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

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CCM-RDC		
Country	DEMOCRATIC REPUBLIC OF CONGO		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	LOW INCOME COUNTRY		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a 're-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Strengthening of prevention and management of HIV/Aids and gender related sexual violence in 54 Health Zones in 5 post-conflict provinces in D.R.Congo		**No**
Tuberculosis[1]	Support for tuberculosis control in D.R.Congo	HSS	Yes
Malaria	Acceleration of universal access to anti-malarial interventions in 139 Health Zones in DRC		No

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	☐	☐

[1] Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

	Yes	No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	☐ Yes	☐ No
The proposal from CCM-D.R.Congo for Round 9 comprises two new submissions (HIV/Aids and Malaria) and one re-submission (Tuberculosis) including Health Systems Strengthening classified as Category 3 in Round 8.		

Currency	☒ USD	or	☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 9:

3. Proposal Summary

3.1 Tuberculosis Element

In the DRC (Democratic Republic of Congo) there is a pyramidal health care system implementing the primary health care policy. Since 2006, the Government has worked to strengthen the Health Care System (HSSS).
The country operates a national program of Tuberculosis control, which has used the DOTS strategy since 1996 and the "STOP-TB" since 2006. The PNT (National TB Program) has a strategic plan for 2006-2015 with a budget of 553,913,004 USD.
The PNT benefited from a Global Fund grant in Round 2 which has been used, and from on-going grants from Rounds 5 and 6. However, the gap in the strategic plan remains an important factor in controlling multidrug-resistant tuberculosis (MDR-TB), the co-infection TB/HIV, the implementation of APSR (Practical Approach to Respiratory Health) and PPM (Mixed Private-Public) strategies and research.

Aim of the current submission:

- to help reduce the gap,
- to consolidate the gains from grants in Rounds 2,5 and 6,
- to ensure their continuation.

Target: To contribute to the reduction in morbidity and mortality from tuberculosis by 2015 in the DR of Congo, fulfilling the Millennium Development Goals and targets of the Stop-TB partnership.

Specific objectives which will help this submission meet the goal are:

Objective 1: to continue extending and improving the DOTS strategy;
Objective 2: To control tuberculosis-HIV co-infection and MDR tuberculosis;
Objective 3: Help strengthen health care through APSR/PAL;
Objective 4: To involve all health-care providers in controlling tuberculosis;
Objective 5: Involve the community in controlling tuberculosis;
Objective 6: Develop research within the PNT.

Key results (indicators) to be achieved in Round 9 are:

- a 70% detection rate for PTM+ (pulmonary TB +) patients and a successful therapy rate of 85% for the 1545 CSDT (Health Center for Diagnosis and Treatment); 5 laboratories regularly achieving QA certification in culturing and meeting ATS criteria; 120 hospitals with radiography facilities to improve PTM0 and TEP

(extrapulmonary TB) diagnosis;

- 33.160 co-infected tuberculosis patients benefit from being jointly managed under the PNLS (National Aids program); 3400 cases of MDR tuberculosis notified and treated for the secondary effects, with 10% hospitalized, in 8 refurbished Centres;

- **200** hospitals following an APSR program;

- **120** private facilities have joined the program, used DOTS and followed ISTC guidelines;

- 25% of all new tuberculosis patients with notified positive smears started on treatment are followed-up/overseen in the community

- an investigation of drug-resistance conducted throughout the country, 24 investigations a year into the prevalence of TB/HIV for the first 3 years and 15 research studies, of which the results are made known.

The **main activities** are:

- To strengthen the classic DOTS strategy in 1 545 CSDT by provision of reagents, microscopes and small items, improve diagnosis of PTM0 by purchase of radiography equipment; refurbish culture laboratories in the provinces, perform screening and molecular biology tests; ensure patient care, supply 601 139 courses of 1st line treatment and 2 960 courses of 2nd line treatment; ensure follow-up and assessment by training, meetings and supervision, appraisal, workshops on guidelines, various certification meetings, provision of information in various formats and granting of incentives to those involved in TB control at central and intermediate level.
- Increased help for those with MDR disease, HIV screening for all those with tuberculosis in the health zones supported by the PNLS;
- Progressively incorporate APSR/PAL (with equipment), PPM and ISTC strategies in the health zones;
- To extend community based DOTS and introduce organizations for former tuberculosis patients, increase awareness, communication, advocacy and social mobilization in tuberculosis;
- carry out research and publish the results.

For this the program seeks a further budget of **128 728 799 USD**.

The CCM-DRC has two principal recipients (PR), Caritas-Congo for Civil Society, and the Ministry of Public Health for the public sector.

3.2 HIV/AIDS Element

The current submission is in line with the complete package for prevention, care, treatment and alleviation of the effect of Aids in 54 Health Zones (HZ) of 5 provinces following conflict in the east of the country, but also to extend/perfect holistic care of the victims of sexual violence in these 54 HZ.

These 54 HZ targeted for inclusion in the HIV/Aids package have had no previous help in this regard, because the war made it impossible to introduce the Aids package as part of the comprehensive United Nations strategy against sexual violence (Annex 13). The 54 zones from 5 provinces were chosen on the basis of whether or not they were health zones currently included in the HIV program and receiving financial help (MAP or Global Fund). These were particularly health zones where heightened military operations produced very high levels of sexual violence (rape). In addition, a 2008 study as part of the above projects produced a map of the interventions, actions and unaddressed needs in relation to prevention of, and response to, sexual violence in the 5 provinces. This study served as a basis since it established the priority areas for intervention, the gap to fill and where to direct financial aid.
To date, province data shows an HIV incidence of between 20 and 30% in victims of sexual violence in the 5 provinces targeted in the current submission (Joint Project Report 2008, Annex 4). According to the 2007 report from Amnesty International cited in the in the national multi-sector strategic plan 2010-2014, 18 407 incidences of sexual violence were reported that year,
This submission is in line with the vision of Rounds 7 and 8 in as far as it extends the fight against HIV/AIDS to the new HZ not yet included in the complete package for prevention, care, treatment and impact alleviation of HIV/AIDS; it is also in line with the national multi-sector strategic plan which specifically targets the victims of gender linked sexual violence. It also responds to the concerns about orphans and vulnerable children (OVC) raised in the RAAAP report (Annex 8) from the DRC Ministry of Social Affairs, Humanitarian and Social Initiatives, supported by Unicef and USAID.
For the reasons given above, the current submission which aims to help reduce the morbidity and mortality from HIV/AIDS infection specifically among the victims of gender linked sexual violence by 2014, has the following four aims:

1. To prevent, by 2014, the transmission of HIV/AIDS in the population of these 54 HZ of 5 provinces, targeting specifically the victims of gender linked sexual violence.
2. Ensure health and medical care for the 14 383 PLVIH among the victims of gender linked sexual violence from the 54 HZ targeted in these 5 provinces.
3. Ensure holistic care for the victims of gender linked sexual violence from the 54 HZ targeted in these provinces.
4. By 2014, improve information strategy and the coordination of activity at all levels.

These objectives will help the national multi-sector strategic plan against Aids to achieve its goals (see Annex 3).
To meet these objectives, the country has identified two principal recipients; the Minister of Health (government PR) and the National Council of Health NGOs, abbreviated CNOS (civil society PR).
Finally, the total budget is **94 181 441** USD. The 54 HZ not yet covered will benefit from the HIV/AIDS complete intervention package and holistic care for victims of sexual violence.

3.3 Malaria Element

The Democratic Republic of Congo (DRC) has one of the highest levels of malaria in Africa with at least 27 million cases in 2006, according to the WHO (ref. Global Malaria Report, 2008, preliminary estimates). In a country larger than the whole of Western Europe, malaria is endemic with static transmission levels and more than 97% of the population affected. The most common pathogenic species responsible is *Plasmodium falciparum.* Malaria is the principal cause of morbidity and mortality and an important factor in poverty in the DRC, the reason for:

- 40% of visits to outpatient clinics among the under 5s (*E*SP 2007 – Annex AP4 page 43);
- 48% of hospitalizations among the under 5s (ESP 2007 – Annex AP4 page 46);
- 37.5% of deaths among the under 5s who have been hospitalized (*ESP 2007 – Annex 1 page 38*);
- 41% of outpatient clinic visits by pregnant women (*PNLP, 2001 AP5 page 17*);
- 54% of hospitalizations of pregnant women (*PNLP, 2001 AP5 page 18*);

Anti-malaria interventions are detailed in the 2009-2014 PNLP strategic plan which aims to reduce mortality and morbidity by 50%. The DRC is divided into 11 provinces which split into 515 health zones. The first grant for malaria, from the Global Fund Round 3 was spread among 119 health zones throughout the country. The second, from Round 8, ensured continued work in these same health zones.

The current submission for Round 9 global funding to control HIV/AIDS, tuberculosis and malaria aims to help reduce morbidity and mortality from malaria by 2014, spreading geographical coverage to a further 139 health zones.

This "scaling up for impact" (SUFI) will be by increasing routine use of impregnated mosquito nets (LLITN) for pregnant women and children under one, use of intermittent preventative treatment and improving care of malaria patients in the new 139 health zones not yet covered by malaria control.

Several criteria determine choice of the 139 HZ: lack of support so the population has no means of prevention and resorts to one-drug-only treatment (monotherapy) contrary to national policy based on international recommendations, with all the risks that carries for the health of the whole population, particularly the development of ACT resistance.

In addition, the Needs Assessment has shown a weakness in communication between the health zones which means that high quality health care is still not provided.

Specific ways in which this submission will help meet the target are:

- Having 80% of children under one and pregnant women sleeping under impregnated nets in the 139 health zones concerned
- Having at least 80% of pregnant women in the 139 health zones concerned receiving intermittent preventative treatment as set out in national directives
- Having at least 80% of care in the 139 health zones concerned complying with national directives
- Strengthening all national and provincial coordination of the National Malaria Program

To achieve these specific aims the following are necessary:

Prevention:

- Prevention by routine use of LLITN: To improve substantially the coverage of pregnant women and children under a year, the emphasis must be on provision of LLITN through prenatal and preschool visits, education/retraining, social mobilization, research and, above all, follow-up/assessment in these 139 health zones.
- Prevention by IPT: the emphasis here will be on the availability of Sulfadoxine Pyrimethamine, education/retraining, social mobilization, research and, above all, follow-up and assessment in the 139 health zones.

Management of malaria cases:

- Biological confirmation: in this proposal the use of Rapid Diagnostic Tests (RDT) currently in use in the 119 health zones having benefited from Round 3 global funding will be expanded to the 139 zones targeted in Round 9 Global Fund grants. This will allow better estimation of the county's real malaria burden and rationalize management of antimalarial resources.
- Artemisinin-based combination treatment: this involves ensuring, in the 139 health zones, that this submission will provide correct management of both uncomplicated and serious cases of malaria, in sanitation conditions conforming with national directives.

The emphasis here will be on availability (RDT, laboratory reagents and medicines), education/retraining, social mobilization, research and, above all, follow-up and assessment in the 139 health zones.

Coordination and partnership

Here, the proposal to Round 9 of the Global Fund will fill gaps in institutional, management and technical capacity to coordinate program structures, at national and provincial level, identified in various assessments of the program. This will be by improving the infrastructure, fixtures, fittings and office equipment, communication technology, education/retraining of staff and ways of working.

Fulfilling these objectives for malaria will also support a Strengthening of the Health System as a whole, anticipated in the general submission from the DRC, particularly relating to the National System of Health Information, community systems, provision of services and the management of supply and distribution.

In this proposal, the CCM-DRC has continued with 2 funding routes (government PR and civil society PR) for implementing measures to conform to Global Fund Directives.

The budget for the malaria Element, in the 139 health zones concerned, comes to 280 495 135 US$ for the next 5 years, and represents 14.3 US$ per person per year for routine measures. Thus, over the entire DRC, the investment from Global Fund Round 9 is 4.06 US$ per person per year.

2. BUDGET

Y1	Y2	Y3	Y4	Y5	Total
55 836 015	61 872 826	61 340 001	48 935 672	52 510 621	280 495 135

3. TITLE OF THE SUBMISSION

ACCLERATION OF UNIVERSAL ACCESS TO MALARIA CONTROL IN 139 HEALTH ZONES WITHOUT SUPPORT FOR THIS DISEASE

4. Program Description

4B. HSS cross-cutting interventions strategy **

Malaria, HIV/Aids and tuberculosis are a major public health problem in DRC. In order to obtain sustainable results in terms of reducing the morbidity and mortality due to the 3 diseases, it is self-evident that the interventions must be part of a comprehensive Health Systems Strengthening framework.

This Round 9 HSS proposal is a re-submission of the Round 8 proposal incorporating the comments of the TRP. Based on these comments, the CCM-DRC has selected two cross-cutting interventions out of the three presented in Round 8.They aim to increase the results of disease control in general and controlling malaria, HIV/Aids and tuberculosis in particular, by making available, in real time, the information needed by service providers and decision makers for taking decisions that improve the offer and quality of care.

The Monitoring and Evaluation report of the three HIV, TB and malaria programs carried out by "Measure Evaluation", with the backing of the Global Fund in 2007 shows the weaknesses common to the three disease programs. These are mainly (i) the poor quality of data; (ii) the duplication of monitoring and evaluation systems leading to multiple reporting, discordant data, increased staff workload, etc.; (iii) incomplete and late reports; and (iv) non systematic and non computerized data management with low levels of storage, data analysis and circulation of health information. Intervention 1 developed in this proposal starts the implementation of the recommendations resulting from the evaluation.

In addition, the organization of the health system based on Health Zones has suffered during more or less two decades of poor governance and armed, inter-ethnic conflict. This has had a very negative impact on health cover and the quality of care, with health infrastructures being destroyed or ageing, equipment stolen, health staff becoming discouraged and migrating inside or outside the country, etc.

The actions for which grants are requested are for support for national measures adopted by the CCM to fill the gaps and repair the weaknesses of the health system as listed in section **4.3.2** of the diseases component.

In this proposal, 4 objectives were selected, 3 of which concern strengthening the health information system in 296 Health Zones and 1 deals with improving the offer and quality of care in 256 Health Zones. Implementing the activities concerning these objectives will help in meeting the Millennium Development Goals (MDG).

This mainly involves the following activities:

- For intervention 1:

  - Objective 1: progressively incorporating the SNIS (National Health Information System) normative framework in **296** Health Zones (HZ) by the end of 2014 by (i) building the capacity of the Health Zone Management Team; (ii) building the capacity of health care providers in health centers and hospitals for collecting, analyzing, interpreting and using health information; (iii) equipping the 296 HZ with information and communication technology and an energy source; (iv) helping organize monthly monitoring meetings in 515 HZ; (v) providing resources for the 296 HZ and (vi) support for organizing half-yearly LQAS (lot quality assurance sampling) surveys in the 296 HZ.

- Objective 2: by the end of 2014, have four functioning Provincial Steering Committees of the Health Systems Strengthening Strategy (PSC-HSSS), by providing resources to improve coordination of health information systems in provinces. This will be by (i) support for the operation of the 4 PPC-HSSS in Bandundu, Equateur, Maniema and Katanga Provinces: (ii) support for organizing half-yearly provincial reviews and quarterly health district reviews; and (iii) writing a half-yearly health bulletin and circulating it in the 11 provinces.

- Objective 3: strengthening the central level in piloting the implementation of the SNIS normative framework and supporting the provinces in health information management, by (i) operational support for the Information Management Commission of the National Steering Committee of the HSSS (NSC-HSSS), (ii) backing missions for supporting and monitoring activities for incorporating the SNIS in the 11 provinces and (iii) ensuring interconnections between the country's 11 provinces at the central level.

o For intervention 2:

- Objective 4: increasing to 50% the population with access to quality health services and care in 256 HZ by the end of 2014 by (i) restoring 1280 Health Centers, (ii) doing minor restorations in the referral hospitals in 120 Health Zones, (iii) equipping 1280 Health Centers, (iv) equipping 120 referral hospitals, (v) strengthening health service management in the 256 Health Zones(vi) providing mobile equipment for 10 rural Health Districts and 120 Health Zones,(vii) paying performance-based incentives to health workers,(viii) carrying out an inventory of the system of procurement and distribution of drugs and other specific resources, (ix) integrating biomedical waste management systems in 256 HZ and (x) supporting integrated supervision in the Health Zones.

The main results expected at the end of this proposal are:

- o 100% of HZ submitting complete reports on all management and public health indicators, in compliance with national directives;
- o at least 80% of HZ submitting reports on time on all management and public health indicators, in compliance with national directives;
- o 50% of the population has access to quality health services and care.

5. Funding Request

5B. HSS cross-cutting funding details **

The total cost for implementing the two HSS cross-cutting interventions described in this proposal is calculated at **178 065 459** USD.

*** Only to be included in one disease in Round 9. Refer to the Round 9 Guidelines for detailed information.*

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

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

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

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

IMPORTANT NOTE:

Applicants are strongly encouraged to read the Round 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal

Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Clarified section 1.1

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	31 796 943	11 190 331	14 437 636	14 948 929	21 807 601	94 181 441
Tuberculosis	14 631 467	18 166 661	35 864 038	28 651 127	31 415 507	128 728 799
Malaria	55 836 015	61 872 826	61 340 001	48 935 672	52 510 621	280 495 135
HSS cross-cutting interventions section 4B and 5B within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*	49,067,480	28, 226, 694	31 853 329	32301329	36 616838	178 065 459
					Total Round 9 Funding Request ➔:	681 470 834

1.2. Contact details

	Primary contact	Secondary contact
Name	Hyppolite Kalambay	François-Xavier N'Siesi
Title	Technical Secretariat Coordinator	Back-up Services Coordinator
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Alternate e-mail address	ccm-rdc@ic.cd	ccm-rdc@ic.cd

1.3. Lists of abreviations and acronymes used by applicant

Acronyme/Abréviation	Signification
ACT	Artemesinin Combination Therapy
AGR	Activités Génératrices de Revenus
ARV	Anti Rétro Viraux
ASF	Association de Santé Familiale
BAD	Banque Africaine de Développement
BDOM	Bureau Diocésain des Oeuvres Médicales
BM	Banque Mondiale
CAD	Club Amis de Damien
CCM	Country Coordinating Mechanism / Instance de Coordination Nationale
CDC	Center for Disease Control
CDR	Centre de Distribution Régional
CE	Commission Européenne
CET	Comité d'évaluation Technique
CHRTS	Centre Hospitalier de Référence de Transfusion Sanguine
CHU	Centre Hospitalier Universitaire
CIC	Conseil InterConfessionnel de Lutte Contre le SIDA
CNMLS	Conseil National Multisectoriel de Lutte contre le Sida
CNOS	Conseil National des ONG de Santé
CNTS	Centre National de Transfusion Sanguine
CPN	Consultation Prénatale
CPS	Consultation Préscolaire
DEP	Direction des Etudes et de la Planification
DOTS	Directly Observed Treatment short Course
DSA	Daily Subsistance Allowance
DSRP	Document de Stratégie pour la Réduction de la Pauvreté
ESP	Ecole de Santé Publique
FEDECAME	Fédération Centrales d'Approvisionnement en Médicaments essentiels
FM	Fonds Mondial
UNFPA	Fonds des Nations Unies pour la Population
FRP	Faire Reculer le Paludisme
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit Gmbh /international Services (IS)
HGR	Hôpital Général de Référence
IDA	International Dispensary Association
IDH	Indice de Développement Humain
IFCOC	Initiative des Pays Riverains des Fleuves Congo-Oubangui et Chari
IMA	Interchurch Medical Assistance
IO	Infections opportunistes
IST	Infections Sexuellement Transmissibles
LFA	Local Fund Agent (Agent local du Fonds)
MAP	Multicountry AIDS Programme
MDR	Multi Drug Résistance
MID	Moustiquaire Imprégnée de longue Durée
MSH	Management Science for Health
MII	Moustiquaires Imprégnées d'Insecticide
MoU	Memorandum of Understanding (Memorandum d'Entente)
NEX	National Exécution
OCEAC	Organisation de lutte Contre les Endémies en Afrique Centrale
OMC	Organisation Mondiale du Commerce
OMD	Objectifs du Millénaire pour le Développement

ONG	Organisation non Gouvernementale
ONUSIDA	Programme conjoint des Nations Unies sur le VIH/SIDA
PAM	Programme Alimentaire Mondial
PCIME	Prise en Charge Intégrée des Maladies de l'Enfant
PIB	Produit Intérieur Brut
PMURR	Programme Multisectoriel d'Urgence de Réhabilitation et de Reconstruction
CCC	la communication pour le changement de comportement
PNLP	Programme National de Lutte contre le Paludisme
CDV	le conseil et dépistage volontaire
ARV	le traitement aux anti retroviraux
PEC IO	la prise en charge médicale des infections opportunistes
OEV	les orphelins et les autres enfants rendus vulnérables
AES	la prise en charge des accidents exposant au sang
PNLS	Programme National de Lutte contre le SIDA
SECUTRANS	Sécurité transfusionnelle
PVV/PA	le soutien psychosocial aux PVV et à celles affectées par le VIH/SIDA
PTME	la prévention de la transmission mère enfant
PNLT :	Programme National de Lutte contre la Tuberculose
PEC TB/VIH+	la prise en charge médicale des tuberculeux VIH+
PEC SIDA	la prise en charge médicale des sidéens
PNMLS	Programme National Multisectoriel de lutte contre le Sida
PNT	Programme National de Lutte contre la Tuberculose
PNTS	Programme National de Transfusion Sanguine
PNUD	Programme des Nations Unies pour le Développement
PO	Purchase Order – Bon de commande
PPTE	Pays Pauvres Très Endetté
PR	Principal Recipient (Bénéficiaire Principal)
PSI	Population Service International
PSM	Procurement Supply Management
PTME	Prévention de la transmission de la Mère à l'Enfant
PVVIH	Personnes vivant avec le VIH/SIDA
RCP+	Réseau Congolais des Personnes vivant avec le Virus
RDC	République Démocratique du Congo
S&E	Suivi et Evaluation
SB	Sous Bénéficiaire
SIDA	Syndrome d'Immuno-Déficience Acquise
SNIS	Système National d' Information Sanitaire
TPI	Traitement Présomptif Intermittent
UNC – CH	University of North California at Chapel Hill
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	Fonds des Nations Unies pour l'Enfance
USAID	Agence Américaine pour le Développement
USD	Dollar américain
VIH	Virus de l'Immunodéficience Humaine
ZS	Zone de Santé

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary

Sector Representation	Number of members
☐ Academic/educational sector	1
☐ Government	11
☐ Non-government organizations (NGOs)/community-based organizations	6
☐ People living with the diseases	1
☐ People representing key affected populations[2]	1
☐ Private sector	1
☐ Faith-based organizations	6
☐ Multilateral and bilateral development partners in country	12
☐ Other *(please specify):* Parliament	1
Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	40

[2] Please use the Round 9 Guidelines definition of *key affected populations*.

[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_AttachmentC_en.xls

2.1.2. Broad and inclusive membership

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

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

The Democratic Republic of Congo is one of the African countries with a long tradition of organizing health systems. From the colonial period to the 1980s, which saw the start of primary health care originating in the DRC, the health system has undergone innovations that have marked the country's history. However the 1990s saw a multi-sectoral crisis which did not leave the Congolese population nostalgic for "the good old days". This contrast is no doubt one of the factors that explain the attraction of the Congolese to the issue of re-establishing the health system through various strategies including the current one, the Health Systems Strengthening Strategy, HSSS.

Almost all members of the CCM-DRC have a deep interest in taking up the challenges so that health programs can have a real impact and reduce the morbidity of the three diseases targeted by the Global Fund, and which aggravate poverty. The organizations comprising the different sectors of the CCM have a wide range of expertise in disease control, and are constantly confronted by the analysis of what underlies the health system, and easily explains the successes and failures of health programs.

Gender awareness

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

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

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

The question of gender and sexual minorities is a very topical one and is freely spoken of in today's DRC immediately after the conflict. Although the different provinces in DRC were affected to different extents by the war, they are all confronted by an exacerbation of gender issues, particularly aspects of violence towards women and the balkanization of minorities. This is a hindrance to disease control.

The DRC has recently made considerable progress legally, reinforcing the law against sexual violence and the law protecting PLWA. Sexual violence has been broken down into fourteen components, to make it easier to focus on particular aspects.

The members of the CCM-DRC are unanimous in focusing the submission of the HIV AIDS component on combating sexual violence in the 5 provinces in the country in which women, girls and minorities are suffering particularly. Members have also assigned for submission an exhaustive survey of the phenomenon in the six other provinces of the country, so that no province is left out. It is quite obvious that, in line with Congolese culture, the members of the CCM-DRC are well aware of the role of women and girls in Congolese lifestyle. They are the driving force behind the whole of life and participate in many health programs. For example they are the ones who are most involved in children's vaccination campaigns, in mass distributions of impregnated mosquito nets, etc. This is why the health proposals developed in Democratic Republic of Congo focused particularly on women, girls and children in general. The various organizations that participate in the CCM sectors are full of experts in gender issues and minority issues. These experts play a predominant part in analyzing gender and minority issues.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.
Multi-sectoral representation within the CCM makes things much easier. This multi-sectoral diversity is regularly put to use in drawing up projects for submission to the Global Fund. By way of example, the public sector members of the CCM have a great deal of proven expertise in the legal aspects of planning health service activities, being familiar with all current DRC legislation on PLVIH and other diseases, children's rights, etc. Civil society organizations (NGOs, faith-based organizations, etc.) are very familiar with the social aspects of projects that the CCM-DRC is submitting to the Global Fund. Bi- and multi-lateral cooperation partners also support the CCM with all their expertise. As shown in the CCM-DRC steps for drawing up the submissions, all possible efforts are made for total transparency in the process, including all multi-sectoral expertise, both within the CCM and outside it.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☉ Applied for funding in Round 7 and/or Round 8 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

2.2.2. Transparent proposal development processes

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

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

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*
As soon as the Round 9 was launched, the Technical Secretariat of the CCM-DRC passed on the message of the Global Fund to all CCM members and partners, to prepare them for drawing up the proposals by beginning with each member drawing up mini-proposals. On March 16, 2009, CCM Assistant Secretary sent a call for micro-proposals throughout the country via the Internet, and also published a call for expressions of interest in a newspaper, "Le Potentiel". The call for expressions of interest was inclusive and encouraged all sectors to present mini-proposals to build up the country proposal. In total, by the deadline of May 5, 2009, the CCM had received fourteen (14) mini-proposals from all the provinces targeted by the guidelines for each of the components.
(b)
During the retreat held in the suburbs of Kinshasa from May 7 to 16, 2009 for drawing up the advanced

draft of the proposal, a team of experts from different sectors of the CCM was formed. The Assistant Secretary sent the team the criteria for assessing the micro-proposals. The team carefully read through each other's micro-proposals in detail, which led to a plenary for discussing the aspects to include in the final proposal and recommendations to make to submitters.

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

As usual, the process began during the CCM General Assembly (GA), communicating the information of the Global Fund launch of the new round. The needs analysis carried out by the heads of the national programs for controlling the three Global Fund targeted diseases generally leads to the decision to submit or not for the next round. The CCM-DRC GA met in December 2008, January 2009 and March 2009. The Technical Secretariat received the approval of the GA to start drawing up the country proposal for submission to Round 9.

From then on, for each component, the task forces, which are actually wider platforms, began discussions on the priorities for interventions and the geographical coverage.

The Technical Secretariat communicates the results of these discussions, often called "guidelines", for submissions to a wider group composed of CCM members and non-members in order to arrive at a consensus.

The process continues inclusively, moving on to data collection and writing drafts of certain parts of the sections in the round.

From May 7 to 16, 2009, the CCM organized a residential workshop for over 40 experts from the different sectors of the CCM. Other experts who are not CCM members joined the working team as and when they were available at the workshop near Kinshasa.

During these ten days, the participants wrote the advanced drafts of submissions for each of the sections. The drafts were read by all the CCM members by e-mail and also during a consensus workshop from May 20 to 21, 2009, so that all the CCM members could make detailed comments on the document page by page.

The various comments were included by a small team, who then submitted the final document to the CCM for approval.

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***[Insert Annex Number]***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.

The different meetings organized by the Global Fund and its partners as well as its current directives are a sufficient reminder of the role of the CCM in overseeing program implementation. This is the guarantee of success. However, it is known that the difficulties CCMs have in doing this fully are usually of a financial nature. Despite this difficulty, and conscious of its responsibilities, the CCM-DRC has developed several processes for monitoring and overseeing the grants received from the Global Fund.

1st process:

The national HIV/Aids, Malaria and TB programs, in their regulatory and normative capacity, have the ability to oversee program implementation. They supervise the schedules of activities planned by the Sub-Recipients before they are funded by the current PR. These national programs for controlling the 3 target diseases, with their respective tack forces, form the skeleton of the CCM-DRC Technical Secretariat

2nd process:

The joint CCM-PR missions. These allow the CCM to verify the use of grants. The CCM Technical

Secretariat and the PR agree on a yearly assessment calendar, and the CCM designates, for each sector, the members who will take part in the missions. The reports from the missions are a means of monitoring the implementation of programs.

3rd process:

Meetings at which the PR reports back to the GA or the Bureau at the agreed frequency.

During these meetings, the PR explains to the members of the GA and the Bureau the activities carried out and the results of the implementation. The amounts of Global Fund grants paid out are also discussed.

4th process:

CCM partners are subcontracted to provide technical support to determine how the grants are being used. CCM operations also receive this type of technical support.

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

In DRCongo, the most important operational unit for implementing activities for controlling the 3 Global Fund target diseases is the Health Zone. The health system has three levels: the central level that has a regulatory and normative role, and the intermediate level that provides the technical support for the outermost level. This outermost level is composed of the 515 Health Zones that implement the program.

The Health Zone is where all activities take place. The community is involved in monitoring activities through members of the health committee. The Health Zone Management Team, comprising a Zone Senior Doctor, a Managing Doctor, a Nursing Supervisor and a Nursing Director, is heavily involved in supervising activities, including those operating on Global Fund grants, although they are not CCM members. This illustrates how well all the activities of the operational unit known as the Health Zone are integrated.

At the Province level, the Health Systems Strengthening Strategy has instituted the Provincial Steering Committee. One of its functions is to ensure that the activities planned by the multiple sources of support received in the country are carried out properly.

The Province Management Team, led by the Provincial Medical Inspector, is responsible for coordinating the partners and their support groups, and also the implementation of activities in the Province.

In certain cases, during the ongoing supervision, non-medical people are also involved, in order to instill greater confidence in the services offered.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*

On April 27, 2009, the CCM launched a call for expressions of interest for candidate Principal Recipients. The deadline for the call was fixed at May 16, 2009. The call was circulated by e-mail and through the media. Posters were put up all over the country.

On May 14, 2009, guided by the CCM Bureau, the Technical Secretariat sent a letter to CCM groups asking them to nominate a representative to join an ad hoc commission to select potential Principal Recipient candidates.

On May 22, 2009, the letters were opened in the presence of Principal Recipients. As soon as the letters were opened, the members of the commission examined the applications in camera to ensure

they complied with requirements. A report was written after this appraisal. In all, 3 applications were received, and they all complied with requirements.

On May 23, 2009, the commission examined the applications from a technical angle. After the deliberations, the commission wrote a formal report.

On May 25, 2009, the commission presented the results of the deliberations to the CCM Bureau, so that they could be announced at the GA on May 27, 2009 for validation of the candidate PRs.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***[2.2.2.4.a.2.]***

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Ministry of Health	HIV-Aids, Malaria, Tuberculosis and HSS	Public
SANRU Program	Malaria	NGO
Caritas Congo	Tuberculosis	NGO
National Council of Health NGOs (CNOS)	HIV-Aids	NGO

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

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
ONE PAGE MAXIMUM

2.2.7. Managing conflicts of interest

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

2.2.8. Proposal endorsement by members

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

2.3. Sub-CCM details

2.3.1. Status of Sub-CCM	
Identify if the sub-national coordinating mechanism:	
(a) Operates under the authority of the CCM and focuses on a particular region or issue.	☐ *Answer s.2.3.2. and s.2.3.3.*
(b) Claims an independent basis to operate without oversight of the CCM	☐ *Answer s.2.3.2. and s.2.3.4.*

2.3.2. Rationale
Why does a Sub-CCM approach represent an effective approach in the circumstances of your country?
ONE PAGE MAXIMUM

2.3.3. CCM Endorsement	
(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal.	***[Insert Annex Number]***
(b) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	***[Insert Annex Number]***

2.3.4. Justification of independence of Sub-CCM
Explain how the Sub-CCM has a right to operate without guidance from the CCM.
ONE PAGE MAXIMUM

2.4. Non-CCM Applicants [delete sections 2.1. to 2.3. and only complete s.2.4 below]

2.4.1. Sector of work

(check one box only):
☐ Academic/educational sector
☐ Government
☐ Non-government organization (NGO)/community-based organizations
☐ People living with the diseases
☐ People representing key affected populations
☐ Private sector
☐ Faith-based organizations
☐ Other: *please specify:*

2.4.2. Status of Non-CCM applicant

(a)	Identify the main justification for submitting a non-CCM proposal *(check one box only)*:	
(i)	Country in conflict, facing a national disaster or in a complex emergency situation	☐ *Go to s.2.4.3.*
(ii)	Country that suppresses, or has not established partnerships, with civil society and non-governmental organizations	☐ *Complete (b) below, and then s.2.4.3.*
(iii)	State without a national government, and not being administered by a recognized interim administration	☐ *Go to s.2.4.3.*

(b) If (ii) applies:

- describe, in date order, all attempts to have activities from the non-CCM proposal included in the CCM's proposal, and the CCM's response; and
- briefly explain why you will be able to do the work and achieve the outputs/outcomes when the CCM has not supported the proposal.

TWO PAGE MAXIMUM

2.4.3. Expected benefit of proposal

Briefly explain how the work included in this proposal (HIV, tuberculosis and/or malaria as relevant) addresses gaps in the existing country efforts.
ONE PAGE MAXIMUM

2.4.4. Non-CCM knowledge and experience in cross-cutting issues

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

Gender awareness The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in: • methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and • the factors that make women and girls and sexual minorities vulnerable.
(b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Multi-sectoral planning The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the applicant in multi-sectoral program design.

2.4.5. Principal Recipient(s)

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.*

Name	Disease	Sector**

[use "Tab" key to add extra rows if needed]		

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

2.4.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
ONE PAGE MAXIMUM

2.4.7. Endorsement by Non-CCM Applicant

Position	Printed Full Name	Signature

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	Comprehensive documentation on **processes** used to invite submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	1. E-mail messages: launch of Global Fund Round 9 2. Newspaper announcement of the Round 9 Call for Micro-proposals 3. E-mail messages on the Round 9 Call for Micro-proposals
2.2.2(b)	Comprehensive documentation on **processes** used to review submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	4.Criteria for reviewing the micro-proposals 5. Minutes for integrating the Malaria micro-proposals 6. Minutes for integrating the HIV-Aids micro-proposals
2.2.2(c)	Comprehensive documentation on **processes** used to ensure the input of a broad range of stakeholders in the proposal development process	7.Minutes of the General Assembly meeting on February 3, 2009 8.List of people present at the meeting on February 3, 2009 9. Minutes of the extended Technical Secretariat meeting on April 15, 2009 List of people present at the meeting on April 15, 2009 10. E-mail messages for taking part in the BITI writing workshop 11. Writing teams 12.Minutes of the Consensus Workshop
2.2.3(a)	Comprehensive documentation on processes to oversee grant implementation by the CCM (or Sub-CCM).	13. TDR Monitoring and Evaluation Commission 14.Calendar of joint UNPD – CCM missions
2.2.3(b)	Comprehensive documentation on processes used to ensure the input of a broad range of stakeholders in grant oversight process.	15. Minutes of the General Assembly meeting on January 13, 2009

Proposal checklist - Section 1 and 2

		List of people present 14. Calendar of joint UNPD – CCM missions
2.2.4(a)	Comprehensive documentation on processes used to select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated). If different processes used for each disease, then explain.	16.E-mail messages of call for expressions of interest for Civil Society PRs 17.E-mail messages for selecting the PRs 18.Members of the PR selection commission 29.Members of the extended Bureau 20.Minutes of the PR selection 21.Minutes of the General Assembly meeting on May 27, 2009
2.2.7	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	22. Management of Conflicts of Interest
2.2.8	Minutes of the meeting at which the proposal was developed and CCM (or Sub-CCM) endorsed.	21. Minutes of the meeting on May 27, 2009
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members.	**Attachment C to the Proposal Form**
Sub-CCM applicants only		
2.3.3 (***CCM Endorsement***)	Documented evidence (including minutes of the CCM meetings) that the CCM in the country reviewed and endorsed the proposal (as relevant).	
2.3.4	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM.	
Non-CCM applicants only		
2.4.1	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
2.4.2(a)	Documentary evidence justifying the one of the three exceptional circumstances for submitting a non-CCM	

Proposal checklist - Section 1 and 2

	proposal	
2.4.2(b)	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

ROUND 9 – Malaria

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	**January 2010**	**December 2014**

3.2 Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing malaria Global Fund grant(s) with the Round 9 malaria proposal?	☐ Yes *(go first to (b) below)* ☒ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 9 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at:*

http://www.theglobalfund.org/documents/rounds/9/CP_PoI_R9_FAQ_GrantConsolidation_en.pdf

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

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

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

DRC uses an annual budget execution cycle that begins on 1 January and ends on 31 December of each year. This means that the State's financial programming through the budget development cycle must first define a budgetary framework before any budgetary conferences are held to decide which sectors should be prioritised over others taking account the macroeconomic framework and medium-term expenditure framework (MTEF). The latter determines the theoretical thresholds necessary to control the macroeconomic aggregates. The MTEF also considers own resources as well as external and exceptional resources mobilized in order to develop activities in the various sectors. In accordance with the principle of budget annuality, these activities are planned on an annual basis running from January to December of the same year. Fiscal cycles are also taken into account when including programs or projects (both long and medium term), regardless of their implementation date. This is done by aligning the project's time-series chart with the actual budgetary period, to allow annual evaluation of the government's implementation of the development program and the impact of implemented State budget activities on the country's various macroeconomic variables.

3.4 Program-based approach for Malaria

3.4.1. Does planning and funding for the country's response to malaria occur through a program-based approach?	☉ Yes. Answer s.3.4.2
	☐ No. ➔ *Go to s.3.5.*
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☐ No. Do not complete s.5.5

3.5 Summary of Round 9 Malaria Proposal

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

Prepare after completing s.4.

The Democratic Republic of Congo (DRC) is one of the highest malaria burdened countries in Africa with at least 27 million cases in 2006 according to the World Health Organisation (ref. Global Malaria Report, 2008, preliminary estimates). In this country which is larger than whole of Western Europe, more than 97% of the population live in areas with stable endemic transmission of malaria. The most commonly found pathogen is *Plamodium falciparum*. Malaria is the leading cause of morbidity and mortality and a significant cause of poverty in DRC:

- 40% of outpatient visits for children < 5 years (Public Health School (PHS), 2007 – appendix AQ 2 page 43);
- 48 % of hospital admissions for children < 5 years (PHS, 2007 – annex AQ 2 page 46);
- 37.5 % of in–hospital deaths for children < 5 years (PHS, 2007 – annex AQ 2 page 38);
- 41 % of outpatient visits by pregnant women (National Malaria Control Program (NMCP), 2001– annex AQ 19 page 17);
- 54 % of hospital admissions by pregnant women (NMCP, 2001 – annex AQ 19 page 18);

Anti-malaria interventions come within the scope of the NMCP 2009-2014 strategic plan which aims to reduce mortality and morbidity by 50 %. The DRC is divided into 11 provinces which are subdivided into 515 health zones. The first Global Fund Grant for malaria was in Round 3 and this concerned 119 health zones located throughout the country. The second was in Round 8 and this ensured continuity of support for interventions in the same health zones.

The goal of the present Global Fund Round 9 Proposal to fight HIV/AIDS, tuberculosis and malaria is to help reduce malaria-related morbidity and mortality between now and 2014 while extending geographic coverage to 139 additional Health zones compared to the previous 2 Rounds

The goal of this Scaling-Up for Impact (SUFI) is to intensify routine interventions to increase the use of LLIMNs by pregnant women and children under one year of age, apply intermittent preventive treatment and improve management of malaria cases in the new 139 health zones not yet covered in the field of malaria control.

These 139 HZs were chosen for several major reasons: the absence of support in these zones where the population continues to lack means of prevention and still uses monotherapy contrary to national policy based on international recommendations with all the risks that this entails for the health of populations in particular through the development of ACT resistance. In this respect it should be pointed out that the marketing of monotherapies has been banned by ministerial decision.

Moreover the Needs Assessment demonstrated the extremely poor coordination in these health zones making it currently impossible to establish high-quality health care.

The specific objectives of this proposal intended to help achieve this goal are as follows:

- At least 80% of pregnant women and children under one year of age sleeping under LLIMNs in the 139 targeted HZs
- At least 80% of pregnant women receiving intermittent preventive treatment according to national guidelines in the 139 targeted health zones
- At least 80% of malaria cases managed according to national guidelines in the 139 targeted health zones
- Reinforcement of 100% of the national and provincial coordination structures of the National Malaria Control Program

The following areas of action were chosen to achieve these specific objectives, :

ROUND 9 – Malaria

Prevention:

- Prevention through routine distribution of LLIMNs: to considerably improve the coverage of pregnant women and children under 1, this proposal will place emphasis on offering LLIMNs during prenatal visits (PNV) and preschool visits (PSV), training/recycling, social mobilization, and especially on monitoring and evaluation in the 139 health zones.
- Prevention by IPT: the proposal will also promote this preventive measure by offering doses of Sulfadoxine Pyrimethamine, training/recycling, social mobilization, and in particular by monitoring and evaluation in the 139 health zones.

Management of malaria cases:

- Laboratory confirmation: according to this proposal, the use of Rapid Diagnostic Tests (RDT) currently in force in the 119 health zones supported by Round 3 Global Fund grants will be scaled up in the 139 health zones targeted by Global Fund Round 9. This will make it possible to better identify the real malaria burden in the country, as well as better manage stocks of anti-malaria drugs.
- Treatment with the artesunate-amodiaquine combination: The objective is to provide the correct management of uncomplicated cases of malaria and serious cases of malaria in healthcare clinics according to national guidelines in the 139 health zones targeted by this proposal.

The emphasis will be on procurement (RDTs, laboratory reagents and drugs), training/recycling, social mobilization, operational research and in particular monitoring and evaluation in the 139 health zones.

Coordination and partnership

Concerning these aspects, the 9th round Global Fund proposal will make it possible to fill the large gaps in the program coordination structures at both national and provincial level that were identified by various evaluations of their institutional, managerial and technical capacities. This involves the reinforcement and improvement of infrastructures, office automation and equipment, means of communication, staff training/recycling and operational resources.

Achieving these objectives for the malaria component will be underpinned by actions to strengthen the Healthcare Systems planned in the DRC general proposal, specifically in the areas concerning the National Health Information System, community systems, provision of services and supply and distribution management.

For this proposal, the CCM-DRC selected two channels of funding (Governmental PR and Public PR) recommended by the Global Fund for implementation of activities.

The budget for the malaria component is USD 280,495,135 over the next five years representing 14.3 USD per person and per year for routine activities in the 139 health zones. The Investment of the Global Fund for the 9th Round is therefore 4.06 USD per person per year for the whole of the DRC.

4 PROGRAM DESCRIPTION

4.1 National prevention, treatment, care, and support strategies

(a) Briefly summarize:

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

The DRC is classified among the countries that are in the malaria control phase, with at least 27 million cases per year according to WHO estimates (ref. Global Malaria Report, 2008, preliminary estimates). This situation warrants the need for a quick scale-up based on the combination of all the basic malaria control interventions listed below. These strategies were adopted by the DRC in 2002 and then updated in 2007 and 2009 with respect to world strategies including those relative to the "Roll Back Malaria" plan and the recommendations of the World Health Organization that target major policies and interventions, be they preventive or curative, to reduce the burden of malaria by at least 50% by 2010, and by 75% by 2015. The current 2009-2013 national strategic plan (*annex AQ1*) was defined after a consensus forum that included the various national and international experts and partners involved in the fight against malaria in the DRC, including civil society.

The strategies selected in this strategic plan (annex AQ1 page 58) are as follows:

❖ **Basic strategies:**

- Stepping up of prevention activities using appropriate individual and collective protective measures such as insecticidal mosquito nets (in particular, by routine distribution during prenatal visits (PNV) for pregnant women and pre-school visits (PSV) for infants under 1, but also through mass distribution campaigns involving immunization, vitamin A supplements and deworming with mebendazole to improve the survival of children under 5) all the other materials that may be treated, indoor spraying with remanent insecticides, destruction of mosquito larvae habitats and home and environmental planning;
- Use of intermittent preventive treatment by pregnant women
- Improvement of quick and effective management of malaria cases at all levels of the healthcare pyramid;
- Intensified management of malaria epidemics;

❖ **Support strategies:**

- Stepping up of participative planning process at all levels, including community level;
- Training;
- Procurement of supplies to fight malaria;
- Improved management of resources;
- Development of research;
- Reinforced promotion of malaria control;
- Intensification of surveillance, monitoring and evaluation.
- Improved coordination of the National Malaria Control Program

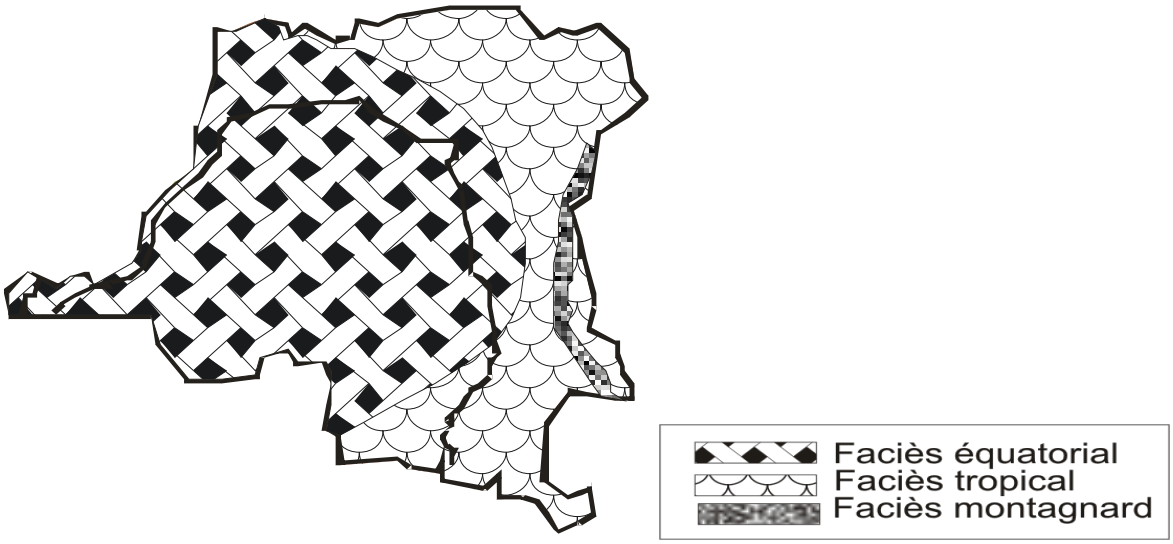
These strategies are the best solution in view of the **epidemiological situation in the country which is characterized by 3 climatic regions:** the equatorial, tropical and mountain climatic regions. In the equatorial region (Central African forests and post-forest savannah) there is intense and permanent anopheline transmission with an inoculation rate of up to 1,000 infected bites per person per year. The tropical region (African wet savannah) is a zone where transmission recurs during long seasonal outbreaks during the rainy season lasting 5 to 8 months (60 to 400 infected bites per person and per year).

Ninety-seven percent (97%) of the Congolese population is exposed in the equatorial and tropical regions, which represent WHO Stratum I. The mountain regions (areas at an altitude of between 1,000 and 1,500 meters) form WHO stratum- IV. The period of transmission is very short in these areas where there is a risk of malaria epidemics. The 3% of the population living in mountainous areas represent 2.1

million people who are exposed to a risk of epidemics.

The map below shows the geographical distribution of these three regions of the DRC:

Figure 1: Epidemiological regions of malaria in DRC



Map taken from the book, Biodiversity of Malaria in the world, published by John Libbey. Mouchet J et al, 2

Implementation of the selected strategies of this 2007-2011 strategic plan will make it possible to improve the expected results[1] in terms of malaria control which are:

- At least **80%** of persons exposed to malaria sleeping under insecticide treated mosquito nets;
- At least **80%** of homes in targeted health zones treated by indoor spraying of remanent insecticides;
- At least **80%** of pregnant women receiving intermittent preventive treatment in accordance with the national guidelines
- At least **80%** of patients infected with malaria receiving diagnosis and treatment according to national guidelines at all levels of the healthcare pyramid including the community;
- At least **80%** of epidemics due to malaria controlled according to national guidelines;
- Strengthening of the national and provincial coordination structures of the National Malaria Control Program
- Regular transmission of data for the main indicators of malaria control.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this

[1] Ministry of health, National strategic plan to fight malaria 2009-2013, page 59

proposal *(or, *identify the specific Annex number from a Round 7 or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

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

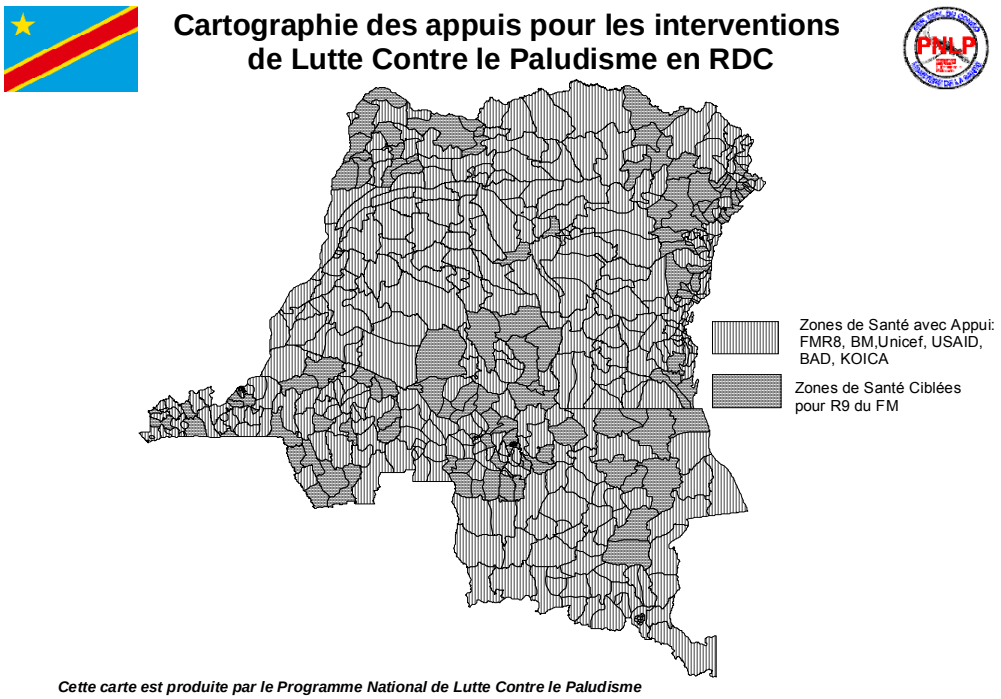
Document	Proposal Annex Number	Page References
☑ National Health Sector Development/Strategic Plan	Annex AQ1	Pages 58 and 59
☐ National Malaria Control Strategy or Plan		
☐ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*		
☐ Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal		
☐ National Monitoring and Evaluation Plan (health sector, malaria specific or other)		
☑ National policies to achieve gender equality in regard to the provision of malaria prevention, treatment, and care and support services to all people in need of services	Annex AQ11	Pages 11 and 12

4.2 Epidemiological Background

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

Figure 2: Map of health zones retained for the Round 9 Global Fund proposal

The map below presents all 139 HA retained for the implementation of Round 9 Global Fund Grants.



These 139 health zones were chosen because of the absence of malaria control interventions mainly due to a lack of financial resources in a country with highly endemic disease and in a post conflict situation.
During the WHO/AFRO Regional Assembly held in 2006 in Addis Ababa in Ethiopia, Member States were strongly encouraged to accelerate the process of improving access of populations to basic health interventions.
In April 2008, the United Nations Secretary General made a vibrant appeal to all humanity to commit itself to offering all individuals, wherever they are and in whatever their geographical, social or economic position, the full package of malaria control interventions before ***31 December 2010***.
The current situation of the DRC shows the efforts made by the government and partners to meet the country's enormous needs. Nevertheless, 139 health zones covering 19,960,656 inhabitants, i.e. 28% of the total population of the country remain without support for malaria control interventions. Hence the DRC's Round 9 Global Fund application. Moreover, systems have been set up to accelerate the implementation of this application in order to achieve the goals planned for 31 December 2010.
This involves in particular applying the voluntary pooled procurement (VPP) system developed by the Global Fund for supplies.

In the DRC, the structure of the general population by age and by sex is broken down as follows:

Table 1: Breakdown of the population of the DRC by age and by sex

Age group	Urban			Rural			Whole country		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
0-4	9.3	8.9	18.2	9.6	9.6	19.2	9.5	9.4	18.9
5-9	7.1	7.3	14.4	7.8	7.8	15.6	7.6	7.6	15.2
10-14	6.6	7.0	13.5	7.0	7.1	14.0	6.9	7.0	13.9
15-19	5.7	5.9	11.6	5.7	5.6	11.3	5.7	5.7	11.4
20-24	4.1	5.0	9.1	3.5	3.8	7.3	3.7	4.2	7.9
25-29	3.3	4.1	7.4	3.1	3.8	6.8	3.1	3.9	7.0
30-34	2.8	3.2	6.0	2.3	2.8	5.1	2.4	2.9	5.4
35-39	2.8	2.5	5.3	2.4	2.7	5.1	2.6	2.6	5.2
40-44	2.3	2.0	4.3	2.1	2.3	4.4	2.2	2.2	4.4
45-49	1.6	1.4	3.0	1.7	1.6	3.3	1.7	1.5	3.2
50-54	1.1	1.1	2.2	1.1	1.4	2.5	1.1	1.3	2.4
55-59	0.8	0.9	1.7	0.8	0.9	1.7	0.8	0.9	1.7
60-64	0.6	0.7	1.3	0.6	0.7	1.3	0.6	0.7	1.3
65-69	0.6	0.3	0.9	0.5	0.5	1.0	0.5	0.4	0.9
70-74	0.3	0.3	0.6	0.3	0.5	0.7	0.3	0.4	0.7
75-79	0.2	0.1	0.3	0.2	0.1	0.3	0.2	0.1	0.3
80+	0.1	0.1	0.2	0.2	0.1	0.3	0.1	0.1	0.2
Total	**49.2**	**50.8**	**100.0**	**48.9**	**51.1**	**100.0**	**49.0**	**51.0**	**100.0**

Source: Ministry of Planning with the support of UNICEF DRC, National survey on the situation of children and women *MICS2/2001* (Annex AP 1)

Based on the structure of the population by age and by sex for the whole country (Table 1), different age groups were added together in order to express the population data as requested in the Round 8 proposal form, hence:

- The 5-9 and 10-14 age groups were added together to obtain the 5-14 age group
- The 55-59, 60-64, 65-69, 70-74, 75-79, and 80+ age groups were added together to obtain the 54+ age group
- The 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50-54 age groups were added together to obtain the 15-54 age group

The data in this table can be used to fill out Table (b), which provides the numbers for the various population groups by age and by sex for the country as a whole

(b) **Size of population group(s)**
(If national data is disaggregated differently then type over the categories proposed)

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	**68 975 017**	(Health area census) PEV Forum at Goma, DRC, March 2007	**2007**
Women > 54 years	**2.6 %** of total population i.e. **1,793,350**	***DRC***, National survey on the situation of children and women **MICS 2**	**2001**
Women 15 – 54 years	24.3 % of total population i.e. **16,760,929**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Women with a pregnancy in last 12 months	**4 %** of total population i.e. **2,759,001**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Men > 54 years	**2.5 %** of total population i.e. **1,724,375**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Men 15 - 54 years	**22.5 %** of total population i.e. **15,519,379**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Girls 5 -14 years	**14.6 %** of total population i.e. **10,070,352**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Boys 5 – 14 years	**14.5 %** of total population i.e. **10,001,377**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**
Girls 0 – 4 years	**9.4 %** of total population i.e. **6,483,652**	***DRC***, National survey on the situation of children and women **MICS 2**	**2001**
Boys 0 – 4 years	**9.5 %** of total population i.e. **6,552,627**	***DRC,*** National survey on the situation of children and women **MICS 2**	**2001**

4.2.2. Malaria Epidemiology in Target Population(s)

Population Groups	Estimated number*	Source of data	Year of estimate	Population Groups	Estimated number*	Source of data	Year of estimate
Episodes of fever during past 12 months (*all populations and all ages together)*	**128,086,607**	MICS 2	2001**	**Episodes of malaria in past 12 months (*all populations and all age together)***	**51,234,643**	WHO*	2008
Episodes of fever during past 12 months: Women > 54 years	**1,793,350**	MICS 2	2001**	**Episodes of malaria during past 12 months: Women > 54 years**	717,340		2008
Episodes of fever during past 12 months: Women 15 - 54 years	**16,760,929**	MICS 2	2001**	**Episodes of malaria during past 12 months: Women 15 - 54 years**	6,704,372		2008
Pregnant women infected with malaria in past 12 months	**0**			**Pregnant women infected with malaria during past twelve months**	0		2008
Episodes of fever during past 12 months: Men > 54 years	**1,724,375**	MICS 2	2001**	**Episodes of malaria during past 12 months: Men > 54 years**	689,750		2008
Episodes of fever during past 12 months: Men 15 - 54 years	**15,519,379**	MICS 2	2001**	**Episodes of malaria during past 12 months: Men 15 - 54 years**	6,207,752		2008
Episodes of fever during past 12 months: Girls 5 - 14 years	**20,140,705**	MICS 2	2001**	**Episodes of malaria during past 12 months: Girls 5 - 14 years**	8,056,282		2008
Episodes of fever during past 12 months: Boys 5 - 14 years	**20,002,755**	MICS 2	2001**	**Episodes of malaria during past 12 months: Boys 5 - 14 years**	8,001,102		2008
Episodes of fever during past 12 months: Girls 0 - 4 years	**25,934,606**	MICS 2	2001**	**Episodes of malaria during past 12 months: Girls 0 - 4 years**	10,373,843		2008
Episodes of fever during past 12 months: Boys 0 - 4 years	**26,210,506**	MICS 2	2001**	**Episodes of malaria during past 12 months: Boys 0 - 4 years**	10,484,203		2008

NB: * The data in Table 4.2.2 on fever episodes and cases of malaria were obtained by multiplying the population figures for each age group (see Table b) by the average number of fever episodes and malaria attacks per age group per year, for the country as a whole.. The average numbers of fever episodes per age group and per year used in this proposal are those used by the country since 2005 as recommended by the WHO. This average number of fever attacks is: 4 for the under 5 age group; 2 for the 5-14 age group; and 1 for the 15+ age group. In all African countries where malaria is endemic, this disease is the cause of 25 to 40% (30% on average) of all outpatient visits and the diagnosis is generally based on laboratory tests (WHO, Report on malaria in Africa, 2003, page 19 annex 5). Taking into account the epidemiological setting in the DRC which is dominated by the equatorial and tropical regions, the hypothesis of 40% was retained. The estimates concerning the above population data are made on the basis of the 2007 population defined during the mixed forum between the Government and health sector partners on the Expanded Program on Immunization (EPI) in March 2007. In order to overcome this problem of lack of precise data about malaria cases, provision has been made since the Round 8 application to set up laboratory tests (rapid diagnostic tests for malaria) to confirm cases in healthcare clinics. The number of cases officially reported is surely grossly under-estimated (by about 5 times), and provides a poor picture of the actual malaria burden in the DRC.

*** Origin: MICS 2, Structure of populations by sex and by age group, page 47, (Annex AP 1). In 2001 the MIC modules for malaria had not yet been developed.*

The same assumptions (same proportions in each population group, same average number of fever episodes and cases by population group) were used to estimate the epidemiology of malaria in the 139 HZs of this proposal. The size of the different population groups targeted in these HZs as well as the epidemiology of malaria may be calculated as follows:

Table 2: Epidemiology of malaria in the 139 HZs targeted by this proposal

Population Groups	Proportion of population	Population size	Mean number of febrile episodes per year	Total yearly number of febrile episodes	Number of cases of malaria (estimated)
Total population of 139 HZs (all ages together) (2009)	100%	19,960,656		37,066,938	14,826,775
Women > 54 years	2.6%	518,977	1	518,977	207,591
Women 15 - 54 years	24.3%	4,850,439	1	4,850,439	1,940,176
Women pregnant during past twelve months	4.0%	798,426	ND		
Men > 54 years	2.5%	499,016	1	499,016	199,607
Men 15 - 54 years	22.5%	4,491,148	1	4,491,148	1,796,459
Girls 5 - 14 years	14.6%	2,914,256	2	5,828,512	2,331,405
Boys 5 - 14 years	14.5%	2,894,295	2	5,788,590	2,315,436
Girls 0 - 4 years	9.4%	1,876,302	4	7,505,207	3,002,083
Boys 0 - 4 years	9.5%	1,896,262	4	7,585,049	3,034,020

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[2] who may have disproportionately low access to malaria prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Malaria program

Describe:

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

The main weaknesses in the implementation of current malaria control strategies are as follows;

1. Regarding prevention:

LLIMN

- Poor availability of long-lasting insecticidal mosquito nets (LLIMN). The number of LLIMNs was insufficient up until 2006. Then with the Round 3 Global Fund grant to fight HIV/AIDS, tuberculosis and malaria then was a rapid increase in the number of LLIMNs in the country. However, despite this surge, the number of nets is still insufficient for a vast country like the DRC;
- Tax reductions and exemptions for anti-malaria supplies are not yet effective and there are long delays at ports;
- The NMCP had not been able to control LLIMN storage sites throughout the country or the means of transport for the distribution of LLIMNs. This made it difficult to distribute LLIMNs both routinely and during mass campaigns;
- Poor coordination capacity of the NMCP with its many partners in a vast country with difficult means of communication;
- Monitoring of activities in the field is made difficult by the poor centralized data collection system;

In order to increase the rate of utilization of LLIMNs and achieve the desired cover by 2013, the NMCP and its Partners undertook in 2006 to carry out integrated campaigns comprising bed-net distribution, immunization, vitamin A supplementation and deworming with mebendazole. Up until then, mass LLIMN distribution campaigns had already been carried out in four provinces:

- Bas-Congo province where the distribution of LLIMNs only concerned children aged from 6 to 36 months;
- Sud-Kivu province where the target was children under 5;
- Equateur province where the target was also children under 5;
- Kinshasa town province where the campaign was not integrated and only involved the distribution of LLIMNs. This campaign resulted in the distribution of 2 LLIMNs per household, i.e. two thirds of the number required.

Concerning the many taxes and customs charges and the long delays at ports, the NMNP had already started to petition the Congolese Government. This procedure led to the defence of the above dossier with the financial commission at the Ministry of Finance. Work at this stage will consist in following-up the resolutions that should be presented to the government with the support of the American *Academy For Educational Development* and we hope that this will result in the dossier being approved before the end of the coming year.

[2] Please refer back to the definition in s.2 and found in the Round 9 Guidelines

A status report on the country's different stores and warehouses and the routes of communication throughout the country is planned to define the storage capacities and different available routes of communication.
In addition, the NMCP has a data bank that must be improved by integrating it in the international GMTP system used by the WHO.

IPT

Despite a high utilization rate of prenatal care services (85%, EDS-DRC 2007 - annex AQ 12) and delivery assisted by qualified health professionals (74%, EDS-DRC 2007), there is still a low IPT coverage (7%, EDS-DRC 2007).
One problem making it difficult to achieve this objective is that woman must pay to procure Sulfadoxine Pyrimethamine as if forms part of the PNV package. Also the agents responsible for conducting prenatal visits are insufficiently well trained in the improved PNV. Appropriate solutions must be found to overcome these difficulties.

To address this problem, the NMCP and its partners are actively seeking funding to set up an appropriate procurement plan and develop a communication system within health zones including Community Relays (CRC) aiming at encouraging pregnant women to attend PNVs in order to obtain the second dose of SP. In addition, the joint NMCP and National Reproductive Health Program plan has scheduled training to increase the number of improved prenatal care providers.

The NMCP has planned a national survey to determine the reasons for the low rates of IPT and propose possible solutions for this deficiency. Scaling up this factor is possible through the PNV services.

IRS

At national level, this preventive measure has come up against major problems which hinder the program from being integrated on a national scale. These include in particular:

- The absence of guidelines on indoor residual spraying in the DRC;
- The lack of entomologists trained about the program;
- The lack of funds to finance this activity.

To address this concern, the NMCP is drafting training handbooks, standards and guidelines on IRS and will train NMCP agents in IRS and entomology and petition for the funding of this preventive measure.
The NMCP also hopes to obtain the support of companies involved in the implementation of this measure during the next 5 years. The target coverage is at least 80% of sprayed homes.

Technical support will be provided through Co-operation with WHO and the Republic of South Africa.

Diagnosis and treatment of malaria:

The NMCP noted the following weaknesses:

- The poor availability of the AS+AQ combination on the market primarily because of the small number of companies able to supply the DRC with AS+AQ
- The poor acceptance of the AS+AQ combination due to the lack of information given to patients about side effects
- Lack of training of HZ executives about the harmonized tools and procedures for managing drugs, the lack of mechanisms for controlling the storage conditions of drugs in general and anti-malarials in particular, in the country
- Failure to update basic teaching programs in medical and health science training institutes on malaria prevention and management policies.
- Lack of a quality-assurance system for RDTs and microscopy; the number of microscope users to be trained was not known.
- Lack of a quality control system or a safety monitoring system for anti-malaria drugs
- Proliferation of an unregulated sector not respecting the guidelines of the national malaria management policy in DRC

As with other supplies, low procurement of the AS+AQ combination is recorded in the DRC, leading to poor cover by this anti-malarial. Because of this problem, most of the population at risk has no access to the effective and high-quality drugs recommended by the Ministry for Health to treat uncomplicated malaria.

To address these problems, the NMCP and its partners have undertaken to (i) actively seek funding through the present proposal for instance, (ii) set up a procurement plan (iii) conduct a pilot study of pre-dosed and pre-packaged ACTs already introduced in the private medical sector in 8 major cities through funding obtained with the Global Fund Round 8 proposal, and (iv) implement a training plan on drug management and storage and also encourage the use of RDTs by health care institutions.
The program will also petition health science training institutes and the Faculties of Medicine to introduce information about malaria control into the basic training cursus for health science and medical students for them to use immediately after leaving school and also public/private companies to involve themselves in the fight against the malaria. Action in this direction through public/private companies was the main theme of World Malaria Day.

Strengthening of central and provincial NMCP coordination structures

In April 2008, a need assessment for the NMCP conducted by the Malaria Consortium (Annex AP3, P81, 82, 83) with the support of the "Roll Back Malaria" Secretariat identified the following gaps and weaknesses:

- Lack of financial resources mobilized to implement the 2009-2013 strategic plan
- Difficult and irregular communication at intermediate level;
- Cramped buildings not at all conducive to the design work which is the main vocation of program executives;
- Outdated basic office equipment and poor office working conditions;
- Low pay and daily allowances for work in the field;
- Lack of coordination of interventions of partners in the field and in particular Global Fund sub-recipients due to the absence of any system of accountability to the NMCP, even if the partners are combined in support of the strategic plan.
- Lack of an integrated communication plan for wider social mobilization. This makes is difficult to implement the interventions. It also compromises the planned national results for the fight against malaria and reduces the effectiveness of the synergy between the efforts of the different partners in the field and hinders availability, good management and scaling up of interventions (LLIMN, IPT, and Treatment).
- The existing NMCP infrastructures are Insufficient and inappropriate

In order to reinforce the NMCP coordination structures, a detailed analysis of the response was made after considering the principal weaknesses/gaps listed above. This analysis has allowed the NMCP to define the main areas requiring reinforcement and identify related activities that have been integrated in the 2009 – 2013 strategic plan. The programming and financial needs have therefore been clearly defined (Annex 3, page 86)

Research

Although this was selected as one of the main program support strategies, the research sector has suffered from many deficiencies

- Absence of a framework for dialog, coordination of research studies or exchange of results of studies carried out in the country;
- Lack of research studies in the field of malaria control.
- Absence or lack of qualified personnel trained in certain areas such as molecular biology, entomology etc.
- Flagrant dilapidation and lack of equipment and research funds in most institutions

To address these concerns, the NMCP and research institutions have drawn up a development plan since 2007 for operational research in the field of the fight against the malaria in the DRC (Annex AP6) by setting up a research working group to analyse the research program and funding.

4.3.2. Health System

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

The description can include discussion of:

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

A. Organization of the healthcare system

The national healthcare system is organized in a 3-level pyramid based on the primary healthcare needs strategy:

1. **The peripheral or operation level** *is made up of 515 urban, urban-rural, rural health zones. The health zone is the base unit for planning and executing primary healthcare activities. This is the level where all the interventions are integrated. In the health zone, there are two echelons of execution linked together by a reference and counter-reference system.*

Table 3: Distribution of health zones by province

Province	Number of Health Zones (HZ) in province	Province	Number of Health Zones (HZ) in province
Kinshasa	35	North Kivu	34
Lower Congo	31	South Kivu	34
Bandundu	52	Eastern Province	83
Western Kasaï	43	Maniema	18
Eastern Kasaï	49	Equator	69
Katanga	67		
Total = 515			

2. **The intermediate level**: *is made up of 11 Provincial Health Divisions and 65 Health District Inspections. Its role is to provide technical support (training, supervision, monitoring, and evaluation), ensure coordination, carry out inspections and transmit or convey information between peripheral and central levels.*

3. **Central level:** *This comprises the ministerial Cabinet, Secretary General, central departments, and specialized national programs and services. The role of the central level is to provide strategic guidance, draft standards and ensure regulation and national coordination.*

B. Weaknesses of the healthcare system

The DRC Healthcare system is organized in a pyramid with three levels which are: (i) the peripheral level composed of the Health Zones (operational unit of the national health policy, (II) intermediate level with the task of providing technical support for the peripheral level and the central level which has a normative and regulatory role. The weaknesses of our healthcare system may be summarized as follows: (i) problems related to the provision of care and health services, (II) problems related to human resources for healthcare, (III) problems concerning the funding of healthcare services, (iv) problems related to the supply of essential and generic drugs and, (v) problems related to the health information system.

Problems of health services, - the problem of services concerns both health care coverage and quality. Coverage by the National health system is very low (26%), depriving a high proportion of the population of basic care. This mean value already masks enormous disparities. Recent studies showed that in Basankusu (Equator Province), 42.7% of households had to walk for more than eight hours to reach the nearest healthcare clinic and this proportion was 21.2% and 3.6% in Befale and Bolomba respectively. This problem of physical accessibility to health facilities affects the fight against tuberculosis, HIV/AIDS

and Malaria.
In addition to the problems of health coverage the healthcare system is also affected by the poor quality of services offered to the population. This is a result of a combination of several factors including the poor quality of basic training of health providers, the rapid rotation of healthcare personnel who are no longer able to acquire sufficient experience, the state of disrepair of infrastructures and basic equipment and the difficulty in organizing integrated, continuous and global healthcare for users in a context characterized by a lack of resources. Moreover HIV/AIDS control services are extremely fragmented, giving rise to serious problems in terms of efficacy and efficiency.
Problems of human resources for health - There are several problems concerning human resources. These include problems of quality of the resources produced, loss of staff motivation because of the low wages paid by the Government and the increasingly frequent internal and external staff turnover. Staff dissatisfied by the low wages is continually seeking better paid posts. This creates an unstable situation in which staff is unable to acquire the experience they need to ensure high-quality care. The question of human resources has been worsened by bonuses paid for specific health problems. This gives rise to a risk of redundancy in a context characterized by the lack of resources and compromises the interest of staff with respect to health problems for which bonuses are not paid.
Procurement of essential and generic drugs - The national system for procuring essential and generic drugs (EDMSS) is composed of a network of Regional Distribution Centres of the MEG (RDC) which are grouped in a federation of MEG central purchasing and distribution offices known by the acronym FEDECAME. 15 RDC exist in the country out of the 40 planned. This system faces several problems including the low turnover of the different RDC, the low recovery rate of costs related to the use of drugs, competition from unregulated private for-profit companies, the setting up of internationally funded parallel circuits intended for the selective fight against certain diseases, the lack of customer loyalty of clients from healthcare structures receiving credits from the RDC, etc. The fact that the status of the FEDECAME has long been criticized may be added to this list of problems.

The health information system - The operation of the health information system remains a real problem in the DRC as it is incapable of providing in real time the information required by decision makers and service providers to make their decisions. This was shown during the evaluation of the M&E systems of the three programs for the fight against HIV, Tuberculosis and Malaria conducted by `Measure Evaluation' with the support of the Global Fund in 2007[3].

The report of this evaluation identified the following problems: (i) little data, (ii) data entered in parallel into the follow-up and evaluation systems leading to redundancies and discrepancies in the data and a work overload for staff, etc., (iii) low completeness and timeliness of reports and (iv) non-systematic and non-computerized data management characterized by a low capacity for data storage, analysis and diffusion of health information.

Health funding - The problems faced by healthcare funding in the DRC may be summarized as follows: (i) Although the available resources in the sector are increasing, they still fall far short of needs, (ii) The allocations of the State health budget do not always take into account the priorities of the sector; (iii) The methods used to finance selective health problems have led to a fragmentation of the healthcare system.

[3] Measure Evaluation, Assessment report of the follow-up and evaluation systems of the PNT, PNLS and NMCP, November 2007

4.3.3. Efforts to resolve health system weaknesses and gaps

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

The strategy to strengthen the healthcare system (HSS) adopted by the Government and its Partners since 2006 is a global response to these weaknesses[4] in so far as it advocates corrective actions able to reorganize the whole healthcare system in order to cover the whole population and offer global, continuous, integrated, effective and efficient healthcare. The cornerstones of this strategy are the revitalization of the health zones (health district) and staff rationalization.

This strategy adopts a holistic approach to medical problems throughout the Health Zone. Basic healthcare providers must be polyvalent and managed at community level by teams of health zone executives. This should ensure that the care offered to the population is integrated, continuous, global, effective and efficient. Nurses in health centres treating malaria, must also be able to manage problems of tuberculosis and HIV/AIDS appropriate to their skills and the technical plateau available at this level. This approach should make it possible to gradually reduce the fragmentation observed in the sector.

The improvement in healthcare cover and quality are important initiatives for the development of the Health Zones advocated by the HSS. The alignment of stakeholders with this strategy means that a large proportion of the funds available in the sector (including domestic resources) is allocated to the resolution of the problems of healthcare cover and quality. This is the case for the World Bank which funds 82 HZs, the African Development Bank which supports the development of 26 HZS, the European Commission which funds 70 HZS, the Global Alliance for Vaccine and Immunization which funds 65 Health zones, Belgium which supports 14 HZ, USAID which supports 57, etc. The total number of HZs receiving this type of support is 259 out of 515.

The problem of human resources is at the centre of all the actions undertaken by the Government and all its partners in the health sector in the DRC. The Government has made an important effort by granting bonuses (still insufficient) to health personnel in addition to the wages discussed above. Partners in the sector (including the Global Fund) have nearly all included bonuses in the financial support that they provide to the health sector, even if there still are a significant number of HZs/HCs where these bonuses are not paid because of a lack of resources.

During its meeting of February 12-13, the National Piloting Committee set up a commission to carry out an in-depth study of all the problems posed by the national drug procurement system. An audit of this system is planned during this study. This will improve the diagnosis of all the problems faced by this sector and the relevant actions that must be taken to improve its performances. All on-going projects provide resources to increase the turnover of the system. The final goal is for this system to absorb all the resources circulating in the sector, including those allocated to the country by the Global Fund.

The normative framework of the NHIS is intended to improve the management of health information in the DRC. With the available resources including those of the Global Fund Round 8, this normative framework will be introduced in 219 Health zones.

The Ministry of Public Health and its partners have undertaken to reform health funding according to the Paris Declaration. This reform will make it possible to set up sector-based budgetary support to improve the efficacy and efficiency of development aid. Three actions have been initiated to set up this reform. These are the uniformization of the coordinating bodies in the sector, the setting up of a fiduciary agency to assume the management of all the funds in the health sector and the use of consensual procedures for the management of the financial resources of the sector.

[4] Healthcare System Reinforcement Strategy, p23,26, 27

4.4. Round 9 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current malaria epidemiology and identified weaknesses and gaps from s.4.2.2 and s.4.3.

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

Priority n°1: at least 80% of pregnant women and infants under one year sleeping under LLIMNs in the 139 HZs

The mass distribution campaigns of LLIMNs scheduled in the approved Round 8 proposal will target the 515 HZ in the DRC in order to benefit the whole population at risk of malaria. With the aim of maintaining the coverage reached during the LLIMN mass distribution campaigns and to ensure that the most vulnerable persons from a biological point of view have and effectively use LLIMNs, the national strategy has planned the routine distribution of LLIMNs for pregnant women and infants less than one year old. This routine distribution of LLIMNs for pregnant women and infants less than one year old will apply in the 139 targeted health zones of the malaria program in the Global Fund Round 9 proposal.

Table 4: Program Needs Analysis in LLIMNs for pregnant women in the 139 targeted health zones

N°	Item	2007	2008	2009	2010	2011	2012	2013	2014
1	Total population	18,814,833	19,379,278	19,960,656	20,559,476	21,176,260	21,811,548	22,465,894	23,139,871
2	Expected proportion of pregnant women in the community	4%	4%	4%	4%	4%	4%	4%	4%
3	Expected number of pregnant women in the community	752,593	775,171	798,426	822,379	847,050	872,462	898,636	925,595
4	Utilization rate (Attendance rates of PNVs)	80.82%	83%	85%	85%	87%	90%	92%	95%
5	Expected number of pregnant women at PNVs	608246	643392	678662	699 022	736 934	785 216	826 745	879 315
6	% Pregnant women attending PNVs who receive a LLIMN	6%	4%	4%	70%	100%	100%	100%	100%
7	Number of pregnant women receiving a LLIMN	35,794	27,122	27,122	489,316	736,934	785,216	826,745	879,315
8	% Pregnant women covered by the offer of a LLIMN during the PNV	5%	4%	3%	60%	87%	90%	92%	95%

ROUND 9 – Malaria

Line 1: Total population in the 139 targeted health zones

Line 2: Expected proportion of pregnant women in the community of the 139 targeted health zones. This proportion is calculated from the national mean derived from the MICS 2 survey.

Line 3: Expected number of pregnant women in the 139 HZs (4% of the population in line 2).

Line 4: The utilization rate of prenatal care services was 85% in the DRC according to the Population and Health survey (EDS) carried out in 2007, page 106. To increase this rate to 95% in 5 years, the NMCP will work in partnership with the National Reproductive Health Programme on the basis of a joint plan drawn up in 2007 (annex 8). The application of this plan began with the second phase of round 3.

Line 5: Number of pregnant women expected at PNVs (New cases). These figures are obtained by multiplying the number of expected pregnant women in the community (line 3) by the PNV attendance rate (line 4).

Line 6: The coverage of the offer of LLIMNs to pregnant women attending PNVs in the 139 HZS was 6% in 2007, i.e. a total of 35,794 LLIMNs distributed (taken from the NMCP 2007 annual report, annex AP7), 4% in 2008, or a total of 27,122 LLIMNs distributed (taken from the NMCP 2008 annual report, annex AP16). This level of distribution for 2008 is projected for 2009 because of the lack of short and medium-term funding for malaria control in the 139 targeted health zones. With the Global Fund Round 9 Proposal, this coverage will pass from 70% in the first year to 100% for the rest of the project. In short, each pregnant woman attending the PNV will be given a LLIMN.

Line 7: Number of pregnant women given an LLIMN.

Line 8: The percentage of pregnant woman offered a LLIMN during a PNV is obtained by dividing the number of pregnant women receiving a LLIMN (line 7) by the number of pregnant women expected in the community multiplied by 100. Line 8 shows the current level of performance and that expected by the Global Fund Round 9 Proposal in the 139 targeted health zones.

Table 5: Program Needs Analysis in LLIMNs for infants under one year of age in the 139 targeted health zones

N°	Item	2 007	2 008	2 009	2 010	2 011	2 012	2 013	2 014
1	Total population	18,814,833	19 379,278	19,960,656	20,559,476	21,176,260	21,811,548	22,465,894	23,139,871
2	Proportion of infants under one year of age expected in the community	3.49%	3.49%	3.49%	3.49%	3.49%	3.49%	3.49%	3.49%
3	Number of infants under one year of age expected in the community	656,638	656,638	696,627	717,526	739,051	761,223	784,060	807,581
4	Rate of utilisation (attendance) of VAR immunization services	54.9%	54.9%	54.9%	72%	80%	85%	90%	95%
5	Number of infants under one year of age expected at VAR immunization services	360,494	472,779	382,448	516,619	591,241	647,040	705,654	767,202
6	% of infants under one year of age attending VAR immunization services and receiving a LLIMN	6%	5%	5%	70%	100%	100%	100%	100%
7	Number of infants under one year of age receiving a LLIMN	22,925	22,851	22,851	361,633	591,241	647,040	705,654	767,202
8	% of infants under one year of age covered by the offer of a LLIMN during VAR immunization services	3%	3%	3%	50%	80%	85%	90%	95%

Line 1: Total population in the 139 targeted health zones.

Line 2: Proportion of infants under one year of age expected in the community of the139 targeted health zones. This proportion is calculated from the national mean derived from the MICS 2 survey.

Line 3: Expected number of infants less than one year old in the 139 HZs (3.49% of the population in line 2).

Line 4: The utilization rate of Varicella (VAR) immunization services was 54.9% in the DRC according to the Population and Health survey (EDS) carried out in 2007, page 124. To increase this rate to 95% in 5 years, the NMCP is working in partnership with the Expanded Program on Immunization (EPI) within the framework of the mass campaigns that are integrated both in the action plan development plan and the implementation plan since 2006 (annexes AQ 7). This strategy will extend to the field of routine interventions. The budget concerning the development of the integrated annual action plans (NMCP, EPI and PRONANUT) is taken into account in the approved Round 8 proposal. It has also been shown that the integration of the distribution of LLIMNs

improves the use of PNV and PSV services justifying the proposed assumptions for the improvement in the utilization rate (attendance) of immunization services. Nevertheless, other actions will be necessary in order to obtain and improve this service utilization rate and in particular communication for a change in behaviour.

Line 5: Number of infants under one year of age expected at VAR immunization services (new cases). These figures are obtained by multiplying the number of infants under one year old expected in the community (line 3) by the VAR immunization services attendance rate (line 4).

Line 6: The coverage of the offer of LLIMNs to infants under one year of age attending immunization services in the 139 HZs was 6% in 2007, i.e. a total of 22,925 LLIMNs distributed (taken from the NMCP 2007 annual report, annex AQ4), 5% in 2008, or a total of 22,851 LLIMNs distributed (taken from the 2008 NMCP annual report, annex AQ5). This level of distribution for 2008 is projected for 2009 because of the lack of short and medium-term funding for malaria control in the 139 targeted health zones. With the Global Fund Round 9 Proposal this coverage will pass from 70% in the first year to 100% for the rest of the project. In short, each child of less than one year in age attending the immunization services will receive a LLIMN.

Line 7: Number of infants less than one year of age given a LLIMN

Line **8**: % of infants under one year of age covered by the offer of a LLIMN at the immunization visit obtained by dividing the number of infants under one year of age receiving a LLIMN during the immunization visit (line 7) by the number of infants less than one year old expected in the community multiplied by 100. Line 8 shows the current level of performance in the 139 HZs and that expected by the Global Fund Round 9 Proposal.

Table 6: Pregnant women and infants under one year of age annually receiving LLIMNs from the health services (PNV and PSV) in the 139 targeted health zones

Item	2007	2008	2009	2010	2011	2012	2013	2014
Number of pregnant women receiving a LLIMN	35,794	27,122	27,122	489,316	736,934	785,216	826,745	879,315
Number of infants under one year of age receiving a LLIMN	22,925	22,851	22,851	36,1633	59,1241	647,040	705,654	767,202
Total number of infants under one year of age and pregnant women receiving a LLIMN in the 139 HZs	**58,719**	**49,973**	**49 973**	**850,949**	**1,328,175**	**1,432,256**	**1,532,399**	**1,646,517**

ROUND 9 – Malaria

Priority No:1	**Achieve at least 80% of pregnant women and infants under one year of age sleeping under LLIMNs in the 139 HZs**	**Historical**		**Current**		**Country targets**			
Indicator name	• % of pregnant women sleeping with an insecticidal mosquito net • % of children aged under 5 sleeping with an insecticidal mosquito net	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		**58,719**	**49,973**	**49,973**	**850,949**	**1,328,175**	**1,432,256**	**1,532,399**	**1,646,517**
B: Extent of need already planned to be met under other programs		**58,719**	**49,973**	**49,973**	0	0	0	0	0
C: Expected annual gap in achieving plans					**850 949**	**1,328 175**	**1,432 256**	**1,532 399**	**1,646 517**
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**850 949**	**1,328 175**	**1 432 256**	**1,532 399**	**1,646 517**

In the Round 9 proposal, a contribution of 100% if requested from the Global Fund for the 139 targeted health zones in order to address the needs in LLIMNs for pregnant women and infants under one year in age. A few scattered and poorly organized actions have already been carried out by certain partners but with limited and insufficient objectives that were far from addressing the needs of the population. This remark is also valid for the other areas of action in the fight against malaria.

Priority n°2: at least 80% of pregnant women receiving Intermittent Preventive Treatment in accordance with the national guidelines in the 139 targeted health zones.

Table 7: Pregnant women receiving intermittent preventive treatment in the 139 Targeted HZs

N°	Item	2007	2008	2009	2010	2011	2012	2013	2014
1	Total population	18,814,833	19,379,278	19,960,656	20.559.476	21.176.260	21.811.548	22.465.894	23.139.871
2	Expected proportion of pregnant women in the community	4%	4%	4%	4%	4%	4%	4%	4%
3	Expected number of pregnant women in the community	752,593	775,171	798,426	822,379	847,050	872,462	898,636	925,595
4	Utilization rate (Attendance) of PNVs	81%	83%	85%	85%	87%	90%	92%	95%
5	Expected number of pregnant women attending PNVs	608,246	643,392	678,662	699,022	736,934	785,216	826,745	879,315
6	% pregnant women using PNV services and receiving intermittent preventive treatment	17%	14%	13%	70%	100%	100%	100%	100%
7	Number of pregnant women receiving intermittent preventive treatment	102 185	89 757	89 757	489 316	736 934	785 216	826 745	879 315
8	% Pregnant women covered by the offer of intermittent preventive treatment services during the PNV	14%	12%	11%	60%	87%	90%	92%	95%

Line 1: Total population in the 139 targeted health zones

Line 2: Proportion of pregnant women expected in the community in the 139 targeted health zones. This proportion is calculated from the national mean derived from the survey MICS 2

Line 3: Number of pregnant women expected in the 139 targeted HZs (4% of the population in line 2).

Line 4: The utilization rate of prenatal care services was 85% in the DRC according to the Population and Health survey (EDS) carried out in 2007, page 106. To increase this rate to 95% in 5 years, the NMCP will work in partnership with the National Reproductive Health Programme on the basis of a joint plan drawn up in 2007 (annex AQ 20). The application of this plan began with the second phase of Round 3.

Line 5: Number of pregnant women expected at PNVs (New cases). These figures are obtained by multiplying the number of pregnant women expected in the community (line 3) by the PNV attendance rate (line 4).

Line 6: Coverage cover of the offer of intermittent preventive treatment to pregnant women attending PNVs in the 139 HZS was 17% in 2007, i.e. 102,185 pregnant women who received IPT (extracted from the NMCP 2007 annual report, annex AQ 4), 14% in 2008, 89,757 pregnant women receiving IPT (extracted from the NMCP 2008 annual report, annex AQ 5) and a projection of 13% is made for 2009. With the Global Fund Round 9 Proposal this coverage will pass from 70% in the first year to 100% for the rest of the project. In short, each pregnant woman attending prenatal care services will receive intermittent preventive treatment.

Line 7: Number of pregnant women receiving intermittent preventive treatment

Line 8: The percentage of pregnant woman offered intermittent preventive treatment during a PNV is obtained by dividing the number of pregnant women receiving intermittent preventive treatment (line 7) by the number of pregnant women expected in the community multiplied by100. Line 8 shows the current level in the 139 HZs and that expected by the Global Fund Round 9 Proposal.

Priority n°: 2	**Achieve a rate of at least 80% of pregnant women receiving Intermittent Preventive Treatment according to national guidelines in the 139 HZs**	**Historical**		**Current**		**Country targets**			
Indicators	% of pregnant women receiving intermittent preventive treatment in accordance with national guidelines	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: A: Country target *(from annual plans where these exist)*		102,185	89,757	89,757	489,316	736,934	785,216	826,745	879,315
B: Extent of need already planned to be met under other programs		102,185	89,757	89,757	0	0	0	0	0
C: Expected annual gap in achieving plans					489,316	736,934	785,216	826,745	879,315
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			489,316	736,934	785,216	826,745	879,315

In the Round 9 proposal, the contribution requested from the Global Fund for the 139 targeted health zones is 100% to address the needs for intermittent preventive treatment of pregnant women.

Priority n°3: Achieve a treatment rate of at least 80% in accordance with national guidelines in the 139 targeted health zones

Table 8: Breakdown of the population in the 139 HZ by age and by sex from 2008 to 2014

		2008	2009	2010	2011	2012	2013	2014
Age group	**% of the population**	**19,379,278**	**19,960,656**	**20,559,476**	**21,176,260**	**21,811,548**	**22,465,895**	**23,139,871**
Women > 54	2,60%	503,861	518,977	534.546	550.583	567.100	584.113	601.637
Women 15-54	24,30%	4.709.165	4.850.439	4.995.953	5.145.831	5.300.206	5.459.212	5.622.989
Men > 54	2.50%	484,482	499,016	513,987	529,407	545,289	561,647	578,497
Men 15-54	22.50%	4,360,338	4,491,148	4,625,882	4,764,659	4,907,598	5,054,826	5,206,471
Girls 5-14	14.60%	2,829,375	2,914,256	3,001,683	3,091,734	3,184,486	3,280,021	3,378,421
Boys 5-14	14.50%	2,809,995	2,894,295	2,981,124	3,070,558	3,162,674	3,257,555	3,355,281
Girls 0-4	9.40%	1,821,652	1,876,302	1,932,591	1,990,568	2,050,286	2,111,794	2,175,148
Boys 0-4	9.50%	1,841,031	1,896,262	1,953,150	2,011,745	2,072,097	2,134,260	2,198,288

The percentage of the population in each age group and sex were estimated from data obtained by the UNICEF National Survey of the situation of children and women MICS2/2001, page 47 (AP1). A growth rate of 3% is applied to obtain the populations of successive years.

Table 9: Expected number of episodes of fever per age group and sex from 2008 to 2014 in the 139 targeted HZs

N°	Item	Number of Cases	Number of cases						
		Mean	2008	2009	2010	2011	2012	2013	2014
1	Women > 54	1	503,861	518,977	534,546	550,583	567,100	584,113	601,637
2	Women 15-24	1	4,709,165	4,850,439	4,995,953	5,145,831	5,300,206	5,459,212	5,622,989
3	Men > 54	1	484,482	499,016	513,987	529,407	545,289	561,647	578,497
4	Men 15-24	1	4,360,338	4,491,148	4,625,882	4,764,659	4,907,598	5,054,826	5,206,471
5	Girls 5-14	2	5 658 749	5 828 512	6 003 367	6 183 468	6 368 972	6 560 041	6 756 842
6	Boys 5-14	2	5,619,991	5,788,590	5,962,248	6,141,115	6,325,349	6,515,109	6,710,563
7	Girls 0-4	4	7,286,609	7,505,207	7,730,363	7,962,274	8,201,142	8,447,176	8,700,592
8	Boys 0-4	4	7,364,126	7,585,049	7,812,601	8,046,979	8,288,388	8,537,040	8,793,151
9	**Total**		**35,987,319**	**37,066,939**	**38,178,947**	**39,324,315**	**40,504,045**	**41,719,166**	**42,970,741**
10	Number of cases of suspected malarial fever expected in children aged under 5 years		14,650,734	15,090,256	15,542,964	16,009,253	16,489,530	16,984,216	17,493,743
11	Number of cases of suspected malarial fever expected in persons aged 5 years or more		21,336,585	21,976,683	22,635,983	23,315,063	24,014,514	24,734,950	25,476,998
12	Number of cases of suspected malarial fever expected in children aged under 5 years and treatable as cases of malaria		14,650,734	15,090,256	15,542,964	16,009,253	16,489,530	16,984,216	17,493,743
13	Number of cases of suspected malarial fever expected in persons aged 5 years or more and treatable as cases of malaria (cases with positive RDTs)		8,534,634	8,790,673	9,054,393	9,326,025	9,605,806	9,893,980	10,190,799

N°	Item		2008	2009	2010	2011	2012	2013	2014
14	Number of cases of uncomplicated malaria to be managed		23 185 368	23 880 929	24 597 357	25 335 278	26 095 336	26 878 196	27 684 542
15	Coefficient of reduction of the incidence of malaria in DRC		0%	0%	0%	0%	25%	50%	50%
16	Reduction in the number of cases of malaria		0	0	0	0	6 523 834	13 439 098	13 842 271
17	Number of cases of uncomplicated malaria to be treated after application of the reduction coefficient		23,185,368	23,880,929	24,597,357	25,335,278	19,571,502	13,439,098	13,842,271
18	**Utilization rate of correct malaria management services**		**0,5%**	**0,5%**	**60%**	**75%**	**90%**	**95%**	95%
19	**Number of correctly treated cases of uncomplicated malaria (line A)**		**123,217**	**123,217**	**14,758,414**	**19,001,458**	**17,614,352**	**12,767,143**	**13,150,158**
20	**Number of serious cases of malaria (1% of the cases of uncomplicated malaria)**		**29 445**	**119 405**	**147 584**	**190 015**	**176 144**	**127 671**	**131 502**
21	Number of persons needing RDT		NA *	NA *	13 581 590	17 486 297	21 613 063	23 498 202	24 203 148
22	Rate of reduction of cases of malaria		NA *	NA *	0%	0%	25%	50%	50%
23	Reduced number of cases		NA *	NA *	0	0	5403265,755	11749101,2	12101574,24
24	Number of persons requiring RDTs with application of the reduction coefficient		NA *	NA *	**13,581,590**	**17,486,297**	**16,209,797**	**11,749,101**	**12,101,574**

(*) NA: Not applicable, as rapid diagnostic tests for malaria have not yet been integrated in the malaria diagnosis algorithm of the DRC,

Lines 1 to 8: Number of cases of fever for one year obtained by multiplying the number of individuals by age group and by sex by the average number of fever episodes per year for this age group. The number of individuals by age group and by sex is given in Table 1.

Line 9: Total number of expected cases of fever for each year. This is obtained by adding lines 1 to 8.

Line 10: Number of cases of fever for all children aged under 5 years. This is obtained by adding the number of cases of fever for girls aged under 5 (line 7) and boys under 5 (line 8).

Line 11: Number of cases of suspected malarial fever for all persons aged 5 years or more This is obtained by subtracting the number of cases of fever in children aged under 5 years (line 10) from the total number of cases of fever for the total population (line 9).

Line 12: Number of cases of suspected malarial fever expected in children aged under 5 years and treatable as cases of malaria. This is the same as the number of all cases of suspected malarial fever, as the diagnosis is clinical in children aged under 5 years and laboratory diagnosis is not performed before institution of treatment.

Line 13: Number of cases of suspected malarial fever expected in persons aged 5 years or more and treatable as cases of malaria (positive cases by RDT). 40% of cases were assumed to be positive for the proposal. This number was obtained by multiplying the number of cases of suspected malarial fever expected in the persons aged 5 years or more (line 11) by 40%. The utilisation of RDT and positive RDT rates will be very carefully monitored according to WHO guidelines.

Line 14: Number of cases of uncomplicated malaria to be managed. This is obtained by adding 100% of cases of suspected malarial fever (clinical diagnosis) in children aged under 5 years (line 12) and the number of positive cases obtained using RDTs (line 13).

Line 15: Malaria case reduction rate. There should be a reduction in the number of cases of malaria as a result of the organization of mass LLIMN distribution campaigns throughout the whole country and the improvement in universal access to malaria control interventions in the 139 HZ thanks to the Global Fund Round 9 proposal. Hypotheses of a reduction of from 0 to 50% are used for this proposal in accordance with the NMCP strategic plan for the 2009-2014 period on the basis of evidence from Rwanda and Ethiopia described in the Global Malaria Business Plan.

Line 16: This line reproduces the reduction in the number of the cases of malaria after applying the reduction rate in the number of cases of malaria.

Line 17: Number of cases of uncomplicated malaria to be managed after application of the reduction coefficient. This is obtained by subtracting the reduction in the number of cases (line 16) from the number of cases of uncomplicated malaria to be managed (line 17)

Line 18: The ACT utilization rate by malaria management services was 0.5% in 2008 when 123,217 patients with uncomplicated malaria received treatment with artesunate amodiaquine in accordance with national guidelines (Extracted from the NMCP 2008 annual report, annex AQ 5) and the projection of 0.5% is maintained for 2009. With the Global Fund Round 9 Proposal this cover will pass from 60% in the first year to 95% at the end of the project. It should be underlined that a ministerial decision has just banned the marketing of anti-malarial monotherapies.

Line 19: Number of cases of uncomplicated malaria correctly managed in children aged under 5 years. This is obtained by multiplying the correct management rate (line 18) by the number of expected cases of uncomplicated malaria (line 17).

Line 20: Number of cases of serious malaria (1% of cases of uncomplicated malaria progress to the severe form).

Line 21: Number of persons requiring RDTs. This is the number of cases of suspected malarial fever for all persons aged 5 years or more (line 11) multiplied by the rate of correct use of malaria case management services (line 18)

Line 22: Malaria case reduction rate. A reduction in the number of cases of malaria is expected to occur after the organization of mass LLIMN distribution campaigns throughout the whole country and the improvement in universal access in the 139 HZs thanks to the Global Fund Round 9 proposal. This reduction was assumed to be from 0 to 50% for this proposal in accordance with the NMCP strategic plan for 2009-2014.

Line 23: This line reproduces the reduced number of persons requiring RDTs after applying the reduction rate in the number of cases of malaria.

Line 24: Number of persons requiring RDTs after application of the reduction coefficient to the number of malaria cases. This is obtained by subtracting the reduction in the number of persons requiring RDTs from the total number of persons requiring RDTs (line 23)

Priority n°: 3	**Achieve at least 80% case management in conformity with national guidelines in the 139 health zones**	**Historical**		**Current**		**Country targets**			
Indicators	% of children with malaria aged under 5 years who are correctly treated	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*			**2,944,542**	**11,940,465**	**14,758,414**	**19,001,458**	**17,614,352**	**12,767,143**	**13,150,158**
B: Extent of need already planned to be met under other programs					0	0	0	0	0
C: Expected annual gap in achieving plans					**14,758,414**	**19,001,458**	**17,614,352**	**12,767,143**	**13,150,158**
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			**14,758,414**	**19,001,458**	**17,614,352**	**12,767,143**	**13,150,158**

In the Round 9 proposal, the contribution requested from the Global Fund for the 139 targeted health zones is 100% to address the needs for diagnosis and treatment of patients with malaria.
It is also expected that the impact of the distribution of LLIMNs during routine visits (PNV - PSV) and especially the mass campaigns, will lead to a substantial reduction in the requirements for ACTs and RDTs. The ACT utilisation rates and positive RDT rates will be very closely monitored throughout the implementation of the application.

➔ *If there are six priority areas, copy the table above once more*

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4.5. Implementation Strategy

4.5.1. *Round 9 Interventions*

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

Where there are planned that benefit the health system that can easily be included in the Malaria Program description (for their major contribution to malaria outcomes), include them in this section only of the Round 9 proposal.

***Note**: In case of other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes, beyond these three diseases), but not easily included in a "disease program strategy, you can include them in the section 4B **in one disease proposal in Round 9.** The applicant will have to decide which disease to include in the section 4B (only once). ➔ Refer to the Round 9 Guidelines (4.5.1.) for information on this choice.*

4.5.1. *Round 9 Interventions*

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

Where there are planned activities that benefit the health system that can easily be included in the Malaria Program description (for their major contribution to malaria outcomes), include them in this section only of the Round 9 proposal.

***Note**: In case of other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes, beyond these three diseases), but not easily included in a "disease program strategy, you can include them in the section 4B **in one disease proposal in Round 9.** The applicant will have to decide which disease to include in the section 4B (only once). ➔ Refer to the Round 9 Guidelines (4.5.1.) for information on this choice.*

The aim of this proposal is to reduce by half malaria morbidity and mortality rate in the Democratic Republic of Congo (DRC) by 2014.

Provision of these Service delivery areas (SDAs) and targeted priorities are expected to reach this objective.

Strategic Direction 1 : To reach at least 80% children under 1 year of age and pregnant women sleeping under 'Long-lasting insecticide-treated mosquito nets' (LLIMNs) in the 139 health zones.

SDA: Insecticide-Treated Mosquito Nets and Malaria Prevention during pregnancy

SDA 'Long-lasting Insecticide-treated Mosquito Nets' (LLIMNs) is aimed at children under 1 year of age, in pre-school visits (PSV) while SDA ' Malaria Prevention during Pregnancy' targets at pregnant women in prenatal visits (PNV), through LLIMNs free distribution in health facilities of the 139 health zones (HZ). This distribution will ensure that the most vulnerable groups, who are pregnant women and children under 1 year of age get and use (LLIMNs).

This routine distribution will also maintain the coverage rate reached through mass campaigns, and which is already beneficial to 139 health zones.

Activity 1.1: Ensuring LLIMNs distribution during prenatal and pre-school visits in Procurement and Inventory management services

Routine distribution of LLIMNs to children under 1 year of age and pregnant women will be free during prenatal (PNV) and pre-school (PSV) visits in the health facilities of the 139 health zones (HZ).

1.1.1. LLIMNs Procurement and Inventory Management:

- Ensuring supply of 6,790,295 (LLIMNs) to children under 1 year of age and pregnant women, according to established plan of actions, and national and international standards and guidelines of services transfer. Ensure that LLIMN quality control is in conformity with national and international standards and guidelines.
- Ensuring LLIMNs routing and distribution, knowing that border access points can be used, particularly Matadi, Kasumbalesa, Goma, Kalemie, Uvira, Aru, etc, according to the health zones to be covered in order to reduce transportation costs.

1.1.2. Micro-planning

Making an inventory of the resources available in HZ, including LLIMNs storage sites

1.1.3 LLIMNs routine distribution implementation

- Submitting bid to transporters, according to current contracting procedures
- Conveying LLIMNs from central and border storage sites to health zones (HZ) via Regional Distribution Centres (RDC).
- Ensuring LLIMNs storage in health zones (HZ)
- Ensuring LLIMNS transport from health zone Central office (COHZ) to health care facilities
- Making copies for distribution of prenatal (PN) and pre-school (PS) cards
- Making copies for distribution of reports and follow-up registers for pregnant woman and children under 1 year of age: 1 register per month by health care facility
- Distributing LLIMNs to children under 1 year of age completing their vaccine calendar and to pregnant women in pre-school (PSV) and prenatal (PNVfor visits.

Activity 1.2. Training

This peripheral activity is included in the Health System Support (HSS) component

- Providing 3-day training for Community Relays in the framework of integrated management of childhood diseases (IMCD), according to national guidelines. This training will help all Community Relays develop skills to fulfil integrated promotional strategies, including those for malaria control in the Community.

Activity 1.3 Social Mobilization

- Making copies for distribution of posters, counselling cards and pictures
- Broadcasting (radio and TV) spots
- Broadcasting songs to promote health information and education in the community, on the proper use of LLIMNs according to national guidelines.
- Organizing sensitization programs on Malaria control, using radio and television channels,
- Ensuring documentary broadcasting on Malaria prevention and control which was produced in Round 8 Funding.
- Organizing interpersonal communication meetings through home visits
- Organizing interpersonal communication meetings by health care workers, during prenatal (PNV) and pre-school (PSV) visits

Activity 1.4. Monitoring and Assessment

Integrated monitoring and assessment activities will apply to all proposal objectives

- Organizing integrated mass supervision for all malaria control interventions (LLIMNs, IPT, case management, Behavioural change communication (BCC)). Supervision missions from central to regional level, and from regional to health zones will be held four times a year, while those from health Community zones (CZ) to health care facilities once a month. Community Relays supervision by ITs will take place once a month and are taken in account outside HSS framework.
- Ensuring issue of quarterly and annual national reviews, with annual national review, in each province. National and regional reviews account for in the proposal approved in Round 8, while those of the 139 health zones are taken in account in HSS component.
- Ensuring issue and distribution of 111.200 Registers and 3,072,770 prenatal (PN) forms.
- Making copies for distribution of 111.200 Registers and 3,072,770 pre-school (PS) forms.

Both Community data-gathering tools, and health facilities supervision guides and data-gathering tools will reinforce health information transmission between peripheral, intermediate and central levels, according to the National Health Information System (NHIS) reinforcement programme.

- Conducting surveys in phase of pre-intervention, halfway through first phase and post-intervention (up to second phase), to determine baseline indicators and development to fight malaria, particularly LLIMNs coverage and use.

LLIMN Remanence Action Specificity

- Performing insecticide remanence monitoring for LLIMNs

Activity 1.5 Operational Research

- Conducting studies on gaps and inadequacies between getting and using LLIMNs, in the Democratic Republic of Congo (DRC) homes, for improved bed nets use. As shown in the different CAPE studies performed in the DRC to determine baseline indicators to fight malaria, the variation is about 10% between getting and using LLIMNs. This study will help identify the reasons for LLIMNs non-use by bed nets owners, and also target sensitization messages for improved use coverage.

Procurement and inventory management, training, supervision, and monitoring and evaluation are primary responsibility of the Governmental Principal Recipient (PR), while distribution of pharmaceutical and health products and social mobilization will be under the responsibility of the Principal Recipient (PR) of the civil society.

Strategic Direction 2: To reach at least 80% of pregnant women that will benefit from Intermittent Preventive Treatment (IPT), according to national guidelines in the 139 health zones

SDA: Malaria Prevention during pregnancy using IPT

This SDA targets at pregnant women in prenatal visits (PNV), providing them with free Sulfadoxine Pyrimethamine (SP) treatment in health/maternity care facilities of the 139 intervention health zones.

Activity 2.1: SP Procurement and Inventory Management

Routine distribution of free Intermittent Preventive Treatment (IPT) will be implemented during prenatal visits (PNV) in the health facilities of the 139 health zones (HZ).

2.1.1. Ensuring supply of 23.420 packs of SP 1,000 tablets, according to an established plan of action, according to standards and national and international guidelines for services transfer.

- Ensuring SP therapy quality control, according to standards and national guidelines.
- Ensuring SP routing and distribution, knowing that border access points can be used. particularly in Matadi, Kasumbalesa, Goma, Kalemie, Uvira, Aru, etc, according to the health zones to be covered, in order to reduce transportation cost.

2.2. Micro-planning

- Making an inventory of the resources available in health zones (HZ), particularly in storage sites for anti-malarial drugs, including SP, adjuvants, medical consumables and Rapid Diagnostic Tests (RDTs).

2.3 SP routine distribution implementation

- Submitting bid to truckers drivers according to current service transfer procedures.
- Conveying SP treatments from central and border storage sites to health zones (HZ) via Regional Distribution Centres (RDC).
- Ensuring SP storage in health zones (HZ)
- Ensuring SP transport from Health Zone Central Offices (HZCO) to health care facilities
- Making copies for distribution of inventory management tools
- Providing free SP to pregnant women during prenatal visits (PNV)

Activity 2.4. Training

Training on intermittent Preventive treatment (IPT) aligns with scope of Minimum Package of Activities

(MPA) Program, to fight malaria as described in section 1.2., for health zones leaders. However, this training will remain specifically designed for prenatal health care providers of National Reproductive Health Program, through refocused prenatal services.

Providing 5-day training for prenatal health care providers in the refocused prenatal facility (PN), including 25 people by health zone (HZ), (5 in General reference hospitals (GRH) and 20 in health care facilities).

Making copies for distribution of 3892 training guides.

Activity 2.5 Social Mobilization

- Broadcasting radio and TV spots in the refocused prenatal visits, including Intermittent Preventive treatment (IPT) in the 139 intervention health zones.
- Organizing interpersonal communication meetings by prenatal health care providers during prenatal visits in health care facilities.

Activity 2.6. Monitoring - Evaluation

2.6.1. Monitoring – Evaluation
Intermittent preventive treatment and other actions to fight malaria will be supervised together in the health zone, according to supervision visits guidelines, as described in Strategic Direction 1. Similar approach to periodical reviews at national and regional levels, will apply to National Health Information System Reinforcement (NHIS) and key indicators surveys in the 139 intervention health zones

Activity 2.7 Operational research

- Ensuring SP efficacy monitoring in Intermittent Preventive Treatment (IPT) among pregnant women. The study will be conducted by the country research institutions, among pregnant women who attend prenatal visits (PNV) and receive two doses of Sulfaxine Pyrimethamine (SP). SP was in fact used as a first-line treatment for simple malaria from 2002 to 2004 in the DRC. The significant failure rates reported during this drug efficacy monitoring led to its replacement with AQ-AS combination therapy. However, SP was maintained for malaria chemo-prophylaxis in pregnant women. As most clinicians then became sceptical about SP efficacy in pregnant women, the need now to monitor SP efficacy as Intermittent Preventive Treatment, is critical component for recommendations towards effective therapies.

Procurement and Inventory management, training, supervisions and monitoring and evaluation systems are primary responsibility of the Governmental Principal Recipient (PR), while distribution of pharmaceutical and health products, and social mobilization will be under the responsibility of the Principal Recipient (PR) of the civil society.

Strategic Direction 3: To reach at least 80 % of Medical Care services according to national guidelines, in the 139 health zones

SDA 3.1 : Diagnostic

The aim is to confirm through blood tests, the maximum malaria cases that will be diagnosed in all the health care Centres of the 139 intervention health zones, according to national guidelines.

In this proposal, blood test will be performed using Rapid Diagnostic Tests (RDT) and microscopy in the 139 HZ, according to current guidelines.

Activity 3.1.1. Procurement and Inventory management of RDTs, reagents for microscopy and medical consumables
RDTs will be free for all the patients who attend care Centres.

3.1.1.1 Procurement and inventory Management of RDTs, reagents for microscopy and medical consumables:

- Ensuring supply of 2.987.391 RDTs kits according to established programme of action and standards and national and international guidelines of services transfer.

- Ensuring supply of 2085 kits of **reagents for microscopy and medical consumables**
- Ensure RDT quality control, in conformity with ISO131485:2003 certification, as recommended by the World Health Organization (WHO). At peripheral level, each batch will undergo monitoring and quality control of the National Laboratory of Public Health (NLPH).
- Ensuring RDTs routing and distribution, knowing that border access points can be used, particularly in Matadi, Kasumbalesa, Goma, Kalemie, Uvira, Aru, etc, according to the health zones to be covered.

3.1.2 Micro-planning

- Making an inventory of the resources available in the health zones (HZ), including RDTs storage sites

3.1.3 Biological diagnostic Implementation

- Submitting bid to transporters in accordance with current contracting procedures.
- Conveying RDTs, laboratory consumables and reagents from central and border storage sites to health zones (HZ) via Regional Distribution Centres.
- Ensuring RDTs, laboratories consumables and reagents storage in HZ
- Ensuring transport of anti-malarial drugs, adjuvants and medical consumables from health Zone Central Offices to health training facilities.
- Performing free RDTs.

3.1.1.4 Ensuring RDT quality control in accordance with WHO guidelines

Activity 3.1.4. Training

Training on microscopy and RDT for microscopists from public and private sectors will be geared towards minimizing presumptive diagnosis, and provide trained staff with improved approach to results interpretation, particularly when tests are negative.

- Making copies of *the microscopists and Lab technicians* training guide for distribution
- Providing training for 834 Lab technicians of the reference facilities, with 2 people for General Reference Hospitals (GRH) and 4 for the 2 Reference Health Care Centres.
- Providing training to RDT use for 3475 health care providers, including 5 people for General Reference Hospital (GRH) and 20 for Health care Centres (CS).

Activity 3.1.6. Monitoring - Evaluation

Both health care and other interventions to fight malaria will be supervised together in the health zone, according to supervision visits, as described in Strategic Direction 1. Similar approach to periodical reviews at national and regional levels, will apply to National program of Health Information Systems Reinforcement (NHIS) and key indicators surveys in the 139 intervention health zones.

SDA 2 : Rapid and Effective Anti-malarial Treatment

Anti-malarial drugs will be free in health education facilities of the 139 HZ.

3.2. Rapid and Effective Anti-malarial Treatment

3.2.1. Procurement and Inventory Management of anti-malarial drugs, adjuvants and medical consumables

3.2.1.1: Ensuring supply of the recommended anti-malarial drugs, according to established programme of action and standards and national and international guidelines for services transfer.

For simple malaria cases to be treated in health care facilities:

- ACT combination therapy
- Paracetamol tablets 500 mg

For severe malaria cases to be treated in reference facilities:

- Quinine tablets 250 mg
- Quinine tablets 500 mg

- Injectable quinine 600 mg
- Glucosed Serum 5%, Baxter 250 ml
- Glucosed Serum 5%, Baxter 500 ml
- Infusion set for adults
- Infusion set for children
- Hypertonic Glucose 50% (Dextrose 50%)
- Injectable Diazepam 10 mg
- Paracetamol tablets 500 mg

- Ensuring quality control of anti-malarial drugs, adjuvants and medical consumables.

3.2.2. Micro-planning

- Making an inventory of resources available in health zones (HZ) described in Strategic Direction 1 (See Activity 1.1.2).

3.2.3 Implementing malaria case management with anti-malarial drugs, adjuvants and medical consumables.

- Submitting bid to truckers drivers, in accordance with current procedures of services transfer.
- Conveying anti-malarial drugs, adjuvants and medical consumables from central and border storage sites to health zones (HZ) via Regional Distribution Centres.
- Ensuring storage of anti-malarial drugs, adjuvants and medical consumables in HZ
- Ensuring transport of anti-malarial drugs, adjuvants and medical consumables from health zone Central office to health training facilities.
- Supplying Inventory management tools.
- Making copies for distribution of 3475b training guides for health care providers of Reference health care facilities
- Making copies for distribution of 3475 training modules in refocused prenatal (PNV) facilities
- Making copies for distribution of 11,815 Forms for health care providers of Reference health care facilities
- Administration of free anti-malarial drugs, adjuvants and medical consumables to patients.

Activity 3.2.4. Training

Training on malaria control will include prevention (LLIMNs, IPT and PID), case management (diagnostic and treatment), health education, procurement and inventory management, and monitoring/assessment.

- Providing 5-day training for 5 health workers of the Community Zone Team (CZT) in the 139 health zones, including the MCZ, MDH, DN, AC, IS. by regional trainers. This training will include prevention (LLIMNs, IPT and PID), case management (diagnostic and treatment), and place emphasis on health education, Inventory management and monitoring/assessment.
- Providing 5-day training for health care workers of Reference health Care Centres by Community Zone Team (CZT) of the health zones, including 20 health workers for 10 General Reference Hospitals (GRH) and 10 for 2 reference Health Care Centres (HCC).
- Providing 5-day training for health care centre ITs by the Community Zone Team (CZT) in the health zone, with 20 health woorkers by health zone.

Activity 3.2.5. Social mobilization

- Broadcasting radio and TV spots on proper malaria case management, according to national guidelines.

Activity 3.2.6 Monitoring-Evaluation

Both health care and other interventions to fight malaria will be supervised together in the health zone, according to supervision visits, as described in Strategic Direction 1. Similar approach to periodical reviews at national and regional levels, will apply for reinforcing National Health Information Systems (NHIS) and key indicator surveys in the 139 intervention health zones.

Activity 3.2.7 Operational research

- Monitoring intra-rectal quinine (suppository) efficacy. National policy on malaria control is silent on pre-reference treatment for severe malaria case in health care facility. In the field, clinicians generally administer intra-rectal quinine. Drug efficacy monitoring will provide this Program with recommendations for effective therapies in this matter.

- Measuring RDT impact on malaria control actions (diagnostic improvement, case management, etc.). Given the validity of this test, RDT used in simple malaria diagnostic can easily improve malaria case management and reduce administration of Artemisinin-based combination therapy (ACT). However, this new technology, which is unknown to health care workers in our country, should undergo impact measurement tests for improved diagnostic, case management and attending rate of health services.

SDA 3 : Malaria Home-based Management

3.3 Malaria Home-based Management

Community-based Health Care Sites

The Site is a geographical area of one or clusters of villages or communities, with difficult access to health care facilities and that benefit from health care in the two trained and supervised voluntary Relays. Malaria, diarrhoea, and pneumonia are treated in these relays, with referral of severe cases, while malnutrition can be diagnosed in children under 1 year of age. Well-researched studies in the Democratic Republic of Congo (DRC) show that malaria is the reason for more than 70 % of the consultations by children under 5.

In addition to providing treatments, these Relays promote family key practices, counselling mother on drugs dispensation and stressing the importance of follow-up care from the 3rd day of the treatment.

Health systems reinforcement (HSR) include technical and managerial capacity-building for peripheral staff, for improved management of pharmaceutical and medical equipment storage. Health care facility nurse ensures close supervision of the Site while central Office coordinates IT activities and supports, for better sites management.

COMMUNITY-BASED HEALTH CARE HISTORY

This strategy was achieved through USAID technical support. National partners in support of this programme of action are : BASICS/USAID, UNICEF, WHO, MSH, Public Health School/Kinshasa, IRC, GTZ, CRS, AXxes/USAID, ECC-SANRU-PMURR, CCISD/PARSS, and HNI.

In September 2005, the letter from GS nº MS 1251/MGB/SG/03/1389/MMB/2005 appointed a central Task force to control national implementation. In July 2007 the foreword of the Implementation Sites Guide was signed by Its Excellency, the Minister of Public health.

Task force initial phase took place in 3 health zones: HZ of KENGE in Bandundu in December 2005 (supported by GTZ), Mt NGAFULA health zone, 2 in Kinshasa (supported by UNICEF), and DEMBA health zone in Western Kasaï (supported by IRC) in 2006.

National Review of implementation that decided and gave the trends on scale up implementation, took place from 22 to 27 October 2007, at an inter-country Review and Exchange meeting with the participation of 8 other African Countries, and held under the aegis of Its Excellency, the Minister of Health of the DRC in WHO conference Hall.

1.1 In July 2008, a feasibility study by the Public Health school on ACT combination therapy and rapid

diagnostic test (RDT) management by the Community, was conducted in KIMPESE health zone in Lower Congo during four months. This study was implemented according to community-based site and malaria case management protocols, both in children under 5 years of age and adults. RDT was performed in patients aged 5 and above. This project was carried out in co-operation with BASICS/USAID, and Integrated Management of Childhood Diseases (IMCD) staff. Reports promising results from this study will soon be published.

1.2 From September 2008, publication of a quarterly newspaper or news bulletin is available on the site, « DRC CCM NEWS ».

DEVELOPMENT OF COMMUNITY-BASED HEALTH CARE SITES IN THE DRC

Currently, 662 Sites operate in 78 health zones, shared out between 10 Regions out of the 11 of the DRC. The two tables below show the Sites progression over the year, and sites breakdown in the different Provinces, and the Partners involved.

Coverage progression over the years

	2006	2007	2008	30 April 2009
Provinces Coverage	3	6	9	10
Coverage in HZ	7	30	55	78
SITE Coverage	54	224	522	662
SITE RELAYS	97	421	953	1233

Provinces Sites Breakdown up to April 30, 2009.

N°	Province	Number of HZ	Number of sites installed	Partners
1	BANDUNDU	11	127	GTZ, CCISD/PARSS, BASICS, MSH/SPS
2	LOW CONGO	1	18	PUBLIC HEALTH SCHOOL, GLOBAL FUND, BASICS, UNICEF, NMCP, PNLMD
3	ECUADOR	2	20	UNICEF, BASICS
4	WESTERN KASAÏ	7	71	IRC, HEALTH NET, BASICS, MSH/SPS
5	EASTERN KASAÏ	12	120	CRS, OMS, BASICS, MSH/SPS,AXXES
6	KATANGA	11	55	AXXES
7	KINSHASA	8	72	UNICEF, BASICS, MSH/SPS,IRC
8	MANIEMA	2	24	SANRU, BASICS
9	NORD-KIVU	None	None	None
10	EASTERN PROVINCE	9	36	IRC, OMS, BASICS
11	SOUTH KIVU	15	119	IRC, OMS, BASICS,AXXES
	TOTAL	78	662	

MALARIA CASE OUTCOME FOR CASES TREATED IN COMMUNITY-BASED HEALTH CARE SITES IN THE DRC

Year	Malaria Cases treated in Community Health Care Sites	Malaria cases treated with (ACT) combination therapy in the community, in children aged between 0-5	Total number tested in the Community. (RDT performed)	Total number of positive RDTs
2006	2602	1972		
2007	6032	5055		
2008	4710	3268	1 675	989
			Patients aged between 5 and 13	317 FDT +
			Patients ≥ 13	672 FDT +

Note: RDTs were performed in the experimental health zone (HZ) of KIMPESE (by the Public Health School)
Demographic and health surveys (EDS 2007) carried out throughout the DRC showed an infant juvenile mortality rate of 148% in the country. Our country is classified among the 6 countries in the world which count alone, 50% of the world infant mortality rate, with 80 % of these deaths occurring in the community.

The country has established Community-based health care sites for nearly three years. in the context of Integrated Management of childhood diseases (IMCD) strategy, to reduce this mortality rate and improve Community-based case management for malaria, ARI and diarrhoea in children under 5 years of age.

The specific nature of this approach in the DRC, stresses not only the importance of health care and counselling to mothers with ill children, but also the follow-up care from the 3rd day of the treatment.

Based on the National Health Systems Reinforcement, Community-based sites approach helped optimize technical and managerial expertise of Practitioner Nurses and health zones leaders (HZ).

Activity 3.3.1: Providing 3-day training to case management in health Community Sites, for Community Zone team (CZT) of health zones, including 3 health workers by health zone, with 417 people overall

Activity 3.3.2: Providing 3-day training to Medical care services (MCS) in Community sites, for ITs, including 5 ITs per HZ, 695 ITs overall to be trained

Activity 3.3.3: Providing 5-day Training to Malaria case management in Community sites, for Community Relays, including 2 Relays per site, 1 out of 10 relays per HZ.

Activity 3.3.4: Ensuring supply of training kits for trainers, Community leaders and community health care facilities

Activity 3.3.5: Ensuring supply of training kits for trainers, Community leaders and Community Relays

Procurement and Inventory Management

Supply and distribution activities are described in section 3.5.
However, this specific equipment should be supplied:

- **Management tools and Materials for Community Health Care Sites**

1. RUMER for Sites
2. Forms for health care sites
3. Timer
4. Register
5. Salter Scale + Weight Pants Spring
6. Wooden Box to store pharmaceutical products and inventory control tools

- **RECO Sites Training modules.**

✓ ***Training aids available for the Relay are:***
- Case Management Form
- Relay Handbook
- Case studies exercise handbook
- All the other working tools needed by the Relay in the field (Timer, Registers, Salter Scale, Medicines, Reports frameworks)

✓ ***Facilitator is provided with:***
- A trainer guide
- Case study handbook with ANSWERS

✓ ***Incumbent nurse***
Incumbent nurse is involved in this training program, as the first supervisor to oversee site interventions more closely and is provided with:
- A trainer guide
- Case studies exercise handbook

Activity 3.11. Monitoring and evaluation

This intervention is included in MST component
- Providing post-training monitoring (at least 3, at one-month interval), after the starting of the Sites. Then continuing with monthly routine monitoring of RECO site.

Strategic Direction 4: To reinforce 100% of NMCP national and provincial coordination frameworks

SDA: Partnerships and Coordination Development (in National, Community, Public and Private Frameworks)

National malaria control program (NMCP) reinforcement in technical and managerial expertise, whether institutional or in human resources, is crucial component for achieving strategic, normative and regulatory implementation of initiatives, such as 'Roll Back Malaria' (RBM) and 'SUFI' (Scale up for Impact) of existing anti-malarial interventions. Various specifically designed training programs for the personnel will be needed, in respect of profiles required by NMCP organization chart, based on WHO standard chart, as well as adequate and well equipped infrastructures.
See monitoring reports of MEASURING (Annex AQ 15,p.10) and Malaria Consortium (Annex AQ 14,pp.80-81).

Through its partner support, National Malaria Control Program (NMCP) has already initiated its technical and managerial capacity-building for 'Roll Back Malaria' programme of action. However, several fields are still in deficit and the activities planned below will be tackling this deficit:

Activity 4.1 : Training and Exchange Mission

- Providing training to information management for health education , for 14 executives, including 3 at

central level (2 of the National Malaria Control Program (NMCP), 1 of the National Health Information Program (NHIP) and 11 of NMCP at regional level.
In fact, shortage of skilled personnel at intermediate level to ensure advocacy and education at lower levels is one of the major challenges. This 3-month training will be spread over the next five years of the project.

- Providing training to Management and Planning, for 14 executives, including 4 executives of the National Malaria Control Program (NMCP) at central level and 11 logisticians of PSD

- Providing training to public health for 10 executives of the National Malaria Control Program (NMCP), including 6 at central level and 4 Regional executives. In view of the identified needs, the program hopes to reach a critical number of executives trained in this field, for capacity-building in malaria control strategies in the country. This 9-month training is at Masters level.

- Providing training to Applied Epidemiology for 7 executives, including 5 of the NMCP and 2 of the Malaria Control Department (MCD) (Great Endemic Disease and Epidemiology Department), to strengthen epidemiologic monitoring in the Program, given the presence of epidemic potential zones. This training will last 3 months.

- Providing 4-week training to operational research, for 4 executives, including 3 of the National Malaria Control Program (NMCP), 1 of the Research Department, 1 of the Multi-Prevention Department, 1 of the Monitoring Department and 1 of the Epidemiological Monitoring Department (EMD).

- Providing training to Planning and Management of Tropical diseases control Programs, for 4 executives, including 6 of the National Malaria Control Program (NMCP), 4 central executives (2 Heads of the Multi-Prevention Department, 1 Head of the Research Department, 1 Head of the Monitoring Department, 2 Heads of the Provincial Services, and 2 Heads of the Malaria Control Department (MCD) (1 Head for the Great Endemic Disease Department and 1 Head for the Malaria department). This training will last 3 months.
- Providing training to Malariology for a core of national trainers.
Malariology is the major field in malaria prevention and control, and it its then essential to train effective number of executives in this field within a short period of time. This objective can only be reached through local-based organization with a team of local trainers.

  Providing training to malariology for 36 national executives: 8 of the National Malaria Control Program (NMCP), 2 of the MCD, 1 of the PNSR, 1 of the Integrated Management of Childhood Diseases (IMCD), 6 of Research Institutions/Universities (1 PHS, 1 Parasitology UNIKIN, 1 UNIKIS, 1 UNILU, 1 UCB, 1 NIBR), 22 Regional executives (2 per province).
  This training will last 3 months per session, with 4 sessions overall and 1 session a year.

- Providing training to medical Entomology for 3 executives, including 2 of the NMCP (1 of the Multi-Prevention Department, 1 of the FRP Monitoring Department, 1 of the Department Research and Development for new medicines, and 1 of the MCD (D4).
Anti-vectorial fight is indeed one of the main components to fight malaria and it is then urgent to train national core of entomologists who will provide Program guidelines for effective implementation of these activities. This training will be at Masters level.

- Providing training to M&A for 17 executives, 5 from the National Malaria Control Program (NMCP), 4 central executives and 11 regional executives, and 2 from the MCD. This short training program will be organized locally.
- Organizing 10 study and exchange missions on NMCP implementation experience, with two missions a year.

Activity 4.2 : Building Refurbishment

- Ensuring NMCP national coordination office refurbishment.
- Ensuring NMCP regional offices refurbishment.

Activity 4.3 : Allocation of equipment and mobile material.

- Supplying NMCP central and regional coordination offices with office furniture,
- Supplying NMCP central and regional coordination offices with computer kits and office equipment,
- Supplying NMCP central and regional office with a 20 kVa generating set,
- Supplying NMCP 11 regional offices with solar Kits, solar panels, accumulators, converters, and equipment.
- Supplying NMCP regional offices (Maniema, Eastern, Ecuador and Bandundu) with 4 speedboats of 15-20 CV (outboard motor and hull*). For supervisions in local and fluvial health zones.*
- Supplying NMCP and MCD central coordination offices with 1 bus and 4 vehicles 4X4.
- Supplying NMCP regional coordination offices with 11 vehicles
- Supplying regional coordination offices with 8 motor bikes, 3 supplied by Unicef
- Providing NMCP Central office with finance management software designed to facilitate NMCP financial and analytical accountancy
- Ensuring equipment of NMCP central coordination office with internal telephone circuits,
- Supplying NMCP central and local coordination units structures with office equipment and consumables.
- Ensuring supply of fuel and rolling materials and generation sets maintenance
- Ensuring supply of yearly telephone and subscriptions to Internet in NMCP central and regional coordination units

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended for the TRP

If necessary, describe adjustments made to the implementation plans and activities to account for each of the "weaknesses" identified in the TRP Review Form" in Round 8 or (Round 9) , if that was the last form applied for, and not recommended for funding.

Submission of Round 8 malaria proposal was recommended by TRP

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in section 4.5.1 above draw on lessons learned from program implementation (whether Global Fund Grants or otherwise)?

For this proposal, NMCP and its partners hope to draw on past and current experiences for scale up impact of these new activities implementation.

With this in mind:

1. Malaria prevention in pregnant women is based on the opportunity offered by prenatal services to reach all those who attend prenatal visits (PNV), to provide them with Intermittent preventive treatment (IPT). Indeed, EDS survey reports showed excellent results.
   This proposal offers to resolve the identified issue of SP shortage , through an essential scale up of SP availability in the 139 targeted HZ and no out-of-stock that would lead to the closure of this service. Co-operation with National Reproductive Health Program, initiated in Round 3, will be more intensified in the Global Fund Round 8 and 9 implementation proposal.
   Moreover, the strategy of giving pregnant women both LLIMNs and SP treatment (as from Round 3) during the National Malaria control Program (NMCP), will be reinforced in this proposal. In fact, in the 35 of the 119 HZ of the Global Fund Round 3, this strategy had an impact four times higher than the national average, for women sleeping under LLIMNs (28% against 7%); and hence, the need to continue and reinforce these activities through targeted communication strategies.

2. Clinical malaria case management will apply to children under 5 years of age. Children aged 5

and above will undergo systematic malaria rapid diagnostic tests.
Submission of this proposal aims to overcome ACT therapy stumbling blocks and provide access to all the health zone population, in particular with the:

- Presence on the market of expired drugs, or counterfeited anti-malarial drugs competing with ACT combination therapy.
- No targeting strategy in the Community (it is estimated that only 26% of the country are present in the public health care facilities, the great majority of the population using self-medication)

Learning from the past, submission of this proposal will offer :

- to provide adequate quantities of good quality drugs,
- to strengthen health care providers training,
- to intensify behavioural change communication,
- to reinforce distribution networks control in the interventions health zones,
- to ensure drug storage and quality safety, with a set-up of quality sample control system (pharmaco-vigilance), taken and tested in each region, with reference framework of counterfeited drugs, based in Kinshasa University.

In this proposal submission, National Malaria Control Programme (NMCP) and its partners hope to draw on lessons learned from past and current experiences, to scale up impact of the new activities implementation.

3. Learning from the past and drawing on lessons learned to achieve expected outcomes, this proposal will be planning the following activities:

- to ensure effective procurement and inventory management to provide planned and adequately quantified SB delivery,
- To strengthen (NMCP) normative and regulatory role,
- To strengthen SB inventory control in co-operation with health zones, for more realistic reference procurement planning.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to providing equal access to high quality services in the prevention, treatment and/or care of malaria, locally available in your country.

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

According to paper *Gender, Health, and Malaria (Annex AP11),* the most vulnerable biological groups with regard to malaria, are children aged between six months and five, pregnant women (especially teenage girls), non-immune people (travellers, workers and populations moving from zones of low transmission to zones of high transmission) as well as people affected with HIV.

Pregnant woman, who is both carrier of HIV and malaria infection is exposed to severe anaemia and unfavourable outcome of pregnancy. Furthermore, poverty is a worsening factor to her access to quality health services. This category of population (pregnant woman and children under 5 years of age) are a priority in order to reach the neediest The level of education and illiteracy lower than that of men often affect a sound aptitude to recognize the symptoms of malaria and take the decision to use the treatments available.

Moreover, 97% of the Congolese population live in stable malaria areas which are characterized by equatorial and tropical facies. Socio-economic crisis in the DRC has affected the family income for nearly twenty years, minimizing population access to basic health care. The Gross National Product (GNP) is less than 100 US$/per year/per inhabitant, which classifies the country among those of the lowest income of the continent.

Given the barriers between genders and biological vulnerability of pregnant women and children under 5

years of age, some specific targeted interventions will be fulfilled in the 139 health zones, to scale up their access to prevention, treatment and care services available. This proposal aims to reach over the next five years:

- at least 80% of pregnant women and children sleeping under LLIMNs in the 139 health zones
- at least 80% of pregnant women who benefit from Intermittent Preventive Treatment, according to national guidelines in 139 health zones
- at least 80% of the population receiving proper health care in public health care facilities of the 139 health zones, according to national guidelines

These strategies are expected to ensure equal access to pregnant women and children under 5 years of age.

In respect of preventive measures, LLIMNs free distribution will be ensured in routine services, particularly in pre-school (PSV) and prenatal (PNV) visits, especially as attending rate of prenatal services is 85%.
For hard-to-reach populations, LLIMNs distribution through integrated campaigns, accepted in Round 8 proposal, will foster on improved LLIMNs availability and require from NGOs sub-recipients of Community Relays, their involvement with LLIMNs distribution to targeted populations in their communities.
The number of LLIMNs that will be distributed in each home during the various mass campaigns, will provide access to these preventive measures for all social classes.

In respect of health care facilities, relevant expertise for simple malaria case management and its complications will be offered to any population without any discrimination, whether poor or rich, from rural areas or not. The proposal focuses on Health Systems Reinforcement and Community commitment, for behaviour and practices that will encourage fight against malaria. The activities proposed, such as training, pharmaceutical and medical equipment supply, providers activity monitoring will help ensure information, access and use of treatment and/or screening for malaria, both for men and women. Interpersonal communication strategies will also be implemented in Community Relays and through mass media to improve health information in the 139 health zones populations. Communication strategies (radio and TV spots, box displaying pictures, leaflets, posters…) will be produced to convey key messages. for equal access to populations at risk, and :

- Encourage women to come at early stage of pregnancy to receive IPT two doses and get their LLIMNs.
- Vulnerability of pregnant women and children under 5 years of age to malaria outcomes
- Higher risk in teenage girls and women affected with HIV when they contract malaria during pregnancy
- Importance to sleep under LLIMNs every night for effective prevention of malaria
- Economic advantages for the family
- National Policy of the NMCP on LLIMNs in target groups during routine services in health care Centres, and advanced strategies developed by NGOs and health zone leaders. Any communication material will also undergo pre-qualitative tests in target groups (supervised discussion groups or personal interviews) to ensure message comprehension and perceptual communication component by pregnant women, and mothers of children under 5 years of age.

4.5.5. Strategy to mitigate the initial unintentional effects

If this proposal (section 4.5.1) includes activities which respond to the health system weaknesses on a disease specific basis, explain:

- The factors considered when deciding to apply for a grant on a disease specific basis,
- the country's proposed strategy to mitigate any potentially disruptive effects from a disease-specific approach ?

One of identified health system weaknesses was " intermittent supply of pharmaceutical and medical equipment for malaria control in health facilities and inadequacy in medical equipment that could

undermine Community's confidence, and eventually lead to facilities closure ".

First, the different partners ensured provision of delivery services, such as Insecticide treated-nets, directly to health facilities, using their own system, as national distribution system was not operational. As malaria control should become routine work, LLIMNs procurement for distribution routine in the 139 HZ, will be purchased and stored in pharmaceutical and medical equipment network of other pharmaceutical products by a BP, experienced in supply and health systems reinforcement. Routine procurement chain management will then develop considerable experience in pharmaceutical products and LLIMNs distribution.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund Grants(s)

Describe any link between the aim of this proposal and the other activities under any existing Global Fund Grant *(e.g., this proposal requires support for a scale up of Artemisinin-based combination therapy (ACT), and an existing grant that give support for service delivery initiatives to secure treatments delivery.*

Proposals should clearly explain if this proposal requires support for the same interventions that are already planned under an existing grant or approved Round 7 or Round 8 proposal, and how there is no duplication. It is also important to explain the reasons for implementation delays of the existing Global Fund grant and the measures taken to resolve these issues, so that they do not affect implementation of this proposal.

Round 8 proposal was in the continuity of previous Round 3 in the 119 intervention health zones, fostering better performance outcomes for:

1. Promoting scale up of insecticide-treated mosquito nets
2. Improving Malaria case management in health training facilities (Reference General Hospitals and Health Care Facilities),
3. Improving Malaria case management/fever in the community
4. Providing Intermittent Preventive Treatment to pregnant woman

Round 9 proposal will also apply to the same interventions for malaria control, and designed to ensure geographical scale up of 39 additional health zones, without support for this disease. The number of health zones that benefit from the Global Fund Grant in the DRC will rise from 119 to 258 health zones. The other health zones will benefit from different partner supports.
However, mass campaigns planned for LLIMNs distribution in Round 8 proposal, will also cover these 139 health zones. Besides, NMCP coordination frameworks reinforcement will be beneficial to the activities aimed at all the 515 health zones of the country.

4.6.2. Links to non-Global Fund source of support

Describe any link between the present proposal and the activities supported through non-Global Fund sources (*summarizing the main realizations planned from that funding on the same terms as this proposal)*.

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

As shown below, the current or expected external funding for malaria control comes from several financial backers in different areas, particularly:

1. **World Bank Grants**: This funding serves to finance health system reinforcement, including malaria control measures in the **191 health zones,** through two projects (Emergency Multi-Sector Rehabilitation (EMSR) and the Programme of Action for Health Systems Support (HSS). Funding of US$100 million comes from World Bank Booster Programs second phase, for Malaria Control in Africa, procurement of LLIMNs and anti-malarial treatments recommended by NPMC for universal access
2. **USAID Grants in t**he framework of **Axxes and CRS** projects also incorporate malaria control plan of action, for procurement of **(LLIMNs and anti-malarial drugs) in 80 health zones** (57 from Axxes project and 23 from CRS support), aimed to **cover 50% of** targets with potential massive coverage from 2010.
3. **The African Development Bank (BAD)** is a source of funding for **health care interventions based on ACT combination therapy (1,000,000 doses)**, and for prevention of malaria during pregnancy, with **IPT and SP treatments and procurement of 78,000 LLIMNs** over three years in **26 Health Zones of the Eastern province** from 2008 to 2010**.**
4. **UNICEF** will provide substantial financial input from 2008 to 2012, for procurement and distribution of ACT, **SP in pregnant women** and LLIMNs in **40 health zones** in all the 11 regions of the DRC **to reach more than 60%** targets coverage, with potential scale up of coverage. UNICEF also participates actively in mass campaigns organized through several regions of the country.
5. **UNITAID** through UNICEF supplied 5.5 million LLIMNs that will be delivered all through the year 2009. This intervention integrates within planning and implementation campaigns.
6. **European Union Grant :** finances National health information systems Reinforcement.
7. **WHO:** in addition to (i) technical expertise, provides (ii) support in materials for control coordination of great endemies and diseases with epidemic potential, (iii) and supports interventions in areas of emergencies

Funding of the different supports for malaria control in the DRC schematized in figure n°4, is summarized in the chronology table n°12 below.

Table 10: Funding for malaria control in the DRC

Organization Name	Area of Activity	Nb. of Health Zones	Period	Expected coverage targets	Observations
MF Round 8	ITN, CTA, TPI	119	2009-2013	CTA: 80% ITN : 80% TPI : 80%	Proposal approved by IMF
USAID/AXxes	ITN, CTA, TPI	57	2007-2009	CTA : 50% ITN : 50 %	Possible extension of duration and funding volume project (*)

				IPT : 50%	
USAID/CRS	ITN, CTA, TPI	23	2007-2009	ACT : 50% IPT : 50 % IPT : 50%	Possible extension of duration and funding volume project (*)
IB, PMURR	ITN, CTA, TPI	108	2007-2009	IPT : 80% IPT : 80% ACT : 80%	Possible extension of duration and funding volume project, through Booster Program phase 2 (*)
IB, PARSS		83	2007-2011		
UNICEF	ITN, CTA, TPI	40	2008-2012	ACT : 80% IPT : 60% IPT : 60%	
BAD	ITN, CTA, TPI	26	2007-2011	ITN : 60% IPT : 60% ACT : 60%	Low supply of LLIMNs

(*) Funding volume extension will help achieve improved malaria control interventions coverage (Annex 13, Mixed meeting report of the Government and stakeholders for malaria control in the DRC)

Table 11: The different partner support for malaria control routine activities (LLIMNs, IPT, ACT) in the health zones of the Democratic Republic of Congo

Financing	Nb of HZ	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
IMF round 8	119											
USAID/AXxess	57											
USAID/CRS	23											
IB, PMURR	108											
IB, PARSS	83											
BAD (African Development Bank)	26											
UNICEF	40											

The purpose of this National Malaria control Program 2009-2013, will be to scale up minimum package of activities (MPA), to fight malaria in the 515 health zones, and promote LLIMNs use, malaria case management with ACT combination therapy and IPT for pregnant women in particular. Future directions call for a focus on synergies between the Global Fund and the aforesaid stakeholders. To reach these goals, Round 9 Grant aims to increase and primarily complete geographical coverage of malaria control interventions for universal access to all the Congolese population.

Submission of the Global Fund Round 8 proposal fosters LLIMNs massive coverage in all the health zones, through mass distribution campaigns, associated with vaccination, vitamin A supplementation and mebendazol treatment. These mass campaigns aim to scale up LLIMNs among the whole population of all the 515 health zones in the country. In addition, routine distribution will be planned in the 119 health zones (Round 8 supported by the GF), 139 health zones (submitted in Round 9) and health zones supported by these partners, (the World Bank, USAID, UNICEF, KOIKA, BAD), for pregnant women and children under 1 year of age.

Overall, 376 health zones are provided support in the framework of Malaria control programme of action, in the DRC. Among these zones, 59 benefit from complementary supports and synergies from two or three partners. These supports are centred on health systems reinforcement that includes fightingt disease including malaria. The table below indicates the support options in the 59 zones of the country that benefit

from the support of more than one partner. It is important to stress that the issue of more than one potential partner support in malaria control Program, will not apply to health zones targeted by Round 9 proposal. With regard to Health systems Reinforcement, some of the 139 HZ benefit from partner support in this work area, while those without support, account for in the Health Systems Reinforcement (HSR) of the Global Fund Round 9.

Table 11b : Harmonization of complementary support to health zones

N°	Province	Health Zone	Partners	Support Option to health zones	
				Health System	Anti-malarial Interventions
1	Bandundu	BANDUNDU	WB-GF	WB	GF
2	Bandundu	FESHI	WB-GF	WB	GF
3	Bandundu	KITENDA	WB-GF	WB	GF
4	Bandundu	BULUNGU	WB-GF	WB	GF
5	Bandundu	GUNGU	WB-GF	WB	GF
6	Bandundu	IDIOFA	WB-GF	WB	GF
7	Bandundu	KIMBAO	GF-UNICEF	UNICEF	GF
8	Low Congo	INGA	WB-UNICEF	UNICEF	WB
9	Low Congo	SEKE-BANZA	WB-UNICEF	UNICEF	WB
10	Low Congo	NZANZA	WB-UNICEF	UNICEF	WB
11	Ecuador	BOLENGE	WB-GF	WB	GF
12	Ecuador	GBADOLITE	GF-UNICEF	UNICEF	GF
13	Western Kasai	TSHIKAPA	WB-GF	WB	GF
14	Western Kasai	KALONDA OUEST	WB-GF	WB	GF
15	Western Kasai	LUEBO	WB-GF	WB	GF
16	Eastern Kasai	DIBINDI	GF-USAID	USAID	GF
17	Eastern Kasai	LODJA	GF-USAID	USAID	GF
18	Eastern Kasai	OMONDJADI	GF-USAID	USAID	GF
19	Katanga	KIPUSHI	WB-UNICEF	WB-UNICEF	WB
20	Katanga	KAMBOVE	WB-GF	WB	GF
21	Katanga	BUKAMA	WB-GF	WB	GF
22	Katanga	KABONDO DIANDA	WB-GF	WB	GF
23	Katanga	KAMINA	WB-GF	WB	GF
24	Kinshasa	KINGASANI	GF	WB	GF
25	Kinshasa	BIYELA	WB-GF	WB	GF
26	Kinshasa	LINGWALA	WB-GF	WB	GF
27	Kinshasa	POLICE	WB-GF	WB	GF
28	Kinshasa	KALAMU II	WB-GF	WB	GF
29	Kinshasa	BANDALUNGWA	WB-GF	WB	GF
30	Kinshasa	KOKOLO	WB-GF	WB	GF
31	Kinshasa	BINZA OZONE	WB-GF	WB	GF
32	Kinshasa	MASINA II	WB-GF	WB	GF
33	Kinshasa	MAKALA	GF-UNICEF	UNICEF	GF
34	Maniema	KASONGO	WB-GF	WB	GF
35	Maniema	KABAMBARE	WB-UNICEF	WB-UNICEF	WB
36	Maniema	SARAMABILA	WB-UNICEF	WB-UNICEF	WB
37	Maniema	KAMPENE	WB-GF	WB	GF
38	Maniema	LUBUTU	WB-GF	WB	GF
39	Nord Kivu	MUTWANGA	WB-UNICEF	WB-UNICEF	WB
40	North Kivu	BENI	WB-UNICEF	WB-UNICEF	WB
41	North Kivu	OICHA	GF-UNICEF	UNICEF	GF
42	Eastern	PAWA	WB-GF	WB	GF

43	Eastern	WAMBA	WB-GF	WB	GF
44	Eastern	ARIWARA	WB-GF	WB	GF
45	Eastern	ARU	WB-GF	WB	GF
46	Eastern	AUNGBA	WB-MF	WB	GF
47	Eastern	VIADANA	WB-UNICEF	WB-UNICEF	WB
48	Eastern	POKO	GF-UNICEF	UNICEF	GF
49	Eastern	GANGA	GF-UNICEF	UNICEF	GF
50	South Kivu	KADUTU	WB-USAID	WB-USAID	WB
51	South Kivu	KANIOLA	WB-USAID	WB-USAID	WB
52	South Kivu	KAZIBA	WB-USAID	WB-USAID	WB
53	South Kivu	MUBUMBANO	WB-USAID	WB-USAID	WB
54	South Kivu	BUNYAKIRI	WB-USAID	WB-USAID	WB
55	South Kivu	KALEHE	WB-USAID	WB-USAID	WB
56	South Kivu	SHABUNDA CENTRE	WB-USAID	WB-USAID	WB
57	South Kivu	BAGIRA-KASHA	WB / PMURR - USAID - GF	WB-USAID	GF
58	South Kivu	UVIRA	WB-USAID-UNICEF	USAID-UNICEF	WB
59	South Kivu	UVIRA	WB-USAID-UNICEF	USAID-UNICEF	WB

Clarified Section 4.6.3

4.6.3. Partnerships with the private sector

(a) If the private sector co-invests the activities of this proposal, or participates in a way that contributes to performance-based outcomes (even if not a specific activity), please state briefly below the main contributions anticipated over the proposal term and how these contributions are essential to the success of this program.

*(Refer to the Round 9 Guidelines for the **definition of private Sector** and some examples of the types of financial and non-financial contribution from the private sector in the framework of co-investment partnership*

Commodity requirements cover the needs of the populations within the Intervention Health Zones benefiting from healthcare across the public and private sector and at the community level. This is why the need arises to collaborate with private healthcare establishments as well, that comply with the regulations and directives of the Public Health Ministry. This will not be co-investment as defined by GF directives. Rather, it will be an extension of the implementation of basic LLITN, RDT, ACT and IPT interventions within the sector. Therefore it is not financial contributions that are needed but rather the contribution of infrastructure, human resources, training, etc.

(b) Indicate in the table below, the annual amount of the anticipated contribution of this partnership with the private sector. *(For non-financial contributions, please indicate a money value if possible and, at a minimum, a description of this contribution.)*

Population relevant to Private sector co-investment (All or *part, and which part, of the population group(s) is/are targeted by the proposal* ➔	NA

Contribution Value (in US$ or EURO)

Refer to the Round 9 Guidelines for examples

Organization Name	**Contribution Description** (in words)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**

[use Tab key to add extra lines if necessary]							

4.7. Program Sustainability

4.7.1. Capacity-building and processes to optimize outcomes in Malaria prevention and control

The Global Fund recognizes that the relative capacity of governmental and non-governmental organizations, including Community-based organizations, can be an important barrier to reaching people and providing them with services (e.g., home-based care, outreach prevention, etc.).

Describe how this proposal contributes to the overall strengthening and/or development of the public, private and Community institutions to guarantee better malaria service delivery and outcomes. ➔ *Refer to country evaluations as relevant*.

By strengthening community-based interventions, already initiated in integrated management of childhood diseases (IMCD) strategy, this proposal also calls for a focus on capacity-building in technical, managerial and monitoring & assessment for health care workers.

Both health care providers from private clinics, and doctors from public sector will attend the same training programs and offer the same provison of delivery services (e.g. IPT 1 and IPT 2, case management, and LLITMNs free distribution).

In addition to the supply in human resources from these private or corporate clinics, and private pharmacies, these institutions will also provide substantial support in infrastructures, particularly health care facilities for a scale-up of prevention and treatment services to the surrounding communities, and storage of pharmaceutical and medical equipment for this project.

This proposal is also designed to strengthen NMCP national and regional coordination frameworks, through improved infrastructures and supply of office automation equipment and means of communication.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks, such as strategies of poverty reduction, initiatives for Heavily Indebted Poor Countries (HIPC), the Millennium Development Goals, an existing national health sector development plan and other important initiatives such as the 'Global Roll-back Strategic Plan' 2006-2015'.

Strategies for malaria control described above align with broader scope of development such as the Millennium Development Goals (MDG), the Global Roll-Back Malaria Strategic Plan (RBM), over the period 2005-2015. Also included in this Programme of action are Papers on strategy of growth and reduction of poverty (PSGRP), and the Call for scale-up and universal coverage launched by the Secretary General of the United Nations in April 2008. Malaria is the first cause of morbidity and mortality, and an important factor of poverty in the DRC. All the activities planned in this proposal, particularly prevention with LLIMNs, IPT treatment and rapid and effective case management harmonize with the objectives of the above plans and initiatives.

1. Millennium Development Goals

The objectives of reduction of malaria morbidity and mortality rates integrate within the Millennium Development Goals. The efforts of the DRC and its partners to reduce malaria morbidity and mortality rate, contribute to reaching the Millennium Goals, particularly its Strategic Directions 1, 2, 4, 5, 6, 8 and

more specifically Direction 6.

2. "Roll-Back Malaria" Initiative

The country adopted (RBM) initiative in February 2001, by appointing a health Task force that includes the National Malaria Control Program (NMCP) and its partners, bi-lateral and multilateral cooperation bodies, international and national NGOs and faith-based and community organizations.
This proposal aligns with the scope of 'Rolling-Back Malaria' (RBM), aimed at reducing malaria mortality rate of 75 % in 2015, versus figure rate in 2005. The selected interventions are in perfect adequacy with RBM initiative strategies and with the recommendations of the Conference of the African Heads of State in Abuja in April 2000, specifically:

- Early and rapid care and treatment of cases using effective drugs;
- Protection of vulnerable people to malaria, using Insecticide-treated Mosquito nets,
- Intermittent preventive treatment,
- Prevention and control of malaria epidemics.

3. Strategy of poverty reduction

The paper on strategy of growth and poverty reduction was drafted and adopted in the Republic of Congo, aimed amongst other things to improve access to social services and reduce vulnerability.

This paper advocates for the fight against disease, as one of the important mainstay of development. It recommends that quality primary health care is ensured to all the population, particularly to vulnerable groups and also in context of the fight against great pandemic diseases such as HIV/AIDS, malaria, tuberculosis, onchocerciasis, or the African human trypanosomiasis, etc.

4. Call by Global Fund and Secretary General of the United Nations for universal coverage

"GF/B17/DP18: Building the Demand for a Scaled up Malaria Response: *The Board acknowledges and commends the call by the UN Secretary General and the Roll Back Malaria (RBM) Partnership to help countries achieve the G8, the World Health Summit and RBM targets* ***to achieve universal coverage of a major malaria control intervention package by December 31, 2010****. In particular, the Board recognizes the epidemiological rationale set forth by the WHO, for a massive scale up of effective preventive measures to reach these targets. As the largest external financier of malaria programs worldwide, the Board is committed to ensuring that the Global Fund is acting as a key partner, along with others, in this extraordinary public health effort to meet the demand from countries to scale up their malaria programs.*

Given the urgency to use additional resources, and increase implementation capacities in the country to achieve universal coverage, ***the Board urges countries to submit ambitious Round 8, Round 9, and continuous Round proposals. These proposals are aimed to scale up comprehensive malaria control programs (particularly distribution of long-lasting insecticide treated nets (LLIMNs) and ACTs) aligning with broader health systems reinforcement."***

The Democratic Republic of Congo noted that this call was critical for universal coverage of populations at risk, and will undertake malaria control interventions for universal access, with feasible and realistic approach.

4.8. Measuring Impact

4.8.1. Impact measurement system

Describe the strengths and weaknesses of the national systems used to track or monitor the realizations towards national malaria outcomes and measuring impact.

If necessary, Refer to a recent national or external evaluation of the IMS in your description.

The National Malaria Control Program drafted M&A plan for strategic programme of action 2007-2011. However, in the initial year of this program implementation, M&A systems evaluation allowed to identify weaknesses which generally affect the different levels of the health system, and particularly the National malaria control Program, such as:

- Poor diffusion of M&A National Program,
- Lack of manual on M&A procedures,
- Poor retro-information system,
- Lack of motivation from the personnel,
- Lack of computerized data management system (software),
- Low budget allocation for M&A program implementation,
- No regular LLIMNs monitoring,
- Process Indicators not clearly defined
- Less clear distinction between indicators collected by NMCP and those requiring particular evaluation.

The National Health Information System developed a normative framework and a package of routine data management tools, including a small number of indicators to fight disease and transmission of information channels that define responsibilities and deadlines for transmission at each level of the health pyramid.

From June 2007, co-operation between NMCP and both national and international partners and experts have produced monitoring and evaluation plan that comes within national scope of monitoring and evaluation system, such as defined in NMCP.

In view of WHO Guidelines to accelerate the appeal for a scale-up of malaria control activities in all endemic countries, the strategic plan 2007-2011 needed update.

NMCP took then the responsibility, with its partners (RBM), to re-examine strategic plan 2007-2011 and M&A plan for update and produced a strategic plan 2009-2013 to address the current challenges of malaria control worldwide and in the Republic of Congo more particularly. M&A program of action adapted to the new strategic plan, was then drafted according to National Health Information System.

Routine Monitoring

Appointed and trained Community Relays should transmit collected data to health zone incumbent nurse in his/her respective competence. Health care Centre staff, together with incumbent nurse trained in NHIS framework, is responsible for compilation and validation of data from Community Relays and this from Care Centres. Monthly data transmission by the head nurse will be compiled, analyzed and validated with the support of incumbent nurses from Care Centres, at the level of health zone Central Office, during monthly monitoring meetings. These meetings on minimum package of activities (MPA), generally organized in all the country health zones should promote the fight against malaria and other diseases.

Participants at these meetings, including incumbent nurses, health zones leaders, hospital managers, partners in support of health zones in several areas, OAC and other organizations involved in the fight against malaria and disease should exchange, analyze, interpret collected data and bring corrective actions to identified gaps.

Health zone leaders should then get validated data from all the health zone, in respect of all the fulfilled actions, and particularly malaria control activities, that they will transmit to their hierarchy and partners involved in fighting malaria. Health zone Community team (CT) will ensure that the problems identified at these monitoring meetings can be the subjects/themes of targeted supervisions.

Health zone Central Office then will transmit data to hierarchy periodically, according to information channel protocols and using all the possible channels. In the frame of this proposal, support to HZ in equipment and communication channels and Internet access will improve data promptness.

Retro-information will be provided at all the levels, following transfer of information channels backward.

Sentinel Sites

In 2003, 11 'Roll-Back Malaria' sentinel sites surveillance were set up to collect non-applicable data in all the country and continuously monitor drug and insecticide efficacy. Training of site key players was included in Round 3 second phase Program for knowledge update.

In addition, existing computer equipment of these sites will soon be completed with a data-gathering

department, for full data monitoring and diffusion in malaria prevention and control.

Evaluation

Surveys (prior to intervention, halfway through malaria control interventions and post-intervention) will be conducted in the 139 health zones (HZ) in this Program framework, through independent institutions which have competence according to survey protocols. This protocol was drafted in co-operation with national and international experts, and validated by the ethics Committee. Other relevant surveys conducted in Round 8 will be called on for implementation of this Round.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and assessment (M&A) strategies of this proposal *(at the PR, sub-recipient and community implementation levels) use* existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection) ?

In the framework of Round 3 implementation, National Malaria Control Program (NMCP) aligned its indicators with National Health Information System (NHIS) department and integrated all its routine data within (NHIS) framework produced by this department. NMCP is then using national channel to collect information in malaria prevention and control.
In the field, all health zone information from the different health facilities and community Relays will be compiled and validated by health zone central office before being transmitted to higher level.

To avoid parallel reporting, quarterly national meetings which involve PRs and all the parties participating in data validation and exchange, were initiated in Round 3 and will continue in this proposal framework.
With regard to National Malaria control Program (NMCP), data will be compiled in a database financed by WHO.

4.8.3. Strengthening monitoring and evaluation systems

What improvements in the M&A Systems in the country (including those of the Principal recipients and Sub-recipients are included in this proposal to offset gaps/inadequacies and/or strengthen reporting into the national impact measurement systems frameworks ?

➔ *The Global Fund recommends that 5 % to 10 % of a proposal total budget is allotted to the M&A activities, to reinforce the existing M&A systems.*

According to evaluations monitored by MEASURE (Annex AQ 15) and Malaria Consortium (Annex AQ 14) in the DRC, the following weaknesses were reported in M&A plan of action:

- inadequate popularization of M&A plan,
- inadequacy in data management reporting (Poor level of completeness and promptness in quality data),
- Lack of data management software,
- Lack of peripheral data-processing tools (e.g. health zone)
- Shortage of data-gathering tools,
- Inadequacy in transportation and communication means, between the different levels of health pyramid,
- Shortage of qualified staff at all levels,
- Low funding allocated to monitoring and assessment systems.

Existing updated M&A plan of action will include measures to strengthen M&A system Program, at all the levels of the health system, whether central, intermediate or peripheral in Round 9 proposal in respect of:

- Personnel training,
- Supply of data-gathering tools,

- Supplies of data-processing kits and means of communication,
- Data Audit,
- Supervision,
- Review of collected data validation at the different levels of the health system.

Data management software and its training program will be provided through the support of WHO AFRO and completed in June 2009.
Similar measures to strengthen monitoring systems will apply to the 139 intervention health zones through Health system Reinforcement (HSR) component, as they account for in the 119 health zones of Round 8.

4.9. Implementation Capacity

4.9.1 Principal Recipient(s)

Describe the technical, managerial and financial capability of each Principal Recipient to manage and supervise implementation of the program (or part of this program, as relevant).

*In this description ,comment on any anticipated barrier to high performance, referring to any previous assessments of the Principal recipient(s), **other than Global Fund Grant Performance reports.** Plans to address capacities needs should be described in the section 4.9.6 below and included (as relevant) in the work plan and budget.*

PR 1	Ministry of Health
Address	Avenue de Justice N° 36, Kinshasa Gombe

PR 1 : Ministry of Public health

The Ministry of Health, is one of the ministries that forms the Congolese Government. At central level, the Minister comprises the Minister Cabinet, the Secretariat-General attached to 13 Central Directorates, and about fifty specialist Programs, including NMCP, NACP, NTCP and NTP– directly involved with the Global Fund Grants. At Regional level, it comprises 11 Regional Departments of Health, Responsible for technical assistance of the periphery, that includes 515 health zones, all dedicated to effective treatments implementation.

For improved external funding management, the Ministry of health, as public PR for this proposal is being fully involved in capacity-building programme of action. The Ministry of Health signed an agreement memorandum with its partners for better coordination and harmonization of interventions that contribute to its reinforcement. A support Committee for external funding management was created by ministerial decree in the Ministry. At the present stage of health sector reform process, projects of programmatic management in this sector are the responsibility of the Committee, which will be assisted by a trustee, recruited on the basis of open tender for financial management aspects. GAVI project, component of the Health Systems Reinforcement, worth 56 million is the first to integrate within this operational management. Other sources of funding in the health sector, whose possibly the 10th European Development Funds (FED) are under way to integrate within this mechanism, which materializes effectiveness of Aid to development through the Declaration of Paris.

In respect of the Global Fund Grant, UNDP - which is PR of the current grants in the Democratic Republic of Congo and the Ministry of Health have agreed on a plan of devolution and on completion of this plan, the Ministry of Health will assume all the responsibilities assigned to public PR in Round 8. In concrete terms, during the 24 months of Round 8 initial phase, UNDP will assume the role of PR. The plan of devolution will need to be completed at the end of this initial phase. The three years of the second phase of the aforesaid round will be under the responsibility of public PR, the Ministry of Health.

It is also important to stress that this national frames reinforcement strategy by public PR, was already implemented by the outgoing PR (UNDP) in phase II of Round 3 Funding, and in Round 7. This strategy will provide the Ministry of health technical frameworks, namely NACP and NPCT, with the capacity to ensure Grants programmatic management and participate in the selection of sub-sub recipients for implementing activities.

The Ministry of health, as a State institution, currently collaborates with several backers. All its structures that comprise Directorates, specialist Programs, and Regional Departments of Health (RDH) are fully

committed to the achievement of these activities, according to the role assigned at each level. Coordination and regulatory activities in the health sector, for HIV/AIDS control and the development of standards and guidelines, supervision, M&A and training at all levels, are therefore public prerogative of the PR, the Ministry of Health.

According to the Global Fund Guidelines on dual-track funding, the DRC recognizes the role of the private sector in the support of health sector and opens the door to other frameworks of the civil society to play the role of PR or possibly of sub-recipients for additional activities.

PR 2	***SANRU (Health Care Program in Rural areas)*** A partnership between ECC-DOM and IMA World Health for the support of primary health care in the Republic of Congo.
Address	Headquarters/HQs: ECC-DOM, Ave. de la Justice N° 75, Kinshasa-Gombe et IMA World Health, PO Box 429, New Windsor, MD 21776

I. Partnership

SANRU Program is a partnership between ECC-DOM and InterChurch Medical Assistance (IMA) created in 2000 and based on the agreement protocol on partnership relations regulations.

The Church of Christ in Congo (CCC) counts 63 ecclesiastical communities. Its Direction of Medical Charities (ECC-DOM) played a significant role in pioneering the development of primary health care and the first health zones such as: Vanga, Kimpese, and Karawa, developed around the hospitals of the CCC.

IMA World Health based in New Windsor, Maryland, is an association created in 1960, gathering 12 Protestant Agencies of Aid and Development for packaged procurement of pharmaceutical products and medical equipment in favour of developing countries. Its expertise developed over the years in respect of funding management of complex projects, mobilization of resources, faith-based NGOs capacity-building, supply of large packaged health products, and health systems reinforcement in several countries. This agency manages resources worth more than US$ 150 million per annum. IMA, is also registered as NGO in the DRC, working in close cooperation with ECC since 2000.

This partnership is commonly identified under the name of ECC-IMA. SANRU Program was initiated in 1981 as a project from bilateral co-operation, entirely managed by ECC-DOM on behalf of USAID and the Ministry of Health.

SANRU Program manages more than US$ 20 Million per annum in the framework of Aid to development Programs. It currently provides support to 115 of the 515 HZ that counts the DRC through projects financed by USAID, the World Bank, the Global Fund, GAVI, Protestant Solidarity and other backers and partners.

II. ORGANIZATIONAL CAPACITY

A. Financial management

SANRU Program (ECC-IMA) manages a portfolio of more than US$ 20 million per year, while IMA World Health, in the framework of implementation projects, totals up more than US$ 150 million per year. (See table below)

Table 12. Funds received from the different donors, exercise 2006 and 2008

Projects	Backers	Nb of HZ	2006	2007	2008

			(USD millions)	(USD millions)	(USD millions)
SANRU III	USAID	56	6	Concluded	
Axxes	USAID	57	4	14	14
PMURR (all sites)	Bank World	42	4	4.5	1
Malaria Global Fund	The Global Fund	25	.95	.26	1.5
HIV/AIDS Global Fund	The Global Fund	25	.95	.1	1.3
Friendship	USAID	1	0.2	0.2	0.2
Protestant solidarity	Belgian Government	6	0.2	0.2	
Program Resident Doctors	German Bank of Development	4	.4	.4	.4
Protection Mother and Child (with GIK)	Abbott Funds	6	0	.15	
Cost Sharing and & Gifts in kind	Pharmaceutical, Mission, etc.	75	3.37	1.97	1.97
Project Global Fund /MALARIA) (PR)*	**Global Fund**				
Project Global Fund/HIV/AIDS ((PR)*	**Global Fund**				
Total (US& million)					

- ***SANRU was accepted as PR of the civil society in Round 8, with a budget of almost 150 million***

B. Health Programs Management

SANRU Program has been giving support to 115 health zones, in several frameworks up to now. Its Human Resources department numbers nearly 20 doctors (MD in Public health for almost all of them), who ensure technical support in the activities of mother and child health, prevention and control disease, including Malaria, HIV/AIDS, health information and programs management. SANRU played a major role in introducing long-lasting insecticide-treated nets, working in close co-operation with NMCP, WHO and UNICEF.

SANRU thus developed capacity-building for management of large projects, fully supporting health zones and, and capacity to integrate within multiple sources of funding and technical components. In the framework of Round 3 (phase 1 and 2), SANRU is sub-recipient for Malaria and HIV/AIDS components in respectively 24 and 12 health zones, shared out between 8 of the 6 provinces of the DRC.

Through NMCP support, SANRU also developed capacity to initiate 'cross-cutting' interventions in health zones, helped by SANRU III and EMSR to better benefit from synergies. A similar approach will be fostered and proposed to its sub-recipients. As sub-recipient, SANRU manages close to 6 US$ million for Round 3 two phases.

Currently ECC-IMA controls a consortium of 3 large organizations, including CRS and World Vision in the frame of primary health care implementation, in 57 health zones. The budget is close to US$ 45 million during 3 years. In the same frame, ECC is also leader of a consortium of 5 NGO's from the civil society, for a new funding by GAVI (Global Alliance for vaccines and immunization), for an amount of US$ 5.6 million, in support of improved vaccination coverage in the 65 health zones of the country .

SANRU is the Principal Recipient for HIV/AIDS and Malaria components in Round 8, in respectively 119 and 196 health zones, shared out between all the 11 provinces of the RDC with a budget of almost US$ 150 million.

C. Pharmaceutical and Medical equipment Procurement

SANRU Program has achieved supply and distribution of more than US$ 10 million, in materials from external and local certified sources since 2000, including procurement and distribution of more than 2 million insecticide-treated bed nets.

ECC and IMA control the standards and regulations of national and international markets and those of pharmaceutical and medical equipment import, transport, storage and monitoring, through all the decentralized distribution networks of the DRC. As PR, SANRU Program will apply guidelines and indicators for effective assistance, as suggested for example, by the Committee of Aid to Development, Friends of Damien Club (CAD) in March 2005.

B. Monitoring and Evaluation

SANRU Program developed monitoring and evaluation tools, specific to each project and ensures that collected data and information are in phase and compatible with the National Health Information System (NHIS). Through its AXxes project for example, SANRU Program developed a 'dashboard' to process, analyze and monitor data received from the health zones.

Note also that ECC-DOM in partnership with the Ministry of Health established a cartography of the health zones from SANRU I. Together they produced the first charts of the different health zones. SANRU produced the current chart of partner support and is very strongly committed to the development of medical cartography of the DRC and GIS integration into the different provinces. Charts digitalization of health zones, and the creation of partner coordination charts was made by SANRU. Experience is this field is an asset to effective information management, monitoring and development of the Global Fund support cartography.

D. Funding and sub-recipient Management

SANRU's two partners gained a proven experience in Funds management subsidized by different partners/backers, and developed great experience in respect of sub-contracts management with sub-recipients of Funds received from partners and backers. The majority of the zones of SANRU I, II and III was managed jointly with several organizations of the civil society, among which the churches, the Red Cross, etc.

For example, ECC-DOM is now responsible for GAVI-CSO Funds Management and the 5 partners consortium management from the civil society, involved with these four sub-recipients: CNOS, the RED CROSS, the ROTARY and the CRS. IMA also manages AXxes Project consortium including these four sub-recipients, responsible for implementation in the field: CRS, World Vision and ECC-DOM.

E. Behavioural Change Communication

Malaria prevention is one of the most important and current activities of all the heath projects implemented by SANRU. In collaboration with the Central office of the health zones, SANRU ensured a major role to the country in promoting LLIMNs use and peri and intra-domiciliary sanitization through its concept of cleansed village.

SANRU implemented sensitization activities in health institutions, churches, schools, whether public or private. Several materials of communication which are currently used at national level, were produced in collaboration with SANRU and the other partners. Besides, a communication model was created, based on the diffusion of key messages through institutional and Community facilities.

In addition, the projects financed by USAID and the Global Fund enabled SANRU to train thousands of people at all the levels and ensure mass and outreach sensitization, in all the health zones which are supported in many fields.

F. Proper malaria case management

Case management according to National Malaria Control Protocol is based on health frames of the health zones, through SANRU support. They involve regular training and retraining of health-care providers at all the levels of the health pyramid in the DRC.

Activities of supply, storage, distribution and ACT combination therapy, other treatments and adjuvants to fight malaria, integrate within other projects at various degrees, particularly those in co-operation with IMA and other partners to address the needs of the population and malaria-sufferers.

III. CONCLUSION

Alliance between ECC-DOM and SANRU know-how in Funds management, good governance, technical monitoring, M&A, and IMA expertise in funding, monitoring and supply of massive pharmaceutical and medical equipment through several countries, will reinforce operational management capacity. Experience in this field is essential component for the DRC and its National Malaria Control Program. SANRU hopes then to be a third-dimensional key player, both giving and receiving support from the two PRs to better foster synergy and complementarity for implementation of Round 9 proposal, in the Democratic Republic of Congo.

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

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	☐ Yes
	☐ No
(b) **If no**, why not?	

***2.* The Sub-recipients**

Two types of Sub-Beneficiaries are to be found as far the government PR (the Ministry of Health) is concerned. They are:

2.1 Public Sub-Recipients

These are Ministry Health structures that include central departments and specialist Programs such as the NMCP. These structures do not refuse their normal roles as guarantors of the national anti-malaria policy. In this respect, they are responsible for regularising and normalising all the interventions related to the different PR, without any exceptions, by normative mechanisms, and monitoring and evaluation regulators.

2.2 Sub-Recipients from civil society or Sub-Recipients for actual implementation operations

The government PR will sign contracts with the Sub-Recipients for implementing a certain number of activities.

These Sub-Recipients will be recruited on the basis of a transparent request to tender open to competition.

(c) **If yes**, how many sub-recipients will be involved?	☐ 1 – 6
	☐ 7 – 20
	☐ 21 – 50

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

Clarified Section 9.3

4.9.3. Pre-identified sub-recipients

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

Experience from previous implementation came from work carried out by the SB during round 3 which is currently in its second phase.

It should be borne in mind that the PNUD (PR in round 3) has begun recruiting SB following a competitive, transparent process conducted by a technical evaluation committee on the basis of standard terms. At the end of this process, 16 SB, also comprising institutions such as the School of Public Health (ESP) and the National Malaria Control Programme (PNLP) were selected to implement their activities.

It should also be borne in mind that the 2 national institutions (ESP and PNLP) were in turn subject to specific mechanisms established by the PNUD for cooperation with government agencies and were therefore strictly speaking no longer considered as SB.

All of these key partners in the implementation signed a framework agreement with the PNUD which set out the terms of collaboration, the goals, the activities to be carried out and the expected results.

DIFFICULTIES ENCOUNTERED BY SUB-BENEFICIARIES

From beginning to end of the first phase, implementation of the project came up against a number of factors which to a greater or lesser extend had an impact on roll-out.

The project was initialised in an unusual set of circumstances in which the PNUD, as Principal Recipient, was required to review certain estimates to take into account changes in national policy in the field of malaria treatment (dropping the SP in favour of the ACT in first line treatment of simple malaria) and the cost of transport which it emerged had been underestimated in the country proposal.

Also, socio-political and military problems have arisen in certain implementation zones (North Kivu).

During phase 1, the SB moved onto actual project implementation. The delay in the supply of inputs and the disbursement of funds had an impact on the implementation of planned contractual activities. This failing, attributable in part to the PR and to the SB (financial allocations not justified in time), sometimes

resulted in discontinuity in the availability of inputs and adequate resources when activities were carried out (one reason is that delayed reporting by sub-beneficiaries has automatically led to a delay in reporting to the Global Fund).

Therefore, the SB embarked on training activities (process activities) but inputs arrived much later owing to procedural problems specific to the PR, thereby resulting in a lack of continuity in implementation, all the more so since the HZ did not have sufficient prior involvement in the planning of programme management.

Accompaniment and monitoring and assessment in certain zones were also hindered by the lack of focus points of certain SB within the Health Zones.

MEASURES TAKEN DURING PHASE 1 OF THE 3RD ROUND

Despite the delay in starting and the difficulties encountered, the PR and the SB have progressively improved performance although there have been peaks and troughs in programme performance. (Technical Evaluation report of Round 3 Sub-Beneficiaries, Annex AP15).

- Joint monitoring and evaluation missions (PNUD-PNLP) are one of the key achievements to date: 5 provinces out of 11 have received joint missions (Maniema, Katanga, Eastern Province, Equator, and Kinshasa).

- Implementation of a committee steered by PNLP comprising the WHO, USAID and PNUD with the task of evaluating the quality of reports submitted and performance and also monitoring of projects by the SB.

- The PR has continued its efforts to improve the regularity of disbursements and payments with effective transition to a biannual frequency.

MEASURES TAKEN FOR PHASE II

For an improved response to requirements, 16 SB have been selected by a technical committee created for this purpose to cover 73 new HZ.

The SB have been invited to participate in workshops:

a) On consolidation of National Monitoring and Evaluation Systems
b) On training for the Technical Support Facility for Western and Central Africa (TSF-WCA) in Dakar.
c) On monitoring and evaluation organised by the PNUD for countries where it acts as the principal recipient of the Global Fund in Cairo.

MEASURES PLANNED FOR THE CURRENT PROPOSAL

For the current proposal, a strengthening is planned of SB competencies in the fields of project management, logistics management, financial management and planning.

4.9.4. Sub-recipients to be identified

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

As we are just before the end of the end of subsidies for round 3 and the beginning of those for round 8 and as round 9 concerns new areas of health, the sub-recipients will be identified as for round 3, i.e. they will be selected by a transparent process going from an open and widely diffused request to tender to the final selection passing via evaluations of administrative, technical, financial and implementation evaluations under the management of the Technical Evaluation Commission, which has been tried and tested with success until present.

4.9.5. Coordination between implementers

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

Comment on factors such as:

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

Given the specific nature of finance for these three diseases (HIV/AIDS, Malaria and Tuberculosis) by a financial backer who has his own instructions and the need to be in line with the national context, coordination of the PR(s) will be carried out **on two levels**:

(i) Internally in the CCM, via the previously instituted Monitoring and Evaluation Commission, which must be reviewed/reinforced (by experts both inside and outside the CCM) and endowed with the requisite resources by means of a plan of action financed by the PRs' own capital and other sources of financing to be identified. This framework guarantees the fundamentally multi-sector-based nature of the CCM with regard to the Global Fund.

(ii) Through national coordination bodies, notably the National Piloting Committee for the HSS and the Provincial HSS Piloting Committees. To do this, the CCM's point of anchorage at a National Piloting Committee level is being defined at present.

4.9.6. Strengthening implementation capacity

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

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

(a) the assistance that is planned;**

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

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

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

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

Evaluation of the National Malaria Control Program by the Malaria Consortium NGO in 2008 for re-qualifying the strategic plan has enabled requirements to be defined within different sectors of the fight against malaria. (Annex AQ14).

Whilst the proposal for the 8th round was being drawn up by the Global Fund, the NMCP and its partners identified other requirements, but budgetary constraints did not allow all these requirements to be taken into account at the time.

These requirements will be taken into account in the context of the present round.

As a result, when the strategic plan was developed on the basis of the evaluation document drawn up by the Malaria Consortium, the NMCP identified all the areas requiring technical assistance to ensure that anti-malaria actions could be implemented.

The DRC conscious of the enormous challenges in purchasing and stock management in procurement requirements offers technical assistance to the Global Fund, via its medicine purchasing, distribution and supply support system called Voluntary Pooled Procurement. The objective is to enable the country to possess adequate technical procurement and stock management capacities as from the second phase of the present round.

The Global Fund will be accompanying the country with its supply team in order to give support to these capacities in the first year of phase 1.

This assistance is a choice for which the country has opted in order to benefit from the skills and know-how to be found in the Global Fund VPP team and other partners for building up its own medicine procurement, supply and storage system.

A commission will be set up for evaluating and monitoring the memo to be signed between the Global Fund and the DRC, the departments involved in managing drugs and medicines will automatically be members.

Technical assistance under consideration: The NMCP has put priority on the following requirements:

Technical assistance proposed	2008	2009	2010	2011	2012	2013
	Number of days	Number of days	Number of days	Number of days	Number of days	Number of days
Drawing up a technical guide on planning, coordination, implementation and distribution of LLIMN	42	30				
Monitoring surveys on LLIMN distribution that has an influence on program indicators	30	15				
Developing standardised comparable databases to be used by the Ministry of Health's partners and teams on health zone, province and central levels in order to monitor LLIMN distribution.	30	30	30			
Permanent technical support by the School for Public Health on training in the use of microscopes	30	30	30	30	30	30
Report after one year's distribution of ACT by an external consultant		30		30		
Developing the implementation plan for the drug monitoring and coordination system between the 3rd department and the NMCP	120	120	120			
Evaluating the extent of the role played by the non-regulated private sector in malaria treatment, including the impact of the IMCD-C on utilisation ratios of the private sector per population		45				
Developing a framework for the private sector's commitment in the anti-malaria policy		75				
Training, evaluating and monitoring the private sector			75			
Developing standardised programs for higher medical education and health training institutes for the benefit of the new anti-malaria policy.	20	20				
Developing main guidelines for implementing an efficient plea.		60				
Reviewing the present monitoring and evaluation guidelines.	10					

This technical assistance (TA) will be obtained using transparency standards in force in the country. Reference terms for each form of assistance will be developed and validated. A request to tender process as per the fiduciary and administrative procedures set up by the BP will be launched for each TA. The choice of TA will be made by a select committee of the NMCP, BP and members of the CCM.

The process for evaluating the efficiency of this assistance will be by establishing monitoring indicators for each TA using the RDT as a basis. The select committee formed by the NMCP, BP and members of the CCM will be responsible for evaluating each TA. An evaluation sheet will be made available for obtaining feedback on the TA from all the interested participating parties (Ministry of Health, CCM, BP, SB, etc).

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ ***Go to s.4B if relevant, or direct to s.5.***
	☐ **Yes** ➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Ministry of Health (National Essential Medicines Procurement Programme)	The National Essential Medicine Procurement Programme is responsible for regulating the National Essential Medicine Procurement System (EDMSS)	☐ Yes ☉ No
Intellectual property rights	Ministry of Justice and Ministry of Health	National directives and standards clearly indicating that pharmaceutical and medical equipments (especially LLIMN and ACT) must comply with WHO Pesticide Evaluation Scheme regulations by using clearly labelled information on products. Directives also stipulate that purchase orders for LLIMN and ACT must be approved by the NEMPP and the NMCP.	☐ Yes ☉ No
Quality assurance and quality control	Ministry of Health, Pharmacy and Medicine Department (DPM) and the FEDECAME Congolese Customs Authorities Medicine quality control laboratory at the faculty of pharmaceutics, University of Kinshasa Provincial laboratories Provincial office in charge of medicines and medical consumables	The Ministry of Health Pharmacy and Medicine Department is National Pharmaceutical Regulations Authority The OCC is responsible for controlling the quality of drugs and medicines on their arrival at the frontier . For routine distribution, the FEDECAME will be under contract for carrying out quality controls at RDC and health zone levels. In this context, provincial laboratories which will receive Minilabs will also be in charge of quality control on HZ levels. Should a non-conformity be discovered, traceability for enabling a batch to be recalled will be guaranteed and appropriate mechanisms will be launched. The faculty of pharmaceutics laboratory, recently set up thanks to WHO finance will carry out independent quality controls.	☉ Yes ☐ No

Management and coordination *More details required in s.4.10.3.*	The National Essential Medicine Procurement Programme (NEMPP)	The FEDECAME is in charge of procurement by organising group purchasing. The Regional Distribution Centres (RDC) handle storage and distribution of MEG and medical consumables The commercial and accounting management software linked with the EDMSS (FEDECAME and SNR) enables medicinal and financial flows to be managed and makes data collection and analysis possible.	◉ Yes ○ No
Product selection	Ministry of Health	The government PR will work in cooperation with the National Anti-Malaria Programme and the 3rd Department for selecting products	○ Yes ◉ No
Management Information Systems (MIS)	NEMPP (NHIS – MED)	The Ministry of Health possesses a National Health Information System (NHIS) with twelve components, including a drug and medicine component NHIS-Med under the authority of the NEMPP. The NEMPP has developed data collection and analysis tools with indicators developed and validated by consensus. These tools produce the data required for information and retro-information concerning MEG and other medical consumables.	◉ Yes ○ No
Forecasting	Ministry of Health	The government PR is in charge of international anti-malarial drug purchases. Together with the NMCP and the Provincial Inspector Doctors and their Provincial Ministers of Health, the government PR will draw up the provisional 5-year drug-procurement plan	○ Yes ◉ No
Procurement and planning	Ministry of Health	The government PR is in charge of international anti-malarial drug purchases. Together with the NMCP and the Provincial Inspector Doctors and their Provincial Ministers of Health, the government PR will draw up the provisional 5-year medicine procurement plan	○ Yes ◉ No

Storage and inventory management *More details required in s.4.10.4*	Ministry of Health	The RDC will be in charge of managing stock and will use the stock management tools developed by the NEMPP	☉ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	Ministry of Health	RDCs with available space are in charge of storage in the Provinces	☐ Yes ☉ No
Ensuring rational use and patient safety (pharmaco-vigilance)	Ministry of Health	A study will be made by the 3rd department of the Ministry of Health on evaluating elements of non-acceptability of the combination A Pharmaco-vigilance system for all the anti-malarial drugs, especially the AS+AQ combination is programmed in the context of the proposal for the 8th round and will be implemented in health training programmes for monitoring side-effects.	☐ Yes ☉ No

Clarified Section 4.10.3

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
SANRU/COP (2008)	PR	ITN : $1,140,000
		Essential Meds : $1,240,491
		Med/Surg Equip : $1,211,966
		Partnership Grants : $ 150,000
		IEC/Fiches : $399,000
SANRU/ECC (2008)	SR	Essential Meds : $420,000
		ITNs : $315,000
		Health Zone Grants : $210,000
SANRU/PMURR (2008)	SR	Essential Meds : $150,000 est
		ITNs : $300,000 est
SANRU/ABBOTT (2008)	Agent	CPN Meds/Kits : $90,000
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

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

Concerning the role of the government PR at the level of the 139 HZs:

For carrying out its activities in the 139 HZs, the proposal stresses the importance of the procurement system developed via the NEMPP and relying on the Global Fund VPP mechanism

The system will use the different RDCs for making stock management and distribution throughout the country easier.

Pharmaceutical and medical equipment will arrive in the country via several entry points, notably Matadi, Bukavu and Kasumbalesa.

The RDC will therefore handle stock management and supply the health zones as per a rhythm agreed upon and depending on consumption. The RDC will also control structures in terms of stock management.

The stock and drug utilisation management tools accepted on a national level will be used in the context of this proposal.

Quality control will be carried out by the OCC on the arrival of products at the frontiers. National and provincial laboratories will be under contract for quality assurance on RDC and Health Zone levels.

The provincial laboratories will also be involved in carrying out quality controls using the minilab kits which will be given to them during round 8.

A national pharmaco-vigilance system will be developed in the country with the Global Fund's financial assistance for round 8

4.10.5. Storage and distribution systems

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

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

RDC N°	Name of RDC	Town	Province	Storage space in cubic meters
RDC01	**CAAMEKI**	Kisantu	Lower Congo	1595
RDC02	**CADIMEK**	Kananga	Western Kasaï	1956
RDC03	**CADMEKO**	Mbuji Mayi	Eastern Kasaï	1800
RDC04	**CAAMEBO**	Matadi	Lower Congo	1173 and 33 in cold storage
RDC05	**CAMESKIN**	Kinshasa	Kinshasa	2450
RDC06	**CAMENE**	Bwamanda	Equator	1600 and 33 in cold storage
RDC07	**CAMEBASU**	Kikwit	Bandundu	1600 and 33 in cold storage
RDC08	**CEDIMEK**	Kamina	Katanga	
RDC09	**CEDIMET**	Tshikapa	Western Kasaï	642

RDC10	**CAMEBAND**	Bandundu	Bandundu	1369
RDC11	**ASRAMES**	Goma	North Kivu	7750
RDC12	**CAMENIHU**	Ariwara	East	720
RDC13	**CADMETA**	Kalemie	Katanga	1348
RDC14	**CAMELU**	Lubumbashi	Katanga	
RDC15	**CADIMEBU**	Bunia	East	853
RDC16	**CAMEKIS**	Kisangani	East	2108

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

Regional Distribution Centres for drugs and medicines are classified under two groups:

- Those that possess trucks capable of transporting at least 12 tons of drugs and health products to health zones and reference general hospitals in the area they cover: Asrames, Camene and Camebasu, Caamebo.
- The others, which do not possess logistics resources for distributing drugs and health products and where the health zones have to come and pick up their supplies

4.10.6. Pharmaceutical and health products for initial two years

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

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

The demand for pharmaceutical and health products complies with national, international and WHO standard treatment directives.

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if:

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

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions.

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

5. FUNDING REQUEST

Clarified Section 5.1

5.1. Financial gap analysis - Malaria

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

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Malaria program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**66367523**	**199704995**	**252148098**	**163866930**	**213103845**	**193603999**	**138919990**	**138919990**
Line A.1 ➔ Total need over length of Round 9 Funding Request				*(combined total need over Round 9 proposal term)*				Budget Total
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	0	3233393	5233806	9623519	9629953	0	0	0
Domestic source **B2** National funding resources	2000000	2000000	2000000	2000000	2000000	2000000	2000000	2000000
Domestic source **B3** Private Sector contributions (national)				3572142	3718387	4088787	4078051	4078051
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	2 000 000	5 233 393	7 233 806	15 195 661	15 348 340	6 088 787	6 078 051	6 078 051
External source **C 1** (*provide source name*) World Bank Booster Ph 1	10000000	10000000	10000000					

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C2** (*provide source name*) World Bank Booster Ph II			23760000	23760000	23760000	23760000	28720000	
External source **C3** **World Bank Country Contribution (Kinshasa)**		13000000						
External source **C4** **UNICEF (several financial backers included JICA)**	5476901	8253027	8925780	9655437	10452091	11321994		
External source **C5** **UNITAID**			26400000					
External source **C6** **BAD**		478667	478667	478667				
External source **C7** USAID	1436667	1436667	1436667					
External source **C8** **DFID**	6500000	6500000						
External source **C3** Private Sector contributions (International)				0	0	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	23 413 568	39 668 361	71 001 114	33 894 104	34 212 091	35 081 994	28 720 000	

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years								
Round 3	10884805	12778346						
Round 8			**96481549**	**49039255**	**64670823**	**82546010**	**46955236**	
Total	10884805	12778346	**96481549**	**49039255**	**64670823**	**82546010**	**46955236**	
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	36 298 373	57 680 100	174 716 469	98 129 020	114 231 254	123 716 791	81 753 287	6 078 051
Calculation of gap in financial resources and summary of total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	30 069 150	142 024 895	77 431 629	65 737 910	98 872 591	69 887 208	57 166 703	132 841 939
Line G = Round 9 malaria funding request *(same amount as requested in table 5.3 for this disease)*				**55836015**	**61872826**	**61340001**	**48935672**	**52510621**

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

In Round 9, the total maximum funding request for malaria in Line G is:

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

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

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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2010-2014 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

%

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

Explain how the annual amounts were:

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

National strategy costing is done on a 5-year basis and takes account of national policy in all its dimensions both for government and community sectors

The 2007 – 2011 strategic plan has been re-qualified for 2009 – 2013 as a result of the latest developments that have occurred on the fight against malaria on world, national and regional levels.

For 2007 and 2008, line A of table 5.1 refers to the annual amounts for the 2007-2011 strategic plan and to the annual amounts for the years 2009, 2010 and 2011 in the 2009-2013 plan

Clarified Section 5.1.2

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

Explain the processes used in country to:

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

The government of DRC is deeply committed to the fight against malaria. Given the country's poverty, the government does not possess sufficient resources. However, a contribution of around 2 million dollars a year is being made by the government through infrastructure provision, electricity supply, water provision, and basic salaries for national and provincial coordinating establishments.

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

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

World Bank

- Booster Ph I – Being implemented at present.
- Booster Ph II – The sum of 100 million dollars was communicated to the country at the mixed Government – financial backer meeting on the fight against malaria held in January 2009. The project is under preparation at present.

UNICEF: In cooperation with JICA – the Japan International Cooperation Agency, contributions have been granted more especially for treatment. UNICEF gives support to 40 HZ in the different provinces. No change in the amounts is expected.

UNITAID: Under the direction of the RBM Harmonization Working Group, an application for 5.5 million mosquito nets for the DRC as a part of a request for several countries. On 30.06.08, the application had not been officially accepted – so there is a possibility that this pharmaceutical and medical equipment will not be successful and that this contribution will not arrive in 2009. Others applications will be made to UNITAID in the coming years for filling this gap if necessary. There will also be other applications to UNITAID for covering the remaining shortages needing to be filled for meeting objectives to cover the whole country.

AfDB: The African Development Bank as also made a contribution of 70,000 mosquito nets and 1 million treatments over 3 years. The agreement has just been signed in 2008, and funds for the first year are expected at the end of 2008.

USAID: The American organization has given support to several HZs in different provinces. Its contribution is confirmed until 2009 with the possibility of an extension. USAID support is an extension of the PMA, which contributes to the country's objective to have proximity treatment available for all the Congolese.

WHO: Over and above technical support, the WHO supplies medicines for emergency zones in the west of the country.

5.2. Detailed Budget

Suggested steps in budget completion:

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

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/rounds/9/single/#budget.

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

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

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

5. Do not include any CCM or Sub-CCM operating costs in Round 9. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/ccm/

Clarified Section 5.3

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	LLIMN SDA	8 726 778	11 991 317	12 636 387	13 004 153	14 168 362	60 526 997
2	Malaria prevention during pregnancy SDA	1 448 074	1 187 446	1 975 855	1 199 883	1 207 162	7 018 420
3	Diagnostic SDA	12 940 758	14 703 117	13 637 291	9 912 788	10 207 089	61 401 043
3	Treatment SDA	21 210 983	24 164 284	24 320 245	17 443 949	17 972 517	105 111 977
3	Home Malaria Treatment SDA	938 951	-	-	-	-	938 951
4	Partnership development SDA	1 537 086	1 479 143	534 582	470 832	400 182	4 421 824
	Overheads	3.276.184	3.746.772	3.717.305	2.942.212	3.076.872	16.759.345
	Management costs PR 1+PR 2 + Sub-recipients	**5 757 201**	**4 600 747**	**4 518 336**	**3 961 856**	**5 478 437**	**24 316 578**
	[use "Add Extra Row Below" from "Table" menu in Microsoft Word menu bar to add as many additional rows as required]						
Round 9 malaria funding request:		**55 836 015**	**61 872 826**	**61 340 001**	**48 935 672**	**52 510 621**	**280 495 135**

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

Clarified Section 5.4

Avoid using the "other" category unless necessary – read the Round 9 Guidelines .

	(same currency as on cover sheet of Proposal Form)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	3 417 070	1 924 481	1 863 118	1 860 276	3 280 672	12 345 617
Technical and Management Assistance	210.275	172.250	156.500	92.750	84.500	716.275
Training	7.054.233	244.000	119.800	119.800	57.400	7.595.233
Health products and health equipment	13.596.937	18.720.681	18.424.149	15.991.044	16.830.071	83.562.883
Pharmaceutical products (medicines)	12.675.842	16.331.937	16.315.284	11.604.675	11.955.877	68.883.616
Procurement and supply management costs	9.108.946	11.962.085	11.812.723	9.362.575	9.764.174	52.010.503
Infrastructure and other equipment	1.280.139	1.108.993	304.382	304.382	304.382	3.302.277
Communication Materials	1.793.750	3.770.500	3.770.500	3.770.500	3.770.500	16.875.750
Monitoring & Evaluation	1.072.807	1.214.861	2.201.021	785.878	1.188.408	6.462.976
Living Support to Clients/Target Populations	-	--	-	-	-	-
Planning and administration	9.700	-	-	-	-	9.700
Overheads	3.276.184	3.746.772	3.717.305	2.942.212	3.076.872	16.759.345
Other: *(Use to meet national budget planning categories, if required)*	**5 757 201**	**4 600 747**	**4 518 336**	**3 961 856**	**5 478 437**	**24 316 578**
Round 9 malaria funding request (*Should be the same annual totals as table 5.2)*	**55 836 015**	**61 872 826**	**61 340 001**	**48 935 672**	**52 510 621**	**280 495 135**

5.4.1. Overall budget context

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

HALF PAGE MAXIMUM

LLIMN, ACT and other medical equipment represent over half of the whole proposal, or 54.35% of the total sum

Product import management represents 18.54% due to the quantities programmed for a country as vast as the RDC

M&E may appear low (2.3%), it is also taken into account transversally by HSS and certain monitoring and evaluation activities by round 8. Lastly, the figure does not include that part of this activity included in PR management costs

PR and Sub-Recipient management costs amount to 8.67%

5.4.2. Human resources

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

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

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

Table 5.4, summarizing the detailed budget, shows an amount attributable to human resources equivalent to 4.4% of the total proposal. In fact, this line represents all the PR costs for managing the proposal and the amount attributable to human resources themselves is even lower than this percentage (See detailed PR cost categories in the detailed hypothesis sheet in the budget)

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national malaria program.

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

In the summary, there is an "Other" line that corresponds to management costs for Sub-Recipients of the proposal. These sub-recipients who work in the field under the supervision of PRs cannot act cost-free, even more so because they must cover – frequently under difficult conditions - 139 health zones in the DRC or a little over one quarter of all the zones in the country.

As a result of experience obtained in previous proposals, the approximate cost represents about 5% of the activities + supplies total. The cost of sub-recipients has been calculated on this basis.

In fact, it represents 4.27% of the overall total for the proposal.

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

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

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

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
5.5.3 Additionality of Global Fund request
Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the malaria program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on malaria outcomes during the proposal term.*

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 9

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 9 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions

Download 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 9 and has completed section 4B and included that section in the Malaria proposal sections.***

Proposal checklist – Section 3 to 5 Malaria

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	AQ1, STRATEGIC PLAN 2009-2013 AQ10 MONITORING & EVALUATION PLAN AQ11 NATIONAL POLICY DECLARATION
4.2.1	Map if proposal targets specific region/population group	AQ17 POPULATION IN 139 HEALTH ZONES
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	AQ14 NEED ASSESSMENT AQ15 MONITORING & EVALUATION MEASUREMENT WORKSHOP REPORT AQ4 EXTRACT OF THE NMCP ANNUAL REPORT FOR 2007 AQ5 EXTRACT OF THE NMCP ANNUAL REPORT FOR 2008
4.4	Document(s) that explain basis for coverage targets	AQ1, STRATEGIC PLAN 2009-2013 AQ6 DRC_BUDGET MACROPLAN FOR THE NMCP-PEV-PRONANUT INTEGRATED CAMPAIGN FOR 2009 AQ7, DRC_BUDGET MACROPLAN FOR THE NMCP-PEV-PRONANUT INTEGRATED

Proposal checklist – Section 3 to 5 Malaria

		CAMPAIGN FOR 2006 AQ16 EDS REPORT 2007
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table**.	**Annex A**
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	**Work plan**
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	x
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	AQ14 NEEDS ASSESSMENT
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	x

Proposal checklist – Section 3 to 5 Malaria

Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**
SDA 3	Information on community health-care	AQ8 DRC_ IMPLEMENTATION GUIDE 2007 (Community health-care sites) AQ9 DRC CCM NEWS 2008 (Bi-monthly newsletter on community health-care sites in the DRC)
Mosquito net SDA	Information on placing contracts	AQ13 CONTRACT PLACING DIRECTIVES
All titles	Acronyms	AQ12 LIST OF ACRONYMS
All objectives except N° 4	Information on operational research	AQ3 DEVELOPMENT PLAN FOR ANTI-MALARIA OPERATIONAL RESEARCH 2007-2011
All sections	List of Annexes	AQ18 LIST OF ANNEXES