# PROPOSAL FORM – ROUND 7

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

| **Applicant Name** | Multisectorial Coordinating Committee for Sao Tome and Principe |
|---|---|
| **Country/countries** | **São Tomé e Príncipe** |
| **Components included in this Proposal Form** *(Check each applicable box below)* | |
| ☐ HIV/AIDS[1] | |
| ☐ Tuberculosis[1] | |
| ☒ Malaria | |

## Timetable: Round 7

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

Board consideration of recommended proposals: 14 - 16 November 2007

1 In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

# Index

## PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS



## REQUIRED ATTACHMENTS



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

## REFERENCE DOCUMENTS FOR APPLICANTS

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

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

# How to use this form

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

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

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

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

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

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

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

**Important notes:**

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

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

# How to use this form

## WHAT IS DIFFERENT COMPARED TO ROUND 6?

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

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

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

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

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

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

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

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

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

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

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

## Health Systems Strengthening – Round 7

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

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

# 1 Proposal Overview

## 1.1 General information on proposal

| Applicant Type |
|---|

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

☒ National Country Coordinating Mechanism

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

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

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

| | Component | Title |
|---|---|---|
| ☐ | HIV/AIDS[2] | |
| ☐ | Tuberculosis[2] | |
| ☒ | Malaria | Consolidating Malaria Control Efforts for Malaria Elimination in Sao Tome and Principe |

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

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

☒ US$

☐ Euro

2 In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

# 1 Proposal Overview

| Summary of Technical Assistance Provided During Proposal Preparation | | |
|---|---|---|
| *Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation **of this proposal** for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.* | | |
| **Section/Component** | **Name of organization or organizations providing assistance and type of assistance provided** | **Duration of technical assistance** |
| ☒ Sections 1 to 3B | The Earth Institute at Columbia University and the UN Millennium Project through the assignment of external consultant<br>WHO, assigned malaria focal person to work with the working group<br>UNDP, assigned two persons to work as a technical resource persons to the working group | May 20 to July 4/2007 |
| ☐ HIV/AIDS component, and/or budget | | |
| ☐ Tuberculosis component, and/or budget | | |
| ☒ Malaria component, and/or budget | The Earth Institute at Columbia University and the UN Millennium Project through the assignment of external consultant<br>WHO, assigned malaria focal person to work with the working group<br>UNDP, assigned two persons to work as a technical resource persons to the working group | May 20 to July 4/2007 |

# 1 Proposal Overview

## 1.2 Proposal funding summary per component

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

*Table 1.2 – Total funding summary*

| Component | Total funds requested over proposal term | | | | | |
|---|---|---|---|---|---|---|
| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
| HIV/AIDS | | | | | | |
| Tuberculosis | | | | | | |
| Malaria | 2,092,233 | 2,142,728 | 1,500,155 | 1,538,415 | 1,424,959 | 8,698,490 |
| Total all components | 2,092,233 | 2,142,728 | 1,500,155 | 1,538,415 | 1,424,959 | 8,698,490 |

# 1 Proposal Overview

## 1.3 Contact details for enquiries by the Global Fund

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

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

| Contact Details for Enquiries on the Applicant's Proposal after Submission | | |
|---|---|---|
| | **Primary contact** | **Secondary contact** |
| **Name** | Herodes Sacramento | Ernesto Rodero |
| **Title** | Director of National Endemic Centre | Coordinator |
| **Organization** | Ministry of Health | Global Fund Unity/UNDP São Tomé |
| **Mailing address** | Bº Qª Stº Antonio, Centro Nacional de Endemias, São Tom | B.P. 109, Avenue des Nations Unies, São Tome et Principe |
| **Telephone** | +239 241 650 / 909 699 | +239 221 122/23 / 918 451 |
| **Fax** | +239 221 227 | +239 222 198 |
| **E-mail address** | sacramentosousa@yahoo.com.br | Ernesto.rodero@undp.org |
| **Alternate e-mail address** | cruzc@afro.who.int | eroderob@gmail.com |

# 1 Proposal Overview

## 1.4 Overview Summary of the Applicant's Proposal

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

With support from the GFATM and other partners, São Tomé et Príncipe (STP) has reduced the number of malaria outpatients visiting the hospital, district health centres and health posts from almost 51,000 in 2002, to about 7,300 in 2006 and is on track to make further reductions in 2007. This new proposal seeks to consolidate these gains by scaling-up LLIN coverage for two more years, and increasing access to quality diagnostic and treatment services, while maintaining universal coverage with IRS. Once universal coverage with LLINs is achieved, STP will shift to a programme ofsurveillance-intensive, integrated vector control. Routine, universal IRS will be replaced by emergency IRS performed at the district-level in response to threatened or detected outbreaks. This new programme will be supported by an integrated clinical and entomological surveillance system capable of identifying threats in a timely manner. The success of ongoing efforts, combined with the island isolation of STP makes the complete elimination of malaria both attainable and sustainable. In addition to the malaria-specific programs, the project will establish strong health systems to provide an institutional environment in which these intensified and diversified activities can thrive. It will engage in and encourage collaborations and partnership between the various sectors of government, NGOs, community groups and other stakeholders.

Elimination's end-stages inevitably bring a period of diminished returns and decelerated progress. Additonal resources must be engaged to attack the subset of mosquito vectors and human reservoirs most difficult to access ecologically and logistically. The failure to commit risks resurgence. The reward for surmounting this resource-intensive threshold is passage into a deintensified, indefinitely sustainable condition of watchful surveillance and occasional mitigation of outbreaks, which may bring increased economic return from tourism and business investment due to the absence of malaria.

Thus, the methods necessary to eliminate malaria from these islands are temporarily more costly on a per capita basis than intervention efforts designed only to reduce burdens. Elimination methods would be impractical in mainland areas where malaria transmission remains intense, where vectors are multiple and diverse, or where migration of vectors and infected human hosts is frequent, however, STP is exempt from each of these disqualifying conditions. Malaria transmission has already dropped dramatically, only a single species and molecular type of malaria vector is present, and STP's distance and isolation from the mainland results in much lower rates of human movement than most other malarious islands.

Because STP's goal is elimination, some of the proposed methodologies may also differ from that used in other programs. Surveillance must be unusually intensive to allow detection of threatened and actual transmission to be identified on a timely basis. Mosquito larviciding, not cost-effective where malaria transmission is intense, becomes practical as a temporary component of an integrated programme attempting to eliminate malaria transmission. Similarly, environmental management becomes manageable in a small island country with highly accessible districts, and where transmission has already been greatly reduced.

The need to pursue intensification towards a stable endpoint is illustrated repeatedly throughout the history of public health when intervention efforts are relaxed after large reductions in burden are gained. Such an event led to the explosive and calamitous resurgence of malaria in Sri Lanka during the 1960's. STP has already experienced such a calamity after its DDT-based IRS programme was interrupted in the 1980s. Thus, the job must be finished to the end. Near elimination is not enough.

Malaria elimination can be achieved in STP in the near future. The National CCM of STP proposes a continuation of present efforts for two more years to ensure that specific coverage indicators for LLIN distribution and outcome indicators for transmission reduction can be obtained. Meanwhile, the country will prepare for consolidation; recruiting, equipping and training District-level health technicians to conduct intensified surveillance and integrated interventions designed to eliminate malaria from all remaining foci. After elimination, STP will shift to a de-intensified programme of sensitive clinical surveillance and emergency epidemic response. Many costly and less sustainable activities such as universal IRS, and eventually even LLIN distribution will be discontinued or dramatically reduced. STP will be left with a stronger health system, a lesser burden, and a more promising and sustainable future.

# 1 Proposal Overview

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

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

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

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

*In this section, please describe:*

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

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

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

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

| **Overview of rationale for multi-country approach**<br>*(maximum one page)* |
|---|
| Not Applicable |

# 1 Proposal Overview

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

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

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

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

| HIV/AIDS | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Round 2 | | | |
| Round 3 | | | |
| Round 4 | | | |
| Round 5 | 228.331 | 132.621 | |
| Round 6 | | | |
| Total | 228.331 | 132.621 | |

*Table 1.6.2 – Previous Global Fund tuberculosis financial support*

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

# 1 Proposal Overview

*Table 1.6.3 – Previous Global Fund malaria financial support*

| Malaria | Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007 | Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007 | [For RCM and RO applicants only] List the countries included in the relevant proposal |
|---|---|---|---|
| Round 1 | | | |
| Round 2 | | | |
| Round 3 | | | |
| Round 4 | 1,885,645 | 1,716,339 | |
| Round 5 | | | |
| Round 6 | | | |
| Total | 1,885,645 | 1,716,339 | |

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

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

# 2 Country Eligibility

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

**These eligibility criteria are:**

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

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

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

## 2.1 Income Level

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

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

# 2 Country Eligibility

## 2.2 Counterpart financing and greater reliance on domestic resources

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

### 2.2.1 CCM and Sub-CCM Applicants

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

***Important notes:***

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

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

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

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

# 2 Country Eligibility

*Table 2.2.1(b) – Counterpart financing tuberculosis*

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

*Table 2.2.1(c) – Counterpart financing malaria*

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

# 2 Country Eligibility

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

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

**RCM and RO Applicants may either**:

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

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

**OR**

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

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

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

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

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

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

# 2 Country Eligibility

## 2.3 Focus on poor or vulnerable populations

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

| | |
|---|---|
| 2.3 | Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal. *(Maximum half a page per component).* |
| | Not Applicable. STP is a Low-Income country. |

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

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

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

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

| | |
|---|---|
| (c) | **Malaria Current High National Disease Burden**<br>Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)* |
| | Not Applicable. STP is a Low-Income country. |

# 3A Applicant Type and Eligibility for Funding

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

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

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

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

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

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

## Confirmation of Applicant Type

*Table 3A – Applicant Type*

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

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

***Importantly*** ➔

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

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

# 3A Applicant Type and Eligibility for Funding

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

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

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

| Name of CCM |
|---|
| Multisectorial Coordinating Committee for Sao Tome and Principe |

### 3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

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

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

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

The National CCM of STP has 29 members that generally convene at least four times per year as a single body at the Ministry of Health. Additional meetings are scheduled as needed to consider special issues. The general role of the CCM is to assist the Ministry of Health with the formulation of health policies, and with the mobilization of resources and funds. In addition, regarding the global found issues the CCM is a top structure in the programme (decision in the preparation of the proposal, submission, coordination, and oversight activities including M&E).The CCM was originally established on October 10, 2000 with 13 original members. In October of 2002, the CCM was expanded to include 10 new members. The IACC was added as an additional partner at that time. To ensure the broadest multi-sectoral representation and partnership among different stakeholders, the members of CCM represent various stakeholders such as the Ministry of Health, WHO, Ministry of Planning and Finance, Ministry of Culture and Education, Social Communication, UNDP, UNICEF, African Development Bank, UNFPA, Portuguese Cooperation, French Cooperation, ICDF Taiwan Cooperation, Red Cross of STP, American Cooperation, Rotary Club, Chamber of Commerce, Industry, Agriculture and Services, NGO Federation of STP, Caritas of STP Inter Sindical, and Catholic Church. The CCM is chaired by the Minister of Health signifying a political commitment in strengthening the functionality of partnership between government and stakeholders. The broad representation of the partners within CCM ensures community involvement, transparency, consistency and coordination of all activities funded by the GFATM. The CCM has also been involved in the implementation of a vaccination programme funded by the Gates Foundation. The CCM has a simple organizational structure; with a President, Vice-President, Secretariat and various technical groups that are formed as needed from among the CCM members according to the needs of the moment.

During the implementation of previously GFATM funded proposal, CCM has been ensuring the participation of all sectors. Decisions are generally derived by consensus after a careful consideration of all technical inputs and concerns. Outside technical experts or consultants are sometimes called in to provide advice on areas of deliberation. The CCM convened several times during the development of this proposal to review draft plans and to provide final approval. One recent meeting included not only CCM members but also other stakeholders and partners in the community. Meetings will be convened during the resource mobilin and implementation phases begin to provide direction and oversight after receiving

# 3A Applicant Type and Eligibility for Funding

briefs on the status and progress of activities. Meetings will also be convened to provide oversight over the monitoring and evaluation process as results become available.

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

# 3A Applicant Type and Eligibility for Funding

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

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

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

| Name of Sub-CCM |
|---|
| Not Applicable |

### 3A.2.1 Mode of operation

Describe how the Sub-CCM operates. In particular:

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

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

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

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

Not Applicable

### 3A.2.2 Rationale

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

Not Applicable

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

Not Applicable

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

# 3A Applicant Type and Eligibility for Funding

## 3A.3 Regional Coordinating Mechanism Applicants
***(includes small island developing states without national CCMs)***

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

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

| Name of Regional Coordinating Mechanism (RCM) |
|---|
| Not Applicable |
| **RCM Secretariat Office Address** |
| Not Applicable |

### 3A.3.1 Mode of operation

Describe how the RCM operates. In particular:

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

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

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

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

Not Applicable

### 3A.3.2 Rationale

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

Not Applicable

# 3A Applicant Type and Eligibility for Funding

| | |
|---|---|
| (b) Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM.<br>*(Maximum of half a page.)* | |
| Not Applicable | |

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

# 3A Applicant Type and Eligibility for Funding

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

**IMPORTANT NOTE FOR APPLICANTS:**

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

*For additional information regarding these requirements, see:*

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

### 3A.4.1 Round 6 Application History

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

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

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

Describe **in detail** any changes in the membership or operations of the Coordinating Mechanism (i.e., CCM, Sub-CCM or RCM) since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted for the selection of members by their own sectors, or to manage conflicts of interest; or oversee the work of implementation partners.
*If new processes have been adopted, these must be described, and relevant documents attached as an annex to your Round 7 proposal.*

No Round 6 application was submitted. Changes in the CCM membership and operations have occurred since the Round 4 Application, however. Two institutional membership have been added because they are very important actors in the HIV/AIDS implementation program. The two members come from UNAIDS and Brazil Embassy (introduction and provision of some ARV treatment), respectively. Operationaly the CCM has, in the process of adoption, a new internal regulation already dicussed in some sessions which has already influence in the functioning of CCM meeting. The CCM is now more operational than in the past. The CCM is in the process of transformation to become the single coordinating body in the country with higher responsibility and capacity.

# 3A Applicant Type and Eligibility for Funding

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

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

**3A.4.3 Principle of broad and inclusive membership**

**(a)** **Requirement 1 ➔ Selection of non-governmental sector representatives**

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

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

| **Documentation relied on to support compliance with Requirement 1** | **Identify which annex to this proposal contains these documents** *Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.* |
|---|---|
| ☒ Selection criteria for each sector developed by each respective sector | CCM Constitution ( **Annex 1**)<br>Letter of FONG - Justification from all CCM members mentioning their representative (**Annex 2**) |
| ☐ Minutes of meeting(s) at which the sector transparently determined its representative | N/A |
| ☒ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member | *FONG Constitution* (**Annex 3**) |
| ☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process | Letter of FONG (minute of FONG, Caritas & Others CCM members (**Annex 4**) |
| ☒ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM. | CCIA enlargement to CCM Proposal nº 25/P. ºCNE/2002 (**Annex 5**) |
| ☐ Other: *(please specify):* | |

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

The annexes submitted above indicate the intersectoral diversity of the representation of the CCM, and the inclusivity and transparency of the process used in its operation and deliberation. All organizations participating in the CCM are contacted directly in advance of all CCM meetings, and considerable flexibility is maintnained in the scheduling and rescheduling all meetings to assure maximum participation and a large quorum. Certain meetings are also announced to a wider array of stakeholders beyond the

CCM membership, to allow opportunities for community participation and comment.

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

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

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

Until recently, the attack rate of malaria in children less than 5 years old in STP was greater than 1 case per child per year. Therefore, anyone with a child, or who had close relatives with children, were directly affected by malaria cases in their immediate or extended families. Beyond this, members of the CCM, just by virtue of living in STP, were themselves at risk of acquiring malaria and had likely acquired malaria sometime in their past, whether or not they were currently infected with malaria parasites. Until the last few years, malaria transmission had been relatively ubiquitous around STP and representation of people affected by the disease in the CCM was inevitable.

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

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

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

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

The CCM invited all partners and stakeholders to participate in the proposal preparations. Official invitation letters (**Annex-7**) were distributed to all parties along with a brief summary of the overall strategy and directions of the malaria control programme with particular emphasis on the effort to eliminate malaria. All parties and other partners including CCM members were also invited to a conference organized by the Ministry of Health and the CCM Secretariat. The conference was held in the presence of his Excellency, -Tome Vera Cruz, the Prime Minister of Sao Tome and Principe. The main agenda of the conference involved the orientation of partners and stakeholders to the malaria elimination process and the preparation process for the GFATM round 7 proposal in order to make the proposal preparation transparent to all stakeholders. During the conference, a working group on the proposal preparation was identified from the participating partners(copy of the official invitation letters to attend the conference is attached – **Annex-8**). The terms of reference of the working group were to oversee development of the proposal, solicit submissions for possible integration into the proposal, conduct consultations and communicate the draft proposal to the CCM. The working group was chaired by CNE, and included representatives from UNDP, WHO and the Centre for Endemic Diseases, as well as representatives of other partners. The working group was supported by external consultants from the Earth Institute at Columbia University.
In the response to the letter of invitation and the explanations and discussions during the conference, 20 different proposals were submitted to the CCM. The working group along with technical staff of the CNE discussed on the potential integration of the proposals into the main proposal. The submitted proposals focused ranged on many preventive and promotive activities which are in line with the strategies of the malaria control program. Through discussion of the working group, 7 of the submission were selected to be integrated with this proposal. The list of proposals and the proposals integrated into this proposal are attached (**Annex-13**).

# 3A Applicant Type and Eligibility for Funding

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

Any comments, criticisms and suggestions from CCM members and other stakeholders regarding the draft proposal were to be collected by the working group on proposal preparation that is managed by the director of malaria control at the Centre for Endemic Diseases. Submissions were also to be accepted during the various proceedings of the CCM that occur during the process of proposal preparation. Concerns expressed and amendments recommended during the course of these proceedings are carefully recorded and considered for inclusion into the final proposal. Several suggestions and concerns expressed at the working group meeting have since been incorporated into the proposal and action plan. Once incorporated, the final proposal is presented at a meeting of the CCM convened in order to finalize a consensus among the membership for submission.

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

During the CCM meetings held to discuss the overall strategy and to introduce some of the details of the proposal UNDP has been selected as the PR by concensus of all due to the lack of capacity of both management and procurement needs of the other potential candidate, the CNE to undertake the complex managerial activities required in a GFATM award. The decision was also supported by the good performance of UNDP till today with both malaria and HIV/AIDS grant.

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

The CCM regularly meets to review progress reports and to discuss the implementation of the programme by the Principal Recipient. Formal meetings are scheduled about four times per year, all of which are attended by the PR, and in which the PR presents status reports on procurement, resource utilin, bottlenecks and other issues. During the interim, any CCM member has full access upon request to the documentation, personnel and activities of the PR.

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

On March 2007, a brainstorming meeting was held at the Ministry of Health in the presence of the Minister of Health and the National Malaria Control staff to discuss the issues and the attendees decided to submit a proposal to the 7$^{th}$ Round of the Global Fund. However, to ensure input from all relevant stakeholders that could be play an important role in malaria control, the Ministry of Health decided to engage all stakeholders in the proposal development process, with particular emphasis to the need of creating multisectorial partnerships. Thus, stakeholders outside of the immediate membership of the CCM were invited to participate in the process, and it was followed up by a national level conference which was organized by the CCM on 15$^{th}$ of June, 2007. During the conference, the views of CCM members as well as those of other partners and stakeholders were represented. The main agenda of the conference was to orient the partners and stakeholders on the the status and plans for malaria elimination in STP and the process for preparation of the GFATM round 7 proposal. The goal of this agenda was to increase the transparency of current and planned malaria intervention activities and the process for preparation and submission of the proposal. The conference was held in the presence of his Excellency, Tome Vera Cruz, the Prime Minister of Sao Tome and Principe. During the conference, inputs from stakeholders such as other sectors of the government (including education, agriculture, environmental agency), Civil Societies and NGOs were obtained, which resulted in the inclusion the objective of establishing multisectoral collaboration and partnership into this proposal.

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

Invitations to certain CCM meetings are extended to stakeholders beyond the specific designated membership of the CCM. This often includes additional parties from the groups already represented in the CCM, as well as community members and other stakeholders who do not currently have a seat in the CCM. These extended meetings generally discuss overall strategies and progress, tentative plans for new initiatives, and the process for preparing and submitting proposals. CCM-only meetings that discuss these same issues in greater technical detail are still broadly representative of stakeholders because of

| |
|---|
| the diverse and comprehensive nature of the actual CCM membership. |

| 3A.4.6 | **Principle of effective management of actual and potential conflicts of interest** | |
|---|---|---|
| | **Requirement 6** ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal? | ☐ Yes<br>☒ No |
| | **If yes**, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**. | |
| Not Applicable | | |

| 3A.4.7 | **Financial Support for Coordinating Mechanism operations** | |
|---|---|---|
| | Does the applicant intend to apply for funding of CCM operations?<br>*Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.* | ☐ Yes<br>*provide details below*<br>☒ No<br>*go to section 3B.1* |
| | **If yes**, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals.<br>**Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.** | |
| | Not Applicable | |

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

# 3A Applicant Type and Eligibility for Funding

## 3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

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

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

| | **Name of Regional Organization** |
|---|---|
| | Not Applicable |
| | **Sector represented by the Regional Organization** *(Check the relevant box below)* |
| ☐ | Academic/educational sector |
| ☐ | Government |
| ☐ | Non-Government Organizations |
| ☐ | People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria |
| ☐ | Private sector |
| ☐ | Religious/faith-based organizations |
| ☐ | Other *(please specify)* |

### 3A.5.1 Mode of operation

*In addition to answering the questions below, Regional Organizations must provide (as additional annexes to this proposal) documentation describing the organization, such as:*

- *Statutes, by-laws of organization (official registration papers); and*
- *A summary of the main sources and amounts of funding over the past three years.*

**Describe below** how the Regional Organization operates. In particular:

The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects;

The extent to which people living with and/or affected by the disease(s) targeted in the Regional Organization's proposal were involved in development of your proposal; and

**The coverage and past experience** of the Regional Organization's operations, with a particular focus on outcomes relevant to the subject of this proposal
*(Maximum of half a page.)*

Not Applicable

# 3A Applicant Type and Eligibility for Funding

| 3A.5.2 Rationale |
|---|
| (a) Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. *(Maximum of half a page.)* |
| Not Applicable |
| (b) Explain how the countries targeted in the Regional Organization's proposal represent a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)* |
| Not Applicable |

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

# 3A Applicant Type and Eligibility for Funding

## 3A.6 Non-CCM Applicants

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

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

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

| | |
|---|---|
| **Name of Non-CCM Applicant** | Not Applicable |
| **Business address** *(including street, town/state and country)* | |

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

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

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

# 3A Applicant Type and Eligibility for Funding

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

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

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

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

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

# 3B Proposal Endorsement

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

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

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

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

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

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

| | Chair | Vice Chair |
|---|---|---|
| **Name** | Dr. Arlindo de Carvalho | Dr Jose Manuel de Carvalho |
| **Title** | Minister of Health | Coordinator of Health Care Department |
| **Organization** | Ministry of Health | Ministry of Health |
| **Mailing address** | Ministry of Health, P.O.Box 23 S.Tome and Principe | Ministry of Health, P.O.Box 23 S.Tome and Principe |
| **Telephone** | +239 241 201 | +239 242 000 |
| **Fax** | +239 221 306 | +239 242009 |
| **E-mail address** | msaude@cstome.net | hilarcarvalho@hotmail.com |
| **Alternate e-mail address** | Avacarvalho@hotmail.com | hilarcarvalho@yahoo.com.br |

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

# 3B Proposal Endorsement

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

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

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

**Summary of Membership of CCM, Sub-CCM or RCM**

The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**.

*Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.*

***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal.***

| Sector Representation | Number of members representing the sector |
|---|---|
| ☐ Academic/educational sector | |
| ☒ Government | 9 |
| ☒ Non-Government Organizations (NGOs)/community-based organizations | 4 |
| ☒ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria | 0 |
| ☒ Private sector | 4 |
| ☒ Religious/faith-based organizations | 2 |
| ☒ Multilateral and bilateral development partners in country | 10 |
| ☐ Other *(please specify):* | |
| **Total Number of Members** | 29 |

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

# 3B Proposal Endorsement

| Summary of Membership of CCM, Sub-CCM or RCM | |
|---|---|
| The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**.<br>*Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.*<br>***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal**.* | |
| **Sector Representation** | **Number of members representing the sector** |
| ☐ Academic/educational sector | |
| ☒ Government | 9 |
| ☒ Non-Government Organizations (NGOs)/community-based organizations | 4 |
| ☒ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria | 0 |
| ☒ Private sector | 2 |
| ☒ Religious/faith-based organizations | 1 |
| ☒ Multilateral and bilateral development partners in country | 13 |
| ☐ Other *(please specify):* | |
| **Total Number of Members** | 29 |

# 3B Proposal Endorsement

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

***Level 1 Endorsement***

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

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

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

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

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

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

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

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

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

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

# 3B Proposal Endorsement

## 3B.2 Regional Organization proposal endorsement

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

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

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

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

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

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

# 4 Component Section *Malaria*

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

| **Relevant item on the Proposal Form** | **Description of the information required in the Annex** | **Title of the Document** and **annex number given to each annex** |
|---|---|---|
| **Section 3A: Applicant Type and Eligibility for Funding** | | |
| ***Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):*** | | |
| 3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM) | Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors). | CCM Constitution (**Annex1**)<br>CCIA enlargement to CCM (proposal nº 25/P.ºCNE/2002 (**Annex 5**) |
| **Documentation describing compliance with the minimum Coordinating Mechanism requirements** (sections 3A.4.3 to 3A.4.6 inclusive): | | |
| Minimum Requirement 1 | Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism. | Letter of FONG (actas FONG, Caritas & Others CCM members (**Annex4**)<br>CCIA acta nº5 (**Annex 6**) |
| Minimum Requirement 3(a) | - solicit submissions for possible integration into the proposal. | Ofício Nº 200/PºCNE/2007 Elaboração do Plano (**Annex 7**)<br>Convite Reunião Sensibilização (**Annex 8**)<br>Indigitação de um ponto focal 15/6/2007 (**Annex 9**)<br>Ofício Nº 218/PºCNE/2007 envio de acta 19/6/2007 (**Annex 10**) |
| Minimum Requirement 3(b) | - review submissions for possible integration into the proposal. | Minutes of Working Group meetings **(Annex 11)**<br>List of proposal selected ( **Annex 12**)<br>Selecting table |

# 4 Component Section *Malaria*

| Relevant item on the Proposal Form | Description of the information required in the Annex | Title of the Document and annex number given to each annex |
|---|---|---|
| | | (**Annex 13**) |
| Minimum Requirement 4(a) and 4(b) | - select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation. | CCM Minute 22/6/2007( **Annex 14**) |
| Minimum Requirement 5(a) and 5(b) | - ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process. | The Conference minute (**Annex 15**)<br>Ofício Nº _218/PºCNE/2007 Envio de acta 19/6/2007(**Annex 10**) |
| 3A.4.6 – Minimum Requirement 6 | Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism | N/A |
| ***Regional Organization Applicants:*** | | |
| 3A.5.1 | Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding. | |
| ***Non-CCM Applicants:*** | | |
| 3A.6 | Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding. | |
| 3A.6.2 b | Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM. | |
| 3A.6.3 *(if submitted for a country where no CCM exists)* | Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies. | |
| **Section 3B: Proposal Endorsement** | | |
| 3B.1.3 ***Level 1 Proposal Endorsement*** *(CCMs, Sub-CCMs and RCMs)* | Minutes of the meeting at which the proposal was developed and CCM endorsed.. | **Attachment C to the Proposal Form**<br>Minutes of Working Group meetings (**Annex 11**) |

# 4 Component Section *Malaria*

| Relevant item on the Proposal Form | Description of the information required in the Annex | Title of the Document and annex number given to each annex |
|---|---|---|
| | | CCM Minute 22/6/2007(**Annex 14**) |
| 3B.1.3 (***Level 2 Proposal Endorsement =*** *Sub-CCMs and RCMs only)* | Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal. | |
| 3B.2.1 (***Level 2 Proposal Endorsement*** *Regional Organizations only)* | Documented evidence that the national CCMs have reviewed and endorsed the proposal. | |
| **Other documents relevant to sections 1 to 3B attached by Applicant:** *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)* | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

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

## 4.1 Requested proposal term for this disease component

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

**Important note:**

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

*Table 4.1.1 – Proposal start time and duration*

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

# 4 Component Section *Malaria*

## 4.2 Disease specific component executive summary

### 4.2.1 Executive summary

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

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

Malaria morbidity and mortality have been greatly reduced in the islands of São Tomé e Príncipe as a result of integrated antimalarial efforts funded by the 4th Round of the GFATM, and an intensified indoor residual spraying operations supported by ICDF Taiwan. Prior to these efforts, malaria had been a major public health problem in the country, accounting for 68% of hospitalins and 48% of hospital deaths. During 2006, the malaria burden has been reduced significantly, accounting for 18% of hospitalin and 5% of hospital deaths. There is a need to pursue intensification of integrated antimalarial measures towards a stable endpoint to prevent an explosive and calamitous resurgence of malaria. STP has already experienced such a calamity after its DDT-based IRS programme was interrupted in the 1980s due mainly to financial reasons.

The National CCM of São Tomé e Príncipe's (STP) application to the 7th Round of the GFATM aims to consolidate reductions in malaria burden through a continuation of current antimalaria efforts and further institutional strengthening, followed by a programme of intensified surveillance and diversified interventions that will lead to the elimination of malaria transmission in STP. The government recognizes that malaria elimination will require the direct involvement of a diversity of sectors, partners, community groups and the people, and this project is expected to establish a multisectorial collaborative partnership for the overall coordination and organization of the malaria prevention and control intervention. This effort will benefit the entire population of STP, which is almost universally exposed to the possibility of malaria transmission, but in particular the pregnant mothers and young children who are most vulnerable to the serious manifestations of this disease.

A shift to the "Consolidation" Phase of malaria elimination is expected to take place two years after the new funding cycle is in place, to allow time to build capacity for the new activities, and to allow the existing IRS programme to produce additional reductions in transmission while LLIN coverage continues to be scaled up with the support of an effective IEC program. The shift will occur on a district by district basis, and will be triggered by specific district-level coverage and outcome indicators. Once universal coverage (and >90% utilization) of LLINs is achieved and the incidence of malaria is near zero in any district during the "Attack" Phase, routine indoor residual spraying (IRS) efforts would cease in that district, and the district-level antimalaria programme would enter a period of "Consolidation." These districts would receive the manpower, equipment and training necessary to conduct a new programme of intensified surveillance and integrated interventions.

The new surveillance programs will be designed to identify and prioritize those sites where transmission risk remains particularly intense, and would include monitoring of larval and adult vector populations, and household fever incidence, revealed initially by community-based surveys and confirmed with RDTs. Risk would be mapped using GPS/GIS technology and targeted with an appropriate combination of emergency IRS, larviciding and/or environmental management. Intervention strategies will be supported with laboratory quality assurance assays to ensure that the methods and materials used in interventions are being applied appropriately and remain effective.

The District-level "Consolidation" Phase, in which some Districts will remain in "Attack" mode, will be followed by a National "Consolidation" Phase in which intensified surveillance and diversified interventions efforts continue throughout STP, supplemented by mass presumptive treatment of community members with ACTs when transmission has become isolated in discrete foci and whenever surveillance reveals foci of active transmission. Because malaria outbreaks are likely to occur frequently as long as neighboring districts remain in "Attack" mode, mass treatment may not be practical until all Districts qualify for entry into "Consolidation".

Finally, the "Maintenance" Phase will commence after all districts have reported two entire years without evidence of locally acquired malaria of malaria transmission and an island-wide parasite blood survey is

completed to validate and certify this outcome. Vigilance will continue after malaria transmission is eliminated from STP because vector mosquitoes will likely remain, and because infected people will likely travel occasionally to STP from other places. Thus, while LLIN programs and routine entomological surveillance could be discontinued, clinical surveillance would continue and the capacity to perform emergency antivector interventions and mass treatment would need to be retained in each district. At this point, the scale of resources and effort is expected to be a small fraction of what was previously necessary, as would be the burden of malaria.

# 4 Component Section *Malaria*

## 4.3 National programme context for this component

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

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

| | |
|---|---|
| ☒ | National Health Sector Development/Strategic Plan |
| ☒ | National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings** |
| ☒ | Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards) |
| ☒ | Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal** |
| ☒ | National Monitoring and Evaluation Plan (health sector, disease specific or other) |

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

**4.3.2 Epidemiological and disease-specific background**

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

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

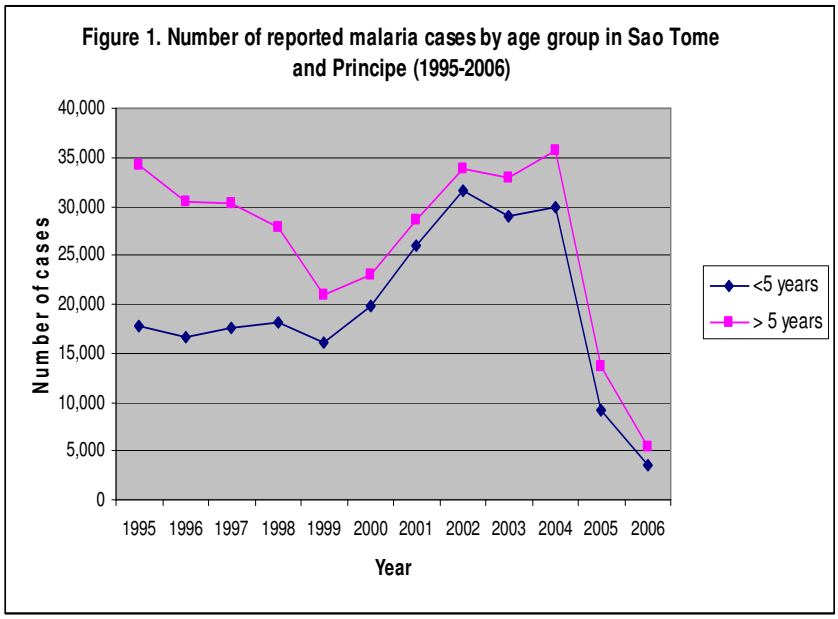
| Population | Estimated number | Year of estimate | Source of estimate |
|---|---|---|---|
| (i) **Total Population** (all ages) | 162,954 | 2007 | National Direction of Statistics population projection based on 2000 estimate |
| (ii) **Current estimates on the stage of the disease in the following population groups**: | | | |
| Population at risk for malaria *(all ages)* | 162,954 | 2007 | National Malaria Strategy, all parts of the country is malarious area |
| Pregnant women at risk of malaria | 8,148 | 2007 | Based on the percentage of pregnant women in the population |
| Children under 5 at risk of malaria | 29331 | 2007 | Based on the percentage of under 5 in the population |
| Estimated malaria episodes per year | 11,458 | 2006 | Calculated from reported cases and KAP survey |
| Reported malaria episodes per year | 9,166 | 2006 | Report from health facilitites |

# 4 Component Section *Malaria*

| Population | Estimated number | Year of estimate | Source of estimate |
|---|---|---|---|
| Malaria deaths per year *(all ages)* | 26 | 2006 | Report from Health Facilities and Community Health Workers |
| Under 5 child mortality (per 1000) | 115 | 2005 | WHO Country Office |
| Number of bed nets in country | 43530 | 2006 | HMIS - CNE |
| Proportion of children under 5 protected by bed nets | 53.5% | 2007 | KAP Survey, CNE |
| Other: *(identify)* Percent pf pregnant women sleeping under bednet | 41.3% | 2006 | KAP Survey, CNE |

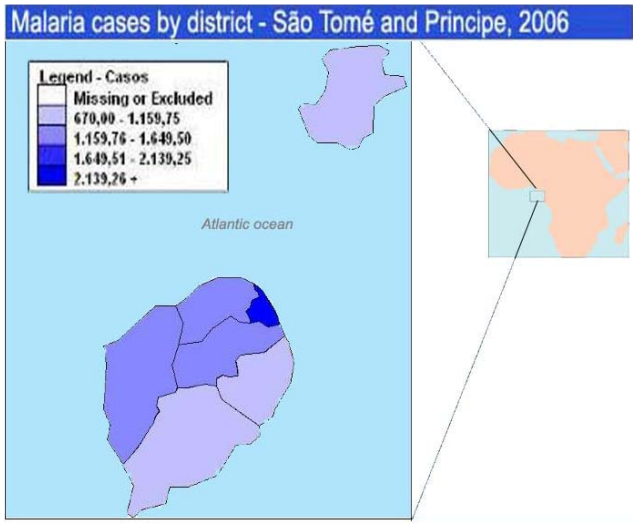
(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons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

Malaria morbidity and mortality have been reduced substantially in the islands of São Tomé e Príncipe since antimalarial efforts funded by the 4th Round of the GFATM and other partners were begun. Prior to these efforts, malaria had been by far the most dominant public health issue in the country, with 15,844 hospitalins and 319 hospital deaths due to malaria in 2002, accounting for 68% of hospitalins and 48% of hospital deaths. During 2006, the malaria burden has been reduced significantly with 1,873 hospitalizations and only 26 malaria related deaths, accounting for 18% of hospitalin and 5% of hospital deaths. Similarly, the number of malaria patients visiting the outpatient departments of the hospital, district health centers and health posts has also decreased substantially from 50,781 reported cases in 2002 to 7,293 reported malaria cases during 2006 (Figure 1). The changes in malaria related outpatient visits, hospitalizations and deaths represent 7-12 fold reductions in 2006 compared to 2002.



# 4 Component Section *Malaria*

According to the MOH data, the proportional hospital mortality of malaria in under fives during 1995-2001 was in the range of 48% to 75%. The pediatric ward was often filled with malaria patients, and children normally shared hospital beds with other children. Thus, a much greater proportion of the hospital facilities and staff were being utilized for the diagnosis and treatment of malaria than for any other medical condition. In 2002, the incidence of morbidity remained greater than one case per person per year in children under five years of age. The epidemiological stratification of the country by district based on the number of reported malaria cases during the year of 2006 is shown in the map below.




The most affected and vulnerable population groups in São Tomé e Príncipe continue to be children under 5 years old and pregnant women, however, since 2002, the reductions in morbidity and mortality due to malaria have been particularly striking in these groups. Specifically, in 2002, 31,650 malaria cases were reported in an estimated 23,714 children under five years of age, for an annual incidence rate of 1.34 reported malaria episodes per child per year. By 2006, this rate had dropped almost ten-fold to 0.14 reported malaria episodes per child per year, representing 3,492 malaria cases among the estimated 25,669 children under five years of age. Only 17 deaths due to malaria in children under five were reported during 2006.

Uncomplicated malaria cases are currently being treated with artesunate-amodiaquine, an artemisinin-based combination therapy (ACT). The extent of *Plasmodium falciparum* resistance to chloroquine and sulfadoxine/pyrimethamine (SP) had been quite high (75-80% clinical efficacy) and it was critically important that these drugs be replaced by ACTs to serve as first-line drugs for the treatment of uncomplicated malaria. The National antimalarial drug policy was changed in 2005, when artesunate-amodiaquine became the first-line drug for uncomplicated malaria. Another artemisinin-based combination therapy (Coartem) became the second line drug of choice to provide additional treatment options in health facilities for special cases and counterindications (e.g. first trimester pregnancy, impaired liver function). Since quinine remains effective, clinicians continue to use it for the treatment of severe malaria. Sulfadoxine/pyrimethamine (SP) is only used for Intermittent Preventive Therapy (IPT) in pregnancy. Although, there is some degree of resistance to SP exists, it is expected that the change of the first-line drug to an ACT will ease the selection pressure against it.

An initial assessment of the efficacy of artesunate-amodiaquine against *Plasmodium falciparum* infections was undertaken soon after the National Drug Policy was altered to establish artesunate-amodiaquine as a first-line antimalarial drug in 2005. The new drug was found to be highly effective under the established protocols.

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

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

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

The National Malaria Prevention and Control Programme in São Tomé e Príncipe aims to reduce malaria morbidity and mortality to zero by completely eliminating malaria transmission in the country. This Programme is guided by a seven year strategic plan and includes the primary strategies of vector control

including IRS, LLINs and early diagnosis and prompt treatment of malaria cases. This will transition into more integrated vector control including larviciding, environmental management and intensified clinical and entomological surveillance systems linked with outbreak preparedness and a timely response capacity. These strategies are supported by activities aimed to provide Information, Education and Communication (IEC) on malaria prevention, early recognition and treatment, BCC and health service strengthening. Technically and administratively, these intervention strategies are supported by an operational research program, and monitoring and evaluation activities. The major objectives of the National Malaria Prevention and Control Programme include achieving universal coverage for early malaria diagnosis and treatment by 2007, universal coverage of all households with LLINs by 2009. One hundred percent coverage of households with IRS to be sustained for an additional two years until universal coverage with LLINs is obtained and malaria incidence has fallen sufficiently low to shift to a strategy of selective application of IRS guided by clinical and entomological surveillance data.

**Early Diagnosis and Prompt Treatment**

São Toméans generally enjoy comparatively good, physical access to health service facilities and community level care in STP. Most communities are situated within a reasonable distance of a hospital, health center or health post. Most facilities have now acquired the necessary diagnostics and medications for malaria care needed to perform early diagnosis and treatment of malaria according to the National guidelines. The National Malaria Control Programme plans to ensure that all remaining Sao Tomeans with less than adequate access will universally be provided such access by the end of 2007 by identifying and remedying situations where coverage and capacity remains less than optimal.

All hospitals, heath centers and most health posts are equipped with microscopy for the examination of blood smears. Some of the health posts not equipped with microscopic diagnostics are currently using RDT for malaria diagnosis. In the remaining health posts without the capacity for parasitological diagnosis, and within communities, diagnostics are based on clinical signs and symptoms. The Artemisinin Based Combination Therapy (ACT), Artesunate-Amodaquine, is used as the first-line drug of choice for the treatment of uncomplicated *P. falciparum* malaria. Coartem (artemether-lumefantrine) is used a second-line drug for patients contraindicated or unable to tolerate the first-line medication. Parenteral quinine is used for the treatment of severe and complicated malaria. The drug of choice for intermittent preventive treatment is sulfadoxine/ pyrimethamine (SP).

**Interventions Against Malaria Vectors**

Currently, the primary measures performed in STP against vector mosquitoes include an Indoor Residual Spraying operation performed under the collaboration and supervision of a bilateral project funded and managed by International Cooperation and Development Fund (ICDF) from the Republic of China, Taiwan, and a Long-Lasting Insecticidal Net (LLIN) distribution programme supported by funding and oversight initiated by the 4$^{th}$ Round of the GFATM. The government has committed to free mass distribution of LLINs through out the country with particular emphases to children under five years of age and pregnant women. Treated bednet coverage in the country overall has reached more than 50% percent, and bednets are generally well accepted by the people, although IEC continues to remain necessary to reinforce and maximize utilization rates. Some of the treated nets being used include some retreatable insecticide-treated nets (ITNs) that were distributed by other partners before the distribution programme funded by the 4$^{th}$ Round of the GFATM took effect, but these will be replaced in future cycles by LLINs. The government plans to achieve universal coverage with LLINs by 2009, when it will become the maint general vector control measure against adult vector mosquitoes.

Several years ago the National Malaria Control Programme entered into a bilateral partnership with the Republic of China, Taiwan to adopt a strategy of intensive vector control measures targeting indoor-feeding and resting adult malaria vectors by spraying residual alpha-cypermethrin indoors in all homes across Sao Tome and Principe. The national programme and its partner have been targeting all households in the country during the consecutive rounds of IRS. The coverage thus far has exceeded 90% of households in each of the three rounds completed thus far. This residual spraying operation was initially intended to continue for three years, with 2007 representing the final year of operations. Given the large reductions in burden that have already been accomplished but the significant transmission that remains, the National Malaria Control Programme recognizes the need to sustain these operations

Although the National Malaria Control Programme recognizes the importance of continuing large-scale IRS for at least two more years in its strategic plan, it is not clear at present precisely by what mechanism this will occur. Possibilities include: extending these operations under the current arrangement with the Republic of China, Taiwan (at the prerogative of this bilateral partner), transferring full supervisory and

and operational capacity to the National Programme with the assistance of the current bilateral partner (again, at the prerogative of the partner), or independently supporting capacity transfer of widespread IRS operations through funding requested from the 7th Round of the GFATM. This latter, most conservative possibility is assumed in the action plan and budget to ensure that this critical need is covered regardless of the final arrangements.

In addition to the two years of full IRS coverage, the later provision and establishment of district-level IRS capacity is also included in the action plan and budget request. These smaller scale, focal operations intended to take effect after several more rounds of largescale IRS operations. It is presently assumed that the bilateral partner will remain engaged given the tremendous success of the programme so far and in recognition of the relative instability of the burden reductions in lieu of elimination, but the situation remains uncertain. All parties appear to concur that it is in the best interest of São Tomé e Príncipe to continue large-scale IRS operations in STP until these gains can be fully consolidated. The precise mechanism for ensuring this continuity of these operations for two more years will require further negotiation.

Thus, the National Strategic Plan for IRS calls for continuation of the regular largescale spraying for two more years until gains in the interruption of malaria transmission have been further consolidated and the LLIN distribution programme has had an opportunity to achieve its target of universal coverage and >90% utilization, Thereafter, the national strategy plans to initiate an intensified programme of surveillance that provides early indications of threatened and actual transmission risk, triggering a rapid response involving focal spraying of houses in communities where excessive malaria transmission or risk of such transmission as indicated by an unusual abundance of mosquito vectors is detected. The withdrawal of large-scale indoor residual spraying is planned to be carried out in a progressive way after universal coverage with ITNs is fully achieved and the surveillance and epidemic preparedness and timely response are well established and strengthened.

The emergency, rapid response IRS operations, once implemented, will be part of an integrated programme of antivector interventions, that will include several methods of source reduction, including biological and chemical larviciding and modification of mosquito breeding habitats through environmental management. While most of the less elevated, less forested rural settlements of STP harbor conditions suitable for breeding of *Anopheles gambiae,* breeding can also occur in towns and peri-urban areas because the settlement pattern generally involves gardens and open areas with rural/semirural characteristics and ecologies.

Larval vector control has previously been performed only on a very limited basis in São Tomé e Príncipe including such practices as chemical larviciding and environmental management. These activities are not presently incorporated into the national vector control programme but form a component in current proposal and strategic plan as a key element in the suite of integrated interventions designed to eliminate malaria transmission completely. District-level training in current methods appropriate to the conditions on Sao Tome will be necessary, and intersectoral collaborations with entities such as the public works, agricultural and environmental sectors are also planned to broaden the involvement to include stakeholders with relevant capacity and expertise. Specific source reduction measures that will be practiced will include filling puddles, open ditches and borrow pits, clearing the flow of drainage ditches and irrigation channels, and preventing the accumulation of standing water in areas where it accumulates after rain by improving drainage.

The larviciding planned as part of the intensified and integrated program of interventions will include a combination of chemical and biological methods, depending on the situations encountered. Collections of young larvae detected during surveillance operations will be treated with *Bacillus thuringiensis israelensis* (bti), an environmentally safe, biological insecticide. Pupae and late instar larvae not affected by bti will be treated with temephos, a non-persistent chemical larvicide that has relatively low human toxicity and which is one of the few insecticides that is registered to treat sources of drinking water (temephos is used in some countries to treat the copepod vectors that carry Guinea worm). Removing breeding sources and killing immature mosquitoes before they can emerge will assist the elimination effort by further depressing the force of malaria transmission and lowering the entomological inoculation rate (EIR).

**Information, Education and Communication**

The Information, Education and Communication (IEC) strategy adopted by the National Malaria Control Programme is used to promote understanding to encourage cooperation with the operations and goals of the strategic plan against malaria. Community residents receive information and communications designed to increase their overall understanding and knowledge of malaria, including how it is transmitted

and how to recognize the onset of its earliest symptoms. The importance of seeking treatment as early as possible is emphasized because timely treatment-seeking behavior is highly correlated with positive outcomes and prognosis, and particularly avoidance of the disease progressing into severe manifestations.

IEC is also currently used to bring sustainable behavioral changes in the use and practice of protective measures against malaria. This includes information regarding the health benefits of the proper use of ITNs and LLINs, and the proper procedures for retreating ITNs (for those who have not yet received an LLIN through the national distribution programme). It also includes explanation of the benefits of participating in the IRS programme and the precautions necessary to maintain its safety (e.g. covering or removing furniture during applications, remaining outside for one hour until the residual solution has become dry) and efficacy (e.g. not washing, painting, or whitewashing interior walls too soon after residual insecticide application). Community health workers as well as members of the community in general receive information on the proper use of Intermittent Preventive Treatment (IPT) for malaria in pregnancy, including an explanation of the vulnerability of pregnant mothers and the proper timing and dosage of SP required to prevent infection. To prepare for future activities, communities will be sensitized through IEC to recognize and practices that create breeding sites for malaria mosquito vectors as well as how to modify existing habitats with community or household-level initiative to render them unsuitable for *Anopheles* larval development.

Communities will be prepared for the strategy of malaria elimination by creating awareness among political leaders, different sectors, partners, community groups and the people at large of the importance of case identification, a strong surveillance system and effective actions, as well as the risk of re-introduction of malaria and occurence of devastating epidemics if the malaria strategies fail. New strategies, such as integrated, intensive surveillance and emergency focal spraying will be explained so that residents are aware of their implementation in advance and can anticipate their impact on the community and recognize their importance once such activities become implemented.

Thus, raising the awareness and interest both of health workers and communities through well-designed IEC materials is a pre-requisite for a successful intervention of malaria control activities. Appropriate IEC materials will be developed in local languages (Portuguese and Creole) targeting the health workers and local communities. New, locally appropriate communication materials including posters, leaflets and mass media spots will be developed to communicate messages supporting both the ongoing and new activities and strategies of the National Malaria Control Programme.

**Surveillance System**

The National Centre for Epidemic Diseases currently performs some surveillance activities that incorporate both entomological and epidemiological elements. It employs the capacity to identify malaria vectors and parasites, to perform and evaluate community-based health surveys and to evaluate the impact and efficacy of diverse interventions. Malaria programme entomologists routinely collect data for on the abundance and behavior of mosquito vectors. The efficacy of chemicals used in antivector measures are assessed regularly using WHO discriminating-dose bioassays. Anti-malarial drug efficacy studies are also undertaken on occasion to assess the clinical efficacy of the first-line drug. The epidemiological surveillance system is based on routine health service data as well as periodic community surveys that are conducted for the estimation of malaria prevalence in the community, the degree of utilization of protective measures and the health-seeking behavior of the people, in order to assess the effectiveness of the antimalarial measures used in the National Programme

The current system, however, lacks the comprehensiveness and consistency that will be necessary to implement the integrated control measures that are planned to achieve the elimination of malaria. It requires additional capacity to be able to perform these activities with greater intensity and consistency at the district level. Additional human resources will need to be recruited and trained, particularly at the district level, to allow for a more decentralized and timely programme of surveillance, that ensure that interventions can be organized rapidly at the district-level in response to information regarding specific malaria transmission threats. Thus, the strategic plan calls for an expansion of the surveillance system to include regular district-level monitoring of larval and adult malaria vector abundance and malaria incidence at the community level. This surveillance system forms a component in a larger, integrated Health Information System to be implemented for the health services in general.

**Operational Research**

Operational research is an important supporting strategy in the overall National Malaria Control

Programme. Its mission focuses on obtaining the evidence required to guide the design of appropriate and effective malaria prevention and control measures and to determine whether methods or materials need to be altered in order to restore, maintain or improve efficacy. The National Programme has previously engaged in operational research involving insecticide resistance, the evaluation of the therapeutic efficacy of antimalarial drugs and on the knowledge, attitude and practices (KAP surveys) in behavioral studies related to malaria perception, treatment seeking behavior and compliance. One of the primary missions of the current operational research effort is to support the IRS programme by evaluating its impact on malaria transmission. This includes entomological assessments, such as measuring the abundance of vectors, determining the duration of effectiveness of residual insecticides (alpha-cypermethrin) and detecting the presence of insecticide resistance to this insecticide. These studies were initiated before the most recent IRS programme came into operation and is followed up periodically to assess any changes that might have occurred throughout these intervention activities.

Previous research conducted by the National Malaria Control Programme indicated that clinical treatment failure to chloroquine had reached as high as 67% before a change in drug policy was inititated. SP resistance had been measured as high as 20%, although the protocol used to establish this places this finding in question as its execution was less than optimal. Similarly, an anomalous 6% failure associated with a test of an artesunate–SP combination can be explained as recrudescence of SP-resistance parasites, after a truncated course of artesunate therapy. Artesunate is quickly eliminated from the body, leaving SP in this case, unprotected from SP-resistant parasites. This operational research information led to the formulation of the current drug policy that pairs a longer course of artesunate (to keep it in the bloodstream for a full week) with amodiaquine instead of SP. Since amodiaquine had never been widely used in STP, and does not generally develop cross-resistance with chloroquine, resistance is not expected to cause a problem as long as established protocols are maintained.. Coartem, for similar reasons, is expected to remain extremely efficacious.

Previous operational research conducted had also demonstrated that the main anopheline mosquito vector in STP – *Anopheles gambiae* s.s. forest form (M), remains sensitive to alpha-cypermethrin, the primary insectide used in LLINs and IRS in STP. Mortality in mosquitoes 24 hours after exposure usually reached 100% and always was greater than 90%. These tests, conducted according to standard WHO protocols were conducted at various sites distributed throughout both islands of São Tomé e Príncipe. Mosquito vectors also remained sensitive to DDT, although this insecticide is no longer in use in STP.

The presence of some exophilic and exophagic behavior in this vector population (also demonstrated by the NMCP operational research) should slow the rate of resistance development by allowing a portion of the mosquito population to escape selection by insecticides, although it also limits the impact of these interventions on mosquito vector abundance. If exophily and exophagy are found to impede progress towards elimination, measures that don't rely on adult mosquitoes to encounter insecticide-treated surfaces in the interior of homes (LLIN,IRS) may need to be emphasized more heavly during the final stages of elimination.

Because the same pyrethroids are being used in multiple types of interventions in STP, it is essential that monitoring of insecticide resistance rates continue on an annual basis. These trends in the past, have been monitored through operational research conducted by the NMCP, but were funded by other partners (WHO). Resources to maintain these essential activities are reflected in the budget and action plan submitted with this proposal.

**Monitoring and evaluation (M&E)**

Monitoring and evaluating the progress of malaria control activities in STP is an integral and essential component of the strategic plan. Further strengthening the capacity to monitor and evaluate the diverse service delivery areas and interventions included in the strategic plan and this proposal is an essential element in supporting these malaria prevention and elimination efforts. Measuring the impacts and outcomes of these various activities goes hand in hand with operational research in providing a lever for managing the quality of these efforts. Effective M&E can identify bottlenecks and obstacles early enough to allow them to be remedied before they can have an adverse effect on disease outcomes and stated goals. M&E becomes particularly critical with scaling-up operations because quality and timely information can have a large effect on the success of LLIN distribution and other activities that are measured using coverage indicators.

The Health facility-based information system is a particularly critical link in the efficient functioning of M&E activities. At present, this system is severely limited with regard to the quantity and quality of information that it tracks and in the timeliness that this information is reported. This information system will need to be

greatly strengthened in order to provide the level of consistent and timely reporting of information that is necessary to manage a strategy that aims to eliminate malaria from STP. Clinical surveillance will be an important trigger for the rapid response efforts at the district level that will engage in emergency, focal IRS wherever there is evidence of active malaria transmission. In turn, facility-based information systems will provide key information back to M&E by indicating how successful and timely these emergency efforts have functioned.

Other useful feedback to be provided by the proposed M&E system includes information on the health-seeking behavior of people, on the level of acceptance and utilization of various preventive measures against malaria. The level of malaria prevalence is a fundamental measure for monitoring the overall effect of all interventions on the population as a while, and for gauging how much additional effort, coverage or efficiency is required to achieve elimination. The M&E system will also pay close attention to the results of operational research including insecticide resistance and anti-malarial drug efficacy, and provides a means of oversight to ensure that such studies are performed on a frequent enough basis, and are conducted with appropriate methods and quality. The M&E system will even monitor itself to ensure that its activities are undertaken on schedule and according to the protocols established in the strategic plan. M&E is the glue that binds all aspects of the control program together, and this proposal will establish an effective system for accomplishing this critical function.

**Health Service Strengthening**

This element of the National Strategic Plan for malaria control is intended mainly to bolster the general health system of STP to provide an institutional environment in which all health problems are treated adequately, and in which a program of intensified and diversified antimalaria activities designed to eliminate transmission can thrive. Some of the institutional strengthening planned affects malaria-specific laboratory facilities, but certain facilties planned, such as the insectary and molecular laboratory, could easily be engaged provide services for interventions against other vector-borne diseases or certain general health threats, once demands for malaria-specific activities becomes reduced.

The two primary means by which the health service delivery system will be strengthened includes developing the capacity of health facilities and institutions and building a greater human resource capacity. Certain basic equipment, software and standardized reporting instruments remain necessary in amny parts of the STP health system to enable the functioning ofan effective health information system. Acquiring this necessary capacity will strengthen the ability of facilities and institutions to provide the level of information processing that is essential to the timely flow and informed management of various health programs, malaria and otherwise. In preparation for the anticipated elimination of malaria from the country, the malaria programme will be establishing an entomological center and insectory at the National Center for Endemic Diseases, a molecular biology laboratory at the ICDF, Taiwan Cooperation Center, and a strong malaria diagnostic laboratory at the referela hospital of São Tomé.

Human resource capacity will be bolstered by recruiting new workers for an array of activities where additional workers at diverse levels are necessary, and providing the initial and refresher training that will allow these workers to perform their jobs adequately. Where particular, highly developed skills and expertise is necessary, the Ministry of Health will recruit experts on health management, epidemiology, data management, entomology and other occupations, both at the national and district levels.

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

**Poverty Reduction Strategy Paper (PRSP)**

A Poverty Reduction Strategy Paper (PRSP) for São Tomé e Príncipe has been developed in conjunction with the World Bank on the bases of the Millennium Development Goals (MDGs) and established priorities in the field of socio-economic development. Malaria has been the leading cause of morbidity and mortality in STP, both of which cause high levels of absenteeism in school and work either directly or due to lost time care for family members or to attend funerals. A high incidence of premature death in

working-age people also has a strong impact on the effective productivity of a population. Together, these phenomena can strongly affect the overall economic development of the country. The PRSP identifies malaria as one of the four priority areas of intervention in the fight against poverty. This paper also recognizes that "serious problems exist with respect to drug procurement and distribution". Malnutrition has been identified to be important in exacerbating the risk of sevre mlaria infection, especially in preschoolers and pregnant women, groups that are already at high risk of developing severe or complicated malaria even when well-nourished. Significant levels of malnutrition among vulnerable groups (>10%) have been reported in recent surveys conducted in STP.

The reduction and eventual elimination of malaria morbidity and mortality through the strategies outlined in this proposal will reduce both direct and indirect economic losses associated wit the burdens of malaria. Thus, the National malaria control prevention and control strategies will contribute to, or will at least provide positive interactions with the goals of the National Poverty Reduction Strategy.

**HIPC**

Some HIPIC resources is planned to finance projects for specific source reduction measures like filling puddles, open ditches and borrow pits, clearing the flow of drainage ditches and irrigation channels, and preventing the accumulation of standing water in areas where it accumulates after rain by improving drainage that will impact to the fight againt malaria. Aditionaly this initiative will allow to finance some activities after the end of this programme and to be consistently sustainable .

**The national strategy developed for poverty alleviation**

The national strategy developed for poverty alleviation includes fighting against malaria as a core component. It recognizes the interaction between poverty and malaria, how malaria creates poverty by depleting the resources of affected households and harming their productivity, while poverty, in turn, causes living conditions, nutritional status, health care access, that increase malaria transmission and worsen the outcomes of malaria infection.

**The Millennium Development Goals (MDG)**

The Millenium Development Goals (MDG) include a number of specific objectives that are directly addressed by this proposal. Priority targets for health improvement include reduction of child mortality by 2/3 in children <5 years old, and improvement of maternal health such that the maternal mortality ratio is reduced by 3/4. São Tomé e Príncipe malaria, in particular, affects children and women. The strategies and interventions in the national malaria prevention and control strategy as well as the specific interventions included in this proposal will have the highest impact in reducing morbidity and mortality in children and women, thus contributing to the health-related MDG goals. Morever, these interventions will contribute to MDG goals beyond health by attacking the links between malaria and poverty, improving household productivity and economic situations in general.

The National Strategy for malaria control in STP conforms to the overall guidelines of the Roll Back Malaria initiative of WHO. It was developed through the support of partners including WHO and UNICEF. Its goals and priorities are also compatible with those stated in the Abuja Declaration and the Millennium Development Goals of the United Nations.

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

The Ministry of Health oversees the National Centre for Endemic Diseases, which includes the National Malaria Programme, which has been initially proposed by the CCM to serve as the Principal Recipient for this proposal (subject to final review and consensus acceptance), transitioning over from UNDP, which had served as PR for the 4th Round GFATM award. This proposed change inherently brings the project and its partners into harmony with country cycles of reporting, budgeting, financial management and procurement.

The existing monitoring and evaluation system is not currently strong enough to be utilized in this project.

However, the monitoring and evaluation unit for HIV/AIDS which was developed through the support of Global Fund is being revised to include malaria and tuberculosis in to the system. The National Centre for Endemic Diseases which oversees malaria, HIV/AIDS and TB will then have a harmonized system for the monitoring and evaluation of the three diseases.

Some assistance from partners will still be required with regard to the procurement of certain types of equipment and the recruiting of certain kinds of technical expertise. STP's systems capacity for auditing, similarly may not suffice to allow them to utilized effectively in this project. However, these changes in the proposed administration of this GFATM-related project bring it one step closer to an autonomous, country-based system of management and oversight, compatible with the routine governmental operations and business cyles of STP.

### 4.3.4 National health system

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

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

São Tomé e Príncipe has made impressive gains in reducing malaria morbidity and mortality between the years 2002 and 2007, with very high coverage of IRS (going from 0% to 93% households sprayed), adoption of a new ACT in the National drug policy (artesunate-amodiaquine), increased coverage with ITNs and LLINs, and sharp declines in the number of reported malaria cases and deaths (from over 60,000 confirmed malaria cases 2002 to less than 10,000 confirmed cases in 2006).

**Strengths**

The physical and geographic accessibility of health facilities and services is comparatively high for residents of STP, and some of the health service providers and support staff of STP's health system tend to be relatively very well-trained and dedicated professionals. Moreover, the health system is highly engaged with the objectives and goals of certain international programs for improving health, and some segments of STP's health system have demonstated an ability to develop collaborative partnerships with NGOs and bilateral partners on specific health-related projects.

However, there remain several important challenges with regard to the health system that will need to be improved in order to improve the health systems as well as ensure the sustainability of the achieved impacts in malaria control efforts.

**Weaknesses**

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.

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 skill 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.

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 continuing training in certain critical fields, including epidemiology or Health Information Systems.

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..

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 preoblems are partly due to the lack of consistent reporting protocols and formats for conveying health surveillance information. 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 threats and efficient monitoring of programme interventions

Low quality laboratory services still pervade the health system's hospitals and district health centers where the necessary training, equipment, supplies and facilties are not always available. 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.

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 communications equipment such as telephone, fax e-mail, or internet, nor do they have the financial and human resources to acquire, maintain or utilize them..

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.

**Threats**

The major threat to the health system and the malaria control programme, in particular, is the risk of malaria epidemics as a result of the reduced partial immunity in the community due to the greatly reduced malaria burden in the past few years. STP experienced a devastating malaria epidemic during the 1980's due to the discontinuation of indoor residual spraying with DDT, and before the health system was strengthened enough to deal with such events. Another possible threat, which has already manifested, is the unwillingness of some community members to utilize LLINs that have already been distribute to them. The utilization rate for ITNs has dropped down slightly in 2007 compared to 2006. Insecticide resistance, particularly with regard to the pyrethroid insecticide (alpha-cypermethrin) which is used both in the IRS and LLINs, is another potential threat that could limit the future efficacy of both measures. Behavioral resistance, an increase in the tendency of adult mosquitoes to feed outdoors or earlier in the evening has already been detected in São Tomé e Príncipe.

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

**Health System Strengthening**

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 been revised recently, and has identified health system strengthening as a major initiative that will be given particular attention. In line with the revised national health policy, the government with the support of partners is planning to undertake human resource capacity assessment by the end of 2007. Some funding from 4th round of GFATM has been allocated for equipping laboratories with the necessary laboratory facilities and refresher training of laboratory technicans. Funding was also sought from GFATM 4th round for recruitement of new staff.

Moreover, the government as well as partners are working in the strengthening of the health system.

it is expected that the gradual decline in the parasite reservoirs and the better preparedness in terms of resources and surveillance systems will help to mitigate the negative consequences of unstable transmission. The proposal also assumes that the current donor support will continue to exist at least until the time when local capacity can takeover.

**Intersectoral collaboration**

The government recognizes that malaria elimination is almost impossible with out the involvement of a different public and private sectors, partners, community groups and the community. A multisectorial collaborative partnership for the overall coordination and organization of the malaria prevention and control intervention will be formed. Among the many stakeholders identified for the establishment of the coordinating bodies, some of the more important players include: the Environmental Agency, Public Works, municipalities, Sea and Air Port Authorities, Ministry of Agriculture, Ministry of Education, Civil Societies, NGOs, and the community at large.

**Surveillance**

The Government of São Tomé e Príncipe has realized the essential role that effective Disease Surveillance will play in the context of malaria elimination and is planning to develop a decentalised and integrated disease surveillance system on which to base timely and effective responses. Although the main focus will be in malaria surveillance system, it is expected that it will be an integrated surveillance system service a wide range of disease entities. Within the general integrated disease surveillance system, the Ministry of Health is determined to develop environmental, entomological and epidemiological surveillance systems. Hiring of new staff and training and refresher training will be undertaken to address the widespread and pervasive human resource problems.

(c) **Coordination and Synergies**

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

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

In addition to supporting the malaria programme activities, most of the system-wide strengthening service areas proposed under this proposal will benefit other health priorities.

**Surveillance**

A vertical malaria surveillance system may allow for a more direct linkage with malaria control activities, however, the STP Ministry of Health recognizes that the overall surveillance function may become inefficient, with health workers having to deal with multiple complicated systems each of which may use different reporting forms and frequencies. This leads to extra cost and training requirements, overloads health workers and distracts them from more important duties such as healthcare. Therefore, the proposed development and strengthening of the surveillance system for malaria, will be designed as part of an integrated overall disease surveillance system, which is decentralized for timely and efficient action. The design of surveillance system, computerin of information and capacity building in epidemiological surveillance skills will serve the whole health system. This will contribute to the improvement of the National Health Information System for communicable diseases (including HIV/AIDS and tuberculosis), and strengthen the efficiency of disease surveillance for use in health planning, management and evaluating control strategies.

**Human resources**

By strengthening health workforces and other basic health system elements, the country will be able to address an array of health areas and create a workforce able to provide a range of health services. The diagnostic and laboratory services that will be strengthened in the context of malaria elimination will serve in the improvement of quality of general services provided in the health facilities. The reduction of malarial

burdens in the health system will allow for a broader emphasis, because malaria will no longer require as disproportionate a share of health worker's attention as before its incidence had been so radically reduced.

**Infrastructure**

Many of the Health Service Facilties of STP require upgrading in many aspects of their basic functionality including communications, information systems, transportation and other infrastructural deficiencies that affect every aspect of health provision beyond malaria. The activities outlined in this proposal that will improve these functionalities in order to improve care and support timely responses against malaria will also provide a basis for improving all aspects of the health system including other communicable disease priorities such as HIV/AIDS. Thus, all areas of healthcare will benefit from most of the improvements that are proposed in order to improve the capacity to eliminate malaria.

**Synergies**

The reduction of malarial burdens in STP and the goal of eventual elimination has and will continue to remove considerable pressure from the health system and its ability to respond to communicable disease threats beyond malaria. An increased availability of hospital beds, reduced demands on the time of health practitioners, greater availability for storage of non-malaria-related pharmaceutical products, less depletion of general healthcare commodities such as IV solutions and syringes, are just some of the areas where the dramtic decrease in malaria cases since 2002 have paid dividends to the ability to focus on other diseases and health problems. This represents more time and resources that can be devoted to the care of patients with afflictions other than malaria, thus representing a valuable synergy.

### 4.3.5 Common funding mechanisms

*This section seeks information on funding requested in this proposal that is **intended to be contributed through a common funding mechanism** (such as Sector-Wide Approaches (SWAp), basket or pooled funding (whether at a national, sub-national or sector level).*

| | | |
|---|---|---|
| (a) | Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism? | ☐ Yes<br>➔ *answer questions below.* |
| | | ☒ No<br>➔ *go to section 4.4* |

(b) Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach?

Not applicable

(c) **Describe the common funding mechanism, whether it is already operational and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

Not applicable

| | |
|---|---|
| (d) | Describe the process for independent supervision of the performance of the common funding mechanism.<br>Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**. ***Attach,*** *as an annex to your proposal****, the most recent external assessment of the operations of the common funding mechanism****.* |
| Not applicable | |
| (e) | Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed.<br>*Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a* ***transparent, efficient and timely manner****.* |
| Not applicable | |
| (f) | Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for malaria activities during the proposal term.* |
| Not applicable | |

# 4 Component Section *Malaria*

## 4.4 Overall Needs Assessment

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

**To help Applicants identify these gaps:**

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

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

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

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

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

## 4.4.1 Programmatic Needs Assessment

**4.4.1 Overall programmatic needs assessment**

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

The programmatic needs associated with the national strategic goal of malaria elimination will vary over time as the malaria control programme evolves in response to reductions in transmission. Some preventive needs (such as LLINs) will remain universal aross the entire population of STP as long as a significant threat of malaria transmission persists. 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. Yet another category (IRS) will involve a sudden shift in the scale of programmatic needs that corresponds in a shift in strategy from universal coverage to focal, surveillance-based response once the appropriate indicators suggest that such a shift is appropriate.

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 current universal IRS strategy covers the entire population of STP on a recurring annual basis. The entire programmatic need of the IRS operation is currently covered by the ICDF, a bilateral partner from Taiwan, but is entering a period of transition that may require alternative support from this GFATM proposal.

Until malaria is eliminated, it is assumed that the entire population of STP (~150,000) 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.

The programmatic needs of 3 key services are summarized below:

**LLINs (universal coverage)**

Full 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 antivector 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 with LLINs in STP now exceeds 50%, thus a program of scaling up will continue for the near future. Together with existing funding, and additional LLINS from this funding for about 35,000 and 40,000 people for the year 2008 and 2009 respectively, will achieve 100% coverage with LLINs. The major replacement will be undertaken during the 3$^{rd}$ year of this project with about 70,000 people requiring replacement of their ITNs. Replacement was considered based on 4 year useful life of bednets. Similarly, about 19,000 and 40,000 people will need replacement nets during the 4$^{th}$ and 5$^{th}$ year respectively.

**IRS ( from routine generalized to emergency focal response)**

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 dectralized 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, this proposal 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.

**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 temporaily as the program enters a period of diminishing returns due to the refractory nature of the sources of transmission that remain. Thus, based on the most recent annual case rates, the current need for ACTs corresponds approximately to the case rate of approximately 12,000 cases of malaria that occurred in 2006, and the continuing decreases in case rates that are expected in the years to follow. It will be prudent to incude 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 this programmatic need, however.

A shift in strategy will occur, however, after universal coverage of LLINs is obtained, that may temporarily increase the programmatic 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 current programmatic need for ACTs, as well as the anticipated need for the near future is covered by funding that remains from the 4th Round of the GFATM.

(b) **Complete table 4.4.1**

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

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

Children under five years old and pregnant women formed the main focus of the 4th Round GFATM and other partners with regard to coverage with LLINs. With universal coverage assumed to be goal for the 7th Round GFATM proposal, the current coverage and planned number of LLINs expected to be available were taken into consideration to determine the number of people that will still need LLINs, with the objective of universal coverage by the end of 2009. Moreover, additional people who will need LLINs for replacement were determined based on 4 years of useful life for LLINs.

The main assumptions made in the determination of programatic needs for IRS is that with an additional two years of intensified integrated vector control and strengthened health systems and strong collaboration and partnership among private and public partners, malaria transmission will be reduced to near zero, and only a few remaining foci of transmission will be the target thereafter. Therefore, the target for IRS operations for the next two years will be all of the households in STP annually, after which the IRS target will become only those households in areas where active foci of transmission are found through surveillance.

The target for the surveillance and health system strengthening is assumed to be the entire population of STP. Surveillance system and health systems strengthening will involve all levels of the health system including at the community level, thus all people are targeted through these strategies. Similarly, collaborative and partnership establishment will target all of the people, as will be for the information, education and communication (IEC) strategy.

In determining the target for case management and diagnostics, it was assumed that the entire combination of antimalarial interventions targeting the whole population of the country for the next year will bring down the burden of malaria. Therefore, the target group for this strategy decreases dramatically in the following two years, and the only targets thereafter will be people that will be targeted for emergency response when cases or outbreaks are identified in the community.

# 4 Component Section *Malaria*

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

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

*Table 4.4.1 – Overall programmatic needs assessment*

| | | Programmatic Gap Analysis | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | | Anticipated | | | | | |
| | | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| **Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)** | | | | | | | | | |
| Key Service 1 | ITNs | 20,046 | 67,138 | 26,884 | 36,697 | 41,488 | 71,960 | 31,841 | 41,793 |
| Key Service 2 | IRS | 154,198 | 158,516 | 162,954 | 167,517 | 172,207 | 10,000 | 5,000 | 2,000 |
| Key Service 3 | Diagnostics and case mangement | 67,754 | 38,192 | 42,966 | 38,669 | 38,236 | 36,899 | 35,899 | 35,899 |
| Key Service 4 | | | | | | | | | |
| Key Service 5 | | | | | | | | | |
| **Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:** | | | | | | | | | |
| Key Service 1 | ITNs | 19,793 | 67,271 | 24,686 | 32,088 | 3,885 | 3,574 | 3,315 | 3,421 |
| Key Service 2 | IRS | 142,154 | 157,548 | 157,603 | 0 | 0 | 0 | 0 | 0 |
| Key Service 3 | Diagnostics and case mangement | 54,816 | 50,484 | 41,547 | 26,249 | 25,325 | 1,879 | 1,933 | 1,493 |
| Key Service 4 | | | | | | | | | |
| Key Service 5 | | | | | | | | | |

# 4 Component Section *Malaria*

| | | Programmatic Gap Analysis | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | | Anticipated | | | | | |
| | | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| **Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 - B^1 = C^1$, $A^2 - B^2 = C^2$ etc.)** | | | | | | | | | |
| Key Service 1 | ITNs | 253 | 0 | 2,198 | 4,609 | 37,603 | 68,386 | 28,526 | 38,372 |
| Key Service 2 | IRS | 12,044 | 968 | 5,351 | 167,517 | 172,207 | 10,000 | 5,000 | 2,000 |
| Key Service 3 | Diagnostics and case mangement | 12,939 | 0 | 1,419 | 12,420 | 12,911 | 35,020 | 33,966 | 34,406 |
| Key Service 4 | | | | | | | | | |
| Key Service 5 | | | | | | | | | |
| **Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL** | | | | | | | | | |
| Key Service 1 | ITNs | *Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.* | | | 4,609 | 37,603 | 68,386 | 28,526 | 38,372 |
| Key Service 2 | IRS | | | | 167,517 | 172,207 | 10,000 | 5,000 | 2,000 |
| Key Service 3 | Diagnostics and case mangement | | | | 12,420 | 12,911 | 35,020 | 33,966 | 34,406 |
| Key Service 4 | | | | | | | | | |
| Key Service 5 | | | | | | | | | |

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## 4.4.2 Strategic actions to strengthen health systems

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| Total funds for essential HSS Strategic Actions requested over proposal term | | | | | |
|---|---|---|---|---|---|
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| **920,693** | **903,034** | **510,034** | **538,729** | **514,729** | **3,387,218** |

# 4 Component Section *Malaria*

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

| | |
|---|---|
| **Action 1** | *(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)*<br><br>**Human resources**<br><br>One of the main challenges of the health system is the uneven distribution and inadequate skills and training of human resources at all levels of the health system including at the managerial and service delivery areas. In particular there is a lack of capacity in management in the areas of planning, supervision and financial management towards scaling up malaria control efforts; a lack of skill in data analysis and use of information for management decision making; a lack of skilled laboratory technicians; lack of an entomologist and entomology technicians; and a limited capacity in spray operations as well as emergency response, all of which will be targeted through this proposal. These deficiencies are particularly apparent at the district level, where increased capacity will be critically important to the success of some of the decentralized intervention activities that are planned in order to eliminate malaria..<br><br>The Ministry of Health plans to undertake a detailed and comprehensive Human Resource capacity assessment in 2007. The Ministry of Health plans apply the results of this assessment to expand its human resource capacity through a comprehensive program extending thoughout the entire health system. The main activities that will be undertaken with regard to human resource capacity in this project will be targeted specifically on the technical aspects of malaria control and health information strengthening as well as limited program management.<br><br>Thus, this programme aims to strengthen the capacity of the health workers through in-service training and recruitment of experts on health management, epidemiology, data management, entomology among others, at the national and district level, and to improve incentives for retaining and motivating existing health personnel.<br><br>To maintain the readiness and capacity to undertake focal spraying in response to small outbreaks and buildup of cases, a mobile team will be created in each district for rapid response of epidemics, particularly during the consolidation and maintenance phases. |

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

| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Training -173 | Training - 673 | 0 | 0 | 0 |
| Recruitment- 30 | Recruitment- 30 | Recruitment- 30 | Recruitment- 30 | Recruitment- 30 |
| Top-up salary- 12 | Top-up salary- 12 | Top-up salary- 12 | Top-up salary- 12 | Top-up salary- 12 |
| Round 7 Funding Request Year 1 | Round 7 Funding Request Year 2 | Round 7 Funding Request Year 3 | Round 7 Funding Request Year 4 | Round 7 Funding Request Year 5 |
| **398,900** | **350,400** | **332,400** | **332,400** | **332,400** |

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

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

# 4 Component Section *Malaria*

| Name of supporting stakeholder ↓ | Timeframe of support for HSS action | Level of financial support provided over proposal term *(same currency as this proposal)* | Expected outcomes from existing and planned support |
|---|---|---|---|
| Government | 2008-2012 | 708,825 | Salary of Malaria personnel |
| Other Global Fund Grants (with HSS elements) | 2008-2009 | 130,000 | Training of 20 laboratory technician<br>Hiring of an epidemiologist |
| Other: *(Taiwan)* | 2008-2009 | 60,000 | Traing of district health managers (7 persons) |
| Other: *(WHO)* | 2008-2012 | 60,000 | Training of staff on case management |
| Other: *(identify)* | | | |
| Other: *(identify)* | | | |

# 4 Component Section *Malaria*

| | |
|---|---|
| **Action 2** | *(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)*<br>**Logistics, including transport and communications**<br><br>Logistics support in transport as well as communication will be crucial in attaining the goal of overall health service development. Particular and pressing needs exist for more efficient and accessible transportion and communications, particularly during the remaining period of intensified application of antimalaria measures as well as for to ensure the mobility and information sharing capability of the rapid response teams to reach areas with reported outbreaks for investigation, treatment of cases and application of appropriate antivectorial measures. For this purpose, each district will be equipped with one vehicle. Moreover, village health workers will be equipped with transportation (motorcycles) in order to enable them to move rapidly within villages for active case detection as well as enable them for timely reporting to district health offices. The village health workers are volunteers and provision of such logistics will also help in motivating their activities.<br><br>Internet, telephone and fax capabilities will also be implemented or updated such that all health facilities and surveillance units can communicate with each other and with the central level. |

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

| Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| All districts will have adequate transportation<br><br>All districts will be equipped with communication facilities (telephone, internet and fax) | 25 health posts will have means transportation (motorcycles)<br><br>50 CHWs will have motorcycle | Another 50 CHWs will have motorcycles | The national malaria control will have two new vehicles | Three districts will have new vehicles (based on the malaria situation) |
| Round 7 Funding Request Year 1 | Round 7 Funding Request Year 2 | Round 7 Funding Request Year 3 | Round 7 Funding Request Year 4 | Round 7 Funding Request Year 5 |
| **521,793** | **552,634** | **177,634** | **206,329** | **182,329** |

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

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

| **Name of supporting stakeholder** ↓ | **Timeframe of support for HSS action** | **Level of financial support provided over proposal term** *(same currency as this proposal)* | **Expected outcomes from existing and planned support** |
|---|---|---|---|
| Government | | | |
| Other Global Fund Grants (with HSS | 2008-2009 | 180,000 | Strengthening the communication faclities |

| | | | |
|---|---|---|---|
| elements) | | | |
| Other: *(World Bank)* | 2008-2012 | 75,000 | Strengthening the information system |
| Other: *(WHO)* | 2008-2012 | 60,000 | Mainly technical support |
| Other: *(identify)* | | | |
| Other: *(identify)* | | | |

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

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

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

The government recognizes that investing in malaria control program alone is not sufficient to scale up and sustain the impact achieved so far. It has decided that health system constraints, such as weak surveillance system and information system, lack of logistics, weak drug supply and management system and lack of human capacity would impede progress toward the goal of malaria elimination. The country has undertaken evaluation of different sectors including the health sector. Based on the finding of the evaluation and recommendations, the government has been in the process of revising the health policy since February 2007. With objective of achieving and sustaining the impact of malaria program and other health services, one of the focus of the health policy revision is strengthening the health system. The activities proposed in this project will complement current and planned efforts to strengthen the health system by government and health sector partners such as the Wrld Bank. The health system strengthening along with the establishment of collaboration and partnership among different partners will have a critical impact for transparency through information sharing and timely monitrotring and evaluation results for accountability.

The strategic actions proposed will initially have little impact on other health programs, but as malarial burdens continue to diminish, and as strengthening proceeds, we anticipate a positive impact on the overall system. Certain unspecialized resources and activities such as improved communications and information systems will have a positive impact on the functioning and performance of the overall health system almost immediately, because these services will not be restricted to or dominated by the malaria programs. Other resources and services (such as transportation, certain human resources) initially developed for malaria control will become available and utilized for other needs as malaria transmission decreases. Thus, the overall effect on the health system will be an improvement in communications, human resources, transportation, etc. none of which can conceivably pose a "threat" to the health system. The long-term sustainability of these strategies will be assisted by the elimination of malaria, which will free resources formerly devoted to malaria treatment, which once consumed the vast majority of resources and attention within the health system.

It is expected that the gradual decline in the parasite reservoirs and the better preparedness in terms of resources and surveillance systems will help to mitigate the negative consequences of unstable transmission. The proposal also assumes that the current donor support will continue to exist at least until the time when local capacity can takeover.

# 4 Component Section *Malaria*

| | | |
|---|---|---|
| (c) | Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7? | ☐ Yes<br>➔ *complete (d) and (e), and then (f)*<br>☒ No<br>➔ *go to section 4.4.2(f)* |

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

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

| | |
|---|---|
| (g) | **CCM and RCM Capacity for Health Systems Strengthening Issue identification**.<br>Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6.<br>➔ *Refer to the Guidelines for further information,, section 4.4.2(g)* |
| The CCM has been engaging more frequently and intensively with the Ministry of Health as the programs associated with and funded by the 4th Round of the GFATM have proceeded, and over time has been learning about the capacity and limitations of the health system. For example, the CCM is aware of and will be kept fully briefed regarding the outcomes of a comprehensive human resource capacity assessment that is being undertaken by the Ministry of Health during 2007. The CCM is much more experienced in their understanding and interaction with the health system than they were when originally convened to apply for early rounds of GFATM funding. It is expected that their knowledge and engagement with the health system will only continue to improve, as will their ability to identify the strengths, weaknesses, threats and opportunities in the health system. | |

## 4.5 Financial Needs Summary

### 4.5.1 Overall Financial Needs Assessment

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

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

The overall financial needs based on costed national malaria elimination strategy, is US 12,675,979. Health service strengthening accounts for 39% ($4,999,599) of the total financial need. Due to the planned intensified vector control measures required for the elimination of malaria from the country, vector control such as ITNs, IRS and vector control also account for 23.2% ($2,944,216) of the total financial needs. As a result of the rapid decrease in malaria burden seen in the last few years, and the expected reduction and elimination of malaria from the country, the financial need for case management and diagnosis is very low, accounting only for 2.8% ($357,417). In fact the majority of this fund is required for improving the quality of diagnositics and case management which are a pre-request for the successful elimination of malaria. The other major strategy is strengthening integrated surveillance system, without which malaria elimination is impossible. Strengthening of integrated surveillance system requires $1,571,247, which accounts to 12.4% of the total financial needs. Monitroing and evaluation is one of the prinicipal strategies of the national malaria control program, and a good share of the financial needs is assigned for monitoring and evaluation purposes. The total financial need for monitoring and evalution is 1,035,000 which accounts to about 8.2% of the total financial needs.

### 4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

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

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

The government has allocated about $749,825 over five years. The government has been allocating more than 12% of the GDP for health over the last few years and it is expected that the share for the health sector will grow in line with the recommendations of the AU to assign 15% of the GDP for health. Sao Tome and Principe is one of the few African countries which reached 12% of GDP for health.

(b) **External Sources**

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

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

The major external financial contributors to the country include the Taiwan Cooperation, World Bank, WHO, and the existing round 4 grant of the Global Fund. It is expected that a total of $2,427,401 is expected from these major external financial contributors over the five year period which corresponds with this proposal term. The majority of the funding is expected from the Taiwan Cooperation Project, $1,279,414. The existing grant from the round 4 grant

of the Global Fund is about $823,487 over the first two years of this proposal term.

### 4.5.3 Overview of Financial Gap

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

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

### 4.5.4 Additionality

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

The potential funding that might be obtained through this proposal will help consolidate the gains made through resources provided by the 4th round of GFATM, the government, the ICDF Taiwan Cooperation and other partners such as the African Development Bank, World Bank, and WHO. These partners will continue to support and compliment the national malaria elimination efforts. The ICDF Taiwan Cooperation is one of the major partners in malaria control efforts and is planning to allocate similar amount of funding for the next two years with a possibility of extending the project for another three years. Their areas of focus in the next few years include support for the strengthening the health systems with particular emphasis to human resource capacity building and institutional strengthening. Moreover, they will continue to undertake larval control measures as an integrated component of vector control. The World Bank and WHO are providing support in the areas of improving malaria case management, LLIN distribution, human resource strengthening and IEC activities.

### 4.5.5 Strategy for achieving sustainability

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

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

STP is aiming for the ultimate condition of sustainable malaria suppression – the complete elimination of malara transmission. The goal of malaria elimination is inherently sustainable because the amount of resources required to maintain a watchful surveillance program and a capacity form small-scale interdiction of outbreaks at the district level, is a small fraction of what was once necessary merely to keep pace with the burdens imposed by unchecked malaria transmission. Elimination, in an isolated island condition such as STP represents a much more stable and sustainable endpoint than it would be on the mainland bordering other malarious countries. Thus, the increased application of resources required by the program in order to move STP into a state of completely interrupted malaria transmission, while not sustainable for long as an indefinite and continuous process without an endpoint, leads to a condition in which resource utilization can be greatly de-intensified and sustained. Thus, a temporary input of intensified resources represents an investment that will pay great dividends in terms of long-term sustainability.

# 4 Component Section *Malaria*

*Table 4.5 - Financial contributions to national response*

| **Financial gap analysis** *(same currency as selected in section 1.1)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Refer back to instructions under section 4.4, step 3*** | **Actual** | | **Planned** | | **Estimated** | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** |
| **Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs** | **2,427,586.6** | **2,044,753.5** | **2,011,735.3** | **3,309,189.1** | **3,041,628.5** | **2,119,133.6** | **2,122,546.5** | **2,083,481.6** |
| Domestic source **B1** : Loans and debt relief (*provide donor name*) | | | | | | | | |
| Domestic source **B2** : National funding resources | 147,800.0 | 151,000.0 | 142,120.0 | 174,487.0 | 126,838.0 | 148,500.0 | 148,000.0 | 152,000.0 |
| Domestic source **B3:** Private Sector contributions (national) | | | | 0 | 0 | 0 | 0 | 0 |
| **Total of Line B entries ➔ Total current & planned domestic resources** | **147,800.0** | **151,000.0** | **142,120.0** | **174,487.0** | **126,838.0** | **148,500.0** | **148,000.0** | **152,000.0** |
| External source **C1**: All current & planned Global Fund | 1,006,263.7 | 569,811.3 | 496,459.0 | 447,757.0 | 375,730.0 | 0.0 | 0.0 | 0.0 |
| External source **C2:** (*Taiwan Gov't*) | 415,000.0 | 377,914.2 | 364,000.0 | 395,414.0 | 196,000.0 | 246,000.0 | 196,000.0 | 246,000.0 |
| External source **C3** (*WB*) | 0.0 | 128,000.0 | 143,000.0 | 33,000.0 | 33,000.0 | 30,000.0 | 30,000.0 | 30,000.0 |
| External source **C4** (*ADB*) | 47,919.9 | 177,530.0 | 3,000.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| External source **C5** (*WHO*) | 28,233.5 | 51,000.0 | 37,000.0 | 35,500.0 | 35,500.0 | 32,500.0 | 32,500.0 | 32,500.0 |
| External source **C4**: Private Sector grants/ contributions (International) | | | | 0 | 0 | 0 | 0 | 0 |
| **Total of Line C entries ➔ Total current & planned external resources** | **1,497,417.1** | **1,304,255.5** | **1,043,459.0** | **911,671.0** | **640,230.0** | **308,500.0** | **258,500.0** | **308,500.0** |
| **Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)** | 1,645,217.1 | 1,455,255.5 | 1,185,579.0 | 1,086,158.0 | 767,068.0 | 457,000.0 | 406,500.0 | 460,500.0 |
| **Line E ➔ Total Unmet need (Line A – Line D) -** | **782,369.5** | **589,498.0** | **826,156.3** | **2,223,031.1** | **2,274,560.5** | **1,662,133.6** | **1,716,046.5** | **1,622,981.6** |
| *The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.* | | | | | | | | |

# 4 Component Section *Malaria*

## 4.6 Malaria component/implementation strategy

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

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

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

**and**

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

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

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

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

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

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

| **4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal**<br><br>If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*<br><br>In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)* |
|---|
| Not Applicable |

# 4 Component Section *Malaria*

**4.6.2 Goals and objectives and service delivery areas**

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

**Goal**

The goal which is consistent with the overall goal of the National Malaria Prevention and Control in Sao Tome and Principe is to further reduce malaria morbidity and mortality to zero with an altimate aim of malaria elimination from the country.

**Objectives and Service Delivery Areas**

***Objective 1.*** To improve national capacity and strengthen quality laboratory confirmation of all cases (100% of cases), and adequate treatment of malaria cases by 2008.

*Service Delivery Area 1.1:* Prompt, effective anti-malarial treatment
*Service Delivery Area 1.2:* Diagnosis

***Objective 2.*** To achieve 100% coverage of ITNs by 2009 and maintain the coverage with regular replacement of worn out nets.

*Service Delivery Area 2.1:* ITNs

***Objective 3.*** To maintain an intensive IRS operation with 100% household coverage until 2009, and move into focal spraying to interrupt foci of malaria transmission by 2012.

*Service Delivery Area 3.1*: Vector control (IRS)

***Objective 4.*** To strengthen integrated disease surveillance system, with the introduction of active case detection, epidemiological investigation of all cases, and entomological surveillance and updating of malaria foci accordingly.

*Service Delivery Area 4.1:* Environmental surveillance
*Service Delivery Area 4.2:* Entomological surveillance
*Service Delivery Area 4.3:* Epidemiological surveillance
*Service Delivery Area 4.4:* Epidemic preparedness and response

***Objective 5.*** To strengthen health systems through institutional support and human resource development.

*Service Delivery Area 5.1:* Human resources
*Service Delivery Area 5.2:* Service Delivery

***Objective 6.*** To establish strong intersectorial collaboration and define clear designation of the role of the various partners in the elimination programme by 2009, and maintain thereafter.

*Service Delivery Area 6.1*: Coordination and partnership development

***Objective 7.*** To create awareness among health personnels and the public on malaria prevention and control, and the risk of epidemics when prevention and control measures are not used properly.

*Service Delivery Area 7.1:* BCC community outreach and mass media

***Objective 8.*** To strengthen monitoring and evaluation and operational research.

*Service Delivery Area 8.1*: Information system & Operational research

### 4.6.3 Specific Interventions, Target Groups and Equity

(a) **Specific Interventions/Activities supported by this proposal**

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom. *(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)*

**Service Delivery Area 1.1: Prompt, effective anti-malarial treatment**

The main activities with prompt, effective anti-malarial treatment considered in this proposal are provision of second line antimalarial drug (Coartem) for uncomplicated malaria, and provision of quinine and supportive drugs for sever malaria. Moreover, in oder to improve the quality of the management of uncomplicated malaria and sever malaria supervision of health facilities and community health workers will be undertaken. Drug for intermittent preventive therapy is also sought for pregnant women. With the expected reduction in malaria cases, and the availability of funding for the first line drug, purchase of the first line drug will not be undertasken through this project.

**Service Delivery Area 1.2: Diagnosis**

The main activities with regard to diagnostics are provision of RDTs to health facilities which do not have microscopy, and community health workers. In addition RDTs are sought for out break investigation. Transportation and handling of RDTs, as well as training of community health workers is also planned to be undertaken with this project.

**Service Delivery Area 2.1:** ITNs

Currently, the government has committed to free distribution of Long-Lasting Insecticidal Net (LLIN) supported by funding and oversight initiated by the 4th Round of the GFATM with particular emphases to children under five years of age and pregnant women. Treated bednet coverage in the country overall has reached more than 50% percent, and bednets are generally well accepted by the people, although IEC continues to remain necessary to reinforce and maximize utilization rates. Some of the treated nets being used include some retreatable insecticide-treated nets (ITNs) that were distributed by other partners before the distribution programme funded by the 4th Round of the GFATM took effect, but these will be replaced in future cycles by LLINs. The government plans to achieve universal coverage with LLINs by 2009, when it will become the dominant general vector control measure against adult vector mosquitoes.

***Specific activities:***

The main activities that will be implemented with regard to ITNs to achieve the universal coverage with LLINs includes:

- Procurement of ITNs to cover all the people as part of generalized attack measures which will include replacement of old nets
- Distribution of ITNs using different distribution mechanisms; the main distribution mechanisms in use are facility based (such as reproductive clinics, under five clinics) and schools. To achieve the universal coverage of ITNs, additional campaigns and community based distribution mechanisms will be employed.
- Advocating and monitoring of proper use of ITNs to ensure high rate of utilization of ITNs. This will be a critical part of the IEC component as there seems to be a tendacy in decreasing the utilization of ITNs when the risk of malaria infection became lower.

**Service Delivery Area 3.1:** Vector control (IRS and larval control)

Several years ago the National Malaria Control Programme entered into a bilateral partnership with the Republic of China, Taiwan to adopt a strategy of intensive vector control measures targeting indoor-feeding and resting adult malaria vectors by spraying residual alpha-cypermethrin indoors in all houses across Sao Tome and Principe. This residual spraying operation was initially intended to continue for three years, with 2007 representing the final year of operations. Given the large reductions in burden that have already been accomplished but the significant transmission that remains, the National Malaria Control Programme recognizes the need to sustain these operations for another two years as part of the attack phase of the malaria elimination program.

The continuation of large-scale IRS for at least two more years is required until gains in the interruption of malaria

transmission have been further consolidated and the LLIN distribution programme has had an opportunity to achieve its target of universal coverage (with >90% utilization). The withdrawal of large-scale indoor residual spraying is planned to be carried out in a progressive way after the surveillance and epidemic preparedness and timely response are well established and strengthened.

The activities that will be undertaken through funding requested from the 7th Round of the GFATM includes decenteralized district level capacity building for widespread IRS operations for the two years, as well as for small scale, focal operations intended to take effect after the largescale IRS operations is discontinued.

***The specific activities are:***

- Build capacity of districts inorder to undertake spray operations independently at district level
- Procurement of insecticides for IRS for 100% coverage of households for the first two years as part of generalized attack measures (Insecticides for emergency reponse purposes is included under emergency preparedness and response)
- Provision of spray pumps and spare parts to each ditrict so that each district will be able to undertake spray operations independently
- Provsion of materials such as tents, coveralls, etc for spray operation
- Distribution and transportation of insecticides and spray equipments to each district
- Procuremtment of vehicles and spare parts to support the spray operation
- Training of spray personnel for field operations
- Spray operation with 100% coverage for the first two years

**Larval control**

Larval vector control has previously been performed only on a very limited basis in São Tomé e Príncipe including such practices as chemical larviciding and environmental management. These activities are not presently incorporated into the national vector control programme but form a component in current proposal and strategic plan as a key element in the suite of integrated interventions designed to eliminate malaria transmission completely. Removing breeding sources and killing immature mosquitoes before they can emerge will assist the elimination effort by further depressing the force of malaria transmission and lowering the entomological inoculation rate (EIR).

- District-level training in current methods appropriate to the conditions on São Tomé e Príncipe will be given.
- Intersectoral collaborations with entities such as the public works, agricultural and environmental sectors are also planned to broaden the involvement to include stakeholders with relevant capacity and expertise.
- Environmental management: Specific source reduction measures such as filling puddles, open ditches and borrow pits, clearing the flow of drainage ditches and irrigation channels, and preventing the accumulation of standing water in areas where it accumulates after rain by improving drainage will be undertaken through mobilization of the community.
- Purchase and distribution of temephos: The larviciding planned as part of the intensified and integrated program of interventions will include a combination of chemical and biological methods, depending on the situations encountered. Through this proposal temphos will be purchased to be used in breeding sites where pupae and late instar larvae are detected during surveillance operations. This measure will be combined with *Bacillus thuringiensis israelensis* (bti) which targets young larvae (bti will be provided by the ICDF Taiwan Cooperation).

**Service Delivery Area 4.1:** Environmental surveillance

***Activities:***

Strengthen environmental surveillance through the mapping of villages and potential breeding sites to support the epidemiological surveillance by determining the origin of malaria case.

- To undertake this activity, GPS units for each ditrict (2 per district), GIS Software for each district and national as well, and computers and accessaries will be purchased.
- Training of national and district level staff in the use of GPS units and GIS will be undertaken
- Data collection (mainly Geographical informations) that will be used for mapping will be collected

- Technical support will be requested for training, supervision of data collection and development of maps

**Service Delivery Area 4.2:** Entomological surveillance

The National Centre for Epidemic Diseases currently performs some entomological surveillance activities that employs the capacity to identify malaria vectors, to evaluate the impact and efficacy of diverse interventions. The current system, however, lacks the comprehensiveness and consistency that will be necessary to implement the integrated control measures that are planned to achieve the elimination of malaria.

***Specific activities***

The main activities proposed in the proposal to strengthen the entomological surveillance capacity include:

- To support the entomological surveillance system, sentinel sites will be established in each district and funding will be need to equip them with the necessary larval and adult mosquito collection equipment.
- Regular collection of data on the abundance and behavior of mosquito vectors will be done in each sentinile site and specimens will be transported to national level for further analysis.
- An entomological laboratory and insectary will be established at the national malaria control center, which will require the renovation of the non-functional existing entomology laboratory, purchase and provision of the necessary equipments such as dissecting microscopes and mosquito cages.
- The efficacy of chemicals (including IRS, ITN and LLINs efficacy) used in antivector measures will be evaluated regularly using discriminating-dose bioassays, and KDR genotype assays (at the Taiwan Cooperation microlaboratory).
- It requires additional capacity to be able to perform these activities with greater intensity and consistency at the national as well as district level. Personnel at district and national level will be trained in larval and adult surveillance and identification.
- Additional human resources will be recruited and trained, particularly at the district level, to allow for a more decentralized and timely programme of surveillance, that ensure that interventions can be organized rapidly at the district-level in response to information regarding specific malaria transmission threats..

**Service Delivery Area 4.3:** Epidemiological surveillance

Epidemiological surveillance will be an important trigger for the rapid response efforts at the district level that will engage in emergency, focal IRS wherever there is evidence of active malaria transmission. However, the epidemiological surveillance as well as the information system of the National Centre for Epidemic Diseases is very weak. The epidemiological surveillance system is mainly based on routine health service data as well as periodic community surveys that are conducted for the estimation of malaria prevalence in the community. Moreover, the current system lacks the comprehensiveness and consistency that will be necessary to implement the integrated control measures that are planned to achieve the elimination of malaria. It requires increased capacity in human resource and facility to be able to perform these activities with greater intensity and consistency at the district level. Huam resource capacity will be developed through training and re-training of existing personnel, and additional human resources will be recruited and trained, particularly at the district level, to allow for a more decentralized and timely programme of surveillance, that ensure that interventions can be organized rapidly at the district-level in response to information regarding specific malaria transmission threats. Thus, the strategic plan calls for an expansion of the surveillance system to include regular district-level monitoring of malaria incidence at the community level. In addition, anti-malarial drug efficacy studies will be undertaken on regular basis to assess the clinical efficacy of the first-line drug. This surveillance system forms a component in a larger, integrated Health Information System to be implemented for the health services in general.

***Specific activities to strengthen the epidemiological surveillance includes:***

- Design an integrated and decentralised disease surveillance system to put in place full and total coverage surveillance operations which is capable of detecting any possible continuation of transmission. These will require external technical support for training and designing of the system.
- Purchase and equip national and district health offices with computers and accessories which will be accompanied with training of personnel and hiring of new staff. Training in data management, field investigation and epidemiological surveillance, and in general health information management will be undertaken
- Develop epidemiological maps of the country through GPS-based surveillance systems and GIS software to locate and track malaria cases and foci over time, and detect any possible reintroduction of malaria

transmission. External technical support with expertise on information technology will be need to undertake this activity.

- Regular active detection of case at community level by village health workers as well as district staff will be undertaken
- Strengten the capacity in case detection, investigation of outbreaks and epidemics
- A central reference laboratory at the referral hospital will be establish
- Establish reliable communication system between the center and periphery using internet and telephone. Each district will be equipped with communication technology such as internet services, telephone services and fax to communicate with national level

**Service Delivery Area 4.4:** Epidemic preparedness and reponse

The intensified programme of surveillance comprised of environment, entomological and epidemiological surveillance will provide early indications of threatened and actual transmission risk, triggering a rapid response involving focal spraying of houses in communities where excessive malaria transmission or risk of such transmission as indicated by an unusual abundance of mosquito vectors is detected. The emergency, rapid response IRS operations, once implemented, will be part of an integrated programme of antivector interventions, that will include several methods of source reduction, including biological and chemical larviciding and modification of mosquito breeding habitats through environmental management. Moreover, the rapid response team will also employ fever or mass treatment in areas where build up of cases is identified.

***Specific activities:***

- Develop epidemic preparedness and reponse manual and plan
- Creat a malaria rapid response team in each district for decenteralizaed rapid response. The team will comprise five technical people who can undertak field investigate and rapid action to prevent the spread of the transmission. This team will be trained inorder to aquire skills and knowledge in rapid response activities
- Aquire stocks of insecticides for focal spraying, and drugs for fever or mass therapy
- Operational costs which include wages and perdiems during field investigation, larval control, focal spray operation and distribution of drugs for fever or mass therapy

**Service Delivery Area 5.1:** Human resources

This element of the National strategic plan for malaria control is intended mainly to bolster the general health system of STP to provide an institutional environment in which all health problems are treated adequately, and in which a program of intensified and diversified antimalaria activities designed to eliminate transmission can thrive. Some of the institutional strengthening planned affects malaria-specific laboratory facilities, but certain facilties planned, such as the insectary and molecular laboratory, could easily be engaged and provide services for interventions against other vector-borne diseases or certain general health threats.

To solve the human resource problems facing the country, the ministry of health is planning to undertake human resource capacity assessment by the end of 2007. The major human resource capacity building needs will be identified during the assessment. However, the National Health Strategy recognizes human resource as the main weakness of the health system. With funding from this proposal, huam resource issues that specifically deal with malaria control activities but that will contribute to the general health systems strengthening will be addressed. The more critical and urgent human resource needs in the context of malaria elimination are strong managerial and planning capacity; skilled laboratory technicians particularly for the establishment of a reference laboratory; creation of rapid response team in each facility; personnel with skill in spray operation; skilled personnel on surveillance system including entomological and epidemiological surveillance; skilled personnels in entomology, epidemiology and biostatistics among others.

***Specific activities***

The National Malaria controls plans to use three approaches to build and strengthen the human resource capacity needs.

- In-service training and refresher training of existing staff on the different needs of the health system
- Human resource capacity will be bolstered by recruiting new workers for an array of activities, and providing the initial and refresher training that will allow these workers to perform their jobs adequately.
- Where particular, highly developed skills and expertise is necessary, the Ministry of Health will recruit experts

on health management, epidemiology, data management, entomology and other occupations, both at the national and district levels.

- Top-up salary to motivate and retain existing staff

**Service Delivery Area 5.2:** Logistics including transportation and communications

Certain basic equipment, software and standardized reporting instruments remain necessary in amny parts of the STP health system to enable the functioning of an effective health information system.

**Activities:**

- Strengthen district offices through data and health management information system
- Provission of vehicles and motorcycles for effective operation of interventions

**Service Delivery Area 6.1:** Coordination and partnership development

***Activities**:*

- Establish an organized intersectorial planning committee
- Develop specific activities to be undertaken by each sector
- Training of committee members
- Experience sharing trips to countries where malaria elimination strategies has been implemented

**Service Delivery Area 7.1:** BCC community outreach and mass media

The Information, Education and Communication (IEC) strategy adopted by the National Malaria Control Programme is used to promote understanding to encourage cooperation with the operations and goals of the strategic plan against malaria.

With this proposal, IEC messages will include information regarding the health benefits of the proper use of ITNs and LLINs. This is an important issue because community surveys on the use of bednets showed that the utilization rate has decreased in 2007 compared to 2006 because of the reduced risk of malaria infection inspite of increased ownership of ITNs. This reversal change in behavior will interfere with the malaria elimination strategy, and more effort will be given in bringing behavioral changes in the use of protective measures in the process of malaria elimination. It will also include information of the benefits of participating in the IRS programme and the precautions necessary to maintain its safety and efficacy.

To prepare for future activities, communities will be sensitized through IEC to recognize practices that create breeding sites for malaria mosquito vectors as well as how to modify existing habitats with community or household-level initiative to render them unsuitable for *Anopheles* larval development. In addition, IEC messages will include the need of timely report of fever cases by the community.

***Specific activities***

To effectively achieve the objectives of the IEC strategy, the following activities will be undertaken through funding from the Global Fund:

- Well-designed and appropriate IEC materials will be developed in local languages (Portuguese, Creole and others, if necessary) targeting the health workers and local communities. New, locally appropriate communication materials including posters and leaflets will be developed to communicate messages supporting both the ongoing and new activities and strategies of the National Malaria Control Programme
- Printing and distribution of IEC materials such as leaflets and posters
- Production of mass media spots and messages
- Broadcasting through news paper, radio and televisions pots on regular and intensive frequency
- The mass media plays a critical role in malaria control activities, and in order to enhance their contribution towards the planned strategy of malaria elimination, a one day workshop will be given to all local media personnel.
- Sensitization and advocacy meetings will be undertaken among political leaders, different sectors, partners, community groups and the people at large. The sensitization and advocacy meetings will emphasized the importance of case identification and early case reporting, a strong surveillance system and effective actions, as well as the risk of re-introduction of malaria and occurence of devastating epidemics if the malaria strategies

fail. New strategies, such as integrated, intensive surveillance and emergency focal spraying will be explained so that residents are aware of their implementation in advance and can anticipate their impact on the community and recognize their importance once such activities become implemented.

**Service Delivery Area 8.1:** Information systems & Operational research

Operational research along with a strong monitoring and evaluation system is an important supporting strategy in the overall National Malaria Control Programme by guiding the design of appropriate and effective malaria prevention and control measures.

***The main activities include***

- Strengthenning of Health facility-based information system: The Health facility-based information system is particularly critical link in the efficient functioning of M&E activities, however, it is severely limited with regard to the quantity and quality of information. Thus, it will be greatly strengthened in order to provide the level of consistent and timely reporting of information that is necessary to manage a strategy that aims to eliminate malaria from STP.
- Strengthen monitoring and evaluation system: Strengthening the capacity to monitor and evaluate the diverse service delivery areas and interventions included in the strategic plan and this proposal through standardization of systems and training of staff and recruitment of new personnel.
- Community based household surveys to collect information on the health-seeking behavior of people, on the level of acceptance and utilization of various preventive measures against malaria will be done yealy.
- Measure the impacts and outcomes of the various activities. Monitoring and evalaution becomes particularly critical with scaling-up operations because quality and timely information can have a large effect on the success of LLIN distribution and other activities that are measured using coverage indicators.
- The level of malaria prevalence is a fundamental measure for monitoring the overall effect of all interventions on the population as a while, and for gauging how much additional effort, coverage or efficiency is required to achieve elimination. To determine the prevalence of malaria, community based blood survey will be undertaken.
- Entomological survey: This includes periodical entomological assessments, such as measuring the abundance and behavior of vectors, determining the duration of effectiveness of residual insecticides (alpha-cypermethrin) and detecting the presence of insecticide resistance to this insecticide.
- Monitroing insecticide resistance: Because the same pyrethroids are being used in multiple types of interventions in STP, it is essential that monitoring of insecticide resistance rates continue on an annual basis.
- Monitroing therapeutic efficacy of antimalarial drugs: The National Programme will be engaged in operational research involving the evaluation of the therapeutic efficacy of antimalarial drugs.
- Undertake annual review meetings

(b) **Target groups**

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

The target groups in all the proposed activities in this project are all the people of STP. All the activities are community level interventions and there is no inclusion or exclusion of certain groups of the society. However, people living in rural villages of the country will benefit more from these interventions because these are people with relatively lower level of access to quality diagnostic and treatment services; information, education and communication services; and with relatively lower levels of ITN and IRS coverage due to lack of transportation and logistics. The nature of community intervention in the context of malaria elimination requires equity in access to malaria services to all people to ensure success of the program. Gevernement representatives from different sectors, NGOs that work with community affected by malaria, Civil Societies which are part of the community were involved during the proposal preparation process, and they continued participating during the implementation and evaluation of the proposal through active participation in CCM and partners meetings.

(c) **Equitable access to services**

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

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 creat enabling environment to village health workers.

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

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

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

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 of all areas on 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.

(e) **Stigma and discrimination**

Describe how this proposal will contribute to reducing stigma and discrimination against people living with and/or affected by HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases.

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.

## Linkages to other programs

**4.6.4 Performance of and linkages to current Global Fund grant(s)**

(a) If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.

*Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.*

***Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained.***

Some of the key services delivery areas proposed in this proposal overlap with key services supported by the 4th round GFATM. These includes ITNs, diagnostics and case management, health services strengthening and surveillance systems. The new or independent key service delivery areas in this project include IRS and

establishment of collaboration and partnership.

Although there was a key service area on ITNs during 4th round GFATM which focused on under five children and pregnant women, the key service delivery area proposed in this project seeks to expand the service to all people in the country as well as replace old ITNs.

Case management and diagnostics was one of the key service delivery areas in the previous GFATM, and it is one of the services included in this project. The funding requested in this proposal is however, a complementary of the previous funding to strengthen a reference laboratory and continuation of the service after the end of the 4th round.

There was limited funding sought during the 4th round of the GFATM for surveillance and health service strengthening, and this projects proposes the need to strengthen an integrated surveillance system in the context of malaria elimination, and a strong health systems to support the same program.

Establishing and strengthening of collaborative partnership among different sectors and partners is a new key service area proposed in the context of malaria elimination as a critical element for successful implementation of the program.

Another new key service delivery area is IRS. IRS operations has been run by the Taiwan Cooperation for the last three years, and their focus of intervention for the next few years will be in larval control and health service strengthening. Since the government recognizes the need for another two rounds of IRS, this project proposes IRS as one of the key service delivery areas.

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

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

In general, the implementation of planned interventions funded through the 4th round of GFATM was satisfactory, which in combination to additionality of other interventions (funded by other partners) led to achievement that exceeded the expected impact indicators. However, there were some challenges and constraints during the implementation of the same grant. The main challenges include limited local market in supplying a variety of nessary materials and certain reticence of them in supplying pro forma invoices; sometime late request of funds by SR that provoke certain slowness in the acquisition process of materials and local consumables. Moreover, insufficient administrative conditions of some SR (ex. lack of electronic mail of CNE; weak management of program excel/accountability and financial issues in SR of the Government, especially in PSR and CNES; insufficient management of administrative questions within the staff of CNES) were the other constraints encountered. Weak health system and difficulty in identification of international consultant with domain of adequate language and skill were also important challenges.

The replacement of ITN to LLN was done progressively using the kit for treatment for the ITN and the LLN to replace the old nets and to expand coverage. Also there was a strong advocacy with the government and other partners in order to stop procurement of ITN and to procure only LLN, which today represent almost all nets in use in the Country. The introduction of ACT, as a consequency of the chloroquine inefficacy, was difficult because of resistance to change at the population and health professional level. For dealing with this two key challenges, determination for improving prescription and compliance through training and retraining of health professional and community health workers; and consistente supervision and BBC sessions. During the implamentation of the previous grant, weakness have been identified in the functioning of the health system and the ministry of health is in the process of addressing these challenges through the support of other partners as well as this project to mantain and improve the success already attaind.

In order to ensure better implemtation of the interventions proposed in this project, a number of steps have been taken and some funding is also sought in this proposal to solve some constraints. Strong partnership was deemed necessary, and to expand the established partnership between the actors, particularly between SR and PR, between some SR, and health district teams which allowed, to continue to have a good execution level during the year. The development and use of manual for SR detailing the procedures is considered important to solve some of the challenges ecncountered with SR. It has become necessary for the SR to follow strictly the orientations in the manual of procedures and request on time the funds to PR. Institutional building capacity has been conceived and

some funding is sought through this proposal. Partners, such as the WHO are supporting technically and in identification of potential consultants to be hired which wil solve the lack of human resource issues.
.

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

The major funding organization in the malaria control activities is the Taiwan Development Cooperation. The main achievements which are planned during the coming few years with this donor organization is to initiate larval control measures using BTI. This will be an integral part of the malaria elimination strategy of the country and the planned outcome is to eliminate malaria transmission foci from the country which is directly linked with the proposed interventions in this proposal. In this proposal, we seeking funding for Temephos (larval control measure) which will be used in combination with BTI depending on the stage of the larval stage. Larval measures are not widely practiced in Sao Tome and Principe, and the major bottleneck could be related with acceptability by the community, and identification of breeding sites approporiate for such larval measures. The Taiwan Cooperation has successfully implemented indoor residual spraying for the last three years and have the human and financial resources to undertake this new intervention along with the malaria control program. One of the major strategy in the implemtation of malaria elimination is information, education and communication, and this strategy will be employed to mitigate negative perception by the community. Moreover, funding is sought for mapping of the country using environmental factors and epidemiological factors, and it is expected that through mapping of potential breeding sites it will be possible to target larvae.

## Private Sector Contributions

| 4.6.6 | Private Sector contributions |
|---|---|
| (a) | If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.<br>➔ *Refer to the Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.* |

Not Applicable

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

| **Size of population group that is the focus of the Private Sector contribution ➔** | Not Applicable |
|---|---|

| **Refer to Guidelines for examples on 'Contribution Description'**<br>*** Add extra rows below to identify each main Private Sector contributor* | | **Contribution Value**<br>*(same currency as selected in section 1.1)* | | | | | |
|---|---|---|---|---|---|---|---|
| **** Private Sector Contribut** | **Contribution Description**<br>*(in words)* | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |

# 4 Component Section *Malaria*

| or Name | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

# 4 Component Section *Malaria*

## 4.7 Principal Recipient information

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

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

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

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

*Table 4.7: Nominated Principal Recipient(s)*

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

| Responsibility for implementation | | | |
|---|---|---|---|
| **Name of Nominated Principal Recipient(s)** | **Sector Represented** | **Name of Contact person** | **Address, telephone, fax numbers and e-mail address of contact person** |
| UNDP | Multilateral | DR Antonio Viegas | UNDP, Avenue des Nations Unies, Sao Tome et Principe<br>POB 109 , Sao Tome<br>Tel : 00 239 221 122<br>FAX : 00 239 222 198<br>Email : antonio.viegas@undp.org |
| | | | |
| | | | |

## 4.8 Programme and financial management

### 4.8.1 Management approach

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

As long as the PR elected will be UNDP, which is the same one that is already working on the implementetion of malaria grant (round 4) and AIDS grant (round 5) the procedures the managerial issues will remain the same, with the Global Fund Unit working at UNDP and following the financial and procurement processes of UNDP.

The implementation of the grant will be as follow: the SRs selected will make a joint planning of the annual (divided by quarter) work plan. After the signature of the contract the money will be transfered quarterly to each SR, according to the activities planned and their performance from the previous quarter.

Regular meeting with PR and SR and supervision visits (technical and financial) from the PR will take place. Conjointly, the SRs and PR will discuss the best solution to deal with some issue. Also the PR will assess regularly the performance of the SR and if there a risk of any constraint, the PR will antecepate (preparing a strategy) to overcome or to avoid the issue. Quarterly the SR will send a report from previous quarter to allow the PR to prepare its report to the Global Fund, moreover, the report will be used to assess the SR to identify the weaknesses and will propose in any case, if possible, the strategy to reinforce the SR. The PR will also use the CCM as a parternership opportunity to reinforce the co-ordination among partners. The work plan and report (progress and fincnacial) will be submitted to the CCM. The PR use the UN facilities and other sources to have a competitive procurement process. The forecast will be made in collaboration with the related SR. The PR have additional staff hired particulary for dealing with the Global Fund grant (1 co-ordinator; 1 financial; 1 M&E staff; administrative assistant; 1 technical staff). The audit to the PR is planned to be done each 2 years, as with the previous grant. Also the PR during the implamentation phase will indentify a possible PR at the governement level for the future. The strategy to reinforce this institution will follow.

### 4.8.2 Principal Recipient capacities

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

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

The 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, finalcial 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.

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

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

It was discussed at the CCM and it was agreed that the CNE, the other potential PR, has not yet the capacities to overtake the management of the project. UNDP is working to strengthen the capacities of the CNE and in the future they will be able to take over. Some measures have been taken regarding this issue like the creation of the Monitoring & Evaluation Unit, or the adquisition of a generator for the CNE. An assessment of the CNE staff has been planned for the next months in order to identify any possible gaps within the CNE in order to be reinforced. The Human Ressources aspect has also been considered in the past and there are some plans to continue working on that side.

# 4 Component Section *Malaria*

| | | |
|---|---|---|
| (c) | Is the nominated PR currently managing a large programme funded by another donor? | ☒ Yes<br>☐ No |
| (d) | Identify the total budget (current and planned) under management by **each nominated Principal Recipient**. | |
| The total Budget under management of PR is USD 1,018. 287 | | |
| (e) | Describe the performance history of the nominated PR in managing these programs/grants.<br>**Specifically**, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes. | |
| According to the performance, the nominated PR has had good management as consistent, transparent and effective. In order to consolidate his management performance, the PR has taken some action, nominating a full time Coordinator for some related areas to follow all the process of their project | | |
| (f) | Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**. | |
| The experience of UNDP as a PR has been satisfactory till today. Both programs are qualified as B1according to the GF criteria what is by itself a good indicative to CCM members. | | |

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

(d) Describe:

(i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process.

(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients *(Also identify significant potential bottlenecks to **transparent strong performance** by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).*

(e) **Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.

**Below** please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. *(maximum two pages).*

(f) **Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal**.
*(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)*

(g) **Where sub-recipients have not been identified prior to proposal submission**, **describe in detail the process that will be used to select sub-recipients** if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved.

The selection of the SR has not been entirely done but normally most of the actual SB for the current malaria grant will continue to work on the program as the results have been satisfactory till today. Some new SB should be considered and an assessment of potential candidates for different activities will be conducted to identify the ideal SR, particulary for sectors others them Ministry of Health

# 4 Component Section *Malaria*

## 4.9 Monitoring and evaluation framework

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

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

### 4.9.1 Monitoring and evaluation plan

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

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

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

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 19**). 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 parasitimia 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.

### 4.9.2 M&E Systems Capacity Assessment

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

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

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

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 harmonizing malaria, HIV/AIDS and Tubeculosis data collection and management for monitoring and evaluation of the programs. This unit will be placed at the CNE which also oversees the implementation of the three disease. A copy of the monitoring and evaluation system organogram, which is under development to be inclusive of malaria and tuberculosis, is attached (**Annex 19**). This project proposal does not include funding for strengthening of monitoring and evaluation system. 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.

# 4 Component Section *Malaria*

## 4.10 Procurement and supply management of health products

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

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

**1.1.1 (a) In the table below, describe the planned roles and responsibilities for procurement and supply management.**
**If a function is planned to be outsourced, identify this in the second column and provide the name of the planned outsourced provider.**

| **Activity** | Which organizations and/or departments are responsible for this function? *(Identify if MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).* | In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).* | Indicate if there is need for additional staff or technical assistance |
|---|---|---|---|
| Procurement policies & systems | UNDP, CNE and FNM (National Drugs Warehouse) | PR / SR | ☒ Yes<br>☐ No |
| Quality assurance and quality control of pharmaceuticals | Pharmaceutical Unit of the government supported by WHO | The pharmaceutical Unit of the MoH collects samples and will passed them over to WHO, who will send them to a laboratory of reference | ☒ Yes<br>☐ No |
| International and national laws (patents) | | | ☐ Yes<br>☐ No |
| Coordination | CCM | The idea is to oriented the CCM to a SWAp approach as it has been done in Mozambique to assure a better co-ordination between different stakeholders. CCM will assure the co-ordinatation | ☒ Yes<br>☐ No |
| Management Information Systems (MIS) | MoH | A SIS (Health Information System) has been developed and is intended to be implemented from 2008 | ☒ Yes<br>☐ No |
| Product selection | CNE (MoH) according to National Guidelines | PR / SR | ☐ Yes<br>☒ No |
| Forecasting | Forecasting of drugs will be done by the Technical Unit od UNDP=GF Unit according to data provided by CNE. Both CNE and UNDP will work closely to assure a good forecasting. Acqusitions will be | PR / SR | ☒ Yes<br>☐ No |

| | | | |
|---|---|---|---|
| | made by UNDP and stocked at the FNM. | | |
| Procurement and planning | UNDP, CNE | PR / SR | ☐ Yes<br>☒ No |
| Storage and Inventory management | CNE, FNM, | SR | ☒ Yes<br>☐ No |
| Distribution to other stores and end-users | CNE, FNM | SR | ☐ Yes<br>☐ No |
| Ensuring rational use | CNE, Health facilities | SR | ☐ Yes<br>☐ No |

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

The Malaria Control Programme functions under the National Centre for Endemic Diseases, which in turn falls under the responsibility of the Ministry of Health. The Malaria Control Programme will be the primary entity responsible for the procurement and supply management of health products before they are distributed into the peripheral health system.

### 4.10.2 Procurement capacity

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

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

| **Organization Name** | **Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)* |
|---|---|
| UNDP (Manuel) | 406,839 |
| FNM | 82,00 |
| | |
| | |

**4.10.3 Coordination**

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

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

Residual insecticides for generalized IRS have been provided up till now by a bilateral partner (Taiwan). These insecticides have been budgeted for as a need in the present proposal due to the uncertaintly regarding the continuity of this arrangement.

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

(a) Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?

☒ Yes
➔ *continue to (b)*

☐ No
➔ *go to 4.10.5*

(b) **If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.

☒ National medical stores or equivalent

☐ Sub-contracted national organization(s) *(specify which one(s))*

☐ Sub-contracted international organization(s) *(specify which one(s))*

☐ Other *(specify)*

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

The storage capacity of the National Medical Stores system is currently more than adequate, particularly in light of the large reductions in malaria infection that have been experienced in STP since 2002. The current and projected storage needs for antimalarial medications are much less now than when the project began, and storage capacity had been adequate previously. Procurements have been reduced recently in order to ensure that excess stocks do not accumulate and fail to rotate for distribution to peripheral health facilties before their expiration date expires. Revise!!!!!!!!!!

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

The distribution needs for the National Medical Stores have been greatly reduced in conjunction with the large reductions in malaria case loads in STPs hospitals, health centres and health posts. The current distribution capacity for delivering antimalarial medications to these facilities has been greatly simplified by this outcome and is more than adequate. There have been no difficulties in distributing medications in a timely manner to these peripheral health facilities.

| | |
|---|---|
| **4.10.5** | **Pharmaceutical products selection**<br>Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use.<br>In section 5.4.1, Applicants are requested to complete **'Attachment B' to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines. |
| | The National Standard Treatment Guidelines (STG) in place for STP are compatible with WHO's STG. |

# 4 Component Section *Malaria*

## 4.11 Technical and Management Assistance and Capacity-Building

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

### 4.11.1 Capacity building and training

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

Much of the gap in capacity that must be remediated to fulfill the goals of this proposal, resides at the District-level. The success of the proposed interventions depends on decentralizing some of the capabilities of the Malaria Control Programme, so that interventions can be staged more rapidly and responsively, in a timely enough manner to prevent small malaria outbreaks from growing out of control.

Thus, this proposal intends to build capacity at the district-level by recruiting, equipping and training small "rapid response teams" in each district that will conduct intensified entomological and clinical surveillance at the community level and would be able to respond independently to surveillance indicators that provide evidence for the threat or existence of elevated transmission. These surveillance teams would, thus, be able to perform emergency, focal IRS and larviciding. They would also coordinate environmental management activities with intersectoral collaborators such as public works or environmental agencies. The budget includes the materials, training and human resource needs required to fill this gap.

Capacity at the central level needs to be improved in order to provide operational support for district-level efforts, to ensure that insecticides remain efficacious and that intervention methods are appropriately applied. These needs include the staffing and equipping of a molecular laboratory and insectary that can provide detailed information on resistance that can inform any changes in insecticide policies. Operational support is also necessary in the form of a locally relevant integrated Health Information System and GPS/GIS health mapping capability.

### 4.11.2 Technical and management assistance

(a) **Needs Assessment**

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

Technical assistance will be required particularly in relation to certain of the new activities that are applied towards achieving the elimination of malaria transmission in STP. Technical assistance will be necessary specifically in the following areas:

1) Health Information Systems

An integrated health information system will need to be created which will monitor the indicence of all disease incidence and health outcomes in STP, including malaria. This system will also be used to track entomological surveillance and risk information and will record where interventions are performed with information on impact and outcomes. Because this system will need to be customized to STPs unique disease profile and will need to be provided in Portuguese, technical assistance will be necessary.

2) GPS/GIS

District-level rapid response teams will need to be trained to use GPS devices to record geographic coordinate to be associated with their surveillance and intervention activities. Health personnel at the district and central level will also require training in the mapping and interpretation of this data using GIS.

3) Focal, emergency IRS

District-level "rapid response teams" will require training in the performance of indoor residual spraying including the formulation of chemicals, the preparation of communities and households for spraying operations, the application of residual insecticides to interior walls, the cleaning and maintenance of spray equipment, and the proper and safe handling of toxic insecticides and the appropriate use of afety gear.

4) Source Reduction and Environmental Management

Technical expertise will be required to determine which methods are most appropriate for source reduction in the vector mosquito habitats that characterize STP. This includes selection of larvicides, methods for application of larvicides, detection of larval habitats, and appropriate environmental modification of larval habitats.

5) Molecular Laboratory and Insectary

Technical expertise in the organization, equipping and operation of a molecular laboratory facility will be necessary to support some of the monitoring and evaluation efforts and operational research that is integral to the success of this malaria elimination effort. Specific needs include operation of Polymerase Chain Reaction (PCR) systems capable to detecting the presence of insecticide resistance mutations, and during the maintenance phase, of characterizing the difference of Plasmodial strains to determine the nature of their origin in order to determine sources of re-infection.

Certain locally available, collaborating partners such as the bilateral agency from Taiwan may be able to provide certain aspects of this technical assistance but it is likely that supplementary assistance will be necessary. This need was assessed by comparing the capability and accessibility of locally available technical experience and evaluating it against the anticipated needs of the new program of intensified surveillance and integrated intervention that will form the basis of STP's strategy to eliminate malaria.

Because a different Principal Recipient has been designated for this proposal (National Malaria Control Programme) than that which had managed the previous 4$^{th}$ Round of the GFATM Project (UNDP), some assistance to enhance the management capabilities of new PR and to pass on "lessons learned" may be required. The former PR, however, is available locally and should be able to provide some level of advice and assistance in this regard.

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

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

Every effort will be made to identify and utilize locally available, technical and management assistance to take advantage of the experience of organizations and individuals that have familiarity with the cultural, institutional and ecological environment of STP, and to avoid unnecessary travel expenses. It is likely that local assistance will be available for management needs and for certain technical needs such as IRS training, although it is possible that the nature or scale of certain needs may exceed the capacity of locally available expertise. If this is determined to be the case, then international assistance may be sought, mainly through consultation with the WHO office, or through organizations, agencies and institutions that have demonstrated the necessary capability and have established relationships through previous collaborations with the National Malaria Control Programme. Otherwise, technical expertise will be identified through examination of relevant publications in the peer-reviewed scientific literature. The anticipated technical needs most likely to require international assistance include design of the Health

# 4 Component Section *Malaria*

Information System, GPS/GIS, and establishment of a molecular laboratory for operational support.

It is anticipated that the provision of certain aspects of this necessary assistance will result in a sustained technology transfer that could be applied to other problems affecting the health system, even after malaria is eliminated.

# 5 Component Budget *Malaria*

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

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

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

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

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

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

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

### 5.1 Detailed Component Budget

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

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

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

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

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

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

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

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

# 5 Component Budget *Malaria*

## 5.2 Summary by objective and service delivery area

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

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

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

| | | **Budget breakdown by SDA** *(same currency as in section 1.1 of the Proposal Form)* | | | | | |
|---|---|---|---|---|---|---|---|
| **Objective Number** | **Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)* | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| **1** | Treatment: Prompt, effective anti-malarial treatment | 21,400 | 21,889 | 40,209 | 30,037 | 23,078 | 136,613 |
| **1** | Treatment: Diagnosis | 8,004 | 7,915 | 13,638 | 13,431 | 10,431 | 53,420 |
| **2** | Prevention: Insecticide-treated nets (ITNs) | 19,362 | 157,927 | 306,181 | 137,755 | 179,111 | 800,336 |
| **3** | Prevention: Vector control (IRS and larval control) | 409,264 | 427,243 | 112,143 | 129,253 | 127,835 | 1,205,737 |
| **4** | Supportive environment: Environmental surveillance | 22,100 | 32,045 | 4,675 | 4,675 | 19,350 | 82,845 |
| **4** | Supportive environment: other - Entomological Surveillance | 71,010 | 17,290 | 17,290 | 25,150 | 17,440 | 148,182 |
| **4** | Supportive environment: Epidemiological surveillance | 158,000 | 30,200 | 40,200 | 30,200 | 40,200 | 298,800 |
| **4** | Supportive environment: epidemic preparedness and response | 10,000 | 148,385 | 113,385 | 113,385 | 113,385 | 498,540 |
| **5** | HSS: Human resources | 398,900 | 350,400 | 332,400 | 332,400 | 332,400 | 1,746,500 |

# 5 Component Budget *Malaria*

| | | Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)* | | | | | |
|---|---|---|---|---|---|---|---|
| **Objective Number** | **Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)* | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| **5** | HSS: Logistics, including transportation and communication | 521,793 | 552,634 | 177,634 | 206,329 | 182,329 | 1,640,718 |
| **6** | Supportive environment: Coordination and partnership development (national, community, public-private) | 203,000 | 125,000 | 73,000 | 117,000 | 80,000 | 598,000 |
| **7** | Prevention: BCC - community outreach | 136,000 | 136,000 | 186,000 | 186,000 | 186,000 | 830,000 |
| **8** | HSS: Information system & Operational research | 113,400 | 135,800 | 83,400 | 212,800 | 113,400 | 658,800 |
| **Total of funds requested from the Global Fund:** | | **2,092,233** | **2,142,728** | **1,500,155** | **1,538,415** | **1,424,959** | **8,698,490** |

# 5 Component Budget *Malaria*

## 5.3 Summary by cost category

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

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

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

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

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

# 5 Component Budget *Malaria*

*Table 5.3 – Budget breakdown by cost category*

| *Use the "MALTable53Line" button in the standard toolbar to insert row at the end of table* | **Breakdown by cost category** *(same currency as in section 1.1 of the Proposal Form)* | | | | | |
|---|---|---|---|---|---|---|
| | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Total** |
| **Human resources** | 598,164 | 588,964 | 552,697 | 585,183 | 562,438 | 2,887,446 |
| **Technical Assistance** | 81,000 | 10,000 | 0 | 0 | 10,000 | 101,000 |
| **Training** | 92,080 | 172,345 | 90,000 | 93,000 | 87,000 | 534,425 |
| **Health products and Health Equipment** | 381,931 | 421,476 | 257,352 | 152,462 | 186,038 | 1,399,259 |
| **Medicines and pharmaceutical products** | 400 | 8,889 | 27,209 | 17,037 | 10,078 | 63,613 |
| **Procurement and supply management costs** | 96,646 | 101,400 | 103,220 | 65,460 | 65,032 | 431,758 |
| **Infrastructure and other equipment** | 571,113 | 555,854 | 188,278 | 206,973 | 192,973 | 1,715,190 |
| **Communication Materials** | 157,500 | 148,000 | 198,000 | 205,500 | 198,000 | 907,000 |
| **Monitoring & Evaluation** | 113,400 | 135,800 | 83,400 | 212,800 | 113,400 | 658,800 |
| **Living Support to Clients/Target Populations** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Planning and administration** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Overheads** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Other:** *(To be further defined to meet national budget planning categories)* | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total funds requested from Global Fund** | **2,092,233** | **2,142,728** | **1,500,155** | **1,538,415** | **1,424,959** | **8,698,490** |

# 5 Component Budget *Malaria*

## 5.4 Key budget assumptions

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

### 5.4.1 Pharmaceuticals and other health products and equipment

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

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

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

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

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

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

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

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

See detailed budget.

### 5.4.2 Human resources costs

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

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

Much of the increase in human resource capacity that the current proposal intends to create in the first two years of the proposal involves the recruitment of district-level personnel who will be engaged in the intensified surveillance and integrated intervention efforts that form the basis of the malaria elimination strategy. It is expected that each "rapid response team" will consist of five personnel from each district, including a team supervisor, who will be trained in clinical and entomological surveillance and focal emergency IRS. Although, this is primarily designed to bolster the malaria-specific capacity of the health system, these activities will bring district health personnel into closer and more frequent contact with the client/target population, and increase the health systems ability to detect the presence and incidence of health threats at the community level beyond malaria.

Regarding sustainability of salaries, it is anticipated that once the goal of elimination is achieved, a fully-staffed "rapid response team" will no longer be necessary and a smaller team can be maintained to perform clinical surveillance, discontinuing the intensive entomological surveillance that was necessary before elimination. Thus, through attrition or otherwise, a smaller team would be maintained, which at this point (post-elimination) could also be engaged in surveillance and response against non-malarial infections. The absence of malaria will also lessen the expense and burden on the overall health system, which will release some measure of resources that could be applying towards sustaining this smaller "rapid response team." This team would retain the capacity, however, to intervene (using focal IRS) against malaria on a contingency basis if cases were introduced by human movement or if new cycles of local transmission were detected.

Several technical positions at the central level will also be necessary to support operational research, monitoring and evaluation and general oversight of the malaria programme and the health system in general. These positions represent a basic essential capacity that is currently lacking in the health system and are expected to be maintained, sustained perhaps through the dividend that will be achieved with the elimination of malaria transmission and its financial burdens on the health system.

### 5.4.3 Other key expenditure items

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

Health information systems will need to be bolstered in advance of an intensified intervention programme that is intended to commence during the third year of this project. Thus, computer equipment and specialized electronic devices (global positioning systems), and specialized software (GIS) are budgeted during the first two years to ensure that the appropriate infrastructure is in place so that the personnel designated to utlize them will be able to become proficient in their use. This information system equipment is divided into two main categories that will be employed for different purposes by different groups of personnel: 1) General health information system equipment for the monitoring of clinical and entomological data for malaria as well as for other health issues. 2) Specific mapping of malaria risk data gathered by district-level surveillance personnel during surveys, including geocoded data captured with GPS units.

At the district level, equipment and supplies for intensified antivector interventions including IRS equipement and safety gear, residual insecticides, larval insecticides, backpack sprayers for application of larvicides, and sueveillance equipment including mosquito traps will also be budgeted for the first two

years. This equipment is not scheduled to become fully operational until the third year of the new intervention strategy, but the equipment will need to be provided to the districts in advance to allow the newly recruited “rapid response teams” tobe become familiar and proficient in its application.

The new strategies will also require the development, production and dissemination of new IEC materials explaining the rationale and impact of these activities at the community-level. These activities again will occur in the first two years to prepare community members for its full implementation during the third year after the project begins.

# 5 Component Budget *Malaria*

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

| **Section 4: Component Strategy – Malaria** | | **Annex Number to your proposal** |
|---|---|---|
| 4.3.1 | Documentation relevant to the national disease programme context. | Plano estratégico Nacional para fazer regredir o Paludismo 2001-2010 (**Annex 16**)<br>Plano Nacional de Desenvolvimento Sanitário ( **Annex 17**) |
| 4.3.5(c)<br>*(**only** if common funding mechanism)* | Documentation describing the functioning of the common funding mechanism. | N/A |
| 4.3.5(d)<br>*(**only** if common funding mechanism)* | Most recent assessment of the performance of the common funding mechanism. | N/A |
| 4.6 | **A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**. | **Attachment A – Malaria** |
| 4.6 | **A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year). | Work Plan (**Annex 18**) |
| 4.6 | **A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals. | N/A |
| 4.8.3 (c) | List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**) | The doc listing the potentials S.R area they are going to work (**Annex 19**) |
| 4.9.1 | National Monitoring and Evaluation Plan/Strategy (if one exists) | O organigrama de monitorização e avaliação ( **Annex 20**) |
| **Section 5: Component Budget – Malaria** | | **Annex Number to your proposal** |
| 5.1 | **Detailed component Budget** | **Annex 21** |
| 5.1<br>*(if HSS strategic actions are included – see* | Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget). | |

# 5 Component Budget *Malaria*

| | | |
|---|---|---|
| *section 4.4.2)* | | |
| 5.4.1 *(and section 4.10.5)* | Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3) | **Attachment B – Malaria** |
| 5.4.2 | Human resources costs. | |
| 5.4.3 | Other key expenditure items. | |
| 5.1 - 5.3 *(if common funding mechanism)* | Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal. | N/A |
| **Other documents relevant to sections 4-5 attached by Applicant:** | | **Annex Number to your proposal** |
| | **Despacho nº 80** TDR da Comissão de revisão | **Annex 22** |
| | **ENRP – Estratégia Nacional de Redução da Pobreza** | **Annex 23** |
| | SIS – Orientação estrategica para Implementação do SIS Operacional Set 2000 | **Annex 24** |
| | **Plan Strategique National pour porter à l`Echelle les intervantions à base Communautaire a STP** | **Annex 25** |
| | **Global Fund report** | **Annex 26** |
| | Draft Analise de Situation pour Harmonization de politique pharmaceutique, Juin 2007 | **Annex 27** |
| | Fase de Consolidação do Controlo do Paludismo em Príncipe | **Annex 28** |
| | Fase de Consolidação do Controlo do Paludismo em São Tomé - DRAFT | **Annex 29** |
| | Fase de Manutenção do Controlo do Paludismo no Príncipe – DRAFT | **Annex 30** |
| | Reforma do Sector de Saúde – Revisão do SIS | **Annex 31** |
| | Estatuto da Central de Aprovisionamento dos Medicamentos Essenciais | **Annex 32** |

## Malaria Attachment A to the Proposal Form

**Program Details**

| | |
|---|---|
| **Country:** | Sao Tome and Principe |
| **Disease:** | Malaria |
| **Proposal ID:** | |

### Program Goal, impact and ouctome indicators

| | Goals |
|---|---|
| 1 | The goal is to eliminate malaria as a public health problem and interupt local transmission, and ultimately eliminate malaria from the country |
| 2 | |

| Impact and outcome Indicators | Indicator formulation | Baseline | | | Targets | | | | | Comments* |
|---|---|---|---|---|---|---|---|---|---|---|
| | | value | Year | Source | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | |
| impact | Incidence of clinical malaria cases (estimated and/or reported) | 11458 | 2006 | MOH (routine HIS or HMIS) | 3867 | 367 | 0 | 0 | 0 | |
| impact | Death rates associated with Malaria: all-cause under-5 mortality rate in highly endemic areas | 115 | 2006 | Malariometric survey | 100 | | 60 | | 20 | |
| impact | Laboratory-confirmed malaria deaths seen in health facilities | 26 | 2006 | MOH (routine HIS or HMIS) | 10 | 5 | 0 | 0 | 0 | |
| outcome | % of U5 children (and other target group) with uncomplicated malaria correctly managed at health facilities | 38% | 2006 | Community survey | 60% | | 100% | | 100% | |
| outcome | % of children U5 sleeping under an ITN | 57.90% | 2005 | Malariometric survey | 80% | 90% | 100% | 100% | 100% | |
| outcome | % of households in malaria areas protected by IRS | 83.50% | 2006 | Community survey | 100% | 100% | | | | |
| outcome | % of pregnant women on Intermittent preventive treatment (IPT) according to national policy (specific to Sub-Saharian Africa) | 66.70% | 2005 | MOH (routine HIS or HMIS) | 75% | 80% | 90% | 95% | 95% | |
| outcome | Proportion of "cases, outbreaks or epidemics" detected within two weeks of onset and properely controlled | 0.0% | 2006 | MOH (routine HIS or HMIS) | | 60% | 80% | 100% | 100% | |
| outcome | | | | please select… | | | | | | |
| please select… | Please Select… | | | please select… | | | | | | |

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

### Program Objectives, Service Delivery Areas and Indicators

| Objective Number | Objective description | Comments |
|---|---|---|
| 1 | To improve national capacity and strengthen quality laboratory confirmation of all cases (100% of cases), and adequate treatment of malaria cases by 2008. | |
| 2 | To maintain an intensive IRS operation with 100% household coverage until 2009, move into focal spraying to interrupt foci of malaria transmission by 2012. | |
| 3 | To achieve 100% of coverage of ITNs by 2009 and maintain the coverage with regular replacement of worn out nets | |
| 4 | To strengthen integrated disease surveillance system, with the introduction of active case detection, epidemiological investigation of all cases, and entomological surveillance and updating of malaria foci accordingly. | |
| 5 | To establish strong intersectorial collaboration and define clear designation of the role of the various partners in the elimination programme by 2009, and maintain thereafter. | |
| 6 | To create awareness among health personnels and the public on malaria prevention and control, and the risk of epidemics when prevention and control measures are not used properly. | |
| 7 | To strengthen health systems through institutional support and human resource development. | |
| 8 | To strengthen monitoring and evaluation and operational research. | |
| 9 | | |

## Malaria Attachment A to the Proposal Form

**Program Details**

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|---|---|
| **Country:** | Sao Tome and Principe |
| **Disease:** | Malaria |
| **Proposal ID:** | |

| Objective / Indicator Number | Service Delivery Area | Indicator formulation | Baseline (if applicable) | | | Targets for year 1 and year 2 | | | | Annual targets for years 3, 4 and 5 | | | Directly tied (Y/N) | Baselines included in targets (Y/N) | Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative) | Comments, methods and frequency of data collection |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Value | Year | Source | 6 months | 12 months | 18 months | 24 months | Year 3 | Year 4 | Year 5 | | | | |
| 1.1 | Treatment: Prompt, effective anti-malarial treatment | Proportion children under five with fever in last 2 weeks who received antimalarial treatment according to national policy within 24 hours from onset of fever. | 90.6% | 2006 | Community survey | | 95% | | | 100% | | 100% | N | Y | Y - cumulative annually | Adequate diagnostics will be available, and treatment will be based on diagnosis except during emergency response for fever treatment |
| 1.2 | Treatment: Diagnosis | Proportion of health facilities equiped with adequate diagnostic facilities | 60% | 206 | MOH (routine HIS or HMIS) | 80% | 90% | 90% | 100% | 100% | | 100% | Y | Y | Y - cumulative annually | |
| 2.1 | Prevention: Insecticide-treated nets (ITNs) | Proportion of households owning atleast one insecticide treated net | 55% | 2006 | Community survey | | 90% | | | 100% | | 100% | Y | Y | Y - cumulative annually | |
| 3.1 | Prevention: Insecticide-treated nets (ITNs) | Number of ITNs distributed | 43'530 | 2006 | MOH (routine HIS or HMIS) | | 22018 | | 24893 | 43176 | 19105 | 25076 | Y | N | N - not cumulative | |
| 3.1 | Prevntion: Vector control (IRS and larval control) | Number of households sprayed with insecticides | 26'051 | 2006 | MOH (routine HIS or HMIS) | | 33503 | | 35942 | 2000 | 1000 | 400 | Y | N | N - not cumulative | |
| 4.1 | Supportive environment: Environmental surveillance | Number of breeding sites managed | 0 | 2006 | MOH (routine HIS or HMIS) | 50 | 50 | | 50 | 1500 | 1500 | 1000 | N | N | N - not cumulative | |
| 4.2 | Supportive environment: other - Entomological Surveillance | Number of entomological surveys done | 0 | 206 | MOH (routine HIS or HMIS) | | 7 | | 7 | 7 | 7 | 7 | Y | N | N - not cumulative | |
| 4.3 | Supportive environment: Epidemiological surveillance | Number of districts that deploy active case detection | 0 | 2006 | MOH (routine HIS or HMIS) | | 0 | | 2 | 7 | 7 | 7 | Y | N | Y - over program term | |
| 4.4 | Supportive environment: epidemic preparedness and response | Number of districts with equipped and trained rapid response team | 0 | 2006 | MOH (routine HIS or HMIS) | | 0 | | 2 | 7 | 7 | 7 | Y | N | Y - over program term | |
| 4.4 | Supportive environment: epidemic preparedness and response | Number of districts with adequate stock of drugs and insecticides for emergency response | 0 | 2006 | MOH (routine HIS or HMIS) | | 7 | | 7 | 7 | 7 | 7 | Y | N | Y - over program term | |
| 5.1 | HSS: Human resources | Number of people trained | 0 | 2006 | MOH (routine HIS or HMIS) | | 40 | | 14 | | | | Y | N | N - not cumulative | |
| 5.2 | HSS (Health Systems Strengthening): Logistics, including transportation and communication | Number of districts with adequate transport and communication facilities | 0 | 2006 | MOH (routine HIS or HMIS) | | 3 | | 7 | 7 | 7 | 7 | Y | N | Y - over program term | |
| 6.1 | Supportive environment: Coordination and partnership development (national, community, public private) | Number of active partnerships involved in malaria control program | | 2006 | MOH (routine HIS or HMIS) | | 20 | | 25 | 30 | 30 | 30 | Y | N | Y - over program term | |
| 7.1 | Prevention: BCC - community outreach | Number of TV/radio session with IEC/BCC activities | 5 | 2006 | MOH (routine HIS or HMIS) | 12 | 12 | 12 | 12 | 24 | 24 | 24 | Y | N | N - not cumulative | |
| 8.1 | HSS: Information system & Operational research | Number of health facilities reporting all indicators according to national guidelines | 0 | 2006 | MOH (routine HIS or HMIS) | | 7 | | 7 | 7 | 7 | 7 | Y | N | Y - over program term | |
| | | | | | please select… | | | | | | | | Y | N | Y - over program term | |