Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CCM-RDC		
Country	DEMOCRATIC REPUBLIC OF CONGO		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	LOW INCOME COUNTRY		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a 're-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Strengthening of prevention and management of HIV/Aids and gender related sexual violence in 54 Health Zones in 5 post-conflict provinces in D.R.Congo		**No**
Tuberculosis[1]	Support for tuberculosis control in D.R.Congo	HSS	Yes
Malaria	Acceleration of universal access to anti-malarial interventions in 139 Health Zones in DRC		No

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	☐	☐

[1] Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

	Yes	No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	☐ Yes	☐ No
The proposal from CCM-D.R.Congo for Round 9 comprises two new submissions (HIV/Aids and Malaria) and one re-submission (Tuberculosis) including Health Systems Strengthening classified as Category 3 in Round 8.		

Currency	☒ USD	or	☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 9:

3. Proposal Summary

3.1 Tuberculosis Element

In the DRC (Democratic Republic of Congo) there is a pyramidal health care system implementing the primary health care policy. Since 2006, the Government has worked to strengthen the Health Care System (HSSS).
The country operates a national program of Tuberculosis control, which has used the DOTS strategy since 1996 and the "STOP-TB" since 2006. The PNT (National TB Program) has a strategic plan for 2006-2015 with a budget of 553,913,004 USD.
The PNT benefited from a Global Fund grant in Round 2 which has been used, and from on-going grants from Rounds 5 and 6. However, the gap in the strategic plan remains an important factor in controlling multidrug-resistant tuberculosis (MDR-TB), the co-infection TB/HIV, the implementation of APSR (Practical Approach to Respiratory Health) and PPM (Mixed Private-Public) strategies and research.

Aim of the current submission:

- to help reduce the gap,
- to consolidate the gains from grants in Rounds 2,5 and 6,
- to ensure their continuation.

Target: To contribute to the reduction in morbidity and mortality from tuberculosis by 2015 in the DR of Congo, fulfilling the Millennium Development Goals and targets of the Stop-TB partnership.

Specific objectives which will help this submission meet the goal are:

Objective 1: to continue extending and improving the DOTS strategy;
Objective 2: To control tuberculosis-HIV co-infection and MDR tuberculosis;
Objective 3: Help strengthen health care through APSR/PAL;
Objective 4: To involve all health-care providers in controlling tuberculosis;
Objective 5: Involve the community in controlling tuberculosis;
Objective 6: Develop research within the PNT.

Key results (indicators) to be achieved in Round 9 are:

- a 70% detection rate for PTM+ (pulmonary TB +) patients and a successful therapy rate of 85% for the 1545 CSDT (Health Center for Diagnosis and Treatment); 5 laboratories regularly achieving QA certification in culturing and meeting ATS criteria; 120 hospitals with radiography facilities to improve PTM0 and TEP

(extrapulmonary TB) diagnosis;

- 33.160 co-infected tuberculosis patients benefit from being jointly managed under the PNLS (National Aids program); 3400 cases of MDR tuberculosis notified and treated for the secondary effects, with 10% hospitalized, in 8 refurbished Centres;

- **200** hospitals following an APSR program;

- **120** private facilities have joined the program, used DOTS and followed ISTC guidelines;

- 25% of all new tuberculosis patients with notified positive smears started on treatment are followed-up/overseen in the community

- an investigation of drug-resistance conducted throughout the country, 24 investigations a year into the prevalence of TB/HIV for the first 3 years and 15 research studies, of which the results are made known.

The **main activities** are:

- To strengthen the classic DOTS strategy in 1 545 CSDT by provision of reagents, microscopes and small items, improve diagnosis of PTM0 by purchase of radiography equipment; refurbish culture laboratories in the provinces, perform screening and molecular biology tests; ensure patient care, supply 601 139 courses of 1st line treatment and 2 960 courses of 2nd line treatment; ensure follow-up and assessment by training, meetings and supervision, appraisal, workshops on guidelines, various certification meetings, provision of information in various formats and granting of incentives to those involved in TB control at central and intermediate level.
- Increased help for those with MDR disease, HIV screening for all those with tuberculosis in the health zones supported by the PNLS;
- Progressively incorporate APSR/PAL (with equipment), PPM and ISTC strategies in the health zones;
- To extend community based DOTS and introduce organizations for former tuberculosis patients, increase awareness, communication, advocacy and social mobilization in tuberculosis;
- carry out research and publish the results.

For this the program seeks a further budget of **128 728 799 USD**.

The CCM-DRC has two principal recipients (PR), Caritas-Congo for Civil Society, and the Ministry of Public Health for the public sector.

3.2 HIV/AIDS Element

The current submission is in line with the complete package for prevention, care, treatment and alleviation of the effect of Aids in 54 Health Zones (HZ) of 5 provinces following conflict in the east of the country, but also to extend/perfect holistic care of the victims of sexual violence in these 54 HZ.

These 54 HZ targeted for inclusion in the HIV/Aids package have had no previous help in this regard, because the war made it impossible to introduce the Aids package as part of the comprehensive United Nations strategy against sexual violence (Annex 13). The 54 zones from 5 provinces were chosen on the basis of whether or not they were health zones currently included in the HIV program and receiving financial help (MAP or Global Fund). These were particularly health zones where heightened military operations produced very high levels of sexual violence (rape). In addition, a 2008 study as part of the above projects produced a map of the interventions, actions and unaddressed needs in relation to prevention of, and response to, sexual violence in the 5 provinces. This study served as a basis since it established the priority areas for intervention, the gap to fill and where to direct financial aid.
To date, province data shows an HIV incidence of between 20 and 30% in victims of sexual violence in the 5 provinces targeted in the current submission (Joint Project Report 2008, Annex 4). According to the 2007 report from Amnesty International cited in the in the national multi-sector strategic plan 2010-2014, 18 407 incidences of sexual violence were reported that year,
This submission is in line with the vision of Rounds 7 and 8 in as far as it extends the fight against HIV/AIDS to the new HZ not yet included in the complete package for prevention, care, treatment and impact alleviation of HIV/AIDS; it is also in line with the national multi-sector strategic plan which specifically targets the victims of gender linked sexual violence. It also responds to the concerns about orphans and vulnerable children (OVC) raised in the RAAAP report (Annex 8) from the DRC Ministry of Social Affairs, Humanitarian and Social Initiatives, supported by Unicef and USAID.
For the reasons given above, the current submission which aims to help reduce the morbidity and mortality from HIV/AIDS infection specifically among the victims of gender linked sexual violence by 2014, has the following four aims:

1. To prevent, by 2014, the transmission of HIV/AIDS in the population of these 54 HZ of 5 provinces, targeting specifically the victims of gender linked sexual violence.
2. Ensure health and medical care for the 14 383 PLVIH among the victims of gender linked sexual violence from the 54 HZ targeted in these 5 provinces.
3. Ensure holistic care for the victims of gender linked sexual violence from the 54 HZ targeted in these provinces.
4. By 2014, improve information strategy and the coordination of activity at all levels.

These objectives will help the national multi-sector strategic plan against Aids to achieve its goals (see Annex 3).
To meet these objectives, the country has identified two principal recipients; the Minister of Health (government PR) and the National Council of Health NGOs, abbreviated CNOS (civil society PR).
Finally, the total budget is **94 181 441** USD. The 54 HZ not yet covered will benefit from the HIV/AIDS complete intervention package and holistic care for victims of sexual violence.

3.3 Malaria Element

The Democratic Republic of Congo (DRC) has one of the highest levels of malaria in Africa with at least 27 million cases in 2006, according to the WHO (ref. Global Malaria Report, 2008, preliminary estimates). In a country larger than the whole of Western Europe, malaria is endemic with static transmission levels and more than 97% of the population affected. The most common pathogenic species responsible is *Plasmodium falciparum.* Malaria is the principal cause of morbidity and mortality and an important factor in poverty in the DRC, the reason for:

- 40% of visits to outpatient clinics among the under 5s (*E*SP 2007 – Annex AP4 page 43);
- 48% of hospitalizations among the under 5s (ESP 2007 – Annex AP4 page 46);
- 37.5% of deaths among the under 5s who have been hospitalized (*ESP 2007 – Annex 1 page 38*);
- 41% of outpatient clinic visits by pregnant women (*PNLP, 2001 AP5 page 17*);
- 54% of hospitalizations of pregnant women (*PNLP, 2001 AP5 page 18*);

Anti-malaria interventions are detailed in the 2009-2014 PNLP strategic plan which aims to reduce mortality and morbidity by 50%. The DRC is divided into 11 provinces which split into 515 health zones. The first grant for malaria, from the Global Fund Round 3 was spread among 119 health zones throughout the country. The second, from Round 8, ensured continued work in these same health zones.

The current submission for Round 9 global funding to control HIV/AIDS, tuberculosis and malaria aims to help reduce morbidity and mortality from malaria by 2014, spreading geographical coverage to a further 139 health zones.

This "scaling up for impact" (SUFI) will be by increasing routine use of impregnated mosquito nets (LLITN) for pregnant women and children under one, use of intermittent preventative treatment and improving care of malaria patients in the new 139 health zones not yet covered by malaria control.

Several criteria determine choice of the 139 HZ: lack of support so the population has no means of prevention and resorts to one-drug-only treatment (monotherapy) contrary to national policy based on international recommendations, with all the risks that carries for the health of the whole population, particularly the development of ACT resistance.

In addition, the Needs Assessment has shown a weakness in communication between the health zones which means that high quality health care is still not provided.

Specific ways in which this submission will help meet the target are:

- Having 80% of children under one and pregnant women sleeping under impregnated nets in the 139 health zones concerned
- Having at least 80% of pregnant women in the 139 health zones concerned receiving intermittent preventative treatment as set out in national directives
- Having at least 80% of care in the 139 health zones concerned complying with national directives
- Strengthening all national and provincial coordination of the National Malaria Program

To achieve these specific aims the following are necessary:

Prevention:

- Prevention by routine use of LLITN: To improve substantially the coverage of pregnant women and children under a year, the emphasis must be on provision of LLITN through prenatal and preschool visits, education/retraining, social mobilization, research and, above all, follow-up/assessment in these 139 health zones.
- Prevention by IPT: the emphasis here will be on the availability of Sulfadoxine Pyrimethamine, education/retraining, social mobilization, research and, above all, follow-up and assessment in the 139 health zones.

Management of malaria cases:

- Biological confirmation: in this proposal the use of Rapid Diagnostic Tests (RDT) currently in use in the 119 health zones having benefited from Round 3 global funding will be expanded to the 139 zones targeted in Round 9 Global Fund grants. This will allow better estimation of the county's real malaria burden and rationalize management of antimalarial resources.
- Artemisinin-based combination treatment: this involves ensuring, in the 139 health zones, that this submission will provide correct management of both uncomplicated and serious cases of malaria, in sanitation conditions conforming with national directives.

The emphasis here will be on availability (RDT, laboratory reagents and medicines), education/retraining, social mobilization, research and, above all, follow-up and assessment in the 139 health zones.

Coordination and partnership

Here, the proposal to Round 9 of the Global Fund will fill gaps in institutional, management and technical capacity to coordinate program structures, at national and provincial level, identified in various assessments of the program. This will be by improving the infrastructure, fixtures, fittings and office equipment, communication technology, education/retraining of staff and ways of working.

Fulfilling these objectives for malaria will also support a Strengthening of the Health System as a whole, anticipated in the general submission from the DRC, particularly relating to the National System of Health Information, community systems, provision of services and the management of supply and distribution.

In this proposal, the CCM-DRC has continued with 2 funding routes (government PR and civil society PR) for implementing measures to conform to Global Fund Directives.

The budget for the malaria Element, in the 139 health zones concerned, comes to 280 495 135 US$ for the next 5 years, and represents 14.3 US$ per person per year for routine measures. Thus, over the entire DRC, the investment from Global Fund Round 9 is 4.06 US$ per person per year.

2. BUDGET

Y1	Y2	Y3	Y4	Y5	Total
55 836 015	61 872 826	61 340 001	48 935 672	52 510 621	280 495 135

3. TITLE OF THE SUBMISSION

ACCLERATION OF UNIVERSAL ACCESS TO MALARIA CONTROL IN 139 HEALTH ZONES WITHOUT SUPPORT FOR THIS DISEASE

4. Program Description

4B. HSS cross-cutting interventions strategy **

Malaria, HIV/Aids and tuberculosis are a major public health problem in DRC. In order to obtain sustainable results in terms of reducing the morbidity and mortality due to the 3 diseases, it is self-evident that the interventions must be part of a comprehensive Health Systems Strengthening framework.

This Round 9 HSS proposal is a re-submission of the Round 8 proposal incorporating the comments of the TRP. Based on these comments, the CCM-DRC has selected two cross-cutting interventions out of the three presented in Round 8.They aim to increase the results of disease control in general and controlling malaria, HIV/Aids and tuberculosis in particular, by making available, in real time, the information needed by service providers and decision makers for taking decisions that improve the offer and quality of care.

The Monitoring and Evaluation report of the three HIV, TB and malaria programs carried out by "Measure Evaluation", with the backing of the Global Fund in 2007 shows the weaknesses common to the three disease programs. These are mainly (i) the poor quality of data; (ii) the duplication of monitoring and evaluation systems leading to multiple reporting, discordant data, increased staff workload, etc.; (iii) incomplete and late reports; and (iv) non systematic and non computerized data management with low levels of storage, data analysis and circulation of health information. Intervention 1 developed in this proposal starts the implementation of the recommendations resulting from the evaluation.

In addition, the organization of the health system based on Health Zones has suffered during more or less two decades of poor governance and armed, inter-ethnic conflict. This has had a very negative impact on health cover and the quality of care, with health infrastructures being destroyed or ageing, equipment stolen, health staff becoming discouraged and migrating inside or outside the country, etc.

The actions for which grants are requested are for support for national measures adopted by the CCM to fill the gaps and repair the weaknesses of the health system as listed in section **4.3.2** of the diseases component.

In this proposal, 4 objectives were selected, 3 of which concern strengthening the health information system in 296 Health Zones and 1 deals with improving the offer and quality of care in 256 Health Zones. Implementing the activities concerning these objectives will help in meeting the Millennium Development Goals (MDG).

This mainly involves the following activities:

- For intervention 1:

  - Objective 1: progressively incorporating the SNIS (National Health Information System) normative framework in **296** Health Zones (HZ) by the end of 2014 by (i) building the capacity of the Health Zone Management Team; (ii) building the capacity of health care providers in health centers and hospitals for collecting, analyzing, interpreting and using health information; (iii) equipping the 296 HZ with information and communication technology and an energy source; (iv) helping organize monthly monitoring meetings in 515 HZ; (v) providing resources for the 296 HZ and (vi) support for organizing half-yearly LQAS (lot quality assurance sampling) surveys in the 296 HZ.

- Objective 2: by the end of 2014, have four functioning Provincial Steering Committees of the Health Systems Strengthening Strategy (PSC-HSSS), by providing resources to improve coordination of health information systems in provinces. This will be by (i) support for the operation of the 4 PPC-HSSS in Bandundu, Equateur, Maniema and Katanga Provinces: (ii) support for organizing half-yearly provincial reviews and quarterly health district reviews; and (iii) writing a half-yearly health bulletin and circulating it in the 11 provinces.

- Objective 3: strengthening the central level in piloting the implementation of the SNIS normative framework and supporting the provinces in health information management, by (i) operational support for the Information Management Commission of the National Steering Committee of the HSSS (NSC-HSSS), (ii) backing missions for supporting and monitoring activities for incorporating the SNIS in the 11 provinces and (iii) ensuring interconnections between the country's 11 provinces at the central level.

o For intervention 2:

- Objective 4: increasing to 50% the population with access to quality health services and care in 256 HZ by the end of 2014 by (i) restoring 1280 Health Centers, (ii) doing minor restorations in the referral hospitals in 120 Health Zones, (iii) equipping 1280 Health Centers, (iv) equipping 120 referral hospitals, (v) strengthening health service management in the 256 Health Zones(vi) providing mobile equipment for 10 rural Health Districts and 120 Health Zones,(vii) paying performance-based incentives to health workers,(viii) carrying out an inventory of the system of procurement and distribution of drugs and other specific resources, (ix) integrating biomedical waste management systems in 256 HZ and (x) supporting integrated supervision in the Health Zones.

The main results expected at the end of this proposal are:

- o 100% of HZ submitting complete reports on all management and public health indicators, in compliance with national directives;
- o at least 80% of HZ submitting reports on time on all management and public health indicators, in compliance with national directives;
- o 50% of the population has access to quality health services and care.

5. Funding Request

5B. HSS cross-cutting funding details **

The total cost for implementing the two HSS cross-cutting interventions described in this proposal is calculated at **178 065 459** USD.

*** Only to be included in one disease in Round 9. Refer to the Round 9 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the Round 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal

Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Clarified section 1.1

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	31 796 943	11 190 331	14 437 636	14 948 929	21 807 601	94 181 441
Tuberculosis	14 631 467	18 166 661	35 864 038	28 651 127	31 415 507	128 728 799
Malaria	55 836 015	61 872 826	61 340 001	48 935 672	52 510 621	280 495 135
HSS cross-cutting interventions section 4B and 5B within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*	49,067,480	28, 226, 694	31 853 329	32301329	36 616838	178 065 459
					Total Round 9 Funding Request ➔:	681 470 834

1.2. Contact details

	Primary contact	Secondary contact
Name	Hyppolite Kalambay	François-Xavier N'Siesi
Title	Technical Secretariat Coordinator	Back-up Services Coordinator
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Alternate e-mail address	ccm-rdc@ic.cd	ccm-rdc@ic.cd

1.3. Lists of abreviations and acronymes used by applicant

Acronyme/Abréviation	Signification
ACT	Artemesinin Combination Therapy
AGR	Activités Génératrices de Revenus
ARV	Anti Rétro Viraux
ASF	Association de Santé Familiale
BAD	Banque Africaine de Développement
BDOM	Bureau Diocésain des Oeuvres Médicales
BM	Banque Mondiale
CAD	Club Amis de Damien
CCM	Country Coordinating Mechanism / Instance de Coordination Nationale
CDC	Center for Disease Control
CDR	Centre de Distribution Régional
CE	Commission Européenne
CET	Comité d'évaluation Technique
CHRTS	Centre Hospitalier de Référence de Transfusion Sanguine
CHU	Centre Hospitalier Universitaire
CIC	Conseil InterConfessionnel de Lutte Contre le SIDA
CNMLS	Conseil National Multisectoriel de Lutte contre le Sida
CNOS	Conseil National des ONG de Santé
CNTS	Centre National de Transfusion Sanguine
CPN	Consultation Prénatale
CPS	Consultation Préscolaire
DEP	Direction des Etudes et de la Planification
DOTS	Directly Observed Treatment short Course
DSA	Daily Subsistance Allowance
DSRP	Document de Stratégie pour la Réduction de la Pauvreté
ESP	Ecole de Santé Publique
FEDECAME	Fédération Centrales d'Approvisionnement en Médicaments essentiels
FM	Fonds Mondial
UNFPA	Fonds des Nations Unies pour la Population
FRP	Faire Reculer le Paludisme
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit Gmbh /international Services (IS)
HGR	Hôpital Général de Référence
IDA	International Dispensary Association
IDH	Indice de Développement Humain
IFCOC	Initiative des Pays Riverains des Fleuves Congo-Oubangui et Chari
IMA	Interchurch Medical Assistance
IO	Infections opportunistes
IST	Infections Sexuellement Transmissibles
LFA	Local Fund Agent (Agent local du Fonds)
MAP	Multicountry AIDS Programme
MDR	Multi Drug Résistance
MID	Moustiquaire Imprégnée de longue Durée
MSH	Management Science for Health
MII	Moustiquaires Imprégnées d'Insecticide
MoU	Memorandum of Understanding (Memorandum d'Entente)
NEX	National Exécution
OCEAC	Organisation de lutte Contre les Endémies en Afrique Centrale
OMC	Organisation Mondiale du Commerce
OMD	Objectifs du Millénaire pour le Développement

ONG	Organisation non Gouvernementale
ONUSIDA	Programme conjoint des Nations Unies sur le VIH/SIDA
PAM	Programme Alimentaire Mondial
PCIME	Prise en Charge Intégrée des Maladies de l'Enfant
PIB	Produit Intérieur Brut
PMURR	Programme Multisectoriel d'Urgence de Réhabilitation et de Reconstruction
CCC	la communication pour le changement de comportement
PNLP	Programme National de Lutte contre le Paludisme
CDV	le conseil et dépistage volontaire
ARV	le traitement aux anti retroviraux
PEC IO	la prise en charge médicale des infections opportunistes
OEV	les orphelins et les autres enfants rendus vulnérables
AES	la prise en charge des accidents exposant au sang
PNLS	Programme National de Lutte contre le SIDA
SECUTRANS	Sécurité transfusionnelle
PVV/PA	le soutien psychosocial aux PVV et à celles affectées par le VIH/SIDA
PTME	la prévention de la transmission mère enfant
PNLT :	Programme National de Lutte contre la Tuberculose
PEC TB/VIH+	la prise en charge médicale des tuberculeux VIH+
PEC SIDA	la prise en charge médicale des sidéens
PNMLS	Programme National Multisectoriel de lutte contre le Sida
PNT	Programme National de Lutte contre la Tuberculose
PNTS	Programme National de Transfusion Sanguine
PNUD	Programme des Nations Unies pour le Développement
PO	Purchase Order – Bon de commande
PPTE	Pays Pauvres Très Endetté
PR	Principal Recipient (Bénéficiaire Principal)
PSI	Population Service International
PSM	Procurement Supply Management
PTME	Prévention de la transmission de la Mère à l'Enfant
PVVIH	Personnes vivant avec le VIH/SIDA
RCP+	Réseau Congolais des Personnes vivant avec le Virus
RDC	République Démocratique du Congo
S&E	Suivi et Evaluation
SB	Sous Bénéficiaire
SIDA	Syndrome d'Immuno-Déficience Acquise
SNIS	Système National d' Information Sanitaire
TPI	Traitement Présomptif Intermittent
UNC – CH	University of North California at Chapel Hill
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	Fonds des Nations Unies pour l'Enfance
USAID	Agence Américaine pour le Développement
USD	Dollar américain
VIH	Virus de l'Immunodéficience Humaine
ZS	Zone de Santé

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1. Members and operations

2.1.1. Membership summary

Sector Representation	Number of members
☐ Academic/educational sector	1
☐ Government	11
☐ Non-government organizations (NGOs)/community-based organizations	6
☐ People living with the diseases	1
☐ People representing key affected populations[2]	1
☐ Private sector	1
☐ Faith-based organizations	6
☐ Multilateral and bilateral development partners in country	12
☐ Other *(please specify):* Parliament	1
Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	40

[2] Please use the Round 9 Guidelines definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_AttachmentC_en.xls

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):		
(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

The Democratic Republic of Congo is one of the African countries with a long tradition of organizing health systems. From the colonial period to the 1980s, which saw the start of primary health care originating in the DRC, the health system has undergone innovations that have marked the country's history. However the 1990s saw a multi-sectoral crisis which did not leave the Congolese population nostalgic for "the good old days". This contrast is no doubt one of the factors that explain the attraction of the Congolese to the issue of re-establishing the health system through various strategies including the current one, the Health Systems Strengthening Strategy, HSSS.

Almost all members of the CCM-DRC have a deep interest in taking up the challenges so that health programs can have a real impact and reduce the morbidity of the three diseases targeted by the Global Fund, and which aggravate poverty. The organizations comprising the different sectors of the CCM have a wide range of expertise in disease control, and are constantly confronted by the analysis of what underlies the health system, and easily explains the successes and failures of health programs.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

The question of gender and sexual minorities is a very topical one and is freely spoken of in today's DRC immediately after the conflict. Although the different provinces in DRC were affected to different extents by the war, they are all confronted by an exacerbation of gender issues, particularly aspects of violence towards women and the balkanization of minorities. This is a hindrance to disease control.

The DRC has recently made considerable progress legally, reinforcing the law against sexual violence and the law protecting PLWA. Sexual violence has been broken down into fourteen components, to make it easier to focus on particular aspects.

The members of the CCM-DRC are unanimous in focusing the submission of the HIV AIDS component on combating sexual violence in the 5 provinces in the country in which women, girls and minorities are suffering particularly. Members have also assigned for submission an exhaustive survey of the phenomenon in the six other provinces of the country, so that no province is left out. It is quite obvious that, in line with Congolese culture, the members of the CCM-DRC are well aware of the role of women and girls in Congolese lifestyle. They are the driving force behind the whole of life and participate in many health programs. For example they are the ones who are most involved in children's vaccination campaigns, in mass distributions of impregnated mosquito nets, etc. This is why the health proposals developed in Democratic Republic of Congo focused particularly on women, girls and children in general. The various organizations that participate in the CCM sectors are full of experts in gender issues and minority issues. These experts play a predominant part in analyzing gender and minority issues.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.
Multi-sectoral representation within the CCM makes things much easier. This multi-sectoral diversity is regularly put to use in drawing up projects for submission to the Global Fund. By way of example, the public sector members of the CCM have a great deal of proven expertise in the legal aspects of planning health service activities, being familiar with all current DRC legislation on PLVIH and other diseases, children's rights, etc. Civil society organizations (NGOs, faith-based organizations, etc.) are very familiar with the social aspects of projects that the CCM-DRC is submitting to the Global Fund. Bi- and multi-lateral cooperation partners also support the CCM with all their expertise. As shown in the CCM-DRC steps for drawing up the submissions, all possible efforts are made for total transparency in the process, including all multi-sectoral expertise, both within the CCM and outside it.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☉ Applied for funding in Round 7 and/or Round 8 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

2.2.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*
As soon as the Round 9 was launched, the Technical Secretariat of the CCM-DRC passed on the message of the Global Fund to all CCM members and partners, to prepare them for drawing up the proposals by beginning with each member drawing up mini-proposals. On March 16, 2009, CCM Assistant Secretary sent a call for micro-proposals throughout the country via the Internet, and also published a call for expressions of interest in a newspaper, "Le Potentiel". The call for expressions of interest was inclusive and encouraged all sectors to present mini-proposals to build up the country proposal. In total, by the deadline of May 5, 2009, the CCM had received fourteen (14) mini-proposals from all the provinces targeted by the guidelines for each of the components.
(b)
During the retreat held in the suburbs of Kinshasa from May 7 to 16, 2009 for drawing up the advanced

draft of the proposal, a team of experts from different sectors of the CCM was formed. The Assistant Secretary sent the team the criteria for assessing the micro-proposals. The team carefully read through each other's micro-proposals in detail, which led to a plenary for discussing the aspects to include in the final proposal and recommendations to make to submitters.

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

As usual, the process began during the CCM General Assembly (GA), communicating the information of the Global Fund launch of the new round. The needs analysis carried out by the heads of the national programs for controlling the three Global Fund targeted diseases generally leads to the decision to submit or not for the next round. The CCM-DRC GA met in December 2008, January 2009 and March 2009. The Technical Secretariat received the approval of the GA to start drawing up the country proposal for submission to Round 9.

From then on, for each component, the task forces, which are actually wider platforms, began discussions on the priorities for interventions and the geographical coverage.

The Technical Secretariat communicates the results of these discussions, often called "guidelines", for submissions to a wider group composed of CCM members and non-members in order to arrive at a consensus.

The process continues inclusively, moving on to data collection and writing drafts of certain parts of the sections in the round.

From May 7 to 16, 2009, the CCM organized a residential workshop for over 40 experts from the different sectors of the CCM. Other experts who are not CCM members joined the working team as and when they were available at the workshop near Kinshasa.

During these ten days, the participants wrote the advanced drafts of submissions for each of the sections. The drafts were read by all the CCM members by e-mail and also during a consensus workshop from May 20 to 21, 2009, so that all the CCM members could make detailed comments on the document page by page.

The various comments were included by a small team, who then submitted the final document to the CCM for approval.

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***[Insert Annex Number]***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.

The different meetings organized by the Global Fund and its partners as well as its current directives are a sufficient reminder of the role of the CCM in overseeing program implementation. This is the guarantee of success. However, it is known that the difficulties CCMs have in doing this fully are usually of a financial nature. Despite this difficulty, and conscious of its responsibilities, the CCM-DRC has developed several processes for monitoring and overseeing the grants received from the Global Fund.

1st process:

The national HIV/Aids, Malaria and TB programs, in their regulatory and normative capacity, have the ability to oversee program implementation. They supervise the schedules of activities planned by the Sub-Recipients before they are funded by the current PR. These national programs for controlling the 3 target diseases, with their respective tack forces, form the skeleton of the CCM-DRC Technical Secretariat

2nd process:

The joint CCM-PR missions. These allow the CCM to verify the use of grants. The CCM Technical

Secretariat and the PR agree on a yearly assessment calendar, and the CCM designates, for each sector, the members who will take part in the missions. The reports from the missions are a means of monitoring the implementation of programs.

3rd process:

Meetings at which the PR reports back to the GA or the Bureau at the agreed frequency.

During these meetings, the PR explains to the members of the GA and the Bureau the activities carried out and the results of the implementation. The amounts of Global Fund grants paid out are also discussed.

4th process:

CCM partners are subcontracted to provide technical support to determine how the grants are being used. CCM operations also receive this type of technical support.

(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

In DRCongo, the most important operational unit for implementing activities for controlling the 3 Global Fund target diseases is the Health Zone. The health system has three levels: the central level that has a regulatory and normative role, and the intermediate level that provides the technical support for the outermost level. This outermost level is composed of the 515 Health Zones that implement the program.

The Health Zone is where all activities take place. The community is involved in monitoring activities through members of the health committee. The Health Zone Management Team, comprising a Zone Senior Doctor, a Managing Doctor, a Nursing Supervisor and a Nursing Director, is heavily involved in supervising activities, including those operating on Global Fund grants, although they are not CCM members. This illustrates how well all the activities of the operational unit known as the Health Zone are integrated.

At the Province level, the Health Systems Strengthening Strategy has instituted the Provincial Steering Committee. One of its functions is to ensure that the activities planned by the multiple sources of support received in the country are carried out properly.

The Province Management Team, led by the Provincial Medical Inspector, is responsible for coordinating the partners and their support groups, and also the implementation of activities in the Province.

In certain cases, during the ongoing supervision, non-medical people are also involved, in order to instill greater confidence in the services offered.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*

On April 27, 2009, the CCM launched a call for expressions of interest for candidate Principal Recipients. The deadline for the call was fixed at May 16, 2009. The call was circulated by e-mail and through the media. Posters were put up all over the country.

On May 14, 2009, guided by the CCM Bureau, the Technical Secretariat sent a letter to CCM groups asking them to nominate a representative to join an ad hoc commission to select potential Principal Recipient candidates.

On May 22, 2009, the letters were opened in the presence of Principal Recipients. As soon as the letters were opened, the members of the commission examined the applications in camera to ensure

they complied with requirements. A report was written after this appraisal. In all, 3 applications were received, and they all complied with requirements.

On May 23, 2009, the commission examined the applications from a technical angle. After the deliberations, the commission wrote a formal report.

On May 25, 2009, the commission presented the results of the deliberations to the CCM Bureau, so that they could be announced at the GA on May 27, 2009 for validation of the candidate PRs.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***[2.2.2.4.a.2.]***

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Ministry of Health	HIV-Aids, Malaria, Tuberculosis and HSS	Public
SANRU Program	Malaria	NGO
Caritas Congo	Tuberculosis	NGO
National Council of Health NGOs (CNOS)	HIV-Aids	NGO

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
ONE PAGE MAXIMUM

2.2.7. Managing conflicts of interest

(a) Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	☉ Yes ***provide details below***
	○ No ➔*go to s.2.2.8.*
(b) **If yes, attach** the plan for the management of actual and potential conflicts of interest.	☑ **Yes** ***[Insert Annex Number]***

2.2.8. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has '<u>Attachment C</u>'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	☑ Yes

2.3. Sub-CCM details

2.3.1. Status of Sub-CCM	
Identify if the sub-national coordinating mechanism:	
(a) Operates under the authority of the CCM and focuses on a particular region or issue.	☐ *Answer s.2.3.2. and s.2.3.3.*
(b) Claims an independent basis to operate without oversight of the CCM	☐ *Answer s.2.3.2. and s.2.3.4.*

2.3.2. Rationale
Why does a Sub-CCM approach represent an effective approach in the circumstances of your country?
ONE PAGE MAXIMUM

2.3.3. CCM Endorsement	
(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal.	***[Insert Annex Number]***
(b) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	***[Insert Annex Number]***

2.3.4. Justification of independence of Sub-CCM
Explain how the Sub-CCM has a right to operate without guidance from the CCM.
ONE PAGE MAXIMUM

2.4. Non-CCM Applicants [delete sections 2.1. to 2.3. and only complete s.2.4 below]

2.4.1. Sector of work

(check one box only):
☐ Academic/educational sector
☐ Government
☐ Non-government organization (NGO)/community-based organizations
☐ People living with the diseases
☐ People representing key affected populations
☐ Private sector
☐ Faith-based organizations
☐ Other: *please specify:*

2.4.2. Status of Non-CCM applicant

(a)	Identify the main justification for submitting a non-CCM proposal *(check one box only)*:	
(i)	Country in conflict, facing a national disaster or in a complex emergency situation	☐ *Go to s.2.4.3.*
(ii)	Country that suppresses, or has not established partnerships, with civil society and non-governmental organizations	☐ *Complete (b) below, and then s.2.4.3.*
(iii)	State without a national government, and not being administered by a recognized interim administration	☐ *Go to s.2.4.3.*

(b) If (ii) applies:

- describe, in date order, all attempts to have activities from the non-CCM proposal included in the CCM's proposal, and the CCM's response; and
- briefly explain why you will be able to do the work and achieve the outputs/outcomes when the CCM has not supported the proposal.

TWO PAGE MAXIMUM

2.4.3. Expected benefit of proposal

Briefly explain how the work included in this proposal (HIV, tuberculosis and/or malaria as relevant) addresses gaps in the existing country efforts.
ONE PAGE MAXIMUM

2.4.4. Non-CCM knowledge and experience in cross-cutting issues

Health Systems Strengthening The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the applicant.
(a) Describe the capacity and experience of the applicant to consider how health system issues impact programs and outcomes for the three diseases.

Gender awareness The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in: • methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and • the factors that make women and girls and sexual minorities vulnerable.
(b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Multi-sectoral planning The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the applicant in multi-sectoral program design.

2.4.5. Principal Recipient(s)

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.*

Name	Disease	Sector**

[use "Tab" key to add extra rows if needed]		

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

2.4.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
ONE PAGE MAXIMUM

2.4.7. Endorsement by Non-CCM Applicant

Position	Printed Full Name	Signature

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	Comprehensive documentation on **processes** used to invite submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	1. E-mail messages: launch of Global Fund Round 9 2. Newspaper announcement of the Round 9 Call for Micro-proposals 3. E-mail messages on the Round 9 Call for Micro-proposals
2.2.2(b)	Comprehensive documentation on **processes** used to review submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	4.Criteria for reviewing the micro-proposals 5. Minutes for integrating the Malaria micro-proposals 6. Minutes for integrating the HIV-Aids micro-proposals
2.2.2(c)	Comprehensive documentation on **processes** used to ensure the input of a broad range of stakeholders in the proposal development process	7.Minutes of the General Assembly meeting on February 3, 2009 8.List of people present at the meeting on February 3, 2009 9. Minutes of the extended Technical Secretariat meeting on April 15, 2009 List of people present at the meeting on April 15, 2009 10. E-mail messages for taking part in the BITI writing workshop 11. Writing teams 12.Minutes of the Consensus Workshop
2.2.3(a)	Comprehensive documentation on processes to oversee grant implementation by the CCM (or Sub-CCM).	13. TDR Monitoring and Evaluation Commission 14.Calendar of joint UNPD – CCM missions
2.2.3(b)	Comprehensive documentation on processes used to ensure the input of a broad range of stakeholders in grant oversight process.	15. Minutes of the General Assembly meeting on January 13, 2009

Proposal checklist - Section 1 and 2

		List of people present 14. Calendar of joint UNPD – CCM missions
2.2.4(a)	Comprehensive documentation on processes used to select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated). If different processes used for each disease, then explain.	16.E-mail messages of call for expressions of interest for Civil Society PRs 17.E-mail messages for selecting the PRs 18.Members of the PR selection commission 29.Members of the extended Bureau 20.Minutes of the PR selection 21.Minutes of the General Assembly meeting on May 27, 2009
2.2.7	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	22. Management of Conflicts of Interest
2.2.8	Minutes of the meeting at which the proposal was developed and CCM (or Sub-CCM) endorsed.	21. Minutes of the meeting on May 27, 2009
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members.	**Attachment C to the Proposal Form**
Sub-CCM applicants only		
2.3.3 (***CCM Endorsement***)	Documented evidence (including minutes of the CCM meetings) that the CCM in the country reviewed and endorsed the proposal (as relevant).	
2.3.4	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM.	
Non-CCM applicants only		
2.4.1	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
2.4.2(a)	Documentary evidence justifying the one of the three exceptional circumstances for submitting a non-CCM	

Proposal checklist - Section 1 and 2

	proposal	
2.4.2(b)	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

ROUND 9 – Tuberculosis

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	01 JANUARY 2010	31 DECEMBER 2014

3.2 Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 9 tuberculosis proposal?	☐ Yes *(go first to (b) below)* ☐ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 9 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at:*
http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FAQ_GrantConsolidation_en.pdf

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	Round 5 and 6 Tuberculosis for RD Congo

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

ONE PAGE MAXIMUM

In the DRC, all official plans and associated budgets are encompassed within the annual cycle commencing 1 January and ending 31 December each year. This cycle proceeds through stages of elaboration of a macroeconomic framework including the setting out of a budgetary framework, the holding of budgetary sessions to assess the priority of the different sectors taking into account medium-term expenditure, a vote on the budget by Parliament and promulgation by the President of the Republic. The financial year in which this budget is implemented is subject to the same annual programme cycle. The majority of partners of the Ministry of Health use the same financial cycle.

Beginning in January 2010, this submission is aligned with previous World Fund grants (Round 5 and Round 6) which began late, resulting in overlaps in relation to calendar years. However, whatever their start dates for implementation were, by aligning their implementation schedules with the current budgetary year, the various grants will enable us to be synchronised in terms of our action plans, activity reports and financial reports.

Moreover, epidemiological reporting, which presents anticipated results and assesses the attainment of objectives is conducted quarterly with an annual total.

ROUND 9 – Tuberculosis

3.4 Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis occur through a program-based approach?	☐ Yes. Answer s.3.4.2
	☉ No. ➔ *Go to s.3.5.*
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☐ No. Do not complete s.5.5

3.5 Summary of Round 9 Tuberculosis Proposal

Provide a summary of the tuberculosis proposal described in detail in section 4.

Prepare after completing s.4.

ONE PAGE MAXIMUM

In DRC, the health system is pyramidal in nature and implements primary healthcare policy. Since 2006, the government has implemented a Strategy for Health System Strengthening (HSS).
The country has operated a national programme to fight tuberculosis applying DOTS strategies since 1996 and Stop Tuberculosis since 2006. The National Tuberculosis Programme or NPT comprises a strategic plan for 2006-2015 which has a budget of USD 553,913,004.
The NTP received grants from the Global Fund in the already completed 2nd Round and in the 5th and 6th Rounds that are currently underway. However, the gap arising from the strategic plan remains sizeable in terms of the fight against multi-drug resistant tuberculosis (MDR-TB), TB-HIV co-infection, the implementation of PAL and PPM and operational research.

The aim of this submission is:

- to contribute to a reduction in this gap,
- to build on the achievements from the interventions of Rounds 2, 5 and 6,
- to ensure continuity.

Aim: To contribute to a reduction in tuberculosis-associated morbidity and mortality between now and 2015 in DR Congo, in line with the Millennium Development Goals and with the targets of the Stop Tuberculosis Partnership.

Specific targets to work towards this goal by means of this submission are:

Target 1: continue with the extension and improvement of the DOTS quality strategy;
Target 2: Fight tuberculosis-HIV co-infection and MDR tuberculosis;
Target 3: Assist in strengthening the health systems through PAL;
Target 4: Involve all care providers in the fight against tuberculosis;
Target 5: involve members of the community in the fight against tuberculosis;
Target 6: Develop operational research within the NTP.

Key results (indicators) to be achieved following Round 9 are:

- A detection rate of 70% of TPM+ patients and a therapeutic success rate of 85% for 1545 TB Detection and Treatment Centres; 5 laboratories regularly conducting an EQA for cultures and ATS; 120 hospitals equipped with x-ray equipment to improve the detection of Microscopy Negative and EPTB;
- 33,160 individuals co-infected with tuberculosis benefiting from joint care with theNational AIDS Programme; 3400 case of MDR tuberculosis notified and treated along with side effects and hospitalisation of 10% (340 cases) in 8 refurbished Centres;
- **200** hospitals with PAL activities;
- 1**20** private establishments involved in the fight against TB programme, participating in DOTS activities and observing ISTC;

ROUND 9 – Tuberculosis

- 25% of new tuberculosis patients with positive smear tests monitored/supervised by the community as a percentage of all notifications of new tuberculosis patients with positive smear tests (treatment commenced)

- A drug resistance survey conducted across the entire country, 24 annual TB/HIV prevalence tests conducted in the first 3 years and 15 operational research studies conducted with the results disseminated.

The **key activities** are:

- Consolidate standard DOTS strategy in 1,545 TB Detection and Treatment Centres through the provision of reagents, microscopes and light equipment, improve detection of Negative Microscopy TB through the acquisition of x-ray equipment; re-kit culture laboratories in the provinces, conduct antibiogrammes and molecular tests; ensure provision of patient support; provide 601,139 1st line TB cures and 2,960 2nd line TB cures; ensure provision of monitoring and evaluation through training, meetings and supervision, assessment, policy formulation workshops, a number of validation meetings, creation of awareness documentation, and the allocation of incentives to personnel involved in the fight at both the central and the intermediate levels.
- Increase provision of care to MDR patients, HIV testing of all tuberculosis patients in the Healthcare Zones with the support of the National AIDS Programme
- Progressively implement PAL (with equipment), PPM and ISTC strategies in health zones;
- Extend community-based DOTS and set up associations of former TB patients; increase awareness, communication, representation and social mobilisation for tuberculosis;
- conduct operational research studies and publish the results.

For this the programme requires an additional budget of **USD 128,728,799**.

Two Principal Recipients/PR were selected by the CRC-CCM, one from civil society, this being Caritas-Congo, and one from the public sector, this being the Public Health Ministry

4 PROGRAM DESCRIPTION

4.1 National program and strategy

(a) Briefly summarize:

- the current tuberculosis national program or strategy;
- how the strategy responds comprehensively to current epidemiological situation in the country; and
- the improved tuberculosis outcomes expected from implementation of these programs or strategy.

ONE PAGE MAXIMUM

The NPT in DRC has been applying the DOTS strategy since 1996 with the supervision of the Union and the WHO. In 2006 it integrated the following essential features of the "Stop TB" strategy:

1. **Pursuit of the DOTS Quality Strategy**
   a. Tuberculosis Testing

Microscopy forms the basis for TB screening, 3 sputum samples are collected over two days from anyone who is ill who has been coughing for more than 15 days.
Diagnosis of extra-pulmonary and negative microscopy tuberculosis is made solely by doctors.
Quality control is carried out systematically for all microscopy laboratories within the NPT screening network.
Individuals with suspected tuberculosis infection living a long way from the Detection Centres take their sputum samples to the nearest Treatment Healthcare Centre. The nurse creates the smears, fixes them to slides and takes the fixed slides to the Detection Centre for hot Ziehl Neelsen staining and study. The fixed slides are transported by the healthcare worker, by bicycle or pirogue, and these then bring back the results and medication for individuals diagnosed with tuberculosis.
Control tests are carried out at the end of the intensive phase, at the end of the 5th month and at the end of treatment.

   b. Treatment of patients with tuberculosis:

Patients are grouped into three categories and the treatment regimes used are the following: Category I & III: 2RHZE/4RH and category II: 2SRHZE/1RHZE/5RHE.
The taking of medication is supervised during the 1st phase by the nurse and in the 2nd phase by a member of the family or community (trained and supervised), of not by the nurse.

   c. Supply of TB medication and ziehl laboratory reagents:

The NPT is supplied with medications, reagents and other inputs through a GDF international tender process.
The NPT supplies the PCLT (Provincial Coordination against Leprosy and Tuberculosis) on a twice-yearly basis.
The PCLT supplies the HZ (Healthcare Zones) on a quarterly basis.
The Healthcare Zones supply the Detection Centres on a monthly basis.
Requirements are determined on the basis of epidemiological data.

   d. Monitoring, Assessment and Impact-Measuring system:

Management of health information is entered into the National Health Information System (NHIS). The NPT compiles, prints and distributes information and awareness literature through the same network as the medications network.
On a quarterly basis it collects data from the system which is first analysed by the Detection and Treatment Centres and added to by the Health Zone Supervisor Teams during monthly monitoring of activities, which are then submitted to and analysed by the Provincial Supervisor Teams (PST/PCLT) at data validation meetings, before being passed on to the central level where they are compiled, analysed and disseminated. Vertical feedback is required at each level. Technical supervision is carried out on a regular basis and personnel training and revision sessions are organised on the basis of shortfalls and needs identified during supervision and assessments. External assessments are conducted on a regular basis both at the level of the

Central NPT Unit and at the intermediate level of the PCLT.
In 2007, analysis of the epidemiological results revealed a positive trend: DOTS coverage increased from 47 to 100% between 1995 and 2007.

- the detection rate for positive microscopy pulmonary TB infections increased from 35 to 61%
- and the success rate for treatment increased from 50 to 86%[1].

2. **The Fight against TB/HIV and MDR-TB**

TB-HIV: A framework for collaboration exists between the two programmes (National AIDS Programme and NTP) at both the central and the intermediate levels. TB Detection and Treatment Centre providers offer HIV testing to all tuberculosis patients and inversely providers treating Persons Living with HIV (PLH) at walk-in HIV treatment centres (WTC) direct these individuals to Detection Centres for tuberculosis testing. The NTP thereby intends to reduce levels of tuberculosis infection and deaths from tuberculosis in Persons Living with HIV.
MDR: Diagnosis is carried out in Kinshasa for all patients within the country. The method used is solid culture medium. The key targets are retreatment failures and MDR patient contacts. Suspected sufferers are put on an empirical six-month treatment (**6** K O Pth Cs ZE) followed by a continuation phase of 18 months (18 O Pth Cs ZE). In order to improve MDR patient care, the NPT aims to:

- Increase coverage through progressive decentralisation (through the creation of culture laboratories and treatment centres near to patients in the provinces)
- Improve screening through the use of rapid techniques (molecular biology and liquid medium cultures)
- Increase targets for screening among category 1 failures, relapses, treatment interruptions and MDR patient contacts.

3. **Health System Strengthening through PAL**

The programme objective is the progressive implementation of the PAL strategy at the level of primary healthcare operations establishments in the targeted Health Zones. The NPT is to ensure personnel training and provide these establishments with adequate equipment and medication for the integrated provision of treatment for lung diseases. The anticipated benefit is an improvement in tuberculosis detection.

4. **Involve all care providers**

Currently, out of 1339 operational Detection Centres, involved in the fight against Tuberculosis, there are:

- 486 Denominational Detection Centres,
- 38 joint state and para-state companies
- 34 private for-profit companies,
- and 781 entirely State-owned companies.

The NPT aims to increase this involvement from the private for-profit sector, traditional healers, pharmacists and other healthcare providers to improve the rate of detection and to prevent the appearance of multi-drug resistant strains.

5. **Involve communities**

Communities are involved through community relays, the family members of patients and associations of former tuberculosis patients who participate in supervision of community DOT and in orienting suspected cases to Detection Centres. The NTP also collaborates with community-based organisations in raising awareness, communications, social mobilisation and representation through the National Anti-Tuberculosis League and the Friends of Damien Clubs. This all contributes to an improvement in the detection and recovery rate for tuberculosis patients.

6. **Operational research**

The programme's Research Unit was set up in 2006 and works in partnership with the country's public health schools and universities. It supervises studies and is involved in the formulation of research protocols. The involvement of PCLTs in the research enables operational problems

[1] Global Tuberculosis Control 2009; WHO Report 2009, p.101

encountered in the fight against tuberculosis to be resolved.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
☐ National Health Sector Development/Strategic Plan		
☑ National Tuberculosis Control Mid Term Strategy or Plan	1	Pages 6-7, 24-26, 38-41
☐ National Tuberculosis Guidelines (medical and laboratory)		
☑ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)* **Health System Strengthening Strategy**	3	Pages 21-22, 27-28, 31-33
☑ Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal **Report on visit carried out from 15 January to 5 February 2008 by the UNION** **Global Tuberculosis Control 2009; WHO report 2009**	12 13	Pages 2-4, 10-12, 14-18, 22-24 Pages 1001-103
☑ National Monitoring and Evaluation Plan (health sector, disease specific or other)	6	
☐ National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

4.2 Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

◉ Whole country	○ Specific Region(s) ***If so, insert a map to show where*	○ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

ROUND 9 – Tuberculosis

***** Paste map here if relevant***

(b) **Size of population group(s)** *(If national data is disaggregated differently then type over the categories proposed)*			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Total country population (all ages)	69.542.924	Ministère de la Santé RD Congo 2007	2008[2]
Women > 25 years	11.581.609	Same	2008
Women 19 – 24 years	3.803.711	Same	2008
Women 15 – 18 years	3.036.576	Same	2008
Men > 25 years	11.016.912	Same	2008
Men 19 – 24 years	3.793.057	Same	2008
Men 15 – 18 years	3.036.576	Same	2008
Girls 0 – 14 years	16.610.605	Same	2008
Boys 0 – 14 years	16.663.878	Same	2008
Other **: *****Refer to the* Round 9 Guidelines *for other possible groups*			
Other **: Displaced in North Kivu, South Kivu, Itun, Eastern Province and Katanga	1.364.578	DRC FACT SHEET UNHCR Branch Office, Kinshasa/DRC	MAY 2008
Other **:			[*use "Tab" key to add extra rows if needed]*

4.2.2. Tuberculosis epidemiology of target population(s)				
Indicators (see the footnote under this table for the references)			**Number or rate or percentage**	**[Calculation] or (reference)**
TB estimates, 2006				
a	Estimated number of new TB cases (all forms)		245 333	(1)
		13 248		
		15 947		

[2] Most recent population data available from the Ministry of Health in 2007 from Projections

ROUND 9 – Tuberculosis

b	Estimated number of new TB cases (all forms) per 100 000 population		392	[a/population*100 000]
c	Estimated number of new smear-positive cases		108 957	(1)
d	Estimated number of new smear-positive cases per 100 000 population		174	[c/population*100 000]
e	Estimated prevalence of TB cases (all forms)		417 066	(1)
f	Estimated prevalence of TB cases (all forms) per 100 000 population		666	[e/population*100 000]
g	Estimated number of deaths due to TB (all forms)		51 102	(1)
h	Estimated number of deaths due to TB (all forms) per 100 000 population		82	[g/population*100 000]
i	Estimated number of HIV-positive new TB cases (all forms)		14 431	(1)
j	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population		23	[i/population*100 000]
k	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined)		7 336	(2)
ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant		3	(2)
TB notifications, 2006				
l	Number of new TB cases (all forms) notified		95 804	(3)
m	Number of new TB cases (all forms) notified per 100 000 population		153	[l/population*100 000]
n	% of estimated new TB cases (all forms) notified		39	[l/a*100]
o	Number of new smear-positive TB cases notified		66 099	(3)
		1 343		
		23 958		
		9 894		
		1 842		
		21 484		
		7 578		
p	Number of new smear-positive TB cases notified per 100 000 population		106	[o/population*100 000]
q	% of estimated new smear-positive TB cases notified -		61	[o/c*100]

	Case detection rate of new smear positive TB		
s	Number of TB cases all forms (new and retreatment) that were tested for HIV	14 484	(3)
t	% of TB cases all forms (new and retreatment) that were tested for HIV	14	[s/l*100]
u	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive	2 129	(3)
v	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB	15	[u/i*100]
w	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT	2 015	(3)
x	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT	95	[w/u*100]
y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART	419	(3)
z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART	20	[y/u*100]
aa	Number of TB cases (new and retreatment) received diagnostic DST	37	(3)
ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases	15	(3)
ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB	1	[ac/k*100]
Treatment outcome, 2005			
ae	Number of new smear-positive cases registered for treatment	63 488	(3)
af	% of all notified new smear-positive TB cases that were registered for treatment	100	[ae/o*100]
ag	Number of new smear-positive TB cases that were successfully treated (2005 cohort)	54 737	(3)
ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2005 cohort)	86	[ag/ae*100]
ai	Number of new smear positive TB cases that failed their treatment	798	(3)
aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2005 cohort)	1	[ai/ae*100]
ak	Number of new smear positive TB cases who died while on TB treatment	3 404	(3)
al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2005 cohort)	5	[ak/ae*100]
am	Number of new smear positive TB cases who defaulted	3 137	(3)
an	% of all new smear-positive TB cases registered for treatment who defaulted (2005 cohort)	5	[am/ae*100]
Other			
Other			
Other			[*use "Tab" key to add extra rows if needed]*

1. Global tuberculosis control: surveillance, planning, financing: WHO report 2008. "WHO/HTM/TB/2008.393".
2. Anti-tuberculosis drug-resistant in the world. Fourth global report. WHO/HTM/TB/2008.394
3. Data from country TB routine recording and reporting system.

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[3] who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

- the main weaknesses in the implementation of current tuberculosis program or strategy;
- how these weaknesses affect achievement of planned national tuberculosis outcomes; and
- existing gaps in the delivery of services to target populations.

ONE PAGE MAXIMUM

The weaknesses set out below relate to implementation of the DOTS strategy and other components of the Stop TB strategy that are poorly integrated into the programme:

- In recent years the rate of screening of PMT+ has ground to a halt at around 61%. The poor access to Detection Centres as a result of the long distances separating them from the population is partly responsible for this. The shortage of x-ray equipment has resulted in the under-detection of Negative Microscopy and EPTB.
- From the standpoint of management and supervision of programme activities, the lack of financing has resulted in irregular data validation meetings and supervision at the level of the PCLT and Health Zones.
- As regards human resources, there is recurrent instability in relation to trained personnel, linked to the precariousness of working conditions, and low and irregular salaries. There is a lack of training for care providers for certain components of the "Stop TB" strategy such as TB-HIV, MDR TB-, PAL and PPM. The majority of laboratory technicians at the central and intermediate levels are not trained in molecular biology and culture techniques.
- Access to HIV testing and ARVs for tuberculosis remains limited owing to the insufficiency of inputs.
- Coverage of activities associated with MDR-TB is insufficient. A low level of detection of MDR cases owing to: 1) difficulty of transporting sputum samples coming from the provinces to the only national laboratory; 2) the long growing times for solid medium cultures. Measures needed alongside patient treatment (hospitalisation, clinical and biological monitoring, nutrition, social and community support, etc) are almost non-existent. This shortfall is responsible for the low success rate and a not inconsiderable number of cases being lost to follow up.
- The lack of appropriate premises for infection control and the lack of personal protection measures for personnel and the family of patients exposes the community to a high risk of contamination.
- The PAL is still not integrated into primary healthcare provision, as a result of which

[3] Please refer back to the definition in s.2 and found in the Round 9 Guidelines.

treatment of lung diseases is not codified.

- In comparison with public and denominational networks, there is little involvement of for-profit private establishments in the fight against tuberculosis.

- Social mobilisation, representation, awareness-raising and communication activities remain insufficient (The Patient Charter Is not widely distributed) and also there is little community involvement in the fight against tuberculosis, TB-HIV co-infection and MDR-TB.

- Only a low level of operational research focussing on the problems encountered in the fight against tuberculosis is being conducted. The seroprevalence of HIV in tubercular sufferers is not known for the country as a whole and the last survey on monitoring of drug resistance was conducted more than 10 years ago.

The failings listed above make it impossible to detect all sufferers in a community and improve the care they receive, which explains the low detection rate, and the high risk of MDR or XDR TB.

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect tuberculosis outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and tuberculosis outcomes (e.g.: PAL services), but perhaps not also malaria and tuberculosis programming and service delivery.*

ONE PAGE MAXIMUM

The health system in DRC forms a three-step pyramid structure comprising: (i) the peripheral level made up of Health Zones (the operational unit of national healthcare policy, (ii) the intermediate level, the goal of which is to provide technical support to the peripheral level and the national level, the role of which is to standardise and regulate. The problems encountered by our health system may be summarised as follows: (i) problems associated with the provision of care and healthcare services, (ii) problems associated with human resources for healthcare, (iii) problems associated with financing of healthcare services, (iv) problems associated with the provision of essential and generic medications and (v) problems associated with the healthcare information system.

Problems associated with healthcare provision,- the problem of healthcare provision concerns both the coverage and the quality of healthcare. Indeed, national healthcare coverage is very low (26%), which deprives a large part of the population of basic healthcare. Within this already low average, enormous disparities are concealed. Recent studies have shown that in Basankusu (Equator Province), 42.7% had to walk more than eight hours to participate in healthcare training, whilst in Befale and Bolomba, the proportions are 21.2% and 3.6% respectively. This problem of physical inaccessibility to healthcare services simultaneously affects the fight against tuberculosis, HIV/AIDS and Malaria.

Besides those problems associated with healthcare coverage, the health system is also beset by problems concerning the quality of services provided to populations. This is the result of a combination of several factors including the low level of basic training of healthcare personnel, a fast turnover of healthcare personnel who are unable to develop sufficient experience, the dilapidated and outdated condition of infrastructure and equipment, and the difficulty of organising integrated, ongoing, total care for users in a context characterised by a lack of

resources. It should be pointed out that services fighting HIV/AIDS are very fragmented, which poses serious problems in terms of efficacy and efficiency.

Healthcare human resource problems,- several problems exist in relation to human resources. These problems concern the quality of personnel turned out, personnel demotivation owing to the low salaries paid by the government and migration – both internal and external – which is becoming increasingly frequent. Indeed, healthcare personnel dissatisfied with the salary that they receive are constantly in search of the highest pay, which creates instability and does not enable personnel to build the experience needed to ensure high quality healthcare provision. The human resources issue is aggravated by bonuses paid for specific healthcare problems. This creates exposure to a risk of duplication, in a context characterised by a lack of resources, and undermines personnel responsibility in relation to healthcare problems for which bonuses are not paid.

Supply of Essential and Generic Medications (EGMs) - The national system for supply of essential and generic medications (NSEGM) is made up of a network of EGM Regional Distribution Centres (RDCs) which are grouped collectively into a group of EGM acquisition and distribution centres, known as FEDECAME. 15 RDCs exist in the country out of the 40 planned. This system addresses a number of problems amongst which may be cited the low turnover of the various RDCs, the low level of cost recovery associated with the use of medications, competition from unregulated private for-profit establishments, the implementation of parallel circuits as a result of international financing namely that designated for selectively fighting certain pathologies, and the absence of a loyalty system for healthcare organisations benefiting from loans from RDCs, etc. Added to this list of problems should be the fact that the status of FEDECAME has been under regular re-examination for some time.

The Health Information System, - the functioning of the health information system remains a real problem at the current time in DRC because it does not make available in real time the information that decision makers and healthcare providers need for decision making. This was demonstrated during the evaluation of the Monitoring and Evaluation systems of the three HIV, Tuberculosis and Malaria programmes conducted by 'Measure Evaluation' with the support of the Global Fund in 2007[4].

Indeed, the report from this assessment revealed the following problems: (i) poor quality of data, (ii) existence of duplication of monitoring and evaluation systems leading to multiple reporting, the existence of data discrepancies, overworked personnel, etc. (iii) poor level of completion and timeliness of reports and (iv) non-systematic and non-computerised management of data characterised by a low capacity for storage, data analysis and dissemination of healthcare information.

Healthcare financing – the problems posed by healthcare financing in DRC may be summarised as follows: (i) although available resources in the sector are increasing, these are still substantially below required levels, (ii) allocation of the State healthcare budget does not always take into account sector priorities and; (iii) financing methods linked to selective healthcare problems have ended up fragmenting the health system.

[4] Measure Evaluation, Evaluation report on monitoring and evaluation of the National HIV/Aids, Tuberculosis and Malaria Programmes, November 2007

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect tuberculosis outcomes.

ONE PAGE MAXIMUM

The Health System Strengthening Strategy adopted by the government and its partners since 2006 is a total response to these failings[5] in the sense that it advocates corrective actions capable of reorganising the health system as a whole to cover the entire population and to provide overarching, ongoing, integrated, effective and efficient basic healthcare services. The revitalisation of Health Zones (healthcare district) and personnel rationalisation form the basis for this.

This strategy promotes a holistic approach to health issues through the Health Zone. Basic healthcare providers must be multifunctional with close supervision by the Health Zone supervisor teams. This will ensure that healthcare provided to the population is integrated, ongoing, overarching, effective and efficient. The nurse at the Health Centre treating malaria must also be able to deal with tuberculosis and HIV/AIDS issues that are part of his/her skill-set and the technical support package available at this level. This approach will enable the fragmentation observed in the sector to be progressively reduced.

Improving the cover and quality of care are key priorities for the development of Health Zones advocated by the HSSS. The alignment of fund providers with regard to this strategy means that a large part of the funding available for the sector (including domestic resources) is oriented towards addressing coverage and quality of care issues. This is the case for the World Bank which is financing 82 HZ, for the African Development bank which is supporting the development of 26 ZS, for the European Commission which is financing 70 HZ, for the Global Alliance for Vaccines and Immunisation which is financing 65 Health Zones, for the Belgian nation which is financing 14 HZ, and for USAID which is supporting 57, etc. The total number of HZ benefiting from this type of support is 259 out of 515.

The human resources issue lies at the heart of all actions that the government and all of its partners are undertaking in the healthcare sector in DRC. The government has made quite substantial efforts in awarding bonuses (although these are insufficient) to healthcare personnel in addition to the salaries mentioned above. Sector partners (including the Global Fund) have almost all built bonuses into the financial support that they provide to the healthcare sector, even though there are still a number of Health Zones or Health Centres where these bonuses are not paid owing to a lack of resources.

During its meeting on 12-13 February, the National Steering Committee set up a commission to carry out an in depth study of the problems posed by the national medication supply system. A status report of this system will be prepared as a part of the study. This will make it possible to better position an appraisal of the sector in order to identify relevant actions that will enable performances to be improved. All of the current projects provide resources that will increase the turnover of the system. Ultimately, the aim is for this system to absorb all of the resources circulating in the sector, including those allocated to the country by the Global Fund.

The standard framework of the NHIS is set to improve the management of healthcare information in DRC. With available resources, including those of the Global Fund from the 8th Round, this standardisation framework is to be introduced in 219 Health Zones.

The Public Health Ministry and its partners have undertaken a reform of healthcare financing in accordance with the Paris Declaration. This reform provides for the implementation of sector-based budgetary support in order to improve the efficacy and efficiency of development aid. Three actions are currently underway to enact this reform. These are the standardisation of coordinating bodies within the sector, implementation of a fiduciary agency for management of all funds in the healthcare sector and the use of consensual procedures in the management of the sector's financial resources.

[5] Health System Strengthening Strategy, p.23,26, 27

ROUND 9 – Tuberculosis

Specifically for fighting tuberculosis the following may be identified:

(i) Projects to tackle TB/HIV financed by the European Commission and USAID in

the provinces of Lower Congo and North Kivu.

(ii) The UNITAID/WHO/FIND for 2009 to 2011 to finance liquid media culture tests with DST and molecular tests.

(iii) Traditional partners implementing activities for fighting tuberculosis are participating in programme activities, namely: training of service providers, supply of medications, inputs and reagents, and equipping of provincial coordinating centres and healthcare establishments.

(iv) Stepping up coordination of the activities of specialist disease fighting programmes by the central administration (4th Administration).

4.4. Round 9 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current tuberculosis epidemiology and identified weaknesses and gaps from s.4.2.2 and 4.3.

Note: All health systems strengthening needs that are most effectively responded to on a tuberculosis disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No: 1	IMPROVEMENT OF DIAGNOSIS	Historical		Current		Country targets			
Indicator name	*Culture laboratories, refurbishment equipment and supplies* *Numbers (%) regularly carrying out an EQA for cultures and ATS*	**20077**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		1	1	3	5	5	5	5	5
B: Extent of need already planned to be met under other programs		1	1	3	3	3	4	4	5
C: Expected annual gap in achieving plans				0	2	2	1	1	0
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	1	0	1	0

Priority No: 2	IMPROVE DIAGNOSIS OF NEG. MICROSCOPY AND EPTB	Historical		Current		Country targets			
Indicator name	Number of X-ray systems supplied	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		515	515	515	515	515	515	515	515
B: Extent of need already planned to be met under other programs		158	158	158	158	208	258	278	278
C: Expected annual gap in achieving plans		357	357	357	357	307	237	237	237
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			50	50	20	0	0

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Priority No: 3	**Procurement and management of supplies: Medication supply and management system**	**Historical**		**Current**		**Country targets**			
Indicator name	Number of % of Detection and Treatment Centers with no 1st line medication stock disruptions out of all Detection and Treatment Centers at the end of a given quarter.	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		103.046	108.198	116.854	118962	124910	131156	117057	122909
B: Extent of need already planned to be met under other programs		103046	108198	116854	118962	124910	37517	0	0
C: Expected annual gap in achieving plans			0	0	0	0	73966	117057	122909
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	0	73966	117057	122909

Priority No: 4	**TUBERCULOSIS/HIV**	**Historical**		**Current**		**Country targets**			
Indicator name	*Number (%) of tubercular patients reported with a positive HIV test out of the total number of tubercular patients reported during the same period*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		14721	16188	16995	17844	18737	19.673	20.657	21.690
B: Extent of need already planned to be met under other programs		12592	13760	14445	15.419	11.606	12.186	12.795	13.435
C: Expected annual gap in achieving plans		2129	2428	2550	2.425	7.131	7.487	7.862	8.255
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			2.425	7.131	7.487	7.862	8.255

ROUND 9 – Tuberculosis

Priority No: 5	**MDR-TB**	**Historical**		**Current**		**Country targets**			
Indicator name	Number of MDR-TB patients with positive smear test confirmed bacteriologically.	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		148	200	300	400	600	700	800	900
B: Extent of need already planned to be met under other programs		220	220	220	220	220	0	0	0
C: Expected annual gap in achieving plans				80	180	380	700	800	900
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			180	380	700	800	900

Priority No: 6	**Patient support**	**Historical**		**Current**		**Country targets**			
Indicator name	Number of patients benefiting from incentives	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		2.055	2. 158	2.266	2379	2498	2623	2754	2892
B: Extent of need already planned to be met under other programs		0	0	0	0	0	0	0	0
C: Expected annual gap in achieving plans		2.055	2. 158	2.266	2379	2498	2623	2754	2892
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			2379	2498	2623	2754	2892

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 9 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, program work area (or, "service delivery area (SDA)"), activities and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*

Where there are planned activities that benefit the health system that can easily be included in the tuberculosis program description (because they predominantly contribute to tuberculosis outcomes), include them in this section only of the Round 9 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 9. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 9 Guidelines (s.4.5.1.) for information on this choice.*

BETWEEN 4 to 8 PAGES

For this Round 9 proposal, two PRs have been selected: **The Ministry of Health** (public sector PR), and **Caritas-Congo** (civil society PR). See below.

PROPOSAL OBJECTIVE

The principal objective of this proposal is to contribute to a reduction in tuberculosis-associated morbidity and mortality between now and 2015 in DR Congo, in line with the Millennium Development Goals and with the targets of the Stop Tuberculosis Partnership. This proposal is to provide continuity with rounds 5 and 6 currently underway and has the following six objectives:

- Pursue and improve DOTS quality strategy
- Fight TB-HIV, and MDR-TB
- Contribute to further consolidation of the health system
- Involve all care providers in the fight against TB
- Give tubercular sufferers and communities the capacity to act
- Encourage and promote operational research

Objective 1: Pursue and improve DOTS quality strategy

SDA 1.2.: Improvement of diagnosis:

According to analysis of the situation, improvement of detection will entail: Strengthening the network of microscopy networks through the acquisition of replacement ordinary microscopes and fluorescence microscopes, light equipment and reagents for peripheral laboratories, refurbishment of a provincial quality control laboratory, increasing the number of culture laboratories through refurbishment and the acquisition of equipment, including molecular biology equipment. To assist in diagnostic access, sputum samples will be transported from Treatment Centres to Detection Centres by bike and pirogue. To improve Negative Microscopy and EPTB diagnosis, the acquisition of x-ray equipment and associated consumables is planned. There are also plans for quality assurance on culture tests and antibiogrammes by a supranational laboratory. To ensure the viability of all acquisitions, equipment maintenance will be indispensable.

Diagnostic interventions begin at the point where the support from round 5 and other partners

such as UNITAID/FIND (molecular biology) ends.

1.2.3. Microscopy laboratory

1. Purchase 100 replacement ordinary microscopes in years 4 and 5 of the proposal
2. Purchase 20 fluorescence microscopes in the first year
3. Exhaustively supply 1,545 Detection and Treatment Centres with reagents and consumables (from year 1 onwards, building upon supplies from both round 5 and round 6), for the 4 final years.
4. Provide for the maintenance of 500 microscopes at a rate of 100 per annum.

1.2.4. Culture laboratory

5. Refurbish 2 culture laboratory buildings in years 2 and 4.
6. Equip 2 culture laboratories in years 2 and 4
7. Equip culture laboratories with reagents and consumables (culture tests).
8. Equip the national molecular biology test laboratory from the 3rd year.
9. Provide for the transportation of sputum samples for culture test from the Detection Centres to PCLT laboratories for provincial and/or national laboratories.

1.2.5. Laboratories for antibiogrammes and sensitivity tests

10. Equip culture laboratories with reagents and consumables (DST).

1.2.6. Other equipment and supplies

11. Purchase 18,540 bicycles for the transportation of sputum samples from the Treatment Centre to the Detection Centre: 7,725 bicycles in year 1, 1,545 bicycles in year 2, to replace those purchased in round 5, 7,725 bicycles in year 3 and 1,545 bicycles year 4.
12. Equip culture laboratories with electricity generators in years 1 and 4
13. Supply fuel and lubricant for the culture laboratory electricity generators.
14. Gradually equip 120 General Referral Hospitals with x-ray equipment and accessories in the first 3 years (50 in year 1, 50 in year 2, and 20 in year 3).
15. Supply 120 General Referral Hospitals with x-ray consumables and reagents.
16. Equip 120 General Referral Hospitals with electricity generators for x-ray equipment.
17. Supply the 120 general hospital electricity generators with fuel and lubricant for the operation of x-ray equipment.
18. Provide for maintenance of radiography equipment from the 3rd year.

1.2.7. Quality assurance programme

19. Carry out external quality assurance for culture tests and antibiogrammes for the five-year period.
20. Refurbish the provincial laboratory for BAAR microscopy quality control at Bunia/Ituri.

For SDA 1.2.: Improvement of diagnosis:

The chosen indicators are:

- *Number (%) of laboratories regularly carrying out an EQA for cultures and ATS*
- *Number (%) of direct microscopy laboratories regularly participating in an EQA*

Target population

- *NPT covering the whole country for Ziehl microscopy with Round 5.*
- *For culture tests, the 5 reference laboratories serving the country's 11 provinces.*

SDA 1.3.: Patient support

The NPT supports the most impoverished tubercular sufferers with the aim of improving their adherence to treatment. Around 2% of reported tubercular sufferers fall within this category and

require financial support. To this end they are provided with a monthly fixed sum to cover food rations and transportation costs.

1.3.2. Incentives for patients

21. Introduce an incentive for the most impoverished tubercular patients (estimated at 2% of all patients), or 13,147 patients in total.

For SDA 1.3.: Patient support

- ***Chosen indicator:*** *Number (%) of patients benefiting from incentives*
- ***Target population:*** *13,147 anticipated tubercular sufferers "in need".*

SDA 1.4.: Medications Supply and Management System

Currently, medication is supplied from two sources: The Global Fund for 90% of national requirements and traditional partners for 10%. From 2009, the Congolese government would like to provide 5% of first line anti-tuberculosis medications. As a consequence, the contribution of the Global Fund will be for 85% of national requirements.

Medications provided by the Global Fund will be supplied until 2011 for rounds 5 and 6 collectively. In 2012 only round 6 will provide for part of the nation's needs.

The support for medications requested in this submission will cover the gap in 2012 and all requirements for 2013 and 2014. Given the long delay experienced in the acquisition of medications in rounds 5 and 6 which has depleted the security stock, this submission is designed to replenish this stock from 2012 onwards.

It should be noted that the cost of transport and insurance to get medications from the provider to the entry ports of Kinshasa and Goma is estimated at 7% of the purchase cost. From these two entry ports, the medications will need to be brought to the 24 coordination centres and then distributed to the 1,545 TB Detection and Treatment Centres. Given that the main mode of transport is air transport, in view of the enormous size of the country and the experiences of rounds 5 and 6, this cost is estimated at 18%, which amounts to a total of 25% of the purchase price.

1.4.1. – 1.4.2. – 1.4.3. First line medications for the following categories:

22. Purchase 1st line medications for categories I and III: 247,288 adult cures.
23. Purchase 1st line medications for category II: 46,775 adult cures.
24. Purchase 1st line medications for Children: 19,869 cures for Children

1.4.4. Security stock for first line medications

25 – 26 – 27: Provide for security stock for first line medications: 287,207 cures

1.4.5. Medication management, supply, storage and distribution

28. Transport medications from the supplier to the country and then distribute medications to the Detection Centres via PCLT and RDCs.

For SDA 1.4.: Medications Supply and Management System

Chosen indicator: *Number (%) of TB Detection and Treatment Centres with uninterrupted stocks of 1st line medication out of all Detection Centres at the end of a quarter.*

Target population

A total of 657,341 sufferers (15% will be treated with the support of other NPT partners and 313,932 sufferers will be treated specifically in Round 9).

DSA. 1.5.1.: Monitoring and evaluation system: Impact measuring

Consists of two sections: Periodic surveys and routine monitoring.

- Surveys will be organised on the seroprevalence of HIV and to assess the level of drug resistance to TB medications.
- For monitoring, periodic updating of IT systems in line with international strategies is

planned and acquisition of software for management of MDR-TB data is planned in this submission.

1.5.1.1. Periodic surveys

29. Conduct a national drug-resistance survey during the first year.
30. Conduct 72 seroprevalence surveys during the first three years.

1.5.1.2. Routine monitoring

31. Produce information aids for routine TB activities from the 3rd year onwards and for new initiatives (MDR-TB, PAL , etc.) from the 1st year onwards.
32. Update information aids for routine TB activities during the first year.
33. Assess monitoring and evaluation tools during the first year at the central level.
34. Assess monitoring and evaluation tools in the 24 PCLTs from the third year.

Reminder: Organise quarterly data validation meetings for the 515 Health Zones from the third year onwards (already included in the cross-cutting HSS proposal).

35. Acquire MDR-TB data management software during the 1st year.
36. Equip the PCLTs with IT tools for MDR-TB data management based on ongoing involvement in MDR-TB activities.

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For SDA 1.5.1.: Monitoring and evaluation system: Impact measuring

The following indicators have been chosen:

- *Existence of a drug-resistance survey report*
- *Number of surveys conducted out of the number planned.*
- *Number (%) of Detection Centres submitting their reports within the desired timeframe, in line with national directives (promptness and completeness of epidemiological reports)*

Target population

- *The entire population covered by the 24 PCLT*

SDA 1.5.2. Programme management and supervision

Meetings and personnel supervision at all levels of the health system and at the community level will help to ensure that the programme is implemented successfully. Rounds 5 and 6 combined cover part of the supervision activities for years 3 to 5. This proposal will make up the gap.

Logistical consolidation will enable care providers to be supervised regularly. Supervision is broken down into three levels: central, intermediate and peripheral.

1.5.2.2. Personnel meetings at the central level

37. Organise quarterly national Task Force meetings from the 3rd year onwards.
38. Organise 20 steering committee meetings for MDR-TB, PAL , TB/HIV, PPM and SOMO for the five-year period, with the exception of the first two years for TB/HIV (one meeting per quarter and per field).
39. Organise bi-annual ethics committee meetings from the first year onwards
40. Organise an annual meeting for provincial coordinators from the 3rd year onwards.
41. Organise an annual meeting of provincial laboratory technicians during the 1st, 3rd and 5th years.

1.5.2.4. Production and distribution of technical guides

42. Updating of technical guides: PATI, MDR-TB, TB/HIV, PAL , PPM, CDQ, SOMO and Monitoring and Assessment.
43. Production and distribution of technical guides: (PATI, MDR-TB, TB/HIV, PAL , PPM, CDQ,

SOMO and Monitoring and Assessment.)

1.5.2.5. Supervision at the national level

44. Organise 72 monitoring visits on aspects of provision of care to sufferers in the 24 provincial coordination centres (i.e. one national visit per year per coordination centre) from the 3rd year onwards and 40 visits in the first two years to cover the gap from previous Rounds.

45. Organise 120 monitoring visits of the administrative and financial sections of the 24 coordination centres (i.e. one national visit per year per coordination centre) throughout the 5-year period.

46. Organise 72 monitoring visits for laboratory activities in the 24 provincial coordination centres (i.e. one national visit per year per coordination centre) from the 3rd year onwards and 20 visits in the first two years to cover the gap from previous Rounds.

47. Organise 72 monitoring visits for medication management activities in the 24 provincial coordination centres from the 3rd year onwards and 20 visits in the first two years to cover the gap from previous Rounds.

48. Organise 43 monitoring visits for MDR-TB activities in the 11 coordination centres throughout the five-year period at the rate of one national visit per coordination centre per year in line with the plan for extension of MDR-TB activities.

49. Organise 24 SOMO activity monitoring visits each year for 5 years.

1.5.2.6. Intermediate level supervision

50. Organise 3,090 supervision visits by provincial coordination centres at a rate of 1,030 per year for the first three years (or 50% of planned visits, with the others covered by traditional partners).

1.5.2.9. Transport

51. Purchase two vehicles for the monitoring of new initiatives (PAL , PPM, and OR) for the central unit in the first year.

52. Purchase 2 outboards (boat hulls + engines) for 2 coordination centres in the first year

53. Provide for maintenance and repair of all vehicles from the 1st year onwards as they are progressively acquired.

54. Purchase 650.8 m^3 of fuel for operation of the Programme's vehicles and generators for five years, in addition to the contribution of traditional partners.

1.5.2.10. Premises, supplies and equipment at the national level

55. Pay operations, communications and insurance costs and national office maintenance costs for the five-year period.

1.5.2.11. Premises, supplies and equipment at the intermediate level

56. Pay operating, communications, insurance, fuel and maintenance costs for 11 PCLT for five years in addition to the contribution of traditional partners.

For SDA 1.5.2. Programme management and supervision:

The chosen indicators are:

- *Number of minuted meetings held out of the number of meetings planned for each of the various fields.*
- *Number of supervisory visits conducted out of those planned..*
- *Existence of a supervision report*.

Target population

- *The entire population covered by the 24 PCLT*

SDA 1.5.3. Human Resource Development (HRD)

In order to meet the programme objectives an increase is planned in the level of personnel training through training both at the national and the international level of key programme

personnel.
The lack of motivation and instability at the human resources level are an obstacle to the carrying out of activities. The submission makes provision for financial support in addition to that of previous rounds and the support of other partners to ensure that personnel are retained. Integration of the Stop TB strategy and the setting up of new culture laboratories have required the recruitment of new units at the central and intermediate levels resulting in additional financial requirements for their training. This will extend out to the peripheral level.
Financial support for peripheral level human resources, with the exception of personnel involved in MDR-TB activities, is provided for within the submission for the HSS component owing to the cross-cutting nature of the actions carried out by the various components.
The expertise of national and external consultants will be required for evaluation of the various issues: Monitoring and assessment, planning, finance, PAL, PPM, TB/HIV, MDR-TB, maintenance of laboratory equipment, etc…

1.5.3.1.1. National level personnel
57. Pay bonuses to 51 personnel members at the central level in addition to those of the traditional partners for the five-year period and support from rounds 5 and 6 for the first two years.
1.5.3.1.2. Intermediate level personnel
58. Pay bonuses to personnel at 11 PCLT out of 24 in addition to those of the traditional partners for five years and support from rounds 5 and 6 for the first two years.
59. Pay personnel bonuses for 11 out of 24 provincial teams responsible for monitoring MDR-TB patients and for provincial laboratory technicians in culture laboratories progressively as they become involved in these activities.
1.5.3.1.3. Peripheral level personnel
60. Pay the bonuses of the care providers at the 14 General Referral Hospitals responsible for monitoring MDR-TB patients progressively as they become involved in these activities.

1.5.3.2.1. External technical assistance
61. Provide for financing of 64 external technical assistance facilities to support the new initiatives and other initiatives (PAL, PPM, MDR-TB, TB-HIV, RO), and monitoring and assessment, laboratory maintenance and medication management activities for five years: 16 per year in the first three years and 8 per year in the two final years.
1.5.3.2.2. National technical assistance
62. Provide for financing of the monitoring, assessment, planning and finance activities of 16 national technical help facilities - 4 per year in the first three years and 2 per year in the final two years.
1.5.3.3.1. Training for patient care, programme management and monitoring and assessment.
63. Organise 3 programme management training sessions for the 24 coordinating doctors in the first, third and fifth years.
64. Organise a training session on programme monitoring and assessment for the coordinating doctors and data managers of the 24 PCLT in the third year.
65. Organise training on the revised programme directives at a rate of: 1 training session in 3 pools for 144 trainers in the 2nd year, 48 training sessions for 2,060 supervisory team members from the 515 HZ in the 3rd year, and 72 training sessions for 3,090 TB Detection and Treatment Centre care providers in the 3rd year.
1.5.3.3.2. Diagnostic training
66. Train 4 provincial culture laboratory technicians at a rate of 2 in the second year and 2 in the fourth year.
1.5.3.3.3. Training for tuberculosis/HIV co-infection
67. Organise 40 training sessions on manual CD4 counting for 1,176 Detection and Treatment Centre laboratory assistants from the 196 HZ overlapping with the National AIDS Programme

based on National AIDS Programme planning.

1.5.3.3.4. Training for MDR-TB

68. Train 160 care providers on multi-drug resistant tuberculosis, at a rate of 30 care providers in the first year, 30 in the second year, 40 in the third year, 40 in the fourth year and 20 in the fifth year.

1.5.3.3.5. Training on PAL

69. Organise 5 training sessions on PAL for 24 care providers at a rate of one session per year for the five-year period.

1.5.3.3.7. Training for community participation

70. Train 10 community relays per Detection and Treatment Centre each year.

1.5.3.3.8. Training for civil society, awareness raising, communications and social mobilisation

71. Train 24 provincial SOMO trainers in the first year in the 1st and the 4th year.

1.5.3.3.9. International training

72. Train 20 central level managers on the new initiatives (TB/HIV, MDR-TB, PAL , PPM,) and SOMO, monitoring and assessment for five years: 2 managers in the 1st year, 4 managers in the 2nd year, 3 in the 3rd year, 3 in the 4th year and 8 in the 5th year.

73. Participate in 10 MDR-TB and co-infection workshops organised by the Stop TB partnership for 5 years at a rate of 2 workshops (MDR-TB and TB/HIV) per year.

74. Finance 3 masters in public health during the first 3 years.

75. Finance 2 doctorates during the first 2 years.

For SDA 1.5.3. Human Resource Development (HRD)

Chosen indicator:

- Number of Detection Centres with personnel trained on tuberculosis-fighting activities out of the total number of Detection Centres

Target population

- *The entire population covered by the 24 PCLT*

Objective 2: Fight TB-HIV, and MDR-TB

SDA 2.1 Tuberculosis/HIV

With the support of previous Rounds 3, 7 and 8 of the Global Fund and other partners, the National AIDS Programme provides a complete package of HIV activities in 196 Health Zones where tuberculosis-fighting activities are already integrated.

This area is overseen through collaboration between the two programmes.

Bearing in mind the difficulties encountered in the implementation of activities in this particular area: - lack of availability of HIV inputs, screening tests and biological monitoring, lack of means for training service providers - the framework of collaboration between the NPT, the National AIDS Programme and partners will be consolidated by these periodic meetings.

This submission makes provision for tubercular sufferers in these 196 HZ to be tested for HIV and for an assessment to be made of their initial CD4 counts and counts after 6 months of treatment. Treatment with cotrimoxazole and ARVs is planned for in the Round 8 Global Fund National AIDS Programme submission.

The NPT is planning to train laboratory assistants to conduct manual CD4 counts at the Detection and Treatment Centres of these 196 HZ. The training of DCPI care providers is envisaged by the National AIDS Programme.

Following tuberculosis treatment, continuity of care will be ensured through the support of the National AIDS Programme, either at the same establishment or through referral to another nearby establishment.

2.1.4. Decrease in the prevalence of HIV/AIDS among tubercular patients
76. Supply the 196 HZ with light laboratory equipment for manual CD4 counting.
77. Provide the 196 HZ with HIV tests and consumables for tubercular sufferers.
78. Supply the 196 HZ with CD4 reagents and consumables for HIV+ tubercular sufferers.

For SDA 2.1: Tuberculosis/HIV
The following indicators have been chosen:
Number (%) of tuberculosis patients receiving HIV screening
Number (%) of tuberculosis patients receiving manual initial assessment and 6-month CD4 counts.
Target population
- *all tubercular sufferers in the 196 HZ*

SDA. 2.2.: MDR Tuberculosis: Prevent and treat MDR tuberculosis bacilli.

This submission will make possible an improvement in the care of MDR-TB sufferers (treatment and monitoring of patients) through the supply of second line medications, medication for side-effects and through an improvement in the working environment. This proposal will allow for care of:1) 3,400 patients in line with the recommendations of the latest GLC technical aid intervention; 2) payment of hospitalisation fees, transport fees and biological and clinical monitoring fees; 3) payment of transport costs re-inclusion of drop-outs and upkeep of contact. The NPT plans incentives for service providers to provide for the treatment of MDR patients. (SDA 1.5.3)

2.2.2. Second line anti-tuberculosis treatments
79. Supply 2,960 second line treatments for five years of which 560 will be to provide the remainder of treatments required for the first two years and 2,400 will be for the three final years: 700 in the third year, 800 in the fourth year and 900 in the fifth year.
2.2.3. Adverse effect medications
80. Supply medication for adverse effects to 3,400 patients over five years.
2.2.4. Re-inclusion of drop-outs and upkeep of contact
81. Organise visits for upkeep of contact and re-inclusion of drop-outs for five years
2.2.5. Support for the green light committee initiative
82. Contribute to the green light committee initiative for five years
2.2.6. Modernisation, refurbishment and building of infrastructures
83. Provide for refurbishment of 14 MDR-TB treatment facilities for control of infection for five years: 3 in the first year, 3 in the second year, 4 in the third year and 4 in the fourth year.
2.2.7. Treatment of MDR-TB patients
84. Provide for biological and clinical monitoring of 3,400 MDR-TB patients expected over the course of the five year period.
85. Pay the hospitalisation fees of 10% of the MDR-TB patients expected over the course of the 5-year period.

For SDA 2.2.: MDR Tuberculosis:

The following indicators have been chosen:
- *Number and % of MDR-tuberculosis cases reported (confirmed by bacteriology)*
- *Number and % successful treatment of MDR-tuberculosis cases*

Target population
- *All of the 3,400 MDR sufferers expected nationally between 2010 and 2014.*

SDA 2.3.2. Fighting infection
This submission will make it possible to improve the fight against infection by preventing the infection of care providing personnel, other hospitalised sufferers and domestic carers
This is intended to make provision for environmental measures for controlling infection by

improved airing of rooms, and individual protection measures involving the purchase of N95 masks and respirators.

2.3.2.2. Environmental measures

86. Provide for environmental infection-fighting measures through the purchase of 2 ventilators per establishment as they become involved in the activity.

2.3.2.3. Lung protection measures

87/1. Provide for individual protection measures for infection fighting through the purchase of 20,400 masks for the anticipated 340 hospitalised patients on the basis of 5 masks per week for 12 weeks of hospitalisation.

87/2. Provide for individual protection measures for infection fighting through the purchase of 176,800 masks for the 3,400 expected MDR-TB patients during out-patient treatment on the basis of 1 mask per week for 52 weeks.

88. Make provision for individual infection-fighting protection measures through the purchase of 176,800 respirators for personnel treating MDR-TB patients on the basis of 1 respirator per patient per week for 52 weeks.

SDA 2.3.2. Fighting infection

The following indicator has been chosen:

- *Number (%) of healthcare establishments implementing anti-infection measures in line with national directives*

Target population

- *The population and healthcare personnel in the 14 sites for treatment of MDR patients..*

Objective 3: Contribute to health system strengthening

SDA 3.2: Practical Approach to Lung Health or PAL

30 to 35% of general consultations with symptoms are associated with the most common lung diseases. Providing efficient standardised care to these sufferers will lead to increased detection of tuberculosis, and improvement in the health system through the provision of adequate care to sufferers which will have the added advantage of reducing costs and increasing the credibility of establishments in the eyes of the population. A status report examining this issue and a feasibility test for extension of the activity is provided for in this submission. This will be followed by training of healthcare providers in PAL (cf. SDA HRD).
A directives guide is to be created and distributed. Supply of medications and light equipment is planned for the designated establishments.

3.2.1. Activities at the national level

89. Produce status report and conduct feasibility study during the first year

3.2.2. Activities at the sub-national level

90. Supply 200 hospitals with PAL Kits and 10% with replacement kits during the first two years: 110 in the first year and 110 in the second year

91. Supply 200 hospitals with spirometers with 10% replacements: 110 in the first year and 110 in the second year.

92. Supply 200 hospitals with betamimetic medications and corticoid inhalers at a rate of 20 in the first year, 60 in the second year, 110 in the third, 160 in the fourth and 200 in the fifth year.

For SDA 3.2: PAL

The following indicator has been chosen:

- *Number and % of establishments conducting PAL activities*

Target population

The population covered by the 200 Hospitals planned for implementation of PAL (approximately 2,000,000 inhabitants)

Objective 4: Involve all care providers in the fight against TB

SDA 4.1/4.2.: All care providers: **(PPM/ ISTC)**

To improve the detection and treatment of tuberculosis cases, provision is made in this proposal for the involvement of all care providers. Denominational establishments play a major role in the fight against tuberculosis. This is less so for businesses, private for-profit establishments, and traditional healers. In order to involve all establishments in this fight, the focus will be on the formulation and implementation of a framework for collaboration in Kinshasa and in the provinces.

Activities at the national level

93. Organise a workshop in Kinshasa for formulating the standard terms of collaboration between private establishments, companies and the NPT in the first year.

4.1.2. Activities at the sub-national level

94. Organise a bimonthly meeting for each provincial coordinating centre during the 1st year and a yearly meeting for subsequent years.

For SDA 4.1/4.2.: All care providers

Chosen indicator:

- *Number and % of private establishments participating in DOTS activities / total anticipated number of private establishments*

Target population:

The population covered by the 120 Hospitals planned for implementation of DOTS (approximately 240,000 inhabitants)

Objective 5: Give tubercular sufferers and communities the capacity to act

Former sufferers and persons affected by or suffering from tuberculosis are organised into associations such as the Friends of Damien Clubs. These play a primordial role in the fight against tuberculosis in DRC through awareness raising.

In this way, a number of avenues will be used to disseminate key messages. Also planned is the production of a quarterly bulletin to raise awareness among care providers and civil society, the updating and production of communications material, translation of the patients' charter into local languages and its distribution, organisation of the world tuberculosis day, training of community relays and the provision of financial support to community organisations to supplement transport costs as an incentive.

SDA 5.1.: Awareness-raising, communications and social mobilisation, Representation, Patients charter for tuberculosis care

5.1.2. Awareness raising

95. Print 12,000 awareness-raising bulletins from the third year onwards (500 per PCLT per year).

96. Create an image box and distribute this to each TB Detection and Treatment Centre in the 3rd and 5th years.

97. Design new awareness-raising posters each year and distribute to TB Detection and

Treatment Centres from the third year onwards.
98. Create a new radio bulletin each year from the 3rd year onwards.
99. Create a new TV bulletin each year from the 3rd year onwards.
100. Play the radio bulletin on 24 local radios within each PCLT area from the 3rd year.
101. Broadcast the TV bulletins on the 11 provincial television channels from the 3rd year onwards.
102. Organise the World Tuberculosis Day in Kinshasa and in each PCLT each year.
103. Organise 10 awareness-raising sessions for media professionals in the 24 PCLTs at a rate of 2 sessions per coordinating centre for the five-year period.
104. Organise an annual awareness raising session for CBO leaders within each HZ for the five year period..
105. Organise an annual meeting of the network of anti-TB ambassadors within each PCLT and at the central level throughout the 5-year period.
5.1.5. Patients charter
106. Print and distribute patients' charter to each sufferer each year.

For SDA 5.1.: Awareness-raising and communications

The following indicators have been chosen:

- *Number of copies of the patients charter distributed*
- *Number (%) of individuals with an awareness of tuberculosis (means of contamination, symptoms, possibility of recovery etc.)*

Target population

- *The whole population covered by the NPT.*

SDA 5.2. Community care for tuberculosis

5.2.5. Incentives for community health workers 107. Provide financial support to community contacts and community-based organisations such as the former TB sufferers circle of friends at a rate of 200$ per TB Detection and Treatment Centre for 1,545 Centres each year.

For SDA 5.2. Community care

The following indicators have been chosen:

- *Number (%) of new tuberculosis patients with positive smear tests monitored/supervised by the community as a percentage of all notifications of new tuberculosis patients with positive smear tests (treatment commenced)*

Target population

- *The whole population covered by the NPT.*

Objective 6: Encourage and promote operational research

SDA 6.1.: Operational research

Operational research based on problems encountered in the tuberculosis programme will be conducted in collaboration with provincial coordination centres and university and research institutions. This proposal will support 15 research subjects during the five-year period and the operation of an ethics committee to support the programme.

6.1.1. Area of study and protocol
108. Carry out 3 research projects on tuberculosis epidemiology (Scope, distribution and trends

of MDR-TB in Kinshasa; Determinants of the high prevalence of TB in Malemba Nkulu; Analysis of causes of death of TB patients in the PCLTs affected by armed conflict).
109. Conduct 2 research projects on the rapid detection of TB cases using new diagnostic tools: (PCR and liquid medium. Contribution of new diagnostic tools in TB screening in adults and children)
110. Carry out 3 research projects on tuberculosis treatments (Factors governing failure/success of MDR treatment in DRC; multicentre study on TB treatment drop-out factors in DRC; Support of community DOTS-Plus in patient care in DRC)
111. Conduct 1 one research project in paediatric tuberculosis diagnosis (Evaluation of scoring system used in paediatric TB screening in Kinshasa)
112. Conduct 2 research projects on TB-HIV co-infection (Implementation of HIV activities in rural Detection Centres; Impact of ARVs on TB treatment in North Kivu)
113. Conduct 2 research projects on integration of the private sector into the fight against tuberculosis (Survey on involvement of for-profit private establishments in the fight against TB; costs and benefits of TB care provision by the professional and profit-making private sector)
114 – 115. Conduct 2 research projects on social mobilisation (Survey on the impact of social mobilisation actions in the fight against TB; Contribution of Friends of Damien Clubs in the detection and treatment of TB in the DRC).

For SDA 6.1.: Operational research

The chosen indicators are:

- *Existence of an operational research programme (yes/no)*
- *Number of completed operational research studies with results disseminated by the global tuberculosis health education system.*

Target population: *All of the 24 PCLTs covered by the Programme.*

1. The PR / Ministry of Health will lead on the following DSA:

Objective 1: Pursue extension and improvement of DOTS quality strategy

1.2.: Improvement of diagnosis:
Purchase of microscopes, culture equipment and reagents for molecular biology test laboratories, EQA and ATS.
1.4 Purchase of first line tuberculosis treatments: Tenders, purchases, and transport to the entry-points of the country.
1.5.1 Monitoring and evaluation, measurement of results: surveys, refresher workshops and formulation of directives, revision, production and evaluation of supports, purchase of epidemiological data management software,
1.5.2. Programme management and supervision: task force meetings, annual meetings of doctors and lab technicians from the PCLT, all of the steering committee and ethics committee meetings, workshops for creating and producing guides, monitoring and supervision visits by the central level focusing for the intermediate levels, transportation of all purchases from abroad to the port of entry in DRC.
1.5.3. Development of human resources: Organisation of all training sessions, placements, national and international technical assistance, financing of masters and doctorates and participation in international workshops,

Objective 2: Fight against TB-HIV co-infection and MDR-TB
2.1. TB/HIV Collaboration: Purchase of HIV tests, and laboratory reagents to point of entry into the country.
2.2 . MDR-Tuberculosis: purchase of second line medications and hospitalisation and clinical

and biological monitoring, adverse effect medications, contribution to green light committee initiative.
2.3.2. Fight infection: MDR protection equipment

Objective 3: Contribute to health system strengthening
3.2 Practical approach to Lung Health /PAL: status report on feasibility test, supply of PAL kits and medications.

Objective 4: Involve all care providers (PPM); international standards (ISTC)
4.1/4.2 Bring in all care providers, PPM/ISTC: workshops on standard terms and collaboration meetings.

Objective 5: Tuberculosis sufferers and Communities / Capacity to act
5.1 Creation of image boxes, radio bulletins, TV bulletins; Awareness-raising, communications and social mobilisation: educational tools, media, awareness-raising costs, Technical Medical Journals, press,

Objective 6: Encourage and promote operational research
6.1.: Operational research Conducting of studies (supported by the NPT research unit that coordinates the conducting of research)

2. The PR/CARITAS-CONGO will lead on the following SDA

Objective 1: Pursue extension and improvement of DOTS quality strategy
1.2.: IMPROVEMENT OF DIAGNOSIS: maintenance, purchase of radio equipment, other equipment and consumables, purchase of bicycles, stockpiling, refurbishment of culture laboratory buildings, transport of samples, refurbishment of Bunia microscopy laboratory.
1.3 Patient support: assistance for bedridden patients, food parcels
1.4 Management of first line TB treatments, transport from DRC port of entry to TB Detection and Treatment Centres, stockpiling, insurance and stock management
1.5.1. Monitoring and evaluation: data validation meetings
1.5.2 Management and supervision of the programme: Equipping with IT tools for management of MDR-TB data, PCLT supervision visits by the PCLT at the peripheral level, purchase of vehicles and boats, maintenance and fuel, distribution of inputs from the port of entry to HZs, operating costs and costs of communications , insurance and maintenance.
1.5.3. Human Resource Development (HRD) Staff incentives and training of community relays.

Objective 2: Fight against TB-HIV co-infection, MDR-TB and other challenges
2.1 Collaboration in the tuberculosis-HIV field: Distribution & Supply of HZs with light laboratory equipment, HIV tests, and CD4 reagents.
2.2 .MDR-Tuberculosis: Transport of second line medications, refurbishment of MDR-TB care facilities, re-inclusion of drop-outs/ patient aid/food parcels.
2.3.2. Fighting infection: Purchase of ventilators and distribution of masks and respirators, refurbishment of consultation/in-patient areas.

Objective 5: Tuberculosis sufferers and Communities
5.1. Organisation of awareness-raising sessions, printing of bulletins and patients charter and airing of TV and radio bulletins.
5.2. Community care for tuberculosis: support for community-based organisations and organisations for former tubercular sufferers.

3. The Main Sub-recipient is the NPT

The NPT is the contracting authority for this submission and specialised Ministry of Health

programme and will be responsible for the technical support of all Sub-sub-recipients, for certification of results and for implementing some specific SDA as in Rounds 5 and 6 that are currently underway. Specifically it will be in charge of the field of detection improvement which is very specific to it, the field of Research with a view to orienting studies in order to capitalise on results, management of all new fields (PPM/PAL) and ensuing social mobilisation.

4. Sub-sub-recipients are the traditional Partners of the NPT

All of the Programme partners, who are from civil society, have been supporting the programme from the beginning and who possess expertise in the management of PCLTs, are sub-sub-recipients in their respective fields of action. In fact the Damien Initiative supports and finances 13 PCLTs, TLM/The Leprosy Mission supports 10 PCLTs, and UBS (The Swedish Baptists Union) supports 1 PCLT in partnership with the Damien Initiative. These ensure the execution of activities through provincial coordination teams.
The Congo National League against Leprosy and Tuberculosis (LNAC) and the Fiends of Damien Clubs will take charge respectively for social mobilisation and for the promotion of associations of former TB sufferers under the auspices of the NPT's social mobilisation unit.
All sub-sub-recipients, in partnership with the NPT and the PCLTs concerned, are responsible for: implementing the project in line with signed agreements, to report on their management of the project to PRs and to report on results to the NPT.

Coordination of PRs will be carried out by the "PR coordination commission" as described in point 4.9.5

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

TWO PAGES MAXIMUM

- The proposal lacks clarity and is technically unsound.

This proposal has been reworked to be clearer and more comprehensible: the implementation strategy in point 4.5.1 has been presented in more detail in relation to DSAs. Also it addresses the various questions raised by the TRP by clearly setting out the range activities or interventions that are fully linked to the specific objectives for fighting TB. It sets out the framework for collaboration existing between the National AIDS Programme and the NPT and the activities that are carried out jointly. The way in which calculations are set out in the budget provides a better description of planned activities in relation to the SDA and the granting of incentives to care providers at every level.

- It refers to activities financed through previous Global Fund Rounds but does not provide information relating to achievements.

This submission has taken into account the foregoing observation, details of which may be found in point 4.6.1 of the form appended to this submission.

- Major system weaknesses such as the procurement and distribution systems for first and second line drugs are described but are not addressed in the current proposal.

The weaknesses identified in the supply and distribution of medication were partially resolved in the Round 6 submission which provided for the refurbishment and equipping of the country's two entry ports, the recruitment of a technical assistance unit and the implementation of a computerised medication management system. After the long delivery delay which depleted reserve stocks at the level of the PCLTs and

which resulted in interruptions to supply of stores at some establishments, this submission makes provision for the replenishment of stores at the central and intermediate levels and for the payment of costs for transport of medication to the Detection and Treatment Centres.

- There is a substantial investment in the provision of ARVs without describing how personnel will be trained for VCT and how referral links to the NAP will be established. Since the ARV commodity component will serve the same population as the Round 8 HIV/AIDS proposal, it would be interesting to see the links between the two programs. However, the proposal's narrative is unclear in this regard.

With the support of previous Rounds 3, 7 and 8 of the Global Fund and other partners, the National AIDS Programme provides a complete package of HIV activities in 196 Health Zones where tuberculosis-fighting activities are already integrated. This area is a product of collaboration between the two programmes. Given the difficulties encountered in implementing activities for this field, a framework for collaboration exists between the NPT and the National AIDS Programme, under the management of the Health Ministry's disease fighting division, which will be backed up by periodic meetings. This submission provides for tubercular patients in 196 HZ to be tested for HIV, and put on treatment (cotrimoxazole and ARV) in line with national directives. Following tuberculosis treatment, continuity of care will be ensured by the support of the National AIDS Programme, either within the same establishment or through referral to nearby establishments. DCPI training of healthcare providers will be carried out jointly with the National AIDS Programme.

- The criteria used for the selection of targeted health zones are unclear and there is no description of how NGO/FBO managed health zones operate and benefit from the activities of the current proposal. This also applies to section 4B on HSS cross-cutting interventions.

With previous financing, the NPT covers all 515 HZ for the DOT'S strategy. There are on average 3 Detection and Treatment Centres per HZ belonging to the State, religious denominations or private establishments. With the support of previous Rounds 3, 7 and 8 of the Global Fund and other partners, the National AIDS Programme provides a complete package of HIV activities in 196 Health Zones where tuberculosis-fighting activities are already integrated. In the HZ, the support of the Global Fund complements those of other partners/NGOs. Incentives are given to all personnel (in both the public and the private sector) on the basis of performance criteria. In the drafting of the Round 9 proposal, this latter was harmonised with the HSS component, providing for the planning and budgeting of supervision and bonuses at the peripheral level.

- The size of the population groups target is not mentioned.

The population of these 196 HZ is estimated at 26,466,821 inhabitants.
The anticipated targets for TB-HIV are 33,160 co infected tubercular sufferers out of the 111,057 identified in the strategic plan.
The target populations are set out in point 4.5.1. for each DSA.

- Contributions of other technical agencies/NGOs/FBO are only mentioned in financial terms, but not in terms of health service delivery.

The fields of intervention of other NPT partners are set out in annex 12.

- Impact/outcome indicators have no baseline data and are only provided for Year 1 and Year 2.

The indicators have had their starting baselines added to them for all 5 years of the proposal (see annex A)

- Part 4.5.1 is a three page summary containing only major interventions without a break down by SDAs and detailed activities.

Section 4.5.1 has been consolidated and further broken down with activities by SDA

and by objective over a dozen pages.

- The budget is not related to objectives/ SDAs/ activities.

The budget has been revised and brought into line with the SDA and related activities.

- The budget organization and calculations are unclear. For instance in section 5.4 technical and management assistance amounts to US$ 400,230 however in the detailed budget this figure for SDA 1 is US$ 500,000. Likewise, for patient support in section 5.3, costs by objective and SDA are US$ 8,628,317 (page 49 of budget) but in section 5.4 the budget item is US$ 10,520,935.

The lay-out and calculation bases for the budget have been revised; the calculation bases are derived from more explicit hypotheses and are therefore clearer.

- The procurement management costs quoted in the budget seem excessive (25 percent of total procurement). These figures should also be broken down into the individual cost components, US$ 7,984,437 or US$ 6,117,445 (depending on the budget one consults).

Considering the immensity of the national territory and taking into account the dilapidated condition of road infrastructures the mode of transport used is essentially air transport. In fact, the NPT covers all 515 of the country's Health Zones. From the experience obtained from rounds 5 and 6 by the PR, the costs of transport and insurance to transport medication, reagents and other laboratory inputs, equipment (laboratory and logistical), and other consumables from the supplier to the two entry ports (Kinshasa and Goma) are estimated at 7% of the purchase cost. Transportation from the ports of entry to the 1,545 TB Detection and Treatment Centres via the 24 PCLTs is estimated at 18%; which amounts to a total of 25% of the purchase price.

- Principal Recipients' and Sub- recipients' management costs also seem excessive (15 percent of total costs) at US$ 20,651,393.

Within the context of the Round 9 submission, PR and sub-recipient management costs have been adapted and harmonised across all components. According to CCM recommendations, public PR management costs have been assessed on the basis of real costs for previous years under management by the UNDP. For the Tuberculosis component this figure is $ 1,681,223 for 5 years. Civil society PR management costs (new PR) have been budgeted at 8% of the total costs for activities that it will generate, i.e. $ 3,948,345 for the 5-year period. Each sub-beneficiary will use 5% of management costs, or $ 5,861,868; total management costs will be $11,491,437.

- Regarding human resource incentives, there does not seem to be a common strategy between partners and the Government. Staff bonuses at National Level come to US$ 1,863,600 for the duration of the grant (for instance the NTP director 50 percent Global Fund bonus is US$ 24,000 and this applies to the whole Global Fund-managed system such as drivers with a 50 percent bonus would receive US$ 3,000). For all of the other levels it is also 50 percent except for the health centre personnel where the Global Fund is expected to cover 100 percent of the bonuses. For the other levels the figure comes to US$ 16,777,000. Apparently, 'development partners' have agreed to personnel bonuses, top ups, and generous training/per diem allowances with no apparent official strategic document in which the bonus system for the whole country is set out and how development partners contribute to it.

The table for personnel incentives has been revised and adapted based on official benchmarks and harmonisation with the National AIDS Programme for Round 8. Round 5 NPT had made provision for 50% of incentives for a restricted number of personnel members (16 workers) whilst the other 50% were provided for by other partners (Damien Initiative, CTB, etc.) Given its workload and requirements, the NPT numbers 51 personnel members not currently provided for by the other partners. The bridge from round 5 is beginning with an improvement in line with the increase as well as the consolidated phases of R5 and R6. R9 will pay the gap from R5/6 in the first two years and in full in the final three years only for central level personnel members and for a some personnel at the intermediate level (11 out of 24 PCLTs), with the peripheral level being part of a cross-cutting component covered by the HSS

proposal.

- This whole bonus section is entitled 'Development of Human Resources'. If Round 5 and 6 are still operational (Round 6 is until 2012) why does Round 8 include this extra bonus from the start? In the narrative there is a symbolic bonus for the health centers across all personnel from Round 5, there is no mention of what arrangements were done in Round 6. The total budget for bonuses is US$ 15,713,160 (objectives 1.5.3 and 2.2) or US$ 15,358,332 in the human resource budget line of the summary detailed budget in Section 5.4.

Rounds 5 and 6 currently underway make provision for staff bonuses within which central level personnel numbers have increased from 16 to 51 following the implementation of new initiatives pursuant to the Programme's strategic development plan. This has resulted in the depletion of planned incentives. Consequently there is a need to make provision for bonuses from the start of Round 9 for readjustment.

Organisation of the calculation bases and budgetary lines have been reviewed in this submission.

The payment of bonuses for operational level care providers has been put into the health system strengthening proposal.

RESPONSES TO TRP OBSERVATIONS ON ROUND 8 HSS COMPONENT

The CCM-DRC analysed the TRP observations on the HSS component submitted in round 8 and realised that these observations are all founded and commends the TRP for its studious examination of the proposal and the pertinence of its observations. Consequently, it was resolved that RDC's HSS proposal for round 9 should be entirely focused on correcting the weaknesses of the round 8 – HSS proposal. Set out below are our responses to the 7 TRB observations.

- **Observation 1:** "*Indicators do not reflect all of the objectives".*

In response to this observation, new indicators are provided in appendix A -HSS. The CCM has redefined its indicators for impact, effect and results taking into account the Directives of the Global Fund and the objectives set by the proposal. The indicators currently defined in annex A – HSS, were also selected on the basis of feasibility criteria (or ease of data collection on the ground and in the current context of DRC).

- **Observation 2:** "*Duplication of activities with the disease specific intervention (see the M&E component in the tuberculosis proposal 4.8.3)".*

Clearly there was indeed duplication with the tuberculosis component concerning activity 4.8.3. To resolve this issue, during the preparation of this round 9 HSS proposal, the CCM decided that certain cross-cutting activities such as M&E, Supervision, Bonus incentives for human resources at the operations level and six-monthly/quarterly reviews at the provincial level should be budgeted for within the HSS proposal. Although the disease component may allude to this activity in the programme description, it does not allocate a budget for it.

However, bearing in mind the specific nature of certain activities associated with each component, such as 'specialised' supervision of the HZ by the next level of the hierarchy (province) or of provincial coordinating centre monitoring projects (for HIV, Tuberculosis and Malaria) by the national level, a specific budget may be allocated by the diseases component. Where this is the case, the activity is not budgeted in the HSS proposal.

In order to ensure effective implementation of this practicality which is intended to eliminate duplication, all components met several times at the CCM Technical Secretariat to discuss and reach a consensus on the subject of horizontal activities. Consequently, the majority of those activities included in this proposal are further innovations for each intervention. All links were created with cross-cutting activities in relation to the three components and existing financing.

- **Observation 3: '**It is unclear how substantial existing funding for improvement of the HMIS system of other donors (US$ 23,187,831) in 397 Health Zones is linked to this component. The applicant notes Global Fund support over 2008-2013 amounting to US$ 15,880,804 for this element. It is unclear how the Round 8 proposal builds upon these activities supported from the previous Rounds.

It is true that in the round 8 submission, we did not provide clear explanations on the links between existing financing and financing requested in round 8. The CCM took careful note of this observation and undertook to provide, this time around, all explanations on the issue of existing links with other financing associated with intervention 1. In line with Global Fund directives in relation to round 9, a further point has been added to the description of each intervention. This is point **a.5**, which sets out links with existing financing.

In response to this observation, it may be seen that:

- explanations have been provided in respect of each funding provider and the amount specified in box (c) of each intervention. As a general rule, the other partners support the consolidation of the NHIS in 100 Health Zones (ZS) that are already operational. They play a role to differing degrees in the other HZ to support M&E activities. The total number of HZ in which other partners play a role is not **more** than 397 HZ. In fact it is 259 HZ because some HZ are supported by two or more partners. The list of HZ and their partners supporting development is provided in annex 3.

- The choice of HZ for intervention 1 excludes the 100 HZ currently with a functioning NHIS and the 119 HZ from the round 8 Malaria component for which the Global Fund has approved support to the NHIS for integration of the NHIS regulatory framework.

-

- If we remove these HZ, totalling 219 from the 515 HZ in the country as a whole, a further 296 remain to be covered by intervention 1. The same applies for existing financing from the Global Fund which has previously focussed more squarely on component-specific M&E activities.

-

- Taking into account financing acquired from the Round 8 Malaria component, the activities targeted for intervention 1 are innovations compared with those of previous financing. Detailed explanations are provided in point **a.5.** of intervention 1.

- **Observation 4: '**The same applies for intervention 2 (which concerns 260 health zones have been supported by other donors) and intervention 3 (which includes 244 health zones). As noted by the applicant, existing Global Fund grants of up to US$ 46,130,450 have been allocated for this same purpose and it is unclear how this Round 8 activity builds upon previous Rounds'.

On the basis of the observation made about intervention 2 of round 8 which related to 259 HZ (and not 260), the CCM has changed the target and requested support for 256 HZ for round 9 HSS intervention 2. Given that all partners supporting development have always focussed on 259 HZ, in order to ensure equity and to improve healthcare cover, 256 HZ have been selected. The links with existing financing are set out in point a.5. of intervention 2.

Following thorough analysis of the activities for which a request for support has been formulated for intervention 3, the CCM did not make a submission for this intervention in round 9. The CCM recognised that no sustainable results can be obtained without the community involvement. The 2008 annual report by the UNDP/Global Fund, appended in annex 10, reveal that the majority of indicators for this intervention show an increase and have even exceeded targets (for example: Percentage of institutional and community leaders reached by representation activities/HIV component was 120% in 2008). It has therefore been decided that community activities and Civil Society Organisations be written into component-specific proposals.

- **Observation 5**: 'In intervention 3 there seems to be a duplication of the supervision. Global Fund support for this intervention amounts to US$ 14,433,324 (from 2008-2013) and it is unclear how this current activity builds upon previous Rounds'.

There was indeed duplication of supervision activity in intervention 3 and HSS intervention 1 for round 8. Given that the CCM will no longer be submitting for intervention 3, this duplication will no longer arise. In round 9, supervision is mentioned in intervention 2 as a cross-cutting activity and is not treated again in intervention 1. This HSS proposal is focussed on 'integrated supervision', not issue-specific supervision. It concerns the operational level. Component-specific supervision of the provinces by the national level and in turn of the HZ by the provinces, is budgeted for by the disease components. The links with existing financing are set out in point **a.5**. of intervention 2.

- **Observation 6: '**The M&E component introduces the NHIS framework in 86 health zones without any explanation of what this activity entails and how it is linked to diseases other than TB/HIV/Malaria.

During round 8, explanations concerning integration of the NHIS regulatory framework in the 86

HZ were not provided in the proposal. This time, the regulatory framework that is the foundation of intervention 1 is described in point **a.1**. of this latter. The NHIS regulatory framework is a policy and strategy document that clearly sets out the new organisation of the NHIS in DRC and the minimum operating conditions of the Health Information System at all three levels of the healthcare pyramid. The activities developed in point **a.4 provide a response** to the concerns raised by the TRP.

The objective pursued is to contribute to health system strengthening through the provision of high-quality healthcare information enabling monitoring, evaluation and planning of the implementation of interventions to provide better healthcare cover. By the end of this intervention, the issue of completeness and timeliness of the reports, which was one of the major challenges facing DRC according to the 2008 annual UNDP/Global Fund report, will largely be resolved following the use of new IT and Communications technologies that are the object of intervention 1.

- **Observation 7: '**The targeted health zones (259) are the same for the other Global Fund Rounds (Round 3, 5 and 6)':
  - i. It is unacceptable to have indicators for these same health zones where the number of participating zones in monitoring all indicators in accordance with national directions is 9 in the first quarter and 37 in the second quarter of Year 1.
  - ii. Round 8 focuses *exclusively* on these same zones (those which have received two Rounds of Global Fund grants).
  - iii. Human resources in these health zones have received both a huge amount of training and salary top-ups and financial compensation, while the other 256 zones do not receive either of the above.

In response to this observation, the following measures have been taken in preparing this HSS/round 9 proposal:

(i) Development of the indicator relating to the number of HZ submitting complete and timely reports out of all public health management indicators taken as a whole has been reviewed. Firstly, the indicator has been redefined and broken down into two parts to facilitate data collection on the ground. We will be monitoring the number of HZ submitting **complete reports** on the one hand and on the other hand the number of those submitting their reports **on time.** These two indicators will allow us to measure the effect of intervention 1. Their revision takes into account support to be provided to target HZs in the light of the spectacular results already obtained in 100 HZ that have implemented the NHIS regulatory framework with the support of the other partners.

(ii) The CCM recognises that round 8 focussed on the 259 HZ that had already benefited from financing from previous rounds of the Global Fund and even from other partners. For round 9, the proposal has set out in advance the HZ selection criteria in relation to each intervention. On the basis of this observation, the 256 other HZ have been targeted for intervention 2 and 296 HZ for intervention 1. Links with other financing have also been set out in the description.

(iii) The CCM has taken into account this observation in our round 9 submission. As a consequence, for human resources, the bonus incentives are to be paid at the operational level in 256 HZ and not in the 259 HZ proposed in round 8. Links with other existing financing have also been set out in the activity description, particularly with the Tuberculosis component and other funders.

In conclusion, the CCM would like once again to commend the round 8 TRP for the pertinence of its observations which have made it possible to improve this round 9 HSS proposal.

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

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While carrying out the activities of the 2nd and 5th Round, the Program was not able to reach its goals for Tuberculosis/HIV activities because the submission of the HIV/AIDS component had not been selected in the same Round, which led to a major lack of input for these activities. This is why the current project includes the items of co-infection management only in health zones supported by the PNLS in rounds 3, 7 and 8. The results of the TB/HIV pilot project with the Union have been capitalized in order to reproduce this model in the 196 HZs covered by the PNLS, i.e. testing all tuberculosis-infected individuals for HIV. Co-infected patients will be given cotrimoxazole prophylactic treatment and will benefit from manual CD4 counting (dynabeads) in the HSTCs and FACSCount/Calibur counting in GRHs; those found to be eligible will be given ART. In addition, during the 5th Round, a symbolic incentive was given to the health centers and distributed among all the personnel. This may also be responsible for the low detection performance. Community relays, which are an asset, could not be efficient because of the volunteer status in an already poor community. The incentive for these personnel is budgeted in common with the HSR component. Delays in the disbursement of funds due to the lengthy procedures of the main previous recipient have often resulted in the deferral of activities, which also led the Program to change PR or even present 2 PRs in order to reduce the risk of a slack period.

The fact that patients' financial problems were not taken into account in previous rounds 5 and 6 was corrected in the present submission via support for these patients, especially those that are co-infected and MDR, as well as taking into account side effects in such patients.

The limits diagnostic centers have displayed in providing effective coverage of distant populations have been readjusted by taking into account the needs of numerous health centers and certain private clinics nearby to have them actually participate in the suspicion, orientation, detection and patient management process.

Finally, the results of the KAP investigations led by the Kinshasa School of Public Health have served to rectify the messages for the sensitization and mobilization of populations.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available tuberculosis diagnosis treatment and care and support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the response between these key population groups).*

TWO PAGES MAXIMUM

The Program data for the period 1996 to 2007 relative to lung tuberculosis patients with positive microscopy shows an average ratio of 1.1 in favor of the male sex. On the other hand, detailed analysis points to a ratio of 0.7 and 0.9 in favor of the female sex for the 0 to 14 and 15 to 24 age groups respectively. There are more young girls in these age groups.

Men clearly form the majority from the age of 35 onward. A future study should elucidate the reason for this trend.

With **a ratio of 1.1**, there is apparently no discrimination in the offer of services for men and women.

	AVERAGE MALE/FEMALE RATIO OF PTB+ PATIENTS FROM 1996 to 2007 in the DR

	OF CONGO							
AGE (years)	0-14	15-24	25-34	35-44	45-54	55-64	65 and over	TOTAL
1996	0.8	0.9	1.1	1.3	1.4	1.4	1.9	1.2
1997	0.8	1.0	1.1	1.3	1.4	1.6	1.8	1.2
1998	0.7	0.9	1.1	1.3	1.5	1.4	1.9	1.1
1999	0.7	0.9	1.2	1.3	1.3	1.5	2.1	1.2
2000	0.7	0.9	1.1	1.3	1.5	1.5	1.7	1.1
2001	0.7	0.9	1.2	1.3	1.4	1.3	1.5	1.2
2002	0.7	0.9	1.2	1.3	1.4	1.3	1.7	1.2
2003	0.7	0.9	1.1	1.3	1.3	1.3	1.8	1.1
2004	0.7	0.9	1.1	1.3	1.3	1.3	1.7	1.1
2005	0.8	0.9	1.2	1.3	1.3	1.3	1.6	1.1
2006	0.7	0.9	1.1	1.3	1.3	1.3	1.5	1.1
2007	0.7	0.9	1.1	1.3	1.3	1.2	1.6	1.1
Average over 12 years	0.7	0.9	1.1	1.3	1.4	1.4	1.7	1.1

In terms of access to care, **rural populations** have to travel large distances to be diagnosed. For this reason, health treatment centers (HTCs) that are the closest to these populations will take care of collecting and shipping samples. They will benefit (in this submission) from support in the form of bicycles, equipment and other incentives to facilitate the transport of slides to diagnostic centers and the shipping of medications from centers for community-based treatment.

With respect to **the main populations affected**, the Program has organized the management of tuberculosis patients in **prison settings** by the prison medical services. However, there are a number of constraints to get them housed alone in suitable cells due to prison overpopulation. A plea will have to be made at the highest level in order to equip cells for tuberculosis patients and other contagious patients. A status report will also need to be made following an investigation.

The Congo Republic is full of war**-displaced populations and refugees**, particularly in the East of the country. A special service will need to be organized for these populations by making relevant care structures able to serve as treatment centers and collect samples for diagnosis as described above. The same applies to **mine diggers and nomad pygmies**, who are distributed across several provinces in the country and for who the proposition is to form community relays among peers in order to bring diagnosis and treatment closer together.

Good collaboration exists with the medical services of **the Army and Police**, who have integrated tuberculosis control activities within their health facilities. However, this is more often the case in large cities. An effort needs to be made for all military and police barracks to have the same facilities.

Sexual minorities exist but do not reveal themselves in public in the DR of Congo. They are probably included among the patients of the Program just like other patients, without discrimination, given that the message conveyed in the general population is that tuberculosis is a curable disease like any other, for which free treatment is available.

4.5.5. Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

The strategy that the country proposes to attenuate the non intentional consequences of the specific approach to tuberculosis is the **HSRS**. Indeed, **the Bamako initiative** had recommended charging for health expenses and the DR of Congo had adopted at the onset (1980) the primary health care policy singled out at Alma Ata.

However, faced with the lack of antituberculosis medication when the program had just adopted the short-scheme rifampicin treatment and the country was having problems due to the war, the Ministry of Public Health introduced a request for medication support from GDF, who offered help provided the **care was given free,** leading the Ministry to choose this approach in **2002** with the result that the activities were disarticulated. Thus, tuberculosis patients stopped paying while other patients paid for their health care.

The lack of income for health facilities in the self-funding context has led to a drop in incentive among health care personnel. In order to correct this, the program had at the time requested funding from implementation partners to compensate this lack of income. This is how symbolic bonuses for personnel appeared in the health system, via tuberculosis management facilities, thus generating discontent among other health care providers.

With the **strategy of health system reinforcement** advocated by the Ministry of Public Health, this situation will have to disappear because the financial support requested to motivate personnel will from now on be pooled in a (**basket fund**) and redistributed among all the agents of the facility.

The same is true for the means made available for peripheral supervision at the intermediate level of Coordination offices; with the reinforcement strategy, such means will gradually be pooled in the basket fund so as to allow provincial supervisor teams (PST) and their leprosy and tuberculosis coordinating doctors to operate harmoniously and on an integrative basis.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 or Round 8 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

BETWEEN 2 AND 4 PAGES SEE APPENDIX N°13

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

The tuberculosis program has benefited for a number of years from permanent support from its implementation partners, the main current partners being Action Damien, the Leprosy Mission, the American Leprosy Mission and the Baptist Union of Sweden, and technical support partners including WHO, UICTMR, USAID, etc. Their support is directly oriented towards buying medication (10% of antituberculosis medication) and operational support for coordination in the provinces, which is supported primarily.

Each partner informs the program about the amount budgeted for implementation. However, forecasts are not always given for the same period of time. This is why in this project, the same amount is applied to years for which partners have not yet scheduled or approved the budget.

The provisional table is provided here as an indication of the way in which partners other than the Global Fund can assist the program by 2014.

	2006	2007	2008	2009	2010	2011	2012	2013	2014
National sources	**2 248 300**	**2 481 800**	**3 564 432**	**2 812 481**	**2 812 481**	**2 812 481**	**2 812 481**	**2 812 481**	**2 812 481**
C1 external resources (*Action Damien /AD with DGCD co-funding*)	2 690 183	2 760 450	3 073 006	3 073 006	3 073 006	3 073 006	3 073 006	3 073 006	3 073 006
C2 external resources (*The Leprosy Mission TLM*)	730 561	949 243	989 578	989 578	989 578	989 578	989 578	989 578	989 578
C3 external resources (*USAID*, UNION)	301 973	504 115	800 000	2 000 000	-	-	-	-	-
C4 external resources (European *Commission*)	342 355	342 355	342 355	516 334	516 334	516 334	-	-	-
C5 external resources (*French Development Agency - AFD*)	-	-	73 085	158 600	96 410	-	-	-	-
C6 external resources (Korean *Cooperation*)	-	-	-	1 352 500	-	-	-	-	-
C7 external resources (Baptist Union of Sweden *BUS*)	-	113 125	185 225	144 625	161 425	161 425	161 425	161 425	161 425
C8 external resources (World Health *Organization WHO*)	-	300 000		300 000		300 000		300 000	
Total External resources	**4 065 072**	**4 969 288**	**5 463 249**	**5 182 143**	**4 836 753**	**5 040 343**	**4 224 009**	**4 524 009**	**4 224 009**
Total GF resources	**503 133**	**6 683 911**	**13 878 589**	**10 885 399**	**7 750 497**	**8 071 860**	**1 227 825**	**-**	**-**

This submission will complement the activities initiated in the form of projects with the support of the other partners in the 515 health zones.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 9 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

ONE PAGE MAXIMUM

The private sector participates in these tuberculosis control activities via a number of large-scale para-state private companies. However, financial contributions are difficult to obtain since they have health structures to manage all company patients, including tuberculosis patients (this is the case for ONATRA, Banque Centrale du Congo, SNEL, Cohydro, Sucrière de Kwilu-Ngongo, Bralima, etc.).

Few of them are also open to the public at large, particularly in the Katanga province (Gecamines and SNCC for instance). Their non financial contribution focuses on diagnosis, the treatment of patients or even hospitalization. This management is free of charge with program drugs but companies pay for their personnel. The latter has been trained by the program in compliance with the norms; it is both supervised and evaluated. And the results are encouraging.

Expansion of this collaboration experience is desirable in the next 5 years; indeed, the object of this mission is to broaden tuberculosis management to all patients in the surrounding area so that it is no longer limited to company employees.

Integration of profit-making private structures will be examined with the use of incentives to cover the lack of income. A collaborative agreement will be signed to consolidate the partnership.

In 2006, analysis of the centers participating in the Program screening and management of patients revealed that the private sector represents more or less half (49.6%) of the HSTCs that manage tuberculosis across the country. Out of the 558 HSTCs participating in tuberculosis control in this sector, denominational national health facilities ensure the management of 486 HSTCs, profit-making private facilities that of 34 HSTCs and companies that of 38 HSTCs.

Thus, the present submission has scheduled the extension of participation with at least 5 extra private facilities per coordination, i.e. a total of 120 facilities to be integrated by 2013.

Altogether, profit-making private and company health centers currently represent **6%** of all the facilities involved in the management of tuberculosis patients in the DR of Congo.

In addition, in view of the population's recourse to alternative medicine with the explosion of self-medication, traditional healers and exorcism ministers, the PPM strategy intends to organize encounters and workshops with these various social categories in view of getting them involved to direct tuberculosis patients toward health centers.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*➔	Data not available

Contribution Value (in USD or EURO)

Refer to the Round 9 Guidelines for examples

Organization Name	**Contribution Description** (*in words*)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach contact, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved tuberculosis service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

ONE PAGE MAXIMUM

In the present submission, capacity reinforcement occupies a privileged position both for governmental structures (at all levels, whether central, intermediate or peripheral) and nongovernmental facilities (private facilities, community based organizations, associations of ex-tuberculosis patients).

The issue for tuberculosis is to improve and achieve earlier detection via the training, sensitization and involvement of everyone as well as the expansion of community DOTS in order to maintain good recovery results. Data analysis and validation meetings, briefing and advocacy meetings, the supervision of ex-patients and the training of community relays, logistical equipment and means of transport are elements that can reinforce capacities and improve the competence of actors, in addition to motivation incentives.

Capacity reinforcement will also have more impact on the challenge posed by multiresistant tuberculosis and TB/HIV co-infection since these patients are often the ones that are without means yet undergo the longest treatment, requiring home visits and psychosocial support in addition to counseling.

Finally, the supervision of both public and private facilities can make them adhere and contribute to the overall reinforcement and development of the public system.

The support of community-based organizations of ex- and new patients is also a guarantee of community system reinforcement.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

ONE PAGE MAXIMUM

As mentioned above, the Government of the DR of Congo has chosen a Health System Reinforcement Strategy since 2006. The latter was taken up in the Growth and Poverty Reduction Strategy Paper (GPRSP) in 2006, which defines the country's general policy.

As a single planning framework for development, the GPRSP has chosen to be modest in scope and to be part of the short and middle-term objectives (2007-2009) as well as the Millennium Objectives for Development (MOD). The tuberculosis control as such is seen as contributing to achieve the Millennium Objectives. The present proposition, which in addition to tuberculosis, involves action against TB/HIV co-infection, therefore finds its rightful place in the framework of broader development. The Government of the DR of Congo has therefore included health among the beneficiaries of HIPC funds, but little attention has been given to the action against tuberculosis so far.

Following visits from international experts, a plea has been addressed to the Ministry of Public Health.

5.8 Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national tuberculosis outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

ONE PAGE MAXIMUM

As part of the capacity reinforcement of the Central Unit of the Program with a multivalent team of national and international experts, the periodic and regular evaluations of the Union and the sporadic evaluations of USAID (FHI), the Green Light Committee, the Global Fund (M&E tools), WHO, GDF and financial audits (NEX-DEX, DELOITTE, KPMG) have led to the following observations:

a) Strengths :

1. Follow-up
   - •Existence of a Program Monitoring and Evaluation Plan;
   - •Existence of tools to collect and communicate epidemiological data at all levels;
   - •Regular collection of data at all levels according to the norms set by the Program;
   - •Analysis of epidemiological reports during three-monthly validation meetings both at the peripheral (health zone) and intermediate (Coordination areas and Provinces) level, and once a year at Central level.
   - •The use of validated data for the planning of activities to reinforce and improve the anti-disease strategy.
2. Supervision
   - •The Program has drawn up a Guide to supervision at the national, intermediate and peripheral level;
   - •The training of central and provincial actors on the subject of supervision techniques has been achieved;
   - • Supervision is performed at all levels of the system and the supervision reports are collected.

b) **Weaknesses:**

1. Follow-up
   - The follow-up and evaluation plan has still not been circulated;
   - The promptness and completeness of epidemiological reports are rarely present at the beginning of each term, both at intermediate and national level;
   - The quality control guide has not been circulated.
   - The program has not yet finalized a manual of procedures to check, validate and control the quality of epidemiological data; this project is underway.
   - The non finalization of a software to centralize data leads to a work overload for the department in charge of epidemiology and increases the risk of transcription errors and hence data interpretation errors. Indeed, the software funded by series 2 did not work since all the modifications that occurred after the new directives of the Program were set up have perturbed its revision (change in

length of treatment, TB/HIV and MDR inclusion, etc.).

- The lack of motivation of the personnel involved in follow-up and evaluation.

2. Supervision

- The Guide to supervision has not been fully circulated at peripheral level;
- Peripheral level personnel have not been trained in the technique of supervision.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

HALF PAGE MAXIMUM

There is a national health information system (NHIS) that uses a number of WHO indicators for all the DRC Programs, including the Tuberculosis Program. As a sub-system of the NHIS, the latter includes the specificity of cohort follow-up of tuberculosis patients, has adopted the data collection canvas that allows calculation of all the indicators of WHO, the Union and all the other backers including the Global Fund. Since the DOTS Strategy was initiated in 1996, this canvas has been regularly adjusted to take into account the new directives included in the Program Manual, which is now in its 4thedition (PATI-4).

The Program information circuit remains the same as that of the NHIS and goes from screening and treatment center (HSTC) to health zone (health district), which transfers the information after centralization and analysis at the intermediate level (coordination area and province), which in turn centralizes, analyses and sends the information to the program. After centralization and analysis at this level, the program sends the report to the Ministry of Public Health and its partners.

Given that these information aids will need to be modified, the tuberculosis program will include the data related to the activities of the community, the PPM and PAL, in order to fill the gap observed when conducting an evaluation with M&E tools.

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

ONE PAGE MAXIMUM

During the evaluation of the national health information system in the DRC, a number of weaknesses were identified, including incomplete territory coverage, poor reliability of the data produced because of the lack of appropriate data management software and flawed data analysis and validation, transmission delays due to lack of means of communication and transport to begin with, and lack of competence and motivation on the part of the service providing personnel.

In view of this situation, the programs of action against the various diseases have developed sub-systems of information for the follow-up and evaluation of specific activities for the control of such diseases. Thus, the Tuberculosis Program has set up a data collection canvas that allows maximum provision of relevant information according to WHO international recommendations, while keeping the same NHIS-defined circuit. This has at times led to a risk

of redundancy with work overload for base personnel and the production of incoherent data at central level. An NHIS reinforcement plan was therefore conceived and a consensus was obtained at central level on the use and circulation of data only communicated by Specific Programs.

The evaluation of the NTP Follow-up and Evaluation System also found a major gap in support in terms of data reporting and participative analysis for each area of intervention in the Program; in the drawing up and circulation of directives on quality control, storage and data filing; and in the training, supervision and motivation of the personnel involved in Follow-up and Evaluation.

This has been the object of a plan to reinforce the capacities of the PR and sub-recipients taken into account in this submission with nearly 6% of the overall budget, including essentially:

1. the finalization of appropriate software to allow safe data recording and automatic analysis at all intermediate levels, and file transfer by Internet at the central level without redundancy in view of the size of the country and the large number of patients screened and managed every year. In the series 5 submission, the Program had already obtained the installation of Internet in all the coordination centers. The request for technical assistance in this context is therefore absolutely necessary and is requested in this submission;
2. the organization of workshops to write up epidemiological reports as well as manuals on the procedures of verification, validation and control of data quality as well as data circulation;
3. the training of all the data managers, namely those at the provincial and national level in Kinshasa and those at the peripheral level during training on the revised Program directives, these training courses being measures designed to correct and reinforce data reporting;
4. the regular supervision, equipment and motivation of the personnel involved in Follow-up and Evaluation at all levels;

5.9 Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	Ministry of Health
Address	Boulevard du 30 Juin, N°4310, Kinshasa Gombe The Ministry of Health is one of the ministries of the Congo Government. At central level, it is comprised of the Minister's Cabinet, the Secretariat General to which are attached 13 Central Directorates and some fifty Specialized Programs including the NMCP, the NACP, the NBTP and the NTP - which are directly concerned by Global Fund grants. The intermediate level (provinces) is composed of 11 Provincial Health Divisions in charge of providing technical support to the peripheral level, which is made up of 515 health zones dedicated to the operationalization of health care. To ensure better management of outside funding, the Ministry of Health, the public PR for the present proposition, is currently in the process of reinforcing its capacities. Together with its partners, the Ministry of Health has signed a memorandum of understanding to ensure better coordination and harmonization of the interventions due to contribute to its reinforcement. A Support Group for the

	management of outside funding within the Ministry was therefore created by ministerial decree. In the current stage of the process of reform of the health sector, the Support Group will be responsible for project programming in this area and will be assisted on financial management issues by a trust agency recruited by a call for tender. The GAVI project, with its health system reinforcement component worth 56 million dollars, will be the first to incorporate this management mechanism. Other funding in the health sector, potentially including the 10th EDF, is being prepared for integration into this mechanism which crystallizes the efficiency of development aid through the Paris Declaration. With respect to funding by the Global Fund, the UNDP - which is the ongoing grant PR in the DR of Congo - and the Ministry of Health have agreed on a devolution plan at the end of which the Ministry of Health will bear all the responsibility assigned to the public PR in round 8. This means that during the 24 months of the 1st Phase of round 8, the UNDP will act as PR. The devolution plan will have to be terminated at the end of the 1st Phase. The three years of the second phase of this round will be under the responsibility of the public PR, i.e. the Ministry of Health. It is also important to emphasize that this strategy of reinforcement of public PR national facilities is already being implemented by the retiring PR (UNDP) for the funding of phase II of round 3 as well as for round 7. It also allows the technical arms of the Ministry of health, i.e. the NACP and the NBTP, to ensure the Grant program management and participate in the selection of sub-recipients of the implementation of activities. As a state institution, the Ministry of Health already collaborates with a number of backers. All these structures such as Directorates, Specialized Programs, Provincial Health Divisions (PHD), etc. are widely implicated in the running of activities in accordance with the role assigned at each level. Thus the coordination of activities and the regulation of health sector activities of HIV/AIDS infection control related to the drawing up of norms and directives, supervision, follow-up, evaluation as well as training at all levels are the responsibility of the public PR, namely the Ministry of Health. In accordance with the directives of the Global Fund regarding dual funding, the DRC is aware of the role the private sector can play to assist the health sector and therefore welcomes other civil society structures to play the role of PR or possibly sub-recipient of activities other than these.

PR 2	**CARITAS CONGO non-profit association**
Address	**26, Avenue BASOKO, Commune de la GOMBE, Ville de KINSHASA, DRC**

[Description]

1. <u>Managerial capacity:</u>

Created in 1960 by the Catholic Church Episcopate of Democratic Republic of Congo (DRC), under the legal entity of a non-profit association (NPA), Caritas Congo is a national, technical and specialized organization of the Catholic Church of Congo responsible for emergency assistance services, social assistance and support for actions of integral and sustainable development, health, peace facilitation, reconciliation and environmental decontamination. It enjoys a legal personality conferred by Decree n° 108 of 4 December 1964.

ROUND 9 – Tuberculosis

At national level

La Caritas has 3 services in charge of the following issues respectively:

- health (Health Promotion Services - HPS)
- humanitarian emergencies and disaster management (Solidarity and Sharing Promotion Services - SSPS)
- sustainable development (Development Promotion Services - DPS)

The three services are administered by a National Coordination Service and benefit from the support of "Support Groups" in charge of administration, finance, communication, revitalization and internal audits.

In the Democratic Republic of Congo, Caritas Congo works as a network with 47 ground organizations called "Diocesan Caritas", of which there are 4 to 5 per administrative province, and is present in districts, territories and local authorities. These diocesan Caritas have a capillarity that allows them to cover the entire national territory by conducting actions in the field of emergency, rehabilitation, solidarity and sharing, food safety, health, nutrition and education management as well as rational management of the environment and the building of peace. This swarming effect makes Caritas Congo the only organization in the DRC to be totally established all over the country. Caritas Congo has created a Web site (www.caritasdev.cd) in order to promote the internal (national) and external (international) visibility of its actions in its 3 areas of action (health, humanitarian emergencies and sustainable development).

Thanks to its North Caritas network, brought together within CARITAS INTERNATIONALIS, Caritas Congo can easily reinforce support if and when outside funds are acquired. This asset also allows it to guarantee gradual pre-funding of activities to ensure good continuity and better program quality. The periodicity of reporting facilitated by the various software tools (GESIS tailored for the catholic network of the DRC in the field of health; Ciel Compta, a local program using an Excel F5 spreadsheet, TOMPRO for financial services and stock management among other things...) is highly flexible (monthly, three-monthly or annual according to need). Caritas Congo also works on access to basic health care in close association with a large number of partners in the DRC.

The NPA Caritas Congo also has a strategic plan for the period 2008-2012, which was launched in 2000 as a revitalization process to meet the challenge of the immense task at hand to serve vulnerable individuals given the continental size of the DRC.

At the sub-regional level

Caritas Congo coordinates the three national Caritas of the Central African sub-region, namely Burundi, Rwanda and the DR of Congo, for which the priority are major emergencies, building peace, the control of HIV/AIDS and sustainable development.

At continental level

Caritas Congo is vice-president of Caritas Africa (organization of 45 national Caritas) and is the focal point of emergencies and HIV/AIDS.

At international level

Caritas Congo is a member of Caritas Internationalis, which has its headquarters in Rome and is one of the largest networks, covering 165 countries and territories distributed over all the continents of the world. Since 2007, Caritas Congo has been elected member of its Board of Directors for a renewable mandate of 4 years. The election of Caritas Congo to the vice-presidency of continental Caritas and the Board of Directors of Caritas Internationalis reflects

the energy of this institution.

2. Technical capacity:

On its own or in partnership with the Congolan State, Caritas Congo manages for the Church over 40% of medical training in the Congo (187 GRHs and 1368 Health Centers distributed over the 515 Health Zones of the DRC) through its Health Promotion Services (HPS) and its 47 Diocesan charitable medical offices (abbreviated DCMO).

At the diocesan level (intermediate and operational level), the NPA Caritas Congo has roughly 500 doctors (general practitioners and specialists), 3,000 nurses and laboratory personnel, 100 nutritionists, 150 health structure administrators-managers, 50 pharmacists or pharmacy technicians and over 5,000 other administrative agents, i.e. a total of 8,000 health agents. Besides providing health services (more than 40% of the offer of health services in the country), it supports health zones and health districts with respect to construction and rehabilitation. In terms of its Health Promotion Services (HPS), Caritas Congo is currently working with the NHIS division of the 5th Directorate of the Ministry of Health, one of its partners, in order to harmonize the data collection system; provide computer equipment for its health system, its DCMOs and its health teams; and meet the needs of the NHIS (National Health Information System).

Because of its experience in the field of emergency and community health as well as its membership within the supranational network of CARITAS INTERNATIONALIS, Caritas Congo has the human and technical resources to manage the entire process of supply, stock management and shipping over the entire national territory of input products, medications and other commodities essential for disease control. Some of its partners have signed with ECHO and have a Framework Partnership Agreement (FPA). Their standardized procedures have been ISO-certified. Caritas Congo has a manual of administrative, financial and accounting procedures in which the rules have been set forth. It has carried out a number of projects with various partners (See below).

The Caritas network has storage facilities all over the provinces of the DRC as well as a large chain of distribution via diocesan pharmacy warehouses. The National Medical Supplies Program NMSP is working with Caritas Congo to complement its network via the setting up of "relay" warehouses, redistributors for the current RDCs, the number of which does not allow full country coverage at present. With the DCMOs, Caritas Congo actively participates in the NMSS (National Medical Supply System) and in the setting up of RDCs across the country (Kisantu, Kananga, Kikwit, Mahagi, etc.).

In terms of social mobilization, over 1,200 catholic network parishes across the country participate in the vaccination campaigns, for instance. They also supervise volunteer blood donors in the country's catholic schools (the Catholic Church has supervised more than 3,000,000 students in this context in 2007). Thanks to USAID grants for the AXxes project, the CARITAS INTERNATIONALIS network is participating in Malaria control action via CRS (American Caritas) with the acquisition of input products (**LLIN, ACT and SP for IPT**) in 25 Health Zones for 2003-2008, with a possibility of extending this period. Caritas Congo has also actively participated in 2007 in the implementation of short-term VCT services on 211 sites across the country as part of the Demographic and Health Survey (DHS 2007). Finally, to date, nearly 60% of health facilities collaborating with the NTP for the management of tuberculosis patients are health teams from or under the authority of the catholic network.

3. Financial capacity:

ROUND 9 – Tuberculosis

The CARITAS network annually mobilizes large amounts of funding totaling 80,000,000 USD from a number of partners. There is an official accounting and finance management service both at national level and at the level of the 47 diocesan facilities. Each diocesan entity is endowed with a division for the management of temporal goods, called the "general diocesan or provincial bursar's office" with a market procurement sub-division called "diocesan or provincial procurement".

About Caritas Congo's experience

- *In relation to the Congolan State*

Since 1960, the Congolan State has used the financial architecture of the Catholic Church to pay the life annuities of the agents of the State and, for several decades, to ensure the distribution of teachers' pay.

Over recent years, following the war impact, the Congolan State has collaborated with Caritas Congo to bring humanitarian aid in the form of equipment or financial aid to the various disaster-stricken populations in the most isolated zones of the country. This collaboration is being pursued with other government programs run in conjunction with the Catholic Church such as the GPRSP, DDR, PMMU, NMACP/MAP, HIPC programs and other organizations such as the BCECO central coordination bureau, the UCOP program coordination unit and others to come.

- *In relation to international cooperation organizations*

The Caritas Congo network is one of the most important partners among the organizations of the United Nations System, including the WFP, UNICEF, the FAO, the HCR and UNDP (with over 14 million dollars), the World Bank, the European Union, the Belgian Technical Cooperation, the French Cooperation Agency, international NGOs such as CRS, DCV, Trocaire, Cordaid, Cafod, KFW, DFID and the Caritas branches across the world.

Evolution of fund mobilization for projects and other activities from 2001 to 2007 at central structure level

Year	Amount in $ US	% relative to 2001
2001	$ 801.903,80	100%
2002	$ 1.397.655,98	174%
2003	$ 2.648.817,00	330%
2004	$ 5.201.871,00	649%
2005	$ 19.708.858,00	2.458%
2006	$ 9.887.123,62	1.233%
2007	$10.373.929,65	1.294%

Let us finally mention that the financial group of Caritas Congo participates in:

- The efficient management of Caritas Congo's real estate and movable and financial assets
- The rational management of project funds emanating from its partners (a bank account is opened and audited for each project)
- The verification and certification of financial status and projects by an annual external audit
- Financial intermediation

- The production of quality financial information
- The keeping of accounting tools
- The publication of various reports and financial statements
- The use of appropriate software (Ciel Compta, a local program using an Excel F5 spreadsheet and TOMBRO, which is currently being installed)

PR 3	[Name]
Address	[street address]
[Description]	

➔ ***Copy and paste tables above if more than three Principal Recipients***

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	X Yes
	☐ No
(b) **If no**, why not?	
(c) **If yes**, how many sub-recipients will be involved?	X 1 – 6
	☐ 7 – 20
	☐ 21 – 50
	☐ plus de 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	X Yes ***[Insert Annex Number for list]***
	☐ No **Answer s.4.9.4. to explain**
(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.	

TWO PAGES MAXIMUM

Not all the sub-recipients are known to date. But those that manage the program for the ongoing Rounds 5 and 6 have agreed to pursue their activities; these are Action Damien and the National Tuberculosis and Leprosy Control Program of the Congo.

The tuberculosis program in the DR of the Congo has always been combined with the national leprosy program and supported by the same implementation partners, concerned about the humanitarian aspect of both of these diseases. Thus civil society is involved in the logistic and financial support for the coordination structures that the State has set up to control tuberculosis.

Action Damien (previously called Damien Foundation) has been active since 1964 in the DR of Congo, well before the actual creation of the national programs. It currently ensures the supply of 10% of antituberculosis drugs for the program partners other than the Global Fund. It also supports 14 of the 24 provincial coordination centers and has extensive experience in the supply of medical and pharmaceutical products, and other equipment. It is therefore requested to cover such vital areas.

The Congo National League was created in 1963, its social role being to mobilize funds for the control of tuberculosis. It has therefore relied more on pleas and social mobilization against tuberculosis, as well as information and education in order to change behavior toward this disease. It has had to support 2 coordination centers with funding from the European Community and the Raoul Follereau NGO. It is heavily involved in the supervision of community-based associations and social communication.

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

Since series 2, followed by series 5 and 6, Action Damien has always been the key sub-recipient for the program. It is involved in all the steps of submission development, which allows it to meet the expectations of the Global Fund and guarantee the level of performance of activities more successfully. It has been the sub-recipient with regard to "training, meetings, international conferences" at rounds 2, 5 and 6. In order to respect the established work schedule, it has had to finance planned activities because of delay in PR (UNDP) procedures. This situation is also true with respect to the Congo's National League for the Control of Tuberculosis.

The National League has always worked on education relative to tuberculosis.

It has been assigned the "social mobilization" component for Rounds 2 and 5 in this context.

It has also served the Program as sub-recipient for USAID funds, etc.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

This work in underway in the CCM-DR of Congo

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

Given the specificity of funding for these three diseases (HIV/AIDS, Malaria and Tuberculosis) by a backer with particular stipulations and the need for alignment with the national context, the coordination of PR(s) will take place at **two different levels**:

(i) Internally to the CCM through the previously created Follow-up and Evaluation Commission, which must be revised/reinforced (experts that are internal and external to the CCM) and endowed with the necessary means through a plan of action financed by the PRs' own funds and other funding sources to be identified. This framework guarantees the fundamental multisectoriality of the CCM to meet the directives of the Global Fund.

(ii) By means of national coordination bodies for instance, the HSRS National Steering Committee and the HSRS Provincial Steering Committees. The anchorage point of the CCM at National Steering Committee level is being defined in order to do this.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

TWO PAGE MAXIMUM

Because the devolution process is underway in favor of the public PR and its key SR, the immediate needs that require reinforcement are currently being resolved. However, while the civil society PR has experience and has its own management tools, it certainly needs some measure of assistance; it would be hazardous at the current stage to give an exhaustive list of

needs in terms of assistance required for capacity reinforcement.

Without being exhaustive, from the point of view of management, the two main recipients being new to the field of funding management and reporting to the Global Fund, they will surely need technical assistance in management to complete their mission more successfully.

Concerning the first PR, the report and even the plan of devolution undertaken by the current PR and already communicated to the Global Fund have already emphasized the areas of devolution. These are the areas pertaining to administrative and financial management, the supply system (Procurement Supply Management) and the follow-up and evaluation system.

5.10 Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ ***Si Go to s.4B if relevant, or direct to s.5.***
	X **Yes** ➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Mini Health (NMSP) and National Tuberculosis Program (NTP)	The NTP ensures the policy and system of supply of antituberculosis drugs	X Yes ☐ No
Intellectual property rights	Ministry of Trade and Industry	Verifies the application of propriety rights relative to the commerce of drugs	☐ Yes X No
Quality assurance and quality control	Mini Health (Directorate of Pharmacies, Drugs and Herbal Medicine) and OCC (Congolan control office)	GDF ensures the quality and quality control for products in the source country via the manufacturer and the SGS. The Directorate of Pharmacies, Drugs and Herbal Medicine controls the WHO prequalification of suppliers for import before giving marketing authorization. It focuses on the analysis bulletins of pharmaceutical products. On the other hand, OCC takes care of quality control when products enter the country	X Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	NTP	Evaluating the overall quantity of drugs in the country, selecting suppliers (call for tender), ordering drugs, receiving shipments (Goma and Kinshasa), planning the distribution and distributing to STC via LTPC and HZs	☐ Yes X No
Product selection	PMC (Patimed Management Committee)	Drawing up the list of essential antituberculosis drugs based on the PATI IV directives	☐ Yes X No
Management Information Systems (MIS)	National Drug Information System (NHIS MED) and PMC (Patimed Committee)	Determining the performance of indicators for antituberculosis drug performance, follow up and analyze drug stock and consumption data at all levels (Central, LTPC HZs and STC)	X Yes ☐ No
Forecasting	PMC (Patimed Committee)	Schedule for antituberculosis drugs	X Yes

			No
Procurement and planning	PMC	Draw up the distribution plan and deliver the drugs to the program beneficiary facilities (LTPC, HZs and STC)	☐ Yes X No
Storage and inventory management *More details required in s.4.10.4*	PMC	Storing the drugs following the relevant norms controlling the stock	☐ Yes X No
Distribution to other stores and end-users *More details required in s.4.10.4*	PMC	Delivering the drugs to the CSDTs via the CPLTs and HZs in accordance with the distribution plan	☐ Yes X No
Ensuring rational use and patient safety (pharmacosurveillance)	PMC and Directorate of Pharmacies, Drugs and Herbal Medicine and NMSP	Following patients clinically, prescribing drugs and managing the drugs (PMC), Organizing the Pharmacosurveillance system (Directorate of Pharmacies, Drugs and Herbal Medicine and NMSP)	X Yes ☐ No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
MINISTTY OF HEALTH/PNT	PR1	
CARITAS CONGO	PR2	
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacosurveillance systems. If existing systems are not used, explain why.

ONE PAGE MAXIMUM

There is a national system for the supply of essential medicines known as NMSS, which includes the FEDECAM federation of wholesale drug suppliers and the RDCs (Regional Wholesale Distributors). It is supervised by the national program for the supply of essential medication (NMSP).

All the specialized programs are eventually due to be integrated in the NMSS, which is still being established at this stage.

Given the coverage of the tuberculosis program (515 HZs) and in view of the results obtained from control efforts, it makes sense to continue with the existing system of supply and distribution via the program and its coordination offices while waiting for the effective operationalization of the NMSS.

The side effects linked to the antituberculosis medication (dizziness, deafness, ear buzzing, etc.) are followed clinically by nurses and doctors. They are subject to medical prescription for the patients, who unfortunately have to buy the medication to treat themselves. In this

submission, the program requests the funds necessary to buy the drugs that will be distributed for free to category-IV patients.

On the other hand, pharmacosurveillance has not been developed to date in our country. The NMSP is working toward this in order to draw up directives.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	x	National medical stores or equivalent
	☐	Sub-contracted national organization(s) *(Specify)*
	x	Sub-contracted international organization(s) *(ACTION DAMIEN)*
	☐	Other: *(Specify)*

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The storage capacity of the NTP is 2,028 m^3 at the central level (including 1,500 m^3 for the central unit in Kinshasa, 120 m^3 for the Action Damien partner in Kinshasa and 1,008 m^3 of space in the ASRAMES warehouse, the Goma Wholesale and Distribution Center).

The global storage capacity in the 24 provincial coordination centers of the program is estimated at 2,640 m^3.

A 6-month minimum safety stock is kept at central level, while 3-month stocks are kept in the provincial coordination centers and the Health Zones, which amounts to 12 months for the entire country.

NTP reagents, small equipment and laboratory consumables bought by the Global Fund/UNDP at Round 5 are also stored in the NTP central warehouse in Kinshasa, where space has therefore become too limited.

The same is true in the provinces where all the pharmaceutical products, reagents and small equipment are stored in the same rooms as inflammable products.

Storage space in the central warehouse and coordination warehouses therefore needs to be increased.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Considering the huge size of the national territory and the state of disrepair of the road infrastructure, air transport is used for the most part. Indeed, the NTP covers the 515 health zones of the country. Based on the PR's experience in Rounds 5 and 6, the cost of transport and insurance to ship medications, reagents and other laboratory input products, laboratory and logistic equipment and other consumables from the supplier to the two entry ports (Kinshasa and Goma) represents 7% of the cost of purchase. Shipping from the entry port toward the 1545 HSTCs via the 24 LTPCs is estimated at 18%, which amounts to 25% of the purchase price.

The coordination centers transport the products to the health zones either once a month or once every three months depending on the distance and the availability of transport means.
In addition, the transport of drugs from the central offices of the HZs to the Treatment Centers is not covered by traditional partners. The drugs are handed over to the registered nurses while carrying out monthly monitoring duties.
It is therefore scheduled in this proposition to transport the drugs, reagents and laboratory consumables all the way to the treatment centers.

This means that the cost of transport for drug distribution will be higher, and is estimated at 25% of the purchase price of the drugs.

4.10.6. Pharmaceutical and health products for initial two years

Complete '**Attachment B-Tuberculosis**' **to this Proposal Form**, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-Tuberculosis' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

Given that this submission comes as consolidation for Rounds 5 & 6, which are ongoing, first-line antituberculosis medication will not be taken into account for the first two years of the present series.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	x Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the HIV or malaria proposal*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

4B. Program description - HSS cross-cutting interventions

Refer to the Round 9 Guidelines for more detailed information on health systems strengthening and linkages to the WHO Building Blocks for effective, efficient, transparent, equitable, and sustainable health systems.

Note: ***If more than one HSS cross-cutting intervention is being applied for, copy and paste the table below for up to five 'HSS cross-cutting interventions'. Re-number each new box as 'Intervention 2', 'Intervention 3' etc.***

*****That is: separate out each major area of HSS cross-cutting support into a new table to ensure clarity about what is being requested*** *(e.g. Intervention 1: strengthening supply chain management of health products; Intervention 2: introducing an innovative health insurance framework targeting the poor; Intervention 3: strengthening diagnostic services at the rural and local level on a cross-functional disease basis to encourage the rationale, non-disease specific use of resources, etc)*

4B.1 Description of 'HSS cross-cutting intervention' ➔ ***Refer to the Round 9 Guidelines for information completing this section.***	
Title: Intervention 1 ** *(Change number for each separate/main intervention)*	**CONTRIBUTING TO IMPROVE THE HEALTH INFORMATION SYSTEM IN THE DEMOCRATIC REPUBLIC OF CONGO**
Beneficiary Diseases: *(e.g., HIV, tuberculosis, and malaria Any others?)*	*All diseases (including HIV, Tuberculosis and Malaria) and other health problems*
Identify the HSS SDA from your "HSS Performance Framework"	*Health information*

(a) **Description of rationale for and linkages to improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:**

MAXIMUM TWO TO THREE PAGES FOR EACH SEPARATE HSS ACTION – *In your answer, follow the same approach as for s.4.5.1. That is, list the overall objective of HSS support, and what specific interventions/activities will be undertaken during the program term to achieve these outcomes; and which of the Principal Recipients named in s.2.2.5 (Eligibility Section) will be responsible for overall implementation and achievement of the outcomes/impact?*

a.1. JUSTIFICATION :

The operation of the health information system remains a real problem to date in the DRC since it does not allow real-time availability of the information that decision makers and service providers need to make decisions. The low capacity of human resources and the lack of equipment and tools for data collection, analysis, interpretation, use and transmission (promptness and completeness of reports) from health zones to the higher echelon; the lack of data consolidation and validation meetings at the peripheral and intermediate level; the lack of a single (joint) system of follow-up and evaluation at these levels, which does not facilitate follow-up and evaluation (F&E) of the interventions of the Minimum Package of Activities (MPA)[6] and Complementary Package of Activities (CPA), including those relative to disease control. This was demonstrated during the evaluation of the F&E systems for the three programs of HIV, Tuberculosis and Malaria control, performed by Measure Evaluation with the support of the Global Fund in 2007[7]. The report of this evaluation has already been communicated to the Global Fund/Geneva among the

[6] The Minimum Package of Activities (MPA) constitutes a set of activities that are performed at the first echelon of the health zone organization, i.e. the Health Center. This package comprises preventive, curative and promotional activities, including those relative to HIV/AIDS, tuberculosis and malaria control.
The Complementary Package of Activities (CPA) constitutes a set of reference activities performed at the 2nd echelon of the Health Zone organization, i.e. the General Referral Hospital. This requires a higher-level technical platform.

[7] Measure Evaluation, Report of evaluation of the follow-up and evaluation systems of the NTP, NACP and NMCP, November 2007.

appendices of the Round 8 HSR component (Appendices 4, 5 and 6). This is essentially about (i) poor data quality, (ii) parallel follow-up and evaluation systems, which lead to multiple reporting, discordant data, work overload for the personnel, etc.; (iii) Low completeness and promptness of reports and (iv) non systematic and non computerized data management characterized by a low capacity for storage, data analysis and circulation of health information.

These flaws in the health system have been described in section 4.3.2 of the Rounds 7 and 8 HIV propositions, the Round 8 malaria proposition and the Tuberculosis, Malaria and HIV propositions of this Round (Round 9).

This situation means that it is difficult to make decisions and plans based on documented evidence so as to achieve results in disease control generally - and more particularly the deadly triad of HIV, Tuberculosis and Malaria - and other health problems.

To remedy this state of affairs, a Health System Reinforcement Strategy (HSRS) was adopted in 2006 by the Ministry of Public Health and its partners. This strategy has been taken up in the Growth and Poverty Reduction Strategy Paper (GPRSP). The HSRS has given rise to the Interim Implementation Plan covering the period 2006-2011 (P106-11)[8]. This plan advocates a reform of the health information system in order for it to become a decision-making tool that can serve to improve the offer and quality of health services. This reform should eventually lead to the setting up of a common framework for the follow-up and evaluation system (Ministry and partners). This will end the multiplication of parallel information systems currently observed in the country. Actions are described in sections 4.3.3. of the previous component propositions.

A normative framework of the national health information system (NHIS) has also been defined in collaboration with partners.[9]

The P106-11 has scheduled the establishment of National and Provincial Steering Committees to ensure better sector coordination. The National or Provincial Steering Committees have scheduled the setting up of 9 and 7 technical commissions respectively, including the commission responsible for the management of health information. These committees have been created by Ministerial Decrees N° 1250/CAB/MIN/S/EKA/024/2006 and 1250/CAB/MIN/S/EKA/025/2006 of 5 September 2006. Copies of these Decrees are given in Appendix 7 and 8 of the present proposition

The mission of the commission responsible for the management of health information is to improve the performance of the health information system (HIS) by decompartmentalization of the existing systems and harmonization of the various information management tools in accordance with the new NHIS normative framework.

The National Steering Committee and the seven Provincial Steering Committees are operational. The operation of their commissions including the information management commission varies according to available resources (material, human and financial). In certain provinces, the financial resources available only cover the operation of the three commissions in the Province of North Kivu, the Eastern Province and the 2 Kasai Provinces. This is a "planning", "Funding" and "Contractualization" commission.

The project of health system reinforcement financed by the Global Alliance for Vaccination and Immunization, GAVI-HSR, will support the operation of the National and Provincial Steering Committees in three provinces. These are South Kivu, Lower Congo and the Province City of Kinshasa. At central level, the commission responsible for Health Information has never been operational since the creation of the NSC-HSRS in 2006 due to lack of sufficient backing, leading to the non coordination of the information system.

The normative framework of the NHIS is a policy and strategy document that clearly describes the new organization of the NHIS in the DRC and the minimum operation conditions of the Health Information System at all three levels of the health pyramid.

[8] Interim implementation plan of the Health System Reinforcement Strategy 2006-2011 (P106-11).
[9] Ministerial decree n° 1250/CAB/MIN/S/BYY/PT/005/2005 of 18 March 2005 bearing on the Organization and Operation of the NHIS in the DRC.

Intervention target

The novel vision of health information management[10], in accordance with the HSRS, is gradually being implemented at various levels in the Health Zones (HZ) since 2005 with the support of partners (EU/PS9FED, USAID/ Project AXxes, World Bank/ PARSS, GAVI-HSR, UNICEF, WHO, UNFPA, GTZ, BTC/ HSSIPL, DFID/ IRC, etc.). To date, 100 of the 515 HZs in the country already have an operational NHIS in compliance with the normative framework (see report on the integration of the normative framework in the provinces, January 2009, in Appendix 6).

During the 8th Round, the DRC obtained funding from the GF via the Malaria component in order to integrate the NHIS normative framework in 119 HZs. There will therefore be a total of 219 HZs with an operational NHIS out of the 515 HZs. This submission therefore *aims to fill the gap of 296 HZs in order to allow the DRC to resolve once and for all the operational weaknesses in the information system, as discussed above.*

Indeed, the implementation of the process of integration of the normative framework in the 100 HZs has allowed the following results to be observed:

- the data quality in the HZs has improved significantly. The program reports of activity and the various bulletins of the NHIS confirm this hypothesis.
- the systems of follow-up and evaluation of the NMCP and NPRH have been harmonized with the NHIS. This harmonization has for instance resolved the issue of work overload and multiple collection tools, etc. Harmonization with the NTP and the NACP is ongoing.
- collection tools as well as the data transmission circuit have been made uniform;
- the completeness and promptness of reports are increasing. Indeed, according to the 2008 NHIS annual report, the percentage of HZs submitting complete reports on all the public health management indicators following national directives has gone up from about 5% in 2006 to 19.4% in 2008. And the percentage of HZs submitting their reports on time has gone from 0% to 15.52%. This performance is due to the progressive integration of the normative NHIS framework in 100 HZs.
- computerized data management with the GESIS software has contributed to improve the HIS (analysis, information transmission, data storage).

Although the data shows a gradual improvement in NHIS indicators, more efforts need to be done in the HZs that are still lacking an operational NHIS.

In addition, there remains the weakness in real-time data coordination and transmission from the provinces to the central level, and in the *use of health information in order to improve the organization and operation of health services and offer quality care to the population.*

a.2. Aim of the intervention[11]:

The aim is to contribute to the reinforcement of the health system through the production of quality health information that allows following, evaluating and planning the implementation of interventions aiming at better health coverage.

a.3. Overall objectives of the intervention;

In order to get quality information with a view to scale up the essential interventions of the PMA and PCA, and in particular those for the control of HIV/AIDS, Tuberculosis and Malaria, the present submission aims for the following goals:

[10] Declaration of the national policy on health information management, 18 March 2005.

[11] This intervention aims to improve the management of routine information including that pertaining to PMA and PCA management in the health zones. Interventions aiming to improve specific information such as that which can only be collected in sentry sites are included in the various components (HIV/AIDS, tuberculosis and malaria).

1. Gradually integrate the SNIS normative framework in 296 zones by 2014.
2. Make four Provincial Steering Committees of the Health System Reinforcement Strategy (PSC-HSRS) operational by 2014 by assigning resources to their operation and thus improve the coordination of the interventions of the health information system in the provinces.
3. Reinforce the central level with respect to the steering of normative framework implementation and to the supervision of provinces in the management of health information.

a.4. Description of activities per goal:

This submission is a resubmission of the HSR/Round 8 proposition; its answers to the TRP observations are listed in section 4.5.2. of the tuberculosis component and also attached in Appendix 5.

It advocates:

a.4.1. In relation to the first objective: *Gradually integrating the SNIS normative framework in 296 HZs by the end of 2014*

The following activities have been scheduled:

(i) Reinforcing the capacities of the Health Zone Supervising Teams (ZST) for the collection, analysis, interpretation and use of health information with the GESIS health information management software. This capacity reinforcement will take place in the course of a 5-day seminar with the participation of 3 people per Zone Supervising Team (ZST). These workshops will be held in the administrative town of each of the 34 health districts to which the 296 HZs are attached.

(ii) Reinforce the capacities of the health service providers in health centers and hospitals in terms of collection, analysis, interpretation and use of health information. This capacity reinforcement will take place in the form of 3-day workshops with one person per Health Center (Registered Nurse) and 2 people per zone hospital (person in charge of statistics and Nursing Director). These workshops will be held in the administrative town of each of the 296 HZs. However, items of data specific to the programs (HIV/AIDS, Tuberculosis, Malaria and other morbid conditions) will continue to be collected and communicated using the existing tools.

(iii) Equip the 296 HZs with computer and communication equipment as well as a source of energy. This means providing these HZs with computer kits, Internet connections (a modem in HZs covered by a telephone network), radio communication as well as the necessary energy source (solar panels).

(iv) Support the organization of monthly monitoring meetings in the 515 HZs. This activity concerns all the interventions, including those of the three components (Malaria, HIV/AIDS and Tuberculosis). Registered nurses from health centers (public, denominational, NGO and private) and personnel in charge of the hospital NHIS will participate in these meetings coordinated by the health zone supervising team (ZST).

Applying the principle of rationalization of health funding established by the HSRS, the CCM has decided that monthly HZ activity monitoring would from now on be an activity that is transversal to all components and therefore emanates from the HSR budget. Thus the target for this activity is 515 HZs. Links with existing funding are described in section a.5. below.

(v) Provide the 296 HZs with operational means (office supplies, computer consumables, equipment repair and maintenance, etc.).

(vi) Support the organization of bi-annual investigations via the LQAS (lot quality assurance sampling) approach in the 296 HZs to enable verification of data quality and health intervention impact, including on malaria, tuberculosis and HIV in the community. This also allows measuring at minimal cost the pertinence of interventions led in the community so as to set up corrective measures.

a.4.2. In relation to the second objective: *Ensure that four Provincial Steering Committees of the Health*

System Reinforcement Strategy (PSC-HSRS) become operational by 2014, by assigning resources to their operation and thus improving the coordination of health information system interventions in the provinces.

This submission will allow:

(i) Operational support for the 4 PSC-HSRS in the provinces of Bandundu, Equator, Maniema and Katanga.

Field experience has shown that the operationality of a National or Provincial Steering Committee commission depends on that of the Committee itself, and that it is neither effective nor efficient (even less so) to have only one operational commission in the National or Provincial Steering Committee.

Given the persistence of steering and coordination problems relative to interventions in these 4 provinces, where PSCs are not yet operational, the funding requested here will allow the PSF9ED positive experience to be applied to these PSCs by giving them office supplies and paying subsistence allowances to meeting participants.

Support is also requested to get the health information management commission to become operational in the 7 other provinces. Support for an information management commission will consist in funding bimonthly meetings gathering 10 people and biannual missions for the two PSC persons to exchanges experiences.

Although the mission and the needs of the Follow-up and Evaluation Operational Unit (FEOE) are described in section 4.8.3. point (a) of the round 8 malaria component, the budget for the operation of this FEOE was already taken into account in the round 8 HSR, which was not recommended for funding.

For this HSR round-9 submission, the reinforcement of the capacities of the 11 FEOEs in terms of follow-up and evaluation, health information and epidemiology training has been scheduled. The FEOE will need equipment such as computer kits, reprographic kits, analytical software, means of transport and communication and operational funds.

The FEOE is responsible for the daily management of the material it has been entrusted with by the health information management commission. It thus ensures the technical secretariat of the health information management commission. It is composed of a limited number of members from provincial services responsible for disease control, development of primary health care and coordination of specialized programs (NACP, NTP, NMCP, NPRH, NBTP, etc.).

(ii) Support the organization of integrated provincial bi-annual reviews. These reviews, which take into account all essential interventions, will take place with the support of 5 central-level delegates, including 2 for Central Management Offices and 3 for the programs. They will take place in the administrative town of each province and will bring together 25 participants for 5 days, including 5 members from the Provincial Supervising Team (PST), 10 specialized program coordinators, 5 Health District representatives and representatives of civil society partners (5 members).

This activity allows the level of result achievement at the provincial level to be evaluated half-way along the way, and appropriate timely measures to be taken to resolve any arising bottlenecks.

This innovation, which consists in evaluating all the activities at the same time, complies with the HSRS and avoids any wastage of resources by organizing several reviews per program in the same place and at the same time.

Given the problem of geographical access of certain HZs and health districts from the administrative town of the province, 4 3-monthly reviews have been scheduled per health district in order to prepare for the bi-annual review. During these reviews, the participants will among other things validate the data, as in the tuberculosis component. In other words, this means applying the positive experience with the tuberculosis component to all other PMA and PCA interventions. These reviews will be organized in the form of residential workshops in 26 health districts corresponding to the 26 provinces currently established by the

Constitution of the Republic. These districts also correspond to the 26 provincial leprosy and tuberculosis coordination centers. Links with existing funding are described in section a.5. below.

(iii) Draw up and circulate a bi-annual health information bulletin in the 11 provinces. This bulletin constitutes an effective way of sharing information with all the parties involved, particularly with provincial authorities and their partners. The funding requested here will allow the payment of printing costs.

a.4.3. In relation to the third objective: *Reinforce the central level with respect to the steering of NHIS normative framework implementation and to the supervision of provinces in the management of health information.*

(i) Support the operation of the Health Information Management Commission of the HSRS National Steering Committee (NSC-HSRS).

This commission must comprise the representatives of Directorates, of Specialized Programs and development partners.

The funding requested in this proposition will bring operational support to the commission for the collection of strategic information necessary to update policies, strategies and protocols for the management of health problems, including those concerned with the control of HIV/AIDS, Malaria and Tuberculosis; to carry out experience exchange missions at international level; to allow the update of the web site of the Ministry of Health, the supply of computer kits to the secretariat of the commission and payment of a subsistence and travelling allowance that guarantees the participation of members in commission meetings.

(ii) Support missions of activity supervision and follow-up to bring about the integration of the NHIS in the 11 provinces.

Central-level personnel is scheduled to supervise the implementation of the NHIS normative framework in the provinces, ensure compliance of the activities undertaken with respect to the norms established and make improvements in case weaknesses are identified. Multivalent teams are scheduled to carry out missions once every six months for each province. Each team will comprise 2 people. The people will need a mission and travelling allowance, which is being requested in this proposition to accomplish their task. Links with existing funding are defined in section a.5. below.

(iii) Ensure interconnection between the central level and the 11 provinces of the country. The server acquired and installed with the support of USAID/Project AXxes has to date allowed interconnection between 3 out of the 6 Directorates scheduled by the new organic framework project of the Ministry of Health.

It is to be noted that funding of previous rounds by the Global Fund has allowed the Internet connection of Programs (NTP, NACP, NBTP and NMCP) and their provincial coordination centers. Furthermore, the funding of other backers (UNFPA, European Union, GAVI ALLIANCE, CTB, etc.) also ensures Internet connection for certain Coordination centers of the Programs (NPRH, PEV, PNLTHA, PNLO, PRONANUT, INRB, etc.).

This submission aims (1) to extend the Internet connection to 3 other Directorates taking into account the reform of the Ministry, which has scheduled 6 Central Directorates, (2) to link all the national Directorates and Coordination centers to one another and to the General Health Secretariat Office on the one hand and, on the other hand, the central level and the provinces to the existing central server, (3) to solicit technical assistance in certain areas (management of the website of the Ministry of Health, management and maintenance of the server, development of more software for data analysis, etc.).

a.5. Links with existing funding

The 296 HZ targets are not involved in the existing funding by the GF and other partners for the following

activities:

- (i), (ii), (iii), (v) and (vi) described under a.4.1.
- (i) and (iii) described under a.4.2.
- (i) and (iii) described under a.4.3.

But the existing funding of the GF (R5, 6, 7 and 8) supports:
- Follow-up and Evaluation (F&E) activities which are specific to each component and are related to the activity (iv) described under a.4.1. Indeed, about 5 to 10% of the budget of preceding rounds was devoted to F&E activities. In order to avoid duplication, this existing funding will continue to support F&E activities based on the following stipulations:

- o program-specific F&E activities are budgeted in each round 9 disease component for the central and provincial level;
- o monthly monitoring of 515 HZs will be cofinanced by the tuberculosis (rounds 5, 6) component until the end of 2011 and that of 358 HZs by the malaria (R8) and HUV/AIDS (R7, 8) component until the end of 2013;
- o the funding requested by the HSR (round 9) component will allow the tuberculosis component to continue supporting monitoring in 515 HZs for the period 2012-14. However, the budget will increase slightly in 2014 because extra funding will be allocated to cover the costs that were covered by the HIV and malaria components in 358 HZs until 2013.

The table below illustrates the links between the various sources of funding and the one requested by the present HSR-R9 component.

Source of funding	Period covered				
	2010	2011	2012	2013	2014
R5&6 Tub_515 HZs					
R7 & 8 VIH (239 HZs)					
R8 Malaria (119 HZs)					
R9 HSR					
Other backers					

- o the announced funding by other partners supports this activity in varying degrees in 259 HZs and will end in 2011. From 2012 onward, these HZs can benefit from other grants that will need to be mobilized from other backers. Meanwhile, the funding of monitoring will be ensured by this HSR proposition, which will cover all the HZs as of 2012.

In other words, the funding requested through the HSR component therefore ensures the continuity of the GF funding for the monitoring of HZ activities over the period 2012- 2014 and a complement to cover 2014 spending in 358 HZs supported by the HIV and malaria components.

- the organization of bi-annual/three-monthly reviews related to the activity (ii) described under **a.4.2.** These reviews are held in particular to validate the data via coordination of specialized programs. The existing funding will stop in 2011 for the Tuberculosis component (R5, 6) and in 2013 for the malaria (R8) and HIV (R7, 8) component. The funding requested as part of this proposition aims to continue three-monthly meetings in 26 Districts in order to cover the period 2012-13 and preserve what was gained via the tuberculosis component. In 2014, extra funding will be allocated to the 26 health districts for the organization of the three-monthly reviews which account for all PHC essential interventions.

Thus, in subsequent submissions, from 2015 onward, there will no longer be any funding requests for reviews or monitoring per program. All requests will aim for all essential interventions per health province

or district in accordance with the principle of creating a basket fund as recommended by the HSRS.

- The other partners support the holding of by-annual reviews in 7 provinces (GAVI-HSR and PS9FED). The funding requested here aims to support the organization of bi-annual reviews in 4 provinces targeted under **a.4.2**.the announced funding by other partners supports this activity in varying degrees in 259 HZs and will end in 2011. From 2012 onward, these HZs can benefit from other grants that will need to be mobilized from other backers. Meanwhile, the funding of monitoring will be ensured by this HSR proposition, which will cover all the HZs as of 2012.

In other words, the funding requested through the HSR component therefore ensures the continuity of the GF funding for the monitoring of HZ activities over the period 2012- 2014 and a complement to cover 2014 spending in 358 HZs supported by the HIV and malaria components.

- the organization of bi-annual/three-monthly reviews related to the activity (ii) described under **a.4.2.** These reviews are held in particular to validate the data via coordination of specialized programs. The existing funding will stop in 2011 for the Tuberculosis component (R5, 6) and in 2013 for the malaria (R8) and HIV (R7, 8) component. The funding requested as part of this proposition aims to continue three-monthly meetings in 26 Districts in order to cover the period 2012-13 and preserve what was gained via the tuberculosis component. In 2014, extra funding will be allocated to the 26 health districts for the organization of the three-monthly reviews which account for all PHC essential interventions.

Thus, in subsequent submissions, from 2015 onward, there will no longer be any funding requests for reviews or monitoring per program. All requests will aim for all essential interventions per health province or district in accordance with the principle of creating a basket fund as recommended by the HSRS.

The other partners support the holding of by-annual reviews in 7 provinces (GAVI-HSR and PS9FED). The funding requested here aims to support the organization of bi-annual reviews in 4 provinces targeted under **a.4.2**.

The table above also illustrates the clarifications that have just been brought concerning the organization of activity reviews in the provinces and districts.

- the activity (ii) described under **a.4.3** does not have any links with the existing GF funding. The missions of province supervision concerning normative framework implementation constitute a specificity that tends to be the responsibility of the NHIS Division. These missions had not been budgeted in the malaria component (round 8). They are funded by the other partners in 7 provinces. The funding requested here will provide support for these missions to be carried out in the 4 other provinces targeted under **a.4.1**. above.

a.6. Implementation capacity

For the HSR component, the CCM has designated the Ministry of Public Health as PR. The Ministry of Health is one of the ministries of the Congo Government. At central level, it is comprised of the Minister's cabinet, the Secretariat General to which are attached 13 Central Directorates and some fifty Specialized Programs including the NMCP, the NACP, the NBTP and the NTP, which are directly concerned by Global Fund grants. The intermediate level (provinces), composed of 11 Provincial Health Divisions, is in charge of providing technical assistance for the peripheral level, which is made up of 515 health zones dedicated to the operationalization of health care.

To ensure better management of outside funding, the Ministry of Health, the public PR for the present proposition, is currently in the process of reinforcing its capacities. Together with its partners, the Ministry of Health has signed a memorandum of understanding to ensure better coordination and harmonization of the interventions that contribute to its reinforcement. A Support Group for the management of outside funding within the Ministry was therefore created by ministerial decree. In the current stage of the health

sector reform process, the Support Group will be responsible for project programming in this area and will be assisted on financial management issues by a trust agency recruited by a call for tender. The GAVI project, with its health system reinforcement component worth 56 million dollars, will be the first to integrate this management mechanism. Other funding in the health sector, potentially including the 10th EDF, are being prepared for integration into this mechanism which crystallizes the effectiveness of development aid through the Paris Declaration.

With respect to funding by the Global Fund, the UNDP - which is the ongoing grant PR in the DR of Congo - and the Ministry of Health have agreed on a devolution plan at the end of which the Ministry of Health will bear all the responsibilities assigned to the public PR in round 8. This means that during the 24 months of the 1st Phase of round 8, the UNDP will act as PR. The devolution plan will have to be terminated at the end of the 1st Phase. The three years of the second phase of the said round will be under the responsibility of the public PR, namely the Ministry of Health.

It is also important to emphasize that this strategy of reinforcement of public PR national facilities is already being implemented by the retiring PR (UNDP) for the funding of the phase II of round 3 as well as for round 7. It also allows the technical arms of the Ministry of health, i.e. the NACP and the NBTP, to ensure the Grant program management and participate in the selection of the sub-recipients of activity implementation.

As a state institution, the Ministry of Health already collaborates with a number of backers. All these structures, i.e. Directorates, Specialized Programs, Provincial Health Divisions (PHD), etc., are widely implicated in carrying out the activities according to the role assigned at each level. Thus the coordination of health sector activities and regulation related to the drawing up of norms and directives, supervision, follow-up and evaluation as well as training at all levels, are the responsibility of the public PR, namely the Ministry of Health.

In accordance with the directives of the Global Fund regarding dual funding, the DRC is aware of the role the private sector can play to assist the health sector and therefore welcomes other civil society structures to play the role of Sub-recipients of activities other than those previously mentioned.

(b) **Indicate below the planned outputs/outcomes/impact** *(through a key phrase and not a detailed description)* that will be achieved on an annual basis from support for this HSS cross-cutting intervention during the proposal term. ➔ *Read the Round 9 Guidelines for further information.*

Year 1	Year 2	Year 3	Year 4	Year 5
60 new HZs have been included in the NHIS normative framework[12]	*120 HZs have been included in the NHIS normative framework*	*180 HZs have been included in the NHIS normative framework*	*240 HZs have been included in the NHIS normative framework*	*296 HZs have been included in the NHIS normative framework*
2 PSC-HSRS health information commissions	*6 PSC-HSRS health information commissions are operational in 6*	*9 PSC-HSRS health information commissions*	*11 PSC-HSRS health information commissions*	*11 PSC-HSRS health information commissions*

[12] The result presented here is cumulative and only concerns the 296 HZs targeted by this intervention. In HSR Appendix A, the progression of this indicator takes into account the integration of the normative framework in the 119 HZs of round 8 of the malaria component.

are operational in 2 provinces	*provinces*	*are operational in 9 provinces*	*are operational in 11 provinces*	*are operational in the 11 provinces of the country*
The NSC-HSRS health information management commission has been made operational	*The NSC-HSRS health information management commission has been made operational*	*The NSC-HSRS health information management commission has been made operational*	*The NSC-HSRS health information management commission has been made operational*	*The NSC-HSRS health information management commission has been made operational*

(c) **Describe below** other current and planned support for this action over the proposal term.

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

Name of supporting stakeholder ↓	**Timeframe of support for HSS action** *(Start date to end date)*	**Amount of financial support provided over proposal term** *(same currency as on face sheet of Proposal Form)*	**Expected outcomes/impact from this support**
Government	*2010 -2014*	1 095 535,98 (1)	- Remuneration of health personnel at all levels of the health pyramid, but not sufficient to motivate the personnel to work and achieve the expected results. - Office supplies and small equipment
Other Global Fund Grants (with HSS elements (*if applicable*)	*20010-2013 (round 5, 6,7 et 8)*	*15.880.804,00$*	- Round 5, 6 and 7: reinforcement of the follow-up and evaluation system specific to the various components (periodic investigations, sentry sites, reproduction of tools and three-monthly reviews, data validation meetings, support for supervision specific for each program, support for monitoring in the target HZs, etc.) - Malaria Round 8 (6 829 811$): integration of the NHIS normative framework in 119 HZs. The links of existing funding

			with the HSR request in round 9 are listed in section **a.5.** above
Other: *(PS9FED at central level)*	*2010*	*150 000*	-Operational support, Equipment, rehabilitation of the NHIS/DDSSP Division offices, training of SNIS/DDSSP (Directorate for Primary Health Care Development) Division supervisors. The request formulated for HSR in round 9 does not aim for support for the NHIS Division, but rather operational support for the Health Information Management Commission of the NSC-HSRS -Support for missions of assistance and supervision of 4 provinces for implementation of the SNIS normative framework; -Operational support for the three commissions (planning, funding and contractualization) of the NSC-HSRS;
Other: *(PS9FED at provincial and HZ level)*	*2010*	*969.650*	- Reinforcement of the capacities of the computer engineers in the 4 target provinces (North Kivu, Eastern Province and the 2 Kasai) for the configuration of the GESIS software in these provinces; - Finalization of the development of the health map in the 4 provinces; - Support for the organization of bi-annual provincial reviews, and of monitoring meetings in the HZs of 4 provinces; - Operational support for the NHIS in 56 out of the 100 HZs that have already integrated the NHIS

			normative framework. The links with other funding and the HSR proposition funding request are described in section **a.5.** above.
Other *(GAVI-RSS)*	*2010-2011*	*1 854 40*	-Support for missions of assistance and supervision of 3 provinces for the implementation of the NHIS normative framework; -Support for monitoring activities in 65 of the 100 HZs that have an operation NHIS. - Operational support for the three PSC-HSRS in 3 provinces (South Kivu, Kinshasa and Lower Congo); - Support for the organization of bi-annual reviews in the 3 provinces; - Support for the supervision of the HZs by the PSTs of target provinces.
Other: *(OMS)*	*2010-2011*	*1.600.000,00$*	Reinforcement of integrated monitoring and response to epidemics and catastrophes via the Directorate for disease control: distribution of tools for the notification of diseases with epidemic potential, support for the missions of investigation and response to epidemics
Other: *(Unicef)*	*2010-2011*	*875.000,00 $*	-Support for provincial tool adjustment workshops, training of provincial NHIS and GESIS trainers -Support for NHIS and GESIS training of ZSTs and NHIS training of service providers -SNIS management tools made available.

			Number of HZs: 41 targeted HZs among the 100 HZs with an operational NHIS
Other: *(PARSS)*	*2010*	*860 .000, 00 $*	-Support for provincial tool adjustment workshops, training of provincial NHIS and GESIS trainers; - Support for NHIS and GESIS training of ZSTs and NHIS training of service providers; - SNIS management tools made available. These activities address 37 of the 82 HZs targeted by PARSS (Health System Rehabilitation Support Project). The request for support formulated in the present round will allow the extension of the SNIS in 47 other HZs hitherto not covered. These 47 HZs are among the 296 target HZs of intervention 1.
Other: *(USAID-AXxes)*	*2007-2009*	*392.000,00$*	Project in the termination phase in 57 targeted HZs among the 100 HZs before the operational SNIS.
Other: GTZ	*2009-2011*	***50.000***	Support for integration of the SNIS normative framework in the Kenge HZ /Bandundu Province. This HZ is among the 100 HZs that have already integrated the SNIS normative framework.

4B.1 Description of the "HSS cross-cutting interventions" ➔ *Consult the Round 9 Guidelines for all additional information in this section.*	
Title: Intervention 2** *(Change numbers for each separate/principal intervention)*	**CONTRIBUTE TO IMPROVING THE OFFER AND QUALITY OF CARE IN THE HEALTH ZONES**
Diseases: *(ex. HIV, tuberculosis and malaria. Others?)*	*All diseases (including HIV, tuberculosis and malaria) and other health problems*
Identify the HSS domain of service delivery based on your "HSS Performance framework"	*Offer of services, Health professionals, Medicine and medical products supply system*

(a) **Description of the rationale and the links that aim to improve/enhance the results for HIV, tuberculosis and malaria:**

MAXIMUM OF TWO OR THREE PAGES FOR EACH HSS ACTION *– In answering this question, use the same procedure as for Section 4.5.1, i.e. draw up the list of global HSS support objectives, interventions/specific activities over the course of the proposal in order to achieve these results as well as the principal recipients named in section 2.2.5 (Eligibility Section) responsible for global implementation and results/outcomes.*

a.1 Rationale

The DRC has a longstanding tradition of developing health services based on the creation of Health Zones[13] (HZ), which are the operational units of the national health policy to offer quality health care to the population for which they are responsible. In the DRC, it quality health care is considered to be offered when it fulfills the criteria of effectiveness, accessibility, continuity, totality, integration, safety and efficiency. It has long been a sectorial development priority to provide health care services in the Health Zones; this is based on a very important public-private partnership. Denominational hospitals often serve as referral hospitals for the HZ. This lengthy experience has encouraged more recent partnerships concluded with NGOs, usually in the framework of donor-financed projects.

The HZ-based organization has been greatly undermined by nearly two decades of bad governance (leading to bi- and multi-lateral breakdown in cooperation) and armed conflict. This has had a very negative impact on health coverage and quality of care (dilapidation and/or destruction of health infrastructures and equipment, loss of motivation and departure of health personnel who have left the country or migrated to different regions, etc.)

Many recent evaluations of the sector have identified several bottlenecks in the offer of health care services, including those in the fight against HIV-AIDS, malaria and tuberculosis. These are:

Health coverage – the weakness in health coverage is a direct consequence of the Government's

[13] The Health Zone (HZ) in the Democratic Republic of Congo (DRC) corresponds to the health district as defined by the WHO. In the DRC, a HZ includes a constellation of approximately 15 to 20 health centres and a General Referral Hospital. It covers a population of approximately 100,000 to 150,000 inhabitants in rural communities and 200,000 to 250,000 in urban areas. Each HZ is directed by a Health Zone supervisory team (ZST).

disengagement from the health sector in the 1990s, infrastructure dilapidation and the destruction of a significant portion of health infrastructures during armed conflict.

The results of HZ evaluation in implementing essential health interventions and the 2007 NHIS report show that health coverage[14] is poor. According to the NHIS report it stands at 26.3%. This situation explains the poor performance registered in 2008, according to the 2008 annual report of the UNDP/GF in Annex 11 for indicators such as the rate of use of PMCTs (57%), the number of uncomplicated malaria cases managed according to national directives (42%) and the MDR [treatment] success rate (50%).

Continuity and totality of care. In the wake of service fragmentation, it has become difficult for patients to access all the services they need in a single health setup, or even within a single Health Zone. Even though this has already been corrected with the Rounds 7 and 8 HIV/AIDS, the best illustration of this situation was encountered during the implementation of Round 3 Phase 1 of the HIV/AIDS unit, where a sick person who was diagnosed in one HZ could not be assured of receiving anti-retroviral treatment in the same HZ, which created serious ethical issues. Health care fragmentation is the result of very selective health care funding during this period (funds aimed at a limited number of diseases); funding has also been directed toward obtaining rapid results.

Issues with human resources. The low salaries paid to health personnel by the Government have resulting in loss of motivation and a high internal departure rate among basic health care services personnel: they would rather provide the "new services"[15] that offer more attractive salaries. This internal turnover has created a situation where personnel who work in basic health care services do not assume responsibility for fighting against the different diseases managed within these "new services". For example, the personnel who work in general referral hospitals in HZ consider that ARV treatment is not a hospital responsibility; instead, they believe that people are paid to be responsible for this activity. As well, competent and experienced managers are departing, leaving their positions to be filled by young university graduates with little experience. Due to these departures of qualified personnel in the HZ, the quality of services has suffered. In Katanga Province, in spite of its economic potential, there are no doctors with more than 10 years' seniority remaining in State structures. All the doctors who used to be there have immigrated to South Africa where the salaries are more attractive.

A decline in the quality of health services offered in the health zones. This is the result of several combined factors including the low quality of basic training of health personnel, rapid turnover of health personnel who no longer develop sufficient expertise, the dilapidated state of basic infrastructures and equipment, the difficulty in organizing integrated, continuous and comprehensive care for users in a context of fragmented health care, all resulting in inadequate effectiveness and efficacy.

The report on the state of health and poverty in the DRC carried out by the Ministry of Health and the World Bank (WB) in 2005 in the development of the Growth and Poverty Reduction Strategy Paper (GPRSP) shows that 82% of households are not satisfied with their health care[16]. This goes far in explaining the low user rate of health services, which is on average 0.15 (0.07-0.42) consultations per inhabitant per year, or less than one consultation per person every 6 years.

Problems related to the supply of essential drugs and specific inputs – The principal complaints

[14] Health coverage is measured by the populating rate residing under 5 km or less than one hour's walk from a Health Care Center.
[15] The "new services" referred to here are the services created to respond to certain specific problems.
[16] *Ministry of Planning. Growth and Poverty Reduction Strategy Paper, July 2007.*

at the operational level are back orders on inventory of essential medicine (ARVs, tuberculostatic drugs, ACT, etc.) or excess inventory in some places[17]. In fact, the national supply system for essential and generic drugs (EGD), which is made up of a network of the Regional Distribution Centers (RDC) of EGDs and known by the French acronym FEDECAME (the central federation of EGD supply centers) includes only 16 RDCs[18] instead of the anticipated 40. The RDCs face many problems, among them slow sales, a low rate of cost recovery related to the use of medicines, competition due to the existence of many supply networks provided by lucrative and unregulated private entities, and the existence of parallel circuits due to international funding, including the one involved in the fight against certain selected diseases.

Problems in Biomedical Waste Management (BMWM). Health care establishments generate a large quantity of waste, 20% of which is infectious, thereby posing a danger to health workers, patients and the community (WHO, 2005). According to the Status Report on BMWM carried out by Kiyombo et al (ESP, 2003), the health structures of the DRC can generate up to 85.2 cubic meters of biomedical waste per week. The same study revealed several problems related to the different stages in the BMWM sector : (i) the lack of selective sorting of biomedical waste, (ii) use of non-standardized waste containers, (iii) storage of waste in inappropriate locations, (iv) waste transportation by inappropriate means, (v) nearly non-existent BMW processing, (vi) inappropriate terminal disposal.
These harmful practices are reinforced by the lack of a national policy on hygiene, a lack of normative documents, inadequate personnel numbers and training, inefficiency of hygiene services, the absence of a budget allocation in medical sanitation training, as well as the lack of equipment. The necessity of efficiently and effectively managing biomedical waste to protect human health and the environment is becoming an emergency and an absolute necessity in the interest of the population.

National Response. To address all of these weaknesses and gaps, the Ministry of Public Health has developed the Health System Strengthening (HSS) strategy, which was adopted in 2006 along with all partners in the sector. This strategy, included in the Growth and Poverty Reduction Strategy Paper (GPRSP), will enable results to be achieved in the MDG on health issues. The HSS strategy is based on the National Interim Health Care Development Plan for implementation, which covers the period between 2009-2014 (NHDP-I 09-14)[19], a copy of which is provided in Annex 9, and is awaiting the development of a definitive National Health Development Plan (NHDP) that would extend over a period of 10 years.

A costing exercise was carried out to find out the cost of developing a Health Zone. It showed that a Health Zone that integrates the management of important endemic diseases such as tuberculosis, malaria and trypanosomiasis needs 18 US dollars per inhabitant per year. The report on this costing exercise is presented in Annex 12.
Among the available resources we can count on are: (i) 5.50 USD per inhabitant per year *(Source : Reviews of public expenses, RDC-BM, 2007, in Annex 18)* from development assistance for the next five years (including Rounds 5 and 6 for Tuberculosis, Rounds 7 and 8 for HIV, Round 8 for Malaria, and Rounds 9) ; (ii) Community contribution evaluated at 7.50 USD[20] per inhabitant per year; (iii) Government contribution of approximately 1.50 USD per inhabitant per year. This gives a total of 14.50 USD per inhabitant per year. The funds that are lacking toward carrying out the NHDP-I 09-14 are 3.50 USD per inhabitant per year, which comes out to approximately 227,500,000 USD for each year on average.

[17] Evaluation report on the capacity of health zones for the scalability of priority interventions, Ministry of Health, 2007). See Annex 17.
[18] NHIS Bulletin / SSP (Primary Health Care) n° 04, Ministry of Public Health, August 2008
[19] National Interim Health Care Development Plan 2009-2014 (NHDP I 09-14)
[20] Analytical report on the cost of health services and funding access in the Kenge Health Zone, GTZ, 2008. See Annex 10

Selection of Health Zones for intervention

With the implementation of Rounds 3, 5, 6, 7, 8 accomplished and 9 in the process of Global Fund solicitation, as well as the other donors (WB, European Union, ADB, USAID, GTZ, Coopération Belge, etc.), all of the 515 HZ in the country have integrated the tuberculosis and malaria programs. As well, 293 HZ will have integrated the fight against HIV/AIDS, if Round 9 HIV is approved. ***All the HZ in the country are therefore eligible*** for this intervention due to the fact that it includes at least two of the three proposals. However, with the support of the Government and health sector partners, 259 HZ already benefit from this type of intervention[21]. Through this intervention, the funding solicited by the country from the GF will enable extending the improvement of the offer and the quality of health service to the 256 remaining HZ[22]. This also meets observation 7 point 3 made by the TRP on the Round 8 HSS proposal. This support will also enable the integration of interventions (Minimum and Complementary Activities Packages) to fight against disease in the HZ. Service fragmentation will be reduced and therefore the effectiveness and efficiency of all interventions will be improved, including the ones for HIV/AIDS, tuberculosis and malaria.

a.2. Goal of Intervention 2:

The goal of this intervention is to contribute to improving the offer and quality of care in the Health Zones.

a.3. Global objective of Intervention 2:

In response to the weaknesses/gaps in the health care system that have not yet been addressed, the funding request aims to achieve the following global objective: "Increase the level of the population with access to quality health care services in 256 HZ to 50% between now and 2014."

a.4. Description of Intervention 2 activities

The principal activities in the framework of this proposal are :

1. Rehabilitate 1280 Health Care Centers in 256 Health Zones.

Five Health Care Centers (HCC) will be rehabilitated in each targeted Health Zone, for a total of 1280 HCCs to be rehabilitated over the 5-year period targeted by the intervention. The rehabilitation of the new HCCs, combined with equipment supply, will improve health care coverage and thus provide a greater proportion of the population with access to care. Access will be provided to populations which, for reasons related to the distance from the Center, do not yet have access to services in the malaria and tuberculosis programs and other health services. For HIV/AIDS in particular, the fact that HCCs have maternity wards will help increase the number of pregnant women who now access PMCT services with poor performances due to systemic constraints (insufficient maternity wards with the functional capacity to integrate the activity). The request for funding solicited here and for the other similar activities listed below is a contribution from the Global Fund for the implementation of 'the infrastructures development plan for the DRC' and for which a copy is provided in Annex 13.

2. Minor rehabilitation of General Referral Hospitals in 120 Health Zones

The General Referral Hospitals (GRH) are very important structures in the management of malaria, tuberculosis and HIV/AIDS cases. In fact, the GRHs manage the serious cases of malaria, multi-resistant strains of tuberculosis and ARV treatments. GRHs also manage blood transfusions, and GRH maternity units manage complications during labor.

Besides the offer for secondary referrals, GRHs are also entrusted with the mission to ensure on-the-

[21] Improvement of health care coverage and quality of care is one of the development priorities of the HZ. It is part of what is usually called "support for HZ development in the DRC". This support is distinct from selective supports aimed at the fight against disease for which it is an important support.

[22] The map of interventions of the different partners in the sector is provided in Annex 3 of this document.

job training for nurses in the Health Care Centers of the DRC; these nurses are responsible for caring for uncomplicated cases of malaria, applying the syndrome-based approach for sexually transmissible infection, etc. To carry out this dual mission, GRHs need to have a satisfactory level of operation. Several of the country's GRHs in the DRC are operating at very low levels. Several GRHs in the DRC are not highly operational for the reasons already mentioned above. A minimum of rehabilitation is necessary to improve the quality of the care offered at this level. Of the 256 GRHs in the targeted HZ, 120 require rehabilitation. This will target services (consultations, laboratory, pharmacy, hospitalization, maternity and PMCT services) that have direct links with referral cases of the three diseases targeted by the GF.

3. Equip 1280 Health Care Centers

The 1280 rehabilitated HCCs will be equipped with medical materials according to national norms. These norms provide for standard kits for HCCs. As with rehabilitation, the HCC equipment will increase user confidence in health care training, which improves the use of services and the quality of care that will be offered there. The list of small items for the HCCs is presented in the Annex.

4. Equip 120 General Referral Hospitals

The specific equipment used for the three diseases (malaria, tuberculosis, HIV/AIDS) is included in the proposals for this Round and the preceding Rounds. The one included in this intervention is for equipment that is not specific to these three diseases, but which maintains the GRH at a level of operation necessary to fulfill its dual mission of ensuring referral-level care and support for the Health Care Center activities. The request for the necessary resources to purchase microscopes, radiology equipment and electric generators is included in the 'Tuberculosis' proposal. One hundred and twenty GRHs will benefit from this equipment. The list of standard equipment for GRHs is provided in Annex 15.

5. Strengthen the ability of managers in the 256 Health Zones to manage health care services

The quality of services also depends on the manner in which they are organized. The management teams as well as the head and attending nurses in the targeted Health Zones will be trained in planning, supervision, services management, integration of specialized programs, quality care insurance, etc. The skills of HC workers in the use of organizational flow charts and the ability of GRHs to manage case referrals will also be reinforced. Therefore, this activity will enable workers to better diagnose cases in general, and especially those related to the disease triad Malaria-HIV/AIDS-Tuberculosis, in treating patients or directing them to the appropriate structures.

In total, 256 Management Teams of 5 persons each will be formed in the Health Zones, for a total of 1280 persons. The training sessions for the management teams will last for 4 weeks. This training will be provided at the intermediate level and the central level of the health system and will be held in 22 pools, corresponding to the chief provincial sites or Health care districts.

Three managers will be trained per HC: the head nurse, the attending nurse and a midwife. The total number of persons to train in the Health Care Centers is 3840. Training will last for 6 days and will be provided by the members of the Management teams of the Health Zones, once they will have been trained as indicated in the preceding paragraph.

Considering that the quality of the personnel training and materials being used to strengthen the skills of managers in the HZ and provinces in the NHIS differ considerably from that of the one related to this intervention, the budget for intervention 1 has been divided.

6. ***Provide 10 Rural health districts and 120 Health Zones with vehicular equipment***

To provide quality care, the activities of the different health training activities must be supervised. To do this, the Health Zones must be provided with vehicular equipment. This will also serve transportation needs when providing health care training in drugs and specific inputs. In the 256 HZ, 120 need vehicles, 48 need outboard engines and the rest need motorcycles. Ten rural Health care

districts[23] will be provided with vehicles for close supervisions of the Health Zones. These Health care districts will be selected from the 33 that cover the 256 HZ. From these 33 districts, 23 have been excluded because they are provided with vehicles through funding from GAVI-HSS or other partners.

The total number of vehicles required by this intervention is therefore 130, and 200 motorcycles are also needed. The cost of purchasing these 200 motorcycles is budgeted for in the "Tuberculosis" proposal. The same goes for the HC that have not been accounted for in the budget here.

7. Grant premiums to health personnel in the form of performance contracts

In the wake of the Government's difficulties paying a decent and regular salary to health personnel, we are experiencing low staff morale and significant internal migration of personnel, irrational use of resources, and even the expatriation of human resources. To close the salary gap and motivate personnel, the Government has introduced the payment of a (professional) risk premium to health personnel working in public administration. Unfortunately, this premium is still inadequate. To remedy this situation, several partners in the sector have undertaken to pay performance premiums through the projects they finance, in order to guarantee outcomes[24].

It should be noted that with the funding obtained in the preceding rounds, the performance premiums will be paid in all integrated TB Detection and Treatment Centers (CSDTs). Currently, the National tuberculosis program pays the premium on the resources of the Global Fund in approximately 1450 CSDTs of the 8000 HCCs in the country.

Premiums paid in the form of performance contracts will motivate health personnel and thus stabilize this resource in health care training, as well as help in achieving the results of the intervention, those of the component diseases (Malaria, Tuberculosis and HIV/AIDS) in this Round and in previous Rounds. Contrary to previous Rounds, the CCM has decided that the premiums for personnel in the national programs and provincial efforts in the fight against the three diseases be accounted for in the respective proposals, where as those of the personnel that work in the Health Zones should be accounted for in the HSS phase.

This decision has been made in light of reports from the field stating that the health personnel tend to care only for health problems for which the premium is paid. During a recent follow-up mission to the implementation of the HSS strategy in the province of Bandundu, the delegation at the central level observed a situation where the health personnel paid per performance in the national TB program refused to care for a case of HIV/AIDS because, as someone said, "he was not paid for that."

The premiums solicited through this intervention will be a useful complement to those that the Government pays to health personnel in the 256 targeted Health Zones. The other development partners also pay complements to the premiums of the personnel in the Health Zones they support (259 Health Zones).

With GF funding, the national TB program pays premiums to 7 persons (Head medical officer in the Zone, supervisory nurse and head nurses in the CSDT) in each Health Zone. These premiums are paid through Round 5 which runs until the end of 2011.

Briefly, the premiums will be paid in the 256 Health Zones targeted by intervention 2 over a period of five years. In the GRHs, 20 persons directly involved in implementing the intervention will be paid, for a total of 5120 persons. In the Health Care Centers, 5 persons will be paid per performance, for a total of 6400 persons. These premiums will be paid for a period of five years. Given that the premiums paid in the Health Zones by the National TB program through Rounds 5/6 will continue until the end of 2011, this intervention proposes to continue payment of these premiums after Round 5 to avoid demobilization of the personnel who receive them. This clearly means that at the end of 2011, the premiums anticipated in this intervention will be extended to 7 persons per HZ in the 259 other HZ that are not targeted by this proposal. Round 8 Malaria has not anticipated incentive premiums in the HZ. The same is the case for Rounds 7 and 8 of the HIV/AIDS proposal. The links between the

[23] In the DRC health system, the Health District corresponds to the 2nd division at the intermediary level, the first division being the provincial one. It is closer to the Health Zones than the provinces and thus constitutes a privileged level for supervision close to the Health Zones.

[24] This is the PS9FED, from the GAVI-HSS project, ASSNIP project, BAD/PAPDDS-Eastern Province, PAHSS, etc.

different financial arrangements are presented in the table below.

Source de financement	Période couverte				
	2010	2011	2012	2013	2014
R5&6 Tub_515 ZS					
R7 & 8 VIH (239 ZS)					
R8 Paludisme (119 ZS)					
R9 RSS	256 ZS	256 ZS	515 ZS	515ZS	515 ZS
Autres bailleurs					

Source de financement = Source of funding

Période couverte = Period covered

VIH = HIV

Paludisme = Malaria

RSS = HSS

ZS = HZ

Autres bailleurs = Other donors

At the central level, 20 managers from the Directorate for the Development of Primary Health Care (DDSSP; in charge of managing routine health information), the Directorate of Studies and Planning (DEP; in charge of managing the health system and strategic information), and the Directorate in the Fight Against Disease (DLM; in charge of coordinating the programs to fight disease) will also be paid per performance, for a total of 60 managers at the strategic level, including 3 Directors, 15 Division Heads, 21 Bureau Heads and 21 auxiliary administrative agents. The central purpose is to motivate the personnel who work at the strategic level and on whom the mission of intervention management depends, to guarantee better monitoring at the intermediate and peripheral levels and therefore to achieve the expected results against tuberculosis, malaria, HIV/AIDS as well as the other endemic diseases and public health problems.

8. Carry out a status report on the supply system and the distribution of medicine and specific inputs

A status report on the national medicine and specific inputs supply system will help identify the problems it faces, describe the conditions and develop a plan to strengthen skills based on the weaknesses identified at all levels. This will allow the system to absorb the financing from the Global Fund aimed at medicines and to thus put an end to the parallel supply networks. While waiting for the results of the status report, given that the availability of pharmaceuticals has been a crucial issue in the HZ since the 1990s, it is necessary and urgent to supply 1280 HCCs and 256 hospitals with standard kits of essential drugs in compliance with national norms and the list of essential drugs established in the national pharmaceutical policy These kits are the annual working capital. The list of medicines for the GRH Kit is provided in Annex 15 and the HC Kit is listed in Annex 16.

9. ***Integrate the activities for biomedical waste management in 256 Health Zones***

A system for biomedical waste management will be set up in the framework of medical training in 256 HZ. The national strategic plan for the management of biomedical waste adopted in 2008 with the support of partners (WHO, UNICEF) expects to (i) improve the institutional and regulatory framework, (ii) strengthen health personnel skills, (iii) provide communication in order to modify practices and (iv) provide material and equipment supply for the Management of Biomedical Waste (MBMW). This plan aims to reduce morbidity and mortality due to HIV/AIDS and other nosocomial diseases transmitted via blood and carried by sharp objects and other biomedical waste items (used gloves, spittoons, human organs, biological fluids, etc.).

The funding solicited here supports the implementation of this plan as recommended at the regional

WHO/Afro workshop held in Accra, Ghana in June 2008. It aims to support the development of norms and directives in biomedical waste management. An international consultant will be recruited to support the national managers in the process of developing these norms and related directives. A workshop to validate documents and guidelines thus developed will also be organized. The workshop will bring together 50 persons over a period of three days.

Six prefabricated incinerators will be installed in each Health Zone, including one at the GRH and 5 in the rehabilitated Health Care Centers.

Support for integrated supervision in the Health Zones

Integrated supervision carried out by a versatile staff will target several fields of services and will provide the advantage of being efficient and saving time. The funding solicited for this will provide integrated supervision in the HCC by the zone supervisor teams. The Health Care Centers will be visited once every month. Besides the vehicular equipment mentioned above, the health zone supervisor teams will need fuel and oil for travel as well as overnight expenses. The links with the existing funding will be established next in point 5.

a.5. Links with existing funding

- Given that the Health Zones, the subject of this funding request, do not have partners in support of development, the risk of duplication of interventions is non-existent here. However, the existing funding from the GF (R5, 6, 7, 8) in some of these HZ does not involve activities 1, 2, 3, 4, 5, 6, 8 and 9 described above. Some materials and equipment specific to the proposals, such as microscopes, already delivered to these HZ or which must be provided in the framework of Round 9 / disease proposals, are therefore not itemized in the HSS phase.
- For activity 7 relating to human resources, the links with existing funding have been established in the description of this activity.
- For activity 10, the funding acquired during the preceding rounds supports specific supervision in each proposal at the three levels of the system. During the preparation of this submission, the CCM decided that the budget for the "specific" supervisions of each proposal would not be taken into account by the HSS phase. A consensus emerged in favor of a request for funding for the integrated supervisions as cross-cutting activities in the HZ. Therefore, the supervision budget presented by the disease proposals only takes into account the supervision at the central level toward the provinces and the provincial coordination toward the HZ. Based on support for monitoring in the HZ, the funding solicited through this submission will:
    - Support integrated supervision in 256 HZ from the 1st to the 2nd year of implementation of the HSS proposal. The amount allocated by the GF for this activity will have the objective of erasing the inequalities created by the other partners' focus on 259 other HZ
    - Maintain the tuberculosis acquisitions by funding the supervision of activities in 2012 and 2013 in all of the 515 HZ
    - Cover the supervision needs in the 515 HZ in 2014, which is year 5 of the implementation of this proposal, by adding a program to cover the integrated supervision of all the interventions in the 515 HZ.

a.6. Implementation capacities*: see intervention 1*

(b) **Indicate the anticipated achievements/results/outcomes below** *(using one key phrase, not a detailed description)* that will be reached/obtained each year with the support of this HSS cross-cutting intervention for the period of the proposal. ➔*Read the Round 9 Guidelines for more information.*

Year 1	Year 2	Year 3	Year 4	Year 5
access to quality	access to quality	access to quality	access to	access to

services and health care by 30% of the population	services and health care by 36% of the population	services and health care by 41.3% of the population	quality services and health care by 46% of the population	quality services and health care by 50% of the population

(c) **Describe below** <u>all other</u> current and anticipated support for this action for the period of the proposal.

*In the column on the left below, indicate the name of the **other sources** of support for the strategic action of the HSS. In the other columns, provide information on the types of results.*

Name of partners supporting the intervention ↓	**Support calendar for the HSS actions (starting and ending date)**	**Amount of financial support provided for the duration of the proposal** *(same currency as selected by Applicant on face sheet of the Proposal Form)*	**Anticipated results / outcomes of this support**
Government	See Intervention 1		
Other grants from the Global Fund (with HSS elements [*if needed*])	*2010-2013 (5 , 6, 7 et 8)*	$46,130,450.00	Support for service delivery specific to each disease proposal (training, equipment, supervision, etc.) The activities specific to each proposal are not the subject of this request for support. The cross-cutting HSS activities aim to improve health coverage and quality of care.
Others: *(PS9FED)*	2009-2010	$2,345,200.45	Strengthening institutional capacities in the 82 HZ not listed with the 256 HZ targeted by intervention 2
Others (GAVI-HSS)	2010-2011	$22,908,500.00	Supporting the development of 65 HZ not listed with the 256 HZ targeted by intervention 2
Others: *(WB-PAHSS)*	2010-2011	$26,550.00	Strengthening

			institutional capacity in the 82 HZ not targeted in intervention 2
Others: *(CTB-ASSNIP)*	2008-2011	NA*	Supporting the development of 7 targeted HZ not targeted in intervention 2
Others: *(ADB-PAPDDS health project)*	2008-2010	$5,700,000.00	Strengthening the institutional capacity of the 26 targeted HZ.

***NA: Not available**

Comments: The other donors support the improvement of health coverage to different degrees in 259 of the 515 HZ. It is important to note that among these HZ, some have one or several partners to support development. These HZ are therefore targeted in intervention 2.

4B.2 Involvement of key HSS partners in the development of the proposal

(a) Briefly describe which principal HSS partners (for example, the ministries of planning, finance, etc., non-governmental sector) have been involved in the identification and development of the appropriate HSS cross-cutting interventions in Round 9. Explain why these partners were selected. Why are they the most relevant to a comprehensive evaluation of the weaknesses and actions of the health care system in the overall context of the country?

The HSS interventions advocated in this proposal fall into the framework of HSS strategy implementation. This strategy defines a set of actions that consist in reorganizing the entire health care system so that it can provide coverage to the whole population through health structures that offer basic and quality health care services.

These actions fall under the government's GPRSP as the contribution of the Ministry of Health in the fight against poverty and therefore are a way to reach the MDG in the field of health. The implementation of these actions has been carried out in a sequential fashion through the government's Priority Actions Program (PAP) since July of 2007. Donors and development partners have aligned with the GPRSP and the PAP to apply the Paris Declaration on the effectiveness of aid.

During the 2008 Annual Review, the Ministry of Health and all partners observed a progressive start, at different degrees, to initiating the HSS strategy in all 11 provinces of the country with the support of projects such as PS9FED, ASSNIP, PAHSS, USAID, GAVI-HSS, and others. From the report of this review, it is evident that malaria, tuberculosis and HIV/AIDS are the principal causes of the excessive morbidity and mortality, especially in the HZ that are only slightly or not at all supported.

To address this situation, and due to the necessity of staging and consolidating the interventions in the previous rounds, the CCM has determined the fields of service delivery for the malaria, tuberculosis and HIV/AIDS proposals as well as the HSS interventions. Based on the observations of the TRP on the HSS proposal in Round 8, the Ministry of Health and all the partners in the HSS strategy have decided to resubmit the HSS proposal in round 9 with a few very significant amendments. Among the participants in this decision are the public sectors (Parliament, the Ministry of Planning, the national police force, the Armed Forces), the Associations for people living with disease, the economic agents, the Agencies of the United

Nations System (WHO, UNICEF, UNFPA, etc.), the representatives and heads of mission of the Bilateral Co-operations and civil society organizations.

A writing team was therefore set up with support of national experts to examine and integrate the observations of the TRP / Round 8 THSS. During the entire period of the writing process, meetings and exchanges were held regularly at the Directorate of Studies and Planning of the Ministry of Health, coordinated by the CCM Technical Secretariat, with the goal of obtaining a consensus on the HSS interventions corrected in this proposal.

The first draft of the HSS proposal was shared with peers during the workshop held from March 31 to April 3, 2009, in Ouagadougou by WHO Afro, UNAIDS, UNICEF, and others. The feedback from this peer review was presented to the CCM and integrated in this submission. During the writing period, special attention was drawn both to the risk of duplicating activities with the tuberculosis, HIV/AIDS and malaria proposals, and to complementarity with the previous rounds and funding from other donors.

The interventions described above address most of the gaps in the national health system as enumerated in section 4.3.2. They were identified by taking into account the priorities of the national policy on health, the interim plan to implement the HSS strategy, the GPRSP, the PAP and support from the partners. They extend to the other social sectors in the upcoming Round(s) in view of a multi-sector fight against these diseases.

A 10-day workshop bringing together national and international experts, civil society organizations, and the other partners in the sector, provided the forum to analyze and integrate all the micro-proposals into the disease proposals in general and into section B in particular.

The proposal elaborated in the wake of these gatherings was submitted for approval to the CCM during the consensus workshop held in Kinshasa on May 20-21, 2009. The recommendations and amendments proposed at that event were integrated into this proposal before the General Assembly was held, in order to sign the document on May 27, 2009.

(b) Has the candidate ensured that: (i) The HSS cross-cutting interventions in this proposal do not duplicate any request for funding included in <u>any other</u> disease proposal, (section 4.5.1 of each disease)? And	[X] Yes
(ii) Do the <u>detailed work plan</u>** **and the** "<u>Performance framework</u>"** (Annex A) for this disease include separate work sheets clearly indicating the HSS cross-cutting interventions for each objective, service delivery area and activity for the first two years of the proposal? ** *If they prefer, applicants may prepare a separate **work plan** for the HSS cross-cutting interventions <u>as well as a</u> separate **Performance framework** (Annex A).*	[X] Yes

4B.3 Strategy to reduce the initial unintended consequences

In the event of initial consequences that disturb the planned investments in all or in part of the HSS cross-cutting interventions defined in section 4B.1 above *(for example, departure or relocation of human resources to other services*:

- Which factors were taken into account when the decision was made to request funding support in all circumstances?

What is the strategy proposed by the candidate to reduce these potentially destabilizing consequences?

When the CCM decided to formulate this request for funding support for the HSS cross-cutting interventions, three important factors that could destabilize the implementation of these interventions were taken into account. These were: (i) health personnel's focused interest in

activities paid for by the highest bidder, (ii) massive and untimely relocation of health personnel to supported HZ and (iii) the presence of Community Relays specialized in Health Areas.

(**i) The interest of health personnel in activities paid for by the highest bidder**

The low State salaries of health personnel and the lack of payment arrangements when staff are newly hired or salaries which remain unpaid for long periods in the health care sector have led personnel to become disenchanted with low-paying activities and to develop survival mechanisms. Awarding performance premiums, which was solicited in this proposal in view of motivating personnel, may result in them devoting more time and energy to the activities supported by the Global Fund to the detriment of the other interventions in primary health care that are not supported.

To remedy these situations, the Government of the Republic has upgraded the Interprofessional Guaranteed Minimum Wage (SMIG) and has decided to regularize the wages of State agents and personnel. As well, the Ministry of Public Health, via the HSS strategy, has set up a common fund (basket funding) to remedy the problem of staff disinterest in unsupported activities. This implies that the performance premium to be allocated to personnel will only be awarded in the framework of *carrying out all Minimum and Complementary Activities Packages* that are part of their job and not only for the ones supported by the Global Fund.

(ii) The massive and untimely relocation of health personnel to supported HZ

The massive and uncoordinated relocation of health personnel to supported health zones takes place in an irrational fashion due to material reasons. To counter this, the Ministry of Public Health has established temporary measures while awaiting the promulgation of the framework law on health care in the process of decentralization. These measures involve, among other things, assignments, relocations, etc. that must be done in accordance with the Health Zone Development Plan (PDSZ).

(iii) The presence of Community Relays specialized in Health Areas

Observations show that the Relays tend to focus mainly on interventions that provide the most inputs and advantages, to the detriment of others. To address this concern, the Ministry of Public Health advocates the set up of versatile CRs that would effectively put an end to CR recruitment per intervention and per program.

ROUND 9 – Tuberculosis

5. REQUEST FOR FUNDING

Clarified Section 5.1

5.11 Analysis of funding gaps - Tuberculosis

➔ *The summary information provided in the table below must be filled out in more detail in Sections 5.1.1 - 5.1.3.*

Analysis of funding gaps *(same currency as selected by Applicant on face sheet of the Proposal Form)*

Comment: ➔ Adjust the table headings as necessary to translate calendar years into fiscal years (for example, end of the 2008 FY, etc.) to align the annual planning with the fiscal cycle.

	Real		Anticipated		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Tuberculosis Program funding must provide for complete diagnostic and treatment services, as well as complete care and support for targeted populations								
Line A ➔ Indicate the annual amounts	**14,761,087**	**40,520,256**	**53 253 975**	**64,547,438**	**65,068,246**	**64,014,821**	**63,593,631**	**67,871,461**
Line A.1 ➔ Total for the funding request period for Round 9	*(total need for the period of the Round 9 proposal)*							
Current and future resources to fulfill funding needs								
B1 National Resource: Loans and debt relief (*CTB)*	837,000	751,951						
B2 National Resource: National funding sources	1,644,800	2,812,481	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**
B3 National Resource: Private sector contributions (national)								
Total of items on Line B ➔ Total NATIONAL Resources (debt relief included), current and anticipated:	2,481,800	3,564,432	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**	**2,812,481**
C1 External resource (*indicate the name of the donor*)								

ROUND 9 – Tuberculosis

Analysis of funding gaps *(same currency as selected by Applicant on face sheet of the Proposal Form)*

Comment: ➔ Adjust the table headings as necessary to translate calendar years into fiscal years (for example, end of the 2008 FY, etc.) to align the annual planning with the fiscal cycle.

	Real		Anticipated		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
C1 External resource ***Action Damien (AD)***	2,760,450	3,073,006	**3,073,006**	**3,073,006**	**3,073,006**	**3,073,006**	**3,073,006**	3,073,006
C2 External Resource ***The Leprosy Mission (TLM)***	**949,243**	**98,9578**	**98,9578**	**98,9578**	**98,9578**	**98,9578**	**98,9578**	989,578
C3 External Resource ***USAID***	**504,115**	**800,000**	**2,000,000**	**2,000,000**	**-**	**-**	**-**	
C4 External Resource ***European Commission***	**342,355**	**342,355**	**516,334**	**516,334**	**516,334**	**-**	**-**	
C5 External Resource ***Development Agency of France (AFD)***	**-**	**73,085**	**158,600**	**96,410**	**-**	**-**	**-**	
C6 External Resource ***Korean Cooperation***	**-**	**-**	**1,352,500**	**-**	**-**	**-**	**-**	
C7 External Resource ***Swedish Baptist Union / (SBU)***	**113,125**	**185,225**	**144,625**	**161,425**	**161,425**	**161,425**	**161,425**	161,425
C8 External Resource ***World Health Organization (WHO)***	**300,000**		**300,000**		**300,000**		**300,000**	
C3 External Resource Private Sector Contributions (international)								
Total items on Line C ➔ Total EXTERNAL Resources (excluding Global fund grants), current and anticipated:	**4,969,288**	**5,463,249**	**8,534,643**	**6,836,753**	**5,040,343**	**4,224,009**	**4,524,009**	**4,224,009**

In Line D below, add supplementary lines for each grant from the Global Fund to present information on the different GF grants.

ROUND 9 – Tuberculosis

Analysis of funding gaps *(same currency as selected by Applicant on face sheet of the Proposal Form)* **Comment: ➔ Adjust the table headings as necessary to translate calendar years into fiscal years (for example, end of the 2008 FY, etc.) to align the annual planning with the fiscal cycle.**								
	Real		**Anticipated**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Line D: Annual amount of all existing grants from the Global Fund for the same disease: Include the non-approved amounts from "Phase 2" as "anticipated" for the corresponding years	**6,683,911**	**13,878,589**	**10,885,399**	**7,750,497**	**8,071,860**	**1,227,825**	0	0
Line E ➔ Total current and anticipated resources (Line E = total Line B + total Line C + total Line D)	**14,134,999**	**22,906,270**	**18,880,023**	**15,399,731**	**15,924,684**	**8,264,315**	**7,336,490**	**7,036,490**
Calculate the gaps in funding resources and synthesis of the total funding requests in Round 9 ***(attach a detailed budget)***								
Line F ➔ Total funding gap (Line F = Line A - Line E)	**626,088**	**17,613,986**	**24,436,499**	**49,147,707**	**49,143,562**	**55,750,506**	**56,257,141**	**60,834,961**
Line G = Funding request for Tuberculosis Round 9 *(same amount as in Table 5.3 for this disease)*				**14,631,467**	**18,166,661**	**35,864,038**	**28,651,127**	**31,415,507**

ROUND 9 – Tuberculosis

Part H – Calculation of "cost sharing" for the candidates with lower middle income and upper middle income

For Round 9, the request for total maximum funding for tuberculosis in Line G corresponds to :

*(a) For **countries with a lower middle income**, an amount such as the total contribution of the Global Fund (all grants) to the national program not exceeding 65% of the funding needs of the national program in the fight against disease for the duration of the proposal;*

*(b) For **countries with an upper middle income,** an amount such as the total contribution of the Global Fund (all grants) to the national program not exceeding 35% of the funding needs of the national program in the fight against disease for the duration of the proposal.*

Line H ➔ Calculation of cost sharing as a percent (%) of total funding from the Global Fund **Cost sharing = (total of the items on Line D for 2010-2014 + total of Line G) X 100** **Line A.1**	**45 %**

ROUND 9 – Tuberculosis

5.1.1. Explanation of funding needs - LINE A of Table 5.1

Explain how the annual amounts were:

- calculated *(for example, by cost evaluation of national strategies, a spending framework over the intermediate term or another basis);* and
- budgeted so as to take account of the needs of government sectors, non-government sectors and community sectors, to ensure the complete implementation of the strategy and national Tuberculosis program.

We used the plan developed with the planning and budget tool in the control of TB from the WHO's updated HALT-TB program for 2006-2015.

5.1.2. National funding – items on LINE B of Table 5.1

Explain the process used in the country to:

- give priority to national funding contributions to the National tuberculosis program *(including the HIPC [heavily indebted poor countries] and other debt relief, as well as grants and loans accounted for in the national budget)*; and
- guarantee that the national resources are used in an appropriate manner, with transparency and equitability, to implement the treatment, diagnostic, care and support strategy at the national, sub-national and community levels.

The budget allocated to the Tuberculosis Program by the Congolese Government includes the salaries of State civil agents and undeveloped real estate infrastructures. As well, through the different grant protocols that have been signed, the Government has committed to participate in funding by awarding a tax exemption for customs and payment of water and electricity bills.

The Tuberculosis Program has been registered in the HIPC budget for supplying medicine.

With regard to loans, only the Coopération Technique Belge was involved in the Tuberculosis Program up to 2008.

In the Ministry of Health, there are entities and follow-up mechanisms to control Resource management: general services from the Ministry of Health, an inspection corps, public finance inspectors and institutional management committees.

5.1.3. External funding *besides the Global Fund – items on* LINE C of Table 5.1

Explain all modifications to anticipated contributions during the proposal (*and the reason for any identified reduction in exterior resources over time).* Any current delay in the access to exterior funding indicated in Table 5.1 must be justified (reasons for the delay and anticipated measures to correct the situation.)

Support for the National TB program besides the Global Fund includes Coopération Technique Belge (Coopération Bilatérale), NGOs and the WHO. The difficulty is that none of these organizations plans the interventions in the Democratic Republic of Congo over a five-year period. The budgets are drawn up on a yearly basis and are sometimes communicated late and even during the year in question.

Therefore, we experience project interruptions or terminations, or sometimes one of the partners has to leave the country or cut off support to structures in the field. Countries in

post-conflict periods do not have an adequate budget to enable them to completely support the fight against tuberculosis.

We observe many other delays between the signing of an agreement and the effective start-up of activities in the field with the disbursement mechanism for foreign funds. These delays persist even when the project is ongoing.

The solutions would be:

1. To be informed on time of the budget discussed and granted
2. Set up a timeline for budget items
3. Establish a plan for fund disbursement and provision for a minimum of 6 months up to a maximum of one year.

Alleviate the mechanism for the disbursement of funds to structures.

5.12 Detailed budget

Steps in budget completion:

1. **Submit a detailed budget proposal in *Microsoft Excel format, as a clearly numbered Annex.*** Whenever possible, use the same numbering for the budget line items and the program description.
   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or as a model in the absence of a detailed national budget framework)*, **consult the information on the budget available here:** http://www.theglobalfund.org/en/rounds/9/single/#budget.
2. Ensure that the detailed budget is consistent with the detailed plan for the program activities.
3. From this detailed budget, **prepare a "*Summary by objective and by service delivery area*"** (Section 5.3.).
4. From this detailed budget, **prepare a "*Summary by category of costs*"** (Section.5.4.)
5. Do not include any CCM or sub-CCM operational cost in Round 9. This support is now available through a separate process in applying for direct funding by the Global Fund (and not by grant allocation). This application process is available online at: htttp://www.theglobalfund.org/fr/ccm/

5.3. Summary of the detailed budget by objective and service delivery area

Objective n°	Service delivery area *(Use the same numbering as in the program description in Section.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Improvement of diagnosis	4,327,677	5,533,104	5,763,211	5,120,271	5,073,322	25,817,584
1	Patient support	642,395	701,495	766,035	836,511	913,466	3,859,902
1	Management of purchases and inventory (first-line medication)	-	-	9,186,364	6,997,367	7,770,010	23,953,741
1	Monitoring and Evaluation	1,365,238	1,046,968	1,997,202	954,670	1,029,339	6,393,417
1	Management and supervision of the program	939,170	871,438	4,292,107	3,968,683	4,181,244	14,252,642
1	HRD	2,310,312	2,900,084	5,787,873	2,388,609	2,484,561	15,871,439
2	Tuberculosis / HIV	1,009,148	2,659,240	1,048,608	1,138,985	1,237,426	7,093,407
2	Multi-drug resistant tuberculosis	774,527	1,467,376	2,545,221	3,004,050	3,410,427	11,201,602
2	Control of infection	209,783	327,115	396,950	471,743	551,442	1,957,033
3	PAL (practical approach to lung						

ROUND 9 – Tuberculosis

Objective n°	Service delivery area *(Use the same numbering as in the program description in Section.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	health)	158,725	124,618	148,720	224,973	292,465	949,500
4	All recipients of PPM / ISTC care (public-public, public-private mixed, and international standards for tuberculosis care)	90,900	44,928	46,725	48,594	50,538	281,685
5	Raising awareness, communication and social programs	452,787	483,270	637,081	651,250	720,520	2,944,907
5	Community care for tuberculosis	231,000	321,360	334,214	347,583	361,486	1,595,644
6	Operational research	185,100	223,704	232,652	241,958	181,445	1,064,859
	Overheads (management - direct)	1,934,707	1,461,962	2,681,073	2,255,879	3,157,816	11,491,437
	Total	**14,631,467**	**18,166,661**	**35,864,038**	**28,651,127**	**31,415,507**	**128,728,799**
Funding request for Tuberculosis in Round 9:		**14,631,467**	**18,166,661**	**35,864,038**	**28,651,127**	**31,415,507**	**128,728,799**

ROUND 9 – Tuberculosis

5.4. Summary of the detailed budget by cost category *(the summary information in this Table must be completed with additional information in Sections 5.4.1 - 5.4.3.)*

Clarified Section 5.4

If possible, avoid using the category "Other" – read the Round 9 Guidelines.

	(same currency as selected by Applicant on face sheet of the Proposal Form)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	909,030	1,020,774	1,418,611	1,507,441	1,530,982	6,386,837
Technical and management assistance	180,000	187,200	194,688	101,238	105,287	768,413
Training	1,698,725	2,250,647	5,147,764	1,293,094	1,475,790	11,866,020
Health products and health equipment	2,607,023	5,067,838	4,115,968	4,576,614	4,888,117	21,255,560
Pharmaceutical products (medicines)	447,141	981,146	9,195,316	7,830,830	8,851,940	27,306,372
Procurement costs and supply management costs	1,124,284	1,959,738	3,534,403	3,190,705	3,518,882	13,328,013
Infrastructure and other equipment	2,156,590	1,418,894	1,391,338	436,863	41,822	5,445,507
Communication material	214,863	223,457	353,365	341,431	382,199	1,515,314
Monitoring and evaluation	1,710,830	1,435,564	5,388,602	4,485,573	4,598,194	17,618.763
Living support for clients/target populations	1,016,319	1,173,467	1,307,172	1,452,293	1,609,764	6,559,016
Planning and administration	50,000	50,000	50,000	50,000	50,000	250,000
Overheads	2,516,662	2,397,936	3,766,810	3,385,046	4,362,530	16,428,984
Other: *(use for corresponding with categories of national budget planning, if necessary)*						

ROUND 9 – Tuberculosis

If possible, avoid using the category "Other" – read the Round 9 Guidelines.	*(same currency as selected by Applicant on face sheet of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Funding request for Tuberculosis in Round 9 (*must correspond to the annual totals in Table 5.2)*	**14,631,467**	**18,166,661**	**35,864,038**	**28,651,127**	**31,415,507**	**128,728,799**

5.4.1. Background to the global budget

Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

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Costs show an increase in the third to fifth years because funding of Round 5&6 stops in 2011, whereas the first two years are attenuated by the current budget. An example of this is the budget increase for the pharmaceutical product category. Paradoxically, the budget amounts for infrastructures and other equipment change by decreasing progressively due to the fact that rehabilitations and purchase of equipment were planned for the first years. Budget for training increases somewhat in the third year because training on revised directives is anticipated for all personnel in the 1545 TB Detection and Treatment Centers (CSDTs).

5.4.2. Human resources

If "Human resources" represents a significant portion of the budget, summarize: (i) the basis of budget calculation for the first two years, (ii) the method of calculating the anticipated costs for years three to five and (iii) how the expenses in human resources strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach all additional information in the form of clearly identified and numbered Annexes.*

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Human Resources represent 5% of the total budget. The costs are broken down in the following manner: central level 2.1 %; intermediate level 1.6% and community level (support for community relays) 1.3%. The human resources at the peripheral level (CSDT) are accounted for in the HSS phase of Round 9. In a context where salaries are too low, performance supports such a s these help to strengthen service delivery.

5.4.3. Other large expenditure items

If other "cost categories" represent important amounts in the summary of Table 5.4, (i) explain the basis of the calculation of these amounts in the budget. Also, explain how these contributions are important for the implementation of the National tuberculosis program.

➔ *Attach all additional information in the form of clearly identified and numbered Annexes.*

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The pharmaceutical products section accounts for:

- The first-line drugs for 3 years and the safety inventory
- Second-line drugs for 5 years and the drugs used to counter adverse effects
- Drugs for managing respiratory disease (PAL)

Anti-tuberculosis medicines are a priority for the program. For the basis of calculations made, please consult the detailed assumptions "first-line medicine, MDR-TB, PAL"

5.5. Funding requests in the framework of a common funding mechanism

In this section, **common funding mechanisms** refer to situations in which all funding is integrated into a common fund to be distributed to the partners in implementation.

Do not complete this section if the country shares items such as supply efforts, but all the other funding is managed separately.

5.5.1. Operational status of the common funding mechanism

Briefly summarize the main characteristics of the common funding mechanism by specifying the name of the fund, its objectives, governing structure and key partners.

➔ *Using clearly identified and numbered Annexes, attach the following documents to your proposal: the protocol agreement, the common monitoring and evaluation procedures, the most recent annual report, the accounting procedures, the list of key partners, etc.*

5.5.2. Performance measures

How often is program performance measured by the common funding mechanisms? Explain how the performance of the program influences the funding contributions to the common fund.

5.5.3 Complementarity of the request to the Global Fund
Explain how the requested funding in this proposal (*if it is approved*) will contribute to the success and results that would otherwise not have been covered by the available resources or provided for in the common funding mechanism. *If the scope of the common fund extends beyond the tuberculosis program, the candidates must explain the process by which they can guarantee that the requested funds will contribute to the weight of the results of the Tuberculosis program during the period of the proposal.*

5B. FUNDING REQUEST - HSS CROSS-CUTTING INTERVENTIONS

Funding request for HSS cross-cutting interventions is optional in Round 9.

IN ROUND 9, SECTION 5B CAN ONLY BE INCLUDED IN ***A SINGLE DISEASE****, with the condition that this disease include in Section 4B the program description of the candidate concerning the HSS cross-cutting interventions.*

Read the Round 9 Guidelines for the account of the HSS cross-cutting interventions.

Section 5B can be downloaded from the Global Fund website. Candidates are invited to click here if they anticipate including " cross-cutting interventions to strengthen the health system" ("HSS cross-cutting interventions") ***in Round 9 and if they have completed Section 4B and have***

5B.1 Detailed budget

Steps in budget completion:

1. **Submit a detailed budget for the HSS cross-cutting interventions** ***in Microsoft*** *Excel format* using the same numbering for the budget line items and the description of the HSS cross-cutting interventions in Section 4B.1.

   - **The detailed budget must be submitted in the form of a clearly numbered Annex.** *The HSS cross-cutting interventions can be prepared on a separate Excel spreadsheet from the budget for the disease or in a separate file (Excel), according to the Applicant's preference.*
   - **For recommendations on the level of detail required** *(or as a model in the absence of a detailed national budget framework)* **read the detailed budget recommendations in Section 5.1 of the Round 9 Guidelines** *(same instructions as for the preparation of the disease budget).*

2. Using this detailed budget, **prepare a "*Summary by objective and by service delivery area*"** (Section 5B.2).
   (*Comment – The SDA for the HSS cross-cutting interventions **are not** the same as the SDA for the diseases. Consult Section 5B.2 of the Round 9 Guidelines for more information).*

3. From this detailed budget, **prepare a "*Summary by cost category*"** (Section 5B.3), and

4. **Ensure that** the detailed budget **is compatible with** the detailed work plan for the HSS cross-cutting interventions **and the** "Performance framework" of the HSS cross-cutting interventions *(Annex A).*

➔ ***READ THE ROUND 9 GUIDELINES FOR MORE INFORMATION***

5B.2 Summary of the detailed budget for the HSS cross-cutting interventions by objective and by service delivery area (SDA)

Clarified Section 5B.2

Table 5B.2 – Summary of the detailed budget by objective and by service delivery area

Objective n°	Service delivery area *(Use the same numbering as for the detailed work plan for the HSS cross-cutting interventions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Health information	7 052 790	4 689 170	6 389 604	6 866 604	8 804 604	33 802 772
2	Health information	24 878 590	6 705 524	7 543 925	7 514 724	9 892 434	56 535 197
3	Health information	14 016 000	14 016 000	15 103 800	15 103 800	15 103 800	73 343 400

ROUND 9 – Tuberculosis

Objective n°	Service delivery area *(Use the same numbering as for the detailed work plan for the HSS cross-cutting interventions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
4	**Services, Health professionals, Medical products and technologies**	3 120 100	2 816 000	2 816 000	2 816 000	2 816 000	14 384 100
	Use "Add Extra Row Below" from the"Table" menu in Microsoft Word menu bar to add as many additional rows as required to ensure consistency with the 'Performance Framework'						
Total funding requested from the Global Fund for the HSS cross-cutting interventions *(total for all the interventions described in the form of programs in Section 4B.1, when it is included in Round 9)*		**49 067 480**	**28 226 694**	**31 853 329**	**32 301 128**	**36 616 838**	**178 065 469**

5B.3 Summary of the Detailed budget by cost category

The summary information in this Table must be completed with additional information in Section 5B.4.

Table 5B.3 – Summary of the detailed budget by cost category

Whenever possible, avoid using the category "other" - Read the Round 9 Guidelines.	**Distribution by cost category** *(same currency as selected by Applicant on face sheet of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	**14,016,000**	**14,016,000**	**15,103,800**	**15,103,800**	**15,103,800**	**73,343,400**
Technical and management assistance	**715,200**	**715,200**	**715,200**	**715,200**	**715,200**	**3,576,000**
Training	**1,262,310**	**1,268,310**	**599,644**	**830,644**	**579,013**	**4,539,921**
Health products and health equipment	**9,400,000**	**0**	**0**	**0**	**0**	**9,400,000**
Pharmaceutical products (medicines)	**3,120,100**	**2,816,000**	**2,816,000**	**2,816,000**	**2,816,000**	**14,384,100**
Procurement and supply management costs	**5,209,675**	**956,250**	**936,500**	**950,000**	**932,750**	**8,985,175**
Infrastructure and other equipment	**10,149,384**	**4,297,384**	**4,306,384**	**4,297,384**	**4,291,384**	**27,341,920**
Communication materials	**1,882,220**	**858,920**	**301,120**	**301,120**	**276,120**	**3,619,500**
Monitoring and evaluation	**1,391,200**	**1,676,800**	**5,557,700**	**5,803,700**	**9,233,700**	**23,663,100**
Living support to clients/target populations	**0**	**0**	**0**	**0**	**0**	**0**
Planning and administration	**735,800**	**1,504,880**	**1,483,280**	**1,483,280**	**1,483,280**	**6,690,520**
Overheads	**1,185,591**	**116,950**	**33,701**	**0**	**1,185,591**	**2,521,833**
Others: *(To be further defined to meet applicant's budget planning categories)*	**0**	**0**	**0**	**0**	**0**	**0**
Total funds requested from Global Fund for HSS cross-cutting interventions (s.4B.1)	**49,067,480**	**28,226,694**	**31,853,329**	**32,301,128**	**36,616,838**	**178,065,469**

ROUND 9 – Tuberculosis

5B.4.1 Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

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The tables of costs in the previous pages show that the total needs for the two HSS interventions have increased somewhat compared to the first submission classified as category 3 in Round 8. In fact, the total amount requested has increased from 52 million USD / Round 8 to **178,065,469** USD for Round 9. This increase is mainly due to:

- The budget itemization of cross-cutting interventions in the HSS proposal. Based on a consensus between the different proposals and partners in development, the CCM decided that the activities such as monitoring of HZ, provincial semesterly reviews and quarterly reviews of health districts, the human resources at the operational level and the supervision of activities in the HZ should be taken into account by the HSS phase. The main targeted advantage is efficient resource distribution by avoiding having to pay for the same activity twice or three times at the same level and by the same partner. The practical ways to avoid duplication with existing funding from the Global Fund or the other partners are described in Section **a.5.** of each intervention. On the basis of this principle, we observe that certain costs such as Monitoring and Evaluation and human resources have increased from the third year due to the fact that they are aimed at maintaining acquisitions from the tuberculosis proposal in the 515 HZ at the end of Rounds 5&6. The same is true for the 5th year that takes into account the needs of all the proposals for the cross-cutting activities.
- In the account of observation 7 of the TRP that refers to the focus of interventions in 259 HZ. This time, the CCM directed intervention 2 in the 256 HZ that did not have support for development. This justifies a significant part of the budget devoted to the minor rehabilitation of infrastructures and their equipment in these HZ. The denominator has therefore changed.

Figure 1 below shows the distribution of costs by category and illustrates what has been stated.

5B.4.2 Human resources

If "*Human resources*" represents a significant portion of the budget, summarize: (i) the basis of budget calculation for the first two years, and (ii) how the human resources expenditures reinforce the capacity of the health care systems to serve clients and target populations.

Useful information to support the assumptions to be set out in the detailed budget includes: a list of proposed positions that is compatible with the assumptions on hours, salaries, etc., included in the detailed budget; and the time (in percentage) that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly numbered Annex and include the number of the Annex in the checklist at the end of this section.*

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Human resources are a significant part of the request for funding in this proposal. The basis of calculation used is the one presented in Annex 1. The amount requested for the first two years is equivalent to the one already paid by the other donors in the 259 HZ where they intervene. The hoped-for advantage is to maintain the personnel at their work positions and to avoid turnover, transfers or departures of trained managers who are then “lost” to the highest bidder. Starting in year 3, we observe an increase in the amount allocated to human resources due to the fact that the amount that was paid until 2011 by the tuberculosis proposal will be covered in the he 259 HZ to preserve the acquisitions of this proposal. The practical maneuvers to avoid duplication have been described in the description of activity 7 in intervention 2.

It is important to mention here that 93.4% of the amount solicited is aimed at paying the premium at the operational level (HZ), 1.64% at the intermediate level and 4.91% at the central level. The small proportion of the budget allocated at the intermediate level (IL) is justified

by the fact that the other existing funding of the Global Fund and the other partners were taken into account. The Global Fund already invests in human resources at the intermediate level through the three proposals by paying the Coordinations personnel. The request formulated here will enable payment of management personnel in the 4 unsupported provinces. In total, 10 agents will be paid in each of these 4 provinces.

5B.4.3 Other important expense items

If other "cost categories" contain important amounts in the summary of Table 5.4, (i) explain the basis of budget calculation for these amounts. Explain how these contributions are important for the implementation of the national program for the disease(s) in question.

➔ *Attach all additional information in the form of a clearly identified and numbered Annex.*

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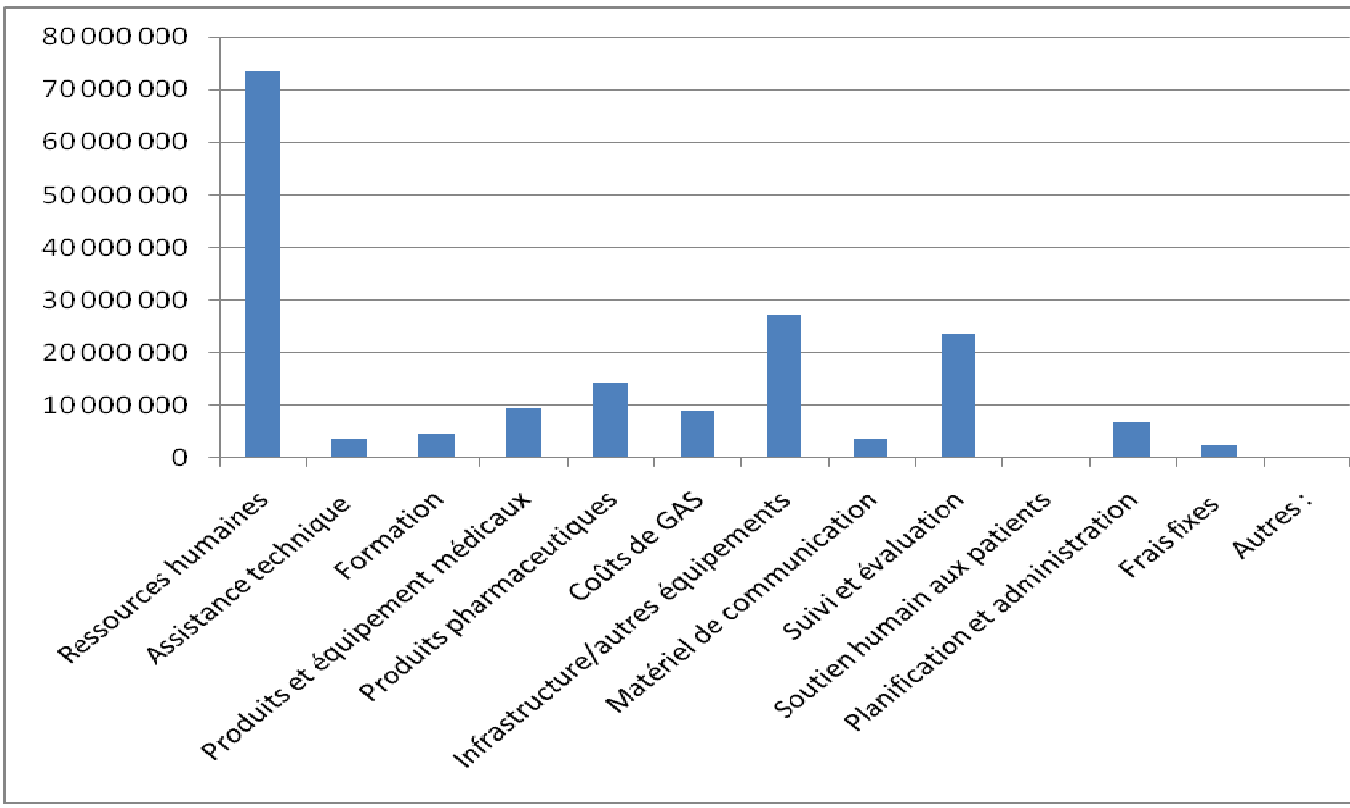
The other important expense items are monitoring and evaluation, infrastructures and equipment, training, and health products. The activities targeted by this request are a global response to the weaknesses of the health system mentioned in Section 4.3.2 of the disease proposals. In the preceding answers, the arguments were advanced in favor of the expenses anticipated for the MONITORING AND EVALUATION and the infrastructures. As for training, this regards more the aspects that provide integration of the normative framework in 296 HZ and from the fact that intervention 2 targeted the 259 HZ in which there were no supporting partners in development. The management staff of these HZ will benefit from the necessary training to improve their ability to organize health services in such a way as to provide quality health care coverage for the population.

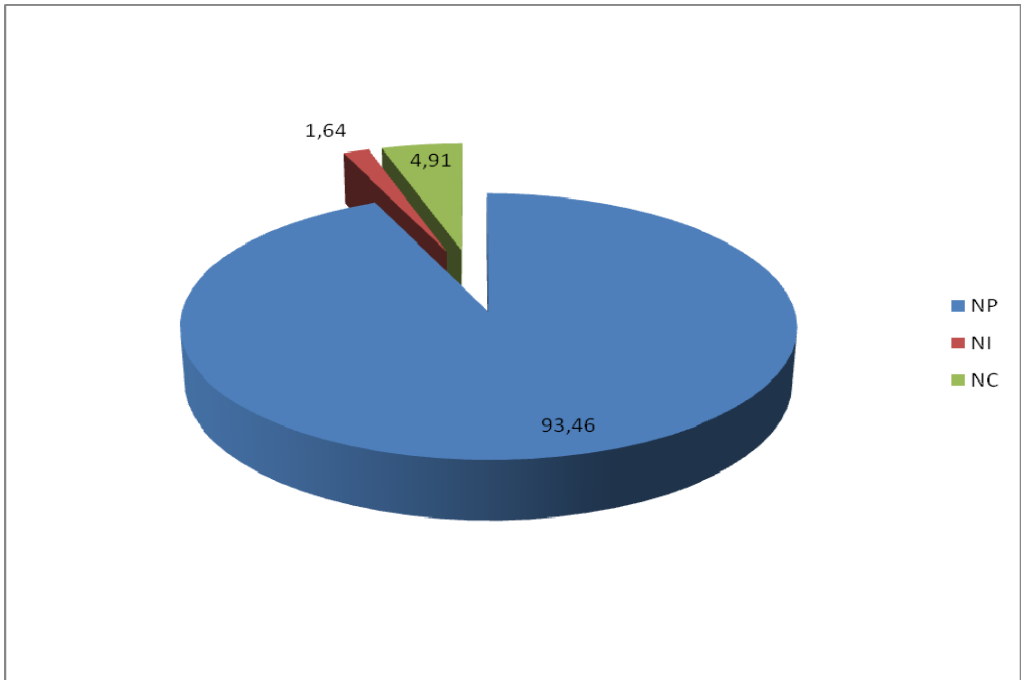
Figure 1 Cost categories for HSS interventions



This figure shows that the Human resources, Infrastructures /other equipment as well as Monitoring & Evaluation are the principal expenses of the HSS proposal in Round 9.

Ressources humaines:	Human Resources
Assistance technique:	Technical Assistance
Formation:	Training
Produits et équipement médicaux:	Health products and health equipment
Produits pharmaceutiques:	Pharmaceutical products
Coûts de GAS:	Procurement and supply management costs
Infrastructures / autres équipements:	Infrastructure / Other equipment
Matériel de communication :	Communication Material
Suivi et évaluation :	Monitoring and Evaluation
Soutien humain aux patients:	Living support for clients
Planification et administration:	Planning and administration
Frais fixes:	Overheads
Autres:	Other

Figure 2 Needs distribution in Human resources according to the health pyramid level



This chart shows that the peripheral level (PL) is the principal recipient of funds sollicited, at 93%.

NP (niveau périphérique)	=	PL (peripheral level)
NI (niveau intermédiaire)	=	IL (intermediate level)
NC (niveau central)	=	CL (central level)

Sections 3 to 4: Program Description		Annex Name and Number
4.1	STRATEGIC PLAN TUBERCULOSIS DRCONGO 2006-2015	ANNEX 1
4. 1	STRATEGIC BUDGET PLAN TUBERCULOSIS DRCONGO 2006-2015	ANNEX 2
4.3.2	HEALTH SYSTEM STRENGTHENING STRATEGY	ANNEX 3
4.5.1	**PERFORMANCE FRAMEWORK**	**Annex A**
4.5.1	**DETAILED ACTION PLAN**	ANNEX 4
4.5.2	**SAMPLE TRP FORM /ROUND 8**	ANNEX 5
4.8.1	**REPORT ON MONITORING AND EVALUATION WORKSHOP**	ANNEX 6
4.9.1	**ADMINISTRATIVE EVALUATION REPORT FOR ACCOUNTING, FINANCE AND PROGRAMMING OF THE NATIONAL TUBERCULOSIS PLAN**	ANNEX 7
4.9.1 *(for non-CCM candidates)*	**Document describing the organization, such as: official registration documents, recent historical summary of the organization, information on the management team**	
4.9.2	**List of sub-recipients who are already identified**	ANNEX 8
4.10.6	**LIST OF PHARMACEUTICAL AND HEALTH PRODUCTS**	**Annex B**
Section 4B: Cross-cutting HSS (once for the entire country proposal)		**Annex Name and Number**
4B.2	**A complete and separate "Performance framework" for cross-cutting HSS *(or add a separate spreadsheet to the "Performance framework" of the disease for which the Section 4B is submitted)*** **Consult the MONITORING AND EVALUATION Guide to fill out this table**.	**Annex A**
4B.2	**A detailed and separate Action Plan for the cross-cutting HSS interventions *(or add a separate spreadsheet to the Action plan of the disease for which the Section 4B is submitted)*** (quarterly information for the first two years and annual for years 3, 4 and 5.)	**Action Plan**
Section 5: Funding information		**Annex Name and Number**
5.2	**A "detailed budget" (quarterly information for the first two years, then annual for years 3, 4, and 5)**	**Detailed budget** **ANNEX 9**

5.4.2	BASIS OF CALCULATION OF THE PREMIUMS FOR PERSONNEL AT THE CENTRAL AND INTERMEDIATE LEVEL (CPLT)	**ANNEX 10**
5.4.3	DETAILED ASSUMPTIONS FOR THE INCREASED EXPENDITURES CATEGORY	**ANNEX 11**
5.5.1 *(if there is a common funding apparatus)*	Documentation describing the operation of the common funding apparatus	
5.5.2 *(if there is a common funding apparatus)*	Final evaluation of the performances of the common funding apparatus	
Section 5B: Funding information on the cross-cutting HSS		**Annex Name and Number**
5B.1	**A separate "detailed budget" for the cross-cutting HSS *(or add a separate spreadsheet to the "detailed budget" of the disease for which Section 4B is submitted).* Quarterly information for the first two years, then annual for years 3, 4 and 5).**	**Detailed budget**
5B.4.2	Information on the basis of calculation of the budget and a chart and/or list of the human resources that are anticipated to be funded by the proposal (only if necessary)	
5B.4.3	Information on the basis of calculation of costs of the items in the "elevated costs category"	
Other documents relating to Sections 3, 4 and 5 attached by the candidate:		**Annex Name and Number**
4.5 .2	**PARTNERS' AREAS OF INTERVENTION**	ANNEX 12
4.6.1.	**LINKS TO OTHER GLOBAL FUND GRANTS**	ANNEX 13
4.8.1	**NATIONAL TUBERCULOSIS PLAN EVALUATION REPORT BY THE UNION**	ANNEX 14
	LIST OF ABBREVIATIONS	ANNEX 15

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	DR CONGO
Disease:	TUBERCULOSIS
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	REDUCE THE MORBIDITY AND MORTALITY DUE TO TB BY 2015 IN DRC, IN COMPLIANCE WITH MILLENNIUM DEVELOPMENT GOALS AND STOP TB PARTNERSHIP
2	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	TB mortality rate	5%	2007	Global Report WHO 2009, p 207	4,9 %	4,8 %	4,7 %	4,6 %	4,5 %	This is the % of deaths in new TPM+ cases
outcome	Case detection rate: new smear positive TB cases	61%	2007	Global Report WHO 2009 p 101	63%	65%	67%	69%	70%	Round 5 indicator lowered according to the new WHO formulation, see baseline in WHO Report 2008
outcome	Treatment success rate: new smear positive TB cases	86%	2007	Global Report WHO 2009, p 207	8 6 %	86 %	87 %	87 %	87 %	Overall objective already reached , but needs improving in some cases and maintaining in others.

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Continue the DOTS quality strategy	
2	Control co-infection TB-HIV and multiresistant TB	
3	Help strengthen heatlh systems via APSR (PAL)	
4	Involve all healthcare providers (PPM)	
5	Involve the communities	
6	Ensure operational research	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.2	Improving diagnosis	Number of labs regularly carrying out QA for cultures and meeting ATS criteria	1	2008	Evaluation report Union n° 10 et IHC n°6 dated Jan/Feb 2008		3		4	4	5	5	N	Y	Y - over program term	The Tuberculosis program	Half-yearly data collection
2.1	TB/HIV	Number (%) of TB patients undergoing HIV screening			NTP report 2008	1,213	2,425	5,991	9,556	17,043	24,905	33,160	Y	N	Y - over program term	The Tuberculosis program	Quarterly data collection
2.2	MDR-TB	Number and % of cases of MDR-TB notified (confirmed by bacteriology)	82	2007	Global tuberculosis report WHO,2009, p.102	200	400	700	1000	1700	2500	3400	N	Y	Y - over program term	The Tuberculosis program	Collection of quarterly data
3.2	PAL (Practical Approach to Lung Health)	Number (%) of structures with actions in this domain	0	2007	Coordination Evaluation Report in 2007	10	20	40	60	110	160	200	Y	Y	Y - over program term	The Tuberculosis program	Quarterly data collection
4.1	All care providers (PPM / ISTC) and international standards for TB care	Number (%) of PPM structures outside the NTP participating in DOTS activities and following the ISTC/Total planned	34	2007	Coordination Evaluation Report in 2007	12	24	36	48	72	96	120	Y	N	Y - over program term	The Tuberculosis program	Quarterly data collection
5.2	Community TB care	Number and % of all new tuberculosis patients with notified positive smears started on treatment followed-up/overseen in the community	NA	2007	Coordination Evaluation Report in 2007	5%	10%	10%	15%	15%	20%	25%	Y	N	Y - over program term	The Tuberculosis program	Quarterly data collection
6.1	Operational Research	Number of operational research studies carried out and results circulated by the overall follow-up and assesment system for TB	7	2007	Coordination Evaluation Report in 2007	1	3	4	6	9	12	15	Y	N	Y - over program term	The Tuberculosis program	Quarterly data collection
1.4					please select…								Y	N	Y - over program term		

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	RDC
Disease:	HSS
Proposal ID:	Round 9

Program Goal, impact and ouctome indicators

	Goals
1	Contributing to strengthen the health system by producing good quality health information that will allow monitoring, evaluating and planning the implemention of interventions for the purpose of improving the health coverage
2	Contributing to improve the availability and quality of health care in HZs

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	HSS: Infant mortality rate	92‰	2007	Specify:	92‰	-	-	-	45‰	The infant mortality rate in the DRC was 126 ‰ in 2001 according to MICS2 before
outcome	HSS: Percentage of Health Zones submitting ***complete reports*** about the total number of management and public health indicators in	19.4%	2008	Specify: NHIS reports	35.7%	52%	68.3%	84.7%	100%	The baseline presented here was calculated on the basis of the 100 HZs having integrated the standardized framework as the numerator and the 515 HZ of the country
outcome	HSS: Percentage of Health Zones submitting ***reports in due time*** about	15.5%	2008	Specify: NHIS	28.4%	41.3%	54.2%	67.1%	>80%	This performance is achievable on account of the new information and communication
outcome	HSS: Proportion of the population with access to good quality services and health care	26.3%	2007	NHIS reports for 2007	30%	36%	41.3%	46%	50%	According to HZ standards, a HZ covers an average population of 100,000 inhabitants and a CS covers an average population of 10,000 inhabitants per Health Area.

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Progressively integrating the National Health Information System normative framework by the end of 2014 in 296 HZs.	
2	Making four Provincial NHIS Steering Committees functional by the end of 2014 by providing them with financial support for the coordination of their health information management system interventions in provinces	
3	Strengthening the central level in steering the normative NHIS framework implementation and supervising the provinces in managing their health information system	
4	Increasing by 50% the number of people with an access to good quality services and health care in the 256 HZs by the end of 2014	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	HSS: Information System	Number of health zones having integrated the NHIS framework	100	2008	Report on the integration of the NHIS normative framework in provinces	142	184	226	268	352	436	515	Y	Y	Y - over program term	Ministry of Public Health	Data collection will be done by means of routine NHIS and the frequency is annual. The 119 round 8
2.1	HSS: Information System	Number of NHIS provincial steering committees having been made functional	7	2008	Activity reports from the HSRS provincial steering committees	8	9	10	11	11	11	11	Y	Y	Y - over program term	Ministry of Public Health	Data collection will be done by means of routine NHIS and the frequency is annual.
2.2	HSS: Information System	Number of functional sanitary information management commissions	0	2008	Annual review report for 2008 and HSRS provincial steering committees activity reports	1	2	4	6	9	11	11	Y	Y	Y - over program term	Ministry of Public Health	Data collection will take place at the Ministry of Public Health Annual Review and at NPC-HSSS meetings. The collection frequency is annual.
3.1	HSS: Information System	Number of semi-annual missions carried out by central level personnel to supervise and monitor integration activities within the NHIS normative framework in the 11 provinces	10	2008	Mission reports, provincial activity reports and activity reports from the Ministry of Health	8	17	27	38	60	82	104	Y	N	Y - over program term	Ministry of Public Health	This data collection will be collected during the Ministry of Public Health Annual Review.
3.2	HSS: Information System	Number of quarterly activity reports from the CPN-HSRS sanitary information management commission	0	2008	NPC-NHIS Activity report	2	4	6	8	12	16	20	Y	N	Y - over program term	Ministry of Public Health	Data collection will take place at the Ministry of Public Health Annual Review and at NPC-
3.3	HSS: Information System	Number of provinces interconnected with the central level server	0	2008	Mission reports, provincial activity reports and activity reports from the Ministry of Health	1	3	5	7	9	11	11	Y	N	Y - over program term	Ministry of Public Health	Data collection will be done during missions performed at the central provincial level. The collection frequency is annual.

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	RDC
Disease:	HSS
Proposal ID:	Round 9

4.1	HSS: (health system strengthening): Service provision	Number of rehabilitated HCs in the 256 targeted HZs	NA	2008	Survey Report on health structures, work completion forms							1280	Y	N	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.2	HSS: (health system strengthening): Service provision	Number of rehabilitated GRH	NA	2008	Survey Report on health structures, work completion forms	10	24	36	48	72	96	120	Y	N	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is annual.
4.3	HSS: (health system strengthening): Service provision	Number of equipped HCs	NA	2007	Survey Report on health structures, work completion forms	100	256	384	512	768	1024	1280	Y	N	Y - cumulative annually	Ministry of Public Health (MPH)	The collection frequency is annual.
4.4	HSS: (health system strengthening): Service provision	Number of GRHs equipped with basic medical facilities	NA	2008	Survey Report on health facilities, work completion forms	10	24	36	48	72	96	120	Y	N	Y - cumulative annually	Ministry of Public Health (MPH)	The collection frequency is annual.
4.5	HSS: Healthcare Professionals	Number of Trained Health Zone management Team Members	NA	2008	Reports on training courses Activity Reports	100	256	384	512	768	1024	1280	Y	N	Y - cumulative annually	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.5	HSS: Healthcare Professionals	Number of trained Health Center managers	NA	2008	Reports on training courses Activity Reports	300	768	1152	1536	2304	3072	3840	Y	N	Y - cumulative annually	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.6	HSS: (health system strengthening): Service provision	Number of rural health districts and HS having received vehicles	0	2008	reports, delivery slips	0	130						Y	Y	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is annual.
4.7	HSS: Healthcare Professionals	Number of employees benefiting from the complementary premium in Health Zones	NA	2008	National health account, pay sheets	11520	11520	11520	11520	13074	13074	13074	Y	N	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.8	HSS: Medical products, vaccines and technology	Number of health facilities regularly supplied with standard kits of essential drugs	NA	2008	reports, delivery slips	1400							Y	N	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is annual.
4.9	HSS: (health system strengthening): Service provision	Number of GRH having incinerators at their disposal in the 256 HZ	0	2008	Survey on health structures, activity reports	25	51	76	102	156	207	256	Y	Y	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.9	HSS: (health system strengthening): Service provision	Number of HCs having incinerators at their disposal	0	2008	Survey on health structures, activity reports	100	256	384	512	768	1024	1280	Y	Y	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is quarterly.
4.10	HSS: Services	Proportion of integrated supervisory visits carried out by managing teams in the 256 HZs	NA	2008	supervision and activity reports	8%	20%	30%	40%	60%	80%	100%	Y	N	Y - over program term	Ministry of Public Health (MPH)	The collection frequency is quarterly.