1.1.1.1 Democratic Republic of the Congo

National Coordination Committee for the Global Fund for the fight against AIDS, Tuberculosis and Malaria

C C M – D R C

1.1.1.1.1 REQUEST FOR FINANCE

TO THE GLOBAL FUND FOR THE FIGHT AGAINST AIDS, TUBERCULOSIS AND MALARIA

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1.3 Kinshasa – August 2006


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List of abbreviations

ABD	African Development Bank
ACT	Artemesinin Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
AIDSPM	AIDS Patient Management
ARVs	Antiretrovirals
ARVs	Antiretroviral treatments
BDOM	Diocese Office for Health Works
BEA	Blood exposure accident management
CBC	Communication for Behavioral Change
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control
CDR	Regional Distribution Center
CIC	Interdenominational Council for AIDS Control
CNOS	National Council of Health related NGOs
CVS	Counseling and Voluntary Screening
DOTS	Directly Observed Treatment short Course
DRC	Democratic Republic of the Congo
DSA	Daily Subsistance Allowance
DSP	Directorate for Studies and Planning
EC	European Commission
FEDECAME	Federation of Supply Centers for Essential Drugs
FHA	Family Health Association
GF	Global Fund
GNP	Gross National Product
GRH	General Reference Hospital
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit Gmbh /international Services (IS)
HA	Health Area
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
ICDM	Integrated Child Disease Management
IDA	International Dispensiary Association
IFCOC	Initiative of the Countries lying along the Congo-Oubangui and Chari Rivers
IMA	Interchurch Medical Assistance
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
LFA	Local Fund Agent
LTITN	Long Term Insecticide Treated Net
M&E	Monitoring and Evaluation
MAP	Multicountry AIDS Programme
MDG	Millennium Development Goals
MDR	Multi Drug Resistance
MoU	Memorandum of Understanding
NCBT	National Center for Blood Transfusions
NEX	National Implementation
NGO	Non Government Organization
NHIS	National Health Information System
NMCAC	National Multisector Council for AIDS Control
NMPAC	National Multisector Program for Aids Control
NPAC	National Program for Aids Control
NPBT	National Program for Blood Transfusions
NPMC	National Program for Malaria Control
NPTC	National Program for Tuberculosis Control
OCEAC	Organization for Endemic Disease Control in Central Africa
OI	Opportunistic Infections
OIPM	Opportunistic Infections Patient Management
OVC	Orphans and other Vulnerable Children

PHC	Public Health College
PLH	Persons living with HIV/AIDS
PLH/AP	Psychosocial support for PLH and Persons Affected by HIV/AIDS.
PMTCT	Prevention of Mother-to-Child Transmission
PMURR	Emergency Multisector Program for Rehabilitation and Reconstruction
PNC	Prenatal Consultation
PO	Purchase Order
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Paper
PSC	Preschool Consultation
PSI	Population Service International
PSM	Procurement Supply Management
RBM	Roll Back Malaria
RGA	Revenue Generating Activities
RHCBT	Reference Hospital Center for Blood Transfusion
SECUTRANS	Transfusion safety
SR	Sub-Recipient
STD	Sexually Transmitted Diseases
TB/HIV+PM	TB/HIV+ Patient Management
TEC	Technical Evaluation Committee
UHC	University Hospital Center
UNAIDS	Joint United Nations Program on HIV/AIDS
UNC – CH	University of North California at Chapel Hill
UNFPA	United Nations Fund for Population
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USAID	US Development Agency
USD	US Dollar
WB	World Bank
WFP	World Food Program
WTO	World Trade Organization

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

PROPOSAL FORM

SIXTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Sixth Call for Proposals for grant funding. This Proposal Form should be used to submit proposals to the Global Fund. **Please read the accompanying Guidelines for Proposals carefully before filling out the Proposal Form**.

Timetable: Sixth Round

Deadline for submission of proposals: 3 August 2006
Board consideration of recommended proposals: 31 October - 3 November 2006

Resources available: Sixth Round

As of the date of the Sixth Call for Proposals, the funding available for this Call is forecast to be in the range of US$ 0 to US$ 565 million, depending mainly on the amount and timing of new pledges to the Global Fund. The amount forecast to be available will be updated on the Global Fund website.

Geneva, 5 May 2006

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ATTACHMENTS TO THE PROPOSAL FORM FOR COMPLETION BY APPLICANTS

A. Targets and Indicators Table (*Complete as separate table for each component)*

B. Preliminary Procurement List of Drugs and Health Products

A list of all annexes to be attached to the Proposal Form by the applicant can be found at the end of sections 3 and 5 the Proposal Form

OTHER REFERENCE DOCUMENTS FOR APPLICANTS

(These and other documents are available at http://www.theglobalfund.org/en/apply/call6/documents/)

Country Coordinating Mechanisms:	The Global Fund's Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility (**CCM Guidelines**)
Monitoring and Evaluation:	Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**)
Procurement and Supply Management:	The Global Fund's "Guide to Writing a Procurement and Supply Management Plan" (**PSM Guide**)

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Guidelines for Proposals (Sixth Call for Proposals)
   - A complete copy of this Proposal Form
   - The Attachments to this Proposal Form.

2. Please read the accompanying **Guidelines for Proposals** before filling out this Proposal Form.

3. For detailed information on how to use the electronic version of the Proposal Form, please see Attachment 4 to the Guidelines for Proposals.

4. In **this Proposal Form** further guidance for completing specific sections is also included in the Form itself, printed in *blue italics*. Where appropriate, indications are given as to the approximate length of the answer. Please try to respect these indications.

5. To **avoid duplication of effort**, we recommend you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

6. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are sending a fully completed proposal.

7. **Attach all documents** requested throughout the Proposal Form.

8. Consult our "Frequently Asked Questions" link: *http://www.theglobalfund.org/en/apply/call6/*

Please note that any information submitted to the Global Fund may be made publicly available.

WHAT IS DIFFERENT COMPARED TO ROUND 5?

The main difference compared to the Round 5 Proposal Form is that **Health Systems Strengthening** is no longer a separate component. It is important to recognize that applicants can still apply for funding for health systems strengthening activities by including such activities in the specific disease components.

In other respects the Round 6 Proposal Form is similar to the Round 5 Proposal Form, and changes have mainly been made for the purpose of improved clarity and presentation.

1 Proposal Overview

1.1 1.1 General information on proposal

Applicant name	CCM
Country	DEMOCRATIC REPUBLIC OF THE CONGO

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

- ☒ National Country Coordinating Mechanism
- ☐ Sub-national Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including small island developing states)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

Please tick the appropriate box or boxes below, to indicate components included within your proposal. Also specify the title for each proposal component chosen. For more information, please refer to the Guidelines for Proposals, section 1.1.

	Component	Title
☒	HIV/AIDS[1]	[Strengthening of national capacities for scaling up preventive action and general HIV/AIDS patient management]
☒	Tuberculosis[1]	Support to the strengthening and extension of the fight against tuberculosis in RDC]
☒	Malaria	Strengthening of the “Roll Back Malaria in DRC” initiative

Currency in which the Proposal is submitted

Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.

- ☒ US$
- ☐ Euro

1.1.1

[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the ‘WHO Interim policy on collaborative TB/HIV activities,’ available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Proposal Overview

1.2 1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding component budget in table 5.1.

Table 1.2 – Total funding summary

Component	Total funds requested (Euro / US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	23 077 198	19 043 621	26 005 766	28 834 586	33 579 049	130 540 049
Tuberculosis	5 964 063	2 568 574	1 206 798	1 130 910	1 227 825	12 098 170
Malaria	766 920	25 101 650	11 977 970			37 846 541
Total	23 844 118	19 043 621	26 005 766	29 P65 496	33 579 049	180 484 760

1.3 1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* in US$
HIV/AIDS	Round 3	113 646 453
Tuberculosis	Round 2 et Round 5	44 207 567
Malaria	Round 3	53 936 608
HSS/Other		

* *Aggregate all past grants, including approved but as yet unsigned amounts. These amounts should include Phase 2 where this has been approved/signed. For more detailed information, see the Guidelines for Proposals, section 1.3.*

2 Eligibility

Only those Proposals that meet the Global Fund's eligibility criteria will be reviewed by the Technical Review Panel.

Eligibility is a multi-step process that depends on the income level of the country (or countries) applying for funding and, in some cases, disease burden.

Please read through this section carefully and consult the Guidelines for Proposals, section 2, for further guidance on the steps to be followed by each applicant.

1.4 2.1 Technical eligibility

2.1.1 Country income level

*Please tick the appropriate box in the table below. **For proposals from multiple countries**, complete the referenced information separately for each country (see the Guidelines for Proposals, section 2.1).*

Country	Democratic Republic of the CONGO

☒	Low-income	➔ *Complete section 2.2 only*
☐	Lower-middle income	➔ *Complete sections 2.1.2, 2.1.3 and 2.2*
☐	Upper-middle income	➔ *Complete sections 2.1.2, 1.2.3, 2.1.4 and 2.2*

2 Eligibility

1.5 2.1.2 Counterpart financing and greater reliance on domestic resources

Please enter information on counterpart financing in table 2.1.2 below if the country(ies) listed above are classified as Lower-middle income or Upper-middle income.

Non-CCM Applicants do not have to fulfil the counterpart financing requirement.

The table should be filled in for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.1.2.

Important note: The field "Total requested from the Global Fund" in table 2.1.2 below should equal the request in section 5 and table 5.1 for each corresponding component.

Table 2.1.2 – Counterpart financing

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
HIV/AIDS	Total requested from the Global Fund (A) [from table 5.1]					
	Counterpart financing (B) [linked to the disease control program]					
	Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %					

2 Eligibility

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Tuberculosis	**Total requested** from the Global Fund (A) [from table 5.1]					
	Counterpart financing (B) [linked to the disease control program]					
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**					

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Malaria	**Total requested** from the Global Fund (A) [from table 5.1]					
	Counterpart financing (B) [linked to the disease control program]					
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**					

2 Eligibility

1.6 2.1.3 Focus on poor or vulnerable populations

*All proposals from Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or vulnerable population groups. Proposals may focus on both population groups but **must** focus on at least one of the two groups. Complete this section in respect of each component.*

1.6.1 Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal? *(Maximum half a page per component).*
1.6.2

1.7 2.1.4 High disease burden

Proposals from Upper-middle income countries must also demonstrate that they face a very high current disease burden. Please enter such information in the section below in respect of each component. Please note that if the applicant country falls under the "small island economy" lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Attachment 1 to the Guidelines for Proposals).

1.7.1 Confirm that the country(ies) is(are) facing a very high current disease burden, as evidenced by data from WHO and UNAIDS. *(Please see the Guidelines for Proposals, section 2.1.4 for more information on the definition of high disease burden.)*
1.7.2

1.8 2.2 Functioning of Coordinating Mechanism

To be eligible for funding, all applicants, other than Non-CCM Applicants and Regional Organizations must meet the Global Fund's minimum requirements for Coordinating Mechanisms.

For additional information regarding these requirements, see:

- *The Guidelines for Proposals, section 2.2 and*
- *The CCM Guidelines.*

Please note that your application must provide documentation to show how the applicant meets these minimum requirements. You will be asked to re-confirm this in the Checklist at the end of section 3.

1.8.1 2.2.1 Broad and inclusive membership
1.8.2 a) People living with and/or affected by the disease(s) 1.8.3 Provide evidence of membership of people living with and/or affected by the disease(s). (This may be done by demonstrating corresponding Coordinating Mechanism membership composition and endorsement in table 3B1.2, and 3B.1.3 in section 3B of the Proposal Form.)
The DRC CCM includes a representative of persons living with HIV/AIDS, Chairman of the NGO called "Congo network for persons living with HIV", RCP+ and a representative of persons affected by tuberculosis, and cured former sufferer of TB, Chairman of the NGO called "Friends of Damien Club". Malaria affects all the population of the DRC; all the members of the CCM are therefore considered as affected by this disease; no specific representative relating to malaria has therefore been considered.

2 Eligibility

b) Selection of non-governmental sector representatives

Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.

(Please summarize the process and, for each sector, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the appropriate annex number.)

The members of the CCM had been selected from the start by the different partners involved in the fight against the 3 diseases on the initiative of the Minister for Health, Chairman of the CCM.

For the transparency and formality of the procedure, the CCM required the non-government sector to officially nominate its representatives to the CCM. The relevant organizations then transmitted to the CCM the ad hoc documents relating to the nomination of their members established by their participatory management bodies with competence in the matter, in particular the Boards of Management for the NGOs. Annex C1 presents the nomination documentation for the members of the DRC CCM.

1.8.4 2.2.2 Documented procedures for the management of conflicts of interest

Where the Chair and/or Vice-Chair of the Coordinating Mechanism are from the same entity as the nominated Principal Recipient(s) in this proposal, describe and provide evidence of the applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest arising in regard to the applicant's operations or responsibilities.

(Please summarize and attach the policy as an annex. Please indicate the appropriate annex number.)

Among the principals for prevention of conflicts described in the CCM Procedures Manual in section 10.3, several provisions are proposed to prevent situations of conflict of interest between the Chair, the Vice-Chairs and the Principal Recipient (PR). We refer to the following, among others:

- All members of the CCM must declare any interest that may interfere with the fulfillment of their functions within the CCM, particularly in relation to studies, discussion or decision-taking relating to financial, administrative or programmatic (technical) provisions.
- The PR may not be a member of the CCM Office and cannot therefore fill the functions of Chair or Vice-Chair of the CCM. It may however participate in the meetings of this organ, upon invitation.

If an organization that is a member of the Office is nominated PR, it must give up its seat in the Office pursuant to the terms of the CCM Procedures Manual (Annex C2).

1.8.5 2.2.3 Documented and transparent processes of the Coordinating Mechanism

1.8.6 As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the CCM's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting where the CCM decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal.

Please describe and provide evidence of the CCM's documented, transparent and established:

1.8.7 **a) Process to solicit** submissions for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.).

The manual of administrative, financial and technical procedures of the DRC-CCM (**Annex C2**) sets out in section 7.2 two approaches for proposal development process:

- The Technical Secretariat establishes a work framework with technicians from the AIDS, Tuberculosis or Malaria Task Forces, under the coordination of the relevant programs and supported by national consultants. This approach enables regular consensus building meetings to

be held, led by a consultant who remains in permanent contact with the national program in question.

- First a call for proposals is launched, as wide as possible, open to all, to enable actors in the field, at national level, to participate in the project. Then, a Review Committee is set up, composed of experts identified by the Technical Secretariat, with precise terms of reference that are approved by the CCM Office.

This proposal is part of the proposal improvement framework presented in Round 5 and which had not been granted financing, but was recommended for subsequent proposal after modification. Thus, as the Round 5 proposal (**Annex C3**) was carried out according to the 2nd approach mentioned above, i.e. a call for proposals at national level followed by the organization of a workshop for integrating proposals and consensus building, the General Assembly preferred to develop this proposal according to the first-mentioned approach, in continuity with actions started during Round 5. However, all the national stakeholders were requested to issue their opinions again through a consensus building workshop that followed the proposal development workshop held from 18 to 22 July 2006 in Kinshasa. Annex C4 presents the message to Round 6 MIP

1.8.8 **b) Process to review** submissions received by the CCM for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

As described in the previous question, this proposal is part of the process for improvement of the Round 5 proposal, classified as category 3, which was the result of a call for proposals launched by the CCM throughout the country, and to which field operators have responded: 23 proposals have been received, including 16 relating to HIV/AIDS and 6 for Malaria. The development team has not examined the aforementioned proposals, but rather reviewed the approach for drafting the new proposal with an updated situation analysis. This team was mainly composed of experts coming from national programs (NMPAC, NPMC, NPAC, NPTC, NPBT) and partners (UNDP, GTZ, CDC Altanta, Fometro, Damien Foundation) with the support of international expertise provided by the Geneva WHO. **Annex C5** is the report of the Round 5 analysis and integration workshop and **Annex C6** is the report of the Round 6 review workshop.

The committee has restated priority areas for intervention for the strategic plans of the three programs for AIDS, Tuberculosis and Malaria, while ensuring that coherence between the different components is maintained.

1.8.9 **c) Process to nominate** the Principal Recipient(s) and **oversee** program implementation.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

The process to nominate the PR and oversee implementation is set out in the Manual of administrative, financial and technical procedures of the CCM (**Annex C2**). In this manual, the process provides for a widespread call for expressions of interest, launched throughout the country and evaluation of candidates based on criteria defined in the procedures manual on the basis of evaluation criteria established by the Global Fund (GF).

However, considering the sociopolitical situation of the country as well as the post-conflict situation in which the DRC is still in, the CCM considers that despite the need to carry out a process of transfer of competencies to the PR, the selection process for the PR must fall within the aforementioned context. In addition, the Procedures Manual itself describes the oversight mechanisms required for implementing grants.

In current conditions, in accordance with the reasons set out above, the CCM has opted to renew the nomination of the UNDP as PR. The Report of the meeting of 27 July 2006 is attached as **Annex C7**. Indeed, the experience accumulated by the PR since 2003 in managing Round 3 for HIV/AIDS and Rounds 2 and 5 for Tuberculosis is an acquired benefit in addition to its readiness to commit to a process for transferring competencies to national structures after a detailed evaluation of the situation.

2 Eligibility

1.8.10 **d) Process to ensure the input** of a broad range of stakeholders, including CCM members and non-CCM members, in the proposal development process and grant oversight process.

1.8.11 *(Please summarize and attach documentation as an annex and indicate the applicable annex number.)*

The CCM has principals relating to the process for developing proposals (Annex C2) which are described in section 7 of the Procedures Manual. To ensure the involvement of stakeholders, the CCM disseminates information, mainly via the Internet as the size of the country and the poor state of the communications system are such that Internet is the fastest means, even though access is poor in the country as a whole.

Members of the technical team responsible for integration or preparation of the proposal are recruited both within the CCM as well as outside, in addition to their involvement in the fight against the diseases of the three components.

This process, which allowed the Round 5 proposals that remain the basis of the current proposal to be brought together, also used the local written press with a widespread call for proposals (**Annex C8**: Report of the Gen. Ass. meeting on 14 July 2006).

As regards implementation oversight, the governance bodies, that regulate interventions, participate in meetings, in particular those of the Directorate for disease control and Directorate for Primary Health Care (PHC). **Annex C6** provides the report of the Round 6 review workshop and **Annex C9** that of the Round 6 drafting consensus workshop.

3A Applicant Type

This section contains information on the applicant. Please see the Guidelines for Proposals, section 3A, for more information regarding the nature of different applicants.

***All Coordinating Mechanism Applicants** (whether national, sub-national, regional (C)CMs) and Regional Organizations **must also** complete section 3B of this Proposal Form and provide the documented evidence requested.*

***Non-CCM Applicants** do not complete section 3B. These applicants must fully complete section 3A.5 of this Proposal Form and provide documentation as an attachment to this proposal supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism structure.*

1.9 3A0.1 Applicant

Table 3A.1 – Applicant

Please tick the appropriate box in the table below, and then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table.

	National Country Coordinating Mechanism	➔ *complete section 3A0.2 and 3B*
	Sub-national Country Coordinating Mechanism	➔ *complete section 3A0.3 and 3B*
	Regional Coordinating Mechanism (including small island developing states)	➔ *complete section 3A0.4 and 3B*
	Regional Organization	➔ *complete section 3A.5 and 3B*
	Non-CCM Applicants	➔ *complete section 3A.6*

3A Applicant Type

1.10 3A0.2 National Country Coordinating Mechanism (CCM)

For more information, please refer to the Guidelines for Proposals, section 3A.2, and the CCM Guidelines.

Table 3A.2 – National CCM: basic information

Name of CCM	**Date of composition** (yyyy/mm/dd)
CCM – DRC	2002/02/27

1.10.1 3A0.2.1 Mode of operation

1.10.2 Describe how the national CCM operates. In particular :

- **The extent to which the CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

1.10.3 (For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the CCM, and a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the appropriate annex number.)

The DRC CCM's mode of operation is governed by Ministerial Decision Nº 1250/CAB/MI/S/CJ/15 of 3 May 2003 of the Minister of Health, on the creation of the CCM (Annex C10), as well as by the Internal Statutes of the CCM (**Annex 9**).

The CCM is structured in three bodies:

- The General Assembly, which is the deliberating body, composed of all the members of the DRC CCM.
- The Office, the body providing impetus and guidance, composed of six members including a Representative of Civil Society, 2 Representatives of the Government sector and 3 Representatives of bi- and multi-lateral cooperation initiatives.
- The Technical Secretariat, a body whose main role is to prepare the technical and administrative dossiers, to implement the CCM activities and produce and file technical and administrative documentation of the CCM. It is composed of the Directors of the three national programs and Representatives of field partners involved in the fight against these diseases.

The Technical Secretariat, with the 3 Task Forces that are represented there, constitutes the permanent consultation framework among the various field operatives. The Chair of the CCM is also a member of the National Multisector Council for AIDS control, sitting with two other members of the CCM. Within this framework, interventions are harmonized regularly with the Multi country Aids Program (MAP) financed by the World Bank. Intervention harmonization meetings between the two programs for the country are organized; a memorandum of understanding has been signed with the PR to facilitate the implementation of activities.

A Monitoring-Evaluation commission has been set up by the General Assembly of the CCM to monitor Global Fund interventions. Within the framework for decision-taking (**Annex C14**), the Technical Secretariat usually meets twice per month, prepares the technical and administrative dossiers, and transmits them to the CCM Office. This meets once every month and decides on the actions to be taken or submits the dossiers to the General Assembly depending on the nature of the matter, for analysis of approval. There were 4 ordinary General Assembly meetings, 8 Office meetings, 16 Technical Secretariat meetings and 7 M-E Commission meetings during 2004. During the first semester of 2006, there have

been 2 General Assembly meetings, X Office meetings and X Technical Secretariat meetings.

Decisions are taken on a consensus basis, or by the majority of votes cast. Members of the CCM are regularly informed on CCM activities and contacts with the Global Fund mainly by email and during meetings. **Annex C11** ROI and **Annex C13** is the 2005 Review report.

➔ *After completing this section, complete section 3B.1*

3A0.3 Sub-national Country Coordinating Mechanism

For more information, please refer to the Guidelines for Proposals, section 3A0.3, and the CCM Guidelines.

Table 3A.3 – Sub-national CCM: basic information

Name of sub-national CCM	**Date of composition** (yyyy/mm/dd)

1.10.4 3A0.3.1 Mode of operation

1.10.5 Describe how the sub-national CCM operates. In particular :

- **The extent to which the sub-national CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

1.10.6 *(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the sub-national CCM, and a diagram setting out the interrelationships between all key actors as an annex to this proposal. Please indicate the appropriate annex number.)*

1.10.7 3A0.30.2 Rationale

1.10.8 a) Explain why a sub-national CCM has been chosen. *(Maximum of half a page)*

b) Describe how this proposal is consistent with and complements the national strategy for responding to the disease and/or the national CCM plans. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A0.4 Regional Coordinating Mechanism (including small island developing states)

For more information, please refer to the Guidelines for Proposals, section 3A.4, and the CCM Guidelines.

Table 3A.4 – Regional Coordinating Mechanism: basic information

Name of regional Coordinating Mechanism (RCM)	**Date of composition** (yyyy/mm/dd)

1.10.9 **3A.4.1 Mode of operation**

1.10.10 Describe how the RCM operates. In particular:

- **The extent to which the RCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and
- **How it coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, or the national strategies of small island developing states who do not have their own national CCM or other national coordinating body.)
- **The RCM's governance structure and processes,** and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

1.10.11 *(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the RCM, and a diagram setting out the interrelationships between key actors across the included countries as an annex to this proposal. Please indicate the appropriate annex number.)*

1.10.12 3A.4.2 Rationale

1.10.13 a) Explain why a RCM approach has been chosen. *(Maximum of half a page.)*

1.10.14 b) Describe how this proposal is consistent with and complements the national strategies of countries included and/or the national CCM plans. *(Maximum of half a page.)*

1.10.15 c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

1.10.16 d) Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM. *(Maximum of half a page.)*

3A Applicant Type

➔ *After completing this section, complete section 3B.1.*

3A.5 Regional Organizations (including Intergovernmental Organizations and International Non-Government Organizations)

For more information, please refer to the Guidelines for Proposals, section 3A0.5.

Table 3A.5 – Regional Organization: basic information

Name of Regional Organization
Sector represented by the Regional Organization

1.10.17 **3A.5.1 Mode of operation**

1.10.18 In addition to answering the sections below, Regional Organizations should provide, as additional annexes to this proposal documentation describing the organization, such as:

- *Statutes, by-laws of organization (official registration papers); and*
- *A summary of the main sources and amounts of funding.*

1.10.19 Describe how the Regional Organization operates. In particular:

- The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects; and
- **The coverage and past experience** of the Regional Organization's operations. *(Maximum of half a page.)*

1.10.20 3A.5.2 Rationale

1.10.21 a) Explain why a Regional Organization has been chosen and the added value of the proposed regional approach beyond the national response of individual countries. *(For example, address cross-border or regional issues. Maximum of half a page.)*

b) Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. *(Maximum of half a page.)*

c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

3A Applicant Type

d) Explain how the Regional Organization represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.2.*

3A Applicant Type

3A.6 Non-CCM Applicants

*Non-CCM proposals are **only eligible for funding under exceptional circumstances listed in section 3A.6.2 below**. For more information, please refer to the Guidelines for Proposals, section 3A.6.*

In addition to answering the sections below, all Non-CCM proposals should include as annexes additional documentation describing the organization, such as: statutes and by-laws of organization (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization; a summary of the organization, including background and history, scope of work, past and current activities; and a summary of the main sources and amounts of existing funding.

Table 3A.6 – Non-CCM Applicant: basic information

Name of Non-CCM Applicant	
Street address	

	Primary contact	Secondary contact
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

1.10.22 Indicate the type of your sector (tick appropriate box):

- ☐ Academic/educational sector
- ☐ Government
- ☐ NGOs/community-based organizations
- ☐ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organizations
- ☐ Multilateral and bilateral development partners in country
- ☐ Other
  (please specify):

3A Applicant Type

1.10.23 3A.6.2 Rationale for applying outside a Coordinating Mechanism
1.10.23.1 a) Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following: i) Countries without legitimate governments; ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or iii) Countries that suppress, or have not established partnerships with civil society and NGOs. 1.10.23.2 *Describe which of the **above conditions** apply to this proposal. (Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.2 for further information.)*

b) Describe your organizations **attempts to include this proposal in the relevant CCM's final approved country proposal** and the responses, if any, from the CCM. *(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM (national, sub-national or regional) as an annex to the proposal.)*

*If this Non-CCM proposal originates from a country in which no CCM exists (for example, a small island developing state), please **also** complete section 3A.6.3.*

1.10.23.3 3A.6.3 Consistency with national policies
1.10.24 Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy). *(Maximum of one page. Provide evidence (e.g., letters of support) from relevant national authorities in an annex to the proposal.)*

➔ *After completing this section, complete section 4.*

3B Proposal Endorsement

1.11 3B.1 Coordinating Mechanism membership and endorsement:

All national, sub-national and regional Coordinating Mechanisms must complete this section. Regional Organizations must complete section 3B.2.

1.12 National/Sub-national/Regional Coordinating Mechanisms

1.12.1 3B.1.1 Leadership of Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information
(not applicable to Non-CCM and Regional Organization applicants)

	Chair	Vice Chair
Name	M. Emile BONGELI YEIKELO YA ATO	M. Sidiki COULIBALY
Title	Minister of Health	Resident Representative UNFPA in DRC
Organization	Ministry of Health	UNFPA
Mailing address	B.P 3088 KIN 1	Kinshasa RDC
Telephone	+ 243 98911240	+ 243 81 994 72 92
Fax		
E-mail address	bongelien@yahoo.fr	Sidiki.coulibaly@undp.org; sidiki@unfpa.org

3B Proposal Endorsement

3B.1.2 Membership information

Please note that to be eligible for funding, national/sub-national/regional Coordinating Mechanisms must demonstrate evidence of membership of people living with and/or affected by the diseases. It is recommended that the membership of the CCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1, and the CCM Guidelines.

*The table below must be completed for **each** national/sub-national/regional Coordinating Mechanism **member**, and the table will therefore need to be extended to cover numerous members.*

Use the "Add_Member" button**  **in the standard toolbar.

*Under "**Type**", please specify which sector the CCM member represents: academic/educational; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; or multi-/bilateral development partners in country.*

Table 3B.1.2 – National/sub-national/regional (C)CM member information

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	MINISTRY FOR PLANNING	Website	
Type	GOVERNMENT		
Name of representative	Mr. MBALA SUNGU	CCM member since	27 – FEB – 2002
Title in agency/organization	Head of Health Division	Fax	
E-mail address	mbalasungu@yahoo.fr	Telephone	+ 243 81 518 6019
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member and reporter of the CCM monitoring-evaluation commission	Mailing address	

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NATIONAL ASSEMBLY	Website	
Type	GOVERNMENT		
Name of representative	Mr MUSA KALUPALA	CCM member since	2005
Title in agency/organization	Program Coordinator	Fax	
E-mail address	sidasensibilisation@yahoo.fr	Telephone	09 99 99 27 82
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	FARDC (DRC government armed forces)	Website	
Type	GOVERNMENT		
Name of representative	TCHALA MUAKU	CCM member since	27 – FEB – 2002
Title in agency/organization	Technical Director, Medical Department	Fax	
E-mail address	dotchafely@yahoo.fr	Telephone	+ 243 98 313 366
Main role in the Coordinating Mechanism and the proposal development	Member	Mailing address	

3B Proposal Endorsement

(proposal preparation, technical input, component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NATIONAL POLICE	Website	
Type	GOVERNMENT		
Name of representative	Mr. Joe KAMANGA	CCM member since	27 – FEB – 2002
Title in agency/organization	Cmd 2nd Medical Service	Fax	
E-mail address	Joe_kamanga@yahoo.fr	Telephone	+ 243 81 504 186
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNDP	Website	www.undp.org
Type	UN Agency		
Name of representative	M. Roberto Garcia	CCM member since	JAN – 2005
Title in agency/organization	Principal Coordinator of the PNUD / GF	Fax	
E-mail address	Roberto.garcia@undp.org	Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input,*	Representative of the PR; Coordination of implementation of the three components	Mailing address	Boulevard du 30 juin, Bld Losonia, Kin-Gombe

3B Proposal Endorsement

component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	WHO	Website	
Type	UN Agency		
Name of representative	Mr. Jean Baptiste ROUNGOU	CCM member since	27 – FEB – 2002
Title in agency/organization	Resident Representative	Fax	
E-mail address	roungouj@cd.afro.who.int	Telephone	+ 243 81 700 64 00
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the CCM, technical support for preparation of proposals and monitoring-evaluation of interventions	Mailing address	Av. des cliniques, Kin-Gombe
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNAIDS	Website	
Type	UN Agency		
Name of representative	Mr. Pierre SOMSE	CCM member since	27 – FEB – 2002
Title in agency/organization	Coordinator	Fax	
E-mail address	Somse.pierre@undp.org	Telephone	+ 24381 882 36 17
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation,*	Member, Technical support for intervention planning	Mailing address	Av. de la justice, Kin-Gombe

3B Proposal Endorsement

technical input, component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNICEF	Website	
Type	UN Agency		
Name of representative	Anthony Bloomberg	CCM member since	27 – FEB – 2002
Title in agency/organization	Resident Representative	Fax	
E-mail address	abloomberg@unicef.org	Telephone	+ 243 81 880 1815
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support for programs	Mailing address	Boulevard du 30 juin, Kin-Gombe
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	EUROPEAN COMMISSION	Website	
Type	Multilateral cooperation organization		
Name of representative	Ms. Nancy VANHAVERBEKE – MERCKX	CCM member since	27 – FEB – 2002
Title in agency/organization	Head of health section	Fax	+ 873 762 067 591
E-mail address	nancy.vanhaverbe-merckx@cec.eu.int	Telephone	+ 243 81894 6702
Main role in the Coordinating Mechanism and the proposal development	4th Vice-Chair , technical support to CCM	Mailing address	Boulevard du 30 juin, Immeuble BCDC, Kin-Gombe

3B Proposal Endorsement

(proposal preparation, technical input, component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	USAID	Website	www.usaid.gov/cg
Type	Bilateral Donor		
Name of representative	Mr. Robert G. Hellyer	CCM member since	27-Feb-2002
Title in agency/organization	Director of USAID	Fax	00 243 880 32 74
E-mail address		Telephone	+ 243 81 700 7194 + 243 81 700 5755
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	2nd Vice-Chair ? Technical support to CCM	Mailing address	Avenue Isiro, 198 Immeuble Mobil, Kin-Gombe Unit31550, APO AE 09828-1550
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	G T Z	Website	
Type	Bilateral Donor		
Name of representative	Mr. Eric VERSCHUEREN	CCM member since	2004
Title in agency/organization	Principal Technical Adviser	Fax	
E-mail address	Eric.verschueren@gtz.de	Telephone	+ 243 98 229 555
Main role in the Coordinating Mechanism and the proposal development	Member, technical and financial support to the operations of the CCM and organization of the proposal preparation	Mailing address	

3B Proposal Endorsement

(proposal preparation, technical input, component coordinator, financial input, review, other)	process		
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	C D C	Website	www.cdc.gov/nchctp/od/gap
Type	Bilateral Donor		
Name of representative	Faustin MALELE	CCM member since	2004
Title in agency/organization		Fax	1-413 – 376 – 0619
E-mail address	fmalele@cdcdrc.org	Telephone	+243 817006688
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support for CCM activities	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	BELGIAN EMBASSY	Website	
Type	Bilateral Donor		
Name of representative	Dr Desmet MARTINUS	CCM member since	27 – FEB – 2002
Title in agency/organization	Cooperation/Health Attaché	Fax	
E-mail address	martinus.desmet@diplobel.be	Telephone	+ 243898989885
Main role in the Coordinating Mechanism and the proposal development	Member, technical support for CCM activities	Mailing address	

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(proposal preparation, technical input, component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	FRENCH EMBASSY	Website	
Type	Bilateral Donor		
Name of representative	Mr. Pierre LAYE	CCM member since	27-Feb-2002
Title in agency/organization	Head of Health	Fax	
E-mail address	pierre.laye@diplomatie.gouv.fr	Telephone	+ 243 81 700 57 28
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	DAMIEN FOUNDATION	Website	
Type	NGO		
Name of representative	Mr. Pamphile LUBAMBA	CCM member since	27 – FEB – 2002
Title in agency/organization	Representative and Medical Director	Fax	
E-mail address	plubamba@ic.cd	Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support for preparation and implementation of Tuberculosis interventions	Mailing address	Av. Pierre MULELE, 162, Kin-Giombe

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National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	CNOS	Website	
Type	NGO		
Name of representative	Mr. Nestor MUKINAY	CCM member since	27 – FEB – 2002
Title in agency/organization	National Chairman	Fax	
E-mail address	cnosrdc@yahoo.fr	Telephone	+ 243 81 517 36 24
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	3rd Vice-Chair, participation in implementation of interventions by local NGOs	Mailing address	B.P. 15205 KINSHASA 1
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	FORUM SIDA	Website	
Type	NGO		
Name of representative	Mr. Georges ENGWANDA	CCM member since	27 – FEB – 2002
Title in agency/organization	Vice-Chairman	Fax	
E-mail address	georgesengwanda@yahoo.fr	Telephone	+ 243 98 244 608
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	Av. Lubudi, 47, Kin-Lemba
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	L N A C	Website	

3B Proposal Endorsement

Type	NGO		
Name of representative	Mrs Ghislaine TSHITENGE	CCM member since	27 – FEB – 2002
Title in agency/organization	Manager	Fax	
E-mail address	ghilsmabel@yahoo.fr	Telephone	+ 243 81 4526317
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, involvement in implementation of interventions	Mailing address	Av. Kabinda opposite the RTNC, Kin-Lingwala
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	RCP +	Website	
Type	NGO		
Name of representative	Mr. Aimé MAMBU MPAKA	CCM member since	27 – FEB – 2005
Title in agency/organization	2nd Vice-Chairman	Fax	
E-mail address	apamazoa@yahoo.fr	Telephone	+ 243 81 700 57 28
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, involvement in implementation of AIDS interventions	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	FEDERATION OF BUSINESSES OF THE CONGO F E C	Website	
Type	PRIVATE SECTOR		

3B Proposal Endorsement

Name of representative	Mr. Marc ATIBU SALEH	CCM member since	27 – FEB – 2002
Title in agency/organization	Director	Fax	
E-mail address	marcatibu@yahoo.fr	Telephone	+ 243 98 114 372
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, member of the CCM monitoring-evaluation commission	Mailing address	Av. des aviateurs, 10, Kin-Gombe
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	A N E P	Website	
Type	GOVERNMENT		
Name of representative	Mr. LUZAZA NDONGO	CCM member since	27 – FEB – 2002
Title in agency/organization	Focal Point / AIDS	Fax	
E-mail address	yazadongo@hotmail.com	Telephone	+ 243 81 517 10 42
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	PUBLIC HEALTH COLLEGE	Website	
Type	UNIVERSITY		
Name of representative	Prof Dr MUNYANGA	CCM member since	27 – FEB – 2002

3B Proposal Endorsement

Title in agency/organization	Director	Fax	
E-mail address	munyangam@yahoo.fr	Telephone	+ 243 99 42798
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support for the preparation of proposals and operational studies	Mailing address	Kinshasha University
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	CATHOLIC CHURCH	Website	
Type	Religious organization		
Name of representative	Mr. Zacharie BEYA	CCM member since	27 – FEB – 2002
Title in agency/organization	Assistant General Secretary	Fax	
E-mail address	conf.episc.rdc@ic.cd	Telephone	+ 243 81 518 6019
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	CHURCH OF CHRIST IN THE CONGO	Website	
Type	Religious organization		
Name of representative	Dr John GIKAPA	CCM member since	27 – FEB – 2002

3B Proposal Endorsement

Title in agency/organization	Coordinator	Fax	
E-mail address		Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, involved in the CCM Monitoring-Evaluation commission	Mailing address	Av; de la justice, Kin-Gombe
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	KIMBANGUSITE CHURCH	Website	
Type	Religious organization		
Name of representative	Mr. Jean Paul DIVENGI	CCM member since	27 – FEB – 2002
Title in agency/organization	Chairman of the commission on the fight against disease	Fax	
E-mail address	jpdnzambi@yahoo.fr	Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, involvement in implementation of interventions	Mailing address	Av. Saio, Kinsaha Kasa Vubu
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	MUSLIM COMMUNITY	Website	
Type	Religious organization		
Name of representative	Mr. GAMAL SHEIH LUMUMBA BIN RAMAZANI	CCM member since	27 – FEB – 2002
Title in agency/organization	Chair	Fax	
E-mail address	islamrdc@yahoo.fr	Telephone	+ 243 99 540 79

3B Proposal Endorsement

Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	SALVATION ARMY	Website	
Type	Religious organization		
Name of representative	Mr. David NKU IMBIE	CCM member since	17 NOV – 2004
Title in agency/organization	Director Physician	Fax	
E-mail address	davidnku@salvos.com	Telephone	+ 243 99 28 511
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support in activity planning and implementation of interventions	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	COUNCIL OF THE REVIVAL CHURCHES	Website	
Type	Religious organization		
Name of representative	Mr. KANKIENZA MWANA MBO	CCM member since	27 – FEB – 2002
Title in agency/organization	National Chairman	Fax	
E-mail address	lemire@yahoo.fr		+ 243 99 81 274
Main role in the Coordinating Mechanism and the	Member		

3B Proposal Endorsement

proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	INTERSYNDICALE	Website	
Type	TRADE UNION		
Name of representative	Mr. KIBISWA	CCM member since	27 – FEB – 2002
Title in agency/organization	Chair	Fax	
E-mail address	naupesskib@yahoo.fr	Telephone	+ 243 81 508 41 52
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	DIRECTORATE OF STUDIES AND PLANNING, MINISTERY OF HEALTH	Website	
Type	GOVERNMENT		
Name of representative	Mr. Hyppolite KALAMBAY	CCM member since	27 – FEB – 2002
Title in agency/organization	Director	Fax	
E-mail address	hkalambay@yahoo.fr bepsante@ic.cd	Telephone	+ 243815203096
Main role in the Coordinating Mechanism and the	Coordination of the Technical Secretariat, involvement in CCM intervention planning	Mailing address	Av; de la justice, 39, Kin-Gombe

3B Proposal Endorsement

proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NMPAC	Website	
Type	GOVERNMENT		
Name of representative	MANDJO	CCM member since	OCTOBER – 2004
Title in agency/organization	National Coordinator	Fax	
E-mail address	jpmandjo@yahoo.fr	Telephone	+2439924872
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat and CCM Monitoring-Evaluation commission, coordination of interventions in the fight against AIDS	Mailing address	Avenue Milambo, 4, Kn-Ngaliema
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NPMC	Website	
Type	GOVERNMENT		
Name of representative	Mr. Benjamin ATUA	CCM member since	30 – DEC – 2003
Title in agency/organization	Director	Fax	
E-mail address	amatindii@yahoo.fr	Telephone	+ 243 98 21 72 43
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation,*	Member of the Technical Secretariat and Monitoring-Evaluation commission, regulatory role in the implementation of interventions	Mailing address	Av. du tourisme, 1, Kin-Ngaliema

3B Proposal Endorsement

technical input, component coordinator, financial input, review, other)			
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NPTC	Website	
Type	GOVERNMENT		
Name of representative	Mr. André NDONGOSIEME	CCM member since	27 – FEB – 2002
Title in agency/organization	Director	Fax	
E-mail address	pnt-rdc@ic.cd	Telephone	+243999946997
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat and Monitoring-Evaluation commission, statutory and regulatory role in the implementations	Mailing address	Av. Kabinda, en face de la RTNC
National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	AIDS TASK FORCE	Website	
Type	UN Agency		
Name of representative	Mr. COMPAORE	CCM member since	27 – FEV – 2002
Title in agency/organization	NPO HIV	Fax	
E-mail address	milengep@cd.afro.who.int	Telephone	+ 243 81 700 64 15
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat and Chairman of the monitoring-evaluation commission	Mailing address	

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	PALU TASK FORCE [*MALARIA*]	Website	
Type	NGO		
Name of representative	Mr. Willy KABUYA	CCM member since	27 – FEB – 2002
Title in agency/organization	Coordinator	Fax	
E-mail address	wkabuya@msh.com	Telephone	+ 243 98 160 862
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat, technical support for implementation of interventions	Mailing address	

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	NATIONAL PROGRAM FOR AIDS CONTROL	Website	
Type	GOVERNMENT		
Name of representative	Mr. OKENGE YUMA	CCM member since	27 – FEB – 2002
Title in agency/organization	Director	Fax	
E-mail address	dokenge@yahoo.fr	Telephone	+243 815000750
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat and Monitoring-Evaluation commission, statutory role in medical patient management	Mailing address	

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National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	TUBERCULOSIS TASK FORCE	Website	
Type	NGO		
Name of representative	Mr. Gérard KABOTO	CCM member since	27 – FEB – 2002
Title in agency/organization	Project Director	Fax	
E-mail address	lnac_dp@yahoo.fr	Telephone	+243 99 44 886
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat, involvement in implementation of interventions	Mailing address	

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	DAMIEN FRIENDS CLUB	Website	
Type	NGO		
Name of representative	Mr. Maxime LUNGA NSUMBU	CCM member since	10 – MAI – 2005
Title in agency/organization	Chair	Fax	
E-mail address	Cad_rdc@yahoo.fr	Telephone	+ 243 81 519 0 773
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	

3B Proposal Endorsement

Member			
Agency/organization	Ministry of foreign affaires and international cooperation	Website	
Type	Government		
Name of representative	Mr TUTA LUBELA	CCM member since	2005
Title in agency/organization	Assistant	Fax	
E-mail address		Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	
Member			
Agency/organization	National Assembly	Website	
Type	Government		
Name of representative	Mr MUSA KALUPALA	CCM member since	10 – MAI – 2005
Title in agency/organization	AIDS coordinator	Fax	
E-mail address	Sidasensibilisation@yahoo.fr	Telephone	00 243 9 99 99 27 82
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Mailing address	Palais du Peuple, Kinsgasa-Lingwala

3B Proposal Endorsement

3B.1.3 National/Sub-national/Regional (C)CM endorsement of proposal

*Coordinating Mechanism members must endorse the proposal. Limited exceptions are described in the Guidelines for Proposals in section 3B.1.3. Please note that the **original** (not photocopied, scanned or faxed) signatures of the CCM members should be provided in table 3B.1.3. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal. The entire proposal, including the signature page and minutes, must be received by the Global Fund Secretariat before the deadline for submitting proposals.*

Applicant name	CCM – DRC
1.12.1.1 Country	1.12.1.2 Democratic Republic of the CONGO

"Each of the undersigned, hereby certify that s/he has reviewed the final proposal and supports it."

Table 3B.1.3 – National/sub-national/regional (C)CM endorsement of proposal

Agency/organization	Name of representative	Title	Date (yyyy/mm/dd)	Signature
Ministry of Health	Mr. Emile BONGELI YEIKELO	MINISTER		
UNFPA	Mr. SIDIKI COULIBALY	Resident Representative in DRC		
Ministry for planning	Mr. MBALA SUNGU	Head of Health Division		
Ministry of Finance	Mr. Benoit MUTAMBAY	Head of Studies		
DRC Armed Forces	Mr. TCHALA MUAKU	Technical Director, Medical Department		
Congo National Police	Mr. Joe KAMANGA	Cmd 2nd Medical Service		
UNDP	Mr. ROBERTO GARCIA	Principal Coordinator of the GF		
WHO	Mr. Jean Baptiste ROUNGOU	Resident Representative in DRC		
ONUSIDA	Mr. Pierre SOMSE	Coordinator		
UNICEF	Mr. Anthony BLOOMBERG	Resident Representative in DRC		
European Commission	Mme Nancy VANHAVERBEKE	Head of health section		
USAID	Mr. Robert G. Hellyer	Director of USAID		
G T Z	Dr. Eric VERSCHUEREN	Principal Technical Adviser		
CDC	Mme KAREN HAWKINS REED	Chief of party		
Belgian Embassy	Mr. Desmet MARTINUS	Head of International Department		
French Embassy	Mr. Pierre LAYE	Cooperation Attaché		
Damien Foundation	Mr. Pamphile LUBAMBA	Representative and Medical Director		

3B Proposal Endorsement

CNOS	Mr Nestor MUKINAY	National Chair		
AIDS Forum	Mr Georges ENGWANDA	Vice-Chair		
LNAC	Mrs Ghislaine TSHITENGE	Manager		
RCP +	Mr. Aimé MAMBU MPAKA	2nd Vice-Chair		
Federation of Businesses in the Congo	Mr. Marc ATIBU SALEH	Director		
A N E P	Mr. LUZAZA NDONGO	Focal Point / AIDS		
Public Health College	Mr. MUNYANGA	Director		
Catholic Church	Mr. ZACHARIE BEYA	Assistant General Secretary		
Church of Christ in the Congo	Mr. Leon KINTAUDI	DOM coordinator		
Kimbanguiste Church	Mr. Jean Paul DIVENGI	Chairman of the CKLMA		
Muslim Community	Mr. GAMAL SHEIH LUMUMBA	Chair		
Salvation Army	Mr. David NKU	Director Physician		
Council of the Revival Churches	Mr. KANKIENZA MWANA MBOO	Chair		
Intersyndicale	Mr. KIBISWA	Chair		
Directorate for Studies and Planning	Mr. Hippolyte KALAMBAY	Director		
Multisector Program for the AIDS Control (NMPAC)	Mr. Jean Lambert MANDJO	National Coordinator		
National Program for Malaria Control (NPMC)	Mr. Benjamin ATUA	Director		
National Program for Tuberculosis Control (NPTC)	Mr. André NDONGOSIEME	Director		
National Program for Aids Control	Mr. OKENGE	Director		
AIDS Task Force	Mr. COMPAORE	NPO HIV		
Malaria Task Force	Mr. Willy KABUYA	Coordinator		
Tuberculosis Task Force	Mr. Gerard KABOTO	Project Director		
Damien Friends Club	Mr. Maxim LUNGA NSUMBU	Chair		
National Assembly	Mr MUSA KALUPALA	Coordinator of the AIDS Work group		
Ministry of international cooperation	Mr TUTA LUBELA	Assistant		

3B Proposal Endorsement

For sub-national and regional Coordinating Mechanisms only, *the Chair and the Vice Chair of the national CCM of each country must also endorse the proposal. Please refer to the Guidelines for Proposals, section 3B.1.3.*

List below each of the national CCMs that have agreed to this proposal and provide documented evidence of this endorsement.

Table 3B.1.3b – Sub-national or regional (C)CM proposal endorsement by national CCMs

Country	Name of CCM	Annex number

3B Proposal Endorsement

3B.2 Regional Organization contact information and proposal endorsement:

1.12.2 3B.2.1 Regional Organization contact information

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication.

Table 3B.2.1 – Regional Organizations: contact information

	Primary contact	Secondary contact
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

1.12.3 3B.2.2 National CCM endorsement of Regional Organization proposal:

Please note that Regional Organizations must receive the agreement of the national CCM membership of each country in which they wish to work.

List below each of the national CCMs that have agreed to this proposal and provide documented evidence of this endorsement. (If no national CCM exists in a country included in the proposal, include evidence of support from relevant national authorities.)

Table 3B.2.2 – Regional Organization proposal endorsement by national CCMs

Country	Name of CCM	Annex number

5 LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Name/Number given to annex in application**
Section 2: Eligibility		
Coordinating Mechanisms only:		
2.2.1 b)	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Annex C1 Documentation on the nomination of non government members
2.2.2	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism.	Annex C2 CCM Procedures Manual
	Documentation describing the transparent processes to:	
2.2.3 a	- solicit submissions for possible integration into the proposal.	Annex C2 CCM Procedures Manual Annex C3 Round Call for Proposals Annex C4 Round 6 Message to MIP
2.2.3 b	- review submissions for possible integration into the proposal.	Annex C2 CCM Procedures Manual Annex C5 Report on the Round 5 analysis and integration workshop Annex C6 Report of the Round 6 review workshop
2.2.3 c	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated).	Annex C2 CCM Procedures Manual Annex C7 Minutes of the General Meeting 072806
2.2.3 d	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	Annex C2 CCM Procedures Manual Annex C8 Minutes of the General Meeting 071406 Annex C6 Report of the Round 6 review

5 LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
		workshop Annex C9 Report of the Round 6 consensus workshop
Section 3A: Applicant Type		
Coordinating Mechanisms:		
3A.2.1, 3A.3.1 **or** 3A.4.1	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors)	Annex C10 Ministerial Decision Annex C11 ROI Annex C12 2006-2007 Action Plan Annex C13 2005 Review Report Annex C14 Diagram of CCM relationships
Regional Organizations:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding.	
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
3A.6.3 *(if from country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	
Section 3B: Proposal Endorsement		
3B.1.3 (*Coordinating Mechanisms)*	Minutes of the meeting at which the proposal was developed and endorsed. For Sub-CCMs and RCMs, documented evidence that national CCM(s) have agreed to proposal.	Annex C15 Minutes of the General Meeting 080206
3B.2.2	Documented evidence that the national CCMs have	

5 LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Name/Number given to annex in application**
(*Regional Organization)*	agreed to proposal.	
Other documents relevant to sections 1-3 attached by applicant:		

4 Componant section *Tuberculose*

PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT. *Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.*

For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.

4.1 Indicate the estimated start time and duration of the component

Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval.

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	November 2006	November 2010

4.2 Contact persons for questions regarding this component

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately six months after the submission of the proposal.

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr André NDOGOSIEME	Dr Etienne BAHATI
Title	DIRECTOR OF THE PNT (NATIONAL PROGRAMME TO CONFRONT TB)	PNT TECHNICAL ADVISOR
Organization	NATIONAL PROGRAMME TO CONFRONT TB	NATIONAL PROGRAMME TO CONFRONT TB
Mailing address	[B.P: 12706 KIN 1]	B.P: 12706 KIN 1
Telephone	00 243 999946997 (GSM)	00 243 998226617 (GSM)
Fax		
E-mail address	ndongosiemea@yahoo.fr	erbahati@gbs.cd

4 Componant section *Tuberculose*

4.3 Component executive summary

4.3.1 Executive summary

Describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results and associated timeframes. Specify the beneficiaries and expected benefits (including target populations and their estimated number). *(Please include quantitative information where possible. Maximum of one page.)*

Goal, objectives, service delivery areas

The Principal Goal of this component is to reduce the morbidity and mortality caused by tuberculosis in the Congolese population and thus contribute to poverty reduction, in accordance with the aims of the "Millennium Development Goals" between now and 2015.

Objectives: The programme's objectives are to increase the cure rate to 85% and the detection rate to 70% for sick people testing positive for tuberculosis in the sputum smear test. This is expected to be achieved in all the provincial coordinations of the DRC, through a large expansion of the DOTS strategy, to cover 100% of the population between now and 2010.

Main Activities: The main activities are described in the 5th round proposal and are derived from our 5-year plan 2006-2010. They are: prevention (detection); the treatment of first-line and multiresistant cases; the treatment of co-infected TB/HIV cases; advocacy, social communication and mobilization; and finally, the institutional capacity strengthening.

For this 6th round proposal we are completing analyses only **for the treatment of first-line cases**. The principal expected result for this submission is to achieve the procurement of sufficient quantities of quality-assured anti-tuberculosis medicines, to test and treat 691,484 sick people during the 5 years of the project, with a reserve stock of 18 months of treatment.

The direct recipients of this submission are the estimated 339,266 tuberculosis sufferers, as well as the 376,216 sick people to be tested and treated over the same period. The medicines for the latter group are planned for the 5th round project, which has been accepted and the Global Fund disbursement currently being negotiated.

But the DRC's entire population will indirectly benefit from the outcome of case treatments. The principal expected advantages are easy access to quality, first-line treatment, leading to an increase in the cure rate. If the cure rate increases and is maintained at 85% throughout the project in all of the provincial coordinations, the transmission of microbes in the community will decrease. This is the best way to prevent tuberculosis and thus reduce the morbidity and mortality resulting from this disease in DRC. And it already forms an important stage of the poverty reduction strategy, as it reduces the morbimortality of the tuberculosis endemic in DRC.

4 Componant section *Tuberculose*

4.3.2 Synergies

If the proposal covers more than one component, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities). *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact).*

Synergy with NACP (AIDS/HIV) and NMCP (Malaria):
For the period 2006-2010, the PNT will be covering 100% of the country's population. The diagnostic and treatment centres for tuberculosis are facilities, such as the hospitals and health centres, where all the health care services are integrated, included NACP and NMCP. The programme expects to treat 691,484 TB sufferers (all forms), the equivalent of 715,582 treatment therapies (reserve stock) in 515 health zones, of which 207,445 are co-infected TB-HIV/AIDS cases.

The collaboration between the PNT and NACP programmes is underway: the harmonization of strategies and information support has been the first outcome of the workshops held for this purpose and supported by the WHO, UNC and CDC. Several initiatives to treat co-infected cases are underway in the country's different Health Zones, implemented by partners from the PNT and NACP, including USAID , UNC/CDC and the WHO.

With this submission, the integration of activities for TB/HIV co-infection in the health centres will give the DRC a head start for the "3 by 5" initiative. This integration will support a better quality of life and contribute to the longevity of people living with HIV. The PNT predicts that 20,745 co-infected TB sufferers will require ARV treatment while they are receiving anti-tuberculosis treatment (10% of co-infected cases). In its 5th round project, the PNT has planned HIV screening tests for these patients, as well as the prevention and treatment of opportunistic infections in the Testing and Treatment Centres (*Centre de santé de dépistage et de traitement, CSDT*), polyvalent health centres that receive and treat all the diseases, including tuberculosis and HIV/AIDS. Supervision for the monitoring and surveillance of co-infection will be jointly performed by the two programmes.

The laboratory materials and reagents planned for the 5th round implementation, which will be underway at the same time as this proposal, are destined for the health centres that incorporate tuberculosis but test and treat other illnesses, and particularly MALARIA, which is the primary cause of morbidity and mortality in our communities. In this submission the "Malaria" component has taken account of the allocated places for these materials (microscopes) for the expansion of its control programme.

4.4 National program context for this component

The information below helps reviewers understand the disease context, and which problems the proposal will address. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies and broader development frameworks need to be clearly documented. Please refer to the Guidelines for Proposals, section 4.4.

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

☒ National Disease Specific Strategic Plan

☒ National Disease Specific Budget or Costing

☐ National Monitoring and Evaluation Plan (health sector, disease specific or other)

☒ Other document relevant to the national disease program context (e.g. : the latest disease surveillance report) *Please specify*.

1. Guide du Programme actualisé (Pati IV) 2. Guide de gestion des médicaments actualisé (Patimed II) 3. Rapport de la Revue externe du Programme de 2005

4 Componant section *Tuberculose*

4.4.2 Epidemiological and disease-specific background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant . With respect to malaria components, also include a map detailing the geographical distribution of the malaria problem and corresponding control measures already approved and in use.. Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.

With the 2004 epidemiological data provided by the PNT and an estimated population of 55,853,000, the WHO has estimated an annual incidence of PTB+ at 159 cases for every 100,000 inhabitants, the prevalence of all forms of tuberculosis at 551 cases for every 100.000 inhabitants, and the annual mortality at 79 deceased for every 100.000 inhabitants. This places the DRC among the 22 countries most affected by TB in the world. It is the 5th most-affected country in Africa and 11th worldwide (WHO Report 2006, WHO/HTM/TB/2006.362).

Since 1987, the programme has recorded a progressively increasing number of PTB+ cases. This number has increased from 15,000 new PTB+ cases in 1987 to 64,406 out of a total of 96,560 tested in 2005. This increase is partly linked to HIV infection, whose average prevalence is 4.5% (NACP, 2003), placing DRC amongst the countries facing a generalized HIV epidemic. The prevalence of HIV infection among adult tuberculosis sufferers (15-49 years old) is estimated at 21%. The WHO estimates that the DRC would be 8th in the world, for countries bearing the burden of TB/HIV co-infection (WHO/CDS/TB/2002.311)

The highest number of tuberculosis sufferers is registered in the large urban areas. 20% of the country's sufferers are registered in the town of Kinshasa. More than 85% of new contagious cases are between 15 and 54 years old, with a slight male predominance (53%). Therefore, adults in the economically-productive age group are the most affected by TB, with a negative impact on the population's poverty level.

Despite the difficult political and socioeconomic situation since 1990 (civil wars and insecurity), the PNT has obtained good results in the fight against TB, thanks to the strong decentralization of the programme, its integration of primary health care services, the permanent support of traditional partners and the stability of personnel at the central and intermediary level. The rate of smear-positive patients recorded increased from 42 cases for every 100,000 inhabitants in 1987 to 111 cases for every 100.000 inhabitants in 2004, against the 160 predicted by the WHO. The detection rate for new PTB+ patients increased from 28% in 1987 to 70% in 2004.

The treatment results for new PTB+ cases show that the success rate has increased from 26% in 1996 (the year that short courses were introduced) to 85% in 2005 (source: unpublished PNT report 2005). These results vary from one zone to the other and from one provincial coordination to the other. 10 of the provincial coordinations, with insecurity and little coverage, mainly in the East of the country, have a treatment success rate of between 72% and 84%, which is below the national average. Detection is weakest in almost the same provincial coordinations of the country where social stigma, mistaken beliefs and insecurity still persist. The detection rate there is an average of 52%, well below the programme's 70% objective, while the national average is 77% in 2005.

In 2004, the WHO estimated that the prevalence of patients with multiresistant forms of TB among the new cases would be 1.7% (WHO Report 2006, WHO/HTM/TB/2006.362).

Since 2005, the PNT has opted for a 6-month course of treatment for new cases and an 8-month course for retreatment cases. The adopted regimens are:

- category 1: 2 RHZE/ 4RH
- category 2: 2 SRHZE / 1RHZE / 5 RHE
- category 3 : 2 RHZ / 4RH.

The GDF's support to the Congolese government from 2002, covering two-thirds of the needs for anti-tuberculosis medicines, ends at the end of 2007. **The principal objective of this submission is to procure supplementary anti-tuberculosis medicines to those requested and obtained in the 5th round, to cover the next 5 years from 2006 to 2010**.

A survey carried out in Kinshasa in 1998 showed that multiresistance among patients who have never been treated has risen to 2.2%, while it was 22.9% among TB patients who have already been treated.

The programme has standardized the course of treatment for patients with multiresistant TB since 2004, in accordance with guidelines from the WHO and the Green Light Committee. An agreement that the Ministry of Health presented to the Green Light Committee was recently secured in June 2006. The accepted courses are as follows:

- Intensive phase: 6 months of Km-Ofx-Prot-Z.Cs
- Continuation phase: 18 months of Km-Ofx-Prot-Z.Cs

The PNT has also adopted the following treatment courses, prescribed by the NACP, for co-infected TB sufferers :

- For the first-line (patients taking anti-tuberculosis medicines with Rifampicine): d4T + 3TC +EFV. In case of neuropathies, the d4T may be replaced by AZT.
- For the second-line: ABC + ddl + LPV/r

4 Componant section *Tuberculose*

4.4.3 Disease-control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.4.3.

a) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include all donor-financed programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships).

4 Componant section *Tuberculose*

b) Describe the role of HIV/AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or Sector-Wide Approaches. Outline any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative .

4 Componant section *Tuberculose*

1. **National context and the condition of Tuberculosis areas**

Despite the country's overall, restrictive socioeconomic situation, the National Programme to confront Tuberculosis (PNT) is making progress in the disease control. At the end of 2005, the principal indicators showed us that we have reached the national averages of a 77% detection rate and an 85% treatment success rate for a 75% population coverage.

But a close-up look reveals that half of the Health Zones (230 HZ at the end of 2005) have cure rates below 85% and varying from 72% to 84%. Similarly, half of the coordinations have a detection rate below 70%, and varying from 41% to 69% for people smear-testing positive for pulmonary tuberculosis. Therefore, a lot more effort needs to be made in order to maintain a good level of cure and detection rates in all of the provincial coordinations.

We underline that these are the results of joint efforts by the permanent implementation partners, technical support partners and other donors. The programme's other strong point is the integration of the PNT in the primary health care services with a fairly stable staff team at the national and intermediary level. Its integration into the basic health facilities, 1545 diagnostic-treatment centres, is the basis of its sustainability.

2. **Control strategy and current programmes**

The PNT has expanded the WHO's DOTS strategy throughout the country since 1996, to effectively carry out the tuberculosis control activities. The efforts to expand this strategy continue, with the guidance and organizational assistance of the Union and the WHO, as part of the international DEWG Working Group team for the Stop TB initiative. Since 2004, new elements have been added to the five essential elements of the DOTS Strategy, to improve the programme's results. These are, notably, the care service activities for people co-infected with TB-HIV/AIDS, people with multiresistant TB, operational research activities, and the intensification of community involvement.

This submission draws elements from the 2006-2010 Strategic Plan, which was drafted to support the above activities and follows on from the 2001-2005 Strategic Plan. Of a total budget of 112,565,788, 16% is allocated for the planned medicine-related activities. The traditional partners have promised to continue their support for the next 5 years, as in the past years. At the end of August 2006, we will end the last year of the Global Fund's 2nd Round grant with a total of 7,973,004 USD. In September 2006 we will start the first phase of the Global Funds' 5th Round. This first phase is 14,598,934 USD out of a total of 36,234,565 USD for five years, and already provides for the purchase of first-line medicines that represent 376,216 treatment treatments.

3. **Programmatic and financing gaps**

The National Programme to confront Tuberculosis (PNT) organized an External Review in 2005, which drew conclusions for all of the programme's activities, including medicines. Analysis shows that the disease control performances are still low (low cure and detection rates) in the provincial coordinations, and Moreso in the Eastern regions, where war has wreaked destruction for seven years and insecurity reigns to this day. The agreements made with GDF have allowed the country to procure first-line anti-tuberculosis medicines for 2/3 of the PNT's needs since 2002, with the remaining 1/3 covered by the other partners, who are Fondation Damien, TLMI, the Belgian Cooperation and ALM. This programme with the Global Fund will be 4 years old, with annual evaluations, and ends in 2006. This is why we have ordered first-line anti-tuberculosis medicines in the Global Fund's Fifth Round, to treat 691,484 tested cases.

The drugs delivery for the fourth and final year of the Global Drug Facility, arrived at the programme in July 2006, almost six months later than the due date. We had to use our reserve stock to avoid stock-outs, which had already occurred in some of the provincial coordinations. Meanwhile, the unit costs of all the drugs, even the combined forms, have risen sharply, increasing from $10 to $20 per treatment for bulk orders (the project's first two years) and from $17 to $26 for the blister-pack forms (the project's last three years), almost double the estimations made when the 5th Round submission was drafted in June 2005. **Therefore, in order to treat the 691,484 expected cases planned for the project's 5th Round starting August 2006, we will need a little more financial means than the PNT DRC budgeted for in the 5th Round grants. The fundamental reason for this 6th Round proposal is therefore to supplement the required treatments for all the sick people who will be tested from 2006-2010, with an 18-month reserve stock available from the project's start.**

4 Componant section *Tuberculose*

4.4.4 National health system

a) Briefly describe the role of the (national) health system, for both the public and private sectors, in reducing the impact and the spread of the disease in question.

Since the Alma Ata resolutions in 1978, the DRC chose the **primary health care services** as its national health policy strategy. To implement this strategy, the territory was subdivided into 306 Health Zones, as units for planning activities and care operations for sick people. In 2005, taking account of the demographic growth criteria in particular, the new subdivision gives us **515 Health Zones**, more than half of which are fully functional.

One Health Zone normally includes one or two hospitals and about 20 health centres. The best-equipped hospital assumes the role of general reference hospital for the Health Zone, and generally serves over 100,000 inhabitants in rural areas, and between 200,000 and 300,000 inhabitants in urban areas.

The management committee of the Health Zone operates with the **community** participation. The method of payment and care charges are one of the committee's tasks. Announcements for free-of-charge anti-tuberculosis medicines and tuberculosis diagnostic texts are displayed in the centre and broadcast throughout the community via the members of this expanded committee.

Most of these health facilities are **public** (State, religious denominations, or state-owned). They barely manage to self-finance using recovered care costs. The very few **lucrative private facilities** are generally located in the large urban areas (the province's capital). These private facilities transfer their sick people to public care centres, where anti-tuberculosis medicines are free.

The fight against Tuberculosis has been integrated into the basic health care services, and the programme organized according to the three levels of the Ministry of Health's organizational chart, each with its specific role:

1. **The Central Unit** at the central level plays a prescriptive role: planning and mobilizing resources, advocacy and coordinating the fight throughout the country.
2. **The Intermediary Level** represented by the provincial coordinations (22 in 2006 and 26 in 2010), which play a technical support role to the Health Zones. A TB coordination is twinned to the fight against Leprosy in the DRC. It covers an average of 25 Health Zones.
3. **The Peripheral Level** is made up of Health Zones (HZ: 515 in 2005), which include the health centres, some of them also equipped with tuberculosis testing and treatment called **CSDT** (*Centres de santé pour le dépistage et traitement de la tuberculose*). In 2006 there were 1100 **CSDT**. Each HZ has 3 CSDT on average. The CSDT is the operational level where the guidelines for the care of tuberculosis sufferers are applied (testing, treatment).

b) Based on the above analysis, please explain whether the current health system will be in a position to properly carry out and maintain the strengthening of activities to fight HIV/AIDS, tuberculosis and malaria. What are the obstacles?

- It is evident that through this organization of the DRC health sector, which recommends the integration of all the programmes into the health facilities, the various interventions to fight tuberculosis are part of its facility's minimum range of services. These disease-control activities are led and evaluated by and with the field operators according to the organizational chart, which allocates the responsibilities of the community, the partners and the Ministry of Health at each level of intervention. The objectives and interventions of the current Global Fund current project are additional to an already-existing and functional health system. By strengthening this system through its interventions, the current Global Fund project will help to sustain the actions to fight Tuberculosis, and particularly the procurement of anti-tuberculosis medicines, via all of the care facilities.
- In this project, the service delivery area concerns the treatment of tuberculosis sufferers. This consists essentially of procuring sufficient quantities of quality medicines. To properly lead and, above all, strengthen the disease control interventions, effective partnership is vital. For this reason, in this current project, we particularly wanted to share the responsibility for procuring anti-tuberculosis drugs among all of the Programme's partners, including the Congolese state via its Ministry of Health. Given the DRC's current socioeconomic situation, it is difficult to expect the government's financial participation for the first two years of the project, beyond the import tax exemptions that it has been granting to the PNT and partners for a long time already. This is a major constraint for us, which must be overcome at all costs if we are to achieve the project's main objective. But, with the end of the war and the imminent establishment of a state of law, economic activities will resume and the State's will be able to financially contribute to the programme activities. The government will be asked to contribute towards the purchase of anti-tuberculosis drugs from the project's third year, for **10%** of the total amount. Meanwhile, it is planned that the other traditional partners (Fondation Damien, TLMI, Belgian Cooperation, ALM and UBS) buy all of the paediatric treatments (8% of total treatments) and 10% of the adult treatments for this project; this means that they must generate a total amount of funds equivalent to **18%** of the total treatments expected for the project's duration. We are requesting the **Global Fund to provide the remaining 72%**, in the 5th Round we have already been granted (…%) and (…%) is being requested for the current 6th Round.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

4.5 Financial and programmatic gap analysis

Interventions included in relation to this component should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Such an analysis should also recognize gaps in health systems, related to reducing the impact and spread of the disease. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described. For more information on this, see the Guidelines for Proposals, section 4.5.

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Use table 4.5.1-3 to provide in summarized form all the figures used in sections 4.5.1 to 4.5.3.

4.5.1 Overall needs assessment

a) Based on an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describe the overall **programmatic** needs in terms of people in need of these key services. Please indicate the quantitative needs for the 3-5 major services that are intended to be delivered (e.g.: anti-retroviral drugs, insecticide-treated bed nets, Directly Observed Treatment Short-Course for TB treatment). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table in section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.5.1*

b) Based on an analysis of national goals and objectives for fighting the disease component, describe the overall **financial** needs. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., costed national strategies, medium-term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [lineA]).*

4.5.2 Current and planned sources of funding

a) Describe the current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and coming years in table 4.5.1-3 [line B]).*

b) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C]).*

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

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Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

[

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]

	Financial gap analysis (*specify the currency:* Euro/US$)						
	Actual		Planned		Estimated		
	2004	2005	2006	2007	2008	2009	2010
Overall needs costing (A)	**12 050 000**	**10 700 000**	**25 325 690**	**23 899 446**	**20 621 312**	**21 682 359**	**21 038 520**
Current and planned sources of funding:							
Domestic source: Loans and debt relief *(provide donor name)*	0	0	0	0	0	0	0
Domestic source: National funding resources	1 930 000	1 500 000	1 030 000	1 500 000	1 500 000	1 700 000	1 700 000
Total domestic sources of funding (B)	**1 930 000**	**1 500 000**	**1 030 000**	**1 500 000**	**1 500 000**	**1 700 000**	**1 700 000**
External source 1 Global Fund Grants	4 502 226	1 904 569	8 206 100	7 915 022	8 316 419	6 543 699	6 775 513
External source 2 ***Fondation Damien***	3 279 225	3 443 816	3 290 904	3 462 697	3 528 451	3 549 020	3 681 108
External source 3 **USAID**	1 500 000	1 800 000	1 532 000	1 500 000	1 500 000	1 500 000	1 500 000
External source 4 **TLMI**	135 000	135 000	135 000	135 000	135 000	135 000	135 000
External source 5 **ALM**	290 000	290 000	290 600	290 000	290 000	290 000	290 000
External source 6 BELGIAN COOPERATION **.**	0	1 300 000	936 000	837 000	0	0	0
External source 7 **UBS**			140 425	113 125	185 225	144 625	161 425
External source 8 **ALTI**	50 000	50 000	50 000	100 000	100 000	100 000	100 000
External source 9 **GDF**	1 400 000	1 400 000	1 400 000	0	0	0	0
External source 10							

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WHO	300 000	300 000	300 000	300 000	300 000	300 000	300 000
External source 11 **EUROPEAN UNION**	0	0	780 000	780 000	780 000	0	0
Total external sources of funding (C)	**11 456 451**	**10 623 385**	**17 061 029**	**15 432 844**	**15 135 095**	**12 562 344**	**12 943 046**
Total resources available (B+C)	**13 386 451**	**12 123 385**	**18 091 029**	**16 932 844**	**16 635 095**	**14 262 344**	**14 643 046**
Unmet need (A) – (B + C)	**-1 336 451**	**-1 423 385**	**7 234 661**	**6 966 602**	**3 986 217**	**7 420 015**	**6 395 474**

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4.5.4 Additionality Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this will continue to be true for the entire proposal period.
As shown in the above table, the financial assistance from the Global Fund is additional to other funds from partners and the Congolese government. Many of our implementation partners have been financing the operation of their national and provincial offices at the national and provincial coordination level for several years. This project is taken from the 2006-2010 budgeted strategy plan, which will cost 112,567,327 USD to mobilize. We have pledges of approximately 80,564,358 USD and a deficit of 32,002,969 USD. With this submission we are requesting 11,000,000 USD, which will cover the needs of 400,000 further expected sufferers (half of the sick people to be tested during the 2006-2010 project) in terms of first-line anti-tuberculosis drugs and some activities associated with the good management of drugs (information support, central depot equipment, staff training)

4.6 Component Strategy

This section describes the strategic approach of this component of the proposal, and the activities that are intended in the course of the program. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance.

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section, all applicants must submit:

- A **Targets and Indicators Table.** This is included as **Attachment A** to the Proposal Form. *(When setting targets in this table, please refer explicitly to the programmatic need and gap analysis in section 4.5.1.a. All targets should show clearly the current baseline. For definitions of the terms used in this table, see the M&E Toolkit provided by the Global Fund. Please also refer to the Guidelines for Proposals, section 4.6)*

- A component **Work Plan** covering the first two years of the proposal period. The **Work Plan** should also be integrated with the detailed budget referred to in section 5.2.

  *The **Work Plan** should meet the following criteria (Please refer to the Guidelines for Proposals, section 4.6):*

  e. It should be structured along the same lines as the Component Strategy—i.e., reflect the same goals, objectives, service delivery areas and activities.

  f. It must cover the first two years of the proposal and should:
  - ***i) be detailed for year 1, with information broken down by quarters;***
  - ***ii) be indicative for year 2.***

  *g. It should be **consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

  *h. It should be integrated with the first two years of the **detailed budget** (please refer to section 5.2.)*

Please note that narrative information in this section 4.6 should refer to the Targets and Indicators Table (Attachment A to this proposal form), but should not consist merely of a description of the table.

4 Component section *Tuberculosis*

4.6.1 Goals, objectives and service delivery areas

Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

a) **The Principal Goal** of this component is to reduce the morbidity and mortality caused by tuberculosis in the Congolese population and thus contribute to poverty reduction, in accordance with the "Millennium Development Goals" targets (WHO).

b) **Impact Indicators**: The rate of tuberculosis prevalence must decrease by 50%, dropping from 551 cases to 175 for every 100,000 inhabitants between now and 2015; and the mortality rate must drop from 79 to 40 cases for every 100.000 inhabitants between now and 2015. The incidence rate must drop from 366 to 183 newly detected cases a year for every 100.000 inhabitants between now and 2050.

c) **The Objectives**: Between now and 2010, increase the treatment success rate to 85% in the 10 provincial coordinations**, whose rates vary between 72% (Eastern Province) and 84% (South Katanga)

d) **Service Delivery Area**: To achieve this objective in 2010-2011, we have only included in this 6th Round submission a service delivery area that complements the service delivery area in the 5th Round proposal to be implemented from August 2006 to 2010. The area included is the quality treatment of Tuberculosis cases.

e) **Coverage Indicators**:

a) The anticipated result with this submission is to treat all the expected cases between 2006-2010, the number of first-line treatments expected for this period rises to [XXX, *sentence end is missing*]. This quantity covers the needs for the number of expected cases over five years, with an additional reserve stock in the first year, equivalent to 18 months of treatment.

b) For that, in order to cover 100% of the population, we must permanently make the **drugs available in 1545 diagnosis-treatment centres** (CSDT) throughout the country.

c) The rational use of these medicines will require **the CSDT staff, old and new to start, train or retrain** in good management and use of anti-tuberculosis drugs.

d) An **external consultant** in drugs management has already been identified and their annual visits planned in the previous submission.

e) To comply with the security standards that guarantee the quality of the drugs, **quality equipment** must be made available at the central depot in Kinshasa.

f) **Principal Activities:**

* This data is taken from estimations made by the WHO in the WHO REPORT 2006

** The 10 provincial coordinations with a treatment success rate below 85% are: South Equator, South-Eastern Kasai, North Kivu, South Kivu, North Katanga, South Katanga, Maniema, East and West and Central Provinces. It is practically the Eastern part of the Country, where the last war raged for 7 years and where there are still lots of insecure areas.

4.6.2 Link with overall national context

Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context in section 4.4. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

The attainment of the proposal's objectives, which are also the programme's objectives, to control Tuberculosis in the country, is the first stage of controlling the tuberculosis endemic. According to the epidemiological data we have achieved this for the whole country. But on closer look, more than 200 Health Zones (almost half) are still below these levels.

4.6.3 Activities

Provide a clear and detailed description of the activities that will be implemented within each service delivery area and for each objective. Please include all the proposed activities, how these will be implemented, and by whom. (*Where activities to strengthen health systems are planned, applicants are also required to provide additional information at section 4.6.6.*)

The main activity in the service delivery area for "treatment of tuberculosis sufferers" that we have chosen to submit for funding in the 6th Round of the Global Fund concerns the procurement of first-line anti-tuberculosis medicines. For us to make the sufficient quantity of quality medicines permanently available everywhere, we need to **retrain/train** the staff who manage the tuberculosis care centres. To collect data concerning the drugs, recently prepared **information support** must be distributed everywhere where treatment is carried out.

We have planned for the provision of extra equipment to optimize storage and distribution at the central level in Kinshasa. We will use the **Asrames services**, a procurement centre based in Goma, for the storage and distribution of drugs for the Health Zones in the East of the country, which includes 5 provincial coordinations (East and West Provinces, North Kivu, South Kivu and Maniema). We are planning for the internal distribution in the West of the country to be carried out via the Programme with a technical assistance in [XXX, *sentence end is missing*].

The procurements will be carried out by the Principal Recipient, **UNDP/Global Fund through the GDF**, which is the WHO-authorised international supplier for first-line anti-tuberculosis medicines. The PNT already has four years of experience through a donation of medicines supplied by the GDF. In addition to the procurement, we receive an annual visit from an external consultant to evaluate the management circuit for the programme's drugs.

As in previous Global Fund projects, we have appointed **Fondation Damien** as the sub-recipient of the activities to train/retrain staff in drugs management. The training is carried out via a pool of programme trainers at central and intermediary levels. The central office teams will train the operators (nurses and doctors in the hospitals and base health centres).

The printing and distribution of information support and the procurement of small equipment at the central depot will be done by the **Programme**.

4.6.4 Performance of and linkages to current Global Fund grant(s)

This section refers to any prior Global Fund grants for this disease component and requests information on performance to date and linkages to this application. For more information, please refer to the Guidelines for Proposals, section 4.6.4.

a) Provide an update of the current status of previous Global Fund grants for this disease component, in the table below.

Table 4.6.4 – Current Global Fund grants

	Grant number	Grant amount*	Amount spent
GF Grant 1	ZAR-202-GO1-TOO	7 973 002	7 601 673

GF Grant 2	In negotiation and awaiting signature	36 234 565	0
GF Grant 3			
GF Grant 4			

* *For grants in Phase 1, this is the original two year grant amount. For grants that have been renewed into Phase 2, this is the total amount, inclusive of Phase 1 and Phase 2.For unsigned Round 5 grants this is the two year TRP approved maximum budget.*

b) Please identify for each current grant the key implementation challenges and how they have been resolved.

c) Are there any linkages between the current proposal and any existing Global Fund grants for the same component? (e.g. same activities, same targeted populations and/or the same geographical areas).

☒ Yes
➔ *complete d)*

☐ No
➔ *go to 4.6.5*

d) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided under current Global Fund grants.

4.6.5 Linkages to other donor funded programs

a) Are there any linkages between the current proposal and any other donor funded programs for the same disease?

☒ Yes
➔ *complete b)*

☐ No
➔ *go to 4.6.6*

b) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided by other donors, including in respect of health system strengthening activities.

4.6.6 Activities to strengthen health systems

Certain activities to strengthen health systems may be necessary in order for the proposal to be successful and to initiate additional HIV/AIDS, tuberculosis, and/or malaria interventions. Similarly, such activities may be necessary to achieve and sustain scale-up.

Applicants should apply for funding in respect of such activities by integrating these within the specific disease component(s). Applicants who have identified in section 4.4.4 health system constraints to achieving and sustaining scale-up of HIV/AIDS, tuberculosis and/or malaria interventions, but do not presently have adequate means to fully address these constraints, are encouraged to complete this section. For more information, please refer to the Guidelines for Proposals, section 4.6.6.

a) Describe which health systems strengthening activities are included in the proposal, and how they are linked to the disease component. *(In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. See the Multi-Agency M&E Toolkit).*

b) Explain why the proposed health systems strengthening activities are necessary to improve coverage to reduce the impact and spread of the disease and sustain interventions. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.6.)*

c) Describe how activities to strengthen health systems, integrated within this component, will have positive system-wide effects and how it is designed in compliance with the surrounding context and aligned with government policies.

d) Are there cross-cutting health systems strengthening activities integrated within this component that will benefit any other component included in this proposal?	☐ Yes ➔ *complete e) and f)* ☒ No ➔ *go to g)*

e) If you answered yes for d), describe these activities and the associated budgets and identify and explain how the other components will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

f) If you answered yes for d), confirm that funding for these activities has not also been requested within the other component. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

g) Is this component reliant on any cross-cutting health systems strengthening activities that have been included within other components of this proposal?	☐ Yes ➔ *complete h)* ☒ No ➔ *go to 4.6.7*

h) If you answered yes for g), describe these activities and the associated budgets and identify and explain how this component will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

4.6.7 Common funding mechanisms

This section seeks information on funding requested in this proposal that is intended to be contributed through a common funding mechanism (such as Sector-Wide Approaches (SWAp), or pooled funding (whether at a national, sub-national or sector level).

a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* ☒ No ➔ *go to 4.8*

b) Indicate in respect of each year for which funds are requested the amount to be funded through a common funding mechanism.

c) Describe the common funding mechanism, whether it is already operational and the way it functions. Identify development partners who are part of the common funding mechanism. Please also provide documents that describe the functioning of the mechanism as an annex. *(This may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

d) Describe the process of oversight for the common funding mechanism and how the CCM will participate in this process.

e) Provide an assessment of the incremental impact on projected targets as a consequence of the funds being requested for this component, which are to be contributed through the common funding mechanism.

f) Explain the process by which the applicant will ensure that funds requested in this application, that are contributed to a common finding mechanism, will be used specifically as proposed in this application.

4.6.8 Target Groups

Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the programme will have on these group(s).

4.6.9 Social stratification

Provide estimates of how many of those expected to be reached are women, how many are youth, how many are living in rural areas and other relevant categories. The estimates must be based on a serious assessment of each objective.

The calculation in the analysis of vulnerable groups only takes into account the PTB+ sufferers on our registration system.

The total number of **new smear test-positive cases** (PTB+) expected between 2006 and 2010 is approximately 518,613 cases, based on our national average of a 10% increase a year. Knowing that **66%** of sick people tested in 2004 were from TB diagnosis and treatment centres in rural areas, we have projected this percentage onto the 2006-2010 total and estimate 342,284 PTB+ cases. **Young people from 0-24 years of age represent 27%** of the PTB+ sufferers, and **women represent 47%** of cases, against 53% for men. These 2004 percentages remain the same **in 2005**.

Table 4.6.9 – Social stratification

	Estimated number and percentage of people reached who are:			
	Women	Youth (<18)	Living in rural areas	Other*
SDA 1 Between now and 2010, increase the treatment success rate to 85% in 10 provincial coordinations that have not yet reached this	136,743 (PTB+)	78,554 (PTB+)	290,941 (PTB+)	
SDA 2				
SDA 3				
SDA 4				

* *"Other" to include target groups according to country setting (e.g. indigenous populations, ethnic groups, underprivileged regions, socio-economic status, etc.) Targets should be defined according to country disease programs.*

4.6.10 Gender Issues

Describe gender and other social inequities regarding program implementation and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities.

4.6.11 Stigma and discrimination Describe how this component will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases.
As explained above, the Programme to confront Tuberculosis is integrated into the primary health care services. In this respect, its interventions cover all of the country, rural and urban areas alike, affecting almost all the layers of the population. The country's health policy recommends that care structures be **self-financing**, meaning that general care services are chargeable. This is a fairly discriminatory measure that affects the very precarious socioeconomic situation of the great majority of the Congolese population. Consequently, the population's accessibility to care facilities is generally poor, as a result of the low purchasing power of over 90% of the sick people. For this reason, the PNT has opted for the **free diagnosis and treatment** of all sick people tested and treated for tuberculosis in all approved public and private facilities. We confirm that since this measure was taken in 1994, we have tested and treated even more sick people than in previous years.

4.6.12 Equity Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs).
See 4.6.11

4.6.13 Sustainability Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the program term. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.13.)*
See 4.6.11

4.7 Principal Recipient information

In this section, applicants should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, section 4.7. for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.

4.7.1 Principal Recipient information

Every component of your proposal can have one or several Principal Recipients. In table 4.7.1 below, you must nominate the Principal Recipient(s) proposed for this component.

As part of this submission, the procurement of first-line anti-tuberculosis medicines will be based on previous experience acquired with the **GDF**, which has supplied the country with quality products of proven effectiveness for four years. The UNDP will pass the procurement order to the GDF (supplier) via a Long Term Agreement (**LTA**), signed between the UNDP and IAPSO (procurement agent for GDF). GDF will make the medicines available in Kinshasa and Goma, the entrance ways for the provincial coordinations in the West and the East of the country respectively.

Table 4.7.1: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☒	Single
	☐	Multiple

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Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact Person**	**Address, telephone, fax numbers and e-mail address**
UNDP	- Medicine procurement - Rehabilitation and equipping of depot	PNT, **GDF**	Name : Babacar M. Cisse Title**: UNDP Country Director** Address: Immeuble LOSONIA, Bld du 30 Juin-Kinshasa Tel.: (243) 817100064 Fax: (243) 88 43 675 E-mail: babacarM.cisse@undp.org - **GDF (Global Drug Facility)** Stop TB Avenue: OMS, CH-1211 Genève, Suisse E-mail: gdf@who.int Telephone: +41 22 791 2385
UNDP	- Distribution of information support - Supervision of drugs supply management activities at intermediary and peripheral level	**PNT**	**PNT-RDC** Avenue Kabinda, opposite the RTNC. B.P: 12706 KIN1 /Kinshasa E-mail: pnt-rdc@ic.cd Telephone: 0999946997
UNDP	Staff training	**FONDATION DAMIEN**	**Fondation Damien DRCongo** Avenue Pierre Mulele, n°162, Kinshasa/Gombe B.P.: 3015 Kinshasa/Gombe E-mail: dfb-kin@ic.cd Telephone: + (243) 998135091. + (243) 816520396

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4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements. *(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM. Maximum of half a page).*

Programmatic and financial management will be carried out by the PR, who will work with the sub-recipients to draft an overall work plan for the implementation of the activities. This work plan will define for each objective and every quarterly period, the activities, budget and relevant costings, the target to reach, the indicator and the person or organization responsible. The PR will use project management software. The adopted work plan will be input into the software for better project management.

A monitoring plan will be established in accordance with Global Fund guidelines. In particular, this consists of drafting a check list to evaluate the aforementioned monitoring plan. The indicators will be those used and collected by the National Programme. The activities will be monitored using four mechanisms, which are: meetings, field missions, supervisions and KAP surveys.

1. Meetings

A meeting will take place every two months, organised by the PR in collaboration with all the sub-beneficiaries. The objective of these meetings will be to observe to what level the indicators have been met as well as the gaps, and to propose corrective measures.
The work will be based on the documentary reviews, including the work plan and attachments. During the meetings, the parties present will:

- monitor the activities within the scope of the program;
- observe the gaps and propose corrective measures;
- assess the achievement level of contractual indicators;
- deliberate over the problems encountered in the field during implementation.

The calendar for meetings will be drafted with the involvement of all those concerned (partners' forum).

2. Follow up missions

The monitoring and evaluation team will carry out field missions. At the central level missions will be carried out for sub-recipients, while at the intermediate level visits will be made to the coordinations who are sub-recipients. Joint PR and PNT missions will be organized for this level. Some health centres will be visited, according to information taken from the documentary review at the level of coordination offices. The monitoring tools are already in place and include, other than the indicators that are in the national health information system, some indicators to reflect the financial use rate.

3 The supervisions

Technical aspects of the activities will be monitored via the supervisions. The objective of the supervision is to ensure that the work in the offices of the provincial coordinations and the testing and treatment health centres (CDT) is carried out according to the PATI IV guidelines and that the resources available to the staff in these facilities are used wisely. All the provincial coordinations, Health Zones and CDTs will be supervised. The provincial coordinations will be supervised by the national office. While the Health Zones and CDTs will be supervised by the teams from the coordinations once every quarter;

4 Component section *Tuberculosis*

Please note that if there are multiple Principal Recipients, section 4.8.2 below has to be repeated for each one.

4.8.2 Principal Recipient Capacities

a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient. Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g. capacity-building, staffing and training requirements, etc.).

.

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes
	☐ No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☒ Yes
	☐ No

d) If you answered Yes for b) or c), provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous grants (Global Fund or other donor).

e) e) If you answered Yes for b) or c), describe how the PR would be able to absorb the additional work and funds generated by this proposal.

The programmatic and financial management will be carried out by the PR, who will work with the program's sub-recipients to draft an overall work plan. This plan for the implementation of activities defines for each objective and every quarterly period, the activities, budget and relevant costings, the target to reach, the indicator and the person or organization in charge of the activity.

A monitoring plan will be set up in accordance with Global Fund guidelines. In particular, this consists of drafting a check list to evaluate the aforementioned monitoring plan . The indicators will be taken from the program's database and routinely used in other projects.

Additionally, in relation to the national programme, the PR will strengthen the management group with national staff, especially in the area of monitoring and evaluation, at a central and peripheral level. For the financial management, the UNDP has enough human resources to assume a further responsibility. Where purchases are concerned, the current partnership with FEDECAME, Asrames and other RDC (Regional Distribution Centres) will allow synergies to develop by simultaneously using the ongoing approach with the Global Drug Facility, the UNDP and the PNT.

4 Component section *Tuberculosis*

4.8.3 Sub-Recipient Information	
a) Are sub-recipients expected to play a role in the program?	☒ Yes → *complete the rest of 4.8.3*
	☐ No → *go to 4.9*
b) How many sub-recipients will or are expected to be involved in the implementation?	☒ 1 – 5
	☐ 6 – 20
	☐ 21 – 50
	☐ More than 50
c) Have the sub-recipients already been identified?	☒ Yes → *complete section 4.8.3. d) - e), then go to section 4.9*
	☐ No → *go to section 4.8.3. f) - g)*
d) Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g. open bid, restricted tender, etc.)	
Given that the fight against Tuberculosis in DRC is carried out as part of an integrated program, the sub-beneficiaries will be selected by a restricted tender. This tender will concern: the institutions involved in the fight against Tuberculosis, organized into the Tuberculosis Task Force. The selection criteria are: - To be a recognised institution in DRC with legal status and ROI. - To be an institution that has been working in the Tuberculosis field for at least three years. - To be free of any previous criminal record. - To have technical capacities in Tuberculosis control management. - To have financial management capacities (the report of other donors being proof thereof). - To present a work plan that corresponds with the project's objectives. - To present a budget whose costing and effectiveness may be analysed against results.	
e) Where sub-recipients applied to the Coordinating Mechanism, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal.	
None	
f) Describe why sub-recipients were not selected prior to submission of the proposal.	
All the partners supporting the fight against Tuberculosis in DRC have participated in drafting the proposal. The PR is responsible for selecting the sub-beneficiaries according to the above criteria.	

g) Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process.
A restricted call for tenders will be launched among the members of the Tuberculosis Task Force (cf. point d). The Terms of Reference will be written and an international call for tenders launched for the International Consultants.

4.9 Monitoring and evaluation

The Global Fund encourages the development of nationally owned monitoring and evaluation plans and monitoring and evaluation systems, and the use of these systems to report on grant program results. By completing the section below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts.

4 Component section *Tuberculosis*

4.9.1 Plans for monitoring and evaluation and 4.9.2 Integration with the national M&E Plan

Describe how the targets and activities indicated in the Targets and Indicator Table (attached as Attachment A to this proposal, see section 4.6) will be monitored and evaluated. Please identify any surveys to which this proposal is contributing.

4 Component section *Tuberculosis*

Monitoring and Evaluation of the programme and this project

1) Monitoring of activities and reporting of indicators for the programme and this project

- the PNT has its own information system, inspired by the system proposed by WHO and the UNION, which uses information support (epidemiological and management), explained in detail in the Programme Guide and inserted into the Ministry of Health guide. Since 2003 we have established the Patimed guide for drugs, which was reviewed in 2005. In the PATIMED II guide an information system has been developed for drugs management at all levels of the DRC's health pyramid.

- The data collection for medicines, as for other epidemiological data and management, is carried out daily in every care facility. The reporting is quarterly for epidemiological laboratory data and management data for drugs and other supplies for testing and treatment sick people. All the data collected from the CDTs (1041 in 2005) is validated each quarter at the intermediary level (22) between the provincial coordination team and the staff in the central offices of all the Health Zones participating in the disease control activities. Afterwards, all the synthesized, analysed and interpreted data for each provincial coordination is synthesized each quarter at the national level. The higher level gives feedback to the level that provided the data each time. The data is published annually by the national level, following analysis of and comments on the program's principal indicators. The monitoring or follow up of medicine management activities carried out during the supervisions at all levels. The supervisions, spread out throughout the quarter and planned at every level of the system, back up the quarterly reports. A supervisions timetable is commonly agreed and drawn up within the implementation partners' forum.

- A support activities' data bank has been created at the Central Unit-level for all reports by the Leprosy and Tuberculosis programs and their partners on the supervisions and training carried out during the year. This data bank may be consulted at any moment and by all the agents in the fight against tuberculosis.

- Also, to resolve the problems of **promptness and completeness** of data that we are currently aware of, we have planned in the 5th Round project that will run at almost the same time as this project and which complements it, to improve the quality and volume of communication, especially between the intermediary and central level, by using the IT and internet tool at the different levels of the health system, with an appropriate budget. In the 6th Round we will again take into consideration the strengthening of staff capacities, especially at the peripheral level, by specific training in the management of anti-tuberculosis drugs.

2. Evaluation of the programme and this project

- For the GDF (Global Drug Facility) project, who will soon have been supplying us with drugs for four years, evaluations are performed each year by the consultant from the Union and MSH. Moreover, the evaluations for all of the PNT's activities are not systematic and are often carried out at the end of an intermediary level project (European Union projects, the Belgian Cooperation…) or national project (USAID, the Program's external review). We carried out our first external evaluation of the PNT in February 2005, as part of the 2nd Round Global Fund grant. The aspects of drugs management is largely accounted for in the External Review, which includes all the programme's activities.

- The programme's performances are indirectly evaluated by punctual surveys of the prevalence of resistance to first-line anti-tuberculosis drugs. We have already done this once in 1998, in the sole province of Kinshasa, with results that showed us the rate of prevalence to multiresistance as 2.1%, and 22% among the old cases tested in 1998 in Kinshasa town (1/10 of the total population). We will probably carry out this survey again in the second half of 2006. We have planned to carry out a 3rd survey in the 5th Round that will cover the whole country in 2010. This will give us a full and comprehensive image of the multiresistance to first-line anti-tuberculosis medicines in DRCongo. The WHO currently estimates the national rate of prevalence to multiresistance at 1.7% for new cases.

4.9.2 Integration with national M&E Plan Describe how performance measurement for this program is proposed to contribute to and/or strengthen the national Monitoring and Evaluation Plan for this component. If a national Monitoring and Evaluation strategy exists, please attach it as an annex to the proposal, and provide a summary of key linkages with the national Monitoring and Evaluation Plan and data collection methods.	
See the explanations to point 4.9.1	

4 Component section *Tuberculosis*

4.10 Procurement and supply management of health products

In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.10

4.10.1 Organizational structure for procurement and supply management

Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities, such as National Drug Regulatory Authority (or quality assurance department), the Ministry of Finance, the Ministry of Health, distributors, etc.

- Where procurement and supply is concerned, a service centre within the UNDP, which is responsible for purchasing, collaborates with a team of consultants to organize the purchases according to the needs set out in the procurement plan. Please note that the procurement and management plan will be written in advance. Quantities and specifications relating to this plan and corresponding to the budget will be defined in the annexes.

- For four years now the GDF has purchased 80% of the PNT's required anti-tuberculosis medicines at an annual average of 1,700,000 USD and traditional partners such as Fondation Damien, Belgian Cooperation, TLMI, ALM and UBS have purchased the rest. The traditional partners centralize their purchases through the Fondation Damien, which makes a restricted, international call for tenders each year. There are two entrance points in the country for all the medicines from the GDF and the partners: Kinshasa (West) and Goma (Goma). The medicines are stored in Kinshasa and Goma for the country's Western and Eastern coordinations respectively.

The medicines are usually distributed twice a year between the central level and the provinces, and each quarter between the provinces and the peripheries (Health Zones), which in their turn serve the health centres and hospitals at least once a month. The costs of all these operations are in the Work Plan for the first year of this submission (TB Annex…). Asrame will oversee the supplies to the East of the country. It has already been supplying medicines for the "primary health care" programmes since 1993, for a sales figure of 3,000,000 USD a year, and it has just built a large capacity storage depot. The Central Unit's central depot organizes distribution to the 17 coordinations in the West of the country, mainly by aeroplane, except for the Lower Congo province.

For four years, a **3-person team from the Central Unit** have arranged the tax exemptions from the Health and Finance Ministries. They then contact the Transit and Transport services within the country. A distribution plan is established for each international delivery and the updated costs and delivery schedule are discussed with the UNDP (logistics service) and each MCP (Provincial Coordination). All the documents relating to these supplies are completed and kept by the services and partners concerned.

4.10.2 Procurement capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?	☐ Principal Recipient Only
	☐ Sub-recipients only
	☒ Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) for procurement of drugs and related medical supplies by that agency.

4 Component section *Tuberculosis*

4.10.3 Coordination

a) For the organizations involved in section 4.10.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

- For four years, since 2002, the PNT has carried out its purchases with a GDF donation that should cover 2/3 of the needs and the remaining 1/3 covered by the traditional implementation partners. The GDF and its partners have just bought medicines for 2006 for a total of **1,987,601 USD, of which 1,677,331 USD is from the GDF (more than 80% of purchases) and 310,270 USD is from the partners (Fondation Damien, TLMI, ALM, Belgian Cooperation…). Below is the quantity of drugs received in 2006, as both combined and individual products.**

$R_{150}H_{75}Z_{400}E_{275}$: 19,919,000 pills
$R_{150}H_{75}Z_{400}$: 2,446,000 pills
$R_{150}H_{75}$: 52,487,000 pills
EMB_{400}: 2,446,515 pills
SM: 466,050 fl of 1gr

<u>Paediatric formulas</u>
$R_{60}H_{30}Z_{150}$: 2,341,000 pills
$R_{60}H_{30}$: 4,755,000 pills

4.10.4 Supply Management (storage and distribution)

a) Has an organization already been nominated to provide the supply management function for this grant?	☒ Yes → *continue*
	☐ No → *go to 4.10.5*

b) Indicate, which types of organizations will be involved in the supply management of drugs and health products? If more than one of the boxes below is ticked, describe the relationships between these entities.	☒ National medical stores or equivalent
	☒ Sub-contracted national organization(s) *(specify which one(s))* ASRAMES: Association Régionale d'Approvisionnement en médicaments essentiels (Regional Association for Procurement of Essential Drugs)
	☐ Sub-contracted international organization(s)) *(specify which one(s))*
	☐ Other *(specify)*

c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

[For tuberculosis and HIV/AIDS components only:]

4.10.5 Multi-drug-resistant TB	
Does the proposal request funding for the treatment of multi-drug-resistant TB?	☐ Yes
	☒ No
If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be carried out through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.5.	

4.11 Technical and Management Assistance and Capacity-Building

Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including in respect of , development of M&E or Procurement Plans, enhancing management or financial skills etc. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.11.

4.11.1 Capacity building

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.

- The problem to be addressed in this project principally concerns the logistical and management circuit for first-line anti-tuberculosis drugs. This circuit includes the procurement by the UNDP, distribution by the PNT (West of the country) and Asrames (East of the country), and the use by the operational health facilities into which the programme is integrated (Diagnostic and treatment centres). At each stage of this drug management circuit the capacities are either present within the program and must be improved by supervisions and training, or must be mobilized within the country (provincial medical store inspectors for supervision and training), or requested from outside the country (consultants for evaluations and training).

- **Estimations of needs:** For procurements we need capacities within the PNT to estimate the needs and pass the order via the UNDP, who will identify the supplier (GDF), who will then purchase and transport the drugs to one of the country's two entrances, Goma via Kigali and Kinshasa. The estimations of needs at the PNT level are carried out by the PATIMED committee, responsible for drugs management as part of the Task Force (forum for exchanges between the PNT and all the partners). In this committee there are pharmacists, logisticians and doctors from the partners and the program's Central Unit. The order is immediately drawn up and sent to the UNDP for purchasing.

- **Purchases:** The purchase of anti-TB drugs is mainly carried out by the GDF (WHO-qualified supplier). The molecules or combinations (paediatric forms, RHZ) that are not available to GDF are purchased from other suppliers following a call for tenders by the UNDP, which has a very experienced international service in this field.

- **Distribution:** Once the drugs have arrived in Kinshasa and Goma, they must reach the depots in the 26 provincial coordinations (twice a year), from where they will be distributed to the different Health Zones (quarterly), which will in turn make them available on a monthly basis to the health facilities. The local capacities of the PNT and its partners, PATIMED and Asrames, are already experienced in distribution. It is planned that they will carry out distribution for the duration of the Project. For all of these staff (logisticians and pharmacists) the training (internal and external) will be organized each year to fill the gaps observed during the supervisions and annual evaluations (external evaluations planned in the 5th Round).

- **Usage:** The drugs must be available in 1545 associated Diagnostic and Treatment Centres. We recently changed the treatment regimen in 2005 from 8 to 6 months of treatment using, for the first time in the programme, blister-packed pills for the last three years of the project. All these changes require the training/retraining of the users who treat tuberculosis sufferers. Several related training courses are planned for the trainers (78 people at intermediate level) and operators (1545 people at the peripheral levels) in order to update their knowledge.

- **Evaluation:** An annual evaluation of the program's drug management and logistic circuit by an external consultant is provided for in the project accepted for the 5th Round, which covers the same period as the project proposed in the 6th Round. The costs for these evaluations have not been budgeted into Round 6.

4.11.2 Technical and management assistance

Describe any needs for technical assistance, including assistance to enhance management capabilities. *(Please note that technical and management assistance should be quantified and reflected in the component budget section, section 5.6)*

. For the first two years of this project we will need a **technical assistant** for the management of drugs and other health products and goods, who will work with the PNT team and the Principal Recipient's logistics team. They will be hired for a permanent two-year contract and will be the counterpart to the PNT's pharmacist and logistician.

They **will help the PNT management** to procure drugs through real estimations of needs, and calls for tenders to purchase quality medicines at lowest cost. They will identify a good transport circuit for the country. They will lend their expertise to the PATIMED committee for a good management of national supplies, nationwide distribution, and ongoing supervision of the drugs management at the intermediary and peripheral level, as well as the preparation of **periodic evaluations**, at least once a year. The cost for this Technical Assistant will be USD 240,000 (full time) for two years.

This technical assistance will complement the **external consultations provided for in the project** submitted to the 5th Round, which consists of 1 or 2 annual visits organized by The Union (international consultant appointed by the WHO to the PNT-DRCongo) and an **MSH consultant**. These latter have been carrying out the annual evaluations of the programme's general development since 2000, and particularly the evaluation of anti-tuberculosis drugs management activities.

5 Budget section *Tuberculosis*

PLEASE NOTE THAT THIS SECTION IS TO BE COMPLETED FOR EACH COMPONENT

In this section, applicants will need to provide summary budget information for the proposed duration of the component. Applicants are also required to provide a more detailed budget as an annex to the proposal. For more information on budget requirements, please refer to the Guidelines for Proposals, section 5.

If part or all of the funding requested for this component is to be contributed through a common funding mechanism (consistent with section 4.6.7)**, applicants should provide:**

- Compile the Budget information in sections 5.1 – 5.6 on the basis of the anticipated use, attribution or allocation of the requested funds within the common funding mechanism; and;

Provide as an annex, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request.

5.1 Component budget summary

Insert budget information for this component broken down by year and budget category, in table 5.1 below.
(The "Total funds requested from the Global Fund" should be consistent with the amounts entered in table 1.2 relating to this component)

The budget categories and allowable expenses within each category are defined in the Guidelines for Proposal, section 5.1. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.

Table 5.1 – Funds requested from the Global Fund

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	120 000	120 000	0	0	0	240 000
Infrastructure and equipment	66 200	0	0	0	0	66 200
Training	490 200	1 302 800	0	13 320	0	1 806 320
Commodities and products	0	0	0	0	0	0

5 Budget section *Tuberculosis*

Drugs	3950761	793 276	802 165	882 417	970 613	7 399 232
Planning and administration	542 188	233 506	109 708	102 810	111 620	1 099 832
Other (please specify) **Printing of drug management guidelines and data management collection tools**	162 100	0	134 600	0	0	296 700
Other (please specify) **Distribution of drugs, guidelines and data collection tools**	632 614	118 991	160 325	132 363	145 592	1 189 885
Total funds requested from the Global Fund	5 964 063	2 568 573	1 206 798	1 130 910	1 227 825	12 098 170

5 Budget section *Tuberculosis*

5 Budget section *Tuberculosis*

5.2 Detailed Component Budget

The Component Budget Summary (section 5.1) must be accompanied by a more detailed budget covering the proposal period, attached as an annex to the proposal. The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.2):*

f) It should be ***structured along the same lines as the Component Strategy****—i.e., reflect the same goals, objectives, service delivery areas and activities.*

g) It should cover the term of the proposal period and should:
- *i) be* ***detailed for year 1 and year 2*** *of the proposal term, with information broken down by* ***quarters for the first year****;*
- *ii) Provide summarized information and assumptions for the balance of the proposal period (****year 3 through to conclusion of proposal term****).*

h) It should state all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.3.

i) It should be integrated with the detailed ***Work Plan*** *for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*

j) It should ***be consistent*** *with other budget analyses provided elsewhere in the proposal, including those in this section 5.*

5.3 Key budget assumptions

Without limiting the information required under section 5.2, please indicate budget assumptions for year 1 and year 2 in relation to the following:

5.3.1 Drugs, commodities and products

Please use Attachment B (Preliminary Procurement List of Drugs and Health Products) in order to compile the budget request for years 1 and 2 in respect of drugs, commodities and health products. Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.

a) Provide a list of antiretroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please complete table B.1 in Attachment B to the Proposal Form.)*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please complete table B.2 in Attachment B to the Proposal Form.)*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please complete table B.3 in Attachment B to the Proposal Form.)*

(For example: Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (); Market News Service, Pharmaceutical Starting Materials and Essential Drugs, WTO/UNCTAD/International Trade Centre and WHO (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); International Drug Price Indicator Guide on Finished Products of Essential Drugs, Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (http://www.stoptb.org/GDF/drugsupply/drugs.available.html).)

N.B.: For a, b and c, see tables B1, B2, in Annex TB 11.

5.3.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over. (Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)

The **human resources we are requesting** in this proposal is **a technical assistant** for the management of drugs and other health products and goods, who will work with the PNT team and the Principal Recipient's logistics team. They will be hired for a permanent two-year contract and will be the counterpart to the PNT's pharmacist and logistician.

They will **help the PNT management** to procure medicines through real estimations of needs, and calls for tenders to purchase quality medicines at lowest cost. They will identify a good transport circuit for the country. They will lend their expertise to the PATIMED committee for a good management of national supplies, nationwide distribution and ongoing supervision of drugs management at the intermediary and peripheral level, as well as the preparation **of periodic evaluations**, at least once a year. The cost for this Technical Assistant will be USD 240,000 (full time) for two years.

This technical assistance will complement the **external consultations provided for in the project submitted to the 5th Round**, which consists of 1 or 2 annual visits organized by The Union (international consultant appointed by the WHO to the PNT-DRCongo) and **an MSH consultant**. These latter have been carrying out annual evaluations of the program's general development since 2000, and particularly the aspects of anti-TB drugs management activities.

5.3.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years. (Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)

The spending categories that relate to the infrastructures and **large equipment** only occupy a small space in this submission, for the simple reason that this submission mainly concerns the procurement of drugs to fill the gaps in the programme in terms of treatments to supply to half of the sick people we test during the five-year plan 2006-2010, covering both the 5th and 6th Rounds of the Global Fund. The large equipment, infrastructure and rehabilitation has been accepted in the 5th Round and disbursement is currently being negotiated for the two first years.

In this submission we are requesting extra, complementary equipment (66,200 US$) for the central depot in Kinshasa that has just been rehabilitated with funds from USAID, Fondation Damien, Belgian Cooperation and Global Fund (first phase of the 2nd Round).

5 Budget section *Tuberculosis*

5 Budget section *Tuberculosis*

5.4 Breakdown by service delivery area

Please provide an approximate allocation of the annual budget for each service delivery area (SDA). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). It is anticipated that this allocation of the budget across SDAs should be derived from the detailed component budget (see section 5.2).

Table 5.4 : Estimated budget allocation by service delivery area and objective.

		Budget Allocation per SDA (in Euro/US$)				
Objectives:	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Increase the treatment success rate to 85% in all Health Zones	Rapid detection and quality treatment for all patients	5 964 063	2 568 574	1 206 798	1 130 910	1 227 825
Total		5 964 063	2 568 574	1 206 798	1 130 910	1 227 825

5.5 Breakdown by implementing entities

Indicate in table 5.5 below how the resources requested in table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.

Table 5.5 - Allocations by implementing entities

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector	PM	PM	PM	PM	PM
Government: PNT/ASRAMES	903 960	124 941	309 671	138 981	152 872
Nongovernmental / community-based org. FONDATION DAMIEN	514 710	1 367 940	0	13 986	0
Multi-/bilateral development partners UNDP/GDF	4 545 393	1 075 693	897 128	977 943	1 074 954
Total	49,3%	21,2%	10%	9,3%	10,1%

5 Budget section *Tuberculosis*

5.6 Budgeted funding for specific functional areas

The Global Fund is interested in knowing the funding being requested for the following three important functional areas - monitoring and evaluation; procurement and supply management; and technical and management assistance. Applicants are required in this section to separately identify the costs relating to these functional areas. In each case, these costs should already be included in table 5.1. Therefore, the tables below should be subsets of the budget in table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).

Table 5.6 – Budgets for specific functional areas

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and Evaluation	PM (round 5)	PM (round 5)	PM (round 5)	PM (round 5)	PM (round 5)	PM (round 5)
Procurement and Supply Management	1 403 102	352 498	404 633	235 173	257 212	2 652 618
Technical and management assistance	120 000	120 000	0	0	0	240 000

Monitoring and Evaluation: *This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.*

Procurement and Supply Management *This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion. Do not include drug costs, as these costs should be included in section 5.3.1.*

Technical and Management Assistance: *This includes: costs of consultant and other human resources that provide technical and management assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.*

N.B.: Table 5.6 is shown in more detail in Annex TB 13 (Budgets for specific functional areas)

4. Component section *Tuberculosis*

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

TUBERCULOSIS COMPONENT

LIST OF ANNEXES ATTACHED TO THE PNT'S 6TH ROUND PROPOSAL TO THE GLOBAL FUND

A. TB component strategy (section 4.1.1)

Annex TB 0: List of abbreviations
Annext TB 1: Pati-IV
Annex TB 2: Information support PATI-IV
Annex TB 3: Management Guide for anti-tuberculosis drugs.
Patimed II
Annex TB 4: Patimed II management tools
Annex TB 5: Synthesis of epidemiological data 2005
Annex TB 6: Development plan 2006-2010
(with logic framework and Budget)
Annex TB 7: External review report 2005
Annex TB 8: Targets and impact indicators (Annex A of the form)
Annex TB 9: Component Work Plan

B. Budget (section 5)

Annex TB 10: Component budget
Annex TB 11: Selection Table B1 and Preliminary Pr List of Drugs and Health Products
Table B2

C. Others

Annex TB 12: PSM TB R5 5 (Plan GAA Global Fund Round 5)
Annex TB 13 – Budgets for specific functional areas
(Table 5.6)
Annex TB 14: Programmatic gap analysis table
(Annex 3 to R6)
Annex TB 15: Budget analysis model.

4. Component section *Tuberculosis*

PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT *Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.*

For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.

4.1 Estimation de la date de début et de la durée de la composanteIndicate the estimated start time and duration of the component

Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval

Table 4.1.1 – Proposal start time and duration

	From (yyyy/mm)	To (yyyy/mm)
Month and year:	**JANUARY 2007**	**DECEMBER 2009**

4.2 Interlocuteurs pour les questions relatives à la composanteContact persons for questions regarding this component

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately six months after the submission of the proposal.

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr Benjamin ATUA MATINDII	Dr Jean ANGBALU EGBANGO
Title	Program Manager	Assistant Program Manager
Organization	National Malaria Control Program	National Malaria Control Program
Mailing address	B.P 3088 KIN 1	B.P 3088 KIN 1
Telephone	+ 243 98217243	+ 243 998 27 86 50
Physical address	1, avenue du tourisme Quartier des pêcheurs C/o Hôpital de la rive KINSHASA - NGALIEMA	1, avenue du tourisme Quartier des pêcheurs C/o Hôpital de la rive KINSHASA - NGALIEMA
E-mail address	amatindii@yahoo.fr palurdc@yahoo.fr	jean_angualuyahoo.fr

4. Component section *Tuberculosis*

4.3 Résumé de la composanteComponent executive summary

4.3.1 Executive summary

Describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results and associated timeframes. Specify the beneficiaries and expected benefits (including target populations and their estimated number). *(Please include quantitative information where possible.) (Maximum of one page.)*

This anti-malarial interventions of this component are part of the NMCP's 2002-2006 strategic plan that was adopted in 2001. They supplement those provided for in the 3rd Round submission to the Global Fund to Fight against HIV/AIDS, Tuberculosis and Malaria in the Democratic Republic of the Congo.

These interventions target 119 health zones and their aim is to reduce the morbidity and mortality linked to malaria in children under 5 years old and pregnant women.

The specific objectives targeted by this component are (1) the increase of coverage of insecticide-treated mosquito nets for target groups (ii) the correct treatment of patients in the health facilities and the community (iii) capacity strengthening for monitoring and evaluation at central, intermediary and peripheral levels.

The expected results in the 119 intervention zones are as follows: 65% of households have at least one ITN, 65% of children under 5 years sleep under ITNs, 65% of pregnant women sleep under ITNs, 80% of children under 5 years with serious malaria receive correct treatment in the health facilities, in accordance with national guidelines, 80% of children under 5 years with simple malaria are correctly treated in the care facilities, 15% of cases of fever/malaria are correctly treated in the community, 100% of care facilities do not experience a stock-out for 3 months.

The general activities planned in order to achieve these objectives are: the procurement of insecticide-treated mosquito nets and ACT for Health Zones, the distribution of ITNs during prenatal and pre-school consultations, door-to-door distribution/sales by Social Mobilization Teams, quality control of anti-malaria drugs and pharmacovigilance.

The principal recipients are pregnant women and children under 5 years in the intervention zones. In 2008 these groups will represent 3,670,901 and 734,180 respectively.
The advantages of this proposal are: the expansion of coverage of ITNs and improvement in the treatment of sick people using artemesinin-based therapies, which are effective on strains of P-falciparum that are resistant to the common anti-malarial drugs, particularly chloroquine and sulfadoxine pyrimethamine.

This project's implementation will cover the period from 2007-2009. These activities will be carried out in each health zone by the operational support partners in collaboration with the central office teams of the health zones. This involves the partners who are currently implementing activities and others who were selected during the first phase of round 3.

4.3.2 Synergies

If the proposal covers more than one component, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities). *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

HIV/AIDS makes each PLWA/HIV more vulnerable to bacterial and parasitical infections, including malaria.

4. Component section *Tuberculosis*

To control malaria during pregnancy, the national strategy recommends administering an extra dose of sulfadoxine pyrimethamine to pregnant women who are HIV+, above the 2 doses administered to pregnant women testing HIV-.

Furthermore, the correct treatment of malaria during pregnancy is also one of the PMTCT measures in the HIV/AIDS component and contributes to reducing the risk of mother-to-child transmission.

Therefore it is necessary to combine the activities for testing HIV+ pregnant women with the prenatal consultation in order to coordinate the protection of the pregnant women through IPT/malaria and the PMTCT/ HIV/AIDS.

4.4 National program context for this component

The information below helps reviewers understand the disease context, and which problems the proposal will address. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies and broader development frameworks need to be clearly documented. Please refer to the Guidelines for Proposals, section 4.4.

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

- ☒ National Disease Specific Strategic Plan
- ☒ National Disease Specific Budget or Costing
- ☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)
- ☒ Other document relevant to the national disease program context (e.g.: the latest disease surveillance report) *Please specify.*

Epidemiological report 2005 by the Ministry of Health's Disease Control Authority.

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4.4.2 Epidemiological and disease-specific background

Describe, and provide the l**atest data** on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on **drug resistanc**e, where relevant . With respect to malaria components, also include a map detailing the geographical distribution of the malaria problem and corresponding control measures already approved and in use.. Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.

Epidemiological Data

Malaria is a major public health problem in the DRC. It is the primary cause of morbidity and mortality, particularly among children under 5 years, and a major cause of death and morbidity among women.
In fact, a survey carried out at the level of the "Roll Back Malaria" sentinel surveillance sites by the NMCP in 2001 showed that malaria constituted:

- 59% of the reasons for external medical visits among children under 5 years
- 48% of the causes for hospitalization among children under 5 years.
- 37% of the causes of deaths among children under 5 years in the hospitals

- 41% of the causes of external medical visits among pregnant women
- 54% of the causes of hospitalisation among pregnant women

Other surveys carried out by the NMCP in Kinshasa in 2000 have shown that:

- 86% of cases (n=4.457) attended to in the GRH's paediatric emergency room were due to malaria. And at the Kingasani Hospital Centre (CHK) malaria was diagnosed in 44% of all received cases (n=85677) for the period 1997-1999.
- At the GRH 87% and at the CHK 85% of transfusions are administered due to anaemia resulting from malaria and 67% (n=85) and 75% (n=1.324) of patients receiving transfusions were children under 5 years.

Table 1: *Tendency of cases and deaths from Malaria in the epidemiological sentinel surveillance sites in DRCongo from 2001 to 2005.*

Province	**2001**		**2002**		**2003**		**2004**	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Bandundu	207330	1366	208047	1759	323603	2233	425536	3017
Lower Congo	314967	2443	135952	213	453860	1818	522024	1823
Equator	93624	54	130208	259	465682	2638	196110	79
Western K	105888	952	151292	982	168458	993	217218	1583
Eastern K	86873	605	157019	1444	255195	1501	251007	1203
Katanga	394761	3371	53592	353	640191	2402	391263	897
Kinshasa	506716	1574	1034822	678	537378	1358	718090	1485
Maniema	79999	388	69421	184	212200	760	197804	393
N Kivu	321779	499	345077	515	626616	811	488194	516
Eastern	33224	108	101947	389	235180	867	273440	1265
S Kivu	54086	267	252791	777	468325	1117	348264	738
Total	**2199247**	**11597**	**2640168**	**7553**	**4386638**	**16498**	**4029059**	**13019**

This table is adapted from the epidemiological report 2005 by the Ministry of Health's National Disease Control Authority (document in the annex).

Principal Vectors

- The most commonly encountered vectors are *Anopheles gambiae* (92%), *Anopheles funestus* (main vector the Eastern high plateau region[8]), *Anopheles nili*, *Anogpheles moucheti*, *Anopheles brunnipes*, and *Anopheles paludis*.

Plasmodial Species

Three plasmodial species have been found. Plasmodium falciparum (P.f.) which is the most frequent species (95%). Plasmodium ovale and Plasmodium malariae are found on their own or in infections mixed with plasmodium falciparum.

Type of endemic

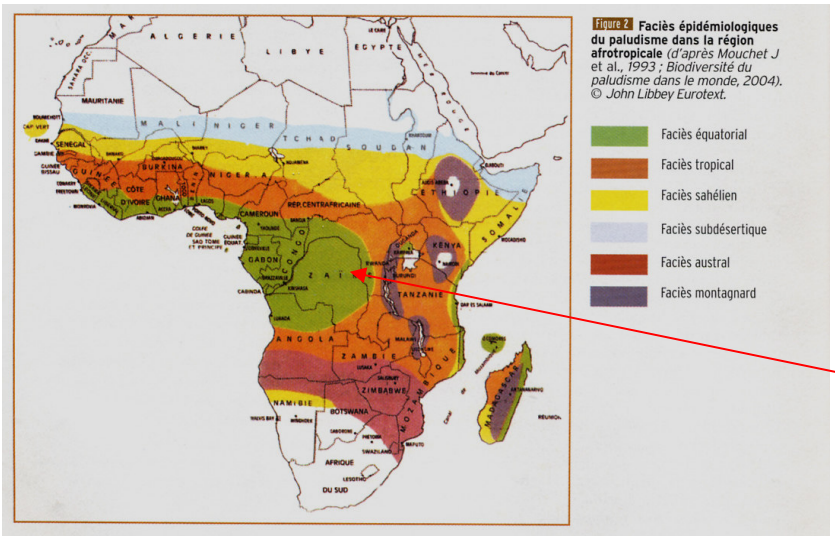
The Democratic Republic of the Congo is dominated by three epidemiological facies, which include:

- the equatorial facies (forests and post-forested savannas in central Africa); anophelien transmission is intense and permanent, capable of reaching 1000 infected bites per person per year; this therefore allows the early development of premunition, at around five years of age. Among children, 30 to 50% of fevers are attributed to malaria; morbidity is spread throughout the year. Serious forms of malaria, in particular neurological forms, are frequent in young children and rare in adults.
- The tropical facies (humid African savannas); transmission is aggravated over a long season (rainy season of 5 to 8 months), (60 to 400 infected insect bites per person per year). Premunition appears later, at about 10 years of age. Morbidity is higher in the rainy season; the serious forms of malaria are prevalent up to a more advanced age.

These two facies, equatorial and tropical, represent stratum-I of the WHO.

- the mountain facies (zones between 1000 and 1500 metres altitude) (WHO, Stratum-IV).
  In these zones, the transmission period is very short (years may even pass without transmission). Premunition is absent; serious forms of malaria are thus observed in the whole population, adults and children. Malaria expresses itself in the form of sharp, annual outbreaks.
  (pseudo-epidemic aspect).

Figure 1: Epidemiological facies in the afro-tropical region



Democratic Republic of Congo (DRC)

- .

Dynamic of the Endemic

The transmission is sporadic and seasonal on the high Eastern plateaus (Katanga), the Southern, North Kivu provinces and Ituri (Eastern Province). The central basin has permanent transmission. It is a hyperendemic (50 to 75% of people infected) and holoendemic zone (over 75% of people infected).
The average inoculation rate varies between 2.8 and 620.5 bites/person/year in Kinshasa and the sporozoitic index rises to 7.2% in the urban areas.[9]

Figure 2: Duration of seasonal malaria transmission

4. Component section *Tuberculosis*

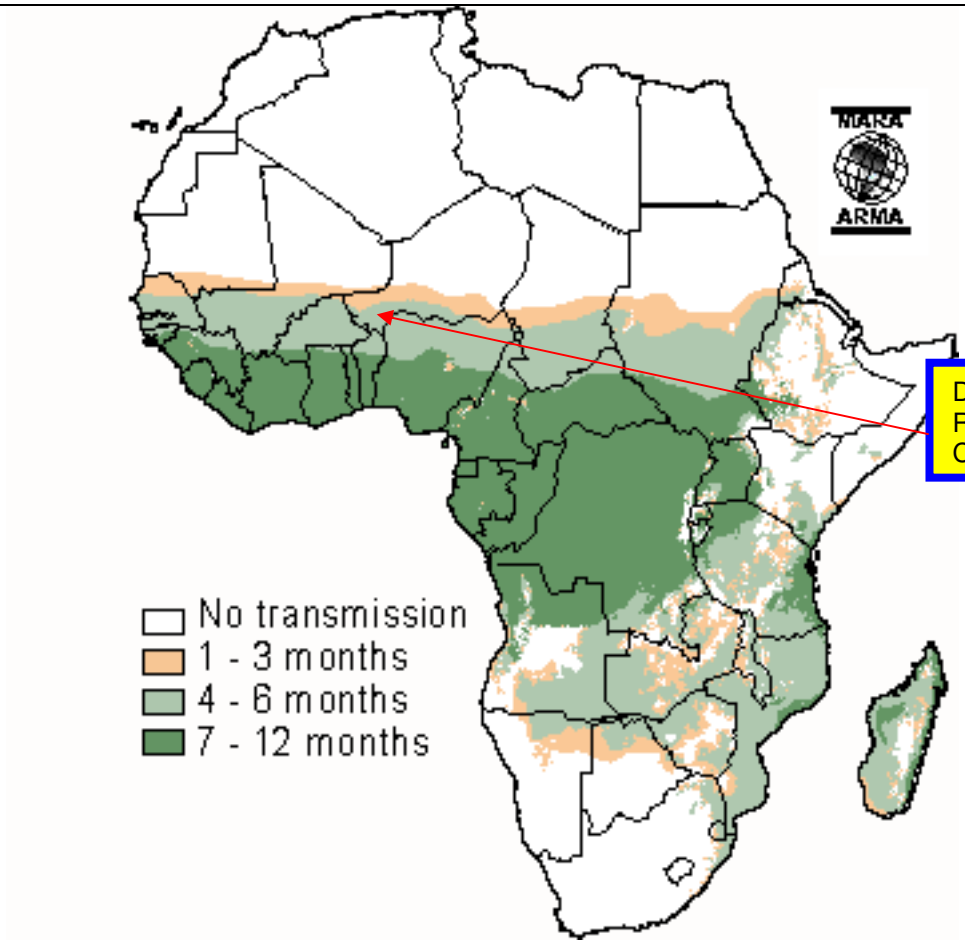


Figure 3: Start and end of the seasonal outbreak period of malaria in at-risk regions in Africa

Democratic Republic of Congo (DRC)

4. Component section *Tuberculosis*

Drug-resistance

1. Anti-malarial drugs

Since 1983, the first cases of resistance to chloroquine were observed in DRC.
Surveillance of the effectiveness of chloroquine and other anti-malarial medicines was implemented by the NMCP on a national scale from 2000.
The treatment failure rates for chloroquine were found to be above 25% in 7 in vivo studies in Kinshasa (32.5%), Mikalayi (29.4%), Kapolowe (34%), Vanga (48.8%), Kimpese (50%), Kisangani (49%) and Bukavu (79.5%).

The results of the following treatment failure rates were obtained with sulfadoxine-pyrimethamine tested during the same studies: Kinshasa (5.5%), Mikalayi (0%), Kapolowe (4%), Kimpese (10.2%), Vanga (4.8%), Kisagani (18.8%) and Bukavu (9.1%)

In 2001, the NMCP adopted sulfadoxine pyrimethamine as the transitory molecule for 2 years while waiting to adopt an artemisinin-based combination therapy.

The studies on treatment effectiveness carried out from 2002 to 2004 by the NMCP showed the treatment failure rates for sulfadoxine-pyrimethamine varying between 2 and 61%, and for combination therapies:

- from 1 to 32% for the AQ-SP combination,
- from 0 to 20% for the ART-SP combination,
- from 0 to 2% for the ART-AQ combination,

In March 2005, during a national consensus forum, the country adopted the artesunate-amodiaquine combination as the first-line drug for the treatment of simple malaria. This choice was sealed by a ministerial decree in April 2005.

This change led to the revision of training and communication guidelines and tools, the initiation of training for service providers and community mobilization teams at all levels.

This revision of malaria treatment protocol had a huge impact on the budget relating to procurement of anti-malarial drugs, because ACT cost 8 times more than the first-line anti-malarial drugs previously used and budgeted for.

In 2005, five studies were carried out by the NMCP and the ESP on the artesunate-amodiaquine and artemether-lumefantrine combinations as part of the surveillance of therapeutic effectiveness in new artemisinin-based treatment combinations, and the results will be made public after the PCR analyses by the CDC/Atlanta/

2. Insecticide

No national evaluation has yet been carried out for the insecticide used to treat Mosquito nets. Therefore the studies are planned and will be carried out in 2007.

4. Component section *Tuberculosis*

4.4.3 Disease-control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.4.3.

a) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include all donor-financed programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships.)

Purpose

The program to fight malaria in the Democratic Republic of Congo essentially aims to reduce malaria-related morbidity and mortality rates, as well as the socio-economic burden associated with it.

The program objectives are:

1. to reduce malaria-related morbidity and mortality rates within communities, and in particular in children less than 5 years old;
2. to reduce malaria-related morbidity and mortality rates in pregnant women;
3. to reduce the socio-economic burden due to malaria.

Strategies

The strategies for fighting malaria centre around two key points:

1. Basic Strategies:

1.1. Case management

a) Simple cases

They are cared for by the family, the community and health centres

- *Family:*

- Lowering temperature
- Administering front-line anti-malarial drugs.

- *Community health worker:*

- Advising families to observe the treatment protocol;
- Performing home case monitoring;
- Helping families to report difficult cases to the health centre;
- Administering front-line anti-malarial drugs.

- *Health Centre:*

- Managing cases with the help of flowcharts;
- Reporting severe cases in time.

b) Severe cases

These cases are managed by the general reference hospital and by tertiary care facilities as well as health-care establishments equipped with the appropriate personnel and equipment.

1.2. Prevention

4. Component section *Tuberculosis*

This consists of the following parts:

a**) Individual prevention**
This is carried out through selective and long-lasting measures:

- chemoprophylaxis: this is reserved for non-immune migrants.
- the intermittent treatment of pregnant women;
- the use of materials treated with insecticide, notably insecticide treated nets (MII).

b) **Collective prevention**

- Selective indoor spraying or fumigation in the case of an epidemic;
- Clean-up of the area: environmental planning must be carried out with the participation of the community and the appropriate State authorities, in collaboration with the Ministry of Health.

1.3. Epidemiological monitoring

Implementation of a health information system to monitor illness, the therapeutic effectiveness of anti-malarial drugs and the behaviour of the vector, within the general framework of integrated epidemiological surveillance.

1.4. Institutional capacity strengthening

- personnel training;
- infrastructure building;
- procurement of drugs, products and laboratory reagents;
- quality control of anti-malarial drugs, products and laboratory reagents

2. Support strategies

This policy recommends the following support strategies:

- operational and applied research;
- partnership;
- health promotion:
    - pleading for the cause;
    - social mobilization;
    - behavior change communication.
- supervision, monitoring and evaluation;

4. Component section *Tuberculosis*

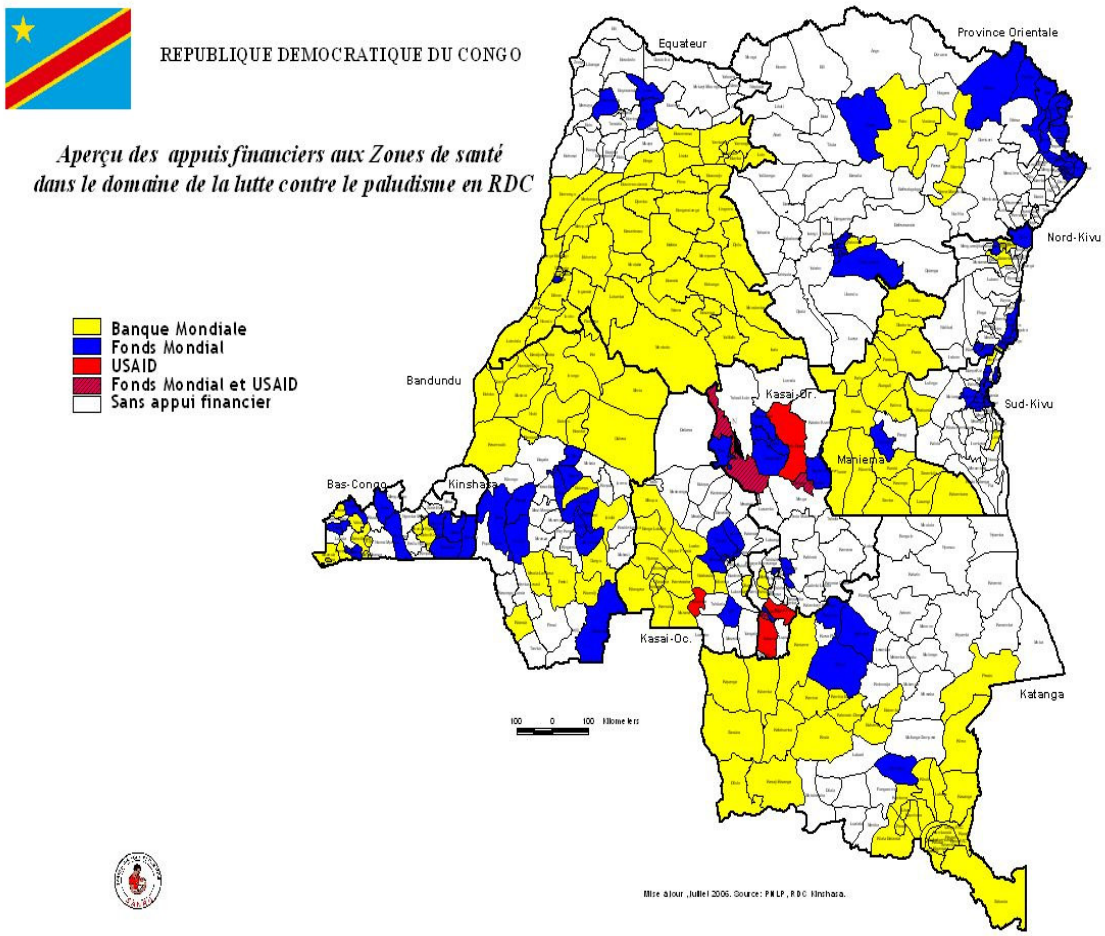
Main programs

Currently, the country benefits from a certain amount of existing or expected funding for the fiscal period of 2006-2010.

These projects are of various types:

- **Support projects in the health zones that enable services to be offered in the ongoing fight against malaria, in the management of cases both in the community and in the health facilities and in prevention (intermittent preventive treatment and promotion of the use of insecticide treated nets)**

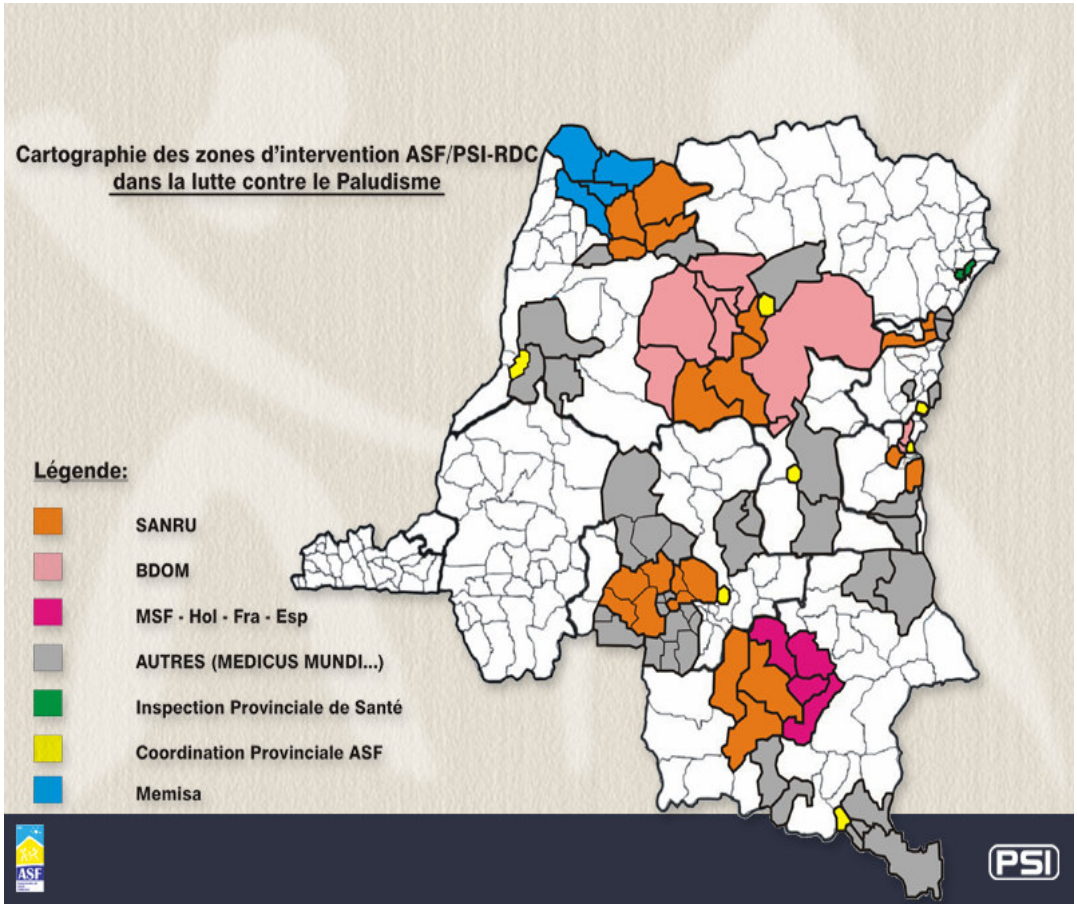
Figure 4: Overview of financial support to the health zones in the fight against malaria



4. Component section *Tuberculosis*

- **The social marketing support project for insecticide treated nets carried out in the country by the Association de Santé Familiale (Family Health Association, ASF), a subsidiary of Population Service International (PSI)**

Figure 5: Map of ASF/PSI intervention zones in the DRC in the fight against malaria



- **The technical support projects of the NMCP, coordinated at the national and provincial levels, which are mainly financed by the Global Fund, the WHO, UNICEF, USAID and the German Technical Cooperation (GTZ)**

- **The structural support programs in the health sector through the European Development Fund (EDF 9), the European Union, the African Development Bank (ADB), the World Bank, Unicef, USAID, the GTZ and the Belgian Technical Cooperation (BTC).**

- **Specific projects aimed at a precise area of service or response to complex emergencies, supported by Japanese cooperation (MIIs) and the European Union (unstable zones in the east of the country), which collaborate with national and international NGOs.**

4. Component section *Tuberculosis*

b) Describe the role of HIV/AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or Sector-Wide Approaches. Outline any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

Poverty-fighting strategies

The Democratic Republic of Congo currently figures among the beneficiary states of the Highly-Indebted Poor Country initiative.

In view of this, a growth strategy and poverty reduction document aimed at, among other things, improving access to social services and reducing vulnerability was drawn up under the coordination of the planning ministry of the Democratic Republic of Congo.

Through this strategy, improving the state of health of the populations is both an economic and social objective for development, and for the reduction of poverty.

To achieve this, the objective is to ensure quality primary health care to the entire population, in particular to vulnerable groups, and to combat large pandemics such as HIV/AIDS, malaria, tuberculosis, onchocerciasis, human African trypanosomiasis, etc.

The results expected thanks to the improvement in the quality of health services should lead to a reduction in infant mortality from 104‰ in 2007, to 89‰ in 2008, compared to a rate of 111‰ in 2006. The level of maternal mortality should also decrease by 2008, to 944 for every hundred thousand live births, compared to 1276 in 2006. The number of assisted births should reach 75.2%, compared to 61.6% in 2006. Finally, vaccine coverage should improve and reach a level of 40% in 2008, compared to 29.6% in 2006.

Millennium Development Goals

The efforts of the DRC and its partners, which aim to reduce malaria-related morbidity and mortality rates, are contributing to the achievement of the Millennium Development Goals, in particular goals 1, 2, 4, 5, 6 and 8.

"Roll Back Malaria" initiative

To bring about political commitment at the highest level in the fight against malaria, the country adopted the RBM initiative in February 2001 by implementing a Task Force that groups the NMCP, and its partners include bi- and multilateral cooperation organizations, international and national NGOs, religious organizations, and the community.
This proposal is in agreement with the "Roll Back Malaria" (RBM) initiative, which aims to reduce malaria-related mortality rates by 50% in the year 2010, in relation to the figures from the year 2000. The chosen interventions are perfectly adapted to the strategies of the RBM initiative and to the recommendations of the Conference of the African Heads of State in Abuja in April 2000, namely:

- Prompt management of cases, with effective drugs
- Protection of pregnant women through the use of insecticide treated nets, and preventive intermittent treatment;
- Prevention of and commitment to fight malaria epidemics

Existing and expected commitment of principal partners and international initiatives

The inclusion of the Millennium Development Goals in the document detailing the strategy for reducing poverty in the DRC expresses the determination of the Congolese government in the fight against malaria.

As a reminder, the objectives relating to reducing malaria-related morbidity and mortality rates are an integral part of the Millennium Development Goals.

Figure 6: Illustration of the economic impact of malaria in endemic regions

4. Component section *Tuberculosis*

PIB

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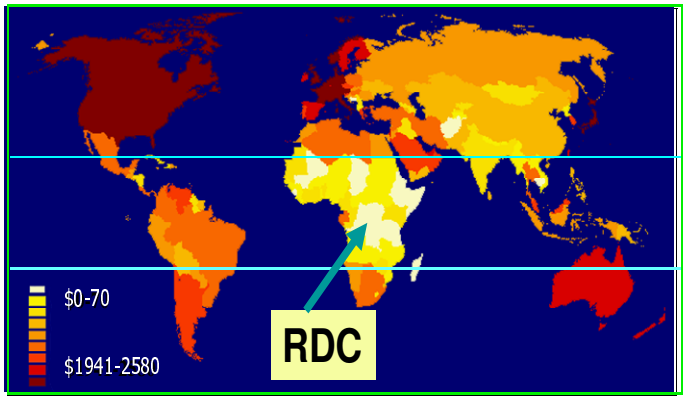
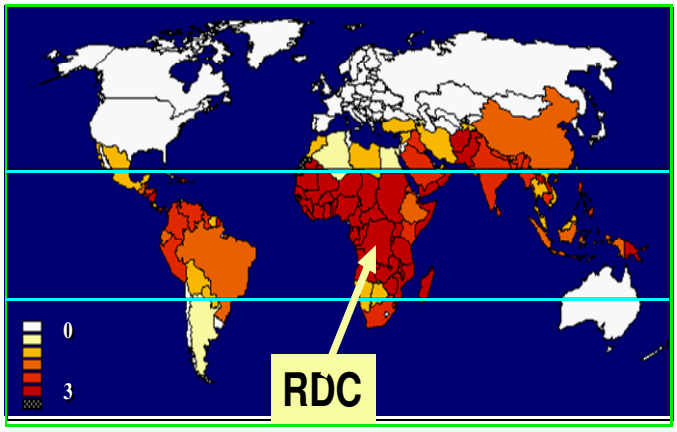


Paludisme



4.4.4 National health system a) Briefly describe the (national) health system, including both the public and private sectors, as relevant to reducing the impact and spread of the disease in question.
The health system of the DRC has a three-level pyramid structure, with each level having its own specific role:

4. Component section *Tuberculosis*

- The peripheral or operational level: this is comprised of 515 Health zones (HZ) which correspond to the Health Districts of the WHO. The Health zone is the basic unit for which health care is planned, and for which primary health care is provided. At this level, the health facilities are organized into two echelons linked together by a system of reference and counter-reference:
  - The first echelon is a network of 7,868 health centres which offer the population a minimum activity package (PMA) of primary health care services.

  - The second echelon is made up of 434 General Reference Hospitals (GRHs) which offer a complementary activity package of primary health care services.

- The intermediate level is made up of 11 Provincial Health Divisions and 65 District Health Inspection Offices. Also at this level, we find 2 Provincial Reference Hospitals and the assimilated provincial facilities (the provincial blood transfusion centre, the provincial reference HIV/AIDS laboratory, and the provincial laboratory for the fight against tuberculosis). The intermediate level ensures technical support to the HZs by performing the coordination, training, supervision, monitoring, evaluation, inspection and control functions. In addition, it imparts the standards established by the central level in operational guidelines and ensures that they are applied.

- The central level includes the Minister's departmental staff, the Secretary General of Health along with central management, and the specialized national programs and services. This level also includes the national hospitals, the university hospitals, the specialized hospitals, and the assimilated health facilities (the national blood transfusion centre, the national reference HIV/AIDS laboratory, the national reference laboratory for the fight against tuberculosis). The central level carries out prescriptive and regulatory roles, and performs coordination and strategic orientation functions.

The HZs function as autonomous and decentralized entities, equipped with their own management mechanisms. An HZ contains 100,000 inhabitants. This population is divided into health areas of 10,000 inhabitants, each served by one health centre.

The State, religious, company, and private health-care establishments (health centres, clinics and hospitals). A mechanism was implemented by the Ministry of Health for the setting up of contracts, which defines relations in terms of rights and duties between the parties concerned.

The national programs to fight malaria, including the NACP, the PNT and the NMCP, follow the health pyramid structure of the DRC, with a national management at the central level, and provincial coordination at the intermediate level. At the Health zone level, the interventions are integrated into the minimum package of activities of the health centre and the complementary package of activities at the General Reference Hospitals.

b) Given the above analysis, explain whether the current health system will be able to achieve and sustain scale up of HIV/AIDS, tuberculosis and/or malaria interventions. What constraints exist?

The health system is in a position to achieve the interventions of the proposal. Four points strengthen this affirmation:

Firstly, with the end of the war in 2002, numerous health zones have returned to a peaceful state, which

has contributed to improvement of the health care coverage of the country. Since then, the government has stepped up its commitment to the health sector through the continually increasing State budget. Nevertheless, there still remain some areas of instability within the eastern part of the country (Uvira, Shabunda, Ituri, North Katanga, etc.).

Secondly, at the same time, numerous donor funding partners are committed alongside the government to financing projects for national reconstruction, of which the health sector is a priority. This momentum of international solidarity is bringing in resources that ensure global support to more than 200 health zones. These partners include, among others:

- The World Bank

  Support for the development of 65 Health zones since 2003, thanks to 49 million dollars in funding, of which 44 million has been in the form of IDA donations, within the framework of the Emergency Multisector Rehabilitation and Reconstruction Project (EMRRP).

  A new Health Sector Rehabilitation Support Project, also financed by the World Bank, is in its start-up phase. Its global budget is $150,000,000 US for 80 health zones.

- The European Union

  The health program of the 9th EDF of the EU, currently in its start-up phase, will bring support to 74 health zones, 4 provincial health divisions, and institutional support at the central level, for a global amount of 80,000,000 € over 4 years. This program aims to consolidate the knowledge gained from the PATS I & II program.

- The ECHO program of the United Nations, through humanitarian aid, brings support to health zones in conflict in the eastern part of the country.

- The African Development Bank, through its program of structural cooperation, supports the DRC. $5 million US has effectively been allocated to the infrastructures of 6 HZs and 8 blood banks in Kinshasa. Currently a project totalling $38 million US is in its start-up phase; this project supports the Health development plan of the province of Orientale: 27 HZs, 4 district inspection offices and the provincial health division.

- The kingdom of Belgium, via NGOs and the direct cooperation of 44 HZs, the Directorate of Studies and Planning, is financing specialized programs for fighting diseases such as trypanosomiasis, tuberculosis, HIV/AIDS, and for supplying essential drugs.

- The French Cooperation is supporting the National Institute for Biomedical Research.

- The United States of America, through USAID, the CDC and the Church of Christ of Congo, Interchurch Medical Assistance (IMA), as well as other NGOs, is supporting the development of 80 HZs (around $30 million US), and a new program totalling $60 million is being developed.

- The GAVI fund is strengthening the Expanded Program on Immunizations through maintenance of the cold chain.

- The Global Fund Rounds 2, 3 and 5 for tuberculosis ($7,973,004 US for 3 years in Round 2, 36 million in Round 5), HIV/AIDS ($113,946,000 US for 5 years) and malaria ($53,936,000 US, also for 5 years), considerably strengthens the fight against these diseases.

- The support of the GTZ essentially centres around fighting HIV/AIDS (including blood transfusions), supporting the Program to Promote Mutual Health Organizations, and providing institutional support to the Department of Primary Health Care, the development of the Strategy Document to Reduce Poverty (DSRP), and the strengthening of the CCM (250,000 euros) within the framework of the Global Fund.

- UNICEF essentially intervenes in communities to aid with the survival of women and children, to protect vulnerable groups, and to aid in development and education. The total amount of expenditures in 2003 (including expenditures for other sectors) came to $38,063,000 US.

- The United Nations Population Fund (UNFPA), through the National Reproductive Health Care Program, is supporting the fight against maternal mortality.

- The WHO is supporting the development of the institutional capacity of the Ministry of Health.

Overall, with all of the financial and technical support mentioned above, the health system, which is

becoming increasingly functional and developing within a general environment of peace and security within the country, will be effectively supported.

Thirdly, thanks to the training of health professional trainers initiated by the WHO, scaling up of the fight against malaria will be facilitated by the implementation of multidisciplinary care teams. Training began in Kinshasa where, for the first time, it enabled the use of training guides for ARVT, prophylaxis, and the treatment of OIs, as well as for counselling. Currently, in Lubumbashi, a first team of provincial trainers is being trained. The NACP, with the support of other development partners, will continue to strengthen training in the other provinces, and thus ensure the durability of this activity.

Lastly, the Federation of Supply Centres for Essential Drugs (FEDECAME) is achieving its mission of supplying essential drugs through an extended network of regional distribution centres (RDC). It benefits from financial and technical support from the 9th EDF of the EU. The implementation of rounds 2 and 3 of tuberculosis and HIV has contributed to the improvement of the technical aspects, in particular logistics and the transport of equipment and drugs.

However, it should be noted that the health system must still face up to the following problems:

1. The break-up of the health system the anarchic manner of practicing health care, the delivery of health care services of questionable quality, and the dehumanization of health care services.

2. Insufficient resources

3. The worsening of the epidemiological situation

4. The deterioration of the ecosystem owing to the relaxation of individual and collective hygiene practices, public health measures and the insufficient supply of clean water.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

The plan to strengthen the national health system of the DRC follows the analysis of the causal factors related to the constraints encountered. The Directorate of Studies and Planning of the Ministry of Health raises the following issues:

- **Frequent emergency situations that form the basis of interventions** that occur in a disparate manner, without following a coherent procedure. However, taking into account the recent political evolution and the return of donor funding to a more structural cooperation, it is the right time to move on to coherent methods of intervention with a long-term view.

- **Absence of a reference proper framework by which to define the services for the health zones**, by not recognizing the services of the health centres, and especially of the hospitals, as primordial elements in all health care activity. The hospital seems to have been “forgotten” as a structuring element of the health zone, and as a structure responsible for supporting the development of services at the 1st echelon.

- **The non-integration of programs and services** is characterized by the major concern being to carry out programs and to measure result indicators, to the detriment of supplying an integrated package corresponding to the fundamental needs of the population.

- **The absence of teamwork at the health zone level**. This is particularly due to the fact that the services in the health centres and in the general reference hospitals are not seen as integrated services with specific functions, but as complementary and required to work in a coordinated manner.

- **The Health Information System presents several weaknesses**: insufficient qualified personnel, lack of equipment and necessary financial resources are all constraints to the improvement of the NHIS management, which presently operates in a compartmentalized and vertical manner. Ultimately, this situation results in the non-availability of relevant information necessary for planning, monitoring and evaluating the national policy on health. Furthermore, when information

exists, it is not sufficiently used or shared.

- **The financing system of the health sector rests mainly on three pillars**: The budget of the State (which is often weak both in the amounts allocated and in its execution of programs), external support (bilateral and multilateral) and the recovery of the costs for health care and services from its users. These last two sources are the most important, and create a strong dependence on external health-care funding. Despite its considerable size, funding obtained from partners deserves better coordination so as to reach as far as possible.

- The malfunctions resulting from the intervention of donors arises within the structure of the Ministry of Public Health, both at central level and intermediate level: the increase in the number of specialized departments and programs that receive support from certain donors. These well-financed programs have since developed a vertical structure, all to the detriment of the development of integrated services, as advocated by the national health policy and the blueprint for health development. The effect of these programs is to drain important resources at intermediate level, leading to a bottleneck at Kinshasa. Therefore, instead of tending to the business of providing development support to the HZs, the intermediate structure turns its attention to the top level to acquire immediate benefits.
- **The lack of a real plan of action at HZ level means that certain donors develop their own plans of action.** They ignore the facilities in charge of the zone, to work directly with the health centres and the community. The incentives paid by external intervening parties and the various methods of retribution for per-diem activities. The lack of a decent salary cannot be replaced, but rather must be addressed in the framework of a performance contract.

In order to strengthen the health system, the Ministry of Health developed the Strategy for Strengthening the Health System, presented to the Forum of donors in Tunis (**See Annex P 10**). This strategy was adopted by all of the partners of the health sector, including the international donors. It centres around 6 points:

Point 1: Revitalization of the health zones and correction of the imbalance resulting at the peripheral level
Sub-points of revitalization of the health zones:
- Development of integrated leadership at the health zone level
- Rationalization of the operations of the health facilities
- Improvement of health coverage in the health zones
- Improvement of quality of care
- Community participation

Point 2: Reorganization of the central and intermediate levels

Point 3: Reorganization of health financing:
Sub-points of the reorganization of financing
- Decentralization of the place for negotiating financing
- Shifting external financing by programs to financing of provincial integrated plans
- Improvement of the financing for the health zones.

Point 4: Strengthening of intra- and inter-sectorial partnerships
Point 5: Development of human resources for health
Point 6: Strengthening of research into health systems

This submission contributes to the strengthening of the health system through training, monitoring and evaluation, and the strengthening of local community action. There is no specific financing request for the health system, but rather an aim towards strengthening it, through integrating activities within the health system in the fight against HIV/AIDS.

4. Component section *Tuberculosis*

4.5 Financial and programmatic gap analysis

Interventions included in relation to this component should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Such an analysis should also recognize gaps in health systems, related to reducing the impact and spread of the disease. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described. For more information on this, see the Guidelines for Proposals, section 4.5.

Use table 4.5.1-3 to provide in summarized form all the figures used in sections 4.5.1 to 4.5.3.

4.5.1 Overall needs assessment

a) Through an analysis of national objectives, and a thorough analysis of disease monitoring data and estimates for the target population, **describe the general programmatic needs** for the people who are in need of the key services offered. Please indicate the **quantitative needs for the 3 to 5** principal services that will be offered (e.g.: antiretroviral **drugs**, **insecticide treated nets**, DOTS treatment for tuberculosis). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table in section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.5.1.*

4. Component section *Tuberculosis*

Programmatic needs

		Programmatic Gap Analysis					
		Actual		Anticipated		Estimated	
		2004	2005	2006	2007	2008	2009
A. People needing key services (3 to 5) offered in the grant component							
Key Service 1	Children less than 5 years old, needing MIIs	3261548	3359395	3460177	3563982	3670901	3781029
	Pregnant women needing MIIs	652310	671879	692035	712796	734180	756206
Key Service 2	Needing ACT treatment	3261548	3359395	3460177	3563982	3670901	3781029
B. People CURRENTLY RECEIVING or ANTICIPATED TO RECEIVE Key Services (3 to 5) delivered in the grant component as financed by current or anticipated resources:							
Key Service 1	Children less than 5 years old benefiting from or who could benefit from MIIs	53717	83423	516578	454704	160270	0
	Pregnant women benefiting from or who could benefit from MIIs	53717	83423	516578	454704	160270	0
Key Service 2	Children less than 5 years old benefiting from or who may benefit from ACT treatment	0	0	865044	1425593	0	0
C. UNMET NEED OR GAP in terms of people in need of Key Services delivered in the grant component (A1–B1 = C1, A2–B2 = C2)							
Key Service 1	Children less than 5 years old not covered by MIIs	598593	588456	175457	258092	573910	756206
	Pregnant women not covered by MIIs	598593	588456	175457	258092	573910	756206
Key Service 2	Children under 5 years old not covered by ACT treatment	3261548	3359395	2595133	2138389	3670901	3781029

The programmatic gap analysis of the malaria component is based overall on the program currently underway, and which targets 119 health zones within the framework of supporting the “Roll Back Malaria” initiative in the DRC.
The determination of the number of individuals in need of services takes into account at-risk individuals, including children under 5 years old and pregnant women needing MIIs, and children under 5 years old needing ACT.

Children under 5 years old, which represent 20% of the general population, are estimated to number 3,670,901 and 3,781,028 in the years 2008 and 2009 respectively. The determination of the number of individuals covered by MIIs is based on these estimates.
Concerning ACT treatment, the estimates of the number of individuals covered or who may be covered is based on the annual estimated number of children by indexing the planned coverage rate coefficient.

Furthermore, pregnant women represent 4% of the general population for each year to be covered. The number of pregnant women covered is calculated annually.

4. Component section *Tuberculosis*

Chart 1: Overview of availability and gaps in ACT

Overview of availability and gaps in ACT in the intervention zones of the GF project in DRC, 2004-2009

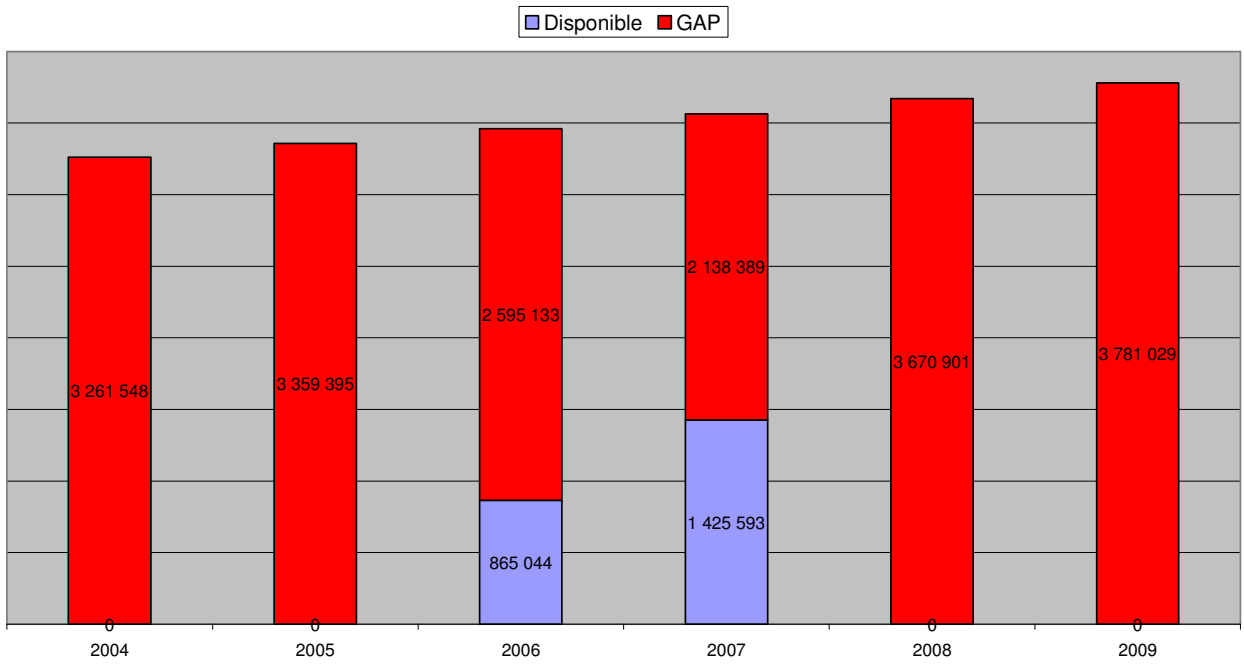


Chart 2: Overview of availability and gaps in MIls for children under 5 years old

4. Component section *Tuberculosis*

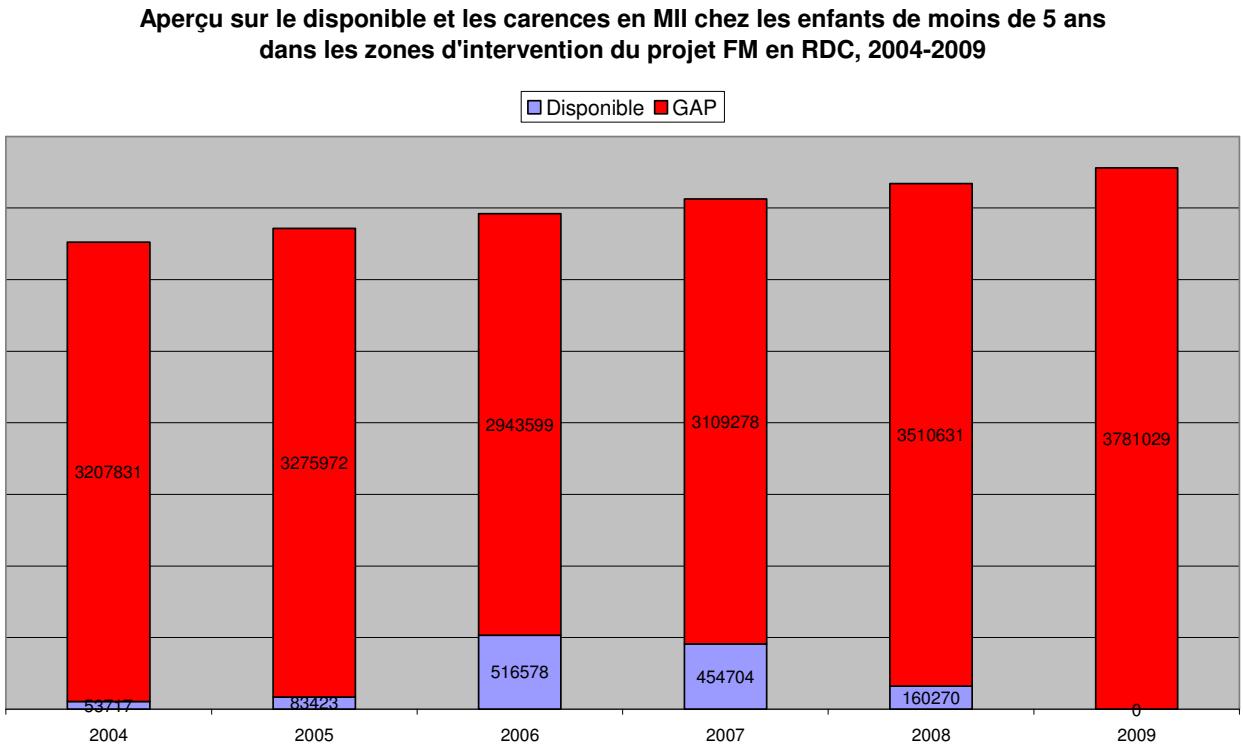
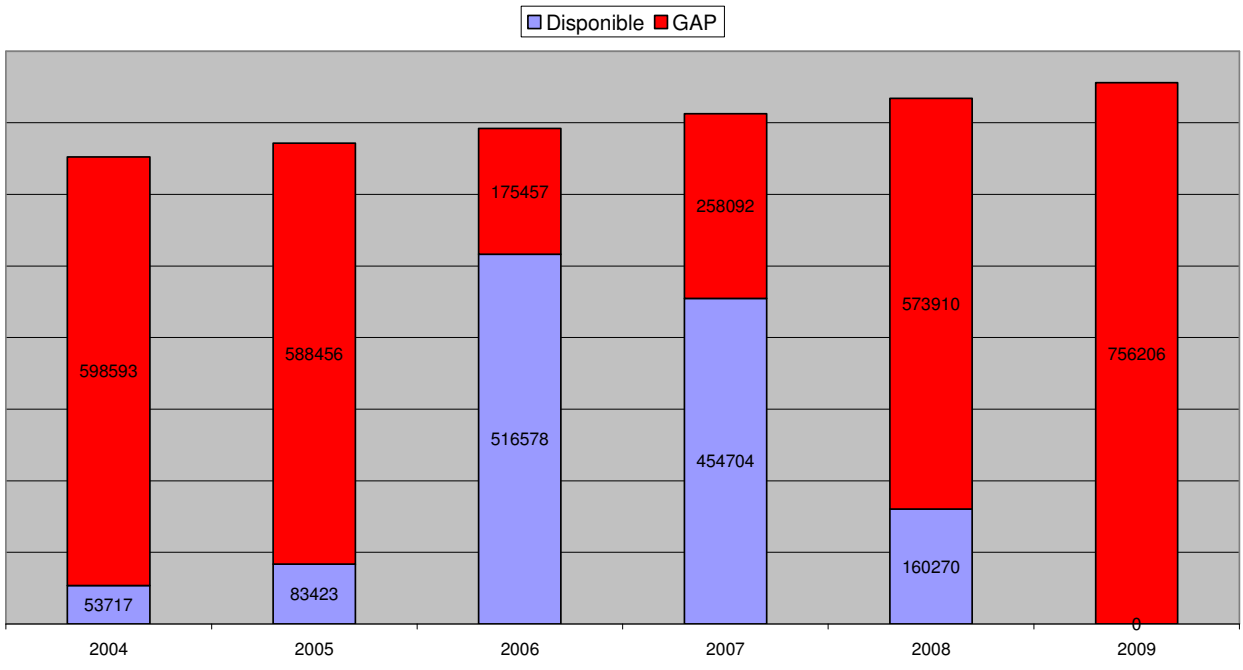


Chart 3: Overview of availability and gaps in MIIs for pregnant women



4. Component section *Tuberculosis*

b) Based on an analysis of the national goals and objectives for fighting the disease component, describe the **overall financial needs**. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., cost of national strategies, medium term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [line A].)*

The Democratic Republic of Congo benefited from a grant in the 3rd round of funding of the Global Fund. At the time of the proposal, the drug sulfadoxine pyrimethamine was planned. However, before its implementation there was a change in policy in the management of simple malaria, with the adoption of front-line ACT treatments, the cost of which is 8 times higher.
This is why the project is now being reorganized. The ACT needs were met in the 3rd year of the 3rd round, and a gap is emerging for years 4 and 5.

With regard to insecticide treated nets, there is also a gap emerging for years 4 and 5, due to the distribution cost of these nets.

This proposal aims not only to fill in these various gaps, but also to further improve the coverage of target populations of the project.

With regard to children under 5 years old, they represent 20% of the general population of the two years to be covered, namely 2008 and 2009, respectively numbering 3,670,901 among 18,354,507 households, and 3,781,028 among 18,905,143 households.
It is important to point out that we have considered grouping children under 5 years old within households, given that the strategy to implement when distributing the MIIs will consist of equipping each household with an insecticide treated net in order to cover the maximum number of children under 5 years old living there.
Thus, ***the number of children under 5 years old needing MIIs for the year 2008*** is obtained by multiplying the number of households in 2008 by the proportion of households having at least one child under 5 years old. This gives **1,861,671 households *needing MIIs*** for the year 2008. *(Assuming the number of households for a given year is obtained by dividing the total population of that year by an average of 7 people per household. The proportion of households having at least one child under 5 years old is obtained by multiplying 71% by the number of households).*
Furthermore, for the year 2009, ***the number of households needing MIIs*** is obtained by multiplying the difference between the number of households in 2009 and that of 2008 by the proportion of households having at least one child under 5 years old (71%). This gives **55,850 *children under 5 years old needing MIIs*** for the year 2009.

Pregnant women represent 4% of the general population for each year to be covered (years 2008 and 2009). The number of pregnant women needing MIIs is therefore obtained by multiplying the proportion of pregnant women in the general population (4%), by the proportion of pregnant women attending prenatal consultation (PNC) (66%). This represents, respectively, ***484,559 pregnant women needing MIIs*** for the year 2008, and ***499,096*** for the year 2009. In total, ***2,580,853*** MIIs will be offered in 2008 and **610,441** in 2009.
Estimating the cost for MIIs distributed in Kinshasa at $7 US per person, the estimated budget for the country is **$18,065,971** US for 2008, and **$4,273,087** US for 2009.

The needs in terms of ACT treatment were determined following the guidelines of the technical information sheet of the NMCP concerning the determination of need for anti-malarial drugs for a given target population.
The ACT treatments that will be offered within the framework of this intervention project concern children under 5 years old. This target population represents 20% of the general population for the two years to be covered, namely 2008 and 2009, respectively numbering ***18,354,507*** and ***18,905,143***. Therefore, the 20% of children under 5 years old represents ***3,670,901*** in 2008 and ***3,781,029*** in 2009.
The 20% of the target population for each year was multiplied by the number of cases of illness in children under 5 years old during a given year, i.e. 4 cases/year. This represents, respectively, ***14,683,606*** cases of illness in 2008, and ***15,124,114*** cases of illness in 2009.

The number of people needing ACT treatment for each year is obtained by multiplying the number of cases of illness each year by the proportion of cases of illness that will actually be managed each year, both in the

health care facilities and in the community.

It is necessary to note, however, that we estimated that ***25%*** of the cases of illness (or 3,670,901 individuals) will be managed in 2008 (of which 20% will be managed by health care facilities and 5% by the community).
Furthermore, ***30%*** of the cases of illness (or 4,537,234 individuals) will be managed in 2009 (of which 20% will be managed by health care facilities and 10% by the community).
Estimating the cost of ACT treatment rendered to Kinshasa at $0.7 US per person, the estimated budget for the country is ***$2,569,631 US*** for 2008, and ***$3,176,064 US*** for 2009.

4.5.2 Current and planned sources of funding

a) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line B].)*

The current and expected contributions to finance the fight against malaria essentially come under the State budget, and are given in the table relating to financial contributions.

b) Describe current and planned financial contributions, anticipated from all relevant external sources (including existing grants from the Global Fund and any other external donor funding) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C].)*

Current and expected external financing within the framework of the fight against malaria in the DRC comes from bi- and multilateral sources that are given in the table relating to financial contributions at the national level in the fight against malaria. These sources include the Global Fund, the World Bank through the Health Sector Rehabilitation Support Project, the WHO, Unicef, USAID, the DFID, the German technical cooperation, the Belgian technical cooperation and the British department for international development.

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

As the needs of the country are immense in the national effort to fight malaria, the financial gap that emerges according to availability and financial resource planning is given in the table relating to the financial contributions at national level in the fight against HIV..

Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

Table 4.5.1-3 - Financial contributions to national response

	Financial gap analysis (*please specify currency:* EUR/USD)						
	Actual		**Planned**		**Estimated**		
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Overall needs costing (A)	**14 723 850**	**55308734**	**57019313**	**58737812**	**60499947**	**62314945**	**64184393**
Current and planned sources of funding:							
Domestic source: Loans and debt relief *(provide donor name)*	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Domestic source: National funding resources	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**0**
Total domestic sources of funding(B)	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**2 000 000**	**0**
External source 1 Global Fund Grants	**0**	**17 548 672**	**7 418 004**	**20 748 534**	**5 341 960**	**2 879 438**	**0**
External source 2 USAID grants	**3 000 000**	**3 000 000**	**2 365 000**	**0**	**0**	**0**	**0**
External source 3 UNICEF grants	**1 000 000**	**1 540 000**	**1 425 076**	**0**	**0**	**0**	**0**
External source 4 Japanese Cooperation grants	**0**	**0**	**2600000**	**0**	**0**	**0**	**0**
External source 5 GTZ grants	**1 370**	**2 230**	**2 060**	**0**	**0**	**0**	**0**

External source 6WHO grants	**53 500**	**12 500**	**162 000**	**0**	**0**	**0**	**0**
External source 7World Bank grants	**0**	**0**	**15 000 000**	**10 000 000**	**5 000 000**	**0**	**0**
External source 8DFID grants	**2000000**	**2000000**	**2000000**	**0**	**0**	**0**	**0**
External source 9European Union grants	**0**	**0**	**0**	**0**	**0**	**0**	
External source 10ADB grants	**0**	**0**	**0**	**0**	**0**	**0**	
External source 11HIPC grants	**0**	**0**	**0**	**0**	**0**	**0**	
Total external sources of funding (C)	**6 054 870**	**24 103 402**	**30 972 140**	**30 748 534**	**10 341 960**	**2 879 438**	**0**
Total resources available (B+C)	**8 054 870**	**26 103 402**	**32 972 140**	**32 748 534**	**12 341 960**	**4 879 438**	**0**
Unmet need (A) - (B + C)	6 668 980	29 205 332	24 047 173	25 989 278	48 157 987	57 435 507	64 184 393