The Global Fund to Fight AIDS, Tuberculosis and Malaria

Geneva, July 2002

For the use of the Global Fund Secretariat:
Date Received:
ID No.:

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

This form is divided into 4 main parts:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed*.

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seek details on the content of the proposal by different components.

How to use this form:

1. **Please read ALL questions carefully**. Specific instructions for answering the questions are provided.

2. Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.

3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).

5. When **using tables**, all cells are automatically expanded as you write in them. Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

6. **To copy tables**, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

   Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: *Table I.a*

Proposal title (Title should reflect scope proposal)**:**	Support programme for Congolese initiative concerning infection by HIV/ AIDS, Tuberculosis and Malaria with regard to prevention, case management and strengthening of capacities	
Country or region covered:	Democratic Republic of Congo (DRC)	
Name of applicant:	National Co-ordination Committee of FMSTP of DRC (CCM/DRC)	
Groups represented in CCM (indicate number of members from each category):	**Government – Ministry of Health 4:** MSP, BEP, PNLS, TB, PNLT	**UN/Multilateral agency 4:** (WHO, UNDP, UNAIDS, E.U.)
	Government – Other ministries 4 : (Min. Int Co-op, Min. Plan, Min. Finance, National Association of Stock Exchange Companies)	**Bilateral agency 1:** (USAID)
	NGOs/Community organisations 6 (BASICS, DAMIEN FOUNDATION, Médecins Sans Frontières Belgium, Network of National Health NGOs, NGOs AIDS Forum, National Anti-tuberculosis League)	**University/educational organisations 1** (College of Public Health of University of Kinshasa)
	Private sector 4 (Federation of Congolese Businesses, UTEXAFRICA, companies belonging to the Association of Pharmacists)	**Religious/ denominational groups 4** (Legal representatives of Muslim community, Church of Christ of the Congo and Kimbanguist Church, Chair of Bishops' Conference of Catholic Church)
	People suffering from HIV/tuberculosis/malaria 1[*] (Congolese Network of People Living with HIV)	**Others** (please specify): **3** Speaker of Parliament (1) Trades Union Council (1), Beneficiaries(2)

[*] *Based on characteristics/national epidemiological profile*

[**] *If the proposal is fully integrated, one component can not be separated from the others, and if breaking the budgets down proves to be unrealistic or unfeasible, fill in the "Total" line only.*

If the proposal is NOT submitted through CCM, explain why:	NOT APPLICABLE

Specify which component(s) is/are targeted by this proposal and the amount requested from the Global Fund:**

Table I.b

			Amount requested from Global Fund per year (in thousands of US dollars)			
			Year 1 2003	**Year 2 2004**	**Year 3 2005**	**Total**
Component(s) (mark with X):	**X**	**HIV/AIDS**	15 575 269	13 914 792	14 516 306	**44 006 367**
	X	**Tuberculosis**	4 502 407	1 907 225	1 563 372	**7 973 004**
	X	**Malaria**	16 354 809	17 029 306	10 014 278	**43 398 394**
		HIV/TB				
		Total	**36 432 485**	**32 851 324**	**26 093 955**	**95 377 764**
Total funds from other sources for activities relating to the proposal			HIV: 15 840 000 TUB: 7,593,863 MALARIA: 6 269 000 **TOTAL: 29,702,863**	HIV: 11 880 000 TUB: 4,882,625 MALARIA: 3 800 000 **TOTAL: 20,562,625**	HIV: 11 880 000 TUB: 5,217,116 MALARIA: 3 500 000 **TOTAL: 20,597,116**	HIV : 39 600 000 TUB: 17,693,608 MALARIA: 10 149 000 **TOTAL: 67,442,608**

Please specify how you wish to see this proposal evaluated[**] (mark with X):

The proposal must be evaluated as a whole	
The proposal must be evaluated as separate components	**X**

Brief summary of the proposal (1 page)(please include quantitative data where possible):

- **Describe the overall goals, objectives and broad activities per component, including expected results and timeframe for achieving these results:**

Component : Infection by HIV/AIDS

The main aim of this programme is to prevent the transmission of HIV/AIDS and to reduce its impact on individuals, families and the community.

This component can be broken down into five areas of intervention. It will be implemented over a period of three years, with an increase in the volume of activities going from 30 to 50% per year. All the areas of activity are intended to reinforce or extend campaigns, which are in progress or are planned, as the case may be.

Area of intervention 1 : Mobilising communities and institutions

Main Objective : To mobilise institutional and community leaders to strengthen

This procedure guarantees an evaluation of the proposal in the same spirit as it is drafted. If proposals are evaluated globally, all the components shall be considered as elements of an inclusive proposal. If they are evaluated separately, the compnents shalll be considered as autonomous components.

and maintain their involvement in the fight against HIV/AIDS

A national mobilisation and partnership campaign is to be launched, involving political religious, community and trade-union institutions, communities of people living with HIV and the private sector, in order to bring about the involvement of all, thus guaranteeing the maintenance of the impetus recently regained in the fight against AIDS.

The main aim of this community mobilisation and participation campaign is to encourage the growth of public involvement, so that the seriousness of the HIV/AIDS phenomenon is better appreciated. It also involves the launching of a large-scale fight against the risks of exclusion and discrimination with regard to those infected and affected in cases of this type.

The main result expected is the participation of the leaders of nation-wide organisations as guarantors that the range of care and preventive measures on offer will remain available for all, and social acceptance for people living with HIV/AIDS. This campaign will be progressive in nature and will initially be focused on 5 provinces, with attention being paid to interventions in progress and /or to the need to provide new impetus for the fight against AIDS.

Area of intervention 2: Prevention and reduction of risks

Main Objective: To prevent risks of transmission of HIV / sexually transmissible infections (STI) within the vulnerable parts of the population.

This area of intervention takes into account the need to reinforce prevention in groups for which the risk is particularly high due to social or individual contexts, which increase the level of exposure. It involves integrating this overall initiative into a strategy of reducing risks and vulnerability, both within communities and within institutions, which are cruelly short of resources for guaranteeing any more reliable and better organised preventative strategy.

The main result expected is a synergy between all the interventions, so that they will have an influence on the attitudes and the behaviour of the populations concerned, but equally so that the public health services, such as blood transfusion centres, will operate more effectively.

Area of intervention 3: Overall case management of persons living with HIV (PLHIV).

Main Objective: To reinforce overall case management of PLHIV and infected persons, integrated into a continuum of care.

The Government of the DRC has committed itself to a national policy with regard to people infected by HIV, which involves large-scale prevention, the treatment of opportunistic infections and the progressive implementation of a national health policy allowing access to ARV's. This commitment on the part of the government has recently been given concrete form through ministerial decree no. 1250 /CAB/MIN/CJ/KIZ/09/02, dated 5th July, 2002, governing the accreditation of centres for the dispensing of treatment by the ARV's and the appointment of doctors to prescribe ARV's. This national initiative is aimed at a rational use of ARV's, which should make it possible to improve the quality of life of people living with HIV-AIDS, but should also make it possible to reduce the impact of this disease. The main result expected is that almost 40,000 people will be put on ARV's, with high-quality clinical and biological follow-up procedures and with an acceptance of psychosocial financial liability regularly provided for. Finally, attention is also paid to the problems of support for and observance of treatments, in order to prevent in advance the risks of therapeutic resistance and evasion.

Area of intervention 4 : Prevention of transmission of HIV from mother to child (PTMC)

Main Objective: To reinforce and extend the prevention of the transmission of HIV from mother to child, including the overall case management of medical expenses for the family unit

This involves developing a coherent intervention procedure regarding women before, during and after their pregnancies, in order to reduce the risk that their children will be contaminated with AIDS. Assuming a 60% attendance at the antenatal clinic during the first year of creation of the site, with a 10% increase in the following years, the intention is to test 28,512 women

and to administer treatment to 8,506 women who are seropositive, by means of 10 new PTMC centres. With regard to PTMC plus, 4,468 seropositive women will benefit from the support of the community mediators.
The main result expected is the involvement of all the professionals and mediators operating in this area, in order for this initiative to provide the maximum benefit to women and to their families, in particular their unborn children. This programme will be implemented in the context of the national policy with regard to maternal breast-feeding.

Area of intervention 5: Epidemiological monitoring and qualitative data management

Main Objective: To reinvigorate the system for monitoring HIV and sexually transmissible infections, with a view to improving the national response to the epidemic.

The strengthening of the epidemiological monitoring system will consist of reinvigorating routine monitoring, increasing the extent of monitoring by key centres (sentinel sites), and putting into place an efficient system of data management and co-ordination. The main result expected concerns the concrete implementation of these activities to obtain information on the development of the epidemic and, should the case arise, the taking of appropriate and pertinent decisions regarding public health.

- **Indicate the beneficiaries of the proposal, broken down by component. and the advantages from which they might benefit** (including the target populations and an estimate of their number):

This proposal from the Democratic Republic of the Congo for the HIV/AIDS component should have an impact on several levels, a direct effect on the health of those affected and of those around them, as well as on the entire health system and the economic system.
As regards affected persons, they can be estimated at several tens of thousands of sick people, together with their families. To be precise, there are 3,902 people with AIDS (out of an active hospital dossier covering about 15,000 patients) who will benefit from ARV treatments and, in a more general way, from an acceptance of psycho-social financial liability, in view of their need for counselling and support, and for intra-family or intra-community mediation. Thanks to the treatment and the acceptance of financial liability, these people can, in their turn, reinforce preventive measures with regard to their families and those around them, which in our view is bound to have a considerable positive impact. We can not quantify this impact but even at this stage we can say that it is going to make it possible to reduce the risks, improve the conditions of life for infected and affected persons and, finally, reduce the degree of stigmatisation which persons living with AIDS and the sick currently have to face. Thus, although the figures are very important, we must go beyond them to analyse the results of this application, the repercussions of which extend far beyond the medical sphere, or even the situation of those who are seropositive or suffering from AIDS. With regard to the risk of transmission through the blood, the intervention will protect the population of 105 health areas (ZS).
In addition, PTMC will make it possible to implement the case management of 8,050 seropositive women and their families. Several groups who have remained isolated from preventative measures for lack of resources (thus preventing the measures from being exhaustive to some extent) will be able to have access to them thanks to this programme. Likewise, all the interventions relating to prevention will in themselves alone make it possible to make considerable inroads into tackling a considerable number of situations where there is a risk of contamination by sexually transmissible infections and of infection by HIV.

In conclusion, with regard to this component, we can confirm that the proposal from the DRC will give new impetus to the country's public health, for it will allow several tens of thousands of people to benefit from access to care and to the prevention of HIV/AIDS, including PTMC, opportunistic infections and sexually transmissible infections. Finally, the present proposal will improve epidemiological monitoring of HIV/AIDS to obtain the best measurement of the programme.

- **Describe the aims, objectives and general activities by component, including the expected results and the schedule to attain these results:**

Component : Infection by tuberculosis

The main aim of this programme is to reduce infection, morbidity and mortality due to tuberculosis while raising the cure rate to 80 % of sick people given treatment and the detection rate to 65% of the tubercular cases expected following microscopy by greater expansion of the DOTS strategy covering 90 % of the population.
This component is orientated around four areas of intervention. It will extend over a three-year period, with an increase in the volume of activities going from 70 to 90% per year. All the areas of activity are intended to reinforce or extend campaigns in progress.

Area of intervention 1: case management of patients undergoing treatment using DOT :
Main Objective : To increase the cure rate for tubercular patients under case management from 70% to 80% between now and 2005
This will involve improving case management of patients undergoing treatment, with special emphasis on case management for people under directly observed treatment (DOT), making tuberculostatic drugs continuously available in health centres for patients suffering from pulmonary tuberculosis testing positive following microscopy, access to second-line medicaments for chronic multi drug resistant patients, and community acceptance of financial liability for patients co-infected with tuberculosis and HIV.

Area of intervention 2: detection of illnesses and monitoring of quality of microscopy:
Main Objective: To increase the detection rate for cases of persons testing positive for pulmonary tuberculosis (tpm+) following microscopy from 53% to 65% between now and 2005, thanks to quality-controlled microscopy
This will involve increasing the detection rate of cases of persons testing positive for pulmonary tuberculosis following microscopy in the DRC by training and retraining technicians, and by supplying 800 diagnosis and treatment centres with microscopes, small-scale equipment and reagents.
In addition, quality control for the Ziehl smear strips will be organised on a network basis, to reduce the divergences between the results from the CDT's and those from the test laboratories.

Area of intervention 3 : social mobilisation through IEC:
Main objective: To mobilise target communities and groups with a view to improving the detection and cure of tuberculosis.
The IEC cells are to be re-organised on a national scale and the directives are to be updated for effective social mobilisation across the country through all layers of society, in particular schoolchildren, students, young peoples' associations and mass communicators (educators, journalists, leaders of various mass associations).

Area of intervention 4: Strengthening of technical skills and institutional capacities on a national scale, and provincial co-ordination:
Main objective: To improve the technical and institutional capacities at the national level and the 22 provincial co-ordination schemes.

This involves refurbishing and equipping offices and laboratories on a national scale and in connection with the 22 provincial co-ordination schemes.
There are also plans for training sessions, refresher courses and participation in international forums and congresses for the officials of the national office and the provincial co-ordination schemes
In order to improve the programme management, it is planned that each year during the project there will be financial audits and external technical consultations.

- **Indicate the beneficiaries of the proposal by component, and the advantages from which they might benefit**

As regards the case management of patients undergoing treatment, the beneficiaries are all the patients tracked down and given treatment over the three-year period between now and 2005, estimated at 265,800, of which 133,000 are persons testing positive for pulmonary tuberculosis following microscopy (spitting Koch bacillus).
As regards the detection of cases and the quality control of the microscopy, the beneficiaries are all those suspected of being ill, those first-line and second-line tubercular sufferers tracked down (chronic multi-resistant), evaluated at more than 3,000,000 people, whose priority need will be bacilloscopy, between now and 2005.
As regards social mobilisation through IEC, the beneficiaries are the population in general, but in particular the schoolchildren, pupils and young peoples' associations. Next come trained mass communicators (educators, journalists and leaders of various mass associations) on all levels, especially from the health centres on the periphery, and finally the officials from the national office (IEC cell) and from the provincial co-ordination schemes.
As regards the strengthening of technical skills and institutional capacities, the beneficiaries are the officials of the national office and the provincial co-ordination schemes, with the offices and laboratories of the Ministry of Health.

- **Describe the aims, objectives and general activities by component, including the results expected and the schedule to attain these results:**

Component Malaria:

Malaria is one of the most serious causes of morbidity and mortality in the DRC. Numerous factors, such as the appearance of strains of *Plasmodium falciparum* resistant to chloroquine, the dilapidated state of the health infrastructures, the lack of co-ordination of anti-malarial activities, the low level of community involvement, and the difficult socio-economic situation have hampered an effective struggle against this endemic disease for several years. Nevertheless, since the launching of the "Roll Back Malaria" initiative (RBM) in 1998, the government and its partners have initiated specific campaigns aimed at reinvigorating the struggle against this scourge.
The aim pursued by this proposal is to contribute to the reduction of morbidity and mortality in the DRC. Our objective is to achieve a 20% reduction in the number of cases and deaths due to malaria in children under 5 and pregnant women in 90 selected Health Areas (ZH) between now and 2005. The activities will be carried out in the following areas of intervention: prevention by use of mosquito nets impregnated with long-lasting insecticides (MII), correct case management, intermittent presumptive treatment for pregnant women, epidemiological monitoring, strengthening of the technical and management capacities of the programme and strengthening of partnership for community mobilisation. These activities will be carried out in partnership with the local implementation agencies in 29 ZHs in 2004 and 22 ZHs in 2005.

The results expected in the intervention zones are: in 60 % of households, children under 5 and pregnant women will sleep under MII's; case management will be correctly assumed for simple and serious cases of malaria in 75% of health organisations; financial responsibility for at least 20 % of cases of simple malaria will be correctly assumed by the community; 80 % of women attending pre-natal consultations will receive intermittent presumptive treatment with sulphadoxine-pyrimethamine (SP); 15 sentinel sites for monitoring the progress of the RBM campaign will be operational; the technical and management capacities of the programme will be reinforced and the RBM partnership will be in place at national, provincial and community level.

- **Specify the beneficiaries of the proposal per component, and the benefits expected to accrue to them** (including target populations and an estimate of their number):

The total population covered by this intervention is 18,544,954 million, i.e. 30% of the total population. The target groups are children under 5 (3,708, 990) and pregnant women (741,800).

- **If there are several components, describe the synergies, if any, expected from the combination of the various components** (By *synergies*, we mean the added value the various components bring to each other, or how the combination of these components may have effects beyond the effects each component taken individually):

The proposal submitted to the Global Fund is complementary to existing financing provided by the Congolese government and the donors for the implementation of the national action plans for combating HIV/AIDS, tuberculosis and malaria, in particular the priority components in the areas of prevention and of the case management of infected and affected persons by the strengthening of institutional and associative capacities.
Apart from the results expected in each of the components, the supplementary benefits expected are:

- better social acceptance for infected persons, in particular where the risk of exclusion is high
- reduction in risk of discrimination and access to individual and family rights, in particular as regards the right of inheritance when a member of the family dies.
- better taking into account of the twin factors of prevention and case management

Through these three components, the project is integrated into the national policy for combating HIV/AIDS, tuberculosis and malaria. This approach should make it possible to perpetuate the provisions for care and prevention and to maintain the institutional commitment of the national and international organisations involved in the implementation of the project.
An improvement in the health system of a specific and direct nature, to the extent that all the experience obtained through the present proposal in the area of scientific knowledge and the development of professional practices will have a knock-on effect in other public health areas.
A reduction in the social and economic impact of these pathologies
An improvement in access to treatments and to their observance
An improvement in the capacity for assuming psychosocial financial responsibility by associative and community mediators.
Through the formulation of an effective national response revolving around a multi-faceted governmental approach, the involvement of civil society and the private sector, and commitment on the part of the community, the intention is to mobilise all elements of society in order that each may make an effective contribution to the fight against these three pathologies. It is true that several links do exist between them, the

most significant of which concerns the fact that the three of them represent a major public health problem with regard to their prevalence, but also with regard to their impact on the health of communities.
Also, due to the fact that throughout the formulation of this application the health professionals made clear their support for underlining the links and synergies between the three components, the persons welcomed at the various case management and prevention centres will benefit from a coherent intervention logic. If we take, for example, women who are pregnant, a global response revolving around the risk of infection by one or other of these pathologies can only reinforce the range of care and preventive measures available from pre-natal consultations and consequently considerably reduce the morbidity and mortality of mothers and children. The same applies for persons in a co-infection situation. In addition, taking into account the determinants of vulnerability common to the three components will make it possible to reduce them in a concomitant manner so that the persons concerned have access to a multi-factor global response.

By reducing the vulnerability factors, it is possible to reduce the impact of these pathologies on the health of populations and their adverse social and economic consequences. Moreover, the joint reflection which took place in connection with the formulation of this present proposal made it possible to capitalise on the professionals' know-how and for them to make mutual commitments regarding prevention and case management. The links and bridges created by the players in the area of the fight against HIV/AIDS, tuberculosis and malaria, in particular as regards co-infected patients, are bound to widen the partnerships' outlook and the inter-disciplinary collaboration. Finally, the participation of the mediators, the true interface between the health professionals and the patients, but also between the professionals from the various components, provides an opportunity to reinforce the synergies and the coherence of the interventions.
The three components of the proposal from the DRC are synergetic on the following levels :

1. health structures, the strengthening of which on the technical level is profitable for each component and for the health system in general
2. health personnel, the training and retraining of whom are profitable for the entire target population
3. the important role of the community, the strengthening of the technical and financial capacities of which, and the greater degree of involvement, will allow it to play its support role in implementing the proposal better
4. on the strategic level, the 3 components of the proposal utilise prevention, case management, follow-up work/evaluation and epidemiological monitoring.
   Even if there are specific factors linked to the diseases, these well-harmonised strategies can provide a good deal of support in relation to the efficiency of the programme
5. the synergies (HIV/ tuberculosis, malaria (anaemia) /AIDS (transfusion) and malaria / mother-child HIV transmission) are well known. The present proposal places special emphasis on case management for HIV positive persons suffering from tuberculosis, children and pregnant women, who are often transfused following malarial anaemia, which is very frequent in the DRC, in the context of an insufficiency of HIV-tested blood.
6. PTMC, included in this proposal, will allow numerous children born to seropositive women to remain healthy as regards HIV/AIDS infection in the context of malarial endemic and resistance to standard anti-malarial drugs.

SECTION II: Information about the applicant

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal (Guidelines par. 14–15)	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines par. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines par. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines par. 27)*	1–9 and 11
Non-CCM	In-country proposal (Guidelines par. 28–30)	12 – 16
Regional Non-CCM	Regional proposal (Guidelines par. 31)	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines par. 32)

Country Coordinating Mechanism (CCM),

Table IIb

Preliminary questions	**(Yes/No)**
a). Has the CCM already applied to the Fund in previous rounds?	yes
b). Has the composition of the CCM changed since the last application?	yes
c). If the composition of the CCM has changed, briefly outline main changes: Expansion of committee to include working parties for 3 diseases, the Speaker of the Parliament, and the 1 trades union confederation of the country, together with recipients (BCECO and UNOPS).	

1. **Name of CCM**:

National Co-ordination Committee of Global Fund to Combat AIDS, Tuberculosis and Malaria in the DRC

2. **Date of constitution of the current CCM**:

   27th February, 2002

3. **Describe the background and the process of forming the CCM**:

   In the name of the Government of the DRC, on the instructions of the Minister of Health, a commission was established to apply the instructions of the GFATM: inventories of usual partners in the fight against the 3 diseases, proposals from members to the Minister, convening of meeting of CCM and granting of official status to CCM by ministerial decision.
   Adhesion by signature of the first submission by all members of CCM.

3.1. If the CCM already exists or includes an existing body, please briefly describe work previously done, programmes implemented and results achieved:

Since its creation, the CCM has had to make decisions on the first and second submissions to the Global Fund by the DRC, and this following working meetings and the appending of the signatures of the members of the CCM. These submissions were made following residential drafting and elaboration workshops, plus several meetings of the technical secretariat. This working method has made it possible to develop the participatory and consensual process on which the submissions of the CCM of the DRC are based.

4. Describe the organisational processes:

The National Global Fund Coordination Committee comprises:

- Co-ordination Committee Executive, made up of 4 members and chaired by the Minister of Health,
- Co-ordination Committee Secretariat, run by Directorate for Research and Planning of Ministry of Health (DEP),
- two special commissions (financial and technical)
- ordinary members.

See general annex I.

5. Describe the mode of operation of the CCM (e.g. frequency of meetings, functions and responsibilities of CCM. Append reports or minutes of previous meetings, (1 paragraph):

The Secretariat carries out the preparatory work for meetings and prepares proposals for decision, and makes available to CCM members the documentation required for decisions to be taken; the chair of the CCM convenes and chairs meetings and the CCM assembly which takes decisions following discussion. Ordinary meetings are held every three months and extraordinary meetings are held when they are felt to be necessary. See general annex II.

6. Describe plans to enhance the role and functions of the CCM over the next 12 months, including plans for promoting partnerships and for extending participation, together with plans for communication with other stakeholders, if necessary (1 paragraph):

- Ensure better co-ordination for drawing up and implementation of projects for the Global Fund to combat HIV /AIDS, tuberculosis and malaria in the DRC.
- Approve projects to be submitted to Global Fund to combat HIV/AIDS, tuberculosis and malaria in the DRC
- Contribute to effort to mobilise resources for combating HIV/AIDS, tuberculosis and malaria in the DRC
- Follow up management mechanisms and procedures of Global Fund to combat HIV/AIDS, tuberculosis and malaria in the DRC
- Ensure follow-up and evaluation of these projects
- In the long term, the CCM will make it possible to develop/reinforce collaboration between the various partners of the DRC with regard to combating HIV/AIDS, tuberculosis and malaria.
- Expand the CCM, if necessary, with a view to involving new partners

7. Members of CCM (*Guidelines, par. II.16 – 22)*:

Please print additional pages if necessary, including the following statement:

"We the undersigned hereby certify that we have participated throughout the CCM process and that we have had sufficient opportunities to influence the process and the application herewith. We have reviewed the final proposal and are delighted to support it. We further pledge to pursue our commitment within the CCM if the proposal is approved and as it moves to implementation"

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Government : 1) Ministry of Health 2) Ministry of International Co-operation 3) Ministry of Planning 4) Ministry of Finance	**Prof. MASHAKO MAMBA N.L.** Mrs. KIRONGOZI MALIYABWANA MISAI KALUME NUMBI DENIS MATUNGULU MBUYAMU	President of the CCM Secretary General for International Co-operation Ministry of Planning Ministry of Finance		
Main role in CCM				
To convene and chair meetings, and to be responsible for inter-sectorial co-ordination				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Congolese Network of People Living with AIDS	Charles TSHILAMBA	Chair of People Living with Aids body		
Main role in the CCM				
To work towards the taking into account of the concerns of People Living with Aids in proposal				

* E.G., people living with HIV/ TB / malaria, NGO/ community organisation, private sector, religious/ faith groups, academic/ educational sector, public authorities.

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Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
NGO /community-based organisation : 1-BASICS 2-Damien Foundation 3-Médecins sans Frontières Belgium[1] 4-National Committee of NGOs for health 5-AIDS forum (ASF/PSI, SWAA, AMO CONGO, etc.) 6-National League for Combating Tuberculosis	 Dr Michel OTHEPA Dr Pamphile LUBAMBA Mr KAWADIO K Mrs GULUNGANA G. Dr KABOTO Gérard	 Representative Representative and Medical Director National Chair Chair Project Manager		
Main role in the CCM				
To ensure that the concerns of the community are taken into consideration – to participate in implementation of scheduled activities.				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Private sector: 1- Federation of Congolese Enterprises 2- UTEXAFRICA 3. National Agency for Public Bodies	 Mr ATIBU SALEH Mr YUMA MULIMBI Pr. NGUB'USIM MPEY NKA	 Director Director General Adm Ex. Sec		

[1] *See letter of withdrawal fromCCM in Annex II b*

4.Companies belonging to Pharmacists' Association	Mr. KALENGA T. KAMB.	Chair		
Main role in the CCM				
To ensure involvement of private sector and taking into account of their concerns and interests				

"We the undersigned hereby certify that we have participated throughout the CCM process and that we have had sufficient opportunities to influence the process and the application herewith. We have reviewed the final proposal and are delighted to support it. We further pledge to pursue our commitment within the CCM if the proposal is approved and as it moves to implementation"

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Religious/ faith group: 1-Muslim community	SHEIKH GAMAL LUMUMBA	President and Representative		
2-Church of Christ in Congo	Mgr. MARINI B.	Nat. President Representative		
3-Kimbanguiste Church	Rev. Dr BAZINGA	Legal Representative II		
4-Catholic Church	Father KABUNGA	Secretary General		
Main role in the CCM				
To make sure that the concerns of religious denominations are taken into account and that they are involved in the implementation of the activities selected.				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UN/Multilateral, bilateral institutions				
1) UNDP	HERBERT P	Resident representative		
2) WHO	Dr L. TAPSOBA	Representative		
3) UNAIDS	Dr MALICK C.	Adviser		
4) European Community	R. KOBIA	Chargé d'Affaires		
5) USAID	ANTHONY W. GAMBINO	Director USAID		
Main role in the CCM				
Technical and financial support for CCM				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Academic sector: College of Public	Patrick	Professor		

Health	KAYEMBE			
Main role in the CCM				
To contribute to evaluation of proposal through research activities/ campaigns scheduled in proposal.				

"We the undersigned hereby certify that we have participated throughout the CCM process and that we have had sufficient opportunities to influence the process and the application herewith. We have reviewed the final proposal and are delighted to support it. We further pledge to pursue our commitment within the CCM if the proposal is approved and as it moves to implementation"

Agency/Organisation (including type*)	Name of representative	**Title**	**Date**	**Signature**
Other: 1-Parliament 2-TUC of the Congo	Victor MUSONGELA	Co-ordinator		
Main role in the CCM				
To make sure that the role of the parliament in legislative and financial matters is taken into account, through the efficiency of the State budget's provisions for these 3 diseases. In addition, to make sure that workers' rights are respected, in particular those of the sick.				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Others Main beneficiary 1- BCECO 2- UNOPS	DIBOBOL K. ABOU TALL	Director General Co-ordinator		
Main role in the CCM				
To be responsible for financial management of Global Fund grant to DRC				

Agency/Organisation (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Task Forces: 1- HIV/AIDS 2- Tuberculosis 3- Malaria	 LEPIRA François MAMPUNZA M.M. MAKINA	 Director PNLS Chair Director a.i.		
Main role in the CCM				
To make sure that the members of the TASK FORCES for the various diseases are involved in the planning and following up of activities.				

*For example, people suffering from HIV/ TB / malaria, NGO/ community organisation, private sector, religious/ faith groups, academic/ educational sector, public authorities.

7.1 Provide as attachment the following documents for private sector and civil society CCM members:

- Statutes of organisation (official registration document)
- A presentation of the organisation, including the context and the background, scope of work, past and current activities
- Reference letters, if available
- Main sources of funding
  (see general annex III).

7.2 If a member of the CCM represents a broader group, please supply a list of other groups represented.

- **FEC**: according to the general directory of the FEC for the year 2002, 797 companies are affiliated to this federation.(see general annex IV)
- **Congolese Network of People Living with HIV**; ALPI plus, COSAHO plus CHECK UP for all, Femme Plus
- **TUC of the CONGO:** bringing together 172 trade unions (see general annex IV)
- **Companies which are members of the Association of Pharmacists:** 5 groups with 109 members. These are laboratories for research and for the production of drugs (7 members), sales and marketing companies for wholesale drugs (7 members), laboratories with a clinical orientation (2 members), Pharmaceutical dispensaries in urban areas (80 members), and in rural areas (programme for integrating pharmacists into rural health areas) (255 members), health press organ (1 member). See general annex IV.
- **National Association of Stock Exchange Companies**, organised in eight Professional Committees which cover the following sectors: Basic infrastructures (CPI with 5 members), Transport (CPT with 6 members), Services and Import-Export (CPS/IMPEX with 19 members), Energy and Hydrocarbons (CPEH with 5 members), Mines and Metallurgy (CPMM with 10 members), Communications (CPCO with 5 members), Agriculture and Stock-rearing (CPAE with 7 members, ENVIRONMENT, Hotels and Tourism (CPEH with 5 members)
- **European Community**: 15 member countries: Germany, Austria, Belgium, Denmark, Spain, Finland, France, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, United Kingdom, Sweden
- **FOSI**: Forum of NGOs on AIDS, with 60 member associations (see general annex IV)
- **HIV/AIDS TASK FORCE** (Expanded Technical Group of UNAIDS): comprises 8 working parties, namely: Social mobilisation (10 members), Transfusion safety (8 members), Sexually transmissible infections (4 members), PMCT (4 members), Case Management (7 members), Epidemiological monitoring (5 members), Research and laboratory (5 members), Management and co-ordination (4 members), see general annex IV
- **TUBERCULOSIS TASK FORCE**: Office of Minister of Health, Directorate for Research and Planning, Board 4 - Epidemiology, Board 3 - Drugs and Laboratories, Board 5 - Primary Health Care, USAID, Sanru, Belgian Co-operation, European Union, Damien Foundation, Leprosy Mission, WHO, UNAIDS, PNLS, National Anti-tuberculosis League
- **MALARIA TASK FORCE** : 20 members, including WHO, UNICEF, BASICS, PNLP, Board 4 - Epidemiology, Board 3 - Drugs and

Laboratories, Board 5 - Primary Health Care, SANRU, ESP, CDC, USAID,

- Médecins Sans Frontières/Belgium, Médecins Sans Frontières/France, Epicentre, Pharmaceutical Faculty, Faculty of Medicine, Association of Drug Producers, CEMUBAC, Ministry of the Environment, Ministry of Public Works, PATS/UE, HCR, Diocesan Office of Medical Works
- **National Committee of Health NGOs (NCHO):** 10 platforms representing 145 NGOs: Network of medico-social organisations (NMSO), (29 members), Women's Health NGO Network (REFOS) (41 members), Development NGO Internal Network (RIOD) (8 members), State Health Institution Managers Internal Network (3 members), FECOCA/WHO (5 members), network of NGOs for widows, orphans, disabled persons and destitute people of the Congo (7 members), Union of NGOs for Integrated Health in the Congo (COSIC) (11 members), Network of United Nations Volunteers in the Congo (REVO-NUC) (13 members), CCAS (16 members) Union of Health Development Consultants (2 members) Others (10 members) see general annex IV

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	Alternate Chair/Vice-Chair
Name	Mashako Mamba	Kalume Numbi
Title	Ministry of Health	Ministry of Planning and National Reconstruction
Address	Avenue du 30 Juin NR 3088 Kinshasa /Gombe DRC	Avenue des Coteaux NR 4155 Kinshasa /Gombe DRC
Telephone	+ (243) 8802765	+ (243) 8802768
Fax		+ (243) 8804562
E-mail	cabsante-rdc@raga.net,	plareco@yahoo.fr
Signature		

9. Contact persons for issues regarding this proposal:

Please note: the persons listed below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the RBM members.

Table II.9

	Primary contact	Second contact
Name	Dr Makamba Mbonariba Audace	Dr Lepira Bompeka François
Title	Director and Departmental Head of Directorate for Research and Planning at Ministry of Health	Director of National Programme for Combating HIV/AIDS
Address	39, Avenue de la Justice, Gombe/Kinshasa	Avenue de la Démocratie (ex. Huileries) Gombe/Kinshasa.
Telephone	+(243) 0817005479	+(243) 08947564
Fax		
E-mail	bepsante@ic.cd	dirpnls@ic.cd

10. For coordinated regional proposals and Small Island States proposals, describe how submitting this regional proposal adds value beyond the national framework / what a national proposal might achieve *(Guidelines, par. II.24),* (1 paragraph):

The proposal from the DRC is national in the sense that it concerns several regions of the country, which it had not been possible to cover due to conflicts. Current events and the agreements, which the Government has just signed, re-introduce the need for a public health policy with regard to the crying needs of those populations which the conflicts had excluded from the range of care offered by the public authorities. Nevertheless, in its section on the prevention and reduction of HIV and STI risks, the present proposal takes into account the presence of foreign troops and of contingents of soldiers, some of whom come from countries where HIV is very prevalent.
Therefore, to prevent risks of exposure for soldiers and for the local populations, prevention campaigns will be organised, which conveys added value at the sub-

regional level, both in border areas and in cross-border areas. Several partners will be associated with these initiatives, in particular the HCR and the MONUC (UNITED NATIONS ORGANIZATION MISSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO), together with NGOs.

10.1. For co-ordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g., letter of endorsement from Chair/Alternate of CCM or equivalent documentation).

11. Sub-national Proposal from Large Countries

11.1. Explain why a sub-national CCM mechanism has been chosen (1 paragraph):

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans *(Guidelines par. II.27),* (1 paragraph):

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment *(Guidelines par. II.27),* (e.g., letter of endorsement or equivalent documentation).

Non-CCM applicant

12. Name of applicant: Not applicable

13. Representative of organization applying:

Table II.13

	Representative	Alternate
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	Secondary contact
Name		
Title		
Address		
Telephone		
Fax		

E-mail		

15. Description of applying organization

15.1. Indicate what type of organization the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organization (NGO) or network of NGOs
	Community based Organization (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Institution
	Faith-based Organization
	Regional Organization
	Other (please specify):

NOT APPLICABLE

15.2. Provide as attachment the following documentation:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

NOT APPLICABLE

16. Justification for applying outside the CCM: not applicable

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons; *Guidelines par. II.28–29*), (1–2 paragraphs):

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g. Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?**

16.3 Include letters from supporting organizations (e.g. human rights groups, NGO networks, bilateral or multilateral organizations, etc) supporting your reasons for not applying through a CCM as attachment.

NOT APPLICABLE

17. For regional proposals from Regional Organizations or International Non Governmental Organizations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines par. II.24),* (1 paragraph):

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

SECTION III: General information about the country

General information about the country

-	Area	2,345,000 Km2
-	Population	60,000,000
-	Rural population %	inhab.
-	Growth rate	70%
-	Birth rate[2]	3%
-	Infant mortality rate per 1,000 live births	48 ‰
		127

See general appendix III.

18. Describe burden or potential burden of HIV/AIDS, tuberculosis and /or malaria:

As regards **HIV/AIDS:**

1. Notification of cases:

The data available give only a partial reflection of the reality, in view of under-notification, aggravated by the war situation obtaining in the DRC.
In fact, whereas 1,300,000 cases of AIDS were expected, only 85,058 cases have been notified, i.e. 6.5%.

2. Prevalence of HIV positive persons/AIDS:

5% on average, although recent studies carried out in the Eastern provinces, in particular in Kalemie (SAVE THE CHILDREN, UK 2001) report figures of the order of 24.2% among pregnant women. This prefigures a catastrophic situation.

- Number of people living with HIV (epidemiological report, UNAIDS 2002):
adults 15 to 49 and children 0 to 14: 1,300,000 cases

3. Incidence of HIV:

New cases of infection expected for year 2001 (Projection Spectrum, PNLS) :	
-Men	77,790
-Women	103,42
-Children	0
	34,580

Number of deaths (2001):
-Deaths due to AIDS Total: 120,000

3. **Blood safety**: Only 3% of blood is tested (National Blood Transfusion Programme)
4. **Rapid propagation factors**:

- Migration/mobility in connection with war (refugees, displaced persons, men in uniform, sexual violence, street children/children, etc)

[2] *Rural environment : 50%o - Urban environment 38%o*

6) **Low use of condoms: 13%**

TUBERCULOSIS:

As regards tuberculosis, the DRC is classified as 11th among the 22 worst affected countries in the world, and as the fourth worst affected country in Africa.

Indicators:

- Incidence for 100,000 inhabitants	301 acc. to WHO (i.e. 156,000 cases)
- Total cases notified in 2000	66,906 (111 for 100,000 inhabitants)
- New smear positive cases	42,054
- Detection rate in 2001	53%
- Breakdown of cases by age group:	
0 - 14	1,423
15 - 54 (productive age)	35,407
55 - plus	3,620
- TB/HIV co-infection rate (WHO estimate, 1999)	50%
- DOTS coverage (in 2001)	70 %
- Cure rate (calculated on the 2000 cohort)	70 %
- Completed treatment (calculated on the 2000 cohort)	9%
	6%
- Deaths (calculated on the 2000 cohort)	1%
- Failure (calculated on the 2000 cohort)	8%
- Abandoned treatment (calculated on the 2000 cohort)	4%
	40%
- Transfer (calculated on the 2000 cohort)	3 to 4 months per bout
- % death from TB due to HIV (WHO)	
- Number of working days lost for 1 tuberculosis patient (STOP TB)	

MALARIA:

Malaria is the prime cause of morbidity and mortality in DRC. This endemic represents economic losses for productive sectors and is a priority health issue.

Indicators:

- Number of cases of malaria acc. to the IRC/OCHA[3] survey in 2001:	10.06 million including:
Total	59 to 86 %
Children	
- Number of cases of death due to malaria	500,000 cases
Total	37 to 60%
Children	5%
Pregnant women (PNLP 2001 survey)	41.1%
- Prevalence of fever among children under 5 years old (MICS II survey in 2001)	10
- Number of bouts of fever among children under 5 years old (PEV/LMT 1998 survey)	52%
- Anti-malaria treatment of children (MICS II 2001 survey)	0.8%
- Treatment of fever by Sulfadoxin-Pyrimethamin (SP)	7%
- Correct case management of anti-malaria patients (PNLP	

[3] *OCHA = Organisation for the Coordination of Humanitarian Affairs*

2001survey) 85%

- % blood transfusions in paediatrics due to malaria in Kinshasa 3
- Number of hospital beds out of 10 in Kinshasa hospitals occupied by malaria patients 60% of harvests lost
- % agricultural losses during outbreaks of epidemics: 29 to 80 %
- Rate of resistance to chloroquine treatment (PNLP, 2001 survey):

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; *Guidelines par. III.39),* (1–2 paragraphs):

1. Context:

   - Gradual deterioration of the economic situation worsened by:
   - Break in structural cooperation since 1990
   - Pillage of 1991 and 1993
   - War of liberation in 1996
   - War of aggression from 1998 until now (2,405,000 displaced persons/refugees, OCHA, 2001 report)
   - Foreign debt, 13 billion USD as to 31 December 2000 (report by the Central Bank of Congo).

2. Economic indicators:

- Human Development Index (UNDP 2001 report)	:0.429 in 1999 (142nd out of 162 countries)
- Human Development (ISDH, UNDP / DRC 2000 report)	:0.442
- HPI (UNDP/DRC 2000 report)	:36.5
- GNP per capita (Central Bank of Congo)	:74 USD
- Life Expectancy at birth (UNDP/DRC 2000)	:45
- Annual average inflation rate 1990-1999 (PRSD 2002)	:787%
- % of population living with under 0.20 USD per day (PRSD 2002)	:76%

3. Opportunities:

   - Resumption of programmes with the World Bank, IMF and ADB
   - Measures of macro-economic stabilisation
   - Poverty Reduction Strategy Document (PRSD/DSRP) drawn up
   - Multi-sector emergency programme for reconstruction and rehabilitation (PMURR) drawn up and amply funded by WB (454 million USD)
   - Good governance
   - Strengthened public/private partnership
   - Intercongolese Dialogue (prospects for political stability), Sun City, Pretoria and Luanda agreements
   - Anti-tuberculosis drugs made available by the Global Drug Fund

- Health system making it possible to reach the health areas in areas of conflict via decentralised coordination offices at intermediate level (provincial and area medical inspections)
- Facilitation for communications by United Nations humanitarian organisations.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislation, etc.; *Guidelines par. III.40),* (1–2 paragraphs):

- State Budget in 2002
  - Public investment for resources - 21,878,O82 USD
  - Investment proportion for health - 1,556,646 USD i.e. 7%
  - Operating expenditure - 4,109,587 USD
  - Proportion of operating expenditure for health - 1,320,034 USD i.e. 32%
  - Total operating investments - 26,087,671 USD

- Multi-sector emergency programme for reconstruction and rehabilitation (PMURR) in DRC (PMURR) 2002-2005: 454,000,000 USD, including 49,000,000 for health, i.e. 10% (IDA loan)
- Existence of policies, strategic plans and Task Forces for programmes to fight HIV/AIDS, tuberculosis and malaria.

21. Financial context

21.1. Indicate the percentage of the total government budget allocated to health*:

Total State Budget : 26,087,671 USD
Proportion for health : 2,876,680 USD i.e. 11%

N.B. the PMURR budget of the government of 454,000,000 USD for 3 years is not included in this amount (10% is earmarked for health).

21.2. Indicate national health spending for 2001, or latest year available, in the Table III.21.2*:

Table III.21.2

	Total national health spending Specify year: **2001-2002** (USD)	**Spending per capita** (USD)
Public (2001)[4]	**3,008,499**	**0.05**
Private (2001)[5]	European Community ECHO 35,000,000 PATS 17,065,577 UNICEF 5,060,000 USAID 37,180,695 BELGIAN COOP.	

[4] *Source: Budget of the DRC Government 2001*

[5] *Source: Ministry of Health 2002*

	18,883,897 ITALIAN COOP. 1,000,000 WHO 8,190,589 GERMAN COOP. 1,100,000 UNDP consolidated appeal 38,801,321	
Total	**137,900,648**	2.29
From total, how much is from external donors?	**134,892,149**	2.24

21.3. Specify in Table III.21.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:**

Table III.21.3

Total earmarked expenditure from government, external donors, etc. Specify Year:2001	**In US dollars:**
HIV/AIDS	19 490 366
Tuberculosis	3 950 666
Malaria	1 758 963
Total	**25,199,995**

Sources: Budget 2001

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives*, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)**:

Owing to the break in actual structural cooperation, the country does not benefit from external budget support – external Interventions take place as part of humanitarian and emergency aid.

In 2001, the Country benefited from 137 million US dollars in the health sector and the 3 diseases were included in it. In 2002, as part of the fight against HIV/AIDS, the Country received a donation of 32.27 million US dollars from various partners as shown in item 22.2 of the table. The Country received 17,716,500 USD for the fight against tuberculosis.

Among future prospects, we a hoping for an 80% reduction in the Country's debt (almost 10 billion USD) as part of the debt-relief initiative for HIPCs (announcement by the President of the World Bank on 13 July 2002). The Paris Club has already wiped off over 4.5 billion.

We are hoping to receive over 15 million USD from the ADB and 5 million USD from Belgian Cooperation for the fight against HIV/AIDS in 2003. Other partners have not yet determined their contributions.

22. National programmatic context

* *HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank*

** *Optional for NGOs*

22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines par. III.41 – 42*), (2–3 paragraphs):

There is a National Committee with a Central National Executive, Provincial Offices and TASK FORCES for each of the 3 programmes. These teams are organised by National Executive staff. The funds are managed by the partners or selected NGOs.

The DRC health system comprises three levels. Each level has its specific role:

- **The operational level: is the Health Area (Zone de Santé - ZS), *basic health planning unit*.** The Health Area (ZS) is a health constituency included within the boundaries of a municipality or a territory, created by an interministerial decree by the Minister of the Interior and the Minister of Health. The role of the Health Area is the planning and development of baseline health activities, in accordance with the country's health policy.

  At this level, the DRC has opted for a two-tier health system:

- The first tier or **echelon** is a network of health centres whose mission is to offer a minimum package of Primary Medical Aid (Minimum Package of Activities PMA) services, with community participation;

The PMA is the standard medical output common to all the structures of the country's health system. This package is a set of activities which, once established in a Health Centre, make it possible to absorb new interventions without infringing requirements related to work organisation, Health Centre funding and staff workload.

The PMA is designed to facilitate health planning, rational management and fairness in the distribution of resource as well as the evaluation of Health Area action plans.

The PMA comprises curative, preventative, promotional and social activities, where the tasks are delegated to nursing staff under the supervision of the ZS supervisory team. These tasks are standardised in the form of instructions or organisation charts.

- **The second echelon** is the General Reference Hospital (HGR) which offers a complementary package of reference health care activities (Package of Complementary Activities - PCA).

The PCA is the standard medical *output* common to health services of the first level of reference, in order to complement the minimum package of activities of the health centre. The role of the reference level is to ensure the continuity of care to patients who require a range of techniques not available at first level for economic, technical and organisational reasons.

The two care echelons are connected between them by a reference and counter-reference system.

Health care institutions (Health Centres and hospitals) may belong at the same time to the State, religious denominations, to State public corporations, to natural or artificial private persons and may be profit or non-profit making. Private institutions like those belonging to religious denominations must be approved by the Ministry of Health.

The role of the executive team covering the BCZS/HGR (Health Area Central Office/General Reference Hospital) combination is to coordinate and structure the entire system properly.

In front-line areas, interventions take place through international NGOs and/or United Nations agencies.

- **The intermediate level is the Provincial Health Executive** and its divisions. Their role is to provide *technical support to the* ZS with coordination, training, follow-up, supervision, monitoring, evaluation, inspection and control functions.

The Health District is the relay between the Provincial Executive and the Health Area.

The Country is divided into 11 Provinces and 48 Health Districts and 306 health areas currently being broken down into 500 sub-areas.

- **The central level** is the ***Cabinet of the Minister***, the ***General Health Secretariat***, ***central executives*** and ***specialised programmes***. These structures play a *statutory role, a coordination and strategic guidance role*.

Consultation mechanisms are provided at all levels of the system and a guideline document for health sector partners (vade mecum) has been drawn up with the involvement of all the partners of the sector.

First-rate human resources are available and would deserve to be motivated in order to make the system more effective.

The social and health infrastructure heavily destroyed by the war is currently being rehabilitated with the help of partners.

At the present time, 60% of the 306 Health Areas are operational.

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes[**]:

As far as HIV/AIDS is concerned:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programmes** (for example, comprehensive HIV/aids prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period) 2002

[**] *For NGOs, specify here your own partner organizations*

WORLD BANK	Multilateral	Prevention, safe blood supplies, case management of STIs and opportunistic infections	8,000,000
UNDP	Multilateral	Activities producing income, voluntary screening and counselling, case management of STIs and opportunistic infections	1,000,000
UNICEF	Multilateral	Mother-child transmission, raising awareness among young people	833,000
UNFPA	Multilateral	Comprehensive prevention of HIV/AIDS (reproductive health, Youth Centre)	6,118,487
WHO	Multilateral	Comprehensive prevention and case management of HIV/AIDS (epidemiological surveillance, case management of STIs and opportunistic infections, safety of blood supplies, ARV)	422,000
HCR	Multilateral	Comprehensive prevention of HIV/AIDS and case management among refugees	1,165,940
WFP	Multilateral	Food support to PLHIV	1,059,626
HCDH	Multilateral	Fight against stigmatisation and discrimination of PLHIV	not determined
ILO	Multilateral	Fight against stigmatisation and discrimination of PLHIV in workplaces in partnership with the Inter-company Committee to fight AIDS and the Business Federation of Congo	not determined
UNESCO	Multilateral	Raising awareness among young people in school	not determined
MONUC	Multilateral	Comprehensive prevention of HIV/AIDS and case management of STIs and AIDS for the benefit of the Blue Berets of the United Nations in DRC	not determined
UNOPS	Multilateral	Prevention of HIV/AIDS on renovated major roads	8,000
FAO	Multilateral	Support for farm production of infected or affected families	not determined
UNAIDS	Multilateral	National strategic planning, drawing up national policies and strategies for the case management of STIs, OIs and ARV, prevention of HIV/AIDS among young people, among students and among servicemen and policemen	458.000
Subtotal 1			**19,065,053**
IPPF	International NGO	Prevention: Training, IEC, Supply of contraceptives within the scope of reproductive health	$9,000

European Community	Multilateral	Prevention of HIV/AIDS: Staff training, Institutional support to NGOs in charge of implementing activities, Technical Assistance, Support for IEC implementation, Logistics Support, Support for the staff of NGOs involved.	$1,667,400
USAID	*Bilateral*	Prevention, support for social marketing of condoms, Training of community stakeholders, Institutional support, support for the implementation of IEC activities, Logistics support	$3,500,000
GERMAN COOP.	Bilateral	Support for PLHIV, Institutional support for the PNLS, support for safe blood supplies (Training, Technical Assistance, Supply, Logistics)	$500,000
ITALIAN COOP.	Bilateral	Support for IEC activity development, (Training, Institutional support, Technical Assistance, Logistics support)	$645,000
MSF Belgium	Bilateral	Support for IEC activity development (Training, IEC, Supply, Logistics, Staff)	$450,000
CHRISTIAN AID	Bilateral	Support for PLHIV and persons affected by HIV.	$127,090
CANADIAN COOP.	Bilateral	Institutional and logistics support as part of prevention actions	$25,000
FRENCH COOP.	Bilateral	Prevention: support for IEC activity development (Training, Technical Assistance, Institutional and Logistics support, Staff)	$46,538
BELGIAN COOP.	*Bilateral*	Prevention: Support for safety of blood supplies and IEC activities (Institutional and Logistics support, Technical Assistance)	$173,525
Subtotal 2			**$7,143,553**
GRAND TOTAL			**$332,250,069**

As far is tuberculosis is concerned:

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programmes** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period: 2003-2005)
WORLD BANK	Multilateral	- Supplies of second-line anti-tuberculosis drugs - Co-infection HIV/TB case management	300,000 (year 2002)
WHO	Multilateral	- Production and printing of training modules - Training support - supervision support	62,500 (Bienum 2002- 2003)

USAID	Bilateral	- Revision and printing of information media - Rehabilitation of premises - Supply of equipment - Training support - Supervision support	777,000 (2002-2003)
EU/Damien Foundation	Multilateral	- Investment - Supply of drugs - Training and supervision support - Additional salaries - Operational research	1,020,000 (2003)
BELGIAN COOPERATION	Bilateral	- Rehabilitation - Equipment - Operations - Training - Supervision - Research - Additional salaries - Supplies of drugs	2,586,800 (2003 to 2005)
LNAC (Ligue Nationale Antituberculeuse et Antilépreuse du Congo)	National NGO (National Association to fight leprosy and tuberculosis)	- Social mobilisation - Supplies of drugs - Logistics support For two Provincial Coordination schemes and a national team	200,000 (2003)
DAMIEN FOUNDATION	International NGO	- Rehabilitation - Equipment - Operations - Training - Supervision - Additional salaries - Supplies of drugs For eight Provincial Coordination schemes and a national team	10,078,408 (2003 to 2005)
THE LEPROSY MISSION INTERNATIONAL	International NGO	- Rehabilitation - Equipment - Operations - Training - Supervision - Additional salaries - Supplies of drugs For eight Provincial Coordination schemes and a national team	467,800 (2003 to 2005)

ALM (American Leprosy Mission)	International NGO	- Rehabilitation - Equipment - Operations - Training - Supervision - Additional salaries - Supplies of drugs For the Equateur-Nord Coordination	Not available
ALTI (Aide aux Lépreux et Tuberculeux de l'Ituri)	International NGO to aid Lepers and TB sufferers	- Rehabilitation - Equipment - Operations - Training - Supervision - Additional salaries - Supplies of drugs For the Ituri Coordination	Not available
SANRU	Local NGO (Protestant Church of Congo)	- Equipment - Operations - Training - Supervision - Additional salaries Primary care projects in 65 Health Areas	3,244,000 (2003 to 2005)
Grand Total			

As far as Malaria is concerned:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programmes** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
USAID/UNICEF UNICEF	UN Agency	Training and attending conferences Prevention and training	2001: 100,000 2002: 50,000 2001: 200,000 2002: 600,000
USAID/BASICS	International NGO	Case management at home, operational research and prevention	2001: 251,000 2002: 300,000
USAID/CDC	American government agency	Case management, operational research	2001: 362,000 2002: 506,000
USAID/IRC	International NGO	Prevention by fighting against vectors, environmental management	2001: 200,000
USAID/SANRU III	National NGO	Case management and prevention	2002: 329,000
USAID/WHO	UN Agency	Rehabilitation of	2002: 79,000

WHO		infrastructures Case management, training and surveillance	2002: 257,000
USAID/MAC	American government agency	Technical Assistance	2002: 150,000

22.3. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines par. III.41 – 42*), (2–3 paragraphs):

Pour HIV/AIDS
There is no programmatic intervention gap since the PNLS has an Interim Plan drawn up with the technical support of UNAIDS. By contrast, there is a drastic shortage of financial resources necessary for the implementation of the plan, especially in the following areas: drugs (ARV), condoms, PNLS management especially as far as human resources and their technical capability are concerned.

For tuberculosis
The major programmatic intervention and funding gaps in the country's current response to **tuberculosis** are:

The high costs of shipping anti-tuberculosis drugs from Kinshasa to the Provinces.
The acquisition of second-line drugs for the case management of chronic patients (multi drug resistant).
The lack of national consensus about prophylaxis at the NHI among persons infected by HIV.
The low detection rate and case management under directly observed treatment.
Little involvement by the community in case management.
The defective condition of infrastructures and equipment of some coordination schemes not supported by partners, requiring a strengthening of institutional capacities.
Shortage of competent and motivated staff.

As far as funding gaps are concerned, it may be noted that the programme has only called on 9,177,449 USD, up to 2002, out of a total of 42,745,189 USD earmarked in the 2001-2005 Master Plan. For the 2003 to 2005 period, the partners have promised 18,451,179 USD. These figures, however, only represent 65% of the needs of the PNT for the 2001-2005 period, i.e. a funding gap of 15,116,561 USD (35%).
It should however be pointed out that that the current trend of the political and socioeconomic context induced us to revise the downward ambitions of the 2001-2005 Master Plan to take into account the actual feasibility of coverage of some regions of the country (DOTS expansion).
The amount of 7,973,004 requested in this proposal takes that feasibility into account.

For Malaria
The joint efforts undertaken up to now do not cover needs in all the areas of intervention. Drug needs are only covered up to .....%, and mosquito nets barely cover 13% of needs in the areas of intervention. The surveillance system is not efficient enough, and no sentinel site is operational yet. Nevertheless, funding is available for starting activities in 9 sentinel sites out of the 15 forecast by the end of 2005 thanks to financial support from USAID/BASICS.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines par. IV.47 – 49).

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines par. 50).

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**	X	**HIV/AIDS**
		Tuberculosis
		Malaria
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

Component: Infection by HIV/AIDS

This component is structured around five areas of intervention:

Area of intervention 1: Community and institutional mobilisation

Main objective: *To mobilise institutional and community leaders to strengthen and maintain their involvement in the combat against HIV/AIDS*

It involves launching a campaign of mobilisation and partnership among political, private, religious, community and trade-union institutions and communities of people living with HIV/AIDS in order to obtain everyone's involvement, so guaranteeing a continued impetus to the fight against AIDS.

The main aim of this campaign of community mobilisation and participation aims to achieve progress in the representation of the target groups so that greater consideration is given to the seriousness of the HIV/AIDS epidemic and its dramatic consequences. It further aims to address the issue of the need to combat risks of exclusion and discrimination with regard to infected and affected persons.

The family has a major role to play in the support that it brings to the persons concerned, so the family must have the right information available so that the case management it proposes does not conflict with the recommendations of professional health staff, on the one hand, and also to avoid risks of exclusion due to ignorance and fear, on the other hand.

The involvement of new social players such as workers and their trade-union representatives is a major asset with regard to the prevention of risks of exclusion from the labour market. This framework is also a space where new methods of solidarity and mutual assistance could be designed inside companies in partnership with employers.

The involvement of religious leaders of all denominations, already highly present in the field of psychosocial care will make it possible to strengthen acceptance of affected persons in society so avoiding risks of stigmatisation and feelings of guilt. Everyone is free to pursue their personal approach to spirituality faced with the ordeal of disease while having the feeling of being heard and understood.

Lastly, the involvement of local and parliamentary representatives remains a future guarantee for a sustained supply of measures of care and prevention through the construction of a judicial and legislative mechanism.

Community leaders (CBO/NGO) play a major role of mediation between families and nursing staff, by developing concrete actions of mediation within communities. This campaign will take place gradually taking into account current interventions and/or the need to strengthen or build a multi-sector partnership and will initially focus on 5 Provinces. (Kinshasa, Katanga, Province Orientale, Equateur and Bas-Congo).

Area of intervention 2: Prevention and reduction of risks

Main objective: *To prevent risks of HIV/STI transmission within vulnerable sections of the population.*

This area of intervention takes into account the need to strengthen prevention in sectors where the risk is particularly high because of social or individual contexts where exposure is greater. It involves integrating this overall approach to the reduction of risks by addressing the different situations of vulnerability both within the target groups and within institutions where there is a drastic shortage of means.

Just like the actions undertaken for vulnerable groups, it is essential to ensure that there is a regular supply of preventative measures available together with a continuum of services allowing people to call on reliable and equipped services.
That is why strengthened safety of blood supplies is a major line of action, all the more so since the current percentage only assures the safety of 3% of blood donations. The strategy to improve the situation facing the country as a whole will focus on the strengthening of inspection of collected blood and compliance with quality standards. It also aims to promote and achieve the loyalty of a pool of regular donors. This means the need for a good communication strategy among the general public and opinion leaders and is linked to the theme of community mobilisation.

As far as public health is concerned, the area of prevention is also underpinned by the availability of condoms, which has proved to be effective in many countries.

The strategy involves strengthening and expanding the social marketing of condoms, especially in rural areas so as to make condoms more available and acceptable. In this way, by improving cost, geographical availability and acceptability, we will be able to measure the repercussion on behaviour in the next surveys.

Area of intervention 3: Overall case management of HIV/AIDS infection.

Main objective: *To strengthen overall case management of PLHIV and Infected People, integrated into a continuum of care.*

The Government of the DRC has therefore committed itself to a national policy with regard to people affected by HIV, which includes the prevention of Opportunistic Infections and the gradual implementation of a national public health policy allowing access to ARVs. This commitment by the Government recently materialised in ministerial decision No. 1250 /CAB/MIN/CJ/KIZ/09/02, dated 05 July 2002, concerning the accreditation of ARV treatment dispensation centres and doctors prescribing generic anti-retroviral (ARV) drugs. This national decision aims to regulate and regularise the rational and optimum use of ARVs in DRC.

This national initiative aims at a rational use of ARVs, which should make it possible to improve the quality of life of people living with HIV/AIDS, but also to reduce the impact of this disease.

The dynamics of this area of intervention come within this context and aim at strengthening and developing the overall case management of people living with HIV/AIDS through access to ARVs, to treatment and to the prophylaxis of opportunistic infections, in accordance with clinical, biological and immunological recommendations. On this occasion, patients are proposed multidimensional case management involving different health and social services. This action takes place on hospital and ancillary premises. Several stakeholders are concerned; health and social, institutional or associative professionals, together with health mediators from partner associations.

Key interventions involve voluntary counselling and testing (VCT), psychosocial support, home and community care and medical case management.
The implementation of these interventions requires close collaboration between nursing staff and members of associations, so as to clearly identify the patient circuit within the case management sites. Furthermore, several stages are planned to make this approach effective, namely: the strengthening of the human and material capacities of NGOs and the availability of treatment and improvement of circuits and dispensation procedures.

On account of the still prohibitive cost for many Congolese households, it is planned to set up a mechanism of national solidarity, and a mechanism to take into account the socioeconomic situations of people whose state of health might require access to ARV. In this way, the participation of community representatives, alongside health and social professionals will be encouraged in all decision-making bodies determining access to treatment, in particular the health and social eligibility committee.

Area of intervention 4: Prevention of transmission of HIV from mother to child (PTMC)

Main objective: *to strengthen and extend prevention of HIV transmission from mother to child by including the overall case management of the family unit.*

In the national strategy, the prevention of HIV transmission from mother to child must be gradually integrated into the prenatal consulting departments (PCD) where women have access to counselling and voluntary screening (VCT).

The prime objective of this area of intervention is to extend coverage of services by setting up 10 new PTMC sites. The second objective is to optimise interventions on existing PTMC sites, so that they become "PTMC plus" sites, as they are called. This approach aims to promote overall case management of pregnant women but also case management of the family unit. In order to do so, a system will be set up which should allow professional health staff to intervene by relying on the contribution by community mediators.

All these activities will complement area of intervention number 3 "Overall case management of infected persons" because after childbirth, women and children whose state of health requires medical case management will be directed towards reference centres.

Implementation will be ensured by the staff of the PTMC sites in collaboration and with the logistic support of national and international organisations and community associations involved in the combat against AIDS.

Basing calculations of a rate of frequentation of prenatal consulting (PCD) of 60% for year 1 of creation of the PTMC site, with a 10% increase during the following years, it is forecast that 28,500 women should be tested and 8506 seropositive women referred to treatment at the 10 new sites. At PTMC plus level, 4468 seropositive women will benefit from the support of community mediators.

Area of intervention 5: Epidemiological surveillance and qualitative management of information

Main objective: *To reinvigorate the HIV and STI surveillance system with a view to improving the national response to the epidemic.*

The national epidemiological surveillance system of the PNLS (National Plan to Fight AIDS) is mainly based on 2 approaches: routine surveillance and surveillance by sentinel sites.

Routine surveillance aims at monitoring morbidity and mortality related to HIV/AIDS/STI. It involves passively collecting data in the Health Areas. The data concern:

- cases of AIDS, Tuberculosis and STI diagnosed in hospitals and Health Centres
- cases of HIV infection among blood donors.

Until now, this routine surveillance system was characterised by the comparatively small number of cases notified, owing in particular to the multiplicity of data collection sheets and circuits, the overload of work at peripheral level, and weakness at coordination level, especially at intermediate level. This state of affairs led the Ministry of Health to

reorganise the notification system through the development of an integrated disease surveillance system (FDS). This new process is currently being implemented.

In 1999, the country opted for the second-generation epidemiological surveillance protocol. This included, in addition to the surveillance of a serological reaction to HIV and Syphilis, the surveillance of high-risk behaviour and practices. Up to now, this protocol could only be applied in 4 sites. The main reasons for this were the lack of trained staff in most sites, the shortage of equipment and input and the lack of monitoring and supervision.

In response to this situation, the Ministry of Health, through the PNLS, established a partnership with some NGOs and cooperation agencies, more particularly:

- WHO and UNAIDS (technical support),
- CDC/USAID (training for 4 sites: Goma, Kindu, Bukavu and Kisangani),
- Norwegian Cooperation (financing of 12 sites for one year) and Italian Cooperation (2 sites for one year).

The purpose is to obtain additional resources to extend coverage of this surveillance and to make it sustainable.
Implementation will be ensured by the staff of Health Areas and sentinel sites.

Strengthening of the epidemiological surveillance system will involve giving a fresh impetus to routine surveillance, extending surveillance coverage by sentinel sites, and setting up and effective system of information management and coordination. This strengthening measure will benefit from the opportunity offered by the World Bank by equipping the PNLS reference laboratory with the appropriate equipment.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	*End March 2003*	**To** (month/year):	*End March 2006*

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Table IV.26.1

Goal	**To reduce the spread of the HIV/AIDS epidemic and its impact on individual citizens, families, communities and productive sectors as part of the Multi-Sector Emergency Programme for Reconstruction and rehabilitation of the DRC (PMURR) and the poverty Reduction Strategy Document (PRSD/ DSRP)**	
Impact indicators *(Refer to Annex II)*	**Baseline** Year: 2002	**Target (last year of proposal)** Year: 2005
Prevalence of HIV among pregnant women from 15 to 24 years of age	5%	5%[6]
Availability of condoms	1.04	2.21
Life expectancy at birth	45	45
Rate of coverage by safe blood supplies	13%	25%
Rate of coverage with STI treatment	12%	25%

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Area of intervention 1: Community and institutional mobilisation

Analysis of the situation

It is an acknowledged fact today in all countries of sub-Saharan Africa that community-based organisations have a leading role to play in the combat against AIDS. Our area of intervention is based on the observation that, in DRC, few communities and institutions take an active part in the combat against AIDS, even though the latter are well organised and therefore represent an opportunity to extend and strengthen the combat against HIV/AIDS.

Of course, the country is experiencing a crisis situation, which imposes constraints, but, above all, it is faced with a new demand as the trend of prevalence of HIV/AIDS continues

[6] *Seroprevalence surveys are currently being conducted and will probably indicate higher prevalence rates*

to grow (see area of epidemiological surveillance). This situation requires the mobilisation of all social stakeholders in order to cope with it as effectively as we possibly can.

The response to the HIV/AIDS epidemic in DRC should not boil down merely to a medical response, because such a response is insufficient. It means that leaders of communities and institutions have to take a major part in this fight.

The political, social and economic issues of this epidemic, as it is taking shape in DRC, should lead us to organise a lasting riposte and a climate where HIV/AIDS can be openly talked about.

In this respect, the current trend of the sociopolitical situation is an opportunity.
It involves launching a national campaign of mobilisation and partnership between political, religious, community and, trade-union institutions, communities of people living with AIDS and the private sector to involve everyone's involvement in the fight.

The fight against AIDS becomes a priority in development programmes owing to the serious socioeconomic and political repercussions of this disease on society.

For the general population, AIDS remains a disease connected with a type of sexual behaviour and the transgression of social norms. It is not yet perceived as an internal attack on the family unit and the population is not yet sufficiently aware of the individual risk related to infection.

The main aim of this campaign to encourage mobilisation and community participation is to achieve progress in the representation of the target groups so that greater consideration is given to the seriousness of the HIV/AIDS epidemic and its dramatic consequences. It further aims to address the issue of the need to combat risks of exclusion and discrimination with regard to infected and affected persons.

In this way, community players should be involved, in all the stages of programme development, in their implementation. This campaign will be organised gradually taking into account current interventions and/or the need to strengthen or build a sector-wide partnership and will initially focus on 5 Provinces. *(Kinshasa, Katanga, Province Orientale, Equateur and Bas-Congo).*

At this time when the DRC is moving towards the availability of anti-retroviral therapies, communication about ARV treatment and screening require a good level of information so that the messages of political leaders, opinion leaders and media professionals are accurate and coherent. That is why our strategy involves promoting a reference system and a common corpus of knowledge based on scientifically validated learning. For example, the content of screening counselling should include information about the treatment of HIV/AIDS and ARV access programmes. It is the right time to disseminate information messages to the population to adjust the knowledge of each social player around often complex themes like the advantages and drawbacks of ARV treatment.

The family has a leading part to play through the support it brings to the persons concerned. That is why it must have the benefit of information, so that the case management that it proposes is not incompatible with the recommendations of professional health staff, on the one hand, and also to avoid risks of exclusion due to ignorance and fear, on the other hand.

The involvement of new social players such as workers and their trade-union representatives is a major asset in the campaign to prevent risks of exclusion from the labour market. This framework is also an area where new mechanisms of solidarity and mutual assistance could be designed within companies in partnership with employers.

The involvement of religious leaders of all denominations, already highly present in the field of psychosocial care will make it possible to strengthen acceptance of affected people in society by avoiding risks of stigmatisation and guilt feelings. Everyone will be free to pursue their personal approach to spirituality in addressing the issue of the disease while having the sentiment of being heard and understood.

Lastly, the involvement of local elected and parliamentary representatives is a further guarantee to make the available care and prevention measures sustainable through the construction of a judicial and legislative mechanism.

Community leaders (CBO/NGO) have a major role of mediation to play between families and nursing staff, by developing concrete mediation actions within communities.

The reflection into the place and role of community leaders in the health system and in particular in the fight against AIDS does not only mean proposing an answer to a legitimate question, but also and first and foremost, laying down the conditions necessary for harmoniously sharing responsibilities in the face of this epidemic. That is why the approach we recommend undertaking at national level involves enabling each citizen to take an active part in the fight against AIDS alongside professional health staff and public authorities.

The mediation approach is a permanent tool for dialogue, participation in the decision-making process and for keeping watch on the risks of exclusion or inequality.

In order to achieve this, training is an essential stage which strengthens the capacities of institutional and community players and brings them into contact with stakeholders in the social network whose mediation interventions they need.

Main objective: ***To mobilise institutional and community leaders to strengthen and maintain their involvement in the fight against HIV/AIDS***

Specific objectives:

1. *To involve opinion leaders and institutional leaders in the fight against AIDS*
2. *To strengthen capacities of intervention of opinion leaders and institutional leaders*
3. *To ensure the follow-up, supervision and evaluation of interventions by supported structures*

Specific objective 1: To involve opinion leaders and institutional leaders in the fight against AIDS

Table IV.27

Specific objective 1:	To involve opinion leaders and institutional leaders in the fight against AIDS			
Outcome/coverage indicators *(Refer to Annex II)*	Baseline	Target figures		
	Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005
1. Percentage of networks of leaders and heads of communities and institutions formed around a joint plea	***0***	**50%**	**100%**	

Table IV.27.1

Specific objective 2:	To involve opinion leaders in the fight against HIV/AIDS						
Broad activities	Process/Output indicators (one per activity) (Refer to Annex II)	Baseline	Target figures			Responsible /Implementing agency or agencies	Costs and source
		Year 2002:	Year 1: 2003	Year 2: 2004	Year 2: 2004		
1. Conducting a community diagnosis survey in the Provinces targeted by the project	Existence of the survey report	0	100%			Partners	52,280 (GF)
1. Setting up the inter-community plea network	Number of network secretariats set up	0	11			PNLS	P.M.
2. Workshop for developing or revising plea supports to each community and institution	Number of plea documents developed	7 plea documents to be revised	100%			PNLS	20,000 (GF)
3. Organising dissemination of the plea: • Television/broadcast • Radio/broadcast • Newspapers/articles & pub. • Production of commercials	Percentage broadcasting of programmes and commercials	10%	25%	50%	50%	PNLS Network	(Total GF: 150,000) 50,000 25,000 25,000 50,000
4. Community conferences in support of media campaign	Number of conferences organised		6 conf.	11 conf.	22 conf.		90,600 (GF)
Total amount requested from the GF for objective 1:							**410,600**

Specific objective 3: To strengthen the capacities of intervention of opinion leaders and institutional leaders

Table IV.27

Specific objective 3:	To strengthen the capacities of intervention of opinion leaders and institutional leaders			
Outcome/coverage indicators ***(Refer to Annex II)***	Baseline	Target figures		
	Year: 2002	ır 1: 2003	Year 2: 2004	Year 3: 2005
1.Percentage of institutional and community leaders trained around a common reference system	*0*	25%	50%	80%
2. Percentage of institutions and organisations supported by materials and equipment in 11 chief towns of Provinces	*0*	25%	50%	80%
3.Percentage of sector intervention plans drawn up and implemented	*0*	100%		

Table IV.27.1

Specific objective 2:	To strengthen the capacities of intervention of opinion leaders and institutional leaders						
Broad activities	Process/Output indicators	Baseline	Target figures			Responsible/ Implementing agency or agencies	Costs and source
		Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005		
1. Workshop for drawing up a common reference system	Number of copies of common reference system drawn up and distributed	0	3000			National executive of the PNLS	16,700 (GF)
2. Training leaders	Number of leaders trained per year	0	300	750	450	PNLS	154,990 (GF)
3. Providing coordination to network secretariats based on one NGO per Province	Number of secretariats supported	0	4	11	11	PNLS Network	390,000 (GF)[7]
4. Equipping networks and relay secretariats	Number of network secretariats equipped	0	12			PNLS	170,675 (GF)

[7] *The community mobilisation network is coordinated by one NGO per Province, which will receive $ 15,000 to implement this activity*

5. Providing equipment maintenance		0	100%	100%	100%		20,400 (GF)
6. Drawing up sector-wide intervention plans in each community	Number of plans drawn up	*0*	*11*				25,530
7. Supporting the implementation of sector-wide plans drawn up	Number of supported plans						See prevention
						Total amount requested from the GF for objective 2:	**752,765**

Specific objective 3: to ensure the follow-up, supervision and evaluation of interventions by supported structures

Table IV.27

Specific objective 3:	To ensure the follow-up, supervision and evaluation of interventions by supported structures			
Outcome/coverage indicators ***(Refer to Annex II)***	Baseline	Target figures		
	Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005
1. Number of follow-up and supervision missions to provincial coordination organisations ensured by national level	0	issions	4 missions	4 missions
2. Number of follow-up and supervision missions ensured by PNLS Provincial Coordination Offices (BCP)at peripheral level	0	20 missions	40 missions	40 missions
3. Number of evaluations made	0		1 internal evaluation	1 external evaluation

Table IV.27.1

Specific objective 3:	***To ensure the follow-up, supervision and evaluation of interventions by supported structures***						
Broad activities	***Process/Output indicators*** *(one per activity)* (Refer to Annex II)	***Baseline*** ***Year: 2002***	***Target figures*** ***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	***Responsible/ Implementing agency or agencies***	***Costs and source***
1. To ensure follow-up and supervision in province at peripheral level	*Number of follow-up and supervision missions carried out*	0	*20*	*40*	*40*	*BPC*	*188400*
2. Producing and distributing the report	*Number of report produced and distributed*	0	*20*	*40*	*40*	*BPC*	
3. Conducting an	*Number of*	*0*		*1*		*Directorate of*	*7,500*

internal evaluation during the second year	*evaluation missions conducted*					*Epidemiology of the Ministry of Health*	*(GF)*
4. Conducting an external evaluation of the programme at end of 3rd year	*Number of evaluation missions conducted*	*0*			*1*	*Consultant body*	*40,000 (GF)*
Total amount requested from the GF for objective 3							*136,400*

Summary of Community Mobilisation budget requested from Global Fund				
Code	**2003**	**2004**	**2005**	**Totals**
Human Resources	60,000	165,000	165,000	390,000
Infrastructure/Equipment	170,675	0	0	170,675
Training/Planning	152,416	121,175	84,229	457,820
Commodities/Products				0
Drugs				0
Monitoring/Evaluation	107,740	118,420	150,920	377,080
Administrative Costs				
Other	6,400	7,000	7,000	20,400
Grand Total	***497,231***	***411,595***	***507,149***	***1,415,976***

Administrative costs are indicated in the overall summary for the component. Refer to cost breakdown in Annex I.

Area of intervention 2: Prevention and reduction of risks

Main objective: *To prevent risks of HIV/STI transmission within vulnerable sections of the population.*

Analysis of the situation:

Many health professionals and association leaders in DRC point out the lack of access to prevention for vulnerable sections of the population. This situation is amplified by the structural destabilisation caused by social and political conflicts and poverty affecting a considerable proportion of the population. We can therefore say that health is a matter of urgency for a good many people in this situation, and figures high up on the list of life's priorities.

Furthermore, 60% of the population is composed of young people under 20 years of age who, after all, are exposed to the risks of HIV/AIDS and other STIs, particularly when preventive measures are in short supply because of exclusion from school. These are target groups for whom access to prevention is doubly limited because of the everyday social and economic difficulties they have to face.

Recent surveys conducted in various areas bear witness to this situation and document the problems of blood transfusion or behavioural risks prevalent among several survey groups.

For instance, in the joint survey by the PNLS and the College of Public Health dating back to 2001, it is revealed that approximately 57% of young people have had unprotected intercourse, usually rather early in life, including 19% with multiple partners. The strategy to be implemented involves developing mobilisation programmes by peer groups and associative mediators so that the messages get across to young people and young people assimilate them to change their own behaviour.

Likewise, a survey conducted among servicemen (in 2001), by the Family Health Association showed that 43% of soldiers surveyed had had sexual intercourse with commercial sex workers, among whom less than 40% used condoms. Over 10% of

servicemen reported that they had contracted a STI during the three months preceding the survey. The reason put forward for not using condoms by 20% of soldiers concerns unavailability. Lastly, in the context of geographical mobility and soldiers posted far away from the family circle, it means strengthening prevention activities to encourage a change in behaviour, but also making condoms regularly available and accessible.

Furthermore, it was estimated in the most recent survey, dating back to 1997, that 29% of commercial sex workers were seropositive. This shows the extent to which this situation is worsening. A study conducted in January 2001 by the FHA shows, however, that 50% of commercial sex workers use condoms. It would therefore be essential to encourage them to ensure that these persons continue this impetus to prevention and thereby significantly increasing the percentage of condom use. Actions undertaken in this area shall be strengthened on existing sites and developed on sites in Provinces.
As far as the situation of refugees is concerned, a significant migratory inflow is observed from seven neighbouring countries. Although there are no specific pathologies, the context of population movements worsens the risk of exposure to infection nonetheless, and more particularly to STI, to HIV and to tuberculosis. Considering the shortage of health coverage, it seems urgent that this programme should provide its contribution to the prevention of risks alongside such organisations as the HCR and in partnership with NGOs. It concerns national populations and foreign troops.

Lastly, on the subject of vulnerable sections of the population, particular attention is focused on the mobility of lorry drivers operating on the main highways. In actual fact, it is estimated that approximately 2,000 truckers pass through the different neighbouring countries, and more particularly along the main Kinshasa-Matadi road. Some actions were undertaken by FHA-PSI[8], together with a vast programme promoted by UNAIDS and the governments of countries situated along the Ubangi-Shari rivers. It means developing these prevention actions in synergy with what has been undertaken by the various partners.

Just like the actions undertaken to target vulnerable sections of the population, it is essential to provide a continuous supply of prevention actions to the public and a continuum of services so that these persons may be able to call on reliable and equipped services.

That is why increased safety of blood supplies is a major line of action, all the more so since the safety of only 13% of blood donations is assured by tests at the present time. Furthermore, the lack of reagents further increases the difficulty of providing safe blood coverage, and thereby increases the average transfusion cost borne by the transfused patient. Prevention is also an issue in the treatment of sickle-cell disease (drepanocytosis) among a doubly vulnerable section of the population. This pathology requires frequently resorting to transfusion, also seriously affected by the lack of transfusion safety. It is currently estimated that HIV is prevalent among 9% to 15% of drepanocytosis patients and so there is an urgent need to reduce HIV and other STI transmission risks. A strategy is needed to improve the situation facing the country as a whole and it will be centred on strengthening the control of collected blood implying compliance with quality standards and campaigns to promote the formation of a pool of regular and safe donors. This means a good communication strategy aimed at the general public and opinion leaders.

As far as public health is concerned, prevention based on the availability of condoms has proved to be effective in many countries. It actually makes it possible to relay prevention messages and give people the opportunity to choose the method most appropriate to their

[8] *Population Service International*

lifestyle. Many players involved in prevention actions point out the lack of availability and accessibility of condoms, especially in provincial and rural areas. According to PSI, 97% of condoms are distributed in urban areas, in partnership with the private and community sectors (NGOs), with an acceptability rate of 20%. The existence of a partnership with the UNPF[9], USAID and the WB is going to contribute to strengthening the availability and accessibility of condoms.
The strategy involves strengthening and extending social marketing in rural areas, more particularly in order to make the condom more available and usable. In this way, by improving the cost, geographical availability and acceptability of the condom, we will be able to measure the behavioural repercussions in future surveys.

This area of intervention takes into account the need to strengthen prevention in sectors where the risk is particularly high because of social or individual contexts where exposure is greater. It involves integrating this overall approach to the reduction of risks into the attitude adopted in various situations where vulnerability is higher both within the populations concerned and within the institutions where there is a drastic shortage of available means.
It means going beyond the notion of prevention centred on the transmission of messages by making the stakeholders involved in protecting their health, so that they feel sufficiently concerned to changed their behaviour.
A similar line of action will involve strengthening staff requirements and improving skills of professional health personnel and their institution.

Table IV.27

Main objective:	To prevent risks of HIV/STI transmission within vulnerable sections of the population				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Target figures**			
	2002	**2003:**	**2004**	**2005:**	
The safety of blood supplies is assured in the health structures covered	**30%**	50%	60%	85%	
Vulnerable sections of the population regularly use condoms during occasional sexual intercourse	40%	42%	44.5%	47%	
Diagnosed STI cases are managed according to the syndromic approach in centres covered by the project	**5%**	10%	20%	40%	
The annual number of condoms used for each Congolese in the 15-49 age bracket is increased.	**1.04**	1.32	1.75	2.21	

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

SPECIFIC OBJECTIVES AND ACTIVITIES TO BE IMPLEMENTED.

[9] *United Nations Population Fund*

Specific objective 1: To assure safety of blood supplies in the health structures covered.

Analysis of the situation/Problems and constraints

Problems and constraints

At the present time, the National Blood Transfusion Programme (*Programme National de Transfusion Sanguine - PNTS*) estimates tested blood coverage, for the entire country, only at 13%.

The country's safe blood requirements in blood units were estimated on the basis of the following parameters hereafter:

Yearly safe blood requirements in blood units	
% population exposed to anaemia (pregnant women, children under five years old, drepanocytosis cases, complications related to disease and traumatism)	0.25
Average frequency of anaemia among the exposed cases	2.5
Access to care	0.27
Rate of anaemia cases requiring transfusion	0.18
Rate of use of transfusion services in case of acute anaemia	0.5
Index of needs of units safe blood	**0.0151875**

On the basis of this index, it is estimated, for the DRC, (population of 60,000,000 inhabitants) that almost 900,000 cases of transfusions are needed in hospitals, every year. But only 13% of the blood supplies used in these transfusions are considered to be safe, i.e. 117,000 blood units.

This situation is related to:

- The vast extent of the territory and the persisting armed conflicts which make some parts of the country difficult to reach
- A context of high morbidity (malaria, malnutrition, parasitic diseases, drepanocytosis, traumatism, obstetrical and surgical complications, etc.), resulting in an increase in transfusion needs compared to available resources
- The shortage of trained staff with knowledge of transfusion standards and practice in hospital environments
- The frequency of stock outages of input intended to ensure blood safety on account of the shortcomings of the input procurement system
- The lack of mobilisation of benevolent blood donors with a consequent qualitative and quantitative lack of blood units. A large part of blood currently comes from family and paid donors, recognised as a source of high risk of HIV and other diseases transmissible by blood.

Opportunities

Progress has been made, through the commitment by the Government and partners, in the areas of compliance with standards, strategy and implementation, especially through:

- The setting up of the National Blood Transfusion Programme (PNTS) and the National Programme to combat drepanocytosis
- The drawing up of a national blood transfusion policy document and a national strategic plan
- The definition of transfusion standards and guidelines
- The development of transfusion guides and training modules

- The establishment of an accreditation system for transfusion structures
- The setting up of a national blood transfusion reference centre (CNTS)
- The assignment of staff at the level of the transfusion programme and structures.

Furthermore, partners have made great efforts to support the implementation of the national transfusion policy. Among these, let us mention:

- The WHO for strengthening technical and institutional capacities
- The GTZ which supports the CNTS and 25 blood transfusion structures in Kinshasa
- Italian Cooperation for the repair and rehabilitation of the national transfusion centre
- Belgian Cooperation for input support to the Provinces of Bas-Congo, Bandundu, Kasaï Occidental and Kasaï Oriental
- MSF/Belgium for input support in the Province of Katanga
- HEALTHNET for input support in Kasaï Oriental, with funding from the European Union
- Memisa/Belgium, which intervenes in the field of blood safety and the fight against HIV/AIDS in Kikwit in the Province of Bandundu, with funding from the European Union

Funding from the World Bank for 2002 is to be added to all that. This funding concerns support for the national transfusion centre, for five blood banks in Kinshasa and for the supply of transfusion equipment and materials and reagents to the main hospitals of the chief towns of the 11 Provinces of the country.

Lastly, it should be noted that the Government has entered the PNTS in the 2002 budget for investment and economic intervention for an amount of 103,000 USD.

The funding requested as part of the GF will make it possible to extend this coverage to the other transfusion structures of the chief towns of the Provinces and in rural areas.

Strategies:

The following strategies are proposed in response to the problems identified:

- Improvement of the case management of risk factors related to anaemia: malaria, malnutrition, parasitic diseases, drepanocytosis, obstetrical and surgical complications
- Quality assurance and stringent control of transfusion directions
- Implementation of an effective input procurement system
- Technical and logistic support to provincial blood transfusion centres and to reference hospital centres for blood transfusion at Health Area level

Expected outcome:

- Coverage of the country's needs for safe transfusion units is raised from 13 to 25% by 2005

The country's needs were estimated at 900,000 units of safe blood supplies per year. The contributions will make it possible to make a further 45,000 units safe for the first year (5%), 67,000 the second year (7.5%) and 90,000 the third year (10%), i.e. 202,000 all in all for a cost calculated at 5,793,990 USD, or 28.6 $/safe blood unit (taking required investments into account).

Table IV.27.1

Objective 1	**To assure safety of blood supplies in the health structures covered**						
Broad activities	**Process/Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline** 2002	**Combined target figures**			**Responsible /Implementing agency or agencies**[10]	**Costs and Sources of funding**
			2003	**2004**	**2005**		

[10] *The CNTS is delegated prime contractor. It will monitor the implementation of the activities carried out by its usual partners, NGOs, associations of benevolent donors, blood banks operating in the field, etc.*

1. Supplying equipment to provincial blood transfusion centres (CPTS) and to the anaemia safe blood centre: cold chain, transfusion equipment and educational material.	Number of CPTS/anaemia centres equipped	6	7	7	7	CNTS / NGOs	WB: 554,150 GF: 232,500 Gov.: 103,000 CDC/Atlanta: 750,000
2. Supplying transfusion kits to Health Districts and to CPTS	Number of Health Districts supplied	20	30	45	60	CNTS / NGOs	WB: 322,455 GF: 3,204,255
3. Reproduction and distribution of guides, standards and training modules and quality assurance manual	Number of beneficiary Health Districts	20	30	45	60	CNTS/ NGOs	GF: 15,000
4. Training staff	Number of persons trained	300	450	675	900	CNTS/ NGOs	WB: 78,000 GF: 384,560
5. Mobilising benevolent blood donors (contacts, awareness-raising and sampling)	% blood donation loyalty among donors	14%	25%	35%	50%	CNTS/CPTS	WB: 81,000 GF: 245,700
6. Equipping the CPTS with a vehicle for mobile blood collection	Number of vehicles	1	7			CNTS/ NGOs	WB: 70,000 GF: 175,000
7. Providing supervision of CPTS by the PNTS	Number of yearly supervisions carried out	14	14	14	14	CNTS/ NGOs	WB: 24,000 GF: 70,560
8. Providing Health District supervision by CPTS	Number of yearly supervisions carried out	44	44	44	44	CNTS/ NGOs	GF: 33,000
9. Providing transport and maintenance (25% of equipment and input costs)	Rate of withdrawal of transport and maintenance costs		33.3%	29.4	37.3	CNTS/ NGOs	GF: 906,689
10. Covering administrative and management costs (10% of funding)	Rate of withdrawal of administrative costs		33.6%	29.8%	36.6%	CNTS/ NGOs	GF: 526,726

Budget summary – safety of blood supplies

Budget Items	2003	2004	2005	Total
Human Resources	81,900	81,900	81,900	**245,700**
Infrastructure/Equipment	407,500			**407,500**
Training/Planning	147,560	118,500	118,500	**384,560**
Commodities	798,235	1,068,085	1,352,935	**3,219,255**
Drugs	-	-	-	-
Monitoring / Evaluation	34,520	34,520	34,520	**103,560**
Other (Transport / maintenance)	301,434	267,021	338,234	**906,689**
Administrative Costs				
Total	**1,771,150**	**1,570,027**	**1,926,088**	**5,267,265**

Refer to cost breakdown in Annex II HIV

Estimate of coverage of the country's needs for safe blood supplies			
	2003	**2004**	**2005**
Number of Health Districts under programme	30	45	60
Health District needs under programme	45,000	67,500	90,000
Country's needs	900,000	900,000	900,000
Contributions	45,000	67,500	90,000
Coverage of country	5%	8%	10%

SPECIFIC OBJECTIVES AND ACTIVITIES TO BE IMPLEMENTED.

Specific objective 2: TO PROMOTE SAFER BEHAVIOUR AMONG VULNERABLE SECTIONS OF THE POPULATION.

2.1. To promote safer behaviour among servicemen.

Analysis of the situation:

- A KAP survey conducted by ASF – ESP in November 2001shows that:
43% of soldiers have had sexual intercourse with commercial sex workers among whom less than 40% used condoms.
10% of servicemen reported that they had contracted STIs during the three months preceding the survey.
20% of soldiers did not use condoms because they were unavailable.
- The war situation: mobility of soldiers, military assignments without family or partners.

- On the initiative of the American Ministry of Defence with the University of CALIFORNIA, the authorities of the Congolese army in KINSHASA and Lubumbashi openly called on the NGOs (ASF) to intervene in their camps in order to raise awareness.

Strategy:

To strengthen activities aimed at changing behaviour in the military camps of Kinshasa, and to extend awareness to the camps of the other Provinces of the country.

Outcome:

Soldiers with raised awareness adopt safer sexual behaviour.

Objective 2	**To promote safer sexual behaviour among vulnerable sections of the population.**						
Broad activities	**Process/ Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Costs and source in $**
		2002	**Year 1**	**Year 2**	**Year 3**		
Objective 2.1. among servicemen							
1. Identifying AIDS focal points for men in uniform	Number of active focal points	**6**	*10 camps in Kinshasa and Lubumbashi*	*13 camps in Kinshasa, Lubumbashi, Bas-Congo and Equateur*	*13 camps in Kinshasa, Lubumbashi, Bas-Congo and Equateur*	Ministry of Defence; with technical support from PNLS, UNDP, FOSI[11], RCP[12]+ (particularly ASF)	0$
2. Training peer educators	Number of peer educators trained	**10**	48	64	64	Idem	40,000 GF 5,000 USAID
3. Training military leaders	Number of trained leaders	**0**	200	260	260	Idem	18,000 GF

[11] *Forum of NGOs on AIDS*

[12] *Congolese PLHIV network*

4. Producing prevention tools	Number of prevention tools developed	**7**	*6 picture boxes *1 poster *1 leaflet *1 brochure *condom sheath *boot brushes with logo Prudence	*4 posters *2 leaflets		Idem	131,120 GF
5. Distributing teaching tools	Number of prevention tools distributed/ disseminated	**0**	*324 picture boxes *25,000 posters *20,000 leaflets *5,000 brochures *7,000 condom sheaths *4,000 boot brushes with logo Prudence	*25,000 posters *20,000 leaflets *5,000 brochures *7,000 condom sheaths *5,000 boot brushes with logo Prudence	*25,000 posters *20,000 leaflets *10,000 brochures *5,000 brushes with logo Prudence	Idem	61,800 (20% salaries) GF
6. Developing an operational circuit to make condoms available in camps.	% increase in points of sale of condoms in camps	**0**	33	50	100	Idem	61,800 (20% salaries) GF 24,000 USAID
7. Strengthening internal communication between persons in camps.	Number of persons having benefited from increased internal communication between persons	**0**	6,000	14,000	14,000	Idem	464,200 GF (including 60% salaries)
8. Promoting the reference system	The % of persons in the target groups aware of the reference centres promoted.	**0**	10	40	60	Idem	10,000 GF
					Total amount requested from GF for objective 2:		**786,920**

2.2. To promote safer behaviour among commercial sex workers.

Analysis of the situation.

- 29% prevalence of HIV serological reaction among commercial sex workers (1997 survey).
- Daily average is one partner per day.
- Condoms not accessible where prostitution is rife.
- 50% of commercial sex workers use condoms (ASF PSI qualitative surveys, Jan. 2001).
- Awareness-raising programmes targeted at commercial sex workers already exist in three Provinces (KIN, LSHI, BKV) by ASF/PSI, MSF/ B, ….
- A grouping of commercial sex workers is being organised in the Province of Kasaï Occidental in partnership with the PNLS, which is a major advantage.

Strategies:

To instil a change of behaviour among commercial sex workers in the red-light districts where prostitution is rife, not covered by programmes. The Province of Bas-Congo with the port of Matadi (10% prevalence, PNLS 2000) and the main Kinshasa-Matadi highway and the Province of Equateur with the port of Mbandaka (SADC soldiers' camp during the war) were selected on this basis considering the vulnerability/high risk of HIV transmission.

Outcome:

Women with raised awareness adopt safer sexual behaviour.

Objective 2	**To promote safer sexual behaviour among vulnerable sections of the population.**						
Broad activities	**Process/Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline**	**Target figures**			**Responsible /Implementing agency or agencies**	**Costs and source in $**
		2002	**Year 1**	**Year 2**	**Year 3**		
Objective 2.2. among commercial sex workers			[2]				
1. Identifying AIDS focal points among commercial sex workers.	Number of active focal points	**0**	*5 sites where prostitution is rife in Matadi and Mbandaka*	*8 sites where prostitution is rife in Matadi and Mbandaka*	*8 sites where prostitution is rife in Matadi and Mbandaka*	PNLS and NGOs (particularly ASF), ABEF, FOSI, RCP+	4,000 US$ GF
2. Training professional peer educators or organisers	Number of professional peer educators or organisers trained	**0**	15	24	24	Idem	32,000 GF
3. Producing prevention tools	Number of prevention tools developed	**2**	*6 picture boxes *1 leaflet *1 brochure	2 leaflets		Idem	91,673 GF

4. Distributing teaching tools	Number of prevention tools distributed/ disseminated	**0**	*144 picture boxes *3,600 leaflets *3,600 brochures *2,400 Prudence T-shirts	*5,760 leaflets *5,760 brochures *3,840 Prudence T-shirts	*5,760 leaflets *5,760 brochures *3,840 Prudence T-shirts	Idem	63,000 GF (20% salaries)
5. Developing an operational circuit to make condoms available in places of prostitution	% increase in points of sale of condoms in places of prostitution (brothels, hotels, streets, etc.)	**0**	10%	30%	50%	Idem	31,500 (10% salaries) GF
6. Developing an operational circuit to make contraceptives available to women in places of prostitution	% increase in points of sale of contraceptives for women in places of prostitution (brothels, hotels, streets, etc.)	**0**	33%	50%	100%	Idem	31,500 (10% salaries) GF
7. Strengthening internal communication between persons. .	Number of persons having benefited from increased internal communication between persons	**0**	2.000	3.200	3.200	Idem	422,860 GF (including 60% salaries)
8. Promoting the system of reference to case management and control centres	% of person of target group aware of reference centres promoted.	**0**	10%	40%	60%	Idem	10,000 GF
Total amount requested from the GF for objective 2:							**686,533**

2.3 To promote safer sexual behaviour among lorry drivers, truckers and other mobile groups of persons.

Analysis of the situation.

Lack of awareness-raising programmes among Congolese lorry drivers compared to lorry drivers in neighbouring countries who are sufficiently aware.
The size of road traffic: on the Kinshasa-Matadi section (the amount of haulage traffic is composed of 450 large lorries and an estimated 2000 lorry drivers).
As the road is renovated, the number of lorries and turnrounds will increase appreciably.

Data about HIV prevalence among lorry drivers are unavailable; the involvement of the drivers' union, however, will make it possible to obtain more reliable data about this high-risk group.
Efforts are in an embryonic state and are made by ASF and PSI (Kasumbalesa) to raise awareness among lorry drivers.
UNAIDS with governments of the countries along the CONGO, UBANGUI and SHARI rivers have set up a programme to fight AIDS called the CONGO UBANGUI-SHARI INITIATIVE.

Strategies.

To develop programmes to raise awareness along the sections where road, river and rail traffic are most fluid (focusing priority on the main KINSHASA-MATADI route).

Outcome:

Mobile groups of persons with raised awareness adopt safer sexual behaviour.

Objective 2	To promote safer sexual behaviour among vulnerable populations.						
Broad activities	**Process/Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline**	**Target objectives**			**Responsible /Implementing agency or agencies**	**Costs and source in $**
		2002	**Year 1**	**Year 2**	**Year 3**		
Objective 2.3. among lorry drivers							
1. Identifying AIDS focal points among lorry drivers	Number of active focal points	**0**	*2 towns Kinshasa and Matadi*	*2 towns Kinshasa and Matadi*	*2 towns Kinshasa and Matadi*	PNLS and NGO, FOSI, RCP+ (especially ASF), ABEF + trucking companies and trade unions	4,000 US$ GF
2. Training peer (professional) educators or organisers	Number of peer professional educators or organisers trained	**0**	10	10	10	Idem	12,000 GF
3. Producing prevention tools	Number of prevention tools developed	**0**	*6 picture boxes *1 leaflet *1 brochure *1 sticker	2 leaflets		Idem	54,930 GF
4. Distributing teaching tools	Number of prevention tools distributed/ disseminated	**0**	*60 picture boxes *2,000 leaflets *2,000 brochures *2,000 Prudence T-shirts *2,000 stickers	*2,000 leaflets *2,000 brochures *1,000 Prudence T-shirts *2,000 stickers	*2,000 leaflets *2,000 brochures *1,000 Prudence T-shirts *2,000 stickers	Idem	30,240 GF (20% salaries)
5. Developing an operational circuit to make condoms available in operations centres	% increase in points of sale of condoms in operations centres (truckstops, etc.)	**0**	10%	30%	50%	Idem	30,240 (20% salaries) GF

6. Strengthening communication between personnel.	Number of persons having benefited from strengthened communication between personnel.	**0**	1,000	2,000	2,000	Idem	160,380 GF (including 60% salaries)
7. Promoting awareness of case management and control reference centres	% of persons of target group aware of promoted reference centres.	**0**	10%	40%	60%	Idem	5,000 GF
Total amount requested from GF for objective 2:							**296,790**

2.4. **To promote safer behaviour among young people**

Analysis of the situation:

Approximately 60% of sexually active teenagers between 15 and 19 years old have never used a condom (sources PNLS-ESP, 2001).
19% of young people have multiple partners (same sources).
The few programmes targeting young people are located in Kinshasa (more particularly UNICEF and the churches).
Other opportunities are offered by awareness-raising programmes with radio broadcasts (radio OKAPI and other local radio stations).
The broadcasting of awareness-raising programmes directed at young people involve both public and private media.

Strategy:

To develop awareness-raising programmes targeting young people through training and providing assistance to peer educators as defined by the global strategy. The action should target young people attending primary and secondary schools and young people not attending school as a priority. One mass-media aspect involving an educational television series will be developed for urban areas in Kinshasa.

Outcome:
Young people with raised awareness adopt safer sexual behaviour.

Objective 2	**To promote safer sexual behaviour among vulnerable populations.**						
Broad activities	**Process/Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Costs and source in $**
		2002	**Year 1**	**Year 2**	**Year 3**		
Objective 2.3. among young people							
1. Identifying AIDS focal points (primary and secondary schools, young people not attending school including street children).	Number of active focal points	**0**	*50 sites in 1 province inside the country*	*150 sites in 3 provinces inside the country*	*150 sites in 3 provinces inside the country*	Ministry of Youth PNLS UNICEF FOSI, RCP+	6,000 US$ GF
2. Training peer educators (p.e) and peer coordinators (coord).	Number of peer educators trained	**0**	100 p.e. 10 coord.	300 p.e. 30 coord.	300 p.e. 30 coord.	Ministry of Youth PNLS UNICEF FOSI, RCP+	55,000 GF
3. Training national television staff	Number of trained staff	**0**	50	50		PNLS ASF FOSI, RCP+	10,000 GF

4. Producing prevention tools (picture boxes, leaflets and other educational materials)	Number of prevention tools developed	**0**	*1 picture box *1 poster *1 brochure 24 programmes	*2 posters *1 brochure	*2 posters	Ministry of Youth PNLS UNICEF ASF (mass media only) FOSI, RCP+	433,000 GF
5. Distributing teaching tools	Number of prevention tools distributed/ disseminated	**0**	*100 picture boxes *10,000 posters *100,000 brochures	*200 picture boxes *30,000 posters *300,000 brochures	*30,000 posters *600,000 brochures	Ministry of Youth PNLS UNICEF FOSI, RCP+	166,320 GF (20% salaries)
6. Developing an operational circuit to make condoms available (male and female)	% increase in points of sale of condoms in sites where young people go.	**0**	10%	30%	50%	Ministry of Youth PNLS UNICEF ASF FOSI, RCP+	166,320 (20% salaries) GF
7. Broadcasting an educational series on television.)	Number of broadcasts.	**0**	0	24	24	ASF PNLS FOSI, RCP+	120,000 GF
8. Strengthening personal communication among young people.	Number of young people having benefited from personal communicatio n	**0**	100,000	400,000	700,000	Ministry of Youth PNLS UNICEF FOSI, RCP+	498,960 GF (60% salaries)
9. Strengthening mass-media communication among young people.	Number of young people having benefited from mass-media communicatio n (educational television series)	**0**	0	2,000,000	2,000,000	ASF PNLS FOSI, RCP+	60,000 GF (promo of series)
10.Promoting awareness of STI and AIDS case management reference centres).	% of young people aware of reference centres.	**0**	10%	40%	60%	Ministry of Youth PNLS UNICEF FOSI, RCP+ ASF	20,000 GF
Total amount requested from the GF for objective 2:							**1,535,600**

See cost breakdown in Annex IV HIV

2.5. **To promote safer sexual behaviours among refugees.**

Analysis of the situation.

Considerable inflow of refugees to the country (355,000), including 60% women and children mainly from 7 countries, namely CONGO (3,000), ANGOLA (175,000), SUDAN (76,000) UGANDA (23,000), RWANDA (26,000), BURUNDI (20000), CENTRAL AFRICAN REPUBLIC (7,000).
The predominant pathologies to be found in refugee camps are Malaria (with severe anaemia among children under 5 years old), tuberculosis, malnutrition and AIDS (6% HIV prevalent among donors according to an estimate by a pilot project on the Nkondo site in Kimpese.).
Their precarious living conditions particularly for newcomers in the country of asylum (shelters, promiscuity, poverty, etc.).
Little preventive health cover and STI/HIV/AIDS cover.
A programme to fight AIDS in refugee communities has been set up through the integrated plan of the United Nations.
An AIDS focal point exists at HCR level and takes charge of the AIDS programme at HCR level.
A pilot project to fight HIV is currently being experimented on the Nkondo refugee site, in the Province of Bas Congo.
The training of refugees as peer educators may be considered as an asset, during their stay in DRC and also when they return to their country of origin. They represent competent human resources, to be integrated into the national programme to fight AIDS in the country of origin.

***Strategies*:**
To mobilise complementary resources for the implementation of the communication for change (CCC) strategy. The other aspects concerning case management and safe blood supplies are dealt with by the HCR.

Objective 2	To promote safer sexual behaviour among vulnerable populations.						
Broad activities	Process/ Output indicators	Baseline	Target figures			Responsible / Implementing agency or agencies	Cost and source of funding
	(one per activity) *(Refer to Annex II)*	2002	2003	2004	2005		
1. Identifying AIDS focal points in sites for refugees and displaced persons (wars and natural disasters ...)	Number of active focal points	0	11	0	0	HCR/NGO Network	$ 30,000 HCR $ 10,000 HCR $ 20,000 GF

2. Training peer educators	Number of progress reports produced by trained peer educators	10	81	81	0		$ 54,072 HCR/ NGO Network $ 15,000 HCR $ 39,072 GF
3. Production of prevention tools	Number of prevention tools developed	1 project / Nkondo site	95 modules, 25 megaphones, 25 IEC kits, 25 picture boxes, 25 video cassettes, 10,000 leaflets, 1,000 posters, production 2 advertising commercials	84 modules, picture boxes, 25 video cassettes, 10,000 leaflets, 1,000 posters, production 2 advertising commercials	176 modules, 1,000 posters, 10,000 leaflets, 50 streamers, 50 video cassettes, production 2 advertising commercials		$ 4,800 HCR $ 11,000 HCR $ 37,000 GF
4. Distributing teaching tools	Number of prevention tools distributed/ disseminated	1 site / Pilot project, Nkondo site	25	25	25		$ 15,300 HCR $ 5,300 HCR/POS $ 10,000 GF
5. Developing an operational circuit to make condoms available (male and female) in sites	% increase in points of sale of condoms in sites.	HCR drug supply circuit	HCR drug supply circuit	HCR drug supply circuit	HCR drug supply circuit		$ 124,980 HCR $ 56,000 HCR $ 86,980 GF
6. Strengthening communication between personnel in sites.	Number of persons having benefited from strengthened communication between personnel.	1 site 5,000 persons	25 sites 57,848 persons	25 sites 173,543	25 sites 173,543		$ 46,000 HCR/ NGO Network $ 20,000 HCR $ 26,000 GF

7.Promoting awareness of case management reference centres.	Number of persons of target group aware of reference centres.	Pilot project, Nkondo site	1 site	25 sites	25 sites		$ 262,800 HCR/ NGO Network $ 55,200 HCR $ 207,800 GF
Total amount requested from the GF for objective 2							**426,852**

CASE MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

Specific objective 3: Correct case management of STIs in health structures

Analysis of the situation/Problems and constraints

Correct and early case management of STIs, joint factors in HIV transmission, is recognised as a major HIV prevention strategy.
According to the survey conducted in 1998 by the Ministry of Health as an inventory of the health sector, STI represents the fifth cause of hospital morbidity.
Surveys conducted by the PNLS as part of sentinel surveillance indicate high rates of syphilis among pregnant women on different sites:

Sites	*1996*	*1997*
Kinshasa	5.3%	12%
Bunia		26%
Mbandaka	7%	

In these same surveys, the following prevalence rates are reported in an STI case management clinic in Kinshasa:

Types of STI	*prevalence*
Genital ulceration (syphilis, herpes ...)	15.2%
Discharge from the urethra (gonococci ...)	17.8%
Vaginal discharge	40.6%
Pelvic inflammation	20.8%

On account of laboratory diagnosis difficulties, the PNLS has defined a national STI case management strategy, based on the syndromic approach.
A national guide has been drawn up for this purpose with the support of the WHO and MSF/Belgium, but still needs to be reproduced and widely distributed.
The syndromic approach has been integrated into the health structures of the towns of Kinshasa and Lubumbashi.
On the whole, the integration of this approach into the structures of the Health Areas, however, leaves a lot to be desired, in view of the fact that many Health Areas are not sufficiently operational and there is a shortage of trained staff and drugs necessary for STI case management.
The recent assessment report by UNAIDS on efforts by the DRC to fight AIDS from 1998 to 2000 indicates that only 12% of the target group has access to STI treatment. This is due to funding by some partners, including Belgian Cooperation which covers STI training and drug support in some provinces, in the area of STI.

The funding application to the GF will make it possible to improve coverage.
Strategies:
The syndromic approach is the strategy proposed to improve STI case management.
Outcome:
STI cases are managed according to the syndromic approach in the health structures concerned by the programme.

Table IV.27.1

Objective 3	**To provide correct STI case management in health structures**						
Broad activities	**Process/Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline** 2002	**Combined target figures** **2003**	**2004**	**2005**	**Responsible/ Implementing agency or agencies**	**Costs and Sources of funding**
1. Reproducing and distributing STI case management guides, training modules and educational equipment	% of operational Health Districts benefiting	12%[13]	30%	45%	60%	PNLS	GF: 15,000
2. Training staff[14]	Number of trained staff	1200	3000	4500	6000	PNLS + partners	GF: 939,560
3. Providing STI kits[15] to health structures	% of operational Health Districts benefiting	12%[16]	30%	45%	60%	PNLS + partners	GF: 2,595,665 Belgian Coop.: 25,000
4. Raising population's awareness about the use of STI services[17]	% target population using STI services	14%	25%	35%	50%	Health staff + NGO/CBO	GF: 36,000 Belg. Coop.: 554, 400
5. Providing equipment and reagents to reference health structures[18]	% of HGR of operational Health Districts benefiting[19]	12%[20]	30%	45%	60%	PNLS + partners	GF: 1,170,000
6. Monthly monitoring and supervision of STI case management in Health Districts	% of supervision fulfilled/forecast	100%	100%	100%	100%	PNLS	GF: 9,000
7. Providing transport and maintenance of input and equipment	Withdrawal rate		42%	25%	33%	PNLS	GF: 945,166

STI case management budget summary

Budget Items	2003	2004	2005	Total
Human Resources	18,000	9,000	9,000	**36,000**
Infrastructure/Equipment	108,000	0	0	**108,000**
Training/planning	484,310	236,625	218,625	**939,560**
Commodities	1,077,000	-	-	**1,077,000**
Drugs	405,105	958,370	1,232,190	**2,595,665**

[13] *Kinshasa: 22 ZS (MSF/B); Katanga: 12 ZS (MSF/B); Bas-Congo: 3 ZS (Italy)*
[14] *For each ZS, 33 persons to be trained (2 pers x 15 CS and 3 pers HGR)*
[15] *Composition of the kit: drugs, condoms, injection equipment (if necessary), gloves*
[16] *Kinshasa: 22 ZS (MSF/B); Katanga: 12 ZS (MSF/B); Bas-Congo: 3 ZS (Italy)*
[17] *Including the concept of case management of partners, and other varied subjects, such as raising awareness about PTMC*
[18] *These include: microscope, sampling equipment for samples for breakpoint testing (gloves, slides, etc.), RPR and TPHA tests*
[19] *For each Health District (ZS), there is an operational general reference hospital (HGR)*
[20] *Kinshasa: 22 ZS (MSF/B); Katanga: 12 ZS (MSF/B); Bas-Congo: 3 ZS (Italy)*

Monitoring / Evaluation	3,000	3,000	3,000	**9,000**
Other (Transport / maintenance)	397,526	239,593	308,048	**945,167**
Administrative Costs				
Total	**2,492,941**	**1,446,588**	**1,770,863**	**5,710,392**

Administrative costs are indicated in the overall summary for the component.

See cost breakdown in Annex III HIV

Specific objective 4: To strengthen availability and accessibility of condoms for men and women.

Analysis of the situation.

The situation in the country regarding condoms appears as follows:
Condoms are not easily available at national level (30%).
Condoms are not easily accessible and available especially in rural areas were 70% of the population live. In actual fact, 97% of condoms distributed by PSI[21] are in urban areas.
The low percentage acceptability of the condom (40%).
The existence of a social marketing programme with PSI/ASF with one steering committee per province. (The steering committees were set up by the WB project and distributed condoms in 10 of the 11 provinces. The committees are run by the PNLS with local NGOs as members. The condoms allocated to the committees come from ASF/PSI, which deals with distribution logistics.)
The existence of one single partner, the UNFPA[22] (FNUAP), which is currently contributing to improving availability and accessibility of condoms. It is going to supply 34 million condoms over the next 3 years. Other partners such as USAID and the WB have not yet determined the amount of their support.
It should be noted that the 11 million condoms funded by the WB will be exhausted before the start of Global Funding. Now, condom requirements for the DRC are going to rise above 40 million per year as demand and availability increase (see Annex IV), a figure which indicates the urgent need for additional condoms. The existence of partners' offices and warehouses. At the present time, there are offices and warehouses, which can operate as a base for distributing condoms.

Strategies.
To strengthen and extend social marketing at the level of the steering committees and at the level of the NGOs expert in social marketing.
To strengthen availability in rural areas by developing cooperation with partners (SANRU, and other NGOs, etc).
To train and place social marketing agents in each province, who will help to make condoms available at times and in places where transmission is high (hotels used by prostitutes and their clients, bars …).
To increase demand for condoms by promoting the brand (Prudence) and by doing CCCs (communication for change campaigns).

Expected outcome:

60% of national needs for condoms are covered.
The distribution circuit is organised throughout the country.
The cost of condoms is compatible with the population's buying power.
Condoms are available for 90% of the target population.

It should be noted that cost-effectiveness per condom distributed is slightly lower compared to some other countries in Africa. This is due to the logistics difficulties occurring in DRC, a huge country with few operational roads, which is why most condoms have to be sent by air. A good follow-up system is also necessary to make sure that they are available inside the country.
A detailed study of condom distribution in DRC is enclosed in Annex IV HIV.

[21] *Population Service International*
[22] *United Nations Population Fund*

Objective 4	To strengthen availability and accessibility of condoms for men and women						
Broad activities	**Process/Output indicators** (one per activity) *(See Annex II)*	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Costs and source in $**
		2002	**Year 1**	**Year 2**	**Year 3**		
1. Ordering condoms	Number of condoms ordered	**28**	36 million including 100,000 for women	48 million including100,000 for women	60 million including 100,000 for women	PNLS ASF/PSI ABEF (condoms for women)	6,460,000 GF 1,870,000 UNFPA
2. Extending the national distribution circuit at government level	Number of provinces with operational steering committee	**10**	10	10	11	PNLS ASF, SANRU, UNFPA, MSF Local NGOs	120,000 GF (monitoring)
3. Extending the national distribution circuit regarding NGOs expert in social marketing	Number of provinces with operational offices	**3**	6	8	11	ASF	2,141,650 GF (including transport of condoms inland)
4. Entering condoms on the list of essential medical supplies	Condoms present on the list. A legal text including condoms on the list of essential medical supplies is available	**0**	done	done	done	PNLS	0
5. Increasing points of sale in places where transmission is high	% of points of sale equipped and operational in places where transmission is high	**0**	10%	30%	50%	ASF NGOs PNLS	216,000 GF

6. Training provincial social marketing teams (NGO, government and private sectors)	Number of training sessions organised	**0**	6	7	9	ASF PNLS	81,000 GF
7. Mass-media condom marketing	Number of TV and radio stations broadcasting commercials	**3**	6	8	10	ASF PNLS	1,078,900 GF
8. Monitoring the project properly	Number of supervision visits made per year.	**6**	12	20	28	ASF PNLS	120,000 GF
9. Management fees						ASF	671,666
Total amount requested (including management fees) from the GF for specific objective 4							10,709,216

BUDGET SUMMARY CONDOMS

Budget Items	**2003**	**2004**	**2005**	**Total**
Human Resources	72000	110400	148800	331200
Infrastructure / Equipment	272250	265100	313100	850450
Training / Planning	30000	41000	55000	126000
Commodities	1984980	2426800	3127120	7538900
Drugs	0	0	0	0
Monitoring / Evaluation	48000	80000	112000	240000
Other (Transport/ Maintenance)	408864	524281	689521	162266
Administrative Costs				
Total	**2,816,094**	**3,447,581**	**4,445,541**	**10,709,216**

See cost breakdown in HIV Annex IV

Area of intervention 3: Overall case management of HIV / AIDS infection

***Main objective**: To strengthen overall case management of PLHIV and Infected people, integrated into a continuum of care.*

Analysis of the situation

These last years, the Democratic Republic of Congo has been experiencing a crisis in a multiplicity of forms. This context of crisis, with the ensuing disorganisation of the health system as its corollary, has increased the direct impact on the state of health of the population and more particularly those already in a vulnerable situation.

In this respect, medical and psychosocial case management of people living with HIV is a major issue considering the individual, family and community impact that this disease represents.

Today, it is proved that early therapeutic intervention, combined with primary and secondary prevention of opportunistic infections, makes it possible to reduce the morbidity and mortality rate considerably.

The Government of the DRC has therefore committed itself to a national policy with regard to people affected by HIV, which includes the prevention of opportunistic Infections and the gradual implementation of a national public health policy allowing access to ARVs. This commitment by the Government recently materialised in ministerial decision No. 1250 /CAB/MIN/CJ/KIZ/09/02, dated 05 July 2002, concerning the accreditation of ARV treatment dispensation centres and doctors prescribing generic anti-retroviral (ARV) drugs. This national initiative aims at a rational use of ARVs, which should make it possible to improve the quality of life of people living with HIV/AIDS, but also to reduce the impact of this disease on all the social systems. In actual fact, anti-retroviral treatment is interesting from an individual, family and collective viewpoint. The medical effectiveness of treatment has been shown. From a social point of view, treatment of adults and children reduces the loss of income and the deterioration of the economic and social situation of families and communities. Access to treatment, when it is appropriately accompanied and well organised, improves the quality and life expectancy of patients and likewise encourages social acceptance of the disease by reducing the risk of stigmatisation and exclusion of HIV/AIDS sufferers.

The dynamics of this area of intervention come within this context and aim at strengthening and developing the overall case management of people living with HIV/AIDS through access to ARVs, to treatment and to the prophylaxis of opportunistic infections, in accordance with clinical, biological and immunological recommendations. On this occasion, patients are proposed multidimensional case management involving different health and social services. This action takes place on hospital and ancillary premises. Several stakeholders are concerned; health and social, institutional or associative professionals, together with health mediators from partner associations.

Key interventions involve voluntary counselling and testing (VCT), psychosocial support, home and community care and medical case management.
The implementation of these interventions requires close collaboration between nursing staff and members of associations, so as to clearly identify the patient circuit within the case management sites. Furthermore, several stages are planned to make this approach effective, namely: the strengthening of the human and material capacities of NGOs and the availability of treatment and improvement of circuits and dispensation procedures.

In order to achieve this, all the players involved, whether nursing staff, social workers or NGO mediators, in the various dimensions of overall case management, will benefit from appropriate training so as to optimise the case management mechanism.
The medical response in the different hospital and ancillary structures will be systematically combined with a psychosocial response provided by clearly identified associations (see list) together with the mediators from those associations.

On account of the complexity of anti-retroviral treatment and the still prohibitive cost for many Congolese households, it is planned to set up a mechanism of national solidarity, and a mechanism to take into account the socioeconomic situations of people whose state of health might require access to ARV.

This egalitarian approach aims at facilitating access for the most deprived people and families. In this way, the participation of community representatives, alongside health and social professionals will be encouraged in all decision-making bodies determining access to treatment, in particular the health and social eligibility committee.

Concurrently with this approach, associative mediators will intervene in case management sites. Through their interventions, associations shall provide an impetus to the approach to access to care and prevention for the people whom they receive either on their premises or within their community. The knowledge that members of associations have of their target groups and health and social mechanisms means that they are able to intervene as an interface to ensure pertinent access adapted to the most vulnerable sections of the population as effectively as possible. The guarantee of the success of this component lies in the synergy established by the formation of a network allowing a continuum of care, so that nursing staff may carry on their tasks as best they possibly can. If the programme ensures the availability of continuous treatment, monitoring mechanisms should be reduced so that they do not form obstacles to access and acceptability of treatment. The contribution by health mediators from associations is therefore seen as taking place wherever care is provided. These mediators should have knowledge and skills in the field of IEC and overall case management combined with a readiness to listen in order to be recognised and complementary to professional health staff. Consequently, they shall have the means to carry out support actions, and have access to updated training in treatment, ethics, etc. just like professional health staff. The mediation approach forms a link between people and nursing departments (by encouraging screening, by bringing people to consulting rooms, by informing patients, etc.), but is not limited to this “relay» function. It can facilitate relationships and make it possible to solve deadlocks or conflicts between nursing staff and those they nurse. It is also in keeping with an impetus to call patient reception and case management practices into question, not only to reveal and discuss malfunction, but also to make proposals. It makes it possible to better coordinate prevention and case management actions, especially if mediators take a full part in some areas where nursing staff and social workers are involved. Their supervisory association shall draw up an agreement with the structure where they intervene.

Strategy

The strengthening of case management capability for PLHIV and infected people will involve promoting screening and counselling systematically proposed in health structures providing treatment of HIV infection with ARVs, treating O.I.s and setting up a team of community mediators, together with economic support activities and legal assistance.

Specific objective 1:	To set up a national ARV procurement, storage and distribution system				
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Target figures**			
	Year: 2002	**Year: 2003**	**Year: 2004**	**Year: 2005**	**Total**
An ARV procurement, storage and distribution circuit is set up.	4	5	3	2	
Quantity of generic ARVs stored and distributed	Data not available	10512	15768	20544	40824
Quantity of speciality ARVs stored and distributed.	Data not available	2100	3180	4140	9420

3902 patients will compose the active dossier of people included over a three-year period, during which they will benefit from case management as defined in the introduction. The indicators represent a 50% increase in the active dossier for the 2nd year and 30% for the third year.

20% of people treated are supposed not to tolerate first-line generic molecules. A lump sum is set aside to allow alternative ARV speciality treatment.

Broad activities related to each specific objective and expected output

Objective 1	***To set up a national ARV procurement, storage and distribution system***						
Broad activities	***Process/Output indicators***	***Baseline***	***Target figures***			***Responsible/ Implementing agency or agencies***	***Cost***
	(one per activity) (Refer to Annex II)	***Year 2002***	***Year 2003***	***Year 2004***	***Year 2005***		
1.1.Identifying ARV importers.	*Number of importers*	*4*	*5*	*3*	*2*	*3rd Directorate of Public Health & PNLS*	*PM*
1.2.Organising the ARV storage and distribution circuit.	*Number of selected ARV distributors.*	*4*	*5*	*3*	*2*	*3rd Directorate & PNLS.*	*PM*
1.3. Training Pharmacist trainers at central level	Number of pharmacist trainers trained.	*0*	3	-	-	Bichat Hospital/ IMT (Antwerp).	20,000$US (G.F.).
1.4. Training Pharmaceutical Assistants	- Number of pharmacists and assistants trained in drug management.	0	16	22	18	PNLS/ WHO	60,000$US (G.F.).
1.5. Training site staff in computing	- Number of persons trained in computing.	0	10	10	9	*PNLS*	15,000 $US (G.F.).

1.6. Equipping the site with computer hardware and cold chain.	- Computer hardware and cold chain acquired.	0	8	3	-	*PNLS*	50,000 $US (G.F.).
SUBTOTAL 1.							***145,000 $US***

Specific objective 2:	**To provide case management of opportunistic infections (O.I.) in health structures supported by the project, according to the standards defined by the PNLS**				
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Target figures**			
	Year 2002	**Year 1: 2003**	**Year 2: 2OO4**	**Year 3: 2005**	
% of HGR[23] of supported Health Areas (ZS) screening and treating O.I.s according to defined standards.	30%	40%	50%	60%	

Objective 2	***To provide case management of opportunistic infections (O.I.) in health structures supported by the project, according to the standards defined by the PNLS***						
Broad activities	***Process/Output indicators*** *(one per activity)* (Refer to Annex II)	***Baseline***	***Target figures***			***Responsible/ Implementing agency or agencies***	***Cost***
		2002	***2003***	***2004***	***2005***		
2.1.Drawing up an O.I. case management guide and module	*An O.I. case management guide and module are available.*	*2*	*Avail-able*	*Avail-able*	*Avail-able*	*PNLS UNDP Fometro*	*8,500 (UNDP) (W.B.)*
2.2.Training/ retraining health staff in O.I. case management	*Number of persons trained (doctors, nurses and laboratory assistants).*	*300*	*450*	*675*	*1025*	*PNLS*	*355,000 $US (G.F.)*[24]
2.3.Reproducing and distributing the O.I. case management guide and module	*Number of guides and modules reproduced and distributed.*	*350 modules 350 guides*	*1000*	*1500*	*2000*	*PNLS*	*UNDP W.B.*
2.4.Making O.I. drugs available in supported health structures.	*Number of structures supplied with O.I. drugs.*	*100*	*150*	*225*	*325*[25]	*PNLS/ UNDP/ FOMETRO*[26]	*1,300,000 US$ (G.F.).*

[23] *Reference General Hospitals*
[24] *F.M : Fonds mondial (Global fund).*
[25] *The number of HGRs will rise from306 (2002) to 504 (2005) by 2005*
[26] *Tropical Medical Fund*

2.5. Strengthening laboratory diagnosis capacity with equipment (mixed microscopes), consumables and reagents.	*Number of laboratories with improved equipment, consumables and reagents.*	*25*	*50*	*75*		*PNLS*	*Lump sum of 30,000 US$ (G.F.) to complement Fometro/W.B. funding*
2.6. Providing clinical and biological monitoring of most needy PLHIV not undergoing ARV treatment.	*Percentage of PLHIV not undergoing ARV treatment biologically and clinically monitored*	*10%*	*30%*	*50%*	*70%*	*PNLS NGOs*	*180,000 US$ (G.F.).*
2.7. Conducting a study of resistance to antibiotics of bacteria resistant to O.I.	*A resistance study conducted.*	*0*	*1*			*(WHO, ESP[27], UNIKIN, PNLS (Laboratory) Partnership DRC/Montpellier*	*60,000 US$ (G.F.).*
2.8. Providing supervision of activities.	*Number of supervisions carried out.*	*4*	*12*	*12*		*PNLS 2/year BPC 4/year BCZS 12/year*	*90,000 US$ (G.F.).*
SUBTOTAL 2							***2,015,000 US$***

Objective 3:	**To improve accessibility and quality of ARV treatment dispensation**				
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Target figures**			
	Year 2002	**Year 2003**	**Year 2004**	**Year 2005**	**Responsible/ Implementing agency or agencies**
Number of patients with access to ARV treatment.[28]	100	876	1314	1712	GSS[29]/ Medical Training.
Number of structures dispensing ARVs according to standards defined by PNLS.	8	8	11	20	PNLS

[27] *College of Public Health*

[28] *At the present time, we estimate an average of 100 people treated by ARVs, by hospital or city doctors. That is how the active dossier of patients included over a three-year period amounts to 3902 patients. During that period, they will benefit from case management as defined in the introduction. The indicators are composed of a 50% increase in the active dossier for the 2nd year, and 30% for the third year. The rise in case management of this activity is progressive and, on the one hand, takes into account the need for organisation of therapeutic case management and, on the other hand, the capacity for implementing this new activity at the level of the different selected sites.*

[29] *GSS: Générale de Santé et Services, i.e. representation of CIPLA Ltd in D.R. Congo.*

III. Broad activities related to each specific objective and expected output:

Objective 3	**To improve the accessibility and quality of ARV drug dispensation.**						
Broad activities	**Process/Output indicators** (one per activity) (Refer to Annex II)	**Baseline** 2002	**Target figures** **Year 1**	**Year 2**	**Year 3**	**Responsible/ Implementing agency or agencies.**	**Cost and source of funding**
3.1. Drawing up an ARV infection treatment guide.	ARV treatment guide available.[30]	Available	Available	Available	Available	PNLS/UNDP IMT / Antwerp.	(PNLS/ GTZ/ IMT)
3.2.Equipping structures with laboratory equipment.	Number of laboratories equipped.	3	3	5	4	PNLS	1,080,000 US$ (G.F.).[31]
3.3. Reproducing and distributing the ARV guide.	Guide reproduced and distributed.	200	200	300	400	PNLS/GTZ	
3.4 Training / retraining hospital and non-hospital staff in ARV use counselling.	- Number of staff trained in ARV counselling. - Number of persons retrained. - Number of seminars organised.		25	25 30 30	30	IMEA[32] Bichat/France PNLS. Cafes.[33]	120,000 US$ (G.F.) 50,000 US$[34]
3.5. Providing continuous training abroad (attending international conferences.	Number of persons trained. Number of persons attending international conferences.	4 15	12	15	15	PNLS/Bichat IMEA / Paris IMT / Antwerp Hospital St Pierre, Brussels.	150,000 US$ (G.F.).
3.6. Making reagents and other basic materials available for screening.	Number of ARV dispensing structures supplied with screening input.	8	16	27	47	PNLS	200,000 US$ Additional bridging sum (G.F.).

[30] This guide was drawn up in partnership with these organisations. It is currently being reproduced and distributed.

[31] The World Bank, Forretro are going to equip two structures in Kinshasa and in Lubumbashi for immuno-biological monitoring. This application concerns the stengthening of equipment; five in the second year and four in the third year. I.e. 120,000 x 4

[32] Institute of African Medicine and Epidemiology, Paris

[33] Cafes: Centre Africain de formation des éducateurs sociaux (African Training Centre for Social Education Workers).

[34] Initial training is provided by USAIDS, and by GSS /CIPLA. The 3 seminars are therefore complementary with initial training.

3.7.Making ARVs available in the different structures.	Number of structures supplied with ARV[35].	8	16	27	47	PNLS/GSS	2,407,140 US$ (G.F.)
3.8. Making various molecular ranges available (patients requiring alternative treatment).	Number of persons presenting side effects and benefiting from case management	0	175	265	345	PNLS	945,000 US$ (G.F.)
3.9. Providing coordination of clinical and biological monitoring in various structures.	Number of central monitoring reports (central, provincial and periphery).	0	6 (2 per level).	6 (2 per level).	6 (2 per level).	PNLS / Consultants.	30,000 US$ (G.F.).
3.10. Providing therapeutic education to beneficiaries (teaching tools for understanding treatment).	Number of beneficiaries educated.	Data not available					140,000 US$ (G.F.).
3.11. Making the ARV circuit operational in dispensation sites.	- ARV drug circuit organised.		8	4		PNLS/GSS	60,000 US$ (G.F.).
3.12. Strengthening monitoring and supervision of hospital and auxiliary activities around ARV/ medical case management.	Number of monitoring, supervision and evaluation reports produced (central, provincial, peripheral).	**1** **2** **2**	2 4 4	2 4 4	2 4 4	PNLS* BPC/IP* BCZS/NGO*	90,000 US$ (G.F.).
Subtotal 3							**5,222,140 US$**

BPC = Provincial Coordination Office
BCZS = Health Area Central Office

[35] *List of accredited structures and compilation of the active dossier of patients undergoing ARV treatment per year. The estimated cost, at 95$ per person treated per month, takes treatment and immuno-biological monitoring into account.*

List of structures accredited to prescribe ARV and the number of patients expected per year.

	Number of patients [36].			
	Year 1	Year 2 (plus 50%)	Year 3 (plus 30%)	Total
University clinics of Kinshasa (adults and children)	120	180	234	534
Kinshasa General Hospital	96	144	187	427
Ngaliema Clinic	72	108	145	325
Paediatric Hospital of Kalembelembe	36	54	70	160
Amo-Congo	240	360	468	1068
Ngaliema centre	36	54	70	160
Hospital St Joseph	120	180	234	534
Clinique Emeraude (Clinic)	36	54	70	160
Provinces (sites currently being identified)	120	180	234	534
Total	**876**	**1314**	**1712**	**3902**

Women and their family benefiting from PTMC, whose state of health requires ARV, will be directed towards these different reference structures (Adult and paediatric).

Summary of standards defined by the PNLS for prescribing A.R.V:

1. Presence of a trained or retrained doctor writer of prescriptions.
2. Existence of a medical and social eligibility committee.
3. Existence of a Voluntary screening and counselling (CDV) unit.
4. Presence of trained community mediators.
5. Presence of one of the doctors and nurses trained in O.I. diagnosis.

Specific objective 4:	**To strengthen the psychosocial case of PLHIV and their Family**			
Outcome/coverage indicators (Refer to Annex II)	**Baseline**	**Target figures**		
	Yr. 2002	**Yr. 2003**	**Yr. 2004**	**Yr. 2005**
% of PLHIV benefiting from case management on ARV case management sites	1%	50%	80%	100%
% of PLHIV families under ARV benefiting from psychosocial accompaniment	1%	50%	80%	100%

[36] *At the present time, we estimate an average of 100 people treated by ARVs, by hospital or city doctors. That is how the active dossier of patients included over a three-year period amounts to 3902 patients. During that period, they will benefit from case management as defined in the introduction. The indicators are composed of a 50% increase in the active dossier for the 2nd year, and 30% for the third year. The rise in case management of this activity is progressive and, on the one hand, takes into account the need for organisation of therapeutic case management and, on the other hand, the capacity for implementing this new activity at the level of the different selected sites.*

I.V. Broad activities related to each specific objective and expected output:

Objective 4	**To strengthen psychosocial case management of PLHIV and their Family.**						
Broad activities	**Process/Output indicators** (one per activity) (Refer to Annex II)	**Baseline**	**Target figures**				
		2002	**2003**	**2004**	**2005**	**Resp. agency**	**Cost**
4.1. Drawing up a reference guide about the psychosocial activities of community mediators.	Reference guide drawn up.	0	1	-	-	PNLS/ IMEA	40,000 US$ (G.F.).
4.2. Setting up an educational committee for approval, recruitment and supervision of community mediators (15 persons x 80 USD / month).	- Number of operational education committees. - Number of meetings held. - Progress report.	0	1 12 -	- 12 -	- 12 -	PNLS, NGO.	45,000 US$ (G.F.).
4.3. Training community mediators in psychosocial case management, adherence to ARV treatment, counselling, and mediation for 21 days.	80 community mediators trained.	0	40	20	20	IMEA/ Paris	240,000 US$ (G.F.).
4.4. Providing compensation to (professionalised) community mediators on case management sites (50 USD/month/ person, part-time).	Number of Mediators in position on sites, receiving compensation.	0	40	20	20	PNLS/ NGO	112,500 US$ (G.F.).
4.5. Supporting PLHIV with basic food (cereals, oils, salt, peas, etc.).	Number of assisted PLHIV.	10,000				WFP/ NGOs	WFP[37].
4.6. Providing support to 15 NGOs to strengthen capacities (10,000 US$).	Number of NGOs presenting a proposal to strengthen capacities.	0	15	15	15	PNLS NGO network.	450,000 US$ (G.F.).
4.7. Supporting the AGR/ARSP provided by the 15 NGOs in the case management structures.	Number of structures and NGOs supported with AGR and ARSP.	0	15	15	15	PNLS, NGOs	675,000 US$ (G.F.).

[37] *People living with HIV are supported by the WFP, which distributes food aid through PLHIV associations (cereals, salt, oil, etc.). The number of people benefiting from this assistance is currently estimated at approximately 10,000.*

4.8. Providing the services of Nutritionists at site level (fees).	- Number of nutritionists. - Number of sites covered. -Number of Nutritionist services provided.	0	4	8	12	PNLS NGOs	15,000 US$ (G.F.).
4.9. Providing legal and trade-union (inter-union) services at site level (fees).	- Number of legal advisers. - Number of trade-union officials. -Number of sites covered. -Number of services provided.	0	4 1 8 In prog.	6 3 11 In prog.	14 11 20 In prog.	PNLS/ NGOs case mgmt sites.	117,000 US$ (G.F.).
4.10. Supporting the coordination of activities on case management sites.	- Number of coordination meetings held. - Number of monitoring and supervision visits (central, intermediate and peripheral).	0	4 (2, 4, 12).	4 (2, 4, 12).	4 (2, 4, 12).	PNLS/ BPC BCZS/ NGO Sites.	(30,000 US$/ yr. x 3) = 90,000 US$ (G.F.)
4.11. Setting up a medical and social eligibility committee per site (transport costs for 7 members x 20 USD per site).	Number of eligibility committees established in sites.	0	8	11	20	PNLS/ Struct-ures	65,520 US$ (G.F.).
4.12. Support for orphans taken over by NGOs (lump sum for 9,000 children, school fees).	- Number of children supported. - Amount of materials supplied.	5,000 WFP (Food costs)	3,000 orph-ans	4,500	1,500	Amo-Congo and other NGOs.	900,000 US$ (G.F.)[38]. Lump sum to complement UNICEF: UNICEF, WFP/CTB[39]
4.13. Support for the social and occupational reintegration of orphans of NGOs.	-Number of adolescents supported. -Type of projects proposed.	0	30	30	40	Amo-Congo and other NGOs	35,000 US$. (G.F.).

[38] *5,000 orphans, children and adolescents are followed by NGOs Amo-Congo with the support of the WFP, UNICEF, and CTB.*
The Global Fund intervenes for 3,000 children, specifically for school fees and the occupational reintegration of adolescents.
[39] *CTB: Belgian technical cooperation.*

4.14. Providing external evaluation.	- External evaluation conducted. - Evaluation report produced and distributed.	0	1 interi m	1 End 2004		PNLS Consult-ant.	70,000 US$ (G.F.).
4.15. Inventory of HIV-related problems at the workplace.	Inquiry report produced, forwarded and distributed.	0	1	-	-	PNLS/ SYNC-ASS.	20,000 US$. (G.F.).
4.16. Research action into implementation of agreements on the mutual insurance of workers and access to care in companies.	Survey report produced and distributed.	0	1	-	-	PNLS/ SYNC-ASS	20,000 US$. (G.F.).
SUBTOTAL OBJECTIVE 4							**2,895,120 US$.**

Specific objective 5:	To improve adherence to ARV treatment.				
Outcome/coverage indicators (Refer to Annex II)	**Baseline** **2002**	**Target figures** **Yr. 2003**	**Yr. 2004**	**Yr. 2005**	**Responsible agencies**
% adherence to ARV treatment in case management sites.	**0**	70%	80%	90%	Case management structures

V. Broad activities related to each specific objective and expected output:

Table IV.27.1

Objective 5	To improve adherence to ARV treatment					
Broad activities	Process/ Output indicators (one per activity) (Refer to Annex II)	Base-line 2002	Target figures Year 2003	Year 2004	Year 2005	Responsible /Implementing agency or agencies	Cost
5.1. Drawing up a study protocol on the use of ARV. (development and validation workshop).	An ARV study protocol available.	**0**	1			PNLS PNLT ESP	5,000 US$ (G.F.).
5.2. Conducting an exploratory survey on the level of adherence/ observance of ARV.	Survey conducted and report available.	**0**	1	1		PNLS PNLT ESP	40,000 US$ (G.F.).

5.3. Distributing findings of survey on the level of adherence and observance of ARV.	Number of copies of survey findings transmitted.	**0**			1000	PNLS	
SUBTOTAL 5						45,000 US$	
GENERAL TOTAL						10,322,160 US$	

Supporting PLHIV with basic food (starchy food, oil, etc.)

List of NGOs

1. Avenir meilleur pour les orphelins du Congo (AMO Congo). (Better Future for Congolese Orphans)
2. Réseau Congolais des PVV (RCP plus). (Congolese PLHIV network)
3. Fondation Femmes plus (FFP). (Women's Foundation)
4. Bureau diocésain des ordres médicales Kinshasa (BDOM). Diocesan medical charity)
5. Forum Sida Kinshasa (AIDS Forum)
6. SWAA/RDC (Society of Women against AIDS in Africa/DRC)
7. Apostolat pour la libération des PVV (Alpi plus). (Apostolate for the liberation of PLHIV)
8. UNIS
9. ECHIMA
10. CESVI (Italian Cooperation)
11. FEDES

Support for associations in the Provinces

OVERALL CASE MANAGEMENT BUDGET
SUMMARY

Budget Items	2003	2004	2005	Total
Human Resources	489458	580953	324609	**1 395 020**
Infrastructure / Equipment	408 085	506 808	445 107	**1 360 000**
Training / Planning	900 639	631 284	638076	**2 170 000**
Commodities	0	0	0	**0**
Drugs	1 670 121	1 202 386	1 839 633	**4 712 140**
Monitoring / Evaluation	354 000	245 000	136 000	**735 000**
Other (Transport / Maintenance)	0	0	0	**0**
Administrative Costs				
Total	**3,822,303**	**3,166,431**	**3,383,425**	**10,372,160**

Administrative costs are indicated in the overall summary for the component.

See cost breakdown in Annex V

Area of intervention 4: Prevention of transmission of HIV from mother to child (PTMC)

Analysis of the situation

PTMC should be integrated into the national strategy in the prenatal consulting departments (PNC) where women have access to advice and voluntary screening.

National policy recommends breast-feeding solely by the mother until the baby is six months old regardless of the serological status of the mother and child.

HIV+ women receive nevrapin during labour and the new-born child receives the drug during the first 3 days after his/her birth.

At the present time, national strategy is based on confirmation of the serological status of children born of seropositive mothers when they are 18 months old. The imminent acquisition of a PCR as part of an IDA donation from the World Bank will make it possible to confirm status from birth. The country has already benefited from a first donation of nevrapin by Boehringer.

PTMC sites are selected according to specific criteria and are infrastructures, which house both the PNC and maternity departments.
The PNLS (National Programme to Fight AIDS) has designated a national focal point and set up a national technical committee for PTMC.

In 2000, PTMC started in the private medical centre of the Heineken brewery /Bralima.
In 2001, the Government with the support of the GTZ started PTMC in 2 pilot sites in Kinshasa (Kigansani, Binza) and will shortly start in a third site (Kintambo). Fourteen other sites have already been selected and should be operational before the end of 2002: 4 sites in Kinshasa (Belgian funding), 6 sites in the Province of Bas-Congo (UNICEF funding), 2 sites in the Province of Nord Kivu (Save the Children), 1 site in the Province of Sud Kivu (UNICEF funding), and 1 site in the Province of Kasaï Occidental (Protestant Church funding).

The analysis of data for the 2 pilot centres shows:

- A test acceptance rate by women in PNC: 50% after 8 months
- Seropositivity among tested cases: 3%
- Awareness of the screening result: 55%
- Acceptance of prevention treatment: data not currently available
- Compliance with treatment: 95%

The main problems and constraints encountered:

- Insufficient integration of PTMC in prenatal consulting
- Staff training incomplete and too short
- Weakness of counselling services
- Fear of knowing serological status and stigmatisation of people
- Low therapeutic coverage
- Small number of case management services for seropositive people.

Opportunities:

- Commitment by the Government and partners to support PTMC
- PTMC considered as a national priority and entered in the interim national plan
- Existence of a technical committee and a focal point
- Donation of nevirapin by the Boerhinger firm and first lot already obtained.

Strategy

Strengthening of PTMC will involve extending coverage of services by making 10 new sites operational as part of Global Fund financing.

In existing PTMC sites, to provide support to PTMC services, a community relay system will be organised for overall case management of the family unit of seropositive women. (These sites are called PTMC PLUS). This is complementary to the area of intervention "Overall case management of infected people", which forms part of this component.

The strategy will be implemented by site staff in partnership and with the support of national and international organisations and community associations involved in the fight against AIDS.

At the present time, 4 are operational including 3 in Kinshasa and 1 in Sud-Kivu (Bukavu). It is planned to set up 10 new sites located in the Provinces of Kinshasa, Katanga, Bas-Congo, Equateur, Kasaï Occidental, Kasaï Oriental and Nord-Kivu and Province Orientale. See cost breakdown in Annex VI.

Beneficiaries

By supposing a PNC frequentation rate of 60% during year 1 of site creation, with a 10% increase during the following years, it is planned to test 28,512 women and provide treatment to 8,506 seropositive women over the 10 new PTMC sites. The number of women to be tested was calculated by multiplying the parameters hereafter:

Population covered by the 10 sites	1,800,000
Birth rate	0.048
PNC use	0.6
Test acceptance rate	0.55
Number of women to be tested	**28,512**

As regards PTMC plus, 4,468 seropositive women will benefit from support from relay persons.

Table IV.27

Main Objective	**To strengthen and extend the prevention of HIV transmission from mother to child by including overall case management of the family unit.**				
Outcome/coverage indicators (Refer to Annex II)	**Baseline 2002:**	**Target figures**			
		2003	**2004**	**2005**	
Number of NEW SINGLE PTMC sites	**0**	3	6	10	
Number of PTMC PLUS sites	**4**	8	18	18	
Test acceptance rate per new site	**40%**	40%	50%	60%	
Awareness of the screening outcome per site	**40%**	50%	60%	80%	
Compliance with treatment	**75%**	80%	85%	95%	
Proportion of monitored children born of HIV+ mothers (only for PTMC PLUS sites)	**No data**	40%	50%	60%	
Among families of HIV+ women, proportion of families having had at least one contact with a Case Management (PEC) centre (Only valid for PTMC PLUS sites	**No data**	5%	15%	30%	

Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Specific objective 1: To strengthen the human capacities of the PTMC programme

Activities:

1. Making user guides and training modules available: existing guides and modules validated at national level will be used for training and made available to all the staff at site level.

2. Training medical and paramedical staff for counselling, screening and treatment. This staff, including advisers, form part of the centres under programme.

3. Training community relays: persons with community recognition or already acting as community representatives will be recruited and trained to form the link between women, their families, PTMC sites and Case Management centres.

4. Training the doctor responsible for coordination and supervision at provincial office level and at the health area where a PTMC site exists.

Table IV.27.1

Objective 1	**To strengthen the human capacities of the PTMC programme**						
Broad activities	**Process/ Output indicators** (one per activity) (Refer to Annex II)	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**
		2002	**2003**	**2004**	**2005**		

1. Making available user guides and training modules	Guides available and distributed in the sites	18	21	24	28	Min. Health, Internat. Org. National Org.	WHO
2. Training medical and paramedical staff (15 pers./site including 2 doctors, 5 midwives, 2 laboratory assistants, 6 advisers)	Number of sites with trained staff	18	21	24	28	Min. Health, Internat. Org. National Org.	82,500 (GF)
3. Training community relays (6 per site)	Number of PTMC PLUS sites with trained relay staff	4	8	18	18	NGO	64,680(GF)
4. Training persons responsible for coordination and supervision (3 per province)	Number of provinces of which the coordinators/ supervisors are trained	5	5	7	11	Ministry of Health	15,600 (GF)
5. Organising campaigns to raise awareness in the community in order to reduce stigmatisation and improve acceptance of PTMC	Number of campaigns	18	21	24	28	Community relays	P.M. (see STI case management objective 3 activity 4)
Total amount requested from the GF for objective 1:							**162,780**

Specific objective 2: To improve acceptance of PTMC as part of prenatal consulting

Activities

1. Providing awareness-raising, information and communication material: Brochures and posters will be produced and made available to staff and women.

2. Making available consumable material for screening.

3 and 4. Providing supplies of screening tests at site level. These tests will go through a safe drug supply circuit appropriate to local circumstances.

5. Providing pre-and post-test counselling.

Table IV.27.1

Objective 2	**To improve acceptance of PTMC as part of prenatal consulting**

Broad activities	Process/Output indicators (one per activity) (See Annex II)	Baseline (Specify year) 2002	Target figures			Responsible/ Implementing agency or agencies	Cost and sources of financing
			2003	2004	2005		
1. Developing and Supplying IEC material and equipment	Number of sites equipped with material	**18**	21	24	28	UNICEF Ministry of Health NGOs	5,000 (UNICEF) (WHO) 3,000 (GF)
2. Making consumable material available for screening	Number of sites equipped	**18**	21	24	28	Ministry of Health	14,217 (GF)
3. Purchasing of screening tests (purchasing plus transport	Tests ordered		3600	8550	16284	Ministry of Health	51,181 (GF)
4 Providing equipment and tests to sites	Number of sites having tests and small equipment	**18**	21	24	28	Ministry of Health and partners	4,500 (GF)
5.Giving pre-and post-test counselling	Number of sites with pre- and post-test counselling carried out	**18**	21	24	28	Health staff	28,434 (GF)
Total amount requested from the GF for objective 2:							101,332

Objective 3: To improve access to transmission prevention treatment

Activities

1.Making protection and disinfecting equipment available. Practices for protecting and disinfecting equipment will be established to ensure protection of staff and women.

2. Making nevirapin (viramun) available: Boerhinger will be asked for a 3-year supply of drugs to cover needs. The drug will be transported to the sites through the safe drugs circuit appropriate to local circumstances. The Global Fund will be requested to assume transport costs.

3. Administering treatment according to the plan recommended at national level.

4. Strengthening infrastructures in new sites: replacing faulty small equipment, purchasing equipment for disinfecting and protection practices, building a small incinerator according to local technology.

Table IV.27

Specific objective 3	To improve access to transmission prevention treatment						
Broad activities	Process/Output indicators (one per activity) (Refer to Annex II)	Baseline (Specify year) 2002	Target figures 2003	*2004*	*2005*	Responsible/ Implementing agency or agencies	Cost and sources of funding

1. Putting protection and disinfecting methods into practice	Number of sites equipped with material	**18**	21	24	28	Ministry of Health	17,012 (GF)
2. Supplying Nevirapin (order and transport)	Number of sites with nevirapin at their disposal	**18**	21	24	28	Ministry of Health	Boerhinger 34,025 (GF)
3. Administering treatment	% of correct treatment	**85%**	90%	95%	98%	Site staff	P.M.
4. Strengthening site equipment	Number of sites with adequate equipment	**18**	21	24	28	Ministry of Health	1,000,000 (GF)
Total amount requested from the GF for objective 3:							1,051,037

Specific objective 4: To promote overall case management (PEC) of the family unit

Activities

Activities related to this objective will only be carried out in PTMC PLUS sites.

Activities 1 to 4. Monitoring HIV+ women and their family at home. Relay persons will provide psychological support and will give counselling to the mother and family.
- Women will be directed to reproductive health services and, if necessary, to case management services.
- Children will be directed, if necessary, to case management structures. The serological status of children born of seropositive mothers will be confirmed by a test 18 months after birth or as early as birth by PCR as soon as possible.
- Partners will be made aware of voluntary screening and directed to appropriate structures.

Activity 6. A nutritional contribution will be provided to all needy children (regardless of the serological status of the mother and child) from 6 months old.

Table IV.27.1

Specific objective 4	**To promote overall case management of the family unit**						
Broad activities	**Process/Output indicators** (one per activity) (Refer to Annex II)	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**
		2002	**2003**	**2004**	**2005**		
1. Monitoring HIV+ women at home during perinatal period	Rate of women monitored	**Not organised**	20%	40%	75%	NGOs	22,341 (GF)
2. Directing children born of HIV+ mothers for monitoring	Rate of children with known status	**Not organised**	20%	40%	75%	NGOs	P.M.
3. Advising the test to the partner	Test acceptance rate per partner	**Not organised**	10%	25%	50 %	NGOs	P.M.

4. Directing seropositive women to reproductive health services	Rate of HIV+ women accepting PF	**5% in general pop. of women**	8%	10%	12%	NGOs	P.M.
5. Informing about and, if necessary, directing HIV+ women and their children towards medical and psychosocial Case Management centres	Rate of women aware of the existence of a Case Management centre and of its services	**Not organised**	40%	70%	85%	NGOs	P.M.
6. Nutritional support	Percentage of children having received nutritional support	**Not organised**	85%	95%	98%	NGOs	151,073 (GF)
Total amount requested from the GF for objective 4:							173,414

Objective 5: To provide PTMC monitoring and evaluation

Activities

1. Organising the monitoring of the PTMC programme. The PTMC management system (woman's monitoring card, compilation of information, drug stock management) has already been defined. This system will be integrated into the Reproductive Health management system.

2. Supervising the medical and paramedical staff of PTMC sites. Supervision will be integrated into reproductive health programme supervision. Supervision will be organised close together in time for the first year of operation of PTMC and then there will be 2 supervisions per year. The supervision of PTMC PLUS sites will be taken over by other sources of funding.

3. Ensuring monitoring and coordination of relay persons. A weekly monitoring system will be provided at each site by a coordinator.

4. Yearly evaluation: a yearly evaluation of this area of intervention will be organised by a team of external consultants composed of an international consultant and two national consultants.

Table IV.27.1

Specific objective 5	**To organise and provide PTMC monitoring and evaluation**						
Broad activities	**Process/Output indicators**	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Cost and source of funding**
		(Specify year)	**Year 1**	**Year 2**	**Year 3**		
1. Organising the management system	Number of sites with operational system	**Development in progress**	21	24	28	Ministry of Health	UNICEF

2.Supervising site staff	Percentage of reports provided	**In progress**	95%	98%	100%	Ministry of Health	11,934 (GF)
3 Monitoring relay persons	Relays monitored (weekly meetings)	**Not organised**	75%	80%	85%	NGOs	35,097 (GF)
4. Organising the yearly evaluation	Evaluation made and report handed in	**Not organised**	Yes	Yes	Yes	Consultants	60,000 (GF)
Total amount requested from the GF for objective 5:							107,031

SUMMARY OF PTMC BUDGET REQUESTED FROM THE GLOBAL FUND

Budget Items	2003	2004	2005	Total
Human Resources	12998	12998	24778	50775
Infrastructure / Equipment	306004	306004	408005	1020012
Training / Planning	43230	76150	43400	162780
Commodities	143992	34930	37548	216471
Drugs	10208	10208	13610	34025
Monitoring / Evaluation	57660	22113	27258	107031
Other (Transport / Maintenance)	1350	1350	1800	4500
Administrative Costs				
Total	**575,442**	**463,753**	**556,399**	**1,595,594**

Administrative costs are indicated in the overall summary for the component.

See cost breakdown in Annex VII

Area of intervention 5: Epidemiological surveillance

Analysis of the situation:

The national epidemiological surveillance system of the PNLS (National Plan to Fight AIDS) is mainly based on 2 approaches: routine surveillance and surveillance by sentinel sites.

Routine surveillance aims at monitoring morbidity and mortality related to HIV/AIDS/STI. It involves passively collecting data in the Health Areas. The data concern:

- cases of AIDS, Tuberculosis and STI diagnosed in hospitals and Health Centres

- cases of HIV infection among blood donors.

Until June 2002, this routine surveillance system was characterised by the comparatively small number of cases notified, owing in particular to the multiplicity of data collection sheets and circuits, the overload of work at peripheral level, and weakness at coordination level, especially at intermediate level. This state of affairs led the Ministry of Health to reorganise the notification system through the development of an integrated disease surveillance system. This new process is currently being implemented.

Until 1999, *surveillance by sentinel sites* was based only on the presence of HIV and Syphilis in pregnant women. Surveillance was initially planned in 23 sites, and was actually implemented in a dozen sites, but regular data, making it possible to form a chronological series, could only be obtained from 4 of them. In 1999, the country opted for the second-generation epidemiological surveillance protocol. This included, in addition to the surveillance of a serological reaction to HIV and Syphilis, the surveillance of high-risk behaviour and practices, but up to now, this protocol could only be applied in 3 sites. The main reasons for this were the lack of trained staff in most sites, the shortage of equipment and input and the lack of monitoring and supervision.

In addition to these 2 approaches, there are *pinpoint surveys* conducted by various stakeholders, unfortunately not coordinated, and the results of which are not often forwarded to the PNLS.

Problems:

Faced with these weaknesses and constraints, partial data from the Eastern regions of the country, in armed conflict, (source: Save the Children-UK survey, Dec. 2001) show that serological reaction to HIV has quadrupled compared with the national average of 5%, reported in 1999. Furthermore, an IRC report, published in 2001, mentions sexual violence and massive movements of populations, so increasing their vulnerability and the risk of explosion of the epidemic. The foregoing emphasises the urgent need for reliable epidemiological surveillance with a view to constructing a riposte adapted to the extent of the problem.

Opportunities:

In response to this situation, the Ministry of Health through the PNLS, has established a partnership with a number of NGOs and cooperation agencies, more particularly:

- WHO and USAIDS (technical support),
- the CDC/USAID (training for 4 sites: Goma, Kindu, Bukavu and Kisangani),
- Norwegian Cooperation (one year's funding for 12 sites) and Italian Cooperation (2 sites for one year).

The purpose of this application is to obtain additional resources and to extend surveillance coverage and make it sustainable.

Strategy

Strengthening the epidemiological system will involve revitalising routine surveillance, extending surveillance coverage by sentinel sites, and setting up an effective information coordination and management system.

Table IV.27

Main Objective:	To reinvigorate the HIV/AIDS/STI epidemiological surveillance system to improve the national response to the epidemic		
Outcome/coverage indicators	**Baseline**	**Target figures**	
(Refer to Annex II)	**2002**	**2003**	***2004***	***2005***
Proportion of Health Areas notifying	**10%**	15%	45%	60%
Number of operational sentinel sites	**3**	12	18	23
Number of Provincial Coordination offices having a database	**0**	3	8	11
Number of Provinces covered by the National Executive database	**0**	3	8	11

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Specific objective 1: to raise the proportion of Health Areas (ZS) notifying AIDS cases on a monthly basis from 10 to 60% by 2005

Activities:

1.1 Training provincial trainers in routine integrated surveillance.
Training requirements for provincial trainers are estimated at 66 trainers on the basis of 6 trainers per province (3 teams of 2 trainers, to obtain a rapid multiplying effect in view of the vast extent of the territory). Support from the WHO has made it possible to train 13 trainers already in 2002. Consequently, 53 still need to be trained, from the 1st year.

N.B. Training actions represent transverse actions for the 3 components.

1.2 Training/retraining Health Area (ZS) in routine integrated surveillance.
Calculated on the basis of 5 persons per Health Area, these requirements have been estimated at 900 persons (for 180 ZS).

N.B. The funds requested from the Global Fund counterbalance the funds ($ 430,000) made available to the 4th Directorate (in charge of Epidemics and the fight against disease) of the Ministry of Health by USAID, a part of which is intended for training at intermediate and peripheral level in 3 Provinces.

1.3 Supplying the Health Areas (ZS) with equipment and supplies.
Supplies and equipment to Health Areas (ZS) consist of data collection tools (collection outline, report forms, etc.) and bicycles. Bicycle coverage is currently provided for 180

Health Areas (ZS) (SANRU/PEV[40]). Considering the life expectancy of bicycles, the requested funds will be used, among other things, to renew this equipment from the 3rd year.

Providing supervision at Provincial level.

1.5 Providing supervision at peripheral level.

N.B. (concerning activities 1.4 and 1.5) The USAID funds referred to in item 1.2 above also covers supervision needs for the first year in 3 Provinces.

[40] *Projet des Soins de Santé Primaires en Milieu Rural (Primary Health Care Project for Rural Areas)*
Programme Elargi de Vaccination (Extended Vaccination Programme)

Table IV.27.1

Specific objective 1:	To raise the proportion of Health Areas (ZS) notifying AIDS cases on a monthly basis from 10 to 60% by 2005						
Broad activities	**Process/ Output indicators** (one per activity) *(Refer to Annex II)*	**Baseline** (**Specify the year) 2002**	**Target figures** **2003**	***2004***	***2005***	**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**
1.1 Training provincial trainers in routine integrated surveillance	# of trained trainers	**13**	66			Directorate in charge of Epidemics and the Fight against diseases of Min. Health	(WHO/ Norwegian Coop.)[41] + 44,100 (GF)

[41] *This fund of 219.000 USD was used to partly carry out (for the year 2002) several activities in the field of epidemiological surveillance, more particularly activities 1.1, 2.3, 2.5, 2.6, 2.8 and 3.3. The funds requested herein will be used to complement these activities for the following years or to extend the coverage of them*

1.2 Training/retraining Health Area staff in routine integrated surveillance	# of trained staff	**150**	1000			Provincial medical inspection	Part of 430,000 (USAID) + 312,750 (GF)
1.3 Supplying Health Areas with equipment and supplies	# of Health Areas equipped	**180**	180 (collection outline)		180 (bicycles)	Directorate in charge of Epidemics and the Fight against diseases of Min. Health	18,000 (SANRU/PEV) + 68,256 (GF)
1.4 Providing supervision at Provincial level	# of supervision visits /year	**2 per prov. per year**	**2X8**	**2X11**	**2X11**	Directorate in charge of Epidemics and the Fight against diseases of Min. Health	15,120 (SANRU/USAID) + 151,253 (GF)
1.5 Providing supervision at peripheral level	# of supervision visits /ZS/yr.	**4**	**4**	**4**	**4**	Provincial medical inspection	162,864 (GF)
Total amount requested from GF for objective 1:							**739,223**

Specific objective 2: to extend the surveillance system for sentinel sites from 3 to 23 operational sites by 2005

The PNLS had decided to have 23 sentinel sites spread throughout the country:

3 in Kinshasa, and 2 in each of the other 10 provinces (1 urban site and 1 rural site).

On account of the socioeconomic and political context (war), the last sentinel surveillance visit could only be made to 3 sites, in 1999. Recent favourable political progress will make the gradual resumption of sentinel surveillance possible.

Activities

2.1 Re-evaluating the viability of the rural sites in the 10 provinces, and if necessary, identifying others. This re-evaluation of rural sites is considered necessary because infrastructures in rural areas have sometimes suffered substantial damage, due to the war.

2.2 Providing training/retraining to the staff of sentinel sites.
N.B. Since *trainer* training is already provided by a WHO project for the Western part, and by a CDC/USAID fund for the Eastern part of the country, this application only concerns the training of staff at sentinel site level.

2.3 Supplying sentinel sites with equipment and consumables.
N.B. The equipment is composed of fridges and refrigeration boxes. The Prevention area (safe blood supplies) has already covered the needs of urban sites. The needs of rural sites are still to be covered.
First-year needs of consumables are covered by WHO/Norwegian Cooperation funding. The 2nd and 3rd years still need to be covered.

2.4 (Locally) recruiting national experts and interviewers for behavioural surveys.

2.5 Collecting samples for sero-monitoring.

2.6 Supervising sentinel sites.

2.7 Equipping the BPC (Provincial Coordination Offices) with the cold chain for the transit of samples.

2.8 Supplying the reference laboratory with reagents for valid quality control.
N.B. For the first year, this activity is covered by the WHO fund of 219,000. This application aims to ensure the continuity of quality control.

Specific objective 2:	**To extend the surveillance system for sentinel sites from 3 to 23 operational sites by 2005**				
Broad activities	**Process/ Output indicators**		**Target figures**	**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**

	(one per activity) *(Refer to Annex II)*		**2003**	***2004***	***2005***		
2.1 Re-evaluating the viability of the rural sites in 10 Provinces and, if necessary, identifying others	# of viable rural sites		10			National Executive of the PNLS	16,000 (GF)
2.2 Providing training/retraining of the staff of sentinel sites (15p/site)	# of staff trained		180 (12 sites)	210 (14 sites)	345 (23 sites)	AIDS Provincial Coordination Offices	24,725 (GF)

2.3 Providing sentinel sites with equipment and consumables	# of sentinel sites supplied					National Executive of the PNLS	(WHO: see Note 1) + 77,850 (GF)
2.4 Recruiting national experts and interviewers for behavioural surveys	# of sites benefiting from expertise					National Executive of the PNLS	37,200 (GF)
2.5 Collecting samples for sero-surveillance	# of visits made					Health Area Central Office	(WHO: see Note 1) + 12,300 (GF)
2.6 Supervising sentinel sites	# of supervision visits					AIDS Provincial Coordination Offices	(WHO: see Note 1) + 8,250 (GF)
2.7 Equipping Provincial coordination Offices (BPC) with cold chain for transit of samples	# of BPCs equipped with cold chain					National Executive of the PNLS	1,650 (GF)
2.8 Supplying the reference laboratory with reagents for valid quality control	Coverage of reagent needs for X contrl ol tests		X	X	X	National Executive of the PNLS	(WHO: see Note 1) + 21,720 (GF)
Total amount requested from the GF for objective 2:							199,695

Specific objective 3: To strengthen the management and coordination capacity of the PNLD for information relating to the HIV/AIDS epidemic

The national database concerning the HIV/AIDS epidemic will be managed and coordinated at two levels: the central and intermediate level.

Activities:

3.1 Drawing up and updating epidemiological databases at central and intermediate levels (Provincial Coordination Offices - BPC).
A database exists at central level but it is incomplete. It will be completed, while databases at intermediate level will be gradually established.

3.2 Equipping the PNLS (National Executive - DN and Provincial Coordination Offices - BPC) with communication hardware (E-mail).

3.3 Supplying computer hardware to the BPC of the Maniema. The other BPCs were taken over by the WHO fund.

3.4 Providing information management training to the DN and BPCs.

3.5 Providing information management supervision in the Provinces.

3.6 Organising the internal review of the information management system.

3.7 Organising an external evaluation of the information management system.

Specific objective 3:	**To strengthen the management and coordination capacity of the PNLD for information relating to the HIV/AIDS epidemic**						
Broad activities	**Process /Output indicators**	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**
		(Specify year) 2002	**2003**	***2004***	***2005***		

3.1 Drawing up and updating epidemiological databases at central and intermediate levels (BPC)	Updated database	Central level	Central level + 3 BPCs	Central level + 8 BPCs	Central level + 11 BPCs	PNLS	6,000 (GF)
3.2 Equipping the PNLS (DN and BPC) with communication hardware (E-mail)	Means of communication installed	0	DN + 11 BPC			DN/PNLS	55,000 (GF)
3.3 Supplying computer hardware to the BPC of the Maniema	BPC supplied with computer hardware	0	1			DN/PNLS	(WHO: 10 BPC out of 11: see Note 1) + 4,300 (GF)

3.4 Providing information management training to the DN and BPCs	# of trained staff	1 pers. at the DN	DN: 1 pers.; 2 pers./BPC			DN/PNLS	21, 450 (GF)
3.5 Supervising information management in the Provinces	# of supervisions made	2 yearly super-visions per BPC	2 yearly supervisions per BPC	2 yearly supervisions per BPC	2 yearly supervisions per BPC	DN/PNLS	50, 400 (GF)

3.6 Organising a data management system to monitor the progress of the response to HIV/AIDS	Existence of a progress monitoring system	ND	1 annual review	1 annual review	1 annual review	DN/PNLS	27,480 (GF)
3.7 Organising an external evaluation of the information management system	External evaluation organised	**0**		1 external annual evaluation		DN/PNLS	P.M. (transverse activity, dealt with elsewhere in this document.
3.8 Maintenance of equipment (for all surveillance)	% of equipment in working order	**NA**	100%	100%	100%		4,605 (GF)
					Total amount requested from the GF for objective 3:		169,235

Specific objective 4: draw up the mapping of the risk and the state of knowledge of populations about HIV/AIDS in the 11 provinces of the country by 2005

These behavioural surveys will be conducted under the coordination of the PNLS, through its central and intermediate structures by the College of Public Health of Kinshasa, the University of Kinshasa.

Activities:

4.1 Conducting behavioural studies in the Provinces on the basis of one in urban areas and one in rural areas. FHI already supports this activity with a budget provision of 100,000$ for 4 sites to be determined. The selected sum fixed for each survey is 25,000 $ per survey.

Specific objective 4:	**Draw up the mapping of the risk and the state of knowledge of populations abo HIV/AIDS in the 11 provinces of the country by 2005**						
Broad activities	**Process/Output indicators**	**Baseline**	**Target figures**			**Responsible/ Implementing agency or agencies**	**Cost and sources of funding**
		(Specify year) 2002	***2003***	***2004***	***2005***		
4.1 Conducting behavioural surveys on specific populations (sex providers, servicemen, young people and traffickers)	# of behavioural surveys conducted per province	**1**		2 2		DN (National Executive) PNLS / ESP (College of Public Health)	100.000 **(FHI)** + 450.000 (GF)
					Total amount requested from the GF for objective 4:		450,000

BUDGET SUMMARY EPIDEMIOLOGICAL MONITORING

Budget Items	2003	2004	2005	Total
Human Resources	37200	0	0	**37200**
Infrastructure / Equipment	169823	20309	16924	**207056**
Training / Planning	391200	6450	5375	**403025**
Commodities	11332	5666	4722	**21721**
Drugs	0	0	0	**0**
Monitoring / Evaluation	149804	579534	127549	**856887**
Other (Transport / Maintenance)	1535	1535	1535	**4605**
Administrative Costs				
Total	**760,895**	**613,494**	**156,105**	**1,530,493**

The administrative costs are indicated in the overall summary for the component.

See cost breakdown in HIV Annex VIII.

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programmes; does the component aim to fill existing gaps in national programmes; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines par. III.41 – 42*), (2–3 paragraphs):

The HIV/AIDS component builds on the activities already implemented within the scope of the PNLS, which only partly covers the 11 provinces of the country. This proposal is going to make it possible to improve coverage by decentralising activities up to 60% of health areas. Furthermore, it is going to strengthen the programmes by filling some gaps stated in various areas, more particularly:

- PTMC especially for community case management of the family unit
- mobilisation of the population through community relays to ensure the continuum of care
- prevention targeted at high-risk groups such as professional sex providers, schoolchildren and children not attending school, servicemen, etc.
- addressing community and institutional leaders for them to become increasingly involved in the fight
- availability of standard tools at peripheral level.

This proposal fits in with the strategic plan of the PNLS which is moreover in keeping with national poverty reduction strategies as defined in the Sector-Wide Emergency, Rehabilitation and Reconstruction Programme (PMURR) and in the Poverty Reduction Strategy Document (DRS).

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:
In all the spheres of activity, People Living with HIV (PLHIV) are an essential part of the intervention continuum:

- As far as the psychosocial and medical case management of PLHIVs and their family is concerned, the participatory process is carried through at several levels. First of all, within the medical and social eligibility committee, in the bodies providing psychosocial accompaniment set up in each site, run by NGOs, which include PLHIV networks.
- Furthermore, the selected approach for the involvement of PLHIV consists of professionalising their involvement so that they intervene upstream from case management around the screening and promotion process within the community, while case management takes place in hospital and ancillary premises and monitors ARV treatment, and downstream by sustaining the impetus of care.
- As far as the area of mobilisation and community participation is concerned, PLHIV are involved in defining the mobilisation strategy and their main task is the fight against risks of exclusion and discrimination.
- In addition, their participation also aims to identify all areas where people are deprived of their rights, and to mobilise local and parliamentary representatives so that legal and/or legislative mechanisms are proposed.
- The involvement of PLHIV was also considered in the area of prevention by seeing to it that individual experience may be communicated to the community, on the one hand, to make progress in public's perception of the phenomenon of AIDS and, on the other hand, to achieve progress in people's attitudes towards risks.
- Lastly, the involvement of PLHIV was taken into account in the field of PTMC insofar as the wellbeing of the family unit as a whole is furthered as soon as the pregnant woman who benefits from treatment of the risk of transmission, her spouse and her children are proposed for psychosocial or, if necessary, therapeutic monitoring.

29.2. Community participation:
A specific area of intervention has been devoted to community participation and mobilisation with regard to the need to sustain an impetus as far as HIV/AIDS in DRC is concerned. In actual fact, there is an incipient mobilisation in this area, despite many concerns, and people want to get further involved in a lasting counterattack against AIDS. The intervention will therefore rely on leaders of opinion, political leaders and representatives, trade-union leaders, religious leaders of all denominations and the heads of community NGOs.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):
This issue has not been specifically addressed in a chapter devoted to women but all throughout the proposed programme such as the issue of vulnerability, support for women within the scope of prenatal consultations, and the participation of women as community mediators, intervening in all the dimensions of the programme. Their contribution is acknowledged, professionalised and compensated.

29.4. Social equality issues (*Guidelines paragraph IV.53*):

The programme takes this basic issue into account, since concern for accessibility to rights and services (right to treatment, right to case management) has been taken into account in all the stages of implementation of actions, by mechanisms of national solidarity implemented by the State of the DRC and by associations and NGOs. Furthermore, the selected approach takes the needs of the person and his/her family into account, both from the medical point of view and the socioeconomic point of view.

As far as the subject of prevention is concerned, the approach based on the policy of reducing risks takes the personal pathway and social deciding factors into account.

29.5. Human Resources development:

These last years, the Democratic Republic of Congo has been experiencing a crisis in a multiplicity of forms. This context of crisis, with the ensuing disorganisation of the health system as its corollary, has increased the direct impact on the state of health of the population and more particularly those already in a vulnerable situation.

The same consequences can be measured regarding the loss of human resources and trained supervisors, putting a very heavy load on the staff in position. That is why two approaches were chosen. One approach involves the strengthening of resources by focusing on coordination and supervision with financial amounts, which would make it possible to allocate allowances in proportion to the workload. The other involves extending the scope of involvement of communities and NGOs, and increasing the number of persons capable of lasting involvement in the fight against AIDS. These people are the community mediators whose involvement is enhanced through professional training and they are paid compensation accordingly.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximise adherence and monitor resistance), *(Guidelines par. IV.55),* (1–2 paragraphs):

The DRC has decided to favour the use of generic products and treatment protocols. The decision is based on a cost-effectiveness option. A ministerial circular, dated 5 July 2002, has just confirmed this decision to opt for rational use. Its main feature is the accreditation of a list of doctors solely authorised to prescribe ARVs in order to ensure that drugs and medicine are administered in accordance with national and international quality recommendations.

In order to encourage adherence and observance of anti-retroviral treatment, two main lines of action were chosen:

- systematically proposing psychosocial accompaniment to persons applying for ARV treatment,
- creating therapeutic education teaching tools to facilitate understanding and use of treatment.

It is planned to analyse the situation, for patients for whom treatment with a range of generic products might prove ineffective and, if necessary, propose an alternative treatment with specialty drugs.

A qualitative study is planned a few months after the start of treatment in order to anticipate and understand the issues involved in adherence to ARV treatment.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

HIV/AIDS BUDGET SUMMARY

Budget Items	2003	2004	2005	Total
Human Resources	1,485,624.00	2,093,456.00	1,008,815.00	**4,587,895.00**
Infrastructure / Equipment	1,828,301.00	1,105,240.00	1,190,152.00	**4,123,693.,00**
Training / Planning	2,288,628.00	1,344,262.00	1,166,927.00	**4,799,817.00**
Commodities	4,627,788.00	3,975,229.00	4,895,951.00	**13,498,968.00**
Drugs	2,085,433.00	2,170,963.00	3,085,434.00	**7,341,830.00**
Monitoring / Evaluation	751,844.00	1,084,027.00	592,687.00	**2,428,558.00**
Other (Transport / Maintenance)	1,063,333.60	946,912.00	1,214,781.40	**3,225,027.00**
Administrative Costs	1,047,937.83	966,704.60	1,083,900.97	**3,098,543.40**
Total	**15,178,889.43**	**13,686,793.60**	**14,238,648.37**	**43,104,331.40**

Annex IX

Table V.30

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overheads, programme management, audit costs, etc*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	**Unit cost** (USD)	**Volume** (specify measure)	**Total cost** (USD)
Epicranian needles	0.05	66,000	3,300
Vacutainer needles	0.05	66,000	3,300
ARV, Generic[42]	77.953	10,512	819,452
ARV, Speciality	1,203.82	175	210,669
Condoms, women	1.00	100,000	100,000
Condoms, men	0.06	36,000,000	1,980,000
Elisa Enzygnost HBS (192 tests)	175.00	224	39,200
Elisa Enzygnost Hepatitis (192 tests)	225.00	224	50,400
Elisa Enzygnost HIV (192 tests)	175.00	224	39,200
Gloves	2.00	18,000	36,000
RPR Kit (100 tests)	15.00	55,320	829,800
Hepanostic test Kit (100 tests)	225.00	1,220	202,500
Rapid test Kit (100 tests)	225.00	900	202,500
TPHA Kit (100 test)	40.00	5,400	216,000
O.I.. drugs	4,000.00	150	600,000
Nevirapin per PTMC site	3,402.50	3	10,208
250-ml blood sachet	2.00	37,125	74,250
450-ml blood sachet	2.00	12,375	24,750
Double plasma sachet	2.00	3,938	7,875
Anti-A, B, AB, D serum	20.00	1,188	23,760
Human antiglobuline serum1	11.00	1,320	14,520
Human antiglobuline serum2	9.00	1,320	11,880
Test for PTMC	3.14	1,146	3,600
Transfusion kits	1.00	33,000	33,000
EDTA vacutainer tube	1.00	33,000	33,000

See breakdown ANNEX X a and b

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The strengthening of the technical capacities of human resources and sufficient motivation of these resources represent a key success factor in the implementation of this proposal. Inasmuch as most health staff are in the public system and at the basic operational level of the health system in RDC, these activities benefit the entire population and all the pathologies, including the one which is the subject of this proposal, are widespread in RDC. The increasingly favourable progress of the sociopolitical situation in the country will make it eligible for the reduction of its debt under the HIPC (Highly indebted poor countries Initiative to reduce debt co-ordinated by the World Bank). The resources saved in

[42] *Considering the high cost of specialty ARVs, it is planned to give preference to the purchase of generic drugs provided that their quality is guaranteed. A budget is forecast for specialties where a generic version does not exist and for patients who do not respond to generic drugs.*

this way will mainly be used for health and education with special focus on the issue of human health resources. Furthermore, the revival of economic activities which will take place when peace returns to the country will make it possible for the government to have substantial resources at its disposal and thereby take over from this programme as far as staff salaries are concerned. The planned reform of public office with the support of several partners including the UNDP and Belgian Cooperation will make it possible to reorganise this sector so making new financial resources available to improve salaries.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines par. V.62*)**:**

Table V.31

HIV TABLE 31

	1999 $	2000 $	2001 $	2002 $	2003 $	2004 $	2005 $
DOMESTIC Public and private BRALIMA **EXTERNAL**							
AFRICAN DEVELOPMENT BANK					9840000	7380000	7380000
WORLD BANK°				8000000	4000000	3000000	3000000
BELGIAN COOPERATION	510367		340245	173525	20000000	1500000	1500000
CANADIAN COOPERATION				25000			
FRENCH COOPERATION				46538			
ITALIAN COOPERATION			500000	645000			
UNFPA				6118487			
GTZ/GERMAN COOPERATION	300000			500000			
HCR				1165940			
IPPF				9000			
MSF/Belgium				450000			
WHO	36000			422000			
USAIDS	150000		26000	458000			
WFP				1059626			
UNDP	600000			1000000			
EU/PATS				1667400			
UNICEF	300000	300000	300000	833000			
UNOPS				8000			
USAID			37180695	3500000			
TOTAL	1896367	300000	37506695	26081516	15840000	1188000	1188000

NB: Only known amounts have been specified

°Estimate of the part of the WB donation granted for AIDS

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

Budget Items	2003	2004	2005	Total
Human Resources				
COMMUNITY MOBILISATION	60,000.00	165,000.00	165,000.00	**390,000.00**
PREVENTION				
Safe blood Supplies	81,900.00	81,900.00	81,900.00	**245,700.00**
STI	18,000.00	9,000.00	9,000.00	**36,000.00**
Servicemen	219,337.00	281,763.00	34,900.00	**536,000.00**
Sex professionals	268,486.00	165,074.00	3,300.00	**436,860.00**
Lorry drivers	82,524.00	84,523.00	3,333.00	**170,380.00**
Young people	76,614.00	407,840.00	220,506.00	**704,960.00**
Refugees	54,312.00	199,488.00	-	**253,800.00**
Condoms	72,000.00	110,400.00	148,800.00	**331,200.00**
CASE MANAGEMENT	489,458.00	580,953.00	324,609.00	**1,395,020.00**
PTMC	25,793.00	7,515.00	17,467.00	**50,775.00**
EPIDEMIOLOGICAL MONITORING	37,200.00	-	-	**37,200.00**
Total Human Resources	***1,485,624.00***	***2,093,456.00***	***1,008,815.00***	***4,587,895.00***
Infrastructures / Equipment				
COMMUNITY MOBILISATION	170,675.00	0.00	0.00	**170,675.00**
PREVENTION				
Safe Blood Supplies	407,500.00	-	-	**407,500.00**
STI	108,000.00	-	-	**108,000.00**
Servicemen	-	-	-	**-**
Sex professionals	-	-	-	**-**
Lorry drivers	-	-	-	**-**
Young people	-	-	-	**-**
Refugees	-	-	-	**-**
Condoms	272,250.00	265,100.00	313,100.00	**850,450.00**
CASE MANAGEMENT	408,085.00	506,808.00	445,107.00	**1,360,000.00**
PTMC	306,004.00	306,004.00	408,004.00	**1,020,012.00**
EPIDEMIOLOGICAL MONITORING	169,823.00	20,310.00	16,923.00	**207,056.00**
Total Infrastructures / Equipment	***1,842,337.00***	***1,098,222.00***	***1,183,134.00***	***4,123,693.00***
Training / Planning				

COMMUNITY MOBILISATION	152,416.00	121,175.00	184,229.00	**457,820.00**
PREVENTION				
Safe Blood Supplies	147,560.00	118,500.00	118,500.00	**384,560.00**
STI	484,310.00	227,625.00	227,625.00	**939,560.00**
Servicemen	43,845.00	14,155.00	-	**58,000.00**
Sex professionals	20,000.00	12,000.00	-	**32,000.00**
Lorry drivers	12,000.00	-	-	**12,000.00**
Young people	28,333.00	36,667.00		**65,000.00**
Refugees	39,072.00	-	-	**39,072.00**
Condoms	30,000.00	41,000.00	55,000.00	**126,000.00**
CASE MANAGEMENT	900,640.00	631,284.00	588,076.00	**2,120,000.00**
PTMC	50,320.00	73,786.00	38,674.00	**162,780.00**
EPIDEMIOLOGICAL MONITORING	391,200.00	6,450.00	5,375.00	**403,025.00**
Total Training / Planning	***2,299,696.00***	***1,282,642.00***	***1,217,479.00***	***4,799,817.00***
Commodities				
COMMUNITY MOBILISATION	0.00	0.00	0.00	**0.00**
PREVENTION				
Safe Blood Supplies	798,235.00	1,068,085.00	1,352,935.00	**3,219,255.00**
STI	1,077,000.00			**1,077,000.00**
Servicemen	103,392.00	70,988.00	18,540.00	**192,920.00**
Sex professionals	114,185.00	53,088.00	50,400.00	**217,673.00**
Lorry drivers	62,088.00	32,154.00	21,168.00	**115,410.00**
Young people	272,992.00	246,324.00	246,324.00	**765,640.00**
Refugees	59,592.00	37,194.00	37,194.00	**133,980.00**
Condoms	1,984,980.00	2,426,800.00	3,127,120.00	**7,538,900.00**
CASE MANAGEMENT				
PTMC	143,992.00	34,930.00	37,548.00	**216,470.00**
EPIDEMIOLOGICAL MONITORING	11,332.00	5,666.00	4,722.00	**21,720.00**
Total Commodities	***4,627,788.00***	***3,975,229.00***	***4,895,951.00***	***13,498,968.00***
Drugs				
COMMUNITY MOBILISATION	0.00	0.00	0.00	**0.00**
PREVENTION				
Safe Blood Supplies				
STI	405,105.00	958,370.00	1,232,190.00	**2,595,665.00**
Servicemen	-	-	-	-
Sex professionals	-	-		-
Lorry drivers	-	-	-	-
Young people	-	-	-	-
Refugees	-	-	-	-

Condoms	-	-	-	**-**
CASE MANAGEMENT	1,670,121.00	1,202,386.00	1,839,633.00	**4,712,140.00**
PTMC	10,207.00	10,207.00	13,611.00	**34,025.00**
EPIDEMIOLOGICAL MONITORING	-	-	-	**-**
Total Drugs	***2,085,433.00***	***2,170,963.00***	***3,085,434.00***	***7,341,830.00***
Monitoring / Evaluation				
COMMUNITY MOBILISATION	107,740.00	118,420.00	150,920.00	**377,080.00**
PREVENTION				
Safe Blood Supplies	34,520.00	34,520.00	34,520.00	**103,560.00**
STI	3,000.00	3,000.00	3,000.00	**9,000.00**
Servicemen	-	-	-	-
Sex professionals				
Lorry drivers	-	-	-	-
Young people	-	-	-	-
Refugees	-	-	-	-
Condoms	48,000.00	80,000.00	112,000.00	**240,000.00**
CASE MANAGEMENT	354,000.00	245,000.00	136,000.00	**735,000.00**
PTMC	57,660.00	22,113.00	27,258.00	**107,031.00**
EPIDEMIOLOGICAL MONITORING	149,804.00	579,534.00	127,549.00	**856,887.00**
Total Monitoring / Evaluation	***754,724.00***	***1,082,587.00***	***591,247.00***	***2,428,558.00***
Other (Transport / Maintenance)				
COMMUNITY MOBILISATION	6,800.00	6,800.00	6,800.00	**20,400.00**
PREVENTION		-		
Safe Blood Supplies	301,434.00	267,021.00	338,234.00	**906,689.00**
STI	397,526.00	239,593.00	308,048.00	**945,167.00**
Servicemen	-	-	-	-
Sex professionals	-	-	-	-
Lorry drivers	-	-	-	-
Young people	-	-	-	-
Refugees	-	-	-	-
Condoms	353,063.60	431,281.00	559,321.40	**1,343,666.00**
CASE MANAGEMENT				
PTMC	3,375.00	482.00	643.00	4,500.00
EPIDEMIOLOGICAL MONITORING	1,535.00	1,535.00	1,535.00	4,605.00
Total Other (Trans-port / maintenance)	*1,063,733.60*	*946,712.00*	*1,214,581.40*	*3,225,027.00*

GENERAL TOTAL	14,159,335.60	12,649,811.00	13,196,641.40	40,005,788.00
Administrative Costs				
Total Administrative Costs (10%)	*1,415,933.56*	*1,264,981.10*	*1,319,664.14*	*4,000,578.80*
GENERAL TOTAL	15,575,269.16	13,914,792.10	14,516,305.54	44,006,366.80

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines par. V.63*):

Table V.33

Resource allocation to implementing partners * (%)	**Year 1**	**%**	**Year 2**	**%**	**Year 3 (Estimate)**	**%**	**Total**	**%**
Government	1,908,504	12%	1,381,351	10%	1,000,062	10%	**4,289,917**	10%
NGOs / Community-Based Org./Faith-based Organisations /Private sector	1,341,873	9%	1,258,848	9%	1,258,848	9%	**3,859,569**	9%
People living with HIV/ TB/ Malaria	965,040	6%	965,040	7%	965,040	7%	**2,895,120**	7%
Academic / Educational Organisations	373,900	2%	315,000	2%	265,000	2%	**953,900**	2%
Others (please specify) **principal recipient: (BCECO /UNOPS)**	10,985,952	71%	9,994,553	72%	1,1027,356	72%	**32,007,861**	72%
Total in USD	**15,575,269**	100 %	**13,914,792**	**100 %**	**14,516,306**	**100 %**	**44,006,367**	**100 %**
	34%		**31%**		**33%**		**100%**	

**** If there is only one partner, please explain why.***

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines par. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

FIRST PRINCIPAL RECIPIENT: BCECO

34. **Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines par. VI.64),* (1–2 paragraphs)**:**

Types of agreement:

BCECO	***UNOPS***
- The obligations and commitments of the BCECO[43] will be entered in the agreements between the GF and the BCECO. The Financing Agreement includes the provisions clearly designating the body entrusted with the technical and financial implementation of the Agreement, in the event the BCECO. • In the agreements with the GF, the BCECO will have the following responsibilities: To ensure the implementation of the Government's projects in all the priority areas of national life: infrastructure, Health, Education, strengthening of human and technical capacities of institutions, combat against poverty and precariousness of vulnerable populations. • To ensure that the rules for drawing up contracts are transparent and competitive in accordance with the procedures of the World Bank. • To apply financial management procedures according to the principles and procedures safeguarding transparency, traceability of transactions and minimum rules acceptable by the World Bank. • Reporting obligation through quarterly operational and financial progress reports to be forwarded to institutional donors.	- Management of the Global Fund to Fight AIDS, Tuberculosis and Malaria in the Democratic Republic of Congo will be the subject of a formal agreement between the Global Fund and the United Nation Office for Project Support (UNOPS) in the form of MSA (Management Service Agreement). This MSA will be endorsed by the UNDP on behalf of the UNOPS; the Project implementation agency. - In this (MSA) agreement with the Global Fund, the UNOPS will have the following responsibilities: i) Implementing this project according to its three main components by providing all the specified services with a view to achieving the different target objectives. ii) Upholding the customary rules of transparency, neutrality, impartiality and competition when concluding different types of contracts in accordance with the procedures allowed in United Nations Systems in agreement with the Global Fund. iii) Drawing up quarterly operational and financial progress reports for the attention of the Global Fund. iv) Issuing invitations to tender locally or

[43] *BCECO: Bureau Central de Coordination (Central Coordination Office)*

• Obligation to have a six-monthly audit of all its operations conducted, on 30 June and 31 December of each year, by an International Audit Firm selected by an international invitation to tender. - In its relations with Local Implementation Agencies (generally Nongovernmental Organisations), the BCECO signs specific agreements specifying the nature of the mandate which is entrusted to these agencies. - Disposal of a Project Account by the Institutional Donor (DONATION or LOAN Account). - Management of a special account to be opened by the BCECO in a private bank previously approved by the Institutional Donor. The chosen bank is required to issue a "letter of comfort" in the form of acceptance of the guarantee of transparency and control by the Institutional Donor and a legal guarantee that funds may not be seized as a result of an judicial decision. - Withdrawals are made in accordance with the procedures described in the withdrawal handbook of the World Bank, by payment through the Account held by the Donor (on the basis of the appropriate fund withdrawal forms) or through the Special Account managed by the BCECO. Payment requests are submitted by persons empowered to commit the BCECO and whose powers have been previously registered with the Institutional Donor and the Bank managing the Special Account.	from the purchasing department based in New York for specific goods and equipment intended for the project. v) Referring project accounts to the customary audit of the United Nations system. - The UNOPS will have to work in the field with local partners, who (which) will be the interfaces with the direct beneficiaries. A specific management unit will be set up for the management of this project. It will be directly supervised by the UNOPS Project Central Management and Coordination Unit, based in Kinshasa. This unit, whose staff will be strengthened, has the delegated authority required to conclude Memoranda of Understanding (MOU), up to 30,000 $US, with local executants. For contracts from 30,000 $US to 100,000 $US, these will be concluded after agreement from a Local Committee. When the contract exceeds 100,000 $US, it is mandatorily required to issue an international invitation to tender. - The amounts concerning the project are paid by periodic tranche (to be determined) to the UNDP payments account, the banking references of which are: Banque Bruxelles Lambert S.A. in Brussels Account No. 301.0186139.77.995 A specific reference will be provided by the UNOPS when the MSA is signed.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

BCECO	UNOPS
➢ The BCECO already has the management handbooks hereafter,	➢ The UNOPS has financial management handbooks and tools

previously approved by the World Bank and increasingly used by partners. - A management and organisation handbook (MOG), - A handbook for drawing up contracts, - An accounting and financial management handbook. These handbooks are intended to be adapted to the requirements of each institutional donor having to enter into a contract with the BCECO, in this event, the GF. ➢ Accounting and financial organisation in accordance with WB requirements. Financial transactions are kept by separate and independent accounting *for* each Funding Agreement: - Bookkeeping, - Management of withdrawals, - Management of bank accounts, - Supporting bank documents and crosschecking, - Quarterly Financial Management Report The accounting structure and financial management shall comply with GF requirements.	which have stood the test of time in the implementation of various types of projects in the country (Democratic Republic of Congo), in Africa and throughout the world. ➢ Financial transactions are recorded through a separate and independent system for each agreement (MSA). This system is the UNDP one and compatible with all the Agencies of the United Nations System.

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines par. VI.65–67)*:

Table VI.35

	First suggestion	**Second suggestion**
Name of PR	BCECO (Central Coordination Office - *Bureau Central de Coordination*)	United Nations Office for Project Services (UNOPS)
Name of contact	Mr DIBOBOL KITMUT Patrice Director-General	Reinhart Helmke
Address	Bld du 30 juin, Alhadef Building, 4th floor KINSHASA/GOMBE	The Chrysler Building 405, Lexingon Avenue, 4th Floor New York, NY 10174 Contact in DRC: German Hulgich UCGC Coordinator UNOPS/Kinshasa Boulevard du 30 juin, Losonia Building, 9th floor

Telephone	8930323/88007810	212-457-4000 (NY) 48385/8805920/9988287(DRC)
Fax	00(243)8801586	212-457-4001(NY) 873762499635(DRC)
E-mail	bceco@micronet.cd	Unops.newyork@unops.org German.hulgich@undp.org

Please note: if you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines par. VI.66–67),* (1–2 paragraphs):

BCECO	UNOPS
The BCECO is an entity set up by the government of the Democratic Republic of Congo (DRC) with the support of the World Bank, which covers its operating costs, for the time being, in order to implement the projects of the Government where financing is provided through financial resources granted by international Institutional Donors in the form of donations or loans. The BCECO was set up on account of the need to make up for the current lack and shortcomings of public administration in the area of contract procedures and financial management. The BCECO enjoys financial and administrative autonomy; it is placed under the supervision of the Ministry of Economy and Finance, official State representative in the areas of international financial cooperation. ➢ Financing agreements currently managed by the BCECO. - Trust Fund Donation Agreement (advance from Canada) No. 27785 DRC for $ CAN. 500,000. - Trust Fund Donation Agreement No. 20224 DRC for 5,000,000 US dollars. - IDA Donation Agreement No. HO05 for 50,000,000 US dollars. ➢ In addition, the Government and the World Bank	By virtue of the Decision No. 48/501 (1994) of the United Nations General Assembly, of which the DRC is a member, the UNOPS is a body independent of the United Nations system. As such, the UNOPS carries out several projects for the DRC with the Agreement of National Authorities. It also operates on the basis of Section 7 of the Agreement on Privileges and Immunity of the United Nations. The UNOPS is one of the main providers of development services of the international community. The UNOPS is also the only entity of the United Nations system which self-finances itself through recovery of the costs of services provided. It operates like a company, and combines the values of the United Nations with the competition requirements of a private-sector company at one and the same time. It is important to point out that, by implementing projects, the UNOPS adapts to the specific procedures required by financial institutions for implementation, withdrawal of funds and the presentation of reports. That is why the UNOPS has the capacity and the qualification required to implement this project as presented by the Government of the DR Congo. Since 1995, the value of the UNOPS portfolio has doubled to reach over 3 billion dollars in the year 2001. The UNOPS annually manages more than 2,500 projects in 145 countries. **The range of services** The UNOPS, through its purchasing department, supports development cooperation, relief (in the

have agreed to entrust the BCECO with the management of 100 million dollars from the IDA Loan intended to finance the Multi-Sector Recovery and Reconstruction Programme (*Programme Multi-sectoriel de Redressement et de Reconstruction - PMURR*), the overall amount of which comes to 454 millions $US.

- Other institutional donors such as the African Development Bank are planning to manage their operations in the Democratic Republic of Congo through the BCECO.
- As part of the donation of 8 million USD from the WB to the fight against HIV/AIDS managed by the BCECO, this structure signed agreements with the following ALEs (Local Implementation Agencies): GTZ (German Cooperation), FOMETRO (Tropical Medicine) and PSI.

Mechanism for mobilising financial resources.

The funds will be paid to the account opened by the BCECO. The CCM is responsible for technical and financial management of the programme financed by the GFATM.

For daily management, the Committee will make use of the services of the BCECO, a State structure jointly set up with the World Bank and which works with the instruments of the WB.

For the management of the fund of the CCM, the BCECO sets up an internal unit having a team selected by it in agreement with the CCM.

The account will be mobilised according to its procedures in force at the BCECO.

The BCECO is monitored by the CCM via an internal audit and external audit. The financing of the audits is taken into account in this proposal. The auditors will be chosen by the CCM further to invitations to tender for international services.

The implementation partners will receive the relevant funds for the implementation of the project activities, on their accounts on the basis of agreements signed between the BCECO and the implementation agencies.

event of disasters) and rehabilitation activities. It implements effective purchasing procedures by issuing invitations to tender concerning a wide range of services, commodities and equipment, such as public works equipment, raw materials for industrial manufacture, building works, fuel and paper. The UNOPS implements, manages and/or supervises the projects which are entrusted to it by Organisations, Programmes, Funds, United Nations Departments, Bretton Woods Institutions, bi- and multilateral Institutional Donors and, last but not least, Governments. In addition to direct purchasing support, the UNOPS implements projects concerning infrastructures, the strengthening of national capacities, demobilisation and community development. It controls, manages and supervises projects and administers loans on behalf of the recipients of international financial assistance.

Comparative advantages

The UNOPS, with overall fundamentals in the region of 3.7 billion US dollars in 2001, makes purchases of goods and equipment for a combined annual total of approximately 300 million US dollars. This means that it has obtained widespread experience in the field of purchasing, large-scale economies and, what is more, it has obtained the trust of the various customers (Organisations, Donors, Governments) on account of its proficiency in providing support to all development activities.

The formulation of project strategies and plans, the drawing up of contracts for works, goods and services, the recruitment of experts and consultants, the administration of training programmes, fund management and project follow-up and the supply of reports feature among the regular activities of the UNOPS.

Traditionally intervening in development and environment projects, the UNOPS has diversified its activities in the areas of the monitoring of human rights, elections, governance, mine clearance, support for peacekeeping operations and the rehabilitation of transport infrastructures.

Transparency and impartiality

As a member of the UN family, UNOPS is committed to

These agreements will stipulate in particular that the first payment will be made on receipt of the funds from the GFATM on the basis of the programme for the first year of the submitted Project. For subsequent re-supplies, the amounts stipulated in the contracts will only be made available after justification of the use of 75 % of the funds previously received and the issue of a progress report on implemented activities. This report must be approved by the Programme, which is specifically responsible for that component as part of the monitoring and evaluation to be carried out by that programme. If the activities scheduled for the first year are not covered halfway through the programme and no major reason is apparent, funding shall be suspended until the project evaluation assignment has been concluded.	upholding neutrality and impartiality and represents no commercial, national or other interests. UNOPS adheres to internationally acknowledged standards regarding project management and it manages projects in a spirit of transparency in the greater interest of the recipient country. Its clients (Governments, Organisations, Donors, etc.) throughout the world appreciate its credibility, its professionalism and its integrity, all the more so since UNOPS safeguards their interests. **Flexibility** UNOPS proposes appropriate solutions for managing complex projects, even in difficult situations, through its innovative and creative approach always aimed at serving the client's interest. Its flexible operational structure, its reserve of specialists and its swift adaptability to unusual or changing circumstances mean that UNOPS proves equal to any challenge. The flexibility of UNOPS is an essential feature of the entire organisation. UNOPS does not have any of the rigidity and unwieldiness, which hampers so many administrative bodies. Through a network of management specialists enabling it to personally take charge of or subcontract all the aspects of projects, UNOPS is acknowledged for its skill in implementing the different activities and doing it well. UNOPS operates in accordance with clearly defined rules, regulations and practices, which guarantees transparency and full responsibility, while presenting sufficient flexibility to carry out the tasks assigned to it according to the instructions of the various institutional donors. **The operational capacity of UNOPS** UNOPS hires over 400 officials, 4000 Experts and consultants per year and has main offices in 9 locations throughout the world, including Africa. UNOPS offers its services in over 145 countries and is consequently well equipped for working in DRC, particularly since it has a coordination office in Kinshasa and project sub-offices spread throughout the country in the provinces of Bas-Congo, Bandundu, Kasaï-Oriental, Katanga, Nord Kivu, Sud

	Kivu and Orientale. This allows it to have better knowledge and the necessary field experience. UNOPS has widespread experience in project management, international purchasing, loan supervision and strengthening of capacities in Africa. The *Africa* Division of UNOPS has a team of specialists in several areas, especially in the sphere of infrastructures. If the situation changes in the field, the expertise and the flexibility of its personnel means that it can provide a fast and appropriate response. In accordance with its approach to the strengthening of capacities, UNOPS will identify and systematically cooperate with local partners in DRC to ensure that the project is sustainable beyond the contract period. While placing emphasis on the strengthening of capacities, UNOPS also undertakes to provide services to its clients with a private-sector approach without the profit aspect. Our clients, and the United Nations system as a whole, have recognised for a long time the commitment of UNOPS for its effectiveness, its swiftness of reaction, its innovatory spirit and its pragmatism. Our procedures and structures are devised in such a way that they make it possible to delegate a maximum of authority to the implementation units, such as the one established in Kinshasa, while taking care to see that they comply with the rules and regulations of the customer, of UNOPS and those of the United Nations. At the present time, UNOPS projects, covering the full extent of the country, with bi- and multilateral funding, are in progress: ✓ Renovation and maintenance of rural roads (Kasaï-oriental, Bas-Congo) ✓ Strengthening of community capacities (Bandundu, Bas-Congo) ✓ Strengthening of community strategies (Nord, Sud Kivu and Province Orientale) ✓ Reintegration and self-sufficiency of refugees and displaced persons (Kisangani, Lubumbashi and Bas-Congo) ✓ Setting up the coordination centre for the action

	against mines (Kinshasa and Province Orientale). ✓ Rehabilitation of the basic infrastructures in Kisangani. Furthermore, it is worth pointing out that UNOPS was chosen to manage the ADB/UNAIDS initiative of the countries situated along the rivers Congo, Ubangui, Chari. This responsibility will contribute to developing synergies with our programme. ***UNOPS activities throughout the World*** UNOPS intervenes in several countries throughout the world through various types of projects among which it is specifically worth mentioning: ✓ Implementation of infrastructure rehabilitation initiatives in the Balkans, ✓ Water supply, sanitation and electricity rehabilitation works in East Timor, ✓ Drawing up housing protection plans in the Yemen, ✓ Building of housing and model education centres in Kirghizistan, ✓ Management and implementation of rehabilitation works on sanitation networks, in Tadjikistan, and over 600 sub-projects in basic sectors such as health, ✓ Education, farming, energy and reintegration of ex-servicemen into civil society, ✓ Implementation of an energy supply programme in eight municipalities in Kosovo. **Mechanism for mobilising financial resources.**

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

BCECO	UNOPS
BCECO relations with the CCM. BCECO is a member of the CCM. The CCM is the mechanism which certifies the technical validation of proposals for activities to be carried out as well as the choice of implementation agencies.	UNOPS, through the channel of the UNDP, which ensures its resident representation in the country, is a member of the CCM. The acquisition of commodities and services will comply with quality requirements in agreement with good practice on the basis of information provided by the Global Fund and direct recipients.

The BCECO has set up an internal unit with a team selected by it with the agreement of the CCM for the management of the CCM funds. Purchases of commodities and services will comply with the WB requirements already applicable within BCECO. Funds will released from the account by the agents authorised by BCECO. The BCECO is monitored by the CCM via an internal audit and an external audit. ***Relations with Local Implementation Agencies (LIE/ALE).*** *Local Implementation Agencies (LIE/ALE) are entities approved by the CCM on the basis of technical criteria and their expertise in the area of intervention concerned, proven experience in the field, credibility and organisation of the financial management system.* The LIE/ALEs are commissioned to implement activities eligible under the conditions of intervention of the Institutional Donor (GF); they are required, under the agreement with the BCECO: - to produce quarterly progress reports, - to keep the accounts after approval of their financial system, - to draw up agreements in accordance with the procedures required by the Institutional Donor and after a favourable opinion from the BCECO. ***Relations between BCECO, National Programmes to fight the 3 diseases and the commissions of the CCM (the technical and the financial commission).*** Coordination and technical monitoring of activities is ensured by the 3 programmes which make reports on the achievements of the LIE/ALE to the technical commission of the CCM at regular intervals. This technical commission gives its progress report on achievements in the areas of intervention to the CCM meeting. The audit department inspects the BCECO and reports to the financial commission. The financial commission gives its report on the financial management of the project to the CCM meeting, as well as its opinion on whether to continue the	UNOPS will draw up memoranda of understanding (MOU) with the local partners assigned to implement different aspects of the project. *These MOU will be concluded locally at the outcome of restricted consultations for amounts up to 100,000 $US (see above).*

partnership with the BCECO or not.	

36. **Briefly indicate links between the overall implementation arrangements described above and other existing arrangements** (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

BCECO	UNOPS
To strengthen management and implementation capacities, the following arrangement is planned: - 5% of administrative costs for BCECO - 5% of administrative costs for the various stakeholders and executants of each component. This will make it possible, among other things, to hire additional human resources for this section.	UNOPS implements several projects in the country with bi- or multilateral funding with as main donors: UNDP, Belgian Cooperation, the European Commission and the World Bank. As regards agreements currently being implemented, UNOPS will establish synergies with this component of the project. Since UNOPS operates without making profits, the cost of its services is extremely competitive. Fees vary according to the specific services requested and an estimate is provided in each particular case as quickly as possible. Experience shows that the amount of these fees is considerably lower than the savings made. UNOPS proposes 5% of the overall amount of each component for its management and administration fees.

37. Outline the plan for conducting monitoring and evaluation by including the following information, (1 paragraph per sub question).

It involves an external evaluation aimed at qualitatively and quantitatively measuring all the activities carried out within the scope of this proposal. The evaluation approaches adopted will be:
Dynamic, in the sense that the different components of the current programme observed through collection tools and indicators will make it possible to measure the results obtained at every stage of the programme.
Participatory in the sense that all the institutional, associative, health and social players will be involved in the approach.
The interviews which will be conducted on the different sites of the programme with the professional staff involved and associative mediators, the analysis of project documents, observation notebooks and assessments of activities will be examined and used to put the viewpoints of the various persons involved into perspective with those of the programme beneficiaries encountered on the sites or in the associations. The relevance, efficiency, effectiveness, impact and viability of the programme will therefore be measured in this way. The method used to evaluate the different components of the programme will adopt the following plan.

1. Preparation and conception

The evaluators will analyse the project documents (presentation report, progress report, financial reports, observation notebooks, data collection sheets of the active succession of patients who benefited from the various health and social services provided by the components of the programme, mail, etc.) so as to present as an introduction to their evaluation reports, a documented opinion on the description of the project, its context, its interventions, its aims, its methodology and its financial management.

2. Relevance

The evaluators will endeavour to identify for each component, the factors which contribute to giving relevance to these components. How does the project take into account the dual aspect of prevention and care?
In what way is the project complementary to other interventions by the different partners in cooperation development?
How is this project integrated into national policy for combating HIV/AIDS, Tuberculosis and Malaria?
In what way is the project relevant for the main persons involved and beneficiaries?

3. Efficiency

To what extent has the project achieved its specific objectives set at the beginning?
What results have been obtained and who benefited from them?
Were there any unexpected results which are relevant in relation to project objectives? Are project activities associated with a better knowledge of pathologies and with a clearer perception of individual vulnerability to these pathologies?
Are activities associated with a decrease in discrimination with regard to the persons concerned? Did the project specify means intended to change behaviours (indicators? strategy?)

What means are devoted to improving access to care and sustaining ongoing care dynamics?
Are project activities associated with an overall decrease in STDs?
Are project activities associated with an increased use of safe blood supplies?

4. Effectiveness

The evaluators will endeavour to identify for each component of the project, the effectiveness of project guidelines in relation to the management system and procedures set up, and will take particular care in highlighting the impedimenta and obstacles. In particular, they will evaluate possibilities and methods for extending the programme in the regions. More precisely, the evaluators will examine the following points:

- Which methodology was selected for managing the project?
- Which management system, follow-up procedures and financing mechanisms are implemented?
- What were the capacities for absorbing funds and the rate of use?
- To what extent are the administrative and financial procedures existing within the management structure set up within the scope of the programme acting as brakes on greater efficiency in project implementation?
- Did the project request the contribution of underused infrastructures or mediators from community-based organisations which strengthen the direct financial contribution or broaden the basis of support by the community, so increasing efficiency as much again.
- Does the project foresee RGAs capable of increasing the participation of beneficiaries with a view to maintaining them within the care momentum?
- Did the project succeed in using local resources?
- Was the decentralised approach planned to increase and sustain the supply of care and prevention
- Is access to care and prevention planned for the provinces of the country where there are risks of conflicts?
- Was there reflection upon the capacities of integration of the services proposed by the project into common law structures?
- Are reports sufficiently regular and detailed to allow the effectiveness of the project to be evaluated?
- As far as procurement is concerned, were the chosen equipment and supplies appropriate and were there efforts of standardisation
- Did the projects benefit in good time from suitable technical assistance from development partners or international NGOs?

5. Impact

The evaluators will endeavour to identify for all the components, the direct impact, i.e. the impact for the beneficiaries and the indirect impact, i.e. the impact on the overall health of beneficiary (example: do women see their physiological and social vulnerability being reduced through the project?)
More specifically, the evaluators will examine the following points:

- Does the project have clearly formulated objectives? Does it have really precise indicators?
- To what extent has the project achieved its main objectives?

6. Viability

The evaluators will endeavour to identify the viability of all the components of the programme.
More specifically, the evaluators will examine the following points:

- What is the extent of the institutional involvement of each national or international organisation taking part in the implementation of the programme?
- Does each structure involved in the programme have the qualified human resources necessary for the operation of the programme, the administrative structures and the appropriate management methods?
- Does the project construct the mechanisms of its own sustainability?
- Are local resources sufficient to cover operational costs?
- Does the project foresee a training schedule for the staff involved in the project more particularly so as to ensure the transfer of knowledge and skills?
- Apart from its sustainability, is there a potential to extend the programme to the different provinces of the country?

At the end of this evaluation, the team will take particular care to identify the priority areas of interventions which shall be developed.

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g. Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines par. VII.76)***:**

Relevant information about HIV/AIDS are provided by:

- The national health information system (*système national d'information sanitaire* - SNIS): monthly collection of routine epidemiological data, drawing up monthly and yearly reports for each health structure and at the different levels of the health pyramid.
- The annual report by the Ministry of Health drawn up by the Directorate for Research and Planning (*Direction d'Etudes et Planification* - DEP).
- The sero-monitoring system by sentinel sites of the PNLS
- Behavioural studies within the scope of monitoring by second-generation sentinel sites
- Weekly epidemiological survey for diseases with an epidemic potential
- MICS surveys conducted every 5 years.(1st edition in 1996, 2nd in 2001)
- The pinpoint survey of health inventories (Ministry of Health, 1998)
- KAP surveys into HIV/AIDS conducted by the different partners involved in the combat programmes.
- Socioeconomic and demographic surveys conducted by different partners and national institutions, more particularly the United Nations System UNDP, WHO, UNAIDS, UNICEF, National Statistics Institute, College of Public Health, Faculty of Social Science of the University of Kinshasa, etc.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

Data collection will be done passively or actively through:

Utilisation of the directory of partners involved in the combat against HIV/AIDS drawn up and updated by the PNLS
Examination of the minutes of the monthly cooperation, orientation and coordination meetings of the partners involved in the combat against HIV/AIDS

Utilisation of the monthly progress reports of the persons involved supporting the combat against HIV/AIDS in the field
Utilisation of quarterly reports forwarded by the provincial coordination offices and the focal points of the various sectors
Analysis, compilation and quarterly updating of data notifying cases of AIDS and STIs forwarded by the provincial coordination offices
Utilisation of data provided by the national health information system, socioeconomic and demographic surveys conducted by different national institutions, more particularly the United Nations System UNDP, WHO, UNAIDS, UNICEF, National Statistics Institute, College of Public Health, Faculty of Social Science of the University of Kinshasa, etc.
Utilisation of behavioural survey reports drawn up every three years as part of monitoring by sentinel sites
Utilisation of HIV and STI prevalence reports drawn up every year as part of monitoring by sentinel sites
Utilisation of the database updated by the PNLS on the basis of the survey reports on HIV/AIDS drawn up in DRC by various research institutions
Utilisation of workshop monitoring, internal review and evaluation reports on the projects financed by the Fund will be made at central level each year of the project.

37.3. Timeline:

Scheduled activities:

Monitoring workshops for project activities will be organised every quarter at provincial level and every six months at national level
An internal project review will be made each year of the project at central level
External audit missions each year
An external evaluation report halfway through and at the end of the project

37.4. Roles and responsibilities for collecting and analysing data and information:

The National Executive of the PNLS will have as its roles and responsibilities:

Updating of the directory of partners involved in the combat against HIV/AIDS
Drawing up the minutes of the monthly cooperation, orientation and coordination meetings of the partners involved in the combat against HIV/AIDS
Drawing up the monthly progress reports of the persons involved supporting the combat against HIV/AIDS in the field
Utilisation of quarterly reports forwarded by the provincial coordination offices and the focal points of the various sectors
Analysis, compilation and quarterly updating of data notifying cases of AIDS and STIs forwarded by the provincial coordination offices
Utilisation of HIV and STI prevalence reports drawn up every year as part of monitoring by sentinel sites
Updating of the database of surveys on HIV/AIDS conducted in DRC by various research institutions
Setting up the management and information system concerning HIV/AIDS

The PNLS in partnership with the FEC (Employers' Association), AIDS Focal Points of the other Ministries and the Forum of NGOs will have as its roles and responsibilities:

Examination of the minutes of the monthly cooperation, orientation and coordination meetings of the partners involved in the combat against HIV/AIDS

Utilisation of the monthly progress reports of the persons involved supporting the combat against HIV/AIDS in the field
Utilisation of workshop monitoring, internal review and evaluation reports on the projects financed by the Fund made at central level each year of the project.

The College of Public Health of Kinshasa and World Vision /Mc Master University will be entrusted with:

Collecting and analysing the data of behavioural surveys and other operational research studies.

The Provincial AIDS Coordination offices will be entrusted with centralising and forwarding reports concerning:

Notifications of cases of AIDS/STIs from Health Areas
Training and supervision
HIV/AIDS combat activities in the provinces
Monitoring by sentinel sites

The Health Area Central Office will have responsibilities for forwarding reports concerning:

Notifications of cases of AIDS/STIs from Health Areas
Local training and supervision
HIV/AIDS combat activities in the Health Areas
Monitoring by sentinel sites (wherever the sentinel site is located)

37.5. Plan for involving target population in the process:

In order to induce target populations to get involved in data collection, the following activities are planned:

- Awareness raising and plea actions among the communities and their leaders, whenever a community survey has to be carried out
- Invitation of community officials and representatives to ceremonies where material and equipment are officially handed over to health services for the benefit of the general population and vulnerable groups (servicemen, sex professionals, young people, STI carriers, long-distance lorry drivers, refugees)
- Regular organisation of conferences or meetings for feedback on HIV/AIDS with community leaders, PLHIV representatives, the focal points of the different sectors and the persons responsible for institutions involved in the combat at all levels.

37.6. Strategy for quality control and validation of data:

- The protocols of the epidemiological and behavioural studies, which will be carried out by the College of Public Health of Kinshasa (or any other partner), together with their findings will be referred for validation to the technical and ethical committee of the National AIDS Combat Committee
- Before the publication of the (internal and external) monitoring and evaluation reports of different projects, the latter reports will be previously examined by the IV Directorate and the Directorate for Research and Planning of the Ministry of Health and by all the partners (WHO, UNAIDS, etc.) then validated at a workshop
- The validation of screening/diagnosis methods and techniques as well as laboratory results will be carried out by the laboratories of the PNLS. The INRB will also ensure quality control of the reagents. The laboratory of the PNLS will also refer to the departments of the IMT (Institute of Tropical Medicine) for quality control. The INRB will also refer to the Institut Pasteur for quality control.
- Quality control reports on condoms will be made at the Faculty of Pharmacy of the University of Kinshasa. The WHO, through its network of approved laboratories, especially in Yaoundé and in Abidjan, will contribute its technical support necessary for the validation of local quality control of condoms.
- The quality control reports on drugs (STI, OI, ARV ...) will be drawn up by the Faculty of Pharmacy of the University of Kinshasa. The WHO, through its network of approved laboratories, will provide the necessary technical support (e.g. studies into anti-malarial resistance
- External financial audits are conducted by specialised agencies after national or international invitations to tender. The validation of audit results will be done according to the procedures of the selected agency.
- The validation of equipment and infrastructure maintenance reports will be carried out by specialised agencies after national or international invitations to tender.

37.7. Proposed use of M&E data:

Monitoring/evaluation data are going to be used to:

1. measure the achievement of the objectives and results defined in the five spheres of intervention of this programme, namely:

- Community and institutional mobilisation
- Prevention and reduction of risks
- Prevention of the transmission of HIV from mother to child
- Overall responsibility for HIV/AIDS infection
- Epidemiological monitoring

2. improve the process of planning, implementation, monitoring and evaluation of a new programme

38. Recognising that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system to produce and input baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: as M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analysing data, preparing reports, etc.

Not applicable to this proposal

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems	**Partner(s)** (which may help in strengthening M&E capacities	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Total requested from Global Fund							
Total other resources available							

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply-chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injection needles, rapid diagnosis tests and commodities such as micronutrient supplements, condoms and mosquito nets (*Refer to Guidelines par. VIII.86*)**.**

Table VIII.39

Component of procurement and supply-chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	For widely available products, national or international invitations to tender. For specialised products, restricted consultations (shopping), minimum 3 suppliers
What procurement procedures are used to ensure open and competitive tenders, expedited product availability and consistency with national and international intellectual property laws and obligations?	Invitations to tender are published in national newspapers and in the international press, for international invitations to tender (Business development) and the information is also disseminated in the embassies in Kinshasa.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	The quality of imported products is controlled by the Congolese Control Office (*Office Congolais de Contrôle* - OCC). The Ministry of Health assures the quality control of imported drugs and those on the market. The national programme to combat Malaria controls the quality of treated mosquito nets The WHO assures the quality control of imported condoms. See annex XI.
What distribution systems exist and how do they minimise product diversion and maximise broad and uninterrupted supply?	Pending total coverage of the country by central purchasing offices (non-profit-making organisations), distribution in health areas is ensured by the various experienced, acknowledged, reliable and effective, government and nongovernmental partner organisations. This distribution is done rapidly to avoid losses and damage during extended storage periods.

40. Describe existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programmes, etc.), (1–2 paragraphs)**:**

41. Provide an overview of the additional resources (e.g. infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

The resources required to support the procurement and distribution of products and services are included in the table V 30 under the human resources, infrastructures and other (transport, maintenance) headings.

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the programme in question, the volume of products in the grant application and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines par. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & e-mail information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
General health and service programme (GSS)	Henri MUKUMBI Av.BASOKO, No. 25 Kin GOMBE Tel. 98 24 71 166 and 081 81 43 811 gsskinshasa@yahoo.com	Price reduction for purchase of ARV®	At least throughout the implementation of this proposal

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines par. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines par. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):
Table IV.23

Component (mark with X):		**HIV/AIDS**
	X	**Tuberculosis**
		Malaria
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

The Tuberculosis component comprises four Areas of intervention arising from our Five-year Master Plan 2001-2005 and the National Programme to Combat TUBERCULOSIS in DRC proposed through the channel of the CCM to the Global Fund for financing.

The Areas of Intervention are:

1. Improving the patient case management procedure for treatment with special emphasis on pulmonary TB. cases with positive microscopy, and TB./HIV co-infected patients.
2. Improving the screening of cases with special focus on the detection of patients spitting Koch tubercle bacillus with intensified microscopy by regular quality control of reading slides.
3. Providing a fresh impetus to social mobilisation throughout the country, in all the layers of the community, with Tuberculosis IEC activities, so as to contribute to the improvement of the cure rate and the detection rate.

4. Strengthening the technical skills of the personnel and institutional capacities at national and international level for providing improved assistance to the persons involved at operational level.

See annex Tub I.

Area of Intervention 1: Case management of patients for treatment

We have structured this component around the three main problems that the programme is currently encountering in relation to the optimisation of patient care.
We firstly wish to prioritise the permanent availability of drugs in all the health centres treating patients by ensuring the transport of these drugs, which are supplied to us free of charge by Global Drug Facility (2/3) and the traditional partners of the programme (1/3), from Kinshasa as far as the Health Centres and hospitals where TB cases are treated.

Secondly, we wish to enable chronic (multi drug resistant patients) to have access to second-line treatment (Dots-Plus).

Lastly, in this area, we will develop community case management of some categories of patients, particularly those who are TB./HIV co-infected, but also all the others who have difficulty in following DOTS in the health structures.

Main objective: To increase the cure rate of treated TB. cases by 70% to 80% from now to 2005.

Specific objectives:

1. To provide DOT (directly observed treatment) to 90% of patients undergoing treatment within three years
2. To put 90% of chronic (multi drug resistant) screened patients under standard 2nd-line (Dot– Plus) treatment
3. To organise the community case management of TB. cases undergoing treatment, including HIV/Tuberculosis cases
4. To integrate the case management of patients in private structures and the penitentiary services of the towns of 7 Provinces (Kinshasa, Matadi, Lubumbashi, Mbuji-Mayi, Kikwit, Kisangani, and Bukavu)

The beneficiaries:

All the screened patients undergoing treatment during three years, from now to 2005, estimated as 265,800 including 133,000 TPM+ (smear positive for Koch tubercle bacillus)

Area of Intervention 2: Detection of cases and quality control of microscopy

In this area, the programme has three main concerns which are: first of all, recording the number of tuberculosis cases, mainly those expectorating bacilli, which are the tuberculosis spreaders. In order to do so, the greatest amount of equipment, reagents and products possible must be made available to the health centres and the quality thereof must be acceptable.

In addition, the already existing quality control network is not yet satisfactory because it is unwieldy, and the results are dissimilar from one province to the next. The revision of the working guide and the improvement of the skills of the technicians of the quality control laboratories and data-collection tools are required.

Thirdly, there is an increasing number of chronic cases in the main towns and cities (failure of first-line category 2). Their bacteriological diagnosis and their exact monitoring can only be done in specialised laboratories carrying out culture and breakpoint testing (antibiogramme). We have one of them in Kinshasa, which is operational and being rehabilitated for the moment, and want to rehabilitate a second one in Lubumbashi (second city of the country) and Goma, which are situated two thousand kilometres to the south and to the east of Kinshasa. These three specialised laboratories will cover the country within three years and will thus contribute to combating the spread of multi drug resistant tuberculosis. It will mainly involve having appropriate equipment and improving the skills of the personnel on the subject.

General objective: Increasing the detection rate of TPM+ cases from 53% to 65% by 2005, through quality controlled microscopy.

Specific objectives:

1. Raise the detection rate of TPM+ cases from 53% to 65% by 2005 in DRC.
2. Assure the quality control of Ziehl smear slides with a view to reducing differences between the results of the CDTs (Diagnosis and Treatment Centres) and those of the control laboratories.

The beneficiaries: all suspected sick cases, first and second-line screened TB. cases (multi drug resistant and chronic), evaluated at over 3,000,000 people who will especially need bacilloscopy, by 2005.

Area of Intervention 3: Social Mobilisation through IEC

From the outset, the programme to combat tuberculosis in DR Congo has been integrated into the health structures and the involvement of the population has been one of the main components of the activities of these health centres. Several messages have been given in different communities but behaviour in favour of cure and a large number of detected patient cases is not making much progress. In order to do so, we firstly want to know the inventory of knowledge, practices and behaviour of the population through a survey, by a reinvigorated unit at national level. Directives and standardised communication tools will be directed from there to the different layers of the population, especially co-infected patients, school-age children, various religious and other associations. The messages will be disseminated through previously identified mass communicators trained by health and communication professionals.

Main objective: To mobilise target communities and groups with a view to improving the detection and cure of tuberculosis.

Specific objectives:

1. To improve the level of knowledge, attitudes and practices of different target communities concerning tuberculosis
2. Strengthening the IEC skills of the players involved.

The beneficiaries: the population in general is the first beneficiary, but particularly schoolchildren, pupils, youth associations. Mass communicators of messages come next (educators, journalists, leaders of different mass associations) from all levels, especially from the periphery of health centres and lastly, the executives of the national committee (IEC unit) and of the provincial co-ordinations.

Area of Intervention 4: Strengthening technical skills and institutional capacities

Some co-ordinations have become too big on account of the number of Health Areas which they serve, with the result that it becomes urgent to split them up in order to sustain and even improve their performance. The 2001-2005 Five-year Master Plan drawn up by the PNT had planned to set up four new co-ordinations, and one has already been set up since this year, 2002. Some others already operating are in such poor condition that they need to be rehabilitated and equipped at the same time as the newly established co-ordinations.
Considering the importance of intermediary and national level in providing assistance to the periphery, we are planning the participation of co-ordinations, which do not have sufficient support in this training sector, at training courses, meetings, congresses at national and international level. This area of intervention also contains an annual external consultation and financial audit of the Programme. These sources of outside expertise will make it possible to provide a follow-up of the programme with the aim of improving activities for a better supervision of the tuberculosis endemic in DR.

Main objective: To improve technical skills and institutional capacities at national level and at the level of the 22 provincial co-ordinations.

Specific objectives:

1. To strengthen institutional capacities at national level and at the level of 22 provincial co-ordinations.
2. To strengthen the technical skills of the personnel of the national committee and in 4 co-ordinations.
3. To organise an external evaluation of management and a technical evaluation of the Programme every year during the project

The beneficiaries of this intervention are the main players and partners of the combat against tuberculosis in the country, especially at central and provincial level (laboratory technicians, provincial coordination doctors, project and programme managers, etc.). However, they also include the Ministry of Public Health through the National Programme to Combat Tuberculosis (PNLT) on account of the equipment, rehabilitation and external evaluations.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	End March 2003	**To** (month/year):	End March 2006

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: ***Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn, each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.***

Indicators*: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the target populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

GOAL OF THE PROPOSAL:

These four areas of intervention are in keeping with our national policy to combat Tuberculosis, which involves extending the DOTS strategy to which our country adhered in 2001, at its highest level of responsibility. That is the spirit in which a Five-year Master Plan was drawn up with the clearly defined objectives and activities. It is a partnership assignment with all the main persons and bodies involved in the Programme. It is to be applied with the main goal to reduce infection, morbidity and mortality due to Tuberculosis. This proposal addressed to the Global Fund, in synergy with the contributions of other partners, will contribute greatly to the control of tuberculosis in DR Congo within five years

It should be noted that at world level, the stop tuberculosis initiative sets the detection of 70% of expected cases and an 85% cure rate for patients undergoing treatment as its general objective. These expected results are the same as those which figure in our Master Plan drafted in October 2001.

In this proposal to the Global Fund, we have slightly tempered our ambitions compared to our master plan to remain more realistic, in view of the evolution of financing of the activities scheduled for the first year of the plan. We therefore proposed to achieve the

objectives of an 80% cure rate and a 65% detection rate for smear positive pulmonary TB. cases by 2005.

Table IV.26.1

Goal	**By 2005, to reduce infection, morbidity and mortality due to Tuberculosis by raising the cure rate for patients undergoing treatment to 80%, and the detection rate for smear positive TB. cases to 65%, through a broader extension of the DOTS strategy to cover 90% of the population.**	
Impact indicators ***(refer to Annex II)***	Baseline Year: 2001	Target **(last year of proposal)** Year: 2005
CURE rate for new patients undergoing treatment	**70%**	**80%**
DETECTION rate	**53%**	**65%**
Rate of Coverage of the population by the DOTS strategy	**70%**	**90%**

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realising the stated goal), (1 paragraph per specific objective):

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Area of intervention 1: case management of TB. cases

Analysis of the situation:

- The National Programme to Combat Tuberculosis (PNLT) estimates the number of TB cases requiring care for three years as 265,800, including 50% TPM+ (smear positive pulmonary TB. cases).
- The short treatment system for tuberculosis, lasting 8 months, has been chosen by our country for over five years. The drugs have to be taken by the patient for two months under the watchful supervision of the nursing staff. These drugs must be financially accessible to

everyone (free). Despite all these provisions written in a guide and distributed throughout all the health structures, some problems still remain which prevent us from curing a large number of cases to whom we are providing treatment.
- Diagnosis and treatment of tuberculosis are provided in 800 Diagnosis and Treatment Centres (CDT) throughout the country where only 10% of the personnel is trained and retrained about the new directives concerning the extension of the DOTS strategy.
- In the cohort of patients undergoing treatment in 2000, we notice that there are co-ordinations which achieved good cure scores. The Kinshasa Coordination is notably one of these, as well as the North Equator (Equateur Nord) Coordination, which exceeded the 80% cure rate. The presence of free drugs, two-thirds of which were offered by the Global Drug Fund (GDF) and the other third by all the other partners of the Programme, means that it is therefore possible for the cure rate of the country to improve very quickly.
- Let us further point out that a pilot project exists since March 2002, the aim of which is to manage cases of HIV/TB co-infection. It is operating in two health areas of the city of Kinshasa (Masina and Bumbu) with financing from USAID (198,000 $ US) through the intermediary of the WHO. It is planned to extend this experience to eight other Health Areas for a total population of 1,000,000 inhabitants, including 3000 expected cases of tuberculosis among which we will have 750 (25%) co-infected cases.

The major problems are:

- 30% of screened and recorded patients are not put under DOTS
- The health structures of towns are overwhelmed by the number of patients with the result that many of them abandon the treatment (2001 annual report of the PNT)
- Private health structures drain away a good many patients from the programme circuit because the programme is only integrated into public structures
- We treated 75 chronic (multi drug resistant cases in Kinshasa in 2000; if we estimate that Kinshasa screens a third of the patients of the country, we have approximately 200 chronic (multi drug resistant patients per year. Unfortunately, very often we do not have any answers to their problem for lack of second-line drugs, and when they are available, they are very expensive.

Opportunities:

- Existence of a gift of tuberculostatic drugs covering one year's needs with reserves, 2/3 of which come from GDF and 1/3 from traditional partners of the Programme (FD, TLMI, ALM, LNAC). We have a promise that this donation should be extended for three years.
- A large number of partners and a new patron.

Main objective: To increase the cure rate for TB. cases under treatment from 70% to 80% by 2005.

Specific objectives:

1. To provide 90% of patients undergoing treatment with DOT supervision (directly observed treatment) within three years
2. To put 90% of chronic (multi drug resistant) patients under standard 2nd-line treatment (Dot– Plus)
3. To organise community case management of TB. cases undergoing treatment *, including HIV/tuberculosis co-infection cases

4. To integrate patient case management into private structures and the penitentiary departments of the towns of 7 Provinces (Kinshasa, Bas-Congo, Lubumbashi, Mbuji-Mayi, Kikwit, Kisangani, Bukavu).

Specific objective 1: To provide 90% of patients undergoing treatment with DOT supervision (directly observed treatment) within three years

Table IV.27

Specific objective 1	To provide 90% of patients undergoing treatment with DOT supervision (directly observed treatment) within three years				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
1. 90% of screened patients are DOT monitored (short directly observed treatment)	***70%***	*80%*	*85%*	*90%*	
2. 80% of patients under DOT are cured	***70%***	*73%*	*75%*	*80%*	

Specific objective 1	**To provide 90% of patients undergoing treatment with DOT supervision (directly observed treatment) within three years**					
Broad activities	*Process/ Output indicators*	*Baseline*	*Target figures*		*Responsible/ Implementing agency or agencies*	*Cost and source of financing*
		2002	*Year 2003*	*Year 2004*	*Year 2005*		
1. Shipping tuberculostatic drugs from Kinshasa to the provinces	*Number of shipments made*	*10*	*19*	*22*	*22*	*PNT*	*GF: 189,000*
2. Organising the validation workshop for PATI IV directives	*PATI IV validated*	*0*	*1*	*0*	*0*	*PNT*	*GF: 6,000*
3. Print and distribute PATI IV [44]	*Number of CDTs having PATI IV*	*0*	*800*	*800*	*800*	*PNT*	*GF: 10,000*

[44] *Each CDT shall have at least one copy of the PATI IV Guide*

4. Train / retrain trainers in new DOTS strategy directives (MCP+ISP) about PATI IV	*Number of trained/ retrained trainers*	*0*	*38*	*421*	*44*	*PNT*	*PM[45]:*
5. Train/ retrain CDT personnel in CCM (correct case management) [46]	*- % of CDTs with trained or retrained personnel*	*10%*	*80%*	*90%*	*100%*	*Provincial Coordination and BCZ*	*GF: 134,400* *NGOs:*
6. Supervise the CDTs [47]	*- % of supervised CDTs*	*100%*	*100%*	*100%*	*100%*	*BCZ and Provincial Coordination*	*PM*

Specific objective 2	To put 90% of chronic (multi drug resistant) patients under standard 2nd-line treatment (DOT– Plus)				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
In the selected structures, 90% of screened chronic cases are treated and accompanied until the end of treatment	***50%***	*70%*	*80%*	*90%*	

Specific objective 2	**To put 90% of screened chronic (multi drug resistant) patients under standard 2nd-line treatment (DOT– Plus)**						
Broad activities	*Process/Output Indicators*	*Baseline*	*Target figures*			*Responsible/ Implementing agency or agencies*	*Cost and source of financing*
		2002	*Year 2003*	*Year 2004*	*Year 2005*		

[45] These activities are combined with those of Area 2 (detection) specific objective 1 activity 4 and 6

[46] Most of the personnel have already been trained in PATI III, but shall be retrained for PATI IV, which contains new directives about the extension of the DOTS strategy

47 We plan for each CDT to be visited at least once a year by the central office team, who are sometimes accompanied by a member of provincial coordination

1. Creating case management sites for multi drug resistant (MDR) cases [48]*	Number of sites created	*1*	*2*	*4*	*4*	*PNT*	*PM*
2. Procuring second-line drugs for the sites (purchasing and transport)	- number of cures available	*75 (in 2001)*	*200*	*420*	*670*	*PNT*	*GF: 244,800 WB: 300,000*
3. Providing training/retraining of MCPs and doctors of the selected sites (Kin, Lumbubashi, Mbuji-mayi and Kananga) in case management of second-line patients [49]**	- number of trained/retrained MCPs and doctors	*2*	*14*	*26*	*26*	*PNT*	*GF: 44,535*
4. Revising and making available information media for second-line patients in hospitals (CDT) selected for their follow-up	- number of sites having revised information media	*1*	*2*	*4*	*4*	*PNT*	*USAID 10,000*
5. Providing treatment and follow-up for all screened patients	- % of chronic (multi drug resistant (MDR)) cases correctly treated and followed among screened patients	50	70%	80%	90%	PNT	USAID: 5,000

Specific objective 3	To organise community case management of TB. cases undergoing treatment[50] , including HIV/tuberculosis co-infection cases

48 We will create case management sites for multi drug resistant (MDR) patients in towns which notify the appearance of a large number of category 2 treated cases which have become chronic. This emergence of multi drug resistant (MDR) cases is often a result of previous bad case management where the programme had delayed establishing itself and also where there is a heavy concentration of private health structures. There is already one site in the city of Kinshasa (university clinics) and we will set up others in the towns of Lubumbashi, Mbuji-mayi and Kananga.

[49] We will associate the provincial coordination doctor with the training of five doctors per site. The former is the person locally responsible for all the activities of the Programme

[50] The rate of persons abandoning treatment, which heavily influences the cure rate, is very high in many CDTs. Among the causes, we note the marked prevalence of HIV/AIDS among the pulmonary tuberculosis patients expectorating bacilli. The latter are often overwhelmed by other health problems and social problems preventing them from regularly following the treatment. A

Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
5% per year increase in the cure rate among treated patients	***70%***	*75%*	*80%*	*80%*	

Specific objective 3	To organise community case management of TB. cases undergoing treatment, including HIV/tuberculosis co-infection cases

Broad activities	Process/ Output Indicators	Baseline	Target figures			Responsible/ Implementing agency or agencies	Cost and source of financing
		2002	Year 2003	Year 2004	Year 2005		
1. Organising a workshop for training modules for community health employees and community leaders	Number of available modules	0	65O			PNT, PNLS	APEFE: 6,000
2. Producing and disseminating training modules for community health employees, and community leaders	Number of modules	0	65O			PNT, PNLS	GF: 10,000 WHO: 20,000
3. Supporting local training of community employees	Number of ZS (Health Areas) receiving training support	0	285			PNT, PNLS	WHO: 10,000
4. Supporting local supervision of community employees	Number of ZS receiving supervision support	0	285	285	285	PNT, PNLS	WHO: 5,000
5. Ensuring case management of HIV/TB. co-infection	% of patient case management		50%	60%	70%	PNLS, NGOs, WHO	USAID: 198,000

Specific objective 4	**To integrate patient case management into private structures and the penitentiary departments of the towns of 7 Provinces (Kinshasa, Matadi, Lubumbashi, Mbuji-Mayi, Kikwit, Kisangani, Bukavu)**	
Outcome/coverage indicators	Baseline	Target figures

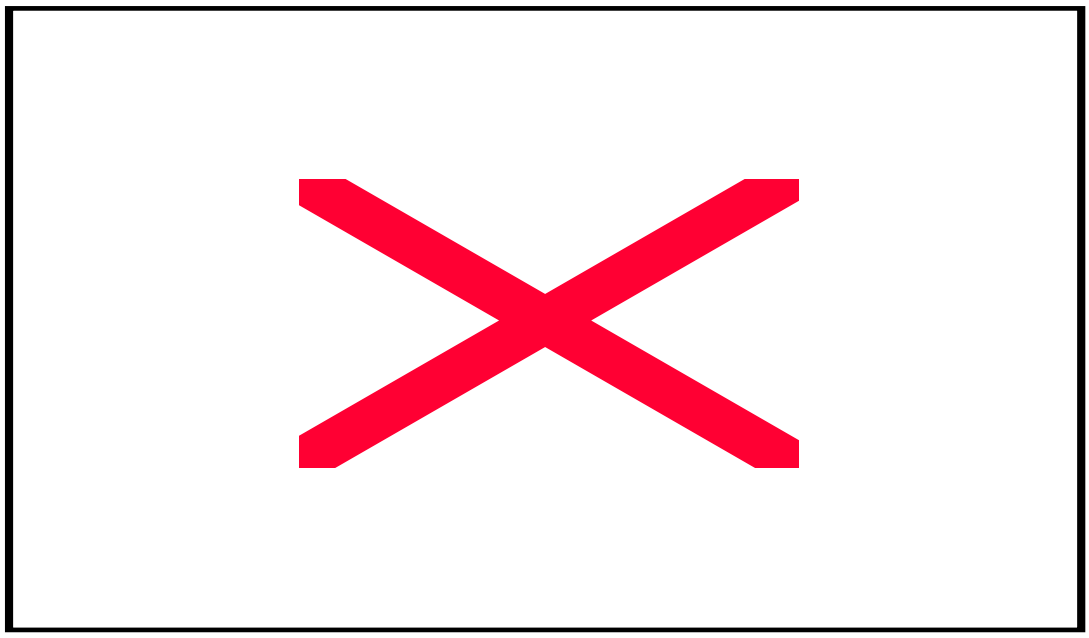
part of those problems should be taken into account by the nursing staff or better still by the community for those persons to attend treatment regularly.

A second factor which explains persons abandoning treatment is the high cost of the drugs in a certain number of health structures which are not subsidised. Now that we will have free drugs for everybody, we think that a strong proportion of patients will no longer be prevented from completing the treatment.

(Refer to Annex II)	Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005	
% of private and penitentiary structures of the targeted towns with correct case management of TB. cases	70%	80%	95%	100%	

Specific objective 4	**To integrate patient case management into private structures and the penitentiary departments of the towns of 7 Provinces (Kinshasa, Matadi, Lubumbashi, Mbuji-Mayi, Kikwit, Kisangani, Bukavu)**					
Broad activities	*Process/ Output indicators*	*Baseline*	*Target figures*			*Responsible/ Implementing agency or agencies*	*Cost and source of financing*
		2002	*Year 2003*	*Year 2004*	*Year 2005*		
1. Making PATI IV available to private structures and prisons	Number of structures with PATI IV	0	100%	100%	100%	PNT, NGOs	NGOs: 5,000 WHO: 1,000
2. Providing the training of doctors and ITs of private structures and prisons	- Number of training sessions provided		1	1	1	PNT, NGOs	GF: 16,260
3. Supervising private structures and prisons	% supervision carried out		100%	100%	100%	PNT, NGOs	WHO: 10,000

Budget summary for Area 1: case management



*Amounts taken in Area 4 case detection.
Refer to Annex III Tub for cost breakdown.

Area of intervention 2: Case detection

Analysis of the situation:

Tuberculosis control is based not only on good case management of patients undergoing treatment, but also on the screening of a large number of cases, particularly those likely to spread the disease throughout the community (pulmonary tuberculosis patients with sputum bacilli). The WHO considers that if 70% of expected cases are discovered (TB. cases expectorating bacilli) and if 85% of TPM+ (smear positive pulmonary TB.) cases undergoing treatment are cured, it may be hoped to reduce the tuberculosis morbidity rate significantly in the country.

According to the epidemiological report for 2001 by the PNT, we are still wide of the mark, with a 53% TPM+ detection rate. For the bacteriological control of slide readings in the CDTs in 2001, 0 to 22% of wrong positive readings and 0 to 39% of wrong negative readings were recorded on the Ziehl examination smears taken, depending on the sites.

The main underlying problems of such low performance in detection are the following:

1. 30% of our population still do not have easy access to health structures. Inaccessibility is often geographical, cultural (beliefs) but, above all, financial (high costs of care in health centres (H.C.)
2. The shortage of material resources, but also of skills and motivation due to the modest financing of the laboratory sector prevents first-rate examinations being carried out as we would wish
3. The anarchic administration of tuberculostatic drugs by health structures, often private and unsupervised by the Programme results in the emergence of chronic cases requiring a lot of effort and means, first of all for diagnosis and monitoring and lastly for cure. Kinshasa 1, a reference and monitoring laboratory for chronic cases, already exists and a second one is necessary to cover the southern part of the country.

STRATEGIES:

Training: We will train the laboratory technicians of new structures and we will retrain those who are already doing the job to maintain or improve their level of performance

Supervision: Will involve monitoring and encouraging laboratory technicians and nursing staff. Monthly supervision is planned for each CDT, four yearly supervisions for each Central Office (Health Areas) and yearly supervision for each provincial coordination from national level.

Evaluation of the impact of actions on the Programme: Evaluation will be done by the PNT, on a yearly basis, with external consultants (if necessary) on the basis of baseline data regularly collected by the information system set up for over ten years. Apart from some delays we experience in forwarding the reports from base to central level, the basic items of analysis are available quarterly at provincial coordination level. Provincial co-

ordinations make a first effort to summarise them before sending them to the national office, which draws the main indicators and trends for them for the country.

Main objective: to increase the detection rate for TPM+ cases from 53% to 65% by 2005, through quality controlled microscopy.

Specific objectives:

1. To raise the detection rate for TPM+ cases in DRC from 53% to 65% by 2005.
2. To provide quality control of Ziehl smear examination slides with a view to reducing differences between CDT results and those of the control laboratories.

Specific objective 1:	**To raise the detection rate for TPM+ cases in DRC from 53% to 65% by 2005.**				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline**	**Combined target figures**			
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	
A 5% yearly increase in the TPM+ case detection rate	**53%**	55%	60%	65%	

Specific objective 1	To raise the detection rate for TPM+ cases in DRC from 53% to 65% by 2005.					
Broad activities	***Process/ Output indicators***	***Baseline***	***Combined target figures***			***Responsible/ Implementing agency or agencies.***	***Cost and source of financing***
		2002	***Year 2003***	***Year 2004***	***Year 2005***		
1. Setting up 200 new CDTs	Number of operational CDTs	800	900	1000	1000	PNT	PM
2. Equipping CDT laboratories with new CH20 Olympus or equivalent microscopes (microscope)	- Number of microscopes available in the CDTs	200[51]	600	800	1000	PNT, PNLP, CTB	GF: 960,000 CTB: 200,000 USAID: 80,000
3. Procuring reagents and small laboratory equipment for CDTs	Number of regularly supplied CDTs	800	900	1000	1000	PNT, LNAC, CTB, DAMIEN FOUNDATION, TLMI	CTB: 540,000 USAID: 60,000 GF: 3,596,000

[51] *At the present time, only 200 out of the 800 CDTs have good microscopes. The OLYMPUS CH 20 brand was validated as being the best suited to field conditions (simplicity, solidity, durability, cost/effectiveness, accuracy and quality of the lens).*

4. Providing support for training and retraining laboratory technicians of Health Areas (ZS) and CDT	Number of trained/ retrained laboratory technicians	400	900	1000		PNT, BCZ, CTB	CTB: 24,000 USAID: 67,000 GF: 247,455
5. Supporting the supervision of health staff (nurses, supervisors, appointed nurses of health centres and laboratory technicians of CDTs)	Number of Health Areas (ZS) provided with supervision	285	300	306	306	Provincial co-ordinations	CTB: 75,000
6. Supporting the supervision of Health Areas (ZS) by Provincial co-ordinations	Number of Provincial co-ordinations provided with supervision	19	20	22	22	PNT, CTB	GF: 108,800
7. Providing yearly supervision of Provincial co-ordinations by the PNT	Number of supervisions carried out by the PNT	19	20	22	22	PNT, CTB	CTB: 60,000 USAID: 20,790 GF: 107,520
8. Conducting operational surveys and research into screening	Number of operational research projects carried out	1	5	8	7	PNT, ESP, Faculty of Medicine Kin World Vision	GF: 210,000
9. Rehabilitating and equipping two additional laboratories for monitoring resistant cases (culture and breakpoint testing)	Number of laboratories rehabilitated and equipped	1	2	2	2	PNT, IMT, Antwerp, CDC	GF: 173,000
10. Supplying CDTs with top lamps for microscopes	Number of lamps delivered to CDTs	0	800	1000	1150	CDC	GF: 115,000

Specific objective 2:	To provide quality control of Ziehl smear examination slides with a view to reducing differences between CDT results and those of the control laboratories.			
Outcome/coverage indicators *(See Annex II)*	**Baseline**	**Combined target figures**		
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**

Reduction varying between 0 and 5% for wrong positive slides and between 0 to 5% for wrong negative slides (*)	WP: 0 to 22% WN: 0 to 39%	WP: 0 to 5% WN: 0 to 5%	WP: 0 to 5% WN: 0 to 5%	WP: 0 to 5% WN: 0 to 5%

Specific objective 2:	*To provide quality control of Ziehl smear examination slides with a view to reducing differences between CDT results and those of the control laboratories.*						
Broad activities	***Process/Output indicators***	***Base line***	***Combined target figures***			***Responsible/ Implementing agency or agencies.***	***Cost and source of financing***
		2002	***Year 2003***	***Year 2004***	***Year 2005***		
1. Training health staff about the new directives related to the organisation of network quality control (nurses, supervisors, appointed nurses in the health centres, lab. technicians)	Number of trained staff	0	48	8	0	PNT, CTB, Damien Foundation	PM
2. Supplying CDTs with new information media, protocols and documentation in relation to quality control	Number of CDTs supplied during the project	0	800	900	1000	PNT, CTB, Damien Foundation	GF: 10,000
3. Controlling the quality of Ziehl smears from CDTs on a quarterly basis	Number of CDTs benefiting from quality control	40%	60%	75%	80	PNT, CTB, Damien Foundation	PM
4. Conducting studies about the quality control system	Number of studies conducted	*1*	*2*	*4*	*6*	PNT, ESP, Faculty of Medicine Kinshasa, World Vision	*PM*
5. Equipping the LPRs with teaching microscopes	Number of teaching microscopes available in the LPRs	*0*	*22*	*22*	*22*	International Union Against **Tuberculosis** and Lung Diseases (IUATLD/ UICTMR)	*GF 84,000*
6. Providing maintenance of teaching microscopes	Yearly number of microscopes maintained	*0*	*22*	*22*	*22*	PNT	*GF 14,500*

BUDGET SUMMARY, AREA 2: DETECTION

Budget items	2003	2004	2005	Total
Human Resources	60,000	80,000	70,000	210,000
Infrastructures / Equipment	725,332	353,331	261,837	1,340,500
Training / Planning	120,555	126,900	0	247,455
Commodities	1,124,000	481,000	481,000	2,086,000
Drugs	0	0	0	0
Monitoring / Evaluation	67,600	74,360	74,360	216,320
Other (Transport / Maintenance)	0	0	0	0
Total	**2,097,487**	**1,115,591**	**887,197**	**4,100,275**

See Annex IV Tub for cost breakdown.

Area of intervention 3: Social Mobilisation

Analysis of the situation

In spite of a strong prevalence of tuberculosis and the technical efforts provided up to now, the main tuberculosis control indicators in our country still remain low. The rate of incidence of TB cases with bacilli in sputum is 78 per one hundred thousand inhabitants and the cure rate of TP+ (pulmonary tuberculosis) patients is 70%. This alarming situation is, among other things, due to the ignorance of the population concerning tuberculosis. Despite some experiments to raise awareness and mobilise people initiated by the PNT and partner NGOs through the International Tuberculosis Days (ITD), and some encouraging initiatives carried out in provincial co-ordinations, there is still a major lack of knowledge, practices and attitudes where tuberculosis is concerned. These statements are more or less corroborated by a KAP survey, not yet published, conducted in Kinshasa in 2001 by the College of Public Health of the University of Kinshasa.

At the present time, it has been clearly established that the families, the tutors of patients, the leaders of the various associations, and former tuberculosis patients, play a decisive role within the community through their psychosocial accompaniment. In actual fact, the tutor is often a family member who undertakes to accompany the sick persons throughout the treatment period and also fetches the drugs from the health centre for the bedridden patient. The health professional also provides voluntary care to the patient within a particularly difficult political and social context. Drawing strength from these encouraging but unevaluated elements, the PNT states that it is urgent to strengthen the IEC capacities of the institution by improving existing information tools, by drawing up a guide containing appropriate, clear and updated messages with a view to reaching the different people in the components of the population capable of popularising the messages: political leaders, community leaders, decision makers, schools, churches, youth leaders, women's associations, etc. Backed by assistance from health professionals, these mass communicators of messages will be able to improve the knowledge, practices and attitudes

of the population about tuberculosis. The resulting change in behaviour may lead to a greater number of detected and cured patients.

In order to achieve these objectives effectively, we need a national consensus about the type of messages intended for the different targets. After that, the different teams involved in popularising the messages within the community shall be identified, trained and monitored, as far as the bottom operational level (CDT). The evaluation of IEC impact on tuberculosis control will also be done on a yearly basis by a strengthened IEC unit, within the PNT.

OPPORTUNITIES

It should be noted that we are going to obtain the support of a communication expert from a Belgian NGO, APEFE, for the three years 2003 up to 2005. The expert will start his/her job at the beginning of 2003. It will be a full-time job, for three years within the IEC unit of the PNT.

STRATEGY

- Training of trainers and message mass communicators
- Supervision of the dissemination of messages at all levels
- Evaluation of IEC impact on a yearly basis and possible readjustment of the messages to be disseminated

Main objective: to mobilise communities and target groups with a view to improving tuberculosis detection and cure.

Specific objectives:

1. To improve the level of knowledge, attitudes and practices of different target communities about tuberculosis
2. To strengthen the IEC capacities of the players involved.

Objective 1:	***To improve the level of knowledge, attitudes and practices of different target communities about tuberculosis.***				
Outcome/coverage indicators *(See Annex II)*	Baseline	Target figures			
	Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005	
Level of knowledge and practices of target populations (schoolchildren, pupils, students, journalists and community leaders) concerning tuberculosis is improved.	20%	30%	40%	50%	

EXPECTED RESULT: The level of knowledge, attitudes and practices is improved.

Objective 1	**To improve the level of knowledge, attitudes and practices of different target communities about tuberculosis.**

Broad activities	Process/ Output indicators	line	Target figures			Responsible/ Implementing agency or agencies.	Cost and source of financing
		2002	Year 2003	Year 2004	Year 2005		
1. Conducting a KAP survey	Number of surveys conducted	0	1	2	3	PNT, ESP	GF: 75,000
2. Drawing up an IEC guide	The guide is available		1	1	1	PNT	GF: 6,000
3. Updating information tools for the different target populations	The tools are updated and validated		1	1	1	PNT, APEFE	GF: 6,000
4. Preliminary testing of the guide and information tools	The tools are subject to preliminary testing and validated		1	1	1	PNT, APEFE	GF: 3,560
5. Reproducing and disseminating the documents drawn up °Guides: °Leaflets: °Mobilisation material °Awareness-raising documents °Picture boxes	Number of printed documents	0	2500 5000002 3 250000 1500	2500 5000002 3 250000 1500	2500 5000002 3 250000 1500	PNT	GF: 3,750 30,000 55,300 200,000 45,000
6. Organising ITDs in the 23 Co-ordinations.	Number of ITDs organised in the Co-ordinations	4	20	23	23	PNT, STOP TB, NGOs	G.F.: 99,000 Partners: 100,000

Objective 2:	To strengthen the IEC capacities of the players involved.				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
Recorded level of knowledge and capacities of players involved concerning tuberculosis.	***5%***	*10%*	*15%*	*20%*	

Target groups: political decision makers and leaders, schools, churches, community directors and leaders, youth leaders, leaders of women's associations, media executives.

Objective 2	**To strengthen the IEC capacities of the players involved**

Broad activities	Process/ Output indicators	Baseline	*Target figures*			*ponsible/ ementing agency or agencies*	*Cost and source of financing*
		2002	*Year 2003*	*Year 2004*	*Year 2005*		
1. Training trainers in communication techniques[52]	- Number of trained trainers		*1*	*1*	*1*	*PNT, CPLT, APEFE*	*GF: 81,555*
2. Organising training for Community Agents in communication techniques [53]	Number of Community Agents trained for each Health Area		*19*	*22*	*22*	BCZ, PNLS and PNLP	*GF: 252,000*
3. Popularising messages for the different targets [54]	Number of popularisation sessions carried out per category		*500*	*1000*	*1500*	*BCZ, CPLT, PNT*	*GF: 360,000*
4. Providing the follow-up, supervision and evaluation of IEC activities at all levels: °PNT towards CPLT °CPLT towards ZS °ZS towards CDT	Number of supervisions and evaluations carried out at all levels	 0	 *20* *20* *200*	 *23* *23* *200*	 *23* *23* *200*	*BCZ, CPLT, PNT*	*PM* *PM* *PM* *PM*

See Annex V Tub for cost breakdown

MOBILISATION BUDGET SUMMARY

Budget Items	2003	2004	2005	Total
Human Resources	178560	179500	179500	537560
Infrastructures / Equipment	0	0	0	0
Training / Planning	33185	27185	27185	87555
Goods	334050	0	0	334050
Drugs	0	0	0	0
Monitoring / Evaluation	6000	6000	6000	18000
Other (Transport / Maintenance)	0	0	0	0
Total	**551 795**	**212 685**	**212 685**	**977 165**

[52] *The product of training is the drawing up of micro-plans by participants.*

[53] *I.e. two Community Agents per CDT for 1000 scheduled CDTs.*

[54] *4 messages per month X 5 USD X 12 months X 1,000 ASC = 720,000 USD*

Area of intervention 4: strengthening of institutional capacities and skills of central and intermediate level staff

Analysis of the situation

In our programme, activities are integrated into the basic health care, at peripheral level, of the CDTs. That is the place where case management and detection generally take place. This operational level regularly needs to be assisted by supervision and training/retraining by the intermediate level, which we call provincial coordination. We have nineteen of them in 2002 and we intend to have twenty-two of them in 2005 according to our Five-year Master Plan. Provincial co-ordinations, in turn, are assisted and monitored by the national office of the PNT.
These new provincial co-ordinations are going to be set up from some which already exist and which are too big to follow the large number of CDTs under their supervision effectively. The buildings, which will be used as offices, laboratories and drug depots, are public buildings granted by the Ministry of Health. Unfortunately, they have often not been maintained for a long time and are in very poor condition. Some additional resources are required to make them really operational. It is hoped to rehabilitate and equip each building of these new co-ordinations. It is also necessary to raise the level of technical skills of the team who will run these new facilities.
The national level will benefit from a grant from Belgian cooperation during these three years to equip the national laboratory and the buildings of the national office. For the first time, the PNT manages all the drugs which are supplied by the traditional partners (Damien Foundation, TLMI, ALM) and GDF. We will therefore receive a yearly supply of approximately one hundred tonnes of drugs, materials and various other medical products. The Ministry of Health promises us a hall, which will be used as a depot, but it will have to be rehabilitated to ensure the safety of any commodities to be stored there. We have some firm promises from partners (FD, Canadian Cooperation) to participate in the rehabilitation of this building and we need additional assistance to hope to finish it and equip it. We also plan to raise the level of management skills of the staff of this pharmaceutical depot.
The other managerial staff of these two levels (national and intermediate), who have been in office for some time, need to sustain and improve their knowledge by attending conferences, congresses, workshops and meetings at national and international level.

Main objective: To improve the technical and institutional capacities of national level and the 22 provincial co-ordinations.

Specific objectives:

1. To strengthen the institutional capacities of national level and the 22 provincial co-ordinations.
2. To strengthen the technical skills of the staff of national office and in 4 co-ordinations.
3. To organise an external management evaluation and a technical evaluation of the Programme every year during the project.

Objective 1:	**To strengthen the institutional capacities of national level and the 22 provincial co-ordinations.**				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
National office and provincial offices made more efficient	***50%***	*60 %*	*70 %*	*80 %*	

* define performance criteria (infrastructure, equipment, office automation, logistics, etc.)

Objective 1	**To strengthen the institutional capacities of the national offices and its 22 provincial co-ordinations:**						
Broad activities	Process/ Output indicators	Baseline	Target figures			Responsible/ Implementing agency or agencies.	Cost and source of financing
		2002	Year 2003	Year 2004	Year 2005		
1. Setting up an IEC unit at national level and at the level of each provincial co-ordination	- IEC units set up and operational		5	15	23		PM
2. Rehabilitating national level infrastructures (national depot) [55]	The national depot is rehabilitated and made operational	0	100%	100%	100%	PNT, PROCURE DIOCESAINE DE KINSHASA (DIOCESE)	GF: 70,000 NGOs: 70,000 USAID: 33,171
3. Strengthening the Programme documentation centre	Equipped library	0[56]	1	1	1	PNT	GF: 27,500
4. Carrying out the rehabilitation of buildings of 5 offices of co-ordinations	number of rehabilitated offices[57]	14	5			PNT, FD	GF: 140,000 CTB: 35,000
5. Rehabilitating lab. buildings of 10 co-ordinations	number of rehabilitated provincial laboratories[58]	13	19	22	22	PNT, NGOs, Damien Foundation	GF: 100,000 NGOs:

[55] *the State gives the building, the NGOs and GF rehabilitate and USAID equips it.*

[56] *documents do exist, but are insufficient and unorganised*

[57] *CPLTs to be rehabilitated: Maniema, Sankuru, K.Oriental, Bandundu Ouest, Tshikapa*

[58] *Laboratories to be rehabilitated: Kinshasa, Kananga, Tshikapa, Mbuji-Mayi, Sankuru, Maniema*

6. Equipping the new provincial co-ordinations: computer and accessories, photocopier, vehicle and telephony	number of provincial co-ordinations equipped	9	19	19		PNT, CTD, Damien Foundation	GF: 490,000 CTB: 414,000

Objective 2:	**To strengthen the technical skills of the staff of national office and in 4 co-ordinations.**				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
Number of staff whose technical performance has been improved	***unknown***	*10%*	*20%*	*30%*	

Objective 2	To strengthen the technical skills of the staff of national office and in 4 co-ordinations.						
Broad activities	Process/ Output indicators	Baseline	Target figures			Responsible/ Implementing agency or agencies.	Cost and source of financing
		2002	Year 2003	Year 2004	Year 2005		
1. Training in operational research in Brussels	number of persons trained	1	1	2	3	ULB/ Brussels	GF: 15,000
2. Training in epidemiology and statistics in Belgium	number of persons trained	0	1	2	3	ULB/ Brussels	GF: 15,000 CTB: 24,000
3. Organising a national planning and validation meeting with 50 persons for 10 days.	Meeting organised	1	1	2	3	PNT/PNEL	GF: 120,000
4. Training or retraining MCPs in TBC training management	Meeting organised	8	20	20	20	PNT/UICTMR (IUATLD)	GF: USAID: 24,600
5.Locally training in computing (Word, Excel, Access) and data management for managerial staff at national and provincial level in Kinshasa	Number of persons trained	3	27	27	27	TRANSYS CDC	GF: 25.700 USAID: 50,000

6. Locally training in English for managerial staff at national and provincial level	Number of persons trained	3	27	27	27	PNT/CPLT	GF: 7,200
7. Management training for managing director	Managing director trained	0	1	1	1	MDF	GF: 5,000
8. Management training for Programme pharmacist	Pharmacist trained	0	1	1	1	MDF, IDA	GF: 5,000
9. Attending annual International Congresses	Number of participants	8	8	16	25	PNT, UICTMR	GF:12,500 UICTMR: 9,000 USAID:
10. Equipping the documentation centre with books and international reviews °Equipment and reviews °Books	Number of books and reviews acquired	 20	 25 25	 50 50	 75 75	PNT, UICTMR	UICTMR: 15,000 GF: 7,500 3,750

Objective 3:	**To organise an external management evaluation and a technical evaluation of the Programme every year during the project.**				
Outcome/coverage indicators (Refer to Annex II)	***Baseline***	***Target figures***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
Evaluation made[59]	*2*	*2*	*4*	*6*	

Objective3	To organise an external management evaluation and a technical evaluation of the Programme every year during the project.						
Broad activities	Process/ Output indicators	Baseline	Target figures			Responsible/ Implementing agency or agencies.	Cost and source of financing
		2002	Year 2003	Year 2004	Year 2005		
1. Organising an annual financial audit of the National Office	Financial Audit conducted	0	1	2	3	Chartered accounting firm to be identified	GF: 30,000

[59] *A financial evaluation and a technical evaluation*

2. Organising one external consultation per year for the Programme	External consultation carried out	2	1	2	3	UICTMR (IUATLD), WHO	GF: 30,000 USAID: 25,000

BUDGET SUMMARY: STRENGTHENING INSTITUTIONAL CAPACITIES AND SKILLS

Refer to Annex VI Tub for cost breakdown.

STRENGTHENING BUDGET SUMMARY				
Budget Items	**2003**	**2004**	**2005**	**Total**
Human Resources	20000	20000	20000	60000
Infrastructures / Equipment	1265000	40000	7500	1312500
Training / Planning	53750	69500	37000	160250
Goods	0	0	0	0
Drugs	0	0	0	0
Monitoring / Evaluation	0	0	0	0
Other (Transport / Maintenance	0	0	0	0
Total	**1 338 750**	**129 500**	**64 500**	**1 532 750**

28. **Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programmes; does the component aim to fill existing gaps in national programmes; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines par. III.41 – 42*), (2–3 paragraphs):

The tuberculosis component builds on the programme already implemented by the Ministry of Health, which covers approximately 70% of the population under the DOTS strategy (2001 epidemiological report of the National Programme to Combat Tuberculosis - NPLT).
This proposal aims at extending this coverage to 90% of the population. In addition, this component is going to strengthen the programme for sections representing gaps in tuberculosis control:

- the low detection rate of 53%
- the low cure rate of 70% for front-line smear positive (TPM+) patients
- case management of multi drug resistant (MDR) cases

The proportion is in keeping with the 2001-2005 five-year plan of the PNT which entered the fight against the tuberculosis endemic among the sector-wide strategies aimed at

reducing infection, morbidity and mortality due to priority health problems, curbs on development and poverty factors.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

In all the fields of activity, TB sufferers are fully involved in the intervention continuum:

As far as case management is concerned, we will develop case management by the community for some categories of patients, particularly those who are TB/HIV co-infected, but also all the others who have difficulty in following DOTS in the health structures.
We have learned through a number of experiences in some co-ordinations, especially the Kinshasa City co-ordination, that the best advocate of the programme is the cured former tuberculosis sufferer who accepts to give evidence of the benefits of the drugs to other members of the community.
These former TB cases are organised in clubs and assisted by medical staff. They perform plays and other cultural activities during international tuberculosis days or on other occasions of public events. In that way, they contribute to their own case management and other people's and they contribute to the screening of many other cases unwilling to attend the health structures.

29.2. Community participation:

We have taken an entire area with a budget of over one million dollars for community participation in the detection and treatment of TB cases. There are already some activities designed to raise awareness among the population at all levels, whether national, provincial or peripheral. But these IEC activities have not yet been evaluated. We do not know therefore whether they are yet suited to the different targets, particularly TB/HIV co-infected patients.

At the present time, it is clearly established that the families, the tutors of patients, the leaders of different associations, and former tuberculosis sufferers, play a decisive part within the community on account of their psychosocial accompaniment. Drawing strength from these encouraging initiatives, the PNT states that it is urgent to strengthen the IEC capability of the institution by improving existing information tools, by drawing up a guide containing updated, clear and tailored messages with a view to reaching the different components of the population capable of popularising the messages: political leaders, community leaders, decision makers, schools, churches, youth leaders and women's associations.
Suitably assisted by health professionals, these mass communicators of messages will be able to improve the knowledge, practices and attitudes of the population concerning tuberculosis. The resulting change in behaviour may lead to more detected and cured patients.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):

On the whole, when we consult the average of our national statistics, we may consider that there is no gender discrimination in the detection and case management of tuberculosis cases, insofar as there are almost as many screened and cured cases of both genders.
When we come down to the co-ordinations, the reality is quite different. In some co-ordinations, like the North-Kivu, we permanently have a male/female gender ratio of 2/1 for several years now for new smear positive cases of screened patients. In addition, these are the co-ordinations where we have a low detection rate, below the national average. (see the PNT 2001 epidemiological report).
In order to understand this phenomenon, apparently one of gender discrimination, we have planned some "gender"-related operational research subjects. These projects will be implemented in a number of health areas and their objective is to clarify the

reason(s) for such a disproportion of screened cases between the two genders. They shall address the issue of improving equal access to care for both genders.

29.4. Social equality issues (*Guidelines paragraph IV.53*):

Well aware that tuberculosis generally affects the poorest layer of the population, and familiar with the current mediocre socioeconomic conditions of a large part of the Congolese population, the programme requested and obtained that all TB cases should be entitled to free drugs. This measure allows access to care for most screened patients.
These drugs are offered free to us by the GDF (2/ 3) and all the traditional partners (1/3). We are applying to the Global Fund to provide transport between Kinshasa and some provinces, which have little support for their activities. In this way, the drugs will be made accessible to the entire Congolese population.
One category of patients difficult to follow is the category of chronic cases who no longer respond to first-line treatment (multi drug resistant (MDR) cases). The second-line drugs they need are excessively expensive, and the treatment is long. Furthermore, these sick patients reach this level after several months of inactivity and having used up the little money they had. A specific request, for them and for three years, is made in the first area of intervention. These drugs will be supplied to them free of charge. In this way, we believe that we address the issue of equal care by providing free drugs to all sick people, both first-line and second-line patients.

29.5. Human Resources development:

These last years, the Democratic Republic of Congo has been experiencing a crisis in a multiplicity of forms. This context of crisis, with the ensuing disorganisation of the health system as its corollary, has increased the direct impact on the state of health of the population and more particularly those already in a vulnerable situation.
The same consequences can be measured regarding the loss of human resources and trained supervisors, putting a very heavy load on the staff in position. That is why we plan to raise the level of technical and management skills of those supervisors and staff, at national and intermediate level, who have been in office for some time and need to refresh and improve their knowledge by attending conferences, congresses, workshops and meetings at national and international level.
The beneficiaries of this intervention are the main players involved and partners in the combat against TB in the country, especially at central and provincial level (laboratory technicians, provincial coordination doctors, project and programme managers.
In addition to these local skills, we need outside expertise for a number of activities such as external evaluations, financial audits, surveys and operational research projects, which are an additional asset for the programme by adding their respective skills.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximise adherence and monitor resistance), *(Guidelines par. IV.55),* (1–2 paragraphs):

For the treatment of TB cases, we follow the DOTS strategies in five components, which ensure greater treatment effectiveness.

- Priority is firstly given to TPM+ (smear positive) patients
- The treatment plans that we use take into account the patient category (seriousness) and are short-term (eight months) combined products (RHZE, RHZ,

RH, EH), with two phases, the first lasting two months with 4 molecules followed by 6 months with two combined molecules

- The drugs for the first two months are given under direct observation by the nursing staff
- Purchases are centralised and quality checked by the WHO (identification of the quality supplier), GDF and local drug quality control bodies
- We have a standard surveillance system throughout the country which enables us to monitor the application of the programme in the field (cure trend), with supervisions and pinpoint evaluation at all levels on a quarterly basis
- A circular from the Ministry of Health exists which bans the sale of tuberculostatic drugs in public chemist's shops. It makes compulsory the exclusive use of anti-tuberculosis drugs by structures approved by the programme.
- A widely distributed programme handbook exists where all the drug guidelines are given. Refresher courses are organised every year at all levels, especially in the health centres and health education institutions to maintain the standard of nursing skills
- As the treatment lasts at least eight months, in certain circumstances (distance from the village, health centre with a lot of patients undergoing treatment), we decentralise care to the community to provide better assistance to the patient undergoing treatment
- Each patient has a treatment book, which he keeps, and a treatment card, which stays at the treatment centre. An absence is quickly noticed and an active search by nursing staff has to be begun to retrieve absconders.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, programme management, audit costs, etc*
Other (please specify):

OVERALL BUDGET SUMMARY

Budget Items	2003	2004	2005	Total
Human Resources	258,560	279,500	269,500	807,560
Infrastructures / Equipment	1,726,168	393,331	269,337	2,388,000
Training / Planning	424,955	351,050	172,450	948,455
Commodities	1,466,050	482,000	482,000	2,430,050
Drugs	81,600	81,600	81,600	244,800
Monitoring / Evaluation	79,600	80,360	80,360	240,320
Other (Transport / Maintenance)	63,000	66,000	66,000	189,000
Administrative Costs	409,293	181,701	151,191	724,819
Total	**4,502,407**	**1,907,225**	**1,563,372**	**7,973,004**

Refer to Annex VII, overall budget

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

TOTAL DRUGS AND COMMODITIES 2003			
Budget Items	**Units 2003**	**Unit Cost**	**2003**
DETECTION			
Reagent kits and small equipment	900	1240	1116000
Info media for CDT	800	10	8000
SUBTOTAL DETECTION	1700	1250	1124000
MOBILISATION			
Video kits +TV	23	1000	23000
Megaphone	500	50	25000
Camera	1	3500	3500
Video tapes	300	10	3000
Film tapes	400	2	800
Reproduction IEC guide	2500	1.5	3750
Reproduction Leaflets	500000	0.06	30000
Reproduction picture boxes	1500	30	45000
Reproduction awareness-raising documents	500000	0.8	400000
Subtotal mobilisation	501500	30.8	445000
CASE MANAGEMENT			
Printing PATI-IV	800	10	8000
Second-line drugs	200	408	81600
SUBTOTAL CASE MANAGEMENT	1000	418	89600
TOTAL DRUGS AND COMMODITIES 2003			**1 658 600**
Second-line drugs. See LIST below.			

Items/purpose	**Unit cost (USD)**	**Quantities (specify unit)**	**Total cost (USD)**
Drugs for chronic cases			
Ethambutol boxes of 1000 tablets	12	250	3000
Ofloxacin boxes of 1000 tablets	110	300	33000
Prothionamide boxes of 1000 tablets	120	300	36000
Kanamycin cartons of 50 btl.	2.6	300	780
Pyrazinamide boxes of 1000 tablets	33	250	8250
Distilled water, carton of 100 btl.	1.75	326	570.5
SUBTOTAL			**81600.5**
Reagent and small equipment			

Basic fuchsin btl. 25 g	15	6400	96000
Phenol crystals btl. 500 g	12	4000	48000
Methylene blue btl. 25 g	16	2000	32000
Immersion oil btl. 100 ml	6	2000	12000
Hydrochloric acid btl. 1L	8	1000	8000
Denatured alcohol btl. 1L	3	8000	24000
Sulphuric acid 95-99% btl. 1 L	25	4001	100025
Slide boxes, 100	8	4000	32000
Microscope slides	1.5	99850	149775
Cuspidors	0.1	4170000	417000
Bottle with spout, 250ml	50	800	40000
Test-tube, 100 ML	4	800	3200
Test-tube, 500ML	5	800	4000
Test-tube, 1000 ML	10	800	8000
Diamond pencil	10	800	8000
Test-tube holder, wood	2	800	1600
Metal holder	5	800	4000
Spirit lamp	25	800	20000
Slide handle	10	800	8000
Aluminium tray	15	800	12000
Timer	25	800	20000
Colouring tray	46	800	36800
Plastic funnel	4	800	3200
Water distiller	1200	23	27600
Wooden dryers	1	800	800
SUBTOTAL			**1 116 000**
Total			**1,197,600.5**

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

In this proposal, the budget item “human resources”, mainly composed of consultancy fees, only represents 1.5% of the overall amount. It is not therefore an important share of the budget.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines par. V.62*)**:**

Table V.31.1

	2000	2001	2002	2003	2004	2005
Domestic (public and private)	16,385	125,106	297,288	318,792	Not yet budgeted for	Not yet budgeted for
External	2,924,106	3,410,560	4,564,783	7,593,867	4,882,625	5,217,116
Total	**2,940,491**	**3,535,666**	**4,862,071**	**7,912,659**	**4,882,625**	**5,217,116**

Detailed information about funding sources

Funding	2000	2001	2002	2003	2004	2005	Total
WHO			39,500	23,000			62,500
World Bank			300,000				300,000
Damien Foundation	2,344,106	3,055,560	2,982,533	3,354,767	3,279,825	3,443,816	18,460,607
TLMI	180,000	230,000	340,000	197,800	135,000	135,000	1,217,800
SANRU			662,750	1,321,500	876,000	1,046,500	3,906,750
USAID			415,000	777,000			1,192,000
LNAC (EU)	400,000	125,000	125,000	200,000			850,000
Belgian Coop.				1,404,800	591,800	591,800	2,588,400
APEFE				15,000			15,000
Subtotal partners	2,924,106	3,410,560	4,564,783	7,593,867	4,882,625	5,217,116	28,593,057
Gvt	16,385	125,106	297,288	318,792			757,571
Total	2,940,491	3,535,666	4,862,071	7,912,659	4,882,625	5,217,116	29,350,628

Funding	2003	2004	2005	Total
WHO	23,000			23,000
World Bank				300,000
Damien Foundation	3,354,767	3,279,825	3,443,816	10,078,408
TLMI	197,800	135,000	135,000	467,800
SANRU	1,321,500	876,000	1,046,500	3,244,000
USAID	777,000			777,000
LNAC (EU)	200,000			200,000
Belgian Coop.	1,404,800	591,800	591,800	2,588,400
APEFE	15,000			15,000
Subtotal partners	7,593,867	4,882,625	5,217,116	17,693,608
GLOBAL FUND	**4,502,226**	**1,904,569**	**1,566,209**	**7,973,004**
Gvt	318,792			757,571
Total	12,414,885	6,787,194	6,783,325	25,985,404

See Annex VIII Tub

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

OVERALL BUDGET FOR THE TUBERCULOSIS COMPONENT

Budget Items	Area	Specific Objective	Activity Ref.	Units 2003	Units 2004	Units 2005	Units/ tot.	Unit costs	2003	2004	2005	Total
Human Resources												
KAP surveys	Mobilisation	SO1	A1	1	1	1	3	25000	25000	25000	25000	75000
Pretest guide	Mobilisation	SO1	A4	1	0	0	1	3560	3560	0	0	3560
Organisation ITD	Mobilisation	SO1	A5	20	23	23	66	1500	30000	34500	34500	99000
Popularisation messages	Mobilisation	SO2	A3	1000	1000	1000	3000	240	120000	120000	120000	360000
International consultation	strengthening capacities	SO3	A2	1	1	1	3	10000	10000	10000	10000	30000
Financial audit	strengthening capacities	SO3	A1	1	1	1	3	10000	10000	10000	10000	30000
Studies and operational research	detection	SO1	A8	6	8	7	21	10000	60000	80000	70000	210000
Subtotal Human Resources									25860	279500	269500	807560
Infrastructure/ Equipment												
Rehabilitation PNT office	strengthening capacities	SO1	A2	1	0	0	1	70000	70000	0	0	70000
*Rehabilitation 5 co-ordination offices	strengthening capacities	SO1	A2	4	0	0	5	35000	140000	0	0	140000
Rehabilitation Co-ordination Laboratories	strengthening capacities	SO1	A5	10	0	0	10	10000	100000	0	0	100000
Equipt PNT documentatio	strengthening capacities	SO1	A2	1	0	0	1	10000	10000	10000	7500	27500

n centre												
Equipt co-ordination documentation centre (reviews, books)	strengthening capacities	SO2	A10	19	3	0	22	10000	190000	30000	0	220000
Computer kits 10 co-ordinations	strengthening capacities	SO1	A2	10	0	0	10	3500	35000	0	0	35000
Photocopier 10 co-ordinations	strengthening capacities	SO1	A2	10	0	0	10	4500	45000	0	0	45000
Pactor telephony 10 co-ordinations	strengthening capacities	SO1	A2	10	0	0	10	6000	60000	0	0	60000
Vehicles 10 co-ordinations	strengthening capacities	SO1	A2	10	0	0	10	35000	350000	0	0	350000
Microscopes 800 CDTs	detection	SO1	A2	400	200	200	800	1200	480000	240000	240000	960000
Rehabilitation 2 Culture Labs	detection	SO1	A9	1	1	0	2	10000	10000	10000	0	20000
Equipment 2 Culture Labs	detection	SO1	A9	1	1	0	2	76500	76500	76500	0	153000
Top lamp for microscope	Detection	SO1	A10	800	200	150	1150	100	80000	20000	15000	115000
Teaching microscope for LPR	Detection	SO2	A5	19	1	1	21	4000	76000	4000	4000	84000
Microscope maintenance + spare parts	Detection	SO2	A6	4	4	4	12	0	2832	2831	2837	8500
Subtotal Infrastructure / Equipment									1725332	393331	269337	2388000
Training / Planning												
Training provincial trainers	Mobilisation	SO2	A1	1	1	1	3	27185	27185	27185	27185	81555
Training CDT staff	Case Management	SO1	A5	48	8	0	56	2400	115200	19200	0	134400
Training doctors	Case Management	SO2	A3	1	1	1	3	14845	14845	14845	14845	44535
IEC guide workshop	Mobilisation	SO1	A2	1	0	0	0	6000	6000	0	0	6000
Information tools workshop	Mobilisation	SO1	A3	1	0	0	0	6000	6000	0	0	6000
Op. research training	strengthening capacities	SO2	A1	1	1	1	3	5000	5000	5000	5000	15000
Training in biostatics & epidemiology	strengthening capacitie	SO2	A2	1	1	1	3	5000	5000	5000	5000	15000

	s											
International Conferences	strengthening capacities	SO2	A9	8	8	9	25	3000	24000	24000	27000	75000
Coordinator training (comput., English, management)	strengthening capacities	SO2	A4	1	2	0	3	11750	11750	23500	0	35250
Training other PNT staff (comp., Eng., management)	strengthening capacities	SO2	A4	1	2	0	3	6000	6000	12000	0	18000
Training of pharmacists & admin.	strengthening capacities	SO2	A4	2	0	0	2	1000	2000	0	0	2000
Training CDT laboratory staff	detection	SO1	A4	19	20	0	800	6345	120555	126900	0	247455
Training community agents	Mobilisation	SO2	A1	19	22	22	63	4000	76000	88000	88000	252000
Training private doctors	Case management	OS4	A2	1	1	1	3	5420	5420	5420	5420	16260
Subtotal Training Planning									424955	351050	172450	948455
Commodities												
Video kits + TV	Mobilisation	SO1	A4	23	0	0	23	1000	23000	0	0	23000
Megaphone	Mobilisation	SO1	A4	500	0	0	500	50	25000	0	0	25000
Camera	Mobilisation	SO1	A4	1	0	0	0	3500	3500	0	0	3500
Video tapes	Mobilisation	SO1	A4	300	0	0	0	10	3000	0	0	3000
Film tapes	Mobilisation	SO1	A4	400	0	0	0	2	800	0	0	800
Reproduction IEC guide	Mobilisation	SO1	A5	2500	0	0	0	1,5	3750	0	0	3750
Reproduction leaflets	Mobilisation	SO1	A5	500000	0	0	0	0,06	30000	0	0	30000
Reproduction picture box	Mobilisation	SO1	A5	1500	0	0	0	30	45000	0	0	45000
Reproduction awareness-raising documents	Mobilisation	SO1	A5	250000	0	0	0	0,8	200000	0	0	200000
Reagent kits and small equipment	Detection	SO1	A3	900	1000	1000	1000	1240	1116000	480000	480000	2076000
Info medium for CDT	Detection	SO2	A2	800	100	100	1000	10	8000	1000	1000	10000
Printing PATI-IV	Case Manage-	SO1	A3	800	100	100	1000	10	8000	1000	1000	10000

	ment											
Subtotal Commodities									1466050	482000	482000	2430050
Drugs												
Second-line drugs	Case Manage-ment	SO2	A2	200	200	200	600	408	81600	81600	81600	244800
Subtotal Drugs									***81600***	***81600***	***81600***	***244800***
Monitoring/ Evaluation												
Supervisions by prov. co-ordinations	Detection	SO1	A6	20	22	22	64	1700	34000	37400	37400	108800
Supervisions par PNT	Detection	SO1	A7	20	22	22	64	1680	33600	36960	36960	107520
Validation of directives	Case Manage-ment	SO1	A2	1	0	0	0	6000	6000	0	0	6000
National planning & validation workshop	Mobilisat ion	SO2	A3	1	1	1	3	6000	6000	6000	6000	18000
Subtotal Monitoring / Evaluation								**1538 0**	**79600**	**80360**	**80360**	**240320**
Other (Transport/maintenance)												
Transport drugs	Case Manage-ment	SO1	A1	19	22	22	63	3000	57000	66000	66000	189000
Subtotal transport									***57000***	***66000***	***66000***	***189000***
TOTAL TUBERCULOSIS									4093097	1733841	1421247	7248185
Administrative Costs									409310	173384	142125	724819
Total									**4 502407**	**1907225**	**1563372**	**7973004**

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines par. V.63*):

Table V.33

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Total**
Government	23%	37%	33%	**28%**
NGOs / Community-Based Org.				
Private Sector				
People living with HIV/ TB/ malaria				

Academic / Educational Organizations	2%	7%	7%	**4%**
Faith-based Organizations				
Others (please specify)	39%	32%	38%	**37%**
Main beneficiary: BCECO[60]/ UNOPS	36%	24%	21%	**30%**
Total	**56%**	**24%**	**20%**	**100%**

**** If there is only one partner, please explain why.***

[60] *Central Coordination Office*

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines par. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines par. VI.64),* (1–2 paragraphs)**:**

(See Component 1: HIV/AIDS)

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

(See component 1: HIV/AIDS)

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines par. VI.65–67)*:

(See Component 1: HIV/AIDS)

Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this organization is best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub-recipients etc), *(Guidelines par. VI.66–67),* (1–2 paragraphs):

(See component 1: HIV/AIDS)

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph):

(See component 1: HIV/AIDS)

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs):

(See component 1: HIV/AIDS)

SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines par. VII.76)*:

Information about tuberculosis in RDC is provided by:
The national health information system (*système national d'information sanitaire - SNIS*): quarterly collection of data about tuberculosis, drafting of quarterly reports by the health areas (ZS) then forwarding to the various coordination offices and the PNT national executive.
The annual report by the Ministry of Health drafted by the Directorate for Research and Planning (DEP).
The findings of surveys and operational research conducted by different partners
MICS surveys conducted every 5 years. (1st issue in 1996, 2nd in 2001)
Pinpoint health inventories (Ministry of Health, 1998)

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

Data collection will be done passively and actively through:

Utilisation of the reports by partners involved in the combat against tuberculosis on a quarterly basis
Monthly review of the minutes of monthly consultation, orientation and coordination meetings of the partners involved in the combat against tuberculosis
Utilisation of the quarterly progress reports forwarded by the provincial coordination offices and the NGOs operating the field
Analysis, compilation and quarterly updating of data about declarations of tuberculosis cases forwarded by the provincial coordination offers
Utilisation of monitoring workshop, internal review and evaluation reports of projects financed by the Fund, which will be carried out for each year of the project at central level
Active collection of data on a monthly basis at the time of follow-up and supervision visits to screening and treatment centres

37.3. Timeline:

Planned timeline:
Quarterly monitoring workshops for project activities at provincial level and every six months at national level
A yearly internal project review will be made at central level
Yearly external audit missions
An external evaluation mission halfway and at project completion

37.4. Roles and responsibilities for collecting and analysing data and information:

The roles and responsibilities of the PNT National Executive:

Validation and updating of the database concerning the activities of partners involved in the combat against tuberculosis
Drafting of minutes of monthly consultation, orientation and coordination meetings of the partners involved in the combat against tuberculosis. At the present time, there are four types of forums: the partner forum, the scientific committee, the drug management committee, and the TB task force
Utilisation of the quarterly progress reports by the persons involved
Utilisation of the quarterly reports forwarded by the provincial coordination offices
Analysis, compilation, quarterly updating and yearly summary of data from declarations of cases forwarded by the provincial coordination offices

The roles and responsibilities of PNT partners will be:

- Institutional support to the PNT
- Mobilisation of resources in support of the combat against TB in DRC
- Participation in the implementation, monitoring and evaluation of activities

The College of Public Health of Kinshasa, World Vision, CDC, IMT/Antwerp and the International Union Against **Tuberculosis** and Lung Diseases (IUATLD/UICTMR) will be accountable for:

- Conducting surveys and operational research
- Monitoring and evaluation

The tasks entrusted to the Provincial Coordination Offices will be:

- Active collection of epidemiological data
- Training and supervision
- Quality control of screening centres
- Validation of data and annual provincial reviews

The Health Area Central Office will be responsible for forwarding reports on:

- Collection, analysis and transmission of data to the coordination offices
- Local training and supervision

The CDTs will be responsible for:

- regularly keeping accurate and complete information media
- promptly forwarding data to the Health Area (ZS) central offices

37.5. Plan for involving target population in the process:

The following activities are planned to induce target populations to get involved in data collection:

- Awareness raising and plea actions among the communities and their leaders, whenever a community survey has to be carried out

Invitation of community officials and representatives to ceremonies where material and equipment are officially handed over to CDTs
Regular organisation of conferences or meetings for feedback on Tuberculosis with community leaders and the persons responsible for institutions involved in the combat at all levels.

Involvement of the different social layers in events organised at the time of international tuberculosis days: plays, sporting events, conferences and debates broadcast on both radio and television, etc.

37.6. Strategy for quality control and validation of data:

- The results of the surveys and operational research, which will be conducted by the College of Public Health of Kinshasa and the other identified partners, will be validated at national level by the scientific committee of the PNT and the IUATLD/UICTMR
- Progress reports are previously examined at monitoring workshops organised by the PNT before being published
- Quality control of the Ziehl smear slides at the CDTs by a re-reading of a sample of these slides at provincial coordination level, with counter-reading at national level
- External financial audits are conducted by specialised agencies after a national or international invitation to tender. Audit results will validated according to the procedures of the selected agency
- Yearly maintenance reports for equipment and infrastructures will be validated by specialised agencies after a national or international invitation to tender.

37.7. Proposed use of M&E data:

Monitoring/evaluation data are going to be used to:

1. measure the achievement of the objectives and the results defined in the four areas of this programme, namely:
    - Social mobilisation
    - Case management of TB cases
    - Detection of cases
    - Strengthening of capacities

2. improve the planning, implementation, follow-up and evaluation process of the new programme.

38. Recognising that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analysing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**

Total requested from Global Fund							
Total other resources available							

SECTION VIII – Information on procurement and management of the supply chain

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	For widely available products, national or international open invitations to tender. For specialized products, restricted consultations (shopping), minimum 3 suppliers
What procurement procedures are used to ensure open and competitive tenders, expedited product availability and consistency with national and international intellectual property laws and obligations?	Invitations to tender are published in the national and international press. In the case of international invitations to tender (Business development), the information is also disseminated within the embassies in Kinshasa.
What quality assurance mechanisms are in place to ensure that all products procured and used are safe and effective?	- When selecting suppliers, we regularly consult the list published by the WHO of pharmaceutical companies it has approved for the quality of their pharmaceutical products (drugs, laboratory products, etc.) - The quality of imported products is controlled by the *Office Congolais de Contrôle* (OCC) [Congolese Inspection Office]. The Ministry of Health assures the quality control of both imported drugs and drugs that are on the market. - Additionally, the GDF assures further quality control of anti-tubercular drugs before they are sent.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	While waiting for the entire country to be equipped with central buying offices (non-profit), distribution is ensured by the various governmental and non-governmental partner organizations in the health zones. This distribution is done rapidly in order to avoid the losses and damage due to prolonged storage.

40. Describe the existing arrangements for procurement of services (e.g. hiring personnel, contracts, training programs, etc.), (1-2 paragraphs)**:**

In most cases, the management of personnel and resources in the periphery and at the provincial level falls under the responsibilities of the civil service. The management of these various resources, such as the hiring and dismissal of personnel and the purchasing,

transfer and sale of state goods, is governed by the texts of the central administration. Other individuals, regional coordinator doctors and the managerial staff at the central level, generally have an individual double contract: one as a state civil servant and another with the player in the regional coordination office.

As non-profit organizations, all programme partners have a contract with the central government for the implementation of their activities. The text of this contract generally allows for the independence of the organizations in their actions, insofar as these actions respect the law. Also provided for is the partner's freedom to manage its different resources, under the condition that this contributes to the smooth progress of the scheduled activities.
The contracts that link the two parties, government and NGO or other partners, have a fixed, renewable term. The contribution of the governmental party consists of various tax exemptions: customs, income taxes and others. Very often, especially at the provincial level, the government will provide the partner organizations of the program with buildings for various uses (offices, storage, laboratory) free of charge.
Locally organized training sessions are generally conducted by the program. Training sessions outside of the country take place in universities that have a collaboration agreement with the Ministry of Health. The costs of participating in these courses cover all services offered by the university in question.

41. Provide an overview of the additional resources (e.g. infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2-3 paragraphs):

The vehicles we are requesting as additional resources for certain regional coordination offices will mainly be used in carrying out the supervision and follow-up of activities in the health centers. The distribution of medicines, of informational media or other documents, of laboratory equipment and products and of treatments will take place during the visits of the coordination team to the health centers.
The renovation of medical warehouses at the central level and of certain regional coordination offices will allow the temporary storage of products and medicines coming from abroad before they are distributed at the peripheral level, in the healthcare structures where the sick are cared for.
For operational research, the partners identified for this activity (World Vision, the College of Public Health, the CDC and the IUATLD) will provide the programme with consultants who will be involved with the activity, often from the beginning of the studies to their end. These institutions generally contribute to the costs of this expertise.
The external consultations and financial audits which take place once a year are so costly that the programme would be unable to afford them. For this activity, the traditional partners only finance the geographic regions where they are directly involved, and it is difficult to convince them to extend their financing to the entire programme.

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requests or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88)*:

Table VIII.42

Programme name	Contact person (with telephone	Resources	Timeframe and

	& email information)	requested (R) or granted (G)	duration of request or grant
WHO	Dr Léonard TAPSOBA	62 500	2002-2003
World Bank	Fometro-Kinshasa	300 000	2003
SANRU	Dr MINUKU Félix 00 243 98186500	3 244 000	2003-2005
USAID	Reggie HAWKINS 00 243 8803142	579 000	2003
FONDATION DAMIEN	Dr Pamphile LUBAMBA 00 243 44358	10 078 408	2003-2005
TLMI	Dr Ndombe Martin 00 243 8943577	467 800	2003-2005
LNAC	Dr Kaboto Gerard 00 243 9944886	200 000	2003
GDF	STOP-TUB (OMS)	4 500 000	2002-2004

42.1. Explain how the resources requested from the Global Fund for the products relative to this component will be complimentary and not duplicative to the additional sources, if any, described above (1 paragraph):

The products requested from the Global Fund in the Tuberculosis component will be complimentary to the products we are already receiving and that we will receive from partners who have supported certain coordination offices for a number of years.
The request to the Global Fund mainly concerns a number of coordination offices that do not have sufficient support, such as the new coordination offices in the provinces of Kasaï-Occidental and Kasaï-Oriental, Sankuru, Maniema and the coordination offices of North Equateur and the Central-Eastern and Eastern Provinces.
When drawing up the present proposal, it was understood that for the entirety of the programme for fighting tuberculosis, it was a question of requesting supplementary resources; for this, we brought together the representatives of various local partners and sponsors in the "*Forum des partenaires du programme*" [Forum of programme partners] during the months of July and August. It is they who assisted us in drawing up the five-year Master Plan in 2000-2001 and who provided the details related to their planning for the next three years.
In addition, the work being done to finalize this proposal is the result of a five-day workshop, with the same partners and sponsors, which made it possible for us to standardize the activities and the various resource contributions. Together with the partners, we have created an inventory of the different products and other resources, we have cleared the deficit with respect to the five-year Master Plan (see section III, point 22.3) and with respect to local support and external partners. The difference is represented in the amount that we are requesting from the Global Fund to cover our needs in relation to the objectives we aim to achieve between now and 2005.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		**HIV/AIDS**
		Tuberculosis
	X	**Malaria**
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2-3 paragraphs):

Component: The "Roll Back Malaria" initiative in D.R. Congo

Summary of the component:

Malaria is one of the major causes of mortality and morbidity in D.R. Congo, particularly amongst young children and pregnant women. It also contributes to the transmission of HIV through its morbid complications such as anemia that requires blood transfusions and paludal placental infections. The fight against malaria in D.R. Congo has been inhibited by a large number of factors, mainly: the appearance of drug-resistant strains, the dilapidation of infrastructures and logistics, the inconstancy of trained personnel, the difficult socio-political and economic context, the low level of community involvement, the breaking down of cooperation and the insufficient coordination between the various participants.

Nonetheless, during the past 3 years, the *Programme National de Lutte contre le Paludisme* (PNLP) [National Programme to Fight Malaria] has demonstrated its desire to do well and has attained valuable results with the support of both its local and international partners. In particular, it has conducted drug-resistance studies upon which the new treatment policy is based. It introduced the use of insecticide-treated mosquito nets (ITMN) in selected sites

throughout the country and formed multisectoral coordination groups (Task Forces) with the aim of optimally implementing the RBM initiative in D.R. Congo.
The requested support, inspired by the RBM strategies, would allow the PNLP and its partners to make advances on multiple fronts while working together. The widespread use of ITMN, achieved through increased awareness-raising in the communities, would help to reduce the paludal morbidity/mortality in the high-risk groups and would prevent the transmission of drug-resistant parasitic strains. Better care in the health centers and within the communities, attained in part through the supplying of materials and inputs, the training of personnel, the improvement of microscopic diagnosis and the rational use of antimalarial drugs, would most likely slow the spread of drug-resistance. The implementation of intermittent preventive treatment for pregnant women would reduce the harmful consequences of malaria in pregnancy (including a probable reduction in the maternal-fetal transmission of HIV). These interventions can only succeed through strengthening the PNLP's technical and administrative capacities throughout the national territory, as well as strengthening partnerships so as to mobilize the communities. This intervention will be implemented in 90 Health Zones, covering a population currently estimated at 18,544,954 inhabitants or 30% of the total population. The target population for this programme is made up of children under 5 years old and pregnant women, numbering 3,708,990 and 741,800 respectively (targeted HZ, see annex I).

This component hinges upon the following six areas of intervention:

1. *The prevention of malaria with the use of long-lasting insecticide-treated mosquito nets*
2. *The treatment of cases within the healthcare structures and within the community*
3. *The intermittent preventive treatment of pregnant women*
4. *Epidemiological surveillance and the management of information*
5. *The strengthening of PNLP's technical and administrative capacities*
6. *Strengthening partnerships for the mobilization of the communities*

Area of Intervention 1:	**The prevention of malaria with the use of long-lasting insecticide-treated mosquito nets in 90 health zones (HZ)**
Main objective 1:	*Reduce the morbidity due to malaria by 20% amongst pregnant women and children under 5 years old between now and 2005 in the intervention health zones*
Beneficiaries:	*Pregnant women and children under 5 years old in 60% of households in the intervention HZ*
Main objective 2:	*Promote the use of treated mosquito nets in urban areas between now and 2005*
Beneficiaries:	*The populations of major provincial towns*

This is a matter of reducing the morbidity of malaria in high-risk groups through promoting the widespread use of long-lasting insecticide-treated mosquito nets in the targeted health zones. This strategy aims to reinforce the practice of sleeping under treated mosquito nets, as scarcely 6.3% of children under 5 years old (MICS 2, 2001) use them. Sufficient coverage of the target groups (>60%) would reduce their malarial morbidity/mortality and would also reduce the spread of drug-resistant strains, which are a major obstacle in the fight against malaria in D.R. Congo.

In order to achieve this, a strong plea will be made to the political authorities to cancel input taxes for this tool and to funding sponsors to increase their financial commitment; a firm order should be made for stocking up on supplies of mosquito nets; a training course will be offered for community health workers in communication, social marketing and insecticide-treatment, and a distribution network will be set up for making the product available to the population. At the same time, the persistency of and resistance to the insecticides will be monitored, following a building of capacities at the national laboratory of the *Institut National de Recherche Biomédicale* (INRB) [National Institute for Biomedical Research].

The implementation of this intervention will take into account the geographic distribution of activities related to ITMN within these health zones. The already existing projects will be reinforced through multiple partners such as UNICEF, IRC, SANRU, religious dominations and other community-based organizations.

Area of Intervention 2: **The treatment of malaria cases within the healthcare structures and within the community**

Main objective: *Improve the treatment of these cases within the healthcare structures and within the community*

Beneficiaries: *Pregnant women and children under 5 years old in HZ with a stable level of endemicity, the entire population in potentially epidemic HZ*

Since November 2001, a new national policy for fighting malaria has been adopted in D.R. Congo. In terms of how malaria cases are treated, this policy recommends the use of Sulfadoxine-Pyrimethamine (SP) as a first-line drug, instead of and to replace chloroquine, which has become ineffective throughout the national territory, as shown by the studies carried out by the PNLP over the past three years. In addition, the difficult accessibility to healthcare creates another major obstacle to early and correct treatment.

New directives for the treatment of malaria cases have been created by the PNLP in collaboration with its partners, a number of whom have already signed on to accompany the PNLP in the implementation of the new policy, in particular through providing support for the supply of drugs, materials and laboratory reagents.

However, although the implementation of the new policy is a priority, it is of little real effect throughout the national territory. Moreover, in a recent analysis of the situation made by the PNLP in a limited number of sentinel zones/sites, it appeared that more than 60% of the community does not consult the health centers in case of fever and that only 7% of those who do consult the health centers for uncomplicated malaria benefit from a correct course of treatment in line with the national directives. Among the members of the community who resort to self-medication, only 5% have knowledge of the recommended treatment plan (PNLP Survey 2001).

Under such conditions, the strategy of treating malaria cases will only have mitigated effects on the global objective of reducing morbidity and mortality. Far-reaching activities including a more widespread diffusion of treatment protocols, the training of caregivers as well as supplying them with inputs, and the introduction of community health workers (liaison officers between the community and the health services) will make it possible to treat cases more effectively, at the structural level as well as the community level. The involvement of a greater number of partners will facilitate the

implementation of the strategy through concerted action. The various tasks will be carried out together with the national coordination bureau, the provincial medical inspectorate, the central office of the health zone, the structural support partners, the local NGOs and the community health workers. One important aspect will be the supply and distribution of antimalarial drugs including, in addition to SP, substances such as quinine and other products which may be used in treatment combinations.

Currently, microscopic diagnosis capacities are very weak in D.R. Congo. Their reinforcement (personnel, equipment and reagents) will be necessary for an improved surveillance of treatment and of drug-resistance.
This capacity building will have a similar effect in the diagnosis and treatment of tuberculosis.

Area of Intervention 3: **The Intermittent Preventive Treatment (IPT) of pregnant women**

Main objective: *Prevent the complications caused by malaria in 80% of pregnant women between now and 2005 in the intervention health zones.*

Beneficiaries: *Pregnant women in the targeted zones*

The negative effects of malaria on pregnancy (such as maternal morbidity, low birth weight, increased maternal-fetal transmission of HIV) are well known today and are dangerous enough that their prevention constitutes a legitimate cause for concern for all participants.
Within the framework of the new national policy for fighting malaria adopted in D.R. Congo since November 2001, the SP chosen to be the first-line drug is also the substance used for the intermittent preventive treatment of pregnant women. The implementation of this strategy will benefit from numerous other concerted initiatives for the survival of mother and child, coordinated by the *Programme National de la Santé de la Reproduction* (PNSR) [National Programme for Reproductive Health]. Supplying intervention zones with SP, educating pregnant women and support for the monitoring of IPT will make up a special area of collaboration between the PNLP and all participants, including community leaders.

Area of Intervention 4: **Epidemiological surveillance and the management of information**

Main objective: *Improve capacities for the surveillance, detection and reaction to epidemics.*

Beneficiaries: *Health services and the community*

In order to monitor the main trends of disease in this country, creating an effective system of epidemiological surveillance has proven to be of urgent necessity. The strategy of integrated surveillance of disease to which our country has adhered would certainly make it possible to resolve numerous surveillance problems raised by the situation analysis, notably the under-reporting of cases and of deaths, the low reaction times and completion of activities, the late detection of epidemics, etc.
However, given the expanse of the national territory, the communication difficulties and the fact that current surveillance is based on the clinical cases of malaria, the data obtained is not of a quality sufficient for monitoring the particular programme targets

and the progress made in the implementation of the RBM initiative. Establishing a network of 15 sentinel sites would allow a better and more immediate monitoring of trends, as well as prompt detection and attack in the case of an epidemic. Particular procedural targets and their indicators have been defined in the strategic plan. These will make it possible to measure the real impact of the interventions. Making use of all partners active in the area of surveillance will allow better coverage of the zones and better management of information. The strengthening of this system will take place with the assistance of CDC/Atlanta, WHO, USAID, INRB, CEMUBAC and ESP.

Area of Intervention 5: **The strengthening of the PNLP's technical and administrative capacities**

Main objective: *Improve the technical and administrative capacities of the PNLP for a better implementation of the RBM initiative in D.R. Congo*

Beneficiaries: *The* Programme National de Lutte contre le Paludisme *(PNLP) and the health services*

In order fulfill its role as coordinator of all activities to be carried out, focusing on their synergy, the PNLP should have sufficient human, material and financial resources at its disposal. The implementation of the RMB initiative requires synergised competencies in a fitting environment. Hence the necessity of strengthening the PNLP's technical and institutional capacities.
This capacity building will take place through the organization of on-the-job training courses at all levels, the granting of equipment and materials, support for operational research as well as reinforcement for coordinating the interventions of the various partners active in the fight against malaria. Furthermore, the identification of PNLP focal points in each province will aim to reinforce the coordination of activities throughout the national territory.

Area of Intervention 6: *Strengthening partnerships for communal mobilization*

Main objective: **Create a multisectoral RBM partnership at the community level**

Beneficiaries: *The health services, the partners and the community*

The health policy of the D.R. Congo is founded upon efficient, complementary and mutually advantageous partnership. Maintaining its normative role, the government relies upon multiple partners for the execution of on-site activities, among which are NGOs, organizations and community groups. These different players are then represented within the consultative and orientation committee that makes up the RBM Task Force. The national Task Force can be credited with conceiving and carrying out activities that are essential to running the National Consensus Forum. Among other projects to its credit, worthy of mention are the definition of reference terms for the Situation Analysis of the fight against malaria in D.R. Congo (ESP-2001), the drug-sensitivity studies in seven provinces and the pilot study for the announcement of the national policy. Other Task Forces have been established in 3 provinces, and the creation of Task Forces in other provinces is planned.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	*March 2003*	**To** (month/year):	*March 2006*

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the target populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

In order to roll back malaria in D.R. Congo and reinforce the implementation of the Five-Year Plan, the six areas of intervention specified in this proposal have the goal of contributing to the reduction of malaria morbidity and mortality in 90 of the 306 health zones in the Democratic Republic of Congo. The intervention will mainly be aimed at pregnant women and children under 5 years old. The long-term impact is a reduction in the number of episodes of fever per child under 5 years old per year, of mortality rates in the same age group and in the proportion of malaria cases seen in health centers. A reduction in the pregnancy complications linked to malaria is also expected.

Table IV.26.1

Goal:	*Contribute to the reduction of malaria morbidity and mortality amongst children under 5 years old and pregnant women in the zones of stable endemicity and amongst the general population in the HZ with epidemic potential between now and 2005*	
Impact indicators ***(Refer to annex II)***	Baseline Year***: 2003***	Target **(last year of proposal)** Year***: 2005***
Number of episodes of fever per child per year	*7*	***5***

Parasitemia in the peripheral blood of pregnant women[51]	***25%***	***15 %***
The proportion of transfusions due to malaria amongst children under 5 years old[51]	***61%***	***40%***
Number of deaths due to malaria seen in the health centers among children under 5 years old[61]	***36%***	***20%***

Source: PNLP Survey 2001

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Area of Intervention 1: *The prevention of malaria with the use of long-lasting insecticide-treated mosquito nets in 90 health zones (HZ)*

Situation analysis

In D.R. Congo, the structured projects for promoting the large-scale use of ITMN supported by the WHO and UNICEF only began in 1999 in three health zones of the city of Kinshasa. Since then, a start has been made on extending the project to other zones and provinces. The priority target groups are children under five years old and pregnant women, groups that are particularly vulnerable to the harmful effects of malaria. However, the insufficiency of logistical, financial and technical means remains the primary obstacle to this extension.

Furthermore, in the conflict zones in the eastern part of the country, microprojects for the distribution of mosquito nets to displaced populations and even vulnerable individuals have only been carried out since 2000. Several NGOs such as OXFAM-UK, IRC, MALARIA PLUS, WORLD VISION, MERLIN and ASRAMES have made contributions to this anti-vector fight, but only in a tentative fashion as they were unable to cover all health areas in the intervention zones.

The majority of these actions have been limited to health zones with structural support. These projects were carried out with a view to gathering sufficient information to allow the support of large-scale distribution activities (Pilot Project).

According to the results of the MICS survey carried out in 2001, the average usage rate of treated mosquito nets among children under 5 years old remains low in D.R. Congo (6.3%). This low rate is due on the one hand to the lack of availability of treated mosquito nets and on the other hand to their price, which a large section of the Congolese population cannot afford.

The experience gained with the support of UNICEF in two revitalized zones of Kinshasa (Kinkole-Maluku) where, after one year, a distribution network based on the community treatment sites noted a usage rate of 20% in the targeted areas. In order to improve this low usage rate, another experiment is currently taking place with the support of UNICEF and BASICS. It consists of door-to-door sales/distribution in another health zone (Kikimi), using community health workers. After three months of intervention, 25% of households are already using treated mosquito nets. An even higher usage rate could be obtained by

[61] These indicators were measured in 7 of the country's sentinel sites during a 12 month period from December 2000 to November 2001

lowering the cost of the mosquito nets, either through tax exemption or through subsidies. Only 21.4% of the treated mosquito nets currently used in Kinshasa are subsidized.

Tests on the persistency of and sensitivity to the insecticides are essential to the monitoring of this type of intervention. The *Institut National de Recherche Biomédicale* (INRB) is a national reference laboratory that could carry out this monitoring once its dilapidated equipment has been improved.

The intervention zone for this component will be made up of the 90 mainly rural HZ and 11 major provincial towns.

Main objectives.

Main objective 1: *Reduce the morbidity due to malaria by 20% amongst pregnant women and children under 5 years old between now and 2005 in the intervention health zones*

Specific objectives:

1. Ensure that 100% of intervention health zones have treated mosquito nets at their disposal between now and 2005.
2. Ensure that 60% of households in the intervention health zones have at least one insecticide-treated mosquito net between now and 2005.
3. Ensure the monitoring of insecticide persistency and vector resistance between now and 2005.

Strategies:
The strategies that will be used to realize the 2 main objectives are:

- Door-to-door distribution/sales
- The sale of treated mosquito nets at prenatal consultations (PNC) and preschool consultations (PSC).

Table IV.27

Specific objective 1:	Ensure that 100% of intervention health zones have insecticide-treated mosquito nets at their disposal			
Outcome/coverage indicators (Refer to Annex II)	**Baseline** *Year: 2002*	**Targets** *Year 1: 2003*	*Year 2: 2004*	*Year 3: 2005*
1.Proportion of intervention zones with the planned number of insecticide-treated mosquito nets		***35%***	***80%***	***100%***

Expected results:

- Insecticide-treated mosquito nets will be available in all intervention zones, to cover 60% of households.

Table IV.27.1

Specific objective 1:	*Ensure that 100% of intervention health zones have insecticide-treated mosquito nets at their disposal*

Broad activities	Process/output indicators **(indicate one per activity) (Refer to Annex II)**	Baseline	Targets			Responsible / Implementing agency or agencies	Costs and sources
		Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***		
1. Make a plea to obtain a tax exemption for imported ITMNs	***Decision for exemption made by the government***	***0***	***100%***			***PNLP Ministry of Health***	***GF 13,800***
2. Supply the HZ with ITMNs (including transport)	***Number of ITMNs ordered and received/expected***		***1092719 (34%)***	***1340008 (76%)***	***756687 (100%)***	***ALE****	***GF 20,890,661 SANRU 300 000***
Amount requested from the Global Fund							*20,904,461*

* *Agence d'Exécution Locale* [Local Implementing Agency]

The total number of treated mosquito nets which will make it possible to attain a coverage of 60% of households in the intervention zones amounts to 3,179,136.
A plea document will be drawn up during a workshop and will be distributed during the meetings that will be held to this effect. The political authorities and the decision-makers within the socio-economic sector will be targeted.
Through the RBM workgroups at the various levels (central, provincial and basic), the partners wishing to take part in this intervention will be identified and included in the project.

Specific objective 2:	***Ensure that 60% of households in the intervention health zones have treated mosquito nets at their disposal between now and 2005.***			
Outcome/coverage indicators **(Refer to Annex II)**	Baseline	Targets		
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***
1. Proportion of households with at least one insecticide-treated mosquito net in the intervention HZ	***NA***	***17%***	***43%***	***60%***

Expected results: 60% of households in the intervention health zones will have at least one insecticide-treated mosquito net, which will lead to a drop in morbidity.

Table IV.27.1

Specific objective 2:	***Ensure that 60% of households in the intervention zones have treated mosquito nets at their disposal between now and 2005.***						
Broad activities	Process/outcome indicators **(Indicate one per activity) (Refer to Annex II)**	Baseline	Targets			Responsible / Implementing agency or agencies	Costs and source
		Year: 2002	**Year 2003**	**Year 2004**	**Year: 2005**		
1. Train 9000 community health workers	***Percentage of trained community health workers***	***0.4%***	***28.4%***	***71.4%***	***100%***	***IPM BCZS PNLP***	***GF 347,540***

2. Supervise community health workers	***Proportion of community health workers having had at least one supervisory visit***	***NA***	***80%***	***80%***	***80%***	***IMP, ALE***	***GF 37,400***
3 Ensure the production of materials for awareness-raising campaigns	Number of anticipated materials produced	***0***	***100%***			***PNLP***	***GF 35,600***
4. Quarterly monitoring of the ITMN coverage of households and their usage	Number of planned monitoring sessions carried out	***4 (100%)***	***4 (100%)***	***4 (100%)***	***4 (100%)***	***IMP***	***GF 74,800***
AMOUNT REQUESTED FROM THE GLOBAL FUND							*495,340*

The training of community health workers will be carried out in each province by 10 provincial trainers who will already have received training. They will organize these training sessions during the first two years. The average number of community health workers to be trained per zone is 100, or a total of 9000 for the 90 intervention health zones. The mosquito nets will be sold at 0.5 USD.
The distribution of treated mosquito nets will take current prospecting studies into consideration. The supervision of community health workers will be carried out by the head physician of the zone and the head nurse of the health area.
The monitoring should be conducted quarterly by the team from the central office for each HZ.

Specific objective 3:	***Ensure the monitoring of insecticide persistency and vector resistance between now and 2005***			
Outcome/coverage indicators **(Refer to Annex II)**	Baseline ***Year: 2002***	Targets ***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***
1. Number of planned persistency and vector resistance studies carried out	***1%***	***25%***	***45%***	***60%***

Expected results: Monitoring of the persistency of and resistance to the insecticide is ensured.

Table IV.27.1

Specific objective 3:	***Ensure the monitoring of insecticide persistency and vector resistance between now and 2005.***					
Broad activities	Process/outcome indicators **(Indicate one per activity) (Refer to Annex II)**	Baseline **Year: 2002**	Targets **Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	Responsible/ Implementing agency or agencies	Costs and source
1. Build the INRB's capacities	***Existence of a functional insectarium***	***0***	***1***			***ITM/Antwerp, CDC***	***GF 5750***

2 Personnel training	*Number of persons trained of the number planned*	*0*	*6*			*CDC*	*GF 1465*
3. Conduct persistency studies	*Number of persistency studies conducted out of the total number planned*	*2*	*11*	*11*	*11*	*INRB*	*GF 48 000*
4 Conduct vector resistance studies	*Number of resistance studies conducted out of the total number planned*	*0*	*11*	*11*	*11*	*INRB*	*GF 48 000*
Amount requested from the Global Fund							*103 215*

Main objective 2: *Promote the use of treated mosquito nets in urban areas between now and 2005*

Specific objectives:

Supply the 11 major provincial towns with stocks of insecticide-treated mosquito nets between now and 2005.

Educate the community on the use of insecticide-treated mosquito nets in the 11 major provincial towns between now and 2005.

Strategies:

Social marketing will be the strategy used for carrying out these 2 specific objectives

Table IV.27

Specific objective 1:	***Supply the 11 major provincial towns[62] with stocks of insecticide-treated mosquito nets between now and 2005.***			
Outcome/coverage indicators **(Refer to Annex II)**	Baseline ***Year: 2002***	Targets ***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***
1. Purchase insecticide-treated mosquito nets		***35%***	***80%***	***100%***

Expected result: Insecticide-treated mosquito nets will be available in the 11 major provincial towns.

Table IV.27.1

Specific objective 1:	***Supply the 11 major provincial towns with stocks of insecticide-treated mosquito nets between now and 2005.***						
Broad activities	Process/outcome indicators **(Indicate one per activity) (Refer to Annex II)**	Baseline	Targets			Responsible/ Implementing agency or agencies	Costs and source
		Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***		

[62] *Kinshasa, Lubumbashi, Kisangani, Goma, Bukavu, Mbandaka, Kindu, Kananga, Mbuji-Mayi, Bandundu, Matadi.*

1. Purchase insecticide-treated mosquito nets	***Number of insecticide-treated mosquito nets purchased out of number planned***	***0***	***30%***	***60%***	***100%***	***ALE PSI***	***GF 1,790,100***
2. Ensure the transport of ITMNs to various major provincial towns	***Number of major provincial towns having received ITMNs***	***0***	***4***	***4***	***3***		***GF 463,320***
3. Stock ITMNs	***Existence of ITMNs in the major provincial towns***	***0***	***4***	***4***	***3***		***GF 556,800***
Total requested from the GF							*2,810,220*

Specific objective 2:	**Educate the community on the use of insecticide-treated mosquito nets in the 11 major provincial towns between now and 2005.**			
Outcome/coverage indicators **(Refer to Annex II)**	Baseline	Targets		
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***
1. Proportion of community members in the 11 urban centers who are aware of the importance of ITMNs	***NA***	***10%***	***20%***	***30%***

Expected result: The population of the 11 major provincial towns is educated on the use of insecticide-treated mosquito nets.

Specific objective 2*:*	*Educate the community on the use of insecticide-treated mosquito nets in the 11 major provincial towns between now and 2005.*						
Broad activities	Process/outcome indicators **(Indicate one per activity) (Refer to Annex II)**	Baseline	Targets			Responsible/ Implementing agency or agencies	Costs and source
		Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***		
1. Train social marketing personnel	***Number of individuals trained out of number planned***	***0***	***30%***	***70%***	***100%***	***PSI***	***GF 93,000***
2. Equip the 11 urban centers with materials	***Number of urban centers equipped with materials out of number planned***		***30%***	***60%***	***100 %***	***PSI***	***GF 148,150***
3 Produce materials for educational campaign	***Number of urban centers with educational materials***	***0***	*30%*	***70%***	***100%***	***PSI***	***GF 252,500***

4. Pay agents responsible for social marketing	***Number of social marketing agents paid out of number planned***	***0***	***30%***	***70%***	***100%***	***PSI***	***GF 328,344***
6. Ensure the follow-up and evaluation of social marketing activities	***Number of supervisory visits conducted out of number planned***	***0***	***80%***	***80%***	***80%***	***PSI***	***GF 201,000***
Total requested from the Global Fund							***1,022,994***

A social marketing agent will be hired for the coordination of sales and promotional activities in the urban centers. The agent will coordinate all activities linked to the sale and promotion of treated mosquito nets with the other on-site partners.
Messages on the correct usage and promotion of ITMNs will be diffused via mass media (radio and TV) as well as interpersonal communications in collaboration with the community health workers located in the city.
The supervision of the social marketing project will be carried out by PSI[63], in partnership with the PNLP and the personnel of the health zone central offices.
The supervision of the sellers will be modeled upon that of the community health workers.
The social marketing project will be launched in 6 urban centers the first year, 3 urban centers the second year and 2 urban centers the third year, for a total of 11 sites at the end of the project.

MALARIA: BUDGET SUMMARY AREA 1: PREVENTION

Budget items	2003	2004	2005	Total
Human Resources	233,284.00	247,536.00	213,264.00	694,084.00
Infrastructure / Equipment	181,850.00	289,200.00	344,000.00	815,050.00
Training / Planning	39,665.00	41,800.00	44,200.00	125,665.00
Commodities / Products	6,205,166.90	7,488,736.80	4,526,687.70	18,220,591.40
Drugs	0,00	0,00	0,00	0,00
Monitoring and Evaluation	61,400.00	90,800.00	108,000.00	260,200.00
Other (Transport / Maintenance)	1,793,302.55	2,148,471.60	1,294,346.15	5,236,120.30
Administrative Costs	833,281.85	1,001,734.44	618,649.79	2,453,666.07
Total	**9,347,950.30**	**11,308,278.84**	**7,149,147.64**	**27,805,376.77**

(See detailed costs in Annex II).

<u>Area of Intervention 2</u>: The treatment of malaria cases within the healthcare structures and within the community

[63] *PSI : Population service International* [International Population Service]

Situation analysis:

For the past several years, an inadequacy has been noted in the treatment of malaria, amongst both medical consultants and community members. The former have lost confidence in the directives heretofore decreed at the central level and have themselves changed the antimalarial prescription rules. Various antimalarial drugs are prescribed willy-nilly and the different hospital structures do not respect the referral system. Only 7% of patients receive appropriate treatment (PNLP Survey, 2001). As for the community, it has turned to self-medication due to being unable to meet the cost of healthcare (ESP Situation analysis, 2001).

Faced with this situation, the Ministry of Health, with the support of its partners committed to the fight against malaria, initiated drug-sensitivity studies from May 2000 to November 2001 in seven representative sites throughout the country. These studies showed a therapeutic failure rate of 29-80% for chloroquine and 0-19% for Sulfadoxine-Pyrimethamine (Study report).

Brought together at the national consensus forum at the end of November 2001 and technically supported by the WHO and other partners such as the CDC/Atlanta, MSF/Epicentre and BASICS, the country started the process of changing the national policy on malaria treatment and took the following transitory decisions:

- Abandon Chloroquine as a first-line treatment for malaria;
- Adopt Sulfadoxine-Pyrimethamine (SP) for the treatment of uncomplicated cases (first-line);
- Adopt oral Quinine as a second-line treatment;
- Adopt parenteral Quinine for the urgent treatment of severe cases;
- Undertake follow-up studies on combinations, favoring SP as one of the components.

Six studies on treatment combinations will be carried out this year (2002) in six provinces of the Republic: three in the east (Kisangani, Rutshuru and Katana) with the technical support of CDC/USAID and IRC, two in the south (Kapolowe) and center (Mikalayi) with the support of the WHO and the last in the west (Kimpese) with the support of DAFRA Laboratories. The two first studies in the east of the country are currently underway. The preliminary results of these studies indicate a satisfactory clinical response, although a high level of parasitic resistance was noticed in one of the sites. The collected data will guide the choice and implementation of the final treatment policy in 18-24 months.

Thanks to the support of the WHO and USAID, a popularization of this transitory policy is taking place throughout the national territory. A training course has been given for medical consultants and community members on the treatment plan and the research on side effects in at least five pilot health zones. The supply of medicines such as sulfadoxine-pyrimethamine is being carried out through the existing networks of a few participants, with the result that the availability of the product is not entirely guaranteed by the different on-site intervention partners. A survey conducted by the PNLP in 2001 showed that 33% of healthcare structures had experienced a stockout of antimalarial drugs during the 3 months preceding the survey.

Although more than half of our population identifies malaria by fever, more than two-thirds of microscopic diagnosis of malaria is illusory and unreliable, as was established by the situation analysis report created by the *Ecole de Santé Publique* [College of Public

Health] in May 2001. The microscopes available are insufficient in number and are generally in poor condition. Accessory equipment (slides, lancets) is desperately lacking. Laboratory reagents are of insufficient quantity and often of dubious quality (ESP Surveys). In order to solve these problems, support from USAID through the *Ecole de Santé Publique* (ESP) will make it possible for our country to build the capacities of these microscopes and to produce high-quality laboratory reagents on-site. CDC/Atlanta's development of an exterior mechanism that increases the luminosity of the microscopes (EARL Light) used in our healthcare structures demonstrates the pertinence of this technical accompaniment. This intervention will be taking place in collaboration with the *Programme National de Lutte contre la Tuberculose* [National Programme for Fighting Tuberculosis], which also uses microscopy to reveal Koch's bacilli.

The strengthening of personnel, structural and community capacities has proven to be indispensable and can only improve the treatment of cases, among others the diagnosis made, and moreover allow the rational management of drugs.

This Area of Intervention thus aims to improve the access to high-quality care by strengthening the process of changing the policy for fighting malaria in D.R. Congo, which requires new treatment plans and the education of personnel and of the community.
This intervention is being carried out with the active participation of on-site partners such as religious dominations and local and international NGOs.

Main objective 2: **Improve the treatment of these cases within the healthcare structures and within the community between now and 2005.**

Specific objectives:

1. Strengthen the technical capacities of healthcare personnel for the correct treatment (CT) of malaria between now and 2005
2. Increase the proportion of health centers capable of confirming the diagnosis of malaria with microscopy from 19% to 75% between now and 2005
3. Involve the community in the treatment of malaria between now and 2005
4. Make antimalarial drugs available in all intervention HZ between now and 2005

Table IV.27

Objective 1:	**Strengthen the technical capacities of healthcare personnel for the treatment of malaria between now and 2005**				
Outcome/coverage indicators:	***Baseline***				
(Refer to Annex II)	**Year: 2002**		**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**
% of trained personnel who prescribe correct treatment.	**NA**		35%	65%	80 %

The baseline data were collected by the PNLP (surveys on the base indicators of the RBM Initiative from 2001).

Expected results: Malaria cases are treated correctly, according to the national strategy.

Table IV.27.1

Specific objective 1*:*	**Strengthen the technical capacities of healthcare personnel for the treatment of malaria between now and 2005**

Broad activities	Process/Output indicators **(indicate one per activity) (*Refer to Annex II)***	Baseline	Targets			Responsible/Implementing agency or agencies	Costs and source
		Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**		
1. Train 110 provincial trainers in treatment.	***Number of persons trained***	***0***	***33***	*77*	***110***	***PNLP***	*PM*
2. Train 2070 health professionals on the correct treatment of malaria according to the national directives	***% of health professionals***	***NA***	***32%***	***100%***		***IMP BCZS***	*GF 425,200*
3. Ensure the supervision of professionals	***% of supervisory visits carried out***	***NA***	***80%***	***80%***	***80%***	***IMP BCZS***	*GF 683,760*
TOTAL requested from the Global Fund							*1,108,960*

Thanks to the already existent training module that has been created for the treatment of uncomplicated and severe malaria cases, 23 healthcare staff members per health zone will be trained at the rate of two per health center during a four-day session.

Table IV.27

Objective 2:	**Increase the proportion of health centers capable of confirming the diagnosis of malaria with microscopy from 19% to 75% between now and 2005**				
Outcome/Coverage indicators *(Refer to Annex II)*	***Baseline***	***Targets***			
	Year: 2002	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	
% of health centers capable of confirming the diagnosis of malaria with microscopy	19%	30%	50%	75%	

Expected result: The health centers will be capable of confirming the diagnosis of malaria with microscopy

Table IV.27.1

Specific objective 2*:*	*Increase the proportion of health centers capable of confirming the diagnosis of malaria with microscopy from 19% to 75% between now and 2005*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/Implementing agency or agencies	Costs and source
		Year: 2002	**Year 2003**	**Year 2004**	**Year 2005**		
1. Training of trainers in microscopy	***Number of persons trained***	***60***	***92***	***110***		***CDC/ Atlanta***	***GF 45 280***

2. Train 1980 health professionals in microscopy	***% of health professionals trained***	***NA***	***32%***	***100%***		***ESP/CDC IMP***	***GF 370,600***
3. Supply health centers with microscopes, materials and laboratory reagents	***% of health centers supplied***	***NA***	***32%***	***74%***	***100%***	***ALE[64]***	***GF 819,000***
4. Ensure the supervision of professionals trained	***% of supervisory visits carried out***	***NA***	***80%***	***80%***	***80%***	***IMP ALE***	***PM***
TOTAL requested from the GF							***1,234,880***

Thanks to the module produced by the PNLP with the support of CDC/Atlanta, 22 health professionals will be trained per health zone at the rate of two for the HGR and one per HC (20). This training will take place over a 10-day session and in tandem so that the identification of central and provincial trainers will be the first step to be taken. Each province will work on training its personnel with support from the central level. This intervention sub-area will be a transversal collaboration with the *Programme National de lutte contre la Tuberculose*, which uses the same materials for the detection of Koch's bacilli (KB).

Table IV.27

Objective 3:	**Involve the community in the correct treatment of uncomplicated malaria between now and 2005**			
Outcome/Coverage indicators	***Baseline***	***Targets***		
(Refer to Annex II)	**Year: 2002**	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**
% of mothers and child minders who are capable of correctly treating malaria.	**< 5%**	35%	65%	75%

The baseline data were collected by the PNLP (surveys on the base indicators of the RBM Initiative from 2001).

Expected result: Malaria cases are correctly treated within the community

Table IV.27.1

Specific objective 3*:*	*Involve the community in the treatment of malaria cases between now and 2005.*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible / Implementing agency or agencies	Costs and source
		Year: 2002	**Year 2003**	**Year 2004**	**Year 2005**		
1. Train community health workers in correct treatment	***% of community health workers trained***	***NA***	***15%***	***75%***	***100%***	***IMP BCZS***	***PM***
2. Ensure the supervision of trained health workers	***% of supervisory visits carried out***	***NA***	***80%***	***80%***	***80%***	***IMP and BCZS***	***PM***

[64] Agence locale d'exécution *[Local Implementing Agency]*

3. Educate the community on the danger signs and the new treatment protocol for the correct treatment of uncomplicated malaria cases	***% of mothers and/or child minders having received an educational message***	***NA***	***20%***	***50%***	***75%***	***ALE***	***PM***
TOTAL requested from the Global Fund							*0*

These health workers will be trained by the provincial group of community leaders. These are the same health workers who are responsible for education re: ITMNs. Regarding the number of persons to be trained, the basis for calculation will take the average of 100 health workers per Health Zone into consideration.
These health workers will be trained in two-day sessions. They will pass on the key information regarding the general signs and danger signs of malaria and how these should be treated. They will rely upon educational materials that have already been developed but that must be copied in order to ensure a larger scope of education. They will also have stocks of emergency drugs at their disposal in rural areas.

Table IV.27

Specific objective 4:	**Make antimalarial drugs available in 100% of intervention HZ between now and 2005**				
Outcome/Coverage indicators *(Refer to Annex II)*	***Baseline*** **Year: 2002**	***Targets*** **Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	
% of healthcare structures with antimalarial drugs in stock	NA	32%	74%	100%	
% of healthcare structures that have not experienced a stockout of antimalarial drugs during the past three months	NA	20%	45%	100%	
% of community health workers with access to a stock of SP	0%	32%	74%	100%	

Antimalarial drugs will be made available in the community through the health centers and the community health workers present in the villages. Management at the HC level will be ensured by the community through the health committee (COSA), while the community health worker will have access to an emergency stock. Note that national policy encourages the setting up of family pharmacies.

The supplying will be based on the target groups, children under 5 years old and pregnant women. On average, 7 episodes of fever/malaria will be expected per child in the community under 5 years old per year. Each pregnant woman will receive two doses of SP. To that number, at least 10% will be added for the other members of the community. The system of supply will be that which is already existent in the health zone, so as not to disturb the operational mechanisms on-site. A system of recovering costs will be promoted. In addition to SP, the other medicines will be Quinine and other substances that could be used in treatment combinations. The preliminary results of two studies on antimalarial treatment combinations conducted in the eastern part of the country (Kisangani and Rutshuru) foreshadow the probable situation of a modular treatment policy that could be implemented.

Expected result: Antimalarial drugs are available in the healthcare structures and from community health workers.

Table IV.27.1

Specific objective 3*:*	*Make antimalarial drugs available in 100% of intervention HZ between now and 2005*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/ Implementing agency or agencies	Costs and source
		Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***		
1. Supply the health structures with antimalarial drugs	***% of health structures supplied***	***NA***	***32%***	***74%***	***100%***	***ALE***	***GF 7,494,411 SANRU 300,000***
2. Supply community health workers with SP and Paracetamol	***% of community health workers supplied***	***0%***	***32%***	***74%***	***100%***	***ALE***	***PM***
TOTAL requested from the GF							*7,494,411*

NB The data from other players are not available, notably those who generally support the HZ.

BUDGET SUMMARY AREA 2: TREATMENT

Budget items	**2003**	**2004**	**2005**	**Total**
Human Resources	592,345.00	825,280.00	402,865.00	1,820,490.00
Infrastructure / Equipment	539,788.00	364,000.00	263,900.00	1,167,688.00
Training / Planning	0.00	0.00	0.00	0.00
Commodities / Products	0.00	0.00	0.00	0.00
Drugs	2,666,721.93	3,179,163.22	1,648,526.21	7,494,411.35
Monitoring and Evaluation	0.00	0.00	0.00	0.00
Other (Transport / Maintenance)	0.00	0.00	0.00	0.00
Administrative costs	379,885.49	436,844.32	231,529.12	1,048,258.94
Total	**4,178,740.42**	**4,805,287.54**	**2,546,820.33**	**11,530,848.29**

The training sessions have been included under the heading of human resources *(See detailed costs in Annex III).*

Area of Intervention 3: **The Intermittent Preventive Treatment of pregnant women**

Situation analysis

The burden of malaria amongst pregnant women is characterized by a high level of morbidity and mortality amongst mothers as well as children. Prevalence surveys (ESP/PNLP 2002) indicate a prevalence of peripheral parasitemia in parturients between 20% in urban areas and 30% in rural areas. In pregnant women, malaria can cause abortions or the birth of low-weight infants. Placental paludal infection increases the risk of the maternal-fetal transmission of HIV.

The anti-malaria policy recently adopted by the Ministry of Health recommends the intermittent preventive treatment (IPT) of pregnant women with the administration of 2 doses of Sulfadoxine-Pyrimethamine (SP), one at the 14th week and one at the 27th week of pregnancy, to prevent the above-mentioned complications (this in addition to the use of insecticide-treated mosquito nets).

However, the experience with chloroquine chemoprophylaxis demonstrated a very low adherence rate. Moreover, the majority of pregnant women only have a prenatal consultation relatively late in the pregnancy, which lowers the possibilities of a correct intermittent treatment.

This strategy is new in D.R. Congo and for the time being is only being applied in a limited number of health zones. A good application of this strategy would require its being extended to a greater number of the country's health zones. The strategy necessitates the involvement of multiple partners currently working in the area of improving the survival rates of mother and child, while at the same time establishing awareness-raising mechanisms that will lead pregnant women to seek early consultation. It is for this reason that the implementation of this strategy is taking place in collaboration with the *Programme National de Santé de la Reproduction* (PNSR) [National Programme for Reproductive Health], part of whose prerogatives is the organization of prenatal consultations throughout the country.

The PNLP and the PNSR are working together to set up a monitoring system to follow the progress of the strategy's implementation. To this end, thirty-two maternity houses rehabilitated by the UNFPA and UNICEF have been identified across the country.

The main expected result is an IPT coverage of at least 80% of pregnant women who visit the prenatal consultation services in the intervention zones between now and the end of 2005.

Specific objective 1:	**Ensure the Intermittent Preventive Treatment of at least 80% of pregnant women who visit prenatal consultation services between now and 2005**				
Outcome/coverage indicators	***Baseline***	***Targets***			
(Refer to Annex II)	**Year: 2002**	**Year 1: 2003**	**Year 2: 2004**	**Year 3: 2005**	
% of women having taken prenatal consultation and who have received 2 doses of SP during their pregnancy	NA	80%	80%	80%	

Specific objective*:*	*Ensure the Intermittent Preventive Treatment of at least 80% of pregnant women who visit prenatal consultation services between now and 2005*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/ Implementing agency or agencies	Costs and source
		Year: 2002	***Year 2003***	***Year 2: 2004***	***Year 3: 2005***		
1. Supply health centers with SP	***% of health centers supplied***	***NA***	***35%***	***70%***	***100%***	***ALE***	***PM***
2. Educate pregnant women on the importance of early prenatal treatment and of IPT	***% of pregnant women having received information on early prenatal treatment***	***NA***	***35%***	***50%***	***80%***	***ALE***	***PM***
3. Ensure the monitoring of the implementation of IPT	***Monitoring reports***	***NA***	***2***	***4***	***4***	***PNLP, IMP and BCZS***	***PM***
TOTAL requested from the GF							**0**

Expected result: At least 80% of women who visit the prenatal consultation services each year in the intervention health zones will benefit from IPT.

Area of Intervention 4: Epidemiological surveillance and the management of information

Situation analysis

An integrated surveillance system is currently in place that was set up at the beginning of 2001 with the support of the WHO and coordinated by the Endemic Disease Department of the Ministry of Health. This system collects data on 13 primary diseases, including malaria. However, due to communication problems, this surveillance system is not yet in effect throughout the national territory, particularly in potentially epidemic zones (in the high plateaus in the east). Under-notification and a low rate of community participation present the greatest problems within the system.

Moreover, this system does not address the aspects specific to the fight against malaria (morbidity and mortality rates among target groups, surveillance of the therapeutic effectiveness of antimalarial drugs, parasitemia, the detection of rapid response to epidemics, the progress of the implementation of RBM). These aspects could be addressed by a sentinel surveillance network.

During the national consensus forum, 30 sites were selected according to their epidemiological features, the population served, the functionality of the health zone, geographical accessibility and the presence of partners. Certain technical support partners such as CDC/Atlanta, BASICS, CEMUBAC, INRB, ESP, WHO, ITM-Antwerp and WORLD VISION-Canada have been identified and can assist in the implementation of this system.

Nine sites will become operational between now and the end of 2003 with the assistance of BASICS, SANRU III, BOM and ESP.

The information gathered from these sites will make it possible to revise intervention strategies and to monitor the trends of the disease and the parasite, as well as the progress in implementing the RBM initiative. The experience gained from watching these sites

could serve to improve the surveillance system and the management of information in the country's other zones.

Main objective: **Improve capacities for the surveillance, detection and reaction to epidemics**

Table IV.27

Objective 1:	**Make 15 sentinel surveillance sites operational in the zones of stable and instable endemicity between now and 2005**				
Outcome/Coverage indicators *(Refer to Annex II)*	***Baseline***	***Targets***			
	Year: 2002	**Year 1 2003**	**Year 2 2004**	**Year 3 2005**	
Number of operational sentinel sites	**0**	**9**	**15**	**15**	

The sites were selected according to their epidemiological features, geographical representativeness, the functionality of the health zone and the presence in the zone of partners who can assist in the implementation.

Expected results: 15 sentinel surveillance sites will be operational between now and 2005

Table IV.27.1

Specific objective:	*Make 15 sentinel surveillance sites operational in the zones of stable and instable endemicity between now and the end of 2005*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/Implementing agency or agencies	Costs and source
		Year: 2002	*Year 1 2003*	*Year 2 2004*	*Year 2005*		
1. Train 90 health personnel in epidemiological surveillance	***% of health personnel trained***	***0***	***60%***	***100%***	***100%***	***Epidemics Department and PNLP, ESP and CEMUBAC, BASICS***	***GF 10,387 BASICS 15,580***
2. Train 30 community health workers in surveillance	***% of community health workers trained***	***0***	***60%***	***100%***	***100%***	***BCZS and IMP***	***GF 600***
3. Equip sentinel sites (microscopes, computers, e-mail)	***% of sites equipped***	***0***	***60%***	***100%***	***100%***	***ALE***	***GF 761,800***
4. Ensure the supervision of surveillance activities	***% of supervisory visits carried out***	***0***	***100%***	***100%***	***100%***	***4e Dept. PNLP ESP CEMUBAC***	***GF 37,200***

5. Draw up an epidemic preparation and reaction plan in the epidemic risk zones	*% epidemic risk health zones with a financed preparation and reaction plan*	*0*	*30%*	*60%*	*100%*	*4e Endemic Disease Dept. PNLP BCZS ALE*	*PM*
6. Position the inputs and equipment necessary for reaction[65]	*% of epidemic risk health zones having the planned inputs and equipment*	*0*	*30%*	*60%*	*100%*	*Endemic Disease Dept. PNLP*	*GF 1,755,000*
7. Carry out drug-sensitivity studies	*Number of studies carried out*	*9*	*3*	*3*	*3*	*PNLP*	*225,000*
7. Mobilize the community around the epidemic preparation and reaction plan	*% of epidemic risk health zones having communal committees for epidemic management*	*0*	*50%*	*100%*	*100%*	*ALE and BCZS*	*PM*
TOTAL requested from the GF							*2,789,987*

Under the coordination of the Department of Epidemiology and Major Endemic Diseases, six persons will be trained per health zone (2 for the HGR and 2 per HC).

Per health zone, two members of the community will be trained and integrated into the data collection network, totaling 30 community health workers.

BUDGET SUMMARY AREA 4: SURVEILLANCE

Budget Items	2003	2004	2005	Total
Human Resources	12,420.00	8,280.00	0.00	20,700.00
Infrastructure / Equipment	345,100.00	353,700.00	63,000.00	761,800.00
Training / Planning	0.00	0.00	0.00	0.00
Commodities / Products	0.00	0.00	0.00	0.00
Drugs	1,755,000.00	0.00	0.00	1,755,000.00
Monitoring and Evaluation	86,160.00	93,600.00	93,600.00	273,360.00
Other (Transport / Maintenance)	1,305.00	870.00	0.00	2,175.00
Administrative Costs	219,998.50	45,645.00	15,660.00	281,303.50
Total	**2,419,983.50**	**502,095.00**	**172,260.00**	**3,094,338.50**

[65] The fifteen sites will be positioned in the following zones: Kabondo (Kisangani), Rutshuru, Kapolowe, Mikalayi, Kinshasa, Kimpese, Bukavu, Bolenge (Mbandaka), Vanga, Nyakunde, Kaziba, Kalima, Tshumbe, Bibanga, Musienene.

(See detailed costs in Annex IV).

Area of Intervention 5: The strengthening of the technical and administrative capacities of the national and provincial coordination offices

Situation Analysis

The programme for fighting malaria is currently characterized by a weak managerial capacity resulting from the insufficiency of human resources, material and financial resources, and a lack of coordination at all levels.
For over 4 years, the D.R. Congo, a country with continental dimensions, has experienced difficult circumstances which inhibit the communication essential to an effective fight against disease in general and malaria in particular. The result has been an increased level of mortality due to malaria.

In order to address these concerns, provincial coordination teams for the fight against malaria will be put into place in the 11 provinces. These teams will have the task of piloting anti-malaria activities and strengthening capacities at the operational level, in collaboration with other programmes and partners.

Moreover, the gradual installment of RBM workgroups in the various national provinces will make it possible to harmonize strategies, with the aim of effective synergetic integration. Three workgroups have already been set up in Kinshasa, Goma and Kisangani. The WHO has just released the amount necessary to set up other groups.

Although we have trained persons working for our national programme, their numbers are insufficient. Hence the necessity of strengthening technical and administrative capacities in applied entomology, parasitology, drug-sensitivity, epidemiology, public health and management.

Operational research, which is essential to orienting the Programme's activities, is still in its early stages.

In order fulfill its role as coordinator of all activities to be carried out, focusing on their synergy, the *Programme National de Lutte contre le Paludisme* (PNLP) should have sufficient human, material and financial resources at its disposal. The information management essential to the correct implementation of the initiative should take place through an adapted operational structure.

Main objective*:* *Improve the technical and administrative capacities of the PNLP's coordination offices for a better implementation of the RBM initiative in D.R. Congo*

Specific objectives:

1. ***Strengthen the technical and administrative capacities of national and provincial coordination teams between now and 2005***
2. ***Equip the PNLP with supplies and equipment for coordinating the RBM initiative between now and 2005***
3. ***Strengthen the operational research activities of the* Programme de Lutte contre le Paludisme *between now and 2005***
4. ***Organize an external administrative evaluation and a technical evaluation of the Programme during each year of the project***

Specific objective 1	*Strengthen the technical and administrative capacities of national and provincial coordination teams between now and 2005*				
Outcome/Coverage indicators **(Refer to Annex II)**	Baseline **Year: 2002**	Targets **Year: 2003**	**Year: 2004**	**Year: 2005**	
Number of coordination teams whose capacities have been strengthened	***0***	***4***	***8***	***12***	

12 coordination teams are scheduled: 1 national and 11 provincial

Expected results:

1. PNLP personnel will be trained
2. Provincial focal points will be identified

Specific objective 1	*Strengthen the technical and administrative capacities of national and provincial coordination teams between now and 2005*						
Broad activities	***Process/Output*** ***indicators*** *(indicate one per activity)* (Refer to Annex II)	Baseline Year 2002	Targets Year 1 2003	Year 2 2004	Year 3 2005	Responsible/Implementing agency or agencies	Cost
1.Train 6 programme personnel in public health	**Number of personnel trained**	**3**	**2**	**4**	**6**	**ESP, *ITM*/ Antwerp**	**GF 66,000**
2. Train 7 programme personnel in entomology	**Number of personnel trained**	**1**	**3**	**5**	**7**	**CDC, ICIPE**	**GF 42,000**
3. Train 6 personnel in parasitology	**Number of personnel trained**	**0**	**2**	**4**	**6**	***ITM*/ Antwerp**	**GF 30,000**
4. Train 6 personnel in epidemiology	**Number of personnel trained**	**4**	**2**	**4**	**6**	***ITM* / Antwerp STI/ Bâle**	**GF 30,000**
5. Train 9 personnel in paludology	**Number of personnel trained**	**4**	**2**	**8**	**9**	**WHO**	**GF 13,500**
6. Train 6 personnel in management	**Number of personnel trained**	**2**	**2**	**4**	**6**	**MDF**	**GF 18,000**
7. Support the operation of the programme	**Number of coordination teams with operating costs**	**1**	**5**	**9**	**2**	**BCECO/UNOPS**	**GF 90,000**
8. Ensure supervision, follow-up and evaluation	**% of supervisory visits carried out**	**5%**	**30%**	**65%**	**100%**	**PNLP, IMP, RBM/ AFRO**	**GF 30,000**
Total amount requested from the Global Fund							**319,500**

Specific objective 2:	*Equip the PNLP with supplies and equipment for the national and provincial coordination teams between now and 2005*	
Outcome/Coverage indicators	Baseline	Targets

(Refer to Annex II)	Year: 2002	Year 1: 2003	Year 2: 2004	Year 3: 2005	
Proportion of planned supplies and equipment furnished	***10%***	***45%***	***75%***	***100%***	
Proportion of planned operating costs released	***20%***	***40%***	***50%***	***60%***	

Expected results: The programme infrastructures are equipped and the operating monies are available.

Specific objective 2	*Equip the PNLP with supplies, equipment and operating monies for the national and provincial coordination teams between now and 2005*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/Implementing agency or agencies	Costs and source
		(Specify year)	***Year1 2003***	***Year 2 2004***	***Year 3 2005***		
1. Purchase 13 computers (2 for the national coordination office and 11 for the provinces)	***Number of computers and accessories purchased out of number planned***	***1***	***6***	***13***	***13***	***BCECO/ UNOPS***	***GF 29,250***
2. Purchase a photocopier	***Number of photocopiers purchased out of number planned***	***0***	***1***	***1***	***1***	***BCECO/ UNOPS***	***GF 5000***
3. Purchase a microcomputer and LCD projector for training sessions	***Number of microcomputers and LCD projectors purchased out of number planned***	***0***	***1***			***BCECO/ UNOPS***	***GF 6500***
4. Purchase 13 4x4 vehicles (2 for the central level and 11 for the provinces)	***Number of vehicles purchased out of number planned***	***1***	***6***	***13***	***13***	***BCECO/ UNOPS***	***GF 325,000***
5. Set up an Internet communication network between the coordination office and the sentinel sites	***Network is operational***	***-***	***1***	***1***	***1***	***BCECO/ UNOPS***	***GF 3000***
Amount requested from the Global Fund							368,750

Specific objective 3	*Strengthen operational research activities between now and 2005*					
Outcome/Coverage indicators **(Refer to Annex II)**	Baseline	Targets				
	Year 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	Responsible/Implementing agency or agencies	Cost and financing source
Number of planned research projects carried out	***10%***	***35%***	***70%***	***100%***	***PNLP***	

*These activities will be carried out at both the central level and at the level of the sentinel sites. They will be based on the response to be made to the particular problems that arise while carrying out the programme activities. They will mainly emphasize the completion of drug-sensitivity surveillance studies in order to facilitate the updating of effective treatment plans.

Expected results

1. research is conducted and the results are distributed
2. operational studies are carried out in relation to the principal interventions

Specific objective 3	*Strengthen operational research activities between now and 2005*						
Broad activities	Process / Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets			Responsible/ Implementing agency or agencies	Cost and financing source
		2002	***Year 2003***	***Year 2004***	***Year 2005***		
1. Conduct a study on accessibility to care	***Number of studies completed***	***0***	***1***			***ESP PNLP***	***GF 20,000***
2. Conduct a study on the determining factors for late prenatal counseling consultations	***Number of studies completed***			***1***		***PNLP***	***GF 20,000***
3. Conduct a study on the accessibility to and use of treated mosquito nets	***Number of studies completed***		***1***			***PNLP Ecole de Santé Publique***	***GF 20,000***
4. Conduct a study on the distribution of medication within the community	***Number of studies completed***			***1***		***PNLP/ Ecole de Santé Publique***	***GF 20,000***
5. Conduct a study on the identification of signs of seriousness and indicators	***Number of studies completed***			***1***		***PNLP***	***GF 20,000***
Amount requested from the Global Fund							100,000

Specific Objective 4:	**Organize an external administrative evaluation and a technical evaluation of the Programme during each year of the project**				
Outcome/Coverage indicators *(Refer to Annex II)*	***Baseline***	***Targets***			
	Year: 2002	***Year 1: 2003***	***Year 2: 2004***	***Year 3: 2005***	
Evaluations carried out[66]	*2*	*2*	*4*	*6*	

Specific objective 4	**Organize an external administrative evaluation and a technical evaluation of the Programme during each year of the project**

[66] *One financial evaluation and one technical evaluation*

Broad activities	*Process/Output indicators* *(indicate one per activity)* (Refer to Annex II)	*Baseline*	*Targets*			*Responsible/ Implementing agency or agencies*	*Cost and financing source*
		2002	Year 2003	Year 2004	Year 2005		
1. Annually organize a financial audit of the *Bureau National* [National Office]	Completed financial audits	0	1	2	3	Accounting firm to be identified	GF: 30,000
2. Organize one external evaluation for the programme per year	External evaluation completed	2	1	2	3	WHO RBM, MAC, CDC, Mc Master University/ World Vision	GF: 30,000
Amount requested from the Global Fund							**60,000**

BUDGET SUMMARY AREA 5: CAPACITY BUILDING

Budget items	**2003**	**2004**	**2005**	**Total**
Human resources	**50,000.00**	**50,000.00**	**0.00**	**100,000.00**
Infrastructure / Equipment	178,000.00	190,750.00	0.00	**368,750.00**
Training / Planning	69,000.00	69,000.00	61,500.00	**199,500.00**
Commodities / Products	0.00	0.00	0.00	**0.00**
Drugs	0.00	0.00	0.00	**0.00**
Monitoring and Evaluation	10,000.00	10,000.00	10,000.00	**30,000.00**
Other (Transport / Maintenance)	30,000.00	30,000.00	30,000.00	**90,000.00**
Administrative costs	33,700.00	34,975.00	10,150.00	**78,825.00**
Total	**370,700.00**	**384,725.00**	**111,650.00**	**867,075.00**

(See detailed costs in Annex V).

Area of Intervention 6: **Strengthening partnerships for communal mobilization.**

***Situation analysis**:*

The terms of the national policy for fighting malaria highlight partnership as one of the supporting strategies and one of the main directives for organizing the fight. Based on mutual advantage and complementarity, multisectoral partnership is facilitated in such a

way that, since September 2000, a workgroup called the RBM Task Force meets regularly on site in order to exchange views and collaborate.

Alongside the initiators of the RBM strategy in the D.R. Congo, the core of this group is made up of recognized civil society organizations. The Ministry of Health took up the option of extending these workgroups to all 11 provinces of the country so as to better bring together the project managers with the beneficiaries, who are the base communities. It is important to emphasize that more than 200 health NGOs – national as well as international – are operational on-site and make real contributions to the implementation of malaria-fighting activities in their respective fields of activity. But their impact would be heightened if their interventions were synergetic and less limited in length. This being said, the religious denominations present throughout the national territory are known for their long-term interventions.

Until now, the fight against malaria has been the privilege of the single health sector. Further, the communities are neither sufficiently mobilized nor organised to ensure the continuity of initiatives taken by the different structural support partners.

In order to increase the successful conditions of the RBM Initiative in D.R. Congo, the PNLP should take its inspiration from the new contractual framework defined by the Ministry of Health to mobilize all its partners so as to achieve synergy in the activities being carried out in the fight against malaria.

***Main objective**: Create a multisectoral RBM partnership at the community level*

Specific objectives:

1. Reinforce the coordination of the various partners' interventions at the community level between now and 2005
2. Support the NGOs, the CBOs and the community health workers in mobilizing the communities between now and 2005

Specific objective 1	*Reinforce the coordination of the various partners' interventions at the community level between now and 2005*					
Outcome/Coverage indicators	Baseline	Targets				
	Year 2002	**Year 1 2003**	**Year 2 2004**	**Year 3 2005**	Responsible/ Implementing agency or agencies	Cost and source of financing
Proportion of health zones with a framework for dialogue on RBM		***25%***	***75%***	***100%***	***IMP/PNLP***	

Expected result**: *The coordination of the partners' interventions in reinforced in the fight against malaria.***

Table IV.27.1

Objective 1	*Reinforce the coordination of the partners' interventions at the community level between now and 2005*				
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline	Targets	Responsible/ Implementing agency or	Cost and source of financing

		(Specify year) *2002*	*Year 1 2003*	*Year2 2004*	*Ye ar 3 20 05*	agencies	
1. Identify the players at the community level	***% of operational players listed***	***NA***	***100%***			***GT RBM BCZS***	***PM***
2. Set up a contractual intervention framework	***% of players who have signed the contract***	***NA***	***100%***			***PNLP***	***GF 1000***
Total amount requested from the Global Fund							1000

The various players in the anti-malaria sector will be identified and organised through the* Bureaux Centrals de la Zone de Santé *(BCZS) [Health Zone Central Offices]. They will sign a partnership memorandum with the organizing power, which will be based on a programme contract that is yet to be created.

Specific objective 2	*Support the NGOs, the CBOs and the community health workers in mobilizing the communities*					
Outcome/Coverage indicators	Baseline	Targets				
	Year 2002	Year 1 2003	Year 2 2004	Year 3 2005	Responsible/ Implementing agency or agencies	Cost and source of financing
Proportion of malaria-fighting activities carried out by the community health workers, the NGOs and the community	***NA***	***25%***	***75%***	***100%***	***BCZS***	

Expected result: The community is involved in malaria-fighting activities.

Table IV.27.1

Objective 2	*Support the NGOs, the CBOs and the community health workers in mobilizing the communities*						
Broad activities	Process/Output indicators **(indicate one per activity)** ***(Refer to Annex II)***	Baseline Specify year) 2002	Targets			Responsible/ Implementing agency or agencies	Cost and sources of financing
			Year 1 2003	Year 2 2004	Year 3 2005		
1.Hold a workshop for planning malaria-fighting activities in the 11 provinces	***Number of workshops held out of number planned***	***1***	***100%***			***PNLP IMP BCZS***	***GF 16,500***
2. Train the community health workers in communication	***% of community health workers trained***	***NA***	***35%***	***100%***	***100%***	***PNLP BCZS***	***PM***
3. Supervise the trained health workers	***% of community health workers having had at least one supervisory visit***	***NA***	***35%***	***100%***	***100%***	***BCZS***	***PM***

4. Provide educational tools	*% of educational tools provided*	*NA*	*35%*	*100%*	*100%*	*PNLP*	*PM*
5. Educate the community on the fight against malaria	*% of households having received at least one informational message*	*NA*	*30%*	*100%*	*100%*	*BCZS NGOs*	*PM*
Total amount requested from the Global Fund							*16,500*

This Area of Intervention does not have its own budget because all its activities are included in the budgets of other areas.

Each province will organize a residential workshop on planning the actions to be taken for the intervention health zones under their jurisdiction.

BUDGET SUMMARY AREA 6: PARTNERSHIP

Budget items	2003	2004	2005	Total
Human Resources	0.00	0.00	0.00	0.00
Infrastructure / Equipment	0.00	0.00	0.00	0.00
Training / Planning	17,500.00	0.00	0.00	17,500.00
Commodities / Products	0.00	0.00	0.00	0.00
Drugs	0.00	0.00	0.00	0.00
Monitoring and Evaluation	0.00	0.00	0.00	0.00
Other (Transport / Maintenance)	0.00	0.00	0.00	0.00
Administrative Costs	1,750.00	0.00	0.00	1,750.00
Total	**19,250.00**	**0.00**	**0.00**	**19,250.00**

(See detailed costs Annex VI)

28. **Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programmes; does the component aim to fill existing gaps in national programmes; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41-42*), (2-3 paragraphs):

The five-year "Roll Back Malaria" (RBM) programme in D.R. Congo was planned while keeping in mind the guidelines of the Development Plan of the health sector for the 2001-2009 period, such as were adopted by the *Etats Généraux de la Santé* [States General of Health]. The current proposition is an action plan that falls under the first three years of the implementation of the aforementioned five-year plan. The Area of Interventions – the prevention of malaria with ITMN, the treatment of malaria cases, the intermittent preventive treatment of pregnant women, epidemiological surveillance, the strengthening of administrative and partnership capacities – are

realistic strategies for making a contribution to reducing morbidity, mortality and poverty, as was proposed by the roll back malaria global initiative.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:
In all project areas, People Living with HIV (PLHIV) are stakeholders in the intervention continuum:
The beneficiaries of this intervention are children under 5 years old and pregnant women in the targeted HZ, as well as the general population in HZ with epidemic potential. The community health workers, who are members of the community, will be responsible for the distribution/sale of treated mosquito nets.

29.2. Community participation:
The community participates in implementing the activities of this component through the community health workers.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):
Pregnant women are among those who benefit from the activities of this component. Children under 5 years old of both sexes make up the 2nd beneficiary group. The general population, regardless of sex, in HZ with an unstable endemicity constitutes the 3rd group of beneficiaries.

29.4. Social equality issues (*Guidelines, paragraph IV.53*):
Insecticide-treated mosquito nets will be sold to the population targeted by this project at a subsidized price equivalent to US$0.50 each.

29.5. Human Resources development:
Training courses will be organised for the following groups:

- Healthcare personnel
- Community health workers
- Social marketing agents

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (*Guidelines para. IV.55),* (1–2 paragraphs):

The drugs that will be used are:

- Sulfadoxine-pyrimethamine
- Amodiaquine
- Quinine
- Artesunate
- Paracetamol

Protocols:

- For any case of uncomplicated malaria in children, give 25 mg/kg body weight of sulfadoxine-pyrimethamine (525 mg tablet) in a single dose. Combine with paracetamol dosed at 15 mg/kg body weight 3x a day for 2 days in order to reduce fever. In adults weighing 60 kg and more, the SP dose is 3 tablets taken at once. NB: children under 2 years old should receive quinine by mouth and not SP.

- If fever persists after 48 hours, perform a thick smear. In the event that it is positive, consider the treatment to have failed and administer quinine p.o. as a second-line treatment in a dose of 3x 10 mg/kg body weight per day for 7 days.
- In case of severe malaria, quinine salt should be given in the loading dose of 20 mg/kg body weight infused in IV fluids (100–500 mL of 5% glucose/kg body weight) intravenously over 4 hours. This should be followed by 8 hours rest. Then continue with the maintenance dose of 10 mg quinine salt/kg body weight in 100 – 500 mL of 5% glucose/kg body weight over 4 hours, followed by another 8 hours of rest. The maintenance dose should be repeated in the same manner until the patient improves or is able to take medication by mouth. Clinicians should treat any complications (anemia, acidosis, dehydration, etc.)
- In case of severe malaria, if the patient has already taken quinine by mouth, the loading dose of quinine salt should not be administered. Begin immediately with the maintenance dose.
- The intermittent preventive treatment of pregnant women.

  Pregnant women will receive 3 tablets of SP at the 14th week and 3 more tablets at the 27th week. SP will not be administered during the first trimester or after the 36th week. During the first trimester, treat pregnant women with quinine salts. The minimum interval between 2 successive doses of SP is 28 days. Under 28 days, quinine by mouth must be administered to pregnant women in case of malaria.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines, paragraph V.56 – 58*):

Table V.30

TOTAL BUDGET SUMMARY OF THE MALARIA COMPONENT

Budget items	2003	2004	2005	Total
Human Resources	888,049.00	1,131,096.00	616,129.00	**2,635,274.00**
Infrastructure / Equipment	1,244,738.00	1,197,650.00	670,900.00	**3,113,288.00**
Training / Planning	126,165.00	110,800.00	105,700.00	**342,665.00**
Drugs	4,421,721.93	3,179,163.22	1,648,526.21	**9,249,411.36**
Commodities / Products	6,205,166.90	7,488,736.80	4,526,687.70	**18,220,591.40**
Monitoring and Evaluation	157,560.00	194,400.00	211,600.00	**563,560.00**
Other (Transport / Maintenance)	1,824,607.55	2,179,341.60	1,324,346.15	**5,328,295.30**
Administrative costs (10%)	1,486,901	1,548,124	910,389	**3,945,414**
Total	**16,355,909**	**17,029,361**	**10,014,278**	**43,399,549**

The budget categories may include the following items:
Human Resources: *consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bed nets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, programme management, audit costs, etc.*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs for the FIRST YEAR ONLY:

Re-treatment in Kinshasa only covered 10% of long-lasting ITMN.

Table V.30.1

Item/unit	**Unit cost** (USD)	**Volume** (specify measure)	**Total cost** (USD)

ITMN	5.6	1,292,719	7,239,226.4
SP (525 mg tablet)	0.02	27,656,229	553,124.58
Artesunate (100 mg tablet)	0.5	3,510,000	1,755,000
Quinine (500 mg tablet)	0.05	8,510,678	382,980.51
Injectable quinine (500 mg vial)	0.13	8,585,082	1,116,060.66
Paracetamol (500 mg tablet)	0.003	47,129,036	141,387.11
Amodiaquine (200 mg tablet)	0.01	21,462,405	107,313.53
Total			**11,295,092.49**

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

As regards this proposal, human resources only represent 4% of the total. The salaries are paid by the government.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)					2,000,000	2,000,000	2,000,000
External	552,002	315,174	1,431,463	2,035,000	6,269,000	3,800,000	3,500,000
Total							

The cooperation offices and agencies that provide global support to the HZ have not been taken into consideration.

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

Total budget for the component

Human Resources	2003	2004	2005	Total
Prevention	233,284.00	247,536.00	213,264.00	694,084.00
Treatment	592,345.00	825,280.00	402,865.00	1,820,490.00
Strengthening of PNLP	50,000.00	50,000.00	0.00	100,000.00
Surveillance	12,420.00	8,280.00	0.00	20,700.00
Partnership	0.00	0.00	0.00	0.00
Sub-total human resources	**888,049.00**	**1,131,096.00**	**616,129.00**	**2,635,274.00**
Infrastructure / Equipment				

Prevention	181,850.00	289,200.00	344,000.00	815,050.00
Treatment	539,788.00	364,000.00	263,900.00	1,167,688.00
Strengthening of PNLP	178,000.00	190,750.00	0.00	368,750.00
Surveillance	345,100.00	353,700.00	63,000.00	761,800.00
Partnership	0.00	0.00	0.00	0.00
Sub-total Infrastructure / Equipment	**1,244,738.00**	**1,197,650.00**	**670,900.00**	**3,113,288.00**
Training / Planning				
Prevention	39,665.00	41,800.00	44,200.00	125,665.00
Treatment	0.00	0.00	0.00	0.00
Strengthening of PNLP	69,000.00	69,000.00	61,500.00	199,500.00
Surveillance	0.00	0.00	0.00	0.00
Partnership	17,500.00	0.00	0.00	17,500.00
Sub-total Training / Planning	**126,165.00**	**110,800.00**	**105,700.00**	**342,665.00**
Commodities / Products				
Prevention	6,205,166.90	7,488,736.80	4,526,687.70	18,220,591.40
Treatment	0.00	0.00	0.00	0.00
Strengthening of PNLP	0.00	0.00	0.00	0.00
Surveillance	0.00	0.00	0.00	0.00
Partnership	0.00	0.00	0.00	0.00
Sub-total Commodities / Products	**6,205,166.90**	**7,488,736.80**	**4,526,687.70**	**18,220,591.40**
Drugs				
Prevention	0.00	0.00	0.00	0.00
Treatment	2,666,721.93	3,179,163.22	1,648,526.21	7,494,411.36
Strengthening of PNLP	0.00	0.00	0.00	0.00
Surveillance	1,755,000.00	0.00	0.00	1,755,000.00
Partnership	0.00	0.00	0.00	0.00
Sub-total Drugs	**4,421,721.93**	**3,179,163.22**	**1,648,526.21**	**9,249,411.36**
Monitoring and Evaluation				
Prevention	61,400.00	90,800.00	108,000.00	260,200.00
Treatment	0.00	0.00	0.00	0.00
Strengthening of PNLP	10,000.00	10,000.00	10,000.00	30,000.00
Surveillance	86,160.00	93,600.00	93,600.00	273,360.00
Partnership	0.00	0.00	0.00	0.00
Sub-total Monitoring and Evaluation	**157,560.00**	**194,400.00**	**211,600.00**	**563,560.00**
Other (Transport / Maintenance)				
Prevention	1,793,302.55	2,148,471.60	1,294,346.15	5,236,120.30
Treatment	0.00	0.00	0.00	0.00
Strengthening of PNLP	30,000.00	30,000.00	30,000.00	90,000.00
Surveillance	1,305.00	870.00	0.00	2,175.00
Partnership	0.00	0.00	0.00	0.00
Sub-total Other (Transport / Maintenance)	**1,824,607.55**	**2,179,341.60**	**1,324,346.15**	**5,328,295.30**
Administrative Costs				
Prevention	833,281.85	1,001,734.44	618,649.79	2,453,666.08
Treatment	379,885.49	436,844.32	231,529.12	1,048,258.93
Strengthening of PNLP	33,700.00	34,975.00	10,150.00	78,825.00
Surveillance	219,998.50	45,645.00	15,660.00	281,303.50

Partnership	1,750.00	0.00	0.00	1,750.00
Sub-total administrative costs	**1,468,615.84**	**1,519,198.76**	**875,988.91**	**3,863,803.51**
GENERAL TOTAL	**16,336,624.22**	**17,000,386.38**	**9,979,877.97**	**43,316,888.57**

33. **Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u>** (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* *(%)*	Year 1	Year 2	Year 3 (Estimation)	Total
Government	3.79%	3.76%	4.48%	4%
NGOs / Community-Based Org.	73.47%	84.99%	72.63%	**77%**
Private sector				
People living with HIV/ TB/ malaria				
Academic / Educational Organizations	0.42%	0.41%	0.60%	**0.5%**
Faith-based Organizations	22.32%	10.84%	22.29%	**18.5%**
Others *(please specify)*				
Total	100%	100%	100%	100%

**** If there is only one partner, please explain why.***

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),* (1–2 paragraphs)**:**

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

(See component I: HIV/AIDS)

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

(See component I: HIV/AIDS)

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

(See component I: HIV/AIDS)

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

(See component I: HIV/AIDS)

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

(See component I: HIV/AIDS)

SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

The information relevant to Malaria is provided by:

1. The *système national d'information sanitaire* (SNIS) [National Health Information System]: Monthly collection of routine epidemiological data, drawing up of monthly and annual reports for each health structure and at the different levels of the health pyramid.
2. The annual report of the Ministry of Health, drawn up by the *Direction d'Etudes et Planification* (DEP) [Directorate for Research and Planning].
3. The surveillance system in the 7 sentinel sites.
4. The results of studies and of operational research conducted by various partners, focused on programme-specific data (morbidity, mortality in children under 5 years old, children 5 years old and older and pregnant women; passive surveillance of treatment efficacy and the side-effects of SP in the sentinel sites; measuring progress in the implementation of RBM).

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

Data collection will be done passively or actively through:

- The quarterly utilization of the reports of partners involved in the fight against malaria;
- The utilization of quarterly reports forwarded by the provincial inspectorates and the NGOs active in the fight against malaria;
- Examination of the minutes of the monthly cooperation, orientation and coordination meetings of the partners involved in the fight against malaria;
- The monthly gathering of data during monitoring and evaluation visits to the health centers and hospitals by the head doctors of the zones;
- The utilization of workshop monitoring, internal review and evaluation reports.

Projects financed by the Fund will be carried out each year of the project at the central level.

37.3. Timeline:

Scheduled activities:

- Monitoring workshops for project activities will be organized every quarter at the provincial level and every six months at the national level;
- An internal project review will be made each year of the project at the central level;

- External audit missions each year;
- An external evaluation report halfway through and at the end of the project.

37.4. Roles and responsibilities for collecting and analyzing data and information:

The National Directorate of the PNLP will have the following roles and responsibilities:

Drawing up and distributing norms and directives for the fight against malaria;
The verification and updating of the database on the activities of the partners involved in the fight against malaria;
Drawing up the minutes of the monthly cooperation, orientation and coordination meetings of the partners involved in the fight against malaria;
Utilization of the monthly activity reports of players who support the fight against malaria;
Analysis, compilation and quarterly updating of routine data on malaria;
Utilization of reports on the prevalence of malaria in the sentinel sites;
Updating data from studies and operational research conducted in D.R. Congo by various partners;
Setting up a system for managing information on malaria.

The PNLP, in collaboration with its partners represented in the RBM Task Force, will have the following roles and responsibilities:

Institutional support of the programme at the central and provincial levels, as well as in the health zones;
The mobilization of resources in support of the fight against Malaria;
Utilization of workshop monitoring, internal review and evaluation reports on the projects financed by the Fund;
Utilization of the results of completed studies and operational research.

The *Ecole de Santé Publique*, CDC/Atlanta, MSF/EPICENTRE, BASICS, ITM/Antwerp, World Vision/Canada, Malaria Action Control, the WHO, McMaster University and the *Institut National de Recherche Bio-médicale* (INRB) will be given responsibilities in:

Conducting studies and operational research
Monitoring and evaluation.

The provincial inspectorates will be responsible for the training of health zone activity leaders and for the quarterly supervisory visits in the health zones. They will also be given responsibilities in the analysis and compilation of data as well as the distribution of information to the health zones and the passing on of reports and meeting minutes to the central level.

The health zones and the community will be given responsibilities in:

- The collection, compilation and analysis of data;
- Sentinel surveillance (in the zones considered to be sentinel sites);
- Placing and supervising community health workers.

37.4. Plan for involving target population in the process:

In order to encourage the target populations to adhere to the new strategies, the following activities are planned:

- The placement of community health workers

- The involvement of NGOs, CBOs and other partners
- The creation of malaria-fighting committees that include all players
- The holding of coordination meetings at regular intervals
- The regular organization of awareness-raising activities with community and religious leaders.

37.5. Strategy for quality control and validation of data:

- The protocols and the methodology of the various studies and research should be the subject of a consensus by the various partners.
- The results of the studies and research to be conducted will be submitted, before their validation, to a multidisciplinary scientific committee and to the ethics committee.
- The quality control reports of reagents and mosquito nets will be made, based on the results provided by the relevant services: the *Office Congolais de Contrôle, Ecole de Santé Publique, Institut National de Recherche Bio-médicale,* the WHO and CDC/Atlanta.
- The external financial audits will be conducted by specialized agencies after national and international invitations to tender. The validation of the audit results will be done according to the procedures of the selected agency.
- The validation of the equipment and infrastructure maintenance reports will be carried out by specialized agencies after national and international invitations to tender.

37.7. Proposed use of M&E data:

The Monitoring and Evaluation data will serve to:

- Measure the achievement of the objectives and results defined in the six different areas of intervention of this programme, specifically:
  The prevention of malaria through the use of long-lasting treated mosquito nets
  The treatment of malaria cases within the healthcare structures and within the community
  The Intermittent Preventive Treatment of pregnant women
  Epidemiological surveillance and the qualitative management of data
  The strengthening of the programme's technical and managerial capacities
  Strengthening partnerships for communal mobilization
  Improving the process of planning, implementation, monitoring and evaluation of the RBM strategy in D.R. Congo.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening	**Partner(s)** (which may help in strengthening	**Resources required** (USD)					
Monitoring and Evaluation Systems)	M&E capacities)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Creation and management of the database							
Providing an information system							
Setting up communication by E-mail							
Training in monitoring and evaluation							
Total requested from Global Fund							
Total other resources available							

NOT APPLICABLE

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	For widely available products, national or international invitations to tender. For specialized products, restricted consultations (shopping), minimum 3 suppliers.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Invitations to tender are published in the national and international press. In the case of international invitations to tender (Business development), the information is also disseminated within the embassies in Kinshasa.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	The quality of imported products is controlled by the *Office Congolais de Contrôle* (OCC) [Congolese Inspection Office]. The Ministry of Health assures the quality control of imported drugs, of mosquito nets and of insecticides.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	While waiting for the entire country to be equipped with central buying and selling offices (non-profit), the distribution/sale of drugs and treated mosquito nets is carried out by the various governmental and non-governmental partner organizations in the health zones. This distribution is done rapidly in order to avoid the losses and damage due to prolonged storage.

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

PNLP personnel are among the Administration civil servants who are under the supervision of the Ministry of Health. On-the-job training takes place at the *Ecole de Santé Publique* of the Université de Kinshasa and in other medical schools throughout the African region of the WHO. A framework exists between the PNLP and the local implementing agencies (national and international NGOs) for the implementation of the various project activities.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

The PNLP will benefit from WHO financing for the renovation of national infrastructures. The distribution of drugs, mosquito nets and insecticides will take place through the *agences locales d'exécution* (ALE) [local implementing agencies].

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
World Bank		$ 3,500,000	From 2003 – 2006
UNICEF	CISSE 00(243)98128506	$ 1,900,000	From 2002 to 2005
WHO	LEONARD TAPSOBA	$ 600,000	2002-2003
BASICS/USAID	MICHEL OTHEPA 002348803974	$ 400,000	2003
SANRU III/USAID	MINUKU 00(243)98186500	$ 470,524	2003
CEMUBAC		$ 300,000	2003
ADRAI		$ 376,876	2000-2003
USAID/CDC Atlanta	REGGIE HAWKINS 00(243)9948023	$ 506,000	2002
HORISON SANTE	MAMPUNZA MAMIEZI	$ 213,017	
GOVERNMENT	Dr MAKAMBA 00(243)817005479		2002-2006
USAID/UNICEF	CISSE 00(243)98128506	$ 50,000	2000
USAID/WHO	LEONARD TAPSOBA	$ 79,000	2002
USAID/MAC	REGGIE HAWKINS 00(243)8803142	$ 150,000	2002
NEPAD		$ 1,212,000	2003-2005

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

As foreseen in the strategic plan, the total amount required by the PNLP for the period 2002-2006 is $ 143,549,387. The funds granted by the partners up to the present time for rolling back malaria in the D.R. Congo amount to $ 7,416,876, or 5.2% of the total budget. The government share is $ 891,400.

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	1
2. Medium Term Expenditure Framework	
3. Sector strategic plans	2
4. Any reports on performance	3
	4

HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	5
6. Baseline data for tracking progress[67]	0
7. National strategic plan for HIV/AIDS, with budget estimates	7
8. Results-oriented plan, with budget and resource gap indication (where available)	See 5

TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	9
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	10
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	11
12. Most recent independent assessment/review of national TB control activities	12

Malaria specific documentation:	**Attachment #**

[67] *Where baselines are not available, plans to establish baselines should be included in the proposal.*

13. Situation analysis 13
14. Baseline data for the tracking of progress 14

1. Country strategic plan to Roll Back Malaria, with budget estimates 15
2. Result oriented plan, with budget and resource gap indication (where available) 16

General documentation:	**Attachment #**
I. Ministerial Decision of 27/02/2002 on the creation of the CCM	
II. a) Meeting minutes of 4 CCM meetings	
b) Letter from the MSF/B Head of Mission – CCM members	
III. Statutes and other documents concerning private associations and civil society	
IV. Association member lists	
V. MICS 2 Indicators (2001) and Diagnostic information (2002)	
VI. Administrative map and map of health zones	

HIV/AIDS specific documentation:	**Attachment #**
1. Basis of calculation for social mobilization costs	
2. Basis of calculation for the cost of safe blood transfusions	
3. Basis of calculation for STI costs	
4. a. Condoms needed	
b. Basis of calculation for condom costs	
5. Basis of calculation for treatment costs	
6. PTMC sites	
7. Basis of calculation for PTMC costs	
8. Basis of calculation for epidemiological surveillance costs	
9. Basis of calculation for HIV synthesis costs	
10. a. Per-unit costs of commodities / drugs	
b. Detailed costs of ARV drugs	
11. CNTS quality control documents	

TB specific documentation:	**Attachment #**
1. Abbreviations	
2. Map of coordination offices	
3. Basis of calculation for treatment costs	
4. Basis of calculation for detection costs	
5. Basis of calculation for social mobilization costs	
6. Basis of calculation of costs for capacity strengthening	
7. Basis of calculation of costs for the general summary	
8. Map of partner locations	

Malaria specific documentation:	**Attachment 7#**
1. Lists of retained or targeted health zones	
2. Detailed cost for prevention	
3. Detailed costs for treatment	
4. Detailed costs for surveillance	

5. Detailed costs for capacity strengthening 6. Detailed costs for partnership budget 7. General detailed costs	_____
Crosscutting documents / activities	**Attachment #**