The Global Fund

FUNDING REQUEST APPLICATION FORM
Full Review

SUMMARY INFORMATION			
Applicant	CCM ETHIOPIA		
Component(s)	MALARIA		
Principal Recipient(s)	FEDERAL MINISTRY OF HEALTH		
Envisioned grant(s) start date	1 January 2018	**Envisioned grant(s) end date**	31 December 2020
Allocation funding request	*$111 849 218*	**Prioritized above allocation request**	*$14 075 566*

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying ***Funding Request Instructions: Full Review****;*
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the Global Fund website.
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;
- Ensure consistency across documentation.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related guidance for more information.

This funding request includes the following sections:

Section 1: Context related to the funding request
Section 2: Program elements proposed for Global Fund support, including rationale
Section 3: Planned implementation arrangements and risk mitigation measures
Section 4: Funding landscape, co-financing and sustainability
Section 5: Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table ("N/A") and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	**Applicable reference document(s)**	**Relevant section(s) & pages nb.**	**N/A**
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	Annex 1. Heath Sector Transformation Plan (HSTP) 2015/16-2019/20 Annex 2. Health Sector Annual Review Meeting Report of 2015/16 (EFY 2008) Annex 3. DHS 2016 Annex 4. National health account (NHA)	Sections 4 - 7; pages 75 -153 Section 2.4.3; pages 37- 39 Section 3; pages 21-46 Section 7; pages 49-56	☐
Health system strategy	Annex 1. HSTP Annex 5. Information Revolution Roadmap Annex 6. Integrated Pharmaceuticals Logistics System (IPLS) Annex 7. PHEM Guideline Annex 8. Human Resources Development Strategy	Sections 3.2.4.1& 3.2.4.4 pages 32; 35-36 Section 1; Page 17 Pages 33- 59 Sections 3& 4, pp. 19-67 Pages 33- 59	☐
Human rights and gender considerations (cross-cutting)	Annex 9. Ethiopian Constitution Annex 10. Health Sector Gender Mainstreaming Manual, 2013	Articles 10, 14, 24, 25, 29, 35, 41 Section 3; Pages 14-44	☐

Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	Annex 11. NSP: 2017-20 Annex 12. MIS 2015 Annex 3. DHS 2016 Annex 19. Evolution of malaria stratification	Pages 1-69 Pages 33- 59 Section 3; pages 21-46 One page document	☐
Disease strategy (including interventions for key and vulnerable populations, as relevant)	Annex 13. Implementation guidelines for distribution and storage of LLIN in Ethiopia Annex 14. Insecticide resistance monitoring and management (IRMM) Annex 15. National Malaria Elimination Roadmap	Page 23-32 Page 15-52 Page 6-29	☐
Operational plan, including budgetary framework	Annex 16. Malaria elimination operational plan July 2016-Dec 2017	Page 1	☐
Program reviews and/or evaluations	Annex 17. MPR 2017 Annex 12. MIS 2015	All document Pages 33- 59	☐
Human rights and gender considerations (disease-specific)	Annex 10. Health Sector Gender Mainstreaming Manual, 2013 Annex 18. National Health Policy Annex 9. Ethiopian Constitution	Section 3; Pages 14-44 Pages 33- 59 Articles 10, 14, 24, 25, 29, 35, 41	☐
Add rows as relevant, for any additional key area as relevant to the funding request			

1.2 Summary of country context
To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations. **(maximum 2 pages per component)**

[*Applicant response*]:

Malaria transmission in Ethiopia is highly variable because it is influenced by altitude, climatic factors, human settlement and population movement patterns.

The parasite species distribution did not show significant change in the past five years. Still, *Plasmodium falciparum* is the major species that contributed 70% of the cases while the rest of cases were mainly due to *P. vivax*. Malaria prevalence has decreased from 1.3 in 2011 to 0.5 in 2015. Historically, the unstable nature of malaria transmission has been characterized by frequent focal and cyclical large-scale epidemics in the Ethiopian highlands. However, no major malaria epidemics have been reported in the country since 2003/2004.

The current malaria stratification shows that the percentage of high malaria transmission districts decreased from 19% in 2013 to 6% in 2016. On the other hand, the percentage of moderate malaria transmission districts increased from 34% in 2013 to 43% in 2016 and those with low malaria risk increased from 12% in 2013 to 17% in 2016. The shift from high to moderate/low epidemiological stratum is an indication of the progressive reduction in the incidence of malaria transmission. It is however to be noted that there were 251,282 malaria cases (7 cases/1000 persons) reported in 2016 from the malaria-free districts, suggesting probable imported cases from neighbouring malaria areas since API shows only the place of testing and treatment but not place of infection. Moving forward, Ethiopia will develop a more refined stratification map, including at health cluster or village level risk maps and will conduct serological surveys as well as operational research on temporal and spatial population movement patterns and malaria risk.

Table 1: Malaria Stratification and Proposed Interventions in Ethiopia, February 2017

Malaria Strata	**API**	**Elevation (m)**	**Population (2017)**	**% Population**	**No. of Woreda**	**% Woreda**	**Interventions**					
							LLIN	**IRS**	**Larval Control**	**Case Mx**	**Surveillance**	**IEC/ BCC**
FREE	0	>= 2000 asl	37 083 083	40.3%	280	33.1%	-	-	-	X	X	X
LOW	>0 &<5	< 2000 asl	17 115 269	18.6%	146	17.3%	X	X*	WA	X	X	X
MODERATE	>=5 &<100		34 782 644	37.8%	365	43.2%	X	X**	WA	X	X	X
HIGH	>=100		3 036 580	3.3%	54	6,4%	X	X	WA	X	X	X
Total			**92 017 576**	**100%**	**845**	**100%**						

*Only 32% of at risk population in highland fringe/epidemic-prone areas will be covered for IRS
**Only 14.8% of districts relatively at boundary of high strata will be considered from moderate for IRS
WA: where applicable; asl: above sea level

There remains a compelling need for continuing the GF contribution for IRS in 32% districts in low transmission stratum, which are known to be epidemic prone areas in the country. This is believed to have prevented the occurrence of malaria epidemics since 2003. Additionally, 14.8% districts from the moderate stratum which have high API will be covered by IRS. This helps to ensure further reduction in reported cases and prevent the likely surge of the disease.

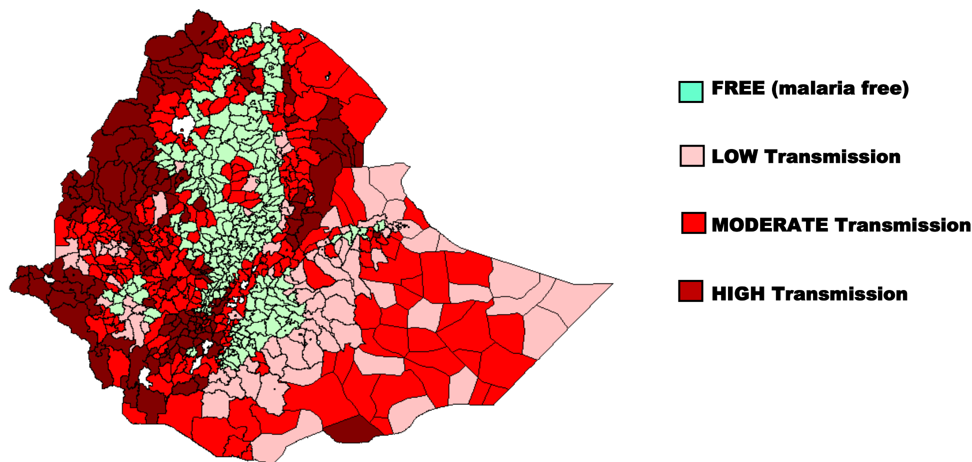

Figure 1: Malaria Stratification Map in Ethiopia, 2014

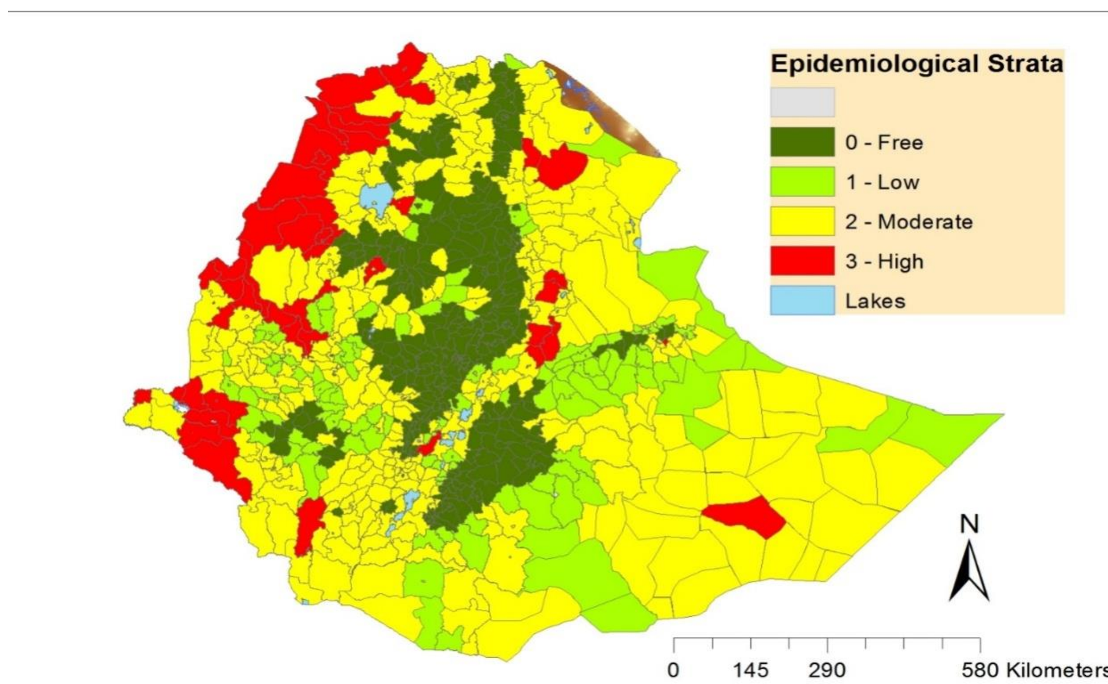

Figure 2: Malaria Stratification Map in Ethiopia, 2017

High malaria transmission districts have decreased with a switch to moderate level, which has therefore increased. There has also been a shift from moderate to low level epidemiological stratum (Annex 19).

This full review submission aims at ensuring universal access to anti-malarial interventions to special at risk populations, which include seasonal workers who move from malaria free areas to malarious areas, and refugees, all representing around 2 million people. To facilitate this, the MOH has formulated and implemented a number of policies and strategies. These include strategies on free service for anti-malarial interventions, the training and deployment of health workforce, the health extension workers (HEWs) for the institutionalization of the community health care services at the grass roots level. The health extension package has a set of preventive, promotive and curative interventions.

Out of these 2 million people, refugees settled in malarious areas are estimated to be half a million (of the 750 000 refugees as per UNHCR Ethiopia Factsheet – 2016). The NMCP has been providing anti-malaria supplies to refugees, whenever requested by responsible organization. In this funding request, specific intervention will be conducted towards refugees and emergency response by the Program in coordination with the governmental organisation: Administration for Refugees and Returnees Affairs (ARRA). Case management activities, communication and information will be conducted accordingly. Distribution of LLINs will also be organised using the current stock available.

Ethiopia's health system is characterized by having mostly female HEWs. Anti-malaria interventions are provided free of charge at community level by HEWs. Thus, women are very much motivated by having a women-driven health system at the grass roots and by accessing the interventions without any inequalities or impediment. Further, the Ethiopian government expressed its commitment to gender mainstreaming in all its sectoral programs, including the health sector, so that women and men participate and benefit equally from its service outlets.

1.3 Past implementation and lessons-learned from Global Fund and other donor investments
a) List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation. b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable. c) Outline lessons learned from investments by other donors as applicable. For each of the above, explain how these lessons learned are taken into account in this funding request. **(maximum 1 page per component)**

[*Applicant response*]:

This full review submission will continue targeting the long-term vision of a malaria-free Ethiopia as stated in the updated NSP 2017 - 2020. There will be no major changes in key interventions - case management, vector control including LLIN mass campaign, targeted IRS, malaria surveillance and IEC/BCC with technical input from local and international partners. Lessons learnt from the implementation of the GF current grant, partners' subventions and RSSH projects will be critical in order to improve the performance of the Programme.

a) List of disease-specific Global Fund grants the 2015 - 2017 allocation and lessons learned from implementation

Under the Concept Note of 2015-2017, including the carry forwarded amount from GF round-8, Ethiopia has been awarded the total amount of $150,578,565 for malaria. The allocated funding has helped to achieve and maintain universal coverage of preventive interventions to all at risk population.

The main achievements/lessons learnt are the following:

- The country managed to sustain high coverage of proven anti-malaria interventions, which in turn ensured prevention of malaria in the population at risk and assured access to care and treatment of malaria cases.

- The implementation helped to reduce the overall burden of malaria as clearly seen from the MPR 2017 and WMR 2016 by more than 40% between 2010 and 2015.
- Parasite prevalence also reduced dramatically, which stands at 0.5% per MIS 2015.
- Nationally, there was a total of 510 malaria related deaths in 2016. Thus, the goal of achieving near zero deaths (no more than 1 death per 100,000 population at risk), which was initially targeted for 2020, has been already achieved. This clearly shows that investment in malaria is paying off.
- Woreda based micro planning has helped to generate village/kebele level data, which helped accurate quantification.
- Having a National Implementation Guidelines for the distribution and storage of LLIN improved the distribution of nets up to end-users.
- Involvement of community-based structures including kebele administration, health extension workers and health development army has played an important role in the distribution, utilization and tracking of LLIN.
- Updating the Case Management Guidelines in 2016 based on the 2015 WHO recommendations has facilitated the adoption of vivax treatment with radical cure with Primaquine.
- The findings of the MPR conducted early 2017 and of the MIS 2015 have been essential in the development of the updated National Strategic Plan 2017 – 2020.

b) **Lessons learned from HSS grants or any HSS investments embedded in the disease-specific grants** are summarized as follows by major thematic areas:

- **Pharmaceutical and Supply Management**

The need for improving the country's PSM system was identified during the implementation of the preceding grant. This has been addressed through designing a system called integrated pharmaceuticals logistics system (IPLS), which in turn improved distribution up to health facilities and tracking of malaria commodities as well. Additionally, the PFSA warehouses have been networked. The recent work on PSM has improved supply chain management capacity, storage and delivery for essential medicines and has offered an opportunity to streamline the malaria products as part of the overall supply chain up to health facilities. This in turn has facilitated the availability of essential supplies for the Program to improve the monitoring of malaria commodities stock status at health facilities (HF), regional and central level and the refilling based on updated consumption report.

- **Surveillance, Data Quality and Data Management, and M&E**

The need for having a real time and quality data has been considered as a priority for the Ethiopia's health system. The FMOH conducted internal and independent assessment of HMIS systems with the view of improving its ability to collect and use routine health system data through the introduction of a single, open-source, government-led HMIS platform (ARM 2015/16). Accordingly, electronic-HMIS is practiced in most health facilities and DHIS-2 validation was completed and piloted at selected sites.

Various monitoring activities conducted in the last three years include monitoring efficacy of anti-malaria drugs, monitoring susceptibility of vectors to insecticides, monitoring distribution and behavior of vectors, and monitoring of durability and longevity of LLIN. These activities have helped to generate latest national evidence in relation to malaria. Results from recent drug monitoring studies have indicated that there is no indication of drug resistance.

- **Human Resource Development and Management**

Additional human resources (28 staff) have helped the Program to implement the planned activities more effectively. HR hiring and deployment, especially, for regions with special

support needs is critical to ensure and facilitate implementation of the planned activities. Accordingly, regional and zonal level HR capacity strengthened in Somali, Gambella, Benshangul Gumuz and Afar regions, where implementation is hampered by inadequate number of trained personnel and high staff turnover. Field visits to and performance reports from these regions indicated that there have been improvements in performance of the planned activities in the above-mentioned regions.

- **Integrated Community Case Management (iCCM)**

The FMOH has given high priority to strengthening of the community based health service delivery system, introducing a new policy for adding treatment of pneumonia to treatment of malaria and diarrhea by HEWs through integrated Community Case Management (iCCM) in October 2009, and a national scale-up was started in 2011. The roll out of the plan at the remaining communities, mainly located in the pastoral regions of Afar and Somali was successfully implemented during the last two years (2015 and 2016). The iCCM approach continue providing an important opportunity to maximize outcomes and reduce overall child mortality. Malaria program has been benefiting a lot from the iCCM and thus death related to under-five children has been reversed in recent years from 204/1000 live birth in 1990 to 67/1000 live birth in 2016 (source DHS 2016).

- **SBCC**

Community empowerment and mobilization is one of the main strategies outlined in the grant implementation. The Ethiopian government and partners worked to improve community awareness through community based communication and social mobilization. The investment on SBCC has resulted in improvement of the LLIN utilization in under-five children (70%) and pregnant women (74%) as measured by MIS 2015.

c) Lessons learned from investments by other donors

PMI has been giving huge support in LLINs and anti-malaria procurement, as well as support to IRS activities in some selected districts. PMI funded commodities procurement is handled through UNICEF. The Coordination mechanism set by malaria program and Pharmaceuticals and Medical Equipment Directorate (PMED) used to guide the procurement of key malaria commodities in harmonized way. NMCP team, PMI, UNICEF and PMED/FMOH are member of the coordination meeting. This coordination mechanism was very important to avoid duplication of efforts, effective use of the grant and advice critical needs of malaria commodities that should be procured by PMI or Global Fund. PMI's support has been decisive in filling the existing gaps that could have caused detrimental effect otherwise.

The SDG pool fund is a funding arrangement of other bilateral and multilateral funding donors that is managed by the FMOH and can be prioritized for major health programs and systems. It has facilitated the Program management in terms of resources and supply and harmonized budget and reporting. The Malaria Program benefited from the SDG pool fund to support prevention and program management in development areas, such as small and large scale mechanized farming, mining, dams. Accordingly, the funding has helped to improve malaria prevention and control in these development areas.

SECTION 2: FUNDING REQUEST (Within Allocation)
This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable. To respond, refer to additional guidance provided in the *Instructions.* Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

2.1 Disease-specific funding request *Not applicable if the application is a standalone RSSH request.*
Given the context and lessons learned outlined in Section 1, a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services. For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved. b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps. For funding requests including both HIV and TB components: c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming. Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate. **(maximum 4 pages per component)**

[*Applicant response*]:

a) Description of the disease-specific funding request, the rationale for prioritizing modules and interventions

Note: *For each intervention, the list of detailed activities, detailed budget per activity and budget assumptions are available in the file: "Ethiopia_Malaria_Gap Analysis_Sheet"*

Module 1. Vector control

The NSP 2017 - 2020 aims to sustain the universal vector control coverage through LLIN and /or IRS interventions in malaria risk areas where applicable.

Given the high level of pyrethroid resistance, LLINs and IRS will continue to be co-deployed in the highest burden and epidemic prone districts as part of the country insecticide resistance management plan which was developed in 2016 and is currently being implemented. There will not be areas in the country for standalone IRS. It is either LLIN alone or LLINs and IRS together. This means that LLIN distribution is targeted for universal coverage (100%) of all

population at risk and that IRS is co-deployed only in proportional malarious areas as indicated under section 1.2.

In this application, the Program will reduce the number of structures for IRS from around 5 million to 4.4 million structures representing 23% of the population at risk compared with 65% in the previous years, given the positive evolution of the stratification as the malaria burden should decrease due to impact of overall interventions.

- **Long lasting insecticidal nets (LLIN)**

The last LLIN distribution campaign was conducted in 2015/16 and over 30 million LLINs were distributed to households in malaria risk areas throughout the country. According to MIS 2015 in a household owing at least one net, use of net by children and pregnant women was 70% and 74% respectively.

During the period 2018 – 2020 the LLIN mass distribution campaign will target all population. Major LLIN mass distribution campaign for replacing old nets is planned for 2019. However, there are areas where small scale replacement of net will be conducted in 2018 and 2020. LLIN planning is based on the WHO recommendation of 1 net for 1.8 people and using woreda level micro-planning data. Accordingly, the total LLIN need for universal coverage is 5,690,864 in 2018, 18,313,031 in 2019 and 3,738,588 in 2020.

The needs for 2018 and 2020 will be fully covered. PMI will cover 100% of the LLINs needed in 2018, 44% in 2019 (8 million LLINs) and 100% in 2020. The resources available from PMI, representing 17 429 452 LLINs will then cover $55,665,312 for three years.

Gap Analysis LLIN	2018	2019	2020	Total
Total Needs	$18 175 197	$58 487 242	$11 940 115	**$88 602 554**
Total Funded	$18 175 197	$25 550 000	$11 940 115	**$55 665 312**
Gap to be funded	$0	$32 937 242	$0	**$32 937 242**
Request to Global Fund	$0	$32 937 242	$0	**$32 937 242**
	0%	100%	0%	**100%**

This funding request application will cover $32 937 242 representing 100% of the gap for the 2019 mass campaign (see Gap Analysis file).

- **Indoor Residual Spraying (IRS)**

The country implements procedures and approaches for rational use of insecticides as stipulated in insecticide resistance monitoring and management (IRMM) strategy. The Program uses Carbamate and Organophosphate classes of insecticides for the IRS. As per the current stratification, IRS is targeted to epidemic risk and high transmission areas. Previously more than 5 million structures used to be sprayed in each year. There is a plan to reduce the unit structures to be sprayed during the period 2018 - 2020. The insecticide in use for IRS will be Bendiocarb in 27%, Actelic in 18.24% and Propoxur in 54.76% of the targeted unit structures.

Regarding source of funding, the Government will fund 49% of the spraying operations while PMI will cover 100% of the Actelic need and 18.24% of the cost of the spraying activities related to training, monitoring and evaluation. The SDG pooled fund will cover 100% of the

Propoxur need. The Bendiocarb need in 2018 and 2019 is already covered through 2017 supply funded by GF current grant.

Gap Analysis IRS	2018	2019	2020	Total
Total Needs	$43 712 524	$46 073 408	$43 235 521	**$133 021 453**
Total Funded	$39 793 360	$38 901 117	$33 269 388	**$111 963 864**
Gap to be funded	**$3 919 165**	**$7 172 291**	**$9 966 133**	**$21 057 589**
Request to Global Fund	$3 919 165	$3 880 376	$9 966 133	**$17 765 674**
	100%	54%	100%	**84%**
Remaining Gap	$0	$3 291 915	$0	**$3 291 915**
	0%	43%	0%	**16%**

The application requests $17 765 674 and will concern the supply of Bendiocarb to cover around 1.2 million structures in 2020, as well as the equipment, the spraying operations activities not already covered by the Government and PMI.

The remaining gap of $3 291 915 concerns the construction of storage facility. It will not be requested for PAAR as it could be covered by the Government and/or partners additional financing opportunities (see Gap Analysis file).

Module 2. Case management:

The program aims at universal diagnosis and treating all positive malaria cases according to the national guidelines. To achieve universal diagnosis of febrile cases and treatment of malaria cases at community level, the health extension program reaching each village with a health post which is equipped with multispecies mRDT, ACT, and iCCM drugs and supplies.

The number of seasonal workers, pastoralists and refugee population is estimated to be 2 million in 2017 and is expected to grow each year as development zones will increase. The needs for covering these key populations are included in the gap analysis.

The private sector has so far been insignificantly involved in diagnosis and treatment services since private health facilities are concentrated in urban setting where malaria is not a major public health problem. However, in line with the goal of malaria elimination endeavor, the FMOH and the NMCP are planning to ensure active involvement of the private sector through the public private partnership (PPP) to increase access to malaria diagnosis and treatment services. A directorate which is responsible for PPP has recently been established under the FMOH to facilitate such initiative towards the private sector involvement.

- **Uncomplicated Malaria drugs (ACT/Primaquine/Chloroquine/Quinine)**

70% of malaria cases are due to *P. falciparum* and will all receive ACT and single dose Primaquine. The remaining 30% are due to *P. vivax*. All patients with *P. vivax* will receive chloroquine and those in elimination area will receive an additional 14-day Primaquine treatment. Though studies show that G6PD deficiency is not a major problem in Ethiopia – and therefore the country does not test for G6PD deficiency-, administration of Primaquine will be closely monitored using DOTS approach to prevent any major side effects that could happen.

As Primaquine is contraindicated to pregnant women (4.5%), pregnant women with P. *falciparum* are treated with quinine in the first trimester and ACT in second and third trimester. Pregnant women with *P. vivax* are treated with chloroquine.

For the period 2018 - 2020 Quinine and Chloroquine treatments will be funded by the Government. The proposed request to GF should cover the full need of 7.8 million ACT treatments and 8.9 million Primaquine treatments.

At this stage, PMI in consultation with the NMCP has agreed to focus financial resources to cover LLIN and IRS activities as a priority.

Thus, access to and availability of treatment shall be ensured to meet universal coverage of all at risk people.

Gap Analysis Uncomplicated Malaria drugs ACT/Primaquine/Chloroquine/ Quinine	2018	2019	2020	Total
Total Needs	$4 845 563	$4 440 568	$3 976 418	**$13 262 549**
Total Funded	$355 963	$326 212	$292 114	**$974 289**
Gap to be funded	$4 489 600	$4 114 356	$3 684 304	**$12 288 260**
Request to Global Fund	$4 489 600	$4 114 356	$3 684 304	**$12 288 260**
	100%	100%	100%	**100%**

This application requests $ 12 288 260 for the period 2018 – 2020 and will cover the full gap for ACT and Primaquine treatments (see Gap Analysis file).

- **Rapid Diagnostic Tests**

The universal diagnosis of suspected malaria cases is a primary objective of the NSP 2017-2020. Diagnosis based on mRDT is used at health posts while microscopy is used at health centers and hospitals. Multi species mRDT detect *P. falciparum, P. vivax* and mixed infections. Up to 70% of suspected malaria cases would be negative for malaria due to impact of vector control and case management on reducing the burden of the disease.

The roll out of iCCM at health post level is also critical for addressing common killers of children such as pneumonia, diarrhea, severe acute malnutrition (SAM) and newborn conditions. Support for iCCM component other than mRDT and treatment is requested through RSSH. Testing of suspected malaria cases have improved and currently at 95%. The program aims at testing 100% suspected malaria during the period 2018 – 2020.

A total of around 16.9 million tests is needed for the period 2018 – 2020, from which contribution from PMI will be 513 000 in 2018. As for ACT, PMI has not budgeted for additional mRDT as priority was given to LLIN and IRS activities.

Gap Analysis mRDT	2018	2019	2020	Total
Total Needs	$2 687 620	$2 612 367	$2 531 384	**$7 831 371**
Total Funded	$237 291	$0	$0	**$237 291**
Gap to be funded	$2 450 330	$2 612 367	$2 531 384	**$7 594 080**
Request to Global Fund	$2 450 330	$2 612 367	$2 531 384	**$7 594 080**
	100%	100%	100%	**100%**

This application requests $ 7 594 080 for the period 2018 – 2020 and will cover the full gap for mRDT (see Gap Analysis file).

- **Severe malaria**

Artesunate injection (IV/IM) is the first line treatment for severe malaria. Severe malaria treatment service is provided at health centers and hospitals. In 2015/2016, over 40,000 malaria admissions were reported and this report indicated significant reduction from 84,000 in 2012/13. Health posts are identifying and referring severe cases to health centers and hospitals with pre-referral treatment.

Gap Analysis Severe Malaria	2018	2019	2020	Total
Total Needs	$332 946	$308 052	$278 531	**$919 530**
Total Funded	$332 946	$308 052	$278 531	**$919 529**
Gap to be funded	$0	$0	$0	**$0**

No fund is requested through this application for artesunate injection and pre-referral treatment as both drugs are fully funded by PMI (see Gap Analysis file).

Module 3. Advocacy communication and social mobilization (ACSM)

Community empowerment and other ACSM activities are critical to improve the utilization of malaria interventions using community, schools, and religious platforms. During the period 2018 - 2020 the Program will implement the following key activities:

- LLINs pre- and post-distribution community mobilization and IEC/BCC on LLINs utilization using electronic and print media
- LLINs pre- and post-distribution community mobilization through HEWs and health development army
- Reproduction of key messages on case management and drug adherence and disseminate in major local languages through electronic national mass media
- World Malaria Day (WMD) commemoration
- Community sensitization using mobile vans in priority malaria hotspot areas.
- Desk review on existing IEC/BCC (prevention, case management and adherence) materials at national level and update the materials

The total need for ACSM intervention is $24 135 504. The Government contribution will cover $21 197 366 for the activity of LLINs pre- and post-distribution community mobilization, representing 88% of the resources needed for the period 2018 - 2020.

Gap Analysis ACSM	2018	2019	2020	Total
Total Needs	$7 822 955	$8 029 143	$8 283 406	**$24 135 504**
Total Funded	$6 817 417	$7 062 844	$7 317 106	**$21 197 366**
Gap to be funded	$1 005 538	$966 299	$966 300	**$2 938 138**
Request to Global Fund	$1 005 538	$966 299	$966 300	**$2 938 138**
	100%	100%	100%	**100%**

The request for funding through this submission is $ 2 938 138 for the period 2018 – 2020 and will cover the full gap for ACSM needed to implement all the other ACSM activities listed above (see Gap Analysis file).

Module 4. Malaria specific RSSH: Monitoring and evaluation

Monitoring and evaluation activities are critical to measure progress of the program and identifying bottlenecks. The FMOH is covering directly the core M&E activities as part of its responsibility. Much of the M&E activity requires coordination across agencies within the MOH, including EPHI/PHEM and Policy and Planning Directorate (PPD)/HMIS and therefore is well adapted to the direct management of the resources by the PR.

During the period 2018 - 2020 the Program has the plan to implement the following specific malaria M&E activities:

- Conduct malaria program review (MPR) in 2020
- Monitor entomological and parasitological indices in sentinel sites
- Conduct malaria indicator survey (MIS) in 2020,
- Annual review meeting at federal, regional, zonal and woreda level
- Supervision from federal, regional and zonal level
- Drug efficacy monitoring
- Monitoring of insecticide susceptibility.
- Post IRS evaluation (bioassay)
- Study on distribution, dynamics and behaviors of specific malaria vectors
- Carryout village/Kebele level malaria stratification
- Printing of epidemic monitoring chart

Of the total need of $46 407 515 for M&E malaria specific activities, PMI will contribute at a level of $600 000 for the MIS and WHO at $30 000 for the MPR, both to be conducted in 2020.

Gap Analysis M&E	2018	2019	2020	Total
Total Needs	$16 137 095	$14 365 934	$15 968 227	**$46 471 256**
Total Funded	$0	$0	$630 000	**$630 000**
Gap to be funded	**$16 137 095**	**$14 365 934**	**$15 338 227**	**$45 841 256**
Request to Global Fund	$3 115 164	$2 855 508	$3 010 911	**$8 981 583**
	19%	20%	20%	**20%**
Remaining Gap	$13 021 931	$11 510 426	$12 327 316	**$36 859 673**
	81%	80%	80%	**80%**

The current request for M&E is of $8 981 583 and shall cover 20% of the total need to implement the activities related to all evaluation, studies and training activities listed above except the annual zonal and woreda review meetings.

The remaining gap of $36 859 673 concerns the activities related to annual zonal and woreda review meetings which will not be requested for PAAR as it could be covered by the Government and partners (see Gap Analysis file).

Module 5. Program Management

Many of the program management activities are related to capacity building, including recruitment of GF focal persons and technical assistances (TAs) at FMOH and for regions with special support needs, and annual planning, coordination meetings and conducting performance reviews for which responsibility within the structure reverts to the MOH.

Continuing the level of support previously covered by GF during the period 2018 - 2020 the Program plan to implement the following key activities:

- Training on comprehensive malariology course for staff of RHBs, District Health Office, hospital and health centers
- Salary for GF focal points, entomologists, epidemiologists, support staff
- Malaria program management with in general health administration,
- Vector control training
- Training on malaria diagnosis and quality assessment
- Training of health professionals on fever case management

The Government will contribute at a level of 78% of the total need for the period 2018 – 2020 representing an amount of $22 659 253 for salaries of the public servants.

Gap Analysis Program Management	2018	2019	2020	Total
Total Needs	$9 576 648	$9 768 290	$9 688 729	**$29 033 667**
Total Funded	$7 287 583	$7 549 936	$7 821 734	**$22 659 253**
Gap to be funded	$2 289 065	$2 218 354	$1 866 995	**$6 374 414**
Request to Global Fund	$2 289 065	$2 218 354	$1 866 995	**$6 374 414**
	100%	100%	100%	**100%**

The request for funding through this submission is $6 374 414 for the period 2018 – 2020 and will cover the full gap of Program Management for salaries of GF focal points, entomologists, epidemiologists, support staff, and all training activities listed above (see Gap Analysis file).

Module 6. Malaria Elimination

Malaria elimination is one of the important undertakings in Ethiopia. The national malaria elimination roadmap was launched in March 2017 and elimination related activities have been started in 239 selected districts.

During the period 2018 - 2020 the total need is $27 985 391 in order for the Program to implement the following key field of activities:

- Surveillance and response, M&E = $14 986 508 (40%)
- Advocacy, sensitization and social mobilization = $11 446 179 (31%)
- Elimination program management = $268 477 (1%)
- Laboratory capacity strengthening = $37 045 391 (28%)

The National Roadmap on Malaria Elimination developed in collaboration with in-country and international partners in 2016 provides the framework and organization that will drive the implementation of the activities.

Gap Analysis Elimination	2018	2019	2020	Total
Total Needs	$8 872 866	$8 285 676	$19 886 849	**$37 045 391**
Total Funded	$0	$0	$0	**$0**
Gap to be funded	$8 872 866	$8 285 676	$10 826 849	**$27 985 391**
Request to Global Fund	$7 275 750	$6 816 058	$8 878 017	**$22 969 825**
	82%	82%	45%	**62%**
Remaining Gap	$1 597 116	$1 469 618	$11 008 832	**$14 075 566**
	18%	18%	55%	**38%**

The current request for malaria elimination is $22 969 825 and shall cover 62% of the total need to implement the activities related to surveillance, advocacy, management and laboratory such as:

- Training of health personnel on overall elimination roadmap
- Case/foci detection and management
- Conduct baseline assessment
- Monitor and review of implementation status
- Training of lab personnel on diagnosis quality
- Procurement and distribution of additional diagnostic tools

The remaining gap of $14 075 566 will need to be covered by above allocation amounts to implement some activities related to social mobilization and to PCR supplies (see Gap Analysis file).

b) Explanation on how the funding request addresses the key funding gaps reflected in the Funding Landscape Table for the disease program in the current allocation cycle, and specify other actions planned to cover remaining gaps.

The total need to meet the objectives for the period 2018 – 2020 is $380 323 276. The contribution from the Government, local and international partners will represent 56% of the total need. The present funding request is $111 849 218 for 2018 - 2020 and covers 29% of the total need, which represents 67% of the gap to be funded. Accordingly, there will be a remaining gap of around $54.2 million.

Gap Analysis Ethiopia	Total	
Total Needs	$380 323 276	100%
Total Funded	$214 246 904	56%
Gap to be funded	$166 076 372	
Request to Global Fund	$111 849 218	29%
	67%	
Remaining Gap	$54 227 154	15%
	33%	

In allocating the funding, care has been taken to prioritize GF funding for maintaining high coverage of preventive interventions and ensuring access to diagnosis and treatment of malaria cases and malaria elimination activities. Support activities such as communication, M&E and program management are also key interventions that should contribute to capacity

building towards improved program performance and advocacy. Planned actions to address these gaps include prioritization of actions so that they are realized in a logical sequencing, while not compromising the overall effectiveness of the program in reaching its goals. In addition, the updated NSP 2017 - 2020 will form the basis of a resource mobilization strategy that will leverage current resources and program performance to secure funding.

As malaria interventions are cost intensive, additional resource mobilization efforts from in-country and global partners will be continued to bridge the identified funding gaps and ensure the sustenance of high coverage of interventions and impacts gained in terms of reduction of cases and deaths due to malaria.

In addition, there is SDG fund pooled from major donors of the health sector and managed by FMOH. This fund will also be prioritized and used for bridging unmet gaps in malaria prevention, control and elimination activities.

2.2 RSSH funding request	
The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a ***single*** application, and preferably to be requested in the first submission.	
Does this funding request include an RSSH component?	☐ Yes ☒ No
If yes, describe the request below and how it is strategically targeted. Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on 'government health spending', Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH. **(maximum 3 pages)**	

[*Applicant response*]:

If no:
a) Indicate when the RSSH funding request was/will be submitted; and, b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request. **(maximum ½ page)**

[*Applicant response*]:

a) Submission of the RSSH funding request was/will be submitted

The RSSH component will be submitted as stand-alone full review proposal during next submission wave, August 20th, 2017.

The CCM Ethiopia has been awarded a total amount of $375 608 887 by the Global Fund with the following proposed allocation per disease component that should also include an allocation for RHHS: $194 160 288 for HIV/AIDS, $51 599 381 for TB and $129 849 218 for Malaria.

On April 7, 2017, the CCM Ethiopia took the decision to allocate an amount of $24 million to RSSH ($18 million from Malaria, and $6 million from TB). HIV allocated funding is not considered for splitting for RSSH, because further reduction from the allocation could bring detrimental effect.

From the total allocation of $375 608 887 the program split is therefore as follows:

- HIV/AIDS = $194 160 288
- TB = $45 599 381
- Malaria = $111 849 218
- RSSH = $24 000 000

b) Highlight of the elements of the planned RSSH investment that will directly support the disease program in this funding request

Elements of the planned RSSH funding request that will directly support the malaria funding request are as follows:

- Financial management
- Health workforce
- Integrated health service delivery
- Health information system
- Procurement and supply chain management

Accordingly, the planned investment on the above-mentioned elements of the RSSH should improve the capacity of the health system, which in turn will facilitate improvement and efficiency of implementation of the planned anti-malaria interventions.

2.3 Focus of application requirement [1] This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries. To respond, refer to guidance provided in the *Instructions.*	
For LMI countries: - Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?	☐ Yes ☒ No
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?	☐ Yes ☒ No
For UMI countries: - Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities?	☐ Yes ☒ No
Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.	

[1] Refer to the Global Fund 2017 Eligibility List for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund Sustainability, Transition and Co-Financing Policy.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION
This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map.** To respond, refer to additional guidance provided in the *Instructions.*

3.1 Implementation arrangements summary	
Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	☐ Yes ☒ No
If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant. If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period. In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation. Include a description of procurement mechanisms. **(maximum 1 page)**	

[*Applicant response*]:

Under the Full Review submission, the NMCP will continue targeting the long-term vision of malaria free Ethiopia as stated in the updated NSP 2017-2020. There will be no major changes on key interventions vector control (LLINs distribution, targeted IRS), case management, malaria surveillance, SBCC and program management. Malaria elimination interventions will be implemented with preliminary approach assuming optimization of interventions in 239 districts targeted.

There will not be changes in the implementation arrangements as well. The Civil Society Organization (CSO), NGOs and private sector will also be involved in the overall implementation process. This has already been discussed and agreed during the country dialogue that took place on May 10th, 2017. Technical inputs from local and international partners will continue to be addressed during programme implementation.

Given the high demand that the program implementation requires and that malaria elimination entails, there is a need to assign dedicated malaria focal persons with appropriate structure at all levels, especially at sub-national level that should be aligned with the NMCP structure. The issue of data quality review requires a systematic approach which should be addressed through the coordinated effort between the program and line partners including Planning and Program Directorate (HMIS) and PHEM. The data quality issue will much be improved through DHIS-2, which will fully be implemented in the coming funding cycle.

Appropriate quantification and planning of malaria commodities including nets, IRS chemicals and RDTs will be ascertained. The issue of improving the procurement and supplies management chain requires a high-level coordination between the program and PFSA at the center, regional hubs, including the implementing partners at the health facilities down the line. Appropriate follow up of fund utilization and timely feed backs for management letters will be given due emphasis.

During the preceding grants the malaria planned activities were implemented through assuring accessibility of health care for all segments of the population and promoting participation of

private sector and NGOs. Moreover, the FMOH has formulated and implemented a number of policies and strategies.

HEWs together with village/Kebele administrators and the community development army (HDA) keep playing a great role in distribution of LLINs, tracking/recording of nets using net-registration pad, educating community and assessing net utilization.

On other hand, the national entomological profile should further be updated through generating representative evidences from the sentinel sites. Vector control intervention should target localities based on village level malaria risk information and its quality should be give due attention. Monitoring of entomological indices, and anti-malaria drug efficacy will be conducted in these sentinel sites. Additionally, evaluating advanced vector control tools and other studies will be conducted by NMCP, EPHI, academic and other research institutions and partners.

3.2 Key implementation risks

Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.

Applicant response in table below.

Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
Operational/ implementation	Sub optimal LLIN utilization and delay in distribution	The national program in collaboration with partners reviewed the comprehensive LLIN universal campaign strategy in March 2017 to strengthen the planning, storage, timely household level distribution and improve community LLIN utilization. The ongoing targeted social mobilization activities will be strengthened at scale to improve utilization of LLINs. The monitoring of the LLINs usage at beneficiary level will be further strengthened to be conducted regularly through the support of the existing community structures, the HEP and HDAs. Further, the regular household visit and inspection by HEWs and HDAs will be strengthened to ensure availability and functionality of LLINs on a timely basis. For LLINs distribution tracking, the existing standard register for proper	2017-2018

		documentation will be supported by electronic register for follow-up and tracking the nets. Additionally, civil service organizations will actively be participated in LLINs distribution and community mobilization.	
Financial management	Low fund liquidation	To address the risk, the existing FMOH grant management system which has a national and sub national structure will be further strengthened based on the gaps that led to poor performance in fund liquidation. Based on the capacity gaps, need based capacity building activities will be conducted for grant finance and grant management staffs at national and sub national level. The current RSSH application has emphasized the need for capacity building and regular performance review of the grant finance and grant management staffs at different levels. The capacity building initiatives also includes the coordination between program and finance for timely and proper implementation and reporting of grant activities to improve fund absorption.	2017-2018
Surveillance, M&E	Lack of real time Surveillance system	The current malaria data sources, Health Management Information System (HMIS) & Public Health Emergency Management (PHEM) have limitation to generate real-time data, which is mostly demanded by elimination program. Fortunately, the FMOH has recently decided that the DHIS-2 is to be implemented to capture the relevant health information and community level data. This will support the generation of real time data and address the requirements of malaria elimination surveillance	2017-2018
PSM	Inadequate real time stock visibility at health facilities	To ensure the availability of real time stock visibility data, health commodity management information system (HCMIS) is already in place in 600 health facilities and will be roll out at national level	2017-2018

Operational and programmatic implementation	Movement of migrant workers to high burden areas and influx of refugees	The MOH/NMCP has identified the issue of migrant workers who happen to move from low malaria transmission /malaria free areas to high burden areas, which in turn could potentially bring malaria surge when these people get back to their respective residences. Additionally, as the country has been receiving influx of refugees from neighboring countries, there is a risk of malaria transmission associated with such movement. Cognizant of this foreseen risk, the NMCP in collaboration with in-country partners, has a plan to look for appropriate interventions that work for migrant laborers and initiate implementation of proven anti-malaria interventions. Moreover, a collaboration with organizations and offices responsible for developmental activities and investors as well those which are responsible for refugees will be sought. This ensures joint planning, monitoring and implementation of appropriate actions to protect these vulnerable groups and prevent the surge of the disease.	
Financial resources	Shrinking financial landscape	It is obvious that the funding landscape has been shrinking globally. This in turn affects financial resource at country level. To address this potential and foreseen risk, the FMOH has a plan for innovative ways of mobilizing additional resources to ensure availability of the needed financial resource for the fight against the disease.	2018-2020
Add rows for additional key risks as necessary			

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY
This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.*

4.1 Funding Landscape and Co-financing		
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below.	☒ Yes	☐ No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? **If yes,** provide a brief description below.	☐ Yes	☒ No
c) Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below.	☒ Yes	☐ No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[2] **If not**, provide reasons below.	☒ Yes	☐ No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported.	☐ Yes	☒ No
(maximum 2 pages)		

[*Applicant response*]:

a) Current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending

A new healthcare financing (HCF) strategy 2017 - 2025 has been developed to guide a transition to a more equitable financing for health through gradual replacement of external fund by domestic fund. The health care financing reform in Ethiopia from 2017 – 2025 is one of the strategic objectives of the strategy is to mobilize adequate resources, through traditional and innovative approaches, from domestic and external sources for sustaining and increasing funds for healthcare. This strategic objective prioritizes three strategic initiatives to improve the domestic resource contribution for health:

1. Progressively increase government resource allocation for health
2. Generate additional finance from innovative financing mechanisms
3. Scale up of prepayment mechanisms.

The strategy also prioritizes enhancing efficiency and effectiveness of resources for health through implementation of the following strategic initiatives:

- Continue to invest on high impact and cost effective interventions

[2] Refer to the Sustainability, Transition and Co-Financing Policy.

- Develop an effective harmonized financing and purchasing functions
- Improve operational efficiency
- Enhance transparent, accountable and sound resource utilization and financial tracking management system
- Assess, identify and implement different performance linked strategies to improve efficiency and effectiveness

e) Support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts

Since 1995/96, six successive National Health Account (NHA) have been conducted including the most recent NHA VI (2013/14). Institutionalization process started following the fifth NHA and the recent NHA has been conducted with FMOH in full leadership with technical and financial support from different development partners.

Health economics and financing analysis case team was established with the resource mobilization directorate and a series of capacity building, technical assistance and additional human resources were hired to strengthen and realize the institutionalization. Therefore, to track and to verify the commitments, regular NHAs will be conducted every two years. No financial support is requested under this application for conducting NHAs as there is a commitment from other development partners and government sources.

4.2 Sustainability
Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically, a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions. b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them. **(maximum 1 page)**

[*Applicant response*]:

a) Explanation of the costs, availability of funds and the funding gap for major program areas and how the government will increasingly take up key costs of national disease plans and/or support health system

As previously explained, the NSP has recently been updated for the period 2017-2020. The budget has been reviewed and the partners' contribution landscape has been updated.

The total budget need to achieve the goal of the NSP 2017-2020 is $506 919 602. At this stage and as per the gap analysis that has been conducted to support the current submission, the identified and known contribution from the partners for the period 2018 - 2020 is reaching an amount of $214 246 904.

Table 3: Partners contribution for the period 2018 - 2020

Interventions	Source of Funding			
	PMI	WHO	Government	SDG
LLIN	$55 665 312			
IRS	$34 534 042		$24 261 096	$53 168 726
ACT/treatment			$974 289	
mRDT	$237 291			
Severe malaria	$919 529			
ACSM			21 197 366	
M&E	$600 000	$30 000		
Program management			$22 659 253	
Elimination				
Total	**$91 956 174**	**$30 000**	**$69 092 004**	**$ 53 168 726**
	43%	**0.01%**	**32%**	**25%**
	$214 246 904			

The direct contribution from the Government of Ethiopia for the period 2018-2020 is $69 092 004 representing 32% of the partners' contribution. The Government will mainly continue paying the salaries and wages of the public servants involved but also contribute to the purchase of medical products.

As indicated in section 4.1, the Government is committed to mobilize adequate resources through traditional and innovative approaches from both domestic and external sources using various strategies in pursuit of mobilizing additional resources needed for the fight against malaria as well as for supporting other diseases plans and the overall health system. The government is committed to gradually increase public health budget from treasury source and scale up prepayment mechanism, including health insurance. Besides its commitment in increasing investment for malaria control and elimination, the government ensures that highly at risk and vulnerable populations living in difficult-to-reach areas of the country, including refugees, will benefit in equitable manner. Government will also continue creating and maintaining enabling environments for implementation of interventions for the benefit of at high risk and vulnerable segments of the population.

b) Description of actions to improve sustainability of Global Fund financed programs. Key sustainability challenges and any current and/or planned action to address them

As mentioned above, sustainability of anti-malaria interventions is very crucial for reducing the burden and ending the disease for good. Therefore, there is unwavering commitment of the Government to sustain the planned anti-malaria interventions. One of the challenges might be a further reduction/cut-off Global Fund and other major donors financing due to the diminishing global funding landscape. Even if, external financial support gets diminished in the years to come, the Government is committed to mobilize additional resources for major public health disease like malaria through various innovative means.

SECTION 5: PRIORITIZED ABOVE ALLOCATION REQUEST / UPDATE

Prioritized Above Allocation Request

Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount).

[C*omponent*] – *Copy the table as needed, if your funding request includes more than one component*

Module	**Interventions**	**Amount requested**	**Brief Rationale, including expected outcomes and impact** (how the request builds on the allocation)
Malaria Elimination	Policy, planning, coordination and management of national disease control programs	$14 075 566	For implementation of activities related to the commemoration of the annual malaria elimination week, school-based sensitization and airtime/TV spots at national level and for PCR supplies (around $1.6 million in 2018, $1.5 in 2019 and 11 million in 2020)
TOTAL AMOUNT		$14 075 566	

Relevant Additional Information (optional)

Provide any additional contextual information relevant to the prioritized above allocation request (e.g. any explanations that further clarify linkages to the allocation funding; any considerations or data that informed the request or updates of the request; etc.)

[Applicant response]: