

**SEVENTH ROUND PROPOSAL FOR THE GLOBAL
FUND**

**Scaling Up Malaria and Tuberculosis
Control in Liberia Through Partnership**



A ROUND 7 GFATM PROPOSAL SUBMITTED BY:
The Liberia Coordinating Mechanism
for
HIV/AIDS, TUBERCULOSIS and MALARIA

4 July 2007

Monrovia, Liberia

MAP OF LIBERIA



Liberia is emerging from more than 14 years of destructive war and a 'culture' of violence. The elections of 2005 have ushered in an era of new leadership and optimism that have already resulted in significant improvements in the health sector.

The population is estimated at 3.6 million with a growth rate of 2.4%. Land area comprises 111,370 square km. Population density is around 30 per square km, but very uneven, with four of 15 counties hosting 70% of the total population. Massive population displacement in the rural areas during the war led to artificially accelerated urbanization, resulting in severe overcrowding in towns and cities. The literacy rate is less than 40%.

Three fourths of the population lives below the poverty line on less than US\$1 a day. The economy is, however, making a modest recovery, and there is a gradual improvement in security in rural areas.

List of Abbreviations and Acronyms

ACT	Artemisinin-based Combination Therapy
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
HIPC	Highly Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSS	Health Systems Support
HTM	HIV, Tuberculosis and Malaria
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Persons
IEC/BCC	Information Education & Communication/Behavior Change Communication
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
LCM	Liberia Coordinating Mechanism
LFA	Local Funding Agency
LLIN	Long Lasting Insecticide Treated Net
LMIS	Liberia Malaria Indicator Survey
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MENTOR	Malaria Emergency Technical and Operational Response
MERCI	Medical Emergency Relief and Corporative International
MERLIN	Medical Emergency Relief International
MOHSW	Ministry of Health and Social Welfare
MSF	Medecins Sans Frontieres
N/A	Not Applicable
NDS	National Drug Services
NLTCP	National Leprosy and Tuberculosis Control Programme
NMCP	National Malaria Control Program
OR	Operational Research
PMI	President's Malaria Initiative
PR	Principal Recipient
iPRS	Interim Poverty Reduction Strategy
PSM	Procurement and Supply Management
RBM	Roll Back Malaria
RFTF	Results Focused Transitional Framework
SC-UK	Save the Children - UK
SP	Sulfadoxine-Pyrimethamine
SWAp	Sector Wide Approach
SWOT	Strength Weakness Opportunity and Threats (analysis)
TB	Tuberculosis
TCC	Technical Coordinating Committee
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WVL	World Vision - Liberia
YMCA	Young Men's Christian Association

PROPOSAL FORM – ROUND 7

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

Applicant Name	Liberia Coordinating Mechanism
Country/countries	Liberia
Components included in this Proposal Form <i>(Check each applicable box below)</i>	
<input type="checkbox"/>	HIV/AIDS ¹
<input checked="" type="checkbox"/>	Tuberculosis ¹
<input checked="" type="checkbox"/>	Malaria

Timetable: Round 7

Deadline for submission of proposals: 4 July 2007

Board consideration of recommended proposals: 14 - 16 November 2007

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

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PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS

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REQUIRED ATTACHMENTS

- A. Targets and Indicators Table *(Complete a separate table for each component)*
- B. Preliminary List of Pharmaceutical and other Health Products *(Complete a separate table for each component)*
- C. Membership details of CCM, Sub-CCM or RCM *(Complete once only)*
- + Detailed Budget *(Complete a separate detailed budget for each component)*
- + Detailed Work plan *(Complete a separate detailed workplan for each component)*

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

REFERENCE DOCUMENTS FOR APPLICANTS

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

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

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
 - The Round 7 Guidelines for Proposals
 - A complete copy of this Proposal Form
 - A complete copy of Attachments A, B and C to this Proposal Form
2. **Read the accompanying Round 7 Guidelines for Proposals** before completing this Proposal Form.
3. Further guidance for completing specific sections is also included in the Proposal Form itself, printed in *blue italics*. Where appropriate, indications are given as to the recommended maximum length of the answer.
4. To **avoid duplication of effort**, we recommend that you make maximum use of existing information (e.g., national health sector development plans, national monitoring and evaluation frameworks, situation analyses of strengths and weaknesses of the existing responses to the disease(s), and documents written to report to the Global Fund on existing grants and/or work supported by other donors/funding agencies).
5. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are submitting a fully complete application.
6. **Attach all documents** requested throughout the Proposal Form **including** a budget, work plan, and all documents you are requested to annex to the proposal.
7. Consult our “Frequently Asked Questions” link:
<http://www.theglobalfund.org/en/apply/call7/documents>

Important notes:

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

How to use this form

WHAT IS DIFFERENT COMPARED TO ROUND 6?

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

1. all **CCM, Sub-CCM and RCM information needs** (including the **eligibility requirements**) are **now** with other 'Applicant Type' information in **section 3A**;
2. **Section 4** has been **re-ordered** to better enable Applicants to describe the overall strategy/country context, how the funding request harmonizes with other in-country actions, and then what will be achieved under this proposal;
3. **Section 4** also requests detailed information **on three key lessons learned arising from the Technical Review Panel's review of Round 6 proposals**. These are:
 - (a) addressing the **comments of the TRP** from proposals not approved in prior Rounds (section 4.6.1) **and attaching the relevant TRP review form(s)**;
 - (b) explaining a Round 7 request for additional funding for the same key services covered by earlier Global Fund grants, where there are **large undisbursed amounts of money** under those earlier grants, including unsigned Round 6 grants (section 4.6.4(a)); and
 - (c) describing how bottlenecks in performance experienced by Principal Recipients ('PR') who are again nominated as PR for Round 7 have been addressed in the proposal;
4. **Section 5 requests less complex budget details**, responding to the comments of Applicants and the Technical Review Panel in Round 6;
5. **Attachment A (Targets and Indicators Table)** has been prepared by disease. Applicants may use the pre-filled list of potential indicators where relevant to their proposal, or overwrite the table;
6. **Attachment B (Preliminary List of Pharmaceutical and other Health Products)** has been prepared in **Microsoft Excel** to assist Applicants to identify key information about products, their pricing and intended suppliers. Again, it has been prepared by disease; and
7. **Contact details and proposal endorsement signatures for CCM, Sub-CCM and RCM Applicants are now located in a new Attachment C**. This is to facilitate an automatic upload of this material into our data base to ensure that we have current contact details accurately displayed on the Global Fund website.

Health Systems Strengthening – Round 7

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

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

1 Proposal Overview

1.1 General information on proposal

Applicant Type

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

- National Country Coordinating Mechanism
- Sub-national Country Coordinating Mechanism
- Regional Coordinating Mechanism (including small island developing states)
- Regional Organization
- Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

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

Component	Title
<input type="checkbox"/> HIV/AIDS ²	
<input checked="" type="checkbox"/> Tuberculosis ²	Strengthening Tuberculosis Control and Management of People with TB/HIV co-infection
<input checked="" type="checkbox"/> Malaria	Scaling up Malaria Control in Liberia through Partnership

Currency in which the Proposal is submitted

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

- US\$
- Euro

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

1 Proposal Overview

Summary of Technical Assistance Provided During Proposal Preparation		
<p>Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation of this proposal for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.</p>		
Section/Component	Name of organization or organizations providing assistance and type of assistance provided	Duration of technical assistance provided
<input type="checkbox"/> Sections 1 to 3B		
<input type="checkbox"/> HIV/AIDS component, and/or budget		
<input checked="" type="checkbox"/> Tuberculosis component, and/or budget	1. Harvard University, USA: Technical Assistance 2. WHO: Technical Assistance 3. Executive Health Care Consultants Ltd. Ghana	4.0 weeks 2.5 weeks 2.0 weeks
<input checked="" type="checkbox"/> Malaria component, and/or budget	1. Quick Impact Malaria Initiative, The Earth Institute at Columbia University: Technical assistance 2. WHO/Roll Back Malaria Harmonization Working Group: Technical assistance <ul style="list-style-type: none"> • External Consultant • Local Consultant 	20 days 37 days 3 months

1.2 Proposal funding summary per component

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

Table 1.2 – Total funding summary

Component	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS						
Tuberculosis	3,431,785	2,977,088	2,959,116	2,343,295	2,820,616	14,531,900
Malaria	\$6,347,301.24	\$6,348,605.30	\$7,402,013.41	\$8,118,208.11	\$9,164,069.84	\$37,380,197.90
Total all components	9,779,086.24	9,325,693.3	10,361,129.41	10,461,503.11	11,984,685.84	51,912,097.9

1 Proposal Overview

1.3 Contact details for enquiries by the Global Fund

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

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	Secondary contact
Name	Mr. Tolbert G. Nyenswah	C. Lawuo Gwesa
Title	Deputy Program Manager, National Malaria Control Program	National Program Manager, National Leprosy & Tuberculosis Control Program
Organization	Ministry of Health and Social Welfare	Ministry of Health and Social Welfare
Mailing address	Ministry of Health & Social Welfare Capitol Bye-Pass Road P. O. Box 10-9009 1000 Monrovia, 10 Liberia	Ministry of Health & Social Welfare Capitol Bye-Pass Road P. O. Box 10-9009 1000 Monrovia, 10 Liberia
Telephone	+231 6 558 612	+231 6 521446
Fax	N/A	N/A
E-mail address	Tgnyenswah74@yahoo.com	lawuogwesa@yahoo.com
Alternate e-mail address		

1 Proposal Overview

1.4 Overview Summary of the Applicant's Proposal

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

(Maximum length of this section is one page in total)

Tuberculosis (TB) is a major public health problem in Liberia being in the top 5 diseases of public health concern. The exact magnitude of TB in the country is currently unknown. However, the WHO estimates an incidence rate for all forms of 301 per 100,000 population (i.e. 10,926 new cases in 2006) and for sputum smear positive of 132 per 100,000 population³ (4,792 new cases in 2006). The age group 15-54 years is most vulnerable to TB and this has obvious consequences for the socio-economic well-being of the county.

Liberia has made significant strides in the control of TB in the country boosted by a Global Fund against AIDS, TB and Malaria in 2004. DOTS service coverage by county is 100% (15 out of 15 counties) but only 202 out of about 385 health facilities (52%) are offering DOTS and 101 of these centres do not have TB diagnostic facilities. Case detection rates (smear positives) increased consistently from 2001 to 2006 (from 52.7% to 60.6%⁴), except for 2003 when there was a civil war.

The dual epidemic of TB and HIV threatens the gains made so far in TB control in Liberia over the past few years.

In line with the Liberia Interim Poverty Reduction Strategy 2006, the National Health Plan and Policy 2007, and the National TB Strategic Plan 2007-2012, this proposal seeks a grant for the sum of US\$ 14,531,900 to fund a scale up of TB control activities in Liberia from 2008 to 2012. The goal of the proposed programme is to reduce the national burden of TB in Liberia by 2015 in line with MDG and Stop TB Partnership targets. The specific objectives are to increase access to high quality DOTS, to establish the management and treatment of MDR-TB, to increase access to integrated TB/HIV services to cover at least 65% of the population, to empower the community and people living with TB to be involved in TB care, to strengthen the health system and to under take research to determine baseline epidemiology status of TB, TB/HIV and multi-drug resistant TB in Liberia. The strategy to reach the goal is consistent with Stop TB strategy and includes pursuance of expansion of high-quality DOTS and enhancement through decentralisation, scale up of an effective TB and HIV collaborative mechanism, health systems strengthening, creating an environment of enticement for the community to get engaged in the campaign to stop TB, involving the private sector and NGOs in TB care and programme related research.

Malaria is hyper-endemic in Liberia and it is a major public health problem. Malaria accounts for 38% of Out-patient attendance and is the leading cause of inpatient deaths. Hospital records show that at least 42.3% of inpatient deaths are attributable to malaria. Further, until 2004, inaccessibility due to poor security conditions meant that medications and disease prevention and control commodities were not available to about two thirds of the country's population.

Malaria infection especially with *P. falciparum* during pregnancy results in a wide range of adverse consequences for the pregnant woman, the developing fetus and the newborn infant. A major effect of malaria infection that is widely observed in pregnant women in Liberia is anemia. This is often severe, life-threatening and sometimes fatal. Low birth-weight babies are therefore common due to the high incidence of malaria in pregnancy.

Eventhough the socio-economic impact of malaria has not been assessed for Liberia, the cost of treatment to the family and the cost of lost days of work could be considerably high.

³ WHO Report 2007

⁴ NTCP 2005

1 Proposal Overview

The main focus of work to be undertaken with this grant is:

1. Prompt and effective treatment of malaria in the general population,
2. Prevention of malaria particularly in pregnant women (LLNs and SP) and in under fives (using LLINs)
3. Strengthening the managerial capacity of the national malaria control program through human resource development (training ,etc) and improved working environment (logistics, incentives).

The operational strategies for achieving the goals of the NMCP are supported by a strong behavior change communication/information, education and communication program.

1 Proposal Overview

1.5 Overview of rationale for multi-country proposal approach

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

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

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

In this section, please describe:

- (a) *the common issue for these countries which presents a strong argument for a regional or cross-border approach;*
- (b) *why a multi-country proposal will be more effective in responding to the issues presented than if each CCM presented the same activities on a country by country basis; and*
- (c) *how the applicant (RCM or RO) worked with the CCM** of each country during the proposal development process to ensure that the funding requested in this proposal does not merely replace existing financing, but contributes additional financing to increase the regions capacity to respond to the disease(s).*

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

Overview of rationale for multi-country approach <i>(maximum one page)</i>
N/A

1 Proposal Overview

1.6 Previous Global Fund grants/proposals recommended for funding

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

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

Table 1.6.1 – Previous Global Fund HIV/AIDS financial support

HIV/AIDS	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2	*7,658,187.00	*7,680,692.00	N/A
Round 3			
Round 4			
Round 5			
Round 6			
Total	7,658,187.00	7,680,692.00	

Table 1.6.2 – Previous Global Fund tuberculosis financial support

Tuberculosis	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2	4,534,017	4,313,467.56	N/A
Round 3			
Round 4			
Round 5			
Round 6			
Total	4,534,017	4,313,467.56	

* Actual expenditure exceeded amount disbursed by Global Fund. Additional funds came from interest rate of PR.

1 Proposal Overview

Malaria	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2			
Round 3	12,140,921	12,140,921	N/A
Round 4			
Round 5			
Round 6			
Total	12,140,921	12,140,921	

Table 1.6.4 – Previous Global Fund HSS and other financial support

HSS or Integrated	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Main disease targeted			
Round 2			
Main disease targeted			
Round 5			
Main disease targeted			
Total	0.00	0.00	

2 Country Eligibility

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

These eligibility criteria are:

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

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

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

2.1 Income Level

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

World Bank classification of Income level of countries/ economies included in proposal	Country/economy name(s) <i>(include the name of each country/economy and its relevant income level for multi-country proposals)</i>	
<input checked="" type="checkbox"/> Low-income	Republic of Liberia	➔ Go straight to section 3A , Applicant Type
<input type="checkbox"/> Lower-middle income		➔ Complete both sections 2.2 and 2.3, and then go to section 3A
<input type="checkbox"/> Upper-middle income		➔ Complete each of sections 2.2 and 2.3 and 2.4, and then go to section 3A

2 Country Eligibility

2.2 Counterpart financing and greater reliance on domestic resources

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

2.2.1 CCM and Sub-CCM Applicants

The table should be completed for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.2.1.

Amounts included in line A and line B in the tables below should be in figures not percentages.

Important notes:

1. The field "Total requested from the Global Fund" in tables 2.2.1(a) to (c) below must equal the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3 for each corresponding component.
2. Non-CCM Applicants do not have to fulfill any counterpart financing requirement.

Table 2.2.1(a) – Counterpart financing HIV/AIDS

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

2 Country Eligibility

Table 2.2.1(b) – Counterpart financing tuberculosis

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

Table 2.2.1(c) – Counterpart financing malaria

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

2 Country Eligibility

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

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

RCM and RO Applicants may **either**:

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

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

OR

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

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

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

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

- (a) 10% to 20% counterpart financing over the proposal term if a Lower-middle income country; or
- (b) 20% to 40% counterpart financing over the proposal term if an Upper-middle income country.

2 Country Eligibility

2.3 Focus on poor or vulnerable populations

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

2.3 Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal.
(Maximum half a page per component).

N/A

2.4 Upper-middle income high disease burden minimum thresholds

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

(a) **HIV/AIDS Current High National Disease Burden**

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

(b) **Tuberculosis Current High National Disease Burden**

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

N/A

(c) **Malaria Current High National Disease Burden**

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

N/A

3A Applicant Type and Eligibility for Funding

This section requires **all Applicants** to:

- (a) Describe what type of applicant they are; and
- (b) Describe how they meet the minimum requirements **to be eligible to submit a proposal**.

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

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

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

Confirmation of Applicant Type

Table 3A – Applicant Type

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

<input checked="" type="checkbox"/>	National Country Coordinating Mechanism	→ Complete sections 3A.1 and 3A.4 and 3B.1
<input type="checkbox"/>	Sub-national Country Coordinating Mechanism	→ Complete sections 3A.2 and 3A.4 and 3B.1
<input type="checkbox"/>	Regional Coordinating Mechanism for multi-country proposals (including small island developing states)	→ Complete sections 3A.3 and 3A.4 and 3B.1
<input type="checkbox"/>	Regional Organization for multi-country proposals	→ Complete section 3A.5 and 3B.2
<input type="checkbox"/>	Non-CCM Applicants for single country proposals only	→ Only complete section 3A.6

Importantly →

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

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

3A Applicant Type and Eligibility for Funding

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

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

Table 3A.1 – National CCM: overview information

Name of CCM
Liberia Coordinating Mechanism (LCM)

3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

- The extent to which the CCM acts as a functional partnership between government and other key stakeholders, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- How it coordinates its activities with other national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

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

The Liberia Coordinating Mechanism (LCM) has a broad-based membership, representing non-governmental organizations (local and international), civil society including faith based organizations, government, the academia, multi-lateral and bi-lateral development agencies, persons living with HIV/AIDS and other relevant partners. The Chair of the LCM is the Minister of Health and Social Welfare of the Republic of Liberia and the Co-chair is Dean of the Mother Patern College of Health Sciences who represents Faith-Based Organizations and is the coordinator of the Catholic Church HIV/AIDS Program. (Attach list of members as an annex)

The LCM meets monthly. However, they may meet twice a month depending on prevailing situation and the need for decisions on outstanding matters. The Chair or Vice Chair may call extraordinary meetings as necessary to address critical issues. Any LCM member may suggest the need for a meeting to the Chair or Vice Chair as indicated in the by-laws (see attached). Proposed agenda items are submitted to the LCM Secretariat to be circulated at least one week prior to the meeting. The LCM Secretariat is headed by a Coordinator, assisted by an Administrative Assistant and an Office Assistant.

There are two sub-committees of the LCM; the Technical Coordinating/Monitoring and Evaluation Committee (TCC/M&E) and the Finance committee. The TCC/M&E committee, chaired by the World Health Organization, was developed to discuss technical and monitoring issues to ensure that implementation is technically sound. The committee assesses proposals and participates in monitoring and evaluation of the implementation of funded programs. It provides technical oversight of the performance of the grant. The Finance Committee, chaired by the Private (Business) Sector deals with financial matters such as timely disbursements by the PR and sub-recipient . These two sub-committees make recommendations to the LCM. Activities of the LCM are governed by the LCM by-laws.

3A Applicant Type and Eligibility for Funding

Quorum and Decision-Making

The LCM conducts business only when two-thirds of the members are present. If no quorum exists, an urgent meeting with the same agenda is called within one week. Decision-making is generally based on a desire for consensus. If consensus is not possible, any LCM member can call for a vote. In order to pass, motions require a two-thirds majority of those present. All LCM decisions and related documentation are made open and available to the public.

Membership Requirements and Termination of Membership

LCM members are expected to attend all regularly scheduled meetings twice a month. Each member is required to attend a minimum of 75% of scheduled meetings in any given year. In the event that a member is unable to attend in person, the member may, in writing, appoint another representative to attend and to carry the same voting powers as the member. Any member who fails to attain the minimum attendance requirement will be asked to relinquish his/her seat and the sector will be asked to nominate another representative in a documented and transparent process.

Individuals intending to terminate membership with the LCM shall give thirty (30) days written notice. The member shall also notify his/her constituency in writing, a copy of which shall be filed with the LCM Secretariat. The sector will then select/elect another LCM representative.

The LCM is a forum for partners to discuss disease control activities, management of funds, financial and management activity reports, and work plans. The LCM requests funding from the Global Fund and oversees the implementation process. All members of the LCM have the same voting rights and discussions are open to the public.

Coordination of activities with other national structures tasked with responsibility for oversight and harmonization in regard to TB and Malaria:

The LCM attends the meeting of the TB Advisory Board where operational and programmatic issues such as program performance and drug requirements are discussed. There are two parliamentary/legislative committees on health, namely the House of Representatives Standing Committee on Health and the House of Senate Standing Committee on Health. The LCM meets with these committees on an ad hoc basis, usually (through the Chairman) to advocate for the national health program and not for individual programs. The last such meeting was an advocacy meeting held in the first quarter of this year (2007) with the House Standing Committee on Health, for budgetary support to re-open more rural health facilities.

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

3A Applicant Type and Eligibility for Funding

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

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

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

Name of Sub-CCM
N/A
<p>3A.2.1 Mode of operation</p> <p>Describe how the Sub-CCM operates. In particular:</p> <p>(a) The extent to which the Sub-CCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders in the region in which the Sub-CCM operates, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;</p> <p>(b) The process by which the Sub-CCM developed under the guidance of a functional CCM and how it became to be formally recognized by that CCM <i>(Note: if there is evidence of a legal framework for the sub-national entity stating its autonomy please provide such evidence); and</i></p> <p>(c) How the Sub-CCM coordinates its activities with other sub-national and national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as Regional and/or National AIDS Councils, Municipal, State or National Parliamentary Health Commissions, Regional and/or National Monitoring and Evaluation Offices and other key bodies).</p> <p><i>(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide a diagram setting out the interrelationships between all key actors as an annex to this proposal including, in particular, the interrelationships with the National CCM. Please indicate the appropriate annex number in your checklist to sections 1 to 3B before the start of section 4.)</i></p>
N/A
<p>3A.2.2 Rationale</p> <p>(a) Explain why a Sub-CCM approach represents an effective approach in the circumstances of your country. <i>(Maximum of half a page.)</i></p>
N/A
<p>(b) Describe how this proposal is consistent with and complements the national strategy for responding to the disease and/or the national CCM plans. <i>(Maximum of half a page.)</i></p>
N/A

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

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

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

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

Name of Regional Coordinating Mechanism (RCM)
N/A
RCM Secretariat Office Address
N/A

3A.3.1 Mode of operation

Describe how the RCM operates. In particular:

- (a) **The extent to which the RCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;
- (b) **How the RCM coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, national monitoring and evaluation offices, or the national strategies of small island developing states who are not required to have their own national CCM or other national coordinating body); and
- (c) **The RCM's governance structure and processes**, and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

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

N/A

3A.3.2 Rationale

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

N/A

3A Applicant Type and Eligibility for Funding

(b) Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM.
(Maximum of half a page.)

N/A

→ After completing this section, complete [BOTH section 3A.4 and section 3B.1.](#)

3A Applicant Type and Eligibility for Funding

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

IMPORTANT NOTE FOR APPLICANTS:

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

For additional information regarding these requirements, see:

- [The CCM Guidelines; and](#)
- ['Clarifications on CCM Minimum Requirements'](#).

3A.4.1 Round 6 Application History

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

Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table to complete other important questions.	
<input checked="" type="checkbox"/> Applied in Round 6 and determined as having met the minimum requirements for Round 6	→ Complete section 3A.4.2 and each of Requirements 3(a), 3(b), 4(a) and 5(a) within sections 3A.4.5 and 3A.4.6.
<input type="checkbox"/> Did not apply in Round 6 or determined ineligible in Round 6	→ Complete sections 3A.4.2 to 3A.4.6 inclusive.

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

<p>Describe in detail any changes in the membership or operations of the Coordinating Mechanism (i.e., CCM, Sub-CCM or RCM) since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted for the selection of members by their own sectors, or to manage conflicts of interest; or oversee the work of implementation partners.</p> <p><i>If new processes have been adopted, these must be described, and relevant documents attached as an annex to your Round 7 proposal.</i></p>
<p>No changes in the membership or operations of LCM have been made since submission of the GFATM Round 6 application to the Global Fund in 2006</p>

3A Applicant Type and Eligibility for Funding

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

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

3A.4.3 Principle of broad and inclusive membership	
<p>(a) Requirement 1 → Selection of non-governmental sector representatives</p> <p>Provide evidence of how the CM members representing each of the non-governmental sectors (i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations), have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.</p> <p><i>Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement AND attach as an annex the documents showing each sector's transparent process for CM representative selection, and each sector's meeting minutes or other documentation recording the selection of their current representative.</i></p>	
Documentation relied on to support compliance with Requirement 1	Identify which annex to this proposal contains these documents <i>Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.</i>
<input type="checkbox"/> Selection criteria for each sector developed by each respective sector	Annex A
<input type="checkbox"/> Minutes of meeting(s) at which the sector transparently determined its representative	Annex B
<input type="checkbox"/> Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	Annex C
<input type="checkbox"/> Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	Annex D
<input type="checkbox"/> Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM.	Annex E
<input type="checkbox"/> Other: LCM Bye-laws (a)	Annex F(a)
<input type="checkbox"/> Other: LCM Restructuring Workshop (b)	Annex F(b)
<input type="checkbox"/>	
<input type="checkbox"/>	

3A Applicant Type and Eligibility for Funding

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

On November 22, 2005 a workshop was held to restructure and expand membership of the Liberia Coordinating Mechanism (LCM), in keeping with the Global Fund guidelines, in order to make the LCM more effective and efficient in carrying out its functions. A total of 32 people, representing the PR, NGOs, SRs, and implementation partners, participated. During the restructuring, all relevant constituencies were invited to select representatives through an open and transparent process. The LCM has a broad-based representation, including representatives from non-governmental organizations (local and international), civil society including faith based organizations, government, the academia, multi-lateral and bi-lateral development agencies, persons living with HIV/AIDS and other relevant partners. Among the 25 LCM members, only 9 represent the government sector, making the Non-governmental representation to account for 64% of the LCM membership.

Academia/ Education Sector

The A. M. Dogliotti College of Medicine, the only medical school in the country, represents the Academic/education sector. The Dean, Dr. Tarbeh Freeman is the representative.

International NGOs

Save The Children Fund-United Kingdom (SC-UK) was elected to represent International Non-governmental Organizations through a documental transparent process (see attached).

Local NGOs

Christian Health Association of Liberia (CHAL) and Medical Emergency and Relief Corporative (MERC) are two of the largest local health non-governmental organizations. Based on their track record in delivering health services to the people of Liberia at the community level, NARDA the umbrella organization for all the community-based organizations in Liberia, nominated these two (2) organizations to represent their sector. This decision was affirmed at a local NGO (LNGO) meeting in July, 2006.

Private Sector

The private sector is represented by the Liberia Business Association and Liberia Banking Association. These two organizations were elected by their respective sectors.

Faith-Based Organizations

The Liberia Council of Churches recommended that the Catholic Church and the Lutheran Church in Liberia (see attached letter from the Liberia Council of churches) represent the Christian Churches, while the Muslim Council of Liberia represents Muslims on the LCM.

Multi-/Bilateral Development Partners

The UN Country team has selected the multi-lateral organizations below as representatives, based on their involvement in the health care delivery system of Liberia. They include: UNDP, UNFPA, WHO, UNICEF and UNAIDS. USAID Liberia represents bilateral organizations involved in health and related sectors.

Government

Based on their involvement with the health issues, several line Ministries were selected by the LCM to participate and become members of the LCM. Government Ministries with representation on the LCM include Ministry of Health and Social Welfare, Ministry of Education, Ministry of Youth & Sport and the Ministry of Gender and Development

People living with or affected by the disease(s)

The entire population of Liberia is at risk of tuberculosis and malaria. Virtually every LCM member has either experienced or have been affected by one of the two diseases. Currently, there is no formal group or association of people affected by malaria or tuberculosis. The LCM therefore feels that the two groups are well represented by the general LCM membership. However, people living with HIV/AIDS in

3A Applicant Type and Eligibility for Funding

Liberia have come together under one organization, a 300 strong member association called Light Association of Liberia. This association is represented on the LCM by its Chairperson. The LCM is keen to see that PLWHA are represented and equally participate in decision making.

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

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

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

The participation of people living with HIV/AIDS (PLWHAs) has been strongly encouraged by the Liberia Coordinating Mechanism (LCM). This organization is known as the Light Association of Liberia. The Light Association of Liberia is the only organization for PLWHAs in the country. It therefore represents PLWHAs on the LCM. The LCM aims to empower PLWHAs. The PLWHAs representative and head actively partakes in the decision making process and has voting rights. The representative also expresses the concerns of the PLWHAs at the regular LCM meetings. The PLWHAs have an office and they meet weekly.

The entire population of Liberia is at risk of malaria and TB, and virtually every member of the LCM has either experienced or been directly affected by the two diseases. Thus, although there is no identifiable group or organization that represents people with malaria or TB, the LCM feels certain that the concerns of those suffering from TB and/or malaria are well-represented on the LCM and throughout this proposal.

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

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

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

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

In anticipation of the Global Fund Round 7 Call for Proposals, a framework for proposal development was presented to the LCM in early February 2007. Subsequently, in response to the publication of the Global Fund Round 7 Call for Proposals, the LCM announced that Liberia would submit a country proposal for Tuberculosis and Malaria. The LCM mandated its secretariat to publish two newspaper adverts to (1) solicit expression of interest in proposal development and (2) solicit proposals/concept notes for inclusion into the national proposal. The two advertisements were placed in the three most widely read newspapers and also sent to all stakeholders by e-mail.

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

In response to the newspaper advertisements, 37 local and international non-governmental organizations submitted concept papers or letters expressing interest in the Global Fund Round 7 proposals. Based on their track records and previous partnerships with the two disease programs, a selected number of these organizations were invited to participate in a proposal development workshop with participation of other key stakeholders. The stakeholders meetings to review concept papers and incorporate them in the

3A Applicant Type and Eligibility for Funding

proposal were held on 22-24 May 2007 for malaria and 21 June 2007 for TB. For each meeting, the program overview and details of the proposal development process were presented. The participants included County Health Teams (CHTs), program implementers, local and international NGO partners as well as bilateral and multi-lateral organizations.

The second phase of this transparent process to select sub-recipients will start if this proposal is approved by the Global Fund. A second call for proposals, in the form of task orders, for specific grant funded activities will be issued. Each task order will specify activities to address the highest priority needs identified in the proposal, with appropriate budgetary allocations. The criteria for selection of sub-recipients will be determined and documented by the LCM. The criteria will be made public through the newspapers and partners meetings for all to know the rules. Among other requirements, each potential sub-recipient will submit a proposal, describing in detail how, when, where, and what activities will be undertaken to achieve program objectives. Specification of indicators, timelines, and appropriate monitoring and evaluation processes must be included in sub-recipient proposals. Sub-recipients will also be required to exhibit proof of sound financial management. An independent proposal review panel will be established to review each proposal, taking into consideration the technical and financial feasibility of the activities proposed to address specific needs identified in the task orders. Sub-recipients will then be selected and notified.

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

- The selection of PR for the Global Fund Round 7 grant application was discussed in the LCM meeting of 29 May 2007 and decision was taken to publish a Call for Expression of Interest in the newspapers to make the selection process competitive and transparent.
- Newspaper adverts were published with the criteria for PR and applications were received from three institutions excluding UNDP, the PR for the Round three Malaria grant.
- The applications were reviewed by a panel who found all the institutions insufficiently qualified for the strategic position of PR.
- At the 27 June 2007 meeting of the LCM, a decision was taken through a unanimous vote (by the 17 voting members who attended) to engage UNDP as PR for both the malaria and TB proposals. UNDP accepted the vote of confidence and reaffirmed its commitment to build the capacity of the MOHSW to take over as PR in the second year of the malaria and TB grant implementation.
- The LCM also decided at the 27 June 2007 meeting that UNDP would serve as PR for one year (the first year).
- In support of national capacity building in post war Liberia, the MOHSW was selected to become PR from the second year of the grant period.
- MOHSW will also be PR for phase two of the Global Fund Round 6 grant received by the National AIDS Control Program in Liberia. The process of building the MOHSW's capacity has commenced with support from DFID and the World Bank. Recruitment of personnel has begun and the external team is expected in Liberia on 01 July 2007.

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

UNDP has developed expertise in managing Global Fund grants around the world. UNDP recruits international procurement experts and provides training to develop skills and competency in all areas of implementation. UNDP (the currently proposed PR) already has in place a highly capable, well-trained, and specialized staff to manage implementation, financial matters, procurement & supply for the grant. The Deputy Resident Representative of UNDP Liberia also benefits from support of the unit dedicated to Global Fund Programming at UNDP's Global Headquarters. This unit will provide

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invaluable expertise and assistance to UNDP Liberia in coordinating and managing implementation of the grant. UNDP Liberia will also rely upon advice from the UNDP Office of Relations and Strategic Partnerships (BRSP), the WHO/Roll Back Malaria Harmonization Working Group, the Service of legal acquisitions unit of the Office of Management (OLPS/BOM), and the Procurement Unit on specific questions that may arise in grant implementation.

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

- Following the announcement of Global Fund Round 7, an invitation was publicly extended to partners (during LCM and Malaria Steering Committee meetings) to join in proposal development process which started with desk reviews at the two program offices.
- Citations were sent to partners for stakeholders meeting on proposal development for 22-24 May 2007 and 21 June 2007;
- A retreat/stakeholders meeting was held (22-24 May 2007 and 21 June 2007) to solicit inputs from a broad cross section of society.
- With the participation of all stakeholders, the LCM decided to promote a single proposal for the country. As described in Requirement 3a & 3b,

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

- The TCC/M&E committee of the LCM oversees technical and programmatic aspects of grant implementation e.g. achievement of targets
- The membership of the TCC/M&E committee includes three LCM members and four 4 non-LCM members.
- Finance committee, from the private (business) sector monitors financial management including timeliness of disbursement and financial reporting.

3A.4.6 Principle of effective management of actual and potential conflicts of interest

Requirement 6 → Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?

Yes

No

If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex.**

Although the current Chair and Vice-Chair of the Liberian Coordinating Mechanism (LCM) are not the same entity as the nominated PR, it is being proposed that the PR responsibilities for Round 7 grant be transferred to the Ministry of Health and Social Welfare after Phase I of grant implementation. This anticipated change may result into The Chair being the same entity as PR. Understanding the consequences of such a scenario in addition to past experiences, the LCM has developed for itself a document that addresses any actual or potential conflict of interest.

The Conflict of Interest Policy document has the following main elements

- 1. Purpose:** the purpose of the document is to ensure fairness in the LCM's decision-making to protect the reputation and integrity of the LCM and its interests, and to ensure broad public trust and confidence in the LCM's decision-making and grant oversight activities.

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- 2. Definition of Conflict of Interest:** The document defines Conflict of interest as a situation that arises when a Covered Individual participates personally and substantially in an official capacity in any particular matter in which, to his or her knowledge, he or she or an Associated Person or Associated Institution has a financial interest, if the particular matter will have a direct and predictable effect on that interest. In general, and without limitation. This section concludes by outlining various scenarios within which conflict of interest may be deemed to exist.
- 3. Transparency and Disclosure:** The document emphasizes the duty for all Covered Individuals to disclose the existence of any conflict of interest, including those that derive from Associated Persons or Institutions, and the nature of such conflict, whenever one becomes aware that a conflict exists or that it is reasonably likely to occur. It further stipulates that all Covered Individuals must complete and submit a “Declaration of Interest Statement” to the Secretariat, to be updated annually and whenever there is a material change in the information they contain.
- 4. Procedure to follow when a Conflict of Interest arises:** This section details procedures to follow as soon as a conflict of interest is disclosed in writing to the Chairman through the Secretariat. Briefly, the LCM secretariat has a duty to review these disclosures and to decide whether a conflict of interest exists and, if so, make appropriate recommendations to the LCM. Once it is determined that a conflict of interest exists, the Covered Individual shall not participate in the matter that has given rise to the conflict and would be granted a waiver to absent him/herself from the full meeting of the LCM. This means that the Covered Individual shall not vote or speak on the matter, and shall absent himself/herself from participating in the decision making on such matter.
- 5. Selection of PRs and SRs and CCM Oversight:** All covered individuals found to have conflict of interest with regard to selection of PRs, SRs and CCM Oversight shall be excused from participating at LCM meetings where selection of Principal recipients is being discussed and specifically when their or the associated organizations application is being considered.

Where the Chair and or Vice Chair of the LCM is from the same entity as the PR the Chair and or Vice Chair shall be excused from participating in the deliberations on the performance of the PR. The covered individual might be allowed to be present but cannot contribute in any way. Depending on who is affected between the Chair and or Vice Chair the specific deliberation shall be chaired by the other or if both are involved any other LCM member appointed by the LCM at that meeting. Moreover, the Chair or Co Chair of the LCM shall not be the head of the organization that is nominated to serve as PR.

- 6. Gifts:** All Covered Individuals and Associated Persons are prohibited from accepting Gifts under circumstances where it could reasonably be construed that the Gift is motivated by the position of the Covered Individual and interests that could be substantially affected by the decisions of the LCM. All Covered Individuals and Associated Persons are likewise prohibited from giving gifts where it could be reasonably construed that the gift is intended to affect the policies or practices of the LCM, PR or any of the programs it funds.

The LCM Secretariat shall distribute a copy of Conflict of Interest Policy to all LCM members and Covered Individuals, along with a copy of the Declaration of Interest form and make sure that all members and Covered Individuals submit their duly signed Declaration of Interest Statement accordingly.

3A Applicant Type and Eligibility for Funding

3A.4.7 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM operations? <i>Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.</i>	<input type="checkbox"/> Yes <i>provide details below</i>
	<input checked="" type="checkbox"/> No <i>go to section 3B.1</i>
<p>If yes, please specify the amount requested and describe how the amount complies with the time limitation and funding categories available, as explained in Section 3A.4.7 of the Guidelines for Proposals.</p> <p>Applicants must ensure that the amount requested is included in the detailed component budget (section 5.1) in a separate identifiable budget line.</p>	
N/A	

→ After completing this section, go to section 3B.1.

3A Applicant Type and Eligibility for Funding

3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

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

Table 3A.5 – Regional Organization: overview information

Name of Regional Organization	
Sector represented by the Regional Organization <i>(Check the relevant box below)</i>	
<input type="checkbox"/>	Academic/educational sector
<input type="checkbox"/>	Government
<input type="checkbox"/>	Non-Government Organizations
<input type="checkbox"/>	People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
<input type="checkbox"/>	Private sector
<input type="checkbox"/>	Religious/faith-based organizations
<input type="checkbox"/>	Other <i>(please specify)</i>

3A.5.1 Mode of operation

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

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

Describe below how the Regional Organization operates. In particular:

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

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

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

3A Applicant Type and Eligibility for Funding

3A.5.2 Rationale	
(a)	Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. <i>(Maximum of half a page.)</i>
(b)	Explain how the countries targeted in the Regional Organization's proposal represent a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. <i>(Maximum of half a page.)</i>

→ After completing this section, complete section 3B.2.

3A Applicant Type and Eligibility for Funding

3A.6 Non-CCM Applicants

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

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

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

Name of Non-CCM Applicant	
Business address <i>(including street, town/state and country)</i>	

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

Indicate the sector represented (check appropriate box):

Academic/educational sector

Government

Non-government Organization (NGO)/community-based organizations

People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria

Private sector

Religious/faith-based organizations

Other *(please specify)*

3A Applicant Type and Eligibility for Funding

3A.6.1 Rationale for applying outside of a CCM, Sub-CCM or RCM

- (a) Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following:
- (i) Countries without legitimate governments;
 - (ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or
 - (iii) Countries that suppress, or have not established partnerships with civil society and NGOs.

Describe in detail which of the **above condition(s)** apply
(Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.1 for further information on how the Global Fund will interpret these criteria.)

3A.6.2 Attempts to have Non-CCM proposal included in the CCM, Sub-CCM or RCM proposal

- (b) Describe **all attempts by your organization to submit this proposal and have it included in the relevant final proposal of a CCM, Sub-CCM or RCM** (as appropriate to the content of your proposal), **providing details of any responses received.**

*(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM, Sub-CCM or RCM as an annex to the proposal. Please ensure that your description clearly sets out whether you provided a copy of your proposal for consideration by the CCM**, Sub-CCM** or RCM**, and if not, why not.)*

(Contact details for CCMs, Sub-CCMs and RCMs are available on the Global Fund website, or by contacting proposals@theglobalfund.org)**

- (c) If you are aware that a CCM is also submitting a proposal in Round 7 for a country or countries included in your proposal, **provide a detailed explanation of why you believe that your non-CCM proposal merits consideration and recommendation for funding as well as any national CCM proposal.**

(Maximum of one page. In this section, please set out any particular issues which you believe support the submission of a Non-CCM Applicant proposal in circumstances where a CCM has applied.)

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

3A.6.3 Consistency with national policies

Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy).

(Maximum of one page. Provide evidence [e.g., letters of support] from relevant national authorities in an annex to the proposal.)

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

3B Proposal Endorsement

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

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

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

3B.1.1 Leadership of the Coordinating Mechanism

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

	Chair	Vice Chair
Name	Walter T. Gwenigale, MD	Sister Barbara Brillant
Title	Minister, Ministry of Health & Social Welfare & Chairman, LCM	DEAN, Mother Patern College of Health Sciences/ Catholic Church & Vice Chair, LCM
Organization	Ministry of Health and Social Welfare	Mother Patern College of Health Science
Mailing address	Ministry of Health & Social Welfare Capitol Bye-Pass Road P. O. Box 10 - 9009 1000 Monrovia, 10 Liberia	St. Teresa's Convent Randall Street P. O. Box 10 - 2472 1000 Monrovia, 10 Liberia
Telephone	+2316523 669	+2316511588 / +23177511588
Fax	N/A	0231- 709-0299
E-mail address	wtgwenigale@uuplus.com	smpchs@yahoo.com
Alternate e-mail address		

→ Go to section 3B.1.2 (membership information).

3B Proposal Endorsement

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

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

→ Go to section 3B.1.3 (proposal endorsement)

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of CCM, Sub-CCM or RCM	
<p>The table below must be completed by each CCM, Sub-CCM or RCM Applicant. This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form.</p> <p><i>Under the heading 'Sector Representation' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, in figures, the number of representatives who are included in the corresponding sector.</i></p> <p>Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal.</p>	
Sector Representation	Number of members representing the sector
<input checked="" type="checkbox"/> Academic/educational sector	2
<input checked="" type="checkbox"/> Government	6
<input checked="" type="checkbox"/> Non-Government Organizations (NGOs)/community-based organizations	3
<input checked="" type="checkbox"/> People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria	1
<input checked="" type="checkbox"/> Private sector	2
<input checked="" type="checkbox"/> Religious/faith-based organizations	3
<input checked="" type="checkbox"/> Multilateral and bilateral development partners in country	6
<input type="checkbox"/> Other <i>(please specify):</i>	
Total Number of Members	23

3B Proposal Endorsement

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

Level 1 Endorsement

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

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

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

Level 1 endorsement	Check this box only if the CCM, Sub-CCM or RCM has completed the membership details and members have signed Attachment C to the Proposal Form	X
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Level 2 Endorsement – Sub-CCM and RCM Applicants only

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

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

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

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

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

3B Proposal Endorsement

3B.2 Regional Organization proposal endorsement

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

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

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

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

Country	Date of CCM Endorsement	Annex number to this proposal

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

4 Component Section *Malaria*

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

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document <u>and</u> annex number given to each annex
Section 3A: Applicant Type and Eligibility for Funding		
Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):		
3A.1.1 (CCM), 3A.2.1 (Sub-CCM) or 3A.3.1 (RCM)	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors).	LCM by-Laws: Annex F (a)
Documentation describing compliance with the minimum Coordinating Mechanism requirements (sections 3A.4.3 to 3A.4.6 inclusive):		
Minimum Requirement 1	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Selection of Non-Governmental Sector Representative: Annex A to E
Minimum Requirement 3(a)	Solicit submissions for possible integration into the proposal.	Call for the Expression of Interest in the Global Fund Round 7 development and request to submit a Concept paper: Annex G
Minimum Requirement 3(b)	Review submissions for possible integration into the proposal.	Invitation to attend a three-day workshop to review Concept papers for possible integration in national Global Fund Round 7 proposal: Annex H
Minimum Requirement 4(a) and 4(b)	Select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation.	Minutes of LCM meeting to show the selection and nomination of Principal Recipient: Annex I
Minimum Requirement 5(a) and 5(b)	Ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	Invitation to attend a three-day workshop to review Concept papers for possible integration in National proposal: Annex J
3A.4.6 – Minimum Requirement 6	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the	Ethics and Conflict of Interest Policy of the : Annex K

4 Component Section *Malaria*

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document <u>and</u> annex number given to each annex
	Coordinating Mechanism	
Regional Organization Applicants:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding.	
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
3A.6.3 <i>(if submitted for a country where no CCM exists)</i>	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	
Section 3B: Proposal Endorsement		
3B.1.3 <i>Level 1 Proposal Endorsement (CCMs, Sub-CCMs and RCMs)</i>	Minutes of the meeting at which the proposal was developed and CCM endorsed..	Attachment C to the Proposal Form
3B.1.3 <i>(Level 2 Proposal Endorsement = Sub-CCMs and RCMs only)</i>	Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal.	
3B.2.1 <i>(Level 2 Proposal Endorsement Regional Organizations only)</i>	Documented evidence that the national CCMs have reviewed and endorsed the proposal.	
Other documents relevant to sections 1 to 3B attached by Applicant: <i>(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)</i>		

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Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document <u>and</u> annex number given to each annex

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

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

4.1 Requested proposal term for this disease component

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

Important note:

If your proposal term is less than five years, please first refer to the Global Fund's Round 7 'Frequently Asked Questions' (No. 132) at:

<http://www.theglobalfund.org/en/apply/call7/documents/documentsfaqs/>

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	January 2008	December 2012

4.2 Disease specific component executive summary

4.2.1 Executive summary

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

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

Malaria is hyper-endemic in Liberia and known to be a major public health problem. The current GFATM Round 7 malaria component proposal is being submitted to solicit funds that are expected to supplement implementation of the national malaria control strategic plans for 2008 and 2009 – 2013. It will therefore contribute towards achieving the strategic goal of this plan which is to reduce morbidity and mortality due to malaria. Likewise, the objectives of this proposal are in conformity with the Draft National Malaria Strategic plan. This proposal will focus on four strategic objectives as outlined below:

1. To increase access to prompt and effective treatment at health facilities and community level to 65% by 2012.
2. To increase the use of Intermittent Preventive Treatment (IPT) of malaria among pregnant women in

4 Component Section *Malaria*

Liberia to 65% by 2012.

3. To increase the use of Long Lasting Insecticide Treated Nets (LLINs) to 80%, especially among pregnant women and children under 5 years of age.
4. To ensure effective stewardship and decentralization of malaria control activities by the national malaria control program

The main challenge that the Ministry has all along been facing is in sourcing funds required to implement the strategic plan. With availability of funds, the main focus of activities to be undertaken with this grant are expected to be geared towards scaling up the use of Artemisinin-based combination therapy (ACT), promoting use intermittent preventive treatment among pregnant women, scaling up use of long lasting insecticide treated nets (LLINs) and strengthening the managerial capacity of the National Malaria Control Program. The operational strategies for achieving the goals of the NMCP are to be supported by a strong behavior change communication/information, education and communication program. In order to achieve the above objectives, this proposal has identified a number of service delivery areas through which program activities will be implemented as outlined below:

SDA 1.1: Prompt, Effective Anti-malaria treatment

SDA 1.2: Supportive Environment: Diagnosis

SDA 1.3: Supportive Environment: Monitoring drug resistance (and adverse effects to the drugs)

SDA 2.1 Malaria in Pregnancy

SDA 3.1: Long Lasting Insecticide Treated Nets (LLINs)

SDA 3.2: Behavior Change Communication (BCC) — Mass Media

SDA 3.3: Behavior Change Communication (BCC) — Community Outreach

SDA 4.1: Human Resources

SDA 4.2: Supportive Environment: Coordination and Partnership Development

SDA 4.3: Information System and Operational Research

SDA 4.4: Procurement and supply management:

SDA 4.5: Infrastructure / Equipment and other supplies

The entire Liberian population estimated at 3.6 million (2006) is at risk of malaria and is therefore expected to benefit from the fund. However, pregnant women estimated at 180,000 (2006) and children aged below five years currently estimated at 540,000 (2006) are more vulnerable to malaria and are expected to be the main beneficiaries of this fund. This application gives priority to these vulnerable groups in most of its service delivery areas.

The health systems strengthening strategic actions which forms an important component of this proposal is expected to benefit the overall health system, focusing on tackling those weaknesses impinging on the efficiency of health service delivery. Specifically the HSS actions aim at building capacity of health workers, strengthening the referral system and health management information system. These actions are expected to enhance service delivery by the county health management teams nationwide.

The expected outcomes from this support includes:

- 40% of children under five years of age (and other target groups) with malaria/fever receiving appropriate treatment within 24 hours of fever onset by 2012
- 85% of households having at least one ITN by 2012
- 80% of children U5 sleeping under an ITN the previous night by 2012
- 80% of pregnant women (and other target groups) sleeping under an ITN the previous night by 2012
- 80% of pregnant women attending ANC taking Intermittent preventive treatment (IPT) according to national policy by 2012

The total request on the major programmatic areas for GFATM round 7 application is as follows:

- Treatment doses of ACT: 7,369,189;
- Long lasting ITNs 1,655,353 ; for under fives and pregnant women
- No. of pregnant women to get SP: 307,095; at least two doses of SP per pregnant woman

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The financial needs for implementing this grant proposal is estimated at. US\$ 37,380,197.90 over a five years period from year 2008 to 2012.

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4.3 National program context for this component

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

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

<input checked="" type="checkbox"/>	National Health Sector Development/Strategic Plan (National Health Plan)
<input checked="" type="checkbox"/>	National Disease Control Strategy or Plan including national targets and indicators, together with the relevant budget and costings: (Draft National Malaria Strategic Plans 2008 and 2009 – 2013)
<input checked="" type="checkbox"/>	Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards) (National Health Policy, National Malaria Policy, IEC/BCC Strategy, Malaria Treatment Guidelines)
<input checked="" type="checkbox"/>	Most recent evaluation reports/technical advisory reviews directly relevant to the proposal (Liberia Malaria Indicators Survey 2005)
<input type="checkbox"/>	National Monitoring and Evaluation Plan (health sector, disease specific or other)

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

4.3.2 Epidemiological and disease-specific background

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

Table 4.3.2 – Estimated disease prevalence within key population groups

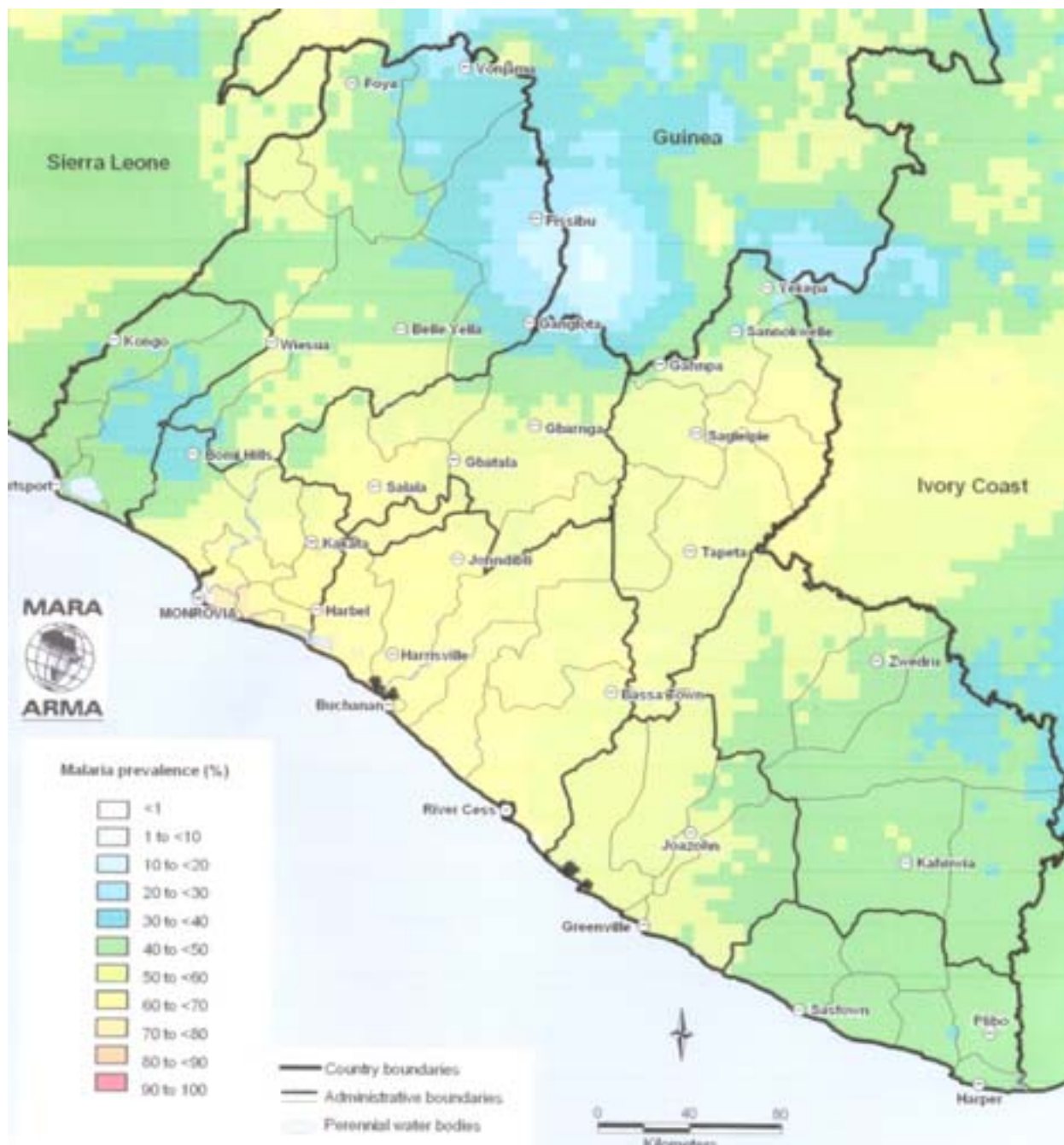
Population	Estimated number	Year of estimate	Source of estimate
(i) Total Population (all ages)	3.6 million	2006	Draft National Malaria Strategic Plan
(ii) Current estimates on the stage of the disease in the following population groups:			
Population at risk for malaria (<i>all ages</i>)	3.6 million (total popn)	2006	Draft National Malaria Strategic Plan
Pregnant women at risk of malaria	180,000 (5% of total popn)	2006	National Health Policy document
Children under 5 at risk of malaria	540,000 (15% total popn)	2006	National Health Policy document
Estimated malaria episodes per year	4,320,000	2006	National Malaria Control Program estimates
Reported malaria episodes per year	1,159,663	2006	HMIS- Liberia

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Population	Estimated number	Year of estimate	Source of estimate
Malaria deaths per year (all ages)	708 malaria deaths/ 1226 total deaths (57% of total deaths)	2005	Liberia Malaria Indicator Survey
Under 5 child mortality (per 1000)	235	2006	National Health Policy – 2007
Number of bed nets in country	645,000	2006	Routine malaria control data base
Proportion of children under 5 protected by bed nets	45%	2007	Post-integrated measles coverage survey
Other: (<i>identify</i>)			

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



Dynamics of malaria epidemiology in Liberia

There is currently no systematic collection of data on the epidemiology of malaria in Liberia to be used to provide a comprehensive description of changes in the stage, type or dynamics of the disease over the past three to five years. This is a result of the protracted war (1989 – 2003) that disrupted the health delivery system, operational research activities and the health management information system, until recently. It is now that the MOHSW and National Malaria Control Program are working towards revitalizing the health information system in order to be able to provide such important data. The most recent data source on malaria situation in Liberia is the Liberia Malaria Indicator Survey conducted

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towards the end of 2005. Such surveys are now planned to be carried out after every two years.

Malaria is endemic in Liberia and is one of the leading public health problems. Results from previous prevalence studies showed hyper to holoendemicity with perennial intense transmission and with considerable immunity outside of childhood in most parts of the country. The major vectors of malaria are *Anopheles gambiae s.s.*, *Anopheles funestus* and *Anopheles melas*; the major parasite species are, *Plasmodium falciparum* (>90%), *Plasmodium ovale* and *Plasmodium malariae*. Malaria is the leading cause of OPD attendance (38%) and is also the number one cause of in-patient deaths. Hospital records suggest that at least 42.3% of in-patient deaths of all ages (laboratory confirmed) are due to malaria. Deaths due to malaria in children under five years of age constitute 46.4% of all in-patient deaths. Likewise, 42.4% of in-patient deaths among pregnant women are due to malaria (LMIS, 2005). However, the figures indicated under the LMIS 2005 above were recorded before large scale interventions were launched with the GFATM Round 3 support. Child mortality rates in Liberia are among the worst in the world (235/1000). Based on these figures, an estimated 65,146 children die of malaria each year in Liberia. Maternal mortality ratio is estimated at 580/100,000. Since pregnant women constitute around 5% of the population (approx. 3.6 million), at any given time in a year, approximately 180,000 pregnant women are at risk of malaria.

The Liberia Malaria Indicator Survey (covering households and health facilities in July - Oct 2005) supported by the GFATM Round 3 grant showed that only 2% of children under five years old with fever in last two weeks received anti-malarial treatment according to the national policy (i.e. within 24 hours of onset of fever). During the survey period, the use of the new anti-malarial treatment policy using ACTs (artesunate plus amodiaquine) was not on a large-scale but nation-wide implementation began shortly after the survey was conducted, hence the low baseline figures. Currently there is a comprehensive implementation plan for nationwide coverage. The survey also showed that the prevalence of malaria in children under five years old was 66%, and the prevalence of anemia in children under five years old was 87%. These figures show that this group is highly vulnerable.

Drug Resistance and current treatment regime

Resistance to chloroquine which was the first line drug for the treatment of uncomplicated malaria was first detected in Liberia in 1988. Although, published data on the increase of chloroquine resistance in the sub-region during that period were few, published and unpublished works by Liberians and partners suggested that by 1993, chloroquine resistance was between 5% and 17% in Upper Lofa and Montserrado counties respectively. By the year 1995, resistance to chloroquine had reached 38% in Grand Bassa County. Extrapolations from studies done in 2001 in Maryland County revealed that resistance to chloroquine stood at 74% on day 14 and 84% on day 28, following PCR analysis.

Resistance to sulphadoxine pyrimethamine (SP) which was the second line drug for the treatment of uncomplicated malaria, was also documented in Harper, Maryland County and the result showed a resistance level of 48% on day 14 and 69% on day 28. In view of the above stated information, a decision was taken in May 2003 to change the treatment policy towards use of artemisinin-based combination therapy (ACT). The main treatment regime for malaria currently used in Liberia is therefore outlined below. It is expected that the same regime will be used during the lifetime of implementation of this proposal:

- Artesunate +amodiaquine is the first line drug for the treatment of uncomplicated malaria
- Quinine p.o. is the second line drug for the management of treatment failures to artesunate + amodiaquine
- Parenteral quinine and intramuscular Artemether for complicated/severe malaria
- Quinine for the treatment of pregnant women with malaria during the 1st trimester and quinine or artesunate plus amodiaquine during the 2nd and 3rd trimesters.

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4.3.3 Disease-prevention and control initiatives and broader development frameworks

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

- (a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.

Applicants should ensure that the information provided below takes into account the cumulative outcomes based on all current and planned support from all stakeholders (government, major international initiatives, international donors and partnerships etc).

The Ministry of Health and Social Welfare of Liberia and its partners are committed to the provision of a comprehensive, accessible, affordable and high quality malaria control and preventive services. The focus is on the reduction of malaria burden in the population, especially among vulnerable groups including pregnant women, children under five years of age and people living with AIDS. Thus, the vision is to have a healthier Liberia with universal access to high quality malaria control and preventive services.

For effective malaria control in Liberia, the following strategic interventions (program areas) have been identified in the national malaria strategic plans 2008 and 2009 to 2013:

1. Case management: focusing on effective management of uncomplicated and complicated malaria for both in- and out- patients including under fives and pregnant women,
2. Prevention: focusing on the pregnant woman for use of Insecticide Treated Nets (ITNs) and Intermittent Preventive Treatment (IPT) as well as use of ITNs among the general population, especially children under five years,
3. Advocacy, Information, Education and Communication: emphasizing awareness creation on all aspects of the disease as well as social mobilization for prevention and control of malaria;
4. Strengthening partnership and program management: focusing on fostering effective partnership among all the stakeholders /partners in malaria control
5. Operational Research: to generate relevant information to guide policy by making evidence based decisions
6. Monitoring and Evaluation: to track progress in program implementation, measure impact and avert epidemics

The main strategies identified for implementing these program areas are interdependent and include:

- Integrated planning of malaria interventions within existing programs such as Family Health/ Maternal and Child Health, HIV/AIDS and Health Promotion
- Program implementation in the context of IMCI and the essential health package/basket outlined in the National Health Policy
- Capacity building at all levels of the health system;
- Resource mobilization and strengthening partnership at all levels

Implementation of the GFATM Round 3 grant has provided a platform from which activities are being rolled out to meet national program goals. Examples include, malaria case management using ACT, provision of IPT, distribution of ITNs to pregnant women and children under five, monitoring and supervisory activities, regular drugs distribution to health facilities, increasing awareness at national, county and community levels on the new malaria treatment policy, and strengthening of Roll Back Malaria partnership at the national and county levels. In early 2007, the National Malaria Control Program began integrating ITNs distribution with measles campaign to accelerate the achievement of the national coverage goal for ITNs. Vector control strategies are focused mainly on ITN distribution. Pilot trials with IRS are planned with support from PMI.

The national malaria strategic plan expects the following outcomes to be in place by year 2013

- 50% of children under five years of age (and other target groups) with fever receiving appropriate

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treatment within 24 hours of fever onset

- 85% of targeted health facilities have anti-malarial drugs at all times
- 80% of targeted health facilities carry out accurate malaria diagnostic tests
- 95% of pregnant women attending antenatal clinics have access to IPT
- 90% of households have at least one ITN
- 85% of vulnerable groups (<5 and pregnant women) sleeping under ITN
- 35% of households who receive IEC/BCC messages have changed their behaviors.
- A functional monitoring and evaluation system, including surveillance, with regular feedback mechanisms established at the national level.

- (c) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context.**

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

Although malaria control efforts are prioritized in the Poverty Reduction Strategies and also in the Highly Indebted Poor Country (HIPC) initiative, Liberia is currently not benefiting from these initiatives. Under the National Transitional Government (which ruled Liberia from 2003 to 2005), Liberia in partnership with the international community developed a transitional framework called the Results Focused Transitional Framework (RFTF). The RFTF set out clear strategies to bring the country back from the shock it received from the years of war. The transitional strategy for 2004 – 2005 articulated in New York in January 2004 focused on sustainable outcomes, acknowledged limited capacities, recognized absorptive constraints, and envisaged implementation mechanisms feasible in the institutional climate. It also visualized systems to monitor implementation and results, evaluate achievements and audit the use of external resources.

Subsequently, the government of Liberia has endorsed the Interim Poverty Reduction Strategy (iPRS) 2006 - 2008. The strategy does acknowledge that morbidity and mortality caused by malaria are significant obstacles to implementation of the poverty reduction strategy. Malaria has been noted to constitute a financial burden on government, households and the private sector through the direct costs of treatment and through lost economic productivity.

The national malaria control effort seeking financial support through this Round 7 grant application will contribute towards the realization of several of the Millennium Development Goals (MDGs) indicated below:

MDG 5: Reduce by two thirds the mortality rate among children under 5.

MDG 6: Reduce by three quarters the maternal mortality rate.

MDG 8: Halt and begin to reverse the incidence of malaria.

MDG 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.

The Ministry of Health and Social Welfare adopted the Roll Back Malaria (RBM) approach in 1998 and subsequently prepared its first five-year malaria control strategic plan 2004-2008 based on the principles of RBM. The draft strategic plans for the periods 2008 and 2009 – 2013 have been developed which are also based on the principles of RBM and maintain strong links with RBM and WHO throughout. The NMCP, IMCI, HIV/AIDS, TB and Reproductive Health programs are committed to work in close collaboration in order to exploit their respective comparative advantages for effective outcomes against malaria.

Liberia is fully committed to the RBM goals as highlighted in the National Malaria Policy and the draft

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National Malaria Strategic Plans 2008 and 2009 - 2013, and is a signatory to the Abuja Declaration. The National Malaria Strategic plan is in line with the Abuja declaration, which the government of Liberia signed in 2000. The measures laid out in the national strategy are attempts to fulfill the WHO/RBM objectives for reducing malaria morbidity and mortality by 50% by the year 2010. Toward this end, the Ministry of Health & Social Welfare has endorsed the use of more effective and globally acceptable strategies for: (1) case management, (Artesunate plus Amodiaquine) (2) multiple preventive measures such as intermittent preventive treatment for pregnant women, the use of long lasting insecticide treated nets (LLINs) and (3) sustained IEC/BCC (4) M&E and (5) improved program management. The strategic plan addresses the essential actions to be taken to reverse the morbidity and mortality trends as a result of malaria.

The resources being sought from the Global Fund through this proposal will be used to support implementation of the National Malaria Strategic Plan, particularly, to fill those financing gaps realized from a shortfall in government and partner financing for malaria control over the next five years. The financial gap analysis section of this proposal gives details of the shortfalls to be filled by the Global fund grant.

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

Planning and budgeting for GFATM activities operate in a system that is parallel/vertical to the national planning system. However, the planning is tied in with priorities identified in the national health plan for malaria and TB. Further, all planning considerations fit into the goals set in the government's interim poverty reduction strategy for the health sector.

The request for funds disbursement and accountability will be based on agreed work plans and procurement plans. The PR for year one of the project is UNDP. Disbursement of funds will be based on an agreed system that is built on programmatic performance indicators.

The MOHSW will be PR beginning year of the grant period. Disbursement of program funds will follow the MOHSW's channel of disbursement. All stakeholders will receive quarterly financial reports. The report will reflect achievements and effective use of funds, among are others. The finance committee of the LCM will ensure that high standards of financial management are maintained.

In preparation for its PR role, the MOHSW is receiving support from the World Bank for establishment of an Office for Financial Management in order to install and implement improved financial management capacity within the ministry. Recruitment to the unit is expected to be undertaken in as phased manner and will begin with the recruitment of the Senior International Financial Comptroller together with the secondment/recruitment of the national comptroller and chief accountant.

The MOHSW will utilize the semi-autonomous agency, the National Drug Service, for procurement of drugs and other commodities. The NDS is expected to be strengthened by GFATM Round 6 HIV/AIDS grant. Further, PMI has made commitments to provide additional support to strengthen the drug distribution capacity of the NDS.

For monitoring and evaluation, the program will update existing checklist of outputs and performance indicators from the approved work plans. The TCC/M&E committee of the LCM will perform oversight roles in monitoring and evaluation to ensure that targets are achieved.

Various routine coordinating mechanisms and structures for the national health system serve to provide alignment and harmonization of partners to the national cycles for planning and reporting. These mechanisms promote transparency and accountability and seek to prevent/avoid duplication of efforts by partners so as to maximize the use of limited resources

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4.3.4 National health system

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

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

Although significant advances have been made to strengthen the national health system since 2005 when a democratically elected government took over in Liberia, there is a need for further strengthening of the system to meet the current demands. The capacity of the current health system is inadequate in terms of human and financial resources. The main health system constraints related to the scaling up of malaria control activities are:

1. **Inadequate human resources:** The public health workforce consists of 3,969 for the entire Liberian population of 3.6 million. With 168 doctors, the doctor to patient ratio is 1 to 21, 428. There are 616 nurses representing a nurse to patient ratio of 1 to 5,844. About one third of the health personnel are traditional practitioners and auxiliary health workers.
2. **Poor remuneration of civil servants including health personnel:** It has been proposed that the average monthly salary of the civil servant be raised to US\$ 50.00. Donor assisted programs therefore usually offer various types of incentives (e.g. food, salary subsidy/cash) to their employees.
3. **Inadequate number of health facilities:** 354 of 490 (72%) pre-war facilities renovated so far. Even though physical repairs have been made, most health facilities lack the required equipment and other supplies to function optimally. The limited number of health facilities is a major contributing factor to low access to health care. Donor support in re-opening of HF has increased access from 16% in 2004 to 41% in 2007
4. **Limited capacity of the drug procurement and supply management system:** Transportation and storage facilities for drugs and medical supplies are inadequate. Nine regional drug depots have been built, only three are fully functional and the rest remain poorly furnished/equipped and staffed
5. **Weak monitoring and evaluation system** including the health management information system: The health management information system has three officers at the national level. Even though programs have M&E officers, the collaboration with the national office is loose.

The constraints outlined above are the major weaknesses of the national health system. There is hope for improving the national health system by building upon the strengths of the system and prudent utilization of the opportunities. The threats to health development will also need to be aggressively addressed through an inter-sectoral approach. The strengths, opportunities and threats are:

Strengths

1. Government commitment to revamp the Liberia Health System
2. Increased population access to health services from 16% in 2004 to the current 41%
3. Highly committed health workers in spite of poor remuneration

Opportunities

1. Ongoing recovery process offer opportunity to build a strong health sector
2. Improved security with country moving from post-conflict to development stage
3. Country has relatively small population as well as small geographical area
4. There is goodwill from the international community
5. Gradual process of decentralization

Threats

1. High level of illiteracy
2. Poor communication infrastructure and utilities, particularly road network
3. Increase in HIV prevalence

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4. Rapid scaling down of relief NGO activities

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

The national priorities in addressing the main health system constraints are:

1. **Continuous training** (basic, post-basic and refresher trainings) of all health cadres of health workers. The Ministry currently funds the training of the entire student body of the A.M. Dogliotti College of Medicine at the University of Liberia. This move was taken to accommodate the large number of aspirants who could not afford the cost of training. The Ministry is bringing effective malaria control as close as possible to the community. As part of primary health care system, community health workers (CHWs) are trained, equipped and deployed. Currently, there are about 2,900 CHWs trained and deployed. About 900 mothers and caregivers have been trained in home-based management of fever and the prevention of malaria.
2. **Refurbishing of the health infrastructure:** This is being realized through the support of bilateral and multilateral organizations including the DFID, the United Nations and the World Bank.
3. **Revitalization of health services:** Through partnership, the government plans to increase access to health care through re-activation of facilities at the average rate of 9% annually over the next five years (Source: National Health Plan). International and national health development partners (NGOs, Faith-based agencies) are also involved in the revitalization of health services.
4. **Addressing the poor remuneration of civil servants** (including health personnel) by the government through an annual salary increment scheme introduced in the 2007/2008 fiscal budget. Through this scheme, the salary of the least paid civil servant was raised from \$30.00 to \$50.00.
5. **Strengthening of drug procurement and supply management** as well as monitoring & evaluation: External partners supporting this area include PMI, DFID and Round 6 GFATM grant for HIV/AIDS component.

It is hoped that gradual increase in the revenue base of the government would translate into the allocation of more resources for basic social services including health services. In its strategy geared towards breaking with the past and moving from conflict to development, the Government of Liberia, through the Interim Poverty Reduction Strategy for 2006-2008 (iPRS), does prioritize provision of improved health services. The government reiterates its desire to be able to at least provide the basic package of health services by the end of 2008.

(c) **Coordination and Synergies**

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

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

HIV infection and malaria are major causes of morbidity in Africa. Even though the exact magnitude of malaria and HIV co-infection in Liberia is currently unknown, it may be a common occurrence because of the high prevalence of the two infections in the West African sub-region. It has been documented that 55% of HIV – infected are reproductive age women. A number of studies have shown interactions

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between malaria and HIV infection. Malaria has been shown to increase mother to child HIV transmission; HIV infection has been shown to reduce responses to IPT using SP, hence two doses of SP may not be adequate. Both Malaria and HIV infection contribute to maternal anemia and possible fetal wastage.

Since, two of the objectives (objective 1 & 2) in this proposal focus on the treatment and prevention of malaria during pregnancy, there will be a collaboration between the malaria, family health and HIV/AIDS programs to provide optimal health care for HIV positive pregnant women and PLWA. Furthermore, considering the 5.2% HIV prevalence rate for Liberia, people living with AIDS have been considered among the target group for LLINs whose other members include pregnant women and children under five.

The collaborative activity between these two programs will immensely contribute towards improving the prognosis of AIDS patients on anti- retro-viral drugs and therefore promote a favorable outcome for the newborns.

Another area of synergy is collaboration between the Expanded Program on Immunization (for measles) and malaria program activities. The synergy begins with integrated plan of action, integrated micro-planning at district level and integrated social mobilization, with co-funding from the Measles Partnership.

Synergy through HSS

The support requested in the malaria component for health systems strengthening through the three selected strategic actions - Human Resources, Information System and Service Delivery - provides an added value to the entire national health system. For example, the availability of a broader range of highly qualified health personnel will make the health delivery system more responsive to a wider range of health needs of the population. The logistical support identified for data collection and processing not only addresses the data/reporting needs of the Malaria Control Program, but the entire health system. A functional ambulance system (with communication system) will support the timely referral of all emergency cases, thereby strengthening service delivery.

4.3.5 Common funding mechanisms

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

(a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	<input type="checkbox"/> Yes → answer questions below.
	<input checked="" type="checkbox"/> No → go to section 4.4
(b) Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach?	

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(c)	Describe the common funding mechanism, whether it is already operational and the way it functions. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. <i>(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)</i>
(d)	Describe the process for independent supervision of the performance of the common funding mechanism. <u>Also describe</u> the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings. <i>Attach, as an annex to your proposal, the most recent external assessment of the operations of the common funding mechanism.</i>
(e)	Describe the Applicant's assessment (including by reference to any criteria used during the assessment process) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal and ensure effective supervision of the work that is proposed. <i>Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a transparent, efficient and timely manner.</i>
(f)	Explain how the funding requested in this proposal (<i>if approved</i>) 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. <i>If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for malaria activities during the proposal term.</i>

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4.4 Overall Needs Assessment

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

To help Applicants identify these gaps:

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

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

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

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

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

4.4.1 Programmatic Needs Assessment

4.4.1 Overall programmatic needs assessment

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

The National Malaria Control Program has a five year National Strategic Plan for the period 2004-2008. Considering that the current strategic plan ends within a year, it has been reviewed and a new five-year strategic plan drafted for the period 2009 – 2013. In addition, the 2008 component of the current plan has been revised to reflect current realities.

The draft plans take into consideration the increase in access to health care in the country (from 16% in 2005 to 41% in 2007) and priority needs for effective scaling-up of malaria prevention and control as the country transitions from post-conflict situation to the phase of sustainable development. This Round 7 GFATM proposal is planned for five years (2008 - 2012), and therefore the programmatic needs in terms of the numbers of fever episodes and people in need of key services (i.e. prompt and effective treatment, IPT

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and LLINs) for the project period are mainly estimated from the analysis of target group population estimates of the country.

The existing major gaps to malaria control in the present analysis are: low coverage of effective anti-malarial treatment, continuing needs of LLINs for the newborn and pregnant women, as well as replacement of LLINs after three years of use. Equally important is the need for intermittent preventive treatment for pregnant women each year. The National Malaria Strategic Plan also identifies the lack of trained personnel to oversee current program activities for effectively scaling up interventions to cover all counties. It is the objective of this proposal therefore, to address these identified gaps in order to scale up the use of ACT drugs, increase and maintain LLINs use and IPT implementation. A coverage of at least 65% of these proposed interventions, especially among the target groups, is needed to achieve the desired goal of reducing the high morbidity and mortality rates due to malaria.

The target population for the prompt and effective treatment is the entire community of Liberia. The target groups for provision of LLINs includes the whole population of Liberia, with special attention to children under five years of age, pregnant women and PLWAs. The target population of children under five years of age and pregnant women is estimated as 540,000 (15% of the total population) and 180,000 (5% of the total population) respectively. The number of treatment doses of ACT required for the general Liberian population over five years is 13,125,891, the number of pregnant women that needs at least two doses of IPT for five years is 546,913. A total of 4,260,802 LLINs are required for the new borns, pregnant women, and the rest of the population including replacement after every three years over a period of five years.. Out of these needs, the procurement of 5,756,702 treatment doses of ACTs, 2,605,449 LLINs, and 239,818 doses of Sulphadoxine pyrimethamine for pregnant women will be covered from the anticipated President's Malaria Initiative (PMI) grant, the Government of Liberia and other partners. The total request on the major programmatic areas for GFATM round 7 application is therefore limited to 7,369,189 treatment doses of ACT; protecting people with 1,655,353 LLINs and 307,095 pregnant women receiving at least two doses of SP. The support for LLINs being solicited from the Global Fund through this application is intended to cover children under five years of age and pregnant women.

All forecasts have been made using an annual population growth rate of 2.4% and a population of 3.6 million for 2006.

(b) **Complete table 4.4.1**

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

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

Overall Needs: The total population of Liberia, estimated at 3.6 million in 2006 is targeted for prompt and effective treatment using ACT. A population growth rate of 2.4% was used to project the expected population estimates from 2008 to 2012. In order to calculate the total treatment doses of ACT required, it was estimated that the average number of malaria episodes for children under five years of age and pregnant women is two episodes per year, and only one episode per year was estimated for the remainder of the population of the country. Out of the total population, 15% are estimated as children under five years of age and 5% as pregnant women for each year.

The annual requirements for LLINs were estimated based on the population size of pregnant women expected for each year and new born babies approximated as 90% of the respective pregnant women population. In addition, net replacements were estimated based on the previous years (2005-2007) distributions. Only 50% of LLINs distributed in 2005- 2007 will be replaced in the years 2008-2010 with the assumption that the remaining under five populations will be out of the range of the target group during the period of net replacements. Nets for the rest of the population were estimated based on the

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assumption of five persons per three nets and replacement of all LLINs after three years. As for the population covered by IPT, all pregnant women expected to access health services for each respective year are considered to be in need of intermittent preventive treatment with sulfadoxine-pyrimethamine.

Portion of unmet needs covered by this proposal: For the prompt and effective treatment as well as for intermittent preventive treatment of pregnant women, it is expected that there will be progressive increase in access to health care services from an estimated 45% in 2008 to 65% in 2012. This increase was considered to determine the portion of unmet needs covered by this proposal and the people currently receiving or expected to receive key services from the total over all needs (A). For example, from a total of 2,038,432 treatment doses required for year 2008, 45% of treatment doses can be delivered to the community considering the level of access to health care. In 2008, it is expected that 55% of this need would be received or expected to be received from PMI, Government and other partners (B); the remaining 45% which makes up the unmet needs is to be covered by this proposal (D). However, for the provision of LLINs it is proposed that this application to GFATM covers children under five and pregnant women, while the rest of the population will be covered by PMI, Government and other partners. Based on the current capacity on the distribution of LLINs to pregnant women and children under fives, 60, 65, 70, 75 and 80% of the overall needs have been targeted for coverage for the years 2008 up to 2012, respectively.

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

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

Table 4.4.1 – Overall programmatic needs assessment

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1*	Prompt & effective anti-malarial treatment (ACT)	674611	1771200	1813709	2038432	2319282	2612440	2918333	3237404
Key Service 2	Intermittent preventive treatment of pregnant women	28109	73,800	75571	84935	96637	108852	121597	134892
Key Service 3**	Provision of LLINs	210816	288000	350208	602964	689695	759168	1088226	1120749
Key Service 4									
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1*	Prompt & effective anti-malarial treatment (ACT)	78762	862903	870576	1121138	1159642	1175498	1167333	1133091
Key Service 2	Intermittent preventive treatment of pregnant women	4161	55747	41564	46714	48319	48934	48639	47212
Key Service 3**	Provision of LLINs	47000	261000	337000	377996	377995	377995	735732	735731

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 4									
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 - B^1 = C^1$, $A^2 - B^2 = C^2$ etc.)									
Key Service 1*	Prompt & effective anti-malarial treatment (ACT)	595849	908297	943133	917294	1159640	1436942	1751000	2104313
Key Service 2	Intermittent preventive treatment of pregnant women	23948	18053	34007	38221	48318	59918	72958	87680
Key Service 3**	Provision of LLINs	163816	27000	13208	224968	311700	381173	352494	385018
Key Service 4									
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1*	Prompt & effective anti-malarial treatment (ACT)	<i>Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (Attachment A) to the Applicant's proposal.</i>			917294	1159640	1436942	1751000	2104313
Key Service 2	Intermittent preventive treatment of pregnant women				38221	48318	59918	72958	87680
Key Service 3**	Provision of LLINs				224968	311700	381173	352494	385018
Key Service 4									

* The Numbers indicated under Key Service 1 are estimated malaria episodes for each year (not the number of people in need of services)

** The numbers shown under Key Service 3 indicate number of nets provided to under fives, pregnant women and two nets per household for the rest of the population

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4.4.2 Strategic actions to strengthen health systems

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

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

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

4.4.2 Description of HSS Strategic Actions included in this component

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

- (i) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this disease component**;
- (ii) **how the actions link to the planned work during the program term and address** key points arising from the analysis of the health system referred to in your response to question 4.3.4 above; and
- (iii) **what other support is currently available or planned for the same actions** to ensure achievement of the planned outputs and outcomes of this proposal.

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

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

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

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

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

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

Total funds for essential HSS Strategic Actions requested over proposal term

Year 1	Year 2	Year 3	Year 4	Year 5	Total
\$ 1, 237,685.00	US\$230,060.00	US\$185,060.00	US\$216,000.00	US\$126,000.00	\$1,994,805.00

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Table 4.4.2 – Summary of Strategic Actions essential to this proposal

(Description of the HSS Strategic Action, its rationale and linkages to this proposal – not more than half a page for each HSS Strategic Action)

Human Resource: To strengthen the capacity and performance of health workers through training (basic, post basic and continuous education) and improved conditions of work

Health care delivery in post war Liberia faces many complex challenges. One of the major challenges is the inadequate number of qualified human resource. There is need to provide basic and post-basic training to increase the number and range of specialties of HWS as well as provide continuous education to keep HWs up-to-date with new technologies and changes in standard operating procedures. Many doctors and other health professionals are limited to the basic skills obtained during their primary training due to training opportunities denied them by 14 years of civil war that ended in 2003.

Action 1

Liberia currently has a health workforce of 3, 969 personnel. There are 168 doctors, representing a doctor/patient ration of 1: 21,428. Further, traditional practitioners and auxiliary health workers make up about one third of the health workforce. (Source: Rapid Assessment Report) The number of health workers is expected to increase at the rate of 10% annually. This low output is due to the high cost of training institutions which most students and their families can not afford. (Three fourths of Liberia’s population is living below the poverty line of less than US\$1.00 per day, with a staggering 52% living in extreme poverty or on less than US\$ 0.50 per day). Of the health work force, there are 168 doctors, 273 physician assistants, 453 registered nurses, 149 laboratory technicians and 100 social workers in the public sector.

This grant application proposes additional training support as follows:

- Post-basic training of 7 health professionals (MSc/MA) –Epidemiology Entomology, Biostatistics, Monitoring and Evaluation , IEC/BCC, Financial Management, Data Management
- Basic training for 20 in medical laboratory technology
- Refresher training for 2,500 HWs of all cadres, 25 registrars in data processing, 100 technicians in laboratory technology and 100 HWs in emergency care to man the ambulance system.

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

Year 1	Year 2	Year 3	Year 4	Year 5
<p>1. Twenty pupils admitted for basic training in Med. Lab Technology</p> <p>2. Foreign training in Biostatistics and Data Management</p> <p>3. Seventy five HWs trained to function as ambulance HWs</p>	<p>1. Twenty pupils admitted for basic training in Med. Lab Technology</p> <p>2. Foreign training in M&E and</p>	<p>1. Twenty laboratory technicians in training</p> <p>2. Foreign Training in Financial Management</p>	<p>1. Twenty complete training</p> <p>2. Foreign training in Epidemiology and Entomology</p>	<p>1. Total of twenty laboratory technicians trained</p> <p>2. Total of 7 with graduate training: entomology, epidemiology, biostatistics, M & E and IEC/BCC</p> <p>3. Total of 75 HWs trained and</p>

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				adequately functioning as ambulance HWs
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
US\$ 132,185.00	US\$104,060.00	US\$59,060.00	US\$90,000.00	US\$ -0-
Describe below other current and planned support for this action over the proposal term				
<i>In the left hand column below, please identify the name of other providers of HSS strategic action support. In the other columns, please provide information on the type of outputs.</i>				
Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term <i>(same currency as this proposal)</i>	Expected outcomes from existing and planned support	
Government	2008 to 2012	Salaries of all Health workers	To maintain and sustain program activities nationwide	
Other Global Fund Grants (with HSS elements)	2007 to 2011 (HIV/AIDS)			
Other: <i>(identify)</i>				
Other: <i>(identify)</i>				
Other: <i>(identify)</i>				
Other: <i>(identify)</i>				

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Action 2	<p><i>(Description of the HSS Strategic Action, its rationale and linkages to this proposal – not more than half a page for each HSS Strategic Action)</i></p> <p>Information System: To revitalize the health information system and make it responsive to the reporting needs of the National Malaria Control Program</p> <p>The Information System is strategic to the effective supervision and monitoring of program activities for measurement of the impact of program implementation. The existing Health Information System is saddled with such problems as inadequate logistics, especially at the periphery (county & district levels) and limited number of human resources. These difficulties affect the timeliness and quality of reporting and are manifested as late submission, incomplete report, delayed collation and late dissemination of feedback. Timeliness of reporting is further challenged by impassable roads 5-7 months of the year due to long periods of rain. During the rains, collection of reports from districts for compilation of county reports can only be done through the use of motorbikes.</p> <p>The required support includes: Forty four motorbikes + helmets for district officers to collect reports within the counties, 3 VHF radios (including installation and maintenance) for HTM program headquarters for follow up and feedback to counties on reports; 15 computers and printers for collation of report, training of county registrars and data clerks and technical assistance through external consultants.</p>			
<p>Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, <u>as a total only</u>, the amount requested for each year. <i>(Specific financial information on the funds requested must be included in section 5 in the detailed budget).</i></p>				
Year 1	Year 2	Year 3	Year 4	Year 5
Increase the timeliness of reporting to 40%	Increase the timeliness of reporting to 45%	Increase the timeliness of reporting to 50%	Increase the timeliness of reporting to 55%	Increase the timeliness of reporting to 60%
The completeness of report questionnaires improved to 30%	The completeness of report questionnaires improved to 40%	The completeness of report questionnaire improved to 60%	The completeness of report questionnaire improved to 80%	The completeness of report questionnaire improved to 100%
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
US\$ 192,000.00	US\$ - 0 -	US\$ - 0 -	US\$ - 0 -	US\$ - 0 -
<p>Describe below other current and planned support for this action over the proposal term</p>				
<p><i>In the left hand column below, please identify the name of other providers of HSS strategic action support. In the other columns, please provide information on the type of outputs.</i></p>				

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Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term <i>(same currency as this proposal)</i>	Expected outcomes from existing and planned support
Government	2008 to 2012	Cost of operating VHF radios in all 15 counties of Liberia	Basic information system established and maintained through radio communication network
Other Global Fund Grants (with HSS elements)	None	None	Not Applicable
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 3	<p><i>(Description of the HSS Strategic Action, its rationale and linkages to this proposal – not more than half a page for each HSS Strategic Action)</i></p> <p>Service Delivery: To establish an effective referral system to support prompt transfer of emergency cases including severe malaria</p> <p>Liberia currently lacks a referral system with functional ambulances supported by an effective communication network and trained medical staff. This situation presents a lack of access to specialized care when needed and contributes to an increase in mortality as severe and critical cases beyond the scope of attending facilities can not be transferred elsewhere for better case management.</p> <p>Health Service Delivery will be strengthened by a referral system that is equipped with functioning ambulances that are backed by an effective communication system. Further, referral centers will be upgraded to adequately respond to/handle/treat emergency cases including severe malaria</p> <p>The support required includes: 25 ambulances (fuel and maintenance), training of health workers to man the ambulance system, 25 car radios (mobile communication for ambulances),</p>			
	<p>Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, <u>as a total only</u>, the amount requested for each year. <i>(Specific financial information on the funds requested must be included in section 5 in the detailed budget).</i></p>			
Year 1	Year 2	Year 3	Year 4	Year 5

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1. Prompt referral of 10% of malaria and other emergency cases.	1. Prompt referral of 20% of malaria and other emergency cases.	1. Prompt referral of 30% of malaria and other emergency cases.	1. Prompt referral of 40% of malaria and other emergency cases.	1. Prompt referral of 50% of malaria and other emergency cases.
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
US\$ 913,500.00	US\$ 126,00.00	US\$ 126,000.00	US\$ 126,000.00	US\$ 126,000.00

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

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

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term <i>(same currency as this proposal)</i>	Expected outcomes from existing and planned support
Government	2008 to 2012	Human resource to operate ambulance – divers, HWs	Regional health facilities adequately managing emergency cases including cases of severe malaria
Other Global Fund Grants (with HSS elements)	None	None	None
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			
Other: <i>(identify)</i>			

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4.4.2 HSS Strategic Actions continued

Risks arising from support for the actions and cross-cutting issues

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

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

The major challenges faced by the national health system include:

- Inadequate number of qualified human resources: there is need to increase the number and range of specialties
- Poor health management information system, and
- Poor health infrastructure for service delivery, among others.

The strategic actions proposed in this grant application will strengthen the health system in the following ways:

- Increase the number and quality of human resource through basic, post basic training as well as continuing education. Not only will the HIV/AIDS, Tuberculosis and Malaria programs benefit from the expertise of the human resource to be trained under this grant proposal, but other programs such as MCH/FP, Health Promotion, Emergency Preparedness & Response and Environmental Health will also benefit.
- All programs of the Health Ministry will benefit from strengthening of data collection and data processing. The data collection/processing system is horizontal at the district level. Data is collected and processed for all programs by a team that will be made mobile to function during both the rainy and dry seasons. The support for health information system will improve timeliness of reporting, enhance the tracking of program impact and help to pre-empt disease outbreaks.
- The ambulance system will support service delivery as a whole, responding to all needs for patient referral no matter the illness.

A key strength of the Malaria Control Program is a wide network of partners including NGOs and community-based groups. The implementation the MOH's decentralization program has presented a good opportunity for strengthening the County health system to take ownership for the Malaria Control Program.

There is no risk that the selected strategic actions pose on the functioning of the health system, key institutions and stakeholders, and other health programs. The government is in the process of upgrading the salaries of civil servants Health workers who benefit from various types of training will be compensated within the existing structure so as to avoid conflict within the workforce.

(c) Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?

Yes
→ complete (d) and (e),
and then (f)

No
→ go to section 4.4.2(f)

(d) **If yes to (c)**, provide a short description of which component(s) and how the HSS Strategic Actions in this component will benefit achievement of the outputs and outcomes targeted in the other component(s).

The National Tuberculosis Control Program and the National AIDS Control Program will benefit from

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the three strategic actions selected by the Malaria component. The human resources for health that will be trained will perform the full range of services; the health information system collects information from all programs; strengthening of the referral system with ambulances and communication system will also benefit TB patients and other types of patients needing referrals

(e) If relevant, provide a detailed justification (*with clear information on direct linkages to this disease component*) for those cross cutting HSS Strategic Actions in this component which you believe should still be funded even if one or both (as relevant) of the other components submitted in Round 7 are not recommended for funding.

(Two page maximum, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component). Refer to the Guidelines for Proposals, section 4.4.2(d) for additional guidance.

All three of the HSS Strategic Actions should still be funded by Global Fund even if the basic National Malaria Control Program is not funded.

1. **Human Resource:** The highest trained members of the five-person management team of the National Malaria Control Program are a medical doctor and a parasitologist. The others are university degree holders who have received on-the-job training and attended certificate courses for the portfolio they hold. The parasitologist functions as the M&E Officer, a responsibility for which she has had training through short courses. The human resource situation limits supervisory capacity of the program and scope of information that is gathered and processed. The graduate training proposed in this grant application (epidemiology, entomology, biostatistics, monitoring and evaluation, IEC/CBB, Financial management and data management) all require one year. This support will therefore have an impact on strengthening the program's managerial capacity before the end of the grant period. Partners of the MOHSW support various types of training but post basic training is yet on a limited scale. WHO is the only health development partner currently providing support for in post-basic training.

The clinical laboratory system is operated by about 261 personnel of which more than 50% are laboratory aides; the need to train more laboratory technicians is dire. All the training needs identified in the malaria component will give the entire health delivery system a major boost in the quality of service.

2. Logistics for **health information** collection and data processing: The support requested in the malaria component will serve as a catalyst in stimulating the generation of data. The national health management information system will receive support from other partners including DFID to strengthen other components of the system such as data collation/processing/analysis at the national level. The support requested from the Global Funds is basically logistics (e.g. motorbikes with helmets computers) to facilitate data collection and compilation at the district level. Motorbikes have been specifically identified because they are an effective means of transportation during the rainy season when even the four wheel drive vehicles are immobilized by the deplorable road conditions. The VHF radios are for the headquarters of the HTM programs for 24-hour communication with the field.
4. Strengthening of the **health service delivery** with ambulances for prompt referrals: This is an area where no support from any health development partner has been directed. The inadequacy of human resource (in quantity and quality) means that many rural health facilities lack the technical capacity to treat complicated cases including severe and complicated malaria. A functional ambulance system will facilitate prompt referrals and thereby, contribute to the reduction of mortality rate. Improvement in malaria case management will also be a benefit of Global Fund support in this area.

The NMCP expects to receive support from a new partner – PMI – and its traditional partners (WHO, UNICEF, USAID and NGOs) for implementation of planned activities. Although in the absence Global Fund support, the targets set for scaling up malaria control activities (e.g. prompt treatment, LLINs

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distribution, prevention of malaria in pregnancy, etc) will not be fully met, some degree of program implementation will still take place. The support from other partners will cover various aspects of program implementation. For example, PMI has made commitments to provide some microscopes and RDT requirements. Also MOHSW is expected to receive about 200 microscopes from the World Bank. No commitments have been received for the three strategic actions selected by the malaria component for health systems strengthening by GFATM.

<p>(f) Are there any cross-cutting HSS Strategic Actions integrated within another component in your Round 7 proposal that will benefit this component? <i>Applicants should ensure that the detailed budget in the other component(s) clearly identify the costs of the HSS Strategic Actions. Applicants must also ensure that there is no duplication of costs included in the various components.</i></p>	<input type="checkbox"/> Yes, Tuberculosis
	<input type="checkbox"/> Yes, Malaria
	<input checked="" type="checkbox"/> No

(g) **CCM and RCM Capacity for Health Systems Strengthening Issue identification.**

Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6.

→ Refer to the Guidelines for further information,, section 4.4.2(g)

The intent and purpose of restructuring the LCM in 2005/6 was to strengthen the capacity of the institution to exercise both fiduciary and programmatic oversight of grant implementation process. The LCM has identified two mechanisms for monitoring and evaluating program activities: (1) field visits and (2) document review. In selecting sites, scope, content and duration of field visits, the LCM Secretariat will consult with the PR. The intent of these monitoring activities is to enable the LCM to offer insights and lessons learned to help the PR to achieve the goals and objectives of the programs.

Members of the LCM are very knowledgeable about the national health policy and national health plan. To promote harmonization of Global Fund work and other national health interventions and priorities, the LCM monitoring activities will be linked to the national M & E framework that is now being developed. In addition to using the tools of strengths, weaknesses, threats and opportunities (SWOT) analysis, the LCM will work with the PR to identify institutional bottlenecks to program implementation and how to overcome them. Since the Round Six proposal, the monitoring and evaluation capacity of the LCM has improved considerably.

4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

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

Summarize the overall financial need in table 4.5.

As indicated in the draft National Malaria Strategic Plan 2009 – 2013, the main objective for controlling

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malaria is to reduce morbidity and mortality due to malaria by 50% by year 2013. The stated objective is to be achieved by implementing a combination of proven cost-effective interventions. These include increasing access to prompt and effective treatment of malaria cases, scale-up use of IPT among pregnant women, scale-up nationwide use of insecticide treated nets and increasing use of personal and community protective measures including selective indoor residual spraying.

The overall financial needs for implementation of the National Malaria Strategic Plan over five years from 2008 to 2012 amounts to US\$ 108,997,798. This amount is based on the revised plan for year 2008 and the draft national malaria strategic plan 2009 – 2013, copies of both documents are attached to this application. Of this amount, the bulk of the funds are required for case management (US\$ 61,986,692) and multiple prevention using LLINs, IRS and IPT (US\$ 24,288,571).

4.5.2 Current and planned sources of funding

(a) Domestic Sources

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

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

The only domestic source for malaria control activities in Liberia has been the Government of Liberia with a contribution of US\$ 122,889 from 2005 to 2007. The economic strength of the Government of Liberia (GOL) is still weak due to 14 years of war however, the government anticipates to progressively increase its budget for malaria control; the budget is expected to amount to a total of US\$ 497,048 over the next five years (2008-2012).

Liberia is yet to qualify for debt relief, therefore there are currently no other reliable national resources such as Heavily Indebted Poor Country (HIPC) debt relief to support disease prevention and control strategies in Liberia.

(b) External Sources

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

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

GFATM, UNICEF, WHO, PMI and Chinese Government are the major external sources of funding for the implementation of malaria control and prevention activities planned in the revised 2008 plan and the draft Malaria Control Strategic Plan 2009 - 2013. Liberia currently has no funding from Global Fund for the malaria component. The latest GFATM Round 3 grant came to an end in February 28, 2007. A total of US\$ 12,140,921 was granted by the GFTAM for the period, 2005-2007. This application seeks for a GFATM Round 7 malaria component grant of US\$ 37,380,197.90 over the next five years from 2008 – 2012. WHO has contributed a total of US\$ 420,931 from 2005-2007. It is expected that WHO would continue providing support amounting to US\$ 817,500 over the next five years.

The Government of China has indicated support worth US\$ 643,500 over the next five years. The President's Malaria Initiative (PMI) has committed itself as one of the major contributors for malaria control activities in the country, and preparatory activities are under way to materialize the anticipated

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support from the Initiative expected to be worth US\$ 37,500,000 over a three years period (2008 - 2010). A total of US\$ 25,000,000 from PMI is expected to be extended to cover a further two years up to year 2012.

Other partners have previously made contributions to support malaria control, these include UNICEF/UNITAID (US\$ 1,111,238 in 2007); UNICEF/Japanese Government (US\$ 2,419,217 in 2006 and 2007); Canadian National Committee for UNICEF (US\$ 276,189 in 2007); MENTOR Initiative/USAID/OFDA (US\$ 1,660,817 in 2006 and 2007); MENTOR Initiative/BPRM (US\$ 818,285 in years 2005 and 2007) and Chinese government (US\$ 128,700 in year 2007).

From 2005 to 2007, Liberia received a total of US\$ 18,430,090 from external sources for malaria control. From 2008 to 2012 it expects to receive a total of US\$ 101,014,647 for malaria control, making the overall total amount from external sources in line C to be US\$ 119,444,737 (2005 – 2012). **Please note:** Not all of the resources go directly to the NMCP; some are channeled through NGOs and contribute towards the national response.

4.5.3 Overview of Financial Gap

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

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

The overall needs for implementation of the national malaria control strategic plan for each year is indicated in Line A. These needs amount to US\$ 108,997,798 over the five years from 2008 to 2012. The only domestic sources expected to be available over the same period are those from the Government of Liberia amounting to US\$ 497,048 (see Total Line B). Currently a number of external sources have committed/expect to commit themselves to contribute to financing these needs. The total external sources over the next five years are US\$ 101,014,647 (see Total Line C). The total current and planned resources therefore amounts to US\$ 101,511,695 (see Line D) leaving a total unmet need of US\$ 7,486,207 (see Line E) over the next five years from 2008 to 2012.

4.5.4 Additionality

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

Funds being solicited in this proposal will be supplementary to government's efforts together with support from other bilateral and multilateral donor agencies to address the urgent short-to-medium term challenges in delivering quality health care services to the Liberian population through the strengthening of the health delivery system.

Currently, the Government's contribution to malaria control includes Human Resources (meager salaries) and provision of office space for the staff. Other RBM partners also continue to support the malaria control activities as evidenced by the budgetary allocations in their respective plans of action for malaria control in Liberia. Currently preparations are under way to get funds from the President's Malaria Initiative (PMI) for malaria control activities in Liberia. Funds requested under this (Global Fund) proposal will contribute to existing and planned resources for the implementation of the National Malaria Strategic Action Plan. The PR through the LCM ensures that funds from the Global Fund remains additional to existing funds committed by Government and its partners and this arrangement will continue in this proposal.

It should be noted that the Government is and will continue to use the Malaria Strategic Plan as a tool to

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mobilize resources for malaria control activities and this has led to support being provided by bilateral and development partners, NGOs and the private sector.

4.5.5 Strategy for achieving sustainability

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

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

Liberia is classified by the World Bank as a low-income country. The country is currently recovering from a long protracted war that has left immense economic demands in every social aspect. It is therefore clear that neither the MOHSW nor the NMCP will be self-financing by the end of this five-year program. Nevertheless, efforts are being made to move the program towards sustainability in the future. The strength of the NMCP and consequently this application is that all the major planned activities are strongly institutionalized by being implemented through the existing health system, involving communities. Distribution of bed nets will be carried out through sustainable organs including health facilities, community members, community leaders, local associations, periodic nationwide campaigns and faith-based organizations.

As evidenced in this application, the program intends to invest in what is currently considered to be the most cost-effective options and internationally accepted best practice for malaria control in the medium-and-long term. Examples are, the use of ACTs for malaria treatment and the use of long lasting treated nets (LLINs). It is on record that LLINs provide by far the most cost-effective option for personal protection. Drug costs for ACTs are expected to go down in response to ACT scaling-up and higher demand on the African and Asian markets. Strengthening program capacity in management and planning is expected to lead to better planning and resource utilization to enable the program to innovatively sustain the developments achieved at the end of this funding.

To ensure that the interventions/activities initiated or expanded by this proposal are sustained, there will be continuous on-the-job training of all health workers and routine supportive supervision/coaching. The national implementation plan will be updated to ensure that in the event of personnel changes, the program activities remain on course. Monitoring and evaluation will continue to track progress in program implementation and measure the outcome/impact of interventions, and subsequently adjust the program accordingly.

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Table 4.5 - Financial contributions to national response

Financial gap analysis (same currency as selected in section 1.1)								
Refer back to instructions under section 4.4, step 3	Actual		Planned		Estimated			
	2005	2006	2007	2008	2009	2010	2011	2012
Line A → Overall disease specific needs costing including essential disease specific health systems needs	11,995,858	10,635,641	9,871,147.00	19,683,709	20,301,508	21,353,476	22,818,158	24,840,951
Domestic source B1 : Loans and debt relief (provide donor name)	0	0	0	0	0	0	0	0
Domestic source B2 : National funding resources	27,216	44,569	51,104	60,118	72,813	90,987	117,283	155,847
Domestic source B3 : Private Sector contributions (national)				0	0	0	0	0
Total of Line B entries → Total current & planned domestic resources	27,216	34,569	51,104	60,118	72,813	90,987	117,283	155,847
External source C1 : All current & planned Global Fund	5,024,741	5,098,262	849,710	0	0	0	0	0
External source C2 : WHO	93,931	163,500	163,500	163,500	163,500	163,500	163,500	163,500
External source C3 : UNICEF/UNITAID	0	0	1,111,238	0	0	0	0	0
External source C4 : UNICEF/Japanese Government	0	1,298,860	1,120,357.4	0	0	0	0	0
External source C5 : Canadian National Committee for UNICEF	0	0	276,189	0	0	0	0	0
External source C6 : MENTOR Initiative/USAID/OFDA	0	841,921	818,896	0	0	0	0	0
External source C7 : MENTOR Initiative/BPRM	479,606	0	338,679	0	0	0	0	0
External source C8 : MENTOR Initiative/BASF/CERF/ECHO		40,000	582,000	0	0	0	0	0

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Financial gap analysis <i>(same currency as selected in section 1.1)</i>								
<i>Refer back to instructions under section 4.4, step 3</i>	Actual		Planned		Estimated			
	2005	2006	2007	2008	2009	2010	2011	2012
External source C9: Chinese Government	0	0	128,700	128,700	128,700	128,700	128,700	128,700
External source C10: PMI	0	0	0	12,500,000	12,500,000	12,500,000	12,500,000	12,500,000
External source C11:								
External source C12: Private Sector grants/ contributions				0	0	0	0	0
Total of Line C entries → Total current & planned external resources	5,598,278	7,442,543	5,389,269	12,792,200	12,792,200	12,792,200	12,792,200	12,792,200
Line D → Total current and planned resources → (i.e. Line D = Line B Total +Line C Total)	5,625,494	7,487,112	5,440,373	12,852,318	12,865,012	12,883,186	12,909,482	12,948,047
Line E → Total Unmet need (Line A – Line D) -	6,370,364	3,148,529	4,430,773	6,831,391	7,436,495	8,470,289	9,908,675	11,892,904
<i>The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.</i>								

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4.6 Malaria component/implementation strategy

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

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

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

and

2. A **Work Plan** → which must meet the following criteria. *(Refer to the Guidelines for Proposals, section 4.6):*
 - a. *Structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*
 - b. *Covers the first two years only of the proposal term and is:*
 - i **detailed for year 1, with information broken down by quarters;**
 - ii **indicative for year 2, with information at least half yearly.**
 - c. **Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.

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



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

4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s).

(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).

In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)*

The following adjustments have been made as a remedy to issues raised as 'weaknesses' by the Technical Review Panel to the GFATM Round 6 application of Liberia's GFATM malaria component proposal in year 2006:

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Comment 1

Unrealistic targets when taking into account the post-conflict situation of the country (only 16 % of the population having access to the health care), as well as the low achievement of targets set for the Round 3 program

Response to Comment 1

Having considered the above comment, we indeed do acknowledge that our application had set unrealistic targets. However, unlike the previous immediate post-conflict years with extremely poor access to health care, Liberia has currently achieved 41% access to health care (Interim Poverty Reduction Strategy Paper, Liberia 2006). Access to health care is expected to continue to rise as the country becomes more peaceful and it transitions from post-conflict to the development stage. Furthermore, with peace, partners (multi-lateral and bilateral) are increasingly committing financial resources to health development. Based on these commitments and government's own capacity, health facilities reactivation is planned at an annual average of 9% (National Health Plan). Targets for the Round 7 application have been set realistically by considering the baseline data currently available (and obtained with support from Round 3 resources) and the projected progressive increase in access to health care.

Comment 2

This proposal does not build on the Round 3 proposal. Many baselines for indicators are reported as "N/A", although these could have easily been obtained through data available from the Round 3 Grant

Response to Comment 2

In this Global Fund Round 7 application, all the targets have baseline data, some of which were obtained from the Liberia Malaria Indicators Survey, conducted with funds from the Round 3 GFATM grant for malaria. For Example the Liberia Malaria Indicator Survey provides important base line data for most of the targets with impact and outcome indicators in Attachment A. Many of the other baseline data for targets and indicators (output) set in this proposal have also been captured from the growing routine health facility data at the Ministry of Health and Social Welfare.

Comment 3

The suggested strategy to distribute bed net provides insufficient detail and is not referred to in the work plan

Response to Comment 3

The strategies in this proposal include mass distribution campaigns for urban and semi-urban areas, health facility-based distribution using ANC services and community-based distribution using community health workers for the rural communities in the country. The suggested strategies are now included in the work plan.

Comment 4

The use of IRS needs further justification

Response to Comment 4

This GFATM Round 7 malaria proposal does not include Indoor Residual Spraying as one of the service delivery areas. PMI will address IRS issues in the National Malaria Strategic Plan. IRS will be conducted selectively in targeted areas as a pilot study. The details of the studies (e.g. justification, selected target areas, number of households, etc.) are not yet available. These details will be elaborated in a well defined plan during the PMI planning exercise, prior to the implementation phase.

Comment 5

The number of objectives in the summary is 4, whereas only 3 are mentioned in the table provided on pages 97-99 of the proposal form; one cell of this table looks truncated (Objective 2), and no SDAs were provided for Objective 3

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Response to Comment 5

The inconsistencies observed in GFATM Round 6 proposal are regrettable. We have been keen with the current Round 7 proposal, having edited it for accuracy, consistency and completeness. We therefore, believe that such errors have not been repeated in this proposal.

Comment 6

The gap analysis on page 112 covers a 3 year period, 2006 - 08 and produces the need for \$26.3m, whereas the project is for 5 years with a similar sum of \$29.4m.

Response to Comment 6

We have taken note of the error. As with our response to Comment 5 above, the current Round 7 proposal has been checked for consistency and accuracy on the gap analysis and all other sections of the proposal.

Comment 7

The steep increase of requested funding from, for example, US\$3.6 million in 2004 to US \$12.million in 2005 and US\$10.6 million in 2006 needs to be explained

Response to Comment 7

Indeed, there was a steep increase in the needs identified in the 2004 – 2008 strategic plan. It should be borne in mind that the 2004 strategic plan was developed immediately after the conflict situation in the country. At that time, there was hardly any data available and less than one third of the country was accessible. With such a paucity of information, it was difficult to make a thorough needs assessment. Therefore for 2004, the funding needs were estimated for the immediate post-conflict situation. Funding needs for 2005 onwards considered anticipated increase in the health needs of the country as more and more areas became accessible. These factors together consequently resulted in such a steep increase in funding levels being applied for from year 2004 onwards.

Comment 8

Funds requested to cover administrative costs (i.e. 25% of the total budget) seem excessive

Response to Comment 8

Indeed we note and acknowledge that administrative costs estimated in the Round 6 proposal were excessive. With the current Round 7 proposal, the funds requested to cover administrative costs (12%) have been significantly reduced in accordance with the guidelines. It is worth mentioning here that, the administrative costs include among others, incentives for NMCP staff . We believe that the incentives for staff should be retained in the budget, otherwise the program runs the risk of losing personnel that it has invested in through various capacity building initiatives, to other programs/sectors.

Comment 9

Some of the unit costs are too high, such as

- *US\$ 1700 per month salary for the Program Manager or US\$ 300 per 10% time of the Chief Medical Officer (in a poor, post-conflict country)*
- *Workshop costs ranging from US\$ 244 to US\$ 500*

Response to Comment 9

The current proposal for Round 7 has addressed the issue of unit costs. Estimates allocated for the unit costs indicated in the TRP comments are corrected to make them more realistic. Wherever possible, standard international price lists have been used as sources of the unit prices used in the budget estimates. However, some costs (e.g. workshop costs) may seem high because the costing is based on the prices of commodities and services on the local Liberian market.

Regarding the monthly salary of the Program Manager, US\$ 1,700.00 is the amount being paid the

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HIV/AIDS Program Manager under the approved Global Fund Round 6 Application. Paying lower incentives to personnel of the same qualification and/or responsibilities could result into morale problems that could adversely affect the program.

4.6.2 Goals and objectives and service delivery areas

Referring to your overall needs assessment in section 4.4.1 above, provide a summary of the proposal's overall goal(s), objectives and service delivery areas.

*(The information below should be **no longer than a one page summary**, and Applicants should provide **detailed quantitative information in Attachment A ('Targets and Indicators Table') to this Proposal Form**).*

The **goal** of this proposal is to reduce malaria related morbidity and mortality among the Liberian population, especially children under five and pregnant women.

This particular proposal aims to sustain the scaling up of malaria control efforts undertaken mainly from the GFATM Round 3 and build on that success, by using proven effective interventions so as to reduce the disease burden in the general population with special attention to children under five and pregnant women.

This proposal aims at addressing the following **objectives**:

1. To increase access to prompt and effective treatment at health facilities and community level to 65%.
2. To increase the use of Intermittent Preventive Treatment (IPT) of malaria among pregnant women in Liberia to 65%
3. To increase the use of Insecticide Treated Nets (ITNs) to 80% among pregnant women and children under 5 years of age
4. To ensure effective stewardship and decentralization of malaria control activities by the national malaria control program

In order to realize the above objectives, a number of delivery service areas have to be addressed as indicated below for each respective objective:

Objective 1: To increase access to prompt and effective treatment at health facilities and community level to 65%.

SDA 1.1: Prompt, Effective Anti-malaria treatment: Funding from this proposal will not only assist in the procurement of the anti-malarial drugs and other supplies for case management but also will be used to build the capacity at all levels of the health care delivery system to provide quality services in the management of malaria cases.

SDA 1.2: Supportive Environment: Diagnosis. Currently, most of the malaria cases are being treated based on clinical diagnosis alone. Since ACTs are expensive drugs, they ought to be used rationally, thus necessitating high level of accuracy in parasitological diagnosis in order to minimise drug wastage. To slow down the development of resistance and to ensure effective treatment and rational drug use, there is need to improve diagnostic accuracy by both microscopy and Rapid Diagnostic Tests (RDTs). This SDA focuses on the training of laboratory technicians; microscopes and RDTs will be provided by other partners (e.g. World Bank – 200 microscopes, PMI – RDTs and microscopes).

SDA 1.3: Supportive Environment: Monitoring drug resistance. Currently, there is only one functioning sentinel site for the monitoring of drug resistance. It is important to establish three (3) additional sentinel sites for better monitoring malaria parasite(s) susceptibility to anti-malarial drugs.

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Objective 2: To increase the use of Intermittent Preventive Treatment (IPT) of malaria among pregnant women in Liberia to 65%.

SDA 2.1: Malaria in Pregnancy: In order to provide quality service for pregnant women, which constitute approximately 5% of the population, additional drugs (SP) will be purchased and distributed to pregnant women through ANC services at health facilities.

Objective 3: To increase the use of Insecticide Treated Nets (ITNs) to 80% among pregnant women and children under 5 years of age.

SDA 3.1: Insecticide – Treated Nets (ITNs): Currently about 45% of under fives and an estimated 40% of pregnant are protected with ITNs. However, every year new pregnant mothers and newborn infants will have to be protected by ITNs. There is also need to replace ITNs used for more than three years by children under five years. The country aims at achieving good value for money by moving towards use of Long Lasting treated Nets (LLINs). Efforts will be made to cover pregnant mothers, children under five and whenever possible, make sure every household receives two free LLINs.

SDA 3.2: Behavioral Change Communication (BCC) — Mass Media: Behavior change communication strategies, to increase awareness of malaria prevention and control, which may result in the adoption of positive behavioral practices, will continue to complement efforts to raise the coverage of these interventions and early health seeking behavior.

SDA 3.3: Behavioral Change Communication (BCC) — Community Outreach: Several communities are being sensitized through BCC activities with activities such as malaria songs and dramas. The Malaria program is working closely with the Ministry of Education and other RBM partners in order to adequately cover the entire country.

Objective 4: To ensure effective stewardship and decentralization of malaria control activities by the national malaria control program.

SDA 4.1: Human Resources: This proposal is seeking funding to increase the human resource capacity of the malaria control staff in terms of increasing the number and providing the required training (e.g. on the job, in-service and full-time training). At the same time staff motivation will be addressed by providing supplementary allowances to their salaries to minimise attrition of qualified staff mainly due to low morale resulting from poor remuneration.

SDA 4.2: Supportive Environment: Coordination and Partnership Development: For a successful implementation of this proposal, the role of RBM partners such as NGOs, the private sector communities etc, is very critical.

SDA 4.3: Information System and Operational Research: Delivery and implementation of the interventions require timely and functional M&E system. An adequate system needs to be put in place to track progress and impact of the interventions. Therefore, the health information system will be significantly improved to ensure the provision of quality data and supportive supervisory visits encouraged in all aspects of implementation.

SDA 4.4: Infrastructure / Equipment and other supplies: There is the need to provide office equipment and supplies including logistics.

SDA 4.5: Procurement and supply management: In an effort to improve the standards for procurement and management supply of medicines (including anti-malarials) and other commodities, there is the need to strengthen procurement and supply management capacity. The storage facilities and distribution mechanism will be improved for medicines and other supplies/commodities.

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4.6.3 Specific Interventions, Target Groups and Equity

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

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom.

(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)

For each Objective and respective Service Delivery Area, a number of activities will have to be carried out as outlined below.

Objective 1: To increase access to prompt and effective treatment at health facilities and community level to 65%.

SDA 1.1: Prompt, Effective Anti-malaria treatment

Activities:

- Procure anti-malarial drugs
- Finalize development and distribute new treatment guidelines
- Training of health personnel on malaria case management at all levels by conducting refresher courses
- Follow-up in-house training and conduct supportive supervision
- Orient and sensitize key stakeholders, partners and general population on the new treatment guidelines
- Strengthen referral system at primary and secondary levels

SDA 1.2: Supportive Environment: Diagnosis

Activities:

- Train laboratory personnel in diagnosis of malaria using microscopy and RDTs

SDA 1.3: Supportive Environment: Monitoring drug resistance (and adverse effects to the drugs)

- Activities
- Strengthen capacity to monitor anti-malarial drug efficacy.

Objective 2: To increase the use of Intermittent Preventive Treatment (IPT) among pregnant women in Liberia to 65%.

SDA 2.1 Malaria in Pregnancy

Activities:

- Procure Sulfadoxine-Pyrimethamine (SP)
- Finalize development and disseminate guidelines for Malaria in pregnancy (MIP) implementation.
- Train health workers on malaria in pregnancy [Workshops, Refresher and training of trainers (TOT) for cascade training strategy]
- Conduct health promotion on the use of IPT
- Strengthen monitoring of IPT implementation (quarterly supervision from central to country level and monthly supportive supervisory visits from county to facility)

Objective 3: To increase the use of Long Lasting Insecticide Treated Nets (LLINs) to 80% among pregnant women and children under 5 years of age.

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SDA 3.1: Long Lasting Insecticide Treated Nets (LLINs)

Activity:

- Procure adequate number of Long Lasting Insecticide treated Nets (LLINs)

SDA 3.2: Behavior Change Communication (BCC) — Mass Media

Activity:

- Sensitize the general population on malaria treatment and prevention through print and electronic media.

SDA 3.3: Behavioral Change Communication (BCC) — Community Outreach

Activity

- Sensitize the general population on malaria treatment and prevention through community activities.

Objective 4: To ensure effective stewardship and decentralization of malaria control activities by the National Malaria Control Program (NMCP).

SDA 4.1: Human Resources

Activities:

- Provide training in relevant program areas
- Support HR needs for NMCP

SDA 4.2: Supportive Environment: Coordination and Partnership Development

Activity:

- Commemoration of Africa Malaria Day (AMD)

SDA 4.3: Information System and Operational Research

Activities:

- Strengthen the HMIS
- Carry out supervision and monitoring of malaria activities at all levels; monthly supervisory visits from County to District, health facility and community levels. Quarterly visits from Central to County level.
- Conduct systematic review of implementation

SDA 4.4: Procurement and supply management:

Activities:

- Strengthen the Drug regulatory and quality assurance system
- Strengthen procurement management and supply systems

SDA 4.5: Infrastructure / Equipment and other supplies

Activities:

- Procure office equipment and other supplies
- Provide ongoing support for program implementation

(b) Target groups

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

The whole Liberian population is at risk of malaria, the disease is highly endemic all over the country and

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everybody is equally exposed to malaria infections. However, it is the pregnant women and children aged below five years who suffer most due to their low immunity. Despite activities described in this proposal attempting to protect every Liberian from malaria, some interventions are of necessity targeted to such immunologically underprivileged segments of the community. The target groups for the provision of ITNs in this proposal are therefore children under five years of age and pregnant women. The target groups for the intermittent preventive treatment are pregnant women. Mothers and caregivers have been and will continue to be extensively involved in the implementation of the proposed activities.

Community participation will be prioritized in the implementation of malaria prevention and control activities. They will be trained among other things, in the management of uncomplicated malaria cases and malaria prevention strategies especially among mothers and caregivers. Women's groups will participate in identifying beneficiaries in the distributions of ITNs and in health promotion activities to raise awareness on the use of ITNs and IPT.

During the evaluation of the proposal, the views and perceptions of the mothers and caregivers will be captured and their active participation in the evaluation process solicited. Provision of prompt and effective treatment and use of ITNs for children less than five years and pregnant women will contribute immensely in reduction of the malaria burden in this vulnerable group. In addition, the use of IPT among pregnant women will significantly improve the pregnancy outcome for both mother and new born.

(c) **Equitable access to services**

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

Equity seeks to ensure access of all affected population to social services including health service. The policy already in place at public health facilities seeks to provide these essential services to the population in need and improve health services utilization. Although the main target population in this proposal are children under five years and pregnant women, it is envisaged that the general population will also benefit from planned activities that will be implemented in both urban and rural areas. To this end, a large number of implementing partners within communities will be mobilized to make sure that there is widespread access particularly for the "hard to reach" areas.

A balance is being sought between equity and sustainability in providing ACTs to patients at no cost to them. ITNs will also be made available free to pregnant women and children under five years of age. The IPT drugs will be provided freely as part of the ante-natal package to pregnant women.

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

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

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

There is no specific marginalized group in the country that is entirely excluded from the service delivery activities. The preventive aspects of this proposal are targeting all children under five and pregnant women who are the most vulnerable in the community. The entire population will certainly benefit from the prompt and effective treatment using effective anti-malarials. Furthermore, the entire population will benefit from the health system strengthening strategic actions of the project and supportive environments included in this proposal.

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(e) **Stigma and discrimination**

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

Malaria is endemic in Liberia. There is no stigma or discrimination associated with malaria infection and disease.

Linkages to other programs

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

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

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

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

The only Global Fund grant obtained for malaria prevention and control in Liberia was the Round 3 grant, that was successfully concluded in February 2007. At the moment there is no unsigned, unutilized or undisbursed Global Fund grant for malaria component in Liberia. The Round 3 malaria proposal had similar goals, objectives, and key service delivery areas as this Round 7 application. This proposal aims to sustain the programmatic areas and aspects of the health system strengthening supported through Round 3 grant. This proposal aims at scaling up those interventions initiated with Round 3 financing. Round 3 was prepared when the country was still in the post conflict stage with accessibility to only five counties out of 15 that are currently accessible. As the country becomes peaceful, the geographical area to be reached increases and therefore more needs become visible. Subsequently, experience gained from Round 3 is expected to be useful in ensuring improved efficiency in the management of Round 7 resources and delivery of malaria control services. It is therefore, important to sustain the program performance through the continuation of support under this Round 7 application and other external and domestic sources.

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

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

Delays in procurement and delivery of equipment, drugs and supplies was the major bottleneck encountered in program implementation of the round 3 GFATM support for malaria control in Liberia. Contrary to GFATM recommendations, a Procurement and Supply Management Plan (PSM Plan) was not developed prior to the beginning of implementation. Thus, drug and medical supply orders were not

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placed until the third quarter, leaving programs no possibility of achieving third quarter targets. UNDP's long chain of procurement processes is designed to ensure transparency and accountability, however, this resulted in delays for sub-recipients. Responsibilities were not clearly defined between the LCM, the PR and the sub-recipients from the outset, leading to reduced quality monitoring and evaluation of programs. Difficulty was also encountered in assessing sub-recipients against ambiguously defined indicators and in monitoring overly ambitious targets based on faulty or unavailable baseline data.

The following adjustments were made in Round 3, and would be incorporated in Round 7, in order to resolve existing and avoid future implementation challenges:

Overall Structure:

- The LCM was restructured in March 2006 in line with GFATM regulations, and in order to carefully define roles and responsibilities

Procurement:

- To improve the pace of delivery, UNDP hired a program manager in 2006
- To prevent delays, UNDP now places all drug procurement orders two quarters ahead of time

Sub-recipients:

- The LCM will select sub-recipients based on a comprehensive, transparent, competitive, and well-documented process
- Responsibilities in light of indicators will be clearly detailed in the Memoranda of Understanding signed between the PR and sub-recipients
- Work plans for the sub-recipients will be directly linked to main program objectives

Budgeting:

- The PR has been actively engaged in detailing the necessary budget and budget items are matched directly to program activities
- Technical assistance costs have been anticipated and budgeted
- Management costs have been anticipated and budgeted
- M&E costs have been anticipated and budgeted

Monitoring and Evaluation:

- M&E reporting tools used in Round 3 will be refined, tested, replicated, and distributed prior to implementation
- M&E activities will be integrated into routine activities of the PR and LCM

Supply Chain Management:

- Funding and training necessary to expand supply chain management capacity have been anticipated
- NDS storage capacity has expanded through renovation funded by the savings made throughout implementation of Round 3
- NDS cold chain expanded to 4,000 liters by equipping the warehouse with a small cold room, with the purchase of 12 refrigerators and a small generator
- A comprehensive approach to further improve NDS cold chain management capacity is currently being developed, involving UNICEF, WHO, MOHSW, UNDP/GFATM and NDS, and aiming to upgrade 6 strategically located sites for proper cold storage
- Software was developed and piloted to link PR, NDS, and MOHSW electronically in Round 6.

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4.6.5 Performance of and Linkages to other donor funding for the same disease

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

UNICEF has been contributing to the provision as well as distribution of LLINs for children under five years of age and pregnant women in eight counties. Furthermore, they have been supporting the provision of SP for intermittent preventive treatment of pregnant women in the same eight counties. WHO also supported in conducting Liberia's malaria indicator survey in 2005. The support included both technical and financial (in addition to the support from the Global Fund). Currently WHO has been providing technical and financial support for the ongoing therapeutic efficacy study of ACT in Liberia, which has also been supported by GFATM. There are no major bottlenecks with other funded programs by external donors, whether bilateral or multi-lateral.

Private Sector Contributions

4.6.6 Private Sector contributions

- (a) If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions (*whether financial or non-financial*) anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.

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

No significant contribution and co-investment is expected from the private sector in the country.

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

Size of population group that is the focus Of the Private Sector contribution →							
Refer to Guidelines for examples on 'Contribution Description' ** Add extra rows below to identify each main Private Sector contributor		Contribution Value <i>(same currency as selected in section 1.1)</i>					
** Private Sector Contributor or Name	Contribution Description <i>(in words)</i>	Year 1	Year 2	Year 3	Year 4	Year 5	Total

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4.7 Principal Recipient information

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

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

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

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

Table 4.7: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through one or several Principal Recipients.	<input checked="" type="checkbox"/> One
	<input type="checkbox"/> Several

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	Sector Represented	Name of Contact person	Address, telephone, fax numbers and e-mail address of contact person
UNDP Liberia Country Office	Multilateral Development Partner – in country	Steven Ursino, Country Director, UNDP	Simpson Building, Mamba Point, Monrovia Liberia, Tel: +231 06532973, email: steven.ursino@undp.org

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements.

(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM, Sub-CCM, or RCM where relevant. Maximum one page.)

The LCM formed a Technical Coordinating Committee (TCC) to recommend the specific division of roles and responsibilities among all partners implementing this proposal. On the basis of recommendations from the TCC, the LCM agreed upon specific responsibilities for each partner to ensure coordinated and efficient grant management. The LCM's primary mandate is to coordinate overall policy and program direction. Throughout, the LCM communicates frequently with the UNDP, MOHSW, NDS, and NMCP to ensure cohesive planning, implementation, and monitoring. As the PR, UNDP will be in charge of program implementation, disbursement of funds against planned activities, and monitoring sub-recipients' adherence to the work plan and timeline. MHSW, as the sub-recipient, will ensure timely, efficient, and quality administration of programs. NMCP, with the guidance of UNDP and MHSW, is responsible for the implementation of programs and the collection of data for monitoring and evaluation purposes. The National Drug Service (NDS) will be responsible for improving procurement and supply management services, working in collaboration with UNDP, and providing warehousing and distribution

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of health commodities.

A strong desire to build national management and procurement capacities was directed by the LCM's consensus decision that the UNDP will serve as the PR for the first phase of the grant and will coordinate a smooth transition for the MOHSW to serve as the PR in the second phase.

Phase I:

The LCM will coordinate **planning** efforts during Phase 1. Regular meetings will be held between the LCM, MHSW, NMCP, UNDP, and all sub-recipients to facilitate coordinated management and to discuss programmatic issues and results. In addition, the LCM will welcome additional participants (whenever found necessary to do so) to these meetings to harmonize grant-specific planning with existing national efforts.

The LCM and UNDP will share responsibility for planning the detailed implementation of Phase 1. The LCM and UNDP will focus on three key steps necessary to efficient and effective grant planning and adherence to the work plan. The *first* step will be to coordinate the development of a procurement and supply management plan prior to implementation. *Second*, the LCM and the UNDP will work together to ensure rapid growth of the government's planning capacity at MOHSW, NMCP, and NDS. The MOHSW has identified a strong need to increase its management capacity and to train staff in computer literacy and program management. In addition; training, hiring staff, and procuring technical assistance are proposed to improve the M&E capacity of NMCP and the procurement capacity of NDS.

UNDP will assume responsibility for grant **implementation** through its Implementation Unit. This unit, supervised by the Deputy Resident Representative, will be coordinated by an international program manager with prior experience in malaria program operations. Implementation will be carried out by an additional five-staff unit: a national field coordinator, a finance manager, a finance assistant, a dedicated procurement specialist, and a national pharmacist. As the recipient of grant funds, UNDP will manage funds and provide planned disbursements according to corporate procedure and in line with international standards. UNDP will provide technical and managerial oversight of sub-recipients implementing programs. Regular meetings will be scheduled for the unit to meet with MHSW, NMCP, and NDS to discuss implementation plans and bottlenecks.

With the assistance of data collected by MHSW and NMCP, the UNDP will be responsible for **monitoring and evaluation** of grant performance. The M&E process for this proposal is described in detail in sections 4.9.1 and 4.9.2 below.

Phase 2:

In Phase 2, the LCM will continue to coordinate **planning** efforts and will ensure smooth transition of the PR responsibilities from the UNDP to the MHSW. The LCM will assess the increased capacity of the MOHSW, the LAC, and the NDS prior to the completion of Phase 1.

The MOHSW, with its newly strengthened capacity, will assume responsibility for grant **implementation** as the PR in Phase 2. It is expected that the NMCP will have built sufficient capacity to ensure high-quality M&E; and NDS will have adequate capacity and expertise to take charge of procurement and supply.

Monitoring and evaluation will be carried out through the efforts of NMCP in Phase 2. NMCP will collect health service delivery data, enter the data into CRIS, provide quarterly analyses, and conduct supervisory site visits on a quarterly basis.

The rationale for this arrangement with respect to program planning and management is to ensure as much as possible, inclusive participation and contribution of all the major players and stakeholders in the management and evaluation of the program, under leadership of the LCM. Since early 2007 the implementation of GFATM Round 6 of the HIV/AIDS component, efforts to build capacity of the MOHSW as prospective PR have been in place. This is in accordance with the approved Round 6 proposal for HIV/AIDS component which equally aims at having the PR responsibility transferred to MOHSW during Phase II of implementation by the end of year 2008. In addition to this arrangement, the MOHSW has just received a World Bank support through the International Development Association

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(IDA) grant for Support Systems strengthening. The IDA grant will among other things, support the MOHSW to develop its operational capacity in effective project management and expand its monitoring and evaluation mechanisms. This is to be achieved through provision of technical assistance and training of MOHSW staff in health financing, contracting with health partners, contract management, financial management, procurement and supply management, ICT and health management information systems. The process of hiring staff to implement this arrangement is currently underway.

4.8.2 Principal Recipient capacities

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

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

UNDP has presently been named as Principal Recipient for over sixty grants in twenty-six countries. Through the Bureau for Development Policy (BDP), Bureau of Management (BOM) and Bureau for Resources and Strategic Partnership (BRSP) UNDP HQ developed tools and methods to effectively manage and implement GFATM-financed projects. This includes Global Long Term Agreements (LTAs) for the procurement of HIV/AIDS, tuberculosis and malaria products for GFATM grants, as well as non-healthcare items. Additionally technical capacities to support GFATM-financed programs are being strengthened in the regional offices to better respond to the needs of the PRs in the Country Offices.

UNDP Liberia has put in place a Unit for the management and implementation of the Global Fund grants, that includes expertise in project management, financial management, supply chain including procurement and monitoring & evaluation. UNDP's primary responsibility in the implementation of the Global Fund grants is to provide capacity development to implementing partners in financial management, procurement, monitoring and program implementation. The Global Fund has expressed satisfaction over this level of preparation.

Based on lessons learned from previous grants, mechanisms have been put in place for the improvement of procurement and supply chain management and overall program monitoring.

- (b) Has the nominated PR previously managed a Global Fund grant?

Yes

No

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

The PR has been selected for the implementation of the Phase I HIV/AIDS Round 6 Grant. An exit plan for capacity development will be developed to ensure the transfer of project management responsibility to the new PR. The over all capacity of other organizations/institutions applying to be PR is still questionable.

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(c) Is the nominated PR currently managing a large program funded by another donor?	<input checked="" type="checkbox"/> Yes
	<input type="checkbox"/> No
(d) Identify the total budget (current and planned) under management by each nominated Principal Recipient .	
The PR has recently started implementation of the HIV/AIDS Round 6 Grant in the amount of 12,005,984 USD	
(e) Describe the performance history of the nominated PR in managing these programs/grants. Specifically , where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.	
The performance of UNDP as the PR for Round 2 and 3 has been adequate. The weaknesses identified in the implementation of previous grants have been addressed and the PR has strengthened the Global Fund Implementation Unit in the areas of Monitoring and Procurement and Supply Chain Management. The PR has designed and is implementing new procurement and supply chain management standard operating procedures in order to improve the management of health products.	
(f) Describe how the Applicant has satisfied itself (including by reference to any assessment criteria) that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a transparent, efficient and timely manner .	
The assessment is based on the PR previous experience with the implementation of Global Fund Grants in the country and globally. Additionally, because the present proposal is a scale up of malaria control activities which was managed by the PR during the last grant, the PR is in a better position to adequately manage the grant.	

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

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<p>(d) Describe:</p> <p>(i) The transparent process by which sub-recipients were identified, the rationale for the number of sub-recipients and the criteria that were applied in the identification process.</p> <p>(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will either receive a significant proportion of the funding from this proposal or who will be involved in on-granting of funding to sub-sub-recipients <i>(Also identify significant potential bottlenecks to transparent strong performance by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).</i></p>
<p>(e) Attach a list of sub-recipients that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.</p> <p>Below please comment on the relative proportion of interventions that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. <i>(maximum two pages).</i></p>
<p>(f) Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal. <i>(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)</i></p> <p>The process is already underway. However, due to its sensitivity it turns out to be a long process. It is just unfortunate that the proposal had to be submitted before conclusion of the process.</p>
<p>(g) Where sub-recipients have not been identified prior to proposal submission, describe in detail the process that will be used to select sub-recipients if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved.</p> <p>The LCM plans to document a competitive and transparent process that will be used to select sub-recipients. The PR will oversee and provide feedback on this process and its enactment. The LCM will determine task orders against activities based on the work plan, and a newspaper and radio announcement will be issued with an open bid seeking sub-recipients. The LCM will form a Technical Review Panel to review contracts. The Technical Review Panel will include in its evaluation of sub-recipient bids: (1) Capacity to implement program activities in the proposed service delivery; (2) financial transparency and credibility (in some cases an audit will be conducted prior to making awards); (3) past experience and track record in implementing activities in the proposed service area and in working in Liberia; (4) past experience working on bilateral projects; and (5) management and technical capacity as reflected in the organization’s human resource capacity.</p> <p>The LCM will award contracts to sub-recipients based on the recommendations of the Technical Review Panel, along with a comprehensive assessment of the institutional, programmatic and financial capacities of the sub-recipients. The LCM will also be guided in its decisions by results obtained from sub-recipients contracted during GFATM Round 3 and lessons learned throughout the administration of Round 3 Malaria component Grant.</p>

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4.9 Monitoring and evaluation framework

4.9.1 Monitoring and evaluation plan

Describe how the data relating to performance against planned outputs and outcomes set out in Annex A will be accurately collected, collated and reported by implementing partners.

A Monitoring and Evaluation (M&E) plan for the NMCP is currently being developed. However, efforts are in progress with other partners to develop a comprehensive integrated monitoring and evaluation plan. The current M&E plan is based on the RBM evaluation plan which routinely collects data that fit in well with the indicators recommended for monitoring targets that have been set for this application. Attachment A provides details of the frequencies for each evaluation. The program **outputs** will be tracked using standardized checklists and forms designed for that purpose periodically according to the reporting schedule of each of the activities. Health personnel will use standardized primary data collection tools to collect data on out- and in-patients with clinical and/or laboratory confirmed malaria. On a monthly basis, health facilities will provide summarized data on services provided, including those from malaria, HIV/AIDS and TB patients. Data from health facilities will be collected and compiled manually by County Registrars who will then forward the data to the County Health Team (CHT) in each of the 15 Counties. It is planned to introduce a computer-based system at County level. The CHT will undertake preliminary analysis of the collated secondary data before submitting the data to the NMCP and the HMIS unit based in the Planning Department of the Ministry of Health & Social Welfare. Currently private health facilities contribute very little or no data at all to the HMIS. This situation will be addressed as part of the integrated Health Systems Strengthening activities in this proposal.

The NMCP will collate malaria data, analyze and report the information on a quarterly basis. Data on number of ITNs distributed, IEC/BCC materials etc., will also be reported using the same method described above. The County Health Team (CHT) will monitor malaria control activities (eg ITNs distribution) in their respective counties and report to NMCP whenever necessary.

Supportive supervision will be done monthly by CHT (especially for case management) to ensure that clinicians are performing as expected. Reports for supportive supervision will also be tracked on forms/checklists at health facilities on a periodic basis. The County Health Officer (CHO) shall ensure data timeliness, quality and accuracy through monthly monitoring.

Quarterly visits to the Counties for verification of reports (ensuring data quality) and monitoring the quality of malaria control interventions will also be carried out by the NMCP. A feedback mechanism on reports collected will be ensured both at county and national level. Monitoring of pharmaco-vigilance will also be done and verified on a quarterly basis.

Reports on the program **outcomes/coverage** (eg. % of Pregnant women using ITNs, etc) will be estimated annually using mini-surveys in areas where interventions have been carried out. This will be a monitoring survey to help the program determine whether ITNs already distributed are being used. IPT coverage will be estimated quarterly using the routine data collected from health facilities.

On a bi-annual basis, program reviews will be conducted to verify performance of program implementation. At the national level, the Liberia Malaria Indicator Survey (LMIS) will be conducted every 2 years (at the beginning-2008, mid-term-2010 and end-term-2012). The LMIS costs for year 2008 will be provided by PMI. The LMIS will report **national outcomes/coverage** of the various malaria interventions both at facility and community levels. This nationally representative community and health facility survey will also provide information on the RBM targets. Data from LMIS is expected to provide a basis for better planning of malaria interventions to the NMCP and its partners.

Operational research studies will be done periodically to provide information needed for proper planning and maximization of resources for optimum results. These studies include efficacy monitoring of drugs and insecticides in use, detailed malaria epidemiology, anti-malaria drug efficacy studies, vector susceptibility to insecticides used for net treatment and indoor residual spraying and exploring the feasibility of using rectal artesunate suppositories as a pre-referral case management approach. Reports on

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these studies will be submitted at the end of each study. More subjects for operational research will be identified in due course depending on implementation obstacles that arise. This application is expected to contribute to the routine supervision, the mid-term and end of term evaluations as well as towards implementation of operational research.

4.9.2 M&E Systems Capacity Assessment

Provide, in only a summary format below, a description of the major gaps identified and how this proposal incorporates a plan to overcome those gaps to support an effective monitoring and evaluation framework in the country.

The only available source of data for the entire Ministry of Health and Social Welfare is the Health Information Management System (HMIS). The HMIS database have however been destroyed by the long protracted 14 years civil war (1989 – 2003). Since then it has not been able to function optimally, and will take time to become fully functional thus making it unreliable for a foreseeable future. Affirmative intervention is required in order to reverse the situation.

Major gaps that have so far been identified include lack of essential human and material resources, capacities to analyze data are very minimal at the national level and almost lacking at the county levels. Data reported are often of low quality and inaccurate and there is no mechanism in place to ensure that feedback is provided to those concerned. Nationally, there is no M&E Plan in place.

Under the GFATM Round 3 malaria grant, M&E was done by directly collecting reports from the health facilities. The proposed plan (above) will be based on review and updating of the previous methods so as to guide monitoring and evaluation activities geared towards scaling up of malaria interventions.

The proposed M&E plan for this Round 7 application will build on existing structures, tools and systems and will be conducted at four levels, namely: community, health facility, county and national levels. This proposal requires support in the form of salary support for the 4 drug monitors at National Drug Service, 44 County Registrars, 15 county data managers and one NDS data manager, 30 data entry clerks, 3,600 community health workers and 15 drivers for county data and monitoring units in order to overcome these gaps. Transport in form of motorcycles and vehicles will be needed for M & E activities.

There is commitment from the President's Malaria Initiative (PMI) to provide support for strengthening Monitoring & Evaluation system at the NMCP. Under the current GFATM proposal, the National Malaria Control Program will still use the national HMIS system to collect general malaria data, but will maintain her own database which will contain more detailed information on all malaria control activities due to limitations of the HMIS.

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4.10 Procurement and supply management of health products

4.10.1 Roles and responsibilities for procurement and supply management of health products			
(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.			
Activity	Which organizations and/or departments are responsible for this function? <i>(Identify if MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).</i>	In this proposal what is the role of the organization responsible for this function? <i>(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).</i>	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	UNDP/MOH&SW	PR/ SR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Quality assurance and quality control of pharmaceuticals	Pharmacy Division/MOH&SW	Quality control and assurance agents	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
International and national laws (patents)	Ministry of Commerce /Ministry of Justice (Attorney Generals Chamber)	SR/Implementing agency	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Coordination	LCM	Coordinating body	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Management Information Systems (MIS)	MOH&SW	SR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Product selection	NMCP	SR	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Forecasting	NMCP/NDS/UNDP	SR/ Storage and Supply Management Agent/ PR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procurement and planning	NMCP/NDS/UNDP	SR/ Storage and Supply Management Agent/ PR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Storage and Inventory management	NDS/NMCP	Storage and Supply Management Agent/SR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Distribution to other stores and end-users	NDS/NMCP	Storage and Supply Management Agent/SR	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Ensuring rational use	NDS/NMCP/CHT	Storage and Supply Management Agent /SR /Implementing Agent	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

UNDP Liberia will be responsible for the procurement and supply management necessary for the Round 7 proposal during Phase 1. In Phase 2, after a significant increase in the capacity of NDS and MHSW and a suitable transition period, these responsibilities will be taken over in full by NDS and MHSW.

UNDP

UNDP Liberia have had the responsibility for procurement and supply chain management as Principal Recipient for the GFATM Round 2 HIV Component grant; GFATM Round 3 Malaria component grant and is currently administering GFATM Round 5 HIV Component. The direct execution unit (UNDP/DEX) currently implements Round 6 HIV Component with a team international procurement experts and national procurement and logistics officers. The head of UNDP/DEX reports directly to the Resident Representative of UNDP Liberia. The UNDP/DEX unit has been responsible for major procurements for the National Transitional Government, such as those for the National Elections and DDRR. Moreover, this procurement unit has been instrumental in supporting the setup and establishment of the newly elected democratic government of Liberia.

All GFATM procurement will continue to be carried out using UNDP procurement regulations, as set forth in the UNDP Procurement Manual. UNDP regulations detail procedures for the procurement of goods and services through competitive and transparent processes. UNDP procures through long-term agreements negotiated with suppliers of WHO or FDA approved drugs and health products.

In Phase 1, in accordance with the existing memorandum of understanding (MOU) between UNDP and NDS, UNDP, in collaboration with the national program, will forecast, procure, receive, clear and immediately transfer drugs and commodities to NDS; NDS will be responsible for storage, distribution, supply management, monitoring, and reporting for all items received. The Procurement and Supply Management plan that must be developed prior to the implementation of Round 7 will be designed by UNDP, in collaboration with MHSW and NDS.

Transition

This proposal recognizes that procurement planning, particularly for LLINs and anti-malarial drugs and medical supplies is complex and demanding, requiring proper forecasting and timely delivery of commodities. In the PSM plan, a detailed work plan will be developed for the expected transition of forecasting and procurement responsibilities from UNDP to MOHSW and NDS.

Appropriate technical assistance will be sought in forecasting, procurement, supply chain management, and establishment of logistics management and information systems. To help accelerate the expansion of the NDS procurement capacity, UNDP will provide technical assistance to contract for a comprehensive 2-month NDS needs assessment conducted by an independent PSM consultant. Subsequently, through a competitive bid, an international PSM consulting firm will conduct an intensive 6-month capacity-building intervention that will set up PSM systems, train personnel, and provide on-site mentorship. This PSM consulting firm will provide follow-up for 18 months thereafter, as needed.

Throughout Phase I, UNDP will train NDS on all GFATM procurement procedures and requirements. During the first 18 months of the Round 7 grant implementation, UNDP will work with NDS to recruit the necessary procurement, logistics, and administrative staff and the MHSW to recruit a Procurement Officer. Dedicated office space for the unit will be secured. Once necessary staff is hired, technical assistance will be provided by the UNDP/DEX Unit in addition to the PSM consulting firm to assist MOHSW and NDS in developing all areas of necessary expertise.

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In the second year of Phase 1, responsibility will be steadily transferred to NDS; this period of overlap will ensure adequate training and support to develop full capacity at MHSA and NDS for a smooth transition at the end of the year. In Phase 2, when the PR role is transferred from UNDP to MHSW, NDS will assume responsibility for procurement, storage, distribution and reporting; MOHSW's Procurement Officer will conduct forecasting, quantification, and coordinate consumption monitoring and reporting; and NACP will provide specifications. Several months before Phase 2 of the grant, the PR and the NDS procurement unit will be prepared to have all systems and staff in place for review by the LFA.

Special attention will be given to coordinating linkages between UNDP, MHSW, and NDS during the transition. Prior to and throughout the course of Phase 2, grant-related information will be shared and available online via a dedicated server, with different levels of access granted to NDS, the PR, and SRs to monitor stock levels and transactions. Effort will be made to harmonize the NDS system with distribution networks already established by groups such as MSF, Merlin, Equip, IRC, Save the Children, and CHAL.

National Drug Services: Organizational structure

The National Drug Service (NDS) is a not-for-profit organization registered under the corporate laws of Liberia in March 1992, with the mandate to procure, manage and distribute pharmaceuticals and related supplies. Its policies are determined by a Board of Directors, which encompasses government functionaries (including the Ministry of Health & Social Welfare), users (including Christian Health Association of Liberia, Liberia Medical and Dental Association), and civil society (including Liberian Bankers Association, Liberia Marketing Association and the Liberia National Bar Association). Policies and objectives set by the Board of Directors are implemented through a 4-person management team consisting of the Managing Director, the Operations Officer/Pharmacist, the Finance Officer and the Coordinator of the Monitoring & Evaluation Unit. The NDS also has a support staff of around 20 persons spread amongst the Administrative Unit, Monitoring & Evaluation Unit and Finance Department.

Currently, the NDS does not have a procurement unit in the conventional sense of the word. Procurement activities are coordinated between the Administrative, Finance, and Operations Departments. In order for NDS to undertake procurement for the Global Fund, it is proposed that a Procurement Unit be set up specifically for that purpose. This dedicated unit and its relationship to the existing structure of NDS is shown in the chart below (dotted line). The new unit will be 100% dedicated to procuring HIV/AIDS drugs and commodities, as well as drugs and commodities for the malaria and TB components. This unit will maintain separate financial management oversight procedures in accordance with GFATM requirements and PR procurement policies and procedures. The new unit will report directly to the Managing Director and will be headed by a Senior Procurement Specialist.

NDS Coordination with other entities

Currently the NDS procures essential drugs and medical supplies for public health facilities and faith-based hospitals and institutions using two main WHO pre-qualified suppliers: IDA, in the Netherlands and Missionpharma in Denmark. In the past (1998-2002, 2003, 10/2005-03/2006), with Technical Assistance from the European Union, NDS has engaged in international tendering procedures in consonance with the European Development Fund (EDF) regulations. In these instances, it was the Tender Evaluation Committee, comprising of EU, MOH and NDS that analyzed and recommended the best sources of supplies.

Under the last Technical Assistance provided by the EU to NDS, a consultant developed procurement guidelines. These guidelines are an assimilation of international procurement procedures drawing on World Bank/Asian Development Bank, European Union, SIDA and the recently approved Liberia's Public Procurement and Concessions Commission Act of September 2005. The Act establishes the various procurement methods and procedures as well as provides for the creation of Procurement Units.

National drug regulatory authority

The Pharmacy Board of Liberia (PBL) is the national drug regulatory authority reporting to the Ministry of Health. The Liberian Pharmacy law requires that all medicines for use in Liberia shall be registered through a quality assurance process. PBL is at the moment responsible for the registration of

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pharmaceuticals only. Provisions were made under Round 2 of the Global Fund to enhance the capacity of the PBL. Funds to further enhance quality assurance of pharmaceutical products have also been budgeted under the Round 7 Malaria grant. Prior to registration, the PBL evaluates all product dossiers to ensure that all pharmaceutical products intended for consumption on the Liberian market are of the required standard. The PBL, owing to its limited capacity, requests importers to provide Batch Analysis Certificates. Liberia has a National Drug Policy in place and the Ministry of Health coordinates its implementation. It is within that policy framework, that NDS is mandated to manage the essential drug program (EDP) of Liberia.

International agreements

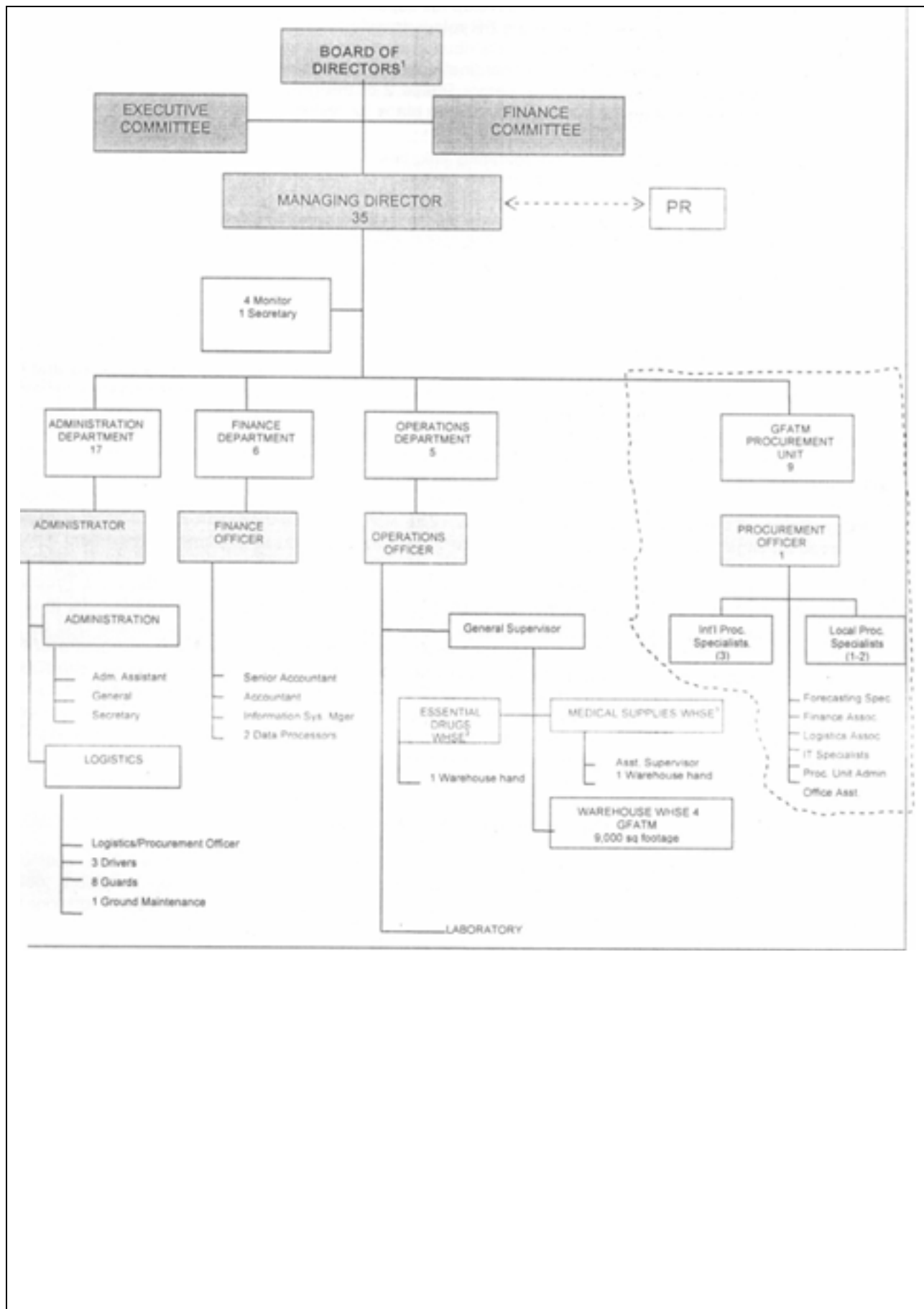
Liberia, as a least-developed country, can subscribe to the provisions of the Doha Agreement with respect to the WTO's Trade and Intellectual Property Rights Agreement (TRIPS) and the public health flexibilities. Liberia intends to use the provisions offered by the TRIPS agreement.

Management capacity

The NDS procurement capacity has been limited to procurement activities guided by technical assistance provided under EU auspices using EDF resources. NDS has also procured using its own financial resources. In 2004, UNDP contracted NDS to procure essential drugs and medical supplies to the tune of US\$0.5m for the disarmament, demobilization, resettlement and reintegration (DDRR) of ex-combatants. In addition to these procurement experiences, NDS provides pharmaceuticals management services for health sector organizations including: Africare, UNFPA, UNICEF and Save the Children-UK. Currently, NDS manages storage and distribution for all of the pharmaceuticals and related supplies provided by Global Fund for the three diseases – HIV/AIDS, tuberculosis and malaria. This proposal has taken careful consideration of the need to increase NDS procurement and supply chain management capacity in order to manage GFATM procurement.

Organisational Chart of the National Drug Supply

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4.10.2 Procurement capacity	
(a) Will procurement and supply management of medicines and other health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also conduct procurement and supply management of these products?	<input type="checkbox"/> Principal Recipient only <input type="checkbox"/> Sub-recipients only <input checked="" type="checkbox"/> Both
(b) For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below.	
Organization Name	Total value of medicines and other health products procured during last financial year
UNDP/GFATM	2,239,540.74
National Drug Service	5,440,966.00
Total	7,680,506.74

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4.10.3 Coordination

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

During the course of the GFATM round 3 malaria grant, UNDP procured all anti-malarial drugs. The total value of drugs procured for 2006 was USD\$ 2,239,540.74.

The NDS has over the past year procured and/or managed drugs and medical supplies for the following Agencies and respective values in US \$ as shown below (Note: not all of these drugs were anti-malarials).

Source	Value of Drugs (US\$)	% Value
UNDP/GFATM	2,239,540.74	29.2%
NDS	5,440,966.00	70.8%
Total	7,680,506.74	100%
Canadian National Committee for UNICEF	241,707.00	
EU	1,179,905.00	
SAUDI	291,324.00	
Government of Liberia	797,375.00	
Chinese Government	128,700.00	
WHO	150,000.00	
UNITAID/UNICEF	903,738.00	
Japanese Government	1,298,860.00	
NDS	449,357.00	
Total	5,440,966.00	

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

The National Drug Service (NDS) has been engaged in managing donations from a number of donors and international organizations as follows:

1. AmeriCares: donated pharmaceuticals and related products for the Liberian people.
2. USAID: donates condoms oral and injectable contraceptives for the reproductive health program in the country

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3. World Relief Organization: presently distributing hospital equipment, medical supplies and laboratory supplies
4. Global Fund: Drugs and related products procured by global funds are currently being supplied to health facilities in the country.

4.10.4 Supply management (storage and distribution)

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

Yes
→ continue to (b)

No
→ go to 4.10.5

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

National medical stores or equivalent

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

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

Other *(specify)*

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

The National Drug Service (NDS) is a semi-autonomous body whose role is to procure, store and distribute pharmaceuticals, drugs, medical equipment, medical equipment, consumables & supplies to end users who are mainly health facilities around the country. Drug delivery is carried out by MOH&SW through the National Drug Service (NDS). The NDS is the sub-recipient responsible for procurement and supply management of medicines and other health products for this proposal.

The NDS currently runs one national depot (with current capacity approximately 13,000 m²) at central level in Monrovia. In addition it has a network of nine (9) sub-depots strategically located at the county level with adequate facilities to store pharmaceuticals and related products. Funds provided under the 3rd Round of GFATM Malaria component grant along with inputs from NDS were used to expand warehousing capacity. The increased volume in procurement of supplies will be stored in facilities as described above. These depots are currently supported with funds from the HIV/AIDS approved Round 6 GFATM Grant in terms of incentives for DDFPs and Depot Assistants and maintenance through NDS.

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

The distribution plan currently in place favors the delivery of supplies from the Central depot at NDS to the County sub-depots using one small truck (7.5 tons capacity) and 3 staff. As the country becomes peaceful and opens up, more areas are becoming accessible making such a distribution capacity to become inadequate. A commitment has been made by HIV/AIDS component GFATM Round 6 approved

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grant to purchase an additional one truck (20 ton capacity). A parallel distribution procedure allows for health facilities and organizations in Montserrado and Margibi counties to access pharmaceuticals from the NDS Central depot.

4.10.5 Pharmaceutical products selection

Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use.

In section 5.4.1, Applicants are requested to complete '**Attachment B**' to this Proposal Form on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.

Yes

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4.11 Technical and Management Assistance and Capacity-Building

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

4.11.1 Capacity building and training

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

The primary constraint likely to impinge on the smooth implementation of this proposal is lack of trained and qualified human resources. This is compounded by lack of operational management capacity across all levels of the health system. As earlier indicated, this situation has resulted from flight of professionals who had to leave the country as a result of political and civil unrest during the war.

In order to ensure that the National Malaria Control Program is able to carry out its function of coordinating and providing expert advice on malaria prevention and control activities in the country, it is necessary that the capacity of the program be upgraded in the technical area, program management and partnership. This will be a continuous process to ensure that the program at all times has the necessary technical capability to carry out its roles including fostering effective partnership among all the stakeholders.

Effective stewardship of malaria control and decentralization of program activities by the National Malaria Control Program up to 2012 is limited due to a low number of NMCP staff trained in public health. It is appropriate that the Program Manager and Deputy Program Manager undergo such training for effective stewardship of the program. At present, none of NMCP staff is trained in public health. Moreover, with no one adequately experienced in operational research at present, the division relies on and will have to rely constantly on the competence of external consultants each time surveys and studies are to be conducted. More capacity building will be needed for the finance officer and IEC/BCC focal person.

Monitoring & Evaluation was a major weakness in the just ended GFATM Round 3 malaria component grant implementation. The President's Malaria Initiative (PMI) support to Liberia has M&E capacity strengthening as a major component. The NMCP will rely greatly on the PMI in supporting the M&E capacity of the Malaria Program.

The MOH&SW currently needs capacity building for the initial two years in order to take over from the UNDP as Principal Recipient (PR). There is currently limited capacity of staff in areas of Procurement and Supply Management (PSM), Financial Management and Monitoring & Evaluation.

At the county level, staff is not well trained in data management and lack essential logistics for data collection. There is also limited manpower at the health facilities due to inadequate trained staff and the low remunerations paid to staff.

The National Malaria Control Program has therefore through this proposal developed the following strategies to address the situation.

A. At NMCP level this includes the training of staff as follows;

3 public health specialists to Masters level:

1 Entomologist

1 Parasitologist

1 Epidemiologist

1 Data Manager in data management and disease surveillance

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1 Finance Officer to MBA level
1 IEC/BCC Specialist to MPH level
1 Monitoring and Evaluation Officer

B. At County level, staff will need to be trained (e.g. by PMI) in

Data management (15),
Data collection (44 county registrars)
Data entry clerks
Malaria case management

C. Technical Assistance

Operational research
Program management
Epidemiology and data management & analysis

All malaria control personnel will receive incentives commensurate with qualifications and experience to safeguard against brain drain

D. Capacity of Principal Recipient

There is urgent need to address building national capacity in all aspects of program management. This is particularly to ensure that the MOHSW has the requisite capacity to serve as PR for phase two of this proposal period (2010-2012). The current PR, UNDP has over the period been able to build enough capacity that does not require further support. The emphasis in this proposal therefore is to build project management capacity within the Ministry of Health and Social Welfare. Immediate demands are in the areas of Program Management, Procurement & Supply Management, Financial Management and Project Monitoring & Evaluation.

4.11.2 Technical and management assistance

(a) Needs Assessment

Describe any needs for technical assistance, including assistance to enhance management capabilities to support the attainment of the planned outputs and outcomes under this proposal. Where relevant, link your response in this section to the potential capacity constraints of the Principal Recipient and/or other implementing partners under this proposal.

(Please note that technical and management assistance should be quantified and reflected in the component budget section, in section 5). In your description, identify the process by which needs were assessed and evaluated.

There is the need to strengthen the Drug regulatory, quality assurance, procurement, management and supply systems in the country to ensure efficiency. For this purpose technical assistance will be needed. Although the Round 3 grant enabled the Program's M&E Officer to acquire some knowledge and skills in monitoring, technical assistance will be needed for certain operational studies (insecticide resistance, vector and parasite species, use of rectal artesunate as pre-referral drug in home-based management of malaria etc) and Program Evaluation (both Mid-term and end-term). The establishment of a functional pharmaco-vigilance system in Liberia means that the Program will require technical assistance for the initial set-up. The past grant supported the implementation of the new treatment policy and this proposal aims to scale up this strategy. There is therefore need for follow-up and Evaluation missions in the form of technical assistance to provide the needed guidance and support for this component of the proposal.

Other Program areas requiring technical assistance are Financial Management System Plan and strengthening the existing Health Management Information System (HMIS) of the MOH&SW under the

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health systems strengthening component.

NDS

Drug regulatory,
Quality assurance
Procurement & Supply Management systems

MOHSW

Program Management,
Procurement & Supply Management,
Financial Management
Project Monitoring & Evaluation

NMCP

Operational research
Program management
Epidemiology and data management & analysis

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

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

Technical and management assistance is required in order to build capacity of the NMCP, PR, SR and other implementing agencies, aimed at enabling these entities to deliver more efficiently in the execution of this proposal. Procurement of such technical and management assistance by the LCM has as its main goal, to obtain the best overall value for the program through competitive processes that are fair to all. In so doing, the LCM is committed to creating an environment that fosters open, global, and transparent competition for the services solicited by promoting open competition through its procurement process.

Verbal or written solicitations will be sent to five or more suppliers selected at random using market or industry directories, in consultation with technical agencies such as WHO, the PR and MOHSW. The competitive process will be based on a combination of a number of factors including product quality and value, wages and benefits, competitive pricing, etc. These factors will have varying importance of weights in any particular procurement. These procurement activities will be conducted in a manner above reproach, with complete impartiality and with no preferential treatment.

This procurement process will apply to local, national and international assistance that will be sought by the LCM. Details of the process will be provided in the Procurement and Supply Management Plan to be developed by the PR and submitted to the Global Fund. The planned assistance in both technical and management aspects is expected to build internal capacity of local players in the two areas which are considered crucial in the implementation of the control program. In so doing, it will have a long term effect in creating an enabling environment for the country to be able to manage disease control at both technical and managerial levels.

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5. Malaria Component Budget - Overview and general guidance

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

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

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

Funding to be contributed through a common funding mechanism

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

- (a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds within the common funding mechanism; **and**
- (b) provide, **as an annex to your proposal**, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Component Budget

A detailed per-disease component budget covering the proposal period must be attached as an annex to your proposal.

The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

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

- (a) *It should be **structured along the same lines as the Component Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities.*
- (b) *It should cover the full term of the proposal, and:*
 - (i) *be **detailed for year 1 and year 2**, with financial information broken down by **quarters for the first year, and at least half yearly for the second year**;*
 - (ii) *provide summarized information and assumptions for the balance term of the proposal period (year 3 and beyond).*
- (c) *It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*
- (d) *It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*
- (e) *Details on HSS Strategic Actions should be clearly identified.*
- (f) *It should be **consistent** with other budget analysis provided elsewhere in the proposal, including those in this section 5.*

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5.2 Summary by objective and service delivery area

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

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

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

Objective Number	Service delivery area By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)	Budget breakdown by SDA (same currency as in section 1.1 of the Proposal Form)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	SDA 1.1	3,501,970.31	3,451,441.05	4,155,806.41	5,022,251.36	5,888,183.84	22,019,652.97
1	SDA 1.2	34,194.93	31,151.50	14,060.00	14,060.00	0	93,466.43
1	SDA 1.3	0	31,244.75	0	28,744.75	0	59,989.50
2	SDA 2.1	75,765.00	58,975.00	57,425.00	57,595.00	49,450.00	299,210.00
3	SDA 3.1	1,349,808.00	1,870,200.00	2,287,044.00	2,114,964.00	2,310,108.00	9,932,124.00
3	SDA 3.2	14,072.50	13,020.00	4,770.00	13,020.00	18,420.00	63,302.50
3	SDA 3.3	28,350.00	22,200.00	27,200.00	22,200.00	22,200.00	122,150.00
4	SDA 4.1	293,100.00	291,600.00	246,600.00	291,600.00	291,600.00	1,414,500.00
4	SDA 4.2	18,800.00	18,800.00	18,800.00	18,800.00	18,800.00	94,000.00
4	SDA 4.3	255,862.50	58,750.00	58,750.00	58,750.00	58,750.00	490,862.00

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		Budget breakdown by SDA <i>(same currency as in section 1.1 of the Proposal Form)</i>					
Objective Number	Service delivery area <i>By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)</i>	Year 1	Year 2	Year 3	Year 4	Year 5	Total
4	SDA 4.4	173,050.00	117,715.00	148,050.00	92,715.00	123,050.00	654,580.00
4	SDA 4.5	602,328.00	383,508.00	383,508.00	383,508.00	383,508.00	2,136,360.00
Total of funds requested from the Global Fund:		6,347,301.24	6,348,605.30	7,402,013.41	8,118,208.11	9,164,069.84	37,380,197.90

5 Component Budget *Malaria*

5.3 Summary by cost category


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

- (a) Different from Round 6, the cost categories in table 5.3 have been expanded to provide greater clarity between different cost categories.
- (b) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.
- (c) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

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

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Table 5.3 – Budget breakdown by cost category

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Breakdown by cost category (same currency as in section 1.1 of the Proposal Form)						
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	203,100.00	201,600.00	201,600.00	201,600.00	201,600.00	1,009,500.00
Technical Assistance	50,000.00	30,000.00	25,000.00	2,500.00	0	107,500.00
Training	428,408.00	404,635.00	333,903.00	386,164.00	324,218.00	1,877,329.00
Health products and Health Equipment	1,349,808.00	1,870,200.00	2,287,044.00	2,114,964.00	2,310,108.00	9,932,124.00
Medicines and pharmaceutical products	2,425,647.00	3,063,198.00	3,799,513.00	4,630,258.00	5,564,540.00	19,483,156.00
Procurement and supply management costs	92,715.00	92,715.00	92,715.00	92,715.00	92,715.00	463,575.00
Infrastructure and other equipment	1,125,820.00	0	0	0	0	1,125,820.00
Communication Materials	73,127.00	72,075.00	63,825.00	72,075.00	77,475.00	358,578.00
Monitoring & Evaluation	82,888.00	104,165.00	82,625.00	107,915.00	82,625.00	460,218.00
Living Support to Clients/Target Populations	0	0	0	0	0	0
Planning and administration	132,280.00	126,509.00	132,280.00	126,509.00	127,280.00	644,859.00
Overheads	383,508.00	383,508.00	383,508.00	383,508.00	383,508.00	1,917,540
Other:						
Total funds requested from Global Fund	6,347,301.24	6,348,605.30	7,402,013.41	8,118,208.11	9,164,069.84	37,380,197.90

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5.4 Key budget assumptions

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

5.4.1 Pharmaceuticals and other health products and equipment

Applicants must complete Attachment B to this Proposal Form (Preliminary List of Pharmaceuticals and other Health Products) to provide details of the budget assumptions for years 1 and 2 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.

Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.

- (a) **Provide a list (by generic product name) of artemisinin based combination therapies and other anti-malarial medicines** to be used in years 1 and 2, and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above.**
(Please complete table B.1 in Attachment B to the Proposal Form.)
- (b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines.**
(Please complete table B.2 in Attachment B to the Proposal Form.)
- (c) Provide **the total cost** for all other medicines to be used over years 1 and 2. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)
- (d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

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

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

Provide any additional information on unit costs below

Unit costs for Pharmaceuticals and drugs were quoted from the International Drug Price Indicator Guide on Finished Products of Essential Drugs (MSH). Other unit costs and services were obtained from various sources both locally and internationally. The following assumptions were however, made in estimating the budget for the current proposal.

Assumption	Value	Source
Training and Workshops		
Daily facility rental in Monrovia	\$ 150	Local market price
Daily facility rental outside Monrovia	\$ 50	Local market price
Out-of-town transportation reimbursement per workshop	\$ 30	Local market price

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Materials needed for 1 workshop (2 boxes pens \$12, 2 packs notepads \$12, 2 flip charts \$16, 1 box markers \$10)	\$	50	Local market price
Facilitator DSA	\$	50	Local market price
Participant DSA	\$	25	Local market price
DSA for drivers	\$	25	Local market price
Cost of fuel per workshop day	\$	20	Local market price
General			
Gallon of fuel	\$	3.5	Local market price
Printing cost (facilitator guide)	\$	10.0	Local market price
Printing cost (participant manual)	\$	8.0	Local market price
Coaching form	\$	1.5	Local market price
Freight cost as percent of FOB price			5%
Travel			
International plane ticket	\$	2,000	
M&E DSA	\$	50	NMCP rates
External Consultancy			
Daily technical fee	\$	250	WHO
DSA	\$	250	WHO
Equipment			
Desktop computers including accessories	\$	3,000	Local market prices
Laptop computer	\$	2,000	Local market prices
office desk and chair	\$	300	Local market prices

5.4.2 Human resources costs

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

(Maximum of half a page).

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

Human resources expenditure in terms of salaries constitute only 2.7% of the total budget over the five year funding duration. This proportion is not considered to be an important share of the budget.

5.4.3 Other key expenditure items

Explain the rationale for how other expenditure categories which form an important share of the budget (e.g., infrastructure and other equipment; communication materials; or planning and administration), have been budgeted for the first two years.

(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)

As expected, expenditure categories that form an important share of the budget are Health Products and Health equipment (26.57%) and Medicines and Pharmaceutical products (52.12%). As indicated in the budget, these categories cater for medicines, pharmaceutical products, health products and health

5 Component Budget *Malaria*

equipment that are needed to address the three major objectives (Objectives 1, 2, and 3) out of the four objectives for this application. These covers procurement and distribution of all antimalarials, malaria rapid diagnostic tests (RDTs), microscopes, laboratory supplies and consumables, syringes, needles as well long lasting insecticide treated nets (LLINs).

The other expenditure categories are not considered to form an important share of the budget, since none of them accounts for more than 5.2% of the budget. Specifically, they range from 0.29% to 5.1% only as follows: human resources (2.7%); Technical assistance (0.29%); training (5.02%); procurement and supply management (1.24%); infrastructure and other equipment (3.01%); communication materials (0.96%); monitoring and evaluation (1.23%); planning and administration (1.73%) and overheads (5.13%).

CHECKLIST OF ANNEXES

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

Section 4: Component Strategy – Malaria		Annex Number to your proposal
4.3.1	Documentation relevant to the national disease program context.	
4.3.5(c) <i>(only if common funding mechanism)</i>	Documentation describing the functioning of the common funding mechanism.	
4.3.5(d) <i>(only if common funding mechanism)</i>	Most recent assessment of the performance of the common funding mechanism.	
4.6	A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table.	Attachment A – Malaria
4.6	A detailed component Work Plan (quarterly information for the first year and indicative information for the second year).	
4.6.1.	A copy of the Technical Review Panel (TRP) Review Form for unapproved Round 5 or Round 6 proposals.	
4.8.3 (c)	List of sub-recipients identified (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	
Section 5: Component Budget – Malaria		Annex Number to your proposal
5.1	Detailed component Budget	
5.1 <i>(if HSS strategic actions are included – see section 4.4.2)</i>	Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget).	
5.4.1 <i>(and section 4.10.5)</i>	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	Attachment B – Malaria
5.4.2	Human resources costs.	
5.4.3	Other key expenditure items.	

CHECKLIST OF ANNEXES

5.1 - 5.3 <i>(if common funding mechanism)</i>	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
Other documents relevant to sections 4-5 attached by Applicant:		Annex Number to your proposal
4.6.1.	TRP Review Forms	

Malaria Attachment A to the Proposal Form

Program Details

Country:	Liberia
Disease:	Malaria
Proposal ID:	

Program Goal, impact and outcome indicators

Goals

- 1 To reduce malaria related morbidity and mortality among the population especially children under five and pregnant women
- 2

Impact and outcome Indicators	Indicator formulation	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	Prevalence of malaria parasite infection (in children underfive)	66%	2005	MIS (Malaria Indicator Survey)	62%		55%		50%	The denominator= The total children <5 sampled, The numerator =The number of children <5 with malaria parasite infection (microscopy or RDT)
impact	Anaemia prevalence in children under 5 years of age	87%	2005	MIS (Malaria Indicator Survey)	85%		70%		60%	The denominator= The total children <5 sampled, The numerator =The number of children <5 with anemia (ie Hb below 8g/dl).
outcome	% of U5 children (and other target groups) with malaria/fever receiving appropriate treatment within 24 hours (community/health facility)	5%	2005	MIS (Malaria Indicator Survey)	10%		25%		40%	Denominator: Total patients receiving appropriate treatment; Numerator: Patients receiving appropriate treatment within 24 hrs of onset
outcome	% of households with at least one ITN	54%	2007	Post-Integrated Measles coverage Survey	65%		75%		85%	Denominator: Total number of households sampled; Numerator: Number of households with at least one ITN.
outcome	% of children U5 sleeping under an ITN the previous night	45%	2007	Post-Integrated Measles coverage Survey	55%		70%		80%	Denominator: Total children underfive sampled; Numerator: Number of children under five who slept under ITN previous night.
outcome	% of pregnant women (and other target groups) sleeping under an ITN the previous night	31%	2005	MIS (Malaria Indicator Survey)	45%		60%		80%	Denominator: Total pregnant women sampled; Numerator: Number of pregnant women who slept under ITN previous night. (Currently the figure for % pregnant women sleeping under ITNs could be higher. The data 31% is before the major scaling up of this intervention with GFATM & other funding. Since then more than 600,000 ITNs have been distributed to pregnant women & children under five).
outcome	% of pregnant women (attending ANC) on Intermittent preventive treatment (IPT) according to national policy (specific to Sub-Saharan Africa)	60	2006	MOH (routine HIS or HMIS)	65		75		80%	The denominator is total pregnant women visiting ANC and the numerator is the number of pregnant women receiving IPT2. Currently routine MCH/ FHD routine data indicates that the IPT coverage is about 60%.

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

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To increase access to prompt and effective treatment at health facilities and community level to 65% by 2012	The objective is a derivative of the objective of the Draft Strategic Plan which ends in 2013
2	To increase the use of Intermittent Preventive Treatment among pregnant women Liberia to 65% by 2012	The objective is a derivative of the objective of the Draft Strategic Plan which ends in 2013
3	To increase the use of insecticide treated nets to 80%especially among pregnant women and children under five years of age by 2012	The objective is a derivative of the objective of the Draft Strategic Plan which ends in 2013
4	To ensure effective stewardship and decentralization of Malaria Control activities by the National Malaria Control Program (NMCP)	The objective is from the Draft Strategic Plan which ends in 2013
5		

Malaria Attachment A to the Proposal Form

Program Details

Country:	Liberia
Disease:	Malaria
Proposal ID:	

Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5				
1.	1.1. Treatment: Prompt, effective anti-malarial treatment	Number of People receiving antimalarial treatment as per national policy	644208	2006	MOH (routine HIS or HMIS)		917294		1159641	1436842	1751000	2104312	Y	N	N - not cumulative	Monthly MOH routine data
1.	1.1. Treatment: Prompt, effective anti-malarial treatment	%age of health facilities with no reported stock-outs lasting over 1 week of nationally recommended antimalarial drugs at any time during past 3 months	48%	2006	MOH (routine HIS or HMIS)		55%		65%	70%	80%	90%	N	N	N - not cumulative	The targets are based on the current 398 facilities implementing the new policy. Data from NMCP quarterly monitoring.
1.	1.2. Treatment: Diagnosis	% age of malaria cases that are laboratory confirmed	35%	2005	MIS (Malaria Indicator Survey)		40%		45%	50%	55%	65%	N	Y	N - not cumulative	HMIS. Quarterly
1.	1.3. Supportive environment: Monitoring drug resistance	Number of functional sentinel sites for monitoring antimalarial drug resistance	1	2007	MOH (routine HIS or HMIS)		1		2	3			N	Y	Y - over program term	Malaria Control Annual report
2.	2.1. Prevention: Malaria prevention during pregnancy	Number of pregnant women receiving correct IPT	55'747	2006	MOH (routine HIS or HMIS)		38'221		48'318	59'868	72'958	87'680	Y	N	N - not cumulative	MOH routine data Monthly
3.	3.1. Prevention: Insecticide-treated nets (ITNs)	Number of LLINs distributed to people at risk (pregnant women and under 5 children)	645'000	2007	MOH (routine HIS or HMIS)		224'968		311700	381174	352494	385018	Y	Y	N - not cumulative	MOH routine ITN distribution data Monthly
1, 2, and 3	3.2. Prevention: BCC - Mass media	Percentage of targeted population who correctly knows the cause of malaria	<43%	2005	MIS (Malaria Indicator Survey)		50%			60%		70%	N	Y	Y - over program term	MIS repeated every two years
4.	4.2. Supportive environment: Coordination and partnership development (national, community, public-private)	Number of RBM coordination meetings held.	12	2006	MOH (routine HIS or HMIS)		12		24	36	48	60	N	Y	Y - over program term	Minutes of Monthly RBM meetings
	4.3. HSS: Information system & Operational research	% of Health facilities or districts submitting monthly reports on time	40%	2006	MOH (routine HIS or HMIS)		45%		55%	60%	65%	70%	N	N	N - not cumulative	Routine HMIS data