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APPLICANT SELF-ASSESSMENT TO INFORM PROGRAM CONTINUATION

The Applicant Self-Assessment is the mechanism by which applicants provide their rationale for a continuation of existing Global Fund-supported grants to deliver program objectives and the highest impact with the available resources. As part of the assessment for Program Continuation, opportunities for programmatic adjustments should be identified for reprogramming as appropriate, taking into account that a revision of grants can take place at any time throughout the grant cycle to ensure that the program is on track to deliver results and achieve the highest impact.

Responses to each question should be brief and should clearly demonstrate how the current investments are in line with the country's need to maximize impact. Reference to supporting documents and evidence is strongly encouraged. This self-assessment must be submitted together with Annex 1 to confirm the inclusiveness of the process.

If the applicant confirms material change for any of the questions below, it is required to explain whether this change will have an immediate impact on the programming (i.e. require a Tailored or Full review) or can be addressed at a later stage (i.e. through reprogramming during grant implementation).

SUMMARY INFORMATION			
Applicant	CCM Senegal		
Component(s)	MALARIA	**Funding amount as per Program Split**	EUR 32,360,808
Principal Recipient(s)	NATIONAL MALARIA CONTROL PROGRAM (NMCP) c/o MINISTRY OF HEALTH AND SOCIAL ACTION		
Envisioned grant start date	1 January 2018	**Envisioned grant end date**	31 December 2020
Funding amount requested for Program Continuation	EUR 32,360,808	**Prioritized above allocation request (PAAR)**	Not applicable[1]

1 The applicant will be invited to submit a prioritized above allocation request during the grant making procedure.

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1. Epidemiological contextual updates	
Are there any relevant changes in the country's epidemiological context as compared to the previous funding request (e.g. important changes in trends in incidence/notification rates or prevalence, key drivers of the epidemics, emerging high-risk behaviors, drug/insecticide resistance, or coverage of interventions in the general population or specific key populations based on the latest surveys or other data sources)?	☐ Yes ☒ No

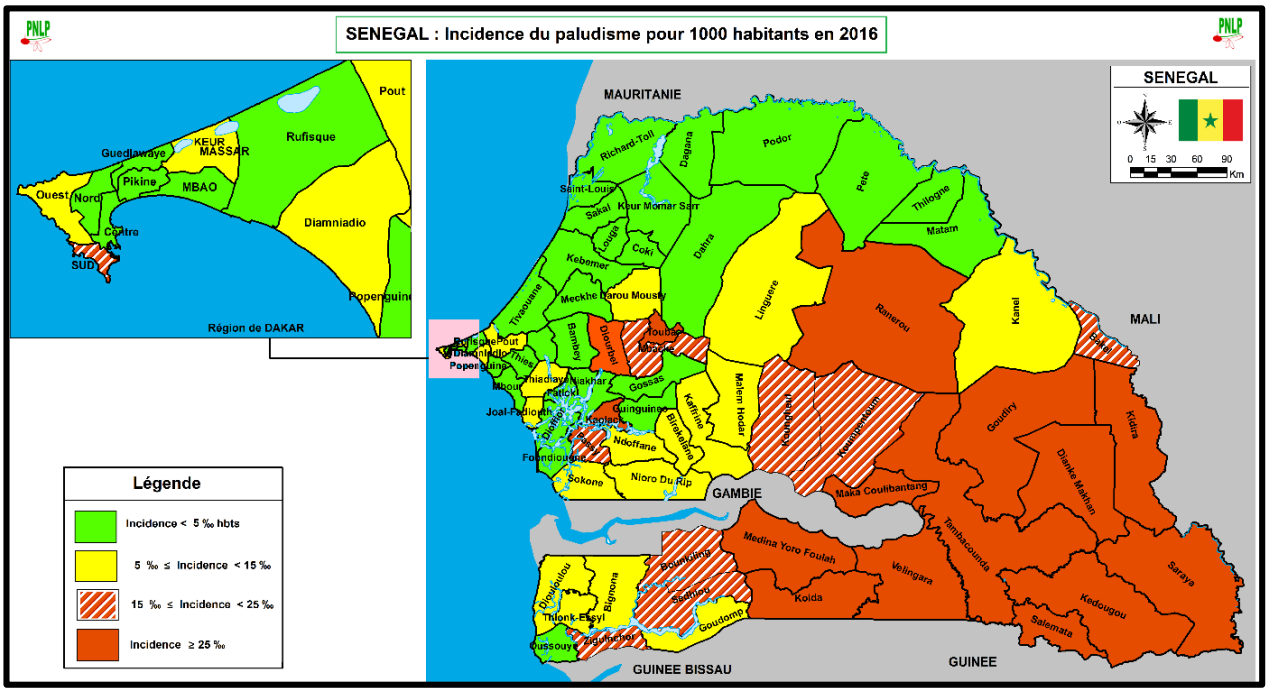
There have been no notable changes in the epidemiological context over the last three years. Transmission is seasonal, in line with periods of high-density vector populations.
The disease is transmitted primarily by *Anophèles (An) gambiae*, *An arabiensis* and *An funestus*. Monitoring of vector sensitivity to different kinds of insecticide has demonstrated resistance to pyrethroids, and sensitivity to carbamates and organophosphates.[2]

Parasite prevalence nationally fell from 1.2 percent in 2014 to 1 percent in 2015.[3] The most common plasmodium species is *Plasmodium falciparum* (99 percent).
Incidence stood at 18.87‰ in 2014, 34.48‰ in 2015 and 23.62‰ in 2016 with a stratification that continues to shows three epidemiological trends.[4] The increase observed in 2015 was partly attributable to the heavy rainfall recorded, the scaling up of the Home-based treatment of malaria (home-based care) program and the expansion of the test to all cases of fever.
The last mapping of incidence in 2016 supported the existence of three zones or strata:

- the green pre-elimination zone with an incidence of less than 5‰
- the yellow intermediate zone with an incidence of between 5 and 15‰
- the red control zone with an incidence of more than 15‰.

[2] UCAD entomological monitoring report 2015-2016 Campaign, page 44.
[3] Ongoing health & demographic survey 2015 page 198.
[4] Epidemiological Bulletins 2014, 2015, 2016 (3a.2014, 3b.2015 and 3c.2016).

SENEGAL: incidence of malaria per 1000 inhabitants in 2016



Between 2014 and 2016, the number of deaths due to malaria fell from 500 to 325 among the general population and from 175 to 100 cases among children aged under five years.

Morbidity and mortality indicators by stratum in 2016

	National	Incidence < 5 ‰		5 ⩽ incidence <15 ‰		Incidence ⩾ 15 ‰	
Number of districts	76	33	43%	19	25%	24	32%
Population 2016	14,799,879	6,953,154	47%	3,453,692	23%	4,393,033	30%
Cases of malaria*	349,540	20,390	6%	30,488	9%	298,682	85%
Cases of serious malaria*	9,918	1,736	18%	1,788	18%	6,394	64%
Deaths linked to malaria*	325	31	9.5%	67	20.5%	227	70%
Deaths in children under 5 years*	100	5	5%	10	10%	85	85%
Incidence* per stratum	23.62%	2.93%		8.82%		76.99%	

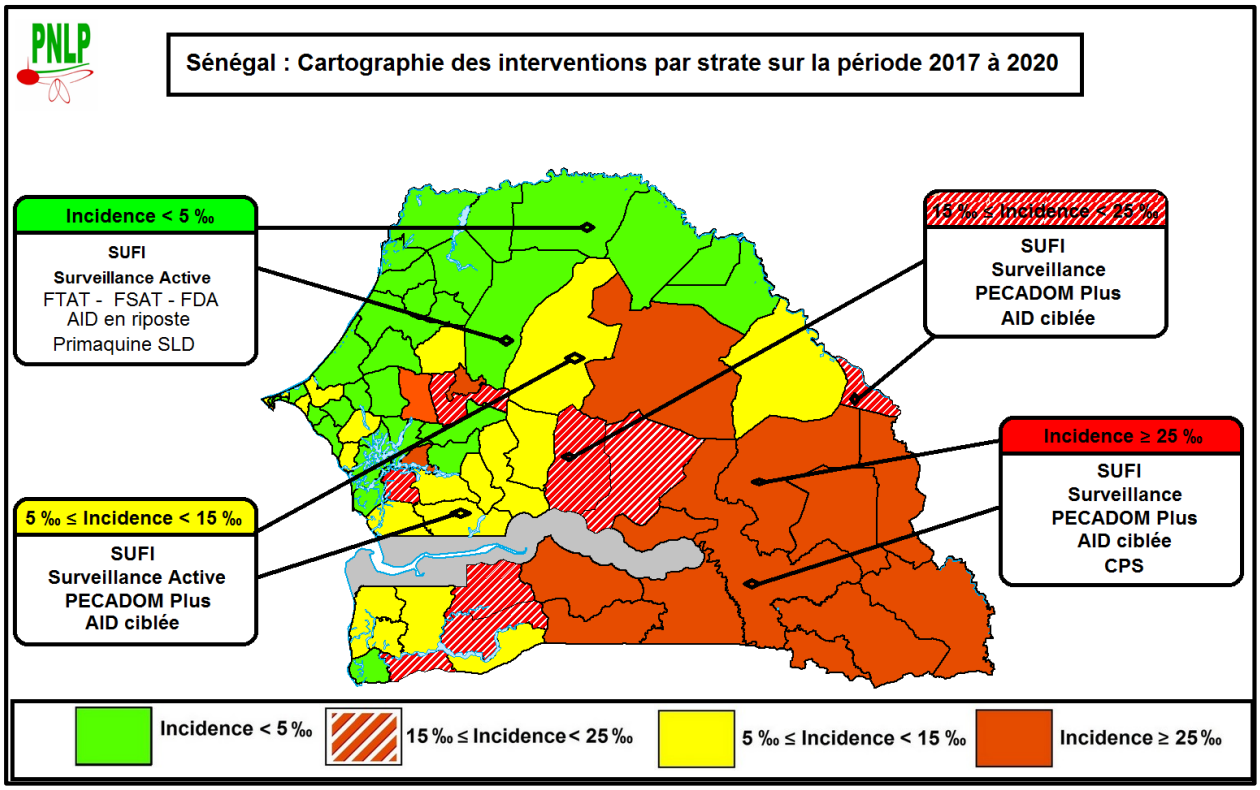
* including cases recorded by the public health care facilities (PHF) and at community level

Monitoring by artemisinin-based combination therapy (ACT) and the sulfadoxine-pyrimethamine-amodiaquine-based combination therapy (SP-AQ) confirms the good efficacy and tolerance of the molecules used.[5]

[5] UCAD study report 2015/2016 on ACT efficacy monitoring pages 21- 22 and 5-SMC Impact Evaluation page.

2. National policies and strategies revisions and updates

Are there new approaches adopted within the national policy or strategy for the disease program as compared to the previous funding request (e.g. “treat all” guidelines for HIV, short-term regimens for MDR-TB, shift in interventions from malaria control to pre-elimination, expanded role of the private sector)?	☐ Yes ☒ No



English translation

Title: Senegal: mapping of interventions by stratum, 2017 to 2020

Legend: Clockwise from the right:

- SUFI, Surveillance, HBTm Plus, targeted IRD
- SUFI, Surveillance, HBTm Plus, targeted IRD, SMC
- SUFI, Active Surveillance, HBTm Plus, targeted IRD
- SUFI, Active Surveillance, FTAT-FSAT-FDA, responsive IRD, SLD Primaquine

Senegal has not reviewed or updated its national policies and strategies.
The policies and strategies required to achieve the pre-elimination objective were taken into account in the 2016-2020 strategic plan, particularly surveillance, which was developed as an intervention, expanding the role of the private sector and introducing new technologies in reporting and data management.

The strategies have been adapted according to the country strata:
- In *areas of low incidence* (less than five cases per thousand), in addition to Scaling-up for Impact (SUFI) interventions (Long-lasting insecticidal nets (LLIN), isoniazid preventive therapy (IPT), Care with rapid diagnostic tests and ACT), surveillance has been consolidated by incorporating case investigation and FDA implementation. The use of primaquine in a single low dose is also envisaged for the treatment of simple malaria according to WHO recommendations.
- In *areas of moderate incidence* (between five and 15 cases per thousand), SUFI interventions have also been strengthened, above all in hotspots.

- In *areas of high incidence* (more than 15 cases per thousand), in addition to SUFI interventions, prevention interventions (LLIN, seasonal malaria chemoprevention (SMC), IRS) and community care (home-based care Plus) have been consolidated.[6]
In cross border areas, an action plan is currently being produced in line with the Elimination Scenario Planning Tool (ESP/GF).

3. Investing to maximize impact towards ending the epidemics

Referring to available evidence and inputs from technical partners and key stakeholders, does the current program continue to be relevant, and is it progressing and generally on track to achieve results and impact? Please provide rationale for the appropriateness of continuing the goals, strategic objectives and key interventions. As relevant, explain the most important challenges being faced and any mitigation measures that have been put in place.	☒ Yes ☐ No

Technical and programmatic reviews have shown that the current program remains relevant. The coverage of high-impact interventions increased between 2015 and 2016.
According to the 2014 and 2015 Demographic and Health Survey (DHS), the percentage of households with at least one LLIN increased from 74 percent to 94 percent and the percentage of people having slept under an LLIN increased from 40 percent to 57 percent. The 2016 Malaria Indicator Survey (MIS) gives an 86 percent rate of use among the population owning an LLIN, with 78 percent among the under-fives and 74 percent among pregnant women.[7]
For IRS, coverage of the populations in the target zones has reached 98 percent in the last two years.[8]
For SMC, theoretical coverage of target groups has reached 97 percent in the last two years.[9]
The rate of IPT2 coverage among pregnant women rose from 40 percent in 2014 to 53 percent in 2015.[10]
In 2015 and 2016, tests were carried out and ACT dispensed at a rate of more than 95 percent in health care facilities and at the community level due to improved availability of supplies at all levels.[11]

Proportional malaria morbidity fell from 3.39 percent in 2014 to 3.29 percent in 2016 and proportional malaria mortality from 3.59 percent in 2015 to 2.11 percent in 2016.[12]
Care, vector support, IPT, SMC, surveillance and monitoring/evaluation will be continued and consolidated.
Some weaknesses exist in the private sector's involvement, particularly in terms of poor monitoring. The same applies to the cross border management of malaria. In this grant, the plan is to provide:

- capacity development of private sector actors as well as regular monitoring of activities;
- implementation of a cross border management plan according to the ESP model.[13]

[6] NSP 2016-2020 page 35.
[7] Provisional MIS Report page 34
[8] Abt IRS Report 2015-2016 (8a. Report 2015 and 8b. Report 2016)
[9] SMC Bulletins 2015-2016 (9a. Bulletin 2015 and 9b. Bulletin 2016)
[10] Ongoing Health & Demographic Survey 2015 Page 170
[11] PUDR 2015 and 2016 (11a. PUDR S2 2015 Indicators of Coverage_1B and 11b. PUDR S2 2016 Indicators of Coverage_1B).
[12] NSP 2016-2020 pp.17-22.
[13] ESP March 2017 meeting report.

4. Alignment with 2017 – 2022 Global Fund Strategy Objectives 2 and 3

Objective 2 to Build Resilient and Sustainable Systems for Health

Does the current grant include an appropriate focus on investments in Resilient and Sustainable Systems for Health (RSSH)? If changes in RSSH investments are needed (in order to maximize reproductive, maternal, neonatal and child health or other areas) please explain how and when these changes should be addressed.	☐ Yes ☒ No

The current grant did not include a health systems strengthening (HSS) component; the activities identified in this area have been taken up and implemented by the HSS grant of the General Health Division for this current period.
However, grant implementation has benefited the health system through:

- capacity development of managers in malariology;
- equipment and training of health officers in entomology;
- provision of microscopes to four sentinel sites.

In the context of the new funding mechanism for the 2018-2020 implementation period, HSS activities have been chosen by joint agreement between the three programs (malaria, HIV and TB), with the validation of the CCM.
In order to contribute to health system strengthening, the NMCP has targeted:

- support for improved management and availability of drugs and essential supplies through the PNA (National Procurement Pharmacy);
- support for improved pharmaceutical regulation through the DPM (Department for Pharmaceuticals and Medicines);
- support for drug quality surveillance through the National Drug Control Laboratory (LNCM);
- support for the capacity development of actors as well as equipment with which to develop the global health information system, focusing on use of the District Health Information System 2 (DHIS 2);
- support for the gender unit.

Implementation monitoring will be done through the CCM and the Consultation Framework of Partners against Malaria (CCPLP).

Objective 3 To Promote and Protect Human Rights and Gender Equality

Is there a need to intensify efforts to address human rights and gender-related barriers to services and to ensure appropriate focus on interventions that respond to key and vulnerable populations? If changes are needed, please explain how and when they should be best addressed.	☒ Yes ☐ No

There is a need to intensify activities aimed at removing human rights and gender-related barriers to accessing service. In fact, some rural populations, border regions and specific groups (children, women and transhumant groups) still encounter geographical and/or financial difficulties in accessing care.

The scaling up of interventions for universal access (LLIN, free ACT and RDTs, IPT, integrated community care that takes the "*daara*" and schools into account), as well as the interventions being implemented by community prevention and promotion actors and targeted interventions (IRS, SMC, cross border work) will help to reduce inequalities in prevention and care.
The different forms of Home-based care for malaria have enabled significant improvements in remote populations' access to care. Early diagnosis and correct treatment of cases has contributed to reducing serious cases and malaria mortality. These encouraging results call for an expansion of the home-based care strategy to other zones and other targets (*daara*, schools, etc.).

When implementing the activities with this future funding, better consideration of gender during data collection and use will enable the needs of specific groups to be taken into account.

5. Effectiveness of implementation approaches

Are the current implementation arrangements effective to deliver on the program objectives and anticipated impact (including the Principal Recipient and the main sub-recipients)? If major changes to the implementation arrangements are needed, please explain how and when they should be best addressed.	☒ Yes ☐ No

The current implementation arrangements are effective and have enabled the objectives to be achieved. The current funding is dual track, with two PRs: the National Malaria Control Program (NMCP) (PR1) and IntraHealth (PR2).
With the support of the health districts, PR1 has scaled up cross-cutting interventions (SUFI) at country level with specific approaches (FDA, SMC, AID) according to the stratum.
PR2 has ensured the mass distribution of LLINs through the 2016 campaign and has also implemented community activities with 10 sub-recipient NGOs, working contractually through 490 community-based organizations (CBOs) around the country.
Between the two PRs, these activities have benefited from the good monitoring of the coordinating mechanisms as well as the cooperation of all actors and partners involved in malaria actions.
By the end of 2016, the grant absorption rate was close to 94 percent.
However, the grant rationalization requirement trends to having one PR, also taking into consideration the mobilization of the bulk of the resources towards the universal campaign planned for 2019.
In the context of this grant, the implementation approach is to consolidate civil society's involvement to reach the community beneficiaries with:

- improved community participation through good networking of districts by the CBOs;
- revitalization of community malaria networks (RCLP);
- strengthened monitoring and evaluation (M&E) for community activities.

Moreover, the implementation approach will be underpinned by the health system's greater accountability due to a decentralization of resources and a consolidation of actors' skills at the operational level through:

- support for the production and implementation of acceleration plans in some districts;
- support for the medical regions to ensure better involvement and close monitoring of the implementation of the districts' acceleration plans.

6. Sustainability, transition and co-financing

Are there changes in domestic or international financing (e.g. due to withdrawal of a major donor or significant increase in domestic allocation/funding), resulting in material impact on funding availability for programmatic interventions and sustainability? If yes, describe how these changes impact the country's ability to meet co-financing (previously referred to as 'willingness to pay') commitments for the current grant implementation period. Please also state if these changes will impact the country's ability to make and realize future co-financing requirements in the next implementation phase.	☒ Yes ☐ No

An analysis of the following table on sources of financing for malaria over the 2018-2020 period shows that 94.5 percent of the resources come from external funding. In the table, the State budget line includes a loan from the Islamic Development Bank (IDB).

Table I: Main sources of funding for malaria control 2018-2020

SOURCES OF FINANCING	AMOUNT (EURO)	PERCENTAGE
GLOBAL FUND	32 360 808	24.6%
LLF/IDB	8 781 166	6.6%
PMI USAID	65 858 744	49.8%
STATE	25 146 897	19%
TOTAL	**132 147 615**	**100%**

The withdrawal of one of the partners would have an immediate negative effect on the implementation of activities and would necessitate financial readjustments on the part of the State to ensure continuity of interventions.

The Senegalese state's strong commitment to preventing and fighting against disease, particularly malaria, offers a guarantee that State counterpart financing would increase if external financing were to increase.

To achieve the objective of universal access to health care, as stated in the 2009-2018 National Health Development Plan (NHDP), the Senegalese state has chosen to gradually increase the Ministry of Health and Social Action's budget (+5.8 percent between 2014 and 2015 and +11.54 percent between 2015 and 2016).

Each year, there is a specific budget line for malaria in the consolidated investment budget (CIB) and in the Multi-annual Expenditure Planning Document (MEPD). This State contribution, at the level of the Directorate for Administration and Management of Equipment (DAGE), is devoted to covering the NMCP's operating costs (see table below), staff recruitment and investment in infrastructure and equipment. The State is currently providing free intermittent preventive treatment for pregnant women with sulfadoxine-pyrimethamine. To this national budget must be added the contributions of the international financial partners.

Table 2: Evolution in State contribution for malaria action (in Euros)

Nature	2013	2014	2015	2016	2017
State counterpart financing		76 225	76 225	**94 183**	
Parasite Laboratory (SLAP) operating budget	68 602	68 602	68 602	68 602	68 602
NMCP operating budget	118 910	118 910	118 910	118 910	190 775
Total in Euros	**187 512**	**263 737**	**263 737**	**281 695**	**259 377**

To ensure the sustainability of the NMCP, the State has had regulatory and financial provisions in place for several years, consisting of:

- The signing of all international support or investment agreements by the Ministry of the Economy, Finances and Planning (President's Malaria Initiative [PMI]/USAID, IDB, Global Fund);
- Compliance with its counterpart commitments for each financing agreement. The NMCP is responsible for monitoring the State's fulfillment of its commitments, in coordination with the CCM and the CCPLP as coordinating mechanisms.

Is your country's 2017/2019 Global Fund allocation for the disease component significantly lower as compared to the spending levels of the current grants[14]? If yes, please provide an explanation on how the scope of the program will be maintained/increased and what are the alternative sources of funding to maintain/increase the current level of coverage.	☐ Yes ☒ No
The funding expected for the 2018-2020 period is identical to current funding. This new grant will largely support the implementation of LLIN coverage planned for 2019, the scaling up of home-based care and improvements in surveillance and monitoring/evaluation.	

Projected need for a material change leading to grant reprogramming

Please indicate the key timing for program and NSP evaluations/reviews, surveys outcomes, or any other relevant information that may inform the potential need for a material reprogramming[15] from now until the expected end of the new grant(s):

Documents, evaluations, surveys and other relevant information	**Expected availability (month/year)**	**Foresee a need for material reprogramming at that time? (Y/N)**
Program Review report (mid-term)	2018	No
Program Review report (final)	2020	No
National Malaria Survey Report	2019	No

All funding requests and resulting grants must comply with and follow the application focus[16] ***and co-financing requirements set forth in the Sustainability, Transition and Co-financing Policy.***[17]

Please complete Annex 1 below to confirm the inclusiveness of engagement with key and vulnerable populations in the process of developing the Program Continuation request.

[14] The 2017 – 2019 allocation amount stands at 70% or less of the current grants' expenditure level over the last three years, calculated by using the last year's expenditure multiplied by three.
[15] Please refer to the Global Fund Operational Policy Note on Reprogramming during Grant Implementation
[16] Including ensuring interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities for all countries, regardless of income level.
[17] Sustainability, Transition and Co-Financing Policy, GF/B35/04

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ANNEX 1: INCLUSIVENESS OF ENGAGEMENT WITH KEY[18] AND VULNERABLE POPULATIONS

Inclusiveness of engagement with key and vulnerable populations in the process of developing the Program Continuation Request (for malaria programs see footnote[19])	
Has the process for developing this request been inclusive, including the views of representatives of key and vulnerable populations, particularly those who are the focus of the program?	☒ Yes ☐ No
Were representatives of key and vulnerable populations informed of the amount of allocation available?	☒ Yes ☐ No
In cases of changes in the implementation contexts (i.e. question 1, 2 and 5 above) or an increase/decrease in allocation, were representatives of key and vulnerable populations consulted on how risks to program quality and sustainability can be mitigated?	☒ Yes ☐ No
Was feedback from representatives of key and vulnerable populations on the quality, content and delivery of the current program taken into account during the assessment process?	☒ Yes ☐ No

The development, implementation and evaluation (mid-term and final reviews) of the different NSPs have always been used as an opportunity for consultation, sharing and decision-making.
The production of the concept note takes place in an environment of continuous dialogue that is favorable to an inclusive and participatory approach.
The establishment of an expanded Task Force to include all stakeholders (technical and financial partners, civil society and beneficiaries) and the joint validation of the route map were the first measures taken to implement this inclusive and participatory approach.
Different activities were organized in the context of the country dialogue:

- an information and sharing meeting with the technical partners
- an agenda item on the concept note, which enabled intermediary and operational actors' expectations to be ascertained during quarterly reviews with the medical regions, districts and EPS
- a feedback meeting with civil society actors, particularly representatives of NGOs, health committees, CBOs, local authorities, the private sector, the CCM, community networks and corporations (associations and Orders).

This inclusive and participatory approach could nonetheless be improved by strengthening civil society's participation in the coordinating mechanisms.

[18] The Global Fund defines key populations as groups that experience both increased impact from one of the diseases and decreased access to services. It also includes groups that are criminalized or otherwise marginalized. For example, in the context of HIV, key populations include: men who have sex with men, transgender people, sex workers, people who inject drugs, and people living with HIV. The Global Fund also recognizes vulnerable populations, who are those who have increased vulnerabilities in a particular context, i.e. adolescent/women and girls, minors and people with disabilities. For a complete definition, refer to the following link to the Global Fund website.
[19] Malaria programs where malaria-focused civil society and/or community organizations are not represented in the CCM are requested to indicate if civil society and community organizations engaged in responding to malaria have been informed and consulted under the "Applicant rationale" section.