Geneva, March 2003

For the use of the Global Fund Secretariat:
Date Received:
ID No:

PROPOSAL FORM

Before starting to fill out this proposal form, please read the Guidelines for Proposals carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

This form is divided into 4 main parts:

SECTION I is an executive summary of the proposal and should be filled out only AFTER the rest of the form has been completed.

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seeks details on the content of the proposal for each component.

How to use this form:

1. **Please read ALL questions carefully**. Specific instructions for answering the questions are provided.

2. Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.

3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).

5. When **using tables**, all cells are automatically expanded as you write in them.
   - Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

- **To copy tables**, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

6. Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

It is recognised that the country of Liberia is in a state of complex emergency. The objectives and activities set out in this document respond to the situation, aiming to bring the most effective malaria control and prevention to the community.

The first way to achieve this effective malaria control is by introducing new efficacious therapies, which are in line with international best practices and recommendations for a situation such as Liberia. Recognising the drug resistance problems, this proposal puts forward a solution which takes on a two-tiered approach, making available combination therapies to trained health staff, while assessing the full gravity of resistance in order to inform policy in the longer term. Secondly, the role of Community level Health Workers will be reinforced, providing them with medications at the grass root level in an effort to resolve the ongoing accessibility and security problems, which have an inevitable effect on attendance and referral at peripheral levels.

The second strategic approach is to make available preventive measures, which have not previously been available over a large area in Liberia. In this respect, the aim is to target vulnerable groups such as pregnant women and children under five.

Each of these approaches will be supported by standardised Health Education and constant and consistent monitoring and evaluation, which is especially important with the introduction of such new approaches to malaria control and prevention in Liberia.

Partners have come together to develop this proposal. The system of implementation for the activities laid out below is one of integrated approach between all partners with coordination, monitoring and evaluation carried out by technical agencies supporting the Malaria Control Division. Thus, at the highest level the Ministry is supported by the World Health Organisation and the European Union in terms of policy, implementing NGO partners in implementation and technical agencies such as MENTOR in monitoring and evaluation.

With this approach the absorptive capacity of the Liberian Coordinating Mechanism is enhanced, while ownership and capacity development of the Ministry of Health is reinforced.

The period of the proposal is for 24 months beginning January 2004.

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund. The proposal once approved becomes public information.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: Table I.a

Proposal title (Title should reflect scope of proposal)**:**	*Bringing malaria treatment and prevention to the community*			
Country or region covered:	*Republic of Liberia*			
Name of applicant:	*Liberian Coordinating Mechanism*			
Constituencies represented in CCM (write the number of members from each Category)**:**	**6**	**Government – Health ministry**	**4**	**UN/Multilateral agency**
	5	**Government – Other ministries**	**1**	**Bilateral agency**
	6	**NGO/Community-based organisations**	**1**	**Academic/Educational Organisations**
		Private Sector	**2**	**Religious/Faith groups**
		People living with HIV/TB/Malaria*	**3**	**Other** (please specify): Bureau of budget and planning
If the proposal is NOT submitted through a CCM, briefly state why:				

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:**

Table I.b

			Amount requested from the GF (USD thousands)			
			Year 1	**Year 2**	**Year 3** **Year 4** **Year 5**	**Total**
Component(s) (mark with X)**:**		**HIV/AIDS**	-	-	-	**-**
		Tuberculosis	-	-	-	**-**
	X	**Malaria**			-	
		HIV/TB	-	-	-	
		Total	**6,282**	**5,863**	-	**12,145**
Total funds from other sources for activities related to proposal			**2,260**	**1,298**		**3,558**

Please specify how you would like your proposal to be evaluated** (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

Brief proposal summary (1 page) (please include quantitative information where possible)**:**

- **Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:**

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

As Liberia is in a state of complex emergency and accessibility to the population is a problem, the rationale behind the proposal is that activities bring as fully as possible malaria treatment and prevention close to the community bearing in mind the situation.

The overall goal of malaria control in Liberia is to reduce morbidity and mortality due to malaria by 50% by 2010

The objectives are:

1. *To increase access to adequate and efficacious drugs and treatment at health facility and community levels including camps for displaced populations.*
    a. *Train health facility and community level health workers (including care-givers) in malaria case management*
    b. *Procure and distribute drugs and supplies*
    c. *Train for laboratory diagnosis*
    d. *Undertake quality assurance of medications*

2. *Increase the use of IPT among pregnant women*
    a. *Train Health workers in the use of IPT*
    b. *Procure and distribute SP*

3. *Increase coverage and use of personal protective measures including Indoor Residual Spraying.*
    a. *Procure and distribute ITMs and IRS insecticide and equipment*
    b. *Train staff in IRS*

4. *Increase awareness and practice of malaria control and prevention in the community*
    a. *Develop and distribute IEC materials*
    b. *Carry-out community education with IEC materials*

5. *Increase in effective and efficient coordination and capacity to undertake monitoring and evaluation*
    a. *Carry-out extensive monitoring and evaluation of malaria control activities specifically case management and control interventions*
    b. *Carry-out effective coordination of partner activities*

This document was developed by all partners to determine the most feasible and best approaches to malaria control in the Liberian context.

The activities outlined will be implemented through collaboration among the partners including Government, Non-Government, training institutions, faith-based organisations and private sectors. Activities will be coordinated at the central level through the malaria steering committee and at the county level through the malaria working groups. The malaria working groups comprise of all partners working at county level and are responsible for involvement and participation of the community through partners.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

The population of Liberia is 3 million. For the purpose of this proposal the target population is that in counties which have been accessible to partners within the previous 6 months as of May 2003 and in which partners have project funding for primary health care or education programmes will be targeted during the first year. The second year will see activities being extending to the remaining counties.

While the case management component of the project targets all of the 3 million population (assuming that half the population will become ill and visit either a health facility or community level health worker) specified above, the preventive side targets pregnant women and children less than 5 years of age. Thus the target group for the preventive side is 510000 children (17%) and approximately 37500 women per annum (5%).

The whole population will benefit from improved case management of malaria at health facilities, especially those where staff are trained and using combination therapies. In encouraging and undertaking Intermittent Preventive Treatment for pregnant women, the benefit for those attending antenatal clinics will be a substantial decrease in the risk of complicated pregnancy and an increase in child birth weight, thus improving the chances of that child surviving its first year of life.

In targeting families with young children for subsidized mosquito nets, the aim is to reduce clinical disease in those children at their most vulnerable age.

- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By synergies, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken)

Although this proposal only involves malaria, there will be as much integration as possible with other, previously accepted, proposals for HIV/AIDS and TB on a practical day-to-day basis. Where there are the means to combine efforts, such as with training of Community Health Workers or transport of materials this will be done to reduce duplication and effectively maximise resources. All efforts have been made to compliment the previously submitted HIV/AIDS and TB components of the funds.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

The proposal is scaling up its existing efforts, while introducing new innovative approaches to make malaria control more feasible in the Liberian context. Careful consideration has been given to the overall problems of the country, and how those practical and workable solutions can be brought to those problems. At the same time, partners have taken a step towards international best practices and will apply these under new policies and protocols to their current activities.

The proposal aims to integrate malaria to current primary health care programmes being implemented by partners. Already, some partners have implemented the use of new treatments specified in the policy and careful note is being taken of their experience with these.

Monitoring and evaluation will be a strong component, aided by the presence of a technical support agency in malaria (MENTOR).

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines Part II.

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal (Guidelines Para. 10–13)	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition (Guidelines Para. 27-28)	1–10
	Small Island States proposal with representation from all participating countries but without need for national CCM (Guidelines Para. 29)	
Sub-national CCM	Sub-national proposal (Guidelines Para. 30)	1–9 and 11
Non-CCM	In-country proposal (Guidelines Para. 31-35)	12 – 16
Regional Non-CCM	Regional proposal (Guidelines Para. 34)	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines Para. 35)

Country Coordinating Mechanism (CCM)

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:** **NARDA and the Deputy CMO have been removed from the LCM** **Save the Children UK is a new addition as NGO representatives in the health sector** **National Drug Service is a new addition to the LCM** **Johns Hopkins MENTOR Initiative (Malaria Emergency Network for Training and Operational research) will be joining the Liberian Coordinating Mechanism as of June 2003 as technical advisors on Malaria and the LCM malaria component monitoring group**	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):
   The Liberia Coordinating Mechanism for Aids, Tuberculosis and Malaria (LCM)

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**

The Liberian Coordinating Mechanism was formed on the 26th February 2002.

3. Describe the background and the process of forming the CCM (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

Ministry of Foreign Affairs, in response to communication received, mandated the Ministry of Health to spear-head the constitution of a broad base body (CCM) for the purpose of guiding Liberia through the application and subsequent implementation process for the Global Fund for AIDS, TB and Malaria. The Ministry of Health, with the input of the various programmatic areas and the technical arm, WHO, constituted the 29 member multi-disciplinary body hereafter known as the Liberia Coordinating Mechanism.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):
The current LCM set up a sub-committee to develop AIDS and TB proposals. Function of the LCM was to approve the document after final draft. The current LCM has worked to develop and submit the last two proposals for HIV/AIDS and TB.

4. Describe the organisational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

Currently the LCM has a secretariat and is headed by a chairperson. Two ad-hoc committees for purposes of proposal review and strengthening of the MRUI proposal and the Global Funds have been constituted. More long -term committees of the LCM will be established prior to implementation.

Terms of Reference

The term of reference of the Liberian Coordinating Mechanism shall include and not limited to the following:

- *The highest policy and decisions making body of the Global Funds in Liberia*
- *Review, approve and submit all project proposal to the Global Funds International.*
- *Coordinate and ensure implementation of Global Funds activities in Liberia.*
- *Have over sight responsible of the sub-committees and secretarial.*
- *Mobilize materials and financial resource for Global Funds Liberia*
- *Make quarterly, mid-term and final reports to Global Funds International and provide feedback to implementing partners.*
- *To coordinate activities with the PR and LFA to ensure Global Fund is expended according to approve project document and is in agreement with Global Funds International guidelines.*
- *Review and approve all local contracts pertaining Global Funds Liberia.*
- *Liaise with and ensure Government commitment to the Global Funds project.*
- *Other tasks and functions that may be deemed necessary by Global Funds International.*

5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The LCM will meet quarterly and the various sub-committees will meet monthly. Currently, the LCM meets weekly due to preparation of the proposals for submission to the Global Fund.

Operating Rules

1. *There must be quarterly meeting of the LCM.*
2. *All sub-committees must meet monthly.*
3. *Citations to all meeting should be sent a week in advance to members.*
4. *There must be two-third membership present at a meet for decision-making.*
5. *Order of meeting:*
    a. *Meet call to order.*
    b. *Invocation.*
    c. *Reading and correction of pervious minutes.*
    d. *Matter arising from the minutes.*
    e. *Pertaining issue*
    f. *Any other business.*

- *All meeting must be chaired by the chairperson or in his absent the co-chairperson preside.*
- *All documentation of the meeting must be kept.*
- *The view of all members on the LCM must be respected.*

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph):

The LCM will undergo many changes in the next 12 months with the intent of strengthening it. The need for broader participation and a clearer definition of roles and responsibilities has been identified. Translating global partnerships into action at the country level with the wider participation of all the stakeholders will be explored. To begin this process, RBM MENTOR Initiative will be joining the LCM as the technical adviser on malaria and as implementing partner for monitoring and evaluation throughout the LCM. MENTORs role will compliment the Malaria Control Division in enhancing coordination of partners undertaking activities for the global funds.

7. Members of the CCM

Please note: All representatives of organisations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
AFRICARE International NGO	Claudette Bailey	Chief of Party		
Main role in CCM				

Member. sub-committee MSC.

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
MERCI Local NGO	Dr Tete Brooks	Executive Director		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
IRC International NGO	Catherine Lumeh	Country Director		
Main role in CCM				
Member and sub-committee MSC				

gency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
CHAL LOCAL NGO	Mrs Ellen Williams	Executive Director		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
World Vision International NGO	Dr Moses Jeuronlon	Health Coordinator		
Main role in CCM				
Member and sub-committee (MSC)				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Education	Evelyn Kandakai	Minister		
Main role in CCM				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

Member

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Malaria Control Division	Dr Joel Jones	Director		
Main role in CCM				
Secretariat sub-committee MSC				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
TB/leprosy control	Dr. Harrison Freeman	Director		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
National HIV/AIDS Control Programme	Mrs. Sara Beysolow-Nyanti	Director		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Bureau of Planning/MoH	Mr. Nmah Bopleh	Assistant Minister		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Finance	Hon. Charles Bright	Minister		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Planning and Economic Affairs	Hon. Roland Massaquoi	Minister		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**

Ministry of Foreign Affairs	Hon. Monie Captan	Minister		
Main role in CCM				
Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Bureau of the Budget	Hon. Emmanauel Gardiner	Director		
Main role in CCM				
Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Liberia Refugee Resettlement Repatriation Commission	Mr. Sam brown	Executive Director		
Main role in CCM				
Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
USAID Bilateral agency	Dr. Adams Lincoln	Head of programs		
Main role in CCM				
Member sub-committee MSC				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Save the Children UK International NGO	Jane Gibreel	Health Coordinator		
Main role in CCM				
Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Lutheran church of Liberia	Rev. Moses Gobah	Director HIV.AIDS Programme		
Main role in CCM				
Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
YMCA Civil society	Mr. Sam hare	Development secretary		
Main role in CCM				
Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
WHO UN Agency	Dr. Omar Khatib	WHO Representative to Liberia		
Main role in CCM				
Member and MSC sub-committee Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNDP UN Agency	Mr. Marc Debernis	Resident Representative		
Main role in CCM				
Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNICEF UN Agency	Mr. Cyrille Niameago	Resident Representative		
Main role in CCM				
Member sub-committee MSC				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNHCR UN agency	Moses Okello	Resident Representative		
Main role in CCM				
Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNFPA UN agency	Mr. Deji Popoola	Representative		
Main role in CCM				
Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Mother Pattern College of Health Sciences Private sector	Sister Barbara Brilliant	Coordinator		
Main role in CCM				
Member				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Liberia medical and dental ass. Academic organization	Dr. Eugene Dolopei	President		
Main role in CCM				

Member				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health and Social Welfare	Dr. Peter S. Coleman	Minister		
Main role in CCM				
Chairman of Liberian coordinating Mechanism				

**** Principal recipient. This will be inline with AIDS and TB PR**

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organisation** (official registration papers)
- **A presentation of the organisation, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

8. Chair of the CCM and alternate Chair or Vice-Chair Table II.8

	Chair of CCM	**Alternate Chair/Vice-Chair**
Name	Dr. Peter s. Coleman	Evelyn Kandakai
Title	Minister of health and social welfare	Minister of Education
Address	Ministry of health and social welfare Po box 9009 Monrovia, Liberia	Ministry of Education Broad Street 1000 Monrovia 10, Liberia
Telephone	00 (377) 47-510137	
Fax	00(231) 226317	
E-mail	Drcoleman@yahoo.com	
Signature		

9.Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	**Second contact**
Name	Dr. Joel J. Jones	Dr. Benjamin T. Vonhm
Title	Director	Focal point malaria
Address	Division of malaria control ministry of health and social welfare	World health organization J& E Building,

	Monrovia, Liberia	Mamba pt, Liberia
Telephone	00(377)47-516577	00(377)47-519570
Fax	00(231)226747	00(231)226747
E-mail	jjonesdr@yahoo.com	Vonhmb.wholr@undp.org

10. For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph): Not applicable

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g., letter of endorsement from Chair/Alternate of CCM or equivalent documentation and minutes of meeting that reflect CCM endorsement). Not applicable

11. Sub-national Proposal from Large Countries

11.1. Explain why a sub-national CCM mechanism has been chosen (1 paragraph): *Not applicable*

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans (1 paragraph): *Not applicable*

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment. *Not applicable*

Non-CCM applicant *Not applicable*

12. Name of applicant: *Not applicable*

13. Representative of organisation applying: *Not applicable*

Table II.13

	Representative	**Alternate**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	Secondary contact
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organisation Not applicable

15.1. Indicate what type of organisation the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organisation (NGO) or network of NGOs
	Community based Organisation (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Sector
	Faith-based Organisation
	Regional Organisation
	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organisation** (official registration papers)
- **A presentation of the organisation, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons) (1–2 paragraphs): *Not applicable*

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g., Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?** *Not applicable*

16.3 Include letters from supporting organisations (e.g. human rights groups, NGO networks, bilateral or multilateral organisations, etc) supporting your reasons for not applying through a CCM as attachment. *Not applicable*

17. For regional proposals from Regional Organisations or International Non Governmental Organisations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph): *Not applicable*

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment. *Not applicable*

SECTION III: GENERAL INFORMATION ABOUT THE COUNTRY SETTING

Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country. For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.
For further guidance, refer to Guidelines Part III

18. **Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:** (Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant) (1 – 2 paragraphs per disease covered in proposal):

Malaria is endemic to Liberia. It is the leading cause of OPD attendance (40-45%) and is also the number one cause of inpatient deaths.[†] Child mortality rates in Liberia are among the worst in the world (235/1000[i‡]) of these deaths, present data suggests that at least 17.8% (41/1000) are attributable to malaria. Based on these figures, an estimated 120000 children under the age of five die each year in Liberia[3]. Thus, conservative figures are that 21300 children die each year in Liberia of malaria alone. This estimate may well be understated because of the nature of the Liberian situation.

Resolving the malaria problem is not easy in Liberia. The first and most important issue is the suspected resistance to first and second line antimalarials. Unpublished work in Liberia suggest that chloroquine resistance was between 5% to 17% in 1993 in different parts of the country, and by 1995, had reached 38% resistance[ii]. The most recent studies in Sierra Leone indicate increased resistance to SP (over 20%) in one area close to the Liberian border. Those same studies in Sierra Leone show that resistance to chloroquine has been by exacerbated the mass displacement of the population across this region in the last 12 years of conflict which has certainly played a major role in accelerating drug resistance. This mass displacement is also a characteristic seen in Liberia. The ongoing conflict has also led to another problem in dealing with health situation in general, that of accessibility.

Inaccessibility due to insecurity and poor infrastructure has meant that medications and control tools have not been available to the population. There is no widespread historical use of Insecticide Treated Nets in Liberia. Studies carried out by partners in various counties in recent years have shown that population knowledge on the control and prevention of malaria is low. As well as this, previous malaria policy had exacerbated the accessibility problem by limiting the use of quinine at peripheral level for treatment of severe malaria.

19. **Describe the current economic and poverty situation** (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases) (1–2 paragraphs)

The country is grouped among the least developed countries in the world ranking 174/175 countries in the UNDPs Human Development Index for 1999.

[†] MCD: Routine Malaria Surveillance Data: 1993-1999
[‡] Desk Analysis WHO 2001

Poor economic growth performance, high rates of inflation; massive displacements of the agricultural labor force combined with almost total disruption of farming activities in rural areas and high unemployment rate exacerbated by lay-offs in the concession sector are manifested unprecedented levels of poverty.

Socio- Economic Profile	
GDP	*$512 million (2001)*
Per Capita Income	*$150 million (1999)*
Population earning less than $1/day[§]	*76.2% (2001)*
Population in severe poverty	*52% (2001)*
Population with formal education	*33.5%*
Adult literacy rate	*38.5%*
Employment rate	*53.9% (of which 52% is self-employment)*

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.) (1–2 paragraphs):

Liberia is committed to the Roll Back Malaria Initiative. This has been shown in many ways with the signing of the following document:

- *The African Child Survival Initiative for combating Childhood Communicable Diseases, 1981*
- *The Resolution of the World Health Summit of Health Ministers, Amsterdam 1992*
- *The African Initiative on Malaria, 1996*
- *The Abuja Declaration on Malaria, 2000*
- *The Millennium Development Goal, New York 2000*

Action has been taken on these declarations such as the drop in tariffs for mosquito nets from 25% to 2.5% with a further commitment to remove these tariffs completely. This ongoing commitment has seen an extreme effort of the Ministry of Health in bringing the populations awareness of malaria control and prevention.

From this proposal there is also a strong sense of commitment from the government. Appropriate policy changes are being made in order to push forward the activities that have been outlined in this document which include classifying Insecticide Treated Materials as medical items to assure duty free privileges, assuring an emergency ad addendum to the current policy to ensure the National Drug Service can bring in combination therapies.

21. **Countries classified as "Lower-Middle Income" or "Upper-Middle Income" by the World Bank are eligible to apply only if they meet additional requirement (Guidelines Para 8). The sections below are required for proposals from these countries.**

21.1 **Co-financing: describe in both narrative and quantitative terms how domestic or external resources will be used to co-finance the activities described in this proposal, indicating the source and the extent of co-financing (i.e., what percentage of the budget for the proposal is covered by other resources and what percentage is being requested from the Global Fund)** (2–3 paragraphs) Not applicable

[§] UNDP reference

21.2. Focus on poor or vulnerable populations: describe how underserved populations of poor and vulnerable groups will be targeted by the proposal (2–3 paragraphs)

Target populations being prioritised throughout this proposal are pregnant women and children under five. Long Life Insecticide Treated Nets and Intermittent Preventive Treatment will be provided at no cost to pregnant women attending antenatal clinic. Further to this, nets are planned to be subsidized for those families with children under five years of age.

As the country is in a state of complex emergency large amounts of the population have been displaced internally. As well as this, there remain many refugees from Sierra Leone and Ivory Coast in Liberia. These populations are benefit under current partner activities and will continue to benefit with the introduction and use of Insecticide Treated Tarpaulins and Indoor Residual Spraying as well as current free treatment at health facilities.

Combination therapy provided through the global funds will be distributed by NDS through various means. Policy will be revisited regarding current payment schemes to ensure that treatment for malaria is as low as possible within the current cost sharing scheme, if not free for beneficiary.

21.3. Greater reliance on domestic resources: describe in both narrative and quantitative terms how over the duration of the proposal the activities described will be increasingly financed using domestic resources, including the changes in the percentage of the budget covered by domestic vs. Global Fund resources (2–3 paragraphs)

The government will make every effort to increase domestic funding of malaria to 40%. It must be recognised that as Liberia is in a state of complex emergency there are many factors preventing current funding to the malaria control programme. However, with the approach taken for the global funds the capacity of the government will be augmented to take on malaria control with the knowledge that at the end of the current conflict, resources will be utilised by trained personnel.

22. National context

22.1. Indicate the percentage of the total government budget allocated to health (optional for NGO applicants)**:** *7.2% (2001) of the current national budget is allocated to health. This is the highest government budget allocation among social services***.**

22.2. Indicate national health spending for 2001, or latest year available, in the Table III.22.2 (optional for NGO applicants):

Table III.22.2

	Total national health spending Specify year: (USD)	**Spending per capita** (USD)
Public	$ 1,178,894	0.50
Private	Unknown	Unknown
Total	$ 1,178,894	0.50
From total, how much is from external donors?	Unknown	Unknown

22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:**

Table III.22.3

Total earmarked expenditures from government, external donors, etc. Specify Year:	**In US dollars:**
HIV/AIDS	-
Tuberculosis	-
Malaria	$ 10000
Total	$ 10000

22.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs) (optional for NGO applicants):

22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.) (2–3 paragraphs):

Since 1997 the health system in Liberia has remained functional mainly because of donor funding through International Non-Governmental Organizations. The Ministry of health has remained active, however with limited resources, implementation of activities has remained low. This implementation has been undertaken by NGOs in the counties. Their activities are carried out in collaboration with the Ministry of Healt,h and all partners act complimentary to each other and to the Ministry in the field.

Drug delivery is carried out by MOH through the National Drug Service. The National Drug Service is a semi-autonomous body whose role is to procure, store and distribute drugs and consumable supplies to health facilities around the country. Support to the NDS is by the European Union. A t a higher level, the European Union, UNDP, UNFPA, UNICEF, WHO and MENTOR are involved in building capacity of the Ministry of Health.

The process of developing this proposal has further strengthened partnership coordination. The activities outlined in the proposal will for the most part be carried out by partner agencies that have the technical and logistical capacity to build on their existing programmes. The malaria component of this plan will be integrated into existing NGO partner programmes. Within those programmes most partners (SC-UK, MERCI, MSFs, MERLIN and IRC, CHAL) are undertaking case management, while others have been involved in, and are experienced in ITN distribution (IRC and MERLIN). MENTOR, as a technical support agency, will be carrying out training for Indoor Residual Spraying and introducing insecticide treated tarpaulins this year as well as carrying out operational research on new antimalarial therapies. Partners named in the document have been consulted and involved throughout the planning process for this proposal. All partners have agreed to upscale their primary health care or other activities to incorporate the newly proposed strategies and protocols. Partner coordination will continue through the already established Malaria Steering Committee and the Malaria working groups which will be set up at county level.

22.6. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes (NGO applicants should specify partner organisations):

Table III. 22.6

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
Malaria Control Division	Government	Malaria control	$ 10000 1-year
Africare	International Non-Governmental Organisation	Primary Health care specifically Community based health care	800000 (2-years)
CHAL	Local Non-Governmental Organisation	Primary Health care	ND
CAAP	Local Non-Governmental Organisation	Health Education	6 months
MERCI	Local Non-Governmental Organisation	Curative and preventive services	1 – year ND
International Rescue Committee	International Non-Governmental Organisation	Primary health care, Sexual Gender based violence program, primary emergency education	ND
MERLIN	International Non-Governmental Organisation	Primary health care	Current project Sept. 2003 ND
World Vision	International Non-Governmental Organisation	Primary health care	2-year ND
MENTOR Initiative	International technical body	Technical support, capacity development and operational research in malaria control and prevention	1-year $ 200000
Oxfam	International Non-Governmental Organisation	Hygiene promotion, water and sanitation	ND
MSFs	International Non-Governmental Organisation	Primary Health care	ND
Save the Children -UK	International Non-Governmental Organisation	Primary Health care, Child protection	2 – year project
Training Institutions	Training Institutions	Education	Ongoing
WHO	UN agency	Technical support	Ongoing
UNICEF	UN agency	Technical support	Ongoing
Concern worldwide	International Non-Governmental Organisation	Health education and water and sanitation	ND
USAID	Bilateral donor	Funding agency	Ongoing
National Drug Service	Semi-autonomous Government body	Drug and medical supply procurement and distribution, training (stock management)	March 2004 $ 3 million through EU
EU	Bilateral agency	Funding agency, technical support	-

MSFs	Implementing agencies	Primary Health care Hospital support	487858
YMCA	Local Non-Governmental Organisation	Health education, Curative services, education and Peer counselling	2 – years $ 22936

22.6. What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.

Table III. 22.7

Source/Agency	Amount In US dollars:						
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
HIV/AIDS							
Global Fund request							
Unmet need							
Total need							
Tuberculosis							
Global Fund request							
Unmet need							
Total need							
Malaria							
Existing malaria funds					2,260,397	1,297,858	3,558,255
Global Fund request					6,282,253	5,863,325	12,145,578
Unmet need							
Total need					8,542,650	7161183	15,703,833

22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (2-3 Paragraphs)

The major programmatic gaps that will be encountered for malaria are Artemesinin- based therapies with rapid Diagnostic Test kits and Long Life Insecticide Treated Nets. As well as program capacity to take responsibility for partner coordination and monitoring and evaluation of malaria control and prevention activities.

Most of the major partner programmes currently support either Primary Health care or Curative services. Although many partners have funding for the coming years, most have not accounted for the higher cost of combination therapy; Artemesinin based drugs and Rapid Diagnostic test kits. On the prevention side, all partners have agreed to upscale their community health projects to incorporate the distribution of Long Life Insecticide Treated Nets as well as education on malaria control and prevention.

22.9. If a SWAp or a similar fund pooling mechanism exists in your country, briefly describe how it is functioning and if you anticipate using it to administer the Global Fund grant
Not applicable

SECTIONS IV – VIII: Detailed information on each component of the proposal

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PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, so the proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 26.

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component.

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		**HIV/AIDS**
		Tuberculosis
	X	**Malaria**

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

As Liberia is in a state of complex emergency and accessibility to the population is a problem, the rationale behind the proposal is that activities bring as fully as possible malaria treatment and prevention close to the community bearing in mind the situation.

The overall goal of malaria control in Liberia is to reduce morbidity and mortality due to malaria by 50% by 2010

The objectives are:

6. *To increase access to adequate and efficacious drugs and treatment at health facility and community levels including camps for displaced populations.*
    a. *Train health facility and community level health workers (including care-givers) in malaria case management*
    b. *Procure and distribute drugs and supplies*
    c. *Train for laboratory diagnosis*
    d. *Undertake quality assurance of medications*

7. *Increase the use of IPT among pregnant women*
    a. *Train Health workers in the use of IPT*
    b. *Procure and distribute SP*

8. *Increase coverage and use of personal protective measures including Indoor Residual Spraying.*
    a. *Procure and distribute ITMs and IRS insecticide and equipment*
    b. *Train staff in IRS*

9. *Increase awareness and practice of malaria control and prevention in the community*
    a. *Develop and distribute IEC materials*
    b. *Carry-out community education with IEC materials*

10. *Increase in effective and efficient coordination and capacity to undertake monitoring and evaluation*
    a. *Carry-out extensive monitoring and evaluation of malaria control activities specifically case management and control interventions*
    b. *Carry-out effective coordination of partner activities*

This document was developed by all partners to determine the most feasible and best approaches to malaria control in the Liberian context.

The activities outlined will be implemented through collaboration among the partners including Government, Non-Government, training institutions, faith-based organisations and private sectors. Activities will be coordinated at the central level through the malaria steering committee and at the county level through the malaria working groups. The malaria working groups comprise of all partners working at county level and are responsible for involvement and participation of the community through partners.

25. Indicate the estimated duration of the component: *Table IV.25*

From (month/year)**:**	1/2004	**To** (month/year)**:**	12/2005

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Where applicable this set of indicators should include the core indicators as listed in Annex A.

Baseline data: Baseline data should be given in absolute numbers and percentage. If baseline data is not available, please refer to Guidelines. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers and percentage.

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.) (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Table IV.26.1 **Goal:**	The overall goal of malaria control in Liberia is to reduce morbidity and mortality due to malaria by 50% by 2010	
Impact indicators	**Baseline**	**Target** (last year of proposal)
	Year:	**Year: 2005**
Outpatient morbidity attributed to malaria (children 0-5yrs)	**MoH, 1998**	Reduce by 20%
Number of inpatient admissions due to severe malaria	**MoH, 1998**	Reduce by 20%
Number of deaths attributed to malaria (children 0-5 yrs)	**21300 per annum (MoH and UNICEF, 2001)**	Reduce by 20%

26.2. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1: To improve access to adequate and efficacious drugs and treatment at the health facility and community levels including camps for displaced population

In Liberia high mortality due to malaria can be directly linked to the absence of appropriate drugs and adequately trained personnel at all levels of the health care delivery system to treat patients diagnosed with the disease. This situation is exacerbated by the fact that the recommended first and second line anti-malarials have been shown to be compromised. While the introduction of new therapies goes some way towards alleviating the situation significant difficulties remain with access. At this time, with little or no referral taking place, priority will be placed on training community level health workers (including care givers) in the management of malaria and training peripheral health care staff in the use of IM Artemether.

Table IV.26.2

Objective 1: To improve access to adequate and efficacious drugs and treatment at the health facility and community levels including camps for displaced population		
Outcome/coverage indicators	**Baseline**	
	Year:	**Year 2 (12/2005):**
Number of health facilities reporting stock ruptures in previous three months	10% (2000,MCD)	0%
Number of malaria cases treated with artemesinin-based derivatives	MSF etc. to be calculated %	50%
Number of malaria cases treated with **non** artemesinin-based derivatives	Not determined/available	50%
Number of uncomplicated malaria cases treated within 48 hours of onset	Not determined	50%

Objective 2: To Increase the use of IPT among pregnant women

The Ministry of health has recently endorsed the use of the Sulphadoxine-Pyrimethamine at all accessible health facilities and communities. The aim in using SP is to suppress rather than clear parasitaemia to prevent severe malaria in pregnancy. As a way of ensuring maximum compliance, women given SP shall be encouraged to take the drug in the presence of the health worker.

Objective 2: To Increase the use of IPT among pregnant women		
Outcome/coverage indicators	**Baseline**	
	Year:	**Year 2:**
Number of pregnant women attending antenatal services who have taken anti-malaria Intermittent Preventive Treatment according to malaria control policy	0 %	40%

Objective 3: Increase coverage and use of personal protective measures including Insecticide Treated Materials and Indoor Residual Spraying

Priority has been placed on preventions that will have the greatest impact on malaria prevalence and thus mortality. To adapt to the current situation in Liberia different types of Insecticide Treated Materials and IRS will be used. Pregnant women and children under five years will be targeted with these tools as best suits the situation. Pregnant women attending antenatal services will be prioritized in receiving Long Lasting Insecticide Treated Nets (LLITNs) at no cost to them. Subsidized rates for families with children under 5 will be decided upon through focus-group discussions and a fund for the further purchase of mosquito nets will be set-up. The MoH encourages the use of LLITNs, which will reduce the need for training on re-treatment, and are more cost-effective in the long term compared to normal nets.

Objective 3: Increase coverage and use of personal protective measures including Indoor Residual Spraying		
Outcome/coverage indicators	**Baseline**	
	Year:	**Year 2:**
Number of households with pregnant women and children under five years with either sprayed houses, Insecticide Treated Tarpaulins or using Insecticide Treated Nets as best suits the situation.	4.6%	60%
Number of all households in accessible communities have at least one ITN.	ND	50%
Number of insecticide treated nets distributed	30000	

Objective 4: Increase awareness and practice of malaria control and prevention in the community

The Desk Analysis that was developed in 2000 identified limited knowledge of malaria as one of the key contributing factors hindering effective malaria control in the country. In order to address this, the division will work along with the IEC division of the Ministry of Health, media institutions, the Ministry of Education and other stakeholders to develop, test and disseminate appropriate health messages relating to all aspects of malaria control.

Those messages will then be used by the community and in clinics to change population attitude and behavior with regards to malaria control.

Objective 4: Increase awareness and practice of malaria control and prevention in the community					
Outcome/coverage indicators	**Baseline**	**Targets**			
	Year:	**Year 2:**	**Year 3:**	**Year 4:**	**Year 5:**
Number of households nationwide that have received IEC messages on the prevention and control of malaria	Approx. 20%	80%			
Number of schools using IEC materials on malaria prevention and control	0%	50%			

Objective 5: Increase in effective and efficient coordination and capacity to undertake monitoring and evaluation

In order to ensure that the Malaria Division is functional, the capacity of both personnel and the division needs to be upgraded. In addition, the division has to work closely with all other stakeholders that are involved in malaria control (the communities, NGOs, private sectors, etc.). The Malaria Steering Committee has been set-up by the Malaria Control Division as a coordinating body to ensure that planned activities and interventions are properly implemented in a standardized manner. The involvement of partners in malaria control and prevention activities has to be clearly defined to ensure proper coordination and standardization of activities. Considering that Liberia is now in the state of complex emergencies, and that resources that are available to control malaria are quite limited, it is important that partnership be strengthened to maximize resources.

Objective 5:Increase in effective and efficient coordination and capacity to undertake monitoring and evaluation					
Outcome/coverage indicators	**Baseline**	**Targets**			
	Year:	**Year 2:**	**Year 3:**	**Year 4:**	**Year 5:**
Number of partners attending MSC meetings	20%	80%			
Number of program staff actively involved in Monitoring and Evaluation activities	0%	80%			
Number of staff actively planning and reporting on monitoring and evaluation activities	0%	80%			

26.3. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 1: To improve access to adequate and efficacious drugs and treatment at the health facility and community levels including camps for displaced population

Broad Activities:

1. Train health facility and community level health workers (including care-givers) in malaria case management

The provision of appropriate treatment goes beyond the availability of safe and efficacious drugs. Service providers must also be trained in the administration of these drugs and at the peripheral level service providers must also know when to refer. To do this, the Malaria Control Division working along with technical partners shall develop appropriate training protocols and guidelines for the treatment of malaria throughout the country at different levels using ACT for both uncomplicated and severe malaria.

2. Procure and distribute drugs and supplies

The procurement and distribution of drugs and supplies will be carried out through the existing National Drug Service. Drugs will be distributed based on monthly epidemiological reports and the ability of the health staff to use recommended therapies.

3. Training for laboratory diagnosis

Laboratory facilities will be improved at referral facilities. For all other CT will only be administered after a positive Rapid Diagnostic Test. Thus, training must be carried out for those technicians working at referral facilities. In addition training in the use of RDTs will be incorporated into training guidelines for CT.

4. Undertake quality assurance of medications

The MCD working in close collaboration with the division of pharmacy will conduct quality assurance test on random samples of antimalarial products procured from sources other than IDA and other internationally recognized pharmaceutical providers for use in the country.

Table IV.26.3

Objective 1:	To improve access to adequate and efficacious drugs and treatment at the health facility and community levels including camps for displaced population				
Main activities	**Process/ Output indicators** (indicate one per activity; refer to Annex A)	**Baseline** **(Specify year)**	**Targets** **Year 1**	**Year 2**	**Responsible/ Implementing agency or agencies**
Train health facility and community level health workers (including care-givers) in malaria case management*	Number of health facility and community level health workers trained (including care-givers) in malaria case management*	< 1% (2002)	50%	100 %	Malaria Control Division, County Health teams, MSF – B, MSF-F, MSF-S, SC-UK, Africare, IRC, MERLIN, MERCI, CHAL
Procure and distribute drugs and supplies	Number of health facilities reporting stock ruptures	25% (2002)	10%	5%	MCD, WHO, UNICEF, NDS, MSF-B, MSF-F, MSF-S
Training for laboratory diagnosis	Number of Laboratory Technicians trained in proper diagnosis of malaria	20% (2002)	60%	100 %	MCD, Mother Pattern, County Health teams, MSF – B, MSF-F, MSF-S, SC-UK, Africare, IRC, MERLIN, MERCI, CHAL
Undertake quality assurance of medications	Percentage of antimalarial drug samples tested for quality	0.5% (2003)	20%	40%	Pharmacy division, MCD

* This refers training in the use of new artemesinin-based therapies

Objective 2:	To Increase the use of IPT among pregnant women				
Main activities	**Process/Output** **Indicators** (indicate one per activity; refer to Annex A)	**Baseline** **(Specify year)**	**Targets** **Year 1**	**Year 2**	**Responsible/Implementing agency or agencies**

Train Health workers in the use of IPT	Number of health workers trained in the use of IPT	0% (2003)	30%	75%	Malaria Control Division, County Health teams, MSF – B, MSF-F, MSF-S, SC-UK, Africare, IRC, MERLIN, MERCI, CHAL
Procure and distribute SP	Number of health facilities using SP as IPT	2% (2003)	40%	80%	MCD, WHO, UNICEF, NDS, MSF-B, MSF-F, MSF-S

Objective 3:	To increase the use of preventive measures especially in vulnerable groups and reduce vector-human contact				
Main activities	**Process/Output indicators** (indicate one per activity; refer to Annex A)	**Baseline (Specify year)**	**Targets**		**Responsible/Implementing agency or agencies**
			Year 1	**Year 2**	
Procure and distribute ITMs and IRS insecticide and equipment	Number and types of ITMs and IRS materials available	20% (2002)	40%	60%	LCM, Malaria Control Division, MENTOR
Train staff in IRS	Number of partner staff trained in IRS	30% (2002)	50%	70%	MENTOR, Malaria Control Division

Objective 4:	To increase the knowledge of malaria in order to improve malaria prevention and management practices (BCC)				
Main activities	**Process/Output indicators** (indicate one per activity; refer to Annex A)	**Baseline (Specify year)**	**Targets**		**Responsible/Implementing agency or agencies**
			Year 1	**Year 2**	
Develop and distribute IEC materials	Number of IEC/BCC materials developed and distributed	10% (2003)	40%	80%	Education division, Africare,
Carry-out community education with IEC materials	Number of community members with knowledge on malaria control and prevention	5% (2002)	30%	60%	Malaria Control Division, County Health teams, MSF – B, MSF-F, MSF-S, SC-UK, Africare, IRC, MERLIN, MERCI, CHAL, Oxfam, Concern, CAAP

Objective 5	Increase in effective and efficient coordination and utilisation of resources available

Main activities	Process/Output indicators (indicate one per activity; refer to Annex A)	Baseline (Specify year)	Targets		Responsible/Implementing agency or agencies
			Year 1	Year 2	
Carry out supervision	Number of Supervisory forms and reports	0% (2003)	50%	100%	MCD, MENTOR, Health agencies implementing PHC programs
Process and collate malaria specific data from county levels	Number of reports to MSC on county level malaria activities	0% (2003)	50%	100%	MCD, MENTOR
Carry out frequent monitoring and evaluation surveys and studies	Number of studies which have been carried out with MCD staff	0% (2003)	40%	80%	MCD, MENTOR, LIBR

27. **Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs):

The recently developed National Malaria Control Strategic Plan provides the framework to coordinate and strengthen partnerships in malaria control activities. This plan also provides the framework for decentralized health services. Malaria prevention and treatment have been identified as priority areas.

All partners and relevant stakeholders are implementing Primary Health Care including malaria control activities in eleven (11) of the 15 counties. This malaria component will be integrated into existing partner programs, thereby increasing and strengthening malaria control interventions, thus reducing morbidity and mortality due to malaria. Partners working throughout the eleven (11) counties have been working in close consultation to develop this proposal and have accepted to implement these activities. Activities, such as distribution of medications etc., for the remaining 4 counties will take place in the second year implementing what has already been developed with partners.

28. Describe innovative aspects to the component: (1–2 paragraphs)

Careful analysis of the Liberian context had led the partners to decide upon strategies which are best suited to address the current problems such as drug resistance and inaccessibility.
This proposal brings together all international best practices to benefit the population of Liberia. In addressing the suspected resistance problem and the ongoing security situation which prevents efficacy studies being carried out, combination therapy will be introduced alongside Rapid Diagnostic Tests (RDTs) for uncomplicated malaria. The use of ITMs such as the newly developed Insecticide Treated Tarpaulins in IDPs camps will be undertaken along with the use of Indoor Residual Spraying (IRS), as these are recommended as the best responses to the

emergency situation. In addition, IPT will be used for pregnant women attending antenatal services nation-wide. .

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:
Support for the prevention and treatment of malaria will be provided to people living with HIV/AIDS (PLWAs) and they will be encouraged to form support groups to enable them cope with the burden of HIV/AIDS and malaria. They will also play a major role in advocacy and peer education.

29.2. Community participation:
Community participation will be prioritized in the implementation of malaria prevention and treatment. Community members will be trained in the management of simple malaria cases and proper awareness on the prevention of malaria.

29.3. Gender equality issues
There is no gender bias in programming and service delivery at all levels of the health care delivery system of Liberia.

29.4. Social equality issues
All people are provided services equally.

29.5. Human Resources development:
The Malaria Control Division plans to train all levels of its staff, nurses, data manager, parasitologist, entomologist, doctors and other essential health workers in the process. Training will be both internal and external. RBM MENTOR has provided training to partners in malaria in complex emergencies (Freetown, January 2003) and will continue to follow-up on this training especially regarding case management and Indoor Residual Spraying with all partners.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category:

Table V.30

Resources needed (USD)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Human Resources	839,718	839,718				**1679436**
Infrastructure / Equipment	793,990	-				**793990**
Training/ Planning	42,964	42,964				**85,927**
Commodities/ Products	1,423,558	1,423,558				**2,849,775**
Drugs	2,621,872	2,992,077				**5,613,949**

Monitoring and Evaluation	100,000	100,000				**200,000**
Administrative Costs	283,374	283,374				**568,747**
Other (Please specify)	PR 3% 176,877	PR 3% 176,877				**353,755**
Total	6,282,253	5,863,325				**12,145,578**

The budget categories may include the following items:
Human Resources: Consultants, recruitment, salaries, etc.
Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.
Training/Planning: Training, workshops, meetings, etc.
Commodities/Products: Bednets, condoms, syringes, educational material, etc.
Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.
Monitoring & Evaluation: Data collection, analysis, reporting, etc.
Administrative: Overhead, costs for Principal Recipients associated with managing the project, audit costs, etc
Other (please specify):

31. For drugs and commodities/products, specify in the table below the use of the commodity, unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Please indicate the International Non-proprietary Name of the medicines, rather than the brand names.

Please indicate what the commodity/drug will be used for (e.g., whether antiretrovirals are for prevention of mother-to-child transmission or adult treatment; whether insecticides are used for net treatment, retreatment or indoor residual spraying).

Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources.** If prices from sources other than those specified above are used, a rationale must be included.

Volumes indicated in the table below should be consistent with activity targets specified in section 26 when these activities involve procurement.

The Total Cost of Drugs and Commodities/Products should equal the sum of the Commodities/Products and Drugs lines for Year 1 in the table above.

Table V.31

Item/unit (using	**Purpose**	**Unit cost**	**Volume**	**Total cost** (USD)

** Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, 3rd edition, May 2002 (http://www.who.int/medicines/library/par/hivrelateddocs/prices-eng.pdf); Market News Service, Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); 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); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (http://www.stoptb.org/GDF/drugsupply/drugs.available.html)

International Non-proprietary Names for pharmaceuticals)		(USD)	(specify measure)	
Artesunate & Amodiaquine	40% of the population who become ill with malaria will visit the health facility.. Of those who visit 90% will be treated for uncomplicated malaria	1	1,200,000 – 100000 (EU supplies) = 980,000	980,000
IM Artemether	10% of population presenting at health facilities will have severe malaria	7.00	120000 – 14285 (EU supplies)(-50000 rectal art. studies) = 55715	390005
Rectal Artesunate		7.00	50000	350000
SP(can of 1000 tabs.)	For use in IPT (5% of women of childbearing age will become pregnant in one year = 37500/yr) and home management of uncomplicated malaria (20% of population)	21.5	675	14175
CHQ 150 mg(can of 1000 tabs.)	Use in areas where staff have not been trained in the use of CT	-	Already stock of CQ in-country with additional being ordered in December	-
Quinine 600mg/2ml(100amp/pk)	Treatment of severe malaria in referral facilities	15.00	1000 – 750= 500 (500 EU/NDS supplies) 250	7500
Quinine 300 mg (Box of 1000)	Complete treatment for patient who has been on parenteral quinine	30.5	5000 – 4000/2 (EU/NDS supplies) = 500	30500
Diazepam 10mg/2ml(100amp/pk)	Treat convulsions and prevent convulsion in hyperpyrexic patients	7.00	150 (+ EU/NDS supplying 10000)	2100
Paracetomol 500 mg(can of 1000)	Relievepain, and reduce temperature	2.5	21912 – EU/NDS supply = 13912/2 = 6956	34780
Paracetomol 100 mg	Relievepain, and reduce temperature	3.00	4488	13464
ASA pd inj. 1800mg	Bring down temperature, headache and pain	0.48	15000/2 = 7500	7200
Blood taking set + cpd 450		2.79	56650 – 2400 (EU/NDS) = 54250/2 = 27125	151358

Dextrose 5% in water (500ml)	For rehydration and maintenance fluid, route for administration of quinine	.7	34160 – 24160 (EU/NDS) = 10000/2 = 5000	7000
ORS (1L: Box of 50)	To replace fluid loss especially in children with diarrhoea	5.65	13000 – 8000 (EU/NDS supplies) = 5000/2 = 2500	28250
Dextrose 50%(50ml)	Relieve hypoglycaemia	.5	15040 – 5040 (EU/NDS supplies) = 10000/2 = 5000	5000
Canula 22 g (100 pieces)	Needed for administration of parenteral medications	29.4	220/2 = 110	6468
Canula 18 g (100 pieces)		29.4	220/2 =110	6468
Scalp vein 23g (100 pieces)		29.4	220/2 =110	6468
Scalp vein 22g (100 pieces)		29.4	220/2 =110	6468
Scalp vein 21g (100 pieces)		29.4	220/2 = 110	6468
Syringes 10 ml (Box of 100)	Needed for administration of parenteral medications	2.8	1000/2 = 500	2800
Syringes 5 ml (Box of 100)		2.15	4000/2 = 2000	8600
Syringes 2 ml (Box of 100)		1.55	3000/2 = 1500	4650
Needles 21G (Box of 100)		2.29	4000	9160
Needles 23G (Box of 100)		1.9	2200	4180
Needles 19G (Box of 100)		2.3	2200	5060
Bathroom scales	Quantities ordered to replace old supplies and provide supplies to uncovered health counties in the second year	15	250	3750
Baby hanging scales		30.41	250	7602.5
Rectal thermometers		0.53	500	265
RDTs	Policy demands that any treatment of Artesunate and amodiqauine will require confirmation with the Rapid Diagnostic tests at peripheral level	0.5	1,200,000 – 200000 (EU/NDS supplies) = 1,000,000	500000
Dispensing bags (Box of 500)	To be used for packaging of oral medications in conjunction with treatment compliance cards at all levels	2.7	1000 (EU/NDS supplies 5 mill)	2700
Gloves (Box of 100)	Supplies for laboratory diagnosis of malaria at referral facilities	5	1000	5000
Lancets (box of 200)		5	500	2500
Slides(box of 50)		5	600	3000
Distilled water (litre)		5	100	500

Disposal bins		3	500	1500
Alcohol (litre)		24	200	4800
Oil emersion (litre)		12	3	36
Slide boxes (50 slides/box)		15	50	750
Giemsa (litre)		40	150	6000
Hydroph Cotton wool 500g		2.28	500	1140
Coplin jars		10	30	300
Drying racks		12.5	30	375
TOTAL DRUGS AND SUPPLIES				**2,621,872**
Long Life Insecticide Treated Nets	Prevention measure specifically targeted at vulnerable groups	6	175000	1050000
Insecticide Treated Tarpaulins	Prevention in IDP camps or vulnerable groups where LLITNs are not appropriate	10	25000	250000
Indoor Residual Spray – Insecticide	For use in IDP targets as emergency measure For use in specifically targeted areas outside IDP camps which are not suitable to ITN use	30	200L	4500
Hudson sprayers	To carry out spraying campaign. Twenty sprayers already provided by MENTOR in previous year	10	50	500
Safety equipment for IRS	For spray teams	10	16	160
Training materials (manuals and wall charts) Treatment compliance cards	Health staff at all levels require manuals and wall charts for constant referral regarding new protocols For use by health staff to explain treatment to patients. For use by patients in the home to ensure compliance to drug doses			118,558
Education materials	Billboards, radio and television messages and education posters for use at community level			
TOTAL Prevention and education				1,423,558
Total Cost of Drugs and Commodities/Products				**4,045,430**

31.1. Budget justification: Please indicate assumptions or formulas used to calculate volume of drug/commodity necessary to achieve coverage targets specified in section 26.

1. Artesunate and amodiaquine

Approximately 60% of the population are expected to have one, and present to either health facilities or Community Level Health Workers with one case of malaria per annum. It is rationalised that 40% of the population will attend the health facility and receive Artesunate and amodiaquine while 20% will receive treatment from Community Level Health Workers.

Of those 40% presenting at health facilities, 90% will have uncomplicated malaria.

2. IM Artemether and Rectal Artesunate

Of those 40% presenting to health facilities, 10% will present with or develop severe malaria.

3. SP (Fansidar)

5% of women in the population will be pregnant at any one time. Over two years it is estimated that approximately 75000 will need to be administered SP as IPT. Further, 20% of the population will be served by Community Level Health Workers using SP.

4. CHQ

Chloroquine is presently in stock at the NDS warehouse and will still be used until it is gradually phase out by December 2003. 25% of the population will still be using chloroquine.

5. Quinine

Quinine will be used only in referral centers for the treatment of severe malaria

6. Diazepam

10% of the population experiencing malaria will require parental diazepam at 2 Amp. per person per year.

7. Paracetomol 500mg & 100mg

60% of the population will be administered paracetamol as part of the treatment protocol with Artesunate and amodiquine.

8. ***Blood Taking set / blood bags***

Children under five and pregnant women experiencing two or more episode of malaria are more likely to require blood transfusion.

9. Dextrose 5% & 50%

10% of the population may require dextrose 5% and 10ml dextrose 50% during admission. 1 person will use 1.5L/year.

10. Medical supplies such as needles, syringes, cotton etc. have been calculated based on the parenteral medications order.

11. ***Laboratory materials such as microscopes and reagents have been caluculated for referral facilities only. Rapid Diagnostic Tests have been calculated according to their use at peripheral levels to confirm diagnosis for prompt treatment with Artesunate and amodiaquine.***

31.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

32. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars:

Table V.32

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	13110	13110	13110	17605	17605		
External	500000	150000	60000	234674	234679		
Total	**513110**	**163110**	**73110**	**252279**	**252284**		

Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

33. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.
Please see budget attached

34. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u>:

Table V.34

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	32.5%	32.5%				
NGOs/ Community-Based Org.	59%	59%				
Private Sector						
People living with HIV/TB/ malaria						
Academic/ Educational Organisations						
Faith-based Organisations	2.6%	2.6%				
Others (please specify)	MOE 0.12% NDS 2.7% PR 3%	MOE 0.12% NDS 2.7% PR 3%				
Total	**100%**	**100%**				**200%**

Total in USD						

- **If there is only one partner, please explain why.**

Please note that a detailed one year work plan and an indicative work plan for the second year need to be provided with detailed budget. See template in Annex B to this form.

Please note: The following three sections (VI, VII and VII) are all related to proposal/component implementation arrangements.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines Para. VI. 67 – 74, including the main responsibilities and roles of the Principal Recipient (PR).

35. Identify your Principal Recipient(s) (PR)

Table VI.35

Name of PR	Ministry of Health	WHO	NGO Representative – Save the Children
Name of contact	Dr Peter S. Coleman	Dr Omar Khatib	Jane Gibreel
Address	Ministry of Health and Social Welfare Capital bypass Hailie Salessie Avenue Monrovia, Liberia	WR World Health Organisation J&E Building, Mamba Point, Monrovia, Liberia	SC-UK Mamba Point Monrovia, Liberia
Telephone	+ 377 47 510137	+ 377 47 506801	+ 377 47 + 231 226561/226538
Fax	+ 231 226317		+ 231 226539
E-mail	drcoleman@yahoo.com		scuk@

Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

This proposal promotes ownership and partnership. With the above combination The Ministry of Health, Non-Governmental Organisations and the World Health Organisation together will pool resources and establish a functional secretariat that will manage the global funds.

WHO and the Ministry of Health have previous and extensive experience in managing funds having undertaken similar roles for the management of the GAVI (Global Alliance and Vaccine Immunisation) and National Immunisation Days funds. Save the Children UK, as the chair of the health sector NGOs coordinating committee is in regular and constant contact with all NGOs implementing health programs. This secretariat will ensure the appropriate and efficient utilization of resources in order to achieve the desired results. The presence of all three bodies on the secretariat will mean that activities carried out for this proposal will be done under their approval and with full transparency and accountability.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.)

All three of the secretariat are members of the Liberian Coordinating Mechanism. Reports regarding activities will be submitted at quarterly LCM meetings for onward transmission to the Global Funds.

All partners have submitted concept papers on their activities for the duration of the Global Funds project have developed this proposal. Thus, their activities and future commitments have been incorporated into this proposal. Thus, a framework for the amounts to be disbursed to sub-recipients is already in place. On receipt of funds, partners will present the activities and detailed plans to the secretariat, after which, funds will be released. Follow-up reports of results from activities are expected to be produced to the Malaria Control Division (as secretary of the Malaria Steering Committee) which will in turn be sent to the Secretariat and the LCM.

36. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

Implementing partners responsibilities are to carry out activities as defined by the national strategic plan. Activities of all the partners will be standardised (training, case definitions, LLITNs pricing and distribution etc.) through the guidelines and strategies outlined in the national malaria strategy and policy. Coordination of activities will be done at two levels as specified in the National Malaria Control Policy:

a. National level through the Malaria Steering Committee
b. County level through the Malaria Working Groups

The PR will disburse funds to the implementing partners according to their approved activity plans. Partners will submit monthly activity reports to the secretariat. The secretariat will scrutinise and compile these reports for onward submission to the LCM.

Implementing partners responsibilities are to carry out activities as defined by the national strategic plan. All partners activities will be standardised (training, case definitions, LLITNs pricing and distribution etc.) through the Malaria Steering Committee and Malaria Control Division. Coordination between partners will be facilitated on a monthly basis by the MSC and on a day-to-day basis by MENTOR as the field support partner. Coordination of activities will be done at two levels as specified in the National Malaria Control Policy:

a. National level through the Malaria Steering Committee
b. County level through the Malaria Working Groups

Implementing partners attending the MSC will report on activities undertaken relating to the national strategic plan and the Global funds project. These reports will be documented by the Malaria Control Division and will be transmitted to the secretariat and LCM.

36.1. Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

This particular management arrangement has been chosen because of its potential for accountability and transparency to all partners, while ensuring ownership and transfer of responsibility to the Ministry of Health. The arrangement ensures a coordinated and integrated approach where all partners act as one unit, supporting each other to undertake a successful malaria control and prevention programme.

37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

The secretariat will require strengthening through recruitment of procurement, financial and logistic officers. This will ensure full adherence to financial deadlines and efficient disbursement of funds to partners.

SECTION VII – Monitoring and evaluation information

38. Outline the plan for conducting monitoring and evaluation including the following information (1 paragraph per sub-question).

38.1. Explain the overall approach to M&E

Monitoring and Evaluation is a strong cross-cutting component of this current proposal. MENTOR is now present in Liberia as a technical body offering field support to partner agencies including the Malaria Control Division. Priority activities are geared towards improvement of case management for simple and severe malaria as well as continued monitoring and evaluation of interventions and newly introduced therapies as part of the emergency protocols. This monitoring will include prevalence surveys, KAP surveys and vector studies which will allow the partners to determine the success of strategies being implemented.

MENTOR will work alongside the Malaria control division to increase the divisions capacity to oversee high standard training according to international best practices as well as monitoring of newly introduced therapies and interventions.

Other agencies, such as Africare and the EU are dedicated to aiding the ministry to strengthen health surveillance systems with the aim to improve monitoring and evaluation. MENTOR with this proposal will work with partners to standardise case definitions of malaria thus helping with more consistent and reliable data collection.

38.2. Describe how the beneficiaries will be involved in M&E

Community involvement in the information management will include the training of community-level health workers to collect, analyse and share data with the people they serve. Regular feedback on surveys and other relevant information collected will be made available to the community for comments, interpretation and appropriate actions.

38.3. Describe how the CCM or other partners will be involved in M&E (e.g., oversight, data review, capacity building, quality control and validation of data).

38.4. Describe what already exists. How does the existing health information system work and how it will be used to manage and/or report proposal data (e.g., Demographic Health Surveys, Living Standards Measurement Surveys)
Currently, data collected from the service delivery points are entered into the general data base of the Division of Epidemiology/MOH, which uses EPI-INFO. There is as yet no well established HIMS at the level of the program. This system will be improved to take account of additional data needed for the GFATM. Data collected will form part of the existing data pool which will be disseminated to partners monthly for their review and action.

38.5. Prepare a table showing the following for each impact, coverage and process indicator listed in section 26: i) the source of data, ii) periodicity of data collection, iii) how the quality of data will be determined/ensured, iv) who (the entity) will be primarily responsible for each indicator, v) and what indicators will be reported through partner organisations.

Type	Indicators	Source	Periodicity	Data Quality	Responsible Party	Indicators through partner organisations
Impact	Outpatient morbidity attributed to malaria (children 0-5yrs)	OPD Morbidity Report	Monthly	Data verification records	MSC, All health implementing partners*	✓
	Number of inpatient admissions due to severe malaria	Hospital admission records	Monthly	Data verification records	MSC, All health implementing partners	✓
	Number of deaths attributed to malaria (children 0-5 yrs)	Hospital admission records	Monthly	Data verification records	MSC, All health implementing partners	✓
Coverage	Number of health facilities reporting stock ruptures in previous three months	Facilities stock records/inventory report	Monthly	Supervision	MSC, All health implementing partners	✓
	Number of malaria cases treated with artemesinin-based derivatives	Newly formatted EPID form for combination therapy	Monthly	Supervision, part of monitoring and evaluation activities	MSC, All health implementing partners	✓
	Number of malaria cases treated with non artemesinin-based derivatives	Newly formatted EPID form for combination therapy	Monthly	Supervision, part of monitoring and evaluation activities	All health implementing partners	✓
	Number of uncomplicated malaria cases treated within 48 hours of onset	Newly formatted EPID form	Monthly	To be determined	All health implementing partners, CHT	✓

	Number of pregnant women attending antenatal services who have taken anti-malaria Intermittent Preventive Treatment according to malaria control policy	Health facility records	Monthly	Supervision by CHT, verification of records	CHT, All health implementing partners	✓
	Number of households with pregnant women and children under five years with either sprayed houses, Insecticide Treated Tarpaulins or using Insecticide Treated Nets as best suits the situation	LLITN distribution network records (Community Health Workers) – Framework to be developed as part of activities	Monthly	Monitoring and evaluation activities	CHT, MENTOR	✓
	Numbers of all households in accessible communities have at least one ITN.	LLITN distribution network records (Community Health Workers) – Framework to be developed as part of activities	Monthly	Monitoring and evaluation activities, Data verification	CHT, MENTOR	✓
	Number of insecticide treated nets distributed	LLITN distribution network records (Community Health Workers) – Framework to be developed as part of activities	Monthly	Monitoring and evaluation activities, Data verification	CHT, All health implementing partners	✓
	Number of households nationwide that have received IEC messages on the prevention and control of malaria	KAP surveys	Monthly	Monitoring and evaluation activities, Data verification	CHT, All health implementing partners	✓
	Number of schools using IEC materials on malaria prevention and control	Health education school supervision	Monthly	Monitoring and evaluation activities, Data verification	CHT, All health implementing partners	✓
Process	Number of health facility and community level health workers trained (including care-givers) in malaria case management*	MCD, CHT and partners records Training records	Quarterly	Data verification	MCD, CHT All health implementing partners	✓

	Number of health facilities reporting stock ruptures	Facilities stock records/inventory report	Monthly	Supervision, Data verification records	NDS, CHT, All health implementing partners	✓
	Number of Supervisory forms and reports being received from CHTs	Forms and data present at national level	Monthly	Verification at central level, follow-up at CHT quarterly meetings	MCD, CHTs, assistance of partners	✓
	Number of reports to MSC on county level malaria activities	Minutes of MSC meetings Reports present and filed for reference at MCD office	Monthly	-	MCD, MENTOR	✓
	Number of evaluation studies which have been carried out with MCD staff	Reports from studies with partners	Ad hoc basis	Standard data analysis and verification carried out monitoring and evaluation through epi info	MCD, MENTOR	✓

38.6. **Describe how data will be analyzed and used by the PR, CCM, and others**

Routine data collected from service delivery points and data collected for specific reasons will be provided to the Malaria Control Division and entered into its database. Said data will be analysed by the Malaria Control Division and interpreted. Results will be passed on to the secretariat. The Malaria Control Division and the CCM will use these results to guide program revision and planning.

39. Recognizing that M & E plans will make use of existing monitoring systems especially for impact and coverage indicators, national information systems may require strengthening. Please specify activities, partners and resource requirements for strengthening M&E capacities.

Please note: Total requested from Global Fund should be consistent with the resources needed for Monitoring and Evaluation as indicated in Table V.30.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.39

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in Strengthening M&E capacities)	**Resources Required** (USD)			
		Year 1	**Year 2**	Year 3 Year 4 Year 5	Total
Develop forms for the collection of malaria specific data	Partners, EU, MCD, Surveillance division and MENTOR				

Training with CHTs with new epidemiological form	MENTOR, MCD, Surveillance division				Incorporated into case management training
Training of CLHWs with community surveillance forms	MCD, MENTOR, SC-UK, MSFs, MERCI, IRC, Africare, MERLIN				Incorporated into Community Level Health Worker Training
Standardised case definition among all partners	MCD, MENTOR				Incorporated into case management training
Training of Health workers with epidemiological forms	MCD, SC-UK, MERCI, IRC, Africare, MERLIN, MSFs				Incorporated into case management training
Surveys to monitor prevalence for impact of ITMs	MENTOR, LIBR, MCD	20000	20000		40000
Monitoring of combination therapy use	MENTOR and MCD	18000	18000		36000
Monitoring of IM artemether at peripheral level	MENTOR and MCD	32000	32000		64000
Assessing and monitoring impact of IPT use for pregnant women	MENTOR, MCD	12000	12000		24000
Feasibility study on the introduction of rectal artemether as a prereferral drug	MENTOR, LIBR and MCD	18000	18000		36000
Monthly analysis of data and production of reports to Malaria Steering Committee	MCD and MENTOR				Incorporated into staff salaries and stationary at office level
Chairing of monthly MSC meeting	Rotation between MSC members				Incorporated into staff salaries and stationary at office level
Quarterly CHT meetings	MCD and CHTs				Incorporated into staff salaries and stationary at office level

Training in the use of RBM Health mapper	MENTOR				MENTOR trainers and participants from partners already accounted for
At least two monthly supervision at health facility	CHT				Accounted for in staff salaries
Global Fund M&E request		100000	100000		200000
Unmet need					
Total resources needed		100000	100000		200000

SECTION VIII – Procurement and supply-chain management information

40. Describe your plans for procurement and supply chain management of health products (including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention [e.g., condoms], and laboratory equipment and support products [e.g., microscopes and reagents]) integral to this component's proposed disease interventions. The plan should include.

i. Procurement responsibilities: A description of whether existing national systems, international or other outsourced procurement agencies, or a mix of both will be used for procurement;
NDS is the main body responsible for national procurement of medications and supplies. Bids are tendered for order through the EU at an international level. Thus, as it has the experience, NDS will remain the main procurement agency for the duration of the global funds project.

ii. Procurement practices: A description of how the Interagency Operational Principles for Good Pharmaceutical Procurement will be adhered to, including competitive purchasing from qualified manufacturers and suppliers to obtain the lowest prices for products of acceptable quality; and a description of how performance of suppliers with respect to the quality of goods and services they supply will be monitored;
A tendering process is undertaken for drug orders above 100000 Euro to ensure lowest possible drug price from recognised companies whom supply quality
.

iii. Supply chain management: A description of how reliability, efficiency, and security will be assured throughout the supply chain;
Supplies are shipped to Monrovia upon payment of 50% FOB and upon a detailed micro-reception of the products to the supplies the remaining 50% FOB is paid.

iv. Avoidance of diversion: A description of inventory management, stock control systems, audit systems, and other means to ensure the avoidance of diversion of products;

The inventory management software used is SAGE line 100. A daily perpetual inventory is taken with the results compared with physical count cardex card figure and logical figure from SAGE 100. Any discrepancy is investigated and concluded before any product is supplied.

v. Forecasting and inventory management: A description of how forecasts of the quantities of health products needed for the programme will be systematically and regularly updated, and how these forecasts will be monitored and regularly compared with actual consumption of these products;
At present, forecast for the existing drugs is mainly done on the average monthly consumption rate. The experience in forecasting is usually drawn from a period of ten years.

vi. Product selection: A list of health products to be procured, including reference to the relevant standard treatment guidelines and essential medicines lists of the World Health Organization, host country government or applicant;
Product selection is largely based on national essential drugs list drawn largely from the WHO essential drugs list.

vii. Donation programmes: A description of any donation programmes that are currently supplying health products (or which have been applied for), including the Global TB Drug Facility and drug donation programmes by pharmaceutical companies, multilateral agencies, and NGOs;
Although some agencies procure their own drugs, these are bought in line with National drug policy and used directly in health facilities being supported by the partners

viii. Compliance with quality standards: A description of how compliance with quality standards for both multisource and single- or limited-source pharmaceutical products will be assured, including a description of how random samples of pharmaceutical products will be tested for compliance with applicable quality standards;
NDS procures from different sources such as IDA and pharmamission. For those medications being brought in country by non-recognised pharmaceutical companies, they will be tested through a random system by the Pharmacy Division in collaboration with the Malaria Control Division

ix. Adherence to treatment protocols, drug resistance, and adverse drug reactions: A description of how patients will be encouraged to adhere to prescribed treatment (e.g., use of fixed-dose combinations, once-a-day formulations, blister packs, and peer education and support), how drug resistance will be monitored and contained, and how adverse drug reactions will monitored;
Drug resistant efficacy studies have been undertaken sporadically in the past in Liberia indicating a suspected resistance to first and second line medications. Emergency protocols will be enforced while other efficacy studies are carried out. Current plans are to undertake efficacy studies for first and second line drugs as well as emergency drugs being introduced.

Compliance will be assured at community level through the use of SP – a one-dose drug, in the presence of the Community Level Health Worker (as treatment) or at health facilities (IPT for Pregnant women). Beyond this, interpersonal communication will be emphasis throughout health worker training to ensure health staff understand and carry out good communication between themselves and patients in explaining treatment regimes. To aid this process, treatment compliance cards, similar to those

recently introduced in Ghana, will also be used for patients to monitor their own treatment.

Monitoring and evaluation is a large component of this proposal with tight monitoring of introduced therapies feasibility as well as effects on population.

x. National and international laws: A description of how national laws and applicable international obligations in the field of intellectual property rights will be complied with, including a description of how the flexibilities provided in the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and referred to in the Doha Declaration on the TRIPS Agreement and Public Health will be used in a manner that achieves the lowest possible prices for products of assured quality
Intellectual Property rights are respected in Liberia

xi. Procurement and supply management indicators: A description of indicators to be used to monitor procurement and supply management (e.g., average lead time between product orders and receipt of goods, average percentage of time out of stock of products at principle warehouses and sentinel treatment facilities, price of products in the latest procurement in comparison with prices from the previous procurement of the same products and with median prices reported in international drug price indicators), with baselines if available.

Procurement and supply management indicators	**Baseline**
Average lead time between product orders and receipt of goods	3-6 weeks
Average percentage of time out of stock of products at principle warehouses and sentinel treatment facilities	30%
Price of products in the latest procurement in comparison with prices from the previous procurement of the same products	ND
Median prices reported in international drug price indicators), with baselines if available	ND
Lead time to re-supply health centres from national level	2 months

41. All procurement of medicines to treat multi-drug resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee of the Stop TB Partnership. Please for a Green Light Committee application form in Annex C.

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	_____
2. Medium Term Expenditure Framework	_____
3. Sector strategic plans	_____
4. Any reports on performance	_____
HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	
6. Baseline data for tracking progress[††]	
7. National strategic plan for HIV/AIDS, with budget estimates	_____
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	_____
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	_____
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	_____
12. Most recent independent assessment/review of national TB control activities	_____
Malaria specific documentation:	**Attachment #**
1. Desk analysis	_____
2. National Malaria strategic plan 2003 – 2005 with budget estimates	_____
3. Global Funds proposal	_____
4. Plan of Action	_____
General documentation:	**Attachment #**

[††] Where baselines are not available, plans to establish baselines should be included in the proposal.

6. LCM members list 7. Profile of implementing partners 8. LCM accreditation documents	_____ _____ _____ _____
HIV/AIDS specific documentation:	**Attachment #** _____
TB specific documentation:	**Attachment #** _____ _____ _____ _____

Annex A: Core indicators to be included, where applicable, in the objective and outcome tables

AIDS, TB AND MALARIA CORE INDICATORS	
HIV/AIDS	
Prevention	Number of people receiving HIV testing (not including testing for routine surveillance)
Prevention	Number of condoms* distributed or sold
Prevention	Number of young people aged 15-24 educated in HIV prevention
Prevention	Number of sex workers reached with targeted HIV/AIDS interventions
Prevention	Number of men who have sex with men reached with targeted HIV/AIDS interventions
Prevention	Number of injecting drug users receiving harm reduction interventions
Prevention	Number of units of blood screened for HIV
Prevention	Number of cases of STIs treated*
Prevention	Number of people with access to workplace-based HIV/AIDS prevention services
Prevention	Number of HIV+ women receiving of antiretroviral therapy to prevent mother-to-child transmission of HIV
Prevention	Number of healthcare facilities offering safe clinical practices**
Treatment, Care and Support	Number of people receiving HIV/AIDS home-based care*
Treatment, Care and Support	Number of people receiving HIV/AIDS palliative care*
Treatment, Care and Support	Number of people receiving treatment for opportunistic infections*
Treatment, Care and Support	Number of people receiving prophylaxis for opportunistic infections*
Treatment, Care and Support	Number of people receiving antiretroviral therapy*
Treatment, Care and Support	Number of HIV/AIDS orphans receiving support
Tuberculosis	
Treatment, Care and Support	Number of treatment units implementing DOTS
Treatment, Care and Support	Number of estimated new smear-positive TB cases detected under DOTS
Treatment, Care and Support	Number of smear-positive TB cases registered under DOTS successfully treated*
Treatment, Care and Support	Number of persons completing DOTS+ treatment for MDR-TB*
Malaria	
Prevention	Number of insecticide treated nets*** distributed*
Prevention	Number of net re-treatment kits distributed*
Prevention	Number of pregnant women who have taken anti-malaria chemoprophylaxis according to national drug policy*
Prevention	Number of children under 5 sleeping under insecticide treated nets
Prevention	Number of homes and buildings sprayed with insecticide
Treatment, Care and Support	Number of uncomplicated malaria cases detected within two weeks of onset
Treatment, Care and Support	Number of malaria cases treated with non artemisinin-based

	derivatives*
Treatment, Care and Support	Number of malaria cases treated with artemisinin-based derivatives*

* Refers to products or treatments financed by resources from the Global Fund
** Includes universal precautions and sterile needles for medical purposes
**
* Includes insecticide treated nets or untreated nets plus insecticide

Annex B: Principal Recipient One Year Budget and Workplans Template-- Illustrative example

Country:	
Disease:	
Grant number:	
Principal Recipient:	
Currency:	

Consolidated Budget & Indicators

		Q1		Q2		Total 6-months
Objectives/Broad activities	**Responsible**	Indicators -- Description	Budget[1)]	Indicators -- Description	Budget[1)]	
Objective 1: Health and Family Education for the Prevention of STDs and HIV/AIDS						
Broad activity 1: Broadcasting of radio programs		Contracts signed with 2 radio stations		8 broadcasts per month on 2 stations for each month after teachers are trained		
Broad activity 2: Education in schools		Contracts signed with 15 schools - development of forms for teacher reports; baseline study prepared		Baseline study completed revealing percentage of youth in participating schools and a sample of out of school youth and parents who can correctly identify 4 ways to reduce risk of HIV transmission; 55 teachers trained		
Broad activity 3: Development and running of youth centre		Identification of site; development of intake forms for centres		100 new youth visitors receive counselling on sexual health; 50 visits by parents; 15 people referred for VCT and STI treatment; 200 condoms distributed		
Objective 2:						
Objective 3:						

Total						

1) Budgets per indicator only if possible, otherwise total budget for quarter

[i] UNICEF (2001). The State Of The World's Children 2001. United Nations Children's Fund.

[ii] Freeman, T.L., & Bolay, F.T. (1995). In vivo response of Plasmodium falciparum to standard chloroqine to standard chloroquine regimen in Buchanan, Grand Bassa County, Liberia (Unpublished).