : Country target Number of LLIN	17437	22814	30153	37603	30000	100236	5012	5012	106371	5319	5319
B : Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*	17437	22814	30153	37603	30000	100236	5012	5012	0	0	0
C : Expected annual gap in achieving plans				0	0	0	0	0	106371	5319	5319
D : Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*			0	0	0	0	0	106371	5319	5319

4.5.2 ***New interventions/scope change of the expiring grant – that are in line with the broader package of interventions to which the expiring grant was contributing.***

Priority No. 1 – new/scope change	**Actual**		**Targeted**								
Indicator name: Focus IRS	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
A : Country target Number of targethouseholds provided with IRS	33941	34634	35341	36062	36783	37519	38269	39035	39815	40612	41424
B : Extent of need already planned to be		34633,9448	35340,76	36062	36783	37519	38269	39035	0	0	0

4 Program Description

met **through existing or known future funding** *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*											
C : Expected annual gap in achieving plans		0	0	0	0	0	0	0	39815	40612	41424
D : Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*			0	0	0	0	0	39815	40612	41424

Priority No. 1 – continuing / Mise à Echelle, Changement de Cible	**Actual**		**Targeted**								
Indicator name Renforcement de la Surveillance épidémiologique, du Monitoring et de l'Evaluation	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
A : Country target *(from annual plans where these exist)* Nombre de cas détectés lors des épidémies de paludisme dans les deux semaines qui suivent leur éclosion	1833	661	539	1081	580	476	390	320	288	259	243
B : Extent of need already planned to be met through existing or known future funding (R4, R7)	1833	661	539	1081	580	476	390	0	0	0	0

4 Program Description

*(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*											
C: Expected annual gap in achieving plans	0	0	0	0	0	0	0	320	288	259	243
D : Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap))*			0	0	0	0	320	288	259	243

4 Program Description

Note to applicants:
The tables in s.4.5.1 (continuing interventions/scale-up) and s.4.5.2 (new interventions/scope change) highlight the main priorities. These priorities and all other activities should be very clearly described in the questions in s.4.6 below to ensure that the Technical Review Panel has a clear understanding of the planned work, and outcomes, over the proposal term.
➔ ***Read the Guidelines for Proposals for more assistance.***

4.6 Analysis of priorities for Rolling Continuation Channel proposal

Scope and Scale Considerations

4.6.1 Continuation of Expiring Grant's strategy	
(a) Does this proposal continue the same objectives, same service delivery areas, and same focus and range of interventions as the expiring grant without any changes to program **scale** (i.e., no substantial increase in coverage) or **scope** (e.g., increasing the population groups covered, or the range of services offered?	☐ Yes ➔ *answer (b) below and then go to section 4.6.4* ☒ Non ➔ *go to section 4.6.2*
(b) If yes: • Describe the **strengths** of the expiring grant that have facilitated successful implementation and strong grant performance to date. Summarize how the strategy of this proposal continues and builds upon these key strengths; and • Explain why continuation of the original proposal's implementation strategy and scale of activities is the most effective approach to achieve sustained disease specific health outcomes and impact consistent with the national plan.	

4.6.2 Program <u>scale</u> adjustments in this proposal	
(a) Does this proposal include a significant planned scale adjustment (whether a <u>scale up</u> by substantially increasing coverage for existing interventions, or, if relevant to the current disease profile, a reduction in interventions) compared to the expiring grant's planned focus and outcomes?	☒ Yes ➔ *answer question (b) below* ☐ No ➔ *go to section 4.6.3*
(b) **If yes to (a)**, summarize the planned **scale** adjustments, and why this change will create more effective and sustained strategies for greater health outcomes and impact.	
The expiring grant was focused only in children under 5 years old and pregnant women. The objective was to reach a rate of utilization over 90% within this vulnerable group. The current proposal aims to reach universal coverage of LLINs, ACT and IRS. Also the two ancient interventions have been subjected to the target changing, moving from children under 5 years old and pregnant women to entire population. LLINs interventions that did not exist in expiring R4, is now include in the second phase of this proposal (the 3 latest years) because of occurring the changing of country epidemiological profile and also because this intervention has been considered in R7 that covers the three initial years of present proposal (2011-2013). Considering the current decreased level of morbidity and mortality, this intervention ought to contribute for reinforcing and keeping the experience of fighting towards malaria elimination in STP. The situation is similar relating to the epidemiological vigilance that results from the decrease of cases which cases became rare and surveillance became indispensable.	

4 Program Description

The transversal activities planed in this proposal have the objective of sustaining the implementation of main interventions and consequently to strengthen the program impact.
It's about:

- Strengthening of the stockage management system;
- Capacity development of associations or groups involved in the implementations of activities;
- Human source strengthening
- Coordination and partnership development;
- Program managing reinforcement
- Behavior Changing Communication;
- Technical assistance.

4.6.3 Program scope change planned in this proposal	
(a) Does this proposal include a proposed change in **scope** as compared to the expiring grant's scope? (e.g., by adding new population groups, or incorporating, as a hypothetical example, treatment to complement prevention services under the expiring grant)	☐ Yes ➔ *answer question (b) below* ☒ No ➔ *go to section 4.6.4*
(b) **If yes to (a)**, summarize the planned scope change and why this change will improve the national response *to the disease, for greater health outcomes and impact.*	
N.A	

4.6.4 Detailed description of activities relevant to scale and scope changes

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

Where there are planned activities that benefit the health system, yet predominantly contribute to outcomes for the disease that is the subject of this proposal, these activities should be included in this description (and not in the optional additional s.4B that applies to cross-cutting health systems strengthening interventions).

Goal : To reduce the burden of malaria in Sao Tome and Principe by reducing morbidity and mortality, toward the elimination

Objectifs :

1. Objective 1 : To attain a coverage of 100% in malaria prevention measures
2. Objective 2 : To ensure correct management of, at least, 90% of malaria cases detected in health facilities and communities, according to the national therapeutically protocol in force
3. Objective 3 : To strengthen the monitoring & evaluation system, the epidemiological surveillance and operational research
4. Objective 4 : To improve the program management capacity and partnership coordination
    - Develop the national capacity to in order to implement anti-malarial activities
    - Develop the communication for the changing of the community behavior
    - To reinforce the supply management of pharmaceutical and medical products
    - To strengthen health system through an institutional support and human **resource reinforcement**

Activities description

4 Program Description

Objectif 1 : To attain a coverage of 100% in malaria prevention measures

SDA 1.1: IRS (Assurer une couverture annuelle d'au moins 85% des ménages avec la Pulvérisation intradomiciliare de 2011 à 2016).

The reach of 100% coverage of IRS is the objesctiv e of the anti-malarial program. It has been carried out thanks to the Taiwan government and it´s also considered in Round 7. This current proposal has in view to carry out annually an IRS from 2014 (2011 to 2013 is covered by the GF R7) in households at the national level. Focus IRS will be also done where unexpected increase of cases are detected.

The detected cases will be treated as described in objective nº 2.

This activity occurred in STP since 2005 after two years of pilot phase within three districts of the country. Up to now, countrywide IRS has been carried out 4 times with an average around 80% people covered in each round of IRS.

So far, **Alpha-Cypermethrine (Pyrethroides)** has been used. It is planed in this proposal to make the changing of the insecticide in order to avoid/retard the appearance of vector resistance. **Bendiocarbe** (Carbamate) will be used from 2011 alternatively (rotation) with **Pyrethroides**. From 2011 to 2013, the IRS needs will be covered by Round 7 that will be replaced by the RCC from 2014.

The implementation of IRS at country level is made by an NGO from civil society that involves the communities among which spray agents are selected under the supervision of CNE.

Regarding focalized indoor residual spray (in response to an epidemic), it will be at responsibility of district rapid intervention teams that imply community spray agents and local committees.

The activities consist of the acquisition of complementary spray materials and also the evaluation of insecticide effectiveness. It´s necessary to strengthen the human resource capacity by training for the sprayers and entomology technicians, what will be done.

SDA 1.2 : Long Lasting Insecticide Nets (LLIN) : (To ensure a coverage of at least 100% of households with a minimum of 3 LLIN, from 2011 to 2016, in order to attain an use rate of at least 85%).

In the perspective of malaria elimination in STP, it´s important to keep the LLIN coverage at 100%. The GF R7 plans to reach 100% of LLIN coverage between 2011 and 2013 and the current proposal aim to maintain this coverage until 2016. So it´s planed to acquire the bednets from 2014.

These bednets will be distributed and installed in accordance with the experience of NGO Red Cross carried out in three districts (10,000 nets) that the evaluation has shown a better use of distributed nets.

It will be also planed to substitute damaged nets through health facilities during CPN and CPS.Women whose benets are damaged, are advised to sign them during the visites. The team will go their home to chek and replace them.

But, whenever an epidemic response is implemented, the distribution and installation of LLIN will also be carried out in the target households, if necessary, at the same time with focalized IRS.

Here, however, the activities point to the acquisition and distribution of LLIN. However, the studies for evaluating the effectiveness of the insecticide used to impregnate the bednets will be regularly carried out.

Operational approaches

Distribution and installation of bednets from house to house;

- **National Health Service:** -This structure will carry out the continuing distribution of LLINs through Reproductive Health Program, by means of antenatal consultations. The beneficiaries will have information on how to install and use it..

- **Community**: - In agricultural and fishing zones, NGO Zatona ADIL will be responsible for distribution, installation and monitoring process (campaign in every 3 years). The distribution and installation will be carried out by agricultural and fishing NGOs as following:

    - For agricultural zones, NGO FENAPA will be hired for distribution and installation with help of local agricultural associations;
    - For fishing zones, NGO GIEPA will be hired for distribution and installation with help of local associations of saleswomen and fishermen;
    - NGO Red Cross will be hired for carrying out distribution and installation in urbane and surrounding non-fishing zones;

Activities related to this intervention aim to:

1. Procurement , stockage LLINs
2. Pre-campaign registration (census) (2011 and 2014)
3. Distribution by 2011 campaign (Covered by R7) and 2014 (RCC)
4. Plan for monitoring LLINS use (2011 and 2014)
5. Post-campaign evaluation(Organization and Evolution) (2011 and 2014)
6. Continuing distribution and replacement through the health services (2011 to 2016)

Objective 2 : To ensure correct management of at least 90% of malaria cases detected in health facilities and communities, in accordance with the national therapeutical protocol in force

The case management is based in cases detection and correct treatment within 24 hours, with the combination Artesunate+Amodiaquine (the first line drug). The health care workers will be trained in the correct diagnosis and cases management to taking into account the current low malaria prevalence. In fact, in this elimination context with low prevalence, a training/retraining is really capital.

SDA 2.1: Diagnostic (To strengthen the quality of malaria diagnosis in communities and healths facilities to 95% until 2016)

According to the therapeutical protocol and the surveillance guideline, all malaria suspected cases must be biologically confirmed (RDT or Microscopes). Notably, 90% of health facility equipped with a laboratory facilities have a functioning microscope diagnosis system. But the all health facilities use RDT, although the these without laboratory facility use only RDT.

The 2009 data reveal an RDT use rate around 60% of diagnosed cases and 40% of microscope use.

As soon as a case is detected (confirmed), a district team will go make test (RDT) to all the family members of such patient. The positive cases is confirmed by the microscope and treated. In 2009, 80% of detected cases as provoked an active research of cases around the family members.

In case of an exceptional increasing of malaria cases in a focal area or an urgent situation, an active search with RDT will be carried out to find out all the positive cases in the area and give the prompt treatment. This strategy has been already considered in GF R7. The current proposal has in view to keep

the high coverage of correct management of cases (over 95%) until 2016.

The supply of the RDT will be according to the consumption. The active search will increase the number of cases to be detected in a first time. But, with the treatment and prevention measures, the number will decrease. The different stocks will be settled for previewing the urgent measures or the appearing of the epidemic.

All positive RDTs are confirmed by microscope. A quality control is after carried out on 100% of positive slides.

It is previewed from 2011 to carry out quality control of 5% of negative RDTs.

SDA 2.2: Treatment (To strengthen the quality of correct malaria cases treatment in communities and health facilities to 95% until 2016)

Over 90% of malaria cases are treated in public health facilities. However, rests of cases are treated in community health posts, private and non-official clinics and by some isolated health professionals and traditional Medicine. The involvement of these partners´ actions in constructive malaria behavior changing promotion is an important element for bringing about accurate cases management and also will contribute for the reduction of morbidity and mortality caused by malaria as well as it will permit to obtain the real country epidemiological data.

The national case management guidelines have been upgraded in 2009, for a better definition of malaria case. It's planed to keep re-updating this guidance in 2013 in the function of cases evolution.

The uncomplicated cases will be treated by the combination Artesunate+Amodiaquine as the first line. It will be established a stockage of anti-malarial Coatem (second line drug) for cases of therapeutic failure, and also quinine for severe cases treatment.

The severe cases will be treated by quinine in the health facilities. The IPT for pregnant women is considered by the UNFPA and Round 7 in a period of 2011 to 2013. It´s expected to keep this present low prevalence until 2013, so it´s probably that the strategy prevention by ITP for pregnant women won´t be no longer necessary.

The quantity of ACT and quinine to be purchased will be in accordance with the consumption and will follow the distribution circuit of essential drugs, by FNM.

The acquisition of ACT will be realized by PR (PNUD) as long as quinine and its associates will be supplied by the government through FNM.

Operational approaches:

Within this plan, actions will be carried out with permanent participation of several partners (communities, NGOs, extra-health departments and others). Among these actions we emphasize the followings:

- To reactivate and rehabilitate communities health centers and train community health workers in malaria cases management:
  - Little rehabilitations (21 centers) ;

- To upgrade the Term of reference for community health centers.
- To train the agents in cases managements and preventive measures promotion (165 CHW x 5 days x 3 years/times). This training will be carried out alternately every other year, during the six years;

- To organize private sector (private clinics, some isolated health professionals and traditional Medicine's practitioners).
- To carry out training in cases management and in epidemiological data collection and furnishing, at district level, and share them with central program:

- **Private clinics (12 unities)**: Despites the training, they will be provided with 1st line drugs and RDT in order to perform an accurate management of cases. In the epidemiological vigilance chain, private clinics play the role of data deliverer place.
- **Isolated health professionals** [(their services are not inside the national/official health service) 9 people x5 days of training x 3 years/times]
- **Traditional medicine's practitioners** (35 people x 5 days x 3 years). They will be prepared for malaria signs and symptoms recognition and also for providing due guidance to the closest health posts as well as to promote the use of preventive measures.

- NGOs will be intermediaries, in association with health districts teams, for mobilizing the traditional medicine's practitioners and CHW by organizing training of trainers and cascade trainings in their jurisdictional areas.

Note: (i) The training of official health professionals and private clinics professionals will be carried out by ICSVSM

- All the actions herein described will be supervised by CNE/PNLP from the planning up to the training conclusion.
- All health professionals regarding cases management and preventive measures promotion will be equally trained (250-Y3;250-Y4 ;500-Y6)
- Medical and pharmaceutical products, not planed in R7 or by any other partners, will be purchased for this intervention.

Objectif 3 : To strengthen the monitoring & evaluation system, the epidemiological surveillance and operational research

- **SDA 3.1 : Diagnosis (Active search of cases and epidemic investigation)**

In the perspective of reaching the elimination of malaria, the activities implementation will bring the decreasing of malaria prevalence. This will require a good case report system. The R7 preview a mapping of villages through a GPS system. This system allows localizing the origin of case. Whenever an abnormal number of case is detected and confirmed, a district team will go down the village for an active search.

Residents of localities with provenience of positive cases will be tested by RDT and all positive cases will be confirmed by microscope. The confirmed cases will be registered and managed. However, it's important to note that 5% of positive and negative RDT will be submitted to quality control in order to monitor their effectiveness.

Each detected case will be treated in accordance with the country therapeutical protocol in force combined with prevention measures, mainly IRS and installation of a bednet, in order to interrupt the

transmission.

The packet of intervention will be implemented with the relief of local committees and CHW that will reinforce the capacity of district teams. These committees will take charge essentially of BCC/Social mobilization.

The activities planed for this intervention is the procurement and the availability of a stock at each district level for management of case detected actively (RDT, Microscope materials, ACT, LLINs, Insecticides) the needed logistic (Carburant and IRS materials).

- **SDA 3.2 : Epidemiological surveillance**

The implementation of WHO Regional Strategy for integrated surveillance of potential epidemics diseases is ongoing and already producing weekly data of mortality and morbidity by potential epidemics diseases, including malaria.

On the purpose of facilitate the analysis of data for precocious detection of malaria epidemics, the epidemic thresholds are already determined by the district in Round 7.

With regard to health facilities, a data retrospective analysis of malaria morbidity and mortality will be carried out and will permit to determinate a epidemic threshold that will be used in health facilities for detecting all abnormal situations.

Once that the case reporting system at health facilities' level not always give enough time for preparing appropriated response, a precocious alert system will be employed, based on the risk factors surveillance and malaria transmission vulnerability vigilance.

Data retrospective analysis (epidemiological, entomological, environmental, climatologically, geographical, demographical) with support of national institutions will permit to identify the risk factors, malaria epidemic vulnerability and determine the indicator of risk to be followed and elaborate map of areas at risk of malaria epidemic.

For the monitoring of epidemic risk indicators, a collaboration will be settled between health department and other national sectors (meteorology, environment, agriculture, fishery and cattle breeding, national geographical institute, national statistic and demographical institute, etc)

For epidemics prevention, a special attention will be given to anti-malaria routine activities inside the areas of malaria epidemic risk: keep high coverage of LLINs, Intermittent preventive treatment (IPT) for pregnant women, active research, focalized IRS in transmission identified foci, social mobilization (BCC), management of diagnosed cases and all other cases detected during the researches, etc)

A previous preparation for response is indispensable and will ensure a rapid implementation of appropriated measures of response to malaria detected epidemics. This preparation that takes into account the existing or planed structures, including health posts and/or private structures, will comprise the elaboration of guidelines (epidemics alert investigation guidelines), training pattern, community sensitization materials and also material for health agents.

The organization at all levels (central, district and community) of multidisciplinary committees of malaria epidemic combat, rapid intervention teams, the restocking of urgency drugs, RDT, laboratory reagents, equipments of insecticide spray, LLIN, etc,- will make part of this preparation.

Epidemiological surveillance signifies also the human source strengthening. This reinforcement will affect firstly the communities for case detection, community organization and health agents. The reinforcement of these agents will be made by training which contents include: risk factor surveillance, case definition, use of epidemiological data collection instruments, analysis and interpretation of these data.

The human source strengthening will after comprise the members of local committees. This training will be axed on the coordination and evaluation of the interventions.

Laboratory technicians of health district with malaria transmission focus and malaria epidemic risk will be trained by CNE/PNLP in microscope and use of RDT.

CNE/PLNP will carry out training for rapid intervention teams about case management, anti-vectorial fight, BCC and evaluation of interventions. Rapid intervention teams will be constituted by health professionals, entomologists, sprayer teams, teams for BCC/social mobilization, etc.
This way, a particular attention will be given to the coordination of response activities that is constituted by:

- Case management;
- IRS (intra-domiciliary and surrounding HH);
- Installation of LLINs;
- Surveillance reinforcement;
- Monitoring of epidemic evolution and needs,
- Social mobilization,
- Mobilization of resources, etc.

A MIS (Malaria Indicator Survey) will be done in 2011 and 2014 (2011 is covered by R7) in order to now and follow the situation regarding toward the ultimate aim of malaria elimination. The parasitaemic test also will be done, following the international standard, through the institution with experience on the MIS in Africa.

- **SDA 3.3 : Entomological surveillance**

The organization of sentinel sites for the entomological surveillance, the data collection and the organization of an entomology laboratory are taken into account in R7. These measures of entomological surveillance are important in this context of elimination. They will allow surveying the transmission and the anti-vectorial measures impact.

The current proposal previews to strengthen the entomological activities by training and reinforcement of human resource able to carry out the entomologic monitoring. It previews also the strengthening of the insectariums, the monitoring of the vector insecticide sensitivity. An entomologic surveillance plan must be elaborated.

Thise entomological activities are important in the malaria elimination context. The surveillance will also care about the vector insecticide resistance for bednets (LLIN) as well as the IRS resistance.

- **SDA 3.4 : Surveillance of drugs resistance**

The effectiveness of the 1st and 2nd line drugs must be evaluated to reassure their effectiveness in uncomplicated cases treatment and also to check the impact in the diminution of parasite reservoir. This is capital in the context of malaria elimination process.

This activity is carried out among the positive patients. Clinical and parasitological follow up is carried out until day 14 all over the country, except Principe where the follow up is carried out at day 28.

This activity is realized by district teams that is constituted, among others, by at least one laboratory technician and one nurse (or male nurse)

Objectif 4 : To strengthen program management capacity and partnership coordination

SDA 4.1: Supply Management (To reinforce the supply management of pharmaceutical and medical products)

The supply system and pharmaceutical products management was identified as a weakness during the R4 implementation. The current RCC proposes to strengthen this key sector in this matter that in this malaria elimination context, all the stock rupture in anti-malarial products can be catastrophic. Also it previews the elaboration and dissemination of the procedure manual of stock management and

distribution of pharmaceutical products.

The reinforcement in human resources and institutional of this sector is planed. Moreover, it´s preview to assess the current situation and install the pharmaceutical regulatory authority. The quality control will be ensured and the pharmacovigilance system will be strengthened.

The activities planed for this intervention are the followings:

- Elaboration of guideline (handbook) for stock management procedure and distrbution (FNM, CNE and Health District)
- Training of 96 pharmacy technicians in utilization of security equipment (utensils) against fire (5 days)
- Enlargement of storage capacity for bed nets
- Technical assistance for evaluating the organization and installation of the Pharmacy Regulatory Authority (1 month)
- Reinforcement of logistic and functioning capacity

SDA 4.2 BCC / Social Mobilization (Develop the communication for the changing of the community behavior)

It´s important, in this context of low prevalence of malaria cases to make the population participate in the measures of fight in order to optimize them. To do this, it´s necessary to carry out mass sensibilization campaign. The KAP survey is planed to check the perception, attitude and practice concerning to the means of malaria combat. These studies allow guiding the sensibilization campaign which will be carried out in schools, young and adult people groups, in churches. It´s planed to be made the reproduction of communication materials. The sensibilization will be also spread by media (Radio and TV).

Activities:

The main planned activities are the training of the media's Staff, The school teachers and The community health workers. The objective is to increase and keep the high coverage rate of the means of anti-malarial fight. The same campaign for the changing of the behavior will help to identify and localize positive malaria cases. The training and supervision of the district communication team will be carried out by the CNES in order to attain a good performance. The inter-personnel communication is planed.

1. Revision of communication strategy related malaria

a. To carry out KAP studies in communities (Year 1, 3 and 5)
b. International technical assistance (Three weeks) for supporting the strategy revision (year 1)
c. Atelier (5 days) for the adaptation of strategy into the new epidemiological context (year 1)

2. Implementation of the communication strategy

To involve and capacitate partners (Ministry of Education/schools, NGOs, Associations of saleswomen , fishermen and farmers, women associations and other formal organizations) in actions that cause positive behavior changing in anti-malarial fight.

Operational approach:

1. The Ministry of Education will be the responsible for training teachers and other educators and distribute anti-malarial sensitization materials in schools, kindergartens and nurseries, with technical assistance of National Program and National Health Education Center (CNES);

a. To carry out KAP studies of teachers and other educators in malaria prevention and case management (year 1)
b. To adapt the training pattern based on the survey's result (yeatr 1)
c. To train 500 teachers and educators in actions that promote positive behaviour changing related to malaria combat.(year 1 and 2)
d. To distribute materials for sensitization (year 1 to 5)
e. To organize interactive programs, in association with social communication organs (publics and privates) (radio and TV), using children - children methodology (4x7distritcts) x year (every years);
f. To carry out studies for evaluating the impact of interactive activities in schools (year 1 and 4);
g. To promote inter-schools musical and painting contests related to malaria.

1. FONG (National NGOs Federation) will be the responsible for training the trainers for NGOs and other associations so that they can autonomously carry out sensitization and mobilization actions about malaria, with technical assistance of National Program and National Health Education Center;

a. To adapt the mobilization and sensitization guidelines(year 1l)
b. To reproduce 1000 copies (year 1)
c. To train 20 trainers(year 1)
d. To train 500 activists (Associations of farmers, fishermen, saleswomen, women associations and other formal organizations (year 1 and 2)
e. To organize intercommunity contests with partnership of public private and community social communication organs (3 contests per quarter per district) (year 1 to 4)
f. To distribute sensitization materials and LLINs (year 1 to 6)
g. To monitor sensitization actions in communities (year 1 to 6)
h. To carry out studies for measuring the impact of interactive activities in the communities (year 1 to 4)

3- The National Health Education Center, with partnership of PNLP, will be the responsible for production of communication materials and activity supervisions. M&E is the responsibility of National Program.

a. To produce communication materials (year 4)
b. To produce 2000 T-shirts per year (year 4 to 6)
c. To produce 4 outdoors per year (year 4 to 6)
d. To reproduce and install in 7 districts 7 districts x 4 outdoors per (year 4 to 6)
e. To reproduce per year : 5000 posters, 10000 booklets (year 4 to 6)

SDA 4.3 Program management and Partnership Coordinating Development (Develop the national capacity for implementation of anti-malarial activities)

In this context of malaria elimination in STP, it´s crucial to have personnel in optimal quality and quantity. There is an urgent need to develop the performance of the human resources. The R4 previewed to organize, inside the health facilities, teams with capacity to deal with correct diagnosis and make effective prompt treatment. It´s also planed to have trained and qualified personnel for IRS, entomological and epidemiological surveillance and also with competence in bio-statistic.

The current proposition plans to strengthen the gain by recruiting international experts for technical support (especially epidemiology and entomology) from 2014 and also provide the participation into international conferences for exchanging experience to eliminate malaria.

There´s also a necessity to recruit a pharmacist (expert), pharmacovigilance, computing auxiliaries. A reinforcement of capacity in marketing, social mobilization, and BCC for changing the attitude is also planned.

It´s also needed to maintain the Global Fund Unit (PR) manager recruited by the support of the R7. At PR level, the training in management and in monitoring & evaluation is important. Further trainings will be carried out for entomology technicians, IRS technicians, communication for professional in favor of anti-malarial fight.

The institutional reinforcement goes in order to maintain the work tools in optimal performance. Therefore, this proposal preview to strengthen the CNE, the Global Fund´s unity (PR) and its sub recipients in computing issue, in administrative and financial management, in teams (center and district) motivation salary.

Activities:

A- Capacity development of new principal recipient

1- To realize an atelier (conference) with partners and principal recipients, for upgrading the objectives and aspirations of the transfer process related to capacity development, in 2010, through other grants;

2- To review current situation of CNE by evaluating its goods and services;
(i)- International and technical consultancy (for three weeks) for CD evaluation to be carried out in 2010, during the execution of financial bridge between the end of R4 and the beginning of RCC7;
- To formulate strategies of CD (Year 1);
- To elaborate and estimate (budget) a CNE capacity plan, according to the results (Year 1);
- To elaborate and estimate the M&E plan of CD strategies (Year 1);

3- To recruit a responsible for monitoring the CD plan.
4- To execute and monitor the CD plan [a certain value is preview (Year 2 and 3 and on word according to the CD plan design and evaluation)];
5- International technical assistance for annual evaluation of CD plan (2 weeks x 3 years) (activities 7 and 8).
- To make annual evaluation of CB plan (Year 1, 2 and 3);
- To readapt the CB plan in accordance with evaluation results;
- To elaborate and estimate the transfer plan (Year 1 and 2);
- To elaborate and estimate the M&E plan of transfer process (Year 3)

B- Execution of transfer to the new Principal recipient

- Program management and financial administration (year 4);
- Monitor and Evaluation (year 4);
- Supply/procurement (year 5);
- Creation of CD monitor cell of new PR and SR (year 3).

C- Development of Coordination and partnership

On the purpose of strengthening the coordination and partnership, STP CCM is in a phase of conclusion

of its ToR Reinforcement Plan in order to attain better coordination of the interventions among the partners, including GF.

Among others, this intervention is a priority for good function and carry out meetings with National Anti-malarial Commission, at least once a year.

On the other hand, the PR must strengthen its communication with CCM and other partners related malaria combat.

With respect to operational level, the district teams will have responsibility to encourage and coordinate community and NGOS interventions with different partners, including GF. An annual meeting will be also planed at each district level for planning and evaluation of anti-malarial actions at operational level.

4.6.5 ***Incorporation of lessons learned into this proposal***

Describe below:

(a) how this proposal **addresses and resolves weaknesses or bottlenecks** encountered during implementation of the expiring grant (including through the selection of additional PR(s) from appropriate sectors); and
(b) how this proposal has taken into account weaknesses identified by the TRP in a recent review of a same disease proposal from the country.

Applicants are encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants *(including 'Phase 2' amounts anticipated to become available).*

The review of Round 4 by the technical review panel (TRP) is inserting in the category A. Some noticed weaknesses were formulated by the TRP as (on) recommendations, this to with purpose to reinforce the coverage and reach the objectives. These recommendations were taken into account. The following table summarizes the recommendations and the proposed actions to develop the performance :

Table n° 01

Weaknesses	**Actions to correct the weaknesses**
• To reassure that the current efforts has been capitalized and the lessons are taken	• The current proposal aims to keep the coverage of anti-malarial interventions over 80%, and this in continuation of R7, from 2014. • This way, it previews to keep the LLIN coverage over 90%, IRS in focal areas – 100%, and cases management - 100% • The objective is to continue reducing the morbidity and mortality and reach the malaria elimination in STP
• To strengthen the human resources (recruitment and training of an additional staff to reinforce the PR) • To strengthen the human resources at government level and other partners • To strengthen the capacity of NE/PNLP and the health districts	• The current submission previews not only a recruitment and reinforcement of PR staff, but also CNE/PNLP and district staff. The objective is to reinforce the entomological activities, the active search and follow up of cases. • To recruit a manager from the Global Fond managing Unity taking into account the number of grants gained by the country (R4 malaria, R5 AIDS, R7 malaria, R8 Tuberculosis and probably R9 AIDS) • In sequence, to recruit and train the personnel involved in the drug supply circuit, to assure the quality an reinforcement of pharmaceutical regulatory authority • A recruitment and training of a personnel to develop the monitoring

	& evaluation system and IEC will allow strengthening the anti-malarial measure in action. • The supplementary personnel will be recruited an trained in IRS
• To strengthen the drug supply system and the monitor & evaluation	• The current proposal proposes to enrich the supply system with a manual of managing procedure and distribution of pharmaceutical products, to train the agents engaged to the pharmaceutical product management (to follow it and provide it with managing tools, computing, logistic for financial and pharmaceutical data management) • The current submission, moreover, proposes to organize the pharmaceutical regulatory authority of STP. • A pharmacist will be recruited inside the PR managing Unity. The objective is to strengthen the PR in supply management and train national experts. • An attention is given to the development of anti-malarial and consumables supply. • However, for the severe cases, the quinine and consumables are purchased by the government through the National drugs fund and by R7
• To strengthen the IEC, the changing of attitude of population in favor of fight against malaria and to increase the coverage of LLIN	• This proposal emphasizes IEC. The communication materials will be produced and communication for behavior changing will be carried out by Medias, inter-personnel communication and theatre. • To support these activities, an expert in IEC will be recruited and the training in communication techniques will be carried out.

4.6.6 Risks arising from disease specific responses to health systems weaknesses and gaps

If the activities described in s.4.6.4 include responses to health systems weaknesses and gaps through a disease specific program approach, describe how the programming for this support has sought to mitigate any risks or unintended consequences of that support (compared responses that are undertaken on a cross-disease basis).

The specific action on view to the elimination of malaria has a risk to miss the diagnosis and cause the loss of the habit of health workers to think about this disease. It will be important to reinforce this class of workers by training/retraining and regular supervisions.

By the other hand, the community also loses the correct attitude in favor with the use of anti-malarial tools. A reinforcement of IEC is useful for perpetuating the habitudes and keeping high the utilizations.

The loss of relative immunity following by the low number of cases can demonstrate a risk of epidemic with high mortality. The ad hoc training is planed for the health care workers. A recruitment of an epidemiologist is planned to strengthen the epidemiologic surveillance and focal IRS. The active search and management of cases is necessary to minimize this risk.

4 Program Description

Program linkages

4.6.7 Links to other grants or programs

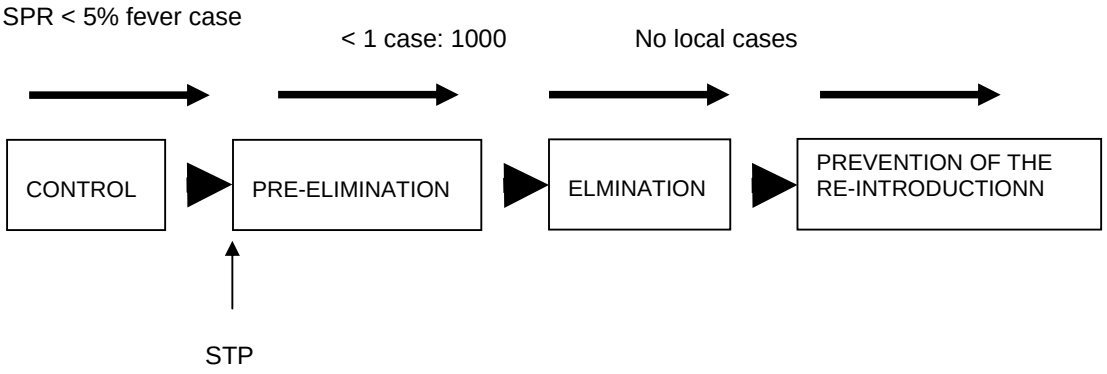
(a) Describe:
• any program or operational links between the focus of this proposal and the activities or interventions supported through: (i) an existing Global Fund grant (including new proposals recently approved) or (ii)

• Whether this proposal is asking for support for the same program areas or interventions as another existing same disease Global Fund grant, and if so, why this is not a request for duplicative funding.

This proposal which is a reinforcement of the gain acquired in the implementation of R4, takes into account the R7 proposal and the interventions of other partners. The search to satisfy the gap and reinforce the weakness noticed in the implementation of R4. It (this proposal) is a contribution to reach the objective of the strategic plan that is the elimination of malaria in STP. The weaknesses have been reported in point 4.4.1.

This proposal includes the interventions not covered by R7 and other intervenient. Particularly, the training on case management, the reinforcement of supply system of pharmaceutical product management and the component communication for changing the behavior, indispensable to ensure the best coverage of all anti-malarial interventions.

The interventions reappearing in this proposal that is similar to R7, is just to cover the final period of R7. This is important to decrease the morbidity and mortality and, thus, reach the elimination of malaria. It is necessary to keep and strengthen the interventions sustainably, in order to minimize the risk of losing all the gains and return to the starting point.



(b) **Only if relevant**, indicate whether any part of the request for funding in this proposal arises from the discontinuation of support from another source? If so, explain the reason why that source of funding is no longer available.

N.A

4 Program Description

4.7 Enhancing in-country capacity and equality

4.7.1. Partnerships with the private sector to support increased coverage and services

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

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

N.A

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

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?)* ➔	Not applicable

Contribution Value (in USD or EURO)
Refer to the Round 8 Guidelines for examples

Organization Name	**Contribution Description** (*in words*)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Use "Tab" key to add extra rows if needed]								

4.7.2 Enhancing social and gender equality

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

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

As described above, if malaria elimination is to be successfully implemented, all interventions will need to be implemented at community level which would ensure equitable access by all community groups to malaria services. In this project, all people will access the malaria services equally to assure universal coverage with all interventions. Emphasis has been given in this project to strengthen districts level health system and communities to create enabling environment to village health workers.

The most impoverished groups generally live in the areas where the conditions for malaria transmission are most intense. These areas will be the most intensively targeted with interventions against malaria in STP. Thus, the very design of the intervention strategy places the most marginalized groups of STP at the center of the target for malaria elimination.

Malaria affects everyone living on STP, and there is no discernible stigma associated there with being bitten by mosquitoes. This is not expected to be a significant issue with regard to the planned intervention strategy. It is possible that some of the activities, such as environmental management, will improve equity in living conditions and health burdens between groups

4 Program Description

4.8 Planning for Sustainability and Impact

For more detailed information on the requirements of this section, see the Guidelines for Proposals s.4.8.

4.8.1 Potential for sustainability

(a) **Strengthening national capacity and processes**

Describe how this proposal makes an important contribution to the strengthening and/or further development of national systems and institutional capacity (including the capacity of the public, private and NGO sectors, and communities affected by the disease). Refer to country evaluation reviews, if available.

Some weaknesses were identified during the implementation of R4 such as:

1. Weakness of supply system
2. Weakness of surveillance system, monitor and evaluation
3. The IEC

The current proposal previews to strengthen these 3 aspects that make part of the reinforcement of health system. In fact, the reinforcement of supply system will allow not only to develop the supply of anti-malarial products (LLIN, insecticides, drugs and others) but also join the anti-malarial products particularly the two other diseases that constitute, with malaria, the Global Fund´s grant. It´s like this, the same for the surveillance system, monitor and evaluation and IEC.

These aspects will follow the training of existed personnel, their motivation especially by supervisions, provision of work equipments and drugs, availability of technical documents and sensibilization of population.

The PR previews also to strengthen the capacity of the NGOs. These weaknesses will be identified during the implementation and reaching of the results of the financial administrative management of each sub recipient.

These weaknesses will be reinforced from case to case. However, in the reinforcement of the global weaknesses noticed in R4, training in management of anti-malarial products, and harmonization of monitoring system will be started.

(b) **Alignment with Broader Developmental Frameworks**

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative and the Millennium Development Goals.

Also include an overview of any links to international initiatives, e.g. as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities, or the 'Roll Back Malaria Global Strategic Plan').

Considering the amplitude of the poverty in S. Tome and Principe, the government created and adopted in 2002 a national strategy to reduce the poverty that mentioned, refering to health matter, that an attention would be given to the development of health quality for the population and thier well being.
This submission joins to the axle of the strategy to reduce the poverty because it fits in the objective of malaria elimination and contribute for the reduction of the poverty.

In fact, malaria with AIDS and tuberculosis were recognized by the african Presidents and governments (Abuja 2000) as the diseases of the poverty.

The national policy for health development PNDS 2001-2005, fully recognizing the social nature of health services as a factor of development, social justice and fight against the poverty, settled 7 objectives which one of them was the realization of actions to combat the diseases more reponsable for the mortality and morbidity : AIDS, tuberculosis and maalaria.

The R4 by which the country was supported, allowed the country to advance considerably toward the milenium objectives for the development.

4 Program Description

This proposal aims, in fact, to reinforce the weaknesses, eliminate malaria and, thus, contribute to reach the MDG relative to malaria.
This proposal will contribute to reach the objectives of the world plan against malaria – Roll back malaria

4.8.2 Evidence of impact/potential for impact

For the questions below, the concept of 'impact' refers to whether there is clear evidence of impact on the relevant disease epidemic or influence of planned interventions on disease prevalence, incidence, mortality and/or averted infections.

(a) **Potential for demonstrating impact**

How will the additional support provided by this proposal increase the capacity of the country to demonstrate that its national disease strategy will have, or has the potential to have, a measurable impact on the burden of the disease (whether expressed in terms of overall morbidity and/or mortality and/or averted infections).

If the indicators of impact (morbidity and mortality) are improved at the end of R4, the targets previewed couldn´t be reached. The proposal R7 previews to increase the coverage in order to reach the elimination of malaria in STP. This proposal describes the measures realized in order to develope the impact measuring report. The current proposal previews to strengthen these measures and extent them until 2015.
The measures discribed in Round 7 previews the development of the data collection at the level of the communities as well as health facilities.

(b) **Impact Measurement Systems (IMS)**
Describe the strengths and weaknesses of in-country systems and organization(s)/team(s) that evaluate potential for health impact, determine country impact measurement indicators, and track/monitor achievements towards national goals.

Note ➔ **If there has been a recent national/external evaluation of the IMS, describe the main findings**.

The national HIS is not functional, but the health ministry is making an effort with the support of World Bank to strengthen it. In the absence of such system, each program and service organized its own data cllection and analysis system to satisfy the planing needs (monitor &evaluation)
In 2007, according to the institutional reinforce plan, CNE has had a monitor & evaluation unity for program against AIDS and malaria.
The evaluation carried out by CNE has showed the followin strengths and weakness:
.

1. **Strengths**:

- Existence of a monitoring & evaluation plan in harmony with national strategy
- Functionality of districts data collection structures
- Development of a coordinating circuit between several intervenient (Public sector, private and NGOs)
- Organization of monthly meetings for data analysis and validation
- Reinforcement of human resource at Central level and in the districts.

2. **Weaknesses**:

- The results of the implementation not enoughly disseminate
- The service reporting system is still weak and doesn´t avoid the double reporting
    - The absence of indicators about the social economic situation and absence mechanism to evaluate the satisfaction of the clients
- Weakness in promptitude

Nowadays the ministry of health proposes to integrate within the CNE the monitoring of 3 diseases. This will be efficient the identification of its weakness and the effort for the development of the system. The R7 takes into account the GAP for the reinforcement of the system.
The materials for collection of data (data files) will be provided to the health agents in the health facilities and also for community health worker. After the collection the data will be guided to the health districts where it will be compiled. At the district level, the data will be collected by qualified personnel's provided with a computer (and other). To speed up the report, internet and the telephone will be available in the districts for the prompt transmission to the CNE, throughout R7.
For the data collected in the community during the inquiry (survey), (using of LLIN, KAP, fever prevalence), the community health workers will participate. This proposal proposes to strengthen this system already described in R7.

4 Program Description

(b) **Strengthening monitoring and evaluation systems**

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?
The ➔ Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.

The monitoring and evaluation of the performance of this project will mainly be based on the routine health information system and community surveys. Moreover report from sub-recipients will also be used as source of data for monitoring and evaluation. Although, the health information system of the country has been weak, the ministry of health with the support of the World Bank is in the process of strengthening the system, and this proposal also seeks funding for gaps in the health information system strengthening. With these supports, the health information system at all levels will be able to collect data and use locally, as well as report on timely fashion to higher level which will be used for monitoring and evaluation purposes of this project, and program planning, budgeting, management and evaluation of health programs.

Through funding obtained from Global fund for HIV/AIDS program, the ministry of health established a monitoring and evaluation unit under the CNE. Currently, the ministry of health is in the process of strengthening the monitoring and evaluation unit to include malaria and tuberculsis as well. Harmonization of program data collection and management for malaria, HIV/AIDS and Tuberculosis under CNE which also oversees the implementation of the three disease, will be more efficient in terms of cost and quality of information.

A copy of the monitoring and evaluation system organogram, which is under development to be inclusive of malaria and tuberculosis, is attached (Annex). This unit will be responsible for analysis of data and reporting as well as feedback. The unit is not a stand alone structure and will be part of the health information system, however, due to the importance of these three disease, the unit will do timely utilization of the information gathered from districts as well as sub-recipients. Specifically, the monitoring and evaluation unit will capture indicators routinely monitored by the three diseases. Data collection from the health posts as well as the villages will be based on a paper-based format to be carried out by health personnel at the health posts and village health workers at community level. The paper based forms will be submitted to the district health office and compiled at the district level which will be equipped with computers and necessary electronic data management systems.

The districts will have trained man power who would be able to utilize the data locally. The district health information system units will be responsible for communicating with the lower levels with feed backs and the higher level with the necessary information on timely basis. In addition to the routine health information system, monitoring and evaluation will be undertaken through community level surveys to collect information on indicators that can't be estimated using the routine health information system. These surveys include prevalence of fever or malaria, treatment seeking behavior, bednet ownership and utilization by different groups of the population, KAP surveys, and malariometric surveys to determine prevalence of malaria parasitaemia at community level.

Moreover, monitoring of sub-recipients will also be done through verification field visits by the PR in case of discrepancy or under-performance based on the report of sub-recipients.

4 Program Description

4.9 Implementation capacity

4.9.1 Principal Recipient capacities

Describe the respective technical, managerial and financial capacities of each PR in this proposal (continuing and new) to manage and oversee implementation of the program (or their proportion) having regard to the proposed changes in scale and/or scope identified in section 4.6.

What plan(s) exist to strengthen the PR(s)' capacity to absorb these changes into their implementation management framework, and ensure strong performance? *Also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).*

The proposed PR has been managing Global Fund grants since March 2005. These grants are include 4th round Malaria and HIV/AIDS components. The PR has the necessary managerial, technical and financial capacity to manage the grant from this proposal. The Global Fund Project support unit within UNDP includes the following staff: Project Manager, Technical Director, Financial Director, Procurement Officer, M&E officer, and Administrative officer. Regarding the new staffing arrangement please refere to the item 4.8.1. The Unit that support
the implementation of these two programs has also passed the training sessions regarding the main axes of the program (managerial; finacial, and procurement). It has also accumulated managerial, financial and procurement experiencies, including M&E process, during the past two years. However the PR will continue to up-to-date its staff to better manage the grants

4.9.2 Sub-Recipient information

(a) Are the majority of sub-recipients (SRs) **from the expiring grant,** continuing their roles and responsibilities in this proposal?	☒ **Yes** ➔ *Go to s.4.9.3*
	☐ **No** ➔ *answer (b) before completing s.4.9.3*

(c) **If no**, explain why, and for new SRs who will either receive a substantial proportion of the funding for this proposal or will be involved in funding to sub-sub-recipients:

(i) describe the **transparent** process by which new SRs were identified **and the criteria** that were applied in the identification process.

(ii) summarize the past implementation experience of these new SRs

N.A

4.9.3 Sub-Recipient capacities

What plans exists to strengthen the capacity of the major SR(s) to absorb the continuing and/or expanded responsibilities under this proposal, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any evaluations by the existing PR(s) of SR capacities (e.g., capacity-building needs, staffing and training requirements, etc.).

The reinforcement of the sub recipients is included in the global SR reinforcement plan. This previews to strengthen the weaknesses noticed by the PR, during the monitoring of the activities implementation.

The current PR previews to reinforce CNE that is one of the principal sub recipient with the purpose of transfer the competences. The CNE is previewed to become the governmental PR. Therefore the training is being carried out in financial and administrative management, monitor & evaluation of the activities and the results according to the Global Fung procedure.

The training in languages was also carried out. The current PR has also rebuilt the CNE section.
The current proposal previews the institutional strengthen of CNE for developing the performance and achieve the objectives established.

4 Program Description

4.10 Management of pharmaceuticals and health products

4.10.1 Overview of changes to the management of pharmaceutical and health products

(a) Does this proposal involve the management of pharmaceuticals and other health products?	☐ **No** ➔ ***Complete s.4B if relevant to this proposal*** *(see insbructions below this s.4.10)* ***and/or go directly to the budget section*** *(section 5)* ☒ **Yes** ➔ *answer question (b)*
(b) **If yes to (a)**, does this proposal give rise to **any change(s)** in the **roles and responsibilities** for management of pharmaceuticals and health products compared to the expiring grant?	☒ **No** ➔ ***Complete section 4.10.2 and then complete s.4B if relevant to this proposal,*** *and/or* ***go to section 5 and Attachment B*** *(detailing quantities and unit costs for health products)* ☐ **Yes** ➔ ***Passez Go to section 4.11 before completing s.4B (if relevant to this proposal)*** *and/or* ***section 5*** *and* ***Attachment B***

4.10.2 Management of pharmaceuticals and health products for continuing PR(s) involving a scale-up of ongoing activities

Describe:

(a) how implementation arrangements relevant to this proposal have been planned to ensure *(including, as relevant, plans to obtain necessary additional technical assistance, training or other capacity building assistance)* that continuing PR(s) have sufficient capacity to absorb the increased responsibilities in respect to the management of pharmaceuticals and health products for the planned scale-up; and

(b) the extent to which the ongoing management of pharmaceuticals and health products under this proposal will be coordinated with other procurement and supply management actions in support of the national disease prevention and control program to ensure greater impact on the disease.

4 Program Description

The products purchased in this grant are selected by the CNE following the Malaria National Treatment Guide. The pharmaceutical products are pre-qualified by WHO as recommended by the Global Fund. The UNDP is responsible for the purchase with support of CNE. These entities has capitalized a lot of experience managing the Round 4 and Round 7 grants. This way, a lot of good (strong) points have been acquired, but equally the weaknesses were noticed and must be corrected in the point of view of RCC management.

Strong Points
The purchased pharmaceutical products are transported by plain with a very operational delivery delay (1 to 3 days) than from the airport to FNM that is responsible for the storage and distribution. The storage is according to the Good Storage Condition. The place is adequate; the products are organized on the shelves and identified by the up-dated storage file. The temperature is monitorized. There are the extinguishers, security against robbers and very considered (lock doors, windows with metallic grills). The FNM trains its agents in good storage management practice and supervises regularly other storages of pharmaceutical products in the country (district and the dispensaries). The storage management is computed and the inventories are realized quarterly. , with an annual in the end. Certain medical products and consumables are stored by the CNE that has a great experience in the matter. The delivery of the bednets from the harbour takes 1 to 2 weeks.

Weak Points
In spite of these good (strong) points, the weak points are identified as the necessity of a good managing of the products that will be purchased in this grant. The FNM doesn't have a procedure manual although the stock management is computed. It´s just an excel table. Because of the previewed increasing of the activity, software of management will be better. Some districts and dispensaries have had to much rupture of products because of the weakness in the utilization of stock management tools. For example, lots of products file are not up-dated. The district commands are not satisfied and finally, the expression of need is not correctly dominated by key agents. These points are taken into account in this grant, including the training and appeal for the use of managing tools. The acquisition of software for stock management and supply is planed through R7. For the safety of all, the fire extinguishers are available in the two storage centers (FNM and CNE), but the number is insufficient, relating to the amount and type of the articles in stock. No agent is trained in using these extinguishers. It´s also important to plan the training for fire situation for agents (handling, extinguishers, fire schools…). The country doesn´t have a national laboratory for quality control of pharmaceutical products. However this quality control in the entry, the routine control is planed to be carried out by an international laboratory contracted to do it. The cost for this is covered by R7. A sample preparation procedure and a training of the agents is planed in this proposal.

The quality assurance of pharmaceutical product, the pharmacovigilance isn´t carried out as well as the registration, because of the absence of a national regulatory authority for pharmaceutical regulation. An international technical assistance is planed for evaluating and defining the procedures in order to operationalize this regulator entity.

About the human resource the FNM and some districts need to be reinforced with qualified personnel. For carrying out this fight in a good way, S. Tome and Principe is benefited with a support of the Global Fund by Round 4 which is finishing and from which the country obtain the RCC and also Round 7. The country is equally benefiter with the support of Taiwan cooperation and Brazil.

For coordinating this fight, the UNDP principal recipient of this grant has got a managing unity tied to the FNM, CNE and the NGO Zatona Adil that are the sub recipient.

The quarterly meetings join these sub recipients together with the districts delegate.

The punctual meeting in case of need is realized between the PR managing unity, Brazil and CNE.
With support of these partners the acquisition and utilization of Rapid Diagnosis Test is done in the community by CNE. This activity allows the prompt management of malaria cases and rational utilization of ACT.

The bednets and the IRS, in their anti-vector action, allow completing the panoply of mixed way of fighting

against the disease. Other actions of Education, Information and Communication are carried out by medias, cultural groups (theatre), church leaders and schools.

Check the table below

In summary, the CNE coordinates all the activities through quarterly meetings joining the principal recipient, the sub recipients and care givers.

Table n° 2

Activities	target	Zone	Responsible
RDT	all	Country wide	Health workers
Distribution of ACT/SP	all	Country wide	Health workers and community health workers
Bed net	all	Country wide	Reproductive Health Program (PSR), CNE, ZATONA
Indoor residual spray	all	Country wide	CNE, ZATONA, Taiwan Cooperation
BCC	all	Country wide	CNE, ZATONA, CNES

4.11 Management of pharmaceuticals and health products New PR(s) and/or newly introduced activities

4.11.1 Table of amended roles and responsibilities

Describe the amended roles and responsibilities for pharmaceutical and health products management under this proposal. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principle Recipient, subrecipient, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	N.A	N.A	☐ Yes ☐ No
Intellectual property rights	N.A	N.A	☐ Yes ☐ No
Quality assurance and quality control	N.A	N.A	☐ Yes ☐ No
Management and coordination *More details required in s.4.11.3*	N.A	N.A	☐ Yes ☐ No
Product selection	N.A	N.A	☐ Yes ☐ No
Management Information Systems (MIS)	N.A	N.A	☐ Yes ☐ No
Forecasting	N.A	N.A	☐ Yes ☐ No
Procurement and planning	N.A	N.A	☐ Yes ☐ No

4 Program Description

Storage and inventory management *More details required in s.4.11.4*	N.A	N.A	☐ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.11.4*	N.A	N.A	☐ Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance))	N.A	N.A	☐ Yes ☐ No

4.11.2 Procurement capacity	
(a) Will management of pharmaceutical and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also procure these products?	☒ PR(s) only ☐ SRs only ☐ Both

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

Organization Name	**Total value of pharmaceuticals and other health products procured during last financial year** *(In same currency as on facesheet of this proposal)*
NA	NA

4.11.3 Alignment with existing systems

Describe the extent to which ongoing management of pharmaceutical and health products under this proposal will be coordinated, to the extent possible and appropriate having regard to country contextual considerations, with other pharmaceutical and health product management actions undertaken in support of the national disease prevention and control program.

The project is managed by UNDP Managing Unity that support the FNM and CNE. The CNE equaly represents the National Anti-malarial Program (PNLP). There is a coordenating circuit between these different entities, and the periodical meetings are carried out every quarters.

The pharmaceutical products of 1st line are managed by the UNDP and 2nd line products are managed by the government . In a recent future the both pharmaceutical products will be managed by the UNDP.

The quality control of the products will be external and this round plans to assure an assistance to set up a sample preparation procedure and training on the same subject.

This grant equaly plans to support the evaluation and study of an operationalization plan to create a national pharmaceutical regulator sector .

To face this deficit, the managin unity previws a reinforcement of its staff (national or international pharmacist/ logistician (logistic).

4.11.4 Storage and distribution systems	
(a) Will the same organization as in the expiring grant provide the supply management (storage and distribution) functions for pharmaceutical and health products during the proposal term?	☒ Yes ☐ No
(b) **Indicate** which types of organizations will be involved in the supply management of pharmaceutical	☒ National medical stores or equivalent

4 Program Description

	☐ Sub-contracted national organization(s) *(specify)*
	☐ Sub-contracted international organization(s) *(specify)*
	☐ Other: *(specify)*

(c) Describe each organization's current **storage capacity** for pharmaceutical and health products, and indicate how a possible scaling up of interventions and increased requirements under this proposal will be transparently and effectively managed.

The FNM is responsible for storage and distribution of ACT and RDT purchased by this grant and destinated to the districts and all dispensaries in the country as well as the pharmaceutical product purchased by the government. The actual (current) capacity is 1035 m^3 so it is very limited. The arrival of a new grant requires an extending of its real capacity at least to 2000 m^3. With this proposal around 750 m3 will be build under this proposal.

The CNE is responsible for the storage of bed nets distributed in campaigns. CNE manages equally the microscope consumable. This entity needs to reorganize its storage (arrangement in shelves, articles identification)

Its storage capacity is greatly outdated and needs an urgent extension and modernization. This real capacity of 330 m^3 must turn into a minimum of 1000 m^3 for a good perspective of storage all the articles expected.

(d) Describe each organization's **current distribution capacity** for pharmaceutical and health products. In your response, indicate how any increased responsibility for distribution of pharmaceutical and health products under this proposal will be managed, and potential challenges addressed. In addition, provide an indicative estimate of the percentage of the country and/or population covered by pharmaceutical and health product management services under this proposal, and the relative percentage increase (if any) this represents on existing distribution arrangements for the nominated distribution partners.

The current applied distribution system is a pulling system. The dispensaries pass the command of their products to the districts and go take it on their own. The districts pass the command to the FNM and use their own vehicle as transport. The distribution is a big point in the country supply system (adequate vehicle, functional, no carburant problem). The good point of the country in relation to FNM is the delivery in maximum 2 hours after haveing received the command.

The following table summarizes the population coverage rate in pharmaceutical and medical products and the objectives to reach with RCC.

Table n° 03

Products	Current population coverage rate in % (source ….)	Augmentation with the RCC
ACT	Not determined	
TDR	Not determined	
Bed nets	52,8% (Report CNE 2009)	100%
IRS	85,6% (Rapport CNE 2009)	100%

It will not have the augmentation but the maintain of this level.

However, for longer development of this distribution performance, a supply and distribution national plan must be created. And each district must have its own plan for supply and distribution of pharmaceutical and medical products.

4.11.5 Pharmaceutical and health products selection

- **Complete 'Attachment B' to this Proposal Form for the relevant disease**, to list all of the pharmaceutical and health products that are requested to be funded in this proposal. Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs').

- If the pharmaceutical products included in 'Attachment B' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

4 Program Description

4.11.6 Multi-drug-resistant tuberculosis (HIV and tuberculosis proposals only)	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?	☐ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☐ No. *Do not include Green Light Committee costs in the budget.*

COPY AND AND INSERT HERE THE OPTIONAL HEALTH SYSTEMS STRENGTHENING CROSS-CUTTING SECTION 4.B IF RELEVANT TO STRATEGY OF ROLLING CONTINUATION CHANNEL PROPOSAL

5 Funding Request

5. Funding request

5.1 Financial gap analysis

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

Financial gap analysis *(same currency as identified on cover page of Proposal Form)*										
Note➔ Adjust headings (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**										
	Actual	**Expected**	**Planned**		**Estimated**					
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
MALARIA program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations										
Ligne A ➔ Provide annual amounts			*$2 767 026*	*$3 337 826*	*$3 818 949*	*$3 047 659*	*$2 851 419*	*$3 559 446*	*$2 856 566*	*$2 858 570*
Ligne A.1 ➔ Total need over length of RCC Funding Request			*(combined total need over RCC proposal term)*							***$18 992 611***
Current and future resources to meet financial need										
Domestic source **B1**: Loans and debt relief (*provide name of source*)			*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Domestic source **B2** National funding resources			*$146 738*	*$148 037*	*$217 953*	*$171 407*	*$451 729*	*$363 215*	*$435 582*	*$435 582*
Domestic source **B3** Private Sector contributions (national)			*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:			*$146 738*	*$148 037*	*$217 953*	*$171 407*	*$451 729*	*$363 215*	*$435 582*	*$435 582*

5 Funding Request

External source **C 1** *(Taiwan gov)*			*$230 331*	*$232 369*	*$342 200*	*$262 037*	*$215 098*	*$172 951*	*$207 409*	*$207 409*
External source **C 2** *(WHO)*			*$37 989*	*$38 325*	*$47 861*	*$36 649*	*$30 084*	*$24 190*	*$29 009*	*$29 009*
External source **C3** *(WB)*			*$35 314*	*$35 626*	*$220 898*	*$169 151*	*$138 851*	*$111 644*	*$0*	*$0*
External source **C4** *(ADB)*			*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
External source **C5** Private Sector contributions (International)			*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:			*$303 633*	*$306 321*	*$610 959*	*$467 837*	*$384 034*	*$308 785*	*$236 418*	*$236 418*
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years			*$2 238 930*	*$2 258 745*	*$2 209 213*	*$1 734 832*	*$1 319 049*	*$0*	*$0*	*$0*
			$2 689 302	$2 713 103	$3 038 125	$2 374 077	$2 154 813	$672 000	$672 000	$672 000
Line E ➔ Total current and planned resources (i.e. Line E = Line B total+ Line C total + Line D Total)			*$2 689 302*	*$2 713 103*	*$3 038 125*	*$2 374 077*	*$2 154 813*	*$672 000*	*$672 000*	*$672 000*

5 Funding Request

Calculation of gap in financial resources and summary of total funding requested through RCC *(to be supported by detailed budget)*										
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)			*$77 724*	*$624 723*	*$780 824*	*$673 583*	*$696 607*	*$2 887 446*	*$2 184 566*	*$2 186 570*
Line G = Rolling Continuation Channel funding request *(same amount as requested in table 5.3)*				*$624 723*	*$514 530*	*$365 647*	*$305 179*	*$2 275 983*	*$1 898 472*	*$1 592 312*

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

In this RCC proposal, the total maximum funding request for in Line G is:

*(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*

*(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term..*

Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

$$\text{Cost sharing} = \frac{\text{(Total of Line D entries over 2011-2016 period + Line G Total) X 100}}{\text{Line A.1}}$$

64%

5 Funding Request

5.1.1 Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and

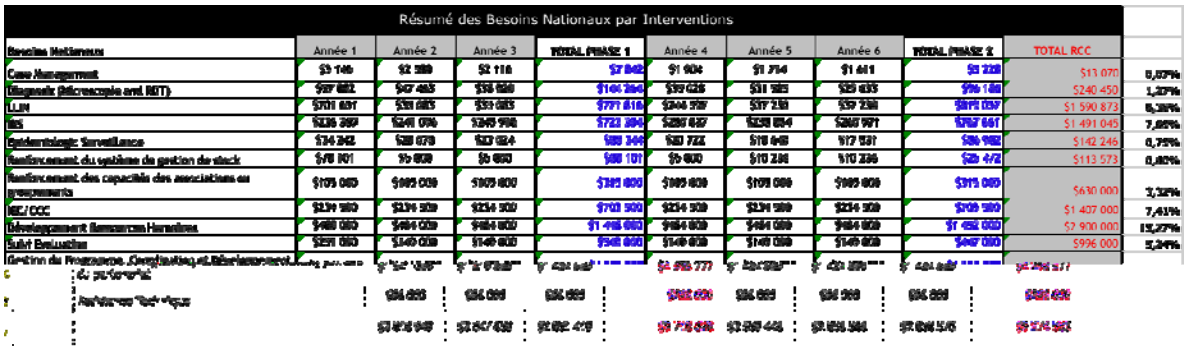
- budgeted in a way that ensues that government, non-government and community needs were included to ensure fully implementation of country's disease program strategies.

The overall financial needs based on costed national malaria elimination strategy, is ***$18 992 611***
(Cf. Gaps analysis, on the sheets in detailed budget attached).

These needs are distributed as following and cover the period 2001 to 2016.

More then 46% of these needs is represented by the program management, the coordination reinforcement and partnership development. The national capacity development represents 15% and more then 17% of needs is represented by preventive interventions (LLIN et IRS). It must be considered that STP is reaching a malaria pre-elimination phase. Therefore, the national capacity development and partnership development become indispensable elements for carring out good epidemiological surveillance and good active case detection.

Tableau 1



Based on country availability analysis (Table 3), represented in the following table, the global amount of funding request of RCC is over $ 6,096,390 with $1,139,214 for the first phase that rests inferior to 140% of second phase of Round 4 (Cf ; Following table).

Tableau 2

Résumé Analyse Gap et Demande de financement RCC	
Besoins Totaux Nationaux [J 16]	$18 992 611
Total de la demande de financement RCC [J 46]	$6,952,123
Total de la demande de financement Phase 1 RCC [E 46]	$1,185,356
Total de la demande de financement Phase 2 RCC [I 46]	$5,766,767
Budget Phase 1 Round 4	$1 543 500
Pourcentage de la demande de financement RCC Phase 1 (140%)	$2 160 900

5 Funding Request

Tableau 3

Résumé des Disponibles Nationaux par Interventions

Case Management	$3 146	$2 580	$2 116	$7 842	$0	$0	$0	$0	$7 842
Diagnosis (Microscopic and RDT)	$57 882	$47 463	$38 920	$144 264	$0	$0	$0	$0	$144 264
LLIN	$701 651	$0	$0	$701 651	$0	$0	$0	$0	$701 651
IRS	$236 369	$241 096	$245 918	$723 384	$0	$0	$0	$0	$723 384
Epidemiologic Surveillance	$34 348	$28 026	$0	$62 320	$0	$0	$0	$0	$62 320

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

Explain the processes used to:

- prioritize domestic financial contributions to the national disease program *(including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; And

- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

As mentioned previously, the Government of Sao Tomé and Principe is committed to scaling-up and sustaining malaria prevention and treatment, with the vision to elimination of the disease. Fight against malaria is included into the national priorities of the National Strategy for Poverty Reduction (NSPR) and into the documents like Political Option 2007-2010. Malaria control is among the national priorities included in the grand scheme diseases control, integrated in the National Strategy for Poverty Reduction SNRP as well as in documents such as politic option 2007-2010, that represents the basis for the National Budget elaboration.

To guarantee that the national funds are used with transparence and equity and to assure an execution of the treatment strategy, diagnosis and care at the national and districts levels, one proposal of the Governmental Bigs Plan Option and one proposal of the National Budget are presented in the Parliament for approval

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

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

The major external financial contributors to the country include the Taiwan Cooperation, World Bank, WHO. It is expected that a total of $2,150,914 is expected from these major external financial since 2007 to 2012. The majority of the funding is expected from the Taiwan Cooperation Project, $1,643,414.

5 Funding Request

5.2 Detailed Budget

Suggested steps in budget completion:

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

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

3. From the same detailed budget, **prepare a** '***Summary by Cost Category***' (section 5.4); and

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

5. Do not include any CCM (or Sub-CCM or RCM) operating costs in this proposal. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available on the Global Fund's website.

5 Funding Request

5.3 Summary of detailed budget by objective and service delivery area

Objective Number	Service delivery area (Use the same numbering as in program description in s. 4.6.4)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
1	Indoor Residual Spraying	-	-	-	987,831	1,019,685	1,024,802	3,032,318
2	Insecticide-treated nets (ITNs)	-	-	-	745,297	37,233	37,233	819,763
3	Diagnosis	-	-	23,039	66,124	59,497	74,963	223,622
4	Prompt, effective anti-malarial treatment	5,250	-	33,000	44,716	13,351	75,788	172,104
5	Epidemiological Surveillance	-	-	296	23,721	380,415	18,721	423,154
6	Entomological Surveillance	-	-	-	8,100	3,226	-	11,326
7	Surveillance of drug resistance	-	-	-	5,000	-	5,000	10,000
8	Supply Management (To reinforce the supply management of pharmaceutical and medical products)	339,950	195,657	153,982	141,132	144,268	144,268	1,119,257
9	BCC - community outreach	77,679	88,779	31,307	12,166	18,198	7,166	235,296
10	BCC - Mass media	-	-	-	58,200	58,200	58,200	174,600
11	Program management and partnership coordination development (Develop the national capacity for implementation of the anti-malarial activities)	57,990	57,290	43,590	34,800	40,200	42,000	275,870
12	Program management and Administration cost	33,661	23,921	19,965	148,896	124,199	104,170	454,812
	TOTAL	514,530	365,647	305,179	2,275,983	1,898,472	1,592,312	6,952,123

5 Funding Request

Objective Number	Service delivery area (Use the same numbering as in program description in s. 4.6.4)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Total requested from the Global Fund:		514,530	365,647	305,179	2,275,983	1,898,472	1,592,312	6,952,123

5 Funding Request

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

Avoid using the "other" category unless necessary – read the Guidelines..	*(same currency as indicated on cover sheet of this Proposal Form)*						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Human resources	24,400	137,916	144,216	441,866	447,266	449,066	1,644,730
Technical and Management Assistance	38,935	26,100	14,050	-	-	-	79,085
Training	85,682	109,161	33,000	48,682	8,119	89,688	374,332
Health products and health equipment	66	66	66	1,114,095	429,148	426,697	1,970,138
Pharmaceutical products (i.e. medicines)	-	-	-	5,347	5,232	5,169	15,747
Procurement and supply management costs (for pharmaceutical and health products)	200	-	-	47,591	52,650	52,650	153,091
Infrastructure and other equipment	242,730	5,250	5,250	5,250	5,250	5,250	268,980
Communication materials	4,865	3,840	3,840	65,266	65,266	65,266	208,342
Monitoring & Evaluation	36,792	14,293	59,692	61,133	415,332	43,228	630,470
Living Support to clients/target populations	-	-	-	-	-	-	-
Planning and administration	79,361	67,521	43,565	152,496	127,799	107,770	578,512
Overheads	1,500	1,500	1,500	334,257	342,410	347,527	1,028,695
Other: *(Use to meet national budget planning categories, if required)*	-	-	-	-	-	-	-
Total funds requested from Global Fund *(Totals in tables 5.3 and 5.4 should be the same)*	514,530	365,647	305,179	2,275,983	1,898,472	1,592,312	6,952,123

5 Funding Request

5.4.1 Overall budget context

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

In this proposal, the costs in relation to the objectives of supply system and monitor & evaluation are coss-cutting and do not explicitly appear as objective in table 5.3.

5.4.2 Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial three years; (ii) the method of calculating the anticipated costs over years four to six; and (iii) to what extent human resources spending will strengthen service delivery.

Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

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

The budget refered to the human resource aims at 3 categories of recipients :

- About the training, district health personnel, the field technicians and the community health workers who will be trained for the implementation of the activities.
- Technical assistance of international experts
- The salary for the experts that will be recruited to strengthen the PR, the CNE/PNLP, the supply sector and communication for changing the behavior.

All this human resources are important to sustain the activities compatible with malaria elimination purpose.

5.4.3 Other large expenditure items

If other 'cost categories' represent important amounts in the summary in the table above explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national disease program.

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

Another important part of the budget is the IEC. In fact, in the intention of eliminating malaria in STP, it´s important to keep the coverage level of all intervention in a high and maximum rate. This is feasible with the mass media.

In fact, the malaria cases will be decreasing and the population maybe will not feel the need of keeping a behavior in favor of the anti-malarial measures. So it´s important to maintain the control (attention) and continue doing the communication in favor of the anti-malarial measure.

5.5 Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners. ***Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately***.

5.5.1 Operational status of common funding mechanism

Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint*

5 Funding Request

Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.
N.A
5.5.2 Measuring performance How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
N.A
5.5.3 Additionality of Global Fund request Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the disease program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on the disease outcomes during the proposal term*.
N.A

COPY HERE AN OPTIONAL SECTION 5B THAT IS TO BE INSERTED INTO THIS PROPOSAL HERE IF THE PROPOSAL INCLUDES S.4B (HEALTH SYSTEMS STRENGTHENING CROSS-CUTTING INTERVENTIONS)

CHECKLIST OF ANNEXES TO BE SUBMITTED

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

Section 2: Applicant Summary (including eligibility) **(please see Checklist of all attached documents already sent separately)**		**Annex Name and Number**
CCM and Sub-CCM applicants		
2.2.3	Comprehensive documentation on processes used to select and nominate Principal Recipients(s) (such as the minutes of the CCM meeting at which the PR(s) was/were nominated).	
2.2.6	Documentation relevant to the minimum requirements for eligibility regarding the proposal's scale and/or scope from the expiring grant.	
2.2.7	Conflict of interest policy of the Coordinating Mechanism where the Chair and/or Vice Chair from the same entity as a nominated PR.	
2.2.8	List of members of the Coordinating Mechanism as signed by those members to confirm endorsement of the proposal.	**Attachment C**
Sub-CCM applicants only		
2.3.1(a)	Signed and dated minutes of the **CCM meetings** at which the CCM reviewed and endorsed the Sub-CCM proposal.	
2.3.1(b)	Letters from the CCM Chair of Vice-Chair endorsing the Sub-CCM proposal.	
Section 4: Program Description		**Annex Name and Number**
4.2	National disease specific prevention and control plan (or equivalent), if one exists.	
4.3.1	Map if proposal targets specific region(s)/population group(s).	
4.4.1	Documentation relevant to the national disease program context..	
4.4.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	
4.5	Document(s) that explain basis for coverage	
4.6.4	**A completed 'Targets and Indicators Table'** **Refer to the M&E Toolkit for help in completing this table.**	**Attachment A**
4.6.4	**A detailed Work Plan** (quarterly information for the first two years, and annually for year 3 to 6).	
4.6.5	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved recent proposal (if relevant)	
4.8.2	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	
4.11.5	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**

CHECKLIST OF ANNEXES TO BE SUBMITTED

Section 4B: HSS Cross-cutting (once only in whole country proposal)		**Annex Name and Numbe**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)*** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first two years and annual information for years 3 to 6).	**Work plan**
Section 5: Funding Request		**Annex Name and Number**
5.2	**Detailed Proposal Budget** (quarterly information for the first two years and annual information for years 3 to 6).	**Detailed Budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5.4.3	Information on basis of costing for 'large cost category' items	
5.5.1 *(if common funding mechanism)*	Documentation décrivant le fonctionnement du dispositif de financement commun	
5.5.2 *(s'il existe un dispositif de financement commun)*	Most recent assessment of the performance of the common funding mechanism	
Section 5B: HSS Cross-cutting financial information		**Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).*** Quarterly information for the first two years and annual information for years 3 to 6.	**Detailed Budget**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5B.4.3	Information on basis of costing for 'large cost category' items	
Other relevant documents attached by Applicant (including for Annex 1 if applicable to the Applicant's CCM eligibility status/application history, s.2.2.1)**:**		**Annex Name and Number**

ANNEX 1 – Coordinating Mechanism MINIMUM ELIGIBILITY REQUIREMENTS

Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements' at
http://www.theglobalfund.org/en/files/apply/rcc/documents/Clarifications_on_CCM_requirements_RCC.pdf.

Principle of broad and inclusive membership

Requirement 1 ➔ Selection of non-governmental sector representatives

(a) Provide evidence of how the Coordinating Mechanism members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**.

*Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for Coordinating Mechanism representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*

Documentation relied on to support compliance with Requirement 1	Identify which annex to this proposal contains these documents
☐ Selection criteria for each sector developed by each respective sector	
☐ Minutes of meeting(s) at which the sector transparently determined its representative	
☐ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	
☐ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	
☐ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the Coordinating Mechanism	
☐ Other: *(please specify):*	

(b) Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1..

Principle of involvement of persons living with and/or affected by the disease(s)

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

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

Principle of transparent and documented CCM, Sub-CCM and RCM grant oversight processes (Requirements 4 and 5).

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation

setting out the Coordinating Mechanism's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting(s) where the Coordinating Mechanism decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal. We will also review how, during the program term, the Coordinating Mechanism will oversee implementation. **Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:**
Requirement 4(b) ➔ Process to oversee/review program implementation by the Principal Recipient(s) during the proposal term.

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

Performance Framework 6-11/ RCC proposal: Indicators, Targets, and Periods Covered

Malaria

Program Details

Country:	São Tome and Principe
Disease:	Malaria
Grant number:	
Principal Recipient:	

Program Goal, impact and ouctome indicators

Goals:	
1	To reduce burden of malaria in Sao Tome & Principe, toward elimination
2	

Impact / outcome Indicator	Indicator	Baseline[1]			Current status[2]			Targets						Comments*
		value	Year	Source	value	Year	Source	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	
Impact	Total number of malaria mortality in under five years children /total number of mortality in under five years old children (all causes)	1,1% (2/180)	2007	MOH (routine HIS or HMIS)	5% (11/211)	2008	MOH (routine HIS or HMIS)	5%	4%	3%	2%	1%	0%	
Impact	Incidence of clinical malaria cases (estimated and/or reported)	17 (2696/157848*1000)	2008	MOH (routine HIS or HMIS)	17 (2696/157848*1000)	2008	MOH (routine HIS or HMIS)	17/1000	15/1000	12/1000	10/1000	8/1000	4/1000	
Impact	Prevalence of malaria parasite infection	4% (4661/132934)	2008	NMCP Community survey (with parasite test-RDT)	NA	2009	Community survey		3.5%				2.0%	
Outcome	% of children sleeping under bednets	53,5%	2007	Community survey	61% (621/1017)	2009	Community survey		65%				85%	Utilisation rate
Outcome	% of households with at least two ITN	58%	2007	Community survey	58%	2007	Community survey		65%				100%	
Outcome	% of households covered by IRS	83.5%	2006	IRS report	85.6%	2009	IRS report		87%			87%		

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description
1	To attain a coverage of 100% in malaria prevention measures
2	Assurer la prise en charge correcte d'au moins 90% des cas de paludisme dignostiqués au niveau des formations sanitaires et au niveu communautaire selon le protocle national
3	To strengthen the monitoring & evaluation system, the epidemiological surveillance and operational research
4	Améliorer les capacités de gestion du programme et la coordination du partenariat

Objective / Indicator Number	Service Delivery Area	Indicator	Baseline (if applicable)[1]			Phase 2		Targets for years 6 - 8						Annual targets for years 9 - 11			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y - over program term / Y - cumulative annually / N - not cumulative)	DTF: Name of PR responsible for implementation of corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	Targets	Results	6 months	12 months	18 months	24 months	30 months	36 months	Year 9	Year 10	Year 11					
1	Treatment: Prompt, effective anti-malarial treatment	Number of health workers trained in management of malaria cases	971	2008	PNLP								250	524	548	1,048	Y	N	Y - over program term		
2	Treatment: Prompt, effective anti-malarial treatment	Number of health facilities supplied with drugs with not reported stock out of ACT (artesunate+amodiaquine), lasting at least 15 days, in the last quarter	21/24 (87,5%)	2008	Supervision report				90%		95%		100%	100%	100%	100%	Y	N	N - not cumulative		
3	Treatment: Prompt, effective anti-malarial treatment	Number of persons with uncomplicated malaria treated in health facilities	5,407	2009	MOH (routine HIS or HMIS)								320	2,047	3,581	5,041	Y	N	Y - over program term		
4	Treatment: Prompt, effective anti-malarial treatment	Number of community health workers retrained in management of uncomplicated malaria cases	460 (cumulative over 4 years)	2008	Training Report										165		Y	N	Y - over program term		
5	Prevention: Insecticide-treated nets (ITNs)	Number of long lasting bednets and insecticide treated nets distributed	99133 (cumulative over the R4 grant life-time)	2009	Reproductive-health and Community NGO Report	107,876	105,607	0	0					106,371	111,690	117,009	Y	N	Y - over program term		
6	Prevention: BCC - community outreach	Number of school teacher & educators trainied in BCC	NA		Training Report				250		500			500	500		Y	N	Y - over program term		
7	Indoor Residual Spraying	Number of structures sprayed with insecticides	19344	2009	SR IRS activity report									39,815	80,427	121,851	Y	N	N - not cumulative		
8	BCC - community outreach	Number of persons who recognized 3 malaria signs	70,5%	2009	Community survey						80%			90%		95%	N	N	N - not cumulative		
	please select…				please select…												Y	N	Y - over program term		

[1] Please insert original baseline data from Phase 1 54.3

[2] Please provide latest data available 70.5

Service Delivery Areas	Impact Indicators	Outcome Indicators	DataSources
BCC - Mass media	Death rates associated with Malaria: all-cause under-5 mortality rate in highly endemic areas	% of U5 children (and other target groups) with malaria/fever receiving appropriate treatment within 24 hours (community/health facility)	DHS/DHS+ (Demographic and Health Survey)
BCC - community outreach	Incidence of clinical malaria cases (estimated and/or reported)	% of U5 children (and other target group) with uncomplicated malaria correctly managed at health facilities	MIS (Malaria Indicator Survey)
Insecticide-treated nets (ITNs)	Anaemia prevalence in children under 5 years of age	% of U5 children (and other target groups) admitted with severe malaria and correctly managed at health facilities	MICS (Multiple Indicator Cluster Survey)
Malaria prevention during pregnancy	Prevalence of malaria parasite infection	% of children U5 sleeping under an ITN	Situation Analysis
Indoor Residual Spraying	Laboratory-confirmed malaria cases seen in heath facilities	% of households with at least one ITN	HMIS
Prompt, effective anti-malarial treatment	Laboratory-confirmed malaria deaths seen in health facilities	% of pregnant women (and other target groups) sleeping under an ITN	Health Facility survey
Home based management of malaria	Malaria-attributed deaths in sentinel demographic surveillance sites	% of pregnant women on Intermittent preventive treatment (IPT) according to national policy (specific to Sub-Saharian Africa)	Health Provider survey
Diagnosis	API (Annual Parasite Index) (specific to Latin America and Asia)	% of households in malaria areas protected by IRS	Key informant survey
Monitoring drug resistance	Incidence of confirmed malaria cases	% of households covered by ITN or IRS	Households survey
Monitoring insecticide resistance			Vital registration systems
Coordination and partnership development (national, community, public-private)			Training records
HSS: Service delivery			Patients records
HSS: Health Workforce			Surveillance systems
HSS: Medical Products, Vaccines and Technology			Other report, specify
HSS: Information system			National Health Account
HSS: Financing			SAMS (Service Availability Mapping Survey)
HSS: Leadership and Goverance			Other survey, specify
			Administrative records