The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information			
Country	**Democratic Rep of Congo**	**Component**	**Malaria**
Funding Request Start Date	**01 January 2015**	**Funding Request End Date**	**31 December 2017**
Principal Recipient(s)	**Ministry of health (MOH)** **Santé Rurale (SANRU asbl.)** **Population Services International (PSI)**		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

Tableau récapitulatif de la demande de financement *

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

a. Epidemiology of malaria in the DRC (Democratic Republic of Congo) and any significant geographic variations in terms of the risk of the disease or its prevalence

In the DRC, malaria is characterised by three epidemiological variants (*PSN [Plan Stratégique National — National Strategic Plan] 2013–2015*, P 15–16, 26):

- Equatorial variant (forests and savannahs): intense and permanent transmission, which can reach up to 1000 infected bites per person per year. With this variant, 30–50% of fevers in children under five years of age are attributed to malaria, and the most severe cases occur in this age bracket.
- Tropical variant (humid areas): There is a long, seasonal increase in transmission during the rainy season, which lasts 5–8 months (60–400 infected bites per person, per year). Morbidity is greater during the rainy season; more severe cases of malaria are observed up to a greater age.
- Mountainous variant (areas at an altitude of over 1000 m): In these areas, the transmission period is very short and years can sometimes pass without any instances of transmission. Severe cases of malaria can occur in all age brackets and can occur as an epidemic or as acute annual outbreaks.

Almost all of the population (97%) lives in stable transmission areas (equatorial and tropical variants). The rest of the population (3%) living in mountainous areas represent the main population group exposed to the risk of malaria epidemics. The stratification is currently being updated and the results will be available before the end of 2014. Following this update, the risk level will be defined in accordance with the projections in PSN 2013–2015 (pages 26, 40).

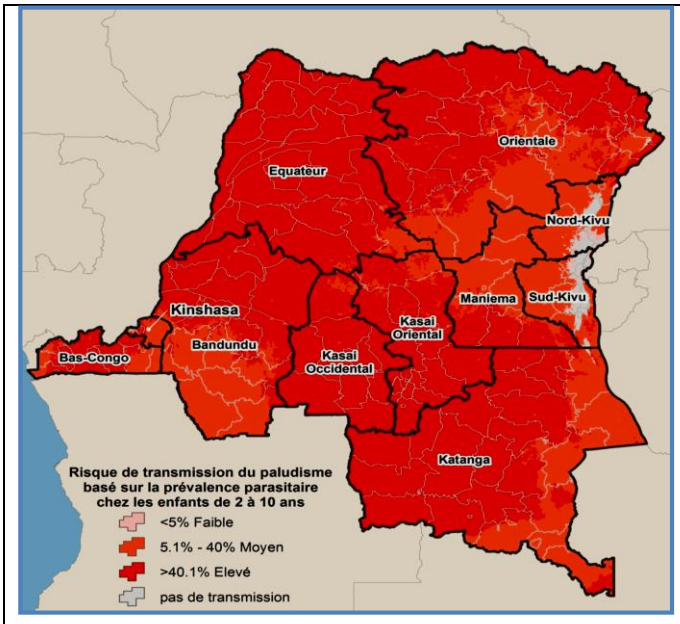


Figure 1: stratification of the risk of malaria transmission in the DRC

Figure 1 shows a geographical disparity of the risk of malaria transmission based on parasite prevalence in different variants. This risk is very low in the mountain variant.

The available data shows the presence of several vectors, the principal being Anopheles gambiae (92%). The Plasmodium falciparum parasite is the predominant species (95%). The Plasmodium ovale and Plasmodium malariae are rarely encountered.

Furthermore, recent entomological studies (Kanza JPB *et al.*, 2013, Bobanga T *et al.*, 2013) show that mosquitoes are becoming resistant to insecticides, in particular Dichlorodiphenyltrichloroethane (DDT), but also to pyrethroids in the following regions: Equateur, Orientale, Sud-Kivu, Bas-Congo and Kinshasa. The choice of insecticide is an important piece of information with regard to the provision of LLINs (Long Lasting Insecticidal Nets).

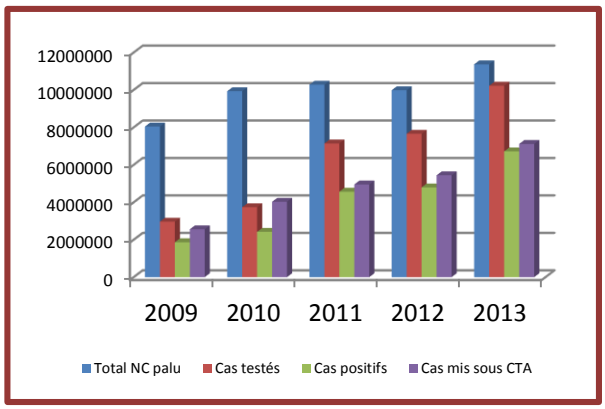


Figure 2: Evolution of the number of cases, tested cases, positive cases and cases put on ACT from 2009 to 2013.

According to the 2013 annual report of the NMCP, from 2009 to 2013, the number of malaria cases increased from 8,042,844 to 11,363,817; the tested cases from 2,961,318 to 10,223,122, the cases put on ACT from 2,553,462 to 7,112,841 (Figure 2). The proportion of severe malaria cases reported remained around a median of 7% (range of variation: 7-9%). Malaria represents on average 40% of all outpatient visits.

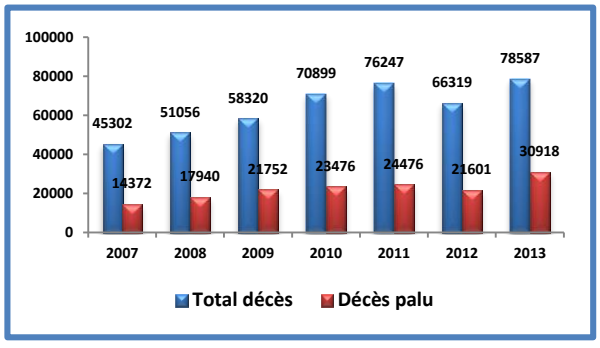


Figure 3 : Evolution des malades décédés dans les structures sanitaires de ZS en RDC pendant la période 2007-2013

Between 2007 and 2013, the number of malaria deaths increased from 14372 to 30918, an increase of nearly 54%. Deaths from all causes, follow the same trend with an increase of 42% over the same period (Figure 3). The increase in severe cases and deaths reported in this period is explained by the improvement in the rate of completeness of reporting but also and especially by the frequent shortages of inputs.

After India and Nigeria, the DRC has the highest mortality rate for children under five years of age (*Reducing the mortality rate for mothers and children in the Democratic Republic of Congo, P.4*). According to the 2010 MICS (Multiple Indicator Cluster Survey), when all causes of death are included, the mortality rate in the DRC for children under five years of age is 158 for every 1000 live births. The UNICEF report, *The State of the World's Children 2011*, showed that 19% of deaths in children under five years of age in the DRC were attributed to malaria.

The goal of the NPMC (National Programme for Malaria Control) is to increase the provision of preventative interventions and treatment in order to reverse malaria morbidity and mortality rates.

b. Key affected populations that may find it incredibly difficult to access prevention and treatment services, and the factors contributing to this inequality

In the DRC, almost all of the population (97%) lives in stable transmission areas and is at risk of contracting malaria. Key and vulnerable populations affected by malaria are mainly children under five years of age and pregnant women (particularly those living with HIV). Populations in hard-to-access areas, prisoners, uniformed men (deployed troops and police officers), street children, displaced populations and indigenous people are also vulnerable due to the conditions and environment in which they live and their lack of access to prevention and treatment services. However, street children, uniformed men and prisoners are taken into account during LLIN mass distribution campaigns.

The performance of the health services in the DRC remains inadequate; use of helath services is low (around 37%) and is the main obstacle to rapid, correct malaria treatment.

Other factors that contribute to infant, child and maternal mortality rates are inadequate geographical and financial accessibility to health care, socio-cultural barriers, the use of questionable medications in communities, abuse through self-medication, a lack of awareness regarding danger signs, delayed health care intervention and the lack of action from communities with regard to combatting malaria.

In order to reduce infant mortality in geographical areas that are some distance from health care services, particularly in rural areas, the Ministry of Health has established community health care facilities as part of its community system policy in order to implement the IMCI-C (Integrated Management of Childhood Illnesses in the community) in December 2005 (IMCI: documentation of best practices in the DRC, USAID-MCHIP [United States Agency for International Development-Maternal and Child Health Integrated Program] 2012).

c. Key human rights barriers and gender inequalities that may impede access to health services

Malaria affects men and women indiscriminately. However, pregnant women are more at risk of contracting and dying from malaria, regardless of the level of endemicity.

Some professions are also considered to be risk factors, such as working in mining areas (Kasai Oriental, Kasai Occidental, Kivu, Katanga and Bandundu), where access to health care services is limited.

Among certain marginalised populations, such as the Pygmies living in the equatorial forest (around 54,000 inhabitants), the disparity in their access to

health care (prevention and treatment) is linked both to their geographical isolation and to their perception of the illness (relying on traditional medication).

Populations living in areas of armed conflict in the east of the country also have very limited access to preventative and treatment services.

d. Context of health and community systems in the country, including any associated constraints

The national health system is based on a **primary health care strategy and** is divided into three levels (PSN NPMC [National Malaria Control Programmes] 2013–2015, pages 10–12):

- **The central level**, which is responsible for standardisation and regulation. Services are available to the population at four tertiary-level university hospitals.
- **The intermediate level**, which comprises 11 DPS (*Divisions Provinciales de la Santé* — provincial health departments) and 65 DS (*Districts Sanitaires* — health districts). Services are available to the population in provincial hospitals; however, only six out of eleven current DPS have operational hospitals (cf. NHDP [National Health Development Programme], page 15, and PSN, page 10). The decentralisation process written into the current Constitution provides for the creation of 26 DPS when the 26 new provinces are created.
- **The peripheral level**, which comprises 516 HZs (health zones) with 393 GRH (general referral hospitals), meaning 123 GRHs are needed to ensure that each HZ has its own hospital, and 8504 planned AS (*aires de santé* — health areas), of which, 8266 have an HC (health centre), meaning that 238 AS are not covered. This level is responsible for implementing the primary health care strategy, including community activities, under the supervision and management of the HZMT (Health Zone Management Team) and the intermediate level.

The operation of the health information system is still problematic, despite the country's efforts to standardise tools and the NHIS (National health information service). The current system does not allow for high-quality information to be made available in real time so that decisions can be taken and plans can be made based on evidence. There are three factors that have caused this situation: (i) lack of human resource capabilities at all levels of the health system, (ii) insufficient standardised collection and transmission tools, and (iii) a lack of equipment for using the DHIS2 (District Health Information System 2) software.

It is important to note that the public health system usually includes non-profit FOSAs (*Formations Sanitaires* — health facilities) from the private sector (non-governmental organisation and religious denomination health services). These FOSAs are regulated and obliged to provide services in the same way as the public sector. Moreover, around half the population has access to the private for-profit sector (private for-profit health care institutions and formal and informal dispensaries), mainly in towns (Littrell M. *et al.*, 2011). This sector does not benefit from the intervention package recommended by the NMCP and does not report its data to the NHIS.

According to the NHDP, the doctor-to-patient ratio in 2009 was 0.2:10,000 in Equateur and1.8:10,000 in Kinshasa. The report also mentions the high level of instability among health-care providers due to internal and external migrations and low salaries. This instability can be observed at all professional

levels of the health care system and affects both the range and quality of services offered. The uneven distribution of human resources in health (HRH) between the provinces remains a problem.

The **community level in the DRC** comprises: (i) the Committee for the Development of Health Area (CODESA) that currently consists of representatives of community-based organizations (CBOs), religious groups, delegates from Community Animation Cells (CAC – Cellule d'Animation Communautaire) and represents the all community relays (RECO) of the health areas, (ii) the CAC, which represents all the CBOs (community-based organisations), including the relays from a village/street, and (iii) Community Relays (RECO) that are chosen by the community.

The SSCs (*sites de soins communautaires* — community health care sites) are located in areas where the nearest HC is over 5 km or an hour's walk away. They are run by trained RECOs. The package of activities implemented at the SSCs includes: (i) case management of simple cases of malaria, diarrhoea, pneumonia and malnutrition, as well as referring cases with danger signs (ii) behaviour change communication, (iii) community-based epidemiological surveillance and (iv) ensuring the availability of high-quality essential medication. Only 3038 SSCs are currently operational, meeting around 20 to 30% of the country's needs.

CBOs play an important role in LLIN distribution campaigns and routine distribution. They also raise awareness through home visits in order to increase the use of available services and the adoption of healthy behaviour patterns.

Community representatives are required to report the results of their activities to an AS-level representative at the specified intervals. This data is validated by RNs (registered nurses) during monthly monitoring meetings.

The **main shortcomings and weaknesses of the community health system** are: (i) poor budgeting and poor application of provincial frameworks during the establishment of sites; (ii) inadequate adoption of the community strategy by HZMTs; (iii) insufficient supervisory visits due to a lack of human, material and financial resources; (iv) lack of RECO reliability, as they leave SSCs due to a lack of interest; (v) poor stock management, leading to frequent shortages of medications and supplies at SSCs; (vi) data from the SSCs not being taken into account by the national health system.

N.B.: *For further details on the shortcomings of the health system in the DRC, see figure 2 on page 12 of PSN 2013–2015 and pages 31–69 of NHDP 2011–2015.*

In the context of improving the performance of the health system, the current implication of the community is a key element to be developed according to the recommendations of the meeting at the Bethany Centre in May 2014 (report annexed).

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints

described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests[1], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

The DRC has a **government action plan for 2012–2016,** which has taken into account the objectives of the health sector. These objectives are detailed in the 2011–2015 NHDP. In line with this document, the NMCP has developed a PSN that covers 2013–2015 and is enshrined in the vision of the DRC to be **"an emerging country free of malaria"**.

a. The key goals, objectives and priority areas of the programme (PSN 2013–2015, pages 33–46).

Goal: To contribute to the improvement of the health of the population by reducing the human and socio-economic burden caused by malaria.

Objectives: (i) To reduce the mortality rate specifically related to malaria by 50% (based on data from 2010) in FOSAs, and (ii) To reduce the malaria morbidity rate by 25% (based on data from 2010).

These general objectives have been divided into 12 specific objectives across six priority areas, as described below.

Malaria prevention: LLINs, IRS (indoor residual spraying); IPT (intermittent preventive therapy) in pregnant women and infants. IRS and IPT for infants are currently in the pilot phase, and are therefore included in operational research.

Correct treatment of malaria cases: biological confirmation of malaria, treatment of confirmed cases at all FOSAs and at community level.

Preparation and response to malaria epidemics and to emergency situations: early detection and response to epidemics.

Programme management: planning, mobilisation of resources, implementation and coordination of activities, advocacy, raising awareness and community mobilisation.

Procurement and supply management: implementing quantity management systems and monitoring systems for supplies, increasing capacities, implementing a quality assurance system, coordination.

Epidemiological surveillance, Monitoring and Evaluation, and operational research: reinforcing epidemiological monitoring, including sentinel surveillance; implementing a monitoring and evaluation system; operational research.

b. Implementation to date, and the main outcomes and impact achieved

[1] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

The number of HZs with a complete MPA (Minimum Package of Activities) for malaria has increased from 271 in 2009 to 464 in 2013 out of the 516 HZs, meaning 89.9% of the country is covered (*NMCP Annual Report 2013*). To date, 52 HZs (10%) remain without support.

The results and impacts recorded are listed below and summarised in Table I.

***Vector control**:* LLINs are distributed in mass campaigns every three years and routinely by health care facilities during CPS (*consultations pre-scholaires* — pre-school consultations) for children under the age of one and at PNCs (prenatal consultations) for pregnant women. The percentage of households owning at least one LLIN has increased from 9.2% in 2007 to 50.9% in 2010.

Malaria prevention during pregnancy: In the DRC, PNC1 coverage is 87% in FOSAs. Only 21% of pregnant women benefited from IPT in 2010 (*MICS-DRC 2010*). According to the NMCP Annual Report, the number of women who received at least two doses of SP (sulfadoxine/pyrimethamine) rose by 27% between 2009 and 2013.

***Diagnosis and treatment of malaria*:** The number of cases tested and treated with ACT (artemisinin-based combination therapy) after diagnosis is gradually increasing. SSCs have been established, but the geographic coverage is far from complete. An SSC expansion plan is being developed and will be available at the end of 2014.

Table I: Development of NMCP performance indicators according to national surveys from 2001, 2007 and 2010

INDICATORS	MICS 2001	DHS 2007	MICS 2010
% of children under the age of five who had a fever in the two weeks preceding the survey and had a finger/heel sample taken for malaria testing.	**NA**	**NA**	**17.2%**
% of children under the age of five who had a fever in the two weeks preceding the survey and were treated with first-line antimalarial drugs recommended for a simple case of malaria.	**NA**	**NA**	**6.1%**
% of children under the age of five with a fever	**41%**	**30.8%**	**27.0%**
% of households with at least one LLIN		**9%**	**51%**
% of children under the age of five who use an LLIN	**0.7%**	**6%**	**38.1%**
% of pregnant women who use an LLIN		**7%**	**42.6%**
% of pregnant women who have benefited from IPT in accordance with national policy		**5.1%**	**20.8%**
% of children under the age of five who had a fever in the two weeks preceding the survey and were treated with antimalarial drugs		**29.8%**	**39%**
% of children under the age of five who had a fever in the two weeks preceding the survey and were treated with antimalarial drugs and received a first-line treatment recommended for simple malaria.		**NA**	**6.1%**
% of children under the age of five who had a fever in the two weeks preceding the survey	**41%**	**30.8%**	**27.0%**
Infant mortality	**126‰**	**92‰**	**97‰**
Child mortality	**213‰**	**148‰**	**158‰**

Sources: MICS 2001, http://www.childinfo.org/files/drc.pdf
DHS 2007, http://www.measuredhs.com/publications/publication-FR208- DHS- Final- Reports.cfm
MICS 2010, http://www.childinfo.org/files/MICS-RDC_2010_Summary_Report_EN.pdf
NA = Not Available

Programme management: The 2013–2015 PSN has been implemented via national, provincial and HZ operational plans. Performance monitoring and evaluation is carried out within a national monitoring and evaluation framework *(PSN 2013-2015, page 47)*. Activities aimed at combatting malaria are coordinated by the NMCP national management, which relies on provincial services with half-yearly data validation and bottleneck management reviews. At an operational level, HZMTs are responsible for these coordination activities

and hold monthly monitoring reviews with health care providers. Implementation is carried out in collaboration with various technical and financial partners. The various partners involved in the fight against malaria are coordinated by means of quarterly malaria task force meetings at national and provincial level, monthly meetings of thematic groups within this task force and weekly NMCP meetings with TFPs.

***Preparation and response to malaria epidemics and to emergency situations*:** An epidemiological surveillance system that reports on a weekly basis, sentinel sites and a national contingency plan to respond to epidemics are all currently in place. The current system allows the severity of epidemic outbreaks to be measured, but doesn't provide an adequate response to mitigate their impact. The PMI (President's Malaria Initiative) has contingency stocks planned for five provinces (Katanga, Kasai Oriental, Kasai Occidental, Sud-Kivu and Orientale Province). A contingency plan also exists for displaced populations and refugees (OCHA).

Advocacy, IEC (Information, Education and Communication) and community mobilisation: A communication PSN is in existence (NMCP Communication plan 06.09.2013 in Annex). Its implementation benefits from a partnership between the NMCP and the organisations that take part in IEC and community mobilisation activities.

***Procurement and supply management*:** The Directorate of Pharmacy and Medicines (DPM) is responsible for regulating medication. A SNAME (*système national d'approvisionnement en médicaments essentiels* — National System for Procurement of Essential Medicines) is in place within the Ministry of Health. A pharmacovigilance system is being developed in collaboration with the national drug monitoring centre.

Epidemiological surveillance, monitoring and evaluation, and operational research: A number of managers at central, provincial and HZ level have been trained in IDSR (Integrated Disease Surveillance and Response), monitoring and evaluation, and research. Monitoring and Evaluation is carried out in accordance with NHIS guidelines; the implementation and performance of these guidelines must be improved within the context of HSS (Health Systems Strengthening).

There is a surveillance system for diseases with the potential to become epidemics under the authority of the Fourth Directorate.

Research and studies are currently underway, in particular relating to the persistence of insecticides, the sensitivity of vectors to insecticides, the therapeutic effectiveness of antimalarial drugs, determinants of late PNCs, and a pilot study regarding rectal administration of artesunate as a pre-referral treatment. Studies have been carried out before and after LLIN mass distribution campaigns.

c. Limits and constraints on implementation and lessons learned that will inform future implementation

Despite the progress achieved, 52 HZs still do not offer the PMA for malaria (*NMCP Annual Report 2013*). A number of limits and constraints have been identified during the implementation of the aforementioned strategic plans, in particular:

Vector control: (i) universal LLIN coverage has not reached one net for every two people in some areas of the country; (ii) the map detailing the distribution of anopheles species has not been updated, (iii) coordination between the

various bodies involved in vector control must be strengthened.

Prevention and treatment of malaria during pregnancy: (i) frequent shortages of SP; (ii) insufficient IPT training for those responsible for prenatal consultations; (iii) the lack of a joint NMCP–NRHP (National Reproductive Health Programme) plan; (iv) the use of non-recommended products (such as monotherapy) for the treatment of simple malaria during pregnancy.

Diagnosis and treatment of malaria: (i) national diagnosis and treatment guidelines are not always observed, especially in the private sector; (ii) financial accessibility to care is limited; and (iii) monotherapy and other unauthorised medications remain in the distribution chain of the public and private sectors, and in parallel markets; (iv) self-medication and traditional practices are deeply ingrained; (v) poor supply and inadequate stock management, particularly at SSC level; (vi) the mobility/unreliable nature of RECOs; (vii) insufficient regulation in the pharmaceutical sector.

Programme management: (i) poor financial contribution from the government to the fight against malaria; (ii) weakness of the NMPC leadership in implementing and following the national strategy; (iii) excessive and inadequate staffing, poor cohesion and insufficient communication among the NMCP team; (iv) poor staff motivation, linked in particular to poor salaries and bonuses; (v) poor communication between the NMCP and its partners; and (vi) limited application of norms and guidelines of the NMCP by the private sector.

The malaria programme performance review carried out in 2013 recommended that an organisational audit of the NMCP be carried out. This audit will take place before the end of 2014, and will identify the main bottlenecks and provide recommendations for improving the management of the programme.

Preparation and response to malaria epidemics and to emergency situations: (i) the majority of HZs do not have a defined threshold for declaring an epidemic (ii) no current mapping of areas with the potential for epidemics; (iii) inadequate ability to analyse epidemiological malaria data at provincial and zonal level; (iv) a need to direct supplies to the six provinces with no PMI support or coverage; (v) inadequate use of weekly notification data at central level (vi) insufficient interpretation of guidelines and training of agents in managing malaria epidemics, and (vii) a lack of cross-sector collaboration (health, meteorology, environment, agriculture etc.).

Advocacy, IEC and community mobilisation: (i) insufficient coordination and leadership of the NMCP in its communication activities; (ii) limited involvement of the private sector; (iii) inadequate communication tools at HCs; and (iv) low level of financial investment in communication activities.

Procurement and supply management: (i) lack of supplies (ACT, RDT [Rapid Diagnostic Test]) to effectively treat malaria due in particular to poor quantity management; (ii) poor cooperation between the NMCP, the national regulatory authority, the national drug monitoring centre, SNAME, particularly FEDECAME (*Federation des Centrales d'Approvisionnement en Medicaments Essentiels* — Federation of Essential Medicine Procurement Agencies) at a central level, RDCs (regional distribution centres) at a provincial level and the NIBR (National Institute for Biomedical Research); (iii) poor ability of SNAME to provide all FOSAs with essential medications and to control the quality and availability of medication in circulation in the country; (iv) problems applying the customs exemption principle for antimalarial supplies for the public sector, causing a delay in the supply of products. Stock management remains inadequate, with repeated shortages of medications and other products,

particularly at a peripheral level.

Epidemiological surveillance, monitoring and evaluation, and operational research: (i) lack of standardised tools to collect, analyse and transmit data, and lack of trained staff, particularly at HZ level; (ii) low proportion of operational sentinel sites; (iii) insufficient use of national laboratories in the surveillance system; (iv) lack of formal collaboration framework between research institutions and the NMCP; (v) poor completion rate for studies that were envisaged by the PSN 2007–2011; (vi) non-integration of monitoring systems at community level (RECO and SSC) in the NHIS; and (vii) insufficient quality control for data; (viii) insufficient IT tools and Internet connection at HZ level required for the operation of DHIS2 software; and (ix) poor CCM (Country Co-ordinating Mechanism) performance in the strategic monitoring of grant implementations.

Carrying out malaria control activities in the DRC has allowed **lessons to be learnt** for the future. The main lessons are as follows: (i) door-to-door distribution of LLINs is a good way to reach specific groups of the population and to improve the usage of LLINs; (ii) the IMCI-C strategy improves access to health care; (iii) observing the methods of payment for paying bonuses to agents helps to improve their performance; (iv) reinforcing health systems is key to carrying out activities linked to the fight against malaria, and is a necessary condition for achieving results; (v) improving the stock system at HZ level improves monitoring and allows for regular reporting on consumption and stock levels; (vi) proper regulations and contracts with the private sector improves the availability of high-quality services for the population; (vii) an increased financial contribution from the government encourages financial partners; (viii) correct CCM operation is essential to optimum grant implementation; and (ix) collaboration with TFPs allows difficulties with implementation to be resolved.

A number of **actions have been taken to remedy the shortcomings related to implementation**. The main actions are described below.

- Leadership and governance: Communication between the NMCP and its TFPs has been revitalised: Weekly meetings are being held at NMCP offices, a task force has been put in place and meets on a quarterly basis; an institutional audit, financed by USAID, is planned for 2014; a credit line for the current grant from the GF (Global Fund) is to be used to reinforce the NMCP leadership.
- Sustainable funding: The government has increased its funding for the fight against malaria by including a line in the budget for $2,802,601 in 2013 and 2014. Free health care for malaria has been established, but applying this scheme effectively remains a challenge.
- Community level: civil society is currently organizing mapping missions of CBOs in 135 HZ, which will continue to include all HZ in the country.
- Medication and other supplies: The NMCP and its partners have undergone cascade training on quantity management. In order to take the realities of the country into account and produce more accurate data, quantification of requirements and medication is carried out by province. Emphasis is placed on collecting data and monitoring supplies so that quantity management is based on real consumption.
- Provision of services: The NMCP has conducted additional training for health care providers at intermediate and peripheral levels on malaria treatment guidelines. Training supervision has been improved. An increase in the number of SSCs and the inclusion of two other childhood diseases (pneumonia and diarrhoea) is planned.

- Health information systems: With support from TFPs, the MPH (Ministry of Public Health) is continuing to make updated data collection tools available for all levels of the health care system. The NMCP holds quarterly meetings to validate data at a provincial level and an annual meeting at a national level. Partners are invited to these meetings to validate data reflecting the situation at a national level. The DHIS 2.0 software has been set-up and posted on-line by the HMIS Division of the Ministry of Health.

d. Main areas linked to the national health strategy, in particular the impact of the implementation of this strategy on the results of malaria control

Table II: Link between the national health strategy and malaria control.

Core strategies — HSS strategy	Impact on malaria control
Revitalisation of the HZ	The HZ is an operational unit of the national health policy. Its development is the only way to implement the basic strategy of PHC (Primary Health Care) and guaranteeing the provision of high-quality, accessible services for the prevention and treatment of malaria.
Reinforcing governance and leadership	The actions that fall under this heading [(i) reform and decentralisation in the sector, (ii) NHIS reform, (iii) research on the health care system, and (iv) improvement of management systems for health care facilities] contribute to improving resource management, minimising risks, producing high-quality data and strengthening the leadership of the malaria control programme.
Development of HRHs	Improving staff capabilities and establishing an adequate incentive system are important aspects in developing HRHs that could lead to achieving the anticipated sustainable results with regard to malaria control.
Reform of the pharmaceutical sector	A correctly functioning SNAME will contribute to improved availability of high-quality antimalarial products in FOSAs
Reform of health care funding	Financial reform would mean that mechanisms could be put in place to allow each level of the health care system to receive funding to achieve its goals. This would improve the planning and implementation of antimalarial interventions at all levels.
Reinforcement of partnerships	In order to have a lasting impact on malaria, the contribution of several sectors is required. As such, intra-sector and cross-sector collaboration are vital.

e. Not applicable.

f. National processes for evaluating and revising the PSN for malaria and the results of these evaluations

The process of drafting the 2013–2015 PSN for malaria began with an MPR (Malaria Programme Review), which resulted in the signing of a memorandum by all stakeholders. The recommendations in this review guided the development of the 2013-2015 PSN, which was developed in collaboration with all the stakeholders. Furthermore, the monitoring and evaluation plan and the implementation plan in its budget were agreed upon by all stakeholders, including the civil society and the key populations that validated them.

At the end of the current 2013–2015 PSN of the NMCP, an inclusive review will be performed, similar to the review completed at the end of 2012. The results of this review will guide the development of the 2016–2020 PSN in accordance with WHO (World Health Organization) guidelines. This PSN will be aligned with the new 2016–2020 NHDP and will continue ongoing interventions to ensure universal coverage of anti-malaria services across the country. Key affected populations will be involved at various levels by integrating all aspects of civil society and the private sector.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

a. Programme areas currently receiving funding and the source of this funding (government and/or donor)

The DRC Malaria Control Programme benefits from the support of various donors. The table below shows a summary of projected funding for each intervention.

Table III: Projected funding from the government and TFPs in different areas of the programme

Area of intervention	Partners	Involvement and coverage			Comments
		2015	2016	2017	
Vector control	Government	No	No	No	PMI stated that, by 2017, they will have distributed 1,200,000 LLINs through mass distribution campaigns and routine distributions, not including those routinely distributed at CPSs and PNCs in their intervention areas. The requirements to carry out mass distribution campaigns in four provinces in 2015 and to start again in 5 HZs in 2016–2017 are not covered. This is also the cases for routine distribution of LLINs in the GF's 219 HZs and 23 HZs that are currently without support.
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	Yes	NA	NA	
	KOICA (Korea International Cooperation Agency)	Yes	NA	NA	
	World Bank	No	No	No	
	Secours Catholique France (Catholic aid France)	No	No	No	
	CIDA (Canadian International Development Agency)	No	No	No	
Case treatment	Government	Yes	Yes	Yes	PMI supports 138 HZs with PMAs and CPAs (Complementary Package of Activities) and has decided to extend supplies and activities to 29 HZs that are without support, and to extend supplies to 14 HZs where support from the World Bank is coming to an end. DFID has decided to offer supplies in 20 coordinated HZs and a complete health care package in 17 HZs without coordination from the GF until 2017. DFID is also involved in treating simple cases of malaria in the private sector. The government is offering support through equipment and reagents for biological confirmation (PESS [*Projet Equipement des Structures Sanitaires* — Health Facilities Equipment Project). Within the framework of this concept note, quinine will be purchased for the HZs supported by the GF and response supplies for the six provinces that do not have PMI support using matching funds.
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	No	No	No	
	KOICA (Korea International Cooperation Agency)	Yes	No	No	
	World Bank	Yes	No	No	
	Secours Catholique France (Catholic aid France)	Yes	Yes	Yes	
	CIDA (Canadian International Development Agency)	Yes	Yes	Yes	
	MSF (Doctors Without Borders)	Yes	Yes	Yes	

Specific prevention interventions (IPT)	Government	No	No	No	DFID has decided to offer IPT in 17 HZs without GF coordination until 2017 USAID/PMI support IPT in these intervention zones
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	No	No	No	
	KOICA (Korea International Cooperation Agency)	Yes	No	No	
	World Bank	Yes	No	No	
	Secours Catholique France (Catholic aid France)	No	No	No	
	CIDA (Canadian International Development Agency)	No	No	No	
Programme management	Government	Yes	Yes	Yes	Not all of the partners have decided on the amount they will commit to the management of the programme
	WHO	Yes	Yes	Yes	
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	Yes	Yes	Yes	
	KOICA (Korea International Cooperation Agency)	Yes	No	No	
	World Bank	Yes	Yes	Yes	
	Secours Catholique France (Catholic aid France)	No	No	No	
	CIDA (Canadian International Development Agency)	No	No	No	
Monitoring and evaluation	Government	Yes	Yes	Yes	Several TFPs have decided to monitor and evaluate malaria control activities until 2017 without all of the amounts having been confirmed.
	WHO	Yes	Yes	Yes	
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	Yes	Yes	Yes	
	KOICA (Korea International Cooperation Agency)	Yes	No	No	
	World Bank	No	No	No	
	Secours Catholique France (Catholic aid France)	No	No	No	
	CIDA (Canadian International Development Agency)	No	No	No	
Behaviour change communication	Government	Yes	Yes	Yes	Several TFPs have decided to monitor and evaluate malaria control activities until 2017 without all of the amounts having been confirmed.
	USAID/PMI	Yes	Yes	Yes	
	DFID (Department for International Development)	Yes	Yes	Yes	
	UNICEF	Yes	Yes	Yes	
	KOICA (Korea International Cooperation Agency)	No	No	No	
	World Bank	No	No	No	
	Secours Catholique France (Catholic aid France)	No	No	No	
	CIDA (Canadian International Development Agency)	No	No	No	

b. Additional government funding commitments expected (willingness to pay) during the implementation period

In order to help ensure the sustainability of malaria control activities, the government has committed to allocating an annual financial contribution through matching funds and other grants. Plans for using the matching funds are provided by the NMCP and validated by the CCM general assembly. The Strategic Oversight committee of the CCM will monitor the implementation. The financial unit of the MPH monitors the budget implementation. The NMCP creates a quarterly statement of requirements addressed to the financial unit of the Ministry of Public Health, which monitors the disbursement of funds at the Ministry of Budget. An annual report on actual expenditure is carried out by NMCP with contributions from the state and areas that have received funding. The Strategic Oversight committee distributes reports monitoring the use of matching funds to CCM members and to all those involved in malaria control.

Moreover, other ministries have government resources and participate in

malaria control in specific circumstances.

c. How has the proposed Global Fund investment attracted other donor resources?

The funding provided by the GF gives the DRC the opportunity to achieve universal coverage of prevention and treatment services for malaria and to respond to the *Call to reduce mortality rates in preventable diseases in mothers and children under the age of five* issued by the MPH.

This NFM (New Funding Model) will reinforce the system and strengthen the leadership of the NMCP in coordinating partners and carrying out interventions. This coordination allows non-funded interventions to be identified and updated annually, and intervention mapping to be shared with all partners. Based on the developed mapping and the commitment of the GF, partners can choose the areas and intervention zones in which they wish to work.

An extension of IMCI, thanks to the NFM, will give other donors the opportunity to support additional interventions to improve the child survival rate.

Furthermore, the HDCG (Health Donor Coordination Group) facilitates coordination and helps to avoid the duplication of projects by directing new interventions to zones and areas with inadequate coverage.

d. Planned action to remedy funding gaps

In order to fill gaps in funding for programme requirements arising from the annual analysis, the advocacy that has been started must be continued. The NMCP will mobilise resources with the support of TFPs (the GF, USAID/PMI, DFID, KOICA, WB [World Bank], UNICEF, WHO). Continuous appeals will be made to the government, national and international cooperation organisations, and the private sector in order to ensure additional financial support to cover the gaps in funding for the fight against malaria and other childhood diseases. Continued financial commitment from the Congolese government is essential in encouraging the support of financial partners.

Current mapping shows that out of the 516 HZs in the country, 52 have no support and the support for 80 others (from the WB) will end in June 2015. For the purposes of the present submission, health service coverage will be extended from 219 to 308 HZs (23 HZs without support and 66 HZs previously supported by the WB). Discussions have been held with partners to ensure coverage for the additional HZs. In addition to the 138 HZs currently supported by PMI, PMI has also committed to support 43 remaining HZs (29 HZs without support and 14 HZs previously supported by the WB), resulting in a total of 181 HZs. 56 HZs are supported by DFID, 20 of which are supported in collaboration with the GF. In the 20 HZs where the GF and DFID are present, there will be an adjustment in funding in order to optimise resources (cf. section 3.2). 5 other HZs are supported by KOICA.

In addition to financial resources, strategy improvement through lessons learnt and revitalising cross-sector collaboration (education, military, agriculture, hydraulics, housing etc.) could also help to reduce funding and programme gaps, and this will be developed through written guidelines.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☐Yes ☐ No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☐Yes ☐ No	
iii. Increasing government contribution to disease program	☐Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

i. Provision of reliable data to assess compliance

The information provided in Table I in relation to the analysis of funding gaps and matching funding originates from the PNCN (*Programme National des Comptes Nationaux* — national accounts programme) This data was compared with data from NMCP financial documents in order to confirm its validity. Other financial data also originates from the GF in order to be made available to the PNCN.

ii. Minimum threshold for public contributions to the malaria control programme

The minimum threshold for contributions from the state has been increased to 6% in accordance with the request from the GF; this demonstrates willingness on the part of the Congolese government to provide support for public health programmes in general and to contribute to malaria control, and to the NMCP

in particular. It should be noted that the increase in government contribution is due to funding through PESS.

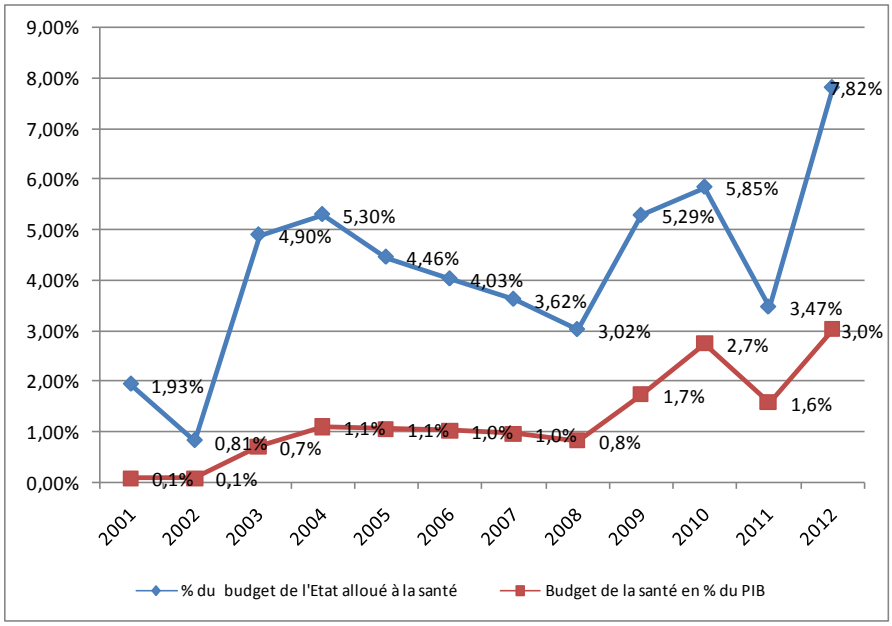
iii. Increased government contribution to the disease control programme

The requirements for matching funding with state contribution in disease control are being observed, as illustrated in Table I. The minimum public contribution to the national HIV/AIDS, tuberculosis and malaria control programme during the funding request period is 5–6% of the total funding from the government and the GF; this corresponds to the standard specified for low-income countries such as the DRC. It should also be noted that funding from the Congolese government for disease control has seen a sharp increase since 2012. Disbursement mechanisms have been streamlined, which suggests that disbursement rates will increase.

b. Increased government contribution to the health sector

Government contribution to the health sector has greatly increased over the last few years. Since 2001, the proportion of the state budget allocated to the health sector has increased from 1.93% to 7.82% and the health budget as a percentage of GDP has increased from 0.1% to 3.0%. There was a 4% decrease in the health budget in 2004, which dropped still further to 3.02% in 2008; these decreases were due to the considerable participation of the country in the war effort. Since the start of the peace process, this contribution has increased from 3.41% in 2011 to 7.82% in 2012. The graph below summarises the changes to government contributions to the health sector.

Table IV: comparative evolution of the health budget as a % of GDP and of the % of the budget allocated by the state to the health sector



Source: mini budget, law on state budget for the years 2001–2012, Kinshasa DRC

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

1. Priority module 4: "Monitoring and evaluation"

In the 2012 MPR, the following gaps were identified in the monitoring and evaluation area:

- Very old epidemiological stratification of malaria *(Mouchet J et al. 2004: Biodiversité du paludisme dans le monde [biodiversity of malaria throughout the world])*
- Insufficient data collection and transmission tools at HZ level
- Poor coverage in terms of sentinel sites; the 11 existing sites (out of the 26 planned) are only partially operational
- Insufficient means to carry out supervisory visits at all levels
- Poor involvement of laboratories in the surveillance system
- Data quality audits not carried out at HZ level
- Malaria database (RBM Monitoring Evaluation) not yet operational due to connectivity issues at the central NMCP offices, while database managers at the central and provincial levels have been trained already;
- Data sharing with partners/stakeholders barely operational
- Poor completion rate for studies (5/23 or 22%) envisaged in the NMCP 2007–2011 five-year research programme
- Lack of integration of monitoring systems at community level (RECO and SSCs) in the NHIS

Other gaps, such as the poor proportion of staff trained in monitoring and evaluation, IDSR, NHIS, the use of the DHIS2 software and operational research.

Based on the conclusions of the MPR, **actions were taken in response to the problems identified**, in particular:

- Training 28 central and provincial agents in monitoring and evaluation with USAID funding in September 2013
- The revision of the regulatory framework for the NHIS was approved in December 2013. This process has been supported by several TFPs, including WHO, USAID, DFID and the Global Fund. Similarly, the standardised single-format tools for collecting and transmitting NHIS data that integrate data about the fight against malaria and data generated by SSCs have been

transmitted to the provinces and health zones for their use
- Adopting the new DHIS 2.0 software for increased speed and training on Tom monitoring software
- Strengthening data auditing with the RDQA (routine data quality assessment) tool standardised from 2013 onwards with funding from the Global Fund
- Creating the DHS 2013 survey with funding from several donors, through a USAID project

These actions were supported by weekly coordination meetings with partners in the fight against malaria.

The new PSN has taken into account recommendations made in the review to improve the capacity of the NMCP to collect and analyse high-quality data. Plans are also in place to revitalise the sentinel sites system and to support operational research efforts concerning malaria with funding from DFID over the period 2014-2018.

2. Priority module 5: Programme management

The 2012 MPR identified the following gaps:

- Low financial contribution of the government to the health budget, including the fight against malaria
- Weak NMCP leadership with regard to implementing and monitoring the national strategy
- Poor framework for coordination between the NMCP and partners
- Poor cohesion and insufficient communication within the NMCP team
- Excessive, inadequate staffing of the NMCP
- Low private sector involvement in malaria control
- Lack of motivation among staff, in particular due to low incomes and bonuses

In addition to the gaps identified by the MPR, the notoriously poor working conditions (dilapidated premises and facilities, no IT systems) of the NMCP do not facilitate day-to-day operations. The current allocation from the Global Fund to the NMCP is insufficient. The present submission includes a request for a contribution to renovate these premises.

To combat some of these shortcomings, an organisational and institutional audit of the programme, funded by PMI, will be conducted before the end of 2014. The anticipated recommendations will help to formulate concrete proposals regarding the organisation, organisational structure, job profiles, recruitment and staff motivation, as well as operating methods and procedures.

In addition, the mechanism for communication and coordination between partners and the NMCP has been revitalized since the second quarter of 2013 by holding weekly departmental meetings and quarterly task force meetings.

However, to adequately meet the programme's aims, it is vital that the NMCP's coordination abilities are strengthened and the frameworks for dialogue between partners in the fight against malaria are consolidated across all areas, including: supply management, collection and analysis of health data, SSCs and training supervision.

Within this context, the Swiss TPH (Tropical and Public Health Institute) will use DFID funding to support the NMCP for the period 2014-2018 in strengthening its administrative and financial management capacities. A project to support operational research will be also implemented by Swiss TPH

over the same period.

In addition, the NMCP will launch an appeal for improved mobilisation of financial resources, both from the Congolese government and from partners, and for more dynamic cross-sector collaboration with the other ministries involved in the fight against malaria.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

In accordance with the conclusions of the national dialogue (see description of the process and implementation of the roadmap for the Malaria Concept note in the CCM Eligibility annexes) and the PSN, the concept note envisages the following actions from 2015:

- Continue interventions in the 219 HZs currently supported by the Global Fund
- Extend interventions to combat malaria in 89 new HZs composed of 23 HZs without support and 66 HZs whose WB funding ends in June 2014 with supply coverage guaranteed until June 2015
- Continue mass campaigns on a national scale

The present request for funding covers a total of 308 HZs and focuses on the following five priority modules:

- The routine distribution of LLINs through mass campaigns
- Provision of treatment for simple and serious cases that have been confirmed by SSCs
- IPT of malaria in pregnant women using SP
- Monitoring and Evaluation, and
- Programme management

Of these 308 HZs, the provision of PMA supplies (routine LLIN, RDT, ACT and SP) for cases of simple malaria as well as artesunate suppositories for pre-referral treatment and injectable artesunate for serious malaria will be covered by DFID in the 20 HZs where DFID and the Global Fund are present. Training, social mobilisation, monitoring, evaluation and HSS activities will be provided by the present submission to the Global Fund.

In accordance with the Global Fund guidelines and in accordance with the decision of the CCM, the present funding application includes a contribution of the malaria component to HSS, especially at NHIS level.

Important: *The entire budget—indicative and above indicative—is absolutely necessary to achieve the targets identified in the national dialogue and defined in the PSN. Any gap in the funding of these priority activities would jeopardise the results obtained in terms of universal coverage, the provision of treatment to affected populations and the fulfilment of the objectives of the fight against malaria in the DRC.*

The budgeting for activities in the present submission amounts to $453,133,234. This exceeds the amount of $304,992,400, which corresponds to the new funding amount of $269,700,143 allocated by the Global Fund and

the amount deferred from the current grant, $35,292,257.

Negotiation was necessary to determine the distribution between the indicative and the above-indicative budgets. Negotiation is carried out each year by and within each intervention block: LLIN for the Campaign, Campaign Activities, Minimum Package of Activities (routine LLIN, RDT, ACT, IPT), Serious Malaria, Epidemic Response, Monitoring & Evaluation, Programme Management, PR (Principal Recipient) Management Costs and contribution of the Malaria component to HSS.

For the purposes of the present submission, the indicative amount is $304,964,018 and the above-indicative amount is $148,169,216.

Module 1: Vector control

1.1. Mass campaign

The concept note aims to continue the mass distribution initiated in 2008 in order to maintain universal coverage by adhering to the nation-wide renewal cycle every 3 years.

This submission aims to achieve mass distribution of LLINs according to national planning in the following provinces:

- In 2015: Nord-Kivu, Sud-Kivu, Katanga, Bandundu (4 provinces)
- In 2016: Kinshasa alone
- In 2017: Maniema, Kasai Occidental, Province Orientale and Bas-Congo

LLINs will be purchased in accordance with international tender procedures and will be WHOPES (WHO Pesticide Evaluation Scheme) Phase 2 certified. The LLINs will be transported to health zones by the most appropriate means. Geographical characteristics and the level of infrastructure in each province will be taken into account to determine the most efficient means of transport (road, boat, train, plane) for delivering LLINs to distribution sites in the best possible conditions.

To achieve these results, the following key activities are planned:

- Drawing up overall campaign plans
- Acquiring LLINs
- Conducting a pre-campaign assessment
- Confirming calculations
- Organising micro-planning workshops in the field
- Organising meetings to confirm micro-planning data (BCZS [health zone central office], DPS, National)
- Ensuring the delivery of LLINs to storage and distribution points
- Providing cascaded training of the teams involved at every level (provinces, districts, health zones, health areas) Carrying out a household census
- Organising the distribution of LLINs
- Validating campaign data
- Monitoring LLINs following distribution
- Conducting a post-campaign evaluation (at least six months after the campaign)

The programme, the authorities and all the partners attach particular importance to maintaining universal coverage through campaigns conducted on a national scale.

The amount needed to fund LLINs is included in the indicative budget for the campaigns in 2015 and 2016, at $73,955,260 and $13,778,431 respectively.

The cost of organising the 2015 and 2016 campaigns, $15,323,993 and $3,352,846 respectively, are included in indicative funding to underline the importance of this strategic intervention and its impact on malaria morbidity.

For 2017, the LLIN funding, amounting to $52,145,928, and the campaign costs of $11,383,956 are included in the above-indicative budget.

Campaign funding request

Mass campaign	Indicative funding	Above-indicative funding	Comments
Acquiring LLINs	$87,733,691	$52,145,928	Average UC (unit cost) = $2.75 PSM cost = 40%
Campaign activities	$18,928,321	$11,434,419	
Campaign subtotal	**$106,662,012**	**$63,580,347**	**Overall cost = $170,242,359**
In %	**63%**	**34%**	**100%**

1.2. Routine

Routine distribution among pregnant women and children under the age of one will continue in the 219 HZs currently supported by the Global Fund and will be extended to 89 additional health zones.

Pregnant women will be given an LLIN at their first PNC and children under the age of one when they have completed their vaccination schedule (VAR).

To ensure and facilitate appropriate use of LLINs by the population, communicating behavioural changes constitutes a major support strategy for both routine distribution and distribution campaigns.

The total cost of routine distribution of LLINs is $35,421,583. Placing 74% in 2015, 76% in 2016 and 77% in 2017 within the indicative amount (total $26,269,037) will allow the current level of coverage to be maintained. Placing the remaining 26% in 2015, 24% in 2016 and 23% in 2017 in the above indicative amount (total $9,152,545) will make it possible to cover the entire target.

Funding request for routine distribution of LLINs

Routine distribution of LLINs	Indicative funding	Above-indicative funding	Comments
Acquiring LLINs	$26,269,037	$9,152,545	Average UC (unit cost) = $2.75 PSM cost = 35%
Routine subtotal	**$26,269,037**	**$9,152,545**	**Overall cost = $35,421,583**
In %	**74%**	**26%**	**100%**

Module 2: Treatment

Treatment of malaria will continue in the 219 HZs currently supported by the Global Fund and will be extended to 89 additional health zones, covering a total of 308 HZs. The NFM grant will also help to develop the IMCI at SSC and community level.

2.1. *Treatment of cases in SSCs*

Public SSCs

The present submission envisages the reinforcement of biological diagnosis with RDT and correct treatment of malaria cases with ACT and disease among children by ensuring the constant availability of health supplies. Supplies for pneumonia and diarrhoea will be provided by UNICEF which, in a memorandum signed with the Global Fund, committed to provide the supplies

against diarrhea and pneumonia in HZ covered by the GF. However, activities of identification, establishment and training of providers, as well as support activities in terms of supervision, monitoring will be covered by this grant.

These activities thus provide a gateway to allow other donors to provide inputs for diarrhea and pneumonia for integrated case management of childhood illnesses. This approach has already been used for the interim financing.

The main activities involved in the correct treatment of cases in SSCs are:

- Supplying health centres and GRHs with RDT and reagents
- Supplying health centres and GRHs with medication
- Ensuring the distribution of IMCI supplies
- Reproducing and distributing treatment guidelines for malaria cases
- Reproducing and distributing IMCI guidelines
- Training personnel from the HZMTs and health care providers from health centres and GRHs on biological diagnosis, malaria prevention and IMCI in the 89 newly covered HZs. Retraining staff who have already received this training in the 219 HZs
- Ensuring correct treatment of malaria in persons aged under five and above – in the community case management component, under 5s are included in the integrated case management of childhood illnesses in community care sites.
- Monitoring biological diagnosis quality in the 308 HZs

Private SSCs

The scale of the private sector and the frequency of self-medication mean that it is difficult to access high-quality ACT in this sector (private health care training courses and medication outlets). In fact, 60% of health services are provided through the private sector (ACTwatch study 2009) and only 2.6% of antimalarials used in this sector are ACTs. In addition, only 21% of private facilities that stock ACTs also provide RDT.

To improve the treatment of malaria in the private sector, a pilot experiment will be conducted in areas of Kinshasa province with the support of DFID in order to determine the added value of ACTs in the local context. Additional resources will be required to cover the whole of Kinshasa province.

A contribution of $4,006,168 is requested to cover RDT and ACT needs for 50% of the area included in the pilot study conducted by DFID in the private sector of Kinshasa province. This request is included in the above-indicative budget. The cost of distributing these supplies will be covered by DFID.

2.2. *Integrated treatment of malaria cases in SSCs*

The strategy for community treatment using relays trained in using RTD and ACT has already been developed in 219 HZs with SSF (Single Stream of Funding) and interim funding, in some cases working alongside other TFPs. This strategy must be extended to cover the 308 HZs targeted by the present grant.

Community treatment at individual sites will encompass diarrhoea and pneumonia to form an integrated strategy with the support of TFPs (UNICEF, WHO, DFID, PMI, CIDA etc.).

The main interventions to be deployed are as follows:

- Identifying and mapping SSCs
- Providing supplies to the 4128 SSCs
- Providing IMCI-C training for HZMTs/RNs (registered nurses) and 8256

RECOs in the 308 HZs
- Ensuring biological confirmation of all cases of malaria by RDT
- Ensuring correct treatment of childhood disease in SSCs
- Ensuring correct treatment of malaria cases among those aged five and above
- Providing post-training monitoring in accordance with SSC management guidelines
- Equipping RECOs in the 89 new HZs
- Supervising RECOs in the 308 HZs
- Supplying SSCs with management tools in the 308 HZs

For each year, the principle for inclusion of supplies for treating malaria (RDT and ACT) is to ensure coverage of 70% for people with access to health care services by 2016, in other words 70% of the 41% of the population with access to health centers.

A slight increase in this rate is anticipated from 70% in 2016 to 75% in 2017. The cost of supplying and distributing these supplies ($31,113,723 for RDT and $25,970,282 for ACT) is included in the indicative budget.

The amount in the above-indicative budget ($29,244,858 for RDT and $18,909,004 for ACT) will cover the remaining proportion of those with access to public sector health care services (30% in 2015, 28% in 2016 and 25% in 2017) to reach 100% of patients with access to health centers, including at community level and the private not-for-profit sector. The contribution by sector will be 82% for public structures, 13% for community care sites, and 5% for the private sector.

Included in the $48,153,862 in the above-indicative budget is $4,006,168 representing the needs of the private sector pilot project, which will be implemented in Kinshasa province.

Funding request for treatment of simple malaria

Treatment	Indicative funding	Above-indicative funding	Comments
Acquiring RDT	$31,113,723	$29,244,858	Average UC = $0.51 PSM cost = 35%
Acquiring ACT	$25,970,282	$18,909,004	PSM cost = 35%
Support activities	$3,139,801	$0	
Treatment subtotal	**$60,223,806**	**$48,153,862**	**Overall cost = $108,377,668**
In %	**56%**	**44%**	**100%**

2.3. ***Treatment of serious cases***

Treatment of serious cases of malaria is also envisaged in the present submission in 288 out of 308 HZs. The needs of the remaining 20 HZs will be covered by DFID.

In addition to quinine treatments used to date, injectable artesunate is already partially supplied as part of the current grants. In line with the WHO recommendation, injectable quinine should be replaced with injectable artesunate in the treatment of serious cases by June 2015.

The systematic substitution of quinine with injectable artesunate has a significant economic impact on the budget. The transfer plan envisions a transition period of 3 years, initially defined as 2013 to 2015 in line with the NSP, but following the challenges of funding gaps and availability of pre-qualified injectable artesunate on the market, the estimated transition period is now from 2014 to 2016.

Therefore, out of an overall amount of $38,272,295, a share of nearly 32% (amounting to $12,091,238) will be requested in the indicative budget and a share of 68% (amounting to $26,181,057) will be included in the above-indicative budget.

Artesunate suppositories are used as pre-referral treatment at community level (SSC) on the way to the health centre or from the health centre to the general referral hospital in order to improve the prognosis of serious malaria and save lives.

From a total of $588,349, the amount in the indicative budget is $181,690 and the amount in the above-indicative budget is $406,659.

Funding request for serious malaria

Serious malaria	Indicative funding	Above-indicative funding	Comments
Injectable artesunate	$12,091,238	$26,181,057	UC = $1.66 PSM cost = 35%
Artesunate suppositories	$181,690	$406,659	
Serious malaria subtotal	**$12,272,928**	**$26,587,716**	**Overall cost = $38,860,644**
In %	**32%**	**68%**	**100%**

2.4. ***Prevention and response to epidemics***

PMI provides contingency stocks for five provinces: Katanga, Kasai Oriental, Kasai Occidental, Sud-Kivu and Province Orientale. Contingency stocks for the country's other six provinces will be covered in the quantification of supplies, which does not take into account stock remaining at the end of the current grants. The present submission envisages investigative activities for confirming epidemics and support in responding to them.

A total of $1,152,000 equating to $384,000 per year is included in the M&E (Monitoring and Evaluation) section of the indicative budget for these response activities.

Funding request for prevention and response to epidemics

Epidemics	Indicative funding	Above-indicative funding	Comments
Activities	$1,152,000	-	$480,000 per year
Epidemic subtotal	**$1,152,000**	**-**	**Overall cost = $1,152,000**
In %	**100%**	**0%**	**100%**

Module 3: Specific prevention interventions

3.1. ***Intermittent preventive treatment for pregnant women***

IPT concerns the 219 HZs currently supported by the Global Fund and will extend to 89 additional health zones. The other HZs are covered by other funding bodies (DFID, USAID/PMI, WB, KOICA, Secours Catholique France) in accordance with the mapping of interventions updated in 2013.

While the rate of PNC attendance is high (PNC 1 at 87% and PNC 2 at 54%, source: PNDS), the IPT coverage rate remains low at 21% (*MICS-DRC 2010*).

However, across all HZs supported by the Global Fund, this coverage was 51.2% in 2010 with disparities between the HZs. (*ESP June 2010*).

In the new NSP, orientations on IPT are fully compliant with the new WHO guidelines, the process of updating the technical guidelines is underway, and quantifications were carried out on this basis.

The aim of the present submission is to extend IPT coverage to 85% of pregnant women benefitting from PNCs in 2017. To achieve this aim, several strategies will be implemented, in particular:

- Making SP permanently available
- Guaranteeing that SP is free of charge in all facilities
- Increasing general and specific awareness of pregnant women and their partners in order to promote rapid PNC attendance and attendance of subsequent PNCs
- Increasing the capacities of PNCs in the 89 new HZs
- Strengthening the partnership by integrating strategies and approaches from the NMCP and the Programme National de Santé de la Reproduction (national programme for reproductive health) relating to the management of malaria in pregnant women (LLIN, IPT, treatment)

The entire amount required for distributing SP ($1,417,865) is included in the indicative budget as a priority intervention for pregnant women.

IPT funding request

IPT	Indicative funding	Above-indicative funding	Comments
Sulphadoxine-pyrimethamine	$1,417,865	-	UC = $26.61 (box of 1000 tablets) PSM cost = 35%
SP subtotal	**$1,417,865**	**-**	**Overall cost = $1,417,865**
In %	**100%**	**0%**	**100%**

Note: The cost of implementing PMA activities (routine LLIN, RDT, ACT and SP) amounts to $3,953,248 and this entire amount is included in the indicative budget.

Module 4: Monitoring and evaluation

The current malaria grant funds supervision in 139 out of 219 HZs. The other HZs are covered by the current HSS grant. This concept note advocates funding of integrated supervision in all 308 HZs targeted in terms of Malaria M&E and HSS M&E.

4.1. Malaria Monitoring and Evaluation

Implementing monitoring and evaluation of activities will rely on the organisational framework of the NHIS, but will also help to strengthen it through the present request for funding.

Surveillance will continue in 11 sentinel sites supported by the Global Fund and will extend to 26 sites in accordance with the new DPS structure. The 15 new sentinel sites will be supported by PMI (6 sites) and by DFID (9 sites).

Annual functionality assessments of these sites will help to refocus implementation activities and identify necessary measures to improve site functionality.

In the context of coordinating activities, the NMCP organises reviews at national and provincial level as well as monitoring meetings at an operational level. The current grant funds the annual review carried out by the NMCP. This support will be extended to the end of 2017 through the current funding request relating to the malaria component.

The annual NHIS review carried out by the Primary Health Care Directorate (D5), the quarterly provincial review of 12 DPS (the other 14 DPS in the country are supported by other partners) and the monthly meetings and bi-annual monitoring of the HZs, which will be extended to the 308 HZs, will all be funded as HSS in the present funding request.

Several important operational research and study themes have been identified to improve strategies for combatting malaria and boosting the results of interventions/actions. These themes include monitoring the resistance of anopheles to insecticides, studies into the therapeutic efficacy of antimalarial drugs and the contribution of the private sector in the treatment of malaria cases. These activities are included in the Malaria component of the budget for the present funding request.

Drug monitoring activities will be continued as HSS activities for the purposes of this funding request.

For the purposes of the present submission, the entire amount required for Malaria M&E ($14,551,522) is included in the indicative budget.

4.2. *HSS*

The HMIS is the platform for integrating data collected from all primary health care programmes and requires the commitment of all partners. To this effect, the current submission proposes continuing to conduct audits of data quality using reproduced NHIS collection tools from 2015 onwards. This process is currently financed by the HSS R9 and SSF Malaria projects in the 245 supported HZs. The Global Fund also funds operations of the NHIS division. The 271 remaining HZs will receive the support of other partners.

This will be complemented by funding for the publication of the bi-annual and annual newsletter from 2015. This funding is currently supplied by HSS. DFID is supporting the implementation of DHIS2 at national level and in six DPS; the other partners will ensure complementarity at an operational level.

The process of implementation of DHIS 2.0 software is underway. In the province of Western Kasai different actors were trained and should begin encoding during the month of June 2014 for the figures of the last 6 months. Training for the province of Kinshasa will be held during the month of June 2014. Two other provinces, Maniema and Equateur, are planned for the current year.

The requirements relate to strengthening capabilities for managing and using the DHIS2 software, as well as developing health mapping.

The funding request must cover the quarterly visits for monitoring the new regulatory framework from 2015. This is currently funded by the SSF Malaria grant.

For the purposes of the present submission, the entire amount required for the contribution of the malaria component to HSS ($27,436,168) is included in the indicative budget.

Module 5: Programme management

5.1. Malaria programme management

The analysis of weaknesses identified in 3.1 relating to programme management has led to the identification of activities that are detailed in the budget. The activities mainly centre on developing management tools, planning, coordination, monitoring and strengthening human and material resources.

This submission also includes activities supporting the NMCP, including meetings of the scientific committee responsible for coordinating research activities, meetings of the quantification committee and supply monitoring.

This submission also includes a request for funds to renovate the central NMCP premises, which is essential to ensuring normal working conditions (building, electricity, Internet connection).

For the purposes of the present grant, the entire amount required for malaria programme management ($7,696,973) is included in the indicative budget.

5.3 Principal recipients (PR) costs

Almost all of the PR costs in this submission ($47,620,259 out of a total of $48,315,005) are included in the indicative budget. The amount of $694,746 included in the above-indicative budget corresponds to the costs for PRs in charge of campaigns, because the 2017 campaign is included in the above-indicative budget.

Funding request summary

Budget by block	Total over 3 years					
	Indicative budget	Indicative %	Above indicative	Above %	Full request	Full %
LLIN campaign	87733691	29%	52145928	35%	139879618	30.87 %
Campaign activities	18928321	6%	11434419	8%	30362741	6.70%
PMA	84770907	28%	57306407	39%	142077315	31.35 %
Serious malaria	12272928	4%	26587716	18%	38860644	8.58%
PMA activity	3953248	1%	0	0%	3953248	0.87%
HSS	27436168	9%	0	0%	27436168	6.05%
M&E	14551522	5%	0	0%	14551522	3.21%
Malaria programme management	7696973	3%	0	0%	7696973	1.70%
Community activities	0	0%	0	0%	0	0.00%
PR costs	47620259	16%	694.746	0%	48315005	10.66 %
Total in USD	304964017	100%	148169216	100%	453133234	100.00 %

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

a. Reasons for choosing and establishing the order of priority for modules and priority interventions

The process for establishing the order of priority of the modules and interventions to combat malaria in the DRC began with the MPR, which consisted in analysing the performance of current programme strategies and formulating relevant recommendations. This was followed by province-level dialogue involving all stakeholders: the government, the provincial Ministry of Health, civil society, the private sector and the education sector. Following on from this dialogue, the priorities with regard to the specific needs of each province and in relation to the PSN have been identified.

After this step, the country malaria dialogue was held from 26 to 28 March 2014. The dialogue brought together more than 150 participants representing all stakeholders in the fight against malaria (public sector, private sector and civil society, technical and financial partners). A number of observers who are not members of the CCM also took part.

The aim of this dialogue was to contribute to drawing up the malaria concept note to obtain funding from the Global Fund for the next three (3) years — an activity that requires the active participation of all stakeholders in the fight against malaria.

After a presentation and a joint discussion about the work of the groups, a consensus was reached on the following priority modules:

a. Vector control
b. Treatment of cases
c. Specific prevention interventions
d. Monitoring and evaluation
e. Programme management

Module I: Vector control→priority intervention: LLIN

It has been shown that using LLINs significantly reduces the transmission of malaria by knock-down effect and by reducing the survival rate of mosquito vectors, resulting in a reduction in the number of parasites circulating in the community.

A data meta-analysis conducted by Cochrane in Sub-Saharan Africa has concluded that universal coverage with insecticide-treated nets reduces infant mortality (with all causes of death included) by 17%.
This same study concludes that the number of simple malarial episodes caused by *P. falciparum* or *P. vivax* is reduced by between 39% and 62%. A separate study (Hill, Lines, Rowland. Insecticide treated nets. Advances in parasitology, 2006) has demonstrated a reduction in the incidence of serious malaria by

45%.
Universal LLIN coverage prevents approximately 83,700 deaths among children under 5 years of age each year. The reduction in mortality among children under 5 years is estimated at 17% after universal coverage is reached. *(Lengeler C. Insecticide-treated bednets and curtains for preventing malaria. Cochrane Database of Systematic Reviews, 2000, (2):CD000363 (update Cochrane Database of Systematic Reviews, 2004, (2): CD000363.*

As the DRC has not yet achieved universal coverage, this major intervention has been fixed as a priority in order to help achieve the objectives set by the MDGs (Millennium Development Goals).

This intervention is more effective when it is understood, accepted and followed by the population, hence the importance of social mobilisation.

Module II: Treatment → priority interventions: confirmation and treatment of cases

According to the 2012 NMCP report, nearly 9.4 million episodes of malaria and approximately 24,000 deaths related to this pathology were recorded during that year. To counter this situation, the NMCP is implementing strategies that may help to reduce malaria morbidity and mortality. These strategies consist of confirming at least 80% of suspected cases of malaria in FOSAs and SSCs by means of RDT or thick blood smear (GE). Next, all confirmed cases must be systematically treated in accordance with national guidelines. Biological confirmation before treatment helps optimise the use of ACT and avoid waste and drug abuse.

Scientific evidence shows that treatment with antimalarials may reduce mortality among children under the age of five by 6%, oral rehydration therapy using rehydration salts with low osmolarity and zinc may reduce mortality among under-fives by 15%, and treatment of pneumonia with antibiotics helps reduce mortality among under-fives by 7%. Combined, these treatments add up to a total possible reduction of mortality among children under the age of five of 28%, corresponding to 162,000 lives saved. (Source: LIST 2010, DRC, LANCET 2000).

Faced with this situation, treatment of cases of malaria has been retained as a priority intervention in addition to the preventive interventions set out in the context of this note.

In addition, the funding will continue to contribute to integrated control of the three major high-mortality diseases among children, namely malaria, pneumonia and diarrhea (except supplies), through the strategy of integrated management of childhood illnesses (IMCI) within FOSAs and at community level.

Module III: Specific prevention intervention→intervention: intermittent preventive treatment in pregnant women

It is a well-known fact that pregnant women are at risk of malaria infection. They are more vulnerable due to their reduced immunity. According to the *DHS report 2007*, malaria was the reason for 54% of hospitalisations among pregnant women. Women in the DRC suffer from poverty and limited access to health services, making malaria prevention all the more important for this target group.

As the DRC is a country with medium to high malaria transmission rates, IPT is recommended by the WHO for all pregnant women at each PNC. IPT reduces

the number of malaria episodes in pregnant women, and prevents miscarriage, premature labour, low birth weight and stillbirths.

Recent evidence:

- Maternal malaria accounts for more than 35% of preventable instances of low birth weight, the greatest risk factor for infant mortality. (Joris Likwela, doctoral thesis, 2012)
- A meta-analysis of national survey data shows that ITP during pregnancy with a combination of SP and LLIN usage correlates to a reduction in both neonatal mortality and LBW (low birth weight) under regular programme conditions. (Eisele et al, 2012)
- In the context of trials, IPT during pregnancy with SP (IPTp-SP) plays a protective role during pregnancy in reducing neonatal mortality. (Menendez et al, 2010)
- IPTp was very cost-effective in the context of prenatal consultations (PNC). (Sicuri et al. 2).

According to the latest data from the 2010 MICS, only 21% of pregnant women received two doses of SP during their last pregnancy. Given the benefits associated with this intervention, it is necessary for it to be implemented, while also developing communication strategies.

Note: For modules IV and V, see section 3.1

b. Impact and expected results

Implementing the activities included in this concept note should contribute to achieving the following main objectives by 2017:

- A reduction in infant mortality from 158 per 1000 to 47.4 per 1000
- A reduction in the number of deaths among patients hospitalised due to malaria from 25 per 1000 to 8 per 1000
- A reduction in the number of confirmed malaria cases from the current figure of 380 per 1000 to 240 per 1000
- A reduction in parasite prevalence among children under the age of five from 20% to 14%
- A reduction in the malaria test positivity rate from 51% to 17%
- An increase in the proportion of households that own LLINs from 51% to 95%
- 87% of the population sleeping under LLINs
- An increase in the percentage of pregnant women receiving IPT from 21% to 85%
- 46% of children under the age of five with a fever being given a parasitological test
- 80% of children under the age of five receiving ACT following biological confirmation of malaria

3.4 Focus on Key Populations and/or Highest-impact Interventions
This question is <u>not</u> applicable for low-income countries.
Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below: a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions. b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.
- Not applicable, since the DRC is a low-income country.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements
Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe: a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s). b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients. c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified. d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients. e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.
a. Compliance with recommendations for a dual-track funding arrangement The DRC has already opted for dual-track funding since Round 8 Malaria and this implementation arrangement will be applied for this concept note. **b. Coordination between the principal recipients** The principal recipients (PR) have signed a Memorandum of Understanding (MOU). This MOU is intended to define the practical arrangements for collaboration between stakeholders as well as the mechanisms for coordinating and standardising interventions in the context of Global Fund grants. PR signatories of this MOU undertake to: • Exchange information and documents relating to the grant in accordance with the defined and agreed information circuit • Reach shared views on answers to questions posed by the Global Fund and/or decision makers/partners at national level relating to implementing the grant

- Reach shared views on what information should be provided to national leaders, the private sector, member sectors and the general public concerning the development of grant activities in the field
- Be actively involved in preparing the terms of reference (TOR) for particular joint studies (DHS, assessments etc.), validating, distributing and using the results, and ensuring that deadlines for these studies are met
- Meet regularly with the CCM to discuss the progress of the grant implementation and to share their experiences and lessons learned to improve the effectiveness of interventions in the field
- Provide the CCM with a copy of reports and other material information relating to the programme, upon reasonable request
- Supply each other with programme data and information concerning medication consumption, usable available supplies, expiry dates, losses and adjustments as well as any other relevant information related to monitoring grant implementation on a quarterly basis
- Use the same tools for organising monitoring and supervision tasks carried out by the programmes at central and provincial level

The parties have also undertaken to identify areas and types of interdependence that will occur within the context of their collaboration in each of the following areas:

- Grant governance, admissibility and management of partnerships with SRs (sub-recipients), the Ministry of Health, the CCM and the Global Fund
- Procurement and supply management (selection, quantification, distribution, supply management)
- Monitoring and evaluation (preparing the programme part of PUDRs [Progress Update and Disbursement Requests], data collection, quality assurance, joint supervision with the Ministry)

This MOU lasts until the end of 2014 and will be evaluated and updated for smoother implementation from 2015.

This update will suggest inclusion of the CCM as a coordination body and the NMCP as an implementation guarantor in meetings between PRs to help them to strengthen coordination and monitoring of the grant as a whole. The strategic oversight committee (CSS) of the CCM will oversee all grant implementation activities. As such, meetings with all PRs will be organised on a regular basis to identify strategic direction and share experiences with the aim of rectifying any bottlenecks.

c. **Arrangements for managing sub-recipie**nts

At this stage, sub-recipients (SR) have not yet been identified for the implementation of this grant. There are, however, already SRs that have been involved in implementing previous and ongoing grants, supporting the HZs. The CCM and the PRs identified will decide on procedures to be followed to ensure the continuity of services introduced previously. SRs will be selected by competitive invitation to tender.

The SRs of the public PR are, as a matter of course, the 26 DPSs, and the specialised directorates and programmes with which the General Secretariat for Health signs performance contracts. Funds for implementing activities are managed by a trust agency. An evaluation of these SRs was conducted by H20/20 in 2010. This allowed 19 out of the 26 existing DPSs to make an initial

start; those DPSs considered to be weak were strengthened. The latest update to this assessment in 2014 recommended working with the 26 DPS by strengthening the capacities of those DPSs with shortcomings.

The civil society PR responsible for antimalarial drug supplies and social mobilisation depends on SRs from national and international civil society organisations. These organisations ensure the implementation of ongoing grants, supporting the HZs using the procedures manual provided to them by the PRs. Several mechanisms have been put in place to reduce the inherent programme-related and financial risks of implementation, including: (i) an external audit; (ii) monitoring before, during and after by the PR; (iii) the validation of expenses related to activities entrusted to an external monitoring agency and (iv) an internal PR audit.

The civil society PR responsible for LLIN mass distribution will have SRs, for which the selection process will be in line with transparency and evaluation criteria as set-out by the guidelines of the Global Fund and the CCM. It works with public institutions (NMCP, DPS, HZs) and community-based organisations. Funds for implementing campaigns are managed by a contracted trust agency. A contract has also been signed with civil society organisations for independent monitoring of LLIN distribution.

As part of this funding request, all current SR will be evaluated in accordance with the rules of the CCM and GF. It will be the same for all new SR.

The community organized around itself through active CBOs and CSOs and social leaders will be involved in the perimeter of interventions at all levels of implementation of activities, including the distribution of LLINs and the community case management with regards to the planning, implementation, monitoring and evaluation. This involvement will ensure ownership and the sustainability of interventions.

A process for strengthening community systems is underway and could lead to a redefinition of the role and the scope of different civil society organisations in implementing the community activities involved in this grant application.

d. Coordination between each designated PR and its various sub-recipients

On the basis of the concept note, the SRs will propose a work plan and a detailed budget for technical and financial validation by the PRs and approval by the Global Fund. After approval, the PRs will provide the SRs and sub-sub-recipients (SSRs) with the resources needed to implement the plan.

Bi-annual coordination meetings will take place between the PRs and SRs to evaluate the implementation.
Quarterly monitoring of the SRs will be organized by each PR to monitor the implementation of activities.
The PRs, NMCP and CCM will present the project to each DPS and the provincial authorities. The SRs will conduct promotion activities in the HZs at the beginning of the project during the data validation reviews.
The monitoring tasks of the civil society and governmental SRs must be carried out collectively so that the DPSs can fulfil their sovereign function of monitoring and supervising the HZs.
Mass distribution activities will be supervised by the NMCP, the DPS and HZs. In addition, coordination will be carried out by the various provincial and local coordination committees.

e. Participation of women's organisations and key populations in the implementation process

The involvement of representatives from women's organisations and key populations in implementing interventions aimed at combatting malaria helps to improve results.
Within community organisations, women and key populations are involved in:

- Promoting the use of LLINs, ITP, quick access to treatment and treatment compliance
- Raising awareness, communication, IEC
- Sanitation around and within homes
- Integrated treatment of cases at community level and in the private not-for profit sector

4.2 Ensuring Implementation Efficiencies
Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.
Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM. In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.
This note forms part of the framework for the continuity of activities already carried out in consolidated rounds 8 and 10. It follows on from the interim funding. There will be no duplication because all the other grants in progress finish in late 2014, whereas the current funding request covers the period from 2015 to 2017. In addition, the gap analysis has taken into account not only current interim funding from the Global Fund but also funding from other donors working in the same field.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	**PSI/ASF**	**Sector**	**Civil Society**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		X Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		The PR (Principal Recipient), PSI, has a unit or department for managing Global Fund grants. This unit is responsible for coordination, planning, monitoring and evaluation, and for the implementation of LLIN (long-lasting insecticide-treated mosquito net) distribution campaigns. The management unit has already completed successful mass distribution in the provinces of East Kasai and Bas-Congo and the city of	

	Kinshasa.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	The PR has no formal SRs or SSRs (sub-recipients or sub-sub-recipients) but always works directly with the Health Zones on an "as required" basis in collaboration with civil society organizations, the police and the political and administrative authorities, as well as other partners during the distribution campaign period. It has just been suggested that PSI could now work with SRs and SSRs, particularly at a peripheral level with community-based organizations, social leaders and other resource staff. This should improve monitoring and evaluation of use after distribution. The PSI monitoring and evaluation unit or department monitors the implementation of LLIN distribution activities. Particular effort is required in terms of monitoring the use of LLINs distributed to households, and this is only possible with the involvement of community-based organizations, which will also have a role to play in raising awareness.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The PR has a central internal audit and control unit or department. The control mechanisms are described in the procedures manual (financial, programme-related, PSM [procurement and supply management], human resources). The PR also has external audits carried out.
4. The financial management system of the Principal Recipient is effective and accurate	The PR has a finance department. The financial management procedures manual sets out the guidelines and directives for disbursement, expenditure or use of funds, and for financial control. The central and provincial internal auditors also carry out financial checks on partners who collaborate in the implementation of activities. The PR must improve the mechanisms for monitoring financial risks related to the security of funds (theft and/or misappropriation), the disbursement of funds and budgetary management (budget overrun and high expenditure in relation to the activities carried out, expenses not related to the project objectives).
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The PR rents warehouses at central level (in Kinshasa) and at provincial or health district level. The cost, however, is very high. These warehouses are managed directly by stock keepers under the supervision of provincial logistics specialists. The warehouses used by the PR meet the standards required by the national policy in terms of storage and security conditions. It has been suggested that one or two known Ministry of Health warehouses be refurbished at central level, along with one of the warehouses at provincial level depending on availability in the

	Provinces, given that the capacity of the RDCs (regional distribution centers) is insufficient.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	Through its international network, ASF/PSI has experience of working with different partners for the supply of inputs, using transparent management procedures.
7. Data-collection capacity and tools are in place to monitor program performance	ASF/PSI works in close collaboration with the NMCP (National Malaria Control Programme), which produces data collection tools and standards. ASF/PSI reproduces these tools in sufficient quantity and ensures that they are available to each entity of the health system responsible for collection, synthesis and compilation.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	ASF/PSI works in close collaboration with the NMCP and the various entities of the health system and provides them with the support necessary to produce the required programme-related results. The PR uses TV channels and radio stations, as well as the written press, to distribute information.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The PR has audit reports for the last two years. The PR complies with and ensures compliance with quality control requirements for LLINs entering the country. Samples are taken for analysis and quality control.
10. Identification of risks and mitigation measures	In general, the PR has identified the major risks at the various levels concerned by the interventions and activities, and has taken measures to mitigate and reduce them as far as possible.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	**SANRU**	**Sector**	**Civil Society**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☒ Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		The PR, SANRU Asbl, has a unit or department for managing Global Fund grants. This unit is responsible for coordination, planning, monitoring and evaluation, and for the implementation of activities related to Global Fund grants. The responsibilities of each structure of the management unit are clearly defined by a	

	functional organizational chart. This unit is the central level of management. The staff at this management authority is recruited via a transparent process of calls for applications on the basis of the skills and expertise required. At provincial and health district level, SANRU Asbl has set up local units for control, monitoring management and implementing project activities. In addition to these decentralized units, the PR, SANRU, counts on the support of stakeholders (NGOs [non-governmental organizations], CBOs [community-based organizations] etc.) known as sub-recipients (SRs) for implementation. These SRs take care of the effective implementation of activities at provincial, district and health-zone level. They provide local monitoring and support service providers.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	The PR has management manuals and monitoring and evaluation manuals that describe, respectively, the operational guidelines for managing and monitoring SRs and SSRs. The central monitoring and evaluation unit and the local units are responsible at their respective levels not only for monitoring and control, but also for strengthening the capacities of SRs. SRs and/or SSRs are supervised and/or monitored each quarter by staff from the central management unit. However, the PR should further improve monitoring and control mechanisms to prevent the cases of theft and/or misappropriation of drugs and other inputs (RDTs [rapid diagnostic tests], LLINs etc.) known to occur in health facilities (hospitals and health centres). As part of their monthly supervision, the PR controllers must support the management teams in the health zones in improving control mechanisms. They will need support from the communities (CBOs etc.) to monitor the implementation of activities in the health areas.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	SANRU Asbl has an internal financial, programme and PSM control system, which is described in its procedures manual. The internal audit department is responsible for ensuring control at all levels. There are controllers in the provinces with particular responsibility for SRs and SSRs in the provinces. The monitoring and evaluation unit is responsible for quality control of programme data through monitoring tasks in the field, routine data quality analysis tasks and OSDV (on-site data verification). The PSM unit does the same for data relating to the management and use of drugs. The PR will need to set up an effective logistics management and information system (LMIS) in collaboration with the ministry of health (PNAM — Programme national d'approvisionnement en médicaments essentiels [national essential medicines programme]).

4. The financial management system of the Principal Recipient is effective and accurate	In addition to its financial control procedures, SANRU Asbl has an internal audit department. External audits are organised by external companies. The internal auditors are responsible for checking financial documents (accounting records, supporting documentation etc.). In the section on financial management, the procedures manual sets out the guidelines and directives for disbursement, expenditure or use of funds, and for financial control. The provincial controllers also carry out financial checks on SRs and SSRs. The PR must improve the mechanisms for monitoring financial risks related to the security of funds (theft and/or misappropriation), the disbursement of funds and budgetary management (budget overrun and high expenditure in relation to the activities carried out, expenses not related to the project objectives).
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The PR, SANRU Asbl, uses warehouses that meet acceptable conditions at central level. The security conditions are consistent with the requirements of the national policy. However, there are sometimes problems with storage capacity. The PR has backup or emergency warehouses, which are sometimes very expensive. The storage capacity should be increased nationally. In general, the PR uses RDCs to store and distribute drugs at provincial health division (PHD) level. These RDCs have the storage capacity recommended by the national pharmaceutical policy. In some PHDs, such as Kindu and Lodja, the warehouses do not meet security and storage standards. With the support of the Global Fund and other donors (including GAVI [Global Alliance for Vaccines and Immunisation]), the PR must support the PHDs in the process of refurbishing certain RDCs.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	The PR has a distribution plan, which it forwards to the RDC. This indicative plan sometimes incorporates adjustments made by the drugs committee in some provinces/districts (drugs committee) to adapt it to each zone and structure based on performance and needs. This is not yet systematic in all PHDs. The PR must support all the provinces to make the provincial drugs committees operational. Drugs are transported by road, air and sea. The PR does not have its own means of transport and uses the services of transport companies. As these companies are sometimes inundated with other requests, they do not fully meet the needs of the PR. This causes irregularities in the supply system in the country. In addition, the cost is sometimes very high as there is a near-monopoly for certain destinations, particularly for air transport. There are also difficulties in ensuring distribution to some health zones and users.

7. Data-collection capacity and tools are in place to monitor program performance	The PR's information system is based on the national health information system (système national d'informations sanitaires — SNIS). The tools used are therefore those of the SNIS. The PR has developed programme reporting tools for the SR and SSR. These tools allow the programme results to be monitored through defined indicators. In addition to the programme-related tools, the PR uses PSM tools developed by PNAM, which allow poor management to be detected.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The PR has an internal communications unit, which is responsible for distributing information relating to the malaria and HIV/AIDS programme. The PR also has a website on the Internet. This site allows it to communicate results and other types of information very widely in real time. The PR uses other channels for sharing information such as radio, television and the written press.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The PR has audit reports for the last two years. The PR carries out product quality control with the support of national and international laboratories. At national level, the PR collaborates with the Faculty of Pharmacy of the University of Kinshasa.
10. Identification of risks and mitigation measures	In general, the PR has identified the major risks at the various levels concerned by the interventions and activities, and has taken measures to mitigate and reduce them as far as possible.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	**Ministry of Health (MOH)**	**Sector**	**Govenment**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		X Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		At central level, the Ministry of Health has structures including a Research and Planning Directorate (Direction d'Etudes et de Planification — DEP), a Support and Management Unit (Cellule d'Appui et de Gestion — CAG) undergoing major restructuring, and Specialised Health Programmes for disease control that plan and schedule activities to control malaria and other diseases and evaluate the diseases (NMCP, national tuberculosis programme, national AIDS programme, NBTP [national blood transfusion programme]). The CAG	

	was the structure that managed the funding received from the Global Fund (GF HSS [Health Systems Strengthening] R9, GF TB R9, GF SSF [Single Stream of Funding] 8-10), GAVI and the European Union (EDF [European Development Fund] 10). At the intermediary level, the country has 26 Provincial Health Divisions (PHD) responsible for the technical support of institutions at the peripheral level consisting of 516 health zones responsible for implementing healthcare through hospitals and health centres. In several management letters, three major issues arose that the Ministry of Health must address in order to become the principal recipient: reform of the CAG, finalisation of contracts with the SRs, which are the Provincial Health Divisions, and standardisation of performance bonuses with all partners. The recruitment of PHD managers has just been completed, and the contract will be signed between the PHDs and the PR, the Ministry of Health, before the programme starts on 1 January 2015. The review of the CCM (Country Coordinating Mechanism) relayed by the General Meeting of 29 May confirmed that the HDCG (Health Donor Coordination Group) and the Ministry of Health will shortly begin negotiations on the matter. Major restructuring of the CAG is in progress and ministerial decrees are expected.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	Via the CAG, the principal recipient had a less efficient management, monitoring and evaluation system, the limitations of which were demonstrated after several evaluations and audits. The major restructuring plans for the CAG include setting up an operational unit for the PR/Ministry of Public Heath with a permanent secretariat, for which two managers will be recruited following a competitive process. The members of the permanent secretariat will be: DLM (Direction de la Lutte contre la Maladie — disease management control), DEP, national AIDS programme, national tuberculosis programme, NMCP, PNAM, NBTP and CAG. Follow-up visits will be scheduled and organised by departments within the Ministry of Health authorised with the restructuring, to ensure that the grants are implemented by the sub-recipients (SRs). The National Health Information System put in place was inadequate for monitoring of the programme and financial indicators for grants administered by the Ministry of Health. This system run by the Primary Health Care Directorate is being improved through funding from several partners, including the GF, to help with routine monitoring of health indicators (DHIS — District Health Information System).

3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The Ministry of Health should recruit a pool of internal auditors responsible for detecting abuse and fraud. This pool should be supported by experts from AGEFIN (KPMG), as stipulated in the contract, in order to enhance their level of expertise. The process for recruiting a qualified internal auditor for the CAG has not been finalised with the announcement of the restructuring of the unit. AGEFIN has set up an internal accounting control system at central level and for the provincial AGEFIN offices that have not yielded satisfactory results. In addition to the internal auditors, each provincial AGEFIN unit has its own controllers. As mentioned above, to address this shortcoming, a decree establishing the general framework for financial management, with clear definition of the responsibilities of each body involved, will be published during the week of 2 June 2014.
4. The financial management system of the Principal Recipient is effective and accurate	The latest evaluations of the Local Fund Agent (LFA) demonstrate that there are shortcomings where improvements need to be made, including the timeliness and completeness of reporting, especially as regards financial management resulting in delays in sending out PUDRs (progress updates and disbursement requests) from the Ministry of Health. With the major restructuring of the CAG, the financial management system of the Ministry of Health provides for: (1) the adoption of work plans budgeted by the CCT (Central Coordination Team), (2) commitment by the beneficiaries (departments, programmes, PHDs), (3) settlement by the CAG, (4) scheduling by the general secretariat, and (5) payment by the trustee (KPMG).
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The Ministry of Health will set up contracts with the Regional Distribution Centres (RDCs) to manage the supply of drugs and other health products for hospitals and health centres in the health zones. These RDCs are combined in a national structure called FEDECAME for making group purchases and distributing to the RDCs. In addition, if storage capacity is exceeded, like other PRs, the Ministry of Health will set up a contract with a storage facility at central level. These national institutions are provided with technical and financial support from the government and partners of the Ministry of Health, including the Global Fund, the European Union and GAVI. A recent study on storage and conditions for keeping inputs in RDCs concluded that there is insufficient storage capacity, and a plan to increase storage has been put forward in the GAVI Alliance proposal.

6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	FEDECAME and the RDCs have considerable experience in product distribution. Via the CAG, some of the Ministry's distribution was carried out through this network and some through the Ministry's PSM and contract services. Shortcomings have been noted and will be improved. A logistics information system is in the process of being established and will allow (1) control of the minimum and maximum stock quantities at each level; at present four RDCs have a logistics information system. Two general meetings of the CCM, on 8 April and 29 May, focused on improving the transportation of inputs, and decisions were made, including the production of a shortlist of carriers common to all PRs, standardisation of the cost of transport between all PRs and establishment of timeframes for paying carriers.
7. Data-collection capacity and tools are in place to monitor program performance	The HMIS (SNIS) has always had data collection tools, but with the new DHIS 2.0 software, the data collection tools have been validated and tested in three provinces, and integration with PSM data is complete and at the training phase in four provinces. At each level of the health pyramid there is a person or a service responsible for collecting information in accordance with the national health information system.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	GESIS was the software that used to be used to collect health information but its limitations were quickly demonstrated in terms of implementation and effectiveness in reporting information at all levels, especially at central level, with major information shortfalls. However, specialized health programs such as the NMCP have developed collection tools to periodically monitor activities and evaluations of programme-related results at all levels with no significant results. Currently, work to integrate data requirements across all programmes and all departments is underway via the new regulatory framework and new software (DHIS 2.0), which has been set up with the assistance of WHO and the GF. Three provinces have already been trained to use this software (Maniema, Western Kasai and East Kasai). Training on integrating PSM data into this tool will start for four provinces this Monday, 2 June 2014.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	In the last two years, the PR, the Ministry of Health, has been audited seven times: by the HDCG regarding procurement, the Ministry of Health to confirm the conclusions of the first audit by the HDCG, the GAVI Alliance to follow up on procurement, the European Union for an organisational audit, the GIZ (German Cooperation) regarding operating capacity, the Global Fund and GAVI on financial management

Type of risk	Risks	Mitigation measures
		and procurement, and the GF with the Office of the Inspector General (OIG) for general investigations. Quality assurance starts with the order, with products pre-qualified by WHO or accepted by the country's pharmaceutical regulatory authorities. On entry into the country, the products are analysed by the national quality control laboratory. When products leave the country's points of entry, random samples are taken and analysed in domestic or foreign WHO-accredited laboratories that meet ISO 17025 criteria.

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues. b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

Type of risk	Risks	Mitigation measures
Politics	Political instability: election postponement, election results being contested etc.	Contingency plan (selection of priority activities, focus on providing priority services, essential personnel, supply and equipment security etc.)
		Strengthening collaboration with humanitarian agencies
Financial	Poor budgeting for supplies in the grants	Use international reference prices for the budget and be sure to include the cost of transport and insurance Technical assistance requirements for PSM The logistics strategy must be implemented at national level, defining the initial location of supplies and taking into account infrastructure so as to easily reach all of the targeted HZs
	Disbursement delay	Compliance with deadlines for filing PUDRs by PRs, compliance with deadlines for reviewing PUDRs by the LFA (local fund agent) and the Global Fund, acceleration of disbursements by the Global Fund
	Poor coverage of the banking system	Use banking agencies where they exist and conclude contracts with agencies for the transfer of funds.
	Poor financial management arrangements	Scheduled and special audits
		Quarterly reviews based on quarterly reports (including verification of items)
		Expert technical assistance in financial management and extension of accounting software to SRs Technical assistance in financial management
		Capacity building (including training)
		Capacity building through training, provision of harmonised management software, budget monitoring for the SRs etc.
		Provision of an SR and SSR Management Manual
		Management arrangements for various funds (reimbursement, direct payment etc.)

Regulatory/legal	Non-compliance with national regulations (list of Essential Medicines/Import Authorisation)	Make sure that the list of Essential Medicines is observed and apply for import authorisation for each order
	Cumbersome customs regulations	Negotiate special treatment with the Ministry of Health for removing medical and non-medical products related to the project. All PRs must have access to an up-to-date interministerial decree (Plan and finance) granting the necessary tax concessions with the essential products listed. Have 2% of the administrative fee removed.
	Unhealthy business environment	Check the existence of structures and regularly monitor invoices from service providers
		Blacklist irregular businesses

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☐ Table 1: Financial Gap Analysis and Counterpart Financing Table
- ☐ Table 2: Programmatic Gap Table(s)
- ☐ Table 3: Modular Template
- ☐ Table 4: List of Abbreviations and Annexes
- ☐ CCM Eligibility Requirements
- ☐ CCM Endorsement of Concept Note