

# CONCEPT NOTE

## MALARIA



### Investing for impact against HIV, tuberculosis or malaria

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

A concept note is divided into the following sections:

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

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

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

**Section 4:** Implementation arrangements and risk assessment.

**IMPORTANT NOTE:** *This template and its associated key tables are subject to minor modifications pending decisions to be taken in early 2014.*

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

## SECTION 1: COUNTRY CONTEXT

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

### 1.1 Country Disease, Health and Community Systems Context

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

- The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.
- Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.
- Key human rights barriers and gender inequalities that may impede access to health services.
- The health systems and community systems context in the country, including any constraints.

#### 2-4 PAGES SUGGESTED

Cameroon is a country in central Africa with a coastline on the Gulf of Guinea and a surface area of 475,650 km<sup>2</sup> (see map no. 1). The estimated population of Cameroon as at 1 January 2014 was approximately 21,657,488 inhabitants and is expected to reach 23,794,164 by 2018, which is an increase of 2.5 percent. Women represented 51 percent of the total population, compared to 49 percent men. Women of child-bearing age (15-49 years) made up almost 24.3 percent of the total population whilst children aged 0 to 5 years represented 17 percent of the population (General Population and Housing Census (RGPH), 2010).



*Fig. 1: Map showing location of Cameroon in Central Africa (Source: INS (National Institute of Statistics), 2011)*

### a. Current epidemiology of malaria in Cameroon (Fig no. 1):

Malaria remains a major public-health problem in Cameroon. At an epidemiological level, conditions are favorable for malaria transmission (human factors, the presence of a vector/anopheles, favorable temperatures, environmental and socioeconomic conditions, etc.).

There are three main epidemiological facies:

(i) the Sahelian zone in the Far North region, characterized by a hot and dry tropical climate, short seasonal transmission (one to three months) and around 10 infective bites per person per month;

(ii) the tropical Sudanese zone in the North and the Adamawa region, characterized by a hot tropical climate, long seasonal transmission (four to six months) and around 20 infective bites per person per month);

(i) the equatorial forest zone in the south of the country, characterized by a hot and humid climate, permanent transmission (seven to 12 months) and around 100 infective bites per person per month.

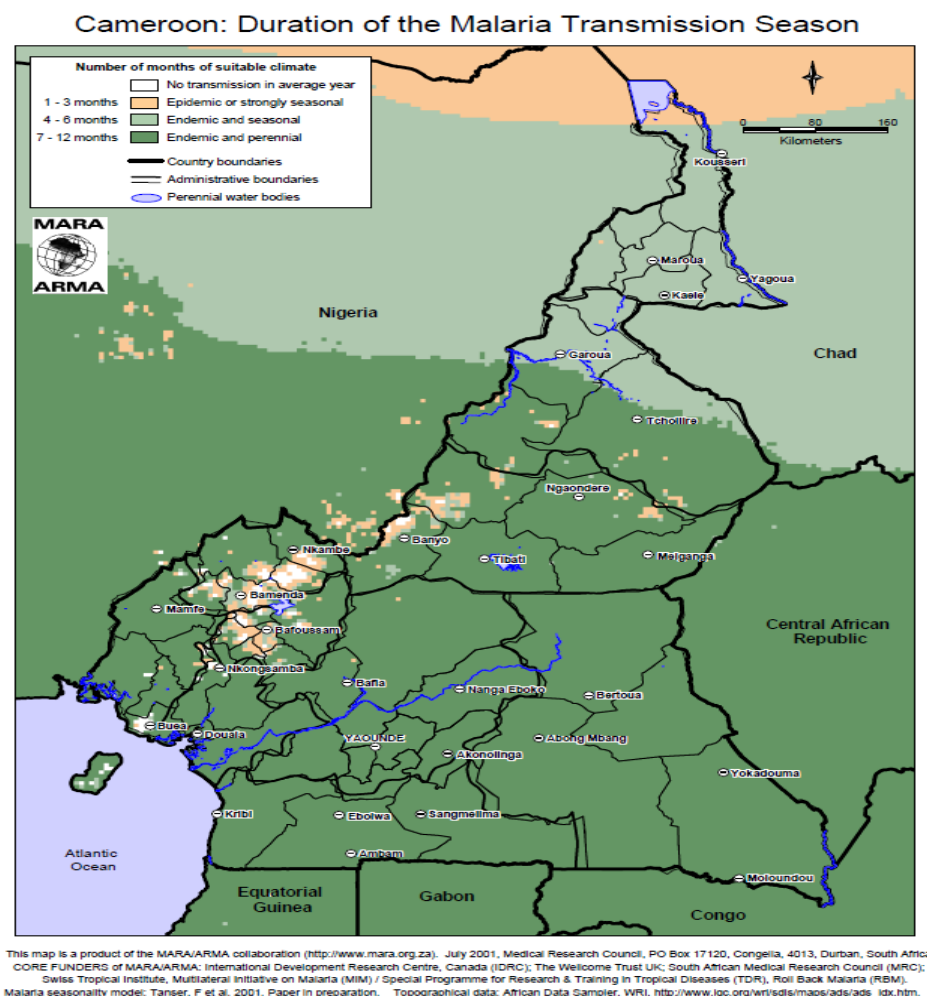


Fig. 2: Map showing duration of malaria transmission in different facies (source MARA/ARMA – Mapping Malaria Risk in Africa)

*Plasmodium falciparum* is the most common species (97.6 percent, Quakyi, 2000), followed by *P. malariae* and *P. ovale*.

Of the 48 species of anopheles observed in Cameroon, 13 are malarial vectors, including three major ones (*An. gambiae* sl, *An. funestus*, *An. nili*) (Hervy et al., 1998).

Average prevalence of the parasite in children under the age of five was 33.3 percent in 2011, with a variation ranging from 36.2 percent in the Far North region to 39.5 percent in the Adamawa region and 57 percent in the Center region (MIS (Malaria Indicator Survey), 2011).

In 2013, malaria accounted for 28.7 percent of medical consultations (all reasons combined) and 49.8 percent of hospital admissions. It causes 22 percent of deaths occurring in the country's health care facilities. In children under the age of five, 45 percent of deaths are linked to malaria (NMCP (National Malaria Control Program) Annual Report, 2013).

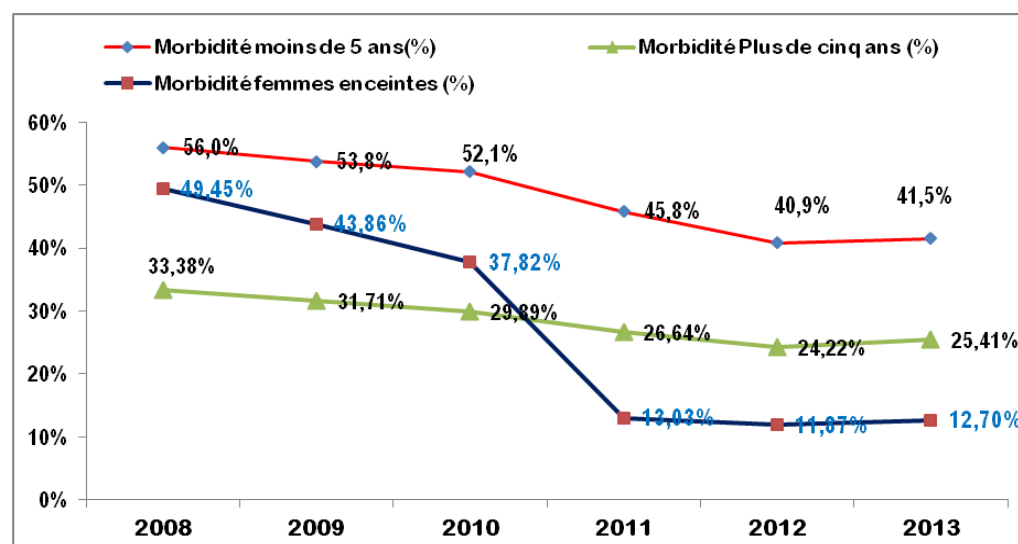


Fig. 3: Change in malaria-related morbidity in health care facilities from 2008 to 2013 (Source: NMCP Annual Reports)

The figure above presents the evolution of the malaria morbidity during the last 6 years. It shows that from 2008 to 2012 there is a decrease of the morbidity in all age groups however from 2012 to 2013 there is an identified increase.

In general terms, malaria-related mortality decreased from 24 percent in 2009 to 22 percent in 2013. This is due in part to all the initiatives taken to control malaria and in particular, the mass distribution campaign in 2011 to boost universal coverage of LLINs (Long-Lasting Insecticidal Nets). These efforts will need to be maintained in order to increase their impact.

The mass distribution campaign in 2011 has included all the 10 regions in Cameroon.

Table 1: Regional distribution of the LLINs distributed during the 2011 campaign.

Region	Estimated quantity by VPP	Received quantity at regional level	Number of distributed LLINs	% of distribution	Distribution Period
ADAMAOUA	481 831	481 831	427 753	89%	26 nov – 1 dec 2011
CENTRE	1 672 641	1 672 721	1 592 743	95%	28 sept-26 dec 2011
EST	380 469	380 469	365 817	96%	29 sept- 5 oct 2011
EXTREME-NORD	1 651 174	1 651 174	1 636 162	99%	25 -30 nov 2011

LITTORAL	1 189 750	1 187 118	1 045 890	88%	1 – 6 Dec 2011
NORD	799 860	799 660	787 544	98%	28 nov-3 dec 2011
NORD-OUEST	856 182	856 850	760 986	89%	1 -15 oct 2011
OUEST	640 361	640 811	633 408	99%	7 - 13 oct 2011
SUD	328 363	328 400	296 857	90%	26 nov-10 dec 2011
SUD-OUEST	656 733	656 733	568 719	87%	6 Dec 2011-Janv 2012

Given the low level of confirmation of cases (around 60%), we have calculated morbidity based on the link between the number of suspect cases of malaria and the number of consultations (all reasons combined). Between 2011 and 2013, there was an improvement in the data collection system, with an increase in the number of health care facilities submitting data from 2,991 to 3,232. This increased the figures for the number of suspected cases of malaria and consultations (all reasons combined), hence the trend towards a stagnation in morbidity between 2011 and 2013. Moreover, the LLINs available are not necessarily used correctly and household coverage of LLINs is low (32% of households have one LLIN per two people). IPT coverage for pregnant women remains low (35% for IPT2 in 2011). 2013 was preceded by major flooding in the North and Far North regions, which resulted in an increase in larval sources; this in turn created favorable conditions for permanent transmission in an environment where malaria is usually seasonal. Both regions are, in fact, major contributors to cases of malaria given their demographic weight.

As a result, Cameroon plans to submit a concept note under the New Funding Model (NFM) to: (i) organize a second mass distribution campaign, which is essential to take place three years after the 2011 campaign, (ii) implement seasonal malaria chemoprevention (SMC) in two of the country's 10 regions (the North and Far North regions, which are the poorest and represent around 29 percent of the population, DHS-MICS (Demographic and Health Survey-Multi-indicator Cluster Survey) 2011, page 24), which are prone to fresh outbreaks of cases of malaria, characterized by a high level of mortality amongst children under the age of five, and finally (iii) continue to implement other high-impact activities (routine distribution of LLINs, IPT (Intensive Preventive Treatment) and treatment of cases, including at the community level) that were funded under Round 9, which is due to terminate in December 2015.

#### **b. Vulnerable populations and difficulties in accessing prevention and treatment services:**

Although the entire population of Cameroon is exposed to the risk of malaria, pregnant women and children under the age of five are the most vulnerable groups.

People in general, in particular pregnant women, children under the age of five and the refugee population groups Bororo, Baka/Bakola, face difficulties in terms of access to care. There is (i) a low level of use of health care services by children under the age of five with symptoms of acute respiratory infection (29.9 percent), fever (22.8 percent) or diarrhea (22.1 percent) (DHS-MICS, 2011) and (ii) a low level of coverage of IPT2 amongst pregnant women (35 percent) (MIS, 2011).

The main reasons for the low level of use of health care facilities by women of child-bearing age in both rural and urban environments were: a lack of autonomy in terms of decision-making (14 percent), geographical inaccessibility (18 percent) and financial inaccessibility (35 percent). (DHS-MICS, 2011).

The other reasons identified by the DHS-MICS 2011 were:

- poor quality of services (poor welcome, a lack of care and stock outs of medicines);
- self-medication;
- use of traditional practitioners;

- sociocultural practices (limited understanding of the seriousness of certain illnesses, etc.); and
- ignorance of the health care options available.

As part of this funding request, in order to mitigate the difficulties faced by the population in general and vulnerable targets (pregnant women and children under the age of five) in particular, in accessing health care, the priority is to stress on the two main activities: mass distribution of free LLINs and seasonal malaria chemoprevention in order to provide more effective prevention for children under the age of five, in particular in the North and Far North regions). On the other hand other high-impact activities will also be implemented, such as routine distribution of LLINs and sulfadoxine-pyrimethamine (SP) during antenatal appointments to provide better protection for pregnant women.

### **c. Human rights barriers and gender inequalities in health-related areas**

Health is viewed as a fundamental right in Cameroon and the State is obliged to offer health care services to all citizens when they are ill. The principle of fairness is a key part of implementing health care policy throughout the country. It aims to ensure universal coverage and care that is financially accessible to the whole population. However, with the crisis in the Central African Republic and the religious conflict in north-eastern Nigeria, there is an evidence that refugee populations are moving into Cameroon in the East, Adamawa, North and Far North regions, which may create the conditions for the emergence of an epidemic or health crisis. Measures are currently being taken to tackle health problems in general and malaria-related problems in particular amongst displaced people (who become more vulnerable to the disease), with help from the UN Refugee Agency and other United Nations institutions (WHO, UNICEF, IOM (International Organization for Migration), etc.) and from civil society organizations (CSO). The NMCP is working with the specialized agencies to reach refugees in the context of SMC, mass LLIN distribution and IPT. Particular attention is also being paid to marginal populations such as the Bororo (itinerant herdsman) and Baka/Bakola (hunter-gatherer forest communities).

As far as the difficulties related to gender and health care, it is important to note the low level of economic and decision-making power associated with women's status and certain wrong beliefs about early visits to health care facilities for antenatal consultations, etc. (DHS-MICS, 2011), which shows that women are more exposed to the consequences of malaria.

This challenge is mitigated, however, by government subsidies for access to:

- prevention: campaigns to distribute free Long-Lasting Insecticidal Nets (LLINs) to the general population and routine free distribution of LLINs and sulfadoxine-pyrimethamine (SP) for Intermittent Preventive Treatment (IPT) to pregnant women during antenatal consultations;
- diagnosis and treatment: free treatment for uncomplicated and severe malaria for children under the age of five and subsidized anti-malarial drugs for the rest of the population.

In addition to subsidies, awareness-raising activities are run by the NMCP and its partners on a regular basis, focusing on methods of preventing malaria (use of LLINs, IPT, etc.) to encourage people to adopt preventive practices and seek treatment.

In the context of this funding request, there are plans to increase all similar development of communications activities in order to improve results and in particular the impact of efforts to control malaria in Cameroon.

### **d. Health system and constraints associated with access to health care:**

The health system in Cameroon is organized on three levels: central, intermediate and peripheral (including the community level). The various health care structures are organized on the same three

levels. Table 1 summarizes the organization of the health system and care available.

Table 1: Organization of the health system and care available at the various levels

Levels	Administrative structures	Skills	Health care structures	Consultation structures
Central	Minister's office, General Secretariat, Departments and similar structures	Policy department; Concept, Policy and strategy development	General referral hospitals, university hospitals, central hospitals and the National Procurement Center for Essential Medicines (CENAME)	Boards or management committees
Intermediate	Regional Public Health Departments	Technical support for health districts and priority programs	Regional hospitals and similar	Coordination committee for special regional funds for health promotion
Peripheral	District health services	Implementation of programs and health services related to beneficiary communities	District hospitals Centres Médicaux d'Arrondissement (Local Medical Centers) Centres de Santé Intégré (Integrated Health Centers)	Health District Health Committee (COSADI), Health District Management Committee (COGEDI), Health Area Management Committee (COGE), Health Area Health Committee (COSA),

Source: Conceptual framework for a viable health district (MoH)

In 2010, there were 1.07 doctors and nurses per 1,000 inhabitants, which is below the minimum standard defined by the WHO, namely 2.3 health care personnel<sup>1</sup> per 1,000 inhabitants in order to provide an appropriate range of services and health care (WHO, World Health Report, 2006). Both ratios conceal marked disparities in the division of human resources between the various regions on one hand, and between rural and urban areas within a single region on the other hand. Such disparities are even more evident between the main hospitals (general, central and regional) and hospitals at a health district level.

<sup>1</sup> Doctors, nurses and midwives

According to the WHO's 2013 health statistics, total health expenditure represented 5.1 percent of GDP. Spending on health by the public authorities accounted for 29.6 percent of total health expenditure compared with 70.4 percent on private health care. It should also be noted that the health budget for 2013 was 5 percent and thus remains below the 15 percent advocated by African heads of state in Abuja in 2000.

Other difficulties and constraints associated with the health system are as follows:

- the lack of technical capacity in terms of human resources, equipment and medical-surgical resources, particularly at the peripheral (district) level.
- the problem of data quality and integration into the national health information system. As far as malaria is concerned, health care facilities scored well, at around 80 percent, in terms of the completeness of data submitted in 2013, but less well (28 percent) in terms of promptness. The major challenges are improving data quality and the submission of data by central and general hospitals.
- the weakness of the Logistics Information Management System (LMIS) for anti-malarial inputs in the public and private sector. There has been a delay in implementing the distribution plan for inputs by the National Procurement Center for Essential Medicines (CENAME), which in turn has led to stock outs (of ACT (artemisinin-combination therapies), SP (sulfadoxine-pyrimethamine) and RDT (rapid diagnostic tests)); also, the poor system for quantifying inputs and monitoring supplies means that the CENAME supplies inadequate amounts of inputs to Regional Pharmaceutical Supply Centers (CAPR);
- inadequate regional monitoring at a central level.
- and limited support by prescribers for instructions on treating uncomplicated malaria through a combination of Artesunate and Amodiaquine (ASAQ).

There is a community health system made up of members of the health committees, who represent their communities at a health area (COSA) and health district (COSADI) level. Community representation thus exists at both levels. In addition, in accordance with national guidelines on incorporating community-driven interventions in Cameroon (published Nov. 2012), which aim to increase community participation in resolving health problems, community service providers are now known by the single title of "Community Health Worker" (CHW) and have been asked to intervene in a number of areas, including home-based management of malaria. The national strategy provides for one CHW per 1,000 inhabitants (Guidelines on community-driven interventions, 2012). CHWs will be recruited in remote rural areas (representing 26 percent of the general population) as part of the efforts to control malaria; the total requirement will be for 5,767 CHWs. In phase 2 of Round 9, 4,354 CHWs were recruited for training in treatment of malaria in the home. Under this concept note, 5,346 CHWs will be trained in comprehensive community treatment in addition to the 421 CHWs trained by other partners (UNICEF, ACMS and JHPIEGO).

Alongside the public and community health system, the private sector plays a significant role in health in Cameroon. It is split between the profit and non-profit sectors, which together represent 27.9 percent of health care facilities in Cameroon (National Health Development Plan (PNDS) 2011-2015, table 4 page 8-9).

There is a good relationship between the public and private sectors, based on partnership, which is expressed in tangible terms through attendance at coordination meetings, transmission of epidemiological data and implementing national strategies to control malaria. Further efforts are required, however, to improve support for national policy within the private profit sector.

Within the context of this funding request, actions will be taken to strengthen the health system and improve implementation of the community-based approach and public-private partnerships.



## 1.2 National Disease Strategic Plans

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

- a. The key goals, objectives and priority program areas.
- b. Implementation to date, including the main outcomes and impact achieved.
- c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.
- d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.
- e. For standard HIV or TB funding requests<sup>2</sup>, describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.
- f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

### 4-5 PAGES SUGGESTED

In 2013, Cameroon carried out an external review of its program, following which it was advised to review its National Strategic Malaria Control Plan (NSP) 2011-2015 (annex 1). As a result, the country has just adopted its new, fourth-generation plan for 2014-2018 (annex 2) This can be outlined as follows:

#### **a. Goal, objectives and priority program areas**

##### **a.1. Goal**

The goal of this strategic plan is to help improve the health of people in Cameroon by reducing the impact of malaria and the socioeconomic burden the disease represents.

##### **a.2. Overall objective**

Reduce malaria-related mortality and morbidity by 75 percent by 2018 compared with 2000.

##### **a.3. Specific objectives**

The main specific objectives of the NSP are as follows:

##### **Prevention**

- Ensure that at least 80 percent of the population sleep under LLINs;
- Protect at least 80 percent of at-risk populations in target zones with Indoor Residual Spraying (IRS);
- Protect at least 80 percent of pregnant women through Intermittent Preventive Treatment (IPT) for malaria in accordance with national guidelines;
- Protect at least 80 percent of children aged from 3 to 59 months in the target areas through seasonal malaria chemoprevention.

##### **Case management**

- Test at least 80 percent of suspected cases of malaria seen in health care facilities and the

<sup>2</sup> Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

- community with a thick smear or Rapid Diagnostic Test;
- Treat 100 percent of confirmed cases of malaria in accordance with national guidelines in health care facilities and in the community;

The NSP 2014-2018 lists some 25 actions, summarized in Table 2 below, to achieve its objectives.

**Table 2: NSP 2014-2018 priority interventions**

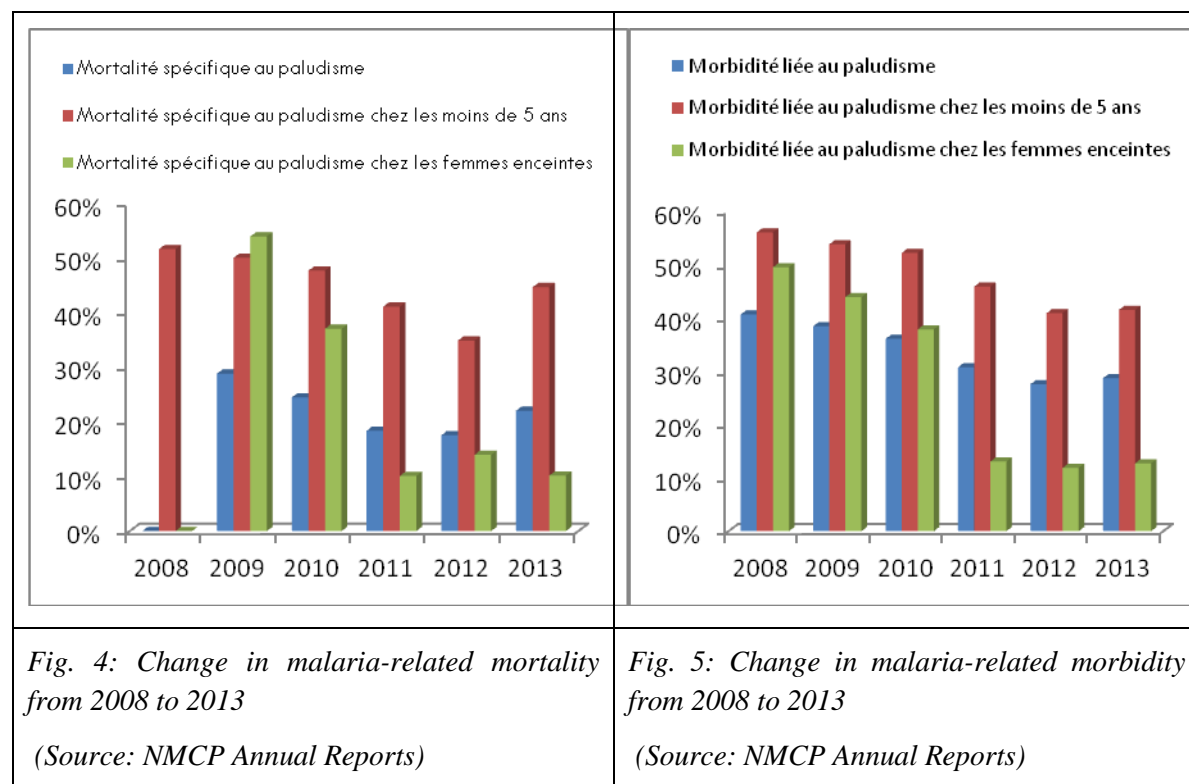
STRATEGIC PRIORITIES	INTERVENTIONS
I-PREVENTION	1. Mass distribution of LLINs for universal coverage 2. Routine distribution of LLINs 3. Indoor residual spraying 4. Administration of sulfadoxine-pyrimethamine to pregnant women during antenatal consultations 5. Seasonal malaria chemoprevention for children aged from 3 to 59 months
II-TREATMENT OF CASES OF MALARIA	6. Biological testing using thick smear and/or RDT of suspected cases of malaria 7. Treatment of confirmed cases of malaria in health care facilities and in the community in accordance with national guidelines. 8. Community ICMI (Integrated Management of Childhood Illness) (integration of HMM (Home-based Management of Malaria)/ICMI) 9. Strengthening of the pharmacovigilance system
III- COMMUNICATIONS	10. Advocacy 11. Behavioral change communication 12. Social mobilization 13. Social marketing and partnership
IV-TRAINING AND RESEARCH	14. Training 15. Operational research
V-SURVEILLANCE – MONITORING-EVALUATION AND RESPONSE TO EPIDEMICS	16. Monitoring and evaluation 17. Strengthening of epidemiological surveillance 18. Response to epidemics 19. Strengthening of the monitoring and evaluation system for interventions
VI-PROGRAM MANAGEMENT	20. Financial mobilization 21. Financial management 22. Governance 23. Planning 24. Stronger coordination and partnership framework 25. Stronger management of purchasing and inventory management

**b. implementation to date, including the main outcomes and impact achieved;**

The NSP 2014-2018 has just been adopted; therefore the results shown are based on the implementation of the previous NSP 2011-2015.

As far as **impact indicators** are concerned (mortality and morbidity), whilst there was a decrease in morbidity and mortality from 2008 to 2013 (Figures 3 and 4), the objective of reducing morbidity and mortality by 75 percent as defined in the strategic plan 2011-2015 was not achieved. Cameroon

is therefore relying on this funding request to boost these impact indicators in order to contribute to achieving MDG 6 by 2015 and in the future.



The overall increase seen in 2013 is a result of the higher number of deaths in the North and Far North regions, which carry significant demographic weight. Indeed, 2013 was preceded by major flooding, which resulted in an increase in larval sources; this in turn created favorable conditions for permanent transmission in an environment where malaria is usually seasonal.

Given the low level of confirmation of cases, we have calculated morbidity based on the relationship between the number of suspect cases of malaria and the number of consultations (all reasons combined). Between 2011 and 2013, there was an improvement in the data collection system, with an average annual increase in health care facilities submitting data of 120. This increased the figures for the number of suspected cases of malaria and consultations (all reasons combined), hence the trend towards a stagnation in morbidity between 2011 and 2013.

As far as **outcomes/output indicators** are concerned, according to the various surveys carried out by the National Institute of Statistics between 2011 and 2013, these have changed in a positive direction as described in Table 3 but have not achieved the objectives laid down in the NSP 2011-2015. As a result, Cameroon is submitting this funding request to boost its outcome indicators by prioritizing two main high-impact interventions (mass distribution of LLINs and SMC for children aged 3 to 59 months).

**Table 3: Change in outcomes/output indicators from 2011 to 2013.**

Outcomes/output indicators	2011 Sources: DHS-MICS; MIS		2013 Source: EPC-LLIN (LLIN post-campaign survey)		NSP objectives 2011- 2015:
	General Population	Households having at least one LLIN	General Population	Households having at least one LLIN	

Percentage of people sleeping under a LLIN during the last 24 hours (%)	13.1	34,5	39.3	72,2	80%
Percentage of children under the age of five sleeping under a LLIN during the last 24 hours (%)	19.2	43,4	46.3	80,6	80%
Percentage of pregnant women sleeping under a LLIN during the last 24 hours (%)	17.0	46,5	40.9	80,9	80%
Percentage of pregnant women receiving at least two doses of SP (IPT) during their last pregnancy (%)	35.0	N/A	N/A		80%
Percentage of children with a fever in the last two weeks who visited a health care facility or care provider	<b>27%</b>	N/A	47% (P69)		80%
Percentage of children under the age of five with a fever in the previous two weeks who received an anti-malarial treatment within 24 hours in accordance with national policy	<b>6.7%</b>	N/A	21%		80%

For **output/coverage indicators**, it can be seen that (Table 4):

1. The percentage of pregnant women receiving at least two doses of SP during antenatal consultations decreased overall between 2008 and 2013, from 67.8 percent to 50.5 percent (National Health Plan (PSN) target: at least 80 percent). The main causes identified are stock outs (delays in procurement and inventory management problems), a delayed start to antenatal consultations and a lack of systematic compliance by care providers. Since 2011, there has been an increase in coverage of IPT2 as a result of implementing corrective measures (improvement of the monitoring system for stocks and supplies and cooperation with the Department of Family Health, which has refocused attention on antenatal consultations);
2. The percentage of cases of uncomplicated malaria in children under the age of five treated in health care facilities increased between 2008 and 2013, from 57.8 percent to 78.6 percent (National Health Plan target: at least 80 percent). This improvement is due in part to free treatment for children under the age of five;
3. The percentage of cases of uncomplicated malaria in children over the age of five treated in health care facilities increased between 2008 (56.8 percent) and 2010 (64.6 percent) and decreased from 2011 (57.1 percent in 2013). This is largely linked to shortages of commodities (National Health Plan target: at least 80 percent).
4. The percentage of malaria cases treated by community health workers remains low. This is the result of problems identified in relation to home-based management of cases of uncomplicated malaria: the lack of community health workers in both quantitative and qualitative terms and the lack of communications on home-based management, supervision and supplies for trained CHWs.

**Table 4: Change in main output indicators from 2008 to 2013.**

Output indicators	2008	2009	2010	2011	2012	2013
Percentage of pregnant women attending antenatal consultations receiving at least two doses of IPT for malaria (%)	67.8	59	42.8	44	48	50.5

Percentage of confirmed cases of uncomplicated malaria in children under the age of five in health care facilities who received an appropriate anti-malarial treatment in accordance with national policy (%)	57.8	61	67.3	68.9	66	78.6
Percentage of confirmed cases of uncomplicated malaria in children over the age of five in health care facilities who received an appropriate anti-malarial treatment in accordance with national policy (%)	56.8	60.1	64.6	60.4	57	57.1
Percentage of cases of malaria treated by community health workers (%)	11.25	-	-	7	14	6

Source: NMCP Annual Reports 2008 to 2013

In order to improve coverage or output indicators in the context of this funding request, adequate responses will be planned to address the main weaknesses identified during the evaluation of the implementation of Round 9, particularly the community component, which will be reorganized.

**c. limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed;**

Strategic priorities	Limitations	Lessons learned/future strategies in the NFM
Case management	<ul style="list-style-type: none"> <li>• Inadequate implementation of directives relating to the treatment of malaria</li> <li>• Access to care still inadequate;</li> <li>• Absence of a functional quality-assurance system;</li> <li>• Pharmacovigilance system not operational;</li> <li>• System for motivating CHWs not functional;</li> <li>• Inadequate management of procurement and inventory management</li> </ul>	<p><b>1. Lessons learned:</b></p> <ul style="list-style-type: none"> <li>- Importance of continuing to disseminate national directives;</li> <li>- Importance of improving procurement and inventory management;</li> <li>- Importance of establishing a long-term system for motivating CHWs</li> <li>- Importance of establishing a functional pharmacovigilance system</li> </ul> <p><b>2. Future actions under the NFM</b></p> <ul style="list-style-type: none"> <li>- Strengthen the procurement and management system; strengthen the pharmacovigilance system; strengthen awareness-raising amongst service providers and populations; implement a long-term system for motivating CHWs.</li> </ul>
Prevention	<ul style="list-style-type: none"> <li>• Low level of women attending antenatal consultations and limited IPT coverage;</li> <li>• Low level of use of LLINs, including amongst pregnant women and children under the age of five;</li> </ul>	<p><b>1. Lessons learned</b></p> <ul style="list-style-type: none"> <li>- The importance of continued awareness-raising amongst target groups on the use of LLINs and IPT</li> </ul> <p><b>2. Future action under the NFM</b></p> <ul style="list-style-type: none"> <li>- Continue to raise awareness on the use of LLINs and IPT.</li> </ul>
Training and research	<ul style="list-style-type: none"> <li>• Lack of harmonization in documents and training curricula</li> </ul>	<p><b>1. Lessons learned</b></p> <p>The importance of increasing skills</p>

	<ul style="list-style-type: none"> <li>• Low rate of completion of planned studies</li> <li>• Limited interest in operational research amongst health professionals</li> </ul>	<p>amongst service providers and operational research;</p> <p>The importance of developing a partnership with universities and research institutions</p> <p><b>2. Future actions under the NFM</b></p> <ul style="list-style-type: none"> <li>- Continue to strengthen skills and develop a partnership with universities and research institutions.</li> </ul>
Communications and social mobilization	<ul style="list-style-type: none"> <li>• Inadequate funds for communications activities and heavy reliance on assistance from partners;</li> <li>• Limited media involvement and irregular dissemination of messages;</li> <li>• Limited take-up of prevention activities by communities;</li> <li>• Limited involvement of economic actors in prevention activities.</li> </ul>	<p><b>1. Lessons learned</b></p> <ul style="list-style-type: none"> <li>- The importance of establishing a task force for advocacy and resource mobilization;</li> <li>- The importance of establishing a platform for cooperation with the media, win-win partnerships with economic actors and community-driven approaches.</li> </ul> <p><b>2. Future actions under the NFM</b></p> <ul style="list-style-type: none"> <li>- Develop and implement a development communications plan</li> <li>- Develop and implement a resource mobilization plan for malaria prevention.</li> </ul>
Monitoring and Evaluation	<ul style="list-style-type: none"> <li>• Epidemiological profile not updated;</li> <li>• Inadequate integrated management of health data</li> <li>• Inadequate epidemiological surveillance of malaria and response, hence the failure to detect epidemics;</li> <li>• Inadequate supervision</li> </ul>	<p><b>1. Lessons learned</b></p> <p>The importance of strengthening the integrated data management system and supervision;</p> <p>The importance of establishing operational sentinel sites</p> <p>The importance of building district capacities for detecting and responding to epidemics</p> <p><b>2. Future actions under the NFM</b></p> <ul style="list-style-type: none"> <li>- implement an integrated data management system for supervision;</li> <li>- increase skills in detecting and responding to epidemics.</li> </ul>

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

- **Integrated planning**

The actions proposed under the NFM are taken from the Strategic Plan 2014-2018. The Plan is aligned with the national health policy developed in the Sectoral Health Strategy (SSS) 2001-2015, in the National Health Development Plan (PNDS) 2011-2015 and in the Growth and Employment Strategy Paper (DSCE) 2010-2020. These actions are intended to contribute to achieving the United

Nations Millennium Development Goals (MDG) 4, 5 and 6.

- **Funding**

Given the low percentage of the national budget allocated to health (5 percent in 2013), funding these actions through this concept note will contribute to mobilizing additional resources to control malaria in particular and diseases in general.

- **Decentralization**

The actions planned within the context of this funding request will be deployed at all levels of the health pyramid, down to community level. As a result, they will contribute to improving the decentralization efforts already underway at a national level; in particular, the scaling up of Home-Based Management (HMM) will be implemented in the context of the community-driven initiatives currently advocated by the MoH.

- **Health information system**

In order to improve data completeness, promptness and quality in relation to strengthening the health information system, work will be done on producing integrated data collection tools, building capacity amongst staff in data management and managing data using information technologies (SMS for Life).

- **Supply-chain management**

Improving procurement and inventory management is another of the planned actions. The aim is to strengthen the abilities of pharmaceutical procurement managers at a regional level, pharmacy assistants and CHWs in relation to procurement and inventory management, supervision and strengthening mechanisms for monitoring of stocks and purchasing at all levels. This will contribute to improving supply-chain management at a national level.

## SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

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

### 2.1 Overall Funding Landscape for Upcoming Implementation Period

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

- a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
- b. How the proposed Global Fund investment has leveraged other donor resources.
- c. For program areas that have significant funding gaps, planned actions to address these gaps.

### 1-2 PAGES SUGGESTED

#### 2.1 Overall Funding Landscape for Upcoming Implementation Period:

In accordance with the decision taken by the Global Fund Board in March 2014 concerning the allocation of resources for 2014/2016, Cameroon could receive US\$ 288.3 million to fight HIV, tuberculosis and malaria and strengthen its health system. This sum includes all the funds available from the Global Fund as at 1 January 2014, including the existing funding. The Global Fund has set

the allocation amount based on the level of morbidity in Cameroon, its income level and several other factors. The Country Coordinating Mechanism (CCM) for the three diseases has calculated the breakdown and malaria should receive a 41 percent of the total allocated amount (Table 5).

**Table 5: Breakdown of funds allocated to Cameroon by the Global Fund proportionately per disease according to the CCM**

Eligible component	Existing funding (US\$)	Additional funding (NFM) (US\$)	Total allocation as at 1 January 2014	Proportion of allocation
HIV	151,949,185	3,238,866	155,188,052	54%
Tuberculosis	8,130,428	6,885,979	15,016,407	5%
Malaria	33,313,455	84,805,945	118,119,400	41%
<b>Total</b>	<b>193,393,068</b>	<b>94,930,790</b>	<b>288,323,859</b>	

**a) Program areas benefiting from funding:**

Cameroon has just revised its NSP (National Malaria Strategic Plan) as part of its efforts to control malaria. In order to combat the disease effectively, 25 areas of intervention grouped into six strategic priorities have been identified.

The total budget for the NSP 2014-2018 is €361,792,008. The funding requirement for the NSP for 2015-2017 is €205,240,340. The current known situation as regards the availability of forecast funding for 2015 to 2017 is €47,045,180. This relates to commitments made by the Government of Cameroon and development partners, including the Global Fund Round 9. Furthermore, in spite of commitments made by the Government, its partners and the contribution from the Global Fund through Round 9, there are no areas of intervention with no funding gap at all. The result is a funding gap of €158,195,160 or 77 percent of the total requirement. Part of this gap will be addressed through this funding request and the remainder by the national Government and its partners.

The details of the funding gap, broken down by strategic priority, are summarized in Table 6 below:

**Table 6: Breakdown of funding gaps in the NSP 2014-2018 by strategic priority for the period covered by the NFM**

Strategic priority	Requirements 2015-2017	Government	GF Round 9	Partners	Total existing funding	Gap	%
Prevention	108,909,173	23,330,316	3,338,315	-	26,668,631	82,240,542	76%
Case Management	42,984,860	6,532,390	2,169,379	2,066,419	10,768,188	32,216,672	75%
Monitoring and Evaluation, Epidemiological surveillance and response	13,184,266	277,974	1,734,680	40,780	2,053,434	11,130,832	84%
Behavioral change communication	7,115,203	416,961	2,058,766	1,089,483	3,565,210	3,549,993	50%
Training and research	15,451,107	-	119,625	18,586	138,211	15,312,896	99%
Program management	17,595,731	1,630,598	2,220,908	-	3,851,506	13,744,225	78%
<b>Total</b>	<b>205,240,340</b>	<b>32,188,239</b>	<b>11,641,673</b>	<b>3,215,268</b>	<b>47,045,180</b>	<b>158,195,160</b>	<b>77%</b>

*Source: Financial Gap Analysis and Counterpart Financing Table*



**b) Mobilization of partner funding**

Investments by the Global Fund, essentially for purchasing LLINs, ASAQ, SPAQ could help to mobilize technical assistance to support the distribution process (micro-planning, logistics management, etc.), allowing other partners (WHO, UNICEF, ACMS, Malaria No More, IRESCO, JHPIEGO, MC-CCAM etc.) to concentrate their efforts on the remaining areas. More specifically, the National Strategic Malaria Control Plan (NSP 2014-2018), recently approved with technical and financial support from partners, is an advocacy tool that can help to mobilize more funding and thus ensure partners are aligned with the country's strategic priorities. In this respect, funding requests will be sent to partners by the end of 2014 to mobilize additional funding for the period 2015-2017.

**c) Actions planned to address funding gaps:**

Based on the table above, there is a funding gap of over 60 percent and the service areas where this is more significant are training and research (99 percent), monitoring and evaluation and epidemiological surveillance (84 percent). The NMCP, in collaboration with its partners, will lead advocacy initiatives at all levels to mobilize funds and address the gaps identified. With this in mind, the Government will mobilize more domestic resources through the national budget and the Debt Reduction-Development Contract with French development bodies. Subsequently, the Government will approach its traditional partners (WHO, UNICEF, Malaria No More, CHAI (Clinton Health Access Initiative) etc.). In addition, it may explore the possibility of credits with international financial institutions such as the AfDB (African Development Bank), IDB (Islamic Development Bank) and WB (World Bank) and contributions from the national private sector through corporate social responsibility. An appropriate advocacy and resource mobilization plan will be developed, implemented and evaluated for each transaction.

**2.2 Counterpart Financing Requirements**

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

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

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

- b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.
- c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

## 2-3 PAGES SUGGESTED

### **b) Willingness-to-pay by the Government:**

In its medium-term spending plan for 2015-2017 in respect of malaria control, the Government has included the following: a) procurement of medicines for treating uncomplicated and severe malaria and Intermittent Preventive Treatment in health care facilities and b) procurement of LLINs for routine distribution to pregnant women during antenatal consultations. Furthermore, the Government will continue to pay the salaries of civil servants and government officials working on the National Malaria Control Program, and will continue to provide maintenance and operational services for the building where the program is run, including the premises of ten (10) regional units.

With regard to the mass distribution of LLINs, the Government is committed to covering the operational costs of the 2015 campaign to the amount of € 9,062,099. This includes: micro-planning, transport and security for LLINs from the port to the regions, storage, counting, supervision, distribution and communications. Although the LLIN “Hang-up” campaign and post-campaign survey are important, they have not been included in operational costs. A budgeted plan has been developed and is attached to this concept note (annex 17).

Monitoring mechanisms and the annual report of government investments will be completed in accordance with the regulatory procedures for the government’s management of financial and accounting matters. There is a government financial control department at both the central and regional levels to ensure that spending is legal and agreed.

### **c) Assessment of the completeness and reliability of financial data:**

#### **c.1. The financial data communicated comes from various sources:**

- The funding requirements for controlling malaria is extracted from the NSP 2014-2018;
- The domestic resources are based on the budgets for 2012 to 2014, a gap analysis, spending notes from the Ministry of the Economy, Planning and Territorial Development (MINEPAT) 2012 to 2014 and the operational budget for the LLIN campaign 2015
- External resources excluding the Global Fund are provided by partners
- Funding sources from the Global Fund are based on current contracts and the NFM allocation letter.

#### **c.2. Assessment of the completeness and reliability of financial data:**

- The NSP in annex sets out a complete and reliable statement of requirements for malaria control from 2014 to 2018.
- The financial data relating to domestic resources, namely the budgets for 2012 to 2014, gap analysis, spending notes from MINEPAT for 2012 to 2014 and the operational budget for the LLIN mass distribution campaign in 2015 are complete, reliable financial statements. Government funding has also been assessed based on assumptions for internal funding for 50 percent of the commodities necessary to continue the fight against malaria.
- External resources excluding the Global Fund funding are provided by partners: UNICEF, WHO, CHAI, Malaria No More, etc. It should be noted, however, that several partners (UNICEF, WHO, etc.) have not yet communicated their funding forecasts for 2015-2017, given that their cooperation programs run for two years and end in 2015. Although these

data are reliable, they are therefore not exhaustive.

- Data on grants from the Global Fund currently being implemented and the NFM allocation letter are reliable.

Based on this analysis, the conclusion is that the funding assumptions are based on reliable data from accurate sources (MINEPAT and Technical and Financial Partners) that formed the basis of the analysis. Given the missing data relating to contributions from certain technical and financial partners for 2015 to 2017, however, adjustments will be made as these data are received.

## SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

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

### 3.1 Programmatic Gap Analysis

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

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

#### **1-2 PAGES SUGGESTED – only for modules that are difficult to quantify**

The programmatic gaps shown in Table 2 come from the gap analysis covering the period of the NSP 2014-2018, which was carried out by the country with the cooperation of all partners involved in the fight against malaria and technical assistance provided by a consultant made available by the CARN (RBM (Roll Back Malaria) Network for Central Africa). Table 2 was completed using the RBM/HWG (Harmonization Working Group) analysis tool and the NSP 2014-2018 (cf. gap analysis tool and NSP 2014-2018).

The programmatic gap analysis for 2015-2017 shows the following gaps:

#### **1. Priority modules and interventions:**

❖ **Vector control – intervention: Mass distribution of LLINs.** The LLIN requirement is 12,322,059 for 2015 for the total population of 22,179,707. This is the most significant programmatic gap for the period 2015-2017. In 2011, the country organized a mass distribution campaign of 8,115,879 LLINs with the support of the Global Fund. The bio-efficacy of these LLINs expires in 2014. As a result, in order to achieve and maintain universal coverage of LLINs, 12,322,059 LLINs need to be procured by late 2014 or early 2015 with Global Fund resources and distributed in 2015 using domestic resources.

❖ **Prevention for specific groups – Intervention: Seasonal malaria chemoprevention for children aged from 3 to 59 months.** The SP-AQ requirements to be covered by this funding request are 2,771,569 doses in 2016 for 659,897 children and 2,841,935 doses in 2017 for 676,651, or 50 percent of the needed amount, since the Government is committed to the procurement of the other 50 percent.

## 2. Other high-impact modules and interventions continued from Round 9:

- ❖ Vector control: routine distribution of LLINs to pregnant women during antenatal consultations (100 percent): From 2011 to 2015, as part of the implementation of Round 9, routine LLIN requirements were covered jointly (50 percent each) by the Global Fund and the Government. The LLIN requirements for 2016 and 2017 to be covered in this funding request are 584,780 for the total of 567,747 pregnant women and 598,637 for the total of 581,201 pregnant women respectively, or 50 percent of routine LLIN requirements. The remaining routine LLIN requirements (50 percent) will be covered by the Government.
- ❖ Prevention for specific groups – IPT for pregnant women: the requirements to be covered in this funding request are 4,912,150 tablets in 2016 for the total of 567,747 pregnant women and 5,028,552 in 2017 for the total of 581,201 pregnant women, or 50 percent of the total need. The Government of Cameroon will cover the remaining 50 percent of the requirements for 2016 to 2017.
- ❖ Treatment – diagnosis and care: case management in health care facilities will be maintained or strengthened. Scaling up treatment at a community level and the continuation of free treatment for cases of uncomplicated and severe malaria in children under the age of five will need greater involvement from the Government and its partners. As a result, the various needs and proportions to be included in this funding request are as follows:

**Table 7:** Breakdown of various requirements by commodities and target by year.

Commodities	2015*	2016	2017
<b>RDT</b>	815,766 (15%) Target: 520,832 cases	1,801,887 (50%) Target: 1, 749,405 cases	1,795,264 (50%) Target: 1,742,975 cases
<b>ACT</b>	638,485 (25%) Target: 628,186 cases	1,375,182 (50%) Target: 1,375,182 cases	1,427,307 (50%) Target: 1,427,307 cases
<b>Artesunate inj</b>	660,740 (31%) Target: 107,708 cases	1,168,296 (50%) Target: 189,011 cases	1,328,199 (50%) Target: 204,932 cases

\*: These are revised quantities following the correction of errors in the PSM (Procurement and Supply-Chain Management) plan in Round 9 (gap analysis tools)

**Source:** Table 2 (Programmatic gaps)

In this respect, the Government has committed to cover 50 percent of the remaining input requirements for 2016 and 2017.

- ❖ Health System Strengthening – Monitoring and evaluation: In respect of monitoring and evaluation, national resources and those from Round 9 available cover only 38 percent of requirements for 2015 and 1 percent of requirements for 2016 and 2017. The same applies to training requirements for staff and community officers and for communications to support the activities, which is 71 percent coverage for 2015 by the Global Fund and the Government. Budget forecasts from the Government and partners show that fewer than 2 percent of communications requirements will be satisfied after 2015. For 2016 and 2017, these requirements cover the production of harmonized registers of health care facilities, building capacity in the health system, strengthening entomological surveillance, quality control on inputs (ACT, RDT, LLINs) and integrated supervision.
- ❖ Program management: Funding from Round 9 and the Government will fund 78 percent of required for 2015. Only 5 percent of requirements are covered by the Government for 2016 and 2017.

The financial gaps breakdown for 2015-2017 is as follows:

**Table 8:** Breakdown of financial gaps based on modules and support interventions for 2015 to 2017

Support Modules/ Interventions	2015	2016	2017
<b>Monitoring and Evaluation</b>	€2,757,061 (62%)	€4,250,818 (99%)	€4,397,931 (99%)
<b>Communications</b>	€145,954 (98%)	€3,518,084 (99%)	€2,041,548 (98%)
<b>Training and Research</b>	€7,778,742 (92%)	€3,422,286 (100%)	€3,570,324 (100%)
<b>Program Management</b>	€3,386,469 (57%)	€5,701,185 (99%)	€5,773,654 (99%)

**Source:** Table 2 Programmatic gaps

Funding requirements for training and research for 2015 are primarily associated with the LLIN mass distribution campaign and the introduction of SMC, which is a new intervention.

### 3.2 Applicant Funding Request

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

#### 4-5 PAGES SUGGESTED

This funding request, for the amount of €62,001,741, targets only the new allocation (new money) and it does not take into consideration the current funds under the Round 9 grants which are coming to an end on the 31 December 2015). This request aims to achieve universal coverage in terms of prevention and treatment activities and to maintain them to achieve a rapid impact. Furthermore the country has decided not to reprogram the present grants which come to an end in December 2015.

**The high-impact priority interventions included in this concept note are:**

- Mass distribution of LLINs across the entire country.
- Seasonal malaria chemoprevention in the North and Far North regions, where there is a high prevalence of seasonal transmission.

In order to ensure continuity of the services covered under Round 9, the high-impact interventions below will be maintained and strengthened:

- Routine distribution of LLINs during antenatal consultations;
- Treatment of suspected cases of malaria in health care facilities and in the community;
- Intermittent Preventive Treatment for pregnant women in health care facilities.

In order to ensure the effectiveness of these interventions, the emphasis will be on:

- Monitoring and evaluation, epidemiological surveillance and response;
- Development communications;
- Training and operational research;
- Program management.

The proposal is entitled: **“Achieve and maintain universal coverage of interventions to fight malaria for a long-term impact”**.

The aim of the project is to contribute to reducing malaria-related mortality and morbidity by 75

percent by 2017 compared to 2000.

Specific objectives of the project:

- Ensure that at least 80 percent of the population sleep under long-lasting insecticidal nets by 2017;
- Protect at least 80 percent of pregnant women through Intermittent Preventive Treatment (IPT) for malaria in accordance with national guidelines by 2017;
- Protect at least 80 percent of children aged from 3 to 59 months in the target areas through seasonal malaria chemoprevention by 2017;
- Treatment of confirmed cases of malaria in health care facilities and in the community in accordance with national guidelines by 2017;
- Strengthen the institutional development of the National Malaria Control Program by 2017.

**Specific objective 1:** Ensure that at least 80 percent of the population sleep under long-lasting insecticidal nets by 2017.

In 2011, 8,115,879 LLINs were distributed, giving theoretical coverage of 1 LLIN per 2.4 people. The post-campaign evaluation showed that 66 percent of households had at least one LLIN whilst only 32 percent of households had one LLIN for two people.

The interventions below will be implemented to increase the proportion of households with at least 1 LLIN for 2 people from 32 percent to 80 percent.

#### **Intervention 1.1: Mass distribution of LLINs**

A mass campaign to distribute 12,322,059 LLINs will be conducted throughout the country to cover a population of 22,179,707 inhabitants in 2015. The calculation is based on 1 LLIN for 1.8 people, in accordance with the principle of universal coverage. The distribution campaign will be a three-stage process, successively covering three to four administrative regions.

The key activities selected for the mass distribution of LLINs are as follows:

- Logistics aspects: purchase the LLINs through VPP (Voluntary Pooled Procurement) and transport them to the ten regions and then the districts.
- Ensure security measures are in place throughout the supply chain.
- Distribute LLINs in accordance with the micro-plans after counting.

The operational costs of the campaign will be covered fully by the Government. A detailed budget for operational costs is attached to this document (annex no. 17).

#### **Intervention 1.2: Routine distribution of LLINs**

LLINs will be distributed for free to pregnant women during antenatal consultations. This strategy aims to distribute 1,142,255 LLINs in 2015, 1,169,559 in 2016 and 1,197,274 in 2017.

The funding needed for routine distribution of LLINs over the three years of the project is €3,034,164. The current grant from Round 9 will cover 50 percent of requirements in 2015, with the remaining 50 percent covered by national resources. This funding request will cover 50 percent of requirements in 2016 and 2017, with the remaining 50 percent covered by national resources.

The key activities selected for routine distribution of LLINs are as follows:

- Logistical aspects: procurement of the LLINs through VPP (Voluntary Pooled Procurement) and transport them to the ten regions and then the districts.
- Ensure security measures are in place throughout the supply chain.
- Distribute LLINs to pregnant women during antenatal consultations.

**Support interventions** are intended to support the distribution of LLINs and in particular to encourage their appropriate use. In this concept note the choice of the support activities has been done considering the weaknesses and challenges met during the implementation of the Round 9 grants activities. The approach used to implement the communication for development strategy will be based on an innovative process that will start with an exploratory study to identify determining factors, agents and conditions that impede or support the correct use of LLINs and IPT on one side and the treatment of cases and the SMC on the other side. On the basis of this behavioral assessment, the communication for development strategy activities will be proposed. This innovative approach to developing the communications strategy is cross-cutting across all key interventions (LLINs, IPT, SMC and treatment). The coordination meetings planned between various actors at all levels will help to ensure consistency between communications activities on the one hand and prevention and treatment on the other. For the LLIN campaign, the costs of the mass-media campaign will be covered by the Government; other activities are addressed in this funding request.

These interventions will be as follows:

- IEC/BCC: Run a development communications campaign before, during and after the distribution campaign.
  - Engage in advocacy at all levels (leaders and decision-makers of all kinds) in order to secure support, ownership and contributions from advocacy targets.
  - Social mobilization of all organized groups (women, young people, educational communities, private-sector organizations, CHWs, etc.) to ensure they are actively involved in distributing and promoting the use of LLINs.
  - Mass media communications will cover the whole of the population with key messages about malaria appropriate to specific target audiences through public, private and community radio stations and television channels.
  - Interpersonal communications through educational talks and counselling will be provided by civil society and community health officers during home visits, at community meetings and during campaigns in business settings and elsewhere. This will help to promote the adoption of recommended behaviors and coverage for people in areas without access to the media.
- Entomological surveillance, monitoring and evaluation.
  - Study the bio-efficacy of LLINs: The WHO protocol will be used (WHO cone test). LLIN samples collected in the field will be tested in the laboratory based on exposure using sensitive anopheles (Kisumu strain). The study will be carried out in cooperation with the OCEAC (Organization for the Coordination of the Fight against Endemic Diseases in Central Africa).
  - Study vector susceptibility to insecticides: The WHO protocol based on mortality after 24 hours will be used; this allows the strain tested to be classified into three categories (sensitive, resistant and sensitivity to be confirmed).
  - Transmission of malaria: Nocturnal captures with pyrethrum will be carried out to measure the entomological parameters of transmission (aggressiveness, sporozoite rate and entomological inoculation rate).

**Specific objective 2:** Protect at least 80 percent of pregnant women through Intermittent Preventive Treatment in accordance with national guidelines by 2017.

IPT has been free of charge in Cameroon since 2007. In spite of this, only 35 percent of pregnant women received at least two doses of IPT during their most recent pregnancy according to the MIS 2011. Furthermore, the WHO has recommended administering at least three doses of SP during pregnancy since 2012. As this was already taken into account in the NSP 2014-2018, in this concept note there will be a requirement for 4,912,150 tablets in 2016 and 5,028,552 in 2017.

The key activities selected for IPT for pregnant women are as follows:

- Procurement of SP tablets
- Supply SP to health care facilities
- Distribute SP to pregnant women in health care facilities and outposts

**Alongside this primary intervention, other IPT support interventions are planned.** The support interventions selected in this concept note take account of the weaknesses and challenges encountered in implementing Round 9 grants. In addition, they propose an innovative approach based on exploring solutions according to the difficulties encountered and implementing an appropriate communications strategy; in this instance, actions aimed towards service providers will also be taken to address the problems associated with free provision. The interventions will be as follows:

- IEC/BCC: Use communication for development strategy for development to encourage the use of IPT by pregnant women.
  - Recruit a consultant to support the development of strategy and communications tools
  - Produce communications tools for IPT
  - Broadcast radio and TV behavior change messages to support IPT
  - Run educational talks during home visits
  - Mobilize community-based organizations
  - Engage in advocacy with decision-makers, leaders and community groups
- Operational research
  - Conduct a documentary review and KAP (Knowledge, Attitudes and Practices) survey to implement a communications approach based on research evidence to increase support from service providers and raise IPT coverage to 80 percent. This research is one of the aspects of the exploratory study described above (see LLIN campaign).
- Epidemiological surveillance, pharmacovigilance and monitoring and evaluation
  - Monitor resistance to SP
  - Engage in pharmacovigilance (collection, analysis, etc.)

**Specific objective 3:** Protect at least 80 percent of children aged from 3 to 59 months in the target areas through seasonal malaria chemoprevention by 2017.

Statistics from the last three years show an upsurge in cases of malaria during the rainy season (July to October) in the North and Far North regions, with high mortality amongst children under the age of five. Seasonal malaria chemoprevention (SMC) will be used during this peak transmission period amongst children aged from 3 to 59 months (28.13 percent of the total population in this age group) with a combination of Sulfadoxine Pyrimethamine + Amodiaquine (SP+AQ), using a door-to-door strategy at a community level and additional distribution sessions for children seen during appointments in health care facilities during the campaign. Community distribution officers will administer one dose of SP+AQ to each target child, under direct supervision, on the first day and two remaining doses will be given to the mother or child-minder for D2 and D3. Follow-up visits will be made to each house on D2 and D3 to ensure the two remaining doses have actually been administered. Doses of SP+AQ will therefore be administered



on three days each month, from July to October in 2015 to 2017. In addition, an indelible mark will be placed on the child's finger to avoid any duplicates. This strategy will also include refugee children and will be implemented in partnership with UNHCR, WHO, UNICEF etc. The North and Far North regions are affected by SMC considering the WHO recommendations of March 2012, outlined in its document entitled "WHO Global Malaria Programme, WHO policy recommendation: Seasonal Malaria Chemoprevention (SMC) for *Plasmodium falciparum* malaria control in highly seasonal transmission areas of the Sahel sub-region in Africa" (see annexes). For the number to cover, cf. page 21 of the Concept Note.

The key activities will be as follows:

- Purchase SP+AQ
- Purchase kits for distribution officers (bag, tunic, pencil, eraser, pencil sharpener and register)
- Calculate quantities and purchase sugar
- Provide health care facilities and CHWs with inputs
- Distribute SP+AQ to beneficiaries

The support activities implemented will be as follows:

- IEC/BCC:
  - Recruit a consultant to support the development of strategy and communications tools
  - Organize a workshop to develop SMC communications tools
  - Produce communications tools for SMC.
  - Broadcast radio and TV behavior change messages to support SMC
  - Run educational talks during home visits
  - Mobilize community stakeholders
  - Organize annual launch ceremonies for the SMC campaign in the two regions concerned
  - Engage in advocacy with decision-makers, leaders and community groups
- Capacity building:
  - Adapt the Medicines for Malaria Venture (MMV) training modules
  - Train District Management Teams in SMC
  - Build capacity amongst leaders and community groups in SMC
  - Train local supervisors, distribution officers and follow-up teams in SMC at the start of each campaign cycle.
- Operational research:
  - Carry out an exploratory study of the communications strategy, adapted to reflect the diversity of target groups (minorities, displaced persons/refugees, general population, etc.).
- Monitoring and evaluation
  - Organize a workshop to develop SMC management tools
  - Organize SMC micro-planning tools
  - Measure radio-TV broadcasts
  - Supervise SMC at all levels
  - Hold evaluation meetings on the SMC campaign at all levels
  - Evaluate the effectiveness of the campaign in 2015
  - Strengthen epidemiological surveillance (routine and sentinel) for malaria, including monitoring resistance
  - Engage in pharmacovigilance (collection, analysis, etc.)

**Specific objective 4:** Treatment of confirmed cases of malaria in health care facilities and in the

community in accordance with national guidelines **by 2017.**

#### **Intervention 4.1.: Biological testing by microscopy or RDT of suspected cases of malaria.**

All suspected cases of malaria will be confirmed in health care facilities by a rapid diagnostic test or microscopy. At a community level, they will be confirmed with RDT by CHWs.

The key activities will be as follows:

- Purchase RDTs through VPP;
- Supply health care facilities through the CYNAME (National Essential Drug Procurement System)

The planned support interventions are:

- Stronger management of purchasing and inventory management
  - Deploy a network application for monitoring stocks in CAPRs (Regional Centers for Pharmaceutical Supply)
  - Implement an instant transmission system for inventory data using SMS for Life messages with a website. This system will provide real-time visibility of inventory levels in health care facilities and avoid stock outs.
  - Train health assistants in inventory management
  - Hold quarterly meetings of the Purchasing and Procurement Management Committees
- Capacity building:
  - Develop and produce training modules;
  - Organize cascade training on integrated community treatment (at Region and District, Health area and Community levels), pharmacovigilance and inventory management (also at Region and District, Health area and Community levels). This training will cover both civil society and the private sector.
- IEC/BCC:
  - Produce posters, leaflets and ads
  - Disseminate communications materials
  - Organize quizzes at training institutions in the regions
  - Develop and produce advocacy materials
  - Organize advocacy meetings with traditional and religious leaders, local public authorities and key players in the employment sector
  - Develop and produce integrated communications materials (picture boxes)
  - Conduct home visits, give educational talks and run counselling sessions
  - Celebrate World Malaria Day in the communities
  - Develop and broadcast radio and television programs on promoting community-driven interventions
- Monitoring and evaluation:
  - Carry out therapeutic efficacy studies in the four sentinel sites every two years
  - Carry out quality control on inputs for treatment of malaria (RDT, ACT)
  - Carry out integrated monitoring at health district, health area and community levels with programs to control malaria, HIV and AIDS and tuberculosis. This will be conducted jointly with civil society organizations. Integration will help to contribute to strengthening the health system (through a rational use of human resources and reduction in monitoring costs) and improving program performance.

#### **Intervention 4.2.: Treatment of confirmed cases of malaria in health care facilities and in the community in accordance with national guidelines.**

Cases of uncomplicated malaria are treated with Artesunate –Amodiaquine (AS-AQ) and Artemether-Lumefantrine (AL) in accordance with national directives. Nonetheless, for regions

with a high level of seasonal transmission where seasonal malaria chemoprevention will be used with a Amodiaquine + Sulfadoxine-Pyrimethamine combination, AL will be used to treat cases of uncomplicated malaria in health care facilities and at a community level, in accordance with WHO recommendations. In these target regions, the selling price of AL will be aligned with the selling price of ASAQ (O FCFA) for children under the age of five.

An integrated approach will be prioritized at a community level. The CHW's package of activities has two components: (i) - treatment of cases of uncomplicated malaria, diarrhea and acute respiratory infection. If there is no remission after 24 to 48 hours, the case must be referred to the nearest health area; (ii) - integrated communications (home visits and talks) on malaria, ICMI, tuberculosis and HIV. Each CHW will therefore receive a kit that will include RDTs, ACT, sachets of ORS (oral rehydration salts), zinc and amoxicillin, an appointments register and a communications register. Each CHW will also receive a bag, case and tunic. UNICEF will cover the cost of purchasing sachets of ORS, zinc and amoxicillin.

The coordination and monitoring and evaluation mechanism for the community strategy will be run jointly by the national health system and civil society.

At the central level, coordination meetings will be organized every two months for planning and reviewing activities. Participants will include the principal recipients in the public sector (Ministry of Health – PR1) and the principal beneficiary in civil society (PR2). Other programs (HIV and AIDS and tuberculosis) and partners will also be invited.

At the regional level, review and planning meetings will take place every quarter. Participants will include the heads of regional units for malaria, HIV and AIDS and tuberculosis prevention and sub-recipients (SR).

At the health district level, monthly coordination meetings will be organized with area heads and supervisors of district civil society organizations (OSCD) and the district management team.

CHWs will be supervised jointly by health area heads and OSCD supervisors, based on an integrated approach taking into account aspects of treating malaria, diarrhea and acute respiratory infections and preventing malaria, HIV and AIDS and tuberculosis. A monthly meeting for sharing lessons learned and problems encountered and signing off the activity reports submitted by CHWs will be organized in each health area with CHWs, health area heads and OSCD supervisors.

The diagram below illustrates the coordination and supervision mechanism for integrated case management at a community level.

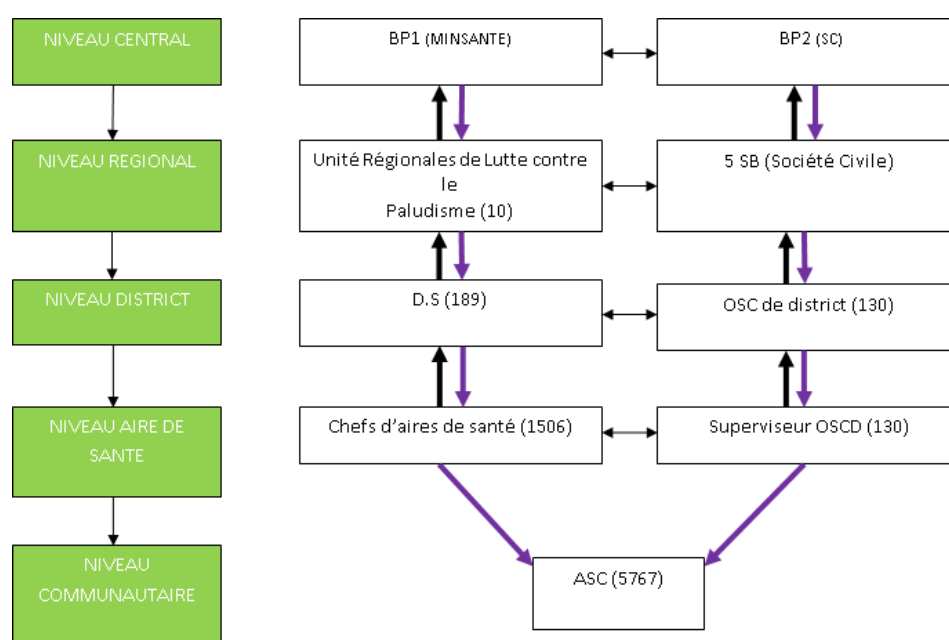


Fig. 6: Coordination and supervision mechanism for integrated case management at a community

*level*

The community approach developed in this Concept Note differs from that of Round 9 insofar as it is an integral part of the national strategy defined in the guide to community-driven approaches. In practice, it is now a question of using multi-skilled CHWs (implementing several means of combating the disease) selected by their communities in areas where access to healthcare services is difficult and based on rationalized coverage of one CHW per 1,000 inhabitants. Furthermore, community activities of this kind will be supervised jointly by civil society organizations and health-area managers in order to ensure effective implementation of the package of interventions delegated to CHWs. Regular coordination meetings involving all stakeholders (public, private, civil society and partners) are planned at all levels.

A second Principal Recipient to implement the strategy is necessary for the following reasons:

- The ratio of doctors and nurses per inhabitant is 1.07 to 1,000, which is below the standard recommended by WHO (2.3 to 1,000) and therefore involves a significant workload for health care personnel in health care facilities. They are unable – in addition to their activities in health care facilities – to ensure effective provision of all promotion, prevention, treatment, monitoring and evaluation at a community level;
- The lack of capacity amongst health care personnel in terms of behavior change communications, advocacy, social mobilization and leadership, which limits ownership of interventions by communities and stakeholders.

The decision has therefore been taken to continue with the Dual Track option, with two PRs, one from government and the other from civil society.

### **Specific objective 5: Strengthen the institutional development of the National Malaria Control Program by 2017.**

#### **Intervention 5.1.: Improved financial and accounting management**

The program has an internal management controller and an internal auditor. In spite of this, problems have emerged in understanding the procedures manual. This concept note provides for capacity building for those responsible for implementation with the aim of ensuring a better understanding of accounting and financial procedures, which will help to reduce risks of inadequate justification of expenses and poor budget implementation.

The key activities to be carried out are as follows:

- Review administrative and accounting procedures manuals
- Train/retrain staff on the administrative and accounting procedures manual
- Train staff in risk management and internal control
- Retrain/train staff in using accounting and financial software
- Train/retrain URLP (Regional Malaria Control Unit) cashiers in cash-box management
- Carry out internal audits
- Have an external annual audit carried out by an independent firm.

#### **Intervention 5.2.: Coordination, monitoring and evaluation**

The weaknesses in coordination, monitoring and evaluation identified were: the absence of coordination meetings; delays in the submission of progress reports from the regions to the center; and a lack of promptness (28 percent) in submitting data from health care facilities to health districts. The emphasis in this concept note will therefore be on coordinating and monitoring activities. The key activities in this respect will be as follows:

- Hold quarterly meetings with districts at a regional level for evaluation of implementation;
- Carry out formative supervision, monitoring and evaluation tasks;

- Carry out verifications of data quality on-site.

A malaria indicator survey (MIS) is planned for 2017 and has been included in the budget for this concept note (cf. detailed budget activity no. 108).

The indicators on which the study will provide information are:

- Outcome indicators:

Proportion of households with at least one LLIN per two people;

Proportion of the population sleeping under an LLIN the previous night;

Proportion of children under the age of five sleeping under an LLIN the previous night;

Proportion of pregnant women sleeping under an LLIN the previous night;

Percentage of pregnant women receiving at least three doses of IPT during their last pregnancy;

Percentage of children aged from 03 to 59 months protected by seasonal malaria chemoprevention in the target areas.

- Impact indicators:

Mortality rate of children under the age of five, all reasons combined, per 1,000 live births.

Parasitic prevalence: proportion of children aged 06 to 59 months with a malarial infection.

The planned funding of €304,898.03 is not sufficient to measure the impact indicators referred to above. However, the first impact indicator will be measured by the DHS or MICS surveys planned in Cameroon in 2017. Additional funding of €101,792 is needed to measure the impact indicator on parasitic prevalence. (Cf. attached budget).

### **Intervention 5.3.: Institutional capacity-building**

Some support staff receive monthly bonuses paid by the State in respect of institutional capacity-building. Other staff members, primarily at executive level (doctors and senior finance staff) have received bonuses funded by the Global Fund since Round 3. In addition, the Central Technical Group of the NMCP and the PR2 and SR need to build capacity in terms of human resources and logistics. The key activities to be carried out in terms of further institutional capacity-building are as follows:

- Pay the salaries of contracted staff of the PR1, PR2 and SR (Global Fund) and bonuses for staff in the public sector;
- Recruit a communications expert for the program;
- Recruit consultants to support its implementation;
- Purchase small items of equipment for central and regional management;
- Purchase six vehicles for regional activities on the basis of five vehicles for the PR1 and one vehicle for an SR of the PR2.

The conceptual framework below illustrates the project submitted in this concept note.

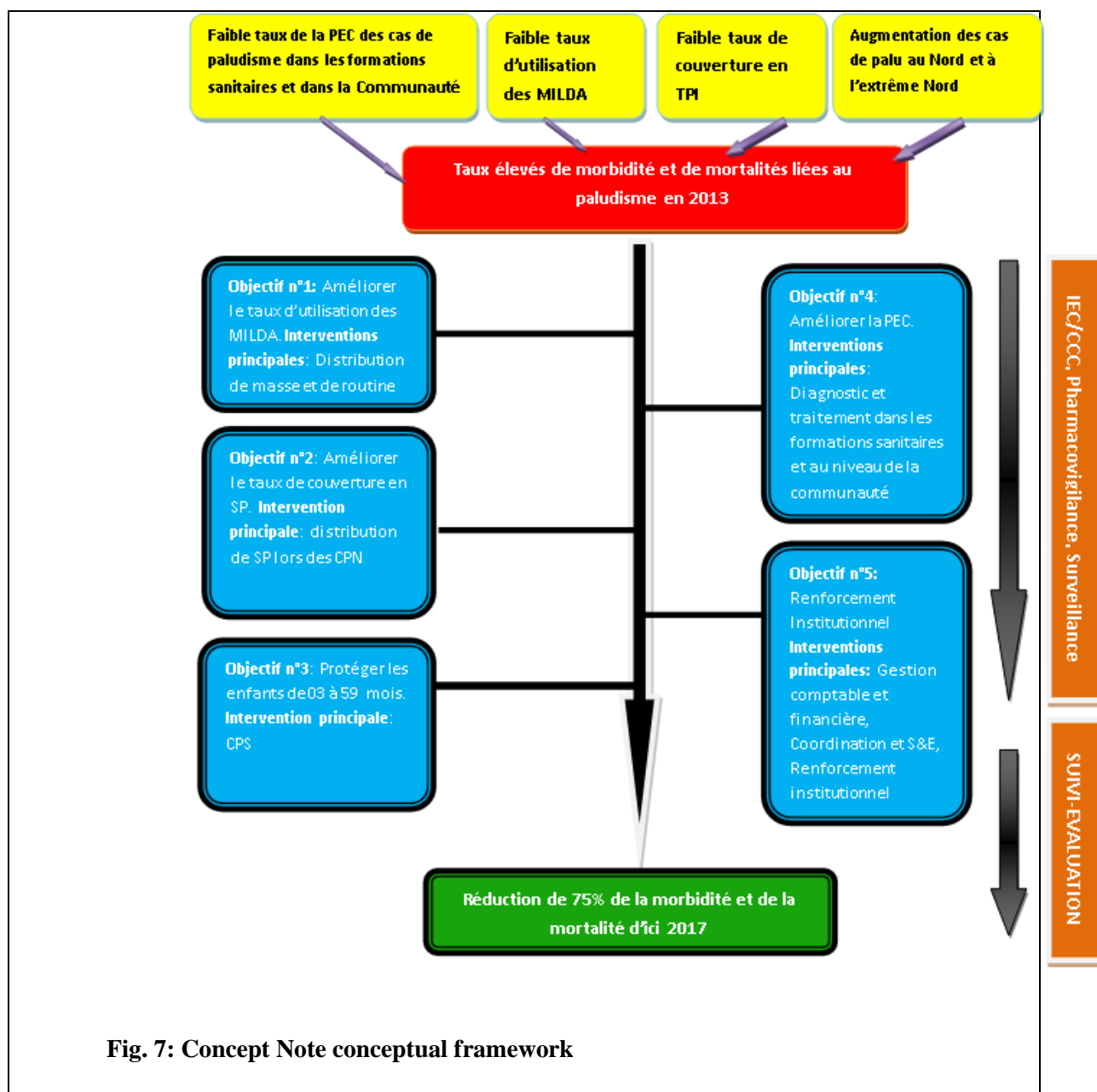


Fig. 7: Concept Note conceptual framework



### 3.3 Modular Template

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

- a. Explain the rationale for the selection and prioritization of modules and interventions.
- b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

### 3-4 PAGES SUGGESTED

- a. Justification of the rationale for the selection and prioritization of modules and interventions.

❖ Priority modules and interventions:

- Vector control – LLIN mass distribution campaign

Cameroon carried out a mass LLIN distribution campaign under Round 9 in 2011. This resulted in the distribution of 8,115,879 LLINs and achieved an absolute increase in availability of at least one LLIN per household of 34 points (33 percent before the 2011 campaign) (DHS-MICS 2011 page 191) to 66 percent in 2013 (EPC-LLIN 2013 table page 33) and an increase in use of 24.5 points (from 13.1 percent before the 2011 campaign to 39.3 percent in 2013) (source: EPC-LLIN 2013). These results need to be improved as they are still far below the NSP targets (100 percent coverage and 80 percent use). Furthermore, it has been noted that the efficacy of LLINs decreases significantly after three years and in addition, high levels of wear and loss of LLINs are found in several households. This may challenge the efforts already made in the country with regard to vector control. As a result of the above mentioned, Cameroon has made vector control and a mass LLIN distribution campaign the primary module and priority intervention for this funding request.

The country is seeking to cover the costs of procurement and delivering all the LLINs required for this campaign through this funding request, whilst the operational costs of the campaign will be paid in full by the Government. The expected co-financing includes these operational costs.

- Prevention for specific groups – Seasonal malaria chemoprevention

Since 2013, Cameroon has observed a seasonal upsurge in cases of malaria, particularly in the North and Far North regions. This affects children under the age of five in particular and is responsible for an increase in mortality (2011, 2012 and 2013 data). The North and Far North regions are characterized by a hot and dry tropical climate, short seasonal transmission (one to three months) and around 10 infectious bites per person per month. 2013 was preceded by major flooding, which resulted in an increase in larval sources; this in turn created favorable conditions for permanent transmission in an environment where malaria is usually seasonal and protection is limited. The two regions bordering Chad are characterized by a Sahelian facies with a hot and dry tropical climate, short seasonal transmission (one to three months) and at least 10 infective bites per person per month. Prevention for specific groups through chemoprevention for children aged 3 to 59 months has been selected as a second module and priority intervention for this funding request to mitigate the upsurge in cases of malaria in Cameroon. This intervention has been advocated by the WHO to control malaria caused by *Plasmodium falciparum* since 2012 and helps countries with a high level of seasonal transmission to reduce morbidity and mortality by at least 80 percent. Seasonal malaria chemoprevention (SMC) is defined as the intermittent administration of complete treatments using anti-malarial medication during the malaria season to avoid the disease, the aim being to maintain therapeutic concentrations of anti-malarial drugs in the blood throughout the period when the risk of malaria is at its highest.

It is recommended in areas of high seasonal transmission of malaria throughout the entire Sahel sub-region and is targeted at areas where:

- malaria transmission and the majority of clinical cases occur over a short period of around four months.
- the level of clinical impact of malaria exceeds 0.1 per transmission season in the target age



group,

- the SP+AQ combination is still effective (efficacy > 90 percent).

A complete treatment of sulfadoxine-pyrimethamine and amodiaquine (SP+AQ) must be administered to children aged 3 to 59 months at regular intervals of one month, starting at the beginning of the transmission season and giving a maximum of four doses over the course of the season (insofar as both medications still have an adequate anti-malarial effect).

Cameroon has taken the WHO's new strategy into account in its new NSP. The objective is to protect at least 80 percent of children under the age of five between 2014 and 2018.

On the basis of this funding request, the country plans to implement the strategy in the North and Far North regions, in accordance with eligibility requirements. It will be implemented in both regions during the monthly campaigns (July, August, September and October) based on a door-to-door strategy at a community level. During the distribution of medicines, the first doses of SP+AQ will be administered under the direct observation of Community Distribution workers selected from the communities; the doses of AQ for the two remaining days will be given to the mother or child-minder of children aged 3 to 59 months. Particular attention will be paid during the distribution campaign to monitoring of side effects (pharmacovigilance), raising awareness of compliance with the correct doses of medicines and eliminating any other factor that could undermine SMC.

The IDB is providing Cameroon with funding to purchase all its input requirements for 2015 to support this strategy. The State will cover the costs of 50% of inputs for 2016 and 2017; remaining needs, including technical assistance, are addressed in this concept note.

Given that this is a new strategy, no resources have yet been mobilized to implement it; as a result, all requirements for implementing it, including technical assistance, are dependent on this funding request.

#### ❖ Modules and interventions continued from Round 9

##### ○ Vector control – Routine distribution of LLINs

Routine distribution of LLINs is carried out in health care facilities and the targeted primarily are the pregnant women coming for their antenatal consultations and women whose children have completed their scheduled immunization program. These LLINs were purchased under Round 9. Given that this will come to an end in December 2015, however, and for the purpose of maintaining continuity, Cameroon is seeking to cover a proportion (50 percent) of its LLIN requirements for 2016 and 2017 through this funding request.

##### ○ Prevention for specific groups – Intermittent Preventive Treatment (IPT) for pregnant women

IPT is one of the strategies included in the NSP 2014-2018. The coverage rate for a second dose of SP was 51 percent in 2013 (NMCP Annual Report, 2013). This is low compared with the national objective of 80 percent. Furthermore, when it reviewed its NSP, Cameroon adopted the WHO strategy of giving pregnant women at least three doses of SP. Until now, the sulfadoxine-pyrimethamine (SP) used for this intervention has been funded by Round 9. Unfortunately, this will come to an end in December 2015. In order to ensure continuity, Cameroon plans to seek under this funding request, the funding for coverage of the 50% of the needs of SP for the period 2016-2017, the other 50% will be covered by the State. Furthermore, the State intends to engage in advocacy with other partners for purchases of SP after 2017.

##### ○ Treatment of confirmed cases of malaria in health care facilities and in the community in accordance with national guidelines.

This high-impact intervention was fully funded under Round 9, which is set to end in December 2015. Some of the requirement has therefore been included in this funding request and the remainder will be covered by the Government and its counterparts. Furthermore given the weaknesses identified during its implementation in Round 9 (inadequate quality of services available, non-compliance with standards, stock outs, etc.), specific corrective measures will be planned to improve support by service providers and populations for national directives (continuous, targeted communications aimed at care providers, capacity-building amongst service providers and

regular supervision, introduction of a regularly updated supply plan, capacity-building in relation to supply and inventory management, weekly monitoring of inventory via SMS and emergency replenishment in the event of stock outs)

- Treatment of confirmed cases of malaria in health care facilities and in the community in accordance with national guidelines.

Treatment of suspected cases of malaria was planned under Round 9, however the strategy was not implemented correctly as planned. As a result, given the shortcomings in the past, a new community strategy will be implemented, including clear coordination and monitoring and evaluation mechanisms from community up to national level. In this respect, it will be important to ensure that the two Principal Recipients work closely together (see fig. 6 Community Strategy Coordination and Supervision Mechanism). As explained above, the community approach developed in this Concept Note differs from the one of Round 9 insofar as it is an integral part of the national strategy defined in the guide to community-driven approaches. In practice, it is now a question of using multi-skilled CHWs (implementing several means of combating the disease) selected by their communities in areas where access to healthcare services is difficult and based on rationalized coverage of one CHW per 1,000 inhabitants. Furthermore, community activities of this kind will be supervised jointly by civil society organizations and health area managers in order to ensure effective implementation of the package of interventions delegated to CHWs.

- Program Support – Monitoring and evaluation and Development communications.

These cross-cutting activities will also be maintained, since an analysis of implementation weaknesses in Round 9 at both health care facilities and community level has shown shortcomings in both aspects. Specific corrective activities (evidence-based development communications, integrated supervision, periodic coordination meetings at all levels, etc.) will be planned under this funding request.

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

- **Mass distribution of LLINs**

According to RBM, universal coverage of LLINs combined with ACT reduces morbidity by at least 50 percent. Distributing 12,322,059 LLINs in a mass campaign will enable us to achieve universal coverage of the country's entire population. We are expecting to achieve coverage of at least 80 percent of households with at least one LLIN per two people at risk. A survey carried out in 2013 shows that the campaign conducted in 2011 helped to avoid over one million cases of fever and almost 2,300 deaths (Kwedom, 2013). The communications activities that accompany the distribution campaign will help to achieve optimal use in the general population and the groups most at risk, namely pregnant women and children under the age of five. A national malaria indicator survey is included in this concept note. In addition, regarding the LLIN distribution, the "Hang-up campaign" and the post campaign evaluation were not included because of lack of funding. The PRs and the partners are aware of this fact and are engaged to mobilize the needed resources. The lobbying on this matter has already started.

- **Seasonal malaria chemoprevention**

The country experiences a periodic increase in cases of malaria in the Sahelian transmission zone during the rainy season. Peak transmission is reached at this point in the winter. Seasonal malaria chemoprevention amongst children under the age of five in the affected regions of the North and Far North will be based on a mass campaign, which aims to protect at least 80 percent of children aged from 3 to 59 months during the next three years. Integrated communications activities will support the implementation of the strategy during each campaign. According to studies by WHO, combining chemoprevention with universal coverage of LLINs reduces cases of malaria by at least 80 percent.

- **IPT amongst pregnant women**

Recent WHO data show the superior performance of more than two doses of IPT amongst pregnant women compared with two doses. SP requirements for IPT amongst pregnant women have therefore

been evaluated on the basis of at least three doses of IPT per pregnant woman. Pregnant women and their husbands will be made aware of this at planned home visits under Round 9 grants, which will continue in the current project. Measures will also be taken to raise awareness amongst care providers in order to provide the same services to all eligible pregnant women.

- **Case management**

All cases of fever suspected of being malaria must be confirmed with a biological test (microscopy or rapid diagnostic test) both in health care facilities and at a community level (home-based management of malaria) in order to rationalize the use of ACT and injectable artesunate (only for severe cases treated in health care facilities). Given the limited coverage of microscopes and qualified microscopists in health care facilities, the emphasis will be on using RDT to confirm cases. The two officially recommended ACTs will be deployed in the country: A combination of Artemether and Lumefantrine for treating cases of uncomplicated malaria in the North and Far North, given the use of the SP+AQ combination for seasonal malaria chemoprevention in the two regions, and a combination of Artesunate and Amodiaquine in the rest of the country.

This is a high-impact intervention under this funding request, and together with other prevention interventions is intended to contribute to reducing morbidity and mortality associated with malaria in Cameroon. .

- **Communication for development strategy**

According to EPC-LLIN data in 2013, in spite of the limited proportion of households that possessed LLINs in terms of universal coverage (32 percent), a large proportion of households with LLINs did make use of them (72 percent). This can be explained by the implementation of communications activities financed by the Global Fund in the context of Round 9 grants.

Almost all pregnant women and people in charge of children had heard of malaria (99 percent). Despite this high percentage, however, only 49 percent of pregnant women and people in charge of children under the age of five recognized fever as the primary symptom of malaria for the group of children under the age of five. Finally, despite the availability of SP, IPT coverage remains very low. All of this shows that, in spite of the availability of commodities, it is important for beneficiaries to be adequately informed and agree to adopt positive behaviors, which will contribute to ensuring the sustainability of interventions to combat malaria.

The strategies and communications activities that will be implemented under this funding request will help to improve the situation. This will involve: i) developing an evidence-based communications strategy; ii) ensuring that key interventions and communications activities are implemented in parallel; iii) specifically targeting minorities and mobile groups; iv) adjusting messages, channels and media depending on the targets concerned; v) intensifying interpersonal communications during home visits; vi) mobilizing the private profit-making sector to secure their support in implementing communications activities.

- **Monitoring and evaluation**

This supporting intervention is essential for monitoring and evaluating program performance. The data collected and analyzed will be used to identify poor performance and its determining factors, and to propose corrective strategies for performance improvement. Routine monitoring activities will be supplemented with operational research work. Collecting, analyzing and disseminating reliable results will contribute to more effective sharing of program results.

Existing or newly designed tools will be reviewed, tested, approved, produced and disseminated; users will be trained in using them. Data collection will follow the national process; the emphasis will be on promptness and completeness so that the evaluation can be done in real time. Data will be meticulously archived to meet subsequent needs for studies, audits, etc.

- **PSM (Procurement and Supply Chain Management) aspects**

Activities to strengthen the supply chain are listed on page 25; their respective implementation levels are as follows:

- CENAME and CAPR level
- Deploy a network application for monitoring stocks in CAPRs (Regional Centers)

<p>for Pharmaceutical Supply)</p> <ul style="list-style-type: none"> <li>- Hold quarterly meetings of the Purchasing and Procurement Management Committees <ul style="list-style-type: none"> <li>• Healthcare facility level: <ul style="list-style-type: none"> <li>- Implement an instant transmission system for inventory data using SMS for Life messages with a website.</li> </ul> </li> </ul> </li> <li>- Train health assistants in inventory management</li> </ul>

### 3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is not applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

- a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.
- b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

#### ½ PAGE SUGGESTED

In accordance with the recommendations of the latest review of the program in 2013, and taking government priorities into account, case management and prevention will be a priority in the new NSP 2014-2018. Promotion of universal access to the package of intervention measures to control malaria, the protection for vulnerable groups and underprivileged populations (refugees, Bororo and Baka/Bakola) are the key elements in the strategic directions and guiding principles of the plan. There will therefore be an emphasis on the fairness in the access to high-quality care for all the population, including people in the most remote areas, with priority given to community-driven interventions with active participation by beneficiaries.

In budgetary terms, this results in the following:

**Table 9:** Breakdown of budget amounts by priority module

Modules	Allocated amount in euros	Percentage of budget
Vector control (Mass and routine distribution of LLINs)	33,793,327	54,5%
Specific prevention interventions (SMC and IPT)	5,070,796	8,2%
Case management (health care facilities and communities)	10,967,033	17,71%
<b>Total amount</b>	<b>49,831,156</b>	<b>80,4%</b>

The proportion of the budget submission for 2015-2017 reserved for target populations and high-impact interventions is 80,4 percent of the total budget.

## SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

### 4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

- a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).
- b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

- c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
- d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
- e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

## 1-2 PAGES SUGGESTED

- a. if applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s);**

The Cameroon CCM has opted for dual-track financing at the submission of the concept note for the Malaria component, with one Principal Recipient in the government sector and one Principal Recipient in the non-government sector.

An invitation call for proposals was launched and disseminated widely to select the project's Principal Recipients (annex no. 20). The CCM analyzed the submitted applications and carried out an evaluation of the organizational capacities of the shortlisted applicants; it then selected the best applicants to manage the grant as Principal Recipients (annex 20).

The CCM analyzed the submitted applications and carried out an evaluation of the organizational capacities of the shortlisted applicants; it then selected the best applicants to manage the grant as Principal Recipients (government sector: the Ministry of Health; non-government sector: PSI/ACMS). The application from PSI is routinely recorded in Cameroon (see MINATD order in the attached file). There is an organic link between PSI and ACMS, which is formalized in a cooperation agreement (see attached file). As a result, ACMS is an executing agency for implementing PSI activities in Cameroon.

- b. if more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients;**

In light of the inadequate coordination between the two Principal Recipients in Round 9, coordination meetings involving the two PR and their SRs will be organized every two months in accordance with the memorandum of understanding to be signed by the two PRs. The coordination committee will be chaired by the two PRs alternately.

The roles of the coordination committee will be to: i) validate the action plans developed by each PR; ii) update progress on implementing activities and the level of achievement of indicators; iii) identify obstacles/challenges and propose corrective solutions; iv) schedule and conduct joint supervision exercises.

Terms of reference will be developed and approved by the two PRs in this respect. All quarterly activity reports from the SRs, audit reports and annual reports will be validated by the coordination committee before being sent to the Global Fund via the CCM.

Monitoring of the SRs' program and financial activities will be guided by an administrative, financial and accounting procedures manual, in line with Global Fund guidelines.

- c. the type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified;**

The Country Coordinating Mechanism (CCM) will select the PRs and SRs following an invitation to call for proposals and evaluation of their organizational capacities. The breakdown of SRs and the packages of activities assigned to them will be based on a geographical breakdown (Zone 1: Adamawa, North and Far North; Zone 2: Center, South and East; Zone 3: North-West and West, Zone 4: Coastal and South-West) and their usual working area. The SRs will be selected following an analysis of their cost-effectiveness and will sign a contract focusing on their performance with the PRs over the lifetime of the project. Management costs will be split in proportion to the

package of activities assigned to each SR. These primarily community activities will be carried out throughout the duration of the project.

The fifth SR will be responsible for ongoing advocacy at all levels. Mass communications, social mobilization and development of partnerships with the private profit-making sector. This SR will draw up service provision contracts relating to the process of developing the communications strategy, producing and handling media, and broadcasting messages.

**d. how coordination will occur between each nominated PR and its respective sub-recipient(s);**

The PRs as the responsible bodies for the grant will use the following mechanisms to ensure good coordination and guarantee performance and transparency in relation to project management:

- Establish a detailed timetable for implementing activities: This will be based on the workplan and activities associated with each SR. It must be submitted to the PR by each SR.
- Coordination meetings: These will be organized monthly between each PR and its SRs.
- Field supervision visits: Each PR will organize quarterly supervision visits to ensure that action plans are being executed by the SRs in accordance with standards and planned time frames. These visits will be used to identify the problems faced by the SRs in implementing activities and propose corrective measures.
- Review and validation of SR quarterly reports: each PR will analyze the reports to ensure that the objectives assigned to the SRs have been achieved and feedback the information.
- Internal SR audits: These will be carried out annually and as required, by the PR.

**e. how representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.**

The Minister for Women and the Family, through the networks of women's groups covering the whole country, will cooperate closely on the implementation of the grant to reach the people who are the most vulnerable to malaria: pregnant women, children under the age of five and the Baka/Bakola. There will be active participation from CHWs, members of CSOs, members of the Health Committees and representatives of local authorities, which are all at risk of malaria. Furthermore, in light of the influx of refugees, the NMCP will work in close cooperation with the WHO, UNICEF and UNHCR to ensure that all the measures taken are in line with the national policy on malaria control.

## 4.2 Ensuring Implementation Efficiencies

**Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.**

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

### 1 PAGE SUGGESTED

This funding request under the new funding model will allow the continuation of high-impact activities (treatment of cases and routine distribution of LLINs) from Round 9, which is due to come to an end in December 2015. Furthermore, it is an opportunity to carry out the second mass LLIN distribution campaign, three years after the 2011 campaign, and finally, it will provide an

opportunity to seek funding for seasonal malaria chemoprevention in the North and Far North regions, which are vulnerable to upsurges in cases of malaria.

The CCM in Cameroon supervises grants for three programs, namely TB, HIV and AIDS and Malaria. In light of this, a meeting has been organized with the other two programs to discuss an integrated approach in the context of strengthening the health system. This will be manifested through coordination meetings at all levels, integrated supervision and an integrated package of activities implemented by CHWs. All programs will be involved in motivating CHWs.

#### 4.3 Minimum Standards for Principal Recipients and Program Delivery

**Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.**

<b>PR 1 Name</b>	MINISTRY OF PUBLIC HEALTH	<b>Sector</b>	
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		x <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Minimum Standards</b>		<b>CCM assessment</b>	
1. The Principal Recipient demonstrates effective management structures and planning		<i>The Principal Recipient has a Technical Secretariat, which coordinates projects financed by the Global Fund and has an internal auditor. The NMCP, which is responsible for the technical aspects of implementation, is coordinated by the Permanent Secretariat. At a central level, there is an Administration section, a Contracts section, a Monitoring and Evaluation section and a Management Control Unit. There are also 10 Regional Malaria Control Units, with accountants who are responsible for financial management and who report directly to the head of the Regional Malaria Control Unit. In addition, the NMCP has an Administrative and Accounting Procedures Manual, which sets out guidelines for managers.</i>	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		<i>The Secretariat of the Principal Recipient coordinates the activities of the NMCP and the sub-beneficiaries. The NMCP has the capacity to provide technical and financial supervision of the sub-beneficiaries through its Monitoring and Evaluation and Administration and Finance sections.</i>	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		<i>Within the NMCP there is a Management Control Unit, which monitors the eligibility and compliance of the operations and expenses in accordance with the Administrative, Financial and Accounting Procedures Manual. These duties are carried out by accountants at a regional level. The internal auditor within the Technical Secretariat conducts half-yearly audits at both a central and regional level.</i>	



4. The financial management system of the Principal Recipient is effective and accurate	<p>The Administration and Finance Unit has a head of the Administration and Finance section, a Chief Accountant and three accountants at a central level. Each of the 10 Regional Units has an accountant.</p> <p>Financial and accounting transactions are managed using the TOMPRO software.</p> <p>In addition, the Caisse Autonome d'Amortissement (CAA) is responsible for releasing funding and paying for services.</p>
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	<p>The Principal Recipient has a National Procurement Center for Essential Medicines and Consumables (CENAME), which supplies the 10 Regional Centers for Pharmaceutical Supply (CAPRs); these are responsible, in turn, for supplying health care facilities with medicines and medical consumables. The CENAME and the CAPRs work in accordance with best practices to ensure product security;</p>
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	<p>The CENAME and the CAPRs have access to logistical resources that enable them to ensure supplies of medicines.</p>
7. Data-collection capacity and tools are in place to monitor program performance	<p>The central monitoring and evaluation section has an expert in monitoring and evaluation and two statisticians, who monitor and evaluate indicators and are responsible for data consolidation. Each Regional Unit has a statistician, who compiles, enters, analyzes and sends reports to the Central Technical Group (GTC); district managers are trained in data collection and submission. The NMCP has collection tools that are made available at all levels.</p>
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	<p>Weekly coordination meetings are organized at a central level. At a regional level, however, information on malaria is shared at scheduled quarterly meetings. Meetings of the Roll Back Malaria committees are held twice a year and represent a further opportunity to share results with partners.</p>
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	<p>Yes. The CENAME and the CAPRs have the technical capacity to monitor products.</p>

#### 4.3 Minimum Standards for Principal Recipients and Program Delivery

**Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.**

<b>PR 2 Name</b>	<b>PSI/ACMS (Population Services International / Cameroon Association for Social Marketing) Cameroon</b>	<b>Sector</b>	<b>Non GOV.</b>
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>Minimum Standards</b>		<b>CCM assessment</b>	
1. The Principal Recipient demonstrates effective management structures and planning.		<i>PSI/ACMS is run by a Board of Directors, and at an executive level by an expatriate Executive Director who previously worked in technical assistance in PSI/Washington, plus three divisions, project coordinators and managers, an accounting and finance department, an internal auditor, an administrative department and a research function. At a regional level, PSI/ACMS has four regional offices: in Garoua for the North, in Douala for the coastal region and the South-West, in Bamenda for the North-West and West and in Yaoundé for the Center, South and East.</i>	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients).		<i>PSI/ACMS has worked with donors (USAID, KFW, CIDA, I i Solutions, etc.) for several years and complies with the management procedures issued by each donor. For partners on the ground at a regional level, with whom it has secondary contacts for implementing activities, each division of PSI/ACMS periodically supervises the sub-beneficiaries for which it is responsible, to ensure that activities are carried out in accordance with each donor's standards and procedures and the allotted time frames.</i>	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud.		<i>PSI/ACMS has an internal auditor who checks transactions on the platform on a daily basis to detect and prevent abuse and fraud. The auditor ensures compliance with standards and procedures in relation to the organization's administrative, accounting and financial management procedures and monitors the implementation of audit recommendations.</i>	
4. The financial management system of the Principal Recipient is effective and accurate.		<i>The PSI/ACMS financial system is coordinated by a financial controller. The financial controller is assisted by the financial coordinator, who is responsible for three accountants at a central level and four accountants at a regional level. Transactions are checked and entered into QuickBooks accounting software once they have been approved by the divisional heads, the</i>	

	<i>financial controller and the Executive Director. PSI/ACMS has access to budget monitoring tools. Each month's financial reports are sent to Cameroon and consolidated by PSI/Washington.</i>
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products.	<i>PSI/ACMS has a central warehouse in Yaoundé and subsidiary warehouses at each of the regional offices in Douala, Bamenda and Garoua, which have the necessary capacity and comply with good storage practices. These warehouses are supervised by a pharmacist, who monitors compliance with integrity, security and quality-control standards.</i>
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions.	<i>In previous years, PSI/ACMS has ensured efficient distribution of products (condoms, mosquito nets, medicines, etc.) in the country's ten regions and enters into subcontracting agreements with transport companies to ship products to its subsidiary offices.</i>
7. Data-collection capacity and tools are in place to monitor program performance.	<i>PSI/ACMS has set up a system to collect and analyze field data. In addition, the Research Unit regularly carries out research on relevant issues.</i>
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately.	<i>All regional PSI/ACMS offices are connected to the central office via a telephone network and internet connections so that they can communicate regularly and at appropriate times with teams in the field. Regular supervision visits also provide an opportunity to communicate. Field activities are consolidated each month using standard tools.</i>
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain.	<i>PSI/ACMS stores products in regional warehouses that are fully compliant with security and quality-assurance standards. PSI/ACMS ensures that all security standards are met when products are being transported.</i>

#### 4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

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

#### 1-2 PAGES SUGGESTED

The analysis carried out by the Portfolio Manager highlighted the risks requiring measures to mitigate them in this concept note and summarized in the following table:

**Table 10:** Risk analysis and mitigation measures

Current risks	Mitigation measures	Observations
<p>1. Vector control:  <i>How will routine distribution be strengthened? What optimization measures will be implemented to reduce the vulnerability of pregnant women and children under the age of five?</i>  <i>What is the country's strategy for achieving universal coverage during the mass distribution campaign in 2015?</i></p>	<p>Targeted, ongoing communication aimed at care providers, target groups and the general population</p> <p>The mass campaign will take place in three stages: A first stage covering three administrative regions (the Center, East and South regions), a second stage covering four administrative regions (Coastal, South-West, West and North-West) and a third stage covering three administrative regions (Adamawa, North and Far North)</p>	<p>- A planned exploratory behavioral survey will be used to develop specific messages to address bottlenecks aimed at service providers and beneficiary populations</p> <p>- This approach will ensure better mobilization of funds, better logistics management and better campaign coordination and supervision</p>
<p>2. IEC/BCC:  <i>What is the country's BCC/IEC strategy for increasing the use of LLINs amongst the general population and priority target groups (pregnant women and children under the age of five)?</i></p>	<p>Implementation of the behavioral change communications (BCC) strategy for primary targets, social mobilization and advocacy based on an integrated, continuous approach.</p>	<p>- A planned exploratory behavioral survey will be used to develop specific messages to address bottlenecks aimed at service providers and beneficiary populations</p> <p>- Amongst the BCC strategies that will be implemented, community health workers (CHWs) will make visits to households in remote rural areas. They will use these as opportunities to raise awareness of the importance of LLINs. Talks will be organized to strengthen</p>

			awareness-raising, along with mass-media communications through community radio stations
3. Community strategy: <i>What lessons have been learned from the implementation of the community component during Phase 2?</i> <i>What is the country's strategy for capacity-building amongst CHWs to enable them to contribute as effectively as possible to managing cases of malaria at a community level?</i>	<ul style="list-style-type: none"> <li>- Plan and budget for selection of CHWs, motivating them and coordinating their activities</li> <li>- Integrated training for CHWs on the package of activities to carry out (malaria, diarrhea and acute respiratory infection)</li> <li>- Regular, integrated supervision</li> <li>- Motivation integrated with other programs (NMCP, HIV and AIDS and Tuberculosis)</li> </ul>		We have taken account of the guidelines provided in the national document on community-driven interventions
4. Integration and possible connections with other interventions <i>What is the strategy for involving the private sector in controlling malaria (staff training, data collection, funding for prevention activities, etc.)? What activities for strengthening the Health System are planned? Must the Concept Note indicate clearly the proportion of the budget allocated to activities to strengthen the system? Who will provide funding for what and also ensure consistency with other programs financed by the Global Fund (TB/HIV)?</i>	Implementation of a participatory, inclusive approach based around the national Roll Back Malaria committee.		<p>The public sector will work with the paramilitary sector and the army as well as the private sector:</p> <ul style="list-style-type: none"> <li>- Non profit (NGOs, CSOs and religious organizations)</li> <li>- Profit (EXXON MOBIL/COTCO, mobile phone companies, etc.)</li> <li>- Equip the private sector with appropriate skills to implement malaria control activities in businesses and neighboring communities</li> </ul>
5. Quality of services <i>What interventions will be proposed to increase the quality of services offered to beneficiary populations?</i> <i>What does the country intend to do to apply national policy and national treatment protocols for malaria, including in relation to the private sector and at a community level?</i> <i>How will requirements for inputs to control malaria, and in particular ACT requirements, be covered and stock outs avoided?</i>	<ul style="list-style-type: none"> <li>• Targeted, ongoing communication aimed at care providers</li> <li>• Capacity-building for service providers and regular supervision</li> <li>• Existence of a regularly updated supply plan</li> <li>• Capacity building in relation to supply and inventory management</li> <li>• Weekly monitoring of inventory by SMS and emergency replenishment in the event of stock outs</li> </ul>		<ul style="list-style-type: none"> <li>• Inventory managers at all levels (region, health district and health care facility) will be targeted</li> <li>• The "SMS for Life" project will be continued</li> </ul>
6. Routine monitoring and surveillance <i>What measures will be taken to improve the National</i>	<ul style="list-style-type: none"> <li>• Contribution to the production of harmonized registers</li> <li>• Reimbursement of transport costs for people</li> </ul>		-Consultation meeting with other programs (TB and HIV) and the

<i>Health Information System and increase its capacity to anticipate events?</i>	responsible for data collection •Regular, integrated supervision of three programs	department responsible for the health information system - Continue transmission of epidemiological data by SMS (SMS for Life project)
7. Human resources <i>What efforts will be made to rationalize and/or integrate the human resources involved in combating diseases financed by the Global Fund?</i> <i>If “dual tracking” is used, the Concept Note must indicate clearly how cooperation will be improved to ensure that grants are really complementary.</i>	Integrated supervision of CHWs with costs shared between the three programs (Malaria, TB and HIV)  Implementation of a coordination, monitoring and evaluation mechanism between the two PRs.	A consultation meeting has already taken place with the three programs  Periodic meetings between the NMCP, PR1, PR2 and SRs.
8. Evaluation, studies and surveys <i>What evaluations, studies and surveys are planned to provide information for indicators and how could Global Fund financing contribute to it?</i>	•National malaria indicator survey in 2016 including measurement of parasitic prevalence •Therapeutic efficacy studies for anti-malarial treatments •Entomological surveillance studies (bio-efficacy of LLINs, evaluation of vector resistance to insecticides, study of malaria transmission)	Efficacy and entomological surveillance studies are planned but funding for the MIS in 2016 will need to be sought
9. New interventions More specifically, if seasonal malaria chemoprevention (SMC) is seen as an option to be implemented in respect of the Concept Note, what aspects will be taken into account at a strategic, programmatic and operational level to ensure a gradual scale-up? Pharmacovigilance is a particularly sensitive aspect that requires specific attention	SMC will be used in the North and Far North regions	The choice of regions is in line with WHO recommendations SMC includes pharmacovigilance
10. Technical assistance What technical assistance is needed over the next implementation period? More specifically, for the LLIN distribution campaign, what are the areas where technical assistance is necessary (micro-planning, logistics management, trust management, risk management, etc.)? What would the contribution from other partners and the Global Fund be in mobilizing technical assistance? The timing and quality of technical assistance must be clearly	Technical assistance has been identified for certain modules	This is detailed in the modular table

defined		

## CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

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

☐ Table 1: Financial Gap Analysis and Counterpart Financing Table

☐ Table 2: Programmatic Gap Table(s)

☐ Table 3: Modular Template

☐ Table 4: List of Abbreviations and Annexes

☐ CCM Eligibility Requirements

☐ CCM Endorsement of Concept Note