The Global Fund
To Fight AIDS, Tuberculosis and Malaria

SINGLE TB AND HIV CONCEPT NOTE

Investing for impact against tuberculosis and HIV in the DRC

Countries with an overlapping high burden of tuberculosis (TB) and HIV must submit a single concept note that presents each specific program in addition to any integrated and joint programming for the two diseases.

In requiring that the funding requests be presented together in a single concept note, the Global Fund aims at maximizing the impact of its investments to make an even greater contribution towards the vision of a world free of the burden of TB and HIV. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

All concept notes should articulate an ambitious, strategically focused and technically sound investment, informed by the national health strategy and the national disease strategic plans (NSPs).

The concept note for TB and HIV is divided into the following sections:

Section 1: The description of the country's epidemiological and health systems context including barriers to access, the national response to date, country processes for reviewing and revising the response, and plans for further alignment of the NSPs, policies and interventions for both diseases.

Section 2: Information on the national funding landscape, additionality and sustainability

Section 3: The funding request to the Global Fund, including a programmatic gap analysis, rationale and description of the funding request, as presented in the modular template.

Section 4: Implementation arrangements and risk assessment.

Applicant information			
Country	**Democratic Republic of the Congo**		
Funding Request Start Date	**1 January 2015**	**Funding Request End Date**	**31 December 2017**
Principle Recipient(s)	**Ministry of Health Caritas, Santé Rurale (SANRU), CORDAID and the National Council of Health NGOs (CNOS)**		

FUNDING REQUEST SUMMARY TABLE

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

Country introduction

The Democratic Republic of the Congo (DRC), located in Central Africa, has an area of 2,345,409 km² for an estimated population of 70,393,473 in 2013 (1), 70 percent of whom are in the under-25 age group. It shares 9,165 km of border with nine countries: the Republic of Congo to the west, Uganda, Burundi, Rwanda and Tanzania to the east, the Central African Republic and the Republic of South Sudan to the north and Zambia and Angola to the south.

The recent history of the DRC has been marked by two decades of politico-military and social disorder which have slowed down the country's development momentum. Over 87 percent of the population lives on less than 1 dollar a day (2), as demonstrated by its GDP per capita, which is one of the lowest in the world (US$ 319). According to the Human Development Index (HDI 2013), at position 186, the DRC is at the bottom of the world rankings.

Over the past ten years, there have been some positive developments in the economic situation of the DRC, especially in terms of economic growth which rose from 7.1 percent in 2010 to 8.5 percent in 2013 (source: the DRC government). Social, economic and political factors have influenced the overall health indicators. Between 2007 and 2012, provision of the DPT-Penta 3 vaccine increased from 45 to 61 percent. Life expectancy at birth increased from 49 in 1990 to 52 for both sexes in 2012 (2). And for the same period, infant mortality fell from 148 to 104 deaths per 1,000 live births (3). The maternal mortality rate fell from 1,100 to 730 per 100,000 between 2000 and 2013 (2).

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

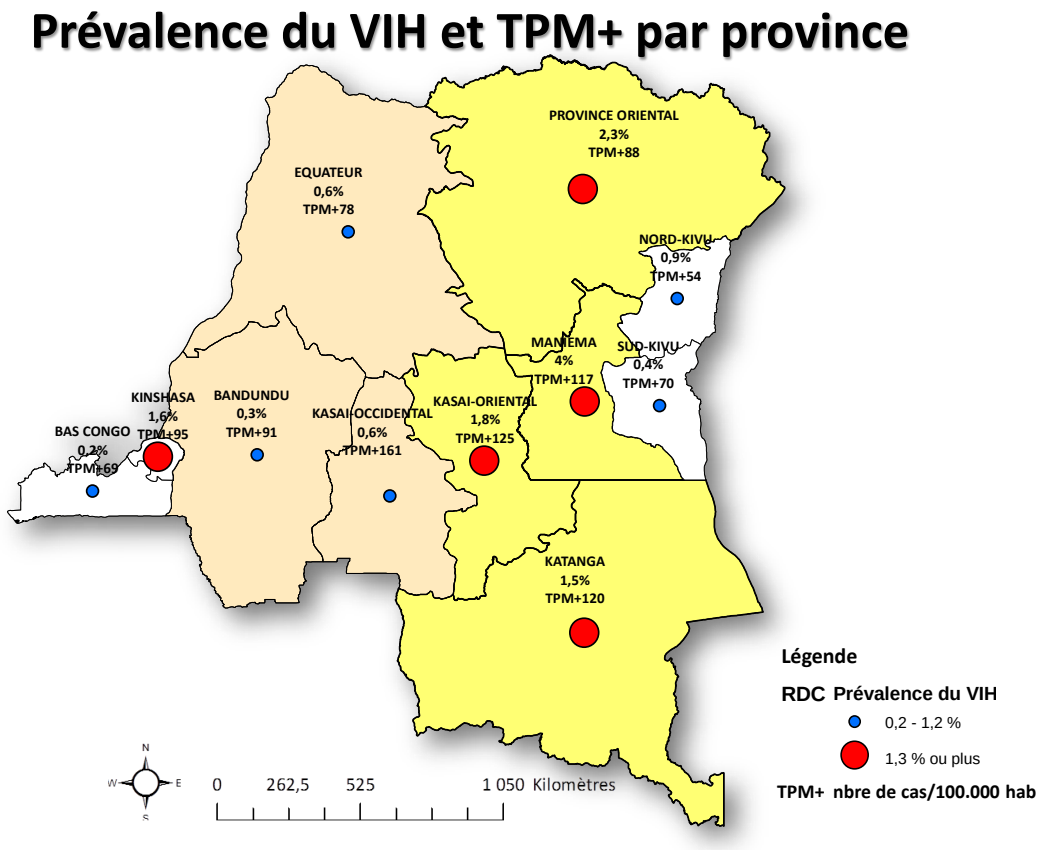
1.1 Country Disease, Health Systems and Community Systems Context

a. Epidemiology of the two diseases and the significant geographic variations in incidence or prevalence of TB and HIV

Current epidemiology of tuberculosis and HIV/AIDS infection

Tuberculosis (TB) and HIV infection are two diseases which are accompanied by a heavy economic and social burden. The DRC, with more than 100,000 cases of TB notified each year, is one of the 22 countries that bear 80 percent of the global burden of TB in general as well as being, on the one hand, one of the 27 countries with 85 percent of the global burden of disease with regard to multi-drug resistant tuberculosis (MDR-TB) (4) and, on the other, one of the 22 countries in which 90 percent of the needs concerning prevention of mother-to-child HIV transmission (PMTCT) are unmet.

Map 1: HIV Prevalence according to the Second DHS-DRC 2013-2014 and notification of cases of smear-positive tuberculosis (PTB+) per 100,000 inhabitants



According to a survey of the most frequent opportunistic infections (OI) found in the DRC carried out by the National AIDS Control Program (NACP), TB is the first opportunistic infection found with regard to HIV/AIDS in the DRC (5) and HIV is one of the most important risk factors for TB, which is also the first cause of death among People Living with HIV (PLHIV) (6).

According to the World TB Report 2013, the World Health Organization (WHO) did estimate that in 2012 there were 380,000 people affected by TB among the DRC population as a whole, in other words a prevalence of 576 cases per 100,000 population. The estimated incidence of cases was 210,000 (a rate of 327 per 100,000 population), of whom 16,000 also infected with HIV would have been expected. However, only 35, 097 TB patients were tested for HIV and 5,748 (16 percent) were confirmed HIV positive. During that same year, the WHO believes that 36,000 people died from TB, in other words a mortality rate of 54 deaths per 100,000 population (4). In 2013, the estimated number of cases of multi-drug resistant TB (MDR-TB) among new smear-positive pulmonary TB cases (PTB+) was 2.5 percent and 10 percent among retreatment cases.

According to the DHS II 2013-2014, the epidemic of HIV infection in the DRC is generalized with a prevalence of 1.2 percent in the general population (3). The prevalence of HIV infection is 3.5 percent (sero-surveillance 2011) among pregnant women attending the antenatal care (ANC). The prevalence of HIV among TB patients is estimated to be 16 percent, with an incidence of 25 per 100,000 population, which makes the DRC one of the countries with the highest rate of TB/HIV co-infection (4). According to Spectrum 2013, HIV-related mortality dropped from 36,000 in 2007 to 32,000 in 2010 respectively and finally to 30,000 in 2013 (7). This reduction in HIV-related mortality is probably due to increased access to antiretroviral therapy (ARV) for PLHIV (34,967 in 2010 versus 79,978 in 2013) (8).

Distribution of TB and HIV cases by age and sex

The incidence of PTB+ is about 30 percent higher among males than among females. The age group most affected by TB is that between 15 and 49 years; children under 15 years represent about 9 percent. Notification data for the years 1998, 2000, 2004, 2008 and 2012 indicate that between 72 and 80 percent of PTB+ cases are under 45 years of age. This age group tended to gradually decrease in size over those five years while the 45 years and over age group continually increased in size from 20 percent in 1998 to 28 percent in 2012.

As for HIV, in the case of women, the prevalence remained unchanged between 2007 and 2013 (1.6 percent) while in the case of men it went down slightly (from 0.9 to 0.6 percent). Which indicates a feminization of HIV infection. Looking at age, in the case of women, prevalence increases rapidly: starting from a minimum of 0.7 percent at 15-19 years, it is more than three times higher at 30-39 years (2.4 percent) and reaches 2.9 percent at 40-49 years. In the case of men, at all ages until 45-49 years, the percentage who are HIV-positive is always much lower than in the case of women (3).

In the case of HIV, the main transmission route is through heterosexual relations (75percent) (9). The reasons for the feminization of the epidemic in the DRC include: (i) the early age at which sexual relations start, (ii) sexual violence (), (iii) multi-partner relations among men and women with little use of condoms; and (iv) the low socio-economic status of women. Male circumcision, which is estimated to be over 99 percent in the DRC, is a protective factor.

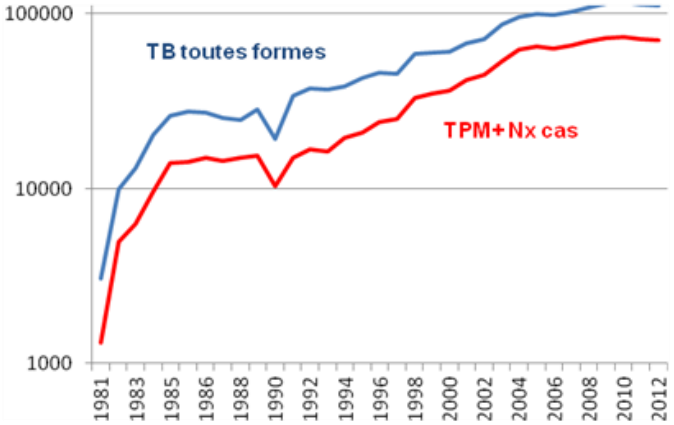
It is important to note that TB and HIV affect the productive and sexually active population.

Evolution of the two endemics

Between 1991 and 2009, notification of the number of TB cases grew significantly before starting to plateau between 2010 and 2012. This increase in notification of the number of TB cases can be correlated with the gradual expansion of interventions in the country by the National Tuberculosis Control Programme (NTP). Which in terms of impact led to a reduction in mortality from 74 to 54 cases per 100,000 population between 1990 and 2012.

Indeed, a study of trends over time carried out by WHO shows that TB-linked prevalence and mortality tended to decline from the early 1990s but have remained static since the mid-2000s; whereas incidence has remained static since the early 1990s (4).

Figure 1: Notification of tuberculosis cases in the DRC 1981-2012 (source: epidemiological profile of TB in 2013) (10).

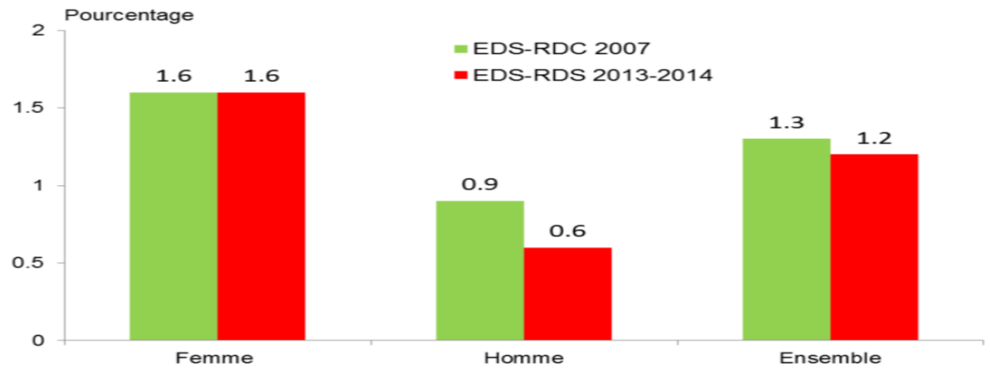


As figure 2 below illustrates, the prevalence of HIV in the general population in the DRC was 1.3 percent and 1.2 percent respectively in 2007 and 2014. Indeed, according to SPECTRUM estimates for 2013, the number of new HIV infections dropped from 41,000 in 2012 to 34,000 in 2013 (7). However, 7,400 new infections occurred in the DRC in the 0-14 age group and especially in the 0-4 group because of mother-to-child transmission during pregnancy, childbirth and breastfeeding.

In the DRC, sexually transmitted infections (STI) are one of the five main reasons for visiting health care facilities. The average prevalence of syphilis among pregnant women aged between 15 and 49 is 4.2 percent and that of hepatitis B among prospective blood donors is 3.5 percent.

According to the Global AIDS Response Progress report (GARP) for 2010 and 2014, there are several possible underlying assumptions for the reduction in new infections, in particular the speeding up of the implementation of ARV treatment (12 percent versus 37.4 percent), improvement in the rate of condom use by sex workers (SW) (62 percent versus 68 percent) and improved knowledge among young people. Indeed the number of young people aged 15-24 able to describe correctly how to prevent the sexual transmission of HIV rose from 17 to 48 percent. In the same time, utilization of condoms among general population is decreasing due to weak availability and accessibility. In response to this, PEPFAR, USAID, ASF/PSI and UNFPA are enhancing their support targeting especially the rural and very poor population through condom distribution via community based actors.

Figure 2: HIV Prevalence according to the DHS-DRC 2007 and the Second DHS-DRC 2013-2014



Geographical disparities in the scale of the two diseases in the DRC

The disease burden of HIV infection, TB and co-infection is unevenly spread across the country.

Thus five provinces have a prevalence of HIV and TB that is higher than the national average: Kinshasa (HIV 1.6 percent, TB 99/100,000 population), Katanga (HIV 1.5 percent, TB 120/100,000 population), Province orientale (HIV 2.3 percent, TB 88/100,000 population), Maniema (HIV 4 percent, TB 117/100,000 population) and Kasaï Oriental (HIV 1.8 percent, TB 161/100,000 population).

The HIV epidemiology shows disparity, with variations in prevalence according to province. Compared to the national average of 1.2 percent, the overall prevalence (both sexes) is lowest in Sud-Kivu (0.4 percent), Bandundu (0.3 percent) and Bas-Congo (0.2 percent). It is considerably higher in Maniema (4.0 percent) and Province Orientale (2.3 percent). In all provinces prevalence is higher among women than men. This is particularly so in Province Orientale (3.9 percent among women compared to 0.5 percent among men) and Kinshasa (2.6 percent and 0.3 percent respectively). The prevalence of HIV is lower in rural areas than in urban areas (1.6 percent compared to 0.9 percent) and the proportion of women who are HIV-positive is higher in urban areas than in rural areas (2.3 percent compared to 1.2 percent).

The high prevalence of HIV found in Maniema and Province Orientale is due not only to the expansion of mining activities, which create the conditions for the increased transmission of HIV infection, but also to the different armed conflicts involving foreign armies and militia from neighboring countries with a high prevalence of HIV, and to the poor provision of care and prevention services.

In-depth studies covering the country as a whole should be carried out in order to better understand the causes and determinants of this disparity.

b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.

Key populations to be considered

The National Strategic Plan for TB 2014-2017 does not, strictly speaking, identify key populations for TB. Nevertheless, instead there are so-called vulnerable and high-risk populations which, like the general population, find it difficult to access care, prevention and treatment services, in particular for PLHIV, children under 15 years of age, contacts of TB patients, prisoners, internally displaced persons and miners.

For HIV, the following groups are considered key populations: sex workers (SW), men who have sex with men (MSM) and injecting drug users (IDUs). So far, current Global Fund grants have failed to include activities related to key populations. Specific activities have been undertaken by the US President's Emergency Plan for AIDS Relief (PEPFAR). However, data concerning the key populations remains fragmented and limited to a few provinces (Kinshasa, Katanga, Province Orientale, Nord- and Sud-Kivu and Bas-Congo). Nevertheless, the prevalence of HIV observed in these populations is much higher than the national average: 6.9 percent in the case of SW and 17.3 percent in the case of MSM (3). In the case of IDUs, the information provided in the HIV NSP 2014-2017 took from several countries in the region data into consideration due to the lack of national data. In relation to these key populations, studies are required in order to establish their mapping, assess their size and determine their socio-demographic characteristics at national level.

In the case of prisoners, internally displaced persons and miners, these groups will also be the subject of innovative interventions and approaches such as active TB screening strategies and Provider-Initiated Testing and Counselling (PICT) in the case of HIV. The funding expected in the framework of this research on prevalence and incidence of the two diseases in these groups will come from various sources (mining companies and additional funding from PEPFAR, USAID, etc).

Besides these key populations, particular attention will be given to populations that are deemed to be vulnerable and at high risk when it comes to HIV, namely victims of sexual violence and street children.

Data on the prevalence of HIV in seven provinces for 2013 shows 25,612 cases of sexual and gender-based violence, of which 89.1 percent were individual or collective rapes, 99 percent of them of women (2013 report by the Ministry of Gender, Family Affairs and Children) (12). According to this report, the highest number of cases was in Sud-Kivu, with 10,706, and 10 percent of women at Panzi hospital in Sud-Kivu who had suffered sexual violence were HIV-positive (11).

In 2009, organizations who work to prevent sexual violence against women (such as the UNFPA, the United Nations Observer Mission in the Democratic Republic of the Congo (MONUSCO) and the UN High Commissioner for Refugees (UNHCR) found that up to 20 percent of survivors of sexual violence who received medical care were HIV-positive (12).

As far as HIV among street children is concerned, prevalence was 1.3 percent according to the most recent Behavioral Surveillance Survey (BSS) for 2012. More than seven out of ten street children (72.8 percent) mentioned condoms as a method of prevention. In this population group, the median age for starting sexual relations is 14 years. It was noted that 38.5 percent of boys compared to 34.9 percent of girls had had sexual relations for money. The rate of condom use during the first and most recent sexual experience was 12.6 and 21.9 percent respectively (13).

Major difficulties regarding access to prevention, care and treatment services for these key populations

In the DRC, the rate of use of curative services by the general population remains low (37 percent) (14). The following are specific factors limiting access to prevention and care and treatment services for the key populations:

- Poor geographical coverage of health facilities providing ARV and PMTCT: only 852 out of 1,791 local health clinics (FOSA), in 350 out of the 516 health zones (HZ) that exist in the country, provide the full package of HIV interventions. According to the level of health care, this full package of HIV interventions comprises the following elements: (i) prevention, (ii) diagnostic, (iii) care and treatment, (iv) support to program management (see also in the annex: intervention package TB, HIV and TB/HIV);
- The context of recurring armed conflicts in the east of the country, resulting in the breakdown of the health care system and significant population movements, thereby reducing their access to health care;
- Age: national guidelines on TB control currently only allow care for children under 15 years of age to be provided by medical doctors, thereby significantly reducing their access to care;
- Membership of an professional group categories: miners (who are particularly exposed to silica), living and working in an overcrowded environment, are at a high risk of a TB outbreak or of being exposed to HIV while the health care services provided by some of the mining companies who employ them do not systematically organize activities to control TB and HIV. Furthermore, artisanal miners have no access to health care services that treat the two diseases;
- Poverty: as stated earlier in the introduction, over 87.7 percent of the Congolese population lives on less than one US dollar a day. This lack of purchasing power limits access to basic social services, including health, as a consequence of the indirect costs they would need to bear. This extreme poverty also affects the key populations and PLHIV, of whom 85 percent, mainly women and girls, live below the poverty line (15);
- Cultural barriers: MSM and SW, who are not accepted at a social level, are subjected to stigmatization, discrimination and regular harassment in health care facilities;
- The absence of specific strategies for IDUs, prisoners, mobile populations and miners, limiting their access to and use of health care services.

c. *Key human rights barriers and gender inequalities that may impede access to health services.*

In the DRC, behavioral factors and socio-cultural norms in terms of gender inequality place the country 142nd out of 146 on the gender-based inequality index. The gender disparity can be seen at the level of financial independence (for 78.6 percent of women who work, decisions about the use of what they earn from working are taken by their husbands) (16). Around 64 percent of women aged 15-49 have been subjected to sexual or physical violence by their husbands or partners (16) despite the existence of legal instruments that guarantee the protection of women and girls in this domain. The persistence of certain harmful traditional practices, such as sororate and levirate, make women and girls more vulnerable to HIV/AIDS (17).

According to the survey PLHIV Stigmatization Index, PLHIV and people affected by HIV suffer various forms of discrimination and stigmatization because of their HIV status: 25 percent said they were excluded from social activities; 33.3 percent said they had lost their jobs and in 55.1 percent of those cases for a reason connected with their HIV status; 6 percent of the victims said they had been refused access to health care, including dental care, because of their HIV status; 50 percent of PLHIV and 20.6 percent of their children had been dismissed or suspended from, or forbidden access to, an educational establishment because of their HIV status; and self-stigmatization was also very common among PLHIV (52.3 percent) (15).

Despite the existence of law No. 08/011 of 14 July 2008 protecting the rights of PLHIV and people affected by HIV, and the fact that the State has decreed free care for patients suffering from TB and HIV, certain human rights violations persist, in particular:

- About 75 percent of PLHIV, of whom 60 percent also suffering from TB, who were eligible for ARV did not receive it (National AIDS Control Program (NACP) annual report, 2012) ;
- Only 53 percent of TB patients expected in the country in 2012 had access to the recommended diagnosis and treatment;
- Protection of confidentiality with regard to HIV status is limited;
- There are socio-cultural obstacles, including androcracy and homophobia, within the community;
- 84.2 percent of PLHIV believe they have been subjected to harassment, insults and even physical assaults because of their HIV status (15);
- Failure to observe the TB patients charter and infection control measures for tuberculosis in both health care facilities and prisons;
- Of the few cases in which proceedings have been started to defend the rights of PLHIV, only 50 percent have been taken up by the courts.

As regards the inequalities linked to gender and sexual violence, as described in the UNAIDS gender assessment tool, this concept note will take up the medical aspects and set up in place specific actions to benefit women and girls in the context of HIV.

d. *The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint* areas of both programs.

Based on the Primary Health Care (PHC) strategy, the national health care system is organized at 3 levels:

The **central level** defines policy, strategies, regulations and guidelines and ensures policy monitoring and implementation through a system of management and compliance monitoring. It comprises the Minister's Office and the General Secretariat of the Ministry of Health (MoH), which has 13 directorates and 52 specialist programs including the NACP and the NTP. In order to address the specific needs of key populations, including MSM and SW, the NACP has set up two specialist services in the city of Kinshasa (the Matonge and Victoire Centers).

The **intermediate** level comprises 11 provincial health inspectorates within which there are 11 provincial health divisions (PHD). In the country as a whole, there are 18 provincial coordination offices devoted to HIV control, 23 devoted to TB control and 65 health districts. This level ensures technical management, the supply of specific drugs and inputs to HZ, monitoring and evaluation of the translation of guidelines, strategies and policies into instructions and data sheets in order to facilitate the implementation of activities at the level of the HZ.

The **peripheral level** is responsible for implementing the primary health care strategy through the integrated provision of services (HIV, TB, Vaccination, maternal, newborn and child health (MNCH), etc.), including community activities, with supervision and technical management from the intermediate level.

This level comprises:

- 516 HZ, 424 of which have general referral hospitals (GRH) and 92 referral health centers (RHC);
- 8,505 health areas scheduled, 8,266 of which have at least one health center (HC) 7,520 of which have a maternity ward.

As far as TB is concerned, there are 1,522 HCs and GRHs/RHCs providing TB diagnosis and treatment (called Health Diagnosis and Treatment Center or CSDT) and 5,312 Treatment Health Centers (CST) providing TB treatment only. TB interventions are available in all 516 HZ.

In the case of HIV, 1,791 local health clinics, out of 2,580 that are scheduled to have maternity wards, have integrated the PMTCT package and 852 of them ensure the provision of ARV. As far as the provision of HIV-related interventions is concerned, 350 out of the 516 HZ do so, in other words 67 percent. This data on provision came from studies of the mapping of interventions and stakeholders carried out in July 2013 (with funding from the Global Fund and PEPFAR) and information taken from epidemiological profile reports.

Of all these facilities (GRHs and HCs), 60 percent belong to the public sector and 40 percent to private profit-making and not-for-profit actors. The private structures have incorporated TB and HIV packages in line with the guidelines and regulations of the two programs, adopting a contract-based approach (Private Public Mix: PPM).

The current structural organization of the health system suffers from inadequate coordination and integration at all levels, the effects of which can be seen on the various pillars of the system, namely governance (planning, monitoring and evaluation), service delivery, human resources, the supply of specific drugs and inputs, the National Health Information System (NHIS), funding, infrastructure and equipment.

Leadership and governance

In 2006, a strategy for health system strengthening (HSS) was developed and followed up with the drafting of the National Health Care Development Plan (*Plan National de Développement Sanitaire / PNDS*) 2011-2015.

In 2009, to ensure the coordination and management of the sector, the Ministry of Health (MoH) set up a National Health Sector Steering Committee (CNP-SS) and Provincial Health Care Steering Committees (CPP-SS) in all 11 provinces. The CNP-SS is a functional structure for intra- and intersectoral consultation at national level whose mandate is to support the MoH in its role as leader and coordinator of the sector. The CNP-SS and the CPP-SS are made up of three day-to-day organizing bodies:

- The national strategic coordination committee;
- The technical coordination committee;
- Technical committees, including the disease control committee, chaired by the Director of Disease Control. The NACP and NTP sit on and participate in this committee.

Other coordination structures work to support the MoH, in particular the Country Coordinating Mechanism (CCM) of the Global Fund, the Inter-Donor Health Group (GIBS),

the Joint United Nations Regional Team on AIDS (JURTA) and the National Multi-Sector Commission to Combat AIDS (CNMLS).

Reform of the sector's financial management has led to the establishment of a coordination unit at the level of the General Secretariat of the MoH, a unit for managing projects and public procurement, a support and financial management unit responsible for activities related to liquidation, and financial management agencies responsible for funds management.

The complexity of coordinating structures within the sector is obvious, hence the need to streamline and standardize the task of coordination.

At the intermediate level, the organizational reform provides for the gradual establishment of 26 (rather than 11) PHD with a streamlined staffing plan and genuine ability to support the HZ.

Service delivery

Services are delivered by the primary level operational structures (HC and GRH/RHC) as well as by care structures at secondary and tertiary level (provincial hospitals and university clinics). At the operational level the care package forms part of a context of vertical support for each of the diseases. Which is why there are HC which provide the TB but not the HIV package (1,522 CSDT versus 852 ARV centers), and why virtually none of the maternity wards have any PMTCT services (7,520 maternity wards versus 1,791 PMTCT). This situation is not conducive to ensuring that the beneficiaries have access to the services that their state of health requires.

Human resources

In 2012, the annual report of the MoH listed a workforce of 121,541 officers and managers, including 58,826 nurses and 4,847 doctors, a ratio of one doctor to every 12 nurses. Furthermore, on average, there were 0.2 doctors and 9 nurses per 10,000 population (1). Even so, this situation shows some disparities because the density of doctors per 10,000 population ranges from 0.2 in Equateur to 1.8 in Kinshasa. This ratio therefore means that doctors have to delegate tasks to nurses. The 2012 NACP report indicates that there is little retraining of staff in terms of integrated service delivery. Some staff are trained in HIV care but not in TB and vice versa. That is the case for the MNCH whose staff have received little PMTCT training.

Low pay and poor working conditions are at the root of the chronic instability and lack of motivation among staff. In order to address questions related to staff motivation and stability, the country has applied for current and forthcoming additional funding, in particular performance-based funding (PBF) with the World Bank.

Drug supply

A National System for Supply of Essential Drugs (SNAME) has been devised to centralize purchasing and decentralize distribution to provincial level through Regional Distribution Centers (CDR). The country currently has 19 CDRs ensuring storage at the intermediate tier and distribution to the peripheral tier.

Despite the creation of SNAME, there are parallel sub-systems of supply, which pose many problems with coordination, standardization, quantification, and indeed logistical capacity building. This has led to:

- Frequent stock out in some HZ and surplus stock in others but with no decisions being made to redeploy them, sometimes meaning that they exceed their expiry date;
- Inefficiency in the transporting (distribution) of drugs and inputs by several different sub-systems to the same HZ, thus increasing logistics costs.

The NTP and NACP each have their own supply system involving the main beneficiaries, partners and the provincial coordinating bodies for these two diseases. In the case of TB in particular, if there are no CDRs, then drugs and inputs are stored in warehouses belonging to the provincial coordinating bodies.

The funding of this Concept Note takes into account all relevant financial contributions of other partners as well as all activities related to drug management, which are: the rehabilitation of CDR, the equipment, the collection of information, etc.. The strengthening of the SNAME proposed in this Concept Note is in synergy with the funding from GAVI II, USAID/SIAPS and other partners such as the World Bank, DFID, and the Belgium Government in the framework of support to the national strategic plan for drug management which is actually under development. For instance, GAVI II will rehabilitate the CDR to ensure a functioning cold chain to store vaccines, but the dry storage will be covered by this Concept Note.

Currently, two projects are about to be established to set up the Information and Logistics Management System (SIGL). In this context the French Initiative 5 % will support 40 health zones in 4 provinces (Kasai Oriental, Kasai Occidental, Nord-Kivu, Province Orientale) and the Concept Note on malaria submitted to the Global Fund in June 2014 will target 110 health zones in 11 provinces (10 health zones per province).

The SIAPS project is planning to set up the SIGL in 25 health zones until December 2014. The software already developed ('District Health Information System 2.0'_ DHIS 2.0) includes the data to be collected, the instruments, the indicators and the drug module, and its pretesting is ongoing. For the first step and as a pilot, this module integrates a limited number of drugs including products related to the fight against HIV and AIDS. A road map for the set-up of the SIGL is about to be finalized with participation of several partner institutions.

The funding of the health system

In 2012, total current expenditure on health was US$ 982,381,026, of which 41 percent was spent by households, 39 percent by partners, 16 percent by the government and 4 percent by businesses (18).

Current expenditure on HIV/AIDS in 2012 amounted to US$ 113,403,828 and for TB was US$ 31,148,760 (18).

In the case of HIV, according to REDES (resources and expenditure for fighting AIDS), which takes both current expenditure and investments into account, the total for 2012 was US$ 229,278,486, with US$ 86,515,451 spent by households and US$ 142,763,035 by institutions. In the case of the latter, 98.1 percent was funded from external and private resources, which shows a high level of dependence on external funding for fighting AIDS (19).

Given the country's needs with regard to these two diseases, additional resources need to be mobilized to support implementation of the NSPs.

Funding of the health system suffers from *fragmentation* of the support provided, *lack of access*, mainly for financial reasons, to health care on the part of the population despite the funding provided, and *poor harmonization* of interventions, as confirmed by the last joint mission by the World Bank and the Global Fund to two provinces, Equateur and Bandundu. These factors contribute to the poor performance of the health system. Against this background, the performance-based financing (PBF) adopted by the MoH is a strategy that supplements other funding strategies. It will be used in the next joint interventions by the World Bank, the Global Fund and other donors to improve the population's access to health care, harmonize interventions and strengthen the health care system for the benefit of the population. Performance-based financing, with its components (contractualization, auditing, purchasing, payment, regulation, etc.), offers opportunities that should be quickly seized to ensure multi-donor co-funding of the health care services and harmonization of the tools used.

Such an approach may also enable current difficulties with regard to the gathering, analysis and distribution of financial information (traceability of funding from the State and partners) to be resolved.

The National Health Information System (NHIS)

The country has a National Health Information System (NHIS) which does not at present allow high-quality information, required for running a program, to be supplied in real time. The normative framework also describes specific sub-systems for each specialized program that, up till now, have allowed the necessary information to be collected.

However, this mechanism has experienced the following inadequacies: lack of coordination between the different sub-systems, the use of several different collecting tools, the weak institutional capacity of the actors and the absence of a single electronic platform for managing and storing data. These deficiencies have brought that, since last year, the MoH, with the support of the Global Fund and other partners, has been looking to improve the NHIS by reviewing and harmonizing its tools and adjusting them in line with the new WHO guidelines, train service providers and introduce the DHIS 2.0 [a health management information software system]. The certification of data and the mapping of contributors and interventions supported by the Global Fund and PEPFAR respectively have generated strategic information that has helped to develop this present concept note.

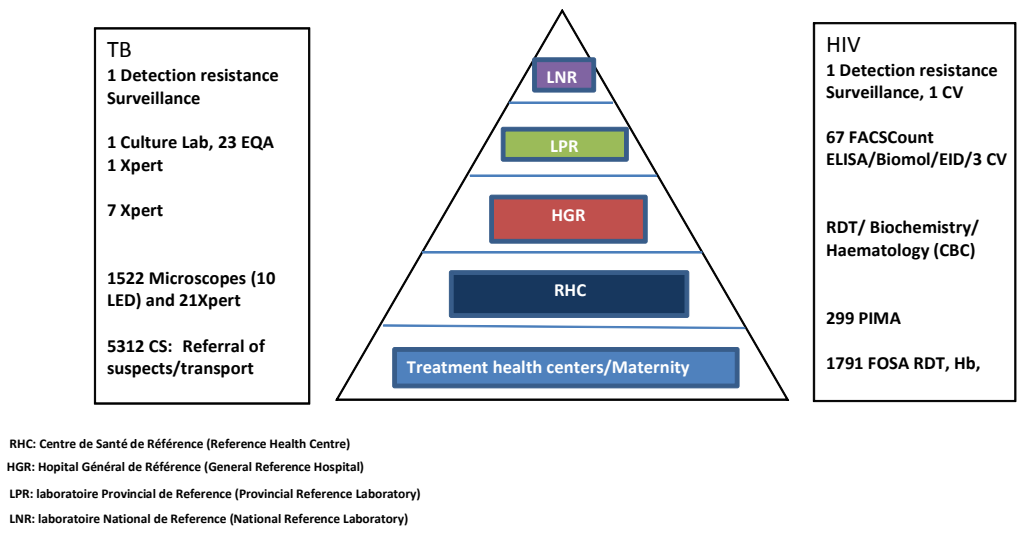
The monitoring and evaluation of joint activities is not currently the best it could be. This may be improved once the health care information system supported in the context of the GAVI II funding, the malaria concept note and the commitments made by other technical and financial partners (TFP) has been updated and revised.

Infrastructure and equipment

The laboratory network in the DRC

In the DRC there is a network of laboratories which plays a key role in controlling the two diseases, and which is organized through the health system.

Figure 3: Network of TB and HIV laboratories in the DRC in 2013



As shown in figure 3, at the end of 2013, the NTP laboratory network comprised: (i) 5,312 HC involved in the referral of suspect cases, transporting of samples/slides and the monitoring of treatment; (ii) 1,522 CSDTs providing TB diagnosis and treatment; (iii) 23 Provincial Referral Laboratories (LPR) organizing microscopy quality control (QC), one of which carries out mycobacteria culture in Lubumbashi; and (iv) the National Referral

Laboratory (LNR) in Kinshasa which carries out drugs susceptibility testing to detect resistance to first- and second-line anti-tuberculosis drugs.

The TB laboratory network currently has 41 Xpert MTB/RIF machines for carrying out molecular biology tests, 29 of which are distributed as follows: 16 in Kinshasa (TB REACH Project and MSF), 10 in Sud-Kivu Province (TB REACH Project), one in Maniema Province (USAID) and two in Nord-Kivu Province (European Union); the remaining 12 have been acquired recently, four through funding from the DRC government and eight thanks to the support of PEPFAR.

Due to its ability to swiftly diagnose TB among PLHIV and resistance to rifampicine, and because it has been endorsed by WHO, the NTP has adopted use of this technology as a means of diagnosing TB and multi-drug resistant TB (MDR-TB) quickly. Over the next three years, the NTP will expand the Xpert MTB/RIF network by acquiring 30 new machines for the LPRs who do not have one yet enabling them to step up TB screening for PLHIV and MDR-TB diagnosis with the help of an operational sample transport system so that the CSDTs are brought closer to the LPRs and diagnosis is speeded up.

The NACP has a National Referral Laboratory for HIV/AIDS and STIs (LNRS) and two Provincial Referral Laboratories (LPR) in Lubumbashi and Kisangani. These three laboratories have a tertiary level technology platform and well-trained staff. It is these three laboratories that are currently responsible for the training of technicians, supervision and the quality assurance system for laboratories that carry out diagnostic analyses of HIV and biological monitoring of PLHIV throughout the country, as well as the disease surveillance system.

As illustrated in figure 4 on HIV side, at the end of 2013, the NACP laboratory network comprised 1,791 laboratories conducting HIV and syphilis screening using rapid diagnosis tests (RDT), as well as haemoglobin checks (either in the context of the PMTCT package and/or the provision of ARV) in 350 HZ. 229 GRH and RHC laboratories are responsible for performing complete blood counts (CBC), tests for glycaemia, blood creatinine and glutamate pyruvate transaminase (GPT/ALAT) and CD4 counts using PIMA and/or FACSCount equipment (67 GRHs). The three LPRS and the private laboratories operated by the NGO DREAM, which are located in Kinshasa and Mbandaka respectively, as well as the laboratory at the Monkole Mother and Child Hospital Center in Kinshasa, are responsible for carrying out, in addition to this minimum set of activities, viral load testing (20) and early infant diagnosis (EID) of HIV in children born to mothers who are HIV-positive. However, only a small proportion of the latter have had access to EID (9.8 percent during the first two months of life). A sample collecting and transport system has been set up in order to give children born to HIV-positive mothers access to early HIV diagnosis through dried blood spots (DBS) and patients on ARV access to biological monitoring and viral load testing. The main constraint found, including with regard to the biological monitoring of HIV patients, remains the low level of access to CD4 count and viral load testing.

The LNRs for TB and HIV supervise the whole national network. They have the best equipped technical platform in the country. They play a standard-setting role (standards, guidelines and guides), evaluate tests and equipment, and organize the quality assurance system. They carry out quality control for all surveillance surveys, the confirmation of HIV and MDR-TB cases, viral load testing, early diagnosis of HIV infection and research into HIV infection and syphilis. They also coordinate the logistics and production of strategic information for the laboratory network. This concept note will help to improve the delivery of laboratory services with regard to the biological monitoring of patients by improving access to CD4 count and viral load testing. In order to achieve this, an improved system for collecting and transporting samples has been set up in order to give children born to HIV-positive mothers access to early HIV diagnosis through dried blood spots (DBS) and patients on ARV access to biological monitoring and viral load testing.

The main constraints on the health system

The main obstacles impeding implementation of the two programs stem from the constraints described for the health care system in general and are illustrated by the inadequate coordination of the interventions being carried out by the two programs, the absence of a joint action plan, and separate resource and program management.

Other points related to the implementation of the two programs have been developed in the TB/HIV road map (21) and described in sub-section 1.3 concerning joint TB/HIV activities.

The community system

The MoH has adhered to the Bamako initiative which recommended community involvement in the support and day-to-day management of primary health care activities by using community health volunteers (CHVs) as the interface between health care structures and the community, community outreach units (CAC), the Health Development Committee (CODESA) and community-based organizations (CBOs), non-governmental organizations (NGOs) and networks of organizations acting outside of the health area or even the HZ.

In the DRC, in the context of fighting HIV, TB and other diseases, several approaches are used to ensure community participation. In particular, peer educators contact the following target groups: young women, people living with the diseases in question and key populations involved in promoting services within the community through their grassroots community organizations (networks, NGOs and CBOs).

As well as promoting health care services, these community actors and organizations organize and deliver clinical services in conjunction with the public sector, such as the National Council of Health NGOs (CNOS), with regard to the management of sub-sub-recipients (SSRs): the Congolese Union of Organizations of People living with HIV (UCOP+), the AIDS Forum (FOSI) and the Congolese Network of Nurses, General Practitioners and Obstetricians (RIGIAC), and PALME with regard to prevention activities, behavior change communication (BCC), care and treatment of PLHIV, improving technical skills, prevention in prisons, monitoring and evaluation and advocacy.

Past experiences have taught us about: (i) the community self-assessment approach, (ii) PLHIV support groups (keeping up and complying with ARV, the practical approach to health, positive prevention, positive care and health, and the distribution of food kits by PLHIV for PLHIV in local health clinics (FOSA)); (iii) the Centres d'Ecoute et Information Convivial pour les Adolescents (CEICA), centers working with young people to promote services Information, Education, Communication (IEC), BCC and condoms; (iv) psycho-social support groups for women who have been the victims of sexual violence; and (v) support groups (SW, MSM).

Civil society organizations (CSOs) have played a major role in mobilizing internal and external resources, especially from the CCM-DRC (Global Fund), National Steering Committee (CNP), the Gavi Alliance Fund and national counterpart funding.

Indeed, the community system in the DRC ought to have unified coordination at every level in order to ensure good governance and the harmonious coordination of community interventions.

As far as fighting TB is concerned, in addition to the community health volunteers and other grassroots community organizations, the TB ambassadors in Sud-Kivu, former TB or co-infected patients, organized under the name Club des Amis Damien (CAD), are very active in providing psycho-social support to patients undergoing treatment and looking for contacts and suspect cases in the community.

To date, there are 108 CADs, with over 1,080 trained members, resulting in the following:

Table 1: Progress of the activities of the former TB patients (CADs)

Année	Suspects orientés par CAD	Malades confirmés TB parmi les orientés			
		TPM+	TPM0	TEP	TOTAL
2 011	2 549	720	52	36	808 (32%)
2 012	4 324	1 155	228	111	1494 (35%)
2 013	7 232	1 512	196	174	1882 (26%)

There are no official clear guidelines on community approaches to co-infection. However, there are some initiatives under way, such as the "Engage TB" approach, active TB research being undertaken with the WHO in Kinshasa and Kikwit.

In the context of current Global Fund grants, there are community organizations which are playing a key role in health care promotion and service delivery as well as in the monitoring of health care systems in terms of equity and service quality. Their support is focused on care, nutrition, psychology, legal matters and guidance with regard to access to services.

For example, UCOP+ provides comprehensive care in the home through PLHIV support groups, the Women's Foundation for women with HIV and TB, the National Network of NGOs for Women's Development (RENADEF), which is active in PMTCT at the grassroots level/Gender and SGBV; the National League against Tuberculosis and Leprosy (LNAC) in the case of TB, and the NGO Progrès Santé Sans Prix (PSSP) provides support for the key populations (MSM and SW); the Congolese Youth Network (RACOJ) provides support with regard to primary prevention in the context of PMTCT, etc.

All of these organizations directly involve local structures and work on a daily basis with health care structures. However, in order to help improve the performance of health care services in the DRC with regard to access to care services, which remains poor (about 34 percent for curative care), and given this intense blossoming of community activities, civil society has received counterpart funding from the government, which has allowed it to start mapping up CBOs, as a result of which 584 local committees in 146 health zones have already been established in the 11 provinces of the country.

The main constraints on the community system are:
Despite the undeniable contribution made by organizations from the community system towards improving access to and the quality of the health and social services available to the population in general and the key populations and vulnerable groups in particular, there are still weaknesses in the following areas:

- Ensuring the continuation of the voluntary work carried out by members of the community with regard to health-related community activities;
- Community participation is only incorporated into the peripheral tier of the health care pyramid;
- Lack of evidence regarding the contribution community activities make to fighting diseases;
- Little collaboration between CSOs and the MoH at all levels;
- Little CSO participation on decision-making bodies and in the planning, management, implementation, monitoring and evaluation of programs connected with the three diseases and others;
- There is no link between the health care information system and the data produced by the community system;
- Lack of coordination, integration, accountability, transparency and traceability of the data collected by actors at the community level;
- Little ability to mobilize resources (both financial and material) for community activities;
- Lack of a formal consultation framework between networks, NGOs, CBOs and the different programs run by the Ministry of Public Health;
- Little account is taken at the level of the national health care system of data resulting from community activities.

1.2 National Disease Strategic Plans

a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.

The DRC has a 2012-2016 Government Action Plan which has taken the goals of the health care sector into account. These goals are laid out in detail in the 2011-2015 National Health Care Development Plan (NHDP). Fully consistent with the latter, the NTP and NACP, together with the NAC (PNMLS), have each developed a National Strategic Plan (NSP) for the period 2014-2017 that is in line with the DRC's vision with regard to its international commitments.

With regard to TB, the goal of the NSP for 2014-2017 is to help reduce TB-related mortality in the DRC by 25 percent by 2025 compared to the estimate for 2012 (54 per 100,000 population) (22).

More specifically, the NSP for TB for 2014-2017 (22) aims to:

- Detect, between now and 2017, an overall total of 570,903 cases of TB of all forms (in other words, a detection rate of 73 percent and a notification rate of 131/100,000 population versus 97/100,000 in 2012);
- Maintain a treatment success rate of at least 90 percent for all new TB cases treated;
- Screen for HIV in at least 479,560 TB patients between now and 2017, in other words 84 percent of notified cases;
- Provide ARV for 72,892 TB/HIV co-infected patients (in other words, 95 percent) from now until end of 2017;
- Screen at least 80 percent of the PLHIV who are monitored by the health care services for detection of TB;
- Between now and the end of 2017, screen at least 6,979 patients with MDR-TB out of the 12,495 cases expected (in other words, 56 percent);
- Successfully treat 5,405 of the 7,207 cases of MDR-TB, in other words 75 percent are placed on second-line treatment;
- Improve the management skills of the NTP at all levels, including those intrinsic to the information system for fighting TB.

The National Strategic Plan for HIV for 2014-2017 reflects the DRC's vision of accelerating the national response in order to secure universal access for PLHIV to prevention, care and support services so that the goal of "Three Zeros" can be achieved: namely, Zero new infection, Zero AIDS-related deaths and Zero cases of AIDS-related discrimination.

This forms part of the overall framework of national efforts to accelerate progress towards attaining the Millennium Development Goals (MDG). The NSP is based on nine guiding principles, namely: (i) the multisectoral nature of the response; (ii) integration; (iii) decentralization of the response; (iv) community participation; (v) partnership; (vi) respect for human rights and gender; (vii) free health care; (viii) coordination; and (ix) good governance.

The goal of the 2014-2017 NSP for HIV is to contribute to the country's development by curbing the spread of HIV through reducing the level of new infections and the impact of HIV infection on the population of the DRC.

More specifically, the 2014-2017 NSP for HIV aims to:

- Reduce by 50 percent the number of new HIV infections, reducing them from 34,000 to 17,000 in the general population and the priority target groups between now and 2017;
- Reduce the number of new infections in children under 15 years of age by 90 percent between now and 2017 (PMTCT);
- Reduce the number of HIV-related deaths by 50 percent, from 32,000 to 16,000 between now and 2017;
- Reduce by 50 percent the impact of discrimination and stigmatization on PLHIV and people affected by HIV, as well as sexual violence and gender-based inequalities between now and 2017;

- Provide an effective response to the HIV epidemic between now and 2017 (support the fight).

In order to ensure better synergy between the two programs to fight HIV and TB and to maximize the impact of investment, in particular by means of joint programming, a TB/HIV road map (21) has been developed based on the strategic plans for the two diseases. The general objective of this road map is to achieve a 50 percent reduction by 2025, compared to 2012 the rate of TB- and HIV-related deaths among PLHIV and TB patients.

In order to achieve these results, the following specific objectives have been jointly defined:

- Test at least 479,560,84 percent of notified TB patients for HIV;
- Treat 95 percent of TB patients who are HIV positive with ARV;
- Provide TB screening for at least 80 percent of PLHIV who are followed by the health care services;
- Provide TB treatment for 100 percent of PLHIV who are co-infected with TB.

b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

Description of implementation

The main features of implementation of the 2006-2012 NSP to fight TB were the following:

- The strategies for fighting TB were implemented by developing and strengthening the national TB control program, including by expanding high-quality Directly Observed Treatment Short Course (DOTS) provision;
- A network of health facilities (1,522 CSDTs versus 1,545 planned in 516 HZ) was set up to ensure standardized detection and treatment of notified patients;
- The gradual expansion of the programmatic management of TB/HIV and MDR-TB in 660 CSDTs and 74 health facilities respectively;
- The effective involvement of the community through associations of former patients, CBOs in referring suspect cases and monitoring of patients undergoing treatment. However, the impact of community activities has been limited due to the factors explained above.

Main outcomes of the implementation of the 2006-2012 NSP for TB

The outcomes recorded as a result of implementing the 2006-2012 NSP are listed below and summarized in Table 2.

Table 2: Trends in the main indicators for fighting tuberculosis in the DR Congo 2006-2013 and the targets for 2017. Smear-positive Tuberculosis cases.

Evaluation of the implementation of the 2012 road map showed the following results:

- 26,037 out of 387,164 PLHIV, or about 7 percent, benefitted from active TB screening

in the country as a whole;
- 35,097 out of 112,499 cases of all types of TB, or 31 percent, had access to HIV screening;
- 3,485 out of 5,748 identified TB/HIV patients, or 60 percent, received co-trimoxazole (CTX) and 40 percent (2,296) received antiretroviral drugs;
- 991 PLHIV benefitted from Isoniazid (INH) prophylaxis in 2012;
- The number of estimated cases of HIV-related TB who **received** treatment for both together rose from 5 percent in 2007 to 12.2 percent in 2012 (19 percent in 2013) of expected cases.

Impact of the implementation of the 2006-2012 NSP for TB

WHO estimates suggest that TB prevalence and mortality rates tended to drop from the early 1990s until 2012. Indeed the mortality rate declines from 74 (28-140) in 1990 to 54 (24-97) per 100,000 population in 2012. The prevalence rate declines from 695 (327-1200) in 1990 to 576 (301-938) in 2012.However in the same time the TB incidence remains stable (4).

Implementation of HIV interventions 2004-2013

The HIV/AIDS control program is based on the provisions of the national policy for fighting HIV/AIDS which were established as part of the technical framing of the NACP in 2001. It should be noted, however, that several organizational and operational changes have taken place since then because of the following:

- In 2008, promulgation of the law (N° 08/11 of 14 July 2008) protecting the rights of persons living with HIV/AIDs and affected persons;
- In 2011, the signing of the order (N° 11/023 of 18 March 2011) amending and completing decree N° 04/029 of 17 March 2004 creating and organizing the National Multisectoral Program to Fight AIDS (PNMLS). The latter operates across several different sectors including health care for which leadership is conferred on the MoH through the NACP.

The NACP has opted for an approach based on incorporating a comprehensive package of interventions for fighting HIV into the health facilities of the HZ, specifically maternal, neonatal and child health and sexual and reproductive health services. This desire to do better is reflected in the position given to fighting HIV in all of the country's strategy documents.

More recently, the national response has benefitted from increased support from the government, the Global Fund, PEPFAR and the United Nations system, especially with regard to speeding up transition to Option B+ in order to eliminate mother-to-child HIV transmission, as recommended in the 2013 WHO guidelines.

Taking an approach that is based on integration of a comprehensive package of interventions has enabled the NACP, with the support of its partners, to have a network of local health clinics (FOSA) providing HIV screening (41 in 2004 rising to 1,264 in 2012), STI care (841 sites in 2009 rising to 1,665 in 2011), ARV treatment for adults and children (573 sites in 2012 rising to 852 in 2013). The country's commitment to the goal of achieving an "AIDS-free generation" has meant the gradual establishment of a network of laboratories devoted to early HIV detection in newborns and improved provision in terms of sites providing PMTCT interventions, increasing from 1,205 sites in 2012 to 1,791 in 2013 (an increase of 49 percent).

Main outcomes of the implementation of HIV interventions for 2004-2013

The efficient implementation of various HIV interventions has led to some improvement in the indicators. Indeed,

- The 2013 NACP report notes that 471,387 of the 844,780 pregnant women expected were tested for HIV (a coverage of 55.8 percent), while coverage for ANC1 (pregnant women who received at least one antenatal care (ANC) during pregnancy) was 88 percent;
- The proportion of pregnant women living with HIV who received ARV to prevent HIV

transmission to their child rose from 13 percent in 2012 to 33 percent in 2013; 3,754 of these women identified as being HIV positive received Option A, and 2,339 women an ARV regimen for their own health. In addition, 817 women (3.2 percent) were placed on Option B+ following adoption of that guideline in 2013 by the DRC (23);;

- The proportion of children born to HIV-positive mothers who were given a virological test for HIV during their first two months of life increased from 3 percent in 2011 to 9.8 percent in 2013 (GARP report 2014);
- The number of adults and children eligible for antiretroviral treatment and had access to it increased from 34,967 (12.4 percent) in 2010 to 79,978 (37 percent) in 2013 (23).

Trends in service provision and the main indicators relating to the fight against HIV/AIDS are reflected in the following figure:

As of the end of December 2013, between 2010 and 2013 provision in terms of HZ PMTCT had increased from 57 percent to 67.8 percent (290 to 350 HZ) and from 46.3 percent to 62.5 percent (239 to 323 HZ) in terms of care and treatment. These trends from 2010 to 2013 can be seen in the beneficiaries, especially pregnant women in the PMTCT, the number of patients undergoing ARV and the co-infected.

Table 3: Trends in the main indicators for fighting HIV in the DR Congo 2010-2013 and targets for 2017

Interventions	Indicators	Baseline 2010	Targets 2013	Outcomes 2013	Targets 2017
Coverage	No. of HZ with PMTCT services	290	516	350	516
Prevention and CT	No. of FOSA/Maternity wards with PMTCT services	851	2,580	1,791	2,580
	No. of HZ with ARV services	239	413	323	516
	No. of FOSA with ARV services	344	1,032	852	2,580
	No. of HIV+ pregnant women who received ARV as their treatment	3,371	20,577	8,575(33 percent)	26,108
	Nombre et % d'adultes et d'enfants atteints d'infection à VIH à un stade avancé sous antirétroviraux	(34967/283 055) 12,4%	214 000	79 978 (37%)	232 067
	No. and percent of adults and children currently on antiretroviral therapy	N/A (Indicateurs introduit en 2013)	440 000	79 978 (17,9%)	464 133
	No. and percent of estimated cases of tuberculosis linked to concomitant HIV who have been treated for both TB and HIV	(489/16,105) 3 percent	17,598	(3,371/17,598) 19 percent	27,238

Impact of implementation

The different interventions implemented within the country have yield the following effects:

HIV counselling and testing:
According to the report of the integrated survey on behavior surveillance and seroprevalence in the DRC carried out in 2013, the percentage of SW who said they had been tested for HIV and knew the result was estimated to be 45.7 percent; the 2013 report by the NGO Progrès Santé Sans Prix (PSSP*)* shows that 7.8 percent of MSM said they had been tested and knew the result.

Treatment, care and support:
The 2013 NACP report notes that 79,978 people (37 percent of eligible PLHIV) received ARV,

of whom 74,923 were adults (94 percent) and 5,055 children (6 percent) (24).

PMTCT:
In total, 8,575 out of the 25,811 HIV-positive pregnant women estimated (33 percent) received ARV in the context of PMTCT. The 2014 GARP report shows that 9.8 percent of children born to HIV-positive mothers were given a virological test for HIV during the first two months of life and only 3,229 out of 25,811, or 12.5 percent, were given ARV prophylaxis (24).

TB/HIV
In 2013, joint data analysis of the implementation of co-infection activities showed the following main outcomes and gaps:

- Of the 113,881 notified TB patients, 62,691 (55 percent) benefitted from Provider Initiated counseling & Testing (PICT), mainly depending on whether or not the two programs were provided and operational at the level of health facilities;
- Only 49,816 of the 62,691 TB patients (79,5 percent) benefited from PICT were tested for HIV. Furthermore, 6,984 patients (14 percent) were co-infected with HIV, of whom 4,866 (70 percent) and 3,371 (48 percent) benefitted from CTX and ARV respectively;
- On the other hand, in care and treatment services for PLHIV, of the total number of 79,978 PLHIV on ARV in 2013, 26,037, or 33.5 percent, were subject to active TB research. The proportion of PLHIV with active TB has not been documented;
- The number of PLHIV who benefitted from INH prophylaxis in 2012 (991 cases) is low.

c. *Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed*

According to the situation analysis with regard to 2012 outcomes carried out when developing the 2014-2017 NSP for TB, the main weaknesses hampering TB control can be summarized as follows:

The goal of expecting 70 percent detection of pulmonary TB cases was difficult to achieve at national level. In total, half of the TB cases attended remained unidentified for the following main reasons:

- The 99 percent CSDT coverage (1,522 CSDTs versus 1,545 that are scheduled) is geographical (taking into account at least three health areas per HZ) but does not correlate with the population covered; it is believed that 26 percent of the population living over 10 kilometers from a health center (HC) providing TB services has no access to such services;
- 77,707 out of the 112,499 TB patients notified in 2012, namely 69 percent, had no access to HIV services because of a lack of inputs in the care structures and HZ not supported by the NACP;
- 361,127 out of 387,164 PLHIV, namely 93 percent, were not subjected to documented active TB research (24);
- 17,994 out of 20,338 TB patients (retreatment cases), namely 88 percent, who should have been assessed for MDR-TB did not have access to the appropriate tests;
- A low level of implementation of isoniazide prophylaxis in children of under five years of age born to mothers infected with bacilliform and in PLHIV;
- Irregular supply and excessive delays in the delivery of TB drugs and laboratory inputs at all levels;
- Delays in the disbursement of funds for the main beneficiaries resulting in disruption of the implementation of activities and the attainment of targets;
- Inadequate public funding of health care, including for fighting TB;
- Heavy reliance (over 80 percent) on external funding preventing the sustainability of interventions;
- Lack of motivation among staff at all levels;
- The geographical and cultural accessibility of the key populations is limited to the program activities;

- Insufficient exchange of strategic information between the CCM and the principal recipients (PRs) and other stakeholders;
- Over half of the staff of the NTP and the CPLTs lack performance contracts, which has contributed to their lack of motivation;
- The non-disbursement of operating costs from the DPSs to enable the CPLTs to manage the actors on the ground at a local level.

According to the situation analysis carried out when drawing up the 2014-2017 NSP for HIV, the main weaknesses hampering the response to HIV infection can be summarized as follows:

- The 67 percent PMTCT service coverage, or 1,791 out of 2,664 (the number of PNC centers providing PMTCT), only represents the geographical coverage which does not reflect the actual coverage of the target populations. According to the NACP, a HZ is said to be "covered in terms of HIV care and treatment" if it has at least two care and treatment (CT) structures. As far as prevention is concerned, a HZ is said to be covered if it has at least five prevention structures. Looking at the 516 HZ in the country, the coverage provided for HIV prevention was 2,580, or five prevention structures per HZ. Those provided for "CT coverage" numbered 1, 032, or two FOSAs at least per HZ. These 2,664 structures constitute the total number of FOSAs, which are either CT structures for PMTCT, CSDTs, CT structures for ARV or structures which combine two or three of these criteria (PMTCT, CSDT or ARV). When expanding coverage, priority will be given to completing the FOSAs for PMTCT by giving them an ARV package so that they are able to offer a comprehensive CT package in the same way as the CSDTs which will be prioritized for receiving the ARV package so that they have a comprehensive CT package for co-infection. In this concept note, the 2,664 FOSAs in the 323 HZ are considered to be the ones which should be targeted for coverage;
- As a corollary, only 8,575 of the pregnant women living with HIV attended were given ARV for PMTCT, in other words a coverage of 33 percent;
- Similarly, ARV coverage in health care structures in the HZ, which was 9.8 percent, meant that only 37 percent of eligible PLHIV were provided with ARV;
- In relation to the early detection of HIV among children through polymerase chain reaction (PCR) testing, poor implementation of the relative guideline meant that only 3,229 of the 25,811 children(12,5 percent) (24) attended were able to benefit from the intervention;
- Weak management capabilities with regard to the supply of stocks of inputs throughout the country;
- Poor availability of HIV screening services in the HZ and therefore in health centers;
- Little alignment between partners (management, reporting);
- Little involvement (by PRs and sub-recipients - SRs) of the management teams of the HZ in the planning and implementation of interventions for fighting HIV/AIDS.

The lessons learned by the two programs from implementation of the TB and HIV plans are as follows:

- Provision of integrated TB/HIV services in health centers is poor, meaning that people have to travel long distances to have access to care;
- The dysfunctional nature of the supply, storage and distribution system for drugs and inputs (involving the program at all levels) has had a negative impact on the successful implementation of the programs for fighting TB and HIV;
- Little involvement in the negotiation of GF grants and weaknesses in the strategic monitoring and operation of the CCM have resulted in delayed implementation of grants;
- The CCM should be involved at the time of negotiating conditions precedent and special conditions to be taken into account when signing the agreements included by the Global Fund in the grant agreements. The final formulation of these conditions in the grant agreement must be meticulously examined and care should be taken to ensure that disbursement is made at the same time for all the principal recipients (PRs)

of a particular component.

In order to remove the key inequalities and constraints underlying the serious difficulties experienced in accessing prevention, treatment, care and management services described in section 1.1, it will be necessary to:

- Improve health care service provision for all populations;
- Ensure the improved quality of TB/HIV care, treatment and prevention services for the prison population, miners and other high risk or vulnerable groups;
- Update the guidelines with regard to care and treatment in prisons;
- Carry out a study of the scale of HIV and TB and the main determinants influencing access to health care, especially delivery of TB and HIV care for MSM, SW and IDUs;
- Coordinate supplies and strategic information;
- Streamline the management of human resources;
- Increase community involvement in interventions to fight TB and HIV.

d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

The strategic plans for HIV and TB, in aiming to reduce morbidity and/or mortality for these two diseases, help to improve the health of the Congolese population in the context of combatting poverty as advocated in the National Health Development Plan (NHDP) 2011–2015 (1). Indeed, target 3 of the PNDS aims specifically, between now and 2015, to stop the spread of HIV/AIDS, control malaria and other major diseases and begin to reverse the current trend. Indicators 5, 7 and 8 of the NHDP relate to HIV and TB. The effective implementation of the NHDP will have an impact on the interventions contained in the strategic plans for HIV (strategic focus 3 of the NSP for HIV (9)) and TB (see the four operational goals of the NSP for TB (22)) and help to attain this target 3 of the NHDP.

Table 4 shows the links between the strategic focus of the PNDS and the TB and HIV interventions planned in the NSPs, as well as the impact of the PNDS on the outcomes of the fight against the two diseases, TB and HIV.

Table 4: Links between the strategic focus of the NHDP and the interventions planned in the NSPs for TB and HIV for 2014-2017

Strategic foci of the PNDS	TB NSP and HIV NSP Interventions	Impact of the implementation of the PNDS on outcomes in the fight against TB and HIV
The development of health zones through: – The development of human resources for health care – Reform of the drugs sector – Reform of health care funding – The construction and/or rehabilitation of health care infrastructure, equipment and the establishment of new technology – Improvement in the management of health care	With regard to the focus 'Support for implementing the TB and HIV NSP 2014 – 2017', the following is envisaged: – The strengthening of basic systems (all development sectors, including the health care system) in order to fight AIDS; – Sustainable funding; – The strengthening of partnerships; – The strengthening of program management.	Implementation of the interventions for fighting TB and HIV requires the establishment of basic systems, in particular a strong health care system. The development of health zones will facilitate the integration and coordination of the interventions to fight TB and AIDS in the health care sector. The construction of new health centers and the rehabilitation of hospitals should facilitate expanded provision of HIV and TB interventions.

information.		
Strategies to support the development of health zones through:	Capacity-building for service providers involved in the strategies for fighting HIV and TB; The development of HIV and TB laboratory services as defined in the DOTS package, MDR-TB and HIV care and treatment; The strengthening of the HIV and TB drug supply system in the DOTS package and focus 5 of the HIV NSP; The mobilization of resources to fund the fight against the two diseases; Strengthening of the system of health care information.	The development of laboratory services; The staff retention strategy will help stabilize a motivated workforce; The establishment of a National System for the Supply of Essential Drugs through which drugs for fighting HIV will be channeled ; The strengthening of the National Health Care Information System (NHIS) will improve the ability of the HC and GRHs to produce information on both HIV and TB. The strengthening of the NHIS may allow it to produce the vast majority of the information on the two diseases.
The strengthening of leadership and governance in the sector through outcomes: (i) Updating/implementing the legislative, regulatory, strategy and policy framework; (ii) Institutional capacity-building in the context of decentralization; (iii) Coordination of the sector at all levels; (iv) effective and efficient management at all levels	The TB NSP envisages strengthening the technical skills and management of the Central Unit and the provincial units of the NTP in the PHD; The HIV NSP envisages improving the mobilization of resources and sound management of financial resources in order to support the response to HIV; Capacity-building to ensure good governance in the management of funds allocated to fighting HIV/AIDS (policies, procedures and training)	Institutional capacity-building at the central, intermediate and peripheral tiers will benefit program management. Sound management of financial, material and human resources in accordance with reform of the health care section should help ensure that the fight against the two diseases is well-managed. Sound management of the resources allocated, in particular for the two diseases, as envisaged in the PNDS, will help improve the efficiency of HIV and TB interventions.
The strengthening of inter-sectoral collaboration through collaboration with the following sectors: education; water, hygiene and sanitation; agriculture, fisheries and livestock farming; gender and family; and other related sectors. The leadership of the MoH is provided by establishing a committee to monitor the	Both the HIV and TB NSPs aim to ensure efficient collaboration and coordination with partners.	Inter-sectoral collaboration is important for the fight against HIV. Interventions such as communications, promotion of interventions and support for PLHIV require collaboration with other sectors. The health care sector for its part provides technical support to other sectors for the fight against HIV. Collaboration with the

implementation of international resolutions and treaties that have been ratified.		research sector and the higher education and university sectors is useful for the two programs in the area of production of human resources and research.

e. ***Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.***

The drafting of the TB NSP for 2014-2017, which is currently undergoing completion and approval, began with a review of program performance. The results of that review, together with recommendations, were submitted to the Minister of Health in the form of an "Aide-mémoire" which was signed by all stakeholders on 19 July 2013. The review of the NTP program was carried out in four stages as recommended in the WHO procedure manual. A consensus-building workshop was then held in Matadi from 18 to 30 November 2013 to determine the priorities to be included in the new National Strategic Plan for 2014-2017.

The drafting of the strategic plan for HIV took place between May and November 2013 and included a review of the performance of the NACP, the drafting of an investment framework, revision of the 2010 – 2014 NSP and the adoption and endorsement of an NSP for 2014 – 2017. The stages and critical elements of this process includes:

1. Program review

Preparatory stage: a document review was carried out, enabling all stakeholders, including the key populations, to be involved in analysis of the documents, and taking a thematic approach at provincial and national level.

Dialogue stage: every province and priority sector (health, education, social affairs, gender and family, justice, defense, media and communications, community organizations and specific groups) was explored.

The review was brought to a close with a national feedback workshop.

2. The drafting of the investment framework was also started in order to guide the strategic plan for HIV for 2014 – 2017 and was developed with the help of UNAIDS in October 2013.

3. Revision of the HIV strategic plan for 2010 – 2014

Based on the priority problems identified during the review, the revised draft of the NSP was produced by a small group of multi sectorial experts and then sent for analysis to the provinces for amendment, feedback and consensus. The comments and suggestions from the provinces were then incorporated and the NSP received technical approval at a national consensus workshop.

4. Adoption and endorsement of the HIV NSP by the DRC government took place during a meeting chaired by the Head of State on 9 June 2014.

This meeting was an opportunity to disseminate the document to all members of the government and the governors of all 11 provinces.

In the framework of the dialogue on the two diseases that was organized at provincial and national level, under the patronage of the Health Minister and based on the strategic plan, and including the key populations, priorities in terms of interventions for fighting them were identified by means of consensus and participation in order to form the framework for writing this concept note.

1.3 Joint scheduling and alignment of strategies, policies and interventions in the fight against tuberculosis and HIV

a. Plans for strengthening the alignment of strategies, policies and interventions in the fight against tuberculosis and HIV at the various levels of the health and community systems.

The two programs are part of the same department within the MoH - the DLM (Disease Control Department) - and are represented on the CNP (National Health Steering Committee), the national body for combating disease which encompasses several sectors, including civil society. The role of the CNP is to define the health strategy guidelines for the DRC.

In addition, the CNP has a ministerial sub-committee for combating disease headed by the Director of the DLM. This sub-committee establishes national policies for combating disease, including TB and HIV/AIDS. The MoH's research and planning department,, known as DEP, is responsible for integrating activities of the two programs into the process established by the MoH for planning and evaluation.

In 2008, a TB/HIV steering committee was set up. Its role is to work together with the ministerial sub-committee (the CNP commission responsible for disease prevention), to define joint strategies against the two diseases, to establish national guidelines, to assist in programming the implementation of joint TB/HIV activities, to enhance supervision and to monitor and evaluate the two programs. Every year a joint operational plan is produced called the 'Road Map'. However, the activities of this committee remain irregular.

Each program develops an NSP covering several years which conforms to the framework of the current NHDP. The NSP of each program includes a TB/HIV component.

An initiative to set up TB/HIV steering committees within seven provincial coordinating offices for the prevention of leprosy and tuberculosis (in Bukavu, Kindu, Lisala, Tshikapa, Lodja, Kananga and Mbuji-Mayi) was successful with the technical and financial support of UNION and the involvement of USAID. However, this initiative came to an end when financial support was discontinued in 2013.

Although there is a Medical Inspector in each province whose role is to coordinate the implementation of national health policy, in practice the two programs work independently due to the lack of clear ministerial guidelines regarding the effective integration of TB and HIV/AIDS activities.

It is important to note that administrative reforms aimed at decentralization are ongoing.. They entail the integration of national program activities into the PHD (Provincial Health Department) at the intermediary level and the BCZs (Central Offices of Health Zones) at the Health Zone level, and to strengthen the role of the zones under the guidance of the Health Zone Management Teams. These reforms form part of the framework of the health systems strengthening (HSS) strategy, which was adopted in 2006 to support the national campaign against poverty in line with the Poverty Reduction and Growth Strategy.

At the level of the health zones, the management team oversees the integration of disease related activities into health care provision through MPAs (Minimum Packages of Activities) at the level of the HCs (Health Centers) and through the Complementary Package of Activities (CPAs) at the level of the referral structures, as well as overseeing public health interventions. TB related services are available at all the Health Zones (HZ) s in the country, whereas the HIV/AIDS services are only available in 350 HZs. In HZs where both are available, the two disease prevention services are not necessarily provided at the same health facilities, and even when they are, most of the time the services are dispensed separately rather than being integrated. An effort to provide an integrated 'one stop shop' is required. A detailed map of the TB and HIV/AIDS control services is available and this should make it easier to support the HZs in undertaking properly integrated TB/HIV interventions.

The contribution of communities in the fight against the two diseases is described in Section 1.1. In 2006, the two programs launched initiatives to involve community entities

in TB/HIV co-infection activities with the financial support of the Global Fund (Series 3), but on a limited scale. Each program independently developed relationships with community organizations. There are few community-based NGOs like the Club des Amis Damien with which the NTP has a working relationship. However, there are several community NGOs working in the HIV CCM (Community Case Management) field. Very few NGOs undertake joint TB/HIV activities at a community level, with the exception of CAD and Femmes-Plus.

Measures to enhance service coverage and quality

In order to strengthen the joint activities of the two programs, it is necessary to:

- Revitalize the existing national coordination mechanism for the two programs. The mechanism's terms of reference need to be clearly specified in order to define its role in terms of: i) coordination with partners, ii) development of TB/HIV co-infection prevention strategies, iii) scheduling, iv) national guidelines, v) training and vi) evaluation.
- Establish a TB/HIV coordination mechanism at the level of each province whose role is to assist in adapting and implementing strategies defined at the national level and to encourage the effective integration of activities to combat the two diseases through the joint annual scheduling of activities and the organizing of monitoring and evaluation.
- Define the joint national prevention strategies outlining specific goals and interventions.
- Develop national implementation guidelines for these interventions in order to achieve these goals.
- Integrate certain aspects of the NSP of each program into a jointNSP which targets common objectives already defined in the TB/HIV Road Map.
- Strengthen the ability of the HZ management teams to integrate, oversee and monitor TB/HIV activities through building their capacity to manage TB/HIV program activities and taking into account TB/HIV interventions in the operational action plans of the HZ.
- Adapt and develop the training modules for the implementation of the aforementioned guidelines in health and community structures.
- Adapt the IT system to ensure appropriate joint monitoring and evaluation.
- Integrate supervision activities between the two programs at the intermediary level (DPSs and coordinating bodies) and at the level of health zones and areas.
- Scrupulous measures must be taken to enhance the coverage and quality of integrated TB/HIV prevention services, including joint or integrated services.
- Ensure that GRHs / RHCs, and progressively all CSDTs, will automatically function as CCM centers offering ARV treatment, and that all VCT centers will become CSTs. Information gathered will be communicated from the grass roots (CSDTs and HZs) to higher levels through the transmission of data and periodic activity reports produced by the NTP and NACP networks. This information will be approved and shared at every level. This process of integration should start with the HZs where TB/HIV interventions are offered. Clear guidelines should lead to the creation of a 'one stop shop'.
- Build the technical capacities of care providers and all the stakeholders (HIV and TB program managers) in managing TB/HIV co-infection.
- Ensure the integration of systematic HIV screening of TB patients and suspected TB cases as well as TB screening among PLHIV at all sites providing HIV services in the 350 HZs (including those supported by PEPFAR funds) where HIV and TB services are simultaneously available and in the 166 GRHs / RHCs in the 166 HZs which are not yet supported but which undertake TB activities.
- Provide regular supplies of HIV and TB products in all the HZs in the country.
- Ensure that community is mobilized for HIV and TB screening and for monitoring and supporting PLHIV who are affected by TB.
- Extend the HIV Complementary Package of Activities to the HZs which are not

covered and increase coverage so that TB patients can benefit from the services of the NACP. The 'one stop shop' approach will make it possible to offer every patient the two complete packages of TB and HIV services.

The scope for joint implementation

The joint implementation of cross-cutting activities such as planning , monitoring and evaluation of programs, strengthening of health and community systems, strengthening of laboratories (through the integration of the complete HIV package in all the CDSTs and the establishment of a single transportation for samples), purchase and stock management and the dissemination and application of guidelines concerning the treatment of co-infection should be indicated in the terms of reference of the coordination mechanisms. This kind of implementation is already possible thanks to the reforms in progress, which have instigated a multi-disciplinary approach within the health zone management teams (ECZSs) in the place of line supervisors and focal points in the HZs.

Expected effectiveness of implementation

The expected effectiveness of this joint implementation will be measured on the basis of:

- The joint implementation of the cross-cutting activities described above including the mobilization of resources.
- Task-sharing between care providers for the integration of TB/HIV activities.
- The functioning of the coordination mechanisms at the central and intermediary levels.
- The offer of TB/HIV services through the 'one stop shop' model at the health facility level.
- The priority accorded to CSDTs in extending interventions against HIV/AIDS infection and to the PMTCT structures.
- With the aim of encouraging the effective and efficient expansion of co-infection activities, the CSDTs will integrate routine HIV screening into their activities. The MPA of the CSDTs will be strengthened to incorporate an initial health check-up to prepare for ARV treatment. The GRHs will be reinforced so that they can provide as a complementary package health monitoring of PLHIV receiving ARV treatment.
- Establishing a single network for transporting samples will enhance access to services not only for suspected MDR-TB cases and PLHIV suspected of being infected with TB but also for children whose mothers are HIV-positive, for whom early diagnosis of HIV through Dried Blood Spot (DBS) will be provided, and for patients receiving ARV treatment, who will be medically monitored and whose viral load will be tested.
- A patient rather than disease-centric approach to treatment.
- The harmonizing of logistical aspects and health information.

b. The obstacles which must be overcome during this alignment process

The alignment of HIV and TB interventions requires a methodical approach and willingness on the part of the stakeholders of the two programs and of their respective partners at the central and intermediary levels. Efforts should be made to build the capacities of the ECZSs to schedule, organize, manage and monitor interventions and activities. Strengthening the supply system should ensure that HIV and TB products are continuously available. The strengthening of the health system, as set out in this standard concept note, should not be envisaged in terms of a single program. It is intended that all programs should benefit from it.

The principal recipients (PRs) and sub-recipients (SRs) selected to implement the TB/HIV concept note should work together and coordinate their activities as described in Section 4. They should possess skills which are relevant to the specific characteristics of these two diseases.

A sound understanding of the reforms of the health sector which are in progress should result in an appropriate strategy for implementing the coordination mechanisms for TB/HIV co-infection.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in the national strategies. The resources allocated by the Global Fund are insufficient to cover the total cost of a technically relevant program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

a. The program areas currently receiving funding support and the source of such funding (government and/or donor).

Funding of various levels exist to cover the areas of intervention defined in the national strategic plans for fighting HIV and TB for the 2015-2017 period, but no area is entirely covered.

Funding for TB, in addition to that from the Global Fund, is provided by the government, Action Damien, PEPFAR, WHO and USAID. As for HIV, funding comes principally from the government, WHO, PEPFAR and UNICEF.

The table below provides a summary of the funding plans for each area of intervention.

Table 5: Availability of funding for each priority area and the funding source, July 2014

Areas of intervention	Partners	Period covered			Observations
		2015	2016	2017	
DOTS package	Government	Yes	Yes	Yes	The total funding announced does not cover all the needs in terms of the DOTS package. The screening gap, with 45 percent of needs not covered.
	USAID	Yes	Yes	Yes	
	WHO	Yes	Yes	Yes	
	TLMI	Yes	No	No	
	Action Damien	Yes	Yes	Yes	
TB/HIV co-infection	Government	Yes	Yes	Yes	According to forecasts based on the data gathered, up to 32 percent of screenings and 26 percent of country needs in terms of the ARV treatment of coinfected patients should be covered between 2015 and 2017.
	PEPFAR/USAID	Yes	Yes	Yes	
	WHO	Yes	Yes	Yes	
	TLMI	Yes	No	No	
	Action Damien	Yes	Yes	Yes	
MDR-TB	Government	Yes	Yes	Yes	According to forecasts based on the data gathered, 17 percent of country needs in terms of screening and treatment should be covered between 2015 and 2017.
	USAID	Yes	Yes	Yes	
	TLMI	Yes	No	No	
	WHO	Yes	Yes	Yes	
HIV screening	Government	Yes	Yes	Yes	The needs covered over the 2015-2017 period represent 2 percent of the country needs.
	PEPFAR	Yes	Yes	Yes	
	UNICEF	Yes	Yes	Yes	
	WHO	Yes	Yes	Yes	
Antiretroviral therapy	Government	Yes	Yes	Yes	15 percent of needs are covered over the 2015-2017.
	PEPFAR	Yes	Yes	Yes	

	WHO	Yes	Yes	Yes	
Prevention of Mother-to-Child Transmission	Government	Yes	Yes	Yes	37 percent of needs are covered over the 2015-2017 period.
	UNICEF	Yes	Yes	Yes	
	PEPFAR	Yes	Yes	Yes	
	WHO	Yes	Yes	Yes	
Sex workers and their clients	Government	Yes	Yes	Yes	The gap is very substantial, with 0.30 percent of needs covered until 2017.
	UNICEF	No	No	No	
	PEPFAR	Yes	Yes	Yes	
	WHO	No	No	No	
Men who have sex with men	Government	Yes	Yes	Yes	The needs covered in terms of raising awareness among MSM are minimal, standing at 0.71 percent.
	UNICEF	No	No	No	
	PEPFAR	Yes	Yes	Yes	
	WHO	Yes	Yes	Yes	

An important partner in the fight against TB, The Leprosy Mission International (TLMI), has announced that from 2016 it is withdrawing from all three of the provinces actually covered: Bas-Congo, Kasai-Oriental and Maniema.

b. How the proposed Global Fund investment has leveraged other donor resources.

This funding request is an opportunity for the country to present to all of its partners not only a clear map of covered HZ but also of the country needs which are not currently covered, as well as the contribution from the Global Fund. This mapping of stakeholders and interventions will initially assist programs in lobbying the government for universal coverage and fairness in service provision, but it will also help them to lobby other donors to contribute to reduction of substantial gaps in each intervention area.

In terms of TB/HIV co-infection, this request should enable some regular partners (bi- and multi-lateral partners, foundations involved in fighting against the diseases which are the subject of this TB/HIV concept note) to fill gaps in integrating HIV services into structures which have already integrated TB but whose HIV package (screening tests and antiretroviral therapy) has not been integrated to date.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

Since the funding gap applies to every area, the two programs will combine their efforts to mobilize both national and external resources. The programs are therefore going to bolster their advocacy activities through a coordination task force, which will provide direction on programming and resource allocation decisions and give the justification for investing in the fight against the two diseases as well as the return on investment which this will entail in terms of infections prevented and lives saved.

In order to make up the financial deficit of the program needs, calculated on the basis of an annual analysis of the funding gaps, advocacy activities which are already underway should be continued. The NACP and the NTP will mobilize resources with the support of their technical and financial partners (WHO, UNICEF, UNFPA, GF, USAID/PMI, DFID, KOICA, WB, UNAIDS, Action Damien, etc.). The government, national institutions like the PNMLS (Multi-Sector National AIDS Control Program) and international cooperation agencies, and the private sector will be constantly lobbied to secure complementary financial contributions to make up the funding deficit in the fight against HIV and TB. The ongoing financial commitment of the Congolese state is essential in encouraging the support of financial partners.

In addition to financial resources, the enhancement of strategies adopted on the basis of lessons learned and a more dynamic synergy between different sectors (social affairs,

education, army, environment, etc.) could also help to reduce the financial and programmatic deficits. This should be set out in written guidelines.

The investment framework developed together by all stakeholders will serve as an advocacy tool and a means of mobilizing resources for strategic investment which is squarely centered on the optimization and best use of resources, the effectiveness and efficiency of interventions and the alignment of resources, results and impact.

2.2 Counterpart Financing Requirements

a. Counterpart Financing Requirements for TB and HIV

Counterpart Financing Requirements	Compliance	Comments
Availability of reliable data to evaluate compliance	Yes	Data on external funding is provided by the partners directly or via the programs. Data on internal resources comes from the National Accounts Department and has been checked against the payments received by the programs.
Minimum threshold for public contributions to the disease prevention program (low revenue, 5 percent)	Yes	The documentary proof and accounting elements available from the programs, cross-checked with the data from the budget monitoring statements from the National Accounts Department, confirm that the 5 percent level of counterpart financing has been achieved for each program.
Increase in the government contribution to the disease prevention program.	Yes	The DRC government responded to the call for funding with a commitment of $59.2M for the 2015-2017 period.

(*) Note:

For the TB component, the rate of counterpart financing is 5.66 percent before the allocation of an amount of US$ 3,376,256 in 2013-2014 from the Equipping Health Facilities Project (PESS) and 10.49 percent after allocation.
For the HIV component, the rate of counterpart financing is 3.75 percent before the allocation of an amount of US$ 3,376,256 in 2013-2014 from the PESS and 5.55 percent after allocation.

The PESS project is an US$ 85-million program which has been entirely financed by the DRC Government since 2012 and comprises 4 components:

- *Acquisition of medical equipment via UNICEF for 1,000 HCs and 200 GRHs;*
- *Renovation / reconstruction through BCECO of the Health Centers and GRHs;*
- *Supply of essential drugs through FEDECAME for 1,000 HCs and 200 GRHs;*
- *Capacity building and program management through BCECO.*

The use of care centers by TB and HIV patients justifies in itself counterpart funding, which for the time being has been set at 4 percent for each of these 2 components.

The PESS project will be carried forward in 2015 and will be extended to new sites.

Table 6: PESS project allocation

Component	Allocation rate	Amount

PESS project	**100 percent**	**$85,203,107**
HIV/AIDS	**4 percent**	**$3,736,256**
Tuberculosis	**4 percent**	**$3,736,256**
Malaria	**25 percent**	**$20,882,489**
Other	**67 percent**	**56,848,107**

b. Amount of supplementary government investment earmarked for national TB and HIV programs for the forthcoming period of implementation which is taken into account in order to benefit from the allocation which the Global Fund has indicated its willingness to grant

The government's contribution to the health sector has greatly improved in recent years. Since 2001, the proportion of the state budget allocated to health has risen from 1.93 percent to 7.82 percent and the health budget as a percentage of GDP has risen from 0.1 percent to 3.0 percent. The health budget reductions of 4 percent in 2004, dropping to 3.02 percent in 2008 were in fact due to the state's high investment in the war effort. Since the beginning of the peace process, this contribution has risen from 3.41 percent in 2011 to 7.82 percent in 2012.

The DRC Government, in its letter of 13 August 2014 signed by the Deputy Prime Minister, the Minister of the Budget and the Minister of Health, has committed itself to contributing at least US$ 59,240,242 over the 2015-2017 period, including $US 32,937,034 in accordance with the minimum counterpart financing required to access 85 percent of the allocation and an additional contribution of $US 26,303 208 required from the government in order to access the allocation in full.

The breakdown by component is as follows:

- HIV: US$ 14,802,466
- TB: US$ 6,742,629
- Malaria: US$ 37,695,147

These funds will be used for taking care of populations that are affected and at risk, capacity building, medical supplies, monitoring / evaluation in general and also for more specific interventions such as campaigns to distribute mosquito nets and to screen for HIV and World Days to raise awareness of the diseases, involving civil society through appropriate community initiatives.

This counterpart financing commitment and an engagement to further contribute financially will be incorporated respectively into the finance legislation for the years 2015, 2016 and 2017. Special measures, in the form of budgetary and accounting mechanisms, will be taken to ensure monitoring and analysis is undertaken by the Global Fund.

The terms and conditions of implementation will be set out in an agreement with the Global Fund and will cover in particular the disbursement plan, the nature of the accounting items and administrative and financial documents to be provided to the Global Fund and the modalities for reporting.

c. Assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

The National Accounts are organized by credit line for each program, department and disease.

According to the classifications of the National Accounts in their budget monitoring statements, the items of program expenditure break down according to the following categories:

- Bonuses and salaries;

- Operational grant;
- Global Fund AIDS Counterpart Financing, TB Counterpart Financing and Malaria Counterpart Financing;
- Financial interventions;
- Social interventions;

For HIV, TB and malaria, the budget lines taken from the budget monitoring statements for the years 2012 – 2013 – 2014 (see annex) show the following amounts:

Table 7: *Government financing with verifiable proof*

Budget line (in USD)	2012	2013	2014
HIV/AIDS	$339,478	$3,167,283	$3,439,910
Tuberculosis	$28,185	$1,561,140	$2,260,266
Malaria		$1,373,075	$1,595,745
Total	**$367,663**	**$6,101,498**	**$7,295,921**

These are the amounts set out in the financial gap analysis and counterpart financing tables under the heading 'domestic source B3: public receipts' (line 14).

The NACP, NTP and NMCP are the recipients of a part of these domestic funds.

The bonuses and salaries are paid directly by the State, but each program keeps a monthly register. These documents are available from each program.

The financing grants are allocated by the government according to needs and the available resources. The funds are paid directly to each program, which must be in a position to provide payment orders.

The counterpart financing of each component is disbursed by the transfer of funds to the Permanent Secretariat of the CCM, which effects bank transfers to the NACP, NTP and NMCP.

Financial and social interventions are in principle registered every year in the national accounts, but in an all-inclusive way encompassing all the health programs. The funds are allocated by the government according to needs and the available resources and are paid directly to each program, which must be in a position to provide payment receipts.

To date, the data gathered from the programs is as follows:

Table 8: *NACP domestic resources*

NACP	2012	2013	2014
Salaries	$126,511	$1,060,703	$1,021,998
Bonuses	$180,532	$403,890	$389,152
Operational grant	-	-	-
Global Fund AIDS Counterpart Financing	-	-	$1,139,436
Financial interventions	-	-	-
Social interventions	-	$108,735	$139,857
NACP total	**$307,043**	**$1,573,328**	**$2,690,443**

Table 9: *NTP domestic resources*

NTP	2012	2013	2014
Salaries	$254,936	$252,080	$253,084
Bonuses	$595,992	$598,688	$609,592

Operational grant	-	-	-
TB Counterpart Financing	-	-	$ 892,194
Financial interventions (*)	$1,850,000	$611,099	-
Social interventions	-	$21,154	-
NTP total	**$2,700,928**	**$1,483,021**	**$1,754,870**

(*) The NTP has benefited from customs, water and electricity exemptions, the total amount of which has been provided by the Ministry of Finance. This should also be valid for HIV and malaria.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. The applicant must detail the investment in TB and HIV prevention programs and also provide information on the expected impact and effectiveness of the joint program planned for the two diseases and, where applicable, the cross-cutting interventions to strengthen the health systems.

3.1 Program Gap Analysis

Taking into consideration the priorities identified during dialogue at the provincial and national levels, the national TB and HIV strategic plans, the TB/HIV road map and the twelve comments from the Technical Review Panel (TRP) concerning the HIV concept note (submitted at the end of February 2014 and rejected by the TRP), the request for Global Fund financing within the framework of this TB/HIV concept note focuses on the following ten modules: 1) Treatment, care and support; 2) TB/HIV; 3) Treatment and prevention of TB; 4) Prevention of mother-to-child transmission; 5) Multidrug-resistant TB; 6) Prevention for MSM and transgender; 7) Prevention for sex workers (SW) and their clients; 8) Prevention for the general population; 9) Program management; 10) Monitoring and evaluation.

As far as the key population groups are concerned, the investment framework is centered on SW and MSM, given that although IDUs are recognized as a key population in the HIV epidemic, the DRC does not possess data on this population which would make it possible at this stage to develop relevant interventions. This area will therefore be the subject of further research.

Cross-cutting modules

The major human rights abuses and gender inequalities (including sexual violence) which may hinder access to health services, as described in Section 1b, are taken into account in this concept note across the various modules. In order to establish a conducive environment, which is a decisive social factor in the return on investment, basic program activities (treatment, care and support, prevention of mother-to-child transmission devoted to general population and key populations (SW, MSM)) will be carried out.

This is also the case with community system strengthening, which is also a decisive social factor, and which will be taken into account across all modules, resulting in an increase in demand through community mobilization (25).

Program management module

Regarding the program management module, which focuses on policy, planning and programming, coordination and management, the NACP and NTP have already developed national strategic plans for 2014-2017, their respective monitoring and

evaluation plans and policy, standards and guideline documents. The national strategic plans provide the basis for annual operational planning and resource mobilization. They are evaluated every two years through external reviews and are adjusted on the basis of recommendations formulated in the course of these reviews, while taking into account the priorities. In addition to the activities indicated above, the NACP and NTP programs provide support to the decentralized bodies and structures through missions to monitor implementation which are carried out either at the national and intermediary level (the DPSs and provincial coordination bodies of each program) or at the peripheral level (ECZSs) by involving community actors. At the central level, the programs hold separate monthly coordination meetings with their technical and financial partners, organize supervision missions, provide these structures with human, material and financial resources, build the skills of service providers at all levels of the health system, and carry out financial monitoring. A collaboration framework has been established to manage TB/HIV co-infection, but its functioning needs to be strengthened.

The DRC possesses a program and a national system for supplying essential drugs (PNAM, SNAME, FEDECAME). In order to facilitate their procurement and to make them commercially available, the drugs used in the fight against these two diseases are registered on the national list of essential drugs. However, there is no single, joint planning system which allows drug procurement at a reduced price.

Gaps

Despite these frameworks, gaps still persist and are hindering the efficient implementation and management of resources, specifically:

- Insufficient human resources capable of correctly caring for patients affected by the two diseases and poor geographical distribution of healthcare personnel, who are strongly concentrated in urban areas.
- Insufficient equipment and materials, which are poorly maintained and distributed geographically.
- Non-alignment of certain partners with laboratory equipment and material standardization guidelines, which complicates the training of personnel, the supply of reagents and spare parts, and maintenance (HIV).
- Difficult working conditions especially in public centers (dilapidated and/or absent infrastructure and equipment, irregular supply of medical products and low remuneration of health personnel by the government) which result in instability, lack of motivation and a marked internal and external flow of health service personnel to the private sector or to other countries, which offer more attractive working conditions and remuneration.
- Absence of definition in the roles and responsibilities of stakeholders at all levels of the system with respect to managing TB/HIV co-infection; coordination meetings involving the various stakeholders in the fight against disease are held irregularly.
- Weak technical support for the ECZSs and health structures from the relevant higher levels.
- Absence of a formal collaborative framework for community-based organizations (CBOs), NGOs and the various programs.

Other gaps associated with grant management (PR, SR, SSR), which are also detailed in Section 4 of this concept note, have been taken into consideration in this section to ensure the coherence of this module. These gaps include in particular:

- Absence of a standardized procedures manual for all PRs involved in managing the grant.
- Non-extension of memoranda of agreement to all stakeholders involved in managing the grant, and failings in the effective implementation of these agreements.

- Failure of the Principal Recipients to involve the DPSs and ECZSs sufficiently in monitoring and undertaking activities relating to Global Fund grants, with a broad range of responsibilities at the level of the SRs and hardly any at the level of the BCZs.
- Weak capacity for managing logistical information and transmitting reports to senior levels.
- Cumbersome procurement procedures.
- Poor coordination of stakeholders and interventions in the area of supplies, sometimes resulting in gaps and duplications in supplies at the level of the health zones.
- Absence of preventive and curative maintenance plans for the equipment ordered within the framework of TB and HIV grants.
- Weak stock management capacity at all levels, entailing a risk of stock-outs or of a surplus of stocks, leading to products exceeding their expiry date.
- Weak functioning of the key structures (DPM, SNAME, PNAM, CDR, FEDECAME) and of the coordination mechanisms at the national and regional levels involved in the national system for supplying essential drugs, including TB and HIV products.

The two programs operate thanks to the resources placed at their disposal by the government and above all thanks to the resources secured from donors, which include the Global Fund and Action Damien. The financial gap remains substantial in view of the challenges faced by the programs in achieving the objectives of the strategic plans. On the basis of this situational analysis, this concept note recommends two priority interventions in order to fill the gaps indicated above:

i. Policy, scheduling and coordination.
   - Support the training of members of the national and regional coordination structures in program and project management.
   - Facilitate the holding of thematic meetings on TB.
   - Contribute to the operations of the NTP and the NACP.
   - Support the organization of the World TB and AIDS Days.
   - Ensure the participation of senior managers in international TB and HIV meetings and conferences.

ii. Grant management.
   - Support the operations of the PRs for HIV, TB and HSS.
   - Provide performance bonuses for NTP and NACP personnel.

The program management budget is 38,402,765 USD representing 18 percent of the total budget of this CN and distributed as follows: 29,319,388 USD (14 percent) for the interventions related to the development of policies, to planning and programming and to coordination, and 9,083,377 USD (4 percent) for grant management. This budget includes also activities to strengthen the health system in the area of drug management, equipment and human resources.

Monitoring and evaluation module

The two national NACP and NTP programs, as well as the PRs, SRs and SSRs concerned by this concept note, have internal monitoring and evaluation units which are responsible for updating and producing strategic information through coordinating data collection, entry, analysis, storage and dissemination. With support from the Global Fund and other partners, a system of information gathering has been established through the rolling out of DHIS 2.0, which should enable programs to align their reporting with the NHIS, even though DHIS 2.0 does not currently cover the whole country.

In addition to information produced through this regular circuit, the NACP organizes epidemiological supervision through the establishment of sentinel sites, which are

distributed across the country for the gathering of the supplementary information required for decision-making.

The two programs also organize joint supervision missions within the framework of collaborative TB/HIV activities or separate missions focusing on the specificities of each program or disease, moving from the central level to the intermediary level to ensure in particular that national standards are applied and adhered to. The same applies in moving from the intermediary level to the peripheral level.

Data on community activities collected in the health areas are reported to the NACP and the NTP by the community SRs. Monitoring the implementation of activities set out in the detailed work and budget plans (WBP) is also carried out by the community SRs.

Given the difficulty of obtaining through the regular system the comprehensive data required to manage a program effectively, the two programs have had recourse to carrying out a number of surveys, albeit sporadically, in order to meet the need for supplementary information on the two diseases:

- For HIV: the first DHS was carried out in 2007 and the second in 2013, while the first BSS was conducted in 2006 and the second in 2012. The latter targeted truck drivers, miners, Sex workers and street children. The HIV surveillance survey of pregnant women is in principle carried out annually, but the two most recent surveys date to 2011 and 2013 respectively. Two Integrated Action Plan (IAP) surveys were conducted in the provincial capitals in 2010 and 2012 respectively. Two surveys on the quality of care and treatment were conducted in 2006 and 2011. A third is in preparation and will be carried out this year.
- For TB, a local survey on drug resistance was conducted in Kinshasa in 1999 and a national drug resistance survey is currently being carried out.

These surveys have also allowed to assess the performance levels for interventions carried out and of the quality of care and treatment (Rapid Services Quality Assessment (RSQA) by the Local Fund Agent (LFA)).

Gaps

The gaps revealed in the area of monitoring and evaluation are summarized and grouped into the following domains of intervention:

<u>Regular communication of information</u>

- Failure of the existing IT system (NHIS) to capture all of the information relating to TB and HIV due to:
  - Absence of suitable data collection tools at various levels to respond to the new WHO 2013 reporting guidelines.
  - Poor availability of data collection tools at various levels.
  - Insufficient personnel trained in managing information on the new guidelines.
  - Absence of procedural manuals on information management.
  - Absence of suitable links and tools for the gathering of data generated by the community system.
  - Absence of a computerized system for managing active files within the framework of the fight against HIV.
- Non-alignment of stakeholders in the fight against HIV with the data collection tools of the NACP (PEPFAR and its implementation partners, PRs and SRs of Global Fund grants, and other stakeholders).
- Insufficient financial resources (systematically under-estimated in the past) for monitoring and evaluation.
- Poor dissemination of the various reports and data exchanges between programs and partners.

Analysis, examination and transparency

- Poor quality of data due to:
  - Insufficient missions to audit the quality of data carried out by the programs (Routine Data Quality Assessment (RDQA) not carried out).
  - Irregularity of meetings to approve data and to discuss monitoring.
  - Low rate of periodic reviews, especially at the intermediary level.
  - Weaknesses in qualitative and quantitative supervision.

Surveys

- Irregular carrying out of periodic surveys, particularly behavioral surveys and surveys on the epidemiological profile of regions in terms of TB and HIV, and irregular supervision of HIV resistance to ARVs and estimations of the size of key populations.
- Limited funding to conduct operational research.

Interventions in the area of monitoring and evaluation are principally funded by the Global Fund as part of its activities to strengthen the health system through its information management component, by DFID through the project set up by IMA World Health, and by WHO, PEPFAR/CDC, UNICEF and the DRC government.

To address the gaps identified above, this concept note proposes a number of actions relating to the following priority areas of intervention:

Regular communication of information

- Analyse and strengthen the monitoring and evaluation system.
- Produce / disseminate data collection tools.
- Produce / disseminate clinical files for HIV+ pregnant women.
- Cover the telephone costs (calls and texts) for transmitting the 62,994 results from the referral laboratories to the sample collection sites.

Analysis, examination and transparency

- Conduct the performance review of the TB and HIV programs and of the co-infection activities outlined in the TB and HIV Road Map.
- Support 6 RDQA missions to audit the quality of the routine data for both programs.
- Support quarterly meetings to validate data at the level of provincial coordination offices.
- Support 3 annual program reviews.

Surveys

- Support the organization of 3 HIV sero-surveillance surveys.
- Support the organization of the TB drug resistance survey.
- Support the organization of the survey on mapping, estimating the size of key populations (MSM, IDUs) and identifying demographic and social determining factors.
- Support the organization of the AIDS Indicator Survey (AIS) survey in 2016, two years after DHS II.

3.2 Applicant Funding Request

In line with the conclusions of the regional and national dialogue on the TB and HIV components (see the reports of the various consultations in the annexes), of the vision outlined in the TB and HIV strategic plans and of the TB/HIV Road Map, this conceptual note sets out plans over the 2015-2017 period to:

- Place 163,567 individuals under ARV treatment with funding from the Global Fund, 115,547 benefiting from the allocated funding and 48,020 from the above allocation funding.

- Treat 219,350 registered TB patients, including 212,001 with the Global Fund allocated funding and 7,349 with above allocation funding.
- Continue HIV interventions in the 239 HZs and TB interventions in the 516 HZs currently supported by the Global Fund.
- Extend HIV interventions to the 111 new HZs, including 92 HZs currently without support and 19 HZs with funding from other partners.
- Cover the entirety of the 516 HZs for the TB package and 350 HZs for the HIV package, extending coverage to the 166 GRHs/RHCs in the HZs not to date covered, aligning activities with the ten modules described in Section 3.1.
- Capitalize the experience gained and the result obtained from Option B+, funded by the UN system (UNICEF, WHO, UNAIDS), the Global Fund and PEPFAR in Katanga in the 6 health zones applying Option B+, and on the implementation of the new 2013 WHO recommendations on the use of ARVs for the treatment and prevention of HIV infection among adults, children and pregnant women, which are aimed at improving the health of PLHIV, the concept note will take into account the key elements of the new recommendations, specifically:
- Organize the transition to new therapeutic dispositions for TB and HIV in the geographical zones with the highest rates of morbidity, taking into account the 2013 DHS.
- Implement a new protocol for identifying individuals in need of ARV treatment, namely: (i) adults and adolescents, (ii) children under 5, (iii) pregnant women, (iv) TB patients, (v) patients with severe and chronic diseases (hepatitis), and (vi) HIV+ partners in sero discordant couples;
- The transition plan for switching to new, simplified dispositions will place an emphasis on:
  - new patients receiving their treatment in accordance with the new guidelines;
  - patients already receiving ARV treatment will be progressively enrolled into the new ARV dispositions, with priority given to TB/HIV co-infected patients, cases of failed ARV therapy and to patients experiencing major side effects from antiretroviral drugs;
  - improvement in patient access to biological monitoring through extending the coverage of the transport network for DBS samples. The use of viral load will be indicated as a priority for patients presenting clinical and immunological symptoms of treatment failure;
  - extending the coverage of services, which will be based on innovative strategies such as decentralization, the delegating of tasks and integration (20).

Of the 516 HZs with the TB package and the 296 HZs where Action Damien and the Global Fund are present, the drugs and human resources will be overseen by Action Damien at the sites where it operates. Of the 350 HZs with the HIV package and the 72 HZs where PEPFAR and the Global Fund are present, the products and human resources will be overseen by PEPFAR and others at the sites where they operate.

In line with Global Fund guidelines and the decision of the CCM, this funding request incorporates the contribution of the TB/HIV component to strengthening the health system, in particular at the level of human resources and the management and supply of drugs and other products (Procurement and Supply Management (PSM). Components relating to the strengthening of the NHIS have been included in the malaria concept note.

The entirety of the allocated and above allocation budget is absolutely required in order to achieve the targets identified in the national consultations and defined in the NSPs and the TB/HIV Road Map. Any discontinuation of the funding of these priority modules would prejudice the results achieved in providing treatment for individuals affected by TB and HIV in the DRC.

Interventions relating to gender and human rights will be treated in a cross-cutting manner in the context of this submission. In the case of human rights, the following strategies will

be developed:

- the creation of a more enabling environment for PLHIV and others affected in the key populations (SW and MSM);
- psychosocial care for vulnerable individuals, with a focus on the legal and legislative framework involving the review and reform of laws, regulations and policies;
- raising the awareness of legislators and police and prison officials regarding the availability of HIV-specific legal services.

Specific actions targeted at women and girls in the context of HIV will also be undertaken, including (i) promoting greater empowerment for women; (ii) strengthening women's capacities to negotiate and make their own decisions; (iii) lobbying to promote female leadership; (iv) psychosocial care for female survivors of sexual violence; and (v) an improvement in the community environment which involves service providers and other community members (families, religious leaders, traditional leaders, journalists and political leaders).

The budget for the activities set out in this submission totals **US$ 295,452,472**, **US$ 215,847,494** of which is the allocated amount and **US$ 79,604,982 USD** the above allocation amount.

Table 10: Budget for the funding request

Component	Indicative	Above allocation	Total
HIV	$131,505,884	$62, 534,777	$188,966,055
Tuberculosis	$54,781,719	$10, 581,520	$65,363,240
HSS	$29, 559, 891	$6,488,685	$36,048,575
Total	$215,847,494	$79,604,982	$295, 452,472

Module 1: Treatment, care and support

The number and proportion of adults and children currently receiving antiretroviral treatment, in terms of the total adult and child population living with HIV eligible for ART(criteria: < 350 CD4), is 79,978/214,000 or 37 percent (8), of whom 72.6 percent (58,112) are located in the five provinces with high prevalence (cf. Section 1, pages 4-5).

This concept note aims to place 163,567 PLHIV on ARV treatment, which is to say 70 percent of the target number set out in the 2014-2017 NSP for HIV (139,032 adults and 24,535 children), including 115,547 PLHIV with the indicative funding and 48,020 with the above allocation funding. Of the 163,567 PLHIV to be put on ART, 117,768 (72 percent) will come from the 5 provinces with high HIV prevalence. These individuals will be identified through the PICT, the active testing for HIV among TB patients, HIV screening of pregnant women and the VCT.

Within the framework of this concept note, the ARV treatment of HIV infection will be based on the 2013 WHO guidelines, adopted by the DRC in August 2013 and according to which the target CD4 count will be 500/ul (20).

In the framework of this concept note module, two essential interventions are taken into account: antiretroviral treatment and monitoring, and care and support for chronic patients.

- For antiretroviral treatment and monitoring, the critical actions planned below will be undertaken:
  - Ensure the continuity of ARV treatment in the 239 HZs currently supported by

the Global Fund, its extension to 111 new HZs, with priority given to the 5 provinces with aTB/HIV prevalence higher than the national average, and to two other provinces with a high incidence of TB: Bandundu and Kasai-Occidental. These 7 provinces contain 70 percent of the country's population (49,178,606 inhabitants). The integration of the 111 HZs will be staggered, involving 61 HZs in Year 1 which were formerly supported by the MAP project (World Bank) and other projects at the country level (e.g., MSF, PEPFAR/PROSANI) and 50 HZs in Year 2 which are priority HCs included in the plan to eliminate MTCT and to extend TB/HIV activities. PEPFAR and the Global Fund are currently supporting complementary activities in 72 HZs. PEPFAR is present in 100 HZs, of which 28 are not receiving a contribution from the Global Fund. The number of patients expected to be placed on ARV treatment between now and 2017 with the support of PEPFAR is 68,000 and 4,267 will be supported by the DRC government. Based on the preceding figures, the Global Fund will cover 70 percent of the targets specified in the 2014-2017 HIV NSP and PEPFAR and the DRC government will cover the remaining 30 percent (an100 percent coverage of the targets specified in the 2014-2017 HIV NSP).

- To date, 1,791 PMTCT sites are operational in 350 HZs, of which only 852 offer antiretroviral treatment concomitantly. An increase from 852 sites to 1,284 sites is planned for Year 1, rising to 1,791 sites in Year 2.
- Patients already receiving ARV treatment will be progressively enrolled into the new ARV dispositions, with priority given to TB/HIV co-infected patients, to cases of failed ARV therapy and to patients experiencing major side effects from antiretroviral drugs.
- The use of viral load will be indicated as a priority twice a year for each patient for biological monitoring and initiation to ARV treatment.
- Delegate the task of initiation to ARVs to the nursing staff and to members of the community for a satisfactory coverage of the beneficiaries and build the capacities of care providers and community actors through training and tutoring.
- Integrate ARV treatment into the TB package in the 2,060 CSDTs operating in 516 HZs as well as systematic TB screening into the activities of the 852 FOSAs providing ARV treatment in 350 HCs.
- Strengthen the capacities of the FOSAs in terms of facilities (ARVs, adults and children), data collection and service provision tools, equipment (PCR, SMS printers) and laboratory reagents, and the minimum facilities required for caring for MSM.

- To care for and support chronic patients, the following activities will be undertaken:
  - Ensure care and treatment for individuals affected by Sexual and Gender-based Violence (SGBV), INH prophylaxis for PLHIV, CTX prophylaxis and the care and treatment of OIs and STIs.
  - Strengthen positive prevention (monitoring adherence to ARV treatment, providing information on risk reduction and support for the sharing of one's serological status with one's partner, information on protected breast-feeding, family planning, home care and the setting up of clinical and community support groups to improve retention rates).

In order to improve the care and treatment of children with HIV/AIDS, particular emphasis will be placed on identifying infected children, giving priority to screening and advice provided by the care provider (PICT) at the level of infant health services, including services focused on ensuring the survival of the child (vaccination, paediatrics, pre-school consultation and malnutrition units). The objective is to expand the provision of HIV/AIDS paediatric care and treatment, while at the same time ensuring that there is an effective referral and counter-referral system in place at the level of care and treatment services, in particular services provided to adults, which should place the emphasis on a family approach (20).

Table 11: Summary of targets and budget for the ARV treatment module

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	Above allocation	% Above allocation	Total	% Total
Treatment, care and support	77,420,922	66.5%	39,088,716	33.5%	116,509,636	100%

The budget allocated to this module is US$ 116,509,636, of which US$ 77,420,922 is the indicative amount to guarantee ARV treatment for 115,547 PLHIV and US$ 3 9,088,716 is the above allocation amount to treat 48,020 PLHIV.

This module aims to guarantee through the allocated funding continuity of treatment for 79,978 PLHIV currently receiving treatment and to place on treatment, between now and the end of 2017, 115,547 PLHIV, while the above allocation amount should additionally provide treatment for 48,020 PLHIV.

Module 2: Tuberculosis/HIV

This concept note sets out plans to screen 232,211 TB patients (60 percent, in line with the 2014-2017 TB NSP) for HIV and to place under ARV treatment 44,346 co-infected patients by the end of 2017: 12,437 in Year 1, 14,135 in Year 2 and 17,764 in Year 3 with the allocated funding.

Within the framework of this concept note, TB/HIV care and treatment will be based on the 2013 WHO guidelines adopted by the DRC in August 2013 (20).

The implementation of TB/HIV joint strategies will focus on combined interventions in the fight against TB and HIV and the involvement of all care providers, with priority given to the five provinces with a high HIV prevalence and in two other provinces with a high level of identified TB cases.

For these two interventions, the emphasis will be placed on the three WHO objectives, namely:

- In order to reinforce TB/HIV collaboration mechanisms, the following activities will be undertaken:
  - Organize quarterly meetings to coordinate collaborative activities at the central and intermediary levels of the 26 DPSs involving all the stakeholders, including community actors, and monthly meetings to monitor the 516 HZs.
  - Carry out joint supervision missions at every level of the health pyramid (26 DPSs and 516 HZs).
  - Integrate HIV screening and ARV treatment into the activities of all 516 GRHs/RHCs in the country, and progressively into the activities of the 2,060 CSDTs in the 516 HZs; integrate systematic screening for TB into the activities of all the FOSAs offering ARV treatment in these 350 HZs. Within the framework of extending ARV treatment, 350 HZs have already integrated the HIV package; this will be extended to the 166 GRHs/RHCs in the 166 HZs which are still without the ARV package.
  - Strengthen the referral system between the CSDTs which offer screening and the GRHs/RHCs offering ARV treatment.

- In order to reduce the rate of TB morbidity among PLHIV, the following activities will be undertaken:
  - Ensure active testing for TB among 185,654 PLHIV (80 percent of 232,067 PLHIV and eligible for ART) under others with the support of 15 new Xpert MTB/RIF machines and the strengthening of the specimen transport network. .
  - Offer INH prophylaxis to 111,392 PLHIV who do not have active TB (60 percent of PLHIV examined) through application of the guidelines and the availability of INH in the facilities providing the HIV services.

- Apply administrative, environmental and individual measures to control infection.

- In order to reduce the rate of morbidity due to HIV infection among TB patients, the following activities will be undertaken:
  - Offer PICT to 246,818 TB patients.
  - Provide Cotrimoxazole prophylaxis for 44,346 TB/PLHIV who are being monitored, and ARV treatment for 44,346 co-infected TB/HIV patients.
  - Organize an effective referral system between facilities offering HIV screening and those offering associated care, including the use of new Xpert diagnostic tools.

Table 12: Summary of the TB/HIV budget module

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	Above allocation	% Above allocation	Total	% Total
Tuberculosis/HIV	17,155,180	86.3%	2,712,193	13.7%	19,867,372	100%

The budget for the TB/HIV module is US$ 19,867,372, of which 86.3 percent will be covered by indicative funding and 13.7 percent by above allocation funding.
Interventions / activities carried out with the above allocation funding will, as a priority, be dedicated to increasing HIV screening among TB patients with the help of the Xpert MTB/RIF, controlling TB infection and involving the community in the fight against TB and HIV. Ultimately, the above allocation funding should result in:

- The screening of 14,607 'additional TB/HIV cases', equating to a total of 4 percent of the targets set out in the 2014-2017 TB NSP.
- The treatment of additional cases will be ensured by the DRC government.

Module 3: Treatment and prevention of tuberculosis

In total, 6,711,924 adults and children suspected of having TB will benefit from TB screening in the 2,060 CSDTs (the 1,522 existing CSDTs and the 558 additional CSDTs between now and 2017), including PLHIV, miners, prisoners, contact cases, SW, MSM and IDUs. The following interventions will be developed in order to meet the needs of this module:

- Screening and diagnosis of patients

In order to increase the care provision coverage and access to prevention and care services for the whole population as well as for key and vulnerable populations, a network of microscopy laboratories is operational in the 1,522 CSDTs, including 20 CSDTs which perform a high number of TB screenings and have fluorescent light-emitting diode (LED) microscopes. They are mainly located in the provincial capitals. For CSDT or LPR laboratories with Xpert MTB/RIF machines, a network for transporting the samples will be operational in order to improve time-frames for TB screening, particularly for PLHIV. As far as the vulnerable populations previously cited are concerned, specific interventions and innovative approaches will be initiated within the framework of this concept note:

- For PLHIV, their children and their contacts: Training of care providers in the new guidelines, transport of the samples, access to screening with the help of radiography, LED microscopes and the Xpert MTB/RIF tool.
- For prisoners: integration of TB prevention and care into prisons, raising awareness of judicial, administrative and military officials, active screening and establishment of infection control.
- For miners and artisan diggers: awareness raising, recourse to 'advanced' strategies making use of mobile teams, transport of samples, integration of care and treatment at the nearest CSDTs.

In total, 257,704 TB patients - 216,471 adults and 41,233 children - will benefit from TB treatment, and the following activities will be developed:

- Extension of TB service coverage from 1,522 to 2,060 between now and 2017 in order to improve accessibility.
- Procurement of reagents and consumables in order to screen 6,711,924 in 2,060 CSDTs between now and 2017, and of microscopes for the 538 new CSDTs for screening.
- Procurement of drugs to treat TB patients in 2,060 CSDTs between now and 2017.
- Community involvement in the 2,060 CSDTs in order to improve the adherence to the treatment, the recuperation of lost of follow-up, the use of curative and preventative services by the general population and in particular by key and vulnerable populations, namely MSM, prisoners, miners, PLHIV, contact subjects and children under 15.

Table 13: Budget summary for the TB care, treatment and prevention module

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	Above allocation	% Above allocation	Total	% Total
Treatment and prevention of tuberculosis	33,242,084	78.4%	9,143,376	21.6%	42,385,460	100.0%

The budget for the 'Care, treatment and prevention of tuberculosis' module is US$ 42,385,460, 78.4 percent of which is covered by the indicative funding and 21.6 percent by the above allocation funding.

The interventions / activities carried out with the above allocation funding will be dedicated, as a priority, to investigating TB index case contacts, a greater involvement of all dispensers of care and community participation in the fight against TB. In line with this concept note, the above allocation funding should result in:

- The screening of 22,638 'additional TB cases', equating to a total of 5 percent of the targets set out in the TB NSP, and the successful treatment of 7,349 'additional cases', equating to a total of 5 percent of the targets set out in the TB NSP.
- The treatment of other additional cases will be funded by the DRC government.

Module 4: Prevention of Mother-to-child Transmission (PMTCT)

This concept note aims to ensure PMTCT ARV treatment for 35,079 HIV+ pregnant women with indicative funding, equating to 53.3 percent of the HIV NSP needs between now and the end of 2017.

Within the framework of this concept note, PMTCT activities will focus on four interventions, namely:

- Primary prevention of HIV among women of reproductive age:
  - Organize 28,677 educational talks on HIV for 9,233,190 women of reproductive age.
  - Screen 3,084,917 pregnant and breast-feeding women at the rate of 677,973 in Year 1, 1,067,168 in Year 2 and 1,339,776 in Year 3.
  - Ensure care and treatment for individuals testing positive for STIs, including 1,604,157 cases of syphilis between now and the end of 2017.
  - Distribute 12,764,117 condoms through the PODIs (Community Distribution Points), CBOs and CHVs.
  - Offer guidance and psychosocial support and urgent contraception and prophylaxis post-exposure to HIV and STIs and 55,843 post-exposure prophylaxis (PEP) kits to survivors of sexual violence (men, women and

adolescents).

- The prevention of unwanted pregnancies among women living with HIV:
  - Ensure the integration of screening and guidance services into the Family Planning (FP) units and offer FP services to all HIV+ women visiting health facilities, with a particular emphasis placed on providing dual protection and screening for cancer of the cervix and womb.
- The prevention of the vertical transmission of HIV:
  - Extend coverage of, and access to, PMTCT services through the strengthening of the comprehensive package of PMTCT interventions in 1,791 PMTCT FOSAs in the 350 HZs, including 239 existing HZs and 111 new HZs between now and the end of 2017.
  - Integrate PMTCT interventions into the MNCH services (PNC - adolescent health - PoNC (post-natal consultation) - CPS (pre-school consultation) of the 111 new HZs in order to achieve coverage in 350 HZs between now and 2017.
  - Integrate the PICT approach into services to promote the survival of children by using the existing care provision services (vaccination, nutrition / malnutrition units, pediatric services, Integrated Management of Childhood Illness (IMCI) services).
  - Build the capacities of service providers and community actors through training sessions and tutoring.
  - Offer PMTCT services to 35,078 HIV+ pregnant women through supplying commodities, products and data collection tools for PMTCT/Option B+ to 1,791 health facilities.
  - Offer HIV screening to pregnant and breast-feeding women and their family members, screening and treatment for syphilis, TB screening and treatment, and SGBV screening and medical care and treatment for survivors and victims of sexual violence.
  - Offer ARV treatment in line with Option B+ to HIV+ pregnant women and to children who have been exposed or indeed infected.
  - Carry out early screening of 28,484 children of HIV-positive mothers considering that 80 % of pregnant women will deliver in the available maternity wards (DHS II);
  - Monitor mother and child up to the age of 18 months through the community system.
- The treatment and care of mothers living with HIV, of their children and of their families:
  - Offer CTX prophylaxis to 35,079 HIV-positive women, active testing for TB and its treatment, and HIV screening of partners and other children.
  - Ensure the treatment of OIs and STIs, CD4 testing and biological monitoring, positive prevention (monitoring of patient adherence, information on risk reduction and support for sharing one's serological status with one's partner, and information on protected breast-feeding, FP and SGBV).
  - Establish ‘mentor mother’ groups to ensure the retention of HIV+ pregnant and breast-feeding mothers at the 350 HZs.
  - Offer ARV treatment in line with Option B+ to 35,079 HIV+ women and to children who have been exposed or indeed infected.

Option B+ for PMTCT will be based on the WHO 2013 guidelines adopted by the DRC in August 2013, according to which all HIV+ pregnant women are eligible for ARV treatment (20).

- In 2014, 904 PMTCT FOSAs with Option B+ in 137 HZs; between now and the end of 2017, 1,791 FOSAs in the 350 HZs in the 11 provinces of the country, with priority given to the 5 provinces with a rate of prevalence above the national average.
- Ensure continuity in PMTCT services in the 239 HZs currently being supported by the Global Fund.
- Ensure the extension of PMTCT to 111 new HZs not funded by the Global Fund, with priority given to the 5 provinces with a rate of prevalence above the national average (61 HZs in Year 1 and 50 HZs in Year 2).
- Delegate the task of ARV initiation to nursing staff and members of the community to achieve a satisfactory coverage of beneficiaries, in line with the guidelines contained in the Integration Guide to the Care and Treatment of PLHIV in the DRC published in August 2013.

Table 14: Summary of the PMTCT budget module

Summary of the budget by module	Total over 3 years					
		Indicative	% Indicative	Above allocation	% Above allocation	Total
PMTCT	18,112,870	84.2%	3,406,793	15.8%	21,519,662	100.0%

This module totals US$ 21,519,662, of which US$ 18,112,870 or 84.2 percent is indicative funding to guarantee PMTCT services and US$ 3,406,793 or 15.8 percent is above allocation funding.
The above allocation funding will enable the needs of this module to be covered, including training for care providers and community actors and educational talks.

Module 5 'Multidrug-resistant tuberculosis'

The continuing extension and improvement of a high-quality DOTS strategy and the care and treatment of MDR-TB patients are the major components of the national strategy to fight TB in the DRC. The proportion of bacteriologically confirmed multi drug resistant TB (new cases and retreatment cases) in 2012 was 12 percent. This low proportion is due to the following principal reasons: currently, only the LNR offers MDR-TB screening services, the network for transporting samples functions poorly and the number of individuals trained in MDR-TB remains insufficient. The extension of the programmatic care and treatment of MDR-TB will be undertaken progressively in the 516 HZs and supported by the deployment of Xpert MTB/RIF machines and the strengthening of the sample transport network.

The implementation of this module will focus on the following interventions / activities:

- The screening and diagnosis of MDR-TB.
  - Strengthen the capacities of care providers and community actors in managing MDR-TB.
  - Equip 15 new structures with Xpert MTB/RIF in order to facilitate MDR-TB screening.
  - Apply infection control measures (administrative, environmental and individual).
  - Make functional and operational the network for transporting the samples of suspected MDR-TB cases.

- Treatment
  - Acquire second-line drugs for care and treatment and drugs to treat undesirable side effects.

Table 15: Summary of the MDR-TB budget module

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	% Indicative	Above allocation	% Above allocation	Total
Multidrug-resistant tuberculosis	9,522,278	93.0%	716,191	7.0%	10,238,470	100%

The total budget of the MDR-TB module is US$ 10,238,470, of which 93 percent is the indicative funding and 7 percent the above allocation funding. With the allocated funding, this concept note states the aim of screening and treating 2,847 MDR-TB cases between now and the end of 2017: 655 in Year 1, 926 in Year 2 and 1,266 in Year 3.

The interventions / activities undertaken with the above allocation funding will be dedicated, as a priority, to increasing MDR-TB screening through an extension of the coverage of the sample transport network, supplying cartridges for Xpert MTB/RIF machines and procuring second-line curative drugs (SLDs). In line with this concept note, the contribution of the above allocation funding should result in the screening and treatment of 211 'additional MDR-TB cases', equating to 10 percent of the targets set out in the TB NSP.

Module 6 'MSM and transgender individuals'

The data available on MSM is provided through the studies on mapping and size estimation of this key population in 6 provinces (Kinshasa, Bas Congo, Katanga, Orientale, North and South Kivu), what shows that 1.9 percent of the population in these provinces are MSM. In this concept note, the same proportion is used to estimate the size of this key population.

Within the framework of this module, MSM will benefit from the following interventions:

- Behavior change in the programs for MSM and transgender individuals.
  - Carry out a study to map and estimate the size of these populations, and to identify the demographic and social determining factors.
  - Procure 12 mobile tents for prevention campaigns.
  - Train 208 peer educators who will work in the 'friendly centers' ('centres conviviaux') in the 6 selected provinces in the programs for MSM and transgender individuals.
- Procure condoms in the programs for MSM and transgender individuals:
  - Procure male condoms for 1,310,258 MSM and transgender individuals and 1,048 aqueous lubricants for male condoms for MSM and transgender individuals.
  - Install 466 distributors of condoms and aqueous lubricants.
- HIV screening and consultancy in the programs for MSM and transgender individuals:
  - Organize 336 VCT mobile night-time sessions focusing on MSM and transgender individuals.
  - Equip 6 mobile VCT teams for advanced strategies targeted at MSM in 6 provinces.
  - Offer HIV screening for 44,880 MSM and transgender individuals complementary to the services offered to the general population.
- Diagnosis and treatment of sexually transmitted infections within the framework of programs aimed at MSM and transgender individuals:
  - Train 6 care providers in the 6 *Centres conviviaux* (friendly centers) in the syndromic care and treatment of STIs (confidential clinics) in the 6 provinces where clear information is already available on this population type.

- Renovate 6 friendly centers aimed at MSM and transgender individuals for their care and treatment.
- Supply the 6 target friendly centers with drugs and other products for treating STIs at confidential clinics among MSM and transgender individuals.

- Other interventions carried out in relation to MSM and transgender individuals:
  - Organize 10 advocacy sessions with associated press agencies, parliamentarians and community leaders in order to promote social legislation on behalf of MSM and transgender individuals.
  - Offer post-exposure prophylaxis at the existing 'MSM-friendly' facilities.
  - Train care providers and other target health facilities in the intervention zones in providing care and treatment for MSM and transgender individuals with dignity and without stigmatization or discrimination.
  - Organize HIV and TB awareness-raising sessions through community organizations.

Table 16: Summary of the MSM budget module

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	% Indicative	Above allocation	% Above allocation	Total
Prevention - MSM and transgender individuals	1,439,464	74.9%	475,898	25.1%	1,915,361	100.0%

This concept note aims to treat 286,751 MSM and to develop prevention activities between now and the end of 2017 with an overall total of US$ 1,915,361, of which US$ 1,439,464 is the indicative funding and US$ 475,898 the above allocation funding.

Module 7 'Sex workers and their clients'

Within the framework of this module, SW will benefit from the following interventions:

- A change in behavior within the framework of programs aimed at sex workers and their clients:
  - Train 450 educator peers to educate sex workers and their clients in HIV, STIs, SGBV and lower risk sexual practices.
  - Organize 60,970 educational talks aimed at sex workers and their clients on HIV, STIs, SGBV and lower risk sexual practices.

- Procure condoms within the framework of programs aimed at sex workers and their clients:
  - Procure 7,621 aqueous lubricating gels and 9,145,542 male condoms aimed at sex workers and their clients.
  - Train 450 sex workers as condom vendors.

- HIV screening and advice within the framework of programs aimed at SW and their clients:
  - Offer screening and guidance to 441,914 SW and their clients.
  - Carry out 1,650 home visits to sex workers living with HIV/AIDS.
  - Undertake operational research at the national level to update the mapping in order to carry out targeted interventions.
  - Renovate 5 friendly centers and organize 168 VCT mobile outings at night.
  - Offer post-exposure prophylaxis at the existing 'MSM-friendly' facilities, besides the existing STI centers because of the proximity between MSM and SW and the absence of discrimination and stigmatization in these centers.

- Organize 140 awareness-raising sessions for SW on TB and HIV, on the use of PNC and FP services, lower risk sexual practices and on SGBV.

Table 17: Summary of the SW and their clients prevention module budget

Summary of the budget by module	Total over 3 years					
	Indicative	% Indicative	% Indicative	Above allocation	% Above allocation	Total
Prevention - Sex workers and their clients	3,227,055	93.5%	225,012	6.5%	3,452,067	100.0%

This concept note aims to screen and treat 972,586 SW and to develop prevention activities between now and the end of 2017 with an overall total of US$ 3,452,067, of which US$ 3,227,055 is the indicative funding and US$ 225,012 the above allocation funding.

Module 8 'Prevention - General Population'

According to the 2013-2014 DHS, the percentage of women and men aged 15-49 who, in reply to the question on whether it is possible to reduce the risk of contracting the AIDS virus by using condoms every time one has sex and by limiting oneself to a single sexual partner who is not infected and who does not have other partners is, respectively, 50.7 percent among women and 66.9 percent among men. In addition, given that of these two categories of person who have had more than one sexual partner during the previous 12 months, only 12 percent stated that they had used a condom during their most recent sexual relationship. As stated before, there is a decrease in the use of condoms.

According to the Mode of Transmission (MOT) survey, the distribution of new infections by population group shows that stable heterosexual couples contribute to the incidence of 63.63 percent of these infections in the general population (26).
According to the SPECTRUM 2013 estimates, the majority of new infections (72.5 percent) occur within the 0-24 year age group, and mainly among 0 to 4-year-olds. This concept note recommends recourse to combined prevention as a strategy to deal with these population categories. On account of the high rate of prevalence recorded, prevention interventions on behalf of the general population will, as a priority, be carried out in 5 provinces (Kasai-Oriental, Katanga, Maniema, Province Orientale and Kinshasa).
Activities aimed at the general population will focus on the following interventions:

- To achieve behavior change within the general population:
  - Organize radio and television programmes for 7,389,980 young people and adults on TB/HIV, human rights, SGBV and gender, via national and local radio stations, and national, local and community television channels.
  - Produce kits of educational material for 7,389,980 young people and adults on the subject of TB/HIV, human rights, SGBV and gender.
  - Train 2,053 peer educators to educate 31,392,847 young people and adults about TB/HIV, human rights (to promote positive models of masculinity), SGBV and gender.
  - Organize 1,320 prevention sessions through the CVCs (Life Skills Units) on HIV/AIDS, TB/HIV, human rights (to promote positive models of masculinity), SGBV and gender for 1,980 primary school teachers.
  - Organize 294,337 educational talks for 7,389,980 young people and adults on TB/HIV, human rights (to promote positive models of masculinity), SGBV and gender.
  - Strengthen the capacities of parliamentarians, judicial police officers, lawyers, magistrates and judges in the field of human rights and HIV.
  - Establish legal clinics.
  - Promote greater independence for women (including training in the management of income-generating activities (IGAs)).

- Give a larger role to community actors in engaging in interpersonal communication (home visits, forums, etc.).

- Procure condoms within the framework of programs aimed at the general population.
  - Offer male and female condoms to young people and adults at the various sites where prevention and care and treatment services are offered, and also distribute them via peer educators and condom vendors.
- HIV screening and consultancy within the framework of programs aimed at the general population:
  - Carry out the study into the co-factors involved in STIs and HIV transmission among young people and adults.
  - Offer screening and guidance for young people and adults through the integration of the PICT into the 'youth centers', the health facilities which offer maternal, neonatal and infant health services, the CSDTs, the CSTs and the STI treatment centers, as part of a mobile strategy.

- Links with reproductive, maternal, neonatal and infant health and sexual violence:
  - Ensure the mobilization of the community with the aim of involving it in the identification of problems, the offering of certain services and, where needed, the referral of certain clients to health facilities, thereby improving the use of the health services on offer.
  - Offer STI screening and treatment for young people and adults and post-exposure prophylaxis.
  - Organize 26 celebrations of World AIDS Day (1 December)

Use conditional money transfers (27) to improve the accessibility of poor people to health and social services. The following activities will be developed as part of this concept note: Pilot studies in each of the 5 priority provinces will be conducted, with an emphasis on young people and women (28).

Interventions on human rights and gender inequalities which may hinder access to health services are determining factors which will dictate the level of impact that essential program activities have. The funding allocated totals US$ 6,887,965, of which US$ 1,813,363 is the indicative funding and US$ 5,074,602 the above allocation funding.

***Table 18**: Summary of the 'Prevention - General Population' module budget*

Résumé du budget par Module	Total sur 3 ans					
	Indicative b	Indicative %	Above indi	Above %	Full reques	Full %
Prévention - Population générale sans Genre	6 887 929	30,57%	15 642 213	69%	22 530 142	100%
Genre et Droits Humains	1 813 363	26,33%	5 074 602	74%	6 887 965	100%
Total Module Population generale	**8 701 292**	**29,58%**	**20 716 815**	**70%**	**29 418 107**	**100%**

This module, with allocated funding of US$ 8,701,292 and above allocation funding of US$ 20,716,815, will make it possible to cover the needs of the general population.

Cross-cutting activities in the areas of human rights and gender inequalities are integrated into the other modules. The other activities, in particular awareness raising, have been

grouped together in this 'General Population' module with a request for indicative and above allocation funding.

3.3 Modular Template

The DRC currently has two updated strategic plans for TB and HIV, which form the basis of this concept note.
These two documents are the reference points for the prioritization criteria which have been put forward and shared at the country-level consultations, and they are in turn are based on the following criteria:

- Alignment on the national priorities of the two national TB and HIV strategic plans.
- Analysis of the epidemiological data and of the dynamics of TB/HIV co-infection.
- Tackling of programmatic and financial gaps.
- Coverage of the needs of the populations most exposed to TB and HIV.
- High-impact interventions.

The choice of priority TB/HIV modules and interventions within this concept notes is based on an analysis of programmatic gaps carried out in the course of the external performance review and the regional and national consultations, the recommendations of which specified 10 modules and priority interventions consistent with the strategic plans and the Road Map. Overall, five modules with a specific HIV component have been selected, three modules with a specific tuberculosis component, one joint TB/HIV module and two cross-cutting modules. The above allocation budget allocated by the Global Fund will be channeled principally into the modules involving antiretroviral treatment, anti-tuberculosis treatment and managing TB/HIV co-infection and multidrug-resistant tuberculosis.

Module 1 'Treatment, care and support'

(a) Reasons for selecting the module

This is judged to be a priority module in order to ensure the continuity of ARV treatment for 79,978 PLHIV currently receiving it, to prevent illnesses and deaths linked to AIDS and to reduce the risk of HIV transmission and the propagation of TB. ARV treatment prevents TB and reduces the risk of TB developing in 65 percent of cases, regardless of the CD4 count (29). In addition, the PLHIV care and support package contributes significantly to improving the quality of life of PLHIV and strengthens their adherence to treatment, as well as improving patient retention rates for ARV, prophylactic, CTX and/or isoniazid treatment. This is also a priority module due to the significant programmatic gaps which have been identified. Only 37.4 percent of PLHIV who are eligible for treatment are benefiting from ARV treatment (8). In order to improve the care and treatment of PLHIV and to prolong and to improve the quality of their lives, it has been concluded that the 2 interventions detailed in Section 3.2 are the most appropriate.

(b) Impact of the module

The grant associated with this concept note will make it possible to reduce mortality associated with AIDS by 43 per every 100,000 inhabitants between now and the end of 2017, reducing it from 75 per every 100,000 inhabitants in 2012 to 32 per every 100,000 inhabitants by the end of 2017. Thanks to this (indicative and above allocation) funding, 163,957 PLHIV will benefit from ARV treatment between now and the end of 2017. The funding total is US$ 116,509,638, of which US$ 77,420,922 is the indicative funding and US$ 39,088,716 the above allocation funding. The above allocation funding by the Global Fund will make it possible to cover at least 29 percent of needs.

Module 2 'Tuberculosis/HIV'

(a) Reasons for selecting the module

An analysis of the major indicators in the DRC shows that in 2013 TB was actively tested for in only 7 percent of documented HIV+ patients and that, taking all types of TB case into account, only 31 percent of TB patients benefited from PICT. Only 720 CSDTs offer the

HIV package (21). This under-performance justifies the choice of this module within the framework of a standard TB/HIV concept note. The 3 interventions chosen for this module will make it possible to improve the coverage of treatment and care for co-infected TB/HIV patients and to contribute to reducing mortality rates and the propagation of disease among the general population.

(b) Impact of the module

This concept note sets out plans to screen 232,211 TB patients (70 percent of the 2014-2017 TB NSP) for TB and to place 44,346 co-infected patients on ARV treatment between now and the end of 2017. The implementation of the priority interventions of this module will enable a reduction in: new infections associated with HIV, mortality rates among co-infected patients, and in the propagation of TB.

Module 3 'Treatment, care and support of tuberculosis'

(a) Reasons for selecting the module

This module has been selected in order to improve the detection rate of TB cases, which was 55 percent in 2012. A detection rate of at least 70 percent should be achieved, as recommended by WHO. This is a priority module because it will result in improved access to TB screening services by taking into account geographical differences and disparities in notification procedures, as well as placing an emphasis on improving the diagnosis and treatment of at-risk and vulnerable populations (prisoners, miners, children, PLHIV, etc.).

The 2 interventions chosen for this module will make it possible to improve the coverage of treatment and care for TB patients and to contribute to reducing mortality rates and the propagation of disease among the general population.

(b) Impact of the module

This module will contribute to a 25 percent reduction (from 54 to 41 per 100,000) in the TB mortality rate and will also lead to an improvement in the therapeutic success rate from 87 percent (2012) to over 90 percent between now and the end of 2017. The funding (indicative and above allocation) will make it possible to diagnose 362,210 TB patients (or 80 percent of the TB NSP) and 22,638 additional cases (5 percent of the TB NSP) and successfully treat 21, 2001 (80 percent) and cover the needs of 7,349 (3 percent) additional people in line with the NSP, using the above allocation budget.

Module 4 'Prevention of Mother-to-child Transmission (PMTCT)'

(a) Reasons for selecting the module

PMTCT leads to a reduction in new infections among newborns with HIV+ mothers. The DRC has one of the highest HIV transmission rates between mother and child, standing at 30.5 percent (8), and enormous gaps in the coverage of needs (9). In total, 86.9 percent of HIV+ pregnant women did not have access to ARV treatment in 2012 to reduce the risk of transmitting HIV to their children, and nearly 94 percent of children with HIV+ mothers did not benefit from early diagnosis of HIV.

The 4 priority interventions within this concept note are based on the comprehensive PMTCT approach and its four pillars, with the aim of rolling out PMTCT on a wider scale, extending Option B+ at a national level and providing pediatric AIDS treatment.

(b) Impact of the module

Funds from the Global Fund will contribute to the availability of antiretroviral drugs with the aim of reducing the risk of HIV transmission from mother to child between now and the end of 2017. This 90 percent Global Fund contribution to the provision of ARV treatment for HIV+ pregnant women between now and the end of 2017, in conjunction with the activities of other partners, will result in the elimination of MTCT in the DRC, reducing MTCT from 30.5 percent to less than 5 percent. Funding for the prevention of vertical HIV transmission is drawn 100 percent from the indicative budget, while for the other 3 interventions (primary prevention of HIV infection among women of reproductive age, prevention of undesired pregnancies among women living with HIV, and treatment, care and support for mothers living with HIV as well as their children and families), 82 percent is covered by the indicative budget and 18 percent by the above allocation budget. The

above allocation funding will thereby result in access to HIV and STI prevention services and improved access to care and support services for the family unit.

Module 5 'Multidrug-resistant tuberculosis'

(a) Reasons for selecting the module

The proportion of MDR-TB cases being screened is very low at 12 percent of the expected cases in 2012. The rate of MDR-TB biological confirmation among patients who have begun receiving second-line drugs has also turned out to be very low, standing at 81 of the 262 patients, or 31 percent. There remains, therefore, a substantial risk of TB-resistant strains being propagated. This concept note aims to fill these programmatic gaps by identifying 75 percent of the estimated number of MDR-TB cases and by successfully treating at least 75 percent of these cases.

The 2 priority interventions chosen should reduce diagnosis time and shorten the contagious period; access to second-line drugs should improve the cure and survival rates among MDR-TB patients.

(b) Impact of the module

Every year, the NTP signals around 341 cases of MDR-TB of the 2,860 expected cases. This concept note aims to identify 75 percent of the estimated number of MDR-TB cases and to successfully treat 75 percent of them. The concept note therefore aims to ensure high-quality MDR-TB screening within a shortened time-frame during the 3 years of the grant, and to place patients on treatment rapidly, not only to disrupt the chain of MDR-TB transmission among the general population but also to reduce the number of deaths linked to MDR-TB.

Module 6 'MSM and transgender individuals'

(a) Reasons for selecting the module

MSM represent 1.9 percent of the DRC's population (1.4 million people according to the UNAIDS report) with an HIV prevalence of 17.3 percent (8), and reports suggest that 15.55 percent of new infections in 2013 originated among MSM (26).

The 5 priority interventions chosen will make it possible to improve levels of awareness about the epidemic among the MSM and transgender sub-group as well as their access to prevention, treatment and care services.

(b) Impact of the module

This module aims to reduce by 4 percent the prevalence of HIV among MSM between now and the end of 2017 and to improve the indicator score (percentage of MSM declaring they used a condom when they last had anal sex with a male partner) from the current 15.30 percent to 60 percent by the end of 2017. The total funding for this module is 75 percent from the indicative budget and 25 percent from the above allocation budget.

Module 7 'Sex workers and their clients'

(a) Reasons for selecting the module

The prevalence of HIV among SW is calculated to be 6.9 percent - 3.4 percent of SW under 25 and 9.6 percent of those aged 25 and over (8). This justifies taking into account this key population in the national response to the HIV epidemic. This choice is also justified by the weak coverage of the needs of SW and of the services available to them, despite the fact that as a population they constitute a 'gateway' path of HIV transmission to the general population, amongst whom an analysis of transmission modes has revealed that 63.63 percent of new infections appear to originate among stable heterosexual couples (26).

The 3 priority interventions chosen in this module will lead to an improvement in the levels of awareness about the epidemic in the SW sub-group and among their clients as well as an improvement in their access to prevention, treatment and care services.

(b) Impact of the module

This module aims to contribute to an improvement in the proportion of SW who used a condom during the last time they had sex with a client from 69 percent to 80 percent. This

concept note aims to screen 972,586 people, 883,828 (91 percent) with indicative funding and 88,759 (9 percent) with above allocation funding, as well as to offer ART to 6,478 people, 2,653 (41 percent) with indicative funding and 3,825 (59 percent) with above allocation funding. The above allocation funding will make it possible to cover 59 percent of the needs not covered.

Module 8 'Prevention - General population'

(a) Reasons for selecting the module

The choice of the 'General population' module is justified by a generalized epidemic (1,2 percent) identified in the 2013 DHS, and by the results of the 'Analysis of HIV Transmission Modes by Population Sub-Group in the DRC', which indicates that 75 percent of new infections appear to originate among stable heterosexual couples and individuals who have occasional sexual relationships (26). In addition, the 'Investment Framework for a Generation without AIDS in the DRC' indicates that 72.5 percent of new infections occur among 0 to 24-year-olds (a substantial proportion of the general population). All of the interventions selected for this module focus on prevention.

(b) Impact of the module

This module aims to contribute to the prevention of new infections by reducing them to 50 percent between now and the end of 2017. Between 2015 and the end of 2017, this should successively result in 4,861,696, 7,010,566 and 8,259,438 men and women aged 15 and over taking an HIV test and receiving its results. This represents respectively 20.0 percent, 28.0 percent and 32.0 percent of the national needs.

Module 9 'Program management'

(a) Reasons for selecting the module

This is a cross-cutting module. Its selection is justified by the support it provides to the activities of the other modules in terms of management and coordination. Two priority interventions have been selected for this module. (i) policy,scheduling and coordination and (ii) grant management.

(b) Impact of the module

This module aims to strengthen the grant management aspect specified in this concept note. The total funding of US$ 38,658,797, of which US$ 38,402,765 is the allocated funding and US$ 256,032 the above allocation funding, will make it possible to achieve the following, critical results:

- The involvement of the DPSs and ECZSs in monitoring the implementation of activities supported by the Global Fund grant.
- An improved capacity for managing logistical information and transmitting reports to senior levels.
- More straightforward procurement procedures.
- Improved coordination of stakeholders and interventions in the area of supplies and stock management at all levels; failings in this area sometimes result in gaps and duplications in supplies at the level of the health zones.
- Enhanced functioning of key structures (DPM, SNAME, PNAM, CDR, FEDECAME) and of the coordination mechanisms at the national and regional levels involved in the national system for supplying essential drugs, including TB and HIV products.

Module 10 'Monitoring and evaluation'

(a) Reasons for selecting the module

This is a cross-cutting module. It has been chosen in order to provide information on performance in terms of how the interventions of the other, specific modules are carried out and also in order to address the gaps observed and detailed in Section 3.1, which have been summarized according to intervention type: (i) regular communication of information and the strengthening of the system for monitoring and evaluation; (ii) analysis, review and transparency, including the performance review of the TB/HIV program; (iii) review of the NSPs for TB and HIV and of collaborative activities focusing on co-infection (TB and HIV Road Map) and (iv) surveys (in particular to develop a better knowledge of the key populations in the DRC). Of the funding requested, US$ 5,960,389

of the indicative budget will cover 'regular communication of information' activities, US$ 1,123,778 will cover analysis, review and transparency activities, and US$ 853,408 USD will be devoted to carrying out surveys.

(b) Impact of the module

This module aims to strengthen grant management. The allocated funding of US$ 11,432,100, of which US$ 8,651,034 is the allocated funding and US$ 2,781,066 the above allocation funding, will make it possible to achieve the following results:

- Enhance the capacity of the IT system (NHIS) to capture all information relating to TB and HIV.
- Alignment of stakeholders in the fight against HIV with NACP data collection tools.
- Sound understanding of how the TB and HIV endemics are developing.

The above allocation funding should allow to consolidate the improvement of the information management strategy during implementation of this CN. To this aim the following activities will be implemented: the active identification of pregnant women, home visits, acquiring of information toolkits. The results produced by the analysis of reliable information and data would contribute to inform and timely decision taking and improve the performance of programs and the health system.

3.4 Focus on key populations and/or highest-impact interventions

This question is <u>not</u> applicable for Low Income Countries.

This does not apply, as the DRC is a low income country.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section collates information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program, including the designated PRs and the other key implementers, is essential to ensuring the success of the programs and of service delivery. For the standard TB and HIV concept note, the national coordination body may designate one or several principal recipients as appropriate, taking into the account the country context**.**

4.1 Overview of implementation arrangements

For TB and HIV (and the strengthening of the health systems, if applicable), provide an overview of the implementation arrangements for the funding request. In your response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not involve a dual-track financing arrangement (i.e. PRs from both the governmental and non-governmental sectors).

b. If several PRs are designated, how will they coordinate their activities for each disease, for both diseases and for cross-cutting interventions to strengthen the health systems, if applicable.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

d. How coordination will be ensured between each nominated PR and its various sub-recipients.

e. How representatives of women's organizations, people living with both diseases, and other key populations will actively participate in the implementation of this

funding request.

a. Compliance with the recommendations for dual-track funding arrangements

The DRC has opted for dual-track funding since Round 8 and this implementation arrangement will be applied to this concept note.

b. Coordination between principal recipients

For the current Global Fund grants, the MoH was chosen as the principal recipient (PR) on the government side and the NGOs CARITAS, SANRU and CORDAID as the non-governmental PRs. A coordination unit for each of the PRs was created to support the programmatic and financial management of the grant. The MoH's unit is assisted by a fiduciary management agency chosen by the PR according to predefined and objective criteria and with the approval of the Global Fund. The MoH as PR has chosen the NACP, NTP, PNTS (National Blood Transfusion Program), DEP (Department of Studies and Planification), DLM (Disease Control Department), DPM (Pharmacy and Drugs Department), DOGS and DPSs as SRs.

Since the implementation of Round 9, the MoH as PR has established a management unit - the CAG (Management Support Unit) - which is supported by a fiduciary management agency. The management of the grant by the MoH encountered functional problems linked to several prior conditions, insufficient funding, the lack of qualified personnel and internal conflicts of interest within the MoH which prevented it from achieving the expected results. In addition, problems linked to procurement, stock management and supply, the monitoring and evaluation of processes to implement the grants allocated to the MoH, reporting to donors and support for health zones by the DPSs were recorded. In light of this analysis, at the beginning of 2014 the MoH engaged in a restructuring of the system for managing internal and external funding.

In view of the size of the country and the complexity of the HIV-related activities, CORDAID and SANRU have been given responsibility for implementing activities in 6 provinces (Equateur, Kinshasa, Maniema, Province Orientale, Nord-Kivu, Sud-Kivu), and 5 provinces (Bandundu, Bas-Congo, Kasai-Occidental, Kasai-Oriental, Katanga) respectively.

SANRU and CORDAID base their actions on a system of SRs composed of NGOs and faith organizations, which sometimes replace the DPSs in organizing training and parallel reporting.

The systems used by SANRU and CORDAID for supplying products and drugs are managed by the Global Fund's VPP (Voluntary Pooled Procurement) mechanism up to the point when these supplies enter the country, and are then relayed by the PRs according to the geographic area covered by their interventions. The CDR network has, in places been used without the participation of the DPSs, but instead in partnership with these two PRs.

For the R9 TB component, CARITAS Congo and the MoH are the PRs designated by the CCM. Following the example of the other PRs, CARITAS Congo has set up a unit to manage the Global Fund grant. The MoH oversees state-level activities, while CARITAS Congo provides support for community activities (motivating the community contact persons and CBOs and supporting the most disadvantaged patients and MDR-TB patients) and oversees the supply of medical products to the MoH warehouses and the supply of non-medical products to the end destinations (beneficiaries: GRHs, HCs). Data reporting is carried out via the MoH circuit. CARITAS Congo gathers data at the level of

the NTP in order to produce its progress reports.

The principal problems with the current system for implementing the Global Fund grants are:

At the institutional level:

- Insufficient communication channels in the country.
- Weak leadership by the CCM, above all in terms of the strategic monitoring of grants.
- Weak accountability of the PRs to the CCM.
- Weak coordination between the PRs and other actors (e.g., each PR has its own unit costs for transporting products, several SRs and technical and financial partners support the same health zone, multiple stakeholders on the ground, several PRs per province).
- Time lags in the implementation of grants from one PR to the next.
- The conditions precedent applicable to the MoH as PR, in particular relating to the signing of contracts with the DPSs on the one hand and disagreements between the GIBS (Inter-donor Health Group) and the MoH on the performance bonus scheme on the other hand, have created a bottleneck for the other PRs.
- Late disbursement of funds at all levels (Global Fund, PRs).
- Non-allocation of funds due to indirect costs in the budgets of the non-governmental PRs.

At the structural level:

- Insufficient leadership by the MoH in the implementing of the HIV component, with the central level not being involved in the processes.
- Limited functioning of the CAG due to the under-funding of its operations, insufficient qualified personnel and conflicts of interest within the MoH.
- Poor functioning of the health system due to the problems cited above (low motivation levels among personnel, poor working conditions in the majority of the care and administrative structures, lack of career prospects for personnel, insufficient investment in infrastructure and equipment (and in its maintenance), problems associated with the system for supplying drugs and consumable materials, insufficient funding of service provision (performance-based funding, health and sickness insurance, high financial contributions from households, TFPs and the DRC government, etc.).
- Limited involvement of the intermediary level and of the provincial supervisory team in managing the grants from the Global Fund.

At the operational level:

- Limited involvement of the key populations.
- Drug and product stock-outs and expiry.
- Recurrent problems with obtaining customs exemptions, necessitating a request for exemption each time an item is imported.
- Limited capacity for storing drugs at all levels (central, CDRs, HCs).
- Time-consuming procedure for providing documents of proof.
- Poor data reporting and poor data quality.
- Inconvenient changes in software for data collection (GESIS and DHIS).
- Stakeholders do not adapt sufficiently to Global Fund requirements.

N.B. An inter-PR meeting with the CCM, held in 2013, allowed the following lessons to be drawn:

- Dual-track funding should enable CSOs to participate actively in implementing projects and strengthen their relationship at all levels with the MoH and the other partners.
- The dividing up of service provision, and consequently of the allocation of resources between PRs, in a dual-track funding approach involves anticipating counter-productive overlaps potentially arising from the high interdependency of activities, so as to alleviate these problems and ensure harmonious implementation.
- The institutional arrangements in a dual-track funding approach would therefore have to take into account the extent to which stakeholders' activities complement each other, with particular attention paid to establishing coherent activity packages for each of the PRs in order to enable them to assume full responsibility for the results which are expected of them.
- The performance of the grant-funded program is compromised when the various risks associated with implementing the project are not taken into account in advance at the planning stage. Consequently, any implementation plan must be accompanied by a risk management plan for each activity in order to ensure that actions are effective and adequately cover target populations.
- In addition to the role of the CCM, which is a key structure for coordinating stakeholders, the leadership role of the MoH needs to be emphasized - PRs and other agencies specializing in certain specific fields areas should only be necessary in areas where the MoH has shortcomings and where they can assist in system strengthening. The coordination systems should be clearly described when grant applications are being developed, taking into account how the ongoing reforms of the sector are progressing.
- Work plans and realistic budgets for SRs submitted at the same time as those for the PR would facilitate an efficient launch of the grant-funded program.
- Multiple SRs do not always facilitate the monitoring and coordination of interventions. An approach involving a single SR with a range of skills per province or district appears to offer an alternative for ensuring good coordination.
- Regular and effective joint monitoring and verification missions among SRs would offer a guarantee of the success of the program, given that the majority of the major risks are located at the SR level.
- Feedback letters sent to the SRs and based on combined analyses of SR reports (both financial and programmatic) would make a major contribution to SRs in terms of monitoring, support and, above all, motivation.
- The managing of logistical information is of critical importance in the context of the DRC, where means of communication are limited and there are high risks of medical products being lost or diverted. Meaningful resources therefore need to be allocated to ensure that this grant management system functions properly.
- The identification of grant-related activities to be implemented should be based on the proven impact of these activities. There is a danger of the already limited resources being wasted.
- Limiting performance indicators to a sensible number would facilitate the collection, processing and transmission of data. The performance of an implementation system can be analyzed using a limited number of indicators (inflation of indicators).
- The effective involvement of the DPSs, under the supervision of the head of the provincial health division, would help to guarantee a reduction in the plethora of SRs and the reallocation of funds to the final beneficiaries. It would also help to guarantee an improvement in performance at the level of the health zones.

- The health center level should constitute a critical level in the monitoring and evaluation system, for which specific measures need to be taken if the quality of data is to be ensured, since it is often at this level that serious quality problems are encountered, compared to quality standards at more senior levels.
- Administrative and legal sanctions should be applied in order to dissuade care providers from diverting the medical products placed at their disposal, thereby improving good governance.

Alignment to the institutional arrangements of the health sector

The CCM of the DRC has opted, with the structural reforms in progress in the health sector, for the implementation of the TB/HIV concept note to contribute to health system strengthening, with significant responsibility being given to the provincial health divisions (DPSs), which will ultimately fulfil the role of the MoH's sub-recipients, in line with the vision shared by the MoH and its partners, in particular the GAVI Alliance, the World Bank, USAID, UNICEF, WHO, UNAIDS, PEPFAR, the European Union, etc.

The objective at the end of the implementation of this grant is for the MoH to be the PR for the HIV component through each of its NACP programs, for the tuberculosis component through the NTP and for the malaria component through the NMCP.

The organizational arrangements within this concept note will have three phases: (i) the first transition phase of 24 months, departing from the existing arrangements and involving the MoH, SANRU, CORDAID, CARITAS Congo as the PRs and with the support of CNOS at the community level, (ii) the second phase of 12 months which will move towards the transfer of PR responsibilities from SANRU and CORDAID to the MoH, and (iii) the third phase, which will see an aligned implementation endorsed by an evaluation of the MoH's capacity to manage the next Global Fund grant post-2017.

At the end of the process, the MoH, as the governmental PR, will be responsible through its NACP, NTP and NMCP programs for state-level activities, in particular the development of standards and guidelines, the strengthening of the health system, initial training and refresher training for personnel, producing health information, monitoring, and validating data for the two diseases targeted by this concept note. It will be answerable to the CCM, the Global Fund and other partners in the following domains:

- The programming of activities.
- The implementation of programmed activities through management structures and public and private health training courses.
- The monitoring and evaluation of implementation processes through the ECZSs, the DPSs and the specialist programs.
- Joined-up initial training and refresher training for personnel.
- The coordination of health system strengthening activities.

It will establish a contract with a fiduciary agency for the financial resources management component within the grant framework of the Global Fund. This financial management agency must guarantee absolute transparency and traceability in the use of the funds made available by the Global Fund.

SANRU and CARITAS Congo, as PRs, will be in charge of activities relating to the supply and distribution of medical products.

Each organization in their respective zone of intervention, namely 5 provinces in the case of SANRU and 6 provinces in the case of CARITAS Congo (corresponding to the current division of provinces - the DRC has a project to re-divide the country into 26 provinces), will be responsible for:

- Procurement of the TB and HIV drugs and products indicated by the concept note.
- The distribution / transportation of drugs and products to the level of the CDRs,

based on framework contracts currently being negotiated by the MoH and the transport companies.

- The provision of technical assistance to the DPSs and CDRs in the field of procurement and stock management during the phase covered by TB/HIV concept note.

CORDAID and CNOS will be responsible, as PRs, for the community component of the Global Fund grant, each within its own zone of intervention (6 provinces for CORDAID and 5 provinces for CNOS) and will be in charge of:

- Supporting the implementation of all the community activities set out by the TB/HIV concept note.
- The monitoring of sub-recipients at the level of the provinces, which in turn will be responsible for the SSRs at the level of the health zones, which will work closely together with the ECZSs and the health facilities.

The community organizations, as SRs and SSRs, will be responsible for community services at the level of the health areas and will take charge with the ECZSs of the joint monitoring of all the integrated services at this level (awareness raising to promote adherence to treatment, DOTS, distribution of ACTs (artemisinin-based combination therapies), Ivermectine, vaccination, performance-based funding monitoring, RDTs, lobbying, etc.).

Note:

The final establishment of this organizational structure must be outlined in a transition plan which includes the transfer of capacities to the current non-governmental PRs. A plan to strengthen the capacities of the NACP, NTP and NMCP programs must be developed and they must undergo an organizational audit.

Under this submission, the MoH, as the governmental PR, will be in charge of managing the HSS component of the present funding request where it pertains to human resources, PSM and the NHIS. The MoH will be assessed on its performance in managing the HSS component and its capacity to ensure a strengthening of its NACP, NTP and NMCP programs with the support of all its technical and financial partners.

Coordination by national coordination bodies

The General Assembly of the CCM sets the general guidelines for implementing Global Fund grants. The CSS (Strategic Monitoring Committee) of the CCM oversees the strategic monitoring of the implementation of grants through periodic meetings with the sectoral programs (NTP and NACP) and the PRs, annual reviews, analyses of the dashboards and PUDRs (Progress Update and Disbursement Request reports), analysis of and follow-up on monitoring letters, and joint field visits involving all stakeholders, whether members or non-members of the CCM.

The CNP at the national level, and the CPPs (Provincial Steering Committee) at the provincial level, ensure the coordination of the activities developed by the MoH.

The specialist programs, through the DPSs, will ensure the monitoring and evaluation of the activities undertaken by the PR and SSRs through regular consultations, periodic reviews, regular meetings to produce the PUDRs, joint supervisory missions and the validation of data provided by the implementing parties.

Coordination between the PRs

A memorandum of understanding will be drawn up between all the PRs and will set out the modalities for communication and collaboration to ensure the smooth implementation of the grant. Monitoring of the implementation of this memorandum will be formally carried out by the PRs every three months in conjunction with the CCS of the CCM.

The PRs will hold ordinary meetings twice monthly and extraordinary meetings at the request of one of the participating parties.

At all levels, coordination between the PRs will take place as follows:

For each disease (TB and HIV)

There will be a single work plan, a detailed common budget and a single performance framework, from which each PR develops its own work plan and performance framework. To provide information on this single framework in order to ensure that the expected results are achieved in the specified time-frame, it is important for PRs to coordinate and dovetail their interventions.

This coordination will be achieved through:

- The sharing of the program results achieved, as defined in the modular framework, and monitoring by consistent IT systems.
- The sharing of experience and lessons learned during the implementation of the grant.
- The rescheduling every six months of activities, depending on how the grant implementation processes unfold.
- The examination of issues linked to monitoring and evaluation, supplies and risk management (dashboards).
- Issues which require the arbitration of the CCM.
- The potential pooling of issues and important decisions identified in the course of the grant implementation.

For both diseases (TB and HIV)

In addition to the aforementioned coordination modalities, the PRs need to harmonize their support for planning and implementing the Road Map for TB/HIV activities. The framework of a joint concept note adds the further challenge of smoothly coordinating the stakeholders of the three implementing PRs (MoH, CORDAID and CNOS) at the peripheral level. This smooth coordination will therefore require a greater involvement on the part of the programs in charge of the two diseases and of the CSS of the CCM in order to ensure that pitfalls are anticipated and that the service providers are properly engaged. The ultimate aim is the effective integration of TB and HIV services into the health facilities. To this end, the TB/HIV steering committee at the level of the DLM will be re-energized. The memorandum of understanding between the various PRs, as described above, will specify the modalities for implementing cross-cutting activities (initial training, refresher training, supervision, supplies) relating to the two diseases in the same geographical regions.

For cross-cutting interventions involving health systems strengthening

Cross-sector interventions to strengthen the health system planned within the framework of the TB/HIV concept note will complement the PESS project, GAVI II funding and the investments planned within the framework of the malaria concept note. The implementation of these HSS activities will be overseen by the MoH and defined in the memorandum of understanding between the PRs.

Drawing on the lessons learned during the implementation of the current HSS grant regarding the limited rate of disbursements by the MoH, the MoH has just initiated a process of restructuring its system for managing funding for this sector.

c. Modalities for managing sub-recipients

The national strategy envisages the integration of joint disease control activities into primary health care, with the HZs as the operational unit. Ideally, the implementation of this grant should strengthen the roll out of this strategy, and the role of the PRs should be limited to supporting the DPSs as sub-recipients, and the DPSs should assume and extend their support role for the ECZSs, which in turn will be responsible for supporting health facilities in the health areas.

In this way, the MoH as PR will rely on the reformed DPSs as sub-recipients. The PR responsible for the community component will contribute to correcting distortions in the

health system where the system has not integrated community organizations at the intermediary level. The PR responsible for the community component will work with sub-recipients from the community at the provincial level. The sub-recipients' anchor point will be the DPSs, so that they are well-placed geographically and are properly able to share information on the implementation of program activities at the level of the health zones and areas. Sub-recipients will be identified, as recommended in the Global Fund guidelines, after a call for tenders, with the criteria being management capacities and, in particular, good financial management capacities.

The modalities for managing SRs will be based on the following activities:

- Harmonizing and identifying elements in the terms of reference of the SRs which will have a particular impact on the content of their work, the objectives and expected outcomes, their roles and responsibilities and their approach to working with the actors on the ground.
- An assessment of the capacities of the current SRs by the PR.
- The conclusions of the assessment of the SRs, accompanied by a plan for building their capacities, will be submitted to the Global Fund after approval by the CCM. The SR assessment form and results will be shared in advance with the CCM.
- The selection of SRs which can harmoniously implement the activities associated with the grant. This choice should take into account the management of previous grants. However, the PR may also enlarge the circle of SRs, through a call for tenders which is transparent and/or competitive, by bringing on board other public, private and civil society institutions, including women's and youth organizations.
- The establishment of a formal contract between the PR and the SRs.
- Where the governmental PR is concerned, contracts with the SRs in the provinces will be established by the PHD and overseen by the Provincial Minister, who will delegate this task to the Secretary General of Public Health in each province.

d. Coordination between each designated PR and its various sub-recipients.

A formal contract will be signed between each PR and its various SRs which clearly defines the rights and obligations of each party. This contract will be shared with the CCM, the TB and HIV national programs and the DPSs where the activities will be undertaken, overseen and approved by the Provincial Minister and the Secretary General of Public Health.

The performance framework for each SR (terms of reference) will be specified in an annex to this contract.

For the purposes of risk management, internal and external audits will be organized by, respectively, the internal auditors of the PR and by an agency recruited to this end.

The monitoring of the activities of the various SRs, in particular the DPSs, CDRs and civil society organizations, will be carried out by the relevant PR according to their various monitoring and evaluation plans and through regular communications, emails, telephone calls, regular meetings, joint missions on the ground, the analysis of periodic reports and feedback, management letters and participation in annual reviews with the involvement of the TB and HIV programs.

Once every six months, each PR will hold a formal meeting (activity review) with all its SRs with the aim of sharing results, experiences and lessons learned during the implementing of activities and of examining issues linked to monitoring and evaluation, supplies, risk management and any problems or bottlenecks which may be hindering smooth implementation.

The PRs will ensure that the SRs attend the meetings held by the DPSs - BTPs (*Bureau Technique Provincial*, Provincial Technical Office) and CPPs - and will be asked to

regularly communicate with the relevant national programs.

e. How representatives of women's organizations, people living with both diseases, and other key populations will actively participate in the implementation of this funding request.

Representatives of women, young people, individuals living with the two diseases and other affected key populations have contributed actively to the processes since the review of the TB and HIV programs and during the national and regional consultations, right up to the stage of the actual drafting of the concept note.

The concept note takes into account the key populations affected by the two diseases. In the case of TB, this concerns PLHIV, children under 15, TB contact cases, prisoners, internally displaced persons and miners, while in the case of HIV, the following groups have been taken into account: SW, MSM, IDUs and prisoners. These populations will be involved in the implementation of this funding request in accordance with the NSPs of the two programs, particularly in relation to HIV component 4 and TB component 7.

Given that the organizations representing these populations are typically grouped into sub-sectors / networks / corporations / CBOs which may or may not be members of the CCM, their capacities can also be leveraged during the implementation of the activities described in this concept note, in particular:

- The mobilization of communities in the campaign against discrimination, stigmatization, SGBV and gender inequalities.
- The establishment and strengthening of legal clinics to provide legal support to victims of stigmatization.
- The mobilization and education of communities (parliamentarians, lawyers, community leaders, the workplace, churches, education institutions, etc.) in order to promote human rights.
- The involvement of PLHIV and other affected individuals in the effective implementation of the 'Positive Health, Dignity and Prevention' initiative.
- The building of the leadership and governance capacities of women involved in combating HIV and of other key populations, in particular MSM and IDUs.
- The application of the national policy on the issue of orphans and vulnerable children.

More specifically, these organizations will develop activities to support the fight against both diseases. In the case of HIV, this will involve monitoring patients on ARV treatment, educational activities led by peer educators, etc. In the case of TB, they will develop community awareness-raising activities relating to TB, particularly in the contexts where the key populations are living (prisons, mines, places where people come into contact with TB patients, primary schools, etc.). They will also refer suspected TB cases (where coughs have lasted for over 2 weeks) to the CSDTs, ensure the transport of the sputum samples of bedridden patients for diagnosis, ensure the provision of community level directly observed treatment, and relocate patients who have ceased to attend health facilities.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the CCM is overseeing other Global Fund grants.

This concept note outlines a continuation of the activities which have already been undertaken during the consolidated Rounds 7 and 8 for HIV, and Round 9 for TB, and provides comprehensive HIV activity packages for the new HZ which had not already integrated the package of HIV services. There will be no duplications because the other

Global Fund grants in progress terminate at the end of 2014, whereas the present funding request covers the 2015 to 2017 period. In addition, the gap analysis has taken into account funding from other donors working in the same domain.

In terms of human resources and the management of medical products and stocks, This concept note places these activities within the framework of a cross-cutting health system strengthening which takes both diseases into account.

Furthermore, this concept note is proposing an approach involving the harmonizing of the measures to support the ECZSs and FOSAs carried out by the PRs, SRs and the other TFPs which are active at the peripheral level and in the same HCs, while at the same time placing an emphasis on system alignment.

As for training, this will take into account the service providers who have already been trained and will focus on the new HCs, addressing the high staff turnover resulting from the unstable working conditions of the personnel who had previously received training. Training activities will be harmonized with interventions to build human resource capacities, supported by the other TFPs.

The monitoring and evaluation activities proposed within the framework of the concept note will be carried out jointly in the case of TB/HIV co-infection, without losing sight of the specific characteristics of these two diseases (monitoring of active TB and HIV patient files, monitoring of MTCT and MDR-TB activities, etc.).

We have not included in this concept note activities to strengthen the national health information system because this area is already covered in the HSS component of the malaria concept note, in line with the new GAVI II funding.

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

The evaluation of the PRs is attached as an annex.

4.4 Current or Anticipated Risks to Program Delivery and PR Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment, including external risks, that might negatively affect the performance of the proposed interventions or the capacities of the principal recipients and key implementers. Also describe past and present performance issues.

b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

a. *With reference to the portfolio analysis, describe any major risks in the country and implementation environment, including external risks, that might negatively affect the performance of the proposed interventions or the capacities of the principal recipients and key implementers.*

Risk type	Risks	Mitigation measures
Politics	Political instability	Contingency plan (selection of priority activities, focus on the delivery of priority services, essential staff, protection of stocks and equipment, etc.) and strengthening of collaboration with humanitarian agencies
Financial	Delay in disbursement by the	Disbursement on schedule

	Global Fund	
	Weaknesses in the banking system	Ensure close monitoring of the system and place a maximum of SR and SSR funds with low-risk service providers
Regulatory / legal	Cumbersome customs regulations	Negotiate with the MoH for special treatment for medical products
	• Business environment lacking in transparency • Limited involvement of other sectors, in particular the financial sector	Verification of the existence of structures and regular checking of service provider invoices
		Blacklisting of companies
Operational	Lack of national infrastructure to ensure the warehousing and distribution of medical products and limited private services available in the market	Find channels for integrating the national system into the supply chain (warehousing and distribution)
		Sub-division of services (warehousing, transport, customs clearance) with the aim of enlarging the circle of service providers
		Passage through the CDRs Create active links with other sectors, in particular the transport sector, in order to facilitate the delivery of medical products, from their procurement to their distribution.
	Poor communications infrastructure (roads, trains, telecommunications)	Alternatives such as air transport
		Alternative supply channels through pooling (dispatch of orders directly to the east rather than requiring everything to transit through Kinshasa)
		Use of the latest technologies (internet, cellphones)
Strategic	Weak supplementary funding from other donors (World Bank / MAP, Clinton Foundation, United, etc.), weak contribution from the government, and ceilings on HIV grants	Strategic communication and information
		Support for mobilizing national resources
Environmental	Accidents, military roadblocks, attacks and theft on the roads (PRs and SSRs)	Analysis of options for deliveries by road, including a cost analysis to assess effectiveness and efficiency (see also the integration of the CDR option)
		Staff oversight of deliveries

	Fires	Fire insurance: checks of all service providers possessing drugs, equipment and medical products for a certain time period

b. **Risk mitigation measures**

See Table above

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility criteria and the endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

X	Table 1: Financial Gap Analysis and Counterpart Financing Table
X	Table 2: Programmatic Gap Table(s)
X	Table 3: Modular template.
X	Table 4: List of Abbreviations and Annexes
X	CCM Eligibility Requirements
X	CCM Endorsement of Concept Note