RAI Regional Steering Committee

Regional Component of the Regional Artemisinin-resistance Initiative (RAI2E) Grant

CALL FOR EXPRESSION OF INTEREST

Package #1: Expanding access to malaria prevention and case management services to underserved populations

I. Context

The RAI Regional Steering Committee (RSC) is inviting proposals from Government and non-government organizations to implement malaria interventions to reach the most at risk hard to reach persons in Cambodia, Lao PDR, Myanmar, Thailand, and Viet Nam.

II. Background

The Regional Artemisinin-resistance Initiative (RAI) was launched in 2013 in response to the emergence of artemisinin resistant malaria in the Greater Mekong region. Funded by the Global Fund to Fight AIDS, TB and Malaria, the first RAI round was a $100-million grant covering the countries of Cambodia, Laos, Myanmar, Thailand, and Viet Nam. The grant, which ends in 2017, supported the increased coverage of impregnated nets, diagnosis and treatment, as well as case detection and surveillance, giving priority to areas of artemisinin resistance.

Global Fund recently announced the expansion to a second phase of RAI, or the RAI2-Elimination (RAI2E), with a total of USD242.3 million over three years. RAI2E is a milestone as the Global Fund's largest regional grant with the first to have a defined goal of disease elimination in a specific geography. The majority of the grant funds have been awarded across the five countries to support their country components of the RAI2E (208.3m USD). The main focus is on malaria case management through expansion of community health volunteers, strengthening surveillance systems, and scaling up elimination activities. In addition, US$34million has been dedicated to a regional component that supplements the country components.

The regional component aims to address overarching issues affecting national strategies, enhancing country components and ensuring regional coherence. The RAI Regional Steering Committee (RSC), a multi-stakeholder governance body, provides strategic guidance, selects recipient implementers, and oversees grant implementation track progress against program objectives and ensures funding is used in accordance with agreed strategic priorities.

The GMS countries have now pursued an expansion of activities targeted at mobile, migrant, ethnic and vulnerable populations (MMEVs). Through various supranational/regional approaches initiated by WHO ERAR and partners, and funded by Global Fund and other donors, there have also been greater bilateral cross-border initiatives around early detection and treatment regimens, information, education and communication (IEC)/behaviour change communication (BCC), engagement with the private sector, the armed forces, and regional activities for information sharing. Nevertheless, reported cases remain high in key geographical areas and within specific groups, particularly among communities and workers living or working near forested areas where malaria transmission occurs, and often along international borders. There are continued challenges for MMEVs to access to prevention, early diagnosis and treatment, case management practices, and current surveillance systems are not yet robust to capture MMEV cases and to better understand their risks for malaria.

The regional component of the RAI2E has seven packages of funding. This Call for Expression of Interest concerns the first package, which is dedicated to **expanding access to malaria prevention and case management services to underserved MMEVs** not already being addressed through the grant country components or other funding sources.

III. Geographic Scope and Priority Areas

The countries of implementation are Cambodia, Laos, Myanmar, Thailand and Viet Nam. Applicants can apply for activities in one country or multiple countries (e.g. in cases where inter-country/cross-border activities are proposed). Within each country, the provinces/states/regions prioritized for implementation were chosen based on a combination of risk strata, epidemiological burden, presence of MMEVs and accessibility to services, as well as consultations with countries (Table 1). It is important to note that for some of the countries, these prioritizations have not taken into account whether current and planned funding cover MMEV targeted malaria services in these areas. For this reason, it is **important to review the implementation landscape before proposing activities** in any area to avoid duplication and ensure relevance. In this regard, consultations with the national program and partners are highly encouraged.

Table 1 Priority areas for implementation

Country	Risk Strata	Provinces/states/regions
Cambodia	Strata 3: API > 5 Strata 2: API 4 to 5	Cluster 3: Kratie, Mondulkiri, Ratanakiri Cluster 4: Oddar Meanchey, Preah Vihear, Stung Treng
Laos	Strata 3: API > 10 Strata 2b[1]: API 5 to 10	Attapeu, Champassak, Saravan, Savannakhet, Sekong
Myanmar	Strata 3a: API > 5; Strata 3b: API 1 – 5	Chin, Kachin, Kayin, Rakhine, Sagaing, Shan North, Shan East
Thailand	District level Strata C1: active/residual non-active foci with API > 1 (district) Village level Strata A1: Active foci Strata A2: Residual non-active foci	Chumporn, Kanchanaburi, Prachuap Khiri Khan, Mae Hong Son, Naratiwat, Ranong, Ratchaburi, Songkhla, Srisaket, Surat Thani, Tak, Ubon Ratchathani, Yala
Vietnam	Zone 3: API > 1	Binh Phuoc, Dak Nong, Gia lai and Dak Lak

Within the above implementation areas, additional country specific prioritizations are available to guide applicants: please refer to *EOI Annex 1 – Country-specific priorities*. Applicants also have the possibility to include areas not listed above, but the rationale for doing so will need to be clearly provided in the proposal.

IV. Target Populations

The focus of this Call is to target the most at risk hard to reach population groups who are somehow marginalized and on the fringes of the public health system. These include but are not limited to the profile types listed in Table 2.

The static/local populations typically refer to populations residing in 'established villages' that are either very close to the forest or harbour people who are exposed to the forest through their occupation or mobility behaviour. These villages can have additional vulnerabilities if they are remote, comprised of mainly ethnic minorities, or in conflict areas, all of which can hinder access to the public health system. In addition, formal settlements in large-scale development construction projects, plantations, and military camps are considered static.

Mobile and migrant persons can be either locals of the country who move within the country, or foreign nationals. 'Migrant' generally refers to persons who are present in the location for more than 6 months but less than 11 months, whereas 'mobile' are those persons present in the location for less than 6 months[2].

Overall, the groups listed in the table below, except those in permanent settlements and established villages close to a health centre, can be considered to have disproportionately low access to malaria services. Key factors contributing to

[1] For Laos, Strata 2b includes API from 1 to 10/1000, however, areas with API of 5 to 10/1,000 are prioritized.

[2] There is no single harmonized definition of MMPs in the GMS. Applicants are encouraged to consult the NSP and other applicable country-specific guidelines (see EOI Annex 2).

this include language barriers with ethnic minority groups, remoteness, illegal status, poverty, marginalization with ethnic minorities and migrants. These factors further contribute to their risk as they are not able to break the cycle that has curbed malaria in other parts of the country. Mobile and marginalized migrant populations and minority groups working or living in the forest and on the forest fringes often carry the greatest burden of both poverty and disease.

<table>
<tr><th>Profiles</th><th>Vulnerabilities</th><th>MMP Type</th><th>Hotspots</th></tr>
<tr><td rowspan="3">-**Forest goers/forest workers** in the informal sector (hunters, small-scale gem/gold miners, people gathering forest products [precious timber, construction timber, rattan/bamboo]

-**Construction/mine workers**

-**Seasonal workers** (farming, rubber, cassava, palm oil, sugar cane, etc.)

-**Security personnel related to forest** (police, border guards, armed groups, forest/wildlife protection services)

-**Farming communities** of traditional slash-and-burn and paddy field farming visiting their forest farms

-**Formal and informal cross-border workforces**

-**Visitors**</td><td rowspan="3">Ethnic minority/ indigenous

Residing in conflict area

Internally displaced

Disability

Language barriers

Poverty

Illegal status</td><td>Static/local (residing >1 year)</td><td>Established villages (ethnic minorities and ethnic majorities)</td></tr>
<tr><td>Migrant (residing 6 - 12 months)</td><td>-Settlements associated with plantations (rubber, oil palm, food)

-Settlements associated with large-scale construction projects (dams, bridges, mines, etc.)

-Settlements for internally displaced people</td></tr>
<tr><td>Mobile (residing <6 months)</td><td>-Transient or mobile camps associated with commercial projects (road/pipeline construction, large-scale logging, deep sea port projects)

-Barracks</td></tr>
</table>

For each profile type, the specific characteristics of mobility, location and vulnerabilities will determine their level of risk, and for any of these groups can vary greatly across the GMS. Further examples are given in *Annex 1 – Country specific priorities*, and implementers are encouraged **to conduct a full characterization of their target groups either prior to or as part of the EoI**. Additional guidance documents are listed in *Annex 2 – List of reference documents*.

V. Scope of Work

Activities funded under this Call will complement the country RAI2E grants and extend essential malaria services to MMEVs that are currently underserved. Proposed projects should supplement, as an extension of the current systems and activities in the country, they should not duplicate or function as parallel systems. This means collaborating with the national program and other implementing partners at national and subnational levels to identify the entry points for added value. At the operational level, this means coordinating with public health facilities and community based systems, linking with existing initiatives, and ensuring the surveillance components of the proposed projects are linked with national surveillance and health information systems.

There are two complementary components (sub-packages) to the funding package. The first is meant to inform the second, while the second will feed information to the first providing an evidence based intervention cycle. Applicants can apply for sub-package 1 separately, but must demonstrate how data collection/surveillance activities will support the targeting of prevention and case management activities implemented under sub-package 2. All applicants of sub-package 2 must include activities that address the evidence base, such as those listed in sub-package 1.

Sub-package 1. Strengthening the evidence base for high risk groups, including MMEVs, to inform targeting of interventions

Quality epidemiological data on MMEVs is currently lacking. Often MMEVs groups are seen and treated as a homogenous entity, considering all as hard to reach. Countries and implementers have not yet developed a more accurate understanding of the true risks surrounding these groups, and have struggled to identify the situations in which

population mobility shapes malaria transmission and epidemiology. Further, limited robust epidemiological and sociopolitical data exist, and when they do exist, are often not used by implementers to better understand MMEVs.

The following are needed to fill in these evidence gaps: data collection strategies that further characterize MMEVs beyond their demographics, including a. the collection of occupational exposure, recent movements, networks, risk behaviors, cultural norms that influence their risks, and receptivity to interventions; b. methodologies for tracking mobile and migrant populations, identifying common routes and patterns of travel, and estimating size of their networks; c. routine mapping of mobile groups, remote villages, underserved areas; d. mapping of geographic areas that are “sources”, or areas of transmission from which infections are exported to other areas, and “sinks”, or areas that often receive imported infections from elsewhere. In addition, implementers should consider novel ways of using available data from routine surveillance, census, surveys, and data from other health areas as well as other sectors (Department of Labour, Department of Foreign Affairs, etc.).

These measures will not only inform the where to target, but also which interventions should be targeted based on the nature of the MMEV’s risks. Data collection efforts should include the formative approach providing the “who” and “what” that can help design targeted interventions, the continuous/periodic monitoring to adjust for the highly dynamic nature of these population groups, and the evaluative approach to determine effectiveness of interventions.

All proposed activities must be closely associated with targeting approaches to service delivery: this may include activities aimed at supporting national program capacity for data collection, analysis, reporting and mapping of at-risk groups; and/or, if proposed in conjunction with sub-package 2, activities aimed at directly informing the targeting and provision of services described in sub-package 2 (below). One-off surveys which are not associated with sub-package 2 activities are outside of the EOI scope. Examples of activities include but are not limited to:

- *Geo-coded database of all points of service delivery*: establish such a database to better track incidence and other indicators associated with case management and response that makes full use of existing data from all relevant sources. With this data, identify areas that lack access to public, private, or community health services and that are considered high-risk for malaria or a common “source” of transmission. The database should be open source and link to national malaria and/or health information systems. There should be a clear plan of how this data will be accessible to the national program and implementers, as well as how it can benefit the wider health system;
- *Mapping MMEV hotspots*: mapping of where MMEVs are most likely to congregate are invaluable for targeting intervention approaches. The term ‘hotspots’ is used loosely here and can include a range such as static ethnic or remote villages, mobile camps, worksites, small concessionaries close to the forest where MMEVs congregate (see Table 2). Beyond location identification, mapping includes but is not limited to collecting epidemiological data to assess risk, data on pathways of movement, seasonality, frequency of mobility to and from hotspot, and timing of departure, transit, and arrival. Mapping of hotspots should occur at least once a year due to continuous changes in development projects, mining and plantation sites, forest topography, and sociopolitical factors that cause people to move;
- *Integrated community level surveillance:* as countries move toward elimination, robust surveillance data becomes more and more critical, an area of weakness for MMEVs. Proposed MMEV interventions should design surveillance as an integrated part of community based activities planned. This can include incorporating the project’s own or the already existing village health workers as part of the data collection and surveillance efforts. Beyond meeting the needs for the project, this information should feed into the national information systems, as well as shared with local health facilities, partners, and community stakeholders;
- *Innovative methods for surveillance:* these approaches should not be high-tech or expensive, as simple, user-friendly, open source approaches are recommended. Other approaches include but are not limited to mHealth, geo-spatial modeling for identifying sources and sinks of transmission, spatial decision support system (SDSS).

Generating the evidence base on MMEVs requires collaboration with national programs and subnational health/malaria authorities, as well as involvement of civil society, local NGOs, and through the direct representation of people affected by malaria.

Sub-package 2. Expanding malaria prevention and case management for hard-to-reach populations at risk

Under the RAI2E, countries have dedicated funds for universal coverage of malaria services. National programs have scaled up of services to all high burden areas, and as much as possible, to underserved areas. Despite this commitment, public health systems are typically centered on the village and the level of coverage depends on the population's access to the village-based services (e.g. health centers, village malaria workers, village health volunteers, etc.). Populations who are static and residing in remote areas or in distant border areas, who are mobile, don't have legal status, or live in conflict areas, may not readily have access to these public services, and require more targeted and proactive approaches. In all countries, NGOs and CSOs have supplemented Government efforts and extended essential malaria services, and/or bolstered the existing ones, with additional financial and human resources and in some cases specialized expertise in reaching the most hard to reach. However, for a variety of reasons, gaps may still exist and MMEVS may be missed. This Call for EoI is meant to address those who are still missed by the current efforts.

In areas where a clear gap in existing services exists, and in agreement with the national program and local authorities, activities can include, but are not limited to:

- *Integrated community volunteer health workers:* volunteer health workers have been the cornerstone of malaria control in the region. As they are part of the community, they are best placed to understand and reach MMEVs. Different types of volunteers will be supported depending on the setting. These include village malaria workers, mobile malaria workers/teams, worksite malaria workers, backpacked malaria workers, and integrated health workers. Support to existing village health workers through capacity strengthening and collaborative team approaches is also warranted;
- *Community case management:* this includes early recognition, prompt diagnostic testing, and treatment as well as any needed follow-up. Where possible, approaches should support integration, rather than vertical parallel processes;
- *Static and mobile malaria posts:* static posts can be established in underserved areas with no facilities or malaria health workers, and are considered a "source' for parasite migration or along common travel routes frequented by high-risk populations. Mobile posts should be set up temporarily in conjunction with mobile malaria workers in hotspots that are temporary and have a large case load. Such hotspots can include small scale roadwork or other construction in or near the forest. Whether static or mobile, malaria posts must be justified with regards to their location and why they are a better option than volunteers, mobile teams, etc;
- *Strategic prevention and IEC/BCC*: while some MMEVs are unaware of malaria, many are already quite familiar and see malaria as a norm, "part of life", and an inevitable occurrence. Beyond the basic education and awareness of malaria, a paradigm shift is needed in community outreach and awareness, to empower MMEVs to be vigilant against malaria by promoting the idea that malaria can be eliminated. Approaches need to be culturally appropriate and gender-sensitive and ensure the community understands malaria, its debilitation on the population, and the realization that its elimination is reachable;
- *Strategic LLIN/personal protection distribution:* access and use of LLINs are not always related as several countries have found. Strategic and/or innovative approaches to support LLIN distribution, other vector control measures (e.g. LLIHNs or other tools for personal protection against outdoor transmission) and their uptake will be considered. In order to ensure uptake of prevention tools, implementers should consider including these as part of their formative research on their target populations, making sure to look at receptivity and barriers to its use and queries on what MMEVs would prefer as protective measures;
- *Private sector case management:* for areas where MMEVs have limited access to public services and evidence exists that private sector, particularly informal providers, are used, there is merit in strengthening capacity of these private providers to respond appropriately, either through referral and/or correct test and

treat. Approaches to train informal providers as a "quasi" village health volunteer, who can provide IEC, testing and treating, has worked well in some countries;

– *Innovative/special preventive, diagnostic and treatment services:* These will be context-specific and designed based on evidence for the target for MMEVs. These can include targeted approaches for LLIN/personal protection, IEC/BCC, mobile and/or teams for intensified case finding and/or micro community case management for new settlements, migrant work sites, forest entry and exit points, etc. Special needs are on the undeveloped workplace programs and collaborating with nascent ethnic health organizations.

For each intervention, there should be strong justification as to why this intervention is advantageous to another. All interventions and activities must have a **strong evidence base**, during project design and throughout the project cycle. All interventions must also align with the national malaria strategies of each country. Intervention approaches should link into a framework of having **sustainable community response,** through close coordination with local authorities, strengthening local capacities to reach MMEVs, and supporting community ownership that can be extended into elimination phase and other health needs, even after the project ends. This is particularly important for the MMEVs, as their vulnerabilities are based on exclusion and disenfranchisement, and hence their sustainability relies on cohesive community level approaches.

VI. Grant Period

Implementation dates for the activities and budget in this grant cover the period of **January 1, 2018 to December 31, 2020.**

VII. Available Funding

The overall envelope available under this Call is as follows:

Sub-package 1 - Strengthening the evidence base for high risk groups, including MMEVs, to inform targeting of interventions: **2m USD**

Sub-package 2 - Expanding prevention and case management for hard-to-reach populations at risk: **12m USD**

Disclaimers:

1. Multiple awards may be issued. The RSC reserves the right not to award any funding through this Call or to award different funding amounts.
2. The issuance of the Call for EoI does not constitute an award commitment on the part of the RSC, nor the Global Fund. All preparation and submission costs are at the applicant's expense.
3. Final detailed budgets and targets will be determined during grant and work plan negotiation with successful applicants in consultation with the CCC and the Global Fund.
4. The applicants understand that any results of the RSC selection process are not legally binding and are subject to the final approval of the Global Fund.

VIII. Eligibility Criteria

Both international and national organizations are eligible to apply. In order to respond to this EoI, applicants must meet the following eligibility criteria:

1. The organization (and any partners/sub-grantees) must be legally registered to operate in the proposed project country/ies, with a Memorandum of Understanding with the respective Ministry.

2. For organizations proposing to implement in conflict and/or semi-autonomous areas, they must demonstrate either through previous/concurrent experience or through Memorandum of Understanding with host country governments that they will be allowed to work in the proposed area.

3. The organization has demonstrated experience in the implementation of similar projects.

4. Conflict of Interest: The grantee's other relationships, associations, activities, and interests should not create a conflict of interest that could prevent full impartiality in implementation of the grant activities.

Any organization that does not meet the minimum eligibility criteria will not be considered.

IX. Guidance for Expression of Interest

The proposal must not exceed 25 pages; a Word template including the below sections is available for applicant's use. In addition to the narrative, applicants must complete *Annex A (Performance Framework)* and *Annex B (budget)*.

The RSC reserves the right to eliminate proposals which are incomplete or exceed the prescribed page limit.

SECTION 1 – ORGANIZATION'S SUMMARY AND CONTACT INFORMATION

1.1 Name of the Organization

1.2 Contact and full address

1.3 Registration status of organization. If a consortium, state the status of each individual organization.

1.4 Brief introduction on the organization's mission, vision, and general areas of expertise (max. ½ page)

1.5 Indication if a recipient of Global Fund grants and if yes, brief summary of funded project(s) (max. ½ page)

1.6 Selection of sub-packages. Applicant is applying for:

☐ Sub-package 1 only

☐ Sub-packages 1 & 2

1.7 Brief proposal summary: geographic area(s), target populations and type of interventions (max. ½ page, details will be described in section 3)

SECTION 2 – INSTITUTIONAL CAPACITY

2.1 Technical Capacity (max: 4 pages)
Describe your organisation's expertise relevant to the scope of work in the EoI, and include a brief summary of relevant projects. Please describe past and current experience related to malaria, as well as experience working with hard to reach populations, especially MMEVs, delivering community based services and strengthening community health systems. Please cite specific results & impact achieved from past/ongoing projects where possible. If you are a current recipient of RAI or GF grant funds, please provide information on ongoing performance and program achievements.

2.2 Geographical Presence (max: 2 pages)

Briefly describe your organisation's experience in the proposed target country(ies), including the sub-national geographical area(s)where you are proposing to work, highlighting existing relationships that can facilitate reaching MMEVs. Describe your organization's current presence and infrastructure, including staff and relevant logistical capacity. If your organization has not worked in the proposed subnational area, please describe your understanding of the area, experience working in similar contexts, how you will ensure your organization can successfully implement in the area, and any steps you have taken toward establishing partnerships in the target area.

2.3 Human Resources and Financial Management Capacity (max: 2 pages)
Describe your organization's national and international (if any) management structure and provide an overview of current staffing, including sufficient qualified and experienced staff to implement the proposed activities (including staff who can work locally / with MMEVs). If applicable, explain your plans and resources to recruit the necessary additional staff.

Please describe the total annual operating budget in 2016, the amount of donor funds managed by your organization and describe your organisation's capacity to manage large donor funds, including Global Fund grants if applicable.

2.4 Data Management and M&E Systems (max: 1 page)
Provide an overview of your information management, M&E, reporting, and supervision systems. Describe, with one or two illustrative examples of how your organization uses M&E data to inform program decisions. Please provide examples of any innovative approaches to data capture and/or adaptations of your M&E system in order to obtain robust information of MMEVs and/or hard to reach most at risk populations.

2.5 Key implementing partners / sub-recipients (max: 1 page)

If your organization plans to work as a consortium or in partnership with other organizations to be subcontracted under this grant, please provide information on your key partners' relevant experience/expertise as well as the proposed collaboration/management structure (including sub-contracting arrangements). Further details on their proposed implementation role can be provided in section 3.2 (partnerships).

SECTION 3 – TECHNICAL PROPOSAL

3.1 Target population/geographical location (max: 2 pages)
Describe the targeted population and geographic area and your rationale for choosing these.

a. Geographic area: describe in detail the areas you plan to implement. Refer to *EOI Annex 1* for each countries priority areas. Include the following:
   - describe the features of the geographical location that make it a priority for consideration in this EoI;
   - provide the rationale for targeting this location as opposed to other underserved areas, including current level of service coverage in the area, based on available evidence;
b. Target population: describe in detail the most at risk hard to reach groups (MMEVs) you plan to reach. Include the following:
   - who are the target group(s) you are planning to reach
   - what is the estimated target population size and provide either a data reference or assumptions behind this information; if estimates are not known, describe planned activities to obtain or fine-tune available baseline information (see sub-package 1 activities)
   - describe the characteristics/risk behaviours that make these group(s) high risk and underserved, referencing available evidence
   - describe the challenges in reaching these groups and how you will overcome these challenges

3.2 Proposed activities and interventions (max: 3 pages)
Describe the interventions you are proposing to implement and include the following aspects in your description:

a. the **key activities** you plan to implement and the **timeline** for implementation including start-up activities (recruitment of staff, etc);
b. **expected results and impact from your interventions and activities**. High level results should be described in the narrative as well as included in the performance framework (*EOI Annex A*);
c. your **strategy** to ensure you reach the target population (MMEV), in other words, how your approach is targeted to the MMEVs you are trying to reach;
d. the **rationale** for your proposed interventions/activities and approach; this should include any evidence base that supports your rationale and how your proposed intervention aligns with the National Strategies and Policies of each of the countries you are proposing to implement;
e. the **partnerships** (including proposed sub-recipients) that will help your organization implement and achieve its targets; describe any consultations your organization had with the national program and partners prior to submission of your EoI; explain how your organization will maintain close links with the national malaria program(s), local authorities, and partners to ensure good coordination and information sharing.

3.3 Evidence based approaches (max: 3 pages)

a. Describe your understanding of the **implementation risks**, **limitations and challenges** of your intervention, including what information and evidence is missing to better understand the target population, and if your interventions will work

b. Describe your organizations **plan** to obtain the necessary **strategic information** and data to further characterize the MMEVs and better target your interventions

c. Describe your organizations **plan** to ensure your interventions are well targeted and continue to be effective over the project period. More specifically, how will you **incorporate an evidence based approach** throughout the project period and how you will engage the community to contribute to your evidence base

3.4 Efficiencies, complementarity and sustainability (max: 2 pages)

a. Describe how your organization will harness your current infrastructure, expertise and relationships to ensure targets are met. More specifically, if your organization is a recipient of the RAI2E country component, describe the mechanism for harmonizing the RAI2E activities with the proposed EoI activities and how you will ensure both operational and cost efficiencies. If not a recipient of the RAI2E, please describe how your organization will **maximize effectiveness and efficiencies** under the proposed grant, while ensuring the targets are met.

b. Describe your understanding of the current implementation landscape in the proposed target country/area(s) including the existing health services infrastructure, and how you propose to complement or build upon existing partner activities or resources (including from other donors)

c. Describe how your proposal incorporates **sustainability** in the community you are implementing in.

SECTION 4 – FINANCIAL PROPOSAL

Please complete the detailed budget template provided in *Annex B - Budget*. Using the comment section or in a brief supporting narrative (max. 2 pages), please explain:

a. What relevant resources may already be in place and available to support proposed activities
b. What additional resources are required, with a brief rationale
c. How your organization will ensure value for money during the project cycle

X. Additional information

Please refer to *EOI Annex 1 - Country Specific Priorities* and *Annex 2 - List of reference documents* for further information. Applicants are encouraged to review these documents, particularly those relevant to their project country/ies.

XI. Appraisal and Selection

APPLICATION COMPONENT	Maximum Score
1. ORGANIZATION'S SUMMARY AND CONTACT INFORMATION	**-**
2. INSTITUTIONAL CAPACITY	**40**
3. TECHNICAL PROPOSAL	**40**
4. FINANCIAL PROPOSAL	**20**
TOTAL	**100**

In addition to individual merit based on the above scoring, all proposals will be considered from a regional perspective in terms of their complementarity and overall impact.

XII. Submission details and deadline

The full application package contains the following:

1. Annex 1 – Country-specific priorities
2. Annex 2 – List of references
3. Narrative (Word) template
4. Annex A (Performance Framework) and B (Budget) – Excel template

All documents (including references) can be downloaded at the below Dropbox link:

https://www.dropbox.com/sh/uhqva5sjrhlsn2u/AABAAKt_HddnBllvLKjz9u82a?dl=0

All applications should be submitted electronically to: RAI2Eproposals@gmail.com. Documents can be attached by email or provided in a DropBox link.

Questions can be sent to RAI2Eproposals@gmail.com until 15 August 2017. A FAQ will be compiled for the most common questions and posted/updated on this website: http://www.raifund.org/en/rsc/calls-for-proposals

Submission deadline: Wednesday 23 August 2017 at midnight/0.00hrs, Bangkok/Phnom Penh time (ICT).