PROPOSAL FORM – ROUND 7

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

Applicant Name	**CCM**
Country/countries	**LAO PDR**
Components included in this Proposal Form *(Check each applicable box below)*	
☐ HIV/AIDS[1]	
☒ Tuberculosis[1]	
☒ Malaria	

Timetable: Round 7

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

Board consideration of recommended proposals: 14 - 16 November 2007

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

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PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS

REQUIRED ATTACHMENTS

A. **Targets and Indicators Table** *(Complete a separate table for each component)*

B. **Preliminary List of Pharmaceutical and other Health Products** *(Complete a separate table for each component)*

C. **Membership details of CCM, Sub-CCM or RCM** *(Complete once only)*

+ **Detailed Budget** *(Complete a separate detailed budget for each component)*

+ **Detailed Work plan** *(Complete a separate detailed workplan for each component)*

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

REFERENCE DOCUMENTS FOR APPLICANTS

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

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

How to use this form

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

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

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

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

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

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

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

Important notes:

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

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

How to use this form

WHAT IS DIFFERENT COMPARED TO ROUND 6?

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

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

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

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

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

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

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

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

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

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

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

Health Systems Strengthening – Round 7

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

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

1 Proposal Overview

1.1 General information on proposal

Applicant Type

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

☒ National Country Coordinating Mechanism

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

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

	Component	Title
☐	HIV/AIDS[2]	
☒	Tuberculosis[2]	Reducing the TB burden in Lao PDR Oct. 2008-Sept. 2013
☒	Malaria	Sustaining Malaria Control in Lao PDR, focusing on Malaria vulnerable population through multisectorial approach

Currency in which the Proposal is submitted

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

☒ US$

☐ Euro

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

1 Proposal Overview

Summary of Technical Assistance Provided During Proposal Preparation		
*Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation **of this proposal** for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.*		
Section/Component	**Name of organization or organizations providing assistance and type of assistance provided**	**Duration of technical assistance**
☐ Sections 1 to 3B		
☐ HIV/AIDS component, and/or budget		
☒ Tuberculosis component, and/or budget	Ministry of Health, Lao PDR, PR Office WHO, technical assistance	Four weeks
☒ Malaria component, and/or budget	Ministry of Health, Lao PDR, PR Office WHO, technical assistance	Three months

1.2 Proposal funding summary per component

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

Table 1.2 – Total funding summary

Component	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS						
Tuberculosis	**2,288,144**	**2,080,102**	**2,181,751**	**2,216,394**	**2,139,531**	**10,905,922**
Malaria	**4,253,254**	**2,805,636**	**6,588,214**	**5,972,424**	**6,045,811**	**25,665,341**
Total all components	**6,541,398**	**4,885,738**	**8,769,965**	**8,188,818**	**8,185,342**	**36,571,263**

1 Proposal Overview

1.3 Contact details for enquiries by the Global Fund

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

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	**Dr. Bounlay Phommasack**	**Dr. Chandavone Phoxay**
Title	**Deputy Director General of DOHP**	**Deputy Director, CCM Secretariat**
Organization	**Department of Hygiene and Preventive, MOH**	**Cabinet, MOH**
Mailing address	**Simeuang Rd., Vientiane Capital**	**Simeuang Rd., Vientiane Capital**
Telephone	**856-21- 242980**	**856-21-253017**
Fax	**856-21-242981**	**856-21-214003**
E-mail address	**onyvanh@theglobalfundlao.org**	**Chandavonep35@yahoo.com**
Alternate e-mail address		

1 Proposal Overview

1.4 Overview Summary of the Applicant's Proposal

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

This proposal of Lao PDR has two disease components i.e. Tuberculosis and Malaria. The goal of the TB component " Reducing the TB Burden in Lao PDR, October 2008-September 2013" is to decrease morbidity and mortality of tuberculosis and to contribute to reducing poverty and meeting the "Millennium Development Goals". There are 4 objectives set to achieve the goal o the TB component to include: (i) to sustain and optimize the quality of DOTS and go beyond 70/85 targets; (ii) to adapt DOTS to respond to MDR-TB and TB-HIV and other vulnerable groups; (iii) to ensure equitable access to quality TB care for all people with TB; and (iv) to strengthen the management capacity of the National TB Programme. Over a five year period, 20,000 TB patients will be treated to reduce mortality. Moreover, the young adult TB patients to be treated will contribute to increasing family income thus reducing poverty. The project will be able to reduce the transmission of TB by maintaining the case detection rate of sputum positive patients above 80% and treatment success rate not lower than 90%. In addition, the upgrading and rehabilitation of a number of health facilities will ensure that outputs and outcomes of this component will be achieved as well as contribute to the improvement of the overall health system.

The goal of the Malaria component "Maintenance of Malaria Control in Lao PDR, focusing on malaria vulnerable population through a multisectoral approach-July 2008-June 2013" is two-fold: (i) by 2012, to reduce malaria morbidity and mortality by 80%(baseline from 2006) and 90% of uncomplicated (Pf) confirmed cases correctly diagnosed and adequately treated with Artemisinin-combination Therapy (ACT) among the population at risk; and (ii) to maintain 80% or more the coverage of protection from malaria for the population at risk through ITNs/LLNs. This component has 4 objectives: (i) to improve access to early diagnosis and appropriate treatment for population at risk; (ii) to improve access to good vector control measures and improve malaria prevention practices among population at risk; (iii) establish innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved; and (iv) strengthen the management of the National Malaria Control Program at all levels nationwide. This malaria project will continue to maintain and sustain the achievements made in the previous rounds (1 & 4). At the same time, it will focus on quality assurance issues, anti-malarial drug resistance and insecticide resistance monitoring.

The Ministry of Health will be the Principal Recipient while the National TB Centre (NTC) and the National Centre of Malariology, Parasitology and Entomology (CMPE) will be the sub-recipients respectively of the two components. Both SRs will be working with a number of partners coming from other government agencies and the NGOs.

1 Proposal Overview

1.5 Overview of rationale for multi-country proposal approach

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

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

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

In this section, please describe:

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

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

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

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

Overview of rationale for multi-country approach *(maximum one page)*

1 Proposal Overview

1.6 Previous Global Fund grants/proposals recommended for funding

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

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

Table 1.6.1 – Previous Global Fund HIV/AIDS financial support

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

Table 1.6.2 – Previous Global Fund tuberculosis financial support

Tuberculosis	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2	USD 2,627,203	USD 2,111,311.75	
Round 3			
Round 4	USD 952,931	USD 552,638.80	
Round 5			
Round 6			
Total	USD 3,580,134	USD 2,663,950.55	

1 Proposal Overview

Table 1.6.3 – Previous Global Fund malaria financial support

Malaria	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	USD 10,577,673	9,371,152	
Round 2			
Round 3			
Round 4	USD 3,279,191	2,441,780	
Round 5			
Round 6			
Total	USD 13,856,864	11,812,932	

Table 1.6.4 – Previous Global Fund HSS and other financial support

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

2 Country Eligibility

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

These eligibility criteria are:

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

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

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

2.1 Income Level

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

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

2 Country Eligibility

2.2 Counterpart financing and greater reliance on domestic resources

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

2.2.1 CCM and Sub-CCM Applicants

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

Important notes:

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

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

Table 2.2.1(a) – Counterpart financing HIV/AIDS

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

2 Country Eligibility

Table 2.2.1(b) – Counterpart financing tuberculosis

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

Table 2.2.1(c) – Counterpart financing malaria

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

2 Country Eligibility

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

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

RCM and RO Applicants may either:

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

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

OR

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

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

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

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

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

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

2 Country Eligibility

2.3 Focus on poor or vulnerable populations

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

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

2.4 Upper-middle income high disease burden minimum thresholds

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

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

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

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

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

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

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

3A Applicant Type and Eligibility for Funding

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

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

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

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

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

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

Confirmation of Applicant Type

Table 3A – Applicant Type

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

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

Importantly ➔

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

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

3A Applicant Type and Eligibility for Funding

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

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

Table 3A.1 – National CCM: overview information

Name of CCM
Country Coordinating Mechanism of Lao PDR

3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

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

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

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

The composition and activities of the CCM reflect the functional partnership that exists between government and other key stakeholders in Lao PDR. The CCM members represent the line ministries of government, civil societies, mass organizations, international nongovernmental organizations, bilateral and multilateral donors, and UN agencies. Furthermore, the membership of the CCM Oversight Committee is also multisectoral. A representative of the Lao Network of People Living with HIV & AIDS is a member of the CCM and at the same time regularly attends the health coordination meetings organized by INGOs who are also members of the CCM. Regular and adhoc CCM and oversight committee meetings are organized for updates and taking stock of the progress of the GFATM projects.

The mandate of the CCM as detailed in the TOR is to discuss, approve and submit viable and appropriate proposals to the Global Fund, and to monitor, evaluate and support the implementation of projects that are initiated by the CCM and financed by the Global Fund and to enhance the cooperation and the coordination among partners and implementers of the GFATM projects.

Decision-making in the CCM is done through the voting process and/or consensus after discussion of an issue. For example, the decision to submit only two components to Round 7 was arrived at after a discussion of the progress of the on-going GF assisted projects. Majority of the members are in attendance in most of the meetings.

In Lao PDR, aid coordination at the macro level rests with the Department of International Cooperation of the Ministry of Foreign Affairs and the Committee for Planning and Investment. The Round Table is a key coordinating mechanism at the ministerial level in the country. To underscore the relationship between CCM and these other national structures, the Chair and the co-chair of Lao PDR CCM are representatives of these two agencies/constituencies. At present the Chair of the CCM is also the Chair of the Round Table.

In addition, donors and INGO members of the CCM are also sitting in the donor coordination group on Health and HIV&AIDS. These donor coordination mechanisms initiated before the advent of the Global

3A Applicant Type and Eligibility for Funding

Fund include a donor coordination group at the policy level, a technical working group at the operational level in the Ministry of Health and various sub-sectoral groups that meet regularly.

The CCM, CCM Oversight Committee and the CCM secretariat is represented in the Steering Committee of the Ministry of Health, a body that is responsible for all the financial and programmatic inputs into the national health programs. This representation ensures that CCM members have access to financial and programmatic information that results to avoidance of duplication of efforts and funding. During the regular meetings of the Steering Committee, CCM Secretariat shares the updates about Global Fund projects and at the same time, CCM secretariat shares with the CCM the information gathered from the Steering Committee meetings. (CCM Annex 1: TOR CCM)

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

3A Applicant Type and Eligibility for Funding

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

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

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

Name of Sub-CCM

3A.2.1 Mode of operation

Describe how the Sub-CCM operates. In particular:

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

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

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

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

3A.2.2 Rationale

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

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

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

3A Applicant Type and Eligibility for Funding

3A.3 Regional Coordinating Mechanism Applicants

(includes small island developing states without national CCMs)

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

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

Name of Regional Coordinating Mechanism (RCM)
RCM Secretariat Office Address

3A.3.1 Mode of operation

Describe how the RCM operates. In particular:

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

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

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

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

3A.3.2 Rationale

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

3A Applicant Type and Eligibility for Funding

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

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

3A Applicant Type and Eligibility for Funding

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

IMPORTANT NOTE FOR APPLICANTS:

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

For additional information regarding these requirements, see:

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

3A.4.1 Round 6 Application History

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

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

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

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

On 11 May 2006 the INGO meeting agreed on 4 selected representatives (Population Services International, Burnet (PSI), Damien Foundation and Medecin Sans Frontier (MSF)) (as attached document in the 1 clarification).

On 27 July 2006 The INGO Liaison Officer informed to other members via email about a new development with regards to Institut Francais de Medecine Tropical (IFMT) who wished to remain on the CCM as part of NGO constituency and Damien Foundation had willingness to withdraw from the CCM as they did not currently have the personnel to carry out their CCM duties satisfactorily (See Annex INGO Selection Clarification (email of INGO on 27 July 2007).

Following an open and fair procedure the CCM constituency, the INGO Liaison Officer sent a letter of nomination the 4 selected organizations to present them on the CCM, dated 22 February 2007 (as attached document in the 1 clarification)

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For PSI/Laos the person who is the CCM member is the Country Director. As actually, PSI/Laos doesn't have the Country director, then the acting country director, Mr. Sythong NOUANSENGSY is assigned to represent PSI/Laos at the CCM.

Lastly, **new CCM members from line ministries, from NGO and others was approved during the 13 March 2007 Meeting of the CCM.**

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

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

3A.4.3 Principle of broad and inclusive membership

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

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

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

	Documentation relied on to support compliance with Requirement 1	**Identify which annex to this proposal contains these documents** *Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.*
☐	Selection criteria for each sector developed by each respective sector	
☐	Minutes of meeting(s) at which the sector transparently determined its representative	The INGO Health Working Group Minutes from the May 11, 2006 Meeting (was attached)
☐	Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	TOR and selection procedure for the 'International NGO' constituency of the GFATM CCM in Lao PDR -Agreed at the INGO Health Working Group Meeting 23rd March 2006 (is attached)
☐	Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	INGO Health Working Group letter to the CCM dated February 22, 2007(was attached) INGO Selection Clarification (email of INGO on 27 July 2007 (is attached)
☐	Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM.	
☐	Other: *(please specify):*	

3A Applicant Type and Eligibility for Funding

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

Following an open and fair procedure and based on the TOR and selection procedure for the 'International NGO' constituency of the GFATM CCM in Lao PDR which greed at the INGO Health Working Group Meeting 23rd March 2006, then the 4 selected organizations from NGO and Academic Institut have presented on the CCM.

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

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

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

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

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

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

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

Process to solicit submissions for possible integration into the proposal was undertaken through several activities. It started with the endorsement of the CCM to submit a proposal to Round 7 given during the 13 March 2007 meeting. This was followed by several brainstorming meetings with different stakeholders organized by the CCM Secretariat and chaired by the Vice Minister of Health. These meetings identified the gaps in the existing projects of the three disease components. A coordination meeting with the National Centres for HIV & AIDS, TB and Malaria by the CCM was also organized to define the key areas for the proposal. These key areas were then submitted for endorsement and approval of the CCM in a joint meeting. A call for Expression of Interest was published for several days in Lao and English newspapers.

(CCM Annex 3: Newspaper Ads to solicit submission of EOI)

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

The process to review the submissions received for possible integration into the proposal was started by the initial review done by the Oversight Committee. There were eight (8) EOIs received from Lao

Red Cross, Promotion Education Development Association (PEDA), Lao Youth for AIDS Prevention (LYAP), CMPE, CHAS, NTC, Cabinet Office and Department of Planning and Budgeting of the Ministry of Health. A joint meeting of the CCM, Oversight Committee, other stakeholders, the National Centres was organized for the final review of the EOIs. It was also in this meeting that a decision to limit the Round 7 proposal to two components was arrived at.

(CCM Annex 4: Minutes of the Joint Meeting to review EOIs)

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

The CCM nominated the current Principal Recipient, a unit in the Ministry of Health, Department of Hygiene and Prevention, to be the PR for Round 7 proposal during the 2nd July meeting. This meeting was organized for the final approval of the R7 proposal. This decision was arrived at because of the following reasons: (i) the current PR Office has gained much experience in terms of working with the GF structures and mechanisms, thus is the most capable body to act as the PR; and (ii) the Round 7 proposal is supplementary to the on-going Global Fund projects thus the current PR was chosen for purposes of continuity and efficiency. The current PR Office's staff are all serving full time to the project activities.

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

The Oversight Committee (OC) of the CCM is the one responsible to oversee/review program implementation during the proposal term. As in the current set-up, semi-annual reports (technical and financial) are submitted by the PR Office to the CCM secretariat and are reviewed by the Oversight Committee. The oversight activity reports (findings, analysis and recommendations) are then submitted by the OC to the CCM Sec who in turn prepares the documents for the CCM meetings. All recommendations need endorsement by the CCM. As mentioned above, the Oversight Committee is made up of a number of technical members of the CCM
(government, INGO, UN agencies).

(OC functions see Annex 1)

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

The inputs of a broad range of stakeholders both CCM and non-CCM members were generated in the different stages of the proposal development.

In the identification of needs and gaps of the three diseases, stakeholders (non-CCM members) at different levels were involved (national down to the district levels). A number of stakeholders from Lao PDR attended a workshop organized by the AAAH to facilitate development of the proposal for Round 7. Inputs from the participants were also considered in the development of the country's R7 proposal.

The EOIs were submitted by both government and NGOs and these EOIs were reviewed by the multisectoral OC. In the development of the two components, technical people from government, NGOs and training institutions were involved. To cite a few of these stakeholders are: Sciences Association for Development Programmes, Health Unlimited, Institute Francophone Medicin Tropical; National Institute for Public Health, Sans Frontiere Entr' Aide, LYAP, PEDA, Lao's Front for Construction Union, Lao Women's Union, and Lao Youth Union. Groups that submitted EOIs for HIV &AIDS component continued to work with the TB and Malaria working groups.

Technical assistance to the two components was provided by WHO and AAAH. Selection of possible partners/SSR for TB and Malaria was also discussed with the OC.

3A Applicant Type and Eligibility for Funding

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

3A.4.6 Principle of effective management of actual and potential conflicts of interest	
Requirement 6 ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No
If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.	

3A.4.7 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM operations? *Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.*	☒ Yes *provide details below* ☐ No *go to section 3B.1*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.**	
The CCM is involved in several functions and therefore requires a CCM Secretariat and Office that facilitates the implementation of these functions. Thus an amount of USD 222,566 is needed for a period of five years. The budget will be utilized for the following: (i) salaries; (ii) office administration; (iii) coordinating mechanisms meeting cost; (iv) communication and information dissemination costs; (v) facilitation costs; and (vi) translation costs.	

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

3A Applicant Type and Eligibility for Funding

3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

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

Table 3A.5 – Regional Organization: overview information

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

3A.5.1 Mode of operation

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

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

Describe below how the Regional Organization operates. In particular:

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

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

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

3A Applicant Type and Eligibility for Funding

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

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

3A Applicant Type and Eligibility for Funding

3A.6 Non-CCM Applicants

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

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

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

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

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

Indicate the sector represented (check appropriate box):

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

3A Applicant Type and Eligibility for Funding

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

(a) *Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following:*

(i) Countries without legitimate governments;

(ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or

(iii) Countries that suppress, or have not established partnerships with civil society and NGOs.

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

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

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

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

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

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

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

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

3A.6.3 Consistency with national policies

Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy).
(Maximum of one page. Provide evidence [e.g., letters of support] from relevant national authorities in an annex to the proposal.)

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

3B Proposal Endorsement

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

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

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

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

3B.1.1 Leadership of the Coordinating Mechanism

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

	Chair	Vice Chair
Name	Dr. Bountheuang MOUNLASY PhD	Mr. Bounsamak XAYASENG Vice Chair of the CCM
Title	Director General	Deputy Director General ,
Organization	Department of International Cooperation, Ministry of Foreign Affairs	Department of Planning, Committee for Planning and Investment
Mailing address	Depart International Cooperation Ministry of Foreign Affairs, Vientiane Lao PDR	Department of Planning, Committee for Planning and Investment, Vientiane Lao
Telephone	856 21 416500	856 21 216 665
Fax	856 21 416067	856 21 216 752
E-mail address	mounlasy@yahoo.com	
Alternate e-mail address		

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

3B Proposal Endorsement

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

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

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of CCM, Sub-CCM or RCM	
The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**. *Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.* ***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal**.*	
Sector Representation	**Number of members representing the sector**
☒ Academic/educational sector	1
☒ Government	8
☒ Non-Government Organizations (NGOs)/community-based organizations	3
☒ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria	1
☒ Private sector	1
☒ Religious/faith-based organizations	1
☒ Multilateral and bilateral development partners in country	4
☒ Other *(please specify):* - Mass organization and civil society - United agencies	5 5
Total Number of Members	29

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

3B Proposal Endorsement

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

Level 1 Endorsement

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

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

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

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

Level 2 Endorsement – Sub-CCM and RCM Applicants only

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

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

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

Level 2 endorsement of Sub-CCM or RCM proposal by National CCMs

List below each of the national CCMs that have agreed to this proposal and ***provide documented evidence of this endorsement, including copies of the CCM meetings at which the Sub-CCM or RCM proposal was discussed and endorsed****. For Sub-CCM proposals which only cover one part of a country, only that country should be listed.*

Country	Date of CCM Endorsement	Annex number to this proposal

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

3B Proposal Endorsement

3B.2 Regional Organization proposal endorsement

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

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

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

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

Country	Date of CCM Endorsement	Annex number to this proposal

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

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

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

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Title of the Document** and **annex number given to each annex**
Section 3A: Applicant Type and Eligibility for Funding		
Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):		
3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM)	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors).	CCM Annex 1: TOR of CCM
Documentation describing compliance with the minimum Coordinating Mechanism requirements (sections 3A.4.3 to 3A.4.6 inclusive):		
Minimum Requirement 1	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	INGO letter, Minute of INGO Meeting , Annex 2
Minimum Requirement 3(a)	- solicit submissions for possible integration into the proposal.	CCM Annex 3: Newspaper Ads to solicit submission of EOI and , Minute of CCM Meeting 13 March 2007-06-24
Minimum Requirement 3(b)	- review submissions for possible integration into the proposal.	CCM Annex 4: Minutes of the Joint Meeting to review EOIs
Minimum Requirement 4(a) and 4(b)	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation.	CCM Annex 5 : Minute of CCM meeting on endorsement R7 proposal and PR selection
Minimum Requirement 5(a) and 5(b)	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	
3A.4.6 – Minimum	Documented procedures for the management of potential Conflicts of Interest between the Principal	

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

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

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

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

4 Component Section *Malaria*

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

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

4.1 Requested proposal term for this disease component

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

Important note:

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

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	July 2008	June 2013

4.2 Disease specific component executive summary

4.2.1 Executive summary

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

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

Existing and/or new needs, goals, objectives. With the support of GFATM through Round 1 and 4, the annual incidence of uncomplicated malaria (probable and confirmed) per 1000 population fell from 9.1 (2001) to 4.3 (2006). The annual parasite incidence per 1000 population also declined from 5.2 (2001) to 3.1 (2006). The number of malaria deaths in hospitals reduced drastically from 187 (2003) to 77 (2006). The number of cases in 2006 when compared to 2005, reduced by 42% in 8 provinces. Despite these impressive reductions in malaria burden, there remained 9 provinces in the year 2006 that showed increases ranging from marginal increases (6 provinces, cumulative increase of 6% from year 2005) to drastic increase (3 provinces, a cumulative increase of 207% from year 2005, Although many reasons could be postulated for the increases, including the scale up and expansion of early diagnosis and treatment (EDAT) through RDTs and ACTs to villages, to better reporting from peripheral sites, other preliminary findings from supervision/monitoring, surveys suggest that:

1. acceptance and compliance of communities to bed nets, bed net coverage per person per household, bed net availability and use among forest goers and mobile populations, vulnerable or high risk populations especially very remote and ethnic populations have to be addressed.
2. Active transmission which is still occurring in remote forested foci and human migration from these endemic foci to non-transmission areas can reintroduce the disease in areas now free of malaria especially among the migrating population from highlands, 47 classified poor districts socio-economic development zones,

3. Significant large scale development projects, ie hydro dams, plantations (cashew nut trees, rubber trees, cassava and rice etc) involve among others, significant land clearing and movement of populations from endemic to non-endemic areas and vice versa. The influx of foreign workers in these plantations would also harbor the risk of introducing resistant strains of parasite. The control of these foci will be essential to obtain a sustained reduction of malaria in the country.

This proposal attempts to address 4 vital objectives with the following target groups/beneficiaries:

Objective 1: Improve access to early diagnosis and appropriate treatment for malaria for population at risk [maintaining 80% coverage of all villages in the designated 47 poorest districts + maintaining EDAT coverage achieved in all other risk areas. While it is expected that over the next 5 years of this proposal term ending 2012, further reductions from the current achievement in malaria rates will be marginal, it is estimated that the population at risk would be approximately reduced to 70% (2.4 million) from the 2001 baseline (3.6 million). Remapping and restratification exercise planned in years 1, 3 and 5 would be vital in determining population at risk and the channeling of resources.

Objective 2 : Improve access to good vector control measures and improve malaria prevention practices among population at risk [maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage with ITN/LLNs . By mid 2008, the population at risk (3.6 million, estimated in 2002) would have been provided with bed nets. This proposal will seek to maintain achievements made in the last 5 years while attempting to remap, restratify and channel resources for malaria control for the next 5 years ahead. The R4Y4-Y5 budget will see existing conventional bed nets re-treated while the gradual replacement with LLNs takes place over 5 years. The NMCPs technical oversight will be to ensure adequate coverage of nets in the high risk areas (at least 100% of targeted village) as well as adequate coverage of the population per village (adequate coverage = at least 1 net for 2.5 persons, and additional nets for mobile/forest goers (at least 80% per village). There are a total of 3,468 villages in the 47 designated poorest districts (target population: 1,274,646) and among the other 67 districts (114-47=67), there are 31 districts with 2,428 villages (target population: 1,199,393) that show a high and/or increasing trend of malaria burden. It is these villages that priority will be given to ensure at least 80% coverage of the population per village. This will coincide with the restratification of at risk villages in year 1, 3 and 5 of the proposal and the distribution of LLNs yearly.

Objective 3 : Establish innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved. The Lao PDR Sixth National Socio Economic Development Plan (2006-2010) and National Growth and Poverty Eradication Strategy (2003) highlights the 47 designated poorest districts that represent 1..26 million of the country's population, covering 2,935 villages and 111,850 poor households (55.4% of total poor households in country and contributing 53% of the total number of malaria cases in 2006). In addressing these gaps among ethnic populations, the NMCP proposes through this proposal to adopt in an intensive advocacy, communication and social mobilization project, involving 5 provinces in a total of 782 villages (over the 5 year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant reaching an estimated 15 major ethnic groups with an approximate population of 260,000. This specific objective will engage, as the main implementing agents, both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE etc) and other local Lao civil associations(PEDA , SADP etc) as well as vital coordination roles of civil societies (Lao Womens Union, Lao Youth Organisation) and including them in all phases of scaled-up malaria control efforts in these ethnic populations. At the end of the proposal term, policy recommendations for scaling-up malaria control plans for poor EMGs will be made available and Lao would host regional (GMS) meeting for info sharing on lessons learnt and best practices and provide forum for partner networking

Objective 4: Strengthen and improve management of the National Malaria Control Programme at all levels nationwide. While continuing with operational activities as per previous Rounds 1 and 4, the salient areas of this proposal will be emphasizing the

quality of implementation and quality assurance issues, as evidenced by 2012 that all monitoring and supervision visits are carried out as planned, antimalarial drug resistance and insecticide resistance data is available form all sentinel sites every year/2 years, quality assurance of commodities ie-RDTs and ACTs, will be part of on-going monitoring plans along with regional microscopy sites for ensuring slide. This proposal will see the a vital and important activity in the formation of a Technical working Group (TWG) for malaria will be a vital and important step in the NMCPs *National Master Plan for Malaria Control (2006-2010).* For Phase 1 (Y1-2) emphasis on supporting the implementation of 3 predefined objectives :

(1) MOH Policy and guidelines on engaging private sector development projects (hydro dam, plantations, mining etc)

(2) Enhancing the role of the National Central Monitoring Unit (CMPE, FDD. Curative, MPSC) on drug (fake/sub-standard quality drugs, procurement of antimalarials through drug revolving funds) and treatment (compliance to STGs, use of RDTs etc) related issues through Regular/ad hoc monitoring and enforcement

(3) Establishing regional malaria surveillance sites for effective coordination, detection and response to outbreaks

(4) Establishing an incentive system for malaria VHWs

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4.3 National program context for this component

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

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

☐ National Health Sector Development/Strategic Plan

☒ National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings**

1. National Malaria Control Policy (1999)
2. National Malaria Strategic Plan (2006-2010)

☐ Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)

☒ Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal**

1. National Malaria Control Policy (1999)
2. National Malaria Strategic Plan (2006-2010)
3. SEAMO TropMed External Evaluation (2006)
4. Evaluation of EDAT (Early Diagnosis and Treatment) with MRDT (Malaria Rapid Diagnostic Test) and ACT (Artemisinin Combination Therapy) / Artesunate in 3 pilot provinces + 3 selected scaled up provinces in Lao PDR (1st draft)
5. WHO/ADB Ethnic minority project report
6. Lao Mekong RBM IEC project, Nov 2002 - August 2003 funded by WHO/ADB *(hard copy only)*
7. Malaria Vectors in the Mekong Countries: a Complex Interaction between Vectors, Environment and Human Behaviour (Publication)
8. National Malaria Monitoring and Evaluation Assessment Plan and Indicators
9. National Socio-Economic Development Plan (2006-2010) *(hard copy only)*
10. National Growth and Poverty Eradication Strategy (2003).

☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)

National Malaria Monitoring and Evaluation Assessment Plan and Indicators

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

4.3.2 Epidemiological and disease-specific background

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

Table 4.3.2 – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	5.62 million	2005	National Population Census 2005
(ii) **Current estimates on the stage of the disease in the following population groups**:			
Population at risk for malaria *(all ages)*	3.6 million	2001	National Malaria Control Programme
Pregnant women at risk of malaria	29,608	2006	MOH
Children under 5 at risk of malaria	206,419	2006	MOH
Estimated malaria episodes per year	17,283 (confirmed malaria)	2006	National Malaria Control Programme 2007
Reported malaria episodes per year	24,253 (probable and confirmed malaria)	2006	National Malaria Control Programme 2007
Malaria deaths per year *(all ages)*	21	2006	National Malaria Control Programme 2007
Under 5 child mortality (per 1000)	97.6	2005	National Population Census 2005
Number of bed nets in country	1,438,634 (150,000LLN + 1,288,634 ITN)	2007 (march)	National Malaria Control Programme 2007

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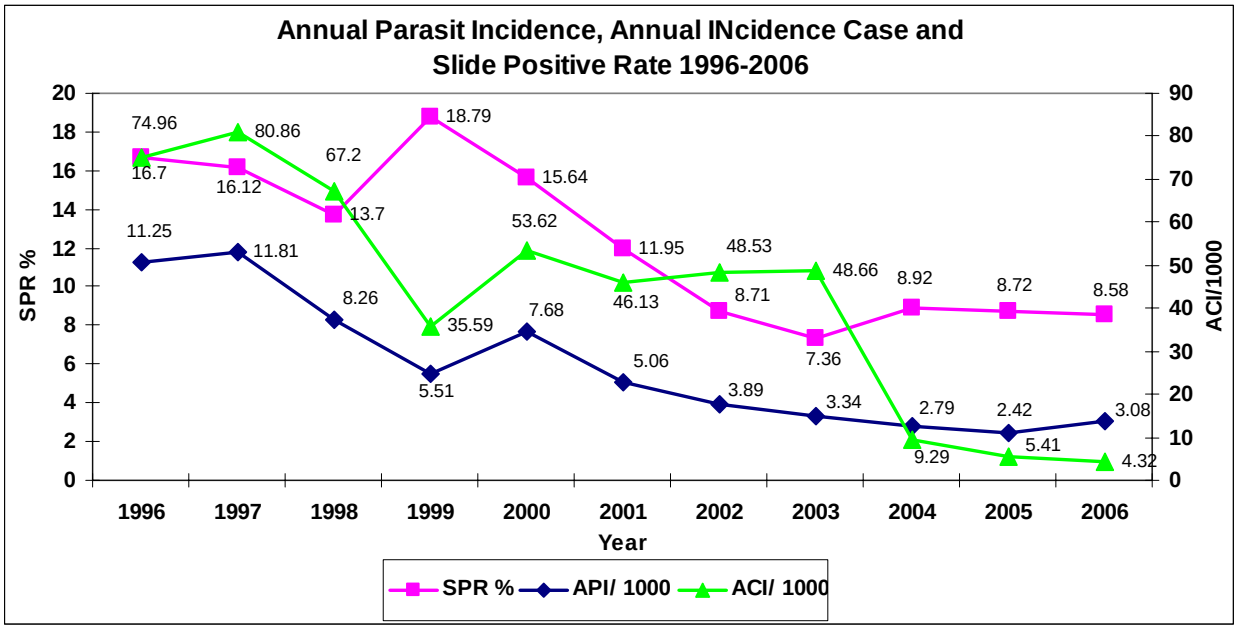
Population	Estimated number	Year of estimate	Source of estimate
Proportion of children under 5 protected by bed nets	28% (data verification in progress)	2006	MICS
Other: *(identify)*			

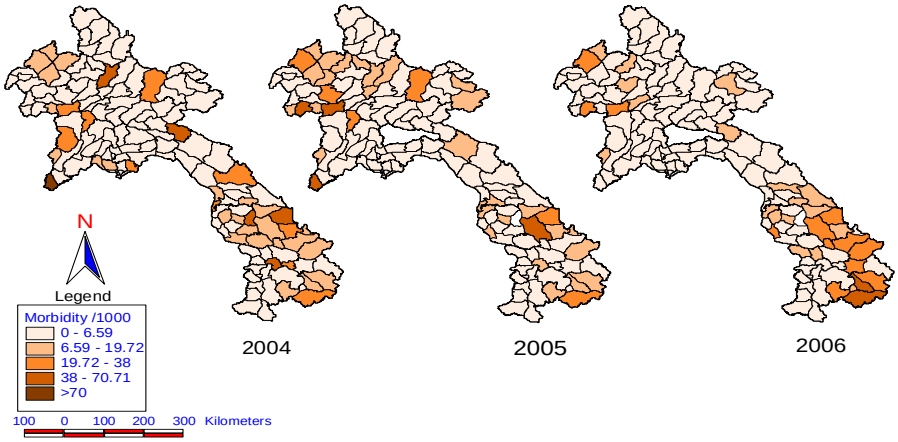
(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons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



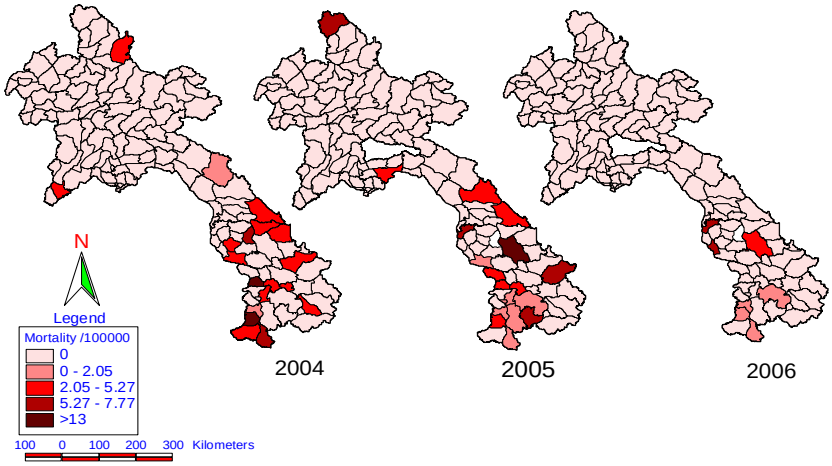
The graphs above and maps below geographically by district, summarizes the changes in malaria transmission in the last 3 years (2004-2006). The burden of disease mobidity and mortality has declined tremendously in most of the districts in the northern provinces. However, in the southern provinces there remained 9 provinces in the year 2006 that showed increases. Although many reasons could be postulated for the increases, including the scale up and expansion of early diagnosis and treatment (EDAT) through RDTs and ACTs to villages, to better reporting from peripheral sites, other observations suggest that acceptance and compliance of communities to bed nets, bed net coverage per person per household, bed net availability and use among forest goers and mobile populations, very remote and ethnic populations have to be addressed. Active transmission which is still occurring in remote forested foci and human migration from these endemic foci to non-transmission areas can reintroduce the disease in areas now free of malaria especially among the migrating population from

highlands, 47 classified poor districts socio-economic development zones. Predominantly in the south, significant large scale development projects, ie hydro dams, plantations (cashew nut trees, rubber trees, cassava and rice etc) involve among others, significant land clearing and movement of populations from endemic to non-endemic areas and vice versa. The influx of foreign workers in these plantations would also harbor the risk of introducing resistant strains of parasite. The control of these foci will be essential to obtain a sustained reduction of malaria in the country.

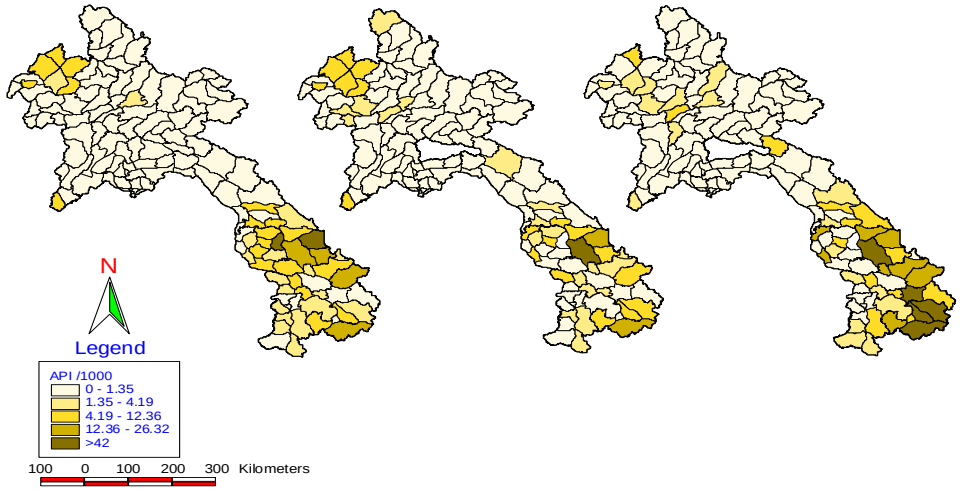
Morbidity rate 2004 - 2006



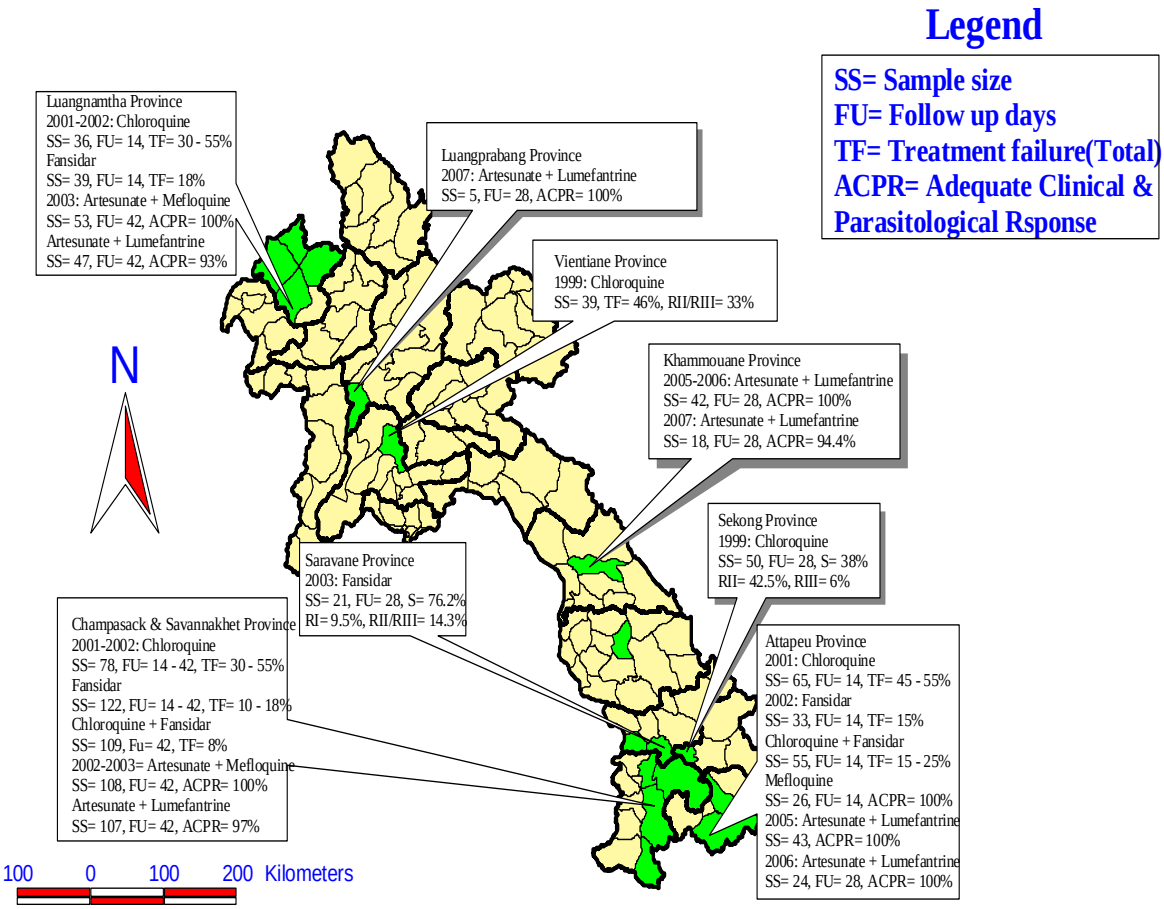
Mortality rate 2004 - 2006



Annual Parasite Incidence rate 2004 - 2006



Trend of anti - malarial drug resistance in the last 5 years



4.3.3 Disease-prevention and control initiatives and broader development frameworks

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

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

GFATM has been the sole donor for Lao's malaria control programme since 2003. Through Rounds 1, commencing 2003 (LAO-102-G02-M-00) and Round 4 in 2005 (LAO-405-G05-M), Prevention and Control of Malaria in Lao PDR has seen impressive gains.

1. Strengthening and scaling up of Bed net activities

National Master Plan of Malaria Control from 2006 -2010 for malaria vector control outline the following relevant areas:

- to ensure an ITN coverage of at least 80% of the population at risk at the same time to make the ITN activities sustainable especially the remote malaria at risk areas.
- To provide nets, insecticides and dipping sets for the population
- To ensure that 50% of the villages in each district finish the ITN before april.

During the first year of Round 1 (May 2003 to April 2004), the NMCP strategy set a target of ITN coverage of 2.2 millions of people already protected. A total of 80,000 bed nets and 18,500 liters of insecticide were procured. By the end of 2004, the NMCP has been able to scale up the number of people protected by ITN to 2.05 millions with the use of the revolving funds to support operational cost at provincial level. National planning workshops were organized on a yearly basis before the rainy seasons for a better coordination of ITN activities, using the revised stratification of the population at risk and a standardized model of calculation for ITN coverage. Following this, the NMCP procured 259,600 bed nets and 30,000 liters of deltamethrin; a total of 2,745,913 persons (76.3%) were protected by ITN by the end of 2005. The NMCP procured 470,000 bed nets in Year 3 (not including procurement from Round IV: 50,000 bed nets + 150,000 LLNs), 39,750 liters of deltamethrin, 1,942 sets of dipping material were delivered to target villages and budgets were transferred to all provinces to carry out malaria control activities. ITN campaigns are now on-going and the results will be available by the end of 2006.

During the first year of Round 4, (July 2005 to June 2006), the NMCP strategy focused on the maintenance of 2.2 millions of people already protected. The NMCP additionally procured 150,000 Long Lasting nets (LLNs) (Olyset net 75,000 and Permanet 75,000, which were focused to remote

villages in 4 provinces of Lounangnamtha, Houaphan, Vientiane and Savannakhet) and 50,000 conventional nets. By the end of 2006, the NMCP has been able to scale up the number of people protected by ITN to 2,393,515 and an addtional 326,766 pop. protected by LLNs (2,720,281 persons) with the use of the Project grant budget to support operational cost at provincial level. National planning workshops were organized on a yearly basis before the rainy seasons for a better coordination of ITN activities, using the revised stratification of the population at risk and a standardized model of calculation for ITN coverage.

To mobilize the community in ITN and treatment seeking behaviour, IEC tools were designed, developed, field tested, printed and distributed to all target sites. These comprise of Posters, Brochures, T-Shirt, CD, VCD, Flip chart, Games card, Radio and TV spots etc.. Some of IEC tools, such as CD, VCD, Radio and TV spots are translated into 3 minority ethnic languages.

Outcomes of Bed net activities:

Indicators	Baseline	Year 1		Year 2		Year 3	
	2001	Targets	Results	Targets	Results	Targets	Results
Round 1 indicators							
Number of bed nets distributed	136,523	180,000	344,100	513,333	524,100	764,000	950,977
Number of bed nets treated and re-treated	400,000	500,000	899,425	733,333	819,707	912,000	974,753
No. of persons protected by IBN	1.2 million	1.5 million	2.2 million	2.2 million	2.05 million	2.6 million	2,370,913

Round 4 indicators	Baseline 2003	Year 1Target	Year 1Results
Number of LLN distributed to populations in remote areas (malaria risk zone 3)	5000	150,000	144,574
Number of persons at risk of malaria in remote areas who use LLN	12,500	375,000	326,766
Number of participants trained at each level on LLN (district, provincial staff and village volunteers)	15(district & 4provinces)	3,047	3,163
Number of villages mobilized for the use of LLN	50	1,520	1,485

The Round 1 year 4 procurements of 320,000 coventional nets have just been distributed and population covered will be known by end of 2007. The year 5 procurements of 288,900 conventional nets will have ensured that by and by the end of 2008 (end of Round 1) the target 3.6 million

population at risk would have been protected.

The proposal plan henceforth is to maintain this achievement in its first year, while restratifying and remaping malaria for the country to redefine population at risk. At the same time, the scale up of LLNs will be done gradually to replace the existing ITNs.

As of the time of writing this proposal, the NMCP has met its set GFATM targets for Round 1 Year 4 and Round 1 Year 2.

2. Early Diagnosis and Treatment

National Master Plan of Malaria Control from 2006 -2010 for malaria diagnosis and treatment outline the following relevant areas:

- to improve the malaria diagnostics through; microscopy, RDT and other techniques
- To continue to monitor the resistance of P.falciparum to anti-malarial drugs
- To carry our QA of the performance of local microscopist, and the readiness of the laboratory at both provincial and district level in malaria diagnosis.
- To set up 2 regional malaria QA microscopy reference centre(north and south)
- To ensure a standard malaria treatment according to the NMCP, especially the use of ACT.
- To regularly supervise both provincial, districts, health centre and village in the treatment of malaria.
- To involve training of private sector in the correct treatment of malaria according the NMCP.

In response to the increasing resistance to malaria drugs, the NMCP has revised the National Malaria Treatment Guidelines to recommend the use of rapid diagnostic tests (RDT) combined with ACT (artemisinin-based combination therapy) Coartem® as 1st line treatment in 2004 for the treatment of P.falciparum malaria and to introduce Artesunate injectable for the treatment of severe malaria nationwide. Following the pilot phase of the introduction of ACT and RDT (Paracheck) into the 3 target provinces,i.e.: Saravane, Sekong and Attopeu) a consensus workshop was organized with the full participation of all 17 provinces together with the concerned departments within the ministry of health (department of curative, prevention etc). As a result of this, a consensus was reached for expanding ACT together with RDT to all 17 provinces, starting with 72 districts 1,309 villages. A total of 624 public health staffs, 2,618 village health volunteers and 95 private practitioners were trained on the treatment of uncomplicated malaria. To support the EDAT activity, 79,470 blisters of ACT (CoArtem), 26,667 packs (1 pack = 25 blisters) of Artesunate suppository

and 10,107 packs (1 pack = 25 tests) of RDTs were distributed to all target provinces, districts, health centers and villages, 44,160 artesunate injectable were also provided to the hospitals dealing with severe malaria patients,.

1,600 manuals of severe malaria management guideline for both provincial and district hospitals and 4,000 manuals of uncomplicated malaria management for health centers and VHWs were produced and delivered to target sites.

AS of end of Year 4 of round 1 (April 2007), 930 public health staff have been trained in EDAT, while the Round 4 Year 1 achievements met its target with 281 physicians trained in management of severe malaria.

Studies to monitor the efficacy of ACT (CoArtem) were carried out in Khammouane and Attopeu provinces, it was found that there is no resistance from P.falciparum against the new ACT (Coartem) used (Result: In Attopeu, 43 patients were followed up for 28 days, sensitivity: 100% ; in Khammuane, 42 patients were followed up for 28 days, sensitivity: 100%).

To strengthen the capacity of provincial microscopist a refreshing Training on Microscopy and Epidemiology for provincial levels was conducted in 2 sites (Savannakhet, Luang Prabang) at the end of December 2005 (5 days/site) with a total of 36 participants from all 17 provinces.

In addition to, supervision of microscopist was conducted in October 2005 in 6 Northern provinces (Phongsaly, Oudomxay, Luang Namtha, Sayabuly, Xiengkhuang and Huaphanh) and supervision of ACT/RDTs use in Sekong, Saravan and Attopeu provinces (May 2005). It was found that most of the microscopist visited can identify malaria positive slides, however more regular visits are still needed particularly for the remote provinces to improve the knowledge and skill in malaria microscopic diagnosis.

Supervision visits monitoring ACT/RDT use in Sekong, Saravan and Attopeu provinces showed that trained VHWs could perform the RDT Test correctly accordingly to the guideline. Study done on the performance of VHW on the use of RDT (Wellcome Trust, 2005) has also confirmed the findings of CMPE, however it is the first time that such a large expansion of ACT and RDT has been scaled up to the whole country, therefore tremendous effort and dedication is needed to collect on these data in time at the central level.

A baseline antimalarial drug use survey (First Drug Use Survey) was implemented in November 2004 in 3 provinces (Luang Namtha, Savannakhet and Attapeu). The second drug use survey *(annex 11)* was implemented in November to December 2005 in 5 provinces (Luang Namtha, Savannakhet, Saravan, Sekong and Attapeu) From the second drug use survery, overall, 64.9% (338/521) of malaria-like patients sought their first treatment in the public sector, including VHW. 26.5% (138/521) of patients were self medicated, inclusive of the ones who sought for treatment from their relative/neighbour. 6.5% reported (34/521) seeking treatment in the private sector, composed of private pharmacy, clinic or practitioner, drug seller, mobile drug vendor and a Chinese hospital. Among the other significant findings were:

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1. Poly-pharmacy is practising among providers in both private and public using up to 5 different drugs, including 2 to 3 anti-malaria drugs, Antibiotic and Vitamins.
2. Regulatory system for supervision, drug supply and distribution, quality assurance should be strengthened
3. Effective case management and sustainability of malaria control requires the participation of the private sector

Outcomes of early diagnosis and treatment

4 Component Section *Malaria*

As of the time of writing this proposal, the NMCP has met most of its GFATM targets for Round 1 Year 4 and Round 1 Year 2.

Indicators	Baseline	Year 1		Year 2		Year 3	
	2001	Targets	Results	Targets	Results	Targets	Results
Round 1 indicators:							
ACI (/1,000 pop.)						**5.46**	**5.40**
No. of probable and confirmed malaria deaths in hospital	244	146	187	122	105	**98**	**77**
% of patients hospitalized with severe malaria receiving correct diagnosis and treatment according to national guidelines		Baseline survey	80%	80%	75%	**80%**	**86.52%**
% of patients with uncomplicated malaria receiving correct diagnosis and treatment		Baseline survey in Nov 2004			0.25%	**20%**	**21.7%**
Number of public health facilities providing anti-malaria treatment	0	27	0	117	41	**97**	**331**
No. of trained private health providers	0	30	0	130	21	**96**	**95**
No. of community members trained in malaria case management	0	120	0	4,120	120	**3,120**	**2,618**
% of health facilities able to confirm malaria through RDT		Baseline survey in Nov 2004			3.3%	**53.70**	**74.11**

Round 4 indicators	**Baseline 2003**	**Target**	**Result**
The number of probable and confirmed malaria deaths in hospital	187	98	77
No. of physicians trained in management of severe malaria with artesunate injectable at provincial and district hospitals	0	278	281

3. Malaria Information System (MIS)

National Master Plan of Malaria Control from 2006 -2010 on Disease surveillance outline the following relevant areas:

- province has to regular check all the MIS and able to understand the malaria situation in its own area, data has to be critically analyzed and know in advance the migration of highlander to the lowland or to the socioŒeconomic development areas. Identify the big construction areas(hydrolic damn, irrigation) for a better coordination intra-sectorial in preventing malaria outbreak
- strengthen the malaria network at the provincial and district level which can provide a correct diagnosis of malaria by microscopy and treat nets and track and ensure good quality of malaria information system(MIS).
  - improve the data collection system and making the MIS easy to understand and simple as possible and follow a same standard for the whole country. Both province and district shall be able to use the MIS for malaria epidemic surveillance and planning process. -
  - improve the data flow from the village up to the central level but also feedback to the data sources.
- Every year the MIS should be reviewed to identify weakness and further training on MIS and how to prompt react on malaria outbreak situation for district level.

The national reporting system (Malaria Information System – MIS) was reviewed and new patient record forms was produced and officially used from March 2006. The Public health staffs were trained on the use of these forms. A health staff assessment was carried out at the end of 2006 to assess the comprehension and routine data capture and entry of staff at different levels. After the training, provision of patient record forms for whole country and a microscft Acess based Software for MIS (Malaria Information System) was set up in CMPE. .Through routine supervision of the provinces, the malaria information system could help CMPE in collecting of more precise information from the provincial and district levels and grass root levels as well. The results warranted minor changes to the MIS forms and was subsequently pre-tested. Printing and training of staffs is now planned.
This proposal aims to fulfill the goals of the strategic plan with its activities outlined in Objective 4 and related SDAs of this proposal.

4. Health Education

4 Component Section *Malaria*

National Master Plan of Malaria Control from 2006 -2010 for malaria health edcuation outline the following relevant areas:

- To produce IEC materials, booklets, pamplets in the field of malaria prevention, dengue control and intestinal parasitic control for all level according the local and specific condition of each region.
- To increase the awareness of the population regarding the severity of malaria through radio broadcasting, newspaper, television, poster and other pictorial tools including the use of mobile IEC team.
- To advocate authority at all level in supporting the health education campaign through intra- and intersectorial collaboration.
- To focus on anthropology or sociology studies on the community in malaria prevention and treatment seeking behaviour.

Through both GFATM rounds 1 and 4, the MMCP attempted to further mobilize the community in ITN accepatance and promote treatment seeking behaviour for malaria through its network. IEC tools were designed, developed, field tested, printed and distributed to all target sites. These comprised of Posters, Brochures, T-Shirt, CD, VCD, Flip chart, Games card, Radio and TV spots etc.. Some of IEC tools, such as CD, VCD, Radio and TV spots were translated into 3 minority ethnic languages. In addition, health promotion campaigns were organized at provincial and district levels.

The Round 4 allocation in Year 1 and 2 also carried out specific activities in villages in community awareness and mobilization with the introduction of LLINs for the first time in Lao in 4 pilot provinces.

Round 1 Year 3 and Round 4 Year 1 production of IEC materials:

Items	Unit	Unit/cost (US$)	Amount (US$)	Remark
Radio Spot	380	0,9	342	Received&delivered
Copy 2000 VCD	2000	1,35	2,700	Received&delivered
T-Shirts	2000	2,5	5,000	Received&delivered
Posters	(5000)	0,85	4,250	Received&delivered
-First products	-2000	0,82	1,649.37	
-Second product	-3000	0,83	2,490	

Brochure - First products - Second products	(20,000) -3080 -18,000	 0,32 0,48	 999.81 8,640	Received&delivered
VCD for LLNs Use promotion (set)		2,000	2,250	Received&delivered
Photo Card (set)		5,000	14,600	Received&delivered

5. Human resources

National Master Plan of Malaria Control from 2006 -2010 on human resource development outline the following relevant areas:

- to provide training in malaria control for all malaria staff with focus on the field of epidemiology, entomology/vector control, treatment and management of severe malaria, project management and financial management, public health and English course.
- To train staff in country as well as overseas training, including short and long-term study.
- To regularly evaluate the performance of the people after training so that further in service training may be needed.
- To improve the library at CMPE for serving as reference reading facilities including internet connection for all staff.

Funding from GFATM Round's 1 and 4 for malaria has provided the opportunity for various capacity building courses and trainings for both provincial and central staff. In Round 4 Year 2 the NMCP focused on local capacity building courses in English, Computer, Finance, Secretarial and Management etc. The need for such courses to be extended to provincial levels in further considered in this proposal. This would allow equall opportunity for staff at lower levels and at the grass-root levels to benefit from capacity building and on-the-job skills trainings.

4 Component Section *Malaria*

	Title of course	Nb of participants	Location of course		Work place	Funding source
			International	National		
1	Training on Finance and supply management	278		Laos	18 provinces	GFATM
2	National workshop on Project management and coordination	83		LAOS	CMPE + 4 target provinces	GFATM
3	Training on Management of Severe Malaria	393		Laos	Central+ Provinces	GFATM
4	Training on Severe Malaria	1	Thailand		Central	GFATM
5	Training on LLN for VHWs	3.163		Laos	Villages	GFATM
6	DTM & H	1	Thailand		Province	GFATM
7	DAP & E	1	Thailand & Malaysia		Central	GFATM
8	Master of Public Health	1	Thailand		Central	GFATM
9	Master of Science in Tropical Medicine (M.Sc.)	1	Thailand		Central	GFATM
10	Microscopy Diagnosis pratical	6	Thailand		Central + Provinces	GFATM
11	Entomology and susceptibility Testing	10	Thailand		Central + Provinces	GFATM
12	Local capacity building courses (Financial accounting, office management, English, Secretarial, Computer etc.	57	Vientiane		Central	GFATM

6. Project and financial management:

#6 highlights the following:

- to develop strategic and master plan including budget needed for the national and provincial level.
- To decentralize the activities and budget to province/district/health centre however under a strict and regular supervision

Strengthening of project management began first at central level and 3 pilot provinces then, to the whole country through the creation of offices, nomination of responsible focal persons, organization of several meetings and workshops, such as the financial management of the GFATM.
A National Management Workshop was organized in October 2004 where detailed 5-year action plans of Round I were reviewed for all provinces and approved by the PR. After the “conditional go” was approved by the GFATM, negotiations with the GFATM through LFA occurred concurrently for Round I Phase 2 and Round IV Phase 1 until the final signature of both grant agreements, which were signed in April and May 2005 respectively.

Under the Round I Year 3 activities, integrated supervision visit, which is composed of different units of CMPE (laboratory, procurement and logistics, finance and project coordinator) to some selected provinces were conducted. In addition, the Round I Year 4 plans will include assessment and evaluations of using of the EDAT strategy while the Round 4 Year 2 will see the evaluation of LLINs acceptance and use in 4 pilot provinces. .

To strengthen the program management of Malaria control project, CMPE has set up two additional units for assisting the project coordinators in tracking activities done, coordinating with PR and provinces and reporting within the time frame. Six staffs were recruited into these two units (Monitoring and Evaluation, Procurement). Another 2 and 3 staffs for Finance and secretariat units respectively.

To provide support in financial and technical assistance, CMPE has contracted along term Expert in Malaria, one local hire financial specialist and one accountant to be based at CMPE.. The former one was recruited through WHO using funds for technical assistance and the later is under CMPEs direct contract In Round 1 Year 4, CMPE additionally hired one local hire accountant in each of the 17 provinces. To ensure proper and timely financial management and reporting to the central financal unit.

It can be said that there has been a significant improvement of planning, implementation, monitoring and reporting both in programmatic and financial issues. At the same time, CMPE staffs are learning the financial, technical and program management skills including knowledge and technical transfer from the two specialists, thus paving ways for long term self sustainability.

8. Private sector involvement

Bed nets

LLINs to be ordered (Specification to be precised)	2006	2007	2008	2009	2010	TOTAL

The social marketing of bed nets was implemented by PSI (Population Services International). PSIs strategy and plans are complimentary to the NMCPs, where distribution is through retailers and private providers.

Round 4

Indicator	Baseline	Year 1	
	2001	Targets	Results
Objective 4 indicators:			
Total of LLIN sold	0	20.000	20.000
Round 1			

	2001	Targets (Y1)	Results (Y1)	Targets (Y2)	Results (Y2)	Targets (Y3)	Results (Y3)
Objective 4 indicators:							
Number of re-treatment tablet sold	10,000 (2002)	200,000	20,020	400,000	240,150	450,000	406,260
Number of new outlet selling re-treatment tablet	0 (2002)	400	102	800	844	1,200	1,152

For the remaining period of the Round 4 term, PSI will focus on the social marketing of LLINs. A total of 342,500 LLIN have been forecasted for this purpose.

Size: L190 cm x W180 cm x H150 cm	X					
Size: L190 cm x W180 cm x H180 cm		**X**	**X**	**X**	**X**	
Color:						
WH White	45,000	**20,000**	**20,000**	**20,000**	**20,000**	125,000
LC2 Pink		**20,000**	**30,000**	**15,000**	**15,000**	80,000
LC4 Blue		**20,000**	**30,000**	**15,000**	**15,000**	80,000
DC2 Green		**19,000**	**14,000**	**12,000**	**12,500**	57,500
Total	45,000	79,000	94,000	62,000	62,500	342,500

Diagnosis and treatment

The role of private sector in malaria control in Lao PDR has just been initiated through the GFATM Round

4 grant. A recent survey on Anti-malarial Treatment Seeking Behaviour (2005) ***(Annex 11)*** revealed that:

1. While 64.9% (338/521) of malaria-like patients sought their first treatment in the public sector, including VHW, 26.5% (138/521) of patients were self medicated, inclusive of the ones who sought for treatment from their relative/neighbour. 6.5% (34/521) sought for treatment in the private sector, composed of private pharmacy, clinic or practitioner, drug seller, mobile drug vendor and a Chinese hospital.
2. Poly-pharmacy is practising among providers in both private and public using up to 5 different drugs, including 2 to 3 anti-malaria drugs, Antibiotic and Vitamins.
3. Regulatory system for supervision, drug supply and distribution, quality assurance should be strengthened
4. Effective case management and sustainability of malaria control requires the participation of the private sector

The GFATM Round 1 proposal included a private sector malaria treatment component: 296 formal private providers were to be trained on the proper use of RDT and ACT, however a supply of both to private facilities was not yet planned. The Lao GFATM Round 4 proposal therefore goes beyond Round 1 and rightly aims to install a mechanism for the participation of the private sector (pharmacies, clinics, practitioners, traditional healers) in the implementation of ACT in Lao PDR. It has set aside a budget of **USD 244,000** for mid 2007-2010 (including ACT procurement) for introduction of ACTs into the private sector. To start this off, a feasibility assessment of a private

sector involvement was planned for 2006 but could not be carried out for several reasons.

With technical support from WHO, a stakeholder workshop was held in Thalat, Vientiane province, from 23-24 February 2007. The objective of the workshop was to jointly prepare a project plan for piloting a mechanism of private sector involvement in malaria diagnosis and treatment in the next 3 years (July 2007-June 2010, Phase II of the GFATM Round 4 project). The main outcome of this workshop was the concensus to form a national Task Force to oversee the initiation and implementation of private sector involvement. The possible plan in the Phase II is outlined in ***annex 12****.*

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

1. Millennium Development Goals

Malaria-related Millennium Development Goals

Goal 6: To combat malaria, HIV /AIDS and other diseases, the target is to have halted by 2015 and begin to reverse the incidence of malaria and other major diseases.

While the related MDG indicators No's:21-22 (Death rate, Morbidity rate due to malaria, proportion of population in malaria risk areas protected by impregnated bed nets) have shown considerable improvements in Lao PDR through funding from GFATM Round 1 and Round 4 for the national malaria control programme (http://www.unlao.org/MDGs/Start.htm), recent surveys and reports *(MOH, 2000, National Health Survey 2000; Lao PDR Reproductive Health Survey, 2000; WHO, Country Health Information Profiles 2000, UNDP, National HDR Report: Lao PDR 2001; Lao PDR, CPC/NSC, LECS II, 1997/98)* within the other health related MDGs also indicate serious disparities in health indicators and in the access to and in the quality of health services especially among the poor, in rural populations, more so in the mountainous areas and among ethnic minorities. This is also made more evident taking into account the problem of possible under-reporting of malaria (and health problems in general) in the poorest and least accessible areas where health facilities do not exist and outreach activities limited. MDG 1 Eradicate Extreme Poverty. Malaria in Laos is closely associated with poverty. Marginalized ethnic minority groups living in the forest and on the forest fringes often carry the greatest burden of poverty and disease. While the malaria control efforts in the last 4 years have catered to reducing malaria burden among the general population of 3.6 million at risk, and achieved good success, the priority now among this population, is to focus in intensifying efforts in reaching similar reductions among the least privileged. This proposal is targeted in such a way that it makes special provision for the poor and underserved by focusing on the Lao government's *National Socio-Economic Development Plan (2006-*

2010) and *National Growth and Poverty Eradication Strategy (2003)*. These national plans highlight the need for priority programmes and strategies for the '47 designated poorest district' of which primary health care is the main priority with emphasis on active involvement of the communities and focus on gender and ethnic balance. ***(annex 13 map).*** In addition, as many of these designated poor areas are populated by ethnic minorities, this proposal has a clear and distinct objective for ethnic minorities, collaborating with both civil and experienced NGO partners in all aspects of planning and implementation.

2. Roll back Malaria (GMP)

The NMCPs focus has been based on the RBM (now termed Global Malaria Partnership) goals and objectives. The current GFATM Rounds' 1 and 4 strategies for malaria in Lao PDR are based on the same objectives as set out by the GMP. In its 2010 target, GMP stresses in particular the lowest two economic quintiles: 80% of people at risk from malaria are protected and 80% of malaria patients are diagnosed and treated. The current achievements in Lao PDR have been towards achieving this through insecticide-treated nets (ITNs) and Long lasting insecticide treated nets (LLITN) and through early diagnosis and effective treatment (EDAT) with RDT (rapid diagnostic test) and artemisinin-based combination therapy (ACT). As of end of 2006, a total of 2.9 million (80.5%) of the 3.6 million at risk of malaria have been protected with ITNs *(source: MIS 2006, GFATM quarterly reports*). As of end of 2006, 67.2% of patients diagnosed (RDT and/or microscopy) with malaria were treated with ACT *(source: GFATM Round 4 Q6 reports)*. These reflect considerable achievements that will be need to be sustained and scaled up under the on-going Phase 2 of Round 4. The GMP has also set a target to reduce malaria burden by 50% by 2010 compared with 2000. The annual 2006 case incidence of malaria in Lao PDR showed a 47.2% reduction (*source: MIS 2006)* from 2000-2006. This proposal will attempt to re-stratify and re-map the burden of malaria in view of these achievements with the objective of maintaining control in these areas and further channel resources to areas that are still at high risk.

The challenge that this proposal aims to achieve instead is based on the GMP targets for 2015 ***(annex 14):***

By 2015:

• malaria morbidity and mortality are reduced by 75% in comparison with 2005 , not only by national aggregate but particularly among the poorest groups

• malaria-related MDGs are achieved, not only by national aggregate but also among the poorest groups in the country

• universal and equitable coverage with effective interventions.

This proposal sets out to specifically target these challenges by:

1. ensuring that costs will continue not to be a barrier for the poor and vulnerable. Curative and preventive interventions for malaria will be free for these vulnerable groups;

2.. making significant investment in monitoring activities, especially to enable tracking of equitable coverage

and access through both on-going passive and active case surveillance, periodic mapping of population movement and malaria vectoral behaviour and effective regular supervision and monitoring;

3. engaging as the main implementing agents both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE, ADRA etc) and vital coordination roles of civil societies (Lao Womens Union, Lao Youth Organisation) and including them in all phases of scaled-up malaria control efforts..

The activities include applying a risk-stratification for targeting interventions to high-risk areas, training of ethnic minority VHWs on EDAT, ITN use and retreatment techniques and health education, providing ITN to poor households, re-treatment of existing bednets and carrying out residual house spraying in selected areas, and developing and implementing locally appropriate IEC in collaboration with other sectors.

3. Lao PDR Sixth National Socio Economic Development Plan (2006-2010)

The indicators and targets for the Sixth National Socio Economic Development Plan coincide with most of those for the MDGs and the Brussels Programme of Action for the Least Developed Countries. It identifies cross cutting areas in its poverty reduction strategies emphasizing targeted interventions to be implemented in the 47 designated poorest districts to achieve more rapid reduction in poverty highlighting decentralisation, focusing on primary health care covering both preventive and curative aspects and active participation of the poor. The 47 designated poorest districts represent 1.26 million of the country's population, covering 2,935 villages and 111,850 poor households (55.4% of total poor households in country). It also identifies (pg45) that there are shortfalls in meeting health requirements of these isolated areas, particularly poor areas with difficult access. In addition, ethnic groups still uphold superstitious beliefs, lead unsanitary lifestyles and mainly rely on shamans for cures. Specific measures (pg110) address ethnic and gender issues that among others highlight the training of ethnic minority women for all aspects of health services, development of relevant IEC and media channels and messages and designation of a gender focal point at village level.. This proposal specifically targets this issue in 2 ways:

1. Priortizing efforts through remaping, restratifying malaria burden once in 2 years and ensuring channelling of resources to achieve adequate coverage of preventive and curative measures to these vulnerable groups.

2. Prioritizing in a specific objective (Objective 3 and related SDAs), an innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved.

4. National Growth and Poverty Eradication Strategy (NGPES, 2003-2020)

Within this strategy, the government has outlined its poverty related health priorities for the 47 designated poorest districts primarily through increasing access to health services, improving their quality and reducing

their costs for poor households and in the poorest areas. Stabilizing and raising the standards of living of ethnic minorities is also a clearly identified priority. In addition, in its exercise to localize the Millennium Development Goals, the government of Lao PDR recognizes the need for control of communicable diseases, including malaria, by prioritizing underserved remote, rural and ethnic minority areas. With regards to malaria, it highlights the poor and ethnic populations' access to treatment, referral, health education and expansion and maintenance of protective measures. In addition, the strategy also aims to strengthen district level health care system with particular effort to attract female and ethnic minority health care workers..

While addressing the issues of poverty directly is seen byond the current capacity of the NMCP, this proposal specifically targets the issue in 2 ways: (as described above). In addition, the involvement of the LWU as a co-partner in the activities outlined in Objective 3, will help promote gender balance in recruitment of new VHWs as well as seek the active involvement of ethnic women in addressing their respective village health problems.

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

This proposal will use the existing Procurement and Supply and Monitoring and Evaluation units of the Principal Recipient. Auditors are contracted according to GFATM rules.
Systems for planning, budgeting, procurement and supply management, monitoring and evaluation and auditing were established for the 3 components (TB, HIV, malaria) in-line with MoH guidelines and according to GF requirements. These systems are now functioning effectively with the support the SR (CMPE's) management unit with coodinators, logistics and finance teams. Systems and procedures by partners to be involved in this proposal will also be effectively aligned with those of the PR. This will also be supported by training of partner staff (SDA 4.10.2) in both grant management, procurement, logistical and financial aspects.
If this proposal is successful, release of R7 funds should be timed to synchronise with the R4 cycle in order to facilitate harmonization of procedures relating to reporting, budgeting, financial management and procurement. It is expected that by the end of the R7 grant the Lao PDR malaria component will be eligible to apply for any future requirements under the GF's RCC mechanism.

4.3.4 National health system

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

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

Strategic planning and policy development

4 Component Section *Malaria*

Strengths and Opportunities

A vital component of this proposal is the active extension of the NMCP to involve country development projects in its control activities. This is within the scope of the National Malaria Control Strategy (2006-2010). The rapid introduction and scaling up of both private and joint private-government development projects in Lao necessitates the development of policies and guidelines that will enable malaria control to be implemented comprehensively. For example, a company from a neighboring country has invested US30 million to grow 10,000 hectares of rubber trees in 3 provinces in the south of Lao. Another significant investment currently seen and also planned for the future in a southern province would see large scale development in the establishment of hydro dams, cashew nut trees, rubber trees, cassava, rice etc. Similar development is also commencing in the northern provinces. This would involve among others, significant land clearing and movement of populations from endemic to non-endemic areas and vice versa. The influx of foreign workers in these plantations would also harbor the risk of introducing resistant strains of parasite. Establishing a network of both information and communication (objective 4: SDA 4.5.2 - through engaging relevant agencies and partners/stakeholders thorugh quarterly/ad hoc TWG meetings and SDA 4.5.3 - stratification process : Liaise with related central and provincial departments to determine available retrospective data and data that can be collected regularly and input into GIS based software, dissemination through central and provincial level meetings) at CMPE at the provincial level, extending the MIS into such development projects (SDA 4.5.4: Supporting the implementation of pilot interventions/activities – predefined objective 1), development of guidelines, SOPs, strategies SDA 4.5.5 ie-treatment for special groups, ITN policy on engaging these private sector development projects which could necessitate revisions of the national malaria control policy.

Threats

Political commitment, delegation of authority from central to provincial level among the different government agencies and their continuing support:

1. Mining companies	Ministry of Mineral and Energy/Industry
2. Plantations	Ministry of Agriculture & Forestry
3. Hydro dams	Ministry of Mineral and Energy
4. Highway and railway projects	Ministry of transport and communication

Commitment of the provincial level malaria station in actively engaging other government agencies in the implementation of a pilot and during the scale up to 6 identified provinces.

Monitoring and evaluation

Strengths

With the formation of the TWG, an integrated approach towards monitoring of treatment and case management of malaria is initiated through the strengthening of the existing Central Monitoring Unit (CMU) which will be comprised of CMPE, FDD, Curative department and MPSC. The CMU will further augment the monitoring activities of the FDDs recently approved GFATM Round 6 grant in combating fake antimalarials and related antibiotics by keeping under review the quality of antimalarial drugs and manufacturing practices, monitoring the procurement process of provincial, district hospitals through the Drug Revolving Funds (ensuring procurement of other antimalarials, ie- quinine, doxycycline, chloroquine (for P.vivax) are through registered/liscenced pharmaceutical companies. It will also liase with the TWG on clinical management as necessary through and recommend action as necessary to deal with substandard products and practices In addition it will also serve to monitor the implementation of current drug policy, adherence to the malaria STGs (through existing site checklist and forms), identify problems and recommend solutions, The CMU in its monitoring feedback to the TWG, will also assess the need to review and revise, or develop as necessary, clinical guidelines for case management and laboratory diagnosis for various cadres of health worker and for use in the community and assess the need to review in-service training needs for case management and laboratory diagnosis and recommend changes to curricula or training packages needed to meet these needs. The inclusion of the MPSC in the CMU will also serve to monitor bottlenecks in the supply chain, storage and needs of antimalarials drugs and medicines in general in the sites supervised and recommend corrective actions to be taken. The inclusion of the CMU within the TWG will see its role further strengthened in reaching a high level concensus within the MOH for remedial action to be taken from its monitoring activities.

Monitoring and supervision will also extend to the activites of bed net distribution. The national malaria policy outlines the free distribution of bed nets and bed net retreatment for poor, remote and ethnic minority populations. However, the role of the provincial and district governor/administration also influences the selection of villages where this distribution and service is given. The NMCP thorugh its central, provincial and district network, in this proposal, has included the participation of these provincial and district governance in various bed net activites (distribution and retreatment of nets) at the provincial and district levels.

Coordination/partnerships/Community and client involvement

4 Component Section *Malaria*

Strengths

SDAs 3.1-3.5 are in support of a distinct objective (objective 3) of this proposal in establishing innovative village

based IEC interventions in malaria endemic ethnic communities that are currently underserved through adopting in an intensive advocacy, communication and social mobilization project, involving 5 provinces in a total of 782 villages (over the 5 year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant, reaching an estimated 15 major ethnic groups with an approximate population of 260,000. (A list of provinces, district involved and target villages ove the 5 years are given in ***Annex 16.(a).*** This specific objective will engage, as the main implementing agents, both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE etc) and other local Lao civil associations(PEDA , SADP etc) as well as vital coordination roles of civil societies (Lao Womens Union, Lao Youth Organisation) and including them in all phases of scaled-up malaria control efforts in these ethnic populations.

Implementation by all partners will be under over all guidance of CMPE and the project TA who will ensure that:

1. national malaria guidelines and policies will be followed by all partners.

2. training curriculum will have standardized content but presentation, delivery and training method may differ for the particular ethnic group

3. IEC materials will be designed by partners, piloted and produced centrally(CMPE/CIEH)

4. All materials from partners will be reviewed and approved by CMPE and the project TA before use/production.

In addition, GFATM project management (financial,logistical and programmatic) training for partner staff is also included as an activity (SDA 4.10.2) to ensure that all procedures are compliant with GFATM/MOH.

Opportunities

At the end of the proposal term, policy recommendations for scaling-up malaria control plans for poor EMGs will be made available and Lao would host regional (GMS – Greater Mekong Subregion) meeting for info sharing on lessons learnt and best practices and provide forum for partner networking.

Threats and measures to overcome

Recruitment of partner staff (administrative and field coordinators). A substantial number of partner staffing is required with the scale up of villages over the Y2-Y5 of this proposed strategy that would

require more human resources from the partners.. With this in view, the proposal has factored in a maximum number of villages (between 6-10 villages per field staff depending on the logistics involved in these remote areas). This will ensure that quality and effectiveness of the strategies are not compramised. Most of the recruitment of partner staff will be done in the first year of the proposal to orientate and familiarize them with the proposal and GFATM procedures. In addition, the partner field staff would also require adequate time to build up rapport, trust and relationships with ethnic minostiy communities.

A number of ethnic minority villages are border villages between Vietnam, Myanmar and Cambodia. The Lao government has strict security measures over specified border areas. The proposal has involved the Lao army and the Military Institute of Preventive Medicine and its network in both ensuring security of the project's activities and staff as well as their involvement in the project activities (the Military Institute has a IEC unit with ethnic minority staff).

Incentive mechanisms for VHWs

This activity has been outlined within the activites of the TWG coordination and oversight. A feasibility assessment, financial controls, delivery mechanisms, concensus and guideline development as well as piloting is planned for Y1-Y2. A supporting budget for scale up is allocated in Y3-Y5 of this proposal.

Strengths

Aptly rewarding malaria VHWs for their contributions in all prevention and control activities at the village level.

Serve as a incentive towards preventing misuse or non conformity to guidelines (ie – free diagnosis and treatment for malaria)

Threats/Weaknesses

Sustainability mechanisms also have to be considered. With the overall decline in the burden of malaria, incentive mechanisms also have to fall within an existing framework or system so that it adds to, and will not function in isolation. This will be explored as part of the feasibility assessment,

TWG debates and possible concensus development afer the pilot intervention in Year 2. The possibility of including other areas and partners ie- targeting other sectors including education, the

workplace, and social services etc will also be explored.

As this particular area has not been addressed in detail at the MOH level, the TWG will be instrumental in exploring this further with assessments and piloting in the Phase 1 of this

proposal.

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

Strategies are addressed as outlined in the section above. In addition, these constraints have also been addressed by the NMCP priorities in reference to the National Master Plan (2006 – 2010) as outlined below:

Strategic planning and policy development

- *Provinces has to regular check all the MIS and able to understand the malaria situation in its own area, data has to be critically analyzed and know in advance the migration of highlander to the lowland or to the socioŒeconomic development areas. Identify the big construction areas(hydrolic damn, irrigation) for a better coordination intra-sectorial in preventing malaria outbreak.*

Monitoring and evaluation

- *CMPE is responsible for the directives and policies and technical guidance, provinces are in charge for the elaboration of annual work plan and budget and district/village are the implementing units within the framework of malaria control*
- *to ensure an ITN coverage of at least 80% of the population at risk at the same time to make the ITN activities sustainable especially the remote malaria at risk areas.*
- *To provide nets, insecticides and dipping sets for the population*
- *To ensure that 50% of the villages in each district finish the ITN before april.*
- *To carry our QA of the performance of local microscopist, and the readiness of the laboratory at both provincial and district level in malaria diagnosis.*
- *To set up 2 regional malaria QA microscopy reference centre(north and south)*
- *To ensure a standard malaria treatment according to the NMCP, especially the use of ACT.*
- *To regularly supervise both provincial, districts, health centre and village in the treatment of malaria.*

Coordination/partnerships/Community and client involvement

.

- *To advocate authority at all level in supporting the health education campaign through intra- and intersectorial collaboration.*

- *To focus study on the anthropology or sociology study on the community in malaria prevention and treatment seeking behwviour*

(c) **Coordination and Synergies**

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

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

The national health sector development plan will be officially announced in August 2007 this year.

4.3.5 Common funding mechanisms

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

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

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

Not relevant

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

Not relevant

(d) Describe the process for independent supervision of the performance of the common funding mechanism.
Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**. ***Attach,** as an annex to your proposal**, the most recent external assessment of the operations of the common funding mechanism**.*

Not relevant

(e)	Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed. *Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.*
Not relevant	
(f)	Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for malaria activities during the proposal term.*
Not relevant	

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4.4 Overall Needs Assessment

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

To help Applicants identify these gaps:

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

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

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

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

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

4.4.1 Programmatic Needs Assessment

4.4.1 Overall programmatic needs assessment

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

Programmatic needs are reflected in the National Malaria Strategic Plan (2006-2010) :

1. To reduce the malaria morbidity by 80%

2. To reduce the malaria mortality by 90%

To achieve this objectives the NMCP has developed the following targets to be achieved by 2006 to 2010 are as follows:

- To maintain the number of nets treated and re-treated for malaria prevention is aimed at protecting 3.6 million people at risk for malaria. By the end of 2012, there will be a gradual increase of LLIN but at the same time a gradual reduction of conventional ITN in all target areas.
- To prioritize malaria control activities for the most malaria affected poorest districts where the majority of the population are ethnic minorities by providing full ITN/LLN coverage and access to ACT/RDT treatment to these communities at risk
- To expand the malaria control for ethnic minorities from the pilot areas in 2 districts of Attopeu province(South of Laos) to 47 poorest districts using best practices from intensive health education campaigns combined with ITN and accessibility to ACT/RDT at the village level.
- To re-stratify malaria endemic areas of the country through passive case detection, blood surveys in selected areas, entomological mapping, bed net use survey etc to determine the current malaria situation which will be later used for strategic planning in the consecutive years.
- To ensure the effectiveness of the current anti-malaria treatment the NMCP continues to monitor the trend of resistance of P.falciparum malaria against CoArtem (current ACT) in 3 sentinel sites.
- To involve private sectors (private clinics and private pharmacies etc) in malaria prevention and treatment at all levels, to engage them in providing malaria best practice (correct diagnosis and treatment, combating counterfeit and substandard anti-malaria drugs) and adherence to the National Malaria Treatment Policies.
- Close liaison with other governmental agencies especially at provincial level to map out and engage private development projects in malaria control (plantations, hydro dams, highways etc that involve significant land clearing, population movement and influx of foreign workers).
- To enable provinces in following and predicting malaria outbreak through the improvement of Malaria Information System (MIS) and in service training of epidemiological staff in early detection of malaria and elaborate of immediate actions to investigate and control malaria outbreak at its early phase.

As malaria trend is in decline in the country, therefore there is an urgent need for re-mapping of malaria endemic areas and based upon its outcomes, the NMCP will re-assess its malaria control strategies on a most cost-effective basis by providing a full malaria intervention package to the 47 poorest and malaria endemic districts(ITN/LLN, EDAT, IEC) while at the same time selective malaria intervention will be applied to the rest of the country .

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(b) **Complete table 4.4.1**

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

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

With the commencement of GFATM Round 1 in 2003, the population at risk for malaria was estimated at 3. 6 million (65% of the country's population). By the end of this grant in April 2008, ITNs would have covered this population at risk. At the same time, access to EDAT would have been made available through all levels of the public health system including VHWs in 6560 villages.

This proposal seeks to:

1. Improve access to early diagnosis and appropriate treatment for malaria for population at risk by maintaining 80% coverage of all villages in the designated 47 poorest districts, while at the same time maintaining EDAT coverage achieved in all other risk areas. However, it is expected that over the next 5 years of this proposal term ending 2012, further reductions from the current achievement in malaria rates will be marginal, it is estimated that the population at risk would be approximately reduced to 70% (2.4 million) from the 2001 baseline (3.6 million). Remapping and restratification exercise planned in years 1, 3 and 5 would be vital in determining population at risk and the channeling of resources.

2. Maintain the same population coverage (3.6 million) with ITNs. However, in ensuring long term sustainability, the NMCP will gradually reduce, over the 5 year term of this grant, the use of ITNs and replace them with LLIN. Emphasis will be on achieving at least 80% coverage in all (100%) of the villages in the designated '47 poorest districts' where the populations are mainly ethnic minorities in addition to other selected districts with high malaria transmission. There are a total of 3,468 villages in the 47 designated poorest districts (target population: 1,274,646) and among the other 67 districts (114-47=67), there are 31 districts with 2,428 villages (target population: 1,199,393) that show a high and/or increasing trend of malaria burden. It is these villages that priority will be given to ensure at least 80% coverage of the population per village. This will coincide with the restratification of at risk villages in year 1, 3 and 5 of the proposal and the distribution of LLINs yearly. These population figures are derived from the 2005 population census. Ethnic population figures and number of villages tend not to be static over time. These will be updated on approval of this proposal through the outlined activities and surveys. Ethnic minority demographics will also be better defined at that time.

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

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

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1	Population having access to EDAT (cumulative)	911,264 (114d x 21v =2394 villages) (22%)	1,535,109 (114d x 36v = 4104 villages) (37%)	3,358,051 (114d x 63v = 7182 villages) (81%)	3,358,051 (114d x 63v = 7182 villages) (81%)	3,358,051 (114d x 63v = 7182 villages) (81%)	2,350,636 (70% reduction)	2,014,830 (60% reduction)	1,679,025 (50% reduction)
Key Service 2	Number of malaria deaths in hospitals	98	73	49	40	37	32	26	20
Key Service3	Population covered by Bed nets (IBN/LLIN) (cumulative)	2.2 million	2.6 million	2.9 million	3.6 million	3.6 million	3.6 million	3.6 million	3.6 million
Key Service 4	Ethnic minorities within the designated 47 poorest district	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
	recieveing targeted malaria IEC interventions								
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1	Population having access to EDAT (cumulative)	911,264 (114d x 21v =2394 villages) (22%)	1,535,109 (114d x 36v = 4104 villages) (37%)	3,358,051 (114d x 63v = 7182 villages) (81%)	3,358,051 (114d x 63v = 7182 villages)	3,358,051	0	0	0
Key Service 2	Number of malaria deaths in hospitals	98	73	49	40	37	0	0	0
Key Service 3	Population covered by Bed nets (IBN/LLIN) (cumulative)	2.2 million	2.6 million	2.9 million	3.6 million	3.6 million	0	0	0
Key Service 4		0	0	0	0	0	0	0	0

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
	Ethnic minorities within the designated 47 poorest district recieveing targeted malaria IEC interventions								
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 - B^1 = C^1$, $A^2 - B^2 = C^2$ etc.)									
Key Service 1	Population having access to EDAT (cumulative)	0	0	0	0	3,358,051 (114d x 63v = 7182 villages) (81%)	2,350,636 (70% reduction)	2,014,830 (60% reduction)	1,679,025 (50% reduction)
Key Service 2	Number of malaria deaths in hospitals	0	0	0	0	0	32	26	20

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 3	Population covered by Bed nets (IBN/LLIN) (cumulative)	0	0	0	0	3.6 million	3.6 million	3.6 million	3.6 million
Key Service 4	Ethnic minorities within the designated 47 poorest district recieveing targeted malaria IEC interventions	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages	3,468 villages
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1	Population having access to EDAT (cumulative)	*Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.*			0	3,358,051 (114d x 63v = 7182 villages) (81%)	2,350,636 (70% reduction)	2,014,830 (60% reduction)	1,679,025 (50% reduction)
Key Service 2	Number of malaria deaths in hospitals				0	0	32	26	20
Key Service 3	Population covered by				0	3.6 million	3.6 million	3.6 million	3.6 million

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
	Bed nets (IBN/LLIN) (cumulative)								
Key Service 4	Ethnic minorities within the designated 47 poorest district recieveing targeted malaria IEC interventions				49 villages	195 villages	391 villages	586 villages	782 villages

4.4.2 Strategic actions to strengthen health systems

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

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

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

4.4.2 Description of HSS Strategic Actions included in this component

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

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

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

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

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

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

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

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

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

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

Total funds for essential HSS Strategic Actions requested over proposal term					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**

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Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)*

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

Year 1	Year 2	Year 3	Year 4	Year 5
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5

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

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

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government			
Other Global Fund Grants (with HSS elements)			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			

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

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

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

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

☐ Yes
➔ *complete (d) and (e), and then (f)*

☒ No
➔ *go to section 4.4.2(f)*

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

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

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

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

☐ Yes, Tuberculosis

☐ Yes, Malaria

☒ No

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

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

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

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4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

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

Summarize the overall financial need in table 4.5.

CMPE has requested $23,332,897 for additional and contributed to overall needs for National Malaria Control Programme from 2008 to 2012 for sustaining Malaria control in Lao PDR, focusing on Malaria vulnerable population through Muti-Sectorial Approch to:

1. Improve access to EDAT Malaria for population at risk [maintain 80% coverage of all villages in the designated 47 poorest districts + [maintain EDAT in all other risk areas (old stratification) for Y I];
2. Improve access to good vector control measures and improve malaria prevention practices among population at risk. [maintain 100% coverage of all villages in the designated 47 poorest districts + [maintain at least 80% population coverage with ITN/LLNs in all other risk areas (old stratification)];
3. Establish innovative village-based IEC intervention in endemic ethnic communities that are underserved;
4. Strengthen & improve management of NMCP at all levels nationwide.

Costs are based on priority orientations within the National malaria control strategies (2006-2010) that are also consistant with RBM strategies.

The cumulated financial gap for the period 2008-2012 is $23,332,897 (= line E of table 4.5.1).

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

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

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

The government contribution (in country resource) is used for staffs salary and

administrative cost such as office and building maintenance. The earmarked financial contributions to the national response for malaria is given in table 4.5 in Line B. (Domestic source **B2** : National funding resource)

(b) **External Sources**

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

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

None since the commencement of GFATM support for malaria through R1 (2003). GFATM has been the sole funder for malaria control in Lao PDR since 2003. No other external donor support is anticipated during the term of this proposal.

The current 2 GFATM grants, Round 1 and Round 4 with a cumulative total amount received of USD 13, 856,864 and expense incurred USD 11,812,932 USD as at 31 March 2007. The remaining funds in country will be used for planned activities for the period up to April 2007 (Round 1 Year 4) and up to June 2007 (Round 4 Year 2).

4.5.3 Overview of Financial Gap

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

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

4.5.4 Additionality

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

Global Fund round 1 will end April 2008 and Global Fund round 7 is expected to start in July 2008 thus avoiding overlap. Global Fund round 4 will end in June 2010. Global Fund resources of round 7 proposal will support either new activities or activities continued from previous rounds without overlapping as shown in the table 4.6.4. ***Annex 15*** further clarifies the time frames and justifications.

The PR has worked in close association with the LFA to design a robust financial monitoring system. This system includes regular external audits to ensure that the handling of project funds (Global Fund and Government contributions) is fully transparent. In addition the NMCP annual reports when combined with the findings from periodic external technical reviews, this information will clearly

demonstrate the sole funding from the Global Fund for Lao PDR malaria control programme.

4.5.5 Strategy for achieving sustainability

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

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

The scope of Round 7 is to sustaining Malaria control in Lao PDR, focusing on Malaria vulnerable population through Muti-Sectorial Approch. While maintaining the coverage of people protected, the scale of this proposal is also larger, in supporting an on-going surveillance and remaping/restratification of malaria and in engaging more non governmental partners for reaching vulnerable or disadvantaged groups. This will ensure sustainability as more responsibility and task are shared among different sectors, both governmental, NGOs and civil.
With the formation of the proposed TWG and its initiation with 4 predefined objectives, the NMCP is initiating a strong commitment towards intersectoral collaboration.

The use of LLIN over the conventional ITNs and the gradual scale up in replacement is also seen as a sustainable strategy which will ensure that the population at risk will still have protection with bed nets through the use of LLIN beyond the proposal's term. In addition, this would also reduce greatly the overall cost of the programme in the future on insecticide and operational costs in retreating conventional nets.

Initiating initial activities towards a public private mix in malaria service is a challenging endeavour for Laos. However, this is seen as vital, to ensure equtible access and to involve other service delivery channels outside the NMCPs network. This proposal, although is limited in its current form to outline detailed strategies, intends to initiate, pilot, evaluate and scale up within the context of a National Task Force for PPM. This will ensure sustainability of the NMCP in other utilizing other self sustaining delivery channels beyond this proposal's term.

This proposal further extends capacity building to provincial levels, through local on-the-job skills training (English, computer, management courses etc) as an investment that will provide a strong platform and well distributed skilled task force for the malaria control programme in Laos for the future.

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Table 4.5 - Financial contributions to national response

Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	6,803,498	5,221,904	7,471,131	7,918,354	7,235,020	6,694,816	6,190,177	6,361,721
Domestic source **B1** : Loans and debt relief (*provide donor name*)								
Domestic source **B2** : National funding resources	446,967.40	491,663.70	540,829.30	594,912.00	654,403.00	719,843.00	791,827.00	871,010.00
Domestic source **B3:** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned domestic resources	**446,967.40**	**491,663.70**	**540,829.30**	**594,912.00**	**654,403.00**	**719,843.00**	**791,827.00**	**871,010.00**
External source **C1**: All current & planned Global Fund Round 1	4,356,137	2,956,580	2,850,708					
External source **C2:** (*provide donor name*) All current & planned Global Fund Round 4	2,000,394	987,019	4,079,594	3,375,987.00	4,059,228.00			
External source **C3** (*provide donor name*)								
External source **C4**: Private Sector grants/ contributions (International)								
Total of Line C entries ➔ Total current & planned external resources	**6,356,531**	**3,943,599**	**6,930,302**	**3,375,987.00**	**4,059,228.00**			

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Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)	6,803,498	4,435,263	7,471,131	3,970,899.00	4,713,613.00	719,843.00	791,827.00	871,010.00
Line E ➔ Total Unmet need (Line A – Line D) -	0	786,641	0	3,947,455	2,521,407	5,974,974	5,398,350	5,490,711
The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.								

Clarification: Line E is equal to sub-total of component budget as shown in table 5.3

Line E + management fee of PR = total funds requested form Global Fubd as shown in table 1.2; 5.2; 5.3 and detailed budget;

4 Component Section *Malaria*

4.6 Malaria component/implementation strategy

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

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

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

and

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

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

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

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

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

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

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

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*

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

Not relevant

4.6.2 Goals and objectives and service delivery areas

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

Proposal Goal is two-fold:

1. By the end of 2012, to reduce malaria morbidity and mortality by 80% (baseline from 2006) and 90% of uncomplicated (Pf) confirmed cases correctly diagnosed and adequately treated with Artemisinin-combination Therapy (ACT) among the population at risk

2. Maintaining 80% or more coverage of protection from malaria for the population at risk for malaria through ITNs/LLNs

The goals will be achieved through 4 main objectives and related SDAs:

Objective 1: Improve access to early diagnosis and appropriate treatment for malaria for population at risk [maintaining 80% coverage of all villages in the designated 47 poorest districts + maintaining EDAT in all other risk areas (old stratification) for Year 1]

SDA1.1 Improved diagnosis through refresher training and training new VHWs on diagnosis and treatment for target areas through 4 day training (y1:maintain 13,120VHWs, y2:80%=10,496, y3: 70%= 9,184, y4: 7,872, y5: 6,560) **SDA1.2** Provide RDTs for all levels of health facility in target areas including VHWs **SDA1.3** Provide ACTs for all levels of health facility in target areas including VHWs **SDA1.4** Provide suppositories for pre-referral treatment **SDA1.5** Provide Artesunate injectable for the treatment of severe malaria.

Objective 2: Improve access to good vector control measures and improve malaria prevention practices among population at risk. [maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage with ITN/LLNs (old stratification)]

SDA2.1 Indentify bed net coverage, acceptance and usage thorugh national bed net survey **SDA2.2** Prodvide insecticide to reatreat existing old conventional nets (ITNs) **SDA2.3** Provide LLN for replancement of remaining ITNs **SDA2.4** Provide IBN Dipping Material for net impregnation **SDA2.5** IBN Campaign for retreatment of nets and promoting use **SDA2.6** Health Education and IEC related activities for bed net and EDAT

Objective 3: Establish innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved.

SDA3.1 Baseline survey for knowledge, behavior and practices among ethnic minorities in target villages **SDA3.2** Planning and consesus workshop for 5 target provinces **SDA3.3** Developed IEC message for Ethnic minority groups (EMGs) in pilot area by partners **SDA3.4** Dissemination of lesson learned and result of the pilot interventions **SDA3.5** ProvideTechnical Assistance for this specific objective

4 Component Section *Malaria*

Objective 4: Strengthen and improve management of the National Malaria Control Programme at all levels nationwide.

SDA4.1 Strengthen epidemiological surveillance through re-maping and restratification of malaria - Analysis of malaria by village using existing MIS/PCD data. SDA4.2 Conduct ACD/malariometric surveys SDA4.3 Liaise with private development projects SDA4.4 Restratification of Malaria SDA4.5 Formation of Technical working group(TWG) and implementation of 3 predefined objectives SDA4.6 Capacity building and strengthening of Malaria Surveillance and reporting system SDA4.7 Technical assistance for Malaria surveillance and information systems SDA4.8 Strengthen microscopy points at all levels SDA4.9 Delivery of Malaria commodities from central to villages SDA4.10 Supportive supervision at all levels SDA4.11 Strengthen entomological surveillance SDA4.12 Monitoring drug resistance in 3 sentinel sites SDA4.13 Quality assurance of RDTs and ACTs rfom field sites SDA4.14 Updating and enforce national Malaria treament guidelines SDA4.15 Coordination meetings at central level with all partners. SDA4.16 Monitoring Public-Private Mix (PPM) in Malaria Control SDA4.17 Carry out external project evaluation SDA4.18 Regional international meeting and training SDA4.19 Capacity building on Management SDA4.20 Long term technical assistance SDA4.21 Office running cost for central, provinces and districts SDA4.22 Financial technical assistance for both central and provincial levels SDA4.23 Providing management and logistic tools for central, provinces and districts SDA4.24 Support cost for freight for all international procurements.

4.6.3 Specific Interventions, Target Groups and Equity

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

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

SDA1.1 Improved diagnosis through refresher training and training new VHWs on diagnosis and treatment for target areas through 4 day training (y1:maintain 13,120VHWs, y2:80%=10,496, y3: 70%= 9,184, y4: 7,872, y5: 6,560)

By June 2008, 13,120 VHW will be trained in 6,560 villages in 114 dsitricts accomplishing the targets set by the GFATM Round 1(2003-3008). While it is expected that over the next 5 years of this proposal term ending 2012, further reductions from the current achievement in malaria rates (incidence, SPR, API ,mortablity and morbidity) will be marginal, it is estimated that the population at risk would be approximately reduced to 70% (2.4 million) from the 2001 baseline (3.6 million. In year

1 of this proposal the refresher training for 6, 560 VHWs (average 1 VHW per village) will be carried out. Remapping and restratification exercise planned in years 1, 3 and 5 would be vital in determining population at risk and the subsequent delineation of high risk areas requiring VHWs to be maintained.. In year 2 of this proposal, there will be villages where scaled down interventions might be required, and other villages where interventions need to be initiated or scaled up.. Training/refresher training will be conducted alternate years (Y1, 3 and 5 of this proposal). On-going supervision from district, provincial and central malaria staff will also ensure that VHWs are regularly supervised. The budget allocated for these monitoring activties are appreciably more than in Rounds 1 and 4 highlighting the NMCPs priority shift from coverage to quality of service delivery. Overall, with the downward trend in malaria, it is expected that approximately 80% or 4,952 VHWs will need to be given refresher training in Year 3. This reduction will continue in Year 5 (50% or 6,560 VHWs). Trainings for VHWs are done at different sites, ie- village, health center, district depending on the feasibility. An evaluation done in early 2007 among VHWs *(Annex 4)* in 6 provinces highlighted the need for improvements to be made in the training process. A notable change in this proposal is the increase in the number of days from two to a four day training which will also include demonstrations on the use of artesunate suppositories and basic communication skills for VHWs. The trainers will either from the provincial or district malaria station or physicians from the respective hospitals who have already been trained thorugh TOT process in the earlier Round 1.

SDA1.2 Provide RDTs for all levels of health facility in target areas including VHWs

Available data from 475 health facilities (IPD+OPD) and 6,560 VHWs averaged 2.1 test/day (this ratio obtained

from MIS Apr-Nov'06). This equates to 5,318,460 test per year. However, CMPE will be enforcing guidelines on usage of RDT in hospitals (SDA 4.5.4 and 4.10 of this proposal) and will reduce procurement to 25% for hospitals (IPD+OPD). The proposal procurement for RDTs has also taken

into consideration a marginal reduction in the number of test done by VHWs and health centers to 0.5test/day which equates to 1,180,800 test/year and 21,375test/year respectively. This justifies a procurement of 46,465 boxes of RDTs in the first year of this proposal. The first year of this proposal coincides with the on-going R4Y4 grant. The allocated budget would be shared with the balance under the first year of this proposal = $615,661. A similar allocation occurs in year 2 of this proposal which coincides with R4Y5 ($283,220 allocated for procurement of RDTs). In year 3 of this proposal, it is expected that the requirement for RDTs would be 80% of the previous year. This 80% reduction is maintained from year 2 to year 5 of this proposal . However, results from the remaping and restratification In year 1,3 and 5 will determine the actual needs.

Procurement of RDTs and ACTs is done by the PR procurement unit through a UN agency (WHO, UNICEF). As this is a temperature sensitive product, QA is assured from supplier to arrival in country where it is stored in a central store with adequate temperature controls. Transportation (SDA 4.9) from central to district and district to health centers and VHWs necessitates temperature controls as well (SDA 4.13). Training of health staff are through activities described in SDA 4.14 to 4.14.4).

SDA1.3 Provide ACTs for all levels of health facility in target areas including VHWs

The procurement of ACTs (Coartem®) is in accordance with the National Treatment Policy. After a pilot introduction in 2005, all 17 provinces since 2006 have been using Coartem as the first line antimalarials for uncomplicated malaria. Drug resistance studies since 2005 have shown no resistance to Coartem. In Year 1 and 2 of this proposal, procurement of ACT will continue from GFATM through the R4Y4 and R4Y5 funding. Subsequently from Year 3 to 5 procurement of ACT will be from this proposal. ACT needs are estimated to reduce from the previous years (70% in Year 3, 60% in Year 4 and 50% in Year 5). These estimates are based on the trend of decline in malaria burden. However, results from the remaping and restratification in years' 1, 3 and 5 (SDA 4.1 to 4.4.3) will determine the actual needs. Training of health staff are through activities described in SDA 1.1 and SDA 4.14 to 4.14.4).

SDA1.4 Provide suppositories for pre-referral treatment

This proposal will continue to support the provision of pre-referral treatment for severe malaria through the use of Artesunate suppositories. Both 50mg (pediatric age group) and 20omg (adults) will be procured. Accurate estimations are difficult to make and the proposed procurement has taken into account the shelf life of the product of 3 years . Training of health staff are through activities described in SDA 1.1 and SDA 4.14 to 4.14.4).

SDA1.5 Provide Artesunate injectable for the treatment of severe malaria.

A recent evaluation in 6 provincial hospitals showed 116 cases of severe malaria over a retrospective 6 month period, out of which 73 (63%) were children<15yrs. In 2006, 1918 cases of severe malaria received artesunate injectable. Due to the declining trend of severe malaria and malaria mortality, this proposal envisages a reduction in the number of cases requiring treatment for severe malaria. Procurement of Artesunate injectable from the concurrent R4Y4 and R4Y5 grants will necessitate procurement from this proposal only in Year 3 to Year 5. From the previous year, an estimated drop to 70% requirement in Year 3 to 50% in Year 5 is estimated. Compliance to standard treatment guidelines will be of importance and this is highlighted in SDAs 4.5.4 through integrated monitoring from the Central Monitoring Unit and SDA 4.10 through regular supervision from malaria staff.

SDA 2.1 Identify bed net coverage, accceptance and usage through national bed net survey

The results of the 2006 MICS (Multiple Indicator Cluster Survey) are yet to be verified. Due to the nature of its sampling methodology, the NMCP will carry out a national bed net survey in year 1 and year 4 of this proposal. This will determine the baseline for the time frame of this Round 7 grant. The suvey will be carried out through technical assistance from a partner with suitable experience in this

field (potential technical assistance is considered from the London School of Hygiene and Tropical Medicine/ITM, University of Antrwep-Belgium/Malaria Consortium) in collaboration with CMPE and National Insititute of Public Health, Laos. The baseline survey in Y1 will also determine the adequate coverage of nets per household. (Adequate = minimum 1 net for 2.5 persons and/or nets available for all mobile/forest goers). This indicator will be a measure of the NMCPs technical oversight to ensure adequate coverage of nets in the high risk areas as well as adequate coverge of the population per village (at least 80% per village).This proposal aims in maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage. It is in these villages that priority will be given to ensure at least 80% coverage of the population per village.

SDA 2.2 Among the covered total population at risk (3.6million), Procure insecticide to retreat old nets

(Y1: 1,179,948, Y2: 1,114,248, Y3: 900,948, Y4: 600,632, y5: 300,317 conventional nets)

SDA 2.4 Provide dipping material for 4,200 villages

SDA 2.5 IBN Dipping campaign for 310 health centers and 4,200 villages

Of the existing 1,179,948 conventional nets procured from the 5 years of Round 1 and Round 4 till 2006, the on-going R4Y4 budget will provide sufficient budget to procure 34,066 liters of insecticide to retreat these nets. However, the total insecticide required is 39,332.liters of which the balance (5,266 liters) will be procured in the first year of this proposal. A similar top up of from the R4Y5 budget of 11, 592 liters to treat the remaining existing 1,114,248 nets in Year 2 of this proposal is also budgted for. The R4Y4-Y5 budget will see exisitng conventional bed nets re-treated. No new conventional nets are planned from end of Round 1 (2008). This proposal over 5 years will see the gradual replacement of conventional nets with LLINs. The procurement of insecticide for retreating conventional nets will be reduced gradually and cease in year 5 of this proposal with the last procurement of LLINs replacing existing conventional nets.

In support of the bed net retreatment activities in the villages, bed net dipping sets and campaigns will continue to be provided to the communities. VHWs, health center staff, district malaria staff supervise these activites in the villages.

SDA 2.3 Procurement of LLN for replacement of remaining ITNs (Y3-Y5)

LLINs was introduced for the first time in Lao PDR in 2006 with an initial procurement of 150,000 nets (75,000 Olyset™ nets and 75,000 Permanet™ nets). The on-going R4Y4 and R4Y5 plans provide for the procurement of 73,000 and 273,000 LLINs respectively. No additional LLINs will be procured thorugh this proposal in years 1 and 2. In years 3 to 5, 333,684 LLINs procured yearly will eventually replace the exsiting conventional nets. A recently concluded 2 part evaluation on the acceptance and bioassay of LLINs is in the final stages of its report. Results from this will help indicate certain preferences of certain communities to the 2 types of LLINs and guide the NMCP in its LLINs plans.

SDA 2..6 Health education for target population in 17 provinces

Traditionally, the IBN dipping campaigns take place over a maximum 6 months (February –July) just before the rainy season and the peak of the malaria season in Lao. These campaigns also allow for health education on malaria prevention,. diagnosis and treatment. SDA 2.6 allows for health education activites to

carry on in the remaining months of the year.

SDA3.1 Baseline survey for knowledge, behavior and practices among ethnic minorities in target villages SDA3.2 Planning and consesus workshop for 5 target provinces

SDA3.3 Developed IEC message for Ethnic minority groups (EMGs) in pilot area by partners

SDA3.4 Dissemination of lesson learned and result of the pilot interventions

SDA3.5 ProvideTechnical Assistance for this specific objective

SDAs 3.1-3.5 are in support of a distinct objective (objective 3) of this proposal in establishing innovative village based IEC interventions in malaria endemic ethnic communities that are currently underserved. The Lao PDR Sixth National Socio Economic Development Plan (2006-2010) and National Growth and Poverty Eradication Strategy (2003) highlights the 47 designated poorest districts that represent 1..26 million of the country's population, covering 2,935 villages and 111,850 poor households (55.4% of total poor households in country and contributing 53% of the total number of malaria cases in 2006). In addressing these gaps among ethnic populations, the NMCP proposes through this proposal to adopt in an intensive advocacy, communication and social mobilization project, involving 5 provinces in a total of 782 villages (over the 5 year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant, reaching an estimated 15 major ethnic groups with an approximate population of 260,000. (A list of provinces, district involved and target villages ove the 5 years are given in ***Annex 16.(a).*** This specific objective will engage, as the main implementing agents, both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and

resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE etc) and other local Lao civil

associations(PEDA , SADP etc) as well as vital coordination roles of civil societies (Lao Womens Union, Lao Youth

Organisation) and including them in all phases of scaled-up malaria control efforts in these ethnic populations. At

the end of the proposal term, policy recommendations for scaling-up malaria control plans for poor EMGs

will be made available and Lao would host regional (GMS) meeting for info sharing on lessons learnt and

best practices and provide forum for partner networking. . In Year 1, the following activities are planned:

(1). Recruitment of partner staff (administrative and field cordinators) through advertisement (2). GFATM

project management (financial and programmatic) training for partner staff (3). Baseline survey in target

villages (4) Concensus meeting - review of results from baseline survey and finalizing Plan of Action. In

Year 2, implementation of field activities by the partners in collaboration with the malaria staff in the target villages.

Implementation by all partners will be under over all guidance of CMPE and TA who will ensure that:

1. national malaria guidelines and policies will be followed by all partners.

2. training curriculum will have standardized content but presentation, delivery and training method may differ for the particular ethnic group

3. IEC materials will be designed by partners, piloted and produced centrally(CMPE/CIEH)

4. All materials from partners will be reviewed and approved by CMPE and the project TA before use/production.

5.Possible interventions include:

a. Design, pilot and produce ethnic sensitive IEC tools, job-aids and materials and trainings on use.

b. Training Village volunteers and lcoal health staff, including village heads, LWU, teachers, LYU, ….

c. Implement regular IEC activities using different locally relevant strategies. Average xx village)

d. monitoring and supervision of field activities

Detailed workplan and budgets are given in ***Annex 16(b) and 16(c).***

A preliminary indicator: Number of villages in targeted ethnic minority areas with ethnic sensitive IEC interventions is introduced as a measure of this objective. (However, if is proposed that other indicators,

both process and outcomes will be better defined after the baseline survey in Year 1. Depending on the

feasibility of reporting these indicators, we would consider adding them at that stage to the proposals indicators in Attachment A.).

To assist the CMPE in this specific objective, a Project Coordinator/Social Scientist has been budgeted for. An initial 11 month/yr contract in Y1-Y2 and for a 9 month/yr in Y3-Y5.

TOR for the TA for the 1st year:
(1) involved in situtational analysis prior to baseline survey.Provide training for counterpart staff.
(2) Oversee the coordination and routine reporting from all partners.
(3) Assess the quarterly achievements in meeting targets and indicators.
(4) identify key behavioral change challenges for malaria control in these communities, review effectiveness of current strategies and interventions, and identify priorities and knowledge and implementation gaps for better malaria control.
(5) Undertake a comprehensive review of health practices and health seeking behavior regarding malaria among selected high risk communities, including a review of social norm and gender differences in

responding to different health concerns;
(6) Prepare a community participation action plan to ensure the full participation of ethnic minorities, women and communities in the project's processes and benefits.
(7) To design and apply social/anthropological methodologies along with the various partners to measure the impact of the selected malaria control strategies on individuals and communities.

Capacity concerns of partners are outlined in *Section 4.11.1* of this proposal.

SDAs 4.1 to 4.4 are activities for the remaping and restratification of malaria. These activities will be implemented in Year 1, 3 and 5 of this proposal.

SDA4.1 Strengthen epidemiological surveillance through re-maping and restratification of malaria - Analysis of malaria by village using existing MIS/PCD data.

This process involves the retrospective collection of malaria data over 3 years (2004-2006 or 2007) by village. **SDA 4.1.1** plans for a preliminary national workshop for concensus on case definitions, source of data, data collection and entry and development of template for data entry. A TA consultant (6 months in the first year) will develop frame work and tools required (See TOR, *Annex 20)* with CMPE technical staffs. The workshop will involve Provincial malaria staff - 2 including Epidemiology staff in a

3 day workshop where the provinces present provincial plans and timeframe on 3rd day. This plan will include sequential dates for district level training according to region -north, central and South for CMPE to participate. Tools (forms, CDs will be produced after the workshop and distributed to all provinces during the district training. Selection of villages for ACD survey (SDA 4.2) will also be determined in this workshop on presentation of available data from the provinces.

SDA 4.1.2 Training of Dsitrict staff on standardized data collection from village. Provincial malaria staff who attended the national workshop will train Provincial hospital -(civil and army staff), DAMS, DHO at 3 regional sites. CMPE staff (2) per site will oversee this activity.

SDA 4.1.3 Supervision of data collection by CMPE Epid staff to 3 provinces per region (3), 1 district per province.

No additional cost is budgeted for the actual data gathering as this would be routine work over a maximum of 6 months by the staffs involved in each of the 17 provinces. In year 2 and 4, a budget has been allocated for supervision from CMPE to the provinces by the designated Epidemiology staff responsible for monitoring the provinces in his/her region. Provinces selected for supervision will be those that show poor performance with MIS reporting.

SDA 4.1.4 Data entry into master software (GIS based, Microsoft transferable for provincial use). Forms and CDs with the provincial data (by village) will be sent to CMPE Epidemiology Unit. Data verification will be done at CMPE with the TA. An additional technical GIS assistance will be engaged during this period.

SDA4.2 Conduct ACD/malariometric surveys**.** ACD surveys will be implemented in 8 provinces, 18 district, 180 villages . These villages will be decided during the national workshop (SDA 4.1.1). The survey period will be done over a maximum period of 6 months in these villages from July to November (malaria season). SDA 4.2 involves 4 phases –a Preparation, Pre-test, Consensus meeting and actual Survey phase. Kindly see ***Annex 17*** for details)

SDA4.3 Liaise with private development projects. For stratification process this activity ensures liaison with related central and provincial departments to determine available retrospective data and data that can be collected regularly and input into GIS based software at CMPE.. At the central level, agencies identified include but not inclusive of (1)Mining companies - Ministry of Mineral and Energy/Industry (2). Plantations - Ministry of Agriculture & Forestry (3). Hydro dams - Ministry of Mineral and Energy (4) Highway and railway projects - Ministry of transport and communication. At the provincial level, the Provincial Public Health department will coordinate this activity along with the Provincial Malaria Station liasing with the provincial office for Forestry, Industry and Trade, CTPC.

Possible data gathered would be maping of existing and planned development project in the particular province which could include among others, location, phase of development (eg..land

clearing), workforce – number of workers, migrants), health infrastructure – clinic, camps, etc, vector control activities. This information will be used in activities related to SDA 4.6 at both central and provincial levels.

SDA4.4 Restratification of Malaria .This activity will be the result of analysis of SDA 4.1-4.3. The findings will be consolidated into a draft restratifaction plan with the help of a WHO consultant. A concensus meeting workshop for Development of policy will be held where the proposed new stratification will be discussed (SDA 4.4.1). The newly formed TWG (SDA 4.5) will also review the proposed stratification. Following a concensus, the printing of a revised National Malaria Policy will be done followed by a disemination workshop conducted at Central and provincial levels in the first quarter of the following year (SDA 4.4.2). These activities will be implemented in Year 1, 3 and 5 of this proposal. In the event that the stratification does not involve changes to the National Malaria Policy, the dissemination workshops will serve to reinforce both central and provincial level staff on the existing stratification of malaria risk areas and the policies of the national malaria programme.

SDA4.5 Formation of Technical working group(TWG) and implementation of 3 predefined objectives

SDA 4.5.1 Formation of Malaria Technical Working Group and its term of reference (TOR) ***annex 18(a).***

In addition, the lead agency of TWG (CMPE) will have working secretariat (Focal person (1) at CMPE + secretatriat (2) (external hire)). This would be essential to coordinate and facilitate effectively all activties of the TWG.

SDA 4.5.2 TWG engage relevant agencies and partners/stakeholders thorugh quarterly/ad hoc TWG meetings

Composition and structure of the TWG is outlined in the attached ***annex 18(a).***

SDA 4.5.3 Development of guidelines, SOPs, etc, printing and dissemination through central and

provincial level meetings

Four predefined objectives have been identified (these objectives were identified in the proposal development process through gap analysis, discussions with senior MOH officals, technical agencies and findings from field monitoring activities). These objectives are also in line with the National Malaria Strategic Plan (2006 – 2010). Through SDA 4.5.3, the TWG will support concensus meetings at central level, facilitate the development and printing of guidelines, SOPs, policies and conduct dissemination meetings at provincial levels.

SDA 4.5.4 Supporting the implementation of pilot interventions/activities.

As mentioned above, 4 prediefined objectives have been identified as prioirty areas to be address within this GFATM proposal:

1. Networking and guidelines on engaging private sector development projects (hydro dam, plantations, mining etc)

2. Establishing regional malaria surveillance sites

3. Central Monitoring Unit (CMPE, FDD. Curative, MPSC) on drug/treatment related issues

4. Establishing an incentive system for VHWs

Details and breakdown of budget estimates are given in ***Annex 18(b).***

Of the four predefined objectives for the TWG over the 5 years, three objectives are measurable in outputs: **(1)** Networking and guidelines on engaging private sector development projects (hydro dam, plantations, mining etc) **(3)**. Central Monitoring Unit (CMPE, FDD. Curative, MPSC) on drug/treatment related issues (**4**). Establishing an incentive system for VHWs

The remaining one, (**2**). Establishing regional malaria surveillance sites and require strong political support and are guraded in terms of outcomes. However, the necessary activities to accomplish these are budgeted for. At the end of Phase 1,if not feasible, these objective (#2 – regional malaria surveillance site) will be negotiated with the GFATM for funds to be reallocated for Phase 2.

SDA 4.4.5 TWG Revise of national malaria control policy (strategies, treatment for special groups, ITN policy etc)

As outlined in SDA 4.4

SDA4.6 Capacity building and strengthening of Malaria Surveillance and reporting system

SDA 4.6.1 Early Warning System (EWS). At present, criteria for outbreaks have not been defined clearly. This proposal seeks to develop a simple (Eg. Excel based graph monitoring - mean +/- 2SD) early warning system (EWS) for outbreaks and early response system at provincial level (this system is to be part of MIS reporting monthly).This will be developed and piloted in Year 1 with technical assistance from WHO (with data obtained from SDAs 4.1-4.3) and pretested and implemented in 17 provinces in Year 2. In year 3, the proppsal seeks to further support this system through revising/updating the system in 17 provinces and central level. The on-going stratification process(SDA 4.1-4.3) conducted in Y1, 3 and 5 will also serve to input and update this EWS. In addition, establishing internet connection at all 17 provincial malaria stations, (SDA **4.6.6**) will greatly reduce delays in sending timely reports, make verification of data process easier and support mapping based information to be exchanged and reported. The budget allocated also takes into accout necessary maintainence and antivirus software. Capactiy building courses for both central and provincial staff towards this activity. (SDA 4.19.1) are also in support.

SDA 4.6.2 Training on MIS, malaria surveillance and EWS for central and provincial malaria staff. This training will be conducted in 3 Sites (Northern, Central and Southern regions), 3 days workshop at each site involving a total of 58 staff from CMPE and provincial levels. (7pp from CMPE and 51pp form Provinces). The contracted technical assistance for malaria surveillance and information systems (4.7.1) will assist in this activity (kindly refer to draft TOR, ***annex 20***.)

4.6.3 Printing of MIS forms and PMS forms (Procurement Management System)

To be done in Y2 once forms have been revised. The emphasis will be to make available computerized reporting thorugh internet (SDA 4.6.5) and through electronic media to speed up reporting time and verification process, complementary to hard copies which can be sent as follow up record.

4.6.4 Five provinces (HPN, BK, PGSL, SK, ATTP) to have specific full time staff for Data management

The current situation in these 5 northern provinces is limited in terms of human resource. The rational, current provincial staffing and task analysis is attached. Kindly refer to ***annex 19***

4.6.5 Supporting regular monthly MIS data collection from remote(Zone 3 –old stratification) areas: HC and VHW for travel (include sending report, collecting supplies, monthly meeting etc). The need for the NMCP to incentify malaria VHWs in clear and very timely. This would not just be as a reward mechanism but also ensure that quality in EDAT through the use of expensive commodities (RDTs and ACTs) is maintained and the potential to misuse is reduced. Policy and consensus will be determined through the activity of the TWG (SDA 4.5.4) which will also include a feasibility assessment, pilot and setting up of financial mechanisms and controls in the first 2 years of this proposal. An indicative budget of $80,000 per year in the remaining 3 years of this proposal term is allocated towards scale up implementation at national level. Strategy for involvement of VHWs in broader health components (ie- EPI, MCH, TB etc) will be determined by the TWG. At the time of writing this proposal it is not clear if the National Health Sector Development Plan (2006-2010), to be tabled in August 2007, outlines a national strategy for VHWs.

SDA4.7 Technical assistance for Malaria surveillance and information systems

The expert will provide technical assistance to the NMCP in the areas outlined in SDAs 4.1-4.4 and 4.6. Proposed time frame: Y1: 6 months, Y2: 5 months, Y3: 3 months, Y4: 2 months, Y5: 3 months.

The specific TA period will be determined by CMPE and will coincide with activities planned in SDAs 4.1-4.4 and 4.6. Kindly refer to ***annex 20*** for draft TOR.

4.8.1 Sustain 3 regional sites for QA of microscopy in close collaboration with WHO/WPRO network.. This activity is already initiated by the NMCP through its Round 1 Year 5 plans. Provincial Malaria stations at 3 sites, Luang Prabhang (northern region) Vientiane- (central region) and Savanakhet- southern region will continue under this proposal's funding to serve as quality control and assurance centers for malaria microscopy. Microscopists from these centers have already been graded experts by WHO through its microscopy competency asessement trainings. Activities will include supervision to field sites – provincial and district hospitals as well as provincial and district malaria stations under their respective regions, strengthening microscopy slide quality assurance through regular monitoring and on-the-job trainings. In support of this, the NMCP will provide 114 compound microscopes for the districts (**SDA 4.8.2**)– district malaria stations and hospitals where malaria slide microscopy is done and through **SDA 4.8.4** providing Laboratory Reagents for province and district for 17 PAMS and 114 DAMNs

Microscopes have not been procured in the grant term of either Rounds 1 and 4 malaria. Most microscopes at district level are old and B.E.R. In addition, stereo microscopes (for entomology) will be provided to 10 provinces in support of technical staff who attened the entomology and susceptibility testing training in Thailand. This will input into activities planned under SDA 4.11 and 4.1 – 4.3.

SDA4.9 Delivery of Malaria commodities from central to villages

SDA 4.9.1 Delivery all commodities from Central to provinces/districts and SDA **4.9.2** Delivery all commodities from districts to health centers/villages are for all procurements (bed nets, RDTs, ACTs, suppositories, injectables, dipping sets, IEC materials etc) . Estimation of cost of

transportation for this proposal has been based on incurred cost for the same in 2007. For some products (RDTs, and suppostories), the medium of transportation necessitates temperature controls as well (SDA 4.13).

SDA4.10 Supportive supervision at all levels

SDA 4.10.1 Supervision for project finance and logistic management and **SDA 4.10.2** Finance and Programmatic training for news partners. These trainings will be conducted by the PR and or Senior SR responsible officer for all provincial malaria staff responsible with the management, financial and logistic aspects of the GFATM malaria grant. In addition, it will also include the training (in year's 1, 3 and 5) of CMPE's contracted partners (NGO's) over the grant term (SDAs in support of objective 3).This will ensure timely programmatic and financial reporting to CMPE.

SDA 4.10.3 Provincial Supervision of malaria FIELD ACTIVITIES to district and villages. This activity is budgeted for an averaged 3 provincial malaria staff to supervise 3 districts (district malaria station, district hospital) and 3 villages (health centers and VHWs) over a maximum duration of 12 days in a month. Note: This activity is implemented only over three quarters because the provinces will focus on Supervision of IBN Dipping campaigns and health education in last quarter of every year.

4.10.4 Supervision of IBN dipping campaigns inlcuding health education in villages. This activity is planned for the 3rd and 4th quarter of each year. In support of the bed net retreatment activities in the villages, bed net dipping sets and campaigns will continue to be provided to the communities. VHWs, health center staff, district malaria staff supervise these activites in the villages.

4.10.5 District Supervision of malaria FIELD ACTIVITIES to health center to villages

4.10.6 Malaria Control activities, Monitoring and supervision from Central (CMPE) to

provinces/districts

This proposal has allocated an overall 15% of its allocation to monitoring and supervision. Maintaining the achievements made so far demands an investment in ensuring the gains are not lost. From the previous 2 GFATM grants, there was insufficient budget to prioritize the role of supervision from the district level which is the closest monitoring unit to the at risk villages. This proposal has allocated for this based on 2 supervisions per quarter from each district malaria station to their respective health center. In addition, staff from the health centers will also be tasked to monitor selected village within their catchment areas every quarter. The allocated budget in the Round 4 grant which overlaps with the Year 1 and 2 of this proposal is insufficient when compared to the scope of increased activities for central and provincial level supervisions and monitoring. A workshop on monitoring and evaluation (SDA 4.10.8) is budgeted for every year for provincial and district staff.

4.10.7 On the job MIS supervision from Epid unit CMPE to province (1 Epid staff assigned to one region (total 3 regions) - to 1 province every quarter for first year).

This activity is budgeted for every year of this proposal in line with the NMCPs strategy for 2 central staff from the Epidemiology unit at CMPE to be assigned responsibility for MIS for provinces in 3 regions (north, central and south). Supervisions are meant to provide on-the-job training, verify data collected and ensure bottlenecks in reporting are solved. Provinces to be supervised will be determined by the Epidemiology unit at CMPE based on MIS returns received from the provinces. In the first year of this proposal, an average of 1 province per quarter per region will be supervised. The frequency in the subsequent years is reduced.

4.10.8 Workshop for M&E (central and provincial staff)

Effective monitoring and supervision is an essential component of this proposal. This workshop to be

held in the 3 regions, will be held every year for provincial staff and selected district staff (total 3 participants per province). Prior to the workshop in the first year, the existing monitoring forms will be fine tuned and translated into Lao language. Electronic copies will also be given through CD to all participants. Trainning will include the use of the monitoring forms for different levels of staff and different sites supervised, proper supervision technique, reporting and feedback and how to institute corrective measures at provincial/district level. GFATM reporting forms for each provincial/district activity within this proposal will also be standardized in the first year. Performance of the provinces will be presented every year. Bottlenecks in GFATM reporting will be discussed and corrective actions taken.

SDA4.11 Strengthen entomological surveillance

The MALVECASIA research network (2002-2005) studied the distribution and insecticide resistance of malaria vectors in Southeast Asia (Vietnam, Cambodia, Laos and Thailand) coordinated by the Institute of Tropical Medicine (Belgium). The project was supported by the INCO-DC programme of the European Commission and by the Belgian Cooperation. The proposal intends to further continue with entomological and related activities in support of this proposal's goal. The key elements of this proposed 5 year technical assistance with ITM would be: (1) to resume mapping of malaria vectors and monitoring insecticide resistance in Lao PDR (2) vector surveillance data incoporated into remaping and restratification process planned in Year 1, 3 and 5 of this proposal through the upgrading of the SEAGIS database and software (3) pilot the introduction of hammock nets and other innovative vector control measures among high risk populations/forest goers (4) capacity building courses for CMPE with the main objective of having a qualified national entomologist by the third year of this grant term. Details of this contracted technical assistance (agreed draft) with ITM is attached in *annex 21*.

SDA4.12 Monitoring drug resistance in 3 sentinel sites

Routine monitoring of drug resistance to the first line antimalarials drug (Coartem) would continue annually through out the term of this grant in three sentinel sites. In addition, the NMCP will consider additional TA from WHO Mekong Malaria Programme (MMP) to ensure standardized protocols are followed at all stages of the monitoring activity.

SDA4.13.1 Introducing PCW in Quality assurance for RDTs

Experiences in Lao PDR and elsewhere has demonstrated the limitations of RDTs in remote tropical areas, where exposure to high temperatures can reduce the sensitivity of the tests. Deficiencies in quality of manufacture are difficult to detect once the tests are in the field. It is therefore essential to develop ways of monitoring test sensitivity in the field. To be useful, these methods must be simple, cheap, and reliable. In 2002-2003, the National Malaria Centre (CNM) in Cambodia and Research Institute for Tropical Medicine (RITM), Philippines, performed a pilot study of positive control wells for the testing of RDTs in western Cambodia. These devices consist of plastic wells containing lyophilised parasite lactate dehydrogenase (pLDH), an antigen which is targeted by some common types of malaria RDT. This study, demonstrated that the wells had potential for wide use in the field. The NMCP in Laos is eager to have an initial pilot to accurately determine the suitability of these devices for use in the national malaria program in Lao PDR and further scale up nation wide. A protocol has already been drafted (***annex 22(a)*** and list of villages proposed, ***annex 22(b).*** No additional budgetary needs are required for operational activites as the implementation sites are the same as in activties under Objective 3 (IEC for ethnic minorities).

SDA4.13.2 Quality assurance of RDTs and ACTs from field sites

The NMCP has initiated this activity in year 2 of the Round 4 grant. Random samples of ACTs and RDTs are collected from health faciities and VHWs on a scheduled basis from provinces by region in

each quarter of the year. ACTs are tested in the national FDDQCC lab while RDTs are sent to the WHO collaborating center, Pasteur Institue in Cambodia. Results from this activity in the last one year have shown no failed samples. This proposal would also be including artesunate suppositories in the list to be quality tested. Further feasibility with FDDQCC is being studied. Considering poor storage conditions at peripheral health facilities, it is vital that on-going monitoring continues to ensure that the population served receive quality assured diagnosis and treatment for malaria.

SDA4.13.3 In support of SDAs 4.13.1-2, a 2 week WHO Short term consultant from WPRO would be engaged for TA. The main TOR would be in the following:: (1). Participate in concensus meeting on PCWs

(2). technical guidance in national PCW plan (3). work with CMPE in finalizing procurement of PCWs, distribution and evaluation plan (4). development of protocols for QA testing, use and procurement of supportive transport systems for RDTs.

SDA4.14 Updating and enforce national Malaria treament guidelines ***(refer to annex 23)***

4.14.1 Refresher courses for management of uncomplicated malaria for health staff from 51 provincial hospitals **4.14.2** Refresher courses for management of uncomplicated malaria for health staff from 114 district hospitals. **4.14.3** Refresher courses for management of uncomplicated malaria for health staff from 310 health centers.

Refresher courses on diagnosis and treatment for health staff at health center, district and provincial level.(health staff from 51 provincial hospitals, 114 district hospitals, 310 health centers). The R1Y5 target ending April 2008 will see 1430 staff trained. This proposal aims to train/retrain an average of 3 staff from each province along with 2 staff from the district,1 staff from a health center during every training that will be oragnised once every alternate year from year 1 of this proposal. This is a measurable indicator for this proposal (attachment A). Trainings for the different levels of staff will be through separate training sessions.

4.14.4 Severe malaria refresher training and clinical updates on clinical management of malaria for physicians at all levels

Through the support of the previous GFATM rounds, the NMCP has sent physicians, representative of 3 regions (north, central and south) for trainings on management of severe malaria in Thailand. These physicians will now be the core trainers for provincial physicians in their respective regions. This activity will see. The R4Y3 target is 699 physicians trained. R4Y4 targets are yet to be determined. Irrespective of the cummulative number trained, this proposal will commence R7Y3 with training 256 physicians from 51 provincial hospitals, 114 district hospitals and 40 nursing/medical college staff. Yearly trainings are necessary due to the high turnover of physicians in most hospitals. This is a measurable indicator for this proposal (attachment A).

SDA4.15 Coordination meetings at central level with all partners.

The increased intersectoral and partner collaborations that the NMCP will take on in fullfiling its objectives within the SDAs mentioned above in this proposal necessitate regular and coordinated meetings for effective feedback and actions to be taken.

SDA4.16 Evaluation of R4 PPM, continuation of R4 PPM in Round 7

With technical support from WHO, a stakeholder workshop was held in Thalat, Vientiane province, from 23-24 February 2007. The objective of the workshop was to jointly prepare a project plan for piloting a mechanism of private sector involvement in malaria diagnosis and treatment in the next 3 years (July 2007-June 2010, Phase II of the GFATM Round 4 project). The main outcome of this workshop was the concensus to form a national Task Force to oversee the initiation and implementation of private sector involvement. The possible plan in the Phase II is outlined in ***annex 12***.. The main activites in Year 1 and 2 of this proposal will build on the concurrent activities in

Round 4.

Round 7 Year 1 (expected commence mid 2008)	Microplannning in the pilot implementation areas
	Supporting the implementation in pilot areas
	In cooperation with WHO, a good monitoring and evaluation system will be set up and implemented.
Round 7 Year 2 (expected commence mid 2009)	National Task Force/TWG identify further areas to strengthen (ie - procurement/distribution channels, regulatory framework and enforcement etc) and formulate Action Plan, and consider feasibility of scale up, establishing/strengthening national regulatory mechanisms
Round 7 Year 3-4 (expected commence mid 2010)	National Task Force/TWG formulate scale up Plan of Action and implement as national strategy
Year 4	Implementation in targeted areas.
Year 5	Evaluation of implementation

SDA4.17 Carry out an external project evaluation

An external evaluation was done in 2006 (report attached in ***Annex 3***). The NMCP would like to have both programmatic and grant management evaluations made in this proposed grant at the end of its Phase 1 and in year 4 of its implementation. Results of these evaluation would be used to make improvements in both future planning (when refinining annual workplans and indicators) and assessing remaining gaps in achieving the proposal's goals and objectives. To ensure transparency, the invitation for an external evaluation will be advertised internationally.

SDA4.18 Regional international meeting and training

SDA for central and provincial staff attending regional/ international meetings, trainings etc (ACT Malaria, GMP Mekong, WHO-WPRO etc) as and when announced. The NMCP will be giving priority for provincial malaria staff to attend these trainings.

SDA4.19 Capacity building on Management

Focuses on local capacity building courses for provincial/district staff in Year 2 and 4 of this proposal. An entomologist will be trained by 2010 through support in SDA 4.11. Details are in attached *annex 24*.

SDA4.20 Long term technical assistance

The NMCP has contracted from Round 4, a long term technical assistance from WHO. The TA would continue to provide technical support in programme management through working with the NMCP on the preparation of work plans, action plans, budgets, and reports as required by (GFATM) in addition to providing technical support for coordination, planning, implementation, monitoring and evaluation of malaria control activities including those supported by GFATM. This arrangement is proposed to be continued beyond the Round 4 grant term and for this proposal's full term. TOR is attached in *annex 25.*

SDA4.21 Office running cost for central, provinces and districts

SDA4.22 Financial technical assistance for both central and provincial levels

SDA4.23 Providing management and logistic tools for central, provinces and districts

As the GFATM is the sole funder for the NMCP, this proposal continues the consolidated requirement over previous rounds in maintaining administrative cost (Fuel, stationery, office maintenance, vehicle maintenance and office quipment maintenance, office equipment for central and provincial malaria stations. This proposal addresses procurements according to programmatic

requirements. With GFATM support in Round 1 and 4, most provincial malaria stations were supplied with vehicles for monitoring and evaluation of activities and field visits except for 2 provinces (Xieng Khuang and Oudomxay). In addition, IEC and communication equipment are also needed in the 17 provinces. This proposal also seeks to assist the district level malaria stations in the designated 47 'poorest districts'with the provision of computers and motorbikes which are not been provided for in the past. This is seen as proportional to the increased scope of activities that these districts will take on during the term of this proposal.

SDA4.24 Support cost for freight for all international procurements.

Budgeted in this proposal are both CIF (10%) and Buffer(10% with UNICEF procurement only) and an administrative charge of 3% for WHO on procurement of insecticide. These percentages are based on 2006 rates. The SR (CMPE) outlines the technical specifications of the product from WHO and the PR determines procurement sources according to GFATM procedures.

(b) **Target groups**

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

In the past few years the government of the Lao PDR has undertaken a comprehensive poverty analysis using various quantitative and qualitative assessments. These include by poverty lines, vulnerability, HPI (Human Poverty Index), and used participatory approaches to determine poverty as perceived by the poor themselves. These assessments have resulted in the formulation of the Lao PDR National Poverty Eradication plan (NPEP, 2003).

The NPEP presents a framework for growth and development in the Lao PDR with a view to eradicate basic poverty by 2010.It is viewed by the government as a platform from which to exist from least developed country (LDC) status by 2020. The NPEP is being accepted by major donors to

the Lao PDR as being equivalent with a national Poverty Reduction Strategy Paper(PRSP).

The government further considers the NPEP as its contribution to the global effort to reduce poverty by half by 2015, as stated in the Millennium Development Goals (MDG). The NPEP incorporates analyses from the various poverty assessments undertaken and applies an operational concept of poverty – the Lao PDR criteria – as detailed in the Prime Minister's Instruction on the Eradication of Poverty: Decree No; 010/PM, 25th June 2001.Poverty in Lao PDR context is defined as: "the lack of ability to fulfil basic humans needs, such as not having enough food, lacking adequate clothing, not having permanent housing and lacking access to health, education and transportation services". The same decree develops poverty indicators at the household, village, and at the district level to measure this. The government considers district-level poverty as a strategy, and 72 priority district have been identified for poverty reduction efforts. The government requests donors to reference their development support within the NPEP.

This proposal references the 72 priority districts (designated 'poor') and among these 72, there are 47 districts which are further classified/designated 'poorest'. This proposal looks at the burden of malaria as well as the population demographics in these 47 poorest districts. There are approximately 50 or more named ethnic minority groups in Lao. This proposal seeks to establish innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved. The Lao PDR Sixth National Socio Economic Development Plan (2006-2010) and National Growth and Poverty Eradication Strategy (2003) highlights the 47 designated poorest districts that represent 1..26 million of the country's population, covering 2,935 villages and 111,850 poor households (55.4% of total poor households in country and contributing 53% of the total number of malaria cases in 2006). In addressing these gaps among ethnic populations, the NMCP proposes through this proposal to adopt in an intensive advocacy, communication and social mobilization project, involving 5 provinces in a total of 782 villages (over the 5 year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant reaching an estimated 15 major ethnic groups with an approximate population of 260,000. This specific objective will engage, as the main implementing agents, both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE etc) and other local Lao civil associations(PEDA , SADP etc) as well as vital coordination roles of civil societies (Lao Womens Union, Lao Youth

Organisation) and including them in all phases of scaled-up malaria control efforts in these ethnic populations.. During the course of development of this proposal, the NMCP had numerous discussions with the concerned partners, most of whom have had previous or are engaged in projects in these ethnic minority areas. Feedback and suggestions and ideas from open discussions were taken into account in the development of this component of the proposal.

(c) **Equitable access to services**

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

Bed nets

Acess to bed nets are made free (or with subsidized cost) through NMCP, PSI (social marketing of

LLINs) and market purchase of ned nets. Bed net are to be distributed free to the poor, remote and

ethnic populations (as per National Malaria Control Policy, ***annex 1***)

All nets to 47 poorest districts will be free. Dipping activites will be without charge to the

communities in these districts.

Diagnosis and treatment

Diagnosis and treatment for malaria in public health facilities including VHWs are without cost as per

national malaria policy. Regular monitoring from the NMCP and through the Central Monitoring Unit

(SDA 4.5.4).

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

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

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

This proposal specifically outlines in a distinct objective (Objective 3; SDA 3.1 – 1.5), efforts to establish innovative village-based IEC interventions in malaria endemic ethnic communities. The Lao PDR Sixth National Socio Economic Development Plan (2006-2010) and National Growth and Poverty Eradication Strategy (2003). highlights the 47 designated poorest districts that represent 1.26

million of the country's population, covering 2,935 villages and 111,850 poor households (55.4% of total poor households in country and contributing 53% of the total number of malaria cases in 2006). It also identifies that there are shortfalls in meeting health requirements of these isolated areas predominantly inhabited by ethnic minorities. Most have their own distinct language and often only a small proportion of group members (predominantly men) speak the national language, making communication of health messages extremely problematic. Poverty in these communities is often extreme. Through GFATM funding, from Round 1 and 4, the NMCP has been able to provide bed nets for protection against malaria in almost all these villages and establish VHWs in most, delivering early diagnosis and treatment. It has also ensured through its National Malaria Policy, that costs are not a barrier for the poor and vulnerable, curative and preventive interventions for malaria will be free for these vulnerable groups. However, the significant gap of effective communication and behaviour change remains a challenge especially with regards to knowledge on malaria transmission and disease, compliance to bed net use and treatment seeking practices. In addressing these gaps among ethnic populations, the NMCP proposes through this proposal to adopt in an intensive advocacy, communication and social mobilization project, involving 8 provinces in a total of 894 villages (over the 5 year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant reaching an estimated 15 major ethnic groups with an approximate population of 260,000. A baseline survey for ethnic population demographics planned for year 1 of this proposal will identify knowledge, behaviour and practices related to malaria prevention and will outline in detail a plan of action tailored in addressing the unique characteristics of the ethnic population in each distinct district/province. This specific objective will engage, as the main implementing agents, both related governmental agencies (Ministry Education, Ministry of Information and Culture, Department of Ethnic and Social Classes of the Lao National Front etc) and resourcing valuable experiences and expertise from NGOs (Health Unlimited, CARE etc) and other local Lao civil associations(PEDA , SADP etc) as well as vital coordination roles of civil societies (Lao Womens Union, Lao Youth Organisation) and including them in all phases of scaled-up malaria control efforts in these ethnic populations. Though the precise IEC strategy (ie-ethnic sensitive IEC tools, job-aids and materials, trainings etc) would vary adapted to risk group behavior, local health infrastructure and environmental conditions, the common objective would be to effectively address ethnic barriers in upholding superstitious beliefs and practices, unsanitary lifestyles and relying on shamans for cures Ethnic minority groups (EMGs)in pilot areas receive, accept and understand IEC messages Through the involvement of village stakeholders and partners, ie-village elder 'Chao Kok Chao Lao', Lao Womens Union, teachers etc, it will also attempt to address gender issues by involving ethnic minority women in all aspects of health activities, development of relevant IEC and media channels. Capacity strengthening of health care providers in addressing specific needs of the EMGs in malaria control will also be a critical part of this project with the delegation of a coordinating and monitoring partner working closely with

provincial, district and health staff. Lessons learned and results of this pilot intervention will be disseminated at country level to the relevant stakeholders and the policy recommendations for scaling-up malaria control plans for poor EMGs will be made available.Technical Assistance through a long term Ethnic IEC Project Manager/Social Scientist is budgeted for to ensure technical oversight and relevance (kindly refer to draft TOR) and to assist in overall project management. The objective of this intervention will be measured in the included indicator: Number of villages in targeted ethnic minority areas with ethnic sensitive IEC interventions and through the Y4 evaluation/survey. However, based on the findings of the baseline survey in Y1, we would like to include other process and outcome measures if feasible.

(e) **Stigma and discrimination**

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

There is no recognized stigma associated with malaria in Laos.

Linkages to other programs

4.6.4	**Performance of and linkages to current Global Fund grant(s)**
(a)	If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why. *Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.* ***Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained**.

Population recieving EDAT

2008	R4Y4 (end of R1)	Maintain EDAT coverage from R1	**3,358,051population** (114d x 63v = 7182 villages) (81% population at risk)
	R7Y1	Remapping and restratification	
2009	R4Y5	Procurements of RDT/ACT for 2009 are budgeted under R4Y5 and will be made based on restratification results from R7Y1	**3,358,051population** (114d x 63v = 7182 villages) (81% population at risk)
	R7Y2	Maintain or reduce coverage depending on Y1 restratification	
2010	R7Y3	Estimated 70% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**2,350,636 population** (70% reduction from 2008 coverage)
2011	R7Y4	Estimated 60% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**2,014,830 population** (60% reduction from 2008 coverage)
2012	R7Y5	Estimated 50% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**1,679,025 population** (60% reduction from 2008 coverage)

Key service maintained from previous GFATM rounds (rounds 1 and 4) in this proposal:

The remaping and restratification of malaria for the country is a vital part of the proposal's objective that would identify on a regular basis (in Y1, Y3 and Y5) the villages that would require continuation of EDAT. The provision of RDTs however, would be maintained at 80% from the initial (2008) coverage as RDTs would still be required to rule out cases of fever due to malaria. The reductions are estimates from current trends that would be revised if the new stratification shows differently.

Population covered by Bed nets (IBN/LLIN)

By mid 2008, the population at risk (3.6 million, estimated in 2002) would have been provided with bed nets. This proposal will seek to maintain achievements made in the last 5 years while attempting to remap, restratify and channel resources for malaria control for the next 5 years ahead. A national bed net survey will be done in the third and fifth year of this proposal. The R4Y4-Y5 budget will see existing conventional bed nets re-treated. No new conventional nets are planned from end of R1Y5 (2008).This proposal over 5 years will see the gradual replacement of existing conventional nets with LLINs.

2008	R4Y4 (end of R1)	Maintain Bed net coverage from R1. Procure 73,000 LLIN in gradual replacement of exisitng conventional nets	**3.6 million population**

2008	(end of R1)	Procure 73,000 LLIN in gradual replacement of exisitng conventional nets	**3.6 million population**
	R7Y1	Remapping and restratification.	Identifying bed net coverage, accceptance and usage through national bed net survey
2009	R4Y5	Procure 237,000 LLIN in gradual replacement of exisitng conventional nets	
	R7Y2	Results of the remaping and restratification along with of bed net survey guide in maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage with ITN/LLNs	**3.6 million population**
2010	R7Y3	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**
2011	R7Y4	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**
2012	R7Y5	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**
2008	R4Y4 (end of R1)	Maintain EDAT coverage from R1	**3,358,051population** (114d x 63v = 7182 villages) (81% population at risk)

Population recieving EDAT

	R7Y1	Remapping and restratification	
2009	R4Y5	Procurements of RDT/ACT for 2009 are budgeted under R4Y5 and will be made based on restratification results from R7Y1	**3,358,051population** (114d x 63v = 7182 villages) (81% population at risk)
	R7Y2	Maintain or reduce coverage depending on Y1 restratification	
2010	R7Y3	Estimated 70% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**2,350,636 population** (70% reduction from 2008 coverage)
2011	R7Y4	Estimated 60% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**2,014,830 population** (60% reduction from 2008 coverage)
2012	R7Y5	Estimated 50% reduction in EDAT coverage (provision of ACTs and delivery throughVHWs, RDTs to be maintained at 80% from 2008)	**1,679,025 population** (60% reduction from 2008 coverage)

Key service maintained from previous GFATM rounds (rounds 1 and 4) in this proposal:

The remaping and restratification of malaria for the country is a vital part of the proposal's objective that would identify on a regular basis (in Y1, Y3 and Y5) the villages that would require continuation of EDAT. The provision of RDTs however, would be maintained at 80% from the initial (2008) coverage as RDTs would still be required to rule out cases of fever due to malaria. The reductions are estimates from current trends that would be revised if the new stratification shows differently.

Population covered by Bed nets (IBN/LLIN)

By mid 2008, the population at risk (3.6 million, estimated in 2002) would have been provided with bed nets. This proposal will seek to maintain achievements made in the last 5 years while attempting to remap, restratify and channel resources for malaria control for the next 5 years ahead. A national bed net survey will be done in the third and fifth year of this proposal. The R4Y4-Y5 budget will see existing conventional bed nets re-treated. No new conventional nets are planned from end of R1Y5 (2008).This proposal over 5 years will see the gradual replacement of existing conventional nets with LLINs.

2008	R4Y4 (end of R1)	Maintain Bed net coverage from R1. Procure 73,000 LLIN in gradual replacement of exisitng conventional nets	**3.6 million population**
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2009	R4Y5	Procure 237,000 LLIN in gradual replacement of exisitng conventional nets	
	R7Y2	Results of the remaping and restratification along with of bed net survey guide in maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage with ITN/LLNs	**3.6 million population**
2010	R7Y3	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**
2011	R7Y4	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**
2012	R7Y5	333,684 LLIN procured in gradual replacement of exisitng conventional nets	**3.6 million population**

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

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

Provision of diagnostics, drugs and bed nets – lead time, specs, QA improved, LLIN will gradually over 5 years replace conventional nets and thus reduce future needs for insecticide and operational costs for retreatment of nets. Recommendations from the Round 4 Grant Scorecard for Phase 2 continued funding ***(annex 26)***, highlights geographic and seasonal factors should be considered for distribution of LLITNs, especially for remote areas. Lead times for delivery of most of the commodities above have improved and with regular and timely disbursements, operational costs will be transferred to provinces for distribution and re-treatment activities on time. IBN distribution will involve provincial and district governors to ensure poitical commitment in the free distribution of nets to the targeted poor districts.

The Round 4 Grant Scorecard also highlights the need for quality controls and assurance mechanisms for ACTs. While combating fake and counterfeit antimalarials has been taken up through GFATM Round 6 grant implemented by the National FDD, this proposal has continued thorugh activities outlines in SDA 4.13 to ensure field testing of ACTs and RDTs. It has also budgeted for WHO technical assistance in this regards to set up and improve current QA mechanisms, reccomendations for storage and transportation and pilot and scale up an innovative field testing tool (PCW) for quality control of RDTs.

In this proposal, health education has activties have been focused on ethnic minorities where initial effort was made in previous round 1 and 4. Limitations of scarce resources (human and operational) at district and health center level has limited the scope and degree of intervention in the past. With this proposal, partners (both NGO, civil and governmental agencies) have been involved and take up both implementing and monitoring functions with a specific outlined objective (Objective 3) for establishing IEC strategies in the target ethnic communities.

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

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

The GFATM is the sole donor for the NMCP in Laos.

4 Component Section *Malaria*

Private Sector Contributions

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

The current and on-going GFATM Round 4 grant initiates the involvement of the private sector through the process of identification of possible private sector in the context of Lao PDR and the mapping of where these private sector entities are in the context of where malaria is and will be in the coming years. These activities will include in Year 3 (2007) of the Round 4 grant, the formation of a national task force with the relevant stakeholders and initiate baseline surveys and feasibility assessments. In year 4 (2008), it will review the findings of the assessment, structure necessary guidelines/policies and see the formation of coordinating committees at provincial and district levels in preparation for pilot interventions.

This proposal in its proposed start date of July 2008, in its first two years, will complement the on-going initiatives of the Round 4 process by allocation of sufficient budget and resouces in support of the pilot interventions including microplanning in the pilot implementation areas and in cooperation with WHO, a good monitoring and evaluation system will be set up and implemented.

In the final year of the Round 4, there will be a review and evaluation of implementation in the pilot areas where the National Task Force will identify further areas to strengthen (ie – procurement /distribution channels, regulatory framework and enforcement etc) and formulate an Action Plan. This will coincide with Year 2 of this proposal, where the feasibility of scale up, establishing/strengthening national regulatory mechanisms (policy, dissemination, training etc) will be done in preparation for a nation wide scale up in Year 3

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

Size of population group that is the focus of the Private Sector contribution ➔	Private sector entities are to be identified along with their contribution mechanisms in Year 2 of this proposal
Refer to Guidelines for examples on 'Contribution	**Contribution Value**

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Description' ** Add extra rows below to identify each main Private Sector contributor		(same currency as selected in section 1.1)					
** Private Sector Contributor Name	Contribution Description (in words)	Year 1	Year 2	Year 3	Year 4	Year 5	Total

4 Component Section *Malaria*

4.7 Principal Recipient information

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

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

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

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

Table 4.7: Nominated Principal Recipient(s)

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

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	**Sector Represented**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**
Ministry of Health	**Programme and Financial Management of GF Grants**	**Dr. Bounlay Phommasack,** **Deputy Director General of POHP,** **Director of the MOH-GF Projects** **Ministry of Health**	**Ministry of Health** **Tel: 856 21 242980** **Fax: 856 21 242981** **E-mail: onyvanh@theglobalfundlao.org**

4.8 Program and financial management

4.8.1 Management approach

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

Principal Recipient (PR) is the local entity nominated by the CCM and confirmed by the Global Fund to be legally responsible for grant proceeds and grant implementation in a recipient country. Periodic disbursement of Funds to the PR is based on the achievement of measurable results supported by descriptive financial and operational report.s

The PR in its executive role has an oblication to obtain and review regular reports from Sub- Recipients(SRs) . The PR submits comprehensive financial, operational and management reports of grant projects – through the LFA - to the Global Fund. The PR requests any additional information - either of a financial, operational or managerial nature - it deems necessary to satisfy itself regarding the financial Management practices of every SR.

Responsibilities of the PR are as follow s:

1. Collaborate with the CCM to monitor and supervise implementation of grant programs;
2. Report the progress of implementing programs – and of program results achieved - to the Steering Committee of the MOH, CCM, to the Global Fund and to any organizations concerned;
3. Manage day to day operation of the GF Program in Lao PDR;
4. Sign Project Grant Agreements with GFATM and be held accountable to GFATM for the subsequent performance of grant agreements;
5. Sign Grant Agreement with SRs;
6. Budget Project Activities for the PR, SRs and Implementing sites;
7. Request Grant Funds from the Global Fund;
8. Manage and disburse Grant Funds to SRs for project activities;
9. Maintain proper accounting records and accounting books and registers;
10. Implement Project Financial and Accounting Management Systems;
11. Maintain Project Computerized Accounting System;
12. Prepare and submit Financial Reports for grant programs;
13. Check and monitor reports from SRs and Implementation Sites on the use of project funds, at regular periodic intervals;
14. Maintain filing, administrative and supporting documentation. Original supporting documents such as invoices, receipts, contracts are kept safely and securely at offices of SRs and Implementation Sites;
15. Consider and approve budget reallocations of SRs;
16. Submit annual report and annual external audit financial report to the LFA and to the Global Fund; and,

Arrange to appoint an External Audit agent to undertake a thorough review of financial statements prepared for each grant program.

4.8.2 Principal Recipient capacities

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

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

The PR Team is organized into three main functional units supported by technical experts drawn from sub-recipients who are primarily responsible for implementing effective strategies to fight the diseases of HIV/AIDS, Tuberculosis and Malaria in this country. The PR Team working in close collaboration with SRs and Implementing sites provides a significant technical and medical resource available both within Vientiane and throughout the provinces. If necessary external experts may be asked to join the Global Fund program to provide specialist advice and guidance as a specific requirement is identified .

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

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

Eight (8) program grants for all three components of Round1, Round 2 and Round 4(HIV/AIDS, TB and Malaria) worth $ 43.0 million has been awarded by the Global Fund. As of 31 March 2007, $ 22.9 milliom US Dollars has actually been received in country with $ 20.2 million being transferred to Sub receipients to fund spending programs (this represents a Cash-utilization rate of 88 % of funds received by the PR

Global Fund Lao Mar-07

Statement of Grant Performance

	Grant	Grant Amount	Grant Disbursement	Cash Held	Net Transfer & Expenditure	Percentage
Lao	102-G02-M-0	12,709,087	10,577,403	1,079,667	9,497,736	90%
Lao	202-G03-T-00	3,530,391	2,627,203	79,321	2,547,882	97%
Lao	405-G04-H	3,014,946	2,912,151	450,460	2,461,691	85%
Lao	405-Go5-M	3,289,689	3,279,191	619,517	2,659,674	81%
Lao	102-G01-H-00	3,407,664	2,611,009	193,949	2,417,060	93%
Lao	405-G06-T	1,175,826	952,931	290,874	662,057	69%
Lao	HIV R2 P2	4,732,927				
Lao	Mal R4 P2	11,212,533				
		43,073,063	22,959,888	2,713,788	20,246,100	88%

As of 31st. March 2006, all Conditions Precedent negotiated and agreed with the GF have been fully met. All funds for grants progams are currently being released to the PR on a semi-annual disbursement basis reflecting the PR and SRs increased management and financial capacity

(c)	Is the nominated PR currently managing a large program funded by another donor?	☐ Yes ☒ No

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

(e) Describe the performance history of the nominated PR in managing these programs/grants.

Specifically, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.

Not Applicable

(f) Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.

Since May 2005, the PR has revised policies and procedures in finance, management and procurement which were approved by the GF following LFA assessments. Additional staff in different units such as finance, M&E and procurement have been recruited to help manage the new financial, managerial anf procurement systems . The PR will continue with

internal technical assistance in Finance, M&E and procurement for a further duration in order to prudently manage and oversee program activity covered by existing and future grants

The PR will efficiently manage additional grant programs which are currently under GF assessment, partly through expanding the work place and staff and by streamlining existing procedures and processes, where possible. The exact nature of these administrative reforms will be agreed with the GF following completion of the LFA capacity assessment

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

(d) Describe:

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

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

After identifying priority areas to be included in the proposd project proposal (priority areas were identified by wide consultation between the Ministry of Health, the CCM Oversight Committee, related Ministries and mass organizations, and NGO partners), - a newspaper advertisement asked for an " Expression of Interest" by organizations wishing to be involved in the proposal development and implementation. All organizations who replied were invited to stake-holder meetings, in which the areas, the focus, and the future role of the different stake-holders were discussed, at length The selection of the SRS (among the many interested agencies and individuals who wanted to be involved) was primarily based on the experience, performance and capacity of this capable organization and the close fit between their suggested ideas and the priority areas.

For this case, the Centre for Malariology, Parasitology, Entomology (CMPE) is the only Institution in the country, with the required technical capability and talent.

The Centre for Malariology, Parasitology, Entomology (CMPE) has presented a concept paper to the CCM and has been approved for being a sub recipient during the CCM meeting of 14 May 2007.

CMPE has demonstrated capacity in managing the two previous GFATM projects round 1 and round 4 (request for continued funding is approved by the Global Fund

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

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

The CMPE (Ministry of Health, Division of Hygiene and Prevention) is the unique sub recipient approved by the CCM for this proposal.

Four sub-sub recipients: Lao Youth Association Project (LYAP), Promotion Education Development Association (PEDA) and Health Unlimited (HU) will collaborate with CMPE in implementing activities in specific districts and provinces and high risk groups. Concept papers have been submitted to the CCM Secretariate and are attached in annex:

Budget breakdown by partners:

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Govt	3,902,994	2,474,039	6,246,548	5,620,033	5,671,466	23,915,081
NGO	350,260	331,597	341,666	352,391	374,345	1,750,259
Academia/Educational sector						
Total	4,253,254	2,805,636	6,588,241	5,972,424	6,045,811	25,665,340

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

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

4 Component Section *Malaria*

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

(d) Describe:

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

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

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For this case, the Centre for Malariology, Parasitology, Entomology (CMPE) is the only Institution in the country, with the required technical capability and talent.

The Centre for Malariology, Parasitology, Entomology (CMPE) has presented a concept paper to the CCM and has been approved for being a sub recipient during the CCM meeting of 14 May 2007. CMPE has appointed two Sub-Sub Recipient (SSR) to actually implement a specific objective of this proposal (objective 3).

CMPE has demonstrated capacity in managing the two previous GFATM projects round 1 and round 4 (request for continued funding is approved by the Global Fund

4 Component Section *Malaria*

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

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

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Academia/Educational sector						
Total	4,253,254	2,805,636	6,588,241	5,972,424	6,045,811	25,665,340

The proposed activities are intensive as well as requiring specific delivery mechanisms. CMPE and its formal malaria network have limited resources in terms of human resources and expertise; have realized the need to engage grass root organizations from different sectors in ensuring this objective will meet its intended target. HU and PEDA will take on key roles of both coordination, implementation in addition to monitoring and reporting under the oversight and coordination of CMPE. ***This are detailed in sections 4.3.4, 4.6.2, 4.6.3, 4.11.1, annex 16(b) and 16(c) of this proposal.***

The tables below summarize SRs by objective and SDA:

Sub recipient	Sector	Relevant objective	Relevant SDA
Center of Malariology, Parasitology and Entomology	Government	Objective 1, 2 and 4	Objective 1: SDA 1.1 – 1.5 Objective 2: SDA 2.1 – 2.6

(CMPE)			Objective 4: SDA 4.1 – 4.23
Health unlimited (HU)	NGO	Objective 3	Objective 3: SDA 3.1 – 3.3
PEDA	Local NGO	Objective 3	Objective 3: SDA 3.1 – 3.3

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

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

4.9 Monitoring and evaluation framework

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

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

4.9.1 Monitoring and evaluation plan

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

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

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

A. ROLES AND RESPONSABILITIES OF CCM, PR and SRs in M&E.

Roles and responsibilities of the CCM

The role of the CCM is to ensure oversight of the planning and implementation of all Global Fund related activities in the country. The CCM exercises its function in a structure defined by the Terms of Reference for the CCM and in line with general guidelines provided by the Global Fund. The CCM can delegate responsibilities, which can include M&E, to committees and its Secretariat as deemed appropriate by the CCM.

The responsibilities of the **CCM** in M&E are:
1. Monitor and evaluate the performance of the PR(s) and the Global Fund projects;
2. Monitor and evaluate the performance of the SR(s) by reviewing the monitoring and evaluation process of the PR(s);
3. Approve major changes in program implementation plans that are to be submitted to the Global Fund;

The following responsibilities are delegated to the **Oversight Committee**:
1. Review reports from the PR and the sub-recipients, including technical, financial and administrative reports and propose to the CCM necessary action if needed;
2. Review PR's workplans and budgeting, and, if necessary, request further clarifications from PR and SR;
3. Review proposed re-programming (technical and financial);
4. Develop together with the PR an "oversight" monitoring plan, and report to the CCM findings of oversight (monitoring) activities.

The following responsibilities are delegated to the **CCM Secretariat**:
1. Ensure a relevant information is provided to the CCM and Oversight Committee;

Roles and Responsibilities of the PR

The PR is the legally responsible entity for the implementation of Global Fund grants in a country. The PR receives funds from the Global Fund and disburses funds to the SRs as agreed by the Global Fund. The PR establishes and maintains a system for monitoring financial management and programme interventions of SRs.

Under the overall responsibility of the Director PR and the Manager PR, the M&E for programme interventions will be carried out by a M&E Unit located within the PR.

The responsibilities of the M&E Unit are:
1. Establish and maintain a comprehensive reporting, monitoring and evaluation system for GFATM funded interventions;
2. Ensure that planning documents are up to date and in accordance with grant agreements. This includes the following planning documents for all SRs:
    a. Workplans
    b. Indicators and targets
3. Ensure that progress reports are submitted to the PR and subsequently to the Global Fund in a timely manner and that information is checked on accuracy, completeness and relevance;
4. Verify the programmatic information on programme progress provided to the PR through:
    a. desk review of the reports
    b. communication with managers, GF coordinators and M&E officers of the SRs
    c. seeking additional information from key informants
    d. undertaking systematic and regular monitoring visits to sites where GF supported activities are implemented (using checklists, documenting the visits and provide feedback to PR management and SRs).
5. Ensure that SRs interventions are proceeding as planned and propose corrective action in the case

that constraints are identified;
6. Develop and conduct training for SRs related to monitoring and evaluation for GFATM related interventions;
7. Facilitate review meetings (quarterly and or monthly) to share lessons learned.
8. Assist the Management in preparing progress reports and presentations for CCM and other venues of information dissemination.

Roles and Responsibilities of the SRs

The SRs enter an obligation to implement activities specified in the workplans, budgets and intended programme results and to report on activities implemented as well as the use of funds.

The SR has the following specific responsibilities:
1. Ensure that all activities in the workplan are carried out as agreed, including the activities delegated to decentralized structures or Sub-Sub-Recipients (SSR). (Provincial and district levels);
2. Establish and/or maintain a monitoring system that provides timely, accurate, complete and relevant information on Global Fund supported interventions; this includes a comprehensive tracking of routine data as well as the quality assurance of services provided to the target group; wherever possible this system should make use of existing information systems;
3. Produce periodic reports in a timely manner and of good quality;
4. Provide assistance to the institutions carrying out Global Fund supported interventions at decentralized level in planning, recording keeping and reporting;
5. Report to the PR on constraints and delays in the implementation of agreed interventions through the periodic reports;
6. Participate in meetings with the PR as requested;

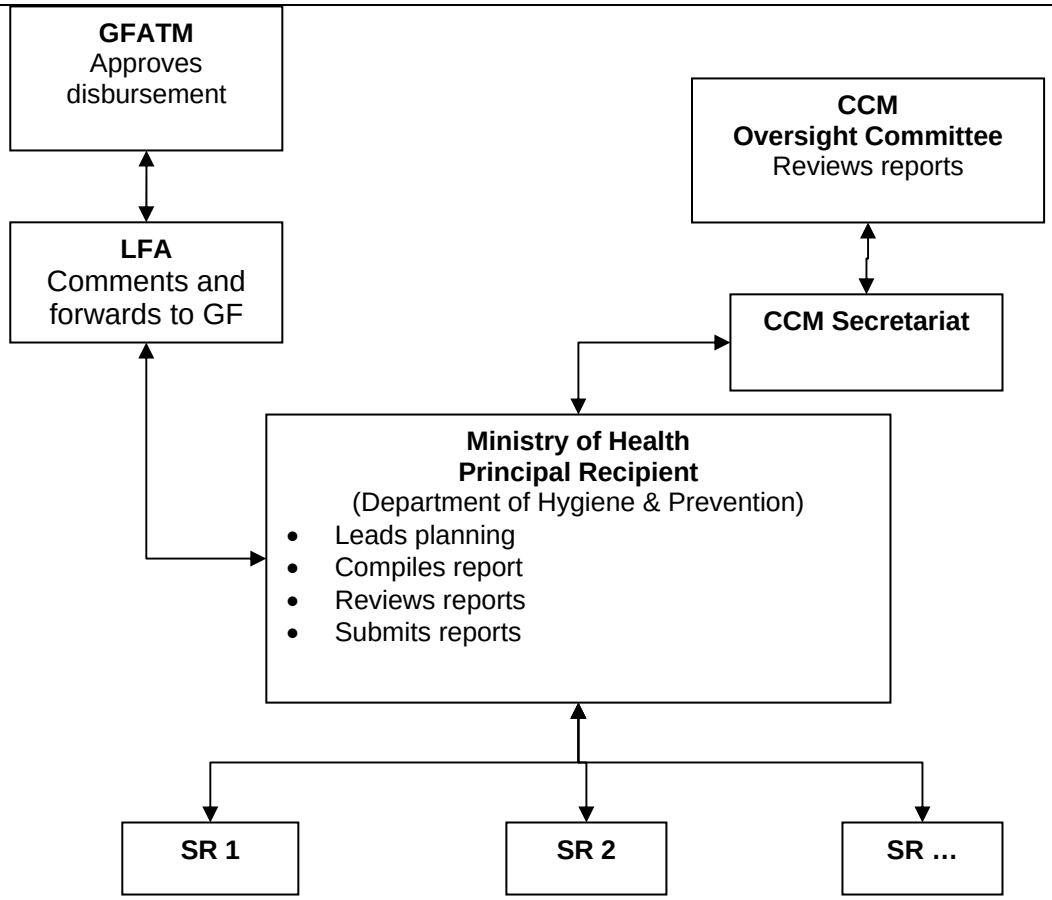
C. REPORTING

Structure

The structure for reporting is shown in the figure below. The PR ensures that reports are submitted on time and that the reports fulfill the requirements of Global Fund.

The SRs all report directly to the PR on the interventions financed through Global Fund grants. The CCM, the CCM Secretariat and the LFA review and comment planning documents and reports.

Figure 1 - Reporting structure for Global Fund interventions



Reporting sequence

The reporting system links the expenditure of funds with achievements of interventions. The sequence of reporting is shown in the Table 6 below. SRs submit quarterly and annual progress reports to the PR. These are compiled into summary reports for each grant by the PR.

Reports are reviewed and commented on by the LFA prior to final submission to the Global Fund through the LFA. The Global Fund examines final reports and LFA's comments prior to making final decision on the next disbursement.

Quarterly disbursement requests are used to document progress against the workplans and also function to request funds for the following period of grant implementation (see below for the forms used for reporting). The disbursement requests contain information on:

- Programme progress – intended results, actual results, reasons for programmatic deviation (if any), other issues, lessons learned and proposed changes
- Cash reconciliation and requirement
- Quarterly budget projection
- Workplan and budget for next quarter by activity

D. The National Malaria Control Programme (NMCP) has its networks in all 17 provinces and 114 districts of Lao PDR. At the national level it has developed a Malaria Information System and has recently reviewed it to adapt to new changes in getting all the relevant information needed.

Data flows from the village health workers to the district anti-malaria nucleus, then to the provincial malaria station and finally, verifies and consolidate as a national data at CMPE. By the end of each quarter the PR verifies the data and send as programmatic report to the GF with cc. to the LFA and CCM.

Re-stratification of malaria endemic areas and Malaria KAP surveys will be carried out to determine the current malaria trend in the country to readjust strategies according to the outcomes of the studies. Every two years there is planning for bed net and blood surveys in selected target provinces(representatives of North, Central and South) to evaluate the bed net coverage in pregnant women and children under 5 years sleeping under ITN/LLN but also the general ITN coverage among general population. KAP surveys will be useful in adapting IEC tools to be used especially among the ethnic minorities as well as vulnerable marginalized population.
Blood and entomological surveys will be also carry out every two years to provide information on impact of malaria control interventions applied in the target areas. In addition to, drug monitoring on the resistance against ACT will be continuing in 3 sentinel sites every years to provide early warning of the trend of P.falciparum resistant strains to the current treatment.

4.9.2 M&E Systems Capacity Assessment

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

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

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

The GF and PR have agreed to implement the M&E Strengthening Tool during the next six months of 2007.

During the GF round 1 and round 4 the PR has carried out an M&E assessment of the SR(CMPE) since the last 2 years, very soon it will also organize an M&E assessment of the malaria control programme with the participation of important key stakeholders, such as WHO, MoH, LFA etc. This proposed Work Plan for malaria incorporates M&E activities(monitoring&supervision, studies, annual workshop etc) with a budget within 15% of the overall budget, it also foresees supervisory field visits for policy makers at various level to feedback to the NMCP on the current strengths and weaknesses as well as bottlenecks identified during the meeting with relevant local authorities and programme managers.

4 Component Section *Malaria*

The emphasis of this proposal is not in the scale up of interventions but in the maintainance and monitoring, supervision and evaluation of all activities in ensuring that the gains made in the previous years are not lost. This is reflected in the M&E budget within this proposal.

4 Component Section *Malaria*

4.10 Procurement and supply management of health products

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

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

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	Global Fund and PR Procurement Unit		☐ Yes ☒ No
Quality assurance and quality control of pharmaceuticals	WHO and UNICEF		☐ Yes ☒ No
International and national laws (patents)	Global Fund and PR Procurement Unit and WHO	Monitor and Supply of goods accordingly to the easonable project's needs following the GF and National Policies	☐ Yes ☒ No
Coordination			☐ Yes ☐ No
Management Information Systems (MIS)	PR and SR Procurement Unit	Manage and follow the GF and Project PSM in proper procedure	☒Yes ☐No
Product selection	SR Technical Group and Procurement Unit	Assess and prioritize of goods to be used for project such as quantity, quality and specification.	☐ Yes ☒ No
Forecasting	SR Technical Group and procurement Unit		☒ Yes ☐ No
Procurement and	PR and SR Procurement	Assess and prioritize of	☐ Yes

planning	Unit	goods to be used for project such as quantity, quality, number and specification. Provide detailed list of goods and budget.	☒ No
Storage and Inventory management	PR and SR Procurement Unit	Monitor and follow up inventory of goods in the warehouse and distribution.	☒ Yes ☐ No
Distribution to other stores and end-users	PR and SR Procurement Unit	Planning of distribution and transportation to target sites, follow up and of goods received	☒ Yes ☐ No
Ensuring rational use	SR Procurement and M&E Unit	Follow up and report of goods used from emd users. Analizing and planning for next procurement.	☒ Yes ☐ No

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

Introduction

The PR is represented in the Ministry of Health by the Hygiene and Prevention Department (see the organizational chart below).

The PR is responsible to procure the SR health products and non-health products needs.

The overall goals of the program is to:

- Decrease the use of counterfeit and substandard antimalarials and related antibiotics, starting from the high risk areas, and then scale up to the entire country by the end of year 5.

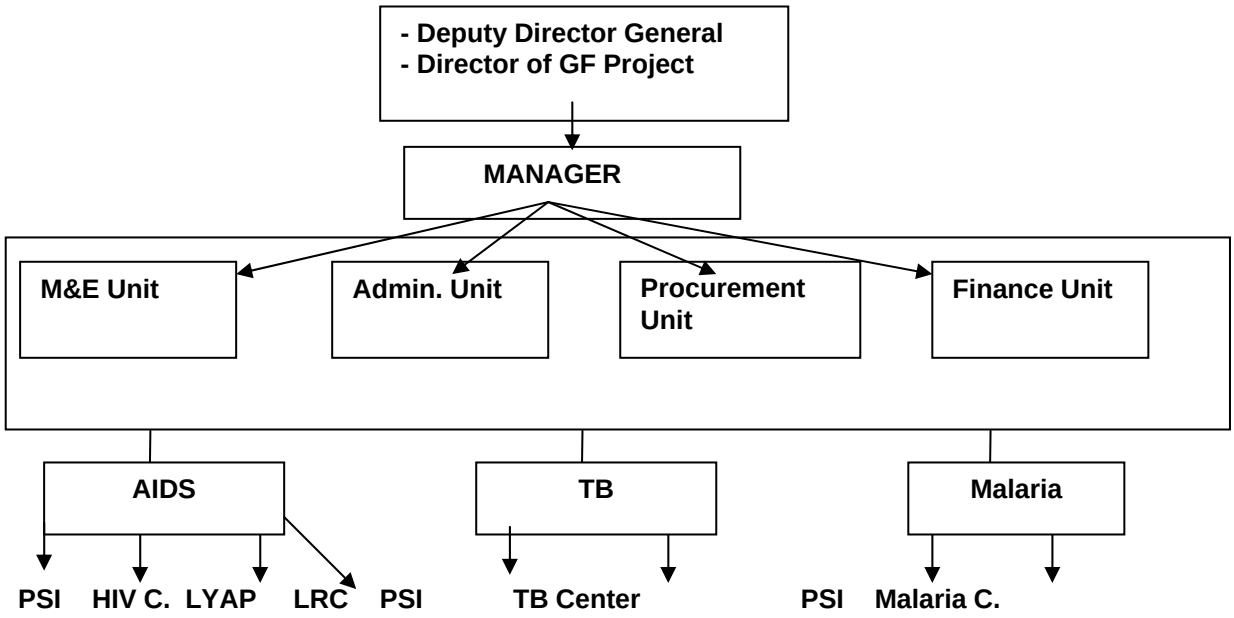
The objectives are:

- Strengthen law and regulation enforcement, and inspection to combat counterfeit and substandard medicines.
- Education of the public, private providers and prescribers on the presence of counterfeit and substandard medicines, and rational use of antimalarials.
- To improve procurement, distribution and storage conditions for antimalarilas and also other medicines in public hath facilities.

Technical Partners include:

- WHO/WPRO: Procurement Agent for the health products.
- UNICEF: Procurement Agent.
- IDA: Procurement Agent

PR Office (MOH), organizational chart:



Procurement Unit: Uses Procurement Manual of **GF-MOH**

Sub-Recipients for the three diseases:

- **Malaria Center:** pharmaceuticals, health and non-health product distribution. Data collection, monitoring, supervision, prevention.
- **TB Center:** Education, Health Center supply, data collection, monitoring, supervision.
- **HIV Center:** Education, Health Center supply (pharmaceutical, health-products…), data collection, monitoring, supervision.
- **PSI:** tablet distribution for mosquito net re-treatment (Malaria).
- **Blood Center and Lao Red Cross:** blood tests.
- **Lao Youth AIDS Prevention Project (LYAP):** HIV prevention for the young people of Lao PDR. Condom distribution.

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

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

Organization Name	**Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)*
WHO	$500,000
UNICEF	$1,600,000
PR (local bidding. Health Commodities and Non-Health Product	$50,000

4.10.3 Coordination

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

GFATM is the sole funder for the malaria control programme in Lao PDR.

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

None

4.10.4 Supply management (storage and distribution)

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

☒ Yes
➔ *continue to (b)*

☐ No
➔ *go to 4.10.5*

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

☒ National medical stores or equivalent

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

☒ Sub-contracted international organization(s) *(specify which one(s))*
WHO, UNICEF

☐ Other *(specify)*

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

Storage conditions have improved at central level with a newly constructed warehouse in the capital Vientiane. However, in the provincial, district, health center and village levels, improvements have to be made especially in ensuring cool storage for temperature sensitive products (ACT, Artesunate suppository and RDTs). This proposal attempts to address these issues within the capacity of the NMCP by activites outlined in SDA 4.13.1 -3. At the same time, the strengthened Central Monitoring Unit (under the oversight of the proposed TWG (SDA4.5.4) will periodically monitor the distribution, storage of these medicines and related health products at the provincial and district levels. The PR and SR (CMPE) procurement and logistics unit will also be conducting regular supervision and monitoring activites in this regard.

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

Between 2004 and 2006 CMPE has managed the distribution of almost 1.4 million bednets and approximately 1.5 million RDTs from both Round 1 and 4. Combining the projections of R4 (y4 -y5)and R7, by the end of this proposals term (2013), CMPE will be responsible for the distribution of approximately 1.4 additional bednets (LLINs) and approximately 4 million RDTs. While the scale up to more villages is unlikey to be significant, the proposal focuses instead in reaching the remote and hard to access villages in the remaining R4 grant term. These increased supply demands are not expected to present any problems as CMPE's distribution capacity is high through its network at the district level. The challenge will be for the distribution of malaria commodities, the most difficult and costly logistic arrangements is from district to villages because of accessibility and transportation conditions for remote village.

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

4.11 Technical and Management Assistance and Capacity-Building

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

4.11.1 Capacity building and training

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

Within objective 1and 2

Health products (SDA 1.2 – 1.5)

Both the long term grant TA (SDA 4. 20) as well as the procurement unit of PR will ensure that technical specifications are accurate and sent to the procurement agencies/suppliers on time. However, the lead times from these agencies will have to be negotiated to ensure that the commodities arrive in country in the specified time period. For certain products, ie- ACTs and LLINs, due to global demands, lead times of upto 6-8 months may be unavoidable. Procurement quantities mentioned in this proposal for Year 1 and 2 are adequate and will ensure no stock out of RDTs, ACTs, suppositories, injectables, LLINs or insecticide. Procurement quantities for years 3 – 5 will have to be revised annually according to actual needs as identified thorugh the remaping and restratfication activities outlined in the proposal (SDA 4.1 – 4.4). Although the insecticide content of LLINs are expected to last for 3-4 years, the physical longevity of LLINs will have to be assessed as well. For this, the proposal has budgeted for bed national bed net surveys (SDA 2.1) in years 1 and 4 which will among others, measure the need to have LLINs replaced due to wear and tear. An estimated 10% loss has been factored into the procurement estimated in this proposal.

Within objective 3

Partner capacity is obviously an area of concern with this objective. During the development of this proposal, these issues have been discussed with the relavant partners and measures to address capacity concerns have been built into the proposal. Overall project coordination has been budgeted for thorugh TA (project coordinator/social scientist) (SDA 3.5) who will work closely with both the IEC unit and its partners to ensure efficient coordination, feedback, reporting and technical relevance of the strategies employed. Partner management capacity will be addressed thorugh programmatic, financial and logistical training budgeted for in SDA 4.10.2. Partner staff field supervision is budgeted for in the respective partner budgets (Annex 16(a)-(c) as well as from CMPE. In addition, the role of HU as one of the partners has also been defined for partner monitoring and will be the first level of reporting at the district level to ensure verifications of all reports at the district level before being sent

to the SR (CMPE).

Interviews, selection and recruitment of field staff from the partners will be done with the participation and involvement of district level malaria staff to ensure no conflict of interest and acceptance.

Within objective 4

Limitations in financial and managerial skills will be the constraint for project management. As outlined in SDA4.10.1-2, this will be handled and assisted by a long term expertise at CMPE for financial/accounting and overall grant management and technical assistance. At the level of the provinces as well, project accountants have been recruited through the Round 4 grant. This proposal seeks to continue with such capacity assistance.

Cooperation of other governmental organization involved in the sharing of data for the mapping of restratification of malaria (SDA 4.3). On-going process of collaboration and information sharing necessary especially at provincial level. This would depend to a good extent on the capacity and commitment of the provincial malaria station director. A strategy to overcome this would be the proposals activity for supportive budgets to provincial level for coordination meetings (SDA 4.3.1) with the various partners. On-going supervision and monitoring from central level would also be able to identify bottlenecks and suggest/refer for solutions.

Technical assistance for Malaria surveillance and information systems

As described in Section 4.6.3 of this proposal, the expert will provide technical assistance to the NMCP in the areas outlined in SDAs 4.1-4.4 and 4.6. The specific TA period will be determined by CMPE and will coincide with activities planned in SDAs 4.1-4.4 and 4.6. Kindly refer to ***annex 20*** for draft TOR.. Capacity building and transfer of knowledge and expertise to both Epidemiology and technical staff at CMPE through this TA would be essential in meeting the objectives of the reamaping and restratification exercises in Year 1, 3 and 5 and would contribute to CMPEs ability in performing such activites independently in the years beyond this proposals term.

TA for Objective 3: Innovative IEC interventions for Ethnic Minority populations

As this would be a new and challenging task for CMPE not only in the proposed technical strategies but also in engaging, networking and coordinating with all relevant partners, CMPE has recognized the need and budgeted for in this proposal, in this specific objective, for a Project Coordinator/Social Scientist. An initial 11 month/yr contract in Y1-Y2 and for a 9 month/yr in Y3-Y5.

TOR for the TA for the 1st year:

(1) involved in situtational analysis prior to baseline survey.Provide training for counterpart staff.

(2) Oversee the coordination and routine reporting from all partners.
(3) Assess the quarterly achievements in meeting targets and indicators.
(4) identify key behavioral change challenges for malaria control in these communities, review effectiveness of current strategies and interventions, and identify priorities and knowledge and implementation gaps for better malaria control.
(5) Undertake a comprehensive review of health practices and health seeking behavior regarding malaria among selected high risk communities, including a review of social norm and gender differences in responding to different health concerns;
(6) Prepare a community participation action plan to ensure the full participation of ethnic minorities, women and communities in the project's processes and benefits.
(7) To design and apply social/anthropological methodologies along with the various partners to measure the impact of the selected malaria control strategies on individuals and communities.

Capacity building and transfer of knowledge and expertise to The IEC unit at CMPE and to other partner staff through this TA would be essential in meeting the objectives of the objective 3 and would contribute to CMPEs ability in performing such activites independently in the years beyond this proposals term.

TA for Entomology

This is outlined in section 4.6.3 of this proposal. (SDA4.11). The MALVECASIA research network (2002-2005) studied the distribution and insecticide resistance of malaria vectors in Southeast Asia (Vietnam, Cambodia, Laos and Thailand) coordinated by the Institute of Tropical Medicine (Belgium). The proposal intends to further continue with entomological and related activities in support of this proposal's goal. Capacity building outputs would see a qualified entomologist trained in CMPE, training of other CMPE staff in writing scientific and other technical papers and training of provincial malaria staff in vector surveillance. In addition technical expertise would be shared with CMPE in the remaping and restratification process planned in Year 1, 3 and 5 of this proposal through incorporating entomological surveillance data into the SEAGIS database. This transfer of knowledge and expertise would contribute to CMPEs ability in performing such activites independently in the years beyond this proposals term. Details of this contracted technical assistance (agreed draft) with ITM is attached in ***annex 21***.

TA for QA systems for RDT/ACT/Suppostitory

This is outlined in SDA4.13.3 in section 4.6.3 . In support of SDAs 4.13.1-2, a 2 week WHO Short term consultant from WPRO would be engaged for TA. The main TOR would be in the following::
(1). Participate in concensus meeting on PCWs
(2). technical guidance in national PCW plan (3). work with CMPE in finalizing procurement of

PCWs, distribution and evaluation plan (4). development of protocols for QA testing, use and procurement of supportive transport systems for RDTs.

This activity along with the inputs of the TA and the development of national framework by the TWG, would ensure that the QA systems would be an integral part of the NMCPs policy and strategic plans.

Long term grant TA

A 2 year grant agreement for a WHO malaria consultant was made under the Round 4 malaria grant. The NMCP has expressed a need for continuity of this arrangement in light of the significant progress and achievements made. The current TOR is attached (Annex 25). The transfer of knowledge and information and day to day support in both grant management and technical issues has been possible with the WHO consultant based at CMPE..

4.11.2 Technical and management assistance

(a) **Needs Assessment**

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

Technical capacity within is high and the institute has strong links with a number of international institutes working in the field of malaria control including: Institute of Tropical Medicine (Antwerp), Mahidol University and ACT Malaria. This proposal engages ITM, University of Belgium for the duration of the grant term for technical assistance in the field of entomology. WHO WPRO also provides strong technical support in the form of technical back-stopping and short-term consultants as necessary. A WHO long term project officer has a permanent office at CMPE. Close contact is maintained with all these partners through regular *ad hoc* meetings and frequent e-mail communications.

Short-term TA will be procured under GF R7 for the external evaluation of the programme.

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

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

A number of shorter-term inputs will be required from National consultants to assist with

management and other specific training issues. Nationals or national instituitions (NIOPH, IFMT etc) will be resourced for specific activities as mentioned in the proposal (research activities, surveys, data analysis, technical inputs in the TWG etc). Short-term international assistance will be required for strategy development and specific technical guidance (relating to a range of issues including remaping and restratification of malaria, malaria information systems, social scientist for the ethnic minority component, quality assurance with diagnosis, treatment – RDTs and ACTs etc) and for the mid-term and end of project evaluations. In order to strengthen national capacity national counterparts will be assigned to work alongside all technical advisors.

This approach will maximize the impact of TA on the long-term capacity of the program to respond effectively to any changes in the malaria situation. Short-term international TA will be procured directly by CMPE using WHO WPRO recruitment channels.

5 Component Budget *Malaria*

5. Malaria Component Budget - Overview and general guidance

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

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

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

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

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

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

5.1 Detailed Component Budget

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

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

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

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

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

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

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

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

5 Component Budget *Malaria*

5.2 Summary by objective and service delivery area

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

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

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

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	SDA1.1 Improved diagnosis	531,360	-	371,952	-	265,680	1,168,992
1	SDA1.2 Provide RDTs	601,272	197,797	481,017	481,017	481,017	2,242,120
1	SDA1.3 Provide ACTs	-	-	212,275	181,950	151,875	546,100
1	SDA1.4 Provide suppositories	-	-	7,800	7,800	7,800	23,400
1	SDA1.5 Artesunate injectable	-	-	4,800	2,880	1,440	9,120
2	SDA2.1 Indentify bed net		-	-	104,300	-	

5 Component Budget *Malaria*

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	coverage, acceptance and ussage	104,300					208,600
2	SDA2.2 Prodvide insecticide to reatreat old nets	63,192	139,104	360,384	240,252	-	802,932
2	SDA2.3 Provide LLN for replancement of remaining ITNs	-	-	1,735,157	1,735,157	1,735,157	5,205,470
2	SDA2.4 Provide IBN Dipping Material	84,000	67,200	58,800	50,400	42,000	302,400
2	SDA2.5 IBN Campaign	-	-	37,884	32,472	27,060	97,416
2	SDA2.6 Health Education for target population in 17 provinces.	34,000	34,000	34,000	34,000	34,000	170,000
3	SDA3.1 Baseline survey for knowledge, behavior and practics	58,605	-	-	58,605	-	117,210
3	SDA3.2 Planning and consesus workshop for 8 target provinces	10,202	36,202	36,202	36,202	36,202	155,010
3	SDA3.3 Developed IEC message		331,597	341,666	352,391	374,345	

5 Component Budget *Malaria*

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	for Ethnic minority groups (EMGs) in pilot area by partners	350,260					1,750,259
3	SDA3.4 Disseminated lesson learned and result of the pilot interventions	-	-	15,000	-	33,149	48,149
3	SDA3.5 Technical Assistance on Ethnic IEC Project	55,000	55,000	45,000	45,000	45,000	245,000
4	SDA4.1 Strengthen epidemiological surveillance	104,594	-	33,582	-	33,582	171,758
4	SDA4.2 Conduct ACD/malariometric surveys	56,580	-	56,580	-	56,580	169,740
4	SDA4.3 Liaise with private development projects	1,222	-	1,222	-	1,222	3,666
4	SDA4.4 Restratification of Malaria	16,158	22,580	27,708	22,580	27,708	116,734
4	SDA4.5 Technical working groups	135,325	223,800	156,275	177,800	161,275	854,475
4	SDA4.6 Capacity building and		70,157	140,157	135,157	130,157	

5 Component Budget *Malaria*

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	strengthening of Malaria Surveillance and reporting system	45,157					520,785
4	SDA4.7 Technical assistance for Malaria surveillance and information systems	55,000	42,000	25,000	17,000	25,000	164,000
4	SDA4.8 Strengthen microscope points at all levels	84,786	30,450	30,450	30,450	30,450	206,586
4	SDA4.9 Delivery of Malaria commodities from central to villages	235,000	219,000	203,000	187,000	171,000	1,015,000
4	SDA4.10 Supportive supervision at all levels	286,428	307,013	296,923	302,261	286,756	1,479,381
4	SDA4.11 Strengthen entomological surveillance	124,000	99,000	47,000	8,000	57,000	335,000
4	SDA4.12 Monitoring drug resistance	24,000	24,000	24,000	24,000	24,000	120,000
4	SDA4.13 Quality assurance of RDTs and ACTs	27,500	10,000	12,500	10,000	12,500	72,500

5 Component Budget *Malaria*

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
4	SDA4.14 Updating and enforce national Malaria treament guidelines	-	-	184,419	61,897	184,419	430,736
4	SDA4.15 Coordination meetings at central level with all partners.	1,400	1,400	1,400	1,400	1,400	7,000
4	SDA4.16 Monitoring Public-Private Mix (PPM) in Malaria Control	45,000	10,000	65,000	72,800	80,000	272,800
4	SDA4.17 Carry out external project evaluation	-	40,000	-	-	40,000	80,000
4	SDA4.18 Regional international meeting and training	10,000	30,626	10,000	30,626	10,000	91,252
4	SDA4.19 Capacity building on Management	-	31,695	-	31,695	-	63,390
4	SDA4.20 WHO long term assistance	183,500	183,500	183,500	183,500	183,500	917,500
4	SDA4.21 Office running cost for		152,190	164,060	165,812	167,653	

5 Component Budget *Malaria*

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	Service delivery area *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	central, provinces and districts	103,200					752,915
4	SDA4.22 Finance technical assistance	33,000	34,650	36,383	38,202	40,112	182,346
4	SDA4.23 Providing management and logistic tools for central, provinces and districts	260,055	-	-	1,500	-	261,555
4	SDA4.24 Support cost of frieght all international procurements	128,469	43,733	325,506	315,453	301,942	1,115,102
4	SDA4.25 Incentive of management and staffs of CMPE	94,890	84,713	208,373	218,791	229,731	836,498
Sub-total of component budget		3,947,455	2,521,407	5,974,974	5,398,350	5,490,711	23,332,897
Management fee of PR		305,799	284,229	613,241	574,074	555,100	2,332,444
Grand total of funds requested from the Global Fund:		**4,253,254**	**2,805,636**	**6,588,214**	**5,972,424**	**6,045,811**	**25,665,341**

5 Component Budget *Malaria*

5.3 Summary by cost category

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

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

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

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

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

5 Component Budget *Malaria*

Table 5.3 – Budget breakdown by cost category

Use the "MALTable53Line" button  *in the standard toolbar to insert row at the end of table*

	Breakdown by cost category *(same currency as in section 1.1 of the Proposal Form)*					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	225,280	279,543	409,987	427,133	445,234	1,787,177
Technical Assistance	471,980	430,630	348,363	303,182	362,092	1,916,246
Training	792,690	241,696	815,574	328,235	706,459	2,884,654
Health products and Health Equipment	822,450	423,751	2,655,008	2,526,476	2,277,824	8,705,509
Medicines and pharmaceutical products	-	-	224,875	192,630	161,115	578,620
Procurement and supply management costs	363,469	262,733	528,506	502,453	472,942	2,130,102
Infrastructure and other equipment	360,895	-	-	1,500	-	362,395
Communication Materials	60,860	63,716	85,714	75,462	97,992	383,744
Monitoring & Evaluation	692,295	601,161	678,867	809,310	731,123	3,512,756
Living Support to Clients/Target Populations	-	-	-	-	-	-
Planning and administration	145,392	205,793	215,446	219,069	222,752	1,008,452
Overheads	12,144	12,384	12,636	12,901	13,178	63,243
Other	-	-	-	-	-	-
Sub-total of component budget	3,947,455	2,521,407	5,974,974	5,398,350	5,490,711	23,332,897
Management fee of PR	305,799	284,229	613,241	574,074	555,100	2,332,444
Total funds requested from Global Fund	4,253,254	2,805,636	6,588,214	5,972,424	6,045,811	25,665,341

5 Component Budget *Malaria*

5.4 Key budget assumptions

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

5.4.1 Pharmaceuticals and other health products and equipment

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

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

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

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

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

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

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

Provide any additional information on unit costs below

IN year's 1 and 2 of this proposal, ACTs, artesunate injectables and suppositories would be procured from the on-going Round 4 budget (R4Y4 and R4Y5). Unit costs in this proposal have been based on the last procurement through Round's 1 and 4 through UNICEF or WHO.

5.4.2 Human resources costs

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

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

No	*Description*	Breakdown by year					
		Y1	Y2	Y3	Y4	Y5	Total
	Human Resource as total of proposal budget	5.71%	11.09 %	6.86%	7.91 %	8.11%	7.66%
	CMPE and Provinces	3.04%	4.27%	3.87%	4.47 %	4.59%	4.08%
	Partners	2.67%	6.82%	3.00%	3.45 %	3.52%	3.58%

The allocated budget for human resources in CMPE are in line with the TOR for the specified tasks of its staff (outlined in Annex 27 (a) of this proposal). Salaries for additional contracted staff at CMPE and provinces (finance and accounting, TA) are essential in strengthening management capacity at both levels. Human resource costs (management and technical/field staff) for partners have been agreed upon during proposal development and take into account cost for staff working in remote villages among the ethnic populations.

Details are given in Annex 5.4.2

Kindly refer to Annex 27 (a) and (b) of this proposal for the SR's structure and TOR.

5.4.3 Other key expenditure items

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

For the 5 year term of this proposal, training costs account for 12.36% of the total budget, health and health related products 49.6% and Monitoring and Evaluation 15%. Details are attached in (Annex 5.4.3)

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL *Malaria*

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

Section 4: Component Strategy – Malaria		**Annex Number to your proposal**
4.3.1	Documentation relevant to the national disease program context.	
	1. National Malaria Control Policy (1999)	1
	2. National Malaria Strategic Plan (2006-2010)	2
	3. SEAMO TropMed External Evaluation (2006)	3
	4.. Evaluation of EDAT (Early Diagnosis and Treatment) with MRDT (Malaria Rapid Diagnostic Test) and ACT (Artemisinin Combination Therapy) / Artesunate in 3 pilot provinces + 3 selected scaled up provinces in Lao PDR (1st draft)	4
	5. WHO/ADB Ethnic minority project report	5
	6. Lao Mekong RBM IEC project, Nov 2002 - August 2003 funded by WHO/ADB *(hard copy only)*	6
	7. Malaria Vectors in the Mekong Countries: a Complex Interaction between Vectors, Environment and Human Behaviour (Publication)	7
	8. National Malaria Monitoring and Evaluation Assessment Plan and Indicators	8
	9. National Socio-Economic Development Plan (2006-2010) *(hard copy only)*	9
	10. National Growth and Poverty Eradication Strategy (2003).	10
4.3.5(c) *(**only** if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	NR

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL *Malaria*

4.3.5(d) *(**only** if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism.	NR
4.6	**A completed 'Targets and Indicators Table'** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A – Malaria**
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	Annex 4.6.1 - Detailed workplan – Year 1 Annex 4.6.2 – Indicative workplan – Year 2
4.6	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals.	NR
4.8.3 (c)	List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**)	Annex 28
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	Annex 8
Section 5: Component Budget – Malaria		**Annex Number to your proposal**
5.1	**Detailed component Budget**	Attachment 5
5.1 *(if HSS strategic actions are included – see section 4.4.2)*	Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget).	NR
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	**Attachment B – Malaria**
5.4.2	Human resources costs.	Annex 5.4.2
5.4.3	Other key expenditure items.	Annex 5.4.3
5.1 - 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	NR
Other documents relevant to sections 4-5 attached by Applicant:		**Annex Number to your proposal**
4.3.3 (a)	Lao 2nd Drug use survey: Survey on Anti-malarial Treatment Seeking Behaviour 2005	11

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL *Malaria*

	Public –Private Mix for malaria – Lao GFATM Round 4 and Round 7 plan	12
4.3.3 (b)	Map of the designated 47 poorest districts in Lao PDR	13
	RBM Global Strategic Plan 2005 - 2015	14
4.5.4	Project Time Frame	15
4.6.3 (a)	Ethnic minority IEC component – target areas – partner work plans and budgets – partner budget summary	 16(a) 16 (b) 16(c)
	ACD sites and budget plan	17
4.6.3 (a)	TWG structure and mechanism	18(a)
	TWG proposed areas (4 predefined objectives)	18(b)
	Additional MIS staffing rationale and plan for 5 provinces	19
	Terms of reference for Malaria Information Systems (MIS) technical assistance	20
	Lao PDR Round 7 proposal for Entomological technical assistance and capacity building	21
	RDT PCW Plan	22(a)
	RDT PCW proposed village list	22(b)
	Summary of Lao PDR National Malaria Standard Treatment Guidelines (2006)	23
	Capacity building plan for Year 2 and 4	24
	TOR for Long term Technical Assistance	25

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL *Malaria*

	Grant Scorecard For Round 4 (LAO-405-G05-M) for Phase 2 continued funding	26
	CMPE (SR) Terms of Reference	27(a)
	CMPEs Structure for Round 7	27(b)
	List of Sub-recipients	28

Malaria Attachment A to the Proposal Form

Program Details

Country:	
Disease:	
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	By the end of 2012, to reduce malaria morbidity and mortality by 80% (baseline from 2006) and 90% of uncomplicated (Pf) confirmed cases correctly diagnosed and adequately treated with Artemisinin-combination Therapy (ACT) among the population at risk
2	Maintaining 80% or more coverage of protection from malaria for the population at risk for malaria through ITNs/LLNs
3	
4	
5	

Impact and outcome Indicators	Indicator formulation	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	Incidence of clinical malaria cases- (Number of malaria cases reported (probable and confirmed) per 1000 population	4.3	2006	MOH (routine MIS - CMPE)	1.5	1.3	1.1	0.9	0.8	Year 1 and year 2 targets correspond to the R4Y4 and R4Y5 targets respectively. Depending on the sign date of this proposal, if approved, these targets will be updated
impact	API (Annual Parasite Incidence)per 1000 population	3.1	2006	MOH (routine MIS - CMPE)	0.9	0.8	0.7	0.7	0.6	Year 1 and year 2 targets correspond to the R4Y4 and R4Y5 targets respectively. Depending on the sign date of this proposal, if approved, these targets will be updated
impact	Number of malaria deaths in hospitals	77	2005	MOH (routine MIS - CMPE)	40	37	32	26	20	Year 1 and year 2 targets correspond to the R4Y4 and R4Y5 targets respectively. Depending on the sign date of this proposal, if approved, these targets will be updated
outcome	% of children under 5 sleeping under bed nets (ITN or LLN) in	28% (under verification)	2006	MICS (Multiple Indicator Cluster Survey)	NMCP Bed net survey (baseline for R7 determined)			NMCP Bed net survey (Target to achieve:80%)		The MICS 2006 has yet to be analyzed and endorsed by the MOH. This figure could change after data has been analyzed by MOH and National Institute of Public Health and discussed with relevant partners.(national and international etc...). Given the limitations of the MICS, we would like to do a more representative bed net survey for the country in Y1 to determine the baseline for the time frame of this Round 7 grant
outcome	% of households that own a bed net (ITN or LLN)	69.6% (4,170/5,995)	2006	MICS (Multiple Indicator Cluster Survey)	NMCP Bed net survey (baseline for R7 determined)			NMCP Bed net survey (Target to achieve: 80% households with adequate number of nets)		The baseline survey in Y1 will also determine the adequate coverage of nets per household. (Adequate = minimum 1 net for 2.5 persons and/or nets available for all mobile/forest goers)
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* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Improve access to early diagnosis and appropriate treatment for malaria for population at risk [maintaining 80% coverage of all villages in the designated risk areas]	
2	Improve access to and improve malaria prevention practices among population at risk. [maintaining 100% coverage of all villages in the designated 47 poorest districts + maintaining at least 80% population coverage with ITN/LLNs in all other risk areas]	
3	Establish innovative village-based IEC interventions in malaria endemic ethnic communities that are currently underserved.	
4	Strengthen and improve management of the National Malaria Control Programme at all levels nationwide.	
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Malaria Attachment A to the Proposal Form

Program Details

Country:	
Disease:	
Proposal ID:	

Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5				
1.1	Treatment: Prompt, effective anti-malarial treatment	Number and Percentage of patients with uncomplicated P. falciparum malaria receiving diagnosis (RDT and/or microscopy) and adequate treatment in public and private sector among total number of confirmed uncomplicated malaria cases (ACT)	67.2% (6119/9103)	2006	MOH (routine MIS - CMPE)	NR	80%	NR	85%	90%	90%	90%	Y	Y	Y - cumulative annually	This indicator is measured by the NMCP through the MIS yearly. A breakdown of public and private sector targets might be possible determined in Phase 2 after a pilot intervention with the private sector is evaluated in at the end of Phase 1 and strategies and policies for private sector involvement are laid out (TWG activity)
1.2	Treatment: Prompt, effective anti-malarial treatment	Number and Percentage of severe malaria cases receiving treatment (artesunate IV)	65.7% (1918/2921)	2006	MOH (routine MIS - CMPE)	NR	80%	NR	85%	90%	90%	90%	Y	Y	Y - cumulative annually	
1.3	Treatment: Prompt, effective anti-malarial treatment	No. of physicians trained and/or retrained in management of severe malaria with artesunate injectable at provincial and district hospitals	393	2006	MOH (routine MIS - CMPE)	0 (R4Y4 activity and target)	0	0 (R4Y4 activity and target)	0	256	512	774	Y	Y	Y - cumulative annually	R4Y3 target is 699. R4 Y4 targets are yet to be determined. Irrespective of the cummulative number trained, we will commence R7Y1 with 256 physicians from 51 provincial hospitals, 114 district hospitals and 40 college staff.
1.4	Treatment: Prompt, effective anti-malarial treatment	Number of village health volunteers RE-trained/trained in malaria case management	13'120	(R1Y5 target ending 2008)	MOH (routine MIS - CMPE)		6560			4592		3280	Y	Y	N - not cumulative	The objectives of this proposal is to gradually reduce reliance on VHWs as the burden of malaria has and continues to decline. VHWs selected will be from high malaria incidence villages after remapping in Y1, Y3 and Y5
1.5	Treatment: Prompt, effective anti-malarial treatment	Number of members of staff from public health facilities re-trained (refresher) and trained (new) in ACT and RDT	1430	(R1Y5 target ending 2008)	MOH (routine MIS - CMPE)	345	345	345	345	691	691	691	Y	N	Y - over program term	
2.1	Prevention: Insecticide-treated nets (ITNs)	Number of existing conventional nets re-treated	1'156'553	(R1Y5 target ending 2008)	MOH (routine MIS - CMPE)	0	1,114,248 (R4Y4 activity and target)	0	900'948	600'632	300'317	0	Y	Y	Y - over program term	This proposal over 5 years will see the gradual replacement of exisitng conventional nets with LLNs
2.2	Prevention:Long Lasting Insecticide treated nets (LLNs)	Number of LLN distributed to populations in remote areas (malaria risk zone 3)	284'400	(R4Y3 target ending 2008)	MOH (routine MIS - CMPE)	0	357'400	0	630'400	964'084	1'297'768	1'631'452	Y	Y	Y - cumulative annually	This proposal over 5 years will see the gradual replacement of exisitng conventional nets with LLNs

Malaria Attachment A to the Proposal Form

Program Details

Country:	
Disease:	
Proposal ID:	

2.3	Prevention:Long Lasting Insecticide treated nets (LLNs)	Number of persons at risk of malaria using LLN	711'000.0	(R4Y3 target ending 2008)	MOH (routine MIS - CMPE)	73,000 LLNs procured (R4Y4)	893'500	273,000 LLNs procured (R4Y5)	1'576'000	2'410'210	3'244'420	4'078'630	Y	N	Y - over program term	Procurement quantities and population at risk will be verified after risk mapping in Y1, Y3 and Y5
2.4	Prevention:Long Lasting Insecticide treated nets (LLNs)	Number of villages among the 47 designated poorest districts and among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	3,468 villages in the 47 designated poorest districts + 2,428 villages in the remaining 67 districts TOTAL: 5,896 villages	2006	MOH (routine MIS - CMPE)	remapping and restratification of malaria by village	number of villages in both areas will be revised and updated and determined along with intended LLNs distribution by end of Year 1	XXX villages (and %) among the 47 designated poorest districts and XXX villages (and %) among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	XXX villages (and %) among the 47 designated poorest districts and XXX villages (and %) among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	XXX villages (and %) among the 47 designated poorest districts and XXX villages (and %) among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	XXX villages (and %) among the 47 designated poorest districts and XXX villages (and %) among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	3,468 villages (100%) among the 47 designated poorest districts and 2,428 villages (100%) among the other high risk villages in the remaining 67 districts, in which at least 80% of the village population is protected by LLN	Y	N	Y - over program term	This indicator is a measure of the NMCPs technical oversight to ensure adequate coverage of nets in the high risk areas as well as adequate coverge of the population per village (at least 80% per village). There are a total of 3,468 villages in the 47 designated poorest districts and among the other districts (114-47=67), there are 31 disttricts with 2,428 villages that show a high and/or increasing trend of malaria burden. It is these villages that priority will be given to ensure at least 80% coverage of the population per village.
3.1	Prevention: BCC - community outreach	Number of villages in targeted ethnic minority areas with ethnic sensitive IEC interventions	4	2007	Quaterly reports from coordinating partners at district level commencing in intervention phase (Y2)	2. recruitment of partner staff (administrative and field cordinators) 2. GFATM program management	Concensus meeting - review of results from baseline survey and finalizing Plan of Action	start of implementation phase	195	391	586	782	Y	N	Y - over program term	
4.	HSS (Health Systems Strengthening): Service delivery	TWG succesfully implement 5 pre-defined objectives	0	2007	Reports/ Guidelines/ Policy documents/ Evaluations	TWG formed and determines scope of addressing the 5 predefined objectives	TWG implement 3 pilot activites	Evaluation of 3 pilots and scale up interventions	Implementation of the 3 scaled up interventions	Evaluation of 1year implementation and revision of guidelines/policy/operational issues	Scaling up implementation	Final evaluation of implementation and reccomendations for policy revision/s	Y	N	Y - over program term	Of the 5 predefined objectives for the TWG over the 5 years, 3 objectives are measurable in outputs. The remaining 2 require strong political support and are guraded in terms of outcomes. However, the necessary activities to accomplish these are budgeted for. At the end of Phase 1,if not feasible, these 2 objectives will be negotiated with the GFATM for funds to be reallocated/ceased for Phase 2.