The Global Fund
To Fight AIDS, Tuberculosis and Malaria

TRANSITIONAL FUNDING MECHANISM (TFM)

SINGLE COUNTRY APPLICANT: SECTIONS 1-2

Deadline for submission: 31 March 2012, 12 Noon CET

Resources and funding under the Transitional Funding Mechanism

Funding under the Transitional Funding Mechanism (TFM) will be dependent on the resources available at the time the Board will approve TRP recommended TFM applications.

Available resources depend on several factors over which the Global Fund has no direct control, in particular the receipt of funding anticipated from donors. The timing of receipt of donor funding will also influence the ability of the Global Fund to commit resources in a timely manner to minimize the disruption of essential services. At this time, the Global Fund cannot guarantee the amount of resources or the timing commitments.

Given this, in accordance with its recent decision, the Board will approve applications on a rolling basis and stagger the timing of commitments (and if necessary vary the duration of commitments) to apply available resources to minimize the disruption of services.

SECTION 1: APPLICANT INFORMATION AND FUNDING SUMMARY

Complete this section only once per applicant

Clarified section 1.1

1.1 Applicant Name and Country Information		
Applicant Name	Country Coordination Mechanism	
Country	Mozambique	
Do you have essential prevention, treatment and/or care programs currently financed by the Global Fund that will face disruption between 1 January 2012 and 31 March 2014?	☑ Yes	☐ No (if No do not submit a TFM request)
Please indicate from which date the disruption occurs (day, month, year) and the grant number(s) of affected grant(s)	30 June 2013 **MOZ-708.G07.T**	
Please indicate the start date of the TFM request	1 July 2013	

1.2 Component/s and Choice of Funding Pool		
Component	**Funding Pool**	
HIV	☐ General	☐ Targeted
Tuberculosis	☑ General	☐ Targeted
Malaria	☐ General	☐ Targeted

1.3 Information on Continuity of Services (CoS)[1] Request		
In this TFM request, are there interventions that will fall within the Continuity of Services policy?	☑ Yes	☐ No
If yes, indicate the grant number(s) of the grants requiring CoS.	**MOZ-202-G04-T-00 & MOZ-708-G07-T**	
If yes, provide a narrative summary of the elements of this request that relate to CoS and include the date used to determine the number of patients on treatment.		

Global Fund contributions to the TB program have been essential to supporting 61,208 people on 1st line and 350 on 2nd line treatment (2011) by providing 1st line drugs, 2nd line drugs for multi-drug resistant TB cases, and TB diagnostic services since July 2008 through round 7 funding. A disruption of treatment would not only result in a loss of life for adult and pediatric patients, but exacerbate an already increasing incidence of multi-drug resistant TB cases in Mozambique. The management and future financial strain on the TB programme to manage more multi-drug resistant TB cases would put undue pressure on an already strained health system.

In addition, it is estimated that 62% of TB patients are HIV infected. An interruption of TB funding would also have implications for the HIV programme, would lead to a major disruption of HIV-TB case management and a significant loss of life for HIV patients co-infected with TB.

Due to the focus of the Transitional Funding Mechanism to focus on essential services to (i) protect the gains achieved; (ii) save lives; and (iii) are high impact, evidence-based, targeted to most appropriate populations and represent good value for money in a resource-constrained environment, the request made for support from the TFM mechanism will focus on the Continuity of Services (CoS) through the provision of 1st line and 2nd line medications for the treatment of tuberculosis. All other support services will be provided by other partners.

[1] The Global Fund's Continuity of Services policy provides up to two years of funding to continue courses of treatment (whether the treatment is for a limited duration or is lifelong) when a grant comes to an end. Additional guidance is provided in the TFM Guidelines.

Transitional Funding Mechanism

Provide in the space below information on the number of people on treatment at the time of this application or expect to be on treatment at time of disruption. → *Complete a separate row for each SDA and type of treatment (e.g. ART, MDR-TB…).*

		Number of people on treatment			
SDA	Type of treatment	Total	Female	Male Child	Female Child
High Quality DOTS	According to the WHO guidelines	61208	N/A	N/A	N/A
TB/HIV	According to the WHO guidelines	36316	N/A	N/A	N/A
Multidrug-resistant TB (MDR-TB)	According to the WHO guidelines	350	N/A	N/A	N/A
Cost per patient on treatment if available (should be in same currency as 1.4)					

Clarified section 1.4

1.4 TFM Funding Summary				
Currency	◉ USD	○ EURO		
Component	**Transitional Funding Mechanism Funding Request** ** Enter the yearly amounts of the incremental (additional) funding requested. It should be identical to the yearly totals in the incremental request table (Section 7.6) for each component for which funding is requested.* *** Applications to the Targeted Funding Pool are subject to the maximum upper ceiling incremental funding request of US$ 5 million for up to two years of proposal term.*			
		Year 1	Year 2	**Total**
HIV	**CoS[1]**			
	TFM other			
	Total Incremental Funding Request			
		Year 1	Year 2	**Total**
Tuberculosis	**CoS[1]**	**0**	**0**	**0**
	TFM other	**4,114,438**	**4,556,713**	**8,671,151**
	Total Incremental Funding Request	**4,114,438**	**4,556,713**	**8,671,151**

		Year 1	Year 2	Total
Malaria	**Total Incremental Funding Request**			

1.5 Contact Details		
	Primary contact	**Secondary contact**
Name	**Prof. Narciso Matos**	**Marechal Nhavoto**
Title	**CCM President**	**CCM Vice-President**
Organization	**FDC**	**National Council for Deans**
Mailing address	**Av. 25 de Setembro, Edifício Time Square, Bloco 2, Maputo**	**Praça 25 de Setembro, 257 R/C Reitoria da UEM,**
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E-mail addresses	**nmatos@fdc.org.mz**	**mnhavoto@gmail.com**

1.6 List of Abbreviations and Acronyms used by the Applicant	
Acronym/ Abbreviation	**Definition**
ACSM	Advocacy, Communication and Social Mobilisation
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control
DOTS	Directly Observed Therapy Short Course
EDP	Essential Drug Program
FLD	First Line Drug
FWG	Health Financing Working Group
GDF	Global Drug Facility
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLC	Green Light Committee

GOM	Government of Mozambique
HAI	Health Alliance International
HIV	Human Immunodeficiency Virus
ICAP	International Centre for AIDS Care and Treatment Program
IEC	Information, Education, Communication
JHPIEGO	The Johns Hopkins Program for International Education in Gynaecology and Obstetrics
MDG	Millennium Dev elopement Goals
MDR-TB	Multi-Drug Resistant Tuberculosis
MoH	Ministry of Heath
MTEF	Medium Term Expenditure Framework
NTCP	National Tuberculosis Control Programme
OIG	Office of the Inspector General- Global Fund
PEPFAR	U.S President's Emergency Plan for AIDS Relief
PES	Plano Económico e Social
PHC	Primary Health Care
PMDT	Mult Drug Treatment Plan
PSM	Procurement and Supply Management
R7	Round Seven
SADC	Southern Africa Development community
SCMS	Supply Chain Management Systems
SDA	Service Delivery Area
SLD	Second Line Drugs
SLICE	Supply and Logistics Internal Control Evaluation
TB	Tuberculosis
TFM	Transitional Funding Mechanism
WB	World Bank
WHO	World Health Organisation

CCM applicants	Sub-CCM applicants	Non-CCM applicants
→ *Complete sections 2.1 to 2.7* → *Delete sections 2.8 to 2.15*	→ *Complete sections 2.1 to 2.10* → *Delete sections 2.11 to 2.15*	→ *Complete sections 2.11 to 2.15* → *Delete sections 2.1 to 2.10*

SECTION 2: REQUIREMENTS FOR ELIGIBILITY

2.1 Proposal development process

Requirement 1: The Global Fund requires all CCMs[2] to:

i. **Coordinate the development of all funding applications through transparent and documented processes that engage a broad range of stakeholders - including CCM members and non-members – in the solicitation and the review of activities to be included in the application.**

ii. **Clearly document efforts to engage key population groups[3] in the development of funding applications, including most-at-risk populations.**

Describe the transparent and documented process used to engage stakeholders, including CCM and non-CCM (or Sub-CCM) members and most-at-risk populations in the development of the TFM application.

In particular, describe how the CCM (or Sub-CCM) determined what are the essential services facing disruption and what other resources, including other ongoing Global Fund grants, could be reprogrammed to potentially meet their need.

Please attach meeting minutes which record the CCM (or Sub-CCM) decisions taken on what to include in the application as well as stakeholder input and participation.

→ *Explain the process for each component in the application*

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The Ministry of Health is a CCM Member. The process used to engage stakeholders in the TFM application, was through:

- The CCM received from the Civil Society Organizations, CCM Members and non-CCM Members a common letter (ANNEX T1) a letter regarding TB treatment situation after R7. The CSO expressed their concern about the critical situation of TB Treatment from after 2013. This letter was also sent to the Minister of Health, WHO and the World Bank .
- The CCM Meetings, (ANNEXES T2, T3) also addressed the issue of the TB treatment disruption due the R11 cancelation. This was putted on the CCM Agenda because the TB treatment guaranteed by Round 7 Phase II implementation will in June 2013. The TFM, as solution advanced by the GF was also discussed, to ensure the TB treatment to cover the period after R7 Phase II. Based on this analysis, the CCM decided to apply.(ANNEX T2)

[2] The requirements outlined here apply to CCMs and sub-national CCMs (Sub-CCMs).
[3] Key population groups include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern.

2.2 Processes to select Principal Recipient(s)

Requirement 2: The Global Fund requires all CCMs to:

i. Nominate one or more PR(s) at the time of submission of their application for funding[4].
ii. Document a transparent process for the nomination of all new and continuing PRs based on clearly defined and objective criteria.
iii. Document the management of any potential conflicts of interest that may affect the PR nomination process.

Describe the transparent process used to nominate new or continuing Principal Recipient(s) and the criteria used for the nomination. Describe how any potential conflict of interest was managed that may have affected the PR nomination process.

Please attach the signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) members nominated the Principal Recipient(s) for each TFM application. Minutes should include a summary of discussions, a list of participants, decision points and a record of who and which constituency took part in the decision making process. CCM (or Sub-CCM) meeting minutes must demonstrate how conflict of interest was managed.

→ Explain the process for each Principal Recipient for each component

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In Mozambique the role of treatment and services provider belongs to the Ministry of Health. The Ministry of Health is the unique institution which provides diseases treatment, including TB. This role is recognized by all stakeholders. Every support provided by donor is focus on the Health System. In this regard, for the TFM application, the only Principal Recipient with treatment mandate in country is the Ministry of Health.

The following explanation about the CCM internal structure is to allow the understanding of the decisions processes levels and how the decisions are made internally. CCM structure in Mozambique is the following: CCM Board (meets by four months and involves all CCM members); CCM Executive Committee(meets by two months- involves six Members), and the 3 CCM Working Groups(1. Proposal Development and Resources Mobilization, 2- Governance, Ethics and Conflict of Interest; 3- Oversight). All CCM Members are distributed in those working Groups.

The CCM Executive Committee, is the CCM intermediate level of decision, meets, as referred before by two months and the members are Working Groups Coordinators (all constituencies are represented), CCM President, CMM Vice-President and CCM Executive Secretary. The matters discussed in Executive Committee are endorsed by the Working Groups. The Executive Committee has two roles: one is to make immediate decisions to keep the CCM activities on and endorses matters to the Board. The Executive Committee meetings are shared by all CCM Members and in working Groups.

The issue related to the TFM application were discussed in the CCM Executive Committee Meetings in January (ANNEX T2) and March (ANNEX T3) and the Endorsement was done by the Board Meeting (ANNEX T7).

The process of Principal Recipient nomination took into account following facts and evidences:

- The role of the Ministry of Health as only treatment provider;
- The TB treatment is provided throughout the Health system (Hospitals and Health Centres). It shows that the services are in place. So, The call for application in this context is not feasible because: (i) the objective of the TFM is to maintain those essential services the s (ii) The TB proposal is focus only on medicines. There not organization who deals with the mandate of providing treatment.
- The Civil society letter means the recognition of the Civil Society Organizations (CCM Members and Non Member) of the Ministry´s of Health obligations as service provider;
- No Scale-up interventions: the TFM-TB is seen as a continuity of the R7 grants, to ensure the essential services with no expansion. The R7 Principal Recipient is the Ministry of Health
- The TFM will maintain the treatment dynamic to avoid disruption on treatment.

The CCM Executive Committee, after listened all the Members, based on CSO Letter and the future of

[4] In exceptional cases, the Global Fund will directly select PRs for the CCM under the Additional Safeguard Policy.

the treatment, decided to submit a proposal. The CCM decided also no to announce publically the call for application, due the common recognition of the MoH´s role in treatment and the TB-TFM proposal will focus on medicines.

The CCM Executive Committee Nominated the MoH as Principal Recipient for the TB-TFM.(ANNEXT2)

For all decision process, the Ministry of Health did no attended the CCM Executive Committee Meetings, where the application options was discussed, because the Ministry of Health is not member of the Executive Committee. The Ministry of Health only sent information about their intention to continue the TB treatment after R7. The MoH is member of a Working Group and Member of the CCM Board. Because of that, the CCM Executive Committee doesn't consider this situation as conflict of Interest or potential Conflict of Interest. The MoH just went to the Executive Committee to present the progress in proposal development process and to Board for Proposal approval and endorsement (ANNEX T3, T7).

Name the Principal Recipient(s) nominated for your application(s)

Name	Component	Sector
Ministry of Health	**TB**	**GOVERNMENT**

2.3 Non-implementation of dual track financing

Dual track financing means that at least one government sector and one non-government sector Principal Recipient have been nominated for each component. If relevant, provide an explanation below as to why dual track financing has not been applied for any of the components in this application.

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In this TB Proposal, the Dual Track Financing is not applicable because:

- The Treatment Centralization on the Health Sector (Government as Service Provider);
- The proposal focus in Medicines;
- The purpose of the TFM is to maintain the essential services;
- The TFM will be the continuation of the R7 Phase II which will end in June 2013;
- The SAD´s Proposed and the budget required is according with the PR´s absorptive and implementing capacity.

So, in context of only one treatment provider, non scale-up interventions, minimum budget request, there is no needs and conditions for the dual track financing.

2.4 Process to oversee program implementation

Requirement 3: Recognizing the importance of oversight, the Global Fund requires all CCMs to submit and follow an oversight plan for all financing approved by the Global Fund. The plan must detail oversight activities, and must describe how the CCM will engage program stakeholders in oversight, including CCM members and non-members, and in particular non-government constituencies and people living with and/or affected by the diseases.

Attach an oversight plan for all financing requested from the Global Fund. The oversight plan must describe the activities the CCM (or Sub-CCM) plans to conduct to oversee program implementation. Moreover, it must explain how the CCM (or Sub-CCM) will engage stakeholders, including CCM and non-CCM members (or Sub-CCM) and in particular non-government constituencies and people living with and/or affected by the disease.	*ANNEX T 4*

Clarified section 2.5

2.5 Broad and inclusive membership

Requirement 4: The Global Fund requires all CCMs to show evidence of membership of people living with HIV and of people affected by TB or malaria (where funding is requested or has previously been approved for the respective disease). People affected by TB or malaria include people who have lived with these diseases in the past or who come from communities where the diseases are endemic.

Requirement 5: The Global Fund requires all CCM members representing non-government constituencies to be selected by their own constituencies based on a documented, transparent process, developed within each constituency. This requirement applies to all non-government members including those members representing people living with or affected by the three diseases, but not to multilateral and bilateral partners.

Since your last eligible application to the Global Fund:

(a) Is there continuing active membership of people living with and/or affected by HIV and of people affected by TB or malaria (where funding is requested or has previously been approved for the respective components)?	○ No	X Yes

(a) When was the last time any changes were made in CCM (or Sub-CCM) members representing non-government constituencies?

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The last CCM membership revision has been made in 2010, when the CCM did it´s last functional review. But the CCM is opened for new members.The CCM Working Group on Governance, Ethics and Conflict of Interest deals with this issue of membership. The CCM was noticed by the Ministry that a new association related with TB was recently created and presented themselves in MoH. The CCM Secretariat contacted the Movimento Contra a Tuberculose to involve them in the present TFM- TB Proposal (ANNEX T5). Furthermore, the CCM will initiated the process of this constituency engagement in CCM through the Governance, Ethic and Conflict of Interest Group, to formalize the Movimento Contra a Tuberculose´s representation in the CCM.

In 2.5, as explained, the CCM did not change the membership since it´s last revision in 2010. Since the CCM was created, there was not in Mozambique Association or Network of People Living with Malaria or TB. Only in last month, March 2012, the CCM was noticed by the Ministry that a new association related with TB advocacy was recently created and presented themselves in MoH. Within the CCM, the Working Group on Governance, Ethics and Conflict of Interest deals with the membership issues and the CCM Executive Committee recommended the CCM Secretariat to contact the Movimento Contra a Tuberculose to involve them in the TB Implementation Grants through their participation in the TFM-TB proposal development. The Movimento Contra Tuberculose endorsed the TFM-TB proposal. (Attached Annex T5). To engage this constituency in CCM, the Governance, Ethic and Conflict of Interest Group is preparing all process to formalize the Movimento Contra a Tuberculose´s representation in the CCM.

(c) Describe in the space below how new members representing non-government constituencies were selected by their own constituency, based on a documented, transparent process, developed within each constituency. Please attach copies of advertisements or correspondence inviting representatives from the non-government constituency to take part in a member selection process or to nominate or select an organization. In addition, please attach minutes from the meeting(s) where member selection took place. Minutes should document the candidates considered, the criteria used for selection (if any), the individuals who took part in the selection process and the organizations they represent.

ONE PAGE MAXIMUM

Not Applicable

2.6 Managing conflicts of interest

Requirement 6: To ensure adequate management of conflict of interest, the Global Fund requires all CCMs to:

i. **Develop and publish a policy to manage conflict of interest that applies to all CCM members, across all CCM functions. The policy must state that CCM members will periodically declare conflicts of interest affecting themselves or other CCM members. The policy must state, and CCMs must document, that members will not take part in decisions where there is an obvious conflict of interest, including decisions related to oversight and selection or financing PRs or SRs.**

ii. **Apply their conflict of interest policy throughout the life of Global Fund grants, and present documented evidence of its application to the Global Fund on request.**

Attach the policy which outlines how the CCM (or Sub-CCM) manages potential and actual conflict of interest, as per the requirement above.	**ANNEX T6**

2.7 Proposal endorsement by members The Membership Details Form (Attachment C) has been completed with the signatures of all members of the CCM (or Sub-CCM).	☐ **ANNEX T9**

Further details for Sub-CCM applicants

2.8 Status of Sub-CCM	
(a) Does the Sub-CCM operate under the authority of the CCM to focus on a particular region or issue?	○ Yes → *answer section 2.9*
(b) Does the Sub-CCM claim an independent basis to operate without oversight of the CCM?	○ Yes → *answer section 2.10*

2.9 CCM endorsement	
(a) Attach the signed and dated minutes of the CCM meeting at which the CCM agreed to endorse the Sub-CCM's TFM request	→ *insert annex number*
(b) Attach a letter from the CCM Chair or Vice-Chair confirming the CCM's endorsement of the Sub-CCM's TFM request	→ *insert annex number*

2.10 Justification of independence of Sub-CCM

Explain how the Sub-CCM has a right to operate without endorsement from the CCM.

ONE PAGE MAXIMUM

Non-CCM applicants

2.11 Sector of work → *check one box only*

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

2.12 Justification for Non-CCM TFM request	
(a) Identify the main justification for submitting a Non-CCM TFM request → *check one box only*:	
(i) Countries without a legitimate government	☐ Yes → *go to section 2.13*
(ii) Countries in conflict, facing natural disasters, or in complex emergency situations (identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs)	☐ Yes → *go to section 2.13*
(iii) Countries that suppress or have not established partnerships with civil society and non-governmental organizations. These circumstances include a CCM's failure or refusal to consider a civil society or non-governmental organization proposal, particularly those targeting highly marginalized and/or criminalized groups, for inclusion into the national composite CCM proposal	☐ Yes → *complete 2.12(b) then 2.12(c)*
(b) If (iii) applies: Describe, chronologically, all attempts by the Non-CCM to communicate with the CCM on the inclusion of the Non-CCM proposed activities in the larger CCM application.	
ONE PAGE MAXIMUM	
(c) Describe how the Non-CCM will be able to implement the TFM request and achieve the outputs/outcomes when the CCM has not supported their request.	
ONE PAGE MAXIMUM	

2.13 Name the Principal Recipient(s) nominated for your proposal(s)		
Name	Component	Sector
[use "Tab" key to add extra rows if needed]		

2.14 Non-implementation of dual track financing
Dual track financing means that at least one government sector and one non-government sector Principal Recipient have been nominated for each component. If relevant, provide an explanation below as to why dual track financing has not been applied for any of the components in this application.
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2.15 Signature by authorized representative of Non-CCM applicant		
Position	**Printed Full Name**	**Signature**
		→ *use "Tab" key to add extra rows if needed*

ELIGIBILITY CHECKLIST

Section	Description	List annex name and number
CCM and Sub-CCM applicants		
2.1	Process used to engage a broad range of stakeholders, including key population groups, in the solicitation and review of activities for integration into the TFM request	ANNEX T5
2.1	Attach a signed and dated version of the minutes of the meeting(s) at which the CCM (or Sub-CCM) members decided what to include in each component and finalized and endorsed the application	ANNEX T2, T3,T7,T10
2.2	Process and criteria used to nominate new or continuing Principal Recipient(s) Attach signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) members nominated the PR(s). CCM (or Sub-CCM) meeting minutes must demonstrate how potential conflict of interest was managed	ANNEX T2
2.4	Attach an oversight plan for all financing approved by the Global Fund	ANNEX T4
2.5	Process used to select CCM (or Sub-CCM) members representing non-government constituencies by their own constituencies Attach copies of advertisements or correspondence inviting representatives from the non-government constituency to take part in a member selection process. Attach the minutes of the meeting(s) where member selection took place	
2.6	Attach the Conflict of Interest policy and highlight the specific sections that respond to the stipulations set out in Requirement 6	ANNEXT6
2.7	Endorsement of the TFM request by all CCM (or Sub-CCM) members	ANNEX T9
Sub-CCM applicants		
2.9	Process used to show that the CCM reviewed and endorsed the TFM request	
2.10	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM	
Non-CCM applicants		
2.11	Documentation describing the organization, and the key governance arrangements, and a summary of the	

	main sources and amounts of funding	
2.12(a)	Documentation justifying the exceptional circumstance for submitting a Non-CCM TFM request	
2.12(b)	Documentation of communication to the CCM for consideration of the TFM request	

Other documents relevant to sections 1 and 2 attached by applicant:
→ Add extra rows to this section of the table as required to ensure that documents directly relevant are attached

	Proposal Endorsement by the CCM President	ANNEX T10
	Attendance List – CCM Executive Committee 27 January 2012	ANNEX T11
	Attendance List – CCM Executive Committee 16 March 2012	ANNEX T12
	PSM- TB Round 7- Phase 2	ANNEX T13
	Green Light Committee Approval Moz 2008	ANNEX T 14
	SLICE Mozambique Report. Final	ANNEX T15
	MOZ PSM Debrief OIG	ANNEX T16
	Final Report DQA- Mozambique	ANNEX T17
	Plano Operacional CMAM	ANNEX T18
	CCM Cover Letter	ANNEX T19
	Ministry of Health Letter. Government TB Funds	ANNEX T20
	TB-TFM Performance Framework	ANNEX T21
	Not Applicable	ANNEX T22
	TFM-TB Financial Gap Analysis	ANNEX T23
	TFM TB Workpaln and Budget	ANNEX T24

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

TRANSITIONAL FUNDING MECHANISM (TFM)

TUBERCULOSIS: SECTIONS 3-8

SECTION 3: COUNTRY CONTEXT

3.1 Essential Services within the Disease Program

Provide a description of the current disease program in the country and the progress being made as well as the challenges to be met in providing essential prevention, treatment and/or care programs within this context.

Introduction

Mozambique is located in southern East Africa, surrounded by the Indian Ocean on the east side and on the west by the countries of Tanzania, Malawi, Zambia, Zimbabwe and South Africa. With a total area of about 801.590 sq Km and a coastline of 2.470 km, it is one of the largest countries in sub-Saharan Africa. It has eleven provinces, eleven large cities, and three main regions namely, the northern, the central and the southern. The country has an estimated total population of approximately 23,049,621 million inhabitants, 52% of women and 48% of men. Only 31% of Mozambicans live in urban areas (INE, 2007). Mozambique is classified as a Low-Income Country (WB 2011).

Mozambique is among the 22 high burden countries for TB with an estimated incidence of 544/100.000 cases, meaning 130.000 new cases per year. The case detection rate is 48% and 34% for smear positive TB and all forms, respectively. Out of the total incident cases 1300 are estimated as being MDR-TB (WHO, 2011). Based on the national data information system from the National Tuberculosis Program , in 2011 47,452 new cases were notified of which 19,537 were smear positive. The case detectionrate is 49% and 48% for alll TB forms respectively. The rate of TB/HIV co-infection is 62%,one of the highest co-infection rates in the world. A drug resistance survey, performed in 2007/08, showed that 3.5% of new cases and 11.2% of retreatment cases of TB are multi-drug resistant. This is the second highest rate of MDRTB in the SADC region. Mozambique began treating MDRTB in 2006, beginning in the capital city of Maputo and slowly expanding the program so that MDRTB is currently being treated in all provinces. The primary financing vehicles for the MDRTB program have been the Global Fund (GF) and the Green Light Committee (GLC) and in 2008 funding was approved to cover 400 new cases of MDRTB.

In 1984, Mozambique was an early pioneer of the global DOTS strategy and became one of the first countries to apply the DOTS principles. Since then, institutional DOTS has been scaled up and attained national coverage. Essential TB services for diagnosis and follow up of treatment by smear microscopy, regular supply of medicines and diagnostic materials are included in the Primary Health Care (PHC) package and are delivered in all districts and, in principle, in all health centers. General PHC services are the backbone for delivering Health Services in Mozambique and are available free of charge through the public health sector.

Currently, Mozambique is treating 47,452 of people people presumed to have drug-sensitive TB, 26,538 of whome are HIV/TB co-infected. There are also 468 patients currently being treated for MDRTB.

Challenges

Despite the considerable progress the country made in the past decade in terms of case notification rates, its case-detection rate still is estimated to be at a 49% in 2011% level (which is far below the WHO target to detect at least 70% of new infectious TB cases). Despite low case detection rates, Mozambique's treatment rates have reached the WHO target to successfully treat at least 85% of new infectious TB cases. XX%, exceeding WHO's target of 85%.

The figure below gives an overview of the trend in notified cases over the last 10 years that more than doubled to a level of 46.000 cases in 2011.

Mozambique faces significant challenges to improve its ability to combat the growing MDR-TB epdiemic. The results of the first MDRTB cohort analysis (2006-2010) demonstrate:

- 51% patients with confirmed MDRTB received treatment
    - Of those treated, 28% died
    - Of those treated, 17% defaulted

Mozambique faces significant challenges to improve its ability to combat the growing MDR-TB epdiemic. The results of the first MDRTB cohort analysis (2006-2010) demonstrate:

- 51% patients with confirmed MDRTB received treatment
    - Of those treated, 28% died
    - Of those treated, 17% defaulted

The table below demonstrates the number of MDR cases diagnosed, those being treated and the treatment results from 2006-2010.

Year	Diagnosed	Started treatment	Cured	Death	Defaulters	Transferred	Without info	On treatment
2006	129	48	27	10	10	1	0	0
2007	163	97	47	28	14	1	7	0
2008	200	136	49	35	22	0	5	25
2009	145	137	0	28	16	1	4	88
2010	95	87	0	0	1	0	0	86
2011	**184**	146	33	31	20	3	4	267
Total	916	651	156	132	83	6	20	466

The capacity to detect MDRTB cases is a major challenge. Suspicion for MDR-TB is typically raised late in the course of disease, if at all. Even then the diagnosis must be confirmed by use of culture in one of 2 reference laboratories. Initially, all MDRTB suspect samples were sent to the national reference lab in Maputo. In 2011, a second reference laboratory was opened in Beira. A third reference laboratory is slated to begin operation in 2013 in Nampula.

There are major challenges in the logistics and transportation system in place to transport sputum specimens from the provinces to the reference laboratories and there are serious delays in communicating final results. As a result the program is losing many patients before they even started treatment.

There are 73 MDR-treatment units in the country, but most of them lackadequate infrastructure and infection control requirements. The country also in 2011 the faced stock outs for second line drugs (SLDs) mainly Cycloserin and Pirazynamide due to a combination of weak forecasting and delays in drug orders primarily caused by near complete dependency on unpredictable and unreliable external funding.

The network of microscopy centers in Mozambique was scaled up quickly from a total of 255 in 2008 to 433 in 2011. Most of the peripheral labs are run by nurses or clinical officers, who did a short course in microscopy. Turn -over of staff is high and therefore the NTCP is organizing training courses and supervision to keep up standards. Shortage of basic lab commodities(slides, stains) have been reported and the transport system of sputums to the referral labs is unreliable. The Ministry of

Health, together with partners (TBCARE, WB, CDC) are undertaking efforts to overcome this. The NTCP together with the malaria program is setting up a system for EQA of direct sputum microscopy.

Regarding the M&E system – a recent data quality audit by the GFATM concluded that the overall quality of data is rather good, although the recording and reporting system for MDR was develop and been implemented, at peripheral level there is a limited capacity for basic statistical analysis.

The political commitment of the GoM to fight tuberculosis is high, but the system cannot track national budgetary contributions to the TB program . Domestic funds cover, for example, all salary costs of staff[1], the running costs of all health facilities, including hospitals and laboratories. Most of its contributions are through the integrated system and hidden in the general health care budget that does not earmark the budget for TB control. A major challenge is that for essential commodities such as the purchase of anti-TB medicines and lab consumables the TB program is depending almost entirely on external sources. At the beginning of year 2012 the MoH did an emergency procurement of 1st line TB drugs to cover the national needs for 3 months in order to avoid further stock outs of key medicines, allocating USD 105,000 from the State Budget. For 2nd line drugs, the MoH filled the gap of USD 251,000 using funds from the State Budget for a procurement through GDF in March 2012.

Clarified section 3.2

3.2 Epidemiological Profile of Target Populations

a) Population Groups in Country

→ Specify the breakdown of the target population into relevant sub-populations (e.g., Females 0-4, Males 5-9, etc.) in the left-hand column. Add extra rows as necessary.

Population Groups	Estimated Number	Year of Estimate	Source of Data
Total target population (all ages and genders)	23,049,621	2011	INE Census 2007
Under five	**4,022,750**	**2011**	**INE Census 2007**
Rural population	**15,907,906**	**2011**	**INE Census 2007**

b) Tuberculosis epidemiology of population(s) targeted in in existing Global Fund grants

Indicators		[Calculation] or (reference)	
		2010	2011
	Total number of notified cases (all forms of TB)	46,149	47,452
	Case notification rate per 100,000 population (all forms of TB)	211	206
	Total number of laboratory-confirmed cases of MDR-TB started on treatment	95	184
	Percentage of TB patients who knew their HIV status	%87.8%	89.5%
	Percentage of TB patients tested for HIV who were HIV-positive	60.6%	62.3%
		2009	2010
	Treatment success rate of new cases	85.4%	85.2%

[1] - comprising more than 60% of the total health budget

		Latest year when survey /surveillance was conducted	Results of survey / surveillance
	TB prevalence rate (from national population-based survey)*	n/a	
	TB mortality rate (from national vital registration)**	2010	49
	Percentage of new TB patients with MDR-TB***	2007-2008	3.5%

SECTION 4: TFM REQUEST SUMMARY

Clarified section 4.1

4.1 Narrative Description of TFM Request

In this section:

1) Describe the essential prevention, treatment and/or care programs currently financed by the Global Fund in the country that are expected to be interrupted, which form your TFM request. In your response, please make reference to the goals and objectives as you present them in the performance framework.

2) Identify the risk of program interruption including a) an estimate of the size of these disruptions in terms of numbers denied essential services and b) a description of the potential impact of these disruptions on new TB infections, quality of life and death.

3) If applicable, describe what reprogramming is being proposed in order to prevent disruption of essential services.

4) Outline which of the proposed TFM interventions would fall under the definition of Continuity of Services[2]

1. Essential treatment programs currently financed by the GF that are expected to be interrupted:

Context of the request:

Mozambique has a high burden of TB, ranking 16th on the list of the 22 high TB burden countries. It also has one of the highest TB/HIV burdens (ranking 5th), due to a high prevalence of HIV (11,5%). The country aims to diagnose and treat 46.000 TB patients and 200 MDR patients, annually.

Mozambique is strongly committed to fight TB and covers the major costs of its control program, such as all salary cost of staff and the running of service delivery. In order to make its commitment more visible within its integrated structure, it earmarked 500,000 USD for purchasing anti-TB medicines, starting in 2013, to be expanded in the years thereafter.

Challenges, previously mentioned in 3.1 to improve its diagnostic capacity are grossly covered with support from other donors.

The request to the GF TFM is for $8 milllion to fund first and second line drugs from July 2013 for a 2 year time period to prevent disruption of services to 92,000 TB and for 400 MDR patients that would have resulted in poor Tx outcomes/ death and have fuelled the MDR TB epidemic. The request aims to sustain the gains achieved by the NTCP in the past.

The drug supplies fall under continuity of services.

As round 7 comes to an end by June 2013, reprogramming is not an option and recent donor meetings suggest that other donors are unable to take up these activities.

Details of the request:

To understand the impact of the termination of the R7 funding by June 30 2013, it is necessary to

[2] The Global Fund's Continuity of Services policy provides up to two years of funding to continue courses of treatment (whether the treatment is for a limited duration or is lifelong) when a grant comes to an ed. Additional guidance is provided in the TFM guidelines

analyze what is currently funded through the GF mechanism.

The R7 phase 2 approved budget includes 61% on pharmaceuticals and 18% on PSM (Procurement and Supply management), of which 70% is allocated to First line Drugs, 5% to pediatric formulas and 20% to MDR. The items included in PSM include shipment, airfreight and insurances (SDA / Activity: 1.4.2. Supplying (procuring and distributing) drugs at all levels through the GDF. If no other funding mechanisms will be found at short notice, stock-outs of anti-TB medicines can be expected for both regular TB for adults and for the treatment of MDR-TB. (Annex T13).

In 2008 the GLC decided to approve the application for access to concessionally priced second-line and TB drugs for enrollment of an initial cohort of 400 patients. In 2010 there were 200 MDR patients on treatment, with the aim to adding 100 patients per year to reach a maximum of 400 patients, as approved through a GLC in 2009, for which a MoU between the MoH and GLC has been signed. (Annex T14).

Table 2 gives an overview of the needs for anti - TB medicines in the period 2012 – 2015. The forecasting was done using Pipeline software system. It is used to define quantities to be ordered and follow-up the shipments. It aims to ensure adequate buffer stock levels between 6 and 12 months for most of the TB drugs. The stocks for MDR at central and provincial level are shorter and vary from 1 to 4 months. The number of patients in the national TB program was 46,174 during 2010, for 2011 the program projected 48,600 patients of which 9.1% children under 15 years. During 2012 and 2013 the projected number of patients will increase to 52,342 and 56,373 respectively based on the epidemiological data with the annual increase baseline of 5,5% (2006-2008). The calculation of needs are based on treatment of 200 MDR patients. Data on expected patients to be treated are provided by the National TB Program, based on the quarterly reports from the provinces.

Area	2012	2013	2014	2015
MDR standardized	$ 651.470,32	$ 677.575,87	$ 777.322,16	$ 799.058,98
TB treatment Adults	$ 2.036.343,60	$ 2.428.520,24	$ 2.450.000,00	$ 2.605.298,84
TB treatment Pediatrics	$ 175.084,72	$ 226.347,36	$ 230.000,00	$ 252.939,03
TB/HIV prophylactic regimens	$ 85.266,58	$ 159.187,41	$ 159.500,00	$ 160.982,53
Tuberculin	$ 2.500,00	$ 709,07	$ 500,00	$ 575,94
Grand Total	$ 2.950.665,23	$ 3.492.339,95	$ 3.617.322,16	$ 3.818.855,33

Note: Be aware that the calculated needs differ from those calculated in section 7, Gap analysis, which include PSM costs.

As discussed both the anti TB medicines for regular TB and for MDR are covered by R7 grants till mid 2013. The R7 funding also includes a budget line for lab consumables (SDA/Activity 1.2.4. Procurement and distribution of laboratory supplies at different level of care), but this budget line has not been approved yet. For 2012 an agreement has been made with the World Bank to spend 1 million USD on lab consumables for TB. Lab consumables will be funded thereafter through the integrated budget for laboratory services of the MoH and GLI. Other budget lines of R7 phase II, that are not approved yet include IEC materials and support to community DOTS, some of which are covered by the TB CARE I program.

The support requested from the TFM is restricted to the supply of anti-TB medicines, which are essential contributions, but they will not address the many challenges that mentioned before in section 3.1. The TFM support must be seen as additional to the efforts the NTCP currently is making to improve its diagnostic capacity and the performance of MDR-TB. In this it is supported by the TB-CARE1 program that, in line with the overall national TB strategy, is focusing on building capacity to diagnose regular TB by equipping laboratories and training and supervision of laboratory staff,. But also by setting up quality assurance systems and by training and supervising of laboratory staff, both for the three reference laboratories as well as for the microscopy centers. In 2011 it supported the writing of a national MDR-TB strategy and will roll this out in the coming years to address the major challenges that affect the fight against MDR-TB. The program provides TA and other support to the Central level and support TB services for two third of the population of Mozambique, particularly in the northern provinces where case notification rates are low.

The goals and objectives used in this TFM application are aligned with those of R7 and are formulated as follows:

Goal: To reduce the prevalence, morbidity and mortality due to tuberculosis in line with the Millennium Development Goal (MDG) by 2015;

Objective 1: To increase the detection and cure rate by expanding DOTS strategy

SDA 1.1 High Quality DOTS

SDA 1.2: Procurement and supply management

Objective 2: To Address TB/HIV, MDR-TB and Other Challenges

SDA 2.1: TB/HIV

SDA 2.2: Multidrug-resistant TB (MDR-TB)

The funding requested through the TFM will enable Mozambique to give continuity to the provision of existing essential services to avoid deaths or a substantial rebound in transmission. The proposed package will be provided at an equal level of cost-effectiveness, compared to the previously funded package and there will be no scaling up (a) in terms of number of people receiving services at any particular time, (b) in terms of geographic coverage or populations and (c) in costs. Although the requested support will serve the population in general in Mozambique, the NTP, in accordance with the principles defined in the National Strategic Plan for TB control in Mozambique, pay particular attention to vulnerable people, determined by poverty, social condition of being a prisoner, refugee or being infected by HIV/AIDS etc.

The funding request includes a continuation of the funding that was included in R7 and will cover the same objective and SDAs /Activities, covered in R7. The funding requested will in priority order cover the following items:

a) Full Procurement of Second line anti - TB medicines, in line with the GLC recommendations

b) Partial procurement of First line anti-TB medicines, with a 20 % co-participation through domestic funding.

2. Risks: Size of disruptions of numbers denied essential services and potential impact on TB infections, quality of life and death

The funding of R7 will come to an end by June 2013 the supply of anti-TB medicines for regular TB and for MDR is not covered. Unless other funding sources will be found, it would mean that part of the regular 46.000 TB patients and all 200 MDR patients will have to discontinue their treatment. This will profoundly deleterious effect on the life of individuals receiving and need of TB treatment.

Secondly - Treatment interruption of both regular and resistant TB will fuel the MDR-epidemic and likely increase the already high incidence of MDR will further increase.

Additionally, an interruption of TB treatment will adversely affect mortality rates of the 24.000 PLWHA, co-infected with TB. TB among this group is major cause of death in Mozambican TB/HIV co-infected patients where 62% of the TB patients are co-infected with HIV, and a stock-out of TB drugs would have a profound implication on this population.

3. Proposed reprogramming:

Since there will be no more funding available after termination of R7, reprogramming is not applicable.

4. Outline of proposed TFM interventions for the Continuity of Services

The funding requested fully fits the criteria of the Continuity of Services (CoS) Policy that aims to continue courses of treatment (most of limited duration) when R7 grant ended.

4.2 TFM Request in the Context of a Consolidated Application

Skip if there are no existing grants that will be ongoing as of the start date of the TFM funding

a) Logframe for TFM request

Prepare a logframe in Microsoft Excel form in the template provided [Attachment D].

The logframe should provide an overview of the goal(s), objectives, service delivery areas (SDAs) and key activities in this TFM request, including the key indicators. Indicate the SDAs and key activities of existing grants to be included in this TFM request and note if they will be continued without change or decreased in scale. Wherever applicable provide the number of people supported by the current grant and the number of people who will continue to be supported through TFM. Also describe all SDAs and key activities. SDAs and key activities from existing grants that will be discontinued will be captured in table 4.2(b).

Develop a numbering system for organizing the goal(s) and linking the objectives, SDAs, and activities. Each goal, objective, SDA and activity should have a unique identifying number. This numbering system should be carried throughout the rest of the TFM request and should match the narrative description and the detailed budget and work plan.

This logframe should be used to present how you have reprogrammed existing funds to cover gaps in essential prevention, treatment and/or care programs.

b) Discontinued Activities

In the table below, list the SDAs and key activities of existing Global Fund grants which would be discontinued with approval of this consolidated TFM request in order to cover the most essential prevention treatment and care services. This table is *only* for SDAs and activities that have been *dropped*. Those which have been *modified* should go in the logframe.

→ ***For this question only:*** *applicants are requested to use the same numbering of SDAs and activities as in the previously approved grant(s).*

Discontinued SDAs and activities	Existing grants	Reason for Discontinuation
1. *[insert SDA]*	*[insert Grant #]*	
1.1 *[insert Activity]*	*[insert Grant #]*	
1.2 *[insert Activity]*	*[insert Grant #]*	
2. *[insert SDA]*	*[insert Grant #]*	
2.1 *[insert Activity]*	*[insert Grant #]*	
2.2 *[insert Activity]*	*[insert Grant #]*	
3. *[insert SDA]*	*[insert Grant #]*	

4.3 Ability to finance through reprogramming of existing Global Fund grants

Justify why the planned interventions described in 4.1 and 4.2 cannot be fully or partly addressed through reprogramming of existing Global Fund grants.

ONE PAGE MAXIMUM

Not applicable, since all GF funds will end by 30 June 2013.

4.4 Other Sources of Funding

Describe efforts made to find other funding sources to meet the potential gap in essential prevention, treatment and/or care programs currently financed by the Global Fund in the country. These sources may be from a) domestic resources or b) other donors.

Domestic sources:

The Ministry of Health, assisted by the pooled funding mechanisms from external partners (Pro-Saúde) is procuring the bulk of its medicines through existing mechanisms. The Mozambique National Health Service is financed by public domestic and external funds (on budget). About half of the recurrent expenditure is financed by external funds. The health budget increased from a level of 317 (in 2007) to 474 (in 2010) million USD. The proportion of the state budget also raised from 11.6 % in 2007 to 12.7% in 2010, but included in this state budget are the external contributions to the domestic budget, channeled through the Ministry of Finance (on-budget).

Counting on the availability of R 7 funding in the previous years, the Ministry of Health did not include anti TB medicines in its budget for pharmaceuticals till 2012. The needs for 2010 were covered by GDF and Rd 2. Those for 2011 were covered by MISAU, GDF, UNITAID and 2012 will be covered by MISAU and Rd 7 ph 2.

Faced with the situation that R7 funding for anti TB medicines will come to an end by mid 2013, the Ministry of Health committed itself to earmark the purchase of anti-TB medicines for an annual amount of USD 500.000 in its budget for medicines from 2013 onwards. This was endorsed by the Health Partners Group in March 2012. A letter of commitment was also submitted from the MoH to the CCM.

Other donors

The major donor directly assisting the NTP is United States Government (USG) via USAID and PEPFAR supporting mainly TB/HIV activities for adults and children at all levels. The implementing clinical partners (Columbia University/ICAP; Vanderbilt University/Friends in Global Health; CARE; Elizabeth Glaser Pediatric AIDS Foundation (EGPAF); ABT Associates-CHASS SMT ; Family Health International (FHI))-CHASS Niassa, Centro de Colaboração em Saúde (CCS) and Ariel covering all 11 provinces in Mozambique to provide a minimum package of TB/HIV services. Through TBCARE I and CDC inputs, community TB care interventions are currently being supported in 36 districts of Mozambique, aiming to reach 45 in the 2012 and 60 in 2013, representing country's coverage of above 60% in terms of population. This includes supporting core TB/HIV activities (PITC for TB patients at TB service, CPT to TB/HIV co-infected patients and referrals to HIV care & treatment as well as strengthening the 3 I's: ICF, IPT,TB IC and MDR-TB management.

The TBCARE I will assist to increase utilization of client oriented health services by strengthening effective linkages between different health services and referral systems. It will support TB screening, contact tracing, pediatric management of TB, MDR-TB case management and the continuum of TB and HIV/AIDS coordinating activities and strengthen laboratory diagnosis of TB and MDR-TB, Malaria, and assisting the National Tuberculosis Program to coordinate effective support from various stakeholders, including in improving human and institutional capacity. As a result TB CARE I will contribute to increase the access of services by expanding and strengthening CB-DOTS from 45 to 60 districts and assisting the development of ACSM and PMDT strategies and its implementation, increasing of the number of children under 5 years old diagnosed with active or latent TB, the expansion and quality of the TB laboratory diagnosis, TB Culture and DST, including of the M&E and TB research. With the support of TBCARE I a TB KAP survey will be conducted in Mozambique from July to September.

As part of the PEPFAR program, The Centers for Disease Control and Prevention (CDC), through their partners the Federal University for Rio de Janeiro (FURJ), The American Society for Microbiology

(ASM) and The Association for Public Health laboratories (APHL) are providing support for to strengthen TB laboratory services including the implementation of an electronic Laboratory Information System (LIS) in the NRL. CDC itself is providing technical assistance to the central level and laboratories with some funding activities at central level. Additionally, the International Association of National Public Health Institutes (IANPHI) for the establishment of a National Public Health Institute that will bring together all national reference laboratories. ASM will support the strengthening of the National Smear Microscopy External Quality Assessment (EQA) program (blind-rechecking of slides), including expansion of the program to include proficiency testing (PT) panels. JHPIEGO, affiliated to Johns Hopkins University is providing TA to central level, mainly related to Infection Control and is funding activities at central level. USG partners are also providing assistance on advocacy, communication and social mobilization (ACSM) to increase TB and HIV/TB literacy amongst the general population.

MSF is providing support to the training of laboratory staff in Gene X-pert's operation in Maputo and Tete provinces.

GTM, The Grupo de Trabalho de Medicamentos- Medicines Working Group - was created in 2006 under the auspices of the SWAp to support the Ministry and Donor partners to monitor the use of PROSAUDE funds for the procurement and distribution of medicines and other commodities, as well as to facilitate the resolution of problems and obstacles that affect the planning, distribution and procurement of medicines using PROSAUDE funds.

SECTION 5: MONITORING AND EVALUATION

5.1 Performance Framework

All applicants must complete a performance framework (Attachment A) which reflects the targeted outcomes of all of the interventions proposed in section 4.1 and 4.2. Ensure that the indicators in the performance framework are linked to those developed in 4.1 and 4.2 b). For detailed guidance on how to complete the performance framework, refer to the guidelines and instructions in the attachment.

Clarified section 5.2 (a)

5.2 (a) Impact and Outcome Measurement					
Describe all planned future surveys, surveillance activities and routine data collection in country that are being used (or will be used) to measure impact and outcome indicators relevant to this proposal. Add rows and change the "Years of Implementation" as needed. Given that the scope of activities funded under the TFM is limited, applicants are strongly encouraged to seek alternate sources of funding (domestic and non-Global Fund) for surveys, surveillance and other data collection that are not routine.					
Impact/Outcome Indicators relevant to the proposal	Year of last data collection	Method of Data Collection/ Data Source	Funding	Years of Implementation	
				Year 1	Year 2
Notification rate of all forms of TB cases (per 100,000 population)	2011	*Routine reporting system*	Total cost	WHO	WHO
			Secured funding amount and funding source	Not calculated	Not calculated
			TFM funding request for routine data collection Source 1	State Budget	State Budget
Treatment success rate, new smear positive TB cases Default Rate, new smear positive TB cases	2011	*Routine reporting system*	Total cost	0	0
			Secured funding amount and funding source	Not calculated	Not calculated
			TFM funding request for routine data collection Source 2	State Budget	State Budget
Treatment success rate, patients with laboratory-confirmed MDR-TB	2011	*Routine reporting system*	Total cost	0	0
			Secured funding amount and funding source	Not calculated	Not calculated
			TFM funding request for routine data collection Source 3	State Budget	State Budget

Clarified section 5.2 (b)

5.2 (b) Program Evaluations (preparing for the Global Fund Periodic Review)

Please describe the arrangements that will be put in place to conduct the program and impact evaluation, including whether an existing national review will be used or whether an ad hoc evaluation will be conducted. In your response, please describe:

(a) what methodology will be used;

(b) the roles and responsibilities of the key stakeholders who will be involved; and

(c) planned timelines for data collection.

The NTP is currently finalizing the draft for the next Strategic Plan (years 2013-2017). The Plan includes an external mid-term review of the strategic plan to be conducted in year 2015 and to be coordinated and lead by WHO with other health partners with the following terms of reference:

1. To evaluate progress made in TB Control since an earlier external programme review carried out in 2010
2. To evaluate the strengths and weaknesses of the general management of the TB Programme with focus on the following:

i. Implementation of institutional and community DOTS expansion to improve NTP
ii. Performance indicators
iii. Monitoring and Evaluation system
iv. Multi-Drug Resistant TB (MDR-TB)
v. Drug management
vi. Laboratory services and management
vii. TB/HIV activities
viii. Capacity to absorb TB Control funding from various sources, including existing GFATM grant(s)
ix. Effectiveness of coordination mechanisms of partners involved in TB Control

The team of the last review conducted in year 2010 was made up of external reviewers drawn from WHO-AFRO IST-ESA, WHO Headquarters, Kenya and Zambia WHO Country Offices, the Dutch TB Association (KNCV) of the Netherlands, and the United States Centres for Disease prevention and Control (CDC). Local experts were drawn from international and local non-governmental organizations within the country. Four teams of at least two external reviewers and up to six internal review facilitators / resource persons were deployed to all the provinces in

the country. The status of achievement of the elements of the Stop TB Strategy as captured in the medium term plan, and the recommendations of the 2006 external review constituted the benchmarks against which assessment was made. In each province, at least two purposely selected districts were sampled and in each selected district, the main public hospital and a number of health facilities selected to represent the hierarchy of health facilities in the country as well as rural/urban divide were visited and reviewed. Management and selected health workers and at least two patients, one male and one female were interviewed to ascertain management, health worker and client perspectives on the areas under review. For ACSM purposes, selected community DOTS groups and patients were interviewed. Interviews and consultation were also held with policy makers in various health and health related ministries as well as with Management and staff of key international organisations, and major nongovernmental organisations and development partners active in TB and TB/HIV control in the country.

The full Report of an external mid-term review of the National Tuberculosis Control Programme Strategic Plan 2008-2012 (March 2010) is attached for your reference.

SECTION 6: PHARMACEUTICAL AND OTHER HEALTH PRODUCTS

If this TFM request seeks funding for any pharmaceutical and/or health products please fill out sections 6.1-6.3

6.1 Management of Pharmaceutical and Health Product Activities

(a) Identify the organizations that will be responsible for the management of each of the following key functions in relation to this TFM request and describe their past management experience.

Function	Name of the organization(s) responsible for this function	Short description of management experience
Procurement policies, and systems	MoH (CMAM & UGEA), Global Fund (GDF), other procurement agent	CMAM mainly uses the public tender system, which is open to national and international bidders. Bidders are obliged to offer ARVs, ACTs and anti-tuberculosis pre-qualified by WHO. All other pharmaceuticals procured by CMAM should follow the guidelines of the Pharmaceutical Department. For TB health products, the NTP with CMAM start the estimation of needs for coming year, then needs are submitted to the GDF which lunches procurement process in collaboration with the CMAM, Pharmaceutical department , NTP and Medimoc. GDF organizes yearly M& E and TA missions to country. All anti TB drugs are expected to be procured via GDF in 2011-2013
Procurement planning	PNCT, CMAM, UGEA, GF (GDF), Procurement Agent	The Procurement Planning is based on expected patients, forecasted consumptions and gap analysis based on the Supply Plan Shipments to maintain the full supply (max 12–min 9) with buffer stocks. The plan shows the expected arrival dates, names of suppliers, quantity and price of each product
Forecasting	CMAM, PNCT, PMU (DPC), GDF	The initial forecast for first –line anti-TB drugs is done centrally by the specialists of the National Tuberculosis Control program with the support of the WHO and is based on the case notification method and drugs are estimated based on the GDF tool. For 1st line drugs, usually 100% buffer stock is taken into consideration. The estimation of second-line drugs is performed based on the tool of the Green Light committee and the buffer stock does not exceed 10%. The estimation of needs for paediatric drugs is performed by using the GDF/WHO tool and 20% buffer stock is taken into consideration. The estimation of all TB drugs is done taking into the consideration the current stock level in the country.

Product selection	PNCT, CMAM, GF (GDF), Procurement Agent	International Nonproprietary Name (INN) is used in all documents. The National list of anti TB drugs are in the Standard Guideline and based on the WHO Essential Drug List.
Coordination of the supply chain	CMAM, PNCT, PMU (DPC), GF (GDF)	Mozambique has enjoyed support to the procurement of medicines and medical supplies over the years through the sector wide approach (SWAp) framework. There is a joint planning process (PNCT, WHO and World Bank) which makes coordination easy and avoids overlap in partner procurements and shares information on what commodities are being procured, the quantities and shipment schedule.
Management Information Systems	DIS/DPS/DDS, PNCT, PMU (DPC)	HMIS: Health workers have been trained to collect information that is needed at different health sites. Information on procurement values is gathered by the logistics department, using national policy. Inventory values, the number of people treated, number of deliveries, number of patients cured, number of new infections etc, is collected through registry books in health facilities LMIS: The DPMs are moving from a paper based management system to computerized systems, all the 10 existing DPMs are using the SIMAM and improving the existing data. The Central level starts to have data to manage HIV, Malaria and other essential drugs. The literacy to use a computerized system to manage medicines is increasing
Inventory management (including storage arrangements)	PNCT, CMAM, CA	The storage of medicines and related products is done through two central warehouses, one in Maputo for the southern and northern regions and the other in Beira for the central region. The majority of 128 districts have benefited from support from different partners but still the conditions of the provincial and district warehouses range from excellent to poor, and some of them need renovation.
Distribution	CMAM, CA, PNCT, DPS	The public health system has around 1,300 health facilities each of which receives TB pharmaceuticals and supplies through via clássica. The distribution of commodities covers the entire public health sector in the country: all 10 provinces, including the central, general and military hospitals. Challenges include availability of transport and meeting increasing fuel costs at the lower levels. This affects the delivery system, either due to scarcity of vehicles (as well as maintenance and spare parts), breakdowns or lack of fuel provisions for the efficient flow of deliveries. Long distances and the poor road network, especially during the rainy season where there is a lot of flooding are some of the operational challenges encountered in the distribution process.
Quality control	MoH (LNCQM, CMAM, Pharmaceutical Department), WHO, GF (GDF)	The LNCQM has prepared a five-year strategic plan (2009–2014) to become ISO 17025 accredited, which need to be formally approved

		by the MOH. PQM, in conjunction with SPS will review the plan with the PD and LNCQM to ensure that the roles and responsibilities of each technical assistance partner are clearly defined. The plan will also take into account the technical assistance being provided by ANVISA (Brazil's MRA) to avoid duplication of efforts. The PQM technical assistance component will focus on five critical areas: a. Infrastructure—Layout of current installations and of potential new lab; b. Equipment—Procurement, proper installation, maintenance, and use; c. Technical Training—Performing analysis according to compendial standards (USP, BP, EP, IP, etc.); and, d. Quality Management System (QMS)—Establishing a QMS that is compliant with ISO/IEC 17025:2005 and WHO GPPQCL. PQM and SPS will coordinate to establish a step-wise strategy for strengthening the capacity of the LNCQM with the ultimate goal of becoming ISO 17025 accredited and WHO prequalified.
Ensuring rational use and patient safety	PNCT, CMAM, PD, DNSP	implemented an Essential Drugs Program (EDP) backed by a National Drug Policy in order to improve rational drug use in the public and private sectors. This initiative involves on-the-job training and promotion of rational use of drugs, especially involving the integration of vertical programs. EDP manuals were produced and disseminated. The National Drug Policy and its applications, (the National Formulary, Kits distribution system, treatment guidelines) and the EDP have contributed to satisfactory standards of drug prescription. The National Formulary basically restricts practitioners in the public sector to confine themselves to the use of approved medicines. Treatment guidelines for different conditions have been developed and staffs continue to be trained and supervised in their use

(b) Describe how the TFM request uses country systems for pharmaceutical and health products management (PHPM) in compliance with national policies and regulations and the Global Fund policies on PHPM.

Identify any programmatic gaps with the existing supply chain and the proposed strategies to address these gaps.

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The initial forecast for first –line anti-TB drugs is done centrally by the specialists of the National Tuberculosis Control program with the support of the WHO and is based on the case notification method and drugs are estimated based on the GDF tool. For 1st line drugs, usually 100% buffer stock is taken into consideration. The estimation of second-line drugs is performed based on the tool of the Green Light committee and the buffer stock does not exceed 10%. The estimation of needs for paediatric drugs is performed by using the GDF/WHO tool and 20% buffer stock is taken into consideration. The estimation of all TB drugs is done taking into the consideration the current stock level in the country. Currently, the TB drugs are introduced to the international pipeline tool which allows to follow-up the stock level of TB drugs at any time.
Quantification of needs for 1st line anti-TB drugs is based on the number of cases registered during the previous years, done according to the average of 3 previous years of TB cases. However, it was taken into consideration that the huge increase of number of cases in 2009 (14% increase) was due to the scaling up of the Community DOTS strategy and introduction of the intensified TB case finding activities among PLWH. Since it is not expected the new changes in case notification methods in coming years, the projection was made that the number of cases should increase by 7% per year.

Gaps:

The system as such is functioning reasonably well and there have been only few stock outs , mainly due to lack of predictability of funding and non-compliance with scheduled delivery of GDF

The Country received many international assessments among others Supply & Logistics Internal Control Evaluation .SLICE (Annex T15, and the Office of the Inspector General (OIG) from October – December 2012. (Annex T16) The quick assessment requested by the Minister of Health had come to the same conclusions of the PSM weaknesses (Annex T17). The country produced an action plan starting from 2012 to improve the logistics of health products. A strategic plan is being produced for implementation from next year. (Annex T18). A round 8 HSS phase 2 is being prepared to be submitted to the GF in order to strengthen the areas pinpointed by the OIG, in order to fill the gap in the PSM system strengthening.

(c) Describe the systems to be used to ensure rational use and patient safety

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The MOH and its partners have implemented an Essential Drugs Program (EDP) backed by a National Drug Policy in order to improve rational drug use in the public and private sectors. This initiative involves on-the-job training and promotion of rational use of drugs, especially involving the integration of vertical programs. EDP manuals were produced and disseminated. The National Drug Policy and its applications, (the National Formulary, Kits distribution system, treatment guidelines) and the EDP have contributed to satisfactory standards of drug prescription. The National Formulary basically restricts practitioners in the public sector to confine themselves to the use of approved medicines. Treatment guidelines for different conditions have been developed and staff continues to be trained and supervised in their use.

6.2 Pharmaceutical and Health Products Required for continuation of essential prevention and treatment services

Complete the Pharmaceutical and Health Products List (Attachment B) and list all of the products that are requested to be funded through the TFM request.

ONE PAGE MAXIMUM

Anti TB medicines:
2FDC/RH 150/75 - Rifampicin 150 mg / Isoniazid 75 mg (H75, R150) /Alu film blister pack of 28 tablets x 24 blisters
3FDC/RHE 150/75/275 - Rifampicin 150 mg / Isionazid 75 mg / Ethambutol 275 mg film-coated tablets. PvC/Alu film blister pack of 28 tablets x 24 blisters
4FDC/RHZE 150/75/400/275 - Rifampicin 150 mg / Isoniazid 75 mg / Pyrazinamide 400 mg / Ethambutol 275mg (H75, R150, Z 400, E275) /Alu film blister pack of 28 tablets x 24 blisters
Streptomycin 1 g inj - Streptomycin 1 g powder for injection. 100 vials in a box
2FDC/RH 60/30 - Rifampicin 60 mg/Isionazid 30 mg dispersible tablets. PvC/Alu film blister pack of 28 tablets x 3 blisters
3FDC/RHZ 60/30/150 - Rifampicin 60 mg/ Isionazid 30 mg/ Pyrazinamide 150 mg dispersible tablets. PvC/Alu film blister pack of 28 tablets x 3 blisters
Ethambutol 100 mg - Ethambutol 100 mg dispersible tablets. PvC/Alu film blister pack of 10 tablets x 10 blisters
Isoniazid 100 mg - Isoniazid 100 mg dispersible tablets. PvC/Alu film blister pack of 10 tablets x 10 blisters
Capreomycin 1gr vial - Capreomycin 1 g powder for injection. 1 vial/ampoule in a carton box
Cycloserine 250 mg - Cycloserine 250mg hard capsules. Alu/Alu strip pack of 10 capsules x 10 blisters in a carton box
Ethambutol 400 mg - Ethambutol 400mg film-coated tablets. PvC/Alu film blister pack of 28 tablets x 24 blisters
Ethionamide 250 mg - Ethionamide 250mg film-coated tablets. PvC/Alu and Alu/Alu strips of 10 tablets x 10 blisters in a carton box
Kanamycin 1gr vial - Kanamycin 1 g solution for injection (4 ml). 10 vials/ampoules in a carton box
Levofloxacin 250 mg tabs - Levofloxacin 250mg film-coated tablets. PvC/Alu film blister pack of 100 tablets
PAS Acid (sachets) - P-aminosalycilic acid (PAS) 4 g enteric coated delayed-release granules in sachets. 30 Alu/PET/Alu/LLDPE sachets in a carton box
Pyrazinamide 400 mg tabs - Pyrazinamide 400mg film- uncoated tablets. Alu/PvC film blister pack of 28 tablets x 24 blisters
Isoniazid 100 mg
Isoniazid 300 mg - Isoniazid 300mg film-uncoated tablets. PvC/Alu film blister pack of 28 tablets x 24 blisters
Tuberculin, 2 Tu/0.1 ml, 1.5 ml, multidoses
Water for injection 5ml - Water for injection, sterile, 5 ml plastic ampoules. 100 ampoules in a box

Clarified section 6.3

6.3 Multi-drug Resistant Tuberculosis

Is the provision of treatment of multi-drug resistant tuberculosis included in this TB TFM request?	◉ Yes *→ include USD 50,000 per year over the full TFM request term to contribute to the costs of Green Light Committee Secretariat support services*
	○ No *→ do not include the Green Light Committee costs*

SECTION 7: FUNDING REQUEST

Clarified section 7.1

7.1 Financial Gap Analysis and Counterpart Financing Calculation

Instructions for completion of the financial gap analysis and counterpart financing table

→ For guidance on how to complete the financial gap analysis and counterpart financing table refer to Section 7.1 of the guidelines and the detailed instructions included in the Excel template. The financial gap analysis and counterpart financing table is available as a separate tab in the Global Fund budget template (Attachment E). For those that do not use the Global Fund budget template, it is available in the separate Excel file along with the mandatory summary budget tables (Attachment F). Applicants only need to complete Attachment E or Attachment F, but not both.

CCM and Sub-CCM applicants must prepare and submit the financial gap analysis and counterpart financing table in Microsoft Excel format. They must also complete sections 7.2 to 7.4. **Non-CCM applicants and multi-country applicants** are not required to complete the financial gap analysis or the counterpart financing table nor Sections 7.2 to 7.4.

(a) Has the financial gap analysis and counterpart financing table been submitted in Microsoft Excel format?	☐ Yes ☐ No

(b) To better contextualize and assess financial data provided in the TFM request, applicants are required to:

1. Provide an overview of the composition of government contribution to the national program; Please specify the levels of government (central, regional, local) that incur spending on the disease programs and the major agencies through which government funds are spent. Elaborate on the availability of earmarked budget line-items to capture government disease spending and the extent to which these budget line-items capture total government spending on the disease program.
2. Indicate whether amounts forecast from each source for the years 2013 to 2014 are an estimation or commitment

1. The Ministry of Health receives contributions through the ProSaude common fund of donors, which is treated much like the state budget. The funds are channeled through the national system and support the MOH's national operations plan (Plano Económico Social or PES). The MOH is conscious of the need to contribute to the TB program as a part of the requirements for the TFM. Senior ministry leadership has agreed on the need to include funding for anti-TB medicines and lab. consumables during the planning and budgeting period for the years in question. There is currently a commitment from the Ministry to contribute $473,578 and $543,832 from the State Budget toward the purchase of essential medicines for TB in the TFM grant years (see Annex 1a in Annex T24). Similarly, the Ministry has committed to purchasing essential TB medicines for the period 01-July-12 - 31-Jun-13 to the sum of $419,184. A letter of commitment was submitted by the MoH to the CCM (Annex T20) - Global Fund's R7 Phase II will also be supporting the period of 01-July-12 to 31-Jun-13.

   Although system strengthening measures are currently being taken, the MOH is currently unable to track expenditures by disease program. However, by comparing the current expenditures budget to the MTEF report's funding estimates for TB, one can see that the TB program represented 2.4%, 2.7%, and 1.9% for years 2010, 2011, and 2012, respectively (…).The table below illustrates the distribution of the 2012 current expenditures budget by geography and implementing agency within the national system. One may assume that the TB program incurs its expenses in a similar distribution.

Geography/Type	2012 Current Expenditure Budget (USD)	%
Geography	**276,876,197**	**100%**
Central Level	115,315,979	42%
Provincial Level	95,168,203	34%
District Level	66,392,014	24%
Agency	**276,876,197**	**100%**
MOH Central	114,373,730	41%
Provincial Directorates	63,190,481	23%
Health Centers	11,706,814	4%
Genl/Prov Hospitals	21,213,157	8%
District Directorates	66,392,014	24%

2. The values in the Financial Gap Analysis represent estimates. Official planning and budgeting is done on an annual basis. The Global Fund data represent R7 Phase II funding for 2012 and 2013, the Grant Agreement that was signed on the 13th March 2012.

Clarified section 7.2

7.2 Estimation of Current and Anticipated Domestic and External Funding

→ Corresponds to LINES B and C in the financial gap analysis and counterpart financing table.

Describe how contributions from various sources of funds were estimated, including reference to:

(a) methodology for estimating current and anticipated funding;

(b) Composition of reported government spending (part or all of government spending; programmatic costs alone or includes apportioned health system costs; recurrent costs alone or includes capital costs);

(c) Whether amounts contributed by each source for the current and previous years pertain to budget, disbursement, expenditure or an estimate of spending;

(d) Whether amounts forecast from each source for the future years pertain to estimation or commitment.

(a) Methodology

The Health Financing Working group recently finalized a health financing review[3] . The Health Financing Working Group (FWG) is composed of representatives of the health partners (ProSaude, USAID, and others) and the Ministry of Health with occasional participation from other relevant public sector institutions such as the Ministry of Finance and Mozambique's Inspector General. The Group aims to get a better insight into budget, expenditure at various levels and by specific area, such as communicable diseases and maternal and child health. It also serves a monitoring function, overseeing system strengthening action plans and ensuring regular audits occur (…). Official budget and expenditure reports are not disaggregated by disease program at this time, but there are ongoing system strengthening efforts with the Admin and Finance Directorate at the MOH to allow for program-level coding of expenditures. A table of these data can be found in section 7.3. For the total sector contributions, we used actual budgets for 2010-2012 and the MTEF draft 4/April/2012 for years 2013-2015.

A second source of information for disease-specific estimates is the synthesis report of the MTEF on the spending on the three diseases, conducted in 2010. Based on program objectives and targets, it forecasts financial sources and a financial gap analysis, conducted by WHO[4]. A table with these

[3] Revisao do Sector da Saude – Area de financiamento - final draft December 2011

4 Malária, HIV/SIDA e Tuberculose, Cenário Fiscal de médio Prazo, 2010-2012, Relatório Síntese4- Artur Gobe,

data can be found in section 7.3. The data from the MTEF Report were combined with updated funding information from the World Bank's line of credit as well as commitments from the Ministry of Health for the purchase of essential TB medicines for the period of July 2012 – June 2015.

The MOH follows an annual program planning process (PES) where the TB program develops a semi-costed activity plan. Not all TB program funding for the country are included in this process for various reasons. The updated MTEF table in section 7.3 represents all known sources of funding specific to the TB program although some other budgets – such as capital expenditures and indirect costs – almost certainly benefit the TB program. However, these latter sources are not included in the TB program funding estimates. The MOH hopes to align GF grants with the PES process in the near future.

(b) Composition of reported government spending on TB

As previously mentioned, data on past expenditures are not available by disease program. However, the MTEF study from 2009 estimates the needs for 2010-2012 at that time to be USD 995,083 annually. The additional USD 1 million in 2012 is from a World Bank line of credit for TB laboratory consumables. The USD $473,578 and $543,832 in 2013-2015 represent a commitment from the MOH's senior leadership to contribute to the purchase of essential medicines for TB. The table containing these details can be found in section 7.3 as well as the Financial Gap Analysis. These estimates are recurrent costs and do not include capital expenditures or other indirect costs that likely benefit the TB program.

(c) and (d) Budget, disbursement, expenditure or an estimate of spending;

Data from the sector-wide contributions of partners and the government are actual budgets for years 2010-2012 and can be further explored in Sheet2 of the Financial Gap Analysis. MTEF data were used to estimate 2013-2014 budgets. The MTEF data table represents estimates in funding needs and probable sources from 2010-2015.

Clarified section 7.3

7.3 Compliance with the Counterpart Financing Requirements

Describe whether the counterpart financing requirements listed below have been met. If not, provide justifications which include actions planned during implementation to reach compliance.

(a) Minimum threshold for counterpart financing
→ Percentage in Line M of the financial gap analysis and counterpart financing table must be greater than or equal to the minimum threshold that applies to the applicant's income level (refer to the Global Fund Eligibility List for 2012 Funding Channels)

(b) Increasing government contribution to national disease program over the TFM request term
→ Figures in Line B of the financial gap analysis and counterpart financing table must increase over time

(c) Increasing government contribution to the overall health sector over the TFM request term
→ Figures in Line I of the financial gap analysis and counterpart financing table must increase over time

(a) Minimum threshold

The minimum threshold for MOH financing is 5% according to the Global Fund Eligibility List for 2012. Although the contributions to the national TB programme are not specified in the integrated general expenditure, costs of salaries of all general health staff and those working for the NTCP are covered by domestic funding. In addition to that the government pays all other recurrent costs of running the TB services in all health facilities and laboratories. By utilizing the MTEF Report and updated funding data, the TB program is estimated to be at least 2% of recurrent health costs. However, a significant portion of capital investments and indirect costs are most certainly attributable to the TB program, but cannot be identified as such using the existing financial management systems. The recent commitment for an annual contributions of $473,578 and $543,832 will augment this percentage. The Financial Gap Analysis estimates **25%** in counterpart financing.

(b) Increasing government contribution to TB

The following table represents the aforementioned MTEF research completed in 2009. Some updates have been made to this table based on new information. These updates are discussed in

the subsequent paragraph. Specific information of the medium term expenditure on the TB program and availability of the different sources gives the following picture. Note that the TFM grant years correspond to 2014-2015 in the table below. Year 2012 Global Fund values match those in Round 7 Phase II for TB.

Available Funding Estimates for TB Program****

	Estimated Funding Availability (USD)					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
State Budget	995,083	995,083	1,995,083	1,414,266	1,468,662	1,538,915
Global Fund	4,179,952	4,780,893	2,513,344	6,070,435	4,064,438	4,506,713
Other External Partners	3,547,734	847,734	847,733	5,434,211	5,434,211	5,434,211
Total	**8,722,769**	**6,623,710**	**5,356,160**	**12,918,912**	**10,967,311**	**11,479,839**

The figures given in 2010 and 2011 are estimated needs from the MTEF of 2009, based on the WHO budgeting tool for TB. Those provided for the years thereafter are expected allocations.

Regarding the state budget –They are annually agreed upon with the Ministry of Finance through the planning cycle and as mentioned earlier due to the existence of R7, the state budget did not included a line for anti TB medicines. The state budget for 2012 will include one million USD one-time funding for lab consumables using a line of credit from the World Bank. From 2013-2015 the State budget will include $995,083 per the MTEF report plus funding for the purchase of essential TB medicines: $419,184, $473,578 and $543,832, respectively. For the purposes of this analysis, the annual funding estimates from the MTEF of $995,083 were used for these years as well. Note that the state budget contribution commitments for the final R7 TB and TFM years of 2013-2015 increase from $1,414,266 to $1,538,915 or 9%.

The contributions of the Global Fund are provisional and depending on approval of the TFM application. The funding from the other partners is to a great extent coming through the TBCARE I mechanism at a level of roughly US $ 5 million annually. The contribution of the other TB partners, previously mentioned in section 4.4 is not included, since it was not quantifiable. Due to expected contributions from the Global Fund's TFM, TB Care I, and the World Bank line of credit, the government's contribution will drop slightly between 2012 and 2013, but will remain high vis-à-vis prior years.

(c) Increasing government contribution to the overall health sector

The Table in Sheet2 of the Financial Gap Analysis includes data from the MOH's Department of Planning and represents actual approved budgets for 2009-2012. It demonstrates a continual increase in government commitments to the health sector over this time, including a 50% nominal increase in 2012. Underlying details and assumptions related to these data can be found in the Sheet2 worksheet in the Financial Gap Analysis workbook. The estimated increase in funding contributions from the government, according to the draft MTEF for April 2012, illustrates an increase of 30% between 2012 and 2015 (51%, 20%, and 19% for 2013, 2014, 2015, respectively). These details can be viewed in Sheet2 of the Financial Gap Analysis.

Funding Source	2009	2010		2011		2012 - Indicative Limits	
	Amt	Amt	Nom Change	Amt	Nom. Change	Amt	Nom. Change
State Budget	**138,142,892**	**149,466,216**	**8%**	**154,107,881**	**3%**	**207,079,693**	**50%**
Recurrent Expenditures	*128,491,181*	*136,410,541*	*6%*	*142,345,404*	*4%*	*185,297,615*	*45%*
Capital Investments	*9,651,711*	*13,055,675*	*35%*	*11,762,477*	*-10%*	*21,782,078*	*107%*
Prosaude Global	**87,036,387**	**86,125,367**	**-1%**	**107,471,893**	**25%**	**91,578,581**	**-5%**
PROSAUDE - Central	*61,672,092*	*60,131,044*	*-2%*	*81,477,570*	*36%*	*62,600,578*	*-14%*
PROSAUDE - Provincial	*25,364,295*	*25,994,323*	*2%*	*25,994,323*	*0%*	*28,978,004*	*24%*
Sub Total	**225,179,278**	**235,591,583**	**19%**	**261,579,774**	***11%***	**298,658,274**	***14%***
Vertical Funding	**30,319,648**	**39,604,299**	**31%**	**16,162,118**	**-59%**	**11,375,759**	**-21%**
On Budget	*30,319,648*	*39,604,299*	*31%*	*16,162,118*	*-59%*	*11,375,759*	*-21%*
TOTAL in USD	**255,498,927**	**275,195,881**		**277,741,892**	**1%**	**310,034,033**	**12%**

The government of Mozambique is aware of the need to allocate more resources to social sectors. So far about 65% of approved State budget is allocated to Education, Health, Water, sanitation and social affairs. Even not being on track with the regards to 15% allocation of domestic funds for the

Health sector. Mozambique is among the countries making progress towards the AU target, with health's share growing between 2000 and 2009.[5]

How much the government will contribute to the health sector for the period 2013-2015 is currently unknown, but the contribution of the government, will likely increase if recent years remain indicative.

Clarified section 7.4

7.4 Financial Gap and Counterpart Financing Data Sources

(a) Describe the sources used to complete the financial gap analysis and counterpart financing table;

(b) Provide an assessment of the completeness and reliability of financial data reported; and highlight any assumptions and caveats associated with the figures.

(c) Provide details of how the country plans to improve data quality consistent with the guidelines for reporting of program financial data to technical partners; and

(d) If applicable, state if the TFM request includes a request for Global Fund support for an expenditure tracking study and/or measures to strengthen financial data collection and reporting data during the first reporting period

Applicants may request up to USD 50,000 for an expenditure tracking study in the first implementation period. This must be included in the detailed budget.

(a) Per section 7.1, the primary sources for Part I of the Financial Gap Analysis are the MTEF Report and more recent updates related to Global Fund's R7 Phase II. Part II was completed using official MOH budgets from 2009-2012 which were provided by the Department of Planning. For years 2013-2015, the MTEF draft from April 2012 was utilized to estimate expected funding for the sector. The team flat-funded years 2013-2015 for ProSaude (common fund of partners) and vertical contributors due to lack of concrete information indicating changes in sector-wide funding commitments.

(b) The amounts from Line D (existing Global Fund grants) were signed March 13th, 2012 and represent commitments until they are disbursed by the GF Secretariat. With the exception of the actual budgets for the sector in years 2010-2012, all other data are estimates at this time. Future commitments from both the government and external sources may differ depending on many variables present during the planning cycle. The commitment levels are determined through the Ministry of Health's annual planning process and resulting report (Plano Económico Social or PES). PES reports from past years are available upon request. Note that the Financial Gap Analysis template utilizes the average of the three most recent years of counterpart financing to compare with the MoH's TFM request. Based on the TB program funding sources identified in the MTEF Report and more recent developments and commitments, the government of Mozambique contributed, at minimum, 25% vis-à-vis the TFM proposal in question.

(c) There is a significant effort in system strengthening for both supply chain and financial management. Action plans have been developed for both areas and there are many partners willing to support these efforts. Global Fund's R8 HSS grant will also support these areas, amongst others. We can expect to have better, more detailed financial expenditure data in out years due to these system strengthening efforts. Similarly, LMIS systems are expected to improve with the investments in system strengthening.

(d) There is no assessment planned with the TB TFM funding. Any assessments related to financial management will be paid with other funding.

[5] Abuja Declaration and Health MDG status indicators, Ten Years After Report

7.5 Detailed Budget and Work Plan

Instructions for completion of the detailed budget and work plan:

→ For guidance on the level of detail and required budget and work plan format (or for a template) refer to the Section 7.5 of the guidelines.

(a) Submit a detailed budget and work plan in Microsoft Excel format. Applicants are strongly encouraged to use the Global Fund budget template or the WHO budget tool. **However, note that TFM requests are only for up to two years of funding.** Applicants may use their own template; however the format in which the budget and work plan is presented must conform to those presented in the TFM request guidelines.

(b) Ensure that the detailed budget and work plan is consistent with the numbering system developed in the logframe and the performance framework.

(c) Do not include a request for CCM or Sub-CCM funding in this TFM request. Requests for funding are available through a separate application. The application is available at: http://www.theglobalfund.org/en/ccm/

(d) Funding duration is up to 2 years

7.6 Summary and Incremental Request Tables

Instructions for completion of the summary budgets:

→ For instructions on how to prepare the summary budgets (or for a template) refer to Section 7.6 of the guidelines.

As a tab in the Global Fund summary budget (Attachment E) or as Attachment F if not submitting the Global Fund summary budget:

(a) Prepare a summary table by objective and service delivery area.

(b) Prepare a summary table by cost category.

(c) Prepare a summary table by PR (where more than one PR is being proposed).

(d) Prepare a summary table which calculates the incremental (new) funding request. This is not necessary if there are no existing grants that will be ongoing as of the start date of the TFM funding

→ The totals of all of these tables should match exactly, and correspond with the totals in the detailed budget and work plan.

7.7 Compliance with Focus of TFM request Requirement

Describe whether the focus of TFM request requirements for the specific funding pool chosen have been met as listed below.

For the General Funding Pool:

a) LMICs must demonstrate that at least 50 percent of the TFM request incremental budget focuses on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context; and

b) UMICs must demonstrate that 100 percent of the TFM request incremental budget focuses on these populations and/or interventions.

For the Targeted Funding Pool, and regardless of the country's income level, applicants must demonstrate that 100% of the TFM request focuses on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context.

(a) According to the Global Fund eligibility list for 2012 funding channels, Mozambique's burden for TB is rated "severe." Moreover, the current financial commitments for the TFM grant years in question is insufficient to meet the needs of the country. The only planned funding for essential medicines is from the State Budget, meaning there is no external funding commitment for essential TB medicines. To alleviate this urgent situation, the Ministry of Health has requested funding for these products to combat this dreadful disease.

SECTION 8: MANAGEMENT STRATEGIES

8.1 Principal Recipient(s)

Describe the technical, managerial and financial capacities of each confirmed or nominated Principal Recipient (PR). All PRs that will be implementing the programs over the lifetime of this TFM request should be included here, whether or not this TFM request is requesting new funds for those PRs.

In the description for each PR: (a) indicate if there are any anticipated limitations to strong performance; (b) refer to any existing assessments of the PR(s); (c) if any existing PR(s) is being re-nominated, explain why; and (d) if a new PR is being nominated, explain why the new PR is a suitable choice e) How multiple PRs will coordinate with each other

→ Copy and paste tables below for each nominated Principal Recipient.

PR 1 Name	Ministry of Health / National Directorate for Planning and Cooperation	**Sector**	Government/Tuberculosis
Mailing address	Avenida Eduardo Mondlane , Nr 1008- C. Postal 264		
Telephone	258 21 42 97 04/ 43 08 14		
Fax	258 21 30 84 01		
E-mail address	cgonçalves@misau.gov.mz		
Does this PR currently manage Global Fund grants in this disease area?	(•) Yes ( ) No		

HALF PAGE MAXIMUM

8.2 Sub-recipients

List identified sub-recipients and describe:

- the number of sub-recipients identified;
- the work to be undertaken by each sub-recipient;
- past implementation experience of each sub-recipient;
- any challenges that could affect performance of each sub-recipient as well as a strategy to address these potential challenges; and
- how they will coordinate with PRs and each other

TWO PAGE MAXIMUM

DOCUMENT CHECKLIST

Clarified section

Section Reference	Mandatory Attachments	File Name
4.3(a)	Logframe (Attachment D) (Not necessary if there are no existing grants for the disease in the country which will be ongoing by the start date of this request)	
5.1	Performance Framework (Attachment A)	Annex T 21. Mozambique TB-TFM Performance Framework
6.2	Pharmaceutical and Health Products List (Attachment B)	Annex T24 TFM_TB_financial_gap_analusis V8
7.1	Financial Gap Analysis Table	Annex T23. TFM_TB_financial_gap_analusis V8
7.5	Detailed Budget and Work Plan	Annex T24 Work plan budget V07
7.6(a)	Summary Budget by Service Delivery Area (SDA)	Annex T24 Work plan budget V07
7.6(b)	Summary Budget by Cost Category	Annex T24 Work plan budget V07
7.6(c)	Summary Budget by Principal Recipient (PR)	Annex T24Work plan budget V07
7.6(d)	Calculation of incremental funding request (Not necessary if there are no existing grants for the disease in the country which will be ongoing by the start date of this request)	
Other documents relevant to section 3-8 attached by applicant		
	PSM Plan- Round 7 Phase II	Annex T 13 MOZ_PSM_TBround7.phase2.PSM
	GLC Mozambique Approval letter	Annex T14 Green Light Committee approval Moz2008
	SLICE Report	Annex T15. SLICE Mozambique Report Final

	Country Team Pre- Assessment- OIG	Annex T 16 Moz PSM Debrief OIG PPTs
	Data & Quality Audit Report	Annex T17 final_report_DQA_Mozambique _HIV+TB
	CMAM Action Plan- 2012	Annex T18 Plano Operacional CMAM v07
	Letter of commitment was submitted by the MoH to the CCM	**Annex T20. Letter of Commitment- MoH**

Performance Framework: Indicators, Targets and Periods Covered

final version 30th March 2012 v02

A. Program details

Country / Applicant:	CCM Mozambique	**Principal Recipients** *(Please select from list or add a new one)*	**PR1**	Ministry of Health of Mozambique
Component:	Tuberculosis		**PR2**	
Start Year:	2013		**PR3**	
Start Month:	July		**PR4**	
SSF/grant number:			**PR5**	

Reporting periods	**Period 1**	**Period 2**	**Period 3**	**Period 4**
Period Covered: from	1-Jul-13	1-Jan-14	1-Jul-14	1-Jan-15
Period Covered: to	31-Dec-13	30-Jun-14	31-Dec-14	30-Jun-15
Due date Progress Update	14-Feb-14	14-Aug-14	14-Feb-15	14-Aug-15
Disbursement Request (Y,N)	Y	Y	Y	Y

	Year 1	**Year 2**
Audit report due dates		

Due date periodic review	NA

B. Program goals and impact indicators

Goals:

1	To reduce the prevalence, morbidity and mortality due to tuberculosis in line with the Millennium Development Goal (MDG) by 2015

Linked to goal(s) #	**Impact indicator**	**Baseline**			**Targets**				**Comments**
		value	**Year**	**Source**	**Year 1**	**Report due date**	**Year 2**	**Report due date**	
					2013		**2014**		
1	TB mortality rate	49	2010	Global TB Report 2011			42	Global TB Report 2015	The target is aligned to MDG target of reducing TB mortality by 50% by 2015, against 1990 level of 84 per 100,000. The indicator reporting will be as per WHO Global TB Report estimates, and would be use to monitor progress towards MDG.

C. Program objectives and outcome indicators

Objectives:

1	To increase the detection and cure rate by expanding DOTS strategy
2	To Address TB/HIV, MDR-TB and Other Challenges

Linked to objective(s) #	**Outcome indicator**	**Baseline**			**Targets**				**Comments**
		value	**Year**	**Source**	**Year 1**	**Report due date**	**Year 2**	**Report due date**	
					2013		**2014**		
1	Notification rate of all forms of TB cases (per 100,000 population)	206	2011	TB Program Annual Report 2011	251	14-Feb-14	264	14-Feb-15	The Global Fund removed the CDR as an indicator for which targets should be set from its performance framework. In the fourth edition of the M&E TB Toolkit, the CDR has been replaced by the case notification rate, which can be directly measured and reported by all national TB programmes.
1	Treatment success rate, new smear positive TB cases	85%	2010	TB Program Annual Report 2011	85%	14-Feb-14	86%	14-Feb-15	Targets aligned with the latest QAD (PAF) March 2011. The numerator is the number of New smear-positive TB cases successfully treated (cured plus completed treatment) among the new smear-positive TB cases registered and assessed during n-1. The denominator is the number of BK+ cases assessed (not necessarily the same as notified).
1	Default Rate, new smear positive TB cases	4.2%	2010	TB Program Annual Report 2011	5%	14-Feb-14	5%	14-Feb-15	The numerator is the number of New smear-positive TB cases defaulted among the new smear-positive TB cases registered and assessed during n-1. The denominator is the number of BK+ cases assessed (not necessarily the same as notified).
2	Treatment success rate, patients with laboratory-confirmed MDR-TB	NA		Please select…	73%	14-Feb-14	75%	14-Feb-15	

D. Service delivery areas and output/coverage indicators

Objective & Indicator Number	Service Delivery Area	Output/coverage indicator	Final target previous implementation period			Latest available baseline/result				Targets								Target cumulation	Tied to	Top 10	Comments
										Period 5		Period 6		Period 7		Period 8					
			N #	%	Year	N #	%	Year	Source	1-Jul-13		1-Jan-14		1-Jul-14		1-Jan-15					
			D #			D #				31-Dec-13		30-Jun-14		31-Dec-14		30-Jun-15					
1.1	SDA 1.1 High Quality DOTS	TB cases (all forms) notified to the national health authorities during a specified period (number)	30,604		Jan-Jun 2013	47,452		2011	R&R TB system, quarterly reports	61,208		33,061		66,121		35,498		Annually	National program	Top 10	Targets alligned with WHO report used for drugs forecast. The cumulative annually refers to the calendar year (Jan-Dec)
1.2	SDA 1.1 High Quality DOTS	New smear-positive TB cases notified to the national health authority during a specified period (number)	12,890		Jan-Jun 2013	19,537		2011	R&R TB system, quarterly reports	25,779		13,982		27,963		14,951		Annually	National program	Top 10	Same as above
1.3	SDA 1.1 High Quality DOTS	New smear-positive TB cases successfully treated (cured plus completed treatment) among the new smear-positive TB cases registered during a specified period (number and percentage)	10,173 / 11,968	85.0%	Jan-Jun 2013	17,075 / 20,038	85.2%	2011	R&R TB system, quarterly reports	20,345 / 23,935	85.0%	10,956 / 12,890	85.0%	21,912 / 25,779	85.0%	12,024 / 13,982	86.0%	Annually	National program	Top 10	The cohort reported in each period corresponds to n-1. Targets calculated according to the success rate. The Performance Measure is the Percentage.
2.1	SDA 2.1 TB/HIV	TB patients who had an HIV test result recorded in the TB register among the total number of registered TB patients (number and percentage)	28,768 / 30,604	94.0%	Jan-Jun 2013	41,896 / 47,425	88.0%	2011	R&R TB system, quarterly reports	57,536 / 61,208	94.0%	31,407 / 33,061	95.0%	62,815 / 66,121	95.0%	34,078 / 35,498	96.0%	Annually	National program	Not top 10	Numerator: number of new TB patients registered during the reporting period who had and HIV test result recorded in the TB register. Denominator: Total number of new TB patients registered during the same period. All cases are included in the indicator (new, retreatment, children). Annual Targets (%) alligned with QAD Saude (March 2011).
2.2	SDA 2.1 TB/HIV	HIV-positive TB patients who receive at least one dose of cotrimoxazole preventive therapy during TB treatment among all HIV-positive TB patients registered over a given time period (number and percentage)	17,479 / 17,836	98.0%	Jan-Jun 2013	24,095 / 26,538	90.8%	2011	R&R TB system, quarterly reports	34,958 / 35,672	98.0%	19,083 / 19,473	98.0%	38,166 / 38,945	98.0%	20,917 / 21,128	99.0%	Annually	National program	Not top 10	Numerator: Number of HIV+ TB patients registered over a given time period who receive at least one dose of cotrimoxazole preventive therapy during their TB treatment. Denominator: Total number of new HIV+ TB patients registered over the same time period. The denominator was estimated considering that 62% of all TB cases with known HIV status are HIV+ .
2.3	SDA 2.1: TB/HIV	Proportion of HIV-positive registered TB patients given antiretroviral therapy during TB treatment (number and percentage)	16,052 / 17,836	90.0%	Jan-Jun 2013	7,661 / 26,538	28.9%	2011	R&R TB system, quarterly reports	32,104 / 35,672	90.0%	19,473 / 19,473	100.0%	38,945 / 38,945	100.0%	21,128 / 21,128	100.0%	Annually	National program	Top 10	Numerator: Number of HIV+ TB patients registered over the reporting period who receive ART (started). Denominator: Total number of HIV+ TB patients registered over the same reporting period. Denominator calculated according to the percentage of 62% of TB cases with known HIV status being HIV+. Following the newly introduced guidelines (Jan 2012), percentage targets are set as 90% (year 2013) in order to reach 100% in year 2014.
2.4	SDA 2.1: TB/HIV	Number and percentage of adults newly enrolled in HIV care who start treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults newly enrolled in HIV care over a given time period	18,158 / 181,577	10.0%	Jan-Jun 2013	17,064 / 222,253	7.7%	2011	HIV/ART Program	36,316 / 363,154	10.0%	24,840 / 206,998	12.0%	49,680 / 413,996	12.0%	33,750 / 225,000	15.0%	Annually	National program	Not top 10	Numerator: Total number of adults newly enrolled in HIV care who start (given at least one dose) treatment of latent TB infection over a given time period Denominator: Total number of adults newly enrolled in HIV care over a given time period (pre-TARV). The denominator for year 2015 shall be adjusted when the National HIV program will finalize the projections beyond year 2014.
2.5	SDA 2.1: TB/HIV	Percentage of adults and children enrolled in HIV care (pre-TARV and TARV) who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care (pre-TARV and TARV) in the reporting period		75.0%	Jan-Jun 2013		33.0%	July2008-June2009	CLINIQUAL		75.0%		80.0%		80.0%		85.0%	Annually	National program	Not top 10	Numerator: Number of adults and children enrolled in HIV care (pre-TARV and TARV) who had their TB status assessed and recorded during their last visit Denominator: Total number of adults and children enrolled in HIV care (pre-TARV and TARV) in the reporting period. Data Source will be CLINIQUAL. Targets alligned with the National Strategic Plan (PEN III)
2.7	SDA 2.2 Multidrug-resistant TB (MDR-TB)	Laboratory-confirmed MDR-TB cases enrolled on second-line anti-TB treatment during the specified period of assessment (number)	175		Jan-Jun 2013	144		2011	National Reference Laboratory, Maputo and Beira	350		175		350		175		Annually	National program	Top 10	Laboratory confirmed MDR-TB cases enrolled on second-line anti-TB treatment during the specified period of assessment. Targets alligned with drugs forecast.