PROPOSAL FORM – ROUND 7

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Round 7 Call for Proposals for grant funding. This Proposal Form should be used by eligible applicants ('Applicants') to submit proposals to the Global Fund. **Please read the accompanying Round 7 Guidelines for Proposals carefully before completing the Proposal Form**.

Applicant Name	CCM
Country/countries	Mozambique
Components included in this Proposal Form *(Check each applicable box below)*	
☐ HIV/AIDS[1]	
☒ Tuberculosis[1]	
☐ Malaria	

Timetable: Round 7

Deadline for submission of proposals: **4 July 2007**

Board consideration of recommended proposals: 14 - 16 November 2007

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/.

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PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS

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4. **Component Section** ..... **32 and/or 68 and/or 103**

5. **Component Budget** ..... **59 and/or 94 and/or 128**

REQUIRED ATTACHMENTS

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

B. **Preliminary List of Pharmaceutical and other Health Products** *(Complete a separate table for each component)*

C. **Membership details of CCM, Sub-CCM or RCM** *(Complete once only)*

+ **Detailed Budget** *(Complete a separate detailed budget for each component)*

+ **Detailed Work plan** *(Complete a separate detailed workplan for each component)*

A checklist of all annexes to be attached to the Proposal Form by an Applicant can be found at the end of sections 3 **and** 5 (per disease component) of the Proposal Form.

REFERENCE DOCUMENTS FOR APPLICANTS

(These and other documents are available at http://www.theglobalfund.org/en/apply/call7/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**)
	'Clarifications on CCM Minimum Requirements – Round 7'
Monitoring and Evaluation:	Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**)
	'M&E Systems Strengthening Tool', June 2006
Procurement and Supply Management:	The Global Fund's 'Guide to Writing a Procurement and Supply Management Plan', January 2006

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Round 7 Guidelines for Proposals
   - A complete copy of this Proposal Form
   - A complete copy of Attachments A, B and C to this Proposal Form

2. **Read the accompanying** Round 7 **Guidelines for Proposals** before completing this Proposal Form.

3. Further guidance for completing specific sections is also included in the Proposal Form itself, printed in *blue italics*. Where appropriate, indications are given as to the recommended maximum length of the answer.

4. To **avoid duplication of effort**, we recommend that you make maximum use of existing information (e.g., national health sector development plans, national monitoring and evaluation frameworks, situation analyses of strengths and weaknesses of the existing responses to the disease(s), and documents written to report to the Global Fund on existing grants and/or work supported by other donors/funding agencies).

5. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are submitting a fully complete application.

6. **Attach all documents** requested throughout the Proposal Form **including** a budget, work plan, and all documents you are requested to annex to the proposal.

7. Consult our "Frequently Asked Questions" link:
   http://www.theglobalfund.org/en/apply/call7/documents

Important notes:

1. Some or all of the information submitted to the Global Fund by Applicants will be made publicly available on the Global Fund website after the Board funding decision for Round 7.

2. The Global Fund Board is currently considering whether to post the evaluation forms prepared by the Technical Review Panel during the proposal review process ('TRP' Review Forms') **on the Global Fund website.** If this decision is taken, the TRP Review Forms for all Round 7 proposals (both approved **and unapproved**) will be published on the Global Fund website after the Board funding decision for Round 7.

How to use this form

WHAT IS DIFFERENT COMPARED TO ROUND 6?

Amendments aimed at improving the ease of completing the Proposal Form include:

1. all **CCM, Sub-CCM and RCM information needs** (including the **eligibility requirements**) **are now** with other 'Applicant Type' information **in section 3A**;

2. **Section 4** has been **re-ordered** to better enable Applicants to describe the overall strategy/country context, how the funding request harmonizes with other in-country actions, and then what will be achieved under this proposal;

3. **Section 4** also requests detailed information **on three key lessons learned arising from the Technical Review Panel's review of Round 6 proposals**. These are:

   1. addressing the **comments of the TRP** from proposals not approved in prior Rounds (section 4.6.1) and **attaching the relevant TRP review form**(s);

   2. explaining a Round 7 request for additional funding for the same key services covered by earlier Global Fund grants, where there are **large undisbursed amounts of money** under those earlier grants, including unsigned Round 6 grants (section 4.6.4(a)); and

   3. describing how bottlenecks in performance experienced by Principal Recipients ('PR') who are again nominated as PR for Round 7 have been addressed in the proposal;

4. **Section 5 requests less complex budget details**, responding to the comments of Applicants and the Technical Review Panel in Round 6;

5. **Attachment A (Targets and Indicators Table)** has been prepared by disease. Applicants may use the pre-filled list of potential indicators where relevant to their proposal, or overwrite the table;

6. **Attachment B (Preliminary List of Pharmaceutical and other Health Products) has been prepared in Microsoft Excel** to assist Applicants to identify key information about products, their pricing and intended suppliers. Again, it has been prepared by disease; and

7. **Contact details and proposal endorsement signatures for CCM, Sub-CCM and RCM Applicants are now located in a new Attachment C**. This is to facilitate an automatic upload of this material into our data base to ensure that we have current contact details accurately displayed on the Global Fund website.

Health Systems Strengthening – Round 7

As in Round 6, there is no separate health systems strengthening (HSS) component in Round 7.

Applicants should request funding support for HSS on a per disease component basis within the disease specific sections of this proposal (section 4 and 5). **Applicants are very strongly encouraged to review the Round 7 Guidelines for Proposal** (sections 4.4 and 4.5) **and this Proposal Form** (introduction in section 4.4) **before they complete these sections**.

1 Proposal Overview

1.1 General information on proposal

Applicant Type

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

	Component	Title
☐	HIV/AIDS[2]	N/A
☒	Tuberculosis[2]	Reducing Tuberculosis morbidity and mortality in Mozambique by 2012, through strengthening of the National TB Control Programme at all levels
☐	Malaria	N/A

Currency in which the Proposal is submitted

*Please check only **one** box below. **Please note that you must use this same currency throughout the whole Proposal Form** (that is, for all components for which funding is sought). It will be assumed that all financial amounts indicated in your whole proposal are in this **one** currency.*

☒ US$

☐ Euro

2 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

Summary of Technical Assistance Provided During Proposal Preparation		
*Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation **of this proposal** for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.*		
Section/Component	**Name of organization or organizations providing assistance and type of assistance provided**	**Duration of technical assistance**
☒ Sections 1 to 3B	N/A (these sections were elaborated by the CCM Secretariat)	N/A
☐ HIV/AIDS component, and/or budget	N/A	N/A
☒ Tuberculosis component, and/or budget	The elaboration of this component was coordinated by the Ministry of Health with technical support from: 1. The Technical Support Facility Southern Africa (in collaboration with Intellfit Africa Research and Training Company, Nigeria provided the lead consultant to oversee and support all aspects of the proposal development process 2. A national individual consultant (Dr. Joaquim Durao) provided support for the financial gap analysis and budget development. 3. WHO Mozambique provided support for the drafting of the ToR for the Lead Consultant and the consultant for the financial gap analysis and budgeting and provided inputs for several parts of the proposal document. Through the WHO Country Office, the Royal Netherlands Tuberculosis Foundation (KNCV) referred to below was hired to work on the proposal for 3 weeks. WHO also provided technical support for the development of the TB Strategic Plan 2008-2012, which was done simultaneously with the development of the Round 7 proposal. 4. Family Health International (FHI) provided a consultant who supported the development of the first draft of the proposal. 5. Health Alliance International (HAI) provided a TB expert (based in Mozambique) who supported the programmatic gap analysis and other technical areas of the proposal. 6. The Royal Netherlands Tuberculosis Foundation (KNCV) provided one consultant who supported the development of the technical areas of the proposal. 7. LEPRA provided support for the partner	1. 8 weeks 2. 8 weeks 3. 9 weeks 4. 7 weeks 5. 8 weeks 6. 3 weeks 7. 4 weeks

1 Proposal Overview

	contribution within the proposal. 8. Columbia University, ICAP provided support for TB/HIV and the M&E part of the proposal. 9. GAP, CDC provided support for laboratory aspects of the proposal, and also for the first draft of the proposal. GAP, CDC also provided a consultant for 3 weeks for the elaboration of the TB Strategic Plan 2008-2012, which was done simultaneously with the development of the Round 7 proposal. 10. FHI (TB-CAP) provided support for the development of the technical parts of the proposal. 11. The Mozambique Red Cross contributed with comments on various drafts of the proposal. 12. Stop TB contributed with comments on various drafts of the proposal. 13. Clinton Foundation contributed with inputs on the laboratory parts of the proposal 14. UNAIDS provided technical support for the contracting of the TSF consultant	8. 6 weeks 9. 8 weeks 10. 1 week 11. 1 week 12. 2 weeks 13. 1 week 14. 2 weeks
☐ Malaria component, and/or budget	N/A	N/A

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 budget summary by cost category in table 5.3 for each disease component. The currency in the table below must be the same currency as indicated in section 1.1 above.

Table 1.2 – Total funding summary

Component	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	0	0	0	0	0	0
Tuberculosis	2,651,567	4,083,736	4,179,952	4,780,893	5,287,680	20,983,828
Malaria	0	0	0	0	0	0
Total all components	2,651,567	4,083,736	4,179,952	4,780,893	5,287,680	20,983,828

1 Proposal Overview

1.3 Contact details for enquiries by the Global Fund

*Please provide full contact details for two persons **who will be available and duly authorized to provide the Global Fund with responses to any questions about the whole Proposal Form after 4 July 2007** (that is, **all of the components** which are applied for and **not** on a disease by disease basis). 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 **three months** after the submission of the proposal.*

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	Romeu Rodrigues	Leila Gharagozloo-Pakkala
Title	Chair, ECOSIDA and Chair, CCM in Mozambique	Representative, UNICEF and Vice Chair, CCM in Mozambique
Organization	ECOSIDA	UNICEF
Mailing address	Av. 24 de Julho 2549, 1st Floor Maputo, Mozambique	1440 Avenida do Zimbabwe Maputo, Mozambique
Telephone	+258-82-3143670	+258-823051900
Fax	+258-21-355600	+258-21491679
E-mail address	romeur@ceta.org.mz	lpakkala@unicef.org
Alternate e-mail address	romeur@ceta.org.mz	lpakkala@unicef.org

1 Proposal Overview

1.4 Overview Summary of the Applicant's Proposal

Provide a brief overview of the components included in this proposal and the main focus of the work to be undertaken. Applicants applying for more than one disease component should **briefly** refer to **each component here**, but provide a disease specific 'Executive Summary' in section 4.2 for each component.
*(Maximum length of this section is **one page in total**)*

Mozambique is one of the countries worst affected by tuberculosis (TB) – with every year more than 30,000 new TB cases reported, and ranking 18th among the 22 highest TB burdened countries in the world (WHO Global Report 2007). WHO estimates that in 2005, less than 50% of new sputum smear positive TB cases were detected and that only 36% of all forms of TB were detected. The low detection rate is attributable to under-diagnosis of existing cases due to an inadequate health care infrastructure, particularly in rural areas. Especially the diagnosis of sputum smear negative and extrapulmonary TB cases suffers from diagnostic constraints.

The National TB Programme's mission is to improve quality of services and interventions in a primary health care system through early case detection and adequate treatment of patients. Furthermore, the country's National TB strategic plan 2008-2012 aims at reducing the country's burden of TB in line with the Millennium Development Goals and the Stop TB partnership targets. Also, the government is intensifying its efforts to reduce absolute poverty by implementing the second Action Plan for the Reduction of Absolute Poverty (2006-2009). Thus, the program will contribute to reducing the current poverty index of 54% in 2003 to 45% by the end of 2009.

Major beneficiaries are TB patients, HIV/TB patients, OVC with TB, miners, prisoners, refugees and the military. The Ministry of Health and private providers of TB care would benefit from provision of TB drugs, equipment and training of staff. The preparation and implementation of this proposal will have the support of a variety of financial and technical partners (the more than 14 Health Common Fund contributors, WHO, PEPFAR/USAID/CDC, HAI, CU, FHI, LEPRA, RC, KNCV).

The Round 7 proposal covers the period 2008-2012 and is anchored on the National TB Strategic Plan 2008-2012. The goal defined in this proposal is to reduce morbidity and mortality due to tuberculosis, in line with the national strategic plan and in line with the MDG. To meet this goal, 6 objectives have been set: 1) Pursue high quality DOTS expansion and enhancement, 2) Address TB/HIV, MDR-TB and other challenges, 3) Contribute to health system strengthening, 4) Engage all care providers, 5) Empower people with TB and communities and 6) Enable and promote research. The major services planned to reach these objectives are: 1) Detection of smear+ cases through extending DOTS services, 2) Counseling and testing for HIV of TB patients, 3) Co-trimoxazole preventive therapy for HIV+ TB patients, 4) Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program), and 5) Information, Education and Communication.

Health systems strengthening strategic actions for the Ministry of Health, include improvement of radiologic diagnostic capacity through provision of more X-ray units and provision of human resources for key areas like M&E, Drug Management and Human Resource Development Plan for TB personnel. Actions for the community are the improvement of the community managed transport system used by DOTS volunteers and also for emergency evacuation of sick TB, HIV/AIDS and pregnant women, through provision of motorcycles to compliment the bicycles currently in use.

The improvement of the Monitoring and Evaluation (M&E) system is important as the present system is not sufficiently in line with internationally recommended M&E guidelines.

The total amount requested in this proposal is US$ 20,983,826 for the five year period (2008-2012), of which US$ 6,735,303 is planned for the first two years and US$ 14,248,525 for the remaining three years.
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1 Proposal Overview

1.5 Overview of rationale for multi-country proposal approach

Only complete this section if your proposal targets more than one country.

Importantly, the difference between a 'Regional Coordinating Mechanism' *and* ***'Regional Organization' Applicant is explained in the Round 7 Guidelines for Proposals****. Please refer to that material before completing this Proposal Form including, in particular, section 3A.4 (RCM), or 3A.5 (Regional Organization).*

The Global Fund is very supportive of proposals which respond to cross-border or multi-country issues which are most effectively addressed through a regional/multi-country proposal that has been developed in close consultation with in-country stakeholders from ***each of the countries included in the proposal****. Preferably, the CCM of each country will have been involved in identification of relevant issues and the development of the multi-country response from an early time so that the CCMs and RCM or RO Applicants can agree which aspects are appropriate for a multi-country approach.*

In this section, please describe:

(a) the common issue for these countries which presents a strong argument for a regional or cross-border approach;

(b) why a multi-country proposal will be more effective in responding to the issues presented than if each CCM presented the same activities on a country by country basis; and

*(c) how the applicant (RCM or RO) worked with the CCM** of each country during the proposal development process to ensure that the funding requested in this proposal does not merely replace existing financing, but contributes additional financing to increase the regions capacity to respond to the disease(s).*

*(**Where there is no CCM for a specific country included in the multi-country proposal because the country is a small island developing state, the applicant should describe how a broad cross-section of stakeholders were transparently and effectively consulted to ensure that there is broad in-country support and understanding of the multi-country approach in such countries).*

Overview of rationale for multi-country approach *(maximum one page)*
N/A

1 Proposal Overview

1.6 Previous Global Fund grants/proposals recommended for funding

*For each component applied for in Round 7, please provide **specific details of the amounts disbursed by the Global Fund and also expended under existing Global Fund grants** (by Round) as **at 31 March 2007**. For more detailed information, see the Guidelines for Proposals, section 1.6.*

Combined HIV/TB grants from Rounds 1, 2 and/or 3, should be included in only the HIV/AIDS table below, or the TB table below.

Table 1.6.1 – Previous Global Fund HIV/AIDS financial support

HIV/AIDS	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0	0	N/A
Round 2	18,588,537	17,01,454*	N/A
Round 3	0	0	N/A
Round 4	0	0	N/A
Round 5	0	0	N/A
Round 6	0	0	N/A
Total	18,588,537	17,01,454*	

* Since the Global Fund's grants are allocated to the Health Common Fund, expenditures of this grant cannot be measured. The amount presented is a pro-rated amount based on the level of expenditure of the Health Common Fund in 2006 (92%).

Table 1.6.2 – Previous Global Fund tuberculosis financial support

Tuberculosis	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0	0	N/A
Round 2	7,215,542	6,638,299*	N/A
Round 3	0	0	N/A
Round 4	0	0	N/A
Round 5	0	0	N/A
Round 6	0	0	N/A
Total	7,215,542	6,638,29*	

1 Proposal Overview

* Since the Global Fund's grants are allocated to the Health Common Fund, expenditures of this grant cannot be measured. The amount presented is a pro-rated amount based on the level of expenditure of the Health Common Fund in 2006 (92%).

Table 1.6.3 – Previous Global Fund malaria financial support

Malaria	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0	0	N/A
Round 2	12,034,024	11,071,302*	N/A
Round 3	0	0	N/A
Round 4	0	0	N/A
Round 5	0	0	N/A
Round 6	0	0	N/A
Total	12,034,024	11,071,302*	

* Since the Global Fund's grants are allocated to the Health Common Fund, expenditures of this grant cannot be measured. The amount presented is a pro-rated amount based on the level of expenditure of the Health Common Fund in 2006 (92%).

Table 1.6.4 – Previous Global Fund HSS and other financial support

HSS or Integrated	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1	0	0	N/A
Main disease targeted	N/A		
Round 2	No information available- the detailed breakdown of the grants into these categories is not available due to the allocation to the Health Common Fund	Not available	N/A
Main disease targeted	Mozambique has signed Round 2 grants for HIV/AIDS, Tuberculosis and Malaria		
Round 5	0	0	N/A
Main disease targeted	N/A		

1 Proposal Overview

Total	No information available- the detailed breakdown of the grants into these categories is not available due to the allocation to the Health Common Fund	Not available	

2 Country Eligibility

Only those applications that meet all applicable eligibility criteria will be reviewed by the Technical Review Panel.

These eligibility criteria are:

- ➔ **Section 2 – *Country eligibility***
- ➔ ***Section 3A – Applicant Type eligibility***
- ➔ ***Section 3B – Proposal signature and endorsement***

Country eligibility *is a multi-step process that depends on World Bank's classification of the income level of the country (or countries) targeted in the proposal* ***at the time of the call for proposals*** *(not the closing date).*

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.

2.1 Income Level

Please check the appropriate box(es) in the table below for the relevant country (or countries for multi-country proposals only), and include the country name in the relevant box(es). ***Multi-country applicants*** *(i.e., RCM or Regional Organization Applicants)* ➔ *see the Guidelines for Proposals, section 2.1 regarding eligibility of your proposal, and complete all relevant sections depending on the income levels for the respective countries.*

World Bank classification of Income level of countries/ economies included in proposal	**Country/economy name(s)** *(include the name of each country/economy* ***and*** *its relevant income level for multi-country proposals)*	
☒ Low-income	Mozambique	➔ *Go straight to* ***section 3A****, Applicant Type*
☐ Lower-middle income	N/A	➔ *Complete* ***both*** *sections 2.2 and 2.3, and then go to section 3A*
☐ Upper-middle income	N/A	➔ *Complete* ***each of*** *sections 2.2 and 2.3* ***and*** *2.4, and then go to section 3A*

2 Country Eligibility

2.2 Counterpart financing and greater reliance on domestic resources

Complete if any country/economy targeted in this proposal is classified as Lower-middle or Upper-middle income under the World Bank's classification of income level.

2.2.1 CCM and Sub-CCM Applicants

The table should be completed for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.2.1.
Amounts included in line A and line B in the tables below should be in figures not percentages.

Important notes:

1. *The field "Total requested from the Global Fund" in tables 2.2.1(a) to (c) below must equal the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3 for each corresponding component.*

2. *Non-CCM Applicants do not have to fulfill any counterpart financing requirement.*

Table 2.2.1(a) – Counterpart financing HIV/AIDS

Financing sources	HIV/AIDS *(same currency as selected in section 1.1)*				
	Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing (B) **[linked to the disease control program]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	N/A	N/A	N/A	N/A	N/A

2 Country Eligibility

Table 2.2.1(b) – Counterpart financing tuberculosis

Financing sources	Tuberculosis *(same currency as selected in section 1.1)*				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing (B) **[linked to the disease control program]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	N/A	N/A	N/A	N/A	N/A

Table 2.2.1(c) – Counterpart financing malaria

Financing sources	Malaria *(same currency as selected in section 1.1)*				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing (B) **[linked to the disease control program]**	N/A	N/A	N/A	N/A	N/A
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	N/A	N/A	N/A	N/A	N/A

2 Country Eligibility

2.2.2 Regional Coordinating Mechanism (RCM) and Regional Organization (RO) Applicants only

RCM and RO Applicants are required to demonstrate compliance with the Global Fund's minimum **counterpart financing** requirements for each Lower-middle income or Upper-middle income country/economy included in the RCM or RO application which is also eligible to apply in Round 7 in its own right. Eligible countries/economies are listed in Attachment 1 to the **Guidelines for Proposals**.

RCM and RO Applicants may either:

(a) **Complete table 2.2.2 below** and **ensure that the CCM endorsements *(required under section 3B.1.3 for RCMs, and 3B.2.1 for ROs)*** for **each** country/economy eligible in Round 7 **include information by that country/economy on its counterpart financing levels**;

If table 2.2.2 is completed, RCM and RO Applicants are reminded that the CCM endorsement letter required under either section 3B.1.3 or 3B.2.1 must also include information validating that country/economy's counterpart financing level for the relevant disease.

OR

(b) **Fully complete the applicable table(s) in section 2.2.1 above** for **each** country/economy listed as eligible in Round 7.

Table 2.2.2 – RCM or Regional Organization summary of Country/Economy Counterpart financing level

Country/Economy	CCM Confirmed Counterpart Financing – first year of proposal term **	CCM Confirmed Counterpart Financing – last year of proposal term **
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

** **Note ➔ RCM and Regional Organization** Applicants must show that each of the countries targeted in this proposal are **moving from**:

(a) 10% **to** 20% counterpart financing over the proposal term if a Lower-middle income country; or

(b) 20% **to** 40% counterpart financing over the proposal term if an Upper-middle income country.

2 Country Eligibility

2.3 Focus on poor or vulnerable populations

All proposals which target Lower-middle income and/or Upper-middle income countries/economies (including multi-country proposals which include countries/economies other than Low-income countries/economies) **must demonstrate a focus on poor** or **vulnerable population groups**. *Proposals may focus on both population groups but **must** predominantely focus on at least one of the two groups. Complete this section in respect of each disease component.*

2.3	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)*.
	N/A

2.4 Upper-middle income high disease burden minimum thresholds

Proposals from Upper-middle income countries/economies must also demonstrate that they currently face a high national disease burden. Please complete the section(s) below relevant to each disease component included in your proposal. Please note that if the Applicant 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 Annex 1 to the Guidelines for Proposals).

(a) **HIV/AIDS Current High National Disease Burden**

For Round 7, the Global Fund has determined that the only Upper-middle income countries which may apply for funding for HIV/AIDS *(whether a single country proposal, or as part of a multi-country proposal)* are Botswana, Equatorial Guinea and South Africa. *(See the Guidelines for Proposals, section 2.4 for more information.)*

N/A

(b) **Tuberculosis Current High National Disease Burden**

Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)*

N/A

(c) **Malaria Current High National Disease Burden**

Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)*

N/A

3A Applicant Type and Eligibility for Funding

*This section requires **all Applicants** to:*

(a) Describe what type of applicant they are; and

*(b) Describe how they meet the minimum requirements **to be eligible to submit a proposal**.*

Throughout this section, Applicants are requested to attach documents to support the information summarized below.
At the end of section 3B all Applicants must complete a 'checklist' to ensure that they attach all documents.

***All Coordinating Mechanism Applicants** (whether CCM, Sub-CCM or RCM) **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 complete section 3A.6 of this Proposal Form and attach documentation supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism (whether CCM, Sub-CCM or RCM) structure.*

Confirmation of Applicant Type

Table 3A – Applicant Type

Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form as indicated on the right hand side of the table as this sets out the road map to fully complete section 3A and 3B.

☒	National Country Coordinating Mechanism	➔ *Complete sections 3A.1 and 3A.4 and 3B.1*
☐	Sub-national Country Coordinating Mechanism	➔ *Complete sections 3A.2 and 3A.4 and 3B.1*
☐	Regional Coordinating Mechanism for multi-country proposals (including small island developing states)	➔ *Complete sections 3A.3 and 3A.4 and 3B.1*
☐	Regional Organization for multi-country proposals	➔ *Complete section 3A.5 and 3B.2*
☐	Non-CCM Applicants for single country proposals only	➔ ***Only** complete section 3A.6*

Importantly ➔

***Each Applicant should only complete one version of the relevant sections set out above** and not a new version for each disease component.*

*Applicants should also **only** complete those sections set out in table 3A above that are indicated as relevant to their application to ensure that they do not expend unnecessary resources on completing sections that do not apply to them.*

3A Applicant Type and Eligibility for Funding

3A.1 National Country Coordinating Mechanism (CCM) Applicants

For more information, please refer to the Guidelines for Proposals, section 3A.1, and the CCM Guidelines.

Table 3A.1 – National CCM: overview information

Name of CCM
Country Coordination Mechanism in Mozambique (Mecanismo de Coordenação do País)

3A Applicant Type and Eligibility for Funding

3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

(a) The extent to which the CCM acts as a functional partnership between government and other key stakeholders, 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

(b) How it coordinates its activities with other national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(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 a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.)

The CCM in Mozambique is harmonized with the existing relevant coordination mechanisms: the Health SWAp and the HIV/AIDS Partners Forum, which operates a Multi-Sector Wide Approach. The details of this harmonization are laid down in the 'Plan for harmonization of the CCM with existing coordination mechanisms', a document finalized in August 2006 (**Annex 1**).

The Global Fund's contributions are allocated to the Health Common Fund and the HIV/AIDS Common Fund. Monitoring and oversight of the Global Fund's grants is carried out as an integral part of the monitoring and oversight of the Health and HIV/AIDS Sectors, as agreed by all partners, including the Global Fund.

A Memorandum of Understanding (**Annex 2**) and a Code of Conduct **(Annex 3**) provide the framework for the collaboration between the Health SWAp partners. The Memorandum of Understanding focuses on the Common Fund (PROSAÚDE) partners (of which the Global Fund is one) and the Code of Conduct applies to all cooperation partners. The Memorandum of Understanding is currently being updated. It is expected that it will be ready for signature by July 2007. The key structures and the working mechanisms of the Health SWAp are described in the Terms of Reference (ToR) of the Health SWAp which were revised in April 2007 (**Annex 4**). The ToR make specific reference to the harmonisation of the CCM with the Health SWAp (paragraph 2.vi). The working mechanisms include bi-annual Sectoral Coordination Committee meetings (CCS in Portuguese) under chairmanship of the Minister of Health, Joint Coordination Committee (CCC in Portuguese) meetings eight times a year and bi-annual 'Enlarged CCC' meetings. In addition, once a year, there is a Joint Annual Evaluation (ACA in Portuguese) of the implementation of the previous year's Economic and Social Plan (PES in Portuguese), of the SWAp approach and of the Partners' performance. (ACA Report for 2006 can be found in **Annex 5**). The Joint Annual Evaluation is a requirement of the Government of Mozambique for all sectors.

The Common Fund for the multisectoral HIV/AIDS response also has a Memorandum of Understanding (**Annex 6**). A Code of Conduct for the HIV/AIDS Partners Forum (**Annex 7**) guides the collaboration in this coordination platform. The Partners Forum meets monthly under the Chairpersonship of the Execlutive Secretary of CNCS, and holds annual Joint Review meetings chaired by the President or Vice President of CNCS (the Joint Review for 2006 can be found in **Annex 8**).

Both the Health and HIV/AIDS sectors annual evaluation processes include provincial visits. The visits include representatives of both the Health SWAp and the Partners Forum, and included government, civil society, bilateral and multilateral donors.

The partnerships in the Health and HIV/AIDS sectors operate mostly in the context of the above mentioned (multi-)SWAp mechanisms. These partnerships are mirrored in the CCM. The harmonization of the CCM with the existing mechanisms has facilitated the participation of all CCM members in the Health and HIV/AIDS Sector monthly and annual reviews. Many organisations who are a member of the CCM participated in these reviews on behalf of their own constituency, but and did not represent the CCM. The 'Plan for harmonisation of the CCM with the existing coordination mechanisms' has formalised the

3A Applicant Type and Eligibility for Funding

representation of the CCM in these sectoral reviews by the CCM members.

As described in the Plan for harmonization, the CCM meets on an ad hoc basis. After the submission of the Round 6 proposal, the CCM has met five times:

1) 29 August 2006 - main agenda item: request for endorsement of the global proposal of the Lutheran World Federation

2) October/November 2006 – main agenda item: submission of the Phase II request for the Ministry of Health's Round 2 grants for HIV/AIDS, Tuberculosis and Malaria

3) 13 February 2007 – main agenda item: decision on participation in the Global Fund's Round 7

4) 3 April 2007 – main agenda itm: review of recommendations on Expressions of Interest and decision on Principal Recipients

5) 29 June 2007 – main agenda item: review and endorsement of the Round 7 submission

A simple diagram showing the interrelationship between the key actors is attached **(Annex 9).**

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

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3A.2 Sub-national Country Coordinating Mechanism (Sub-CCM) Applicants

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

Table 3A.2 – Sub-national CCM: overview information

Name of Sub-CCM
N/A

3A.2.1 Mode of operation

Describe how the Sub-CCM operates. In particular:

(a) The extent to which the Sub-CCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders in the region in which the Sub-CCM operates, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) The process by which the Sub-CCM developed under the guidance of a functional CCM and how it became to be formally recognized by that CCM
(Note: if there is evidence of a legal framework for the sub-national entity stating its autonomy please provide such evidence); and

(c) How the Sub-CCM coordinates its activities with other sub-national and national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as Regional and/or National AIDS Councils, Municipal, State or National Parliamentary Health Commissions, Regional and/or National Monitoring and Evaluation Offices and other key bodies).

(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 a diagram setting out the interrelationships between all key actors as an annex to this proposal including, in particular, the interrelationships with the National CCM. Please indicate the appropriate annex number in your checklist to sections 1 to 3B before the start of section 4.)

N/A

3A.2.2 Rationale

(a) Explain why a Sub-CCM approach represents an effective approach in the circumstances of your country.
(Maximum of half a page.)

N/A

(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.)

N/A

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

3A Applicant Type and Eligibility for Funding

3A.3 Regional Coordinating Mechanism Applicants

(includes small island developing states without national CCMs)

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

Table 3A.3 – Regional Coordinating Mechanism: overview information

Name of Regional Coordinating Mechanism (RCM)
N/A
RCM Secretariat Office Address
N/A

3A.3.1 Mode of operation

Describe how the RCM operates. In particular:

(a) **The extent to which the RCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) **How the RCM coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, national monitoring and evaluation offices, or the national strategies of small island developing states who are not required to have their own national CCM or other national coordinating body); and

(c) **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.

(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 stakeholders across the included countries as an annex to this proposal. Please indicate the appropriate annex number in your checklist to sections 1 to 3 before the start of section 4.)*

N/A

3A.3.2 Rationale

(a) 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.)

N/A

3A Applicant Type and Eligibility for Funding

(b)	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.)*
N/A	

➔ *After completing this section,* ***complete BOTH section 3A.4 and section 3B.1****.*

3A Applicant Type and Eligibility for Funding

3A.4 Functioning of Coordinating Mechanism (CCM, Sub-CCM and RCM Applicants)

IMPORTANT NOTE FOR APPLICANTS:

All CCM, Sub-CCM and RCM Applicants must meet, and continue to meet, the Global Fund's minimum requirements for eligibility for funding. This section asks Applicants to describe the operations of their Coordinating Mechanism, and update information provided in Round 6. You will be asked to re-confirm this in the Checklist at the end of sections 1 to 3B of this Proposal Form.

For additional information regarding these requirements, see:

- *The CCM Guidelines; and*
- *'Clarifications on CCM Minimum Requirements'.*

3A.4.1 Round 6 Application History

Table 3A.4.1 – Applicant's Round 6 Application History

Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table to complete other important questions.	
☒ Applied in Round 6 **and** determined as having met the minimum requirements for Round 6	➔ ***Complete section 3A.4.2 and*** *each of* ***Requirements 3(a), 3(b), 4(a) and 5(a)*** *within sections* ***3A.4.5 and 3A.4.6.***
☐ Did not apply in Round 6 **or** determined ineligible in Round 6	➔ ***Complete*** *sections 3A.4.2 to 3A.4.6* ***inclusive.***

3A.4.2 Changes in CCM, Sub-CCM or RCM from Round 6 Application

o Describe **in detail** any changes in the membership or operations of the Coordinating Mechanism (i.e., CCM, Sub-CCM or RCM) since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted for the selection of members by their own sectors, or to manage conflicts of interest; or oversee the work of implementation partners.
If new processes have been adopted, these must be described, and relevant documents attached as an annex to your Round 7 proposal.

As described in section 3.A.1.1, the CCM adopted a plan for harmonization of the CCM with existing coordination mechanisms in August 2006. This plan was submitted to the Global Fund Secretariat in August 2006 as part of additional information on the CCM provided at that time.

The plan for harmonization formalized the participation of CCM members in the Health SWAp and the HIV/AIDS Partners Forum, in line with the (multi-) SWAp structures in Mozambique. Monitoring and oversight of the Global Fund grants is carried out as an integral part of the monitoring and oversight of the Health and HIV/AIDS Sectors, including the respective Common Funds to which the Global Fund contributes. The CCM meets on an ad hoc basis to discuss specific issues like Phase II requests and proposal development.

Small changes in the CCM membership are new representatives of the international NGO network NAIMA+ and the representatives of the Health SWAp focal donors, in line with the rotating chairs of these institutions. These changes are documented in **Annex 10a and 10b.** Membership/endorsement information of other non government CCM members is documented in **Annexes 10c-f.**

3A Applicant Type and Eligibility for Funding

***Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements – Round 7' at**: http://www.theglobalfund.org/en/apply/call7/documents*

***Applicants are reminded that 'Coordinating Mechanism'** ('CM') **for the purposes of this section means either a CCM, Sub-CCM or RCM Applicant as relevant**.*

3A.4.3	**Principle of broad and inclusive membership**
(a)	**Requirement 1 ➔ Selection of non-governmental sector representatives** Provide evidence of how the CM members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**. *Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for CM representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*

	Documentation relied on to support compliance with Requirement 1	**Identify which annex to this proposal contains these documents** ***Please indicate the applicable annex number** in your checklist to sections 1 to 3B before the start of section 4.*
☐	Selection criteria for each sector developed by each respective sector	Not necessary for Mozambique to complete (as per 3.A.4.1.)
☐	Minutes of meeting(s) at which the sector transparently determined its representative	Not necessary for Mozambique to complete (as per 3.A.4.1.)
☐	Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	Not necessary for Mozambique to complete (as per 3.A.4.1.)
☐	Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	Not necessary for Mozambique to complete (as per 3.A.4.1.)
☐	Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM.	Not necessary for Mozambique to complete (as per 3.A.4.1.)
☐	Other: *(please specify):*	Not necessary for Mozambique to complete (as per 3.A.4.1.)

(b)	**Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1**
Not necessary for Mozambique to complete (as per 3.A.4.1.)	

3A Applicant Type and Eligibility for Funding

3A.4.4 Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s)

Describe the involvement of people living with and/or affected by the disease(s) in the CM.
(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section).

Not necessary for Mozambique to complete (as per 3.A.4.1.)

3A.4.5 Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5)

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

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.

The CCM met on 13 February 2007 (minutes in **Annex 11**) to agree on the principle of submitting a proposal for the Global Fund's Seventh call for Proposals and the proposal drafting and submission process to be followed. The CCM, the Health SWAp and the Partners Forum were informed of the launching of Round 7 and the timeline agreed for Mozambique, via e-mail on 2 March (**Annex 12**). Advertisements inviting organizations to submit expressions of interest were placed in one national newspaper (Noticias) on 7 March and two national newspapers (Noticias and Savana) on 9 March (**Annex 13**). The same announcement, along with the guidelines for the expressions of interest, (**Annex 14**) were circulated to the CCM with the request for the documents to be circulated among the members' constituencies (**Annex 13**).

Requirement 3(b) ➔ Process to review submissions received by the CM for possible integration into this proposal.

A Subcommittee of the CCM appointed in the CCM meeting of 13 Februray 2007 (minutes in **Annex 11**) reviewed the 29 expressions of interest received and made a recommendation for a classification of the expressions of interest according to the following categories: A: recommended to be included in Mozambique's submission, B: recommended to be included in the submission pending some clarifications, C: recommended for funding from locally available funds, D: not recommended for A, B or C in its current shape. In addition to the expressions of interest from the Ministry of Health and the National AIDS Council (CNCS), five expressions of interest were classified in categories A and B, 12 in category C and 10 in category D. The five successful expressions of interest included one focusing on TB, three focusing on HIV/AIDS and one covering both HIV/AIDS and TB.

The CCM reviewed and endorsed these recommendations in its 3 April meeting (minutes in **Annex 15**). It was agreed that the proposal would consist of two components: an HIV/AIDS component coordinated by CNCS and a Tuberculosis component coordinated by the Ministry of Health. It was also agreed that the CCM would facilitate technical support for the expressions of interest in the C category, to strengthen proposal development capacities in the country. All applicants received feedback in writing.

Requirement 4(a) ➔ Process to nominate the Principal Recipient(s) for proposals.

This issue was discussed in the CCM meeting of 3 April 2007 **(Annex 15).** The CCM recommended that in principle, the Principle Recipients would be the National AIDS Council (CNCS) for the HIV/AIDS component and the Ministry of Health for the Tuberculosis component. The CCM also stated that the details of the collaboration between the Principle Recipients and the Sub-Recipients would need to be

elaborated during the proposal development process.
Requirement 4(b) ➔ **Process to oversee/review** program implementation by the Principal Recipient(s) during the proposal term.
Not necessary for Mozambique to complete (as per 3.A.4.1.)
Requirement 5(a) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in the proposal development process.
On 2 May, the CCM Secretariat, together with the Principle Recipients organized a meeting with the NGOs whose proposals had been classified in Categories A and B, to outline the envisaged proposal development process and agree on the collaboration mechanisms. Two working groups were established, one coordinated by CNCS for the development of the HIV/AIDS component* and the other one coordinated by MoH for the development of the TB component (preparatory work on the TB component had started in mid April in light of the availability of a key consultant). The working groups met according to agreed schedules, and consultations were held with relevant stakeholders. Coordination meetings between the two working groups were held on 18 and 25 May and 4 June. The working group for the TB proposal met with all key stakeholders in the area, either bilaterally or in working group meetings. The first and second draft of the proposals were shared with the CCM (with the request to share it among the members'constituencies), as well as with the Health SWAp and the HIV/AIDS Partners Forum by e-mail **(Annex 16**). For more details about the proposal development process, see **Annex 17** * The HIV/AIDS Component is not submitted for Round 7
Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in grant oversight processes.
Not necessary for Mozambique to complete (as per 3.A.4.1.)

3A.4.6	**Principle of effective management of actual and potential conflicts of interest**	
	Requirement 6 ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No
	If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.	
	N/A	

3A Applicant Type and Eligibility for Funding

3A.4.7 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM operations? *Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.*	☐ Yes *provide details below* ☒ No *go to section 3B.1*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.**	
N/A	

➔ *After completing this section,* ***go to section 3B.1.***

3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

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

Table 3A.5 – Regional Organization: overview information

Name of Regional Organization	
N/A	
Sector represented by the Regional Organization *(Check the relevant box below)*	
☐	Academic/educational sector
☐	Government
☐	Non-Government Organizations
☐	People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
☐	Private sector
☐	Religious/faith-based organizations
☐	Other *(please specify)* N/A

3A Applicant Type and Eligibility for Funding

3A.5.1	**Mode of operation**
	In addition to answering the questions below, Regional Organizations must 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 over the past three years.* **Describe below** 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; The extent to which people living with and/or affected by the disease(s) targeted in the Regional Organization's proposal were involved in development of your proposal; and **The coverage and past experience** of the Regional Organization's operations, with a particular focus on outcomes relevant to the subject of this proposal *(Maximum of half a page.)*
	N/A

3A.5.2	**Rationale**
(a)	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.)*
	N/A
(b)	Explain how the countries targeted in the Regional Organization's proposal represent a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)*
	N/A

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

3A Applicant Type and Eligibility for Funding

3A.6 Non-CCM Applicants

Non-CCM proposals are only eligible for funding under exceptional circumstances listed in section 3A.6.1 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 documents evidencing the key governance arrangements of the organization; a summary of the background and history of the organization, scope of work, past and current activities; and a summary of the main sources and amounts of existing funding over the past three years.*

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

Name of Non-CCM Applicant	N/A
Business address *(including street, town/state and country)*	N/A

	Primary contact	**Secondary contact**
Name	N/A	N/A
Title	N/A	N/A
Organization	N/A	N/A
Mailing address	N/A	N/A
Telephone	N/A	N/A
Fax	N/A	N/A
E-mail address	N/A	N/A
Alternate e-mail address	N/A	N/A

Indicate the sector represented (check appropriate box):

☐	Academic/educational sector
☐	Government
☐	Non-government Organization (NGO)/community-based organizations
☐	People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
☐	Private sector
☐	Religious/faith-based organizations
☐	Other *(please specify)*
	N/A

3A Applicant Type and Eligibility for Funding

3A.6.1	**Rationale for applying outside of a CCM, Sub-CCM or RCM**
	*(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. ***Describe in detail** which of the **above condition(s)** apply* (Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.1 for further information on how the Global Fund will interpret these criteria.)
	N/A

3A.6.2	**Attempts to have Non-CCM proposal included in the CCM, Sub-CCM or RCM proposal**
	(b) Describe **all attempts by your organization to submit this proposal and have it included in the relevant final proposal of a CCM, Sub-CCM or RCM** (as appropriate to the content of your proposal), **providing details of any responses received**. *(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM, Sub-CCM or RCM as an annex to the proposal. Please ensure that your description clearly sets out whether you provided a copy of your proposal for consideration by the CCM**, Sub-CCM** or RCM**,and if not, why not.)* ***(** Contact details for CCMs, Sub-CCMs and RCMs are available on the Global Fund website, or by contacting proposals@theglobalfund.org)***
	N/A
	(c) If you are aware that a CCM is also submitting a proposal in Round 7 for a country or countries included in your proposal, **provide a detailed explanation of why you believe that your non-CCM proposal merits consideration and recommendation for funding as well as any national CCM proposal**. *(Maximum of one page. In this section, please set out any particular issues which you believe support the submission of a Non-CCM Applicant proposal in circumstances where a CCM has applied.)*
	N/A

*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.*

3A.6.3	***Consistency with national policies***
	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.)*
	N/A

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

3B Proposal Endorsement

3B.1 Coordinating Mechanism Applicants *(CCM, Sub-CCM and RCM)* membership and endorsement

All national (CCM), sub-national (Sub-CCM) and regional Coordinating Mechanisms (RCM) Applicants must:

(a) ***Fully complete this section****; and*

(b) ***Complete and attach*** ***'Attachment C'*** *to list all of the members of the Coordinating Mechanism, their contact details and email addresses. (This excel file is available for completion by downloading it from the Round 7 documents website of the Global Fund.)*

3B.1.1 Leadership of the 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	Romeu Rodrigues	Leila Gharagozloo-Pakkala
Title	Chair	Representative
Organization	ECOSIDA	UNICEF
Mailing address	Avenida 24 de Julho 2549, 1st Floor Maputo, Mozambique	1440, Ave. do Zimbabwe Maputo, Mozambique
Telephone	+258-823143670	+258-823051900
Fax	+258-355600	+258-21491679
E-mail address	romeur@ceta.org.mz	lpakkala@unicef.org
Alternate e-mail address	romeur@ceta.org.mz	lpakkala@unicef.org

➔ *Go to section 3B.1.2 (membership information).*

3B Proposal Endorsement

3B.1.2 Membership information of CCM, Sub-CCM or RCM

Please note that to be eligible for funding, CCM, Sub-CCM and RCM Applicants must demonstrate evidence of membership of people living with and/or affected by the disease(s). Also, it is recommended that the membership of the CCM, Sub-CCM or RCM 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.

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of CCM, Sub-CCM or RCM	
The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**. *Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.* ***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal**.*	
Sector Representation	**Number of members representing the sector**
☒ Academic/educational sector	1
☒ Government	5
☒ Non-Government Organizations (NGOs)/community-based organizations	2
☒ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria	2
☒ Private sector	2
☒ Religious/faith-based organizations	1
☒ Multilateral and bilateral development partners in country	3
☐ Other *(please specify):*	
Total Number of Members	16

➔ *Go to section 3B.1.3 (proposal endorsement)*

3B Proposal Endorsement

3B.1.3 CCM, Sub-CCM and RCM proposal endorsement

Level 1 Endorsement

CCM, Sub-CCM and RCM members must endorse their own proposal for an application to be eligible.

This is demonstrated by each member of the Coordinating Mechanism (whether CCM, Sub-CCM or RCM) ***signing Attachment C in the final column once all membership information has been completed.***

Please note that the ***original*** *(not photocopied, scanned or faxed)* ***signatures of the CCM, Sub-CCM or RCM members*** *must be provided in* ***Attachment C****. The minutes of the CCM, Sub-CCM or RCM meeting at which the proposal was considered and endorsed must be attached as an annex to this proposal. The entire proposal, including Attachment C and the minutes, must be received by the Global Fund Secretariat by 4 July 2007.*

Level 1 endorsement	Check this box **only** if the CCM, Sub-CCM or RCM has completed the membership details and **members have signed Attachment C** to the Proposal Form	☒

It should be noted that the CCM, after its meeting held on 29 June 2007 (**Annex 18**), requested the Global Fund to extend the deadline for the HIV/AIDS Component since more in depth consultations were required about this Component, with the most senior levels of the key ministries involved. The extension of the deadline was not granted, after which it was agreed not to proceed with the submission of the HIV/AIDS Component as part of the Round 7 submission (see **Annex 19** for the CCM letter and the Global Fund's response).

Level 2 Endorsement – Sub-CCM and RCM Applicants only

For sub-national (Sub-CCM) and regional Coordinating Mechanism (RCM) Applicants only, the national CCM of the country (or countries for RCM applications) must also endorse the Sub-CCM or RCM proposal*.*

This endorsement must be evidenced by providing the Global Fund with written confirmation of the endorsement from the Chair and/or Vice-Chair of the relevant CCM(s) ***together with*** *a copy of the minutes of the CCM meeting at which the Sub-CCM or RCM proposal was* ***presented for review by the national CCMs and transparently discussed*** *and endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.1.3.*

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

Level 2 endorsement of Sub-CCM or RCM proposal by National CCMs

List below each of the national CCMs that have agreed to this proposal and ***provide documented evidence of this endorsement, including copies of the CCM meetings at which the Sub-CCM or RCM proposal was discussed and endorsed****. For Sub-CCM proposals which only cover one part of a country, only that country should be listed.*

Country	Date of CCM Endorsement	Annex number to this proposal
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

3B Proposal Endorsement

N/A	N/A	N/A

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

3B.2 Regional Organization proposal endorsement

3B.2.1 National CCM endorsement of Regional Organization proposal:

*Regional Organizations **must receive** an **endorsement in writing from the CCM for all countries targeted in the proposal** unless the country does not have a CCM (by reason that it is a small island developing state without a CCM, or it is a country which has never been eligible for funding from the Global Fund and does not therefore have a functional CCM). **This endorsement must be evidenced by** written confirmation from the Chair and/or Vice-Chair of all relevant CCMs **and** a copy of the minutes of the CCM meeting at which the Regional Organization's proposal was transparently discussed and, if relevant, endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.2.*

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

Table 3B.2.1 – Regional Organization proposal endorsement by national CCMs

Country	Date of CCM Endorsement	Annex number to this proposal
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

*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 **and the precise title of the document** on the right hand side of the table.*

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Title of the Document** and **annex number given to each annex**
Section 3A: Applicant Type and Eligibility for Funding		
Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):		
3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM)	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 1: Plan for Harmonization Annex 2: MoU PROSAÚDE Annex 3: CoC Health SWAp Annex 4: ToR Health SWAp Annex 5: ACA Report 2006 Annex 6: MoU HIV/AIDS Common Fund Annex 7: CoC Partners Forum Annex 8: HIV/AIDS Annual Joint Review 2006 Report Annex 9: Diagram on the interrelationships between key actors
Documentation describing compliance with the minimum Coordinating Mechanism requirements (sections 3A.4.3 to 3A.4.6 inclusive):		
Minimum Requirement 1	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Annex 10a: Representation in the CCM of NAIMA+ and endorsement/ membership Annex 10b: Representation of the Health SWAp focal donors in the CCM Annex 10c: Membership of MONASO Annex 10d: Membership of

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
		RENSIDA Annex 10e: Membership of the Christian Council of Mozambique Annex 10f: Membership of ECOSIDA
Minimum Requirement 3(a)	- solicit submissions for possible integration into the proposal.	Annex 11: Minutes of CCM meeting of 13 February 2007 Annex 12: E-mails about the launch of Round 7 and the agreed timeline for Mozambique Annex 13: newspaper advertisements and e-mails inviting for expressions of interest Annex 14: Guidelines for the development of expressions of interest (English translation)
Minimum Requirement 3(b)	- review submissions for possible integration into the proposal.	Annex 15: Minutes of the CCM meeting of 3 April 2007 and table with classification of Expressions of Interest
Minimum Requirement 4(a) and 4(b)	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation.	Annex 15: Minutes of the CCM meeting of 3 April 2007
Minimum Requirement 5(a) and 5(b)	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	Annex 16: E-mails about the first and second drafts of the proposals Annex 17: Note about the different working group and coordination meetings

MOZAMBIQUE ROUND SEVEN TUBERCULOSIS COMPONENT

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
3A.4.6 – Minimum Requirement 6	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	Not applicable since the Chair and Vice Chair are not of the same entity as the PRs
Regional Organization Applicants:		
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.	N/A
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.	N/A
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.	N/A
3A.6.3 *(if submitted for a country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	N/A
Section 3B: Proposal Endorsement		
3B.1.3 ***Level 1 Proposal Endorsement*** *(CCMs, Sub-CCMs and RCMs)*	Minutes of the meeting at which the proposal was developed and CCM endorsed..	Annex 18: Minutes of the CCM meeting of 29 June 2007 Annex 19: Request for extension of deadline and response from The Global Fund. **Attachment C to the Proposal Form**
3B.1.3 (***Level 2 Proposal Endorsement =*** *Sub-CCMs and RCMs only)*	Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal.	N/A

MOZAMBIQUE ROUND SEVEN TUBERCULOSIS COMPONENT

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
3B.2.1 (***Level 2 Proposal Endorsement*** *Regional Organizations only)*	Documented evidence that the national CCMs have reviewed and endorsed the proposal.	N/A
Other documents relevant to sections 1 to 3B attached by Applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

REDUCING TUBERCULOSIS MORBIDITY AND MORTALITY IN MOZAMBIQUE BY 2012, THROUGH STRENGTHENING OF THE NATIONAL TB PROGRAMME AT ALL LEVELS

MOZAMBIQUE ROUND SEVEN TUBERCULOSIS COMPONENT

List of Acronyms

ACRONYM	MEANING
AIDS	Aquired immuno-deficeny syndrome
ACSM	Advocacy Comunication Social Mobilization
BCC	Behaviour Change Communication
BIEF	Importation authorization
CCM	Country coordination mechanism
CDC	Center for Diseases Control
CFR	Case fatality rate
CNCS	National AIDS Council
CPT	Cotrimoxazole preventive therapy
CVM	Mozambican Red Cross
CBO	Community based organization
CB-DOTS	Community based direct observed treatment strategy
CMAM	Central medical store
CU	Columbia University (ICAP)
DAM	Department of Medical Assistance
DANIDA	Danish International Development Agency
DDS	District health authority
DEE	Department of communicable diseases
DFID	United Kingdom Department for International Development
DDS	District Health Authority (Direcção Distrital de Saúde)
DOTS	Direct observed treatment strategy
DPC	Department of planning and cooperation
DPS	Provincial Health Authority (Direcção Provincial de Sa
DR	Defaulter rate
EDP	Essential drug program
EMB	Ethambutol
EOI	Expression of interest
FCM	Financial management committee
FDC	Fixed dose combination
FINIDA	Finnish International Development Agency
FHI	Family Health international
FOB	Free on Board
GDP	Gross domestic product
GF	Global Fund
GLC	Green light committee
GF-ATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOM	Government of Mozambique
GT SWAP	Sector Wide Approach Working Group
ICB	International Competitive Bidding
ICC	Inter-agency Coordinating Committee
ISICIA	High Institute for Health Sciences
HAI	Health Alliance International

HIPC	Highly indebted poor country
HF	Health facility
HIV	Human immunodeficiency virus
HBC	Home based care
HRZE	Isoniazide-Rifampicin-Pirazinamide-Ethambutol
HR	Isoniazide-Rifampicin
HRD	Human resources development
HSS	Health Systems Strengthening
ICAP	International Center for AIDS care and treatment Program (CU)
ICB	International competitive bidding
IDA	International Development Association
IEC	Information Education Communication
ILEP	International Federation Against Leprosy
INE	National Statistic Institute (Instituto Nacional Estatistica)
INH	Isoniazide
ITS	Sexually Transmitted Infections
IUATLD	International union against tuberculosis and lung diseases
KAP	Knowledge, Attitude and Practice
KNCV	Abbreviation for Royal Netherlands Tuberculosis Foundation
KPMG	Accounting Firm
LCB	Limited competitive binding
LFA	Local Funding Agency
LEPRA	British's Leprosy Relief Association
MDR	Multi drug resistance
MTEF	Medium term expenditure framework
MEDIMOC	Private Enterprise contract by the Ministry for Drug Procurement and Distribution
MDG	Millennium Development Goals
MMAS	Ministry of Women and Social Action
MISAU	Ministry of Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
M&E	Monitoring and evaluation
MZM	Meticais (Mozambican Currency)
MAP	World Bank Multi-country Aids Programme
NAIMA	Network of NGOs working in Health and HIV/AIDS
NGO	Non Governmental Organization
NHS	National Health System
NLR	National Reference Laboratory
NTLCP	National Tuberculosis and Leprosy Control Program
NTP	National Tuberculosis Program
NTCP	National Tuberculosis Control Program
PARPA	Poverty Reduction Strategic Plan
PHC	Primary Health Care
PROSAUDE	Mozambican health common fund
POA	Annual operating plan
PESS	Health sector strategic plan
PLWHA	People Living with HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PAL	Practical approach to lung health

PICT	Provider initiated counseling and testing
PMTCT	Prevention of mother to child HIV transmission
PNCT	National TB Program (Programa Nacional Control Tuberculose)
OE	State budget (Portuguese)
OI	opportunistic infections
OVC	orphans and vulnerable children
RC	NGO
RCM	Regional Coordinating Mechanism
RENSIDA	Association of PLHA (Portuguese)
RESP	Public Health and Education Sector
RMP	Rifampicin
SADC	Sub-regional Organization for Development of Southern African Countries
SDC	Swiss Development Cooperation
SM	Streptomycin
SISTAFE	Government flow of funds
SR	Success rate
SRL	Super-national reference laboratory
SWAP	Sector wide approach
SS+	Sputum Smear Positive
STG	Standard treatment guidelines
STI	Sexually transmitted infections
SWOT	Strength, Weaknesses, Opportunities, Threats
TAP	Treatment Accelerating Program
TARV	Anti Retroviral Treatment
TB	Tuberculosis
TB-CAP	Tuberculosis control program
TRP	Technical Review Panel
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WTO	World Trade organization
XDR-TB	Extreme drug-resistant tuberculosis

4 Component Section *Tuberculosis*

***PLEASE NOTE THAT SECTION 4 and SECTION 5 MUST BE COMPLETED FOR EACH SEPARATE DISEASE COMPONENT**. This section is only for your tuberculosis component, and sections 4 and 5 for HIV/AIDS and malaria are separately identified in this Proposal Form (refer to the section headings to find the section relevant to your proposal).*

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

4.1 Requested proposal term for this disease 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 within 12 months of Board approval.

Important note:

If your proposal term is less than five years, please first refer to the Global Fund's Round 7 'Frequently Asked Questions' (No. 132) at:
http://www.theglobalfund.org/en/apply/call7/documents/documentsfaqs/

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	January 2008	December 2012

4.2 Disease specific component executive summary

4.2.1 Executive summary

Describe the overall strategy of the proposal component, by referring to challenges, existing and/or new needs, goals, objectives and planned outcomes and outputs to be achieved through the additional funding requested in this proposal, specifying the main beneficiaries (including target populations and their estimated number). Also specify any institution/facilities that will benefit from any support for health systems strengthening strategic actions.

*(**Maximum of one page in length**, highlighting, in a summary format only, key aspects from information described in your answers to the questions within section 4).*

Mozambique is one of the countries worst affected by tuberculosis (TB) – with every year more than 30,000 new TB cases reported, and ranking 18th among the 22 highest TB burdened countries in the world (WHO Global Report 2007). WHO estimates that in 2005, less than 50% of new sputum smear positive TB cases were detected and that only 36% of all forms of TB were detected. The low detection rate is attributable to under-diagnosis of existing cases due to an inadequate health care infrastructure, particularly in rural areas. Especially the diagnosis of sputum smear negative and extrapulmonary TB cases suffers from diagnostic constraints.

In 2005, the estimated incidence of sputum smear positive TB in Mozambique was 185 cases per 100,000 persons compared to 447 TB cases of all forms per 100,000 persons (WHO Global Report 2007). National data shows a 63,5%, increase in the number of new TB cases notified within the past five years, which can be associated with the HIV/AIDS epidemic widely generalized in Mozambique. In 2004, the national HIV prevalence for adults aged 15-49 was 16%, according to a Ministry of Health report.

Unfortunately, the case detection and cure rate are still below the WHO targets of respectively, 70% and 85%. In 2005, FDC and the six month regimen containing rifampicin in both phases were introduced in the country, with DOT performed also in the continuation phase. In August 22 2006, TB supervisors and deputy supervisors received training on voluntary counseling and testing for HIV for all diagnosed TB patients and a sequence of provincial and district trainings were performed. As the scale up of this activity was introduced in the second half of 2006, data on the burden of TB due to HIV infection is currently limited.

The NTP's mission is to improve quality of services and interventions in a primary health care system

through early case detection and adequate treatment of patients. Furthermore, the country's National TB strategic plan 2008-2012 aims at reducing the country's burden of TB in line with the Millennium Development Goals and the Stop TB partnership targets. Also, the government is intensifying its efforts to reduce absolute poverty by implementing the second Action Plan for the Reduction of Absolute Poverty (2006-2009). Thus, the program will contribute to reducing the current poverty index of 54% in 2003 to 45% by the end of 2009.

In relation to MDR-TB, the MOH suspects that laboratory confirmed MDR-TB cases are significantly under-detected. While the process of applying to the Green Light Committee (GLC) is on going, the NTLCP is acquiring 2nd line drugs through the GLC procurements procedures and treating multi-drug resistant TB (MDR-TB) patients following the regimens recommended by WHO. In February 2007, a new national drug resistance survey was initiated.

Major beneficiaries are TB patients, HIV/TB patients, OVC with TB, miners, prisoners, refugees and the military. The Ministry of Health and private providers of TB care would benefit from provision of TB drugs, equipment and training of staff. The preparation and implementation of this proposal will have the support of a variety of financial and technical partners (the more than 14 Health Common Fund contributors, WHO, PEPFAR/USAID/CDC, HAI, CU, FHI, LEPRA, RC, KNCV).

The Round 7 proposal covers the period 2008-2012 and is anchored on the National TB Strategic Plan 2008-2012. The goal defined in this proposal is to reduce morbidity and mortality due to tuberculosis, in line with the national strategic plan and in line with the MDG. To meet this goal, 6 objectives have been set: 1) Pursue high quality DOTS expansion and enhancement, 2) Address TB/HIV, MDR-TB and other challenges, 3) Contribute to health system strengthening, 4) Engage all care providers, 5) Empower people with TB and communities and 6) Enable and promote research. The major services planned to reach these objectives are: 1) Detection of smear+ cases through extending DOTS services, 2) Counseling and testing for HIV of TB patients, 3) Co-trimoxazole preventive therapy for HIV+ TB patients, 4) Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program), and 5) Information, Education and Communication.

Health systems strengthening strategic actions for the Ministry of Health, include improvement of radiologic diagnostic capacity through provision of more X-ray units and provision of human resources for key areas like M&E, Drug Management and Human Resource Development Plan for TB personnel. Actions for the community is the improvement of the community managed transport system used by DOTS volunteers and also for emergency evacuation of sick TB, HIV/AIDS and pregnant women, through provision of motorcycles to compliment he bicycles currently in use.

The strengthening of the Monitoring and Evaluation (M&E) system is important as the present system is not sufficiently in line with internationally recommended M&E guidelines. Under this proposal an M&E person for the NTP will be recruited as the NTP acknowledges M&E as an essential component to monitoring the progress of program implementation in order to adapt and adjust activities to ensure the highest level of impact. More investment to this activity will allow the NTP to capture some of the new indicators, such as those related to DOT in the community, MDR-TB, TB/HIV and IEC activities. With the strengthening of a M&E officer at the national level, it will be possible to carry out several surveys to identify strengths and weaknesses in the program.

The total amount requested in this proposal is US$ 20,983,828 for the five year period (2008-2012), of which US$ 6,735,303 is planned for the first two years and US$ 14,248,525 for the remaining three years.

4 Component Section *Tuberculosis*

4.3 National program context for this component

The information below helps reviewers understand the disease context, what is working well and will be built upon, which problems the proposal will address and the major constraints for the implementation of the proposed component. Please refer to the Guidelines for Proposals, section 4.3.

4.3.1 Indicate whether you have any of the following documents** *(check the appropriate box),* **and if so, please attach them as an annex to your proposal:**

☒	National Health Sector Development/Strategic Plan (Health Sector Strategic Plan (PESS) for 2001-2005-2010, Attachment 1, Government 5 year plan 2005-2009, Attachment 6);Health Policy Declaration, Attachment 7, POA 2006 Attachment 9). The Medium Term Expenditure Framework (MTEF) 2008-2010 was approved by the Council of Ministers on 12 June 2007 (Attachment 32)
☒	National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings (**National Strategic Plan TB 2008-2012, Attachment 2)
☒	Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards) (Draft Strategic Plan Laboratories, Attachment 4; Draft Human Resources Development Plan, Attachment 5)
☒	Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal (**WHO National Tuberculosis and Leprosy Program Review Feb 2006, Attachment 10)
☐	National Monitoring and Evaluation Plan (health sector, disease specific or other)

*** Applicants will be asked to refer to these documents, where they exist, throughout this section 4 as further support for the proposal's overall strategy.*

4.3.2 Epidemiological and disease-specific background

(a) In table 4.3.2 below: (i) identify the total population of the country/countries; **and** (ii) then provide current estimates of the stage of the disease in the listed specific population groups. *The 'source of estimate' (final column in the table below) may be from recent published estimates of WHO, but may also be published national estimates or statistics.*

Table 4.3.2 – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	20,366,795	2007	National Institute of Statistics
(ii) **Current estimates on the stage of the disease in the following population groups**:			
People living with all forms of tuberculosis	35,639	2006	National TB Program 2006 Report
People with new smear-positive tuberculosis	16,742	2006	National TB Program 2006 Report
People treated for new smear-positive tuberculosis	17,877	2005	National TB Program 2006 Report
Tuberculosis related deaths per year	24,498	2005	Stop TB Annual Report 2006

4 Component Section *Tuberculosis*

Population	Estimated number	Year of estimate	Source of estimate
Number of cases of multi-drug resistance per year	1,172	1999	MacArthur et al 2001
Case detection rate of new smear-positive cases	49% 17,877	2005	WHO Report 2007 Global TB Control
DOTS treatment success rate	80% 14,302	2005	National TB Report 2006
Treatment cure rate	79% 14,123	2005	National TB Report 2006
Treatment default rate	7.2% 1,287	2005	National TB Report 2006
Death Rate	11.7% 2,092	2005	National TB Report 2006
Other: *(identify)* Treatment failure rate	1.2% 215	2005	National TB Report 2006

(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons for their use. Any data on drug resistance should also be included (where relevant). *(Maximum two pages.)*

Globally, Mozambique is one of the countries worst affected by tuberculosis (TB) - every year more than 30,000 new TB cases are reported. According to the World Health Organization (WHO Global Report 2007), the country ranks 18th among the 22 highest TB burdened countries in the world.

TB is a generalized epidemic in Mozambique and is one of the leading causes of illness and death in adults. However, WHO estimates that, in 2005, less than fifty percent of new sputum smear positive TB cases were detected and that an even lower proportion (36%) of all forms of TB was detected. The low detection rate is attributable to under-diagnosis of existing cases due to an inadequate health care infrastructure, particularly in rural areas. While the detection of sputum smear-positive cases is low in Mozambique, the detection of sputum smear-negative and extra-pulmonary TB cases is considered even lower due to even further diagnostic constraints. Persons living with HIV/AIDS are much more likely to have sputum smear-negative and extra-pulmonary TB disease, particularly with advanced immuno-suppression. In 2005, the estimated incidence of sputum smear positive TB in Mozambique was 185 cases per 100,000 persons compared to 447 TB cases of all forms per 100,000 persons (WHO Global Report 2007).

Further, national data as shown in the table below, reveals that, within the past six years, the number of TB cases notified has increased by 57%, from 22,636 in 2001 to 35,632 in 2006. This increase is largely attributed to a greater burden of TB cases among persons living with HIV/AIDS rather than due to improved diagnostics. In the same time period, the relative proportion of smear-positive TB declined from 62% to 51%, and smear-negative pulmonary and extrapulmonary TB increased from 31% to 43%.

Table: Reported cases (All categories), 2001-2006

Year	Smear + Pulmonary TB	%	Smear - Pulmonary TB	%	Extra Pulmonary TB	%	Relapses & Other Retreatment *	%	TOTAL
2001	13,967	62	4,738	21	2,337	10	1,594	7	22,636
2002	15,236	58	6,224	24	2,936	11	1,721	7	26,117
2003	16,138	55	7,847	27	3,441	12	1,681	6	29,107
2004	16,998	54	8,758	28	3,930	12	1,828	6	31,514
2005	17,877	53	9,184	27	4,771	14	1,886	6	33,718
2006	18,275	51	10,618	30	4,929	14	1,810	5	35,632

Source: NTCP Annual reports

* Failures, Treatment After Defaults and other re-treatment cases.

In 2004, a large proportion, 13%, of 17,058 registered new smear-positive cases died. Currently, a large proportion of persons with TB disease who are living with HIV/AIDS are likely to die before being diagnosed or initiating treatment. WHO estimates that, in 2005, 24,498 persons died from TB and that over half of these deaths were among persons living with HIV/AIDS. Between 2003 and 2005, the cure rate among new sputum smear-positive patients increased from 74% to 79% while the success rate increased from 76% to 80%. This improvement is attributed to a decrease in defaulters and transfers. However, the cure rate is still below the WHO target of 85%. Further, as previously mentioned, under-detection implies that many persons, particularly HIV-infected persons, are dying prior to diagnosis and treatment. Notwithstanding, re-treatment cases would be expected to have even lower treatment success but this data is not readily available.

Table: Treatment outcomes of New Smear Positive cases, 2001-2006. (Treatment Success rate - SR; Defaulter rate – DR; Case Fatality rate – CFR)

YEAR	SR (%)	DR (%)	CFR (%)
2001	75.4	8.7	9.7
2002	76.9	7.4	10.7
2003	74.2	8.1	11.8
2004	75.4	7.2	12.7
2005	78.9	5.4	11.7

Source: NTCP Annual reports

As with TB disease, HIV/AIDS is a generalized epidemic in Mozambique. In 2004, the national HIV prevalence for adults aged 15-49 was 16%, according to a Ministry of Health report. The proportion of HIV-infected persons varies by region in Mozambique; the greatest proportions of persons infected with HIV are in the southern (18%) and central provinces (21%) whereas the lowest proportion of persons infected is in the northern region (10%). Scaling up of HIV testing among TB patients was introduced in the second half of 2006 and, therefore, data on the burden of TB due to HIV infection is currently limited. However, in the first quarter of 2007 according to national statistics, 4,971 (56%) of 8,885 TB patients tested were HIV-positive. As expected, due to converging epidemics of HIV and TB, the southern and central regions of the nation are most affected by TB among persons living with HIV/AIDS with approximately 50-80% of TB patients infected with HIV. In 2006, the Sofala province reported 70% of their TB patients to be HIV-positive. According to the WHO, 50% of TB patients are estimated to be

infected with HIV, nationwide.

TB surveillance data on children is currently limited. Between 1987 and 1992, the National TB Control Programme (NTCP), in conjunction with IUATLD, performed a series of tuberculin surveys on 9-year-old school children which found a 1.7% annual risk of tuberculosis infection. However, current data on annual risk of infection is unknown and reported age-stratified data is currently limited to new, sputum smear-positive cases. In 2005, 266 (1.5%) of 17,877 persons under 15 years old were reported among 17,877 new smear-positive patients. However, low case detection likely affects diagnosis in children. Among the six countries bordering Mozambique, the average proportion of new smear positive TB cases detected in children under 15 years old among all reported new smear-positive cases was 3.2% (range: 1.1-3.7%). However, the highest proportion (3.7%) among children was in South Africa where case detection rates are considered the highest. Children are more likely to have sputum-smear negative and extra-pulmonary TB, but this data is unavailable with the current recording and reporting system. Similarly, data on trends of notified TB cases by sex is limited. Among bordering countries, the ratio between male and female cases was between 1.0 and 1.7 with the highest ratio observed in Tanzania. This factor suggests that males are slightly more likely to develop TB, as observed in many parts of the world. However, this observation is likely biased if women have less access to TB services than men or are more likely to be HIV-infected than men.

According to the current national treatment policy and aligned with WHO recommended guidelines, the main treatment regimes in use are as follows: A.) **new cases**: 2HRZE/4HR and B.) **retreatment cases**: 2HRZES/1HRZE/5HRE. Furthermore, since April 2005, fixed dosage combinations (FDCs) of first line drugs are routinely used in Mozambique. Mozambique is still in the process of applying to the Green Light Committee (GLC). In the meantime, the NTLCP is acquiring these 2nd line drugs through the GLC procurements procedures and treating multi-drug resistant TB (MDR-TB) patients following the regimens recommended by WHO.

MDR-TB is defined based on international standards as a TB case with an isolate resistant to at least two essential first line drugs, namely isoniazid and rifampicin. The MoH is concerned that MDR-TB may be on the rise. Due to insufficient laboratory capacity and a low level of clinical suspicion among clinicians, the MOH suspects that laboratory confirmed MDR-TB cases are significantly under-detected. MDR-TB is a concern for the MoH, and in 2006 a MDR-TB National Coordinator at the Central Unit of the NTP was appointed, followed by the training of 22 clinicians to address MDR-TB nationwide.

Between 1998-1999, a drug resistance survey was conducted in selected provinces and revealed that among 1,028 new case isolates examined, 36 (3.4%) were found to be MDR-TB (MacArthur et al, IJTLD 2001). However, this survey had some methodological weaknesses in representative sampling due to accessibility problems related to security issues. Most recently, in 2003, a small study among HIV-infected TB patients was performed at several referral hospitals in Maputo and revealed that among 69 new case isolates examined, 4 (5.8%) were found to be MDR-TB (Nunes et al., IJTLD 2005). Among 38 re-treatment cases, the MDR-TB prevalence was 15.8%. Based on these figures, the incidence of MDR-TB in Mozambique is thought to be relatively higher than in 1999, as it is in other countries in the Southern African region. In February 2007, the NTP initiated a new national drug resistance survey in collaboration with the supra-national reference laboratory in Milan and the World Health Organization. In the table below results of drug sensitivity testing for the 129 MDR-TB cases in 2006 is presented.

TESTED			New SS+		Relapses		Defaulters		Failures		Chron. &	
Resistant	Nr	%	Nr	%	Nr	%	Nr	%	Nº	%	Nr	%
INH+RMP	23	17.8	2	8.7	13	56.5	0	0.0	4	17.4	4	17.4
INH+RMP+ EMB	2	1.6	0	0.0	1	50.0	0	0.0	0	0.0	1	50.0
INH+SM+ RMP	74	57.4	12	16.2	28	37.8	2	2.7	16	21.6	16	21.6
INH+SM+ RMP+EMB	30	23.3	1	3.3	7	23.3	0	0.0	13	43.3	9	30.0

Preliminary data from the recently started resistance survey confirm that drug resistance is a problem in Mozambique (5 resistance strains identified out of 90 culture in 11 clusters, e.g. 5.5%).

Recently, an outbreak of extensively drug resistant tuberculosis (XDR-TB)—MDR-TB with additional resistance to 2nd line drugs—was identified in South Africa. Due to the frequent cross border movements

between Mozambique and South Africa, the MoH and international partners are concerned that XDR-TB poses a serious threat for Mozambique. Second-line drug testing is not performed in Mozambique to detect XDR-TB. However, the NTP will utilize a supra-national reference laboratory to routinely test selected isolates for resistance to 2nd line drugs for confirmation of XDR-TB.

4.3.3 Disease-prevention and 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 4.3.3.

(a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.
Applicants should ensure that the information provided below takes into account the cumulative outcomes based on all current and planned support from all stakeholders (government, major international initiatives, international donors and partnerships etc).

The National Tuberculosis Program has completed thirty years of its creation in the Ministry of Health (1977- 2007). TB is integrated in the primary health care system in the country and the main mission of the program is to improve quality of services and interventions by early detection and adequate treatment of patients and follow up.

Throughout the country, policies based on WHO recommendations and the main elements of the DOTS strategy are fully provided by the government free of charge within the basic management health units; diagnosis and follow up of patients by sputum smear microscopy; regular supply of quality drugs; standard case management with a six month FDC regimen using DOT, and standard recording and reporting cohort system.

Presently, the program is guided by the new National strategic plan 2008-2012, which has recently received input from various partners at a stakeholders meeting. This plan incorporates the Global Stop TB strategies and the design began with the international review in 2006, followed by inputs from two consultants (one local) and validation from a consultant from the Stop TB Partnership.

National Strategic Plan TB 2008-2012 (Attachment 2)
The new strategic plan will focus more on the recommendations from the Stop TB Initiative. This National strategic plan aims at reducing the global burden of TB in line with the Millennium Development goals and the Stop TB partnership targets.

The main components of the National Strategic Plan:
1. Pursue high quality DOTS expansion and enhancement,
2. Address TB/HIV, MDR-TB and other challenges,
3. Contribute to health system strengthening,
4. Engage all care providers,
5. Empower people with TB and communities,
6. Enable and promote research.

The present strategic plan focuses on increasing the detection rate, strengthening the laboratory network, improving case-management and patient support, tackling the emerging MDR/XDR problem and further expanding TB/HIV collaborative activities as well as implementing a quality monitoring and evaluation system allowing impact measurement of program activities. An important component of the plan is aimed at extending and strengthening the DOTS strategy. In order to improve the case detection rate, the plan focuses on increasing the suspicion of TB among health workers working in the different components of the health care system (e.g. health centres, VCT centres, communities, et)c. The introduction of the new 6 month-regimen with fixed dose combination drugs in 2005 made the treatment delivery process easier to manage for both patients and staff. Another relevant component of the Strategic Plan is aimed at enhancing the ACSM activities in order to spread correct information within the civil society contributing to early diagnosis and effective treatment (e.g. the key interventions in TB control). The entire package cannot be implemented without addressing the issue of human resources and strengthening the NTP Central Unit.

Although DOTS coverage (in terms of population coverage) is considered to be 100%, based on the

principles of the new Stop TB Strategy the Government of Mozambique is committed to further extend quality DOTS services to people living far from district health services as DOTS is presently only in the main health centre in the district headquarters (basic administrative unit) of the 128 districts in the country.

Therefore, expansion of DOTS means to ensure that a greater percentage of the population live in an area where DOTS is available and can access these services. It will mean involving peripheral health facilities (going beyond the one health centre per district) and the community in TB care according to the principles of the New Stop TB Strategy, as captured by the new National TB Strategic Plan 2008-2012.
WHO will be providing four Technical advisers to support the implementation of this plan; one in the NTP and one in the three regions of the country. Each Regional technical adviser will support the implementation in a group of provinces.
Furthermore, a number of partners (HAI, CU, CDC, FHI, LEPRA, RC) are and will be supporting the implementation of this plan.

The priorities, orientations, strategies and interventions presented in this plan were made taking into consideration the context of TB in the country, the weaknesses and the strengths of the health system providing TB services.
This plan also takes into account the regional situation of the disease, especially in the SADC region, and finally in the world to make sure that the plan goes in line with the global and regional strategies such as the Global Plan to Stop TB and the Millennium Development Goals.
By implementing this plan, the main aim is to expand existing health care services, access to diagnosis and treatment to the most vulnerable groups. To achieve this, the NTP will ensure the implementation of the above six components of this strategy. Moreover, the implementation of this strategy will be framed on successful experiences in different areas that the country has on one hand (achieved with the support of local and international NGOs), and also based on international recommended frameworks from previous and recent international reviews. MOH and NTP have recognized the pitfalls affecting the TB programme and decided to use the 2006 International Review's recommendations as the basis to initiate a serious process aimed at reaching WHO targets and MDGs.

International review 2006: MOH's responses to recommendations

In 2006 the National TB Program of Mozambique was visited by an international review team consisting of Union, WHO, Milan SRL and London School of Tropical Medicine and Hygiene staff. In the executive summary the team made the following recommendations:

1. the Minister of Health define the place and priority of TB in Mozambique in light of the declaration of TB as a Regional Emergency and actions to address this challenge, taking into consideration the Global Plan for Tuberculosis; - in March 2006 the Minister of Health declared TB a national emergency and actions to address this emergency were in the 2007 TB plan: improvement of quality of diagnosis and treatment, strengthening of DOTS to improve access of people living in underserved areas, expansion of DOTS to the community and intensifying TB/HV collaborative activities.

The table below summarises the evolution of DOTS to other peripheral health facilities from 2006 to 2007 (1st quarter):

Province	Total number of HF	HF with DOTS in 2006	Coverage (%)	HF with DOTS in the 1st quarter/2007	coverage (%)
C. Delgado	96	73	76%	86	86
Niassa	124	107	86%	107	86
Nampula	194*	92	47%	133	68%
Zambézia	175	25	14%	65	37%
Manica	81	61	65%	73	90%
Sofala	132*	22	16%	60	45%
Tete	101	79	78%	76**	75
Inhambane	104	55	52%	104	100%
Gaza	122	58	47%	66	54%
Maputo Prov.	162	71	43%	152	93%
C. Maputo	42	23	54%	23	54%

Total geral:	**1333**	**666**	49%	**945**	70%

*The number of health facilities has been recently reviewed and updated.

** Three health centers closed.

2. the Minister of Health expedite administrative procedures and ensure clear communications for timely expenditures in the Global Fund for AIDS, Tuberculosis and Malaria, taking into consideration the imminent reporting requirements for Phase I and the fact that Mozambique is a 'pilot' for the funding mechanism through the sector-wide approach that neighbouring countries in the region will be watching as they prepare their plans;

The government flow of funds, named **SISTAFE** (a program implemented in July 2006) allows to have a timely expenditure of funds to the provincial and district levels, in January of every year. Moreover, the central level of the MOH is capable of providing funds if there are delays in the SISTAFE system. In the case of the Common Fund, the new Memorandum of Understanding recognizes the elimination of triggers in relation to expenditures.

3. the Minister of Health ensure coordination of activities designed to assist those with tuberculosis and HIV, following international guidelines for such collaboration, in order to rapidly improve access to HIV care for tuberculosis patients and to engage the tuberculosis services in the efforts to address the crisis of HIV;

In March 2006 in all provinces supervisors for TB, HIV/AIDS, malaria, leprosy and ITS (Infectious Transmitted Diseases) were appointed by the Minister of Health; integrated TB/HIV activities were further extended in 2006, with training of all provincial TB supervisors and their deputies in counselling and testing for HIV in TB patients and offering co-trimoxazol preventive therapy to co-infected patients as part of a TB/HIV care package. Additionally, 7 clinicians underwent international training-of-trainers in TB/HIV collaborative activities, being ready to replicate the training cascade at Provincial level based on the standard materials developed in Portuguese (see TB Strategic Plan 2008-2012).,

4. the Minister of Health revisit existing plans to improve access of members of the community to tuberculosis diagnosis and treatment, ensuring that services are provided in the remaining 80% of health institutions where there are personnel, providing treatment as near to the place of residence of patients as possible;

Decentralisation of treatment has been further implemented to ensure that by the end of 2007 100% of peripheral health facilities will be able to provide at least the continuation phase of the treatment and, where possible, the initial phase as well.

5. the Minister of Health adopt a plan for human resources development with priority for engaging health personnel in the existing facilities for tuberculosis treatment, expanding and coordinating human resources for expanding laboratory services, extending plans for supervision for the extended services and defining a policy for engagement of volunteers.

The department of Human Resources within the MOH is developing a national human resources development plan in which the TB human resources needs will be incorporated. A focal person within NTP will ensure that the principles of the plan will become operational within the TB programme. The new 2008-2012 TB Strategic Plan captures the priority need to strengthen the NTP Central Unit as a pre-requisite to ensure timely implementation of NTP activities.

The Community Involvement Strategy (Attachment 13a) was discussed from 13-15 June 2007 in a meeting chaired by the Health Minister Attachment 13b-d). Under this strategy only two cadres of Community Workers would be available, the Community Health Workers, who would be government employees, and would undergo a 6 month training. The community volunteers or activistas, who would not be remunerated, or at best would be paid in cash/kind by the communities and/or NGOs. The reward and incentive systems for the DOTs Volunteers, in this proposal are programmed with this new policy in mind.

6. the Minister of Health operationalize plans for strengthening and extending access to diagnostic services (such as regional laboratories and radiography services);

40% of the health facilities in the country already offer diagnosis and treatment of TB, and in 2006 41 more health facilities offered diagnostic laboratory services; plans for decentralisation of culture

facilities to the Central Hospital in Beira were made, and the rehabilitation and equipment for the laboratory in the Central Hospital in Beira will be done in 2007; an assessment of the chest radiography diagnostic facilities needs will be performed in 2007. The 2008-2012 TB Strategic Plan includes also the extension of culture services to the Central Hospital in Nampula, following recommendations of previous international reviews/ missions. A comprehensive plan of training to ensure capacity building to managed adequately the new laboratories has been also developed within the new Strategic Plan.

In June 21 2007, the New Health Laboratory Development Plan (Attachment 4) was reviewed by a Stakeholders meeting, it had earlier under gone a technical review by WHO. This plan would ensure proper maintenance and sustainability for all the laboratory investments. Similarly the laboratory technologist training school (ISICIA), in which the MOH had made significant investments, would graduate its first class of the four year B.Sc Laboratory Technology Degree holders in 2008, and produce an average of 30 such personnel per year. These badly needed manpower would boost the TB Control and other related activities of the MOH by improving laboratory and diagnostic services, particularly in the rural areas.

7. the Minister of Health designate, without delay, a Manager for the National Tuberculosis Programme and ensure sufficient technical staff at the Central Unit;

A NTP manager was appointed in February 2006 and 5 more staff were hired at national level: 3 full time and 2 part-time; two biologists and 2 technician were recruited for the NRL. As mentioned above, new key positions had been identified within the new TB Strategic Plan to meet the recommendation of previous international reviews/ missions, as recruitments are being made.

8. the Minister of Health outline a mechanism to draw on and coordinate technical support among partners and technical experts to address the emergency of tuberculosis;

A national TB/HIV technical working group was created in September 2006, which included all NGOs working in TB/HIV care. A national TB meeting with officials from the MoH (NTP) and representatives from all provinces was held in February 2007 where partners were invited to strengthen coorperation and coordination, focusing on underserved communities. The plan is to have these meetings bi-annually. The new Strategic Plan further underlines the importance of establishing an ICC (Inter-Agency Coordinated Committee) mechanism, allowing both coordination of technical activities and sharing of programmatic data essential to strengthen the M&E component of the new TB Strategic Plan.

9. the Manager of the National Tuberculosis Programme pay particular attention to drug supplies to ensure no interruption and efficient flow of drugs, including the permanent presence of a buffer stock;

Since March 2006 buffer stock for 3 months for the Southern region and 6 months for the Central and Northern region was guaranteed, where before this was only 1 months; cooperation with CMAM is strengthened and technical assistance from a pharmacist was given to the NTP. The new Strategic Plan promotes establishment of a stronger link between NTP and CMAM, as well as implementation of a computerised tool allowing NTP to monitor the entire drug management cycle.

10. the Manager of the National Tuberculosis Programme call on the resources of the Stop TB Partnership for technical assistance.

The NTP is receiving technical assistance from various partners, including TB-CAP, WHO and CDC. The new Strategic Plan has been developed through technical assistance provided by WHO and CDC and various NGOs (HAI, ICAP, LEPRA). Additional information on the activities of these organisations is provided below.

Achivements made under the National TB Strategic Plan 2003-2008

Under the outgoing strategic plan, the focus was on improving the detection rate, increasing the laboratory network, better follow up of patients on treatment, improvement of monitoring and evaluation system and improvement of integrated TB and HIV activities. An important part was extending and strengthening the DOTS strategy. In order to improve the detection rate the plan focused on increasing the suspicion of TB in health workers in various parts of the health care system, like health centres, VCT centres, as well as in communities to help with early detection. Another part was the enhancement of information within the population about TB and its treatment (IEC).

The introduction of the 6 month regimen with fixed dose combinations in 2005 made treatment easier for patients and treatment staff, and drug management improved, though some stock outs still occurred in

the transition period. The number of health centres performing smear microscopy increased from 176 (2003) to 250 (2006). More staff were recruited at central level, as well as at health facility level and were trained.

Contribution of Partners

WHO

Provides support to the NTP for DOTS expansion through activities like training of clinicians and laboratory technicians ; expansion of Quality Control of smears in provinces ; regular supervision and review meetings ; promoting for involvement of news partners (the private sector and communities) ; development of an efficient TB drug management system, and increased laboratory culture capacity. The WHO also provide technical assistance to the NTCP through a Programme Officer for Tuberculosis, and would be providing 4 more technical experts to support the implementation of the new TB strategic plan.

Global Fund

R2 of the GF is at present the most significant source of funding of the TB control. It supports the following major activities, as they were then described - DOTS expansion, HIV/TB, PAL, HBC, PPM, IEC/BCC and HSS.

ILEP

The International Federation of Anti-Leprosy Associations counts 5 member NGOs in Mozambique (AIFO, Damien Foundation, The Netherlands Leprosy Relief Association – NLR ; The Leprosy Mission International – TLMI ; LEPRA – Health in Action) which are supporting the National Program for Tuberculosis and Leprosy. After the Global Fund, they are the biggest contributors to a TB-Leprosy fund. The 5 NGOs are currently contracted by the MOH through the Pro Saúde (Health Common Fund) under the Global Fund Round 2 for TB to implement complementary activities with province and district health services, and also involve civil society actors. They work in the provinces next listed. AIFO – Inhambane and Manica; Damien Foundation – Tete; Netherlands Leprosy Relief Association – Nampula, Niassa and Cabo Delgado (Northern Region); TMLI – Cabo Delgado and LEPRA – Maputo, Gaza and Zambézia, where they carry out TB and Leprosy activities. ILEP NGOs work complementary with provincial health directorates where they are based and their role is mainly to co-organise training of professionals and an average of 300 volunteers per Province, support monitoring and evaluation and Leprosy elimination activities. ILEP NGOs participate in national and provincial meetings to plan and evaluate programme achievements and they are involved in implementation and monitoring.

TB CAP

The USAID funded Tuberculosis Control and Assistance Program is supporting the strengthening of laboratory capacity and improvement of access to quality TB laboratory diagnosis, including expansion of sputum culture capacity to Beira and Nampula that will be strengthened as reference laboratories for their respective Centre and North regions. TBCAP also provides a technical support to adapt the Community-Based (CB) DOTS strategy in Mozambique and facilitate its implementation in two pilot districts of three provinces (Gaza, Sofala and Zambézia) in order to decentralize services and improve access to DOTS during the full course of TB treatment. TBCAP is also involved in the expansion of TB/HIV collaborative activities building on the achievements of the previous TBCTA “Getting Started” project, including : expansion of provider initiated counseling and testing (PICT) for TB patients followed by Cotrimoxazole Preventive Therapy (CPT) anti-retroviral therapy (ART) and intensified TB case-finding in Voluntary Counselling and Testing

Columbia University / ICAP

ICAP is supporting 31 HIV care and treatment services in Maputo City and Province, and in Gaza, Inhambane, Zambézia and Nampula Provinces through direct technical assistance, supervision, infrastructure and logistical support. ICAP specific support to TB is related to TB/ HIV collaborative activities, each of the 31 sites implements screening for TB among HIV patients in ART clinics, CTX prophylaxis for TB/HIV co-infected patients, access to INH prophylaxis for eligible patients, prompt access to ART treatment for eligible patients, follow up of TB/HIV co-infected patients, basic measures to reduce TB infection transmission, training staff on TB/HIV issues, referral to and from TB clinics, improved TB/HIV data recording and reporting, link with volunteers and community based organizations to improve adherence to treatment and TB contacts tracing. ICAP also provides technical assistance to the MoH centrally in Maputo.

Health Alliance International

HAI is supporting the expansion of the HIV treatment programme and of TB/ HIV collaborative activities at province and district levels in Sofala and Manica Provinces. The NGO provides technical assistance at health facility level for TB, HIV and TB/ HIV, supports laboratories and specifically the TB programme. HAI is committed to provide more technical assistance in the Provinces of Nampula and Tete.

Italian Cooperation

The Italian Cooperation will stop their activities in TB control in 2007.

MSF Luxemburg

MSF Luxemburg is running a CB DOTS project in Angonia District in Tete Province since 2005 ; this project also has a HIV component, external consultations and support cover both target groups and co-infected patients.

Around 100 Community Volunteers were trained to detect and refer patients to the health facilities and improve treatment adherence. They work in close collaboration with the health services and also facilitate the transport of smear tests to laboratories. The two district laboratories are supported to improve the diagnosis process, MSF provides an additional technical support to the main laboratory in Tete city, and has also started to support the TB programme in some other districts – training nurses and health staff.

CVM (Mozambique Red Cross)

The Mozambican Red Cross is committed to involvement in DOTS expansion at community level through the reactivation and training of its network of Volunteers and has participated in several preparatory meetings at national and provincial levels.

(b) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context**. *(Also include an overview of any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' (e.g., for HIV/TB collaborative activities) or the 'Roll Back Malaria Global Strategic Plan').*

The second Action Plan for the Reduction of Absolute Poverty (PARPA II – Attachment 3) of the Government of Mozambique for 2006-2009 aims at reducing the incidence of poverty from the figure of 54% in 2003 to 45% by the end of 2009.

This PARPA II, which is also framed around the MDGs succeeded a previous action plan designed for 2001-2005 and it has the same priority areas as the PARPA I, such as human development in health and education; improved governance; development of basic infrastructure and agriculture, rural development and also stresses the need to improve macroeconomic finance and management. Moreover this plan includes in the priorities more integration of the national economy and improved productivity.

In particular, it focuses on the district as the basis for development; the creation of a favorable environment for the increase of the productive sector nationwide; strengthened financial sector; increased involvement of the private sector in the economy of the country and improved system to collect government revenues and equitable distribution of financial resources.

This plan has three pillars of orientation which includes the pillar of governance, the human capital and the economic development pillar, namely: The governance Pillar which envisages to have the estate of the government as the main promoter of human capital development and also economic development. The Human Capital Pillar of this plan aims at reducing the incidence of diseases affecting the most vulnerable, focusing particularly on AIDS, TB and malaria. Finally, the economic development pillar centres the attention on improving infrastructure, apart from promoting equitable distribution of available resources and adequate legislation to assure human rights.

As a consequence of the implementation of this plan, additional objectives will be met such as improved monitoring of the economic development, increased private sector activities; more opportunities for partnerships with private sector in order to create the supportive environment for trade. The government will also increase the annual budget for the health sector to reach 15% of investment from the national

budget by 2009.

The health area component of this plan has PHC services, the fight against endemic diseases such as diarrheas, malaria, tuberculosis, leprosy and HIV/AIDS, as the priorities. The HIV/AIDS epidemic is clearly seen as an additional vulnerability factor; therefore its fight requires a multisectoral approach. Besides the objective of expanding access to health services, other issues are also taken into consideration such as improved quality of services, more efficiency and efficacy in the provision of services.

The whole contribution on training, expansion of services (actually access to health services is below 50%) and on human capacity building will demonstrates commitment from the Government to achieving the TB control Strategic plan goals and the MDGs.

If this proposal is approved it will support the country contributing to continuous expansion of services to underserved communities.

The recently developed new National TB Strategic Plan, is based on the global plan to STOP TB, and it benefited from inputs from Stop TB WHO, which sent one Consultant to support its development process. This proposal is based on the new TB Strategic Plan, hence it is in line with the Stop TB strategies.

Health Policy Declaration

The Health Policy Declaration of the Ministry of Health (Attachment 7), is another important health framework to support the Government in the reduction of poverty and therefore contribute to reducing the incidence of the most prevalent diseases, including TB.

The objectives in the Health Policy Declaration match with the Millennium Development Goals. Reduction of TB prevalence and mortality in line with the strategic plan and the MDGs will allow the country to achieve the specific objectives defined in this declaration:

- Reduce TB prevalence rate of 636/100.000 population observed in 2004 to 450/100.000 in 2010 and 320/100.000 population in 2015,
- Reduce TB death rate of 12% observed in 2004 to 8 % in 2010 and 6 % by 2015,
- Increase the detection rate of new smear positive cases of 45% observed in 2004, to 65 % by 2008 and 70% by the end of 2010,
- Increase TB treatment success rate from 76 % observed in 2004 to 80 % by the end of 2007 and 85 % by 2010,
- Reduce defaulter rate of 8% observed in 2004 to 6 % by the end of 2010 and 5 % until 31st of December 2015,

Furthermore, the Health Policy Declaration gives strong attention for an increased investment in the health sector to deliver high quality equitable health care with a commitment of at least 15% of the state budget to the health sector from 2007. This decision was taken by the African Heads of State in Abuja in 2006. The decision also calls for an increased per capita expenditure on health from US$10 in 2002 to $21 in 2010 and $34 in 2015 as recommended by the Commission on Macroeconomics and Health.

Additionally, under this declaration the MOH has to provide quality primary health care services, assuring access to the essential drugs for the treatment of the main frequent diseases. Community involvement and mobilization is another important component of this health policy which is also an important area of this proposal. The main objective is to contribute for improving the health status of the population, which will also need the involvement of different partners. The Government Policy, technically reflected in the new TB Strategic Plan 2008-2012, meets the main priorities defined in all the key WHO documents recently produced e.g. the new Stop TB Strategy, the Global Plan to Stop Tuberculosis 2006-2015, the the current policy for TB/HIV collaborative activities, and the Universal Access initiative that followed the previous 3 x 5 initiative.

(c) Describe how this proposal seeks to: (1) use, to the extent that they exist, country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

This proposal would be implemented through the Health Common Fund mechanism described below, and through this it would achieve the two objectives, namely use country systems and ensure greater

donor harmonization and alignment to country cycles.

The Ministry of Health has a Health Common Fund (PROSAUDE) to which most of the key bilateral donors including the Global Fund are contributors, there are about 14 contributors in all.. The Common Fund is the mechanism through which the external funds are channeled to compliment governments funds for the health sector. It is governed by the MOU, and two coordinating meetings, the GT SWAP and Sector Coordinating Committee. The Common Fund MOU stipulates that partners support an agreed health sector strategy, with joint planning, budgeting, audit, monitoring and evaluation. Under the Common Fund the relevant departments and processes of the Ministry of health are used for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing.

Several partners who do not contribute to the Common Fund, including USAID and the UN systems participate in the Health SWAp and are members of the SWAp working groups. They also participate in the Sectoral Coordination Committee which takes place twice a year. This is the highest decision making meeting where important issues such as annual plan, the annual joint evaluation report as well as the audit report are approved

Thus the SWAp Mechanism has allowed the Health Sector in Mozambique to achieve greater harmonization and alignment of partners to the country's cycle in regard to procedures for reporting, budgeting, financial management and procurement.

Due to its importance, particular attention is paid to procurement, and there is a procurement manual for implementation of the Common Fund. This manual was developed in line with the overall government procurement process and is one of the annexes of the PROSAUDE Memorandum of Understanding. The manual has been prepared to provide basic procurement rules for procurement of Goods, Services and Works, within MOH departments and directorates. This Manual also sets out the procedures to be followed by MOH in the procurement of Goods, Services (including Consulting Services) and Works required by MOH in the implementation of donor funded projects.

The purpose and objective of the manual is to ensure that suitable qualified suppliers and contractors are chosen without bias or discrimination, and that best value for money is obtained, with full transparency and accountability.

For medicines there is a specific procurement process and this is also an annex to the memorandum of understanding of PROSAUDE.

4.3.4 National health system

(a) Briefly describe the main health systems constraints related to this component by focusing on the strengths, weaknesses, opportunities and threats of the health system.

Please consider the list of health systems strengthening strategic actions ('HSS Strategic Actions') outlined in section 4.4.2 of the Guidelines for Proposal when providing this description.

Health Care Provision

Led by the Ministry of Health (MoH), the National Health Service (NHS) is the main provider of health care in the country. There is a small private sector, concentrated in some cities, providing only curative care. The not-for-profit sector is even smaller, most of them running government health facilities, under agreement with the Ministry of Health, with cost-sharing between the two partners taking place.

The NHS network comprises:

- 3 Central Hospitals (Maputo, Beira and Nampula);
- 7 Provincial Hospitals, one in each provincial capital, except those with Central Hospitals;
- 27 Rural Hospitals;
- 4 General Hospitals, located in urban areas;
- 435 Health Centres (urban and rural);
- 652 Health Posts (mostly rural);
- 18,000 health staff.

In addition to health care facilities, the MoH runs a network of training institutions for all categories of health personnel, with the exception of medical doctors; these are trained in universities, under the Ministry of Education. Recently, the High Institute for Health Sciences (ISICIA) was created, under the MoH, to provide university-level training to non-doctor professionals. ISICIA would be graduating its first set of graduate laboratory technologists in 2008. Public and private universities train other categories of health personnel, such as pharmacists, dentists, biochemists, biologists etc who are hired by the MoH.

Research specialized institutions are the National Institute for Health and Manhiça Health Research Centre.

The health care delivery system is organized in three levels, namely:

- Primary level, which provides promotive, preventive, and basic curative care, within the Primary Health Care framework. Practical training of health personnel, including medical students, also takes place at this level. The activities are carried out in Health Centres and Posts, as well as in communities, by health personnel and community health workers;
- Secondary level, comprised by the general and rural hospitals, provides curative and preventive care and constitutes the referral for health centres. Training of personnel and occasional research also takes place in general and rural hospitals;
- Tertiary level, which, through provincial hospitals, provides a wider range of curative care, training of personnel and referral to the general and rural hospitals; occasional research takes place as well;
- The Central Hospitals have a regional referral role for the provincial hospitals and offer comprehensive curative and rehabilitative care. The Maputo Central Hospital has an additional role as the national referral hospital. Medical students are trained at this level, as well as specialists. A new university was recently created in Nampula and the central hospital there will host medical students.

Challenges of the Health Sector

The Mozambican health system is a mixed economy of public and private sector players and some institutions which are a combination of the two. The public sector remains under resourced with the result that services are of variable quality and can only cover a minority of the population. The growth of the private sector could improve the supply of good quality health services in the country. The NHS is by far the largest provider of health care services and faces a series of challenges such as: increased needs for mobilization and utilization of available funds, reduction in the fund allocation and inequities and improved quality of services. Huge inequalities exist with regards to resource allocation, deployment of staff and availability of services among various geographic areas, between the urban and rural population, and between the poor and the non-poor. The following are some of the challenges:

- Inadequate funds allocated for service delivery
- Inequitable access to health care, especially by vulnerable groups
- Inadequate infrastructure for the delivery of quality services
- Poor quality of care in both public and private sectors
- Low salaries of health staff in the public sector and lack of incentives to work in remote areas
- Poor management and leadership capacity, especially in monitoring, evaluation, supervision and for evidence-based, delegated decision making
- Inadequate capacity in human resource development including training and personnel management
- Inadequate capacity for financial management.

Health Status

The health status of Mozambican people is among the poorest in the world. The disease pattern remains pre-transitional, that is, mainly infectious and parasitic diseases, diarrhea, acute respiratory infection, measles, malaria, and tuberculosis and child malnutrition. Like most countries in the sub region the problem of HIV/AIDS has continued to burden not only the health sector but the whole fabric of society and has compromised the prospects of poverty reduction and the creation of wealth at all levels. The country is estimated to have almost 1.6 million persons infected with HIV in 2005, and adult prevalence rose from of at least 14% in 2002 to over 16.2% in 2004.Three basic health status indicators, infant mortality, under-five child mortality, and maternal mortality, are among the highest in the world.

Malnutrition is prevalent, particularly among children. Data indicates that about 30-40 percent of children surveyed suffer from chronic malnutrition (stunted growth) while six percent of children have acute malnutrition, indicated by wasting. Nutritional problems directly aggravate other health problems and increase the overall burden of diseases.

Health service provision
The management system under the NHS is still rather centralized. The resources are allocated from the Ministry of Health to provincial directorates of health, and to district directorates of health. Provinces program their annual activities based on an analysis of past performance and needs. More recently efforts are being made for the provinces and districts to embark on more substantive planning for health service delivery. New planning methods are being piloted in several provinces.

National health expenditures
According to the NHA estimate, the health sector spent about US$140 million 1997. This is equivalent to US$8.84 per capita and is comparable to the level of health spending in many low-income countries, such as Malawi and Ghana. This level falls short of the US$12.00 standard established under the World Development Report, 1993, and the US$9.24 standard under Better Health in Africa, 1994. Table 7 indicates there are four major sources of funds for health financing: government treasury, external donors, employers, and households. External aid financed more than 50 percent of the total health expenditures and the government took 22 percent of the share. Even at high levels of poverty, households spent almost as much as the government did on health care (19 percent) (see Figure 3). Funds from each source were channeled through financing agencies that either provide or purchase health services. Much of the health expenditure is channeled through the MOH (54 percent). In fact, health has become one of the larger sectors of the public sector.

Equity in access to health care
Available and accessible health services are still insufficient to address the needs of the population, with approximately 50% of the population not having appropriate or acceptable access to services. Inequitable geographical distribution of health facilities, poor infrastructure and the shortage of human resources for health are affecting universal access to health care. The poor have much worse health status than the non-poor. In addition to socioeconomic status, inequality in access to health care contributes to their inferior health status. Household survey data show large differences in health behavior and health access between the poor and non-poor, although the poor generally suffer more from illness.

Overall, Maputo City has about seven times more per capita than Zambézia does. The progress in narrowing the funding gap is slow, and inequality in resource allocation persists. The inequality in fund allocation clearly results from unequal distribution of other resources such as health professionals and infrastructure, which can change only slowly over time. An inequality also exists in levels of care. While primary level facilities deliver 37 percent of the activity outputs measured in health care units, they only receive 22 percent of the government resources. On the other hand, the three central hospitals only produce 15 percent of the services (measured by service units) but receive 37 percent of these funds. Although it is important to remember that the central hospitals provide a more sophisticated level of care and supply services that benefit the other levels, such as training, when commenting on the proportion of funds allocated to them.

Human Resources
The low numbers of health staff, the poor planning for sufficient and appropriately trained staff to meet health needs, and the limitations in the quality of training available, all contribute to a poor availability of human resources in the health sector. Health training institutions are currently not producing sufficient health professionals to fill vacant posts, while at the same time the quality of training is reducing through scarcity of qualified trainers. The distribution of staff across the country is not equitable with no clear deployment policy and strategy.

Institutional challenges
Organizationally, the ministry encounters a lack of clarity about roles and functions within its departments and institutions linked to inadequate management skills. The challenge is to build institutional linkages for managing, coordinating and monitoring the implementation process in order to facilitate central departments, programs, institutions and field personnel to interact closely and work as teams to produce common outcomes. There is unnecessary duplication of resources, especially in terms of personnel and finances, when planning, training and supervision for different programs are conducted independently and

separately leading to lack of clarity within line management.

(b) Describe the national priorities in addressing these constraints.

The Ministry of Health is being restructured, also at district level the MOH and MMAS staff would be working together to enhance delivery of services and avoid duplication and overlap of NGO and CBO activity.

The strategic plans to develop the laboratories and to improve community involvement have all been launched.

The ISICIA's capacity is being built to produce enough graduate health manpower.

Health facilities are been adjusted for geographic access.

(c) **Coordination and Synergies**

Briefly describe how disease specific programs are coordinated within the framework of the National Health Sector Development Plan, where one exists. For instance how the proposed component relates to (where appropriate) the national communicable disease strategy and to priorities in the plan.

If the Applicant's proposal covers more than one component, also describe any synergies expected from the combination of different components. For example, HIV/TB 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.)

The Health Sector Strategic Plan aims to improve the health status of population". One of the main objectives is to reduce the burden of communicable diseases and the impact of HIV/AIDS. The main communicable and endemic diseases in Mozambique are Malaria, Tuberculosis and HIV/AIDS. The Tuberculosis Strategic Plan aims to reduce the global burden of TB in line with the Millennium Development goals and the Stop TB partnership targets.

The health sector strategic plan gives priority to the following areas:

1. To increase the detection and cure rate by expanding DOTS to the Community.
2. Address TB/HIV, MDR-TB and Other Challenges.
3. Health Systems Strengthening.
4. Empower People with TB and Communities.

With the declaration of 2006 as the year of acceleration of the access to HIV prevention, taking into consideration the impact of HIV epidemic fueling TB cases, with TB being the 1st cause of death among HIV patients, and since TB is curable, there is a need of (1) increasing detection of cases, reducing the impact of HIV among TB cases (2) by testing as many TB cases as possible and introducing Cotrimoxazole preventive therapy when ARVs are not available. The above activities show clearly the added value TB and HIV collaboration brings to both programmes.

Counselling and Testing is an indirect operational support activity to HIV/AIDS. Access to TARV is being accelerated to make it universal. For TB patients where TARV is not available, cases will have access to Cotrimoxazole. It will be supplied by the ITS/HIV/AIDS Programme under treatment of opportunistic infections.

The support for the training of clinical staff, treating nurses and laboratory technicians/technologists as proposed in this component is in line with the capacity building initiatives of the National TB Strategic Plan. The training activities would also benefit HIV/AIDS, as the same staff will have strengthened the Health Services and improve access to HIV/AIDS and other services.

The same applies to supporting renovation of infrastructure, in particular rehabilitation of laboratories and purchase of equipment (reagents etc) this enhances service delivery by improving capacity for laboratory diagnosis.

4.3.5 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), basket 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 section 4.4*

(b) Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach?

Yes, the funding requested will be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities.

(c) **Describe the common funding mechanism, whether it is already operational and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

The Government of Mozambique receives both General Budget Support and Direct Budget Support. Direct Budget Support is provided in various sectors, including the Health Sector and the Multisectoral Response to HIV/AIDS. The latter one is explained in more detail in the HIV/AIDS component.

The money being requested for in this proposal would be going into the health common fund (PROSAUDE).

The Ministry of Health is financed through three different sources: the State Budget (OE), Common Funds, and Vertical Funds. In 2006, the relative contributions of these sources to overall funding of $348 million (not including investment funds), was 31%, 30%, and 39% respectively.

In 2000, Mozambique adopted a sector wide approach in policy and programming (SWAP) for health, led by the MoH. The MoH and its partners signed a Code of Conduct in May 2000. A revised Code of Conduct was signed in 2003 (Attachment 33). A common fund was established in 2003, and an MoU was signed between MoH and the cooperation partners (Attachment 8**).** The Global Fund is a common fund partner and a signatory to this MoU. Currently, there are around 29 development partners, of which 16 contribute to the common fund. Following a joint effort by the MoH and its partners, a Health Sector Strategic Plan (PESS) for 2001-2005-2010**)**, endorsed by the partners, and approved by the Council of Ministers in 2001. This Strategic Plan became the basic strategy document for government and external partners to work towards a common vision in health. This Plan was drafted concurrently with the first Action Plan for the Reduction of Absolute Poverty (PARPA) for 2001-2005. Annual Operational Plans (POAs) provide the details of implementation of policies and strategies defined in the PESS. The PESS is currently being updated and the new version, which will cover the period up to 2012, should be ready by the third quarter of 2007.
1.

Three pooled funds for the health sector have been established: a common general fund (PROSAÚDE), a provincial common fund, and a drugs and medical supplies common fund. (The Provincial Fund is a complement of the State Budget for the implementation of activities at provincial level) (POA 2007, Attachment 9).Development partners contributing to these common funds review and negotiate the Plans of Action (POA) with the MoH before approving and releasing their funds to the common funds. Some donors, do not contribute directly to any of the common funds but do participate actively in SWAP

planning and discussions. These separately funded programmes and the activities they support are expected to be reflected within the POAs.

Mozambique is the first country in which the GFATM funds, starting with the Round 2 grant, are channeled through the common funding mechanisms of the SWAp. The Global Fund has signed the MoU and in 2006 the GFATM contribution to the common fund budget was more than $23 million between HIV/AIDS, tuberculosis, and malaria, and as such, the GF is the largest major contributor to the Common Funds is the GF (24% in 2006). This is entirely allocated to PROSAUDE.

This mechanism combines funds provided by the signatory partners and deposited into a FOREX account at the Central Bank of Mozambique. The funds are transferred by the Ministry of Finance upon request by Ministry of Health. The Ministry of Health is responsible for managing the funds including their allocation in accordance with policy and strategies priorities of the sector. The use of common fund system ensures an effective and efficient use of health resources, by using 1) A standard national instrument to plan, prepare budget, manage, carry out assessments and audits, 2) Similar mechanisms for fund management which reduce transaction costs and bureaucratic work, involves fewer staff members and less time to process and carry out the accounting of funds from different cooperation partners. All signatory partners and other partners, jointly with Ministry of Health, review the sector priorities and performance in accordance with Ministry of Health´s planning, budgeting and monitoring cycle.

The general flow process related to PROSAUDE funds is presented below:

Step 1. Contributions by PROSAUDE Signatory Partners are deposited into the FOREX account The Forex account is opened in name of the Ministry of Finance at Bank of Mozambique (The Central Bank) and denominated in USD. The bank of Mozambique should notify the Signatory Partners, MF and Ministry of Health in writing of the receipt of the external funds.

Step 2. The request of funds from the FOREX account is made by DAF (Department of Administration and Finance, Ministry of Health) with the approval of CGF. The funds are transferred from the FOREX account to the DAF bank account in MZM. The transfer of funds is made through the Central Treasury Account (CTA) in MZM, by converting the $ from the Forex, applying the exchange rate corresponding to the date on which the funds are transferred to the CTA.

Step 3. Once the funds in DAF bank account, they are transferred to the Cost Centres bank accounts for the executions of programmed activities and payments.

Due to the complexity of the Common Funding Mechanism, the volume of funds involved, as well as insufficient staff with experience and technical capacity in the area of finances, the Ministry of Health has recruited an international consulting firm (KPMG) to provide Technical Assistance in implementing a new financial management system.

Three levels and structures for dialogue and consensus have been established to allow the MoH and its partners, through a consultation process, to forge a productive relationship based on mutually agreed priorities and strategies. These structures, which are described in detail in the SWAp ToR (Attachment 29), include :

2. Sector Coordination Committee (CCS) – chaired by the Minister of Health, this committee meets twice a year and includes the Minister of Health's cabinet, provincial health directors, other ministries, and representatives of development partners active in health. Its role is to endorse key reports and recommendations and keep development partners informed about significant issues or decisions related to health;
3. The SWAp Forum (GT SWAP), – a smaller working group of the MoH and all partners, used to meet monthly up to April 2007. This structure has since been replaced by the Joint Coordination Committee (CCC) which includes six MoH senior staff and four partners and meets eight times per year under the chairpersonship of the Permanent Secretary of MoH. Enlarged CCC meetings with a larger group are held twice a year and are also chaired by the Permanent Secretary. Participants include MoH staff, other key ministries, National AIDS Council, bilateral and multilateral agencies, global initiatives, civil society organizations, national and international NGOs, the private sector, medical associations and academic institutions;
4. SWAp Working Groups – made up by mostly technical staff of the MoH and partners to jointly review or oversee specific areas of health policy or implementation. The groups cover such areas as human

resources, HIV/AIDS, TB and malaria, health systems, drugs, avian flu, and maternal and child health.

In addition, Joint Annual Evaluations (ACA) are held once a year, in line with the Government's requirements (for the 2006 ACA Report, see Attachment 30).

The harmonization of the CCM with the existing mechanisms, including the Health SWAp, was formalised in August 2006 (Attachment 31). Monitoring and oversight of the GF grants (which are allocated to the common fund) is carried out through the existing systems with which the CCM is harmonised.

The vertical funds received by MoH represent a heterogeneous group of partners which channel their funds through intermediate agencies and NGOs. This group includes several bilateral partners, UN agencies, global initiatives, and development banks. These funds include investment resources and usually are not executed by the public sector.

(d) Describe the process for **independent supervision** of the performance of the common funding mechanism.
Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**, *as an annex to your proposal, **the most recent external assessment of the operations of the common funding mechanism**.*

The Common Funding Mechanism is assessed annually through inspections from the Ministry of Finance and the Administrative Court. Apart from these regular inspections it is also subject to an annual independent/external audit as described in the MoU. This audit is currently being done by an International auditing firm (Ernst & Young). The reports of these inspections and external audit are presented to all interested parties (Government and Cooperation Partners). Attachment 11 shows the audit report for 2005.

(e) Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure **effective supervision** of the work that is proposed.
*Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.*

The Health Common Fund can absorb the additional funds, because its structures are robust and are being continuously improved upon by all its stakeholders- the government, the donor partners, civil society and CBOs. Also the Global Fund through its staff (the portfolio Manager) and the CCM and LFA are represented in the main bodies that supervise the Health Common Fund.

Everything possible within the MOU will be done to ensure that NGOs who succeeded in the EOL access the GF via the Common Fund.

The Sector Coordination Committee (CCS) – chaired by the Minister of Health, meets twice a year and includes the Minister of Health's cabinet, provincial health directors, and representatives of development partners active in health. Its role is to endorse key reports and recommendations and keep development partners informed about significant issues or decisions related to health. The Global Fund is represented at its meetings through its staff (the portfolio manager) and or the CCM and LFA.

The Joint Coordination Committee (CCC) which includes six MoH senior staff and four partners, meets eight times per year under the chairpersonship of the Permanent Secretary of MoH. Enlarged CCC meetings with a larger group are held twice a year and are also chaired by the Permanent Secretary. Participants include MoH staff, other key ministries, National AIDS Council, bilateral and multilateral agencies, global initiatives, civil society organizations, national and international NGOs, the private sector, medical associations and academic institutions;

The representation of the Global Fund in the SWAp, ensures that the work being proposed in this proposal would be prioritised in the annual operating plan of the Health Common Fund. In line with the harmonisation of the CCM with the Health SWAp (see Attachment 31), CCM members have access to

the audit reports.

The Health Common Fund MOU requires the creation of the Financial Management Committee (FCM), which is responsible for fund management and execution, as well as the achievement of the objectives of the financing granted. The FCM is chaired by the Permanent Secretary and includes the following officers: National Director of Health, Director of Planning and Cooperation, Director of Administration and Management, and the Director of Human Resources. The financial management of the common funds follows the norms and procedures agreed in the MOU. The MOU specifies the norms for disbursement, norms for transfer of funds, reporting on expenditures (accounts statements) and independent auditing. It further includes agreed procedures for financial management and procurement.

The supervision of the Health Common Fund can also be looked at from the perspective of the political, sectoral, programmatic and consumers (beneficiary) levels. Much of what has been described above is the sectoral level.

Political Level Supervision of the Health Common Fund

Oversight of programme implementation takes place through the existing political oversight system, which has at the top a decision making body of political representatives being the Health Minister and very senior representatives of the donors.

Sectoral Level Supervision of the Health Common Fund

The national health programme is coordinated by the Ministry of Health, and the main coordination forum is the Health SWAp. The working mechanisms include a Sectoral Coordination Committee (CCS), a Joint Coordination Committee (CCC) and Health SWAp working groups, which each have a set frequency of meetings (see above under 4.3.5.c) to review progress made in implementing the National Health Sector Strategic Plan (PESS 2000-2010).

Programmatic level supervision by (CCM, Principal Recipients and Sub-recipients)

The Health SWAp Working Groups consisting of mostly technical staff of both MoH and cooperation partners elaborate annual plans and review annual progress in the Annual Joint Review (ACA in Portuguese) process

Supervision by The Beneficiaries/Communities

Through democratic and social networks, these communities supervise the Common Fund, because they provide feedback to their elected representatives, traditional rulers, CBO leadership etc on the status of health (TB control) activities. This is in essence consumer supervision and oversight of the Common Fund.

Implementation of Common Fund funded activities to date has involved working with communities' political, traditional, religious and informal leadership, district heads, elected representatives, traditional/religious leaders, and women and youth leaders. The various community leaders, PLWHAs, representatives of key groups such as women and young people, and CBOs are made part of supervision and monitoring teams. They are also supported and empowered to play active roles in implementation, participating in advocacy, IEC, surveys, special studies and micro planning of activities. Project personnel like community volunteers are selected from their own communities as far as it is practicable, in order to ensure that IEC messages and care under the project are offered in the appropriate cultural context of the target population. The communities are encouraged to participate in the reviews of project activities and are constantly updated on constraints and progress.

(f) Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for tuberculosis activities during the proposal term*.

The activities in MDR TB, improvement in diagnostic capacity (laboratory and radiodiagnosis- overseas

training of laboratory technologists etc)) and TB/HIV would not have been possible.

The Common Fund has not got sufficient funds to support the TB programme, this is amply demonstrated by the Financial Gap Analysis, and the fact that the Global Fund is one of the biggest contributors to the Common Fund. So in the absence of this additional Global Fund resources, the Common Fund cannot support the TB activities proposed here. The HIV/AIDS pandemic, and lack of adequate technical and managerial capacity meant that in the last few years the TB programme had lost considerable grounds. A lot of investments- manpower, equipment, drugs etc is needed to reposition TB control.

4.4 Overall Needs Assessment

The outputs and outcomes planned to be achieved under this proposal (if approved) **should be based on an analysis of financial and programmatic gaps in national plans/programs to prevent and control the disease**.

To help Applicants identify these gaps:

Step 1 **Section 4.4.1** requests Applicants to identify gaps in the main programmatic areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main gaps only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*;

Step 2 **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Round 7 Guidelines for Proposal (section 4.4.2). *Section 4.4.2 below also requests information on other current and planned levels of support for these same actions; and*

Step 3 **Section 4.5** requests Applicants to identify the overall disease specific financial need for the country/countries targeted in this proposal. **This table asks Applicants to identify,** on a national disease specific basis, **the overall financial needs required to prevent and control the disease**. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Thereafter, in section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.

4.4.1 Programmatic Needs Assessment

4.4.1 Overall programmatic needs assessment

(a) **Based on an existing Health Sector Strategic Plan** *(or, if not in existence, an analysis of national/regional goals, together with careful analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies)*, **describe the overall programmatic needs in terms of people in need of these key services**. Please indicate the quantitative needs for three to five main services that are intended to be delivered for this disease component (e.g., Directly Observed Treatment Short-Course for tuberculosis treatment). Also specify clearly how much of this need is currently covered (or will be covered) over the proposal term by domestic sources or other donors.

Please note that this gap analysis should guide the completion of the Targets and Indicators Table required under section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.4.1.

The goal defined in this proposal is to reduce morbidity and mortality due to tuberculosis, in line with the national strategic plan and in line with the MDG. To meet this goal, 6 objectives have

been set:

1. Pursue high quality DOTS expansion and enhancement,
2. Address TB/HIV, MDR-TB and other challenges,
3. Contribute to health system strengthening,
4. Engage all care providers,
5. Empower people with TB and communities,
6. Enable and promote research.

The major services planned to reach these objectives are:
1. Detection of smear+ cases through extending DOTS services.
2. Counseling and testing for HIV of TB patients.
3. Co-trimoxazole preventive therapy for HIV+ TB patients .
4. Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program).
5. Information, Education and Communication.

In the WHO Global TB Report 2007, the expected incidence rate in Mozambique was 447/100,000 for all forms of TB and 185/100.000 population for sputum smear positive TB cases. These figures form the basis of the calculation of the population in need in the years 2007 - 2012. For 2005 and 2006 the actual figures were used. Projections of the country's population were taken from the INE (National Institute of Statistics).

2005 - 89,332
2006 - 91,488
2007 - 91,040
2008 - 93,218
2009 - 95,435
2010 - 97,689
2011 - 99,985
2012 - 102,324

1. Detection of smear+ cases through extending DOTS services to peripheral health facilities and the community.

Diagnosis and treatment under DOTS is available in all districts, but many people do not live near these health facilities as described in section 4.3.4. DOTS services will be extended to peripheral health facilities and communities. In the community, volunteers will identify TB suspects, collect sputum samples and support the patient with the treatment with supervision from the lowest health centre level. The emphasis is on identifying and treating sputum smear positive cases.

2. Counseling and testing for HIV of TB patients.

Extension of training to all TB treatment staff to offer counseling and testing to all TB patients. This service will be implemented and strengthened to the lowest possible level.

3. Co-trimoxazole preventive therapy (CPT) for HIV+ TB patients.

TB patients who are HIV positive are offered CPT at the TB treatment side. This approach is in an early phase and will be extended to all HIV-positive TB patients. It is more patient friendly as they can receive CPT in the same place as the TB treatment.

4. Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program).

The availability to diagnose and treat MDR-TB is limited. Once the application to the GLC has been approved, diagnosis and treatment of MDR-TB according to WHO guidelines can be implemented.

5. Information, Education and Communication (IEC).

Patients have to be informed on the symptoms and transmission of TB, on the diagnosis through smear microscopy and the availability of free treatment through the DOTS strategy, and other relevant aspects of TB. This should all contribute to treatment adherence. They also need information on the relation between HIV and TB and where to go for advice.

(b) **Complete table 4.4.1**

Table 4.4.1 is designed to assist Applicants to clearly illustrate overall programmatic needs in terms of people in need of key services. Applicants should note that this gap analysis should be used to guide the completion of the Targets and Indicators Table in Attachment A to the Proposal Form (see section 4.6 of the Guidelines for Proposals). **In addition, please specify below** relevant information concerning the groups targeted and any assumptions including target size.

Projections of the country's population were taken from the INE (National Institute of Statistics).

1. Detection of smear+ cases through extending DOTS services.
In table A the estimates for the years 2007 – 2012 are based on a sputum smear positive incidence rate of 185/100.000 (WHO Report 2007). The figures in table B are based on a detection rate of smear positive cases of 51% in 2007, 52% in 2008, 53% in 2009, 54% in 2010, 55% in 2011 and 56% in 2012. The last 5 years detection rate increased yearly with an average 1%.

2. Counseling and testing for HIV of TB patients.
Patients with all forms of TB should be tested for HIV, and in table A the estimates for the years 2007 – 2012 are based on a incidence rate of all forms of TB of 447/100.000 (WHO Report 2007). The figures in table B are based on a detection rate of all cases of 40%, 42%, 44%, 46%, 48% and 50% for the years 2007 – 2012. Of those detected 45%, 60%, 75%, 85%, 90%, 95% in the years 2007- 2012 will be tested for HIV. For the calculation in table D it is also assumed that under this proposal the detection rate of all cases will increase with 2,5% per year.

3. Co-trimoxazole preventive therapy (CPT) for HIV+ TB patients.
The figures in table A are based on 50% of all TB patients being HIV positive, of which 90% receive co-trimoxazole. Some patients will be allergic or for other reasons not eligible for CPT, and therefore 90% was chosen. In table B it is assumed that with the current activities 15%, 20%, 25%, 30%, 35% and 40% of all detected HIV positive TB cases will receive CPT. CPT for HIV+ TB patients started in 2006, and although the systematic reporting of this activity has been addressed by the new 2008-2012 Strategic Plan, the reporting system has not been implemented yet.

4. Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program).
The people in need of MDR-TB diagnosis is estimated to be 3,5% of the number of sputum smear positive cases, based on the findings of MacArthur et al. A GLC application is under way, but as of yet not approved, and therefore in table B the figures for 2007-2012 are 0. Under the proposal 0,0, 100, 175 and 250 will be treated in year 2008-2012 as the GLC might ask for additional improvements in the diagnosis and treatment of MDR. The rapid scale-up of MDR diagnosis is limited by the laboratory capacity for culture and DST, presently confined in Maputo. The regional laboratories in Beira and Nampula will become operational for culture activities at the end of 2007 or early 2008, and for drug sensitivity testing during the implementation of the present proposal, as addressed by the 2008-2012 strategic plan.

5. Information, Education and Communication (IEC)
Patients with all forms of TB should receive IEC, and in table A the estimates for the years 2007 – 2012 are based on an incidence rate of all forms of TB of 447/100.000 (WHO Report 2007). The figures in table B are based on a detection rate of all cases of 40%, 42%, 44%, 46%, 48% and 50% for the years 2007 – 2012.

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1	Detection of smear+ cases through extending DOTS services.	37,092	33,484	37,679	38,580	39,498	40,431	41,381	42,349
Key Service 2	Counseling and testing for HIV of TB patients	88,533	91,488	91,040	93,218	95,435	97,689	99,985	102,324
Key Service 3	Co-trimoxazol preventive therapy for HIV+ TB patients.	N/A	41,170	40,968	41,948	42,946	43,960	44,993	46,046
Key Service 4	Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program)	N/A	1,172	1,319	1,350	1,382	1,415	1,448	1,482
Key Service 5	IEC.	88,533	91,488	91,040	93,218	95,435	97,689	99,985	102,324
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1	Detection of smear+ cases through extending DOTS services.	17,877	16,742	19,216	20,062	20,934	21,833	22,759	23,715
Key Service 2	Counseling and testing for HIV of TB patients	N/A	4,727	14,566	21,533	29,394	35,950	41,994	48,604
Key Service 3	Co-trimoxazol preventive therapy for HIV+ TB patients.	N/A	1,058	2,185	4,307	7,348	10,785	14,698	19,442
Key Service 4	Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment	N/A	129	0	0	0	0	0	0

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
	program)								
Key Service 5	IEC.	33,718	35,639	36,416	39,151	41,991	44,937	47,993	51,162
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 - B^1 = C^1$, $A^2 - B^2 = C^2$ etc.)									
Key Service 1	Detection of smear+ cases through extending DOTS services.	19,215	16,742	18,462	18,518	18,564	18,598	18,621	18,634
Key Service 2	Counseling and testing for HIV of TB patients	N/A	86,761	76,473	71,684	66,041	61,740	57,991	53,720
Key Service 3	Co-trimoxazol preventive therapy for HIV+ TB patients.	N/A	40,112	38,783	37,641	35,597	33,175	30,295	26,604
Key Service 4	Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program)	N/A	1,043	1,319	1,350	1,382	1,415	1,448	1,482
Key Service 5	IEC.	54,815	55,849	54,624	54,066	53,443	52,752	51,992	51,162
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1	Detection of smear+ cases through extending DOTS services.	*Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.*		77 (0.4%)	948 (5.1%)	1,860 (10%)	2,814 (15.1%)	3,811 (20.5%)	
Key Service 2	Counseling and testing for HIV of TB patients			2,237 (3.1%)	2,815 (4.3%)	3,492 (5.7%)	3,000 (5.2%)	2,430 (4.5%)	

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 3	Co-trimoxazol preventive therapy for HIV+ TB patients.				5,693 (15.1%)	6,652 (18.7%)	7,215 (21.7%)	7,302 (24.1%)	6,558 (24.7%)
Key Service 4	Diagnosis and treatment of MDR-TB (GLC approved MDR-TB treatment program)				0 (0%)	0 (0%)	100 (7.1%)	175 (12.1%)	250 (16.9%)
Key Service 5	IEC.				466 (0.9%)	954 (1.8%)	1465 (2.8%)	2000 (3.8%)	2558 (5%)

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4.4.2 Strategic actions to strengthen health systems

***As explained at the start of section 4.4**, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.*

***The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy**.*

Before completing this section, Applicants should refer to the Round 7 Guidelines for Proposals, section 4.4.2. where significantly greater detail is provided on HSS Strategic Actions supported in Round 7.

4.4.2 Description of HSS Strategic Actions included in this component

(a) **Complete table 4.4.2 below to describe for up to five actions** *(copy the table as many times as relevant)*:

(i) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this disease component**;

(ii) **how the actions link to the planned work during the program term** and **address** key points arising from the analysis of the health system referred to in your response to question 4.3.4 above; and

(iii) **what other support is currently available or planned for the same actions** to ensure achievement of the planned outputs and outcomes of this proposal.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame *(please also ensure you provide this Plan as an annex to the proposal as requested in section 4.3.1)*.

To clearly demonstrate the link requested in (ii) above, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to the information on the revised indicators for HSS in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

***Remember to expand the table for up to five HSS Strategic Actions**.*

4.4.2A Summary of funding requested for HSS Strategic Actions in Round 7

In the table below summarize, on a per year basis, the total of the funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed by you in table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**). Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

Total funds for essential HSS Strategic Actions requested over proposal term					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
60,760	588,000	198,000	498,300	498,300	1,843,360

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* Human Resources - Recruiting one pharmacist, one Human Resource Development expert. Funding for the 11 Provincial Coordinators for STI/TB/HIV/Malaria paid for by the Global Fund under the HIV/AIDS Round 6 proposal (until 2010), would be provided under this proposal for two more years (2011-2012). - Revising basic curricula for various health cadres. At central level, a pharmacist and a HRD officer are needed to improve drugs procurement and management and the development of a national HDR plan for TB care. The provincial coordinators improve greatly the coordination of diseases of high prevalence and especially the coordination between TB, HIV/AIDS and ITS. The 3 diseases are so closely related that the loss of the coordinators would reduce the overall program performance. This action will contribute to SDA 1.4 (drug procurement and supply management), 1.7 (human resources for objective 1 to increase case detection and cure rate by strengthening DOTS) regarding the pharmacist and HDR officer. The provincial coordinators will contribute greatly to SDA 2.1 (Scaling up the implementation of TB/HIV Activities). - Basic curricula (of nurses, clinical officers, doctors, laboratory staff of all levels) need to be updated to increase diagnostic capacity in general and for TB and HIV/AIDS in particular. This will contribute in the medium to long term to increased diagnostic and treatment capacity, objective 1 to increase case detection and cure rate by strengthening DOTS; objective 2: address TB/HIV, MDR and high risk groups.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
TOR and Job desriptions revised Advertisements Placed Staff recruited and functional	Improved drug management, and human resource planning for TB and other diseases	Improved drug management, and human resource planning for TB and other diseases	Improved drug management, and human resource planning for TB and other diseases Coordination of STI/TB/HIV/Malaria activities at provincial level would be sustained.	Improved drug management, and human resource planning for TB and other diseases Coordination of STI/TB/HIV/Malaria activities at provincial level would be sustained.
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
18,000	48,000	18,000	318,300	318,300

Describe below other current and planned support for this action over the proposal term

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

Name of supporting stakeholder ⬇	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as this proposal)*	Expected outcomes from existing and planned support
Government	Not available. In the State Budget, TB specific HSS activities are not specified.		
Other Global Fund Grants (with HSS elements) TB Round 2	2008-2009 (last 2 years of Round 2)	$ 1,080,000	Strengthened human resources
Other: *(identify)* USAID	2006-2012	$ 217,500	Strengthened human resources
Other: *(identify)* ILEP Group	2007-2012	$ 360,000	Strengthened human resources
Other: *(identify)* PROSAUDE	2007-2012	$94,000	Strengthened human resources

Action 2	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal **– not more than half a page for each HSS Strategic Action**)* Technology Management – include x-ray and bronchoscopy Radiographic imaging is an important element of TB diagnosis, especially in high HIV-prevalent settings. The capacity for radiographic diagnosis is limited at the moment, especially outside provincial capitals and it is proposed to expand the radiology services in all provinces, so more people have easier access to this part of diagnosis. Equipment will be purchased and installed for radiology units in 11 provinces (2 provinces each year of the proposal), and staff trained by the supplier on maintenance. As far as possible manufacturers whose equipment are already in use within the health sector will be given preference to reduce maintenance costs and facilitate easy maintenance. Radiation protection measures will be installed, both in buildings as for staff. Films and developer equipment will be purchased. Bronchoscopy equipment including video for training purposes for the Central Hospital in Maputo will be purchased. This hospital acts as the referral center for the whole country, as no doctors outside the capital can perform the procedure. The present equipment is old and not suitable for training purposes. This action will greatly contribute to diagnosis of smear negative TB, which is prevalent in HIV infected people, objective 1 to increase case detection and cure rate by strengthening DOTS; objective 2: address TB/HIV, MDR and high risk groups.
Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*	

Year 1	Year 2	Year 3	Year 4	Year 5
Equipment (including Bronchoscopy) ordered and installed Staff trained to use new equipment	Equipment ordered and installed Staff trained to use new equipment Improved radiologic diagnosis for TB and other diseases	Equipment ordered and installed Staff trained to use new equipment Improved radiologic diagnosis for TB and other diseases	Equipment ordered and installed Staff trained to use new equipment Improved radiologic diagnosis for TB and other diseases	Equipment ordered and installed Staff trained to use new equipment Improved radiologic diagnosis for TB and other diseases
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
21,380	500,000	180,000	180,000	180,000
Describe below other current and planned support for this action over the proposal term				

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

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	Not available. In the State Budget, TB specific HSS activities are not specified.		
Other Global Fund Grants (with HSS elements) TB Round 2	2008-2009 (last 2 years of Round 2)	$ 0	
Other: *(identify)* USAID TBCAP	2008-2012	$ 362,500	Improved diagnostic capacity
Other: *(identify)* PROSAUDE	2008-2012	$ 282,000	Improved diagnostic capacity

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

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Action 3	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* <u>Community Logistics (Transport and Communications) for TB patients using Motorcycle Ambulances.</u> Two systems of bicycle ambulances are already in use and maintained by communities for Maternal Health and HIV/AIDS HBC. The TB system would benefit from the experience gained by these existing systems, and as much as is practicable would be integrated with them. Motorcycles have a greater range and speed than bicycles. 15 Motorcycles and 30 mobile phones would be bought in year 1 and 2 to expand these systems and to improve their communications. They would be given to the communities based on need, with the ones with the most difficult terrain being the priority Only 40% of the population lives within a 20km range of a health facility, making access for the very ill in rural areas problematic. This action will contribute to improved access for the critically ill patients with TB, TB/HIV, and other diseases. (objective 1 to increase case detection and cure rate by strengthening DOTS; objective 2: address TB/HIV, MDR and high risk groups.)

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, <u>as a total only</u>, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
Assessment and integration of TB with MCH and HBC community ambulance schemes Procure motorcycle ambulances and mobile phones Present equipment to communities at high profile political event for social mobilization	Procure motorcycle ambulances and mobile phones Present equipment to communities at high profile political event for social mobilization Improved transportation of critically ill patients, including patients with TB, MCH and HIV/AIDS	Improved transportation of critically ill patients, including patients with TB, MCH and HIV/AIDS	Improved transportation of critically ill patients, including patients with TB, MCH and HIV/AIDS	Improved transportation of critically ill patients, including patients with TB, MCH and HIV/AIDS
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
21,380	40,000	0	0	0

Describe below other current and planned support for this action over the proposal term

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

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Name of supporting stakeholder ⬇	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as this proposal)*	Expected outcomes from existing and planned support
Government	Not available. In the State Budget, TB specific HSS activities are not specified.		
Other Global Fund Grants (with HSS elements) TB Round 2	2008-2009 (last 2 years of Round 2)	$ 0	
Other: *(identify)* USAID PEPFAR HBC	2008-2012	$ 50,000	Improved transportation of critically ill patients

4.4.2 HSS Strategic Actions continued
Risks arising from support for the actions and cross-cutting issues

Applicants are strongly encouraged to refer to the Guidelines for Proposals before completing (b) to (g) below.

(b) Describe your consideration of the broader implications of the proposed strategic actions and their potential impact on the functioning and performance of the health system, key institutions and stakeholders and other health programs (through a SWOT or other similar exercise). Describe, especially, any risk mitigation strategies in response to potential threats to the health system, and proposed options for ensuring long-term sustainability of the strategies built into this proposal.

1. Human Resource
2. Health Technology Management – X-ray and bronchoscopy equipment
3. Logistics (Transport and Communications for communities) for critically ill patients (Incl TB) using Motorcycle Ambulances.

The three actions above would improve quality of laboratory services, diagnostic x-rays, strengthen community transport systems and fill critical human resource gaps.

The investment in health technology would be sustained as radiologists and radiographers and related staff will have better and more equipment to work with. This would boost staff morale and also contribute to the reduction of the brain drain, as it demonstrates that conditions in the health service can improve.

The radiology and bronchoscopy equipment will benefit the entire health system and not just the TB sector.

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(c)	Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?	☐ Yes ➔ *complete (d) and (e), and then (f)* ☒ No ➔ *go to section 4.4.2(f)*

(d)	**If yes to (c)**, provide a short description of which component(s) and how the HSS Strategic Actions in this component will benefit achievement of the outputs and outcomes targeted in the other component(s).

Not applicable since the Round 7 Proposal only contains a TB Component.

(e)	If relevant, provide a detailed justification (*with clear information on direct linkages to this disease component)* for those cross cutting HSS Strategic Actions in this component which you believe should still be funded even if one or both (as relevant) of the other components submitted in Round 7 are not recommended for funding. *(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component). Refer to the Guidelines for Proposals, section 4.4.2(d) for additional guidance.*

Not applicable since the Round 7 Proposal only contains a TB Component.

(f)	Are there any cross-cutting HSS Strategic Actions integrated within **another component** in your Round 7 proposal that will benefit this component? *Applicants should ensure that the detailed budget in the other component(s) clearly identify the costs of the HSS Strategic Actions. Applicants must also ensure that there is no duplication of costs included in the various components.*	☐ Tuberculosis ☐ Malaria ☐ HIV/AIDS

Not applicable since the Round 7 Proposal only contains a TB Component.

(g)	**CCM and RCM Capacity for Health Systems Strengthening Issue identification**. Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6. ➔ *Refer to the Guidelines for further information,, section 4.4.2(g)*

This is not applicable to the situation in Mozambique since the CCM is harmonized with the existing coordination structures such as the Health SWAp. The Health SWAp members have a broad range of skills and organizational strengths, including related to (health) systems strengthening. These skills are applied in the SWAp Working Groups and ongoing discussions about the Annual Operational Plan and the Annual Joint Review.

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4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, describe the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis). As described in step 3 under section 4.4, such analysis should recognize any required investment in the HSS Strategic Actions described in section 4.4.2 above.

Summarize the overall financial need in table 4.5.

The programmatic Gap Analysis above presents the total expected cases of all forms of TB taking into account the population projections and the incidence rates estimated by the WHO. The number of patients that the system will be able to detect and treat, although below the above referred numbers, will increase over the years due to an expected increase of patients with TB and due to an expected increase of the detection rate from 49% (2006) up to 65% (2012).

The per patient estimated cost for TB control in 2006 was USD 297 according to the WHO Report 2007. It is worthwhile mentioning that the unit cost report by WHO doesn't include TB/HIV activities and includes only a limited response on TB MDR needed activities. To treat all expected cases of TB over the next 5 years (2008 – 2012), using the above referred figure and assuming an inflation rate of 5% a year, the cost would amount to $ 177.3 million.

The Draft TB National Strategic Plan 2008 – 2012 (Attachment 2) while taking into account the present capacity to deliver services, encompasses measures to enhance the activities of the program alongside the STOP TB recommendations and it is estimated to cost about $ 50 million over the five years period covered by this proposal.

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B.

Actual and estimated funding for TB health related activities from domestic sources is part of the state budget and is reflected in table 4.5. The state budget figures includes all debt relief that has been granted to the Government of Mozambique as well as general development loans and the general budget support from development partners. It is anticipated that during the 5 years of the proposal the amount of State contribution will amount up to $ 5.7 million.

The above figure is based on the assumption that domestic funding for TB activities will increase at least 5% annually from 2008 in line with the draft of the PESS 2007-2012 (Health Sector Strategic Plan, Attachment 1), supported by an annual 10,2% estimated increase of the GDP for the years 2008 - 2012.

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to this component (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line C.

Evidence from elsewhere shows that it is very difficult to obtain reliable and timely information on external support to a sector, mostly due to a lack of an integrated financial management system as well as to poor communication and to the fact that most development partners still pledges their support on an annual basis.

Coincidently, 2006-2007 seems to be the end period of the grant agreements of all major development partners supporting the Health Sector which poses additional difficulties in this exercise of estimating future funding. As there is no clear indication of funding for beyond this period.

However, positive developments have occurred in the Mozambican Health Sector as nowadays most of external support to the sector is channelled through three common funds, one to support centrally controlled expenditures (PROSAUDE), the second for medicines and medical supplies managed at central level (Common Fund for Medicines) and the third to support provincial level expenditures (Provincial Common Fund). It is expected that the consolidation and integration process will continue in the near future with the merging of the three common funds into one to support health expenditure and investment. After initial procedural related difficulties, in late 2004 the Global Fund has joined PROSAUDE. The three common funds in 2007 are supported by 14 development partners, including the Global Fund.

With the above in mind some caution should be taken in interpreting the figures shown in the table 4.5. What respects to the Global Fund, for sake of consistency, although the actual disbursements in 2005 and 2006 were made into the PROSAUDE, they are registered as Global Fund. The amounts expected for 2008 and 2009 derives from the disbursement proposal of the un-disbursed Phase I and the approved funding of the Phase II of Round 2, submitted by the MOH to the Global Fund at beginning of the current year.

Data from Ministry of Health reports suggests that 9.1% (2006) of the external funds are dedicated to TB Programme “direct” expenditure controlled at central level, including the Common Fund. The TB Programme receives also project financial support parallel to Common Fund mechanisms. The expected funding from these sources are as follows:

The WHO support is expected to be maintained at the 2007 projected level of funding of USD 173.400 totalling USD 867.000 during the proposal period.

USAID/CDC channel PEPFAR funding to support TB related activities through 3 international NGO’s (HAI – Health Alliance International, ICAP and TBCAP). The recent approval of the continuation of PEPFAR funding indicates that during the five year period the level of funding through the NGO’s could be maintained at the projected level for 2009. Therefore a contribution of about USD 0.5 million in 2008 and USD 0,65 million in each of the following years of the proposal period, totalling USD 3.1 million is expected.

The direct support to the TB Programme from the Italian Government will be phased out during 2007. So no additional funding is expected from 2008.

ILEP Group indicated that it expects to maintain the USD 2.6 million bi-annual contributions (for leprosy and tuberculosis) over the period of the proposal, totalling a USD 6.5 million direct contribution to Mozambique, from which about 1.2 million is expected to be directed to the TB Programme.

The total external support for the TB Programme is therefore estimated to be USD 11.7 million, excluding the funding to be requested under this proposal to the GFATM

4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal in section 5.*.

The estimated financial gap will be about $ 2.7 millions in 2008 and increasing annually up to about $ 9.2 million in 2012. The financial accumulated gap during the five year period is estimated to amount $ 32.1 million. The increase in the gap is due mainly to increased needs over time and assuming that the expected commitments to TB will be maintained.
An important proviso is related to medicines estimation costs. The existence in the Region of TB XDR, namely in South Africa , could have a major implication in the numbers and cost of treating TB patients with drug resistance and have an impact on all estimations used for this proposal.

4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources. Explain plans to ensure that this will continue to be true for the entire proposal term.

The Global Fund is channelled through PROSAUDE common fund. PROSAUDE is managed according to an Annual Operational Plan developed by the Ministry of Health and endorsed by the Health SWAp as a condition for annual disbursements. PROSAUDE also feeds a Provincial Common Fund. Provincial Operational Plans should also be prepared and approved by the Ministry of Health for the funds to be released. These mechanisms will ensure that established priorities in the Health Policy and especially in the Health Sector Strategic Plan, and in the specific strategic plans to fight STI/HVI/AIDS, TB and Malaria, will be respected and therefore that the required resources will increase the expected funds and fill the gap for the period 2008-2012.

The existence of a programme budget supported by an adequate programmatic and financial management system is a condition to enable the Ministry of Health and its partners in ensuring enforcement of prioritization and that funds are additional. This issue is being addressed through the development and installation of a health proprietary integrated financial management system, along with the implementation of the SISTAFE (State Budgetary Administration System). The SISTAFE was already installed and is running since mid 2006 in the central Ministry of Health and is being installed in all Provincial Health Directorates which should be covered by the end of 2007. It is foreseen that the proprietary financial management package, which is expected to help with consolidation of all financial operations and activities, will be available from 2007.

Resources will be additional to the State Budget, PEPFAR, TAP, MAP and other vertical programme funding.

4.5.5 Strategy for achieving sustainability

Describe the strategies and approaches that will be used during the proposal term to ensure that the interventions/activities initiated and/or expanded by this proposal will more likely be sustainable (continue) beyond the proposal term. *(See section 4.5.5 of the Guidelines for Proposals.)*

Note ➔ *Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term. Rather, their description should include how the country/countries targeted in the proposal are addressing their capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-finanical resources to ensure effective prevention and control of the disease(s).*

The development of the Laboratory Strategic Plan which would be made operational in the life of this

proposal and the investment in the Higher Institute for Health Sciences (ISICIA) shows that the government of Mozambique would continue to sustain and maintain the investments in the laboratories and in other diagnostic areas. Similarly ISICIA established in the last four years is providing university level training for health workers who are not doctors. Its first set of students would graduate and join the health manpower in 2008, and this would improve the quality and quantity of middle level manpower- laboratory technologists etc to manage the health system and improve service delivery.

The development of the Community Involvement Strategy would impact positively on the DOTs. The cadres of community health workers- government employees, volunteers (activistas) would be rationalized under this policy, with agreed criteria for remuneration by government and NGOs. This would lead to greater and better coordinated community mobilization and investment in health activities, benefiting TB control. It would aid contact tracing and support for treatment adherence.

The intensive technical assistance requested for in this proposal is also a source of sustainability. This is because it would be well managed, with each Technical Adviser/Expert having a carefully selected national counterpart. These national counterparts would ensure follow up, and future capacity building of fellow Mozambicans, so that investments made in these areas would be sustained. Also the networks to be established between the Technical Advisers and their national counterparts would continue to enhance knowledge exchange, long after the formal assistance would have ended. The assistance would cover critical areas -laboratories, drug management, M&E, MDR TB and radiology. Each Technical Adviser/Expert is expected to build the capacity of their national counterpart/institution. To ensure that this is done, the attainment of relevant skills and attitudes of the national counterpart would be the key item in the annual performance appraisal of the Technical Advisers

The various capacity building activities in this proposal, for the different cadres, e.g. for community volunteers, health workers, etc would be implemented diligently. It would ensure that all trainees acquire the required skills and competencies. Human resource is the key to health sector sustainability, the trained well motivated cadres would continue to sustain the TB programme well beyond 2012.

4 Component Section *Tuberculosis*

Table 4.5 - Financial contributions to national response

Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	6.322.674	6.451.708	6.791.272	7.545.858	9.321.162	9.951.199	10.846.643	11.831.882
Domestic source **B1** : Loans and debt relief (*provide donor name*)								
Domestic source **B2** : National funding resources	956.443	975.572	995.083	1.029.911	1.081.407	1.135.477	1.192.251	1.251.864
Domestic source **B3:** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned domestic resources	956.443	975.572	995.083	1.029.911	1.081.407	1.135.477	1.192.251	1.251.864
External source **C 1**: All current & planned Global Fund	1.255.750	5.959.792	1.999.887	2.661.374	2.323.856	0	0	0
External source **C2** WHO	52.500	173.400	173.400	173.400	173.400	173.400	173.400	173.400
External source C3 (USAID/CDC)	31.600	513.600	540.750	530.750	643.250	653.250	653.250	653.250
External source C4: (Italy)	52.000	226.000	226.000	0	0	0	0	0
External source C4: (Ilep Group)	0	130.000	130.000	130.000	260.000	260.000	260.000	260.000
External source C5: (*Health Common Fund*)	280.559	295.325	302.708	302.708	308.762	314.938	321.236	327.661
External source **C6**: Private Sector grants/ contributions (International)								
Total of Line C entries ➔ Total current & planned external resources	1.672.409	7.298.117	3.372.745	3.798.232	3.709.268	1.401.588	1.407.886	1.414.311

Line D ➔ Total current and planned resources ➔((i.e. Line D = Line B Total +Line C Total)	2.628.852	8.273.689	4.367.828	4.828.143	4.790.675	2.537.065	2.600.137	2.666.175
Line E ➔ Total Unmet need (Line A – Line D) -	3.693.822	-1.821.981	2.423.443	2.717.714	4.530.487	7.414.134	8.246.506	9.165.707

The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.

4 Component Section *Tuberculosis*

4.6 Tuberculosis component/implementation strategy

This section describes the strategic approach of the proposal, and the activities that are intended to be supported over the proposal term. 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 4.6, all applicants must submit by disease component:

1. 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 needs analysis** in section 4.4. All targets should be measurable and identify the current baseline. **Importantly, this table will be utilized to measure performance of the program over the whole proposal term.** For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. Refer to the Guidelines for Proposals, section 4.6.*

and

2. A **Work Plan** ➔ which must meet the following criteria. *(Refer to the Guidelines for Proposals, section 4.6):*

   a. *Structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

   b. *Covers the first two years only of the proposal term and is:*
      *i **detailed for year 1, with information broken down by quarters;***
      *ii **indicative for year 2, with information at least half yearly.***

   c. ***Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

***Please note that other documents are also required to be submitted to ensure a complete application for Round 7 funding**. Applicants are strongly encouraged to use the by-disease checklist after section 5 to ensure that all necessary documents are attached to the proposal submitted to the Global Fund.*

IMPORTANT INFORMATION FOR APPLICANTS RE-SUBMITTING A PREVIOUSLY UNAPPROVED ROUND 5 or ROUND 6 PROPOSAL FOR THIS SAME DISEASE COMPONENT

4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*

In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)*

Background

Mozambique applied in Round 6 for a TB grant, which was graded as a Category 3. The TRP comments are attached (Attachment 14). Since the last proposal, significant efforts were made to ensure that these issues were addressed and corrected. Further, the new National TB Strategic TB Plan for Mozambique 2008-2012 (Attachment 2) addresses many of these issues, comprehensively.

Specific responses to comments:

Low spending rate, performance of procurement and supply management in the context of SWAP, and absorptive capacity

The Moh is doing all the best efforts for addressing this constraint under the SWAP. Annually inspections and independent/external audits Will allow improvements as mentioned in previous paragraphs.

MDR-TB – In this proposal, most activities to address MDR-TB have been placed within their own SDA. However, some activities which will have direct benefits to the MDRTB treatment component as well as broader programmatic implications, and as outlined in the National Strategic Plan and aligned to this plan, are included elsewhere including laboratory strengthening (SDA 1.2), 2nd line drug procurement (SDA 1.4), revision of recording and reporting systems (SDA 1.5). Further, a drug resistant survey is ongoing with various funding sources (Ministry of Health, WHO, SNRL Milan) which will be utilized as baseline data for this project. We proposed an additional DRS survey for comparative purposes in the 5th year of this proposal.
We used the Stop TB budgeting tool to calculate the cost of MDR-TB drugs and services, which were insufficiently budgeted in Round 6. We further consulted with the most recent WHO Guidelines for MDRTB Management, WHO experts as well as CDC experts to develop this plan for budgeting MDRTB treatment. Following WHO's recommendations, we budgeted 3,000USD per patient for 2nd line drugs through the GLC in addition to laboratory renovations, inpatient facilities, and other measures. In summary, we propose to treat 750 MDR-TB patients under a GLC project with GFATM funding from this proposal. The number of patients will be scaled up with 200 patients in Year 3, 250 patients in year 4 and 300 patients in Year 5.

We started the proposed treatment for Year 3 in anticipation of necessary renovations for inpatient facilities, training and laboratory renovations as well as the anticipated GLC recommendations to be made which are currently unknown. However, we would ask that the GFATM remain flexible to start treatment earlier should the NTP meet the requirements of the GLC to start the project earlier.

Discrepancy between detailed problem analysis and lack of detail in the description of the strategy and activities to achieve the goal: Our current program analysis for this proposal utilized the broader context of National Strategic Plan for TB Control 2008-2012 (Attachment 2) and considered complimentary activities from the Round 2 GFATM approved TB proposal as well as other activities from partners and HIV/AIDS programs for linkages to activities.
In this context, the proposal team spent considerable effort defining the TB situation in Mozambique and further mapping out the programmatic gap. The objectives, SDAs and activities were developed only after the gap analysis was complete, and they were designed to fill in the gaps to meet the overall goal **To reduce the prevalence, morbidity and mortality due to TB in line with the MDGs by 2020**.

Complementarity between objectives and activities in the Round 2 proposal and TBCAP not always clear (DOTS and community DOTS). MISAU and the partners conducted a mapping exercise in October 2006 that covers all activities on TB by all partners. As part of this proposal development process, we updated the mapping exercise. Last year TB CAP was in the design phase, and the specific coverage and details with regards to Mozambique were not available at the time the proposal was prepared. TB CAP is now fully operational and its plan of action for 2006-2010 is in place, it intends to expend in this five year period $7.8m, broken down as $1.3m in 2006, $1.3m in 2007, $1.5m in 2008, $1.7m in 2009, and $2m in 2010 with activities that include Community based DOTS on a small scale and Laboratory capacity and improvement of access to quality TB laboratory diagnosis including expansion of cultures to Beira and Nampula; TB/HIV collaborative activities and programme management improvement. While this proposal has a national scope for coverage, TBCAP activities will cover only 3 provinces in the country. As part of this proposal process, all partners with TB activities were contacted, and we did a thorough programmatic gap analysis. We were especially careful not to include any ongoing or already funded activities in this proposal.
In this proposal, we delineated activities to meet the set objectives of achieving complemetarity.

Lack of details on the large number of supervision planned in the proposal (support for 13761 days of supervision each year). Mozambique is a very large country with 12 provinces and 128 health districts. In the Round 7 proposal, we have been more clear in how we budgeted supervision activities. As in the National Strategic Plan for TB Control 2008-2012 (Attachment 2), we further proposed to combine supervisory visits for different technical issues simultaneously in the same visits. This means that during the five year duration of this proposal the NTP will perform supervisory visits from the national

level to the provincial/district level; from the provincial to the district level and also will include the district visits to the CBOs sites in the community. The detailed description can be seen in the budget attached.

Lack of justification on difference between training cost for clinical staff and for treating staff ($14,280 v's $5,000 for 20 participants each course): The budget was reviewed and this error was corrected.

Impact indicators: on failure not adequate; and on population DOTS coverage not clearly defined (already 100% since 2000 in the WHO Global Report). We reviewed and revised our M&E plan for this proposal, paying special attention to impact indicators. As recommended in the M&E toolkit, we did not include DOTS expansion as an indicator for this proposal but other indicators that would support evidence for improved quality DOTS expansion in the country. Technically, Mozambique is considered a 100% DOTS country as each district has DOTS services, as described throughout this proposal. However, in practice, access to DOTS services is highly limited in rural areas and the quality of DOTS in other areas is low. We aim to improve both the coverage of DOTS to reach underserved areas and the overall quality of DOTS country-wide. Indicators and targets follow as much as possible those in the National Strategic Plan for TB Control 2008-2012 (Attachment 2).

Strengthening of the Round 7 proposal – The round 7 proposal is stronger than round 6 in many ways. First, the objectives and activities are based on the National Strategic Plan for TB Control 2008-2012 (Attachment 2), which is based on the Stop TB plan of action. The proposal is now five years in length rather than three. The proposal was developed by a very involved working group including many civil society organizations (HAI, Pathfinder, LEPRA, ICAP, Red Cross, CDC, KNCV) as well as many staff and directors from MISAU. Therefore, there has been more time to discuss ideas, refine drafts, and target activities.

The objectives, SDAs and activities have been substantially revised, and we aimed to make them much more specific. One sub-recipient (HAI- Attachment 18) has been identified, and included in the proposal and other possible sub-recipients (Attachment 16) have shown interest and would be applying later through the Common Fund procedures. All the NGOs listed in Attachment 16 and 18, participated actively in the preparation of this proposal.

TRP Round 5 Comments
There is no relationship as such between this proposal and the Round Five proposal ranked in Category 3 (TRP Comments in Attachment 14), which focused on HSS through provision of infrastructure (construction of health facilities and houses for health staff). However some of the comments in that report have been taken into consideration in the preparation of this proposal, so for example this proposal would not be engaged in any form of renovation. The renovation of laboratory facilities would be done by PEPFAR/USAID partners.

The HSS actions requested for here are well defined and address the specific needs of the TB programme, while benefiting the wider health system..

4.6.2 Goals and objectives and service delivery areas

Referring to your overall needs assessment in section 4.4.1 above, provide a summary of the proposal's overall goal(s), objectives and service delivery areas. *(The information below should be **no longer than a one page summary**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**).*

Goal:
The overall goal of this proposal with a five year duration 2008-2012, is to reduce the prevalence, morbidity and mortality due to tuberculosis in line with the MDGs by 2020. This goal is based on the National Strategic Plan for TB Control 2008-2012 (Attachment 2), which was recently revised and updated. It aligns with the global plan recommended by the STOP TB partnership and the regional (SADC) goals, which are all in line with the UN Millennium Development Goals.

Specifically, we aim to achieve a case detection rate of at least 65% and a cure rate of at least 83% in year 5. This will be possible through the implementation of the main strategic activities defined in the national strategic plan. By achieving these targets, the country will be moving towards the MDGs.
Moreover, the grant will contribute for reducing the current death rate from 12% (2005 results) to 8% and also reducing treatment defaulter rate from 7.2% (2005 results) to below 5% by 2012.
It also includes specific attention to those TB patients co-infected with TB/HIV as well as the problem of MDR-TB in the country.

Objectives and SDAs:

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

- 1.1 Political commitment
- 1.2.Improving diagnosis
- 1.3 Standardized treatment with supervision and patient support (DOT)
- 1.4 Drug procurement and supply management quality
- 1.5 Monitoring and evaluation system
- 1.6 Program management and supervision
- 1.7 Human Resources

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

- 2.1: Scaling up the implementation of TB/HIV collaborative activities
- 2.2: MDR-TB: Strengthen case management and surveillance of MDR/XDR TB
- 2.3 Address high risk groups

Objective 3: Health Systems Strengthening

- 3.1: Health Systems Strengthening
- 3.2: PAL

Objective 4: Engage all care providers

- 4.1: Public private mix

Objective 5: Empower People with TB and Communities

- 5.1: Advocacy, communication and social mobilization (ACSM)
- 5.2: Community TB care
- 5.3: Patients charter

Objective 6: Use evidence-based methods to evaluate health benefits of interventions

- 6.1: Program based operational research

4.6.3 Specific Interventions, Target Groups and Equity

(a) **Specific Interventions/Activities supported by this proposal**

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom. *(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)*

The interventions and activities supported in this proposal are described below. The workplan in Attachment 15 provides the details about when the activities are planned to be implemented. All activities are the responsibility of the Ministry of Health, however, the Ministry realizes the need to collaborate with different partners in the field, especially at the implementation level, and the one NGO whose EOI was successful (Attachment 18), is incorporated in the proposal. In Attachment 16a and 16b, a number of other NGO partners have indicated where they could play a role in the implementation of these activities

using the Common Fund procedures.

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

SDA 1.1 POLITICAL COMMITMENT

Activities:

1.1.1 Forming national Mozambique StopTB partnership to further establish and strengthen partnerships as well as coordination of activities.
1.1.2 TB Coordinators at provincial level hold awareness events on TB prevention – In year 1 of the proposal, TB coordinators in Gaza, Zambezia, Nampula, Manica and Sofala provinces will organize a TB awareness event with the attendance of provincial governors and other figures. The events will also be transmitted on radio to reach a wider audience.
1.1.3 TB Coordinators at provincial level in all provinces hold awareness events on TB prevention. The events will also be covered by radio.
1.1.4 TB awareness events are held at the health district level – TB Coordinators will also work with health workers in each health district to organize TB awareness events. Every year of the proposal, TB awareness events will be held in 30 health districts. The activities will be organized by the DDS (District Health Directorate) with support from the DPS.

TB has been recognized as a significant health issue at the national level and the proposal will aim to decentralize activities and responsibilities to the provincial, district and community levels. In 2007, TB was declared as a national emergency, with a visit from UN Special Envoy Jorge Sampaio and the participation of the President of Mozambique.

It is now important that commitment of all political levels become involved and therefore in the first year a national Stop TB partnership will be formed with involvement of as many stakeholders and partners as possible. TB awareness events will be organized from year 1 in some provinces and district, with involvement of all provinces from year 2.

SDA 1.2 IMPROVING DIAGNOSIS

Activities: Laboratory:

1.2.1 Proficiency testing between NRL and a Supranational Reference Laboratory (SRL), 2x/year.
1.2.2 Upgrade regional laboratories for sensitivity testing (Beira and Nampula).
1.2.3 Create a transport system in the 11 provinces for the transportation of specimens for culture and DST to the regional reference laboratories.
1.2.4. Procurement and distribution of laboratory supplies at different level of care and also to the laboratory of the Higher Institute of Health Sciences (ISICIA) for the training of graduate laboratory technologists. .
1.2.5 Establish Quality Assurance program
1.2.6 Supervision of laboratory services: from national to provincial level, and from provincial to district level 2x/year. Supervision from national to provincial level will be integrated where possible. This is further described in activity 1.6.3.

Smear microscopy is the cornerstone of TB diagnosis and all requirements for smear microscopy, such as sputum sample containers and reagents, are provided with MoH funding. In 2006 the rapid expansion of the ARV treatment program saw many laboratories renovated under USAID funding through PEPFAR and TBCAP, which was continued in 2007. With TB CAP and CDC funding many labs in 2006 and 2007 were further equipped for TB diagnostic microscopy. For this reason there are no basic requirements or rehabilitations for laboratories included.

In 2007 and 2008 the regional laboratories in Beira and Nampula will be renovated and equipped to perform culture and DST for TB diagnosis. This is funded by USAID through PEPFAR and TB CAP and supported by CDC and HAI (Beira). Culture for TB of specimens is presently done in the National Reference Laboratory in Maputo and not well embedded into TB diagnosis. Guidelines and a transport system for samples from the districts to the regional laboratories will be developed to include culture more firmly into TB diagnosis in the first year. Under this proposal the regional laboratories in Beira and Nampula will be equipped to perform sensitivity testing as well.

In September 2007 a workshop will be hold to update the quality control guidelines, as quality assessment and control is important to maintain good quality bacteriology. Under this proposal an

extension of the Quality Assessment program is planned with the preparation of smear slides by the NRL which will be send to the provincial laboratories in year 2 and to 35 district laboratories in the years 3-5. The quality control program, in which the district send samples to the provincial laboratory and the provincial to the national laboratory will be continued based on the revised guidelines (September 2007). The NRL will perform the quality control with a Supranational Reference laboratory, based on WHO guidelines.

Capacity building of TB laboratory staff:

1.2.7 Technical assistance from a recognized supranational reference laboratory staff to increase overall laboratory capacity.
1.2.8 Refresher training for laboratory staff.
1.2.9 Train 4 laboratory technologists or biologists depending on availability) to perform culture, species identification of Mycobacterium and drug susceptibility testing for a period of six months in an external TB reference laboratory. These laboratory technologists or biologists will work in the regional and provincial laboratories.
1.2.10 Continuing professional education for laboratory staff: refresher training and/or attendance of regional/international laboratory meetings/conferences.

The capacity in Mozambique for the laboratory is limited at present and technical assistance is required throughout the grant period to improve all parts of laboratory performance. In 2007 the Ministry of Health decided to recruit biologists to work in the national and regional laboratories, higher qualified laboratory staff being difficult to recruit. However this situation would change once the ISICIA graduates its first set of 30 graduate laboratory technologists in 2008, and the same number annually thereafter. Thus from 2008, either laboratory technologists or biologists, but preferably the former will receive training outside the country in all aspects of laboratory TB diagnosis. In 2007 two biologists were sent to Brazil to receive this training funded by the MoH and CDC. Under this proposal this program will be extended to train more laboratory technologists or biologists for the provincial laboratories as well and to build up a greater capacity in this area. CDC has funding to train 4 more laboratory technologists or biologist in 2008 and 2009 and we propose to train two more each year from year 1-5 under this grant. For the trained staff to keep up to date with new developments, continuing professional education is planned each year of the proposal.

Also the laboratory at the ISICIA would be supported with some laboratory equipment and laboratory reagents from those that would be procured for the laboratories in hospitals and clinics. This is to support the school to ensure that the laboratory technologists in training get adequate practical exposure, and are well prepared for the challenges they would face in the health sector upon graduating.

Health facility:

1.2.11 Training clinical staff, including clinical officers (“técnicos de medicina”) and nurses, TB infection and prevention, diagnosis, TB/HIV, X(M)DR-TB, childhood TB and infection control, based on most recent guidelines. 20 clinicians in 4 provinces each year.
1.2.12 Enhancing and improving radiology diagnostic skills for TB.
1.2.13 Intensifying contact tracing in children below 5 years.

Most diagnosis of TB is done at health facility level and a training program for 20 clinical staff is running with Ministry of Health funds in 4 provinces each year. Funds are requested to expand training to the other seven provinces and to ensure availability of facilitators and supply of training material.
In addition, these training materials will be revised on a yearly basis to include the most recent developments.

The WHO developed new guidelines for the diagnosis of smear negative and extrapulmonary TB at the end of 2006, which place much more emphasis on chest X-rays. The availability of X-ray facilities in Mozambique is limited to the provincial capital and a few districts. The Ministry of Health has planned an extra X-ray facility in each province for 2007, but further expansion is necessary and therefore X-ray facilities in 2 provinces each year are planned under this proposal. This will of course not only benefit TB patients, and as such forms part of strengthening the health system. See section 4.4.2 and description of objective 3. Due to the limited availability at present, the clinicians need to be trained in X-rays reading, which is also planned under this proposal for 3 provinces each year from year 2.

In a high burden country like Mozambique, contact tracing is not the most important intervention. However, children below 5 years of age who live in the same household as an adult with smear positive pulmonary TB have a high risk of getting infected, and after infection a high risk of developing TB disease including the severe forms. Therefore contact tracing in this group has formed part of Mozambique's TB control program for many years. Lack of transport means that this activity does not take place, and procurement of motorbikes and fuel for these are planned under this proposal, starting year 1.

SDA 1.3 STANDARDIZED TREATMENT WITH SUPERVISION AND PATIENT SUPPORT (DOT)

The new treatment regiment with fixed dose combination of HRZE was introduced in 2005. Information about TB, the treatment and prevention to patients is not well developed and is necessary to improve of aspects of TB care.

Activities:

1.3.1. Implementing the patient support component in the DOT with the provision of information (IEC) about TB, treatment, promotion of adherence to the treatment, and counseling wherever necessary. Development of IEC material on several aspects of TB care in various forms (leaflets, video, drama).

The DOTS strategy was expanded to cover all 128 districts (the main basic management units or "areas") in 2000. Therefore at present there is a 70% provision of DOTS. However, these health provision units (1 district health centre per distrcict) are not accessible to most of the population (about 50%), So, under this proposal the NTP is planning to involve the community in TB care (objective5, SDA 5.2), to expand TB services to the most remote areas.

There is little information material available for patients, to support diagnosis and treatment and general knowledge about TB. This activity will develop IEC material for TB patients and their families to support diagnosis and treatment in various forms in year one, and thereafter will be provided by TB treatment staff to all patients.

SDA 1.4 DRUG PROCUREMENT AND SUPPLY MANAGEMENT QUALITY

Activities:

1.4.1. Recruiting local pharmacist (see activity 3.1.2.c.). The pharmacist will work around 25% for the NTP, and therefore is further described under 3.1.2.

1.4.2. Supplying (procuring and distributing) drugs at all levels through the GDF.

1.4.3 Translating and adapting WHO guidelines on drug management.

1.4.4. Conducting quarterly supervision for drug management to regional, provincial and district medical stores. Supervision from national to provincial level will be integrated where possible. This is further described in activity 1.6.3.

1.4.5 Technical assistance, monitoring and training by an international drug management expert.

Drug procurement and supply management will be strengthened through recruitment of a local pharmacist for the national level in year 1 as well as through technical assistance from an international consultant in each year of the grant. New guidelines on drug management, based on the latest WHO recommendations will be produced in year 1, and regular supervision to provincial and district level is planned.

The last GDF review recommendations will be implemented in coordination with CMAM and other programmes to achieve improved drugs management and logistics to avoid stockouts.

SDA 1.5 MONITORING AND EVALUATION SYSTEM

Activities:

1.5.1. Recruit an M&E expert for the NTP and provide all necessary equipment.

1.5.2 Recruiting an international M&E expert (WHO medical/technical officer) for the NTP and provide necessary equipment 2 years.

1.5.3 Adapting existing national recording and reporting tools to new WHO and international recommendations e.g., surveillance forms for TB, TB/HIV, MDRTB.

1.5.4. Evaluating the national TB program.

1.5.5. Produce an annual statistics summary report.

It is recognized that the capacity for monitoring and evaluation needs to be built up in the country. Presently, the NTP central unit faces problems delivering data on indicators required by the round 2 Global Fund grant. Data on sex and age distribution are not collected, and the system is not up to date

with reporting on TB/HIV indicators. The NTP has no M&E officer and the present M&E system for tuberculosis needs to be revised and updated, with TB/HIV and MDR indicators.
It is planned under this proposal to hire a local M&E expert in year 1, who will work closely with an international M&E expert, also planned to be contracted in year 1. It is planned that the international expert will stay for 2 years during which the capacity at the national level as well as provincial level will be strengthened in TB control and analytic skills. During the first 2 years the M&E system will be revised and updated. The NTP M&E expert will take part in the integrated supervision described under SDA 1.6.

SDA 1.6 PROGRAM MANAGEMENT AND SUPERVISION
Activities:

1.6.1. Updating and disseminating the national TB control manual.
1.6.2. Reviewing and improving the supervision system.
1.6.3. Integrated supervision (NTP staff together with laboratory, pharmacy and M&E staff): 2x/yr from national to provincial level, 2x/yr from provincial to district level, 2x/yr from district to peripheral health facility level.
1.6.4. Purchase office equipment for central NTP unit.

A national TB control manual is essential for a NTP and needs to be present at all levels. The current one was developed since 2003 and needs to be revised and updated, which is planned for year 1. Supervision is an important tool for the functioning of the NTP, and to keep improving the system. The present supervision system will be critically reviewed and adapted to recent developments in year 1. There is a close relationship between M&E, the TB control manual and the supervision system, therefore it is planned to revise the present tools in year 1, with a presentation and implementation workshop in all the provinces in year 2.

SDA 1.7 HUMAN RESOURCES
Activities:

1.7.1. Recruiting TB Human Resource Development (HRD) coordinator (see activity 3.1.2.b). The HRD coordinator will work around 25% for the NTP, and therefore is further described under 3.1.2.
1.7.2. Developing national TB human resources plan.

One of the main constraints to good TB control in Mozambique is the limited human resources. Some of the proposed activities try to address this. The Ministry of Health has a Human Resources Development (HRD) plan, but the NTP does not. In this proposal it is planned to recruit a HRD officer, who will work within the Ministry of Health, and in this sense it is part of the HSS – human resources, see objective 3. An important task for this HRD officer is to make a situational analysis of the HR situation specifically for TB, and the develop a plan for HRD focusing on how to maintain a TB workforce to meet the challenges of the TB programme.

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

SDA 2.1 : SCALING UP THE IMPLEMENTATION OF TB/HIV ACTIVITIES
Activities

2.1.1 Recruiting of National TB/HIV coordinator.
2.1.2 Implementing TB/HIV task force at provincial level.
2.1.3 Intensifying TB case finding in PLWHA.
2.1.4 Introducing Isoniazid preventive therapy (IPT).
2.1.5 Promoting of HIV prevention for TB patients.
2.1.6 HIV/AIDS care and support for HIV infected TB patients, including co-trimoxazole preventive therapy.

In 2006 the Minister of Health created the position of the TB/HIV provincial coordinator, who is supposed to oversee the implementation and expansion of the referred activities, and the same position at national level is very necessary. This new officer will be recruited right at the beginning of year 1, to strengthen the linkage between the National TB and National HIV Directors and with the National AIDS Council, liaise with the already existing Provincial TB/HIV coordinators. An important task of this coordinator will be strengthening the National TB/HIV task force created in 2006 to promote more collaboration with HIV leadership and implementing partners.

To enhance the expansion of collaborative activities and the decentralization of coordinating committees TB/HIV task forces will be put in place in each Province in year 1. These will include representative of the Provincial Health Directorate, the TB/HIV Provincial Coordinator, representative of TB supervisors, representative of ART facilities Clinical Directors, representatives of stakeholders implementing activities in that Province and representatives of local community based organizations.

Routinely active TB screening among HIV infected persons is not taking place on a large scale yet and was slowly increasing in 2006 and 2007. This will be strengthened, with emphasis on areas where HIV patients are concentrated like VCT services, ART facilities, PMTCT programs, as well as in the community through HBC programs and HBC volunteers who will be trained on TB/HIV issues and simple tools be disseminated. Moreover, the National TB/HIV Task Force will promote a review and update of the available TB diagnosis algorithms in order to develop tools to facilitate TB diagnostic capability, especially for smear negative TB and extra-pulmonary TB.

Infection control guidelines (described under SDA 2.2) will be developed in year 2 to improve prevention of institutional transmission, very important in HIV-infected people.

Isoniazid preventive therapy (IPT) in PLWHA to prevent TB is not yet developed due to reluctance by clinicians to prescribe it, due to the lack of specific operational guidelines, and to the weakness of diagnostic capacities in order to rule out active tuberculosis. National guidelines on how to implement IPT will be developed in year 1 and clinicians will be trained on identifying patients eligible for IPT, administering prophylaxis, and following cases in order to prompt identify adverse effects or development of active TB. The Program will also promote advocacy and information of people living with HIV/AIDS about IPT through HBC volunteers and the media. Isoniazid availability will be ensured. IPT will be promoted among patients through patient groups and HCB programs.

Counseling and testing for HIV is currently being offered as part of the TB service in most health facilities and it will be expanded to all. The Tuberculosis control program will strengthen the existing referral linkage with HIV/AIDS program. All TB patients identified with HIV will be referred to HIV/AIDS care and support services where they will receive a continuum of care and support also after having completed their tuberculosis treatment.
Moreover, Cotrimoxazole prophylaxis will be strengthened for TB patients identified co-infected with HIV at the TB clinic as a means of preventing the occurrence of other opportunistic infections. Data regarding co-infected patients will be recorded and reported through new TB registers recently implemented nationwide. Moreover, every effort will be made to ensure the linkage with HIV care and treatment facilities, also in order to monitor and evaluate activities addressed to co-infected patients.

SDA 2.2: STRENGTHEN CASE MANAGEMENT AND SURVEILLANCE OF MDR/XDR TB

Activities:

2.2.1. Isolation of MDR cases: wards with at least 6 beds in each of the 3 existing Central (Maputo, Beira, Nampula) Hospitals.
2.2.2. Improving the diagnosis and treatment of MDR-TB.: adapt the clinical manual to the lower cadres of health workers, like clinical officers (“técnicos de medicina”) and nurses, as they will be involved in follow up of patients. Training on MDR for these groups is already mentioned under SDA 1.2, health facility, activity 2. DOTS-plus pilot project (GLC approved).
2.2.3. Equip the national reference laboratory (NRL) in Maputo with a liquid culture system.
2.2.4. National drug resistance survey. Early 2007 a national drug resistance survey was started and the results are expected in the first half year of 2008. It is necessary to repeat the survey at the end of grant period to be adequately informed about the MDR situation.
2.2.5. Improving infection control measures.
2.2.6. Continuing professional education on MDR/XDR for national and provincial health officers.

MDR-TB poses a serious threat for Mozambique and several activities are necessary to improve the diagnosis and treatment of MDR-TB cases, as well as to prevent transmission. The country is preparing a Green Light Committee (GLC) proposal, which will be submitted in July 2007. It is expected that the GLC asks for more preparations before Mozambique can start with a GLC approved DOTS-plus project. Money budgeted for treatment in the first two years will then be used to complete preparations for DOTS-plus treatment of MDR-TB cases with technical assistance from the GLC. In case the GLC does approve the application, there will be money to treat patients.

Presently, the diagnostic capacity for MDR-TB is low, with the only possibility for cultures in the NRL in Maputo. In 2006 129 cases of MDR-TB were diagnosed, whereas the latest survey showed 3,5% of all cases to be MDR. Renovation and equipment for culture and DST for the regional lab in Beira by the end of 2007 and the regional lab in Nampula early 2008 is already planned with funding from Ministry of Health and partners, as described under SDA 1.2. Under this proposal it is planned in year 3 to equip the NRL in Maputo with a liquid culture system, which will contribute to a more rapid diagnosis. Testing for second line drugs is not possible in Mozambique and it is proposed to send samples to South Africa.

In 2007 a MDR survey was started in the country and will run for a year. Under this proposal it is planned to repeat the survey in year 4, to further assess the MDR situation.

Infection control is important for the prevention of all forms of TB, and even more so for the prevention of MDR-TB. Therefore it is planned to make available 6 beds in the 3 central hospitals in Maputo, Beira and Nampula for isolation of MDR-TB patients, with installation of infection control measures. This might not be sufficient in-patient capacity to address the need in the country, but more isolation wards are not realistic. Patient contact with MDR-TB cases at the sub-national level will be concentrated in the provincial hospitals, where simple infection control measures are proposed in year 2 in the form of fans, and for the protection of health staff in the form of N95 masks in year 2-5.
At other levels it is necessary to develop and implement guidelines for infection control, based on the addendum WHO guidelines for TB infection control in the era of expanding HIV care and treatment. Promotion of administrative, environmental and personal protection measures in health care and congregate settings will take place.

SDA 2.3: ADDRESS HIGH RISK GROUPS

Activities:

- 2.3.1 Identifying focal person responsible in the NTP to manage services for high risk groups.
- 2.3.2 Offering TB services to prisoners, similar to what is offered to the community. Health services within prisons are the responsibility of the Ministry of Internal Affairs and reinforcement of coordination between the two Ministries is necessary to ensure adequate services are offered.
- 2.3.3 IDPs/refugees: Integrating TB services into the national emergency plan.
- 2.3.4 Miners: Developing programs and activities for early detection of TB in miners.
- 2.3.5 Childhood TB: recent international guidelines have to be adapted to the Mozambican situation.

Within the NTP there is no staff for high risk groups and it is planned in the first year to recruit a person for management and development of services for high risk groups. A first task is to map activities already taking place for high risk groups and to develop a policy addressing high risk groups.

The health services within prisons are the responsibility of the Ministry of Internal Affairs, and coordination between this ministry and the Ministry of Health needs to be strengthened and maintained throughout the grant period. At present the prisoners are supposed to receive the same TB care as people in the community and the prisons do report to the NTP. However, this is not followed up closely and more needs to be done.

There are limited number of refugees in Mozambique, but due to natural disasters there are regular internally displaced persons. In 2007 the Zambezi river flooded, resulting in thousands of people needing to leave their homes. Under this proposal it is planned to integrate TB care into the existing national emergency plan, and to have packages with material, e.g. patient education material, ready at the national level to disperse to any area in need of these.

Miners working in the South African mines have a higher risk of TB. Coordination would be strengthened with the Ministry of Labor, as well as the National AIDS Council and the South African Government.

Childhood tuberculosis is under diagnosed. This might be related to reduced suspicion in clinicians, and also to difficulties related to the diagnosis. The NTP annual report of 2006 shows that TB in children less than 15 years old, represents 18% of TB cases diagnosed in 2006. Out of total (3129), 2138 were smear negative cases (21,0%); 337 (1,8%) smear positive and 654 (13,3%) extra pulmonary TB cases. The new M&E tools, planned in the national TB strategic plan 2008-2012 will include age and sex, so that more detailed information will be available in the future on childhood TB. Very recently, the NTP has

translated the international guidelines of childhood TB into Portuguese and will adapt them to the Mozambican situation and will also perform training for clinicians and other health professionals in the use of the guidelines.

Objective 3: Health Systems Strengthening

SDA 3.1 HEALTH SYSTEM STRENGTHENING

Services for TB care will profit from a strengthening of the Mozambican health system.

Activities:

3.1.1. Human resources. Continuation of funding for provincial TB/HIV/AIDS/Malaria/ITS coordinator. Recruitment of part-time pharmacist and HRD officer. Revision of basic curricula for various categories of health staff.

3.1.2. Health technology management: Provision of X-ray capacity in all provinces and bronchoscopy facility in central hospital in Maputo.

3.1.3. Logistics – provide improved transport and communication facilities for communities.

The present funding from the Global Fund round 6 HIV proposal for the provincial TB/HIV/AIDS/Malaria/ITS coordinators ends in 2010. As the coordinators perform an important task in linking the related diseases, under this proposal we ask for 2 more years of funding. The NTP would like to employ full time a pharmacist and a HRD officer but given the limited availability of staff, this does not seem a realistic option. Therefore it is proposed the recruit these officers within the Ministry of Health in year 1, so that both the NTP and the broader Ministry of Health benefits from their capacities.

The revision of the basic curricula of clinical officers, nurses, and laboratory staff of all levels to include infectious diseases (including TB) forms part of a strengthened health work force.

Diagnosis of smear negative tuberculosis, as well as other lung diseases is problematic in Mozambique due to lack of diagnostic facilities, mainly Xray and bronchoscopy. 1 X-ray machine for each province will be procured during the grant period. The X-ray machine will be installed in radiation protected rooms and equipment for development and viewing of the X-rays will be purchased as well. Protective material for staff working with X-rays will be bought. Diagnosis of lung diseases including TB, as well as diagnostic capacity of other disease entities would be improved.

Bronchoscopy to support diagnosis of lung diseases (including TB) is only available in the Central Hospital in Maputo. The equipment is very old and not suitable for training purposes. Under this grant we propose to renew the equipment in Maputo, and include video for training purposes. Unfortunately, there are no doctors outside Maputo who can perform this procedure, and Maputo acts as the referral center for the whole country. This situation would be rectified as this grant would enable more doctors would be trained in this procedure, and other sources of support would later be sought to provide bronchoscopy services in the 3 central hospitals.

In many areas, especially the underserved areas, it is difficult for critically ill patients, including the ones with TB and TB/HIV, to reach health services. Improving the capacity of the community managed emergency transport scheme will alleviate this. This would be done by buying motorcycle ambulances to complement the existing bicycle ambulances, and mobile phones would also be provided to improve communication.

SDA 3.2 PAL

Activities:

3.2.1. Develop a PAL strategy with standardized case management for acute respiratory infections and asthma in persons over 5 years of age, with special emphasis on management of lung problems in HIV infected people. Production and dissemination of standard case management guidelines and incorporation of these into existing training of health facility workers.

The Practical Approach to Lung Health was developed in Mozambique in 2003, but did not receive sufficient attention at the time. Under this proposal it is planned to be updated by a panel of physicians in year 1 with dissemination throughout the country by means of provincial workshops in year 2. It is planned as well to update the approach in year 4.

Objective 4: Engage all care providers.

SDA 4.1 Public-private Mix

Activities:

4.1.1. Performing survey of all private and non-governmental TB care providers.
4.1.2. Engaging private and non-governmental care providers for delivering of TB services.

TB care is mainly provided by the Ministry of Health, but there are private clinics and non-governmental organisations delivering TB services as well. It is of great importance that all TB providers follow the NTP guidelines and protocols, and report all TB patients to the NTP. It is planned to have a survey of all providers in year 1, to gather information on what these providers are doing and as well to collect from all providers the data on their activities in the last few years. These figures will contribute to improving the baseline data on targets used within the GF reporting, as it is recognised that the 2006 data do not fully reflect all on-going activities and this will give a more realistic view.

After all providers have been identified, in year 2 they will be engaged in TB care according the NTP protocols. This will include training on the most recent protocols, providing diagnostic equipment and drugs. Reporting of all TB patients (data collection) to the NTP will be included into the supervision of all providers.

Objective 5: Empower People with TB and Communities

SDA 5.1: ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION (ACSM)

Activities:

5.1.1. Developing and performing KAP study.
5.1.2. Developing national strategy for ACSM activities and build up NGO capacity in this field.

There is need to better know and understand the knowledge, attitudes and practices regarding TB within the general public, patients and health care providers to be able to develop cultural adapted information and BBC material. This is planned in the first year.

A national strategy is needed to firmly put ACSM on the agenda within TB care and activities will be planned. Building up NGO capacity in this area will be an important part of this activity.

SDA: 5.2 COMMUNITY TB CARE

The coverage of health system is such that many people live far from health facilities. To improve TB care, it is essential to engage communities through volunteers and also to engage the traditional healers. This will also contribute to the knowledge of TB in communities.

Activities:

5.2.1. Engaging community based organizations, including HBC organizations, in TB activities.
5.2.2. Phased training at the provincial and district level for volunteers and traditional healers.
5.2.3. Supervision, monitoring and evaluation of CB DOTS at district level.
5.2.4. Developing IEC materials for use in the community.(posters, videos, drama)
5.2.5. Producing and distributing national DOT guidelines.
5.2.6. Motivation of volunteers.
5.2.7. Provincial TB supervisors will receive refresher training on community based DOTS.

Volunteers would be given t shirts, caps and bags annually during World Tuberculosis day celebrations to motivate them. Annually the most enterprising volunteers per district would be given gifts like portable radios, agricultural seeds and cooking utensils, these items would be brought with non Global Fund resources. The agricultural seeds would be sourced from the Ministry of Agriculture. IEC/BCC materials for example posters, and particularly drama skits in the local languages, that would be performed in village markets by the volunteers would be used to create awareness about TB. Also TB adverts and spots in local languages would be produced on video cassettes and distributed free to rural cinemas to use as interludes. These rural cinemas use televisions, video machines and portable electricity generators to show video films, and they are very popular in the villages.

The IEC/BCC items, (shirts, caps, bags, videos etc)would be launched in high profile media events with senior political leaders and other stakeholders in attendance to further create awareness.

SDA: 5.3 Patients charter
Activities:
5.3.1. Involving patients: Patients charter for TB care.
Patient and community involvement in TB care is relatively weak in Mozambique, and under this activity we plan to support TB patient group representatives to educate communities about TB. This can be schools, faith-based institutions, governmental and non-governmental organizations, and worksites. Some representatives from these groups will be invited to attend national TB conferences and activities to emphasize the perspective of the patient.

Objective 6: Use evidence-based methods to evaluate health benefits of interventions
SDA 6.1: Program-based operational research
Activities:
6.1.1. Selecting operational research collaborators.
6.1.2. Conducting Operational Research Studies.

Health systems can be improved and strengthened by research in the operational setting. What works best under which conditions can be evaluated and adapted based on the findings. Under this proposal we plan to appoint a local operational research coordinator who will liaise with national and international research institutions from the end of year 2. Graduate students, national and international, will be recruited to perform part of the studies.
Within this objective, we plan to perform 3 operational research studies in the second part of the grant period. These studies will address: 1) use of new WHO guidelines for diagnosing smear negative and extra-pulmonary TB, 2) screening for TB in PLWHA, and 3) follow up and patient outcome of isoniazid preventive therapy. For these studies, we anticipate that, in general, routinely collected programmatic data will be used, but some validation of such data may be necessary.
To ensure prompt and efficient implementation, the studies would be contracted out by competitive bidding using Common Fund procedures to national and international research institutions who are already in Mozambique, e.g the universities (Columbia, Vanderblit, Federal University of Brazil etc) and NGOs with research capability e.g FHI. International institutions would be partnered with a Mozambican institution to ensure transfer of skills.

(b) **Target groups**

Provide a description of the target groups (and, where relevant, the rationale for inclusion or exclusion of certain groups). In addition, describe how the target groups were involved during planning, implementation and evaluation of the proposal prior to submission to the Global Fund. Describe the impact that the program will have on these group(s).

In Mozambique, TB is a disease that affects different groups in the community, namely rich and poor people, all ages, sex and races. Nonetheless, poor people and those with lower access to provision of health services are more affected.

The target groups to be benefited by this proposal will be the **communities** in general including **TB patients, TB/HIV patients, MDR-TB patients** of all ages, as both preventive and curative activities will be provided. **Health care providers** will also benefit through training which will allow increased knowledge and skills to better provision of care to those in most need.

The NTP will restart collecting disaggregated data by age and sex in order to have an idea of access to these services as a means of addressing gender issues. Moreover, this proposal aims at addressing high risk groups such as children, miners, prisoners and also displaced /refugees because they are at high risk of contracting TB. The MCP has a representative of people living with HIV who reviewed the proposal and provided feedback.

Communities

Community members are targeted in this proposal for ACSM activities. Communities will be engaged to participate in TB care activities acknowledging that each community is responsible to promote and protect their own health. A civil society organization like the RED Cross has played an important role in providing inputs to the proposal development, particularly in the proposed community health related activities and the NTP will work closely with them. Furthermore, involving the communities in TB activities will enhance access to a variety of other TB services as awareness on the existence of services free of charge will be increased. The plan is to provide phased training at the provincial and district level for volunteers and

traditional healers. Experiences gained in some provinces and other programs working with these members of the community have shown a greater contribution of both groups to increased case detection.
More IEC materials for use in the community will be developed, and also the radio will be used to promote TB awareness
Motivation of volunteers and other groups involved in ACSM by providing bicycles, t-shirts, caps, bags, seeds, kangas and other incentives, is an important component of the community activities, which in the end will benefit the an entire community.

TB, TB/HIV Patients

The scaling up of TB/HIV activities will ensure increased access to TB, TB/HIV and HIV/AIDS related services such as prevention, care and treatment and home based care services also free of charge by the targeted groups. The plan is to reduce the transmission of both TB and HIV/AIDS within the communities. In regard to the latter, recent data has shown that about 1.4 million people are infected by HIV and 500 new infections are reported daily. Furthermore, reports have revealed that particularly adults from 15 to 49 years of age and children less than five are at particular risk.

This will only be possible with the support of this proposal and the implementation of all the following activities: recruiting a national TB/HIV coordinator; implementing TB/HIV task force at provincial level; intensifying TB case finding in PLWHA.; introducing Isoniazid preventive therapy (IPT); promoting of HIV prevention for TB patients; HIV/AIDS care and support for HIV infected TB patients, including co-trimoxazole preventive therapy.

Health care providers

As mentioned above, health care providers are targeted for additional training and supervision under this proposal. If this proposal succeeds, more training for implementation of community DOT, voluntary counseling and testing to all TB patients will be enhanced in order that more patients have access to these services.

Special groups: Children, IDPs/refugees, prisoners, miners

In Mozambique, the key target groups that need specialized services are children, prisoners, IDPs/refugees and miners. Children are at high risk because they contract the disease from their families, and treatment must be specialized for them.

There are small groups of refugees living in areas in the North of Mozambique, as well as seasonal internally displaced people from floods, cyclones and other natural events. TB can spread rapidly under these conditions, and health care is often weak. Programs for IDPs will be geared towards the episodic nature of emergencies. Emergency kits of TB drugs and training materials will be available, and will be dispatched when people are displaced from their homes.

Many Mozambicans, mostly men, work as miners in South Africa, which places them at high risk for both HIV and TB. Because they travel frequently, adherence to TB (and HIV) drugs can be a challenge. The aim of this program is to target adherence education programs to miners and their families, and to target TB programs to the miners and their families.

Intravenous drug use is not a significant problem in Mozambique and therefore programs are not intended to target them.

Involvement of Target Group in Proposal Development

The target groups were involved in the development of the proposal through their representatives on the CCM. RENSIDA, the association of PLHA is represented on the CCM, thus people with HIV/TB are involved. The CCM drafted the adverts for EOI, selected the subrecipients and principal recipient, and endorsed the proposal.

The communities had participated actively in the previous monitoring and evaluations of the TB programme, which included focus group discussions and these reviews, formed the basis for the development of this proposal, thus their views and concerns are reflected in the design of this proposal. For example incentives for volunteers, had household utensils included (to be funded from other sources) because in some communities the female volunteers would not ride bicycles due to cultural reasons, so another appropriate means of compensating them needed to be found. Also the communities wanted a

faster means of evacuating sick members, hence the introduction of motorcycle as opposed to bicycle ambulances (Attachment 17).

(c) **Equitable access to services**

Describe how principles of equity will be ensured in the selection of clients 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).

This proposal aims to expand DOTS services by reaching out to communities far from health centers. Currently, most of the population lives at a far distance from a health facility, more than 5km which is the minimum recommended by the WHO).

Indeed, poverty is an important risk factor that contributes to reduced access to existing services. In the case of Mozambique, the poor population has low access to primary health care services and therefore they are more at risk of migrating to the neighbouring countries, a situation that also poses a serious risk of HIV transmission.

In order to increase access to DOTS and to other TB related services, this proposal has the plan of using of community volunteers to collect sputum samples, supervise DOT, and conduct health education (ACSM activities) about TB, the proposal greatly increases access to health services for people in rural areas. For targeting people living with HIV and also TB, the program will use the national policies already developed to ensure equitable access to resources such as ARVs. Through the selection and training of community volunteers, it will be possible to target a wider segment of the population than those that traditionally visit health centers (i.e. men, indigents, etc.)

Additionally, as mentioned in previous paragraphs, there is no fee for TB medications in Mozambique, a policy which will enable more access if the proposed activities involving the community are put in place with this project.

(d) **Social inequalities targeted in this proposal**

Describe how this proposal addresses the needs of specific marginalized groups in the country/countries targeted in this proposal. *For example, if your proposal targets a gender, age-group or other demographic presently excluded or underrepresented in existing service delivery activities, identify this and describe how the group(s) will be targeted.*

Please ensure that you include appropriate targets and indicators to monitor performance against these strategies in '**Attachment A**' (Targets and Indicators Table).

Inequalities between rich and poor people are still existing in Mozambique, where children are in the group of the most marginalized people in the country. In relation to TB usually the source of infection in most children is an infectious adult in the household. The NTP aims at improving detection of children with a smear positive TB patient, as this activity has been under-reported.

Health services are free, so screening or outpatient departments attendance is free. There are no limitations except when services are not available or the suspects/patients cannot meet the costs of transport fee to reach the unit.

Thus poverty particularly rural poverty, poses a serious inequality to TB care. This proposal tackles this problem by deal with poverty attempting to increase the number of clinics within a district that has a microscope. Tuberculosis control activities are integrated in general health services. As primary care, TB is diagnosed and treated at health centres. Due to lack or poor condition of infrastructure, not every health centre has a microscopy forcing suspects/patients to walk long distances to reach a microscopy centre.

Social discrimination arises linked to uneven distribution of health units and services in rural areas. If this proposal succeeds in assisting the national health services to expand laboratories, more diagnostic centres will be available and closer to the population. Community DOTS is another friendly approach to bring diagnosis and treatment closer to communities, working for the Health Services to detect (and cure) more patients and to the people in need as services are made available and provided at a more convenient distance.

Mozambique is committed to continue multisectoral strategies to reduce girl's, women's, boys and men

vulnerabilities by addressing gender issues. Women have more contacts with the Health Services than men because of counselling and testing integrated in the prenatal clinics, which provides women with more opportunities to access counselling and testing services for HIV. Efforts would be made under the ACSM to mobilise and target men and women alike to access TB services. This would be done through social mobilisation activities in communities, as well as through meetings with key people in the community like religious leaders and traditional healers. These activities complement the work of the health facility staff, which are trained to request people to be examined and investigated when TB is suspected.
A majority of service providers in the health sector is women. This is particularly the case for the community based "activistas" (Community Based volunteers), who perform Home Based Care.
Their standard salary is half of the minimal wage. Contrary to many other countries, these (mostly) women receive a stipend for their work. However HBC for DOTS and HIV/AIDS falls more disproportionately on women, so efforts would be made to recruit more men as HBC givers and DOTS Agents.

(e) **Stigma and discrimination**

Describe how this proposal will contribute to reducing stigma and discrimination against people living with and/or affected by HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases.

There is stigma and discrimination against people living with HIV/AIDS, and to a lesser extent TB. By offering treatment for TB and referrals to HIV care, stigma will be reduced, as some of the funds of this proposal will be used for the implementation of community TB activities including ACSM activities through the media, distribution of leaflets, posters, radio and lectures, which will promote behavior change and reduction of stigma and discrimination. By working with many different community organizations, more people will see anti-discrimination messages.

Political commitment activities including World TB Day events will show that leaders in the community are aware of TB and can talk openly about it, which will also decrease stigma and discrimination.

Linkages to other programs

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

(a) If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.

*Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.*

Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained.

TB Round 2 Disbursement Rate	
Rd2 Approved	14.200.659,00
Phase I	9.202.140,00
Disbursed	7.215.542,00
%	78%

SDA	ROUND 2	ROUND 7	RELATIONSHIP BETWEEN ROUNDS 2 and 7
DOTS Expansion to remote and pheriphery	Yes	Yes	Expansion of planned outputs and outcome
HIV/TB	Yes	Yes	Expansion of planned outputs and outcome
PAL	Yes	Yes	Expansion of planned outputs and outcome
Home Based Care	Yes	Yes	Complementary but not overlapping intervention, as it is the transport and communication for the HBC that round 7 would be improving
PPM	Yes	Yes	Complementary but not overlapping intervention
CSAM	Yes	Yes	Expansion of planned outputs and outcome
MDR/TB	No	Yes	New and independent intervention
HSS	Yes	Yes	New and independent interventions because 1. improvement of radiodiagnostic and bronchoscopy services in this round 7 proposal are new 2. Support to provincial TB/HIV/AIDS/STI Coordinators is new
Operational Research	No	Yes	New and independent interventions.
Policy Direction	TB Strategic Plan 2003-2007	TB Strategic Plan 2008-2012	New and independent interventions because the new strategic plan has a lot of activities that the old one has not got.

The NTCP is already supported through the second round. Activities covered are similar but the current proposal focuses on a consolidation and an expansion of services provided, and also promotes a better implementation scheme including the coordination with counterparts and civil society. Since the second round was approved at a time when earmarked funding and vertical programs were normal processes within Ministry of Health, that a decentralization process started with a new common funding mechanism and that a more integrated approach has been promoted regarding the implementation of national programs, the activities realized through the second round have been modified or implemented in another way, and slower than originally planned.

The coordination with partners has been limited mainly because of key staff changes at senior levels in the Ministry of Health and because strategies and orientations have been progressively developed from 2006 – which was the year of the ART expansion and HIV services integration. The year 2007 has been declared an emergency for TB and the focus improved consistently with the realization of the XIXth

National TB meeting in February, which confirmed new orientations such as the CB DOTS strategy. The strengthening of human resources started at national level but the expansion process was delayed due to to the numerous changes at central level, the process is now underway.

The expanded components relate to an improved expansion of the CB DOTS strategy and the mobilization of the civil society, mostly through a network of NGO and IO counterparts. Since the Ministry of Health and NTCP are expanding the access to TB treatment through more health units, conditions are created to expand the CB DOTS strategy with more counterparts at country level. This process will be gradual, since all the health units are not – and will not be – able to provide the TB treatment.

However the need to articulate and delegate some responsibilities to civil society counterparts at field level has been improved in this proposal and will mostly be realized by international NGOs in partnership with national NGOs, institutions and civil society.

Round two is currently under process and the implementation rhythm improved and scaled up from late 2006, with the new NTCP Director taking functions and a better interaction between partners. Most activities were delayed due to constraints explained above but will be realized in the next two years.

Despite all these challenges the implementation rate for the round 2 proposal was 78% as shown above.

The Round 6 proposal was not successful because of the following elements:

- slow absorption rate, given the lack of administrative and financial procedures, lack of effective plan to monitor procurement and supply management, and somehow to a lack of strategic orientations form central to provincial level given the changes at Ministry of Health National levels ;
- plan and activities to manage MDR-TB were unclear, divided in objective 1 (second line drugs, laboratory support) and 3 (drug resistance surveillance) with excessive number of MDR case per year and insufficient cost for second line drugs ;
- discrepancy between detailed problem analysis and lack of detail in the description of the strategy and activities to achieve the goal ;
- complementarity between objectives and activities in the Round 2 proposal and TBCAP not always clear (DOTS and community DOTS);
- missing explanation on the large number of supervision planned in the proposal ;
- lack of justification on difference between training cost for clinical staff and for treating staff ;
- impact indicators not adequate regarding failure and unclear on population DOTS coverage ;
- R6 goals, objectives and SDAs were not always consistent ;
- lack of technical assistance and capacity development needs - including absorptive capacity ;
- need to include NGOs as sub-recipients, involve the community and address gender issues
- health systems strengthening is a big issue for Mozambique and must be addressed ;
- weakest sections are : gender, equity, stigma and discrimination, sustainability, selection of sub-recipients, budget (not linked to activities, and some figures were incorrect), M&E
- need to finalize and adopt new national TB strategy ;
- need to apply to Green Light Committee ;
- need to include national budgets, additional grants and existing supports.

These comments have been taken into consideration for the R7 proposal, a more detailed description has been given in section 4.6.1. This is why the present proposal as well as the National Strategic TB Control Plan for Mozambique 2008-2012 (Attachment 2) were developed with an unprecedent effort in Mozambique, under the direct coordination of Ministry of Health with involvement of many partners.

(b) Where there are any linkages in this proposal to planned interventions already supported by Global Fund grants, **describe, by reference to information generated in regard to those existing grants**,** how implementation bottlenecks and lessons learned have been incorporated into the implementation strategy for this proposal to better ensure the overall feasibility of the planned interventions*(maximum one page).*

*(**Applicants should refer to, for example, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1.)*

Main objectives of the “HIV/ AIDS care, treatment and support for persons with HIV/ AIDS”, round 2

proposal main SDA's and indicators measured on August 2006 are the following (extracted from the Grant Performance Report on the Global Fund website) :

1. To promote the use of facility and home-based health services for the prevention, treatment and care of HIV/ AIDS – overall performance 67% of IHN (= health facilities ?) with IEC services

2. to strengthen and expand Voluntary Counseling and Testing – overall performance 59% related to the progressive expansion of VCT services and number of people attended

3. to strengthen and expand the health facilities for the prevention and treatment of AIDS related opportunistic infections (OI's) and provision of HAART therapy – overall performance is 72% for the proportion of health facilities offering VCT services and 96% for the number of people (PLWHA's) on ART (number of sites offering OI's not measured at the time of reporting)

4. to strengthen and expand services for mother-to-child transmission (PMTCT) – number of health facilities with functioning PMTCT services is 70% ; 70% of HIV infected pregnant women received prophylaxis

5. to strengthen and expand home-based-care for PLWHA's – number of health facility sites with HBC services reached 70% ; 87% of the target number of people to receive HBC services

6. to strengthen MINISTRY OF HEALTH capacity to implement, supervise, monitor and evaluate HIV/ AIDS prevention and care – 63% of the total number of people were trained in M&E at different levels

The link with the current grant on HIV/ AIDS is strong but general interaction, common planning and implementation of TB/ HIV collaborative activities have not been a great success throughout 2006. The PNCT has trained its staff to provide VCT to TB patients and has systematically referred the HIV+ patients for treatment, however this activity started and expanded during the second semester of 2006. The PNCT also has implemented CPT but the implementation of TB preventive activities from the HIV/ AIDS National Program have been partly introduced and must be improved.

From the lessons learned it is planned to have a TB/ HIV Coordinator under this proposal in order to better plan and implement TB/ HIV collaborative activities with staff and support from both National Programs. Common sentinel posts for HIV will also be used for TB from 2008.

As to malaria, the current program "Building capacity to scale up the roll back malaria in Mozambique" was positively evaluated for its major components (scale-up community-based malaria prevention and treatment and to provide preventive services through indoor-residual-spraying), out of a more limited result regarding the distribution of insecticide-treated nets.

4 Component Section *Tuberculosis*

4.6.5	Performance of and Linkages to other donor funding for the same disease
	Provide an overview of the main achievements (in terms of outcomes and impact on the disease) which are planned over the same term as this proposal through the support of other external donors, whether bilateral or multi-lateral. Also describe if there are any major bottlenecks to implementation in those grants/programs which may be relevant to the implementation strategy for this proposal, and if so, what steps will be taken to mitigate such challenges.

TB CAP is now fully operational and its plan of action for 2006-2010 is in place, with activities that include Community based DOTS on a small scale and Laboratory capacity and improvement of access to quality TB laboratory diagnosis including expansion of cultures to Beira and Nampula; TB/HIV collaborative activities and programme management improvement. TBCAP activities will cover only 3 provinces in the country.

TB Control partners have proposed to hire additional staff to minimize human resource constraints including, for example, a data analyst proposed to be recruited by the CDC to increase capacity for TB surveillance and monitoring on the national level. CDC would also be doing some national and regional laboratory strengthening.

Other external donors are renovating laboratories and buying laboratory equipment (microscopes)

There are no significant bottlenecks, but all partners with TB activities and government are improving diagnosis and redoubling their efforts, given the challenge TB poses for Mozambique.

Private Sector Contributions

4.6.6	Private Sector contributions
(a)	If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs. ➔ *Refer to the Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.*

Not applicable since as yet there is no co-investment from the private sector for the objectives of this proposal.

(b)	Referring to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution.)	
	Size of population group that is the focus of the Private Sector contribution ➔	N/A

4 Component Section *Tuberculosis*

Refer to Guidelines for examples on 'Contribution Description' *** Add extra rows below to identify each main Private Sector contributor*	Contribution Value *(same currency as selected in section 1.1)*

** Private Sector Contributor Name	Contribution Description *(in words)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

4.7 Principal Recipient information

In this section, Applicants should describe their proposed implementation arrangements, including the nominated 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 Applicant, the term 'Principal Recipient' should be read as the planned implementing organization.

The Applicant may nominate one or several Principal Recipients to lead implementation and undertake reporting to the Global Fund during the proposal term.

*To be eligible for funding in Round 7, CCM, Sub-CCM and RCM Applicants must ensure that each Principal Recipient has been **transparently selected** (refer to section 3A.4.5 of this Proposal Form)*

Table 4.7: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through one or several Principal Recipients.	☒ One
	☐ Several

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	**Sector Represented**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**
Ministry of Health	Government	Dra. Rosa Marlene Manjate	+258-824638610 +258-21301897 rmanjate@dnsdee.misau.gov.mz

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, Sub-CCM, or RCM where relevant. Maximum one page.)

Ministry of Health is the proposed Principal Recipient. The rationale is that it has the mandate to coordinate, monitor and engage in advocacy for the control and eradication of both TB and health sector response of HIV/AIDS. Its technical capacity is based on its technical staff, which also receives WHO technical support from all WHO levels (Country, regional and headquarters). It also receives support from UNAIDS. Ministry of Health also has the mandate to regulate health care providers in both the public and private sectors.

In general, partners involved in TB Control are invited to planning meetings where yearly plans (objectives, targets and resources) are presented and responsibilities shared to implement activities and monitor program results and performance. ILEP NGOs usually take the responsibility of supporting the province they are operating in. The Central Unit takes overall responsibility for overall coordination and management. This approach has proven adequate as partners participate in the annual or other plans and either problems or constraints to be faced are known to all. It is also a system not to duplicate or waste resources and time. In addition, specific areas of each partner are discussed and ways on how to complement the health sector areas of work agreed.

Implementation of the TB component will be overseen by the Ministry of Health and the Health SWAp, with which the CCM is harmonised.

The TB Management Committee meets monthly and have technical subcommittees, namely

(1) Treatment, care, and support (DOTS and MDR TB) and transition to horizontal programmes as proposed under this round 7 proposal
(2) Laboratory issues
(3) M&E, co-chaired by the National Institute of Statistics
(4) Advocacy and IEC
(5) Public private Mix
(6) Proposal review sub-committee
(7) Technical assistance management sub- committee

These technical subcommittees are the organs through which task teams are organised to implement activities in a synergistic manner. The key departments responsible for the implementation of activities within each sub-recipient institution are represented in the relevant subcommittee: e.g., the Epidemiological Department of the MOH is part of the treatment and care subcommittee.

The Advocacy and IEC sub-committee co-ordinates and approves all advocacy and IEC activities. It draws up the master IEC and advocacy work plan for the TB component, ensuring that IEC activities are well synchronised with other programme activities, for example, ensuring that trained staff and equipment are available in health centres before embarking on mass media community outreach for DOTS. It ensures technical standards are maintained in communication activities undertaken through this proposals, for example, ascertaining that all IEC materials are pre-tested. It also coordinate and rationalise media buying (airtime on radio and television, and newspaper adverts etc.) for cost effectiveness.

The M&E subcommittee is the organ through which supervision, monitoring, and evaluation activities are be coordinated and monitored. The sub-recipients are responsible for furnishing MOH with the data required to monitor and evaluate programme implementation and effectiveness. The National Statistics Institute will oversees collection of data from population-based surveys and monitors the quality of data provided through other channels. NTLCP collects data from provinces (even partners operating in provinces use the same channel as they are involved in implementation and monitoring) and reports to the Department o Communicable Disease (DEE) and to Planning Department (DPC).
The M&E activities will be implemented within this M&E framework.

The technical assistance management sub-committee would ensure that the extensive technical support requested under this proposal is well coordinated and procured in a timely manner. It would ensure that a local counterpart is identified for each external Technical Adviser, and that transfer of skills and capacity building occurs. It would draw up and implement the annual technical assistance plan, and evaluate all such activities.

The TB Proposal Review Sub-Committee will review proposals from NGOs submitted under the Ministry's tender procedures and suggest modifications to be made where relevant. Each sub-recipient will be responsible for reviewing and approving proposals for sub-contracts or sub-grants to implement scheduled activities, and will be responsible for monitoring activity implementation, fund utilization and reporting.

A contract will be signed between MOH and each sub-recipient who is to receive funds. The contract will indicate the mechanism for disbursement and accounting for funds and state the expected outputs of each undertaking. Additionally it will spell out the roles and responsibilities of MOH and the sub-recipient. It will also specify the financial regulations, including clarifying activities that can be undertaken with monies and recording and reporting expectations and commitments.

The Treatment, Care and Support Subcommittee will submit semi-annual progress reports to the TB Management Committee of MOH. MOH in close collaboration with key partners such as the National Institute of Statistics will also be responsible for reviewing annual surveillance data and available national behavioural data to ascertain whether the programmes are having the desired impact. The National TB Control Programme will be responsible for ensuring effective and efficient implementation of all Treatment, Care and Support activities, by ensuring that the Treatment, Care, and Support subcommittee conducts routine supervision visits, monitors service delivery reports submitted by each IHN, monitors quarterly reports submitted by the IHN sites, and it reviewed the results of the mid-term external evaluation (Phase 2 review). It will be responsible for identifying significant delays or deficiencies in implementation, determining remedial action, and monitoring progress. Particularly it would ensure that annual targets are attained.

MOH will be responsible for developing and enforcing policy and implementation guidelines for all areas relating to medical intervention. It will be responsible for the content and, in general, the administration of training for health care professionals. The NTLCP Central Unit has developed supervision tools for all activities and for routine supervision of DOTS implementation. The MOH Central level will continue to be responsible for monitoring drug resistance. The MOH Central and Provincial levels will be responsible for ensuring stocks of drugs and supplies are available to the District level in a timely manner. The MOH Central level will be responsible for obtaining data for indicators to be reported to the Annual Joint Evaluation.

In the almost two years of the implementation of the Round 2, the District Medical Officer (DDS) and the ILEP NGOs (where applicable) were jointly responsible for ensuring the effective and efficient implementation of programme activities in a given district. Planning and monitoring of district-level activities was overseen by the District and Provincial Supervisors answerable to Chief Medical Officers. Any problems in implementation or impediments to achievement of targets were first addressed at the district level and, if necessary, brought to the next appropriate level.

As planned under the Round 2 proposal, after these two years of implementation, MOH personnel are expected to have been deployed to staff Integrated Health Network sites and the role of the NGOs will shift from service delivery and project management to technical assistance. At this stage, the District Medical Officer and associated MOH staff will be responsible for effective functioning of and integration of the IHN sites into routine health services (converting it from a vertical to an horizontal programme), including achievement of targets, submission of progress reports and resolution of impediments to implementation. NGO staff will serve in an advisory and training capacity, unless MOH determines that a particular site needs additional inputs from the NGO to become fully functional.

<u>Sub-Recipients</u>
HAI is the only sub-recipient identified so far, through the Expression of Interest process coordinated by the CCM.

Other Potential sub-recipients

Attachements 16a and 16b provide a list of other potential sub-recipients and the SDAs and geographic levels (provinces) in which they plan to participate in the implementation of this proposal.

All potential sub-recipients need to submit project proposals to MOH in line with MOH's guidelines.

Partners

At this moment, no national NGOs are involved in TB control. However, the Mozambican Red Cross is about to restart its TB activities.. International NGOs involved in TB were AIFO, Damien Foundation (Tete), Netherlands Leprosy Relief (NLR, operating in Northern provinces with headquarters in Nampula), TLMI (Cabo Delgado) and LEPRA (Maputo and Gaza provinces till 2005 and Zambézia from 2006 onwards). These NGOs form ILEP. They assist provincial directorates in implementation and to produce quarterly programmatic reports, including financial and service delivery data to MOH. New national NGOs will soon be supported to embark in TB control.

The Beneficiaries/Communities

The project would work with the existing community political, traditional, religious and informal leadership, working closely with district heads, elected representatives, traditional/religious leaders, and women and youth leaders. The various community and religious leaders, traditional healers, PLWHAs, representatives of key groups-women, youths etc, and CBOs will be empowered to play active roles in advocacy, education, and treatment support, in particular for Community DOTS. Volunteers will be selected from their own communities as far as it is practicable, in order to ensure that IEC messages and care under the project are offered in the appropriate cultural context of the target population, aiming at increasing detection and treatment results. The communities will be encouraged to participate in the reviews of DOTS activities and will be informed of constraints and progress.

Monitoring and Supervision

Joint supervision missions, comprising NTLCP staffs. ILEP NGOs, TB CAP and others, will be undertaken at least twice a year. All the project sites in the beneficiary communities and institutions would be covered at least once a year. The objective of the supervisions would be to monitor progress and provide technical support in DOTS implementation.

An annual review will be undertaken as part of the existing annual review process, to assess performance of project management at all levels and intermediaries, cost-effectiveness, quality and probity of financial, procurement and accounting practices and implementation issues. This evaluation will recommend any necessary modifications to the institutional arrangements and will be conducted in close co-ordination with all stakeholders.

The Government of Mozambique is strongly committed to the implementation of DOTS. With the technical support of WHO, NLCP and other partners, MOH representatives have worked intensively to prepare, revise and refine this round seven proposal to the Global Fund as well engage in the just concluded successful phase 2 review and extension of the current Round 2 Global Fund Tuberculosis component. The National TB and Leprosy Programme has ensured that there is no duplication, but synergies between this proposal and the Round 2 proposal. The Government of Mozambique is determined to implement this proposal and combat the spread of TB and TB/HIV in the country.

4.8.2 Principal Recipient capacities

*Please note that if there are multiple Principal Recipients, section 4.8.2 below **must be completed separately for each one**.*

(a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient ('PR'). Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, referring 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.).

MOH- MANAGERIAL, FINANCIAL AND M&E

MOH is fully operational, and has been implementing tuberculosis control since it was created, and it also implements the Health Sector Response to HIV/AIDS since the late eighties. It has offices in all of the provinces. It developed the National TB Control Strategy 2008-2012, participated in the development of the National HIV/AIDS programme M&E framework and has contact with all of the NGOs and institutions implementing TB and HIV/AIDS activities in Mozambique. The MOH manages the Health Common Fund.

The MOH is currently monitoring the National Health Sector Response to HIV/AIDS and is reporting to both Government and donors through the National AIDS Council programmatic and financial issues related to the programme. In collaboration with the partners, a Performance Appraisal Framework is currently being developed, which will include a set of key indicators on which MOH will report to all partners, thereby eliminating the need to respond to different partners

The MOH has the mandate to regulate healthcare providers, set clinical practice standards, and also regulate the drugs and treatment regiments used in the health system. It has experience of supervising NGOs rendering clinical health services and has regular contact with them. It will handle procurement through the donor assisted drug pool based in the pharmaceutical department of its Directorate of National Health.

The assessment by the Local Fund Agent and the audit of the Common Fund identified some issues which require attention. These issues are currently being addressed. The audit report highlighted, among others the fact that the financial control mechanisms need to be strengthened. The MOH is already addressing these issues and is in an ongoing dialogue with the cooperation partners about the progress in the implementation of the audit recommendations.

To overcome the constraints, the Ministry of Health is initiating the following actions:

- To implement an integrated system of financial management from mid 2007;
- To create an Internal Control Unit in DAF with the aim of increasing the monitoring and supervisory capacity;
- To improve the communication between the MF and MOH;
- To increase the human resources capacity in quality and quantity in the area of financial management;
- To prioritize the spreading and sensitization of the instruments/manual/regulations of financial management;
- To support the roll out of the e-SISTAFE for the payment of local staff.
- To restructure the DAF with emphasis on fund management and reporting systems

MOH- TECHNICAL ISSUES ABOUT TB PROGRAMME MANAGEMENT

The Programme Management would be enhanced. Though some people work at the Central TB Unit, they do not have adequate skills to do their job. This applies to Drug management, Data management (M & E). Data needs to be better interpreted and regular feed back system to provinces improved. Data are discussed at national meetings.
There is a need to recruit a drug and data management officer and a TB/HIV Coordinator. And since activities have to be scaled up, at least one more Medical officer has to be added to the TB central Unit. At provincial level, the recently new appointed Medical Coordinators for

Leprosy/Malaria/TB/ITS/HIV/AIDS and Reproductive Health will be crucial to the implementation.

(b)	Has the nominated PR previously managed a Global Fund grant?	☒ Yes ☐ No

If yes to (b), explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

MOH is the line ministry responsible for the health sector, it manages the Health Common Fund, and it is responsible for TB, Malaria and health sector response to HIV/AIDS. It has well established systems for disease control, drug procurement, M&E etc. It is currently the PR for the Global Fund grants listed below, and its been PR for this proposal would aid in its harmonization and coordination with existing grants.

TB- Phase 2 of Round 2

Malaria- Phase 2 of Round 2 and Round 6

HIV/AIDS- Phase 2 of Round 2 and Round 6

The MOH manages the health Common Fund, which in 2004 had USD 75, 290,128, 2005 -USD 106,250,453 and 2006 -USD 98,401, 054. It is anticipated that it would have USD 122,677,722 in 2007

(c)	Is the nominated PR currently managing a large program funded by another donor?	☒ Yes ☐ No

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

The MISAU also manages the health Common Fund, which in 2004 had USD 75, 290,128, 2005 -USD 106,250,453 and 2006 -USD 98,401, 054. It is anticipated that it would have USD 122,677,722 in 2007.

(e) Describe the performance history of the nominated PR in managing these programs/grants.

Specifically, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.

The LFA assessment of the MOH shows that performance is satisfactory, and the challenges of managing Global Fund resources through a Common Fund are being addressed. Some of these challenges were made as conditions precedent to the Phase 2 disbursements, and they are discussed below. The conditions for the first disbursement have been met.

1. COMMON FUND AUDIT REPORT FINDINGS- The Audit and Finance Working Group of the Health SWAp is working on this to ensure that the planned actions are expedited.
2. POOR TRACK RECORD OF USE OF NGOS AND WORKING WITH NGOS- As shown by the preparation of this proposal and the development of the Community Development Strategy, government continues ti improve its capacity and ability to work with NGO partners.
3. PERFORMANCE BASED ASSESSMENT FRAMEWORK (PAF)- The M&E working group of the Health SWAp is working on this, and liasing with the Global Fund and other SWAp members to ensure that the PAF satisfies the requests for information on key indicators and thereby eliminates the need for parallel reporting.

(f) Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.

The PR would be able to absorb the additional workload because funding has been approved as below under the Common Fund (from other donor resources) for the following additional staff to be recruited and trained as in the table below. Some of this TA would be in the area of financial management. This capacity building is especially important at the provincial and district level, in order to streamline the

Task	Description	Estimated cost in USD
Post graduate and degrees	3 new post graduate and 6 new under graduate courses started in financial area	29.100
Training in public accounting, procurement and English language	All 11 provinces involved	250.000
Recruitment of new professionals in hospital administration	4 technician to be recruited	7.883
Recruitment of new professionals in public accounting	2 professionals to be recruited	3.941
Recruitment of new professionals in accounting (medium level)	4 technician to be recruited	7.883
Recruitment of economists and administrators	4 technician to be recruited	16.870
General capacity building	Technical Assistance provided by KPMG	120.000
Training in financial management	Staff from financial areas	200.000
Scholarships to staff	Scholarships provided to staff from Finance Department to attend university courses	75.000
	TOTAL	710.677

decentralization process.

4.8.3 Sub-Recipient information

(a)	Are sub-recipients expected to play a role during the term of the proposal? *(Only in the very rarest of cases would the Global Fund expect there to be no sub-recipients.)*	☒ **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 4.8.3. (d) –(e) and (f) and then go to 4.9*
		☐ No ➔ *go to 4.8.3. (g) – (h)*

(d) Describe:

(i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process.

(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients *(Also identify significant potential bottlenecks to **transparent strong performance** by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).*

i. Process/Criteria: Advertisements (Attachment 24a) requesting expressions of interest were put in the three of the major national newspapers between March 7-9, 2007, and widely circulated on e-mail list services (Attachment 24b) of the national and international NGOs, the CNCS, and both the Common Fund and HIV/AIDS Partner Forums. The CCM had met on Febuary 13 2007 to decide on the EOIs and the selection criteria (minutes, Attachment 24c), and it also established a sub-committee to review the 29 proposals received, and provided recommendations to the CCM during its meeting on April 3, 2007 (Minutes, Attachment 24d). Proposals were reviewed (matrix with the classification of the EOIs, Attachment 24e) based on their alignment with objectives and activities of the Principal Recipient, the technical and financial capacity of the NGO, and the capacity of the NGO to participate in the round 7 proposal development process.

Proposals were ranked into 4 categories, including A (those recommended for inclusion in the round 7 proposal), B (those recommended for inclusion in the proposal after clarifications and/or modifications), C (those not recommended for inclusion in the round 7 proposal but recommended for funding via other existing local funding mechanisms), and D (those not recommended for inclusion in the round 7 proposal nor referral to local funding mechanisms). The approved recommendation was that out of the 29 proposals only 2 NGOs were successful for TB, of which only 1 decided to continue in the TB proposal (the other one decided to focus on the HIV/AIDS proposal).

ii. Though it is expected that 6-20 NGOs will be involved in implementing the activities planned in this proposal, only Health Alliance International has already been identified to be a sub-recipient.

PAST EXPERIENCE OF HAI

Health Alliance International (HAI) is a nonprofit NGO founded in Mozambique as the Mozambique Health Committee in 1987 with headquarters in Seattle, USA, and affiliated with the University of Washington School of Public Health and Community Medicine.

The key element of HAI's approach involves partnering with Ministries of Health (MOH) to strengthen existing services and promote innovative new programs. HAI technical staff share offices and work side by side with local health system counterparts to develop and implement programs and services for integration into MOH strategies.

This year HAI marks 20 years of supporting the MOH in Manica province, and 10 years in Sofala province, in the provision of clinical care, promotion of public health management, and the support of community linkages with health services. In 2007 HAI began supporting provincial health authorities in Tete and Nampula provinces. Activities have included general support for Primary Health Care, HIV/AIDS control (including integration with TB control activities), building laboratory capacity, integrated management of antenatal care, malaria control, child survival, among others. Furthermore, HAI staff has worked in direct service provision by supporting the DPS in improving clinical skills according to government norms via training, project design, supervision, and evaluation. In 2002 HAI was selected by the MOH as its in-country care and treatment partner with the Clinton Foundation to support the development of the national plan to scale-up HIV/AIDS care and treatment. Subsequently, HAI has supported MOH staff at the central level in their efforts to expand antiretroviral treatment (ART) through the national public health system.

Since the inception of the National Strategic Plan for HIV/AIDS, HAI has collaborated with the Provincial Health Authorities in the design and implementation of the various components of HIV, including care and treatment for HIV/AIDS, voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), STI management (with a focus on pregnancy), home-based care (HBC), and general laboratory support.

Because HIV/AIDS and TB are so much linked and activities become increasingly integrated, and with the extension of HAI's activities in Nampula and Tete, it seems a logical step to develop more activities in TB control. In 2007 a clinical advisor for the HIV treatment program was recruited who has extensive knowledge of TB control and is working closely both with the HIV program and the TB program. Therefore, in the proposal HAI has pledged support in almost all SDAs, and not only SDA 2.1 Scaling up the implementation of TB/HIV activities.

HAI has a strong financial and administrative management capacity to support the achievement of

program goals. HAI's 2007 Mozambique budget totals over $12,000,000 USD, financed by over 8 different funding sources including the MOH Common Fund. HAI has had a flawless audit record with no findings within the last 15 years, and is widely regarded as having an efficient financial management system.

(e) **Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.

Below please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. *(maximum two pages).*

HAI will be implementing activities in Manica and Sofala Province and give technical assistance to the provincial TB program in these provinces as well as in Nampula and Tete Province. As it is HAI's policy to work with the government, non of the interventions are undertaken outside the government as such. See Attachment 18 for the SDAs in which HAI would be working.

(f) **Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal**.
(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)

Other NGOs have expressed interest to become sub-recipients e.g.: Red Cross Mozambique (CVM), ICAP/Columbia University and LEPRA.

These NGOs did not express their interest following the advertisements in March 2007, but they and several other NGOs have been extensively involved in the preparation of this proposal. For several weeks members from these NGOs formed part of the writing group. They also have together with HAI prepared an Attachment (Attachment 16a: Overview of possible contributions by other NGOs and Attachment 16b- Geographic (central and provincial) level participation by other NGos) in which the NGOs describe in which activity they would be able to participate and in which part of the country. Mozambique is a very large country, and most NGOs are not active throughout the country. An exemption is CVM, who is active in all provinces. The NGOs working in TB in Mozambique are a close knit family, with very good collaboration and coordination.

It would still be possible for these NGOs to become sub-recipients or to participate in these activities because of the following reasons 1) the need to apply both Common Fund and Global Fund requirements in selecting Sub-recipients, and 2) the weak capacity of the NGOs who expressed an interest in TB activities, as demonstrated by the fact that only 2 proposals were deemed appropriate by the CCM, the situation is that while some Sub-recipients have been identified and selected through the Global Fund EOI described above, others would still have an opportunity of being selected to participate in the proposal using the Common Fund mechanisms.

The procedures and rule of the Common Fund is being applied along with the Global Fund requirements. Under the Common Fund, NGOs are able to apply for funds through the MOH's tender processes.

So even the NGOs that succeeded with the Global Fund EOI and are already written into this proposal still have to apply for the funds using the Common Funds mechanisms. Similarly NGOs whose proposals were not successful, and for whom capacity building has been programmed through the Common Fund, would also still be able to access the Global Fund resources by applying to the Common Fund at a future date.

The CCM being part of the policy making and oversight bodies of the Common Funds would do all within the spirit of the Common Fund rules to facilitate the application of these NGOs whose Global Fund EOI were successful to access the Common Fund.

The reality therefore is that there is opportunity for more NGOs to apply and get funds to implement activities. This would be done through the Common Fund, of which Global Fund grants are an integral part. The transparent process for this is described below.

Smaller and weaker NGOs and institutions that are capable would be grouped under bigger lead sub-

recipients, who would mentor and develop them.

(g) **Where sub-recipients have not been identified prior to proposal submission**, **describe in detail the process that will be used to select sub-recipients** if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved.

In June 2006, the MOH established a Contract Management Unit for the contracting of NGOs. The selection process will be through public tender using the procurement procedures in use in public sector (Decreto 54/2005). Some of the criteria to be considered will be: experience of the NGO in TB and HIV/AIDS issues, management capacity, and absorption of funds capacity. Others would be having ongoing activities including offices and health facilities in the project sites, being a registered legal entity according to the laws of the country, and therefore being able to sign contracts, possessing capacity for programmatic and financial management, evidenced by management of previous grants, evidence of good corporate governance by having a functioning Board of Directors and electing/appointing its principal officers according to its constitution. Where necessary the project would provide support for capacity building for management systems, and monitoring and evaluation.

The application process of NGOs to the Common Fund would begin early in the first year as soon as the success of this proposal is announced by the Global Fund Board, so that by the time the negotiations between the Global Fund and PR are concluded, and the grant agreements signed, the NGO proposals to the Common Fund would be at the stage where only their budgets need to be approved. This way no time would be lost.

Smaller and weaker NGOs and institutions that are capable would be grouped under bigger lead sub-recipients, who would mentor and develop them.

4.9 Monitoring and evaluation framework

The Global Fund encourages the development of nationally owned monitoring and evaluation (M&E) plans and M&E systems, and the use of these systems to report on grant program results in the overall context of country priorities and movement towards reaching the Millennium Development Goals. When completing the section below, applicants should clarify how and in what ways monitoring and evaluating implementation of the work supported by this proposal relates to existing data-collection efforts.

Applicants are strongly encouraged to refer to the M&E Toolkit when completing this section.

4.9.1 Monitoring and evaluation plan

Describe how the data relating to performance against planned outputs and outcomes set out in the 'Targets and Indicators Table' *(required to be annexed as 'Attachment A' to your proposal, see section 4.6)* will be accurately collected, collated and reported by implementing partners during the proposal term to the Applicant (if CCM, Sub-CCM or RCM), the Global Fund and the body responsible for national monitoring and evaluation.

Please also identify any surveys which are planned to be supported (in whole or part) by the funding requested in this proposal, the rationale for such surveys, and how the surveys (and their outcomes) support and feed into single national data collection systems.

(Where a National M&E plan exists, Applicants may attach this to their application as a clearly named and numbered annex.)

The Ministry of Health has made a strong commitment in this proposal to adapt and improve the current M&E systems within the National TB Program in order to accurately collect, collate, and report the key TB and HIV/AIDS indicators that will be used to measure performance against planned outputs and outcomes. Although M&E has not been a priority in the past in terms of the percentage of allocated funds, it is now recognized as an essential component to monitoring the progress of program

implementation in order to adapt and adjust activities to ensure the highest level of impact. In addition, a new National Strategic TB Plan has been developed with M&E as a central component of the planned activities.

With roughly 12% of the proposed Round 7 Global Fund grant dedicated to M&E, a number of key activities are planned in order adapt and improve the current M&E systems (see SDA 1.5 in the work plan for more details), as well as ensure that there are sufficient available human resources. It is expected that this increased investment in M&E will help to close the information loop that allows routinely collected program data to be analyzed and assessed in a timely manner in order to monitor and adjust program implementation to maximize outcomes and impacts. Furthermore, local and international partners will work in close collaboration with the Ministry of Health to support M&E activities, share valuable data and experiences, and to provide any necessary technical support.

The Ministry of Health is the PR and is therefore responsible for reporting the data relating to performance against planned outputs and outcomes set out in the Attachment A Targets and Indicators Table. This data will be accurately collected through the National TB Program's quarterly reporting system, whereby data is collected by each health facility and sent to the provincial level, where it is collated and then delivered to the Ministry of Health's M&E unit at the central level.

At the central level, this paper-based data will then be entered into an electronic database in order to derive the key indicators listed in Attachment A. It is important to highlight that while the data needed to report the majority of these performance monitoring indicators is available in the current reporting instruments, it will be necessary to modify and adapt some of these tools in order to capture some of the new indicators, such as those related to DOT, MDR-TB and TB/HIV integration activities. In addition, supervision activities at the district level will also be implemented in order to ensure that the reported data is submitted in a complete and accurate manner.

TB DATA

The M&E unit within the Ministry of Health receives the collated data from the country's eleven different provinces, and then compiles the data into a national summary, which is submitted to the Monitoring Unit on a quarterly basis. There is a set of 12 standardized forms that are used to collect data at the patient and facility level, most of which adhere to the WHO's recommended TB recording and reporting forms and registers standards. Three of these forms are used to submit quarterly reports on case detection, treatment results, and drug stocks. Adjustments will be made to those forms which deviate from the WHO's recommended standards for TB recording and reporting forms. For instance, changes will be made to the MoH's quarterly reports to allow data to be disaggregated by age and sex. In addition, the CDC will fund a TB data analyst for the central level and support the development of an electronic TB registry for the national and provincial level, fed by the district aggregated data.

M/XDR-TB DATA

Multi-drug and extensively drug resistant TB are a serious concern for the National TB Program, especially as they relate to HIV positive patients who are highly susceptible to these more resistant strains of TB. A number of key activities have been planned to address this concern, such as isolation wards for regional TB care clinics, improved diagnosis and treatment for MDR-TB, and a national drug resistance survey. Performance on the activities related to M/XDR-TB will be evaluated by Performance Indicator 2.6, which measures the percent of MDR-TB suspects who are confirmed MDR-TB cases.

Furthermore, the National TB Program is in the process of organizing a database to measure the burden of X/MDR-TB. The main source of data for this database is the form that accompanies strains to the national referral laboratory. A comprehensive referral system must also be developed for both samples and patients in order to allow equity in the access to DST services and M/XDR-TB treatment.

HIV/AIDS TB DATA

Data on TB/HIV integration activities are a key component of the Round 7 Global Fund proposal. New TB registers have already been adapted and disseminated to all TB clinics in order to facilitate the collection of data on the percent of patients at TB clinics tested for HIV (Performance Indicator 2.2), as well as the

percent of eligible TB patients who are HIV positive and on cotrimoxazole prophylactic treatment (Performance Indicator 2.5). In addition, there are plans to make additional changes to the TB patient register in order to capture information on HIV prevention counseling for TB patients (Performance Indicator 2.4).

The National TB Program is also working in close collaboration with the National HIV/AIDS Care and Treatment Program in order to integrate TB prevention, control and treatment activities. Partner organizations have already piloted TB screening questionnaires within AIDS care and treatment clinics, and the Ministry of Health recently approved a new patient follow up form for AIDS care and treatment clinics that specifically includes information on TB screening, diagnosis, and treatment. With these adjustments already made in the patient forms, it will be necessary to make some small adjustments in the HIV/AIDS monthly Ministry of Health reporting forms to incorporate data on the number of patients being screened for active TB (Performance Indicator 2.1). Activities are also planned to develop guidelines and algorithms for isoniazid prophylactic treatment in HIV positive patients, as well as adjustments to the monthly reporting instruments to include this key indicator on the number of eligible HIV positive patients receiving isoniazid prophylactic treatment (Performance Indicator 2.3).

HUMAN RESOURCES FOR M&E

Human resources are a critical component to this M&E plan. Plans are in place to hire, with financial support from this proposal, a full time local M&E expert, who will be supported for 2 years by an international expert and receive periodic technical assistance by an international M&E expert.

In addition, the Ministry of Health has a Personnel Information System (PIS), which tracks the number of newly graduated health care personnel who are available to work in the health sector. The PIS is constantly updated to provide the latest information on available public sector staff. This system also monitors training and other capacity building activities.

One of the key activities planed for Round 7 includes the development of a national TB human resources plan (see 1.7.2 in work plan), which will be integrated with the PIS through a human resources database to monitor information on staff turnover, performance, training, and supervision activities. This human resources database will be updated on a regular basis through human resource surveys to provide the latest data to make timely adjustments.

Surveys

There are five planned surveys that will be supported by the funding. The first involves a planed survey on human resources in order to assess key human resource needs as they relate to staff turnover, capacity, performance, and supervision activities (see activity 1.7.2.e in work plan), which will be inputted into a specialized human resources database to facilitate human resource planning. The second survey includes a national drug resistance survey, which will be the first national survey on M/XDR-TB in Mozambique (see activity 2.2.4 in work plan). The data will provide crucial information necessary for strengthening case management and surveillance of MDR/XDR TB. The third proposed survey involves a countrywide assessment of all private and NGO TB care providers (see activity 4.1.1 in work plan). This survey is necessary to update policies on private and NGO TB care providers, as well as to determine the knowledge gaps to develop training refresher courses for community TB care providers. The fourth survey planned includes a KAP study on ACSM activities in order to facilitate the development of a national ACSM strategy to build up NGO capacity in this field (see activity 5.1.1 in work plan). Finally, the fifth survey planned involves a survey to assess the impact of training activities on community TB care for community-based organizations, which is a part of the larger effort to engage community-based organizations in TB activities (see activity 5.2.1.d in the work plan).

In addition, a feasibility survey will be performed to evaluate readiness for a potential future national TB prevalence survey. This survey would measure the cumulative impact of recent TB control interventions in Mozambique and support fine-tuning of WHO estimates of TB incidence. This measure is essential for evaluating achievements towards the MDG TB indicators. However, current human resource and infrastructural limitations in Mozambique give pause to dedicating precious resources away from direct care services for this activity, albeit important, and was therefore, not considered for funding in this proposal.

4.9.2 M&E Systems Capacity Assessment

Where there is no National M&E plan **or** the work anticipated under this proposal is anticipated to place additional burden on existing national, regional and/or sub-regional M&E systems, **Applicants are strongly encouraged to review the '*M&E Systems Strengthening Tool*' and provide, in only a summary format below, a description of the major gaps identified and how this proposal incorporates a plan to overcome those gaps to support an effective monitoring and evaluation framework in the country.**

In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5.

The Global Fund recommends that between 5 to 10% of the total component budget is utilized to strengthen M&E systems.

The proposed activities anticipated to take place under this proposal are expected to place additional burdens on the existing national TB M&E systems. There are a number of major gaps in the current national TB M&E systems; however, this proposal incorporates a range of different activities in order to overcome these gaps to ensure an effective monitoring and evaluation framework within the country.

The work anticipated under this proposal will place additional burdens on the current TB M&E systems as there are insufficient financial and human resources, technical capacity, and monitoring tools. To tackle the first constraint related to financial resources, the proposal has allocated 12% of the total anticipated R7 Global Fund budget to strengthen M&E systems. This substantial investment in M&E will allow the MoH to address both the lack of human resources and technical capacity by employing a local M&E expert for the National TB Program, as well as recruit an international M&E expert to provide technical support to the MoH´s M&E department.

In order to address the burdens that will be placed on monitoring tools and systems due to the additional anticipated activities (in particular, those related to M/XDR-TB and HIV/AIDS), there are plans to adapt the existing national recording and reporting tools to incorporate the latest WHO and international recommendations. Furthermore, this will ensure that the required performance tracking indicators (see Attachment A) can be reported in an accurate and timely manner, as well as provide an effective tool for monitoring and evaluating program performance.

Overall, these additional burdens placed on the National TB M&E systems created by the work called for under this proposal will be constantly assessed and addressed through the anticipated regular supervision, performance, and planning meetings that will take place at both the national, provincial and district levels. The combined effect of these activities should be sufficient to strengthen the National TB M&E systems in the face of the additional burdens that will be placed on these systems during the anticipated program implementation.

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 health products (including medicines). When completing this section, Applicants should refer to the Guidelines for Proposals, section 4.10.

4.10.1 Roles and responsibilities for procurement and supply management of health products

(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.
If a function is planned to be outsourced, identify this in the second column and provide the name of the planned outsourced provider.

Activity	Which organizations and/or departments are responsible for this function? *(Identify if MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	CMAM		☒ Yes ☐ No
Quality assurance and quality control of pharmaceuticals	LNCQM		☒ Yes ☐ No
International and national laws (patents)	CMAM	Pharmaceutical department	☒ Yes ☐ No
Coordination	CMAM/PNCT	MEDIMOC	☒ Yes ☐ No
Management Information Systems (MIS)	CMAM/PNCT	MEDICMOC	☒ Yes ☐ No
Product selection	PNCT/CMAM		☒ Yes ☐ No
Forecasting	PNCT	CMAM	☒ Yes ☐ No
Procurement and planning	CMAM		☒ Yes ☐ No
Storage and Inventory	CMAM/		☒ Yes

management	MEDIMOC		☐ No
Distribution to other stores and end-users	CMAM/	MEDIMOC	☒ Yes ☐ No
Ensuring rational use	PNTC	CMAM	☒ Yes ☐ No

(b) Briefly describe the organizational structure of the unit with overall responsibility under this proposal for procurement and supply management of health products, including medicines. Indicate how it coordinates its activities with other entities such as the National Drug Regulatory Authority, Ministry of Finance (for budgeting and planning), Ministry of Health, drug storage facilities, distributors, etc.

Within the Mozambican the Central Medical Stores (Central de Medicamentos e Artigos Medicos – **CMAM**) is a body which depends on the National Direction of Medical assistance (DAM). It has the mandate of administration and coordination of tasks related to the planning, procurement, storage, and distribution of pharmaceuticals and medical supplies for the National Health Service in the country.

Policy and planning

Procurement is performed in accordance with the Governmental Decree 54/05 of December 13, for the procurement of works, goods and services by governmental bodies and subordinated institutions (based on international standards). Procurement laws also comply with management guidelines for procurement of goods and services agreed by the international partners for use of donor pool moneys, and the World Bank/IDA for goods purchased from the IDA credits. For specific programs within the MOH, for example the Blood Banks, X-Ray services, TB and others, the role of CMAM is to coordinate the planning process and to ensure that within the limit of available resources, funds are allocated and procurement is done, in accordance with internationally accepted standards. For others programmes within the MOH, CMAM will receive requests from individual programmes, and based on funds available, CMAM will procure medicines or commodities requested.

In accordance with the Strategic Plan for the Pharmaceutical Sector approved by the government and international partners, the use of out-sourcing for procurement was agreed and established, in order to ensure the highest standards in the procurement of pharmaceuticals for the public health sector. The role of the MOH/CMAM is focused in the planning, monitoring, and control of the contractor to ensure that the procurement methodology guarantees free and fair competition and that the procured goods are safe and comply with international quality standards. Medimoc SARL, a private company, has been contracted to execute the procurement, physical management, and distribution of pharmaceuticals from the two main MOH's warehouses located in Maputo and Beira.

Pre-qualification of suppliers

In 2005 the MOH/CMAM assisted by internationally recognized organizations, conducted the second process of pre-qualification of suppliers. Technical assistance was provided by N.V. Netherlands Inkoopcentrum (NIC), the former procurement agent of the Dutch Government, to elaborate a list of potential suppliers that offer adequate guarantees in terms of product quality, contract performance, sub-contractors, auditing and monitoring, recall operation, supply guarantee, compliance with international standards, financial stability, and post sale assistance.

The pre-qualification of suppliers is organized by groups of products as follows:

1. **Drugs:** Pharmaceuticals (bulk), essential drugs, drug kits, malaria drugs, TB medicines, vaccines, infusion solutions and giving sets, raw materials for use in pharmaceutical production. (Note: vaccine suppliers invited to submit tenders to MOH are only those qualified by WHO).
2. **Medical supplies:** Anesthetic material, dental material, suture and bone wax, glassware, implants, prostheses, blood bags, X-ray supplies, dressing materials.
3. **Laboratory supplies:** Laboratory equipment, diagnostic reagents, consumables.

Suppliers may be added to the list during the period of the pre-qualification: If the following conditions are met:

a) For the group of products where the number of qualified suppliers is limited, a second qualification will be performed based on the documents of the non-qualified suppliers and on compiled historical data of suppliers for that product or group of products with previous good contract performance.
b) For the group of products where the list of suppliers is limited (less than 5 qualified), if new suppliers express interest in supplying goods to the MOH, they may be added to the list if they have been qualified by WHO.

Procurement & Tendering Systems

The procurement of pharmaceuticals and medical supplies is based on the following criteria:

1) Intellectual property laws: In 1999 the Government of Mozambique approved the Industrial Property Code (Decree 19/99) a law based on international criteria to protect intellectual property. In 2000 the National Parliament ratified the WTO protocol on the protection of intellectual property although it was not required to do it before 2006 (now postponed until 2016). Because Mozambique accepted the WTO protocol on the protection of intellectual property rights, patent laws are enforced and therefore drug production of patented brands, or importation of drugs in violation of patents in Mozambique or in the country of production is not allowed. Because 1) No patent has been granted by Mozambique so far, and 2) Mozambique does not plan to import drugs that would violate patent in the country of production, procurement of drugs and medical supplies for the public health sector complies with Intellectual Property Laws.

2) **Use of generic brands:** To ensure that procurement process will not be limited or influenced by commercial brands, the Government of Mozambique has established that procurement of all pharmaceuticals supplied to the public health sector must be based on the generic names.

3) **National Formulary of** Pharmaceuticals: As defined by the Law of Pharmaceuticals approved by the National Parliament, to ensure that patients are prescribed appropriate and necessary drugs, and that the public health sector will be able to supply them, procurement of pharmaceuticals, unless approved by the Ministry of Health, is limited to the pharmaceuticals on the National Formulary of Pharmaceuticals.

4) **Requirement for prior approval of import by the MOH / Regulatory Authority:** To ensure that the requirements in 1, 2 and 3 of this section are met prior to importation of pharmaceuticals into Mozambique, the importer has to apply for an Importation Authorization (BIEF – Boletim de Importação de Especialidades Farmacêuticas) to the MOH. The BIEF is part of the legal documents required by Customs Authorities to process the importation.

Types of Tendering Procedures in Procurement

Mozambique uses a number of procurement strategies and tendering system depending on the product, amount involved and source of the product. The following are some of the systems used in procurement and the appropriate ways to be used under the Global Fund programme.

1) ICB – International Competitive Bidding

Due to the long cycle of importation procedures (an average of 15 months), this method is used for large-scale purchase of goods (more than USD 4.000.000) financed by the World Bank / IDA credits and following the respective guidelines for the procurement of goods and services. In the first stage a list of goods to be procured is submitted to the WB for prior review.

2) LCB – Limited Competitive Biding

As agreed and approved by the international partners, to ensure a cycle of imports of about 8 to 10 months, for the medium scale purchase of goods (less than USD 4.000.000) goods are procured based on a limited competitive biding where a list of pre-qualified suppliers are invited to present the bids.

3) International Direct Procurement

To minimize the effect of predicted stock-outs, international direct procurement of goods with a total cost of less than USD 100.000 is allowed and for each tender a prior approval by the Minister of Health and international partners (for donor pool purchases) is required. The minimum requirements include invitation of at least 5 pre-qualified suppliers and a presentation of an evaluation report with a minimum of 3 bids.

4) Direct Contracting

Direct contracting is used to purchase goods in an emergency condition where the contract is awarded to the last bidder contracted in an ICB or in LCB and the primary condition is immediate delivery of the goods. Other conditions of contracting include payment of cash against documents and maintenance of FOB price. The direct contracting is also used to purchase good under property brands that cannot be replaced by similar products.

Product Quality Assurance

The mechanisms summarized below ensure the quality control of imported and distributed goods:

- **Certificates of Origin.** Issued by laboratories certified by accredited bodies acceptable to the MOH as well as the WHO (certification scheme of pharmaceutical moving in international commerce) have to be included in all bid documents.
- **Pre-award sample testing**. Prior to any award of contract, samples are required and tested by the National Pharmaceutical Quality Control Laboratory.
- **Contracting of independent laboratories**. For large-scale purchases, independent laboratories are contracted by the MOH for sampling and testing prior to shipment.
- **Mandatory pre-shipment inspection** on quality and quantity for the government performed by ITS (Intertek Testing Services)
- **Pre-distribution testing.** Upon reception and before distribution, pharmaceuticals and products are sampled and tested.

Random testing is performed in warehouses and health facilities.

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

(b) For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four organizations will be involved in procurement.*

Organization Name	**Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)*
CMAM	**58.830 (US$ 1000)**

4.10.3 Coordination

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

***Table Showing percentage weight of funding sources**

Source of funding	%
FCMSM - Pool of donors	52%
Governmental Budget	29%
Common Fund for Health	18%
IDA - World Bank	1%
Total	**100%**

***FCM Common Drug Fund**

Table showing donors for CMAM for 2005

Funding Source	Processes	Funds Received (US$)	Funds As %
FCMSM* - Pool of donors	4	32,352	54,99
Governmental Budget	17	13,128	22,32
Common Fund for Health	12	10,848	18,44
IDA – World Bank	2	2,155	3,66
CMAM – Revenue From Sales	10	347	0,59
TOTAL	45	**58,830**	100.00

Table showing major donors to the FCMSM* - in the first six months of 2006.

Funding Source	Funds Received Period Jan-Jun 2006 (US$)	Funding As A % Of Total Funding
Denmark	1,624,375	5
France	1,219,404	4
Others	10,704,963	37
European Union	4,982,128	17
Norway	10,257,178	35
TOTAL	28,788,048	100

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

The participation of donation programs:

- WHO, drugs and health products : Leprosy Drugs
- PEPFAR, drugs and health products : ART, Condoms
- UNICEF, drugs and health products : Vaccines, Nutritional support

- USAID, drugs and health products : Contraceptives
- UNFPA, drugs and health products: Contraceptives
- MSF, drugs and health products: Essential Drugs and ART
- GDF/IAPSO, drugs and health products: TB drugs

4.10.4 Supply management (storage and distribution)

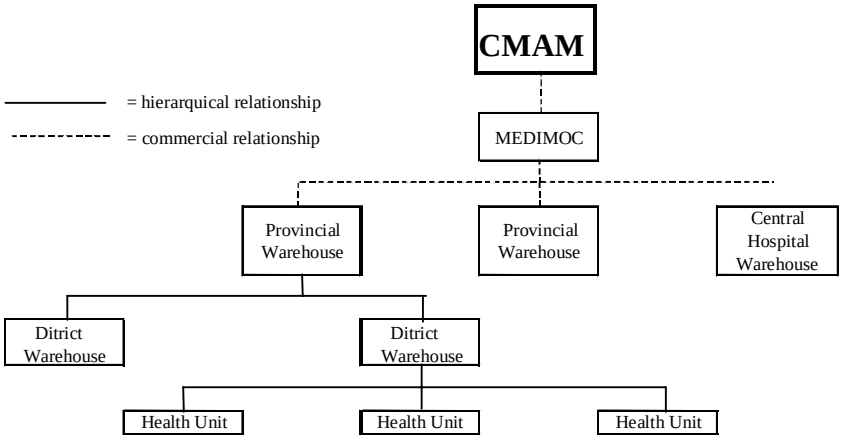
(a)	Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	☒ Yes ➔ *continue to (b)* ☐ No ➔ *go to 4.10.5*
(b)	**If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	☒ National medical stores or equivalent ☒ Sub-contracted national organization(s) *(specify which one(s))* MEDIMOC ☐ Sub-contracted international organization(s) *(specify which one(s))* ☐ Other *(specify)*

(c) Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how the increased requirements under this proposal will be transparently and effectively managed.

The National Health Service drug distribution system comprises of has four levels of storage and distribution: the central level (central warehouses of Maputo and Beira), the provincial and district levels and the health unit, that delivers medicines to the patients. This is shown in the organigram below.

In terms of TB drugs and diagnostic tests kits, warehouse capacity is not expected to be a problem. However, it might be necessary, at some levels, to hire more storage space for short periods of time while definitive capacity is being built.

MINISTRY OF HEALTH - Periferical Level
Simplified Organogram(Drug Supply)



(d) Describe each organization's **current distribution capacity** for medicines and other related health products and indicate how the increased coverage will be managed, and potential challenges addressed if any. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal, and the extent of incremental increase that is on existing distribution arrangements.

Commodities and equipment under the TB and its elements of HIV/AIDS/TB, and hence the need to mention the ART distribution, will be distributed according to the existing systems and channels of distribution. Different funding, planning, procurement, storage and distribution arrangements exist, according to the type and quantities of the commodity. The distribution channels include:

1. The 'via clássica', that corresponds to the normal system of acquisition and distribution of basic medicines. These products are supplied quarterly, on the basis of requisitions provided by the provincial warehouses. All the health facilities up to the level of Health Centre are supplied by "via clássica".

2. The system of Kits of the Essential Drug Program (EDP) for the primary level health facilities. The number of Kits supplied to each province is determined on the basis of the number of outpatient visits, not depending on requisitions. All primary level health facilities, including health posts (normally staffed by an elementary nurse) and community health posts (staffed by community health workers) receive kits (A, B, C) according to the level of staff qualification); all the country is duly covered by the EDP.

3. 'Push systems' of distribution for the vertical programs. These programs communicate to CMAM the quantities to be sent to each province every quarter.

The entry points of the imported pharmaceutical products are the ports of Maputo and Beira. Merchandise that demands special preservation and airlift are imported through the airport of Maputo.

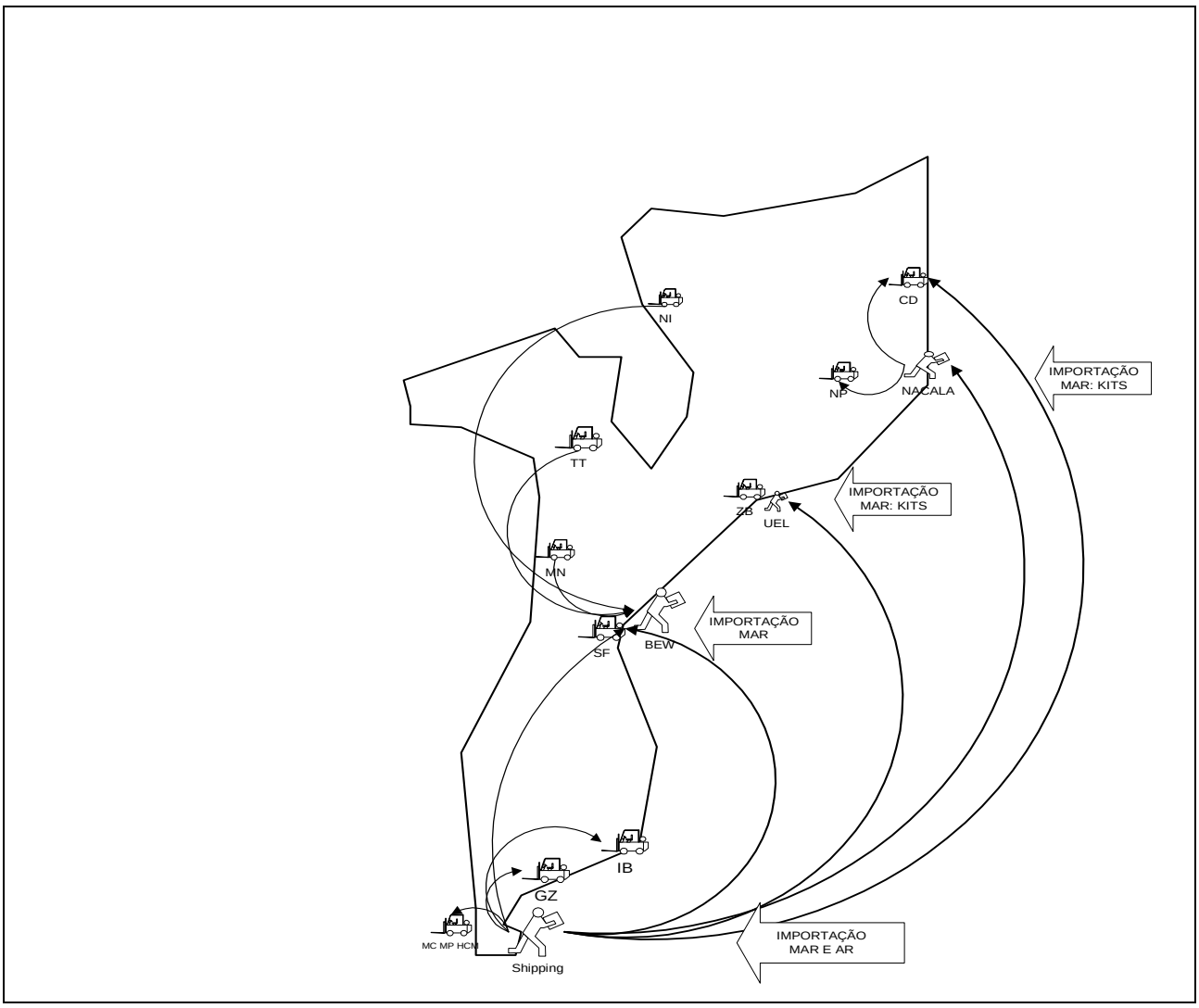
The medicines distributed by the 'via clássica' and those for the vertical programmes, are stored in the Central Warehouses (Maputo and Beira), managed by MEDIMOC S.A.R.L.

The Maputo Central Warehouse (in reality diverse warehouses spread through the City) is responsible for the medicine distribution to the City of Maputo, Central Hospital of Maputo and the provinces of Maputo, Gaza, and Inhambane. The Maputo Central Warehouse is also responsible for the distribution to the provinces of Zambézia, Nampula, and Cabo Delgado, since it is easier to carry drugs by sea than by road from Maputo to these places. The Beira Central Warehouse is used to distribute medicines to the Beira Central Hospital and to the provinces of Sofala, Manica, Tete, and Niassa, by road.

With exception of the City of Maputo, each Province has a **Provincial Warehouse**, which stores medicines and makes the distribution to the lower level. The **District Warehouse**, functioning in the headquarters of the District, supplies outpatient and hospital wards pharmacies and distributes the products of the 'via clássica' and the EDP Kits to other Health facilities (Health Centres, Health Posts and Community Workers).

In the case of TB and ARVs all are stored in the **Warehouses** of Maputo and Beira, and from there are distributed to all the country. In the future, as the capacity to manage these drugs get improved and the demand grows, they will be stored also in Nampula.

Current logistic capacities are sufficient to cover existing needs. With the planned TB programme expansion as in this proposal, and AIDS-related services scaling up as in the successful HIV/AIDS round 6 proposal, ARV correct distribution and thorough control would become major issues. However, the drug management and distribution system seems to be robust and well organized enough to face the challenge and it will be further enhanced with transport means and TA to be provided by the successful round 6 HIV/AIDS GF proposal. Therefore, we expect that all the needs across the country will be covered.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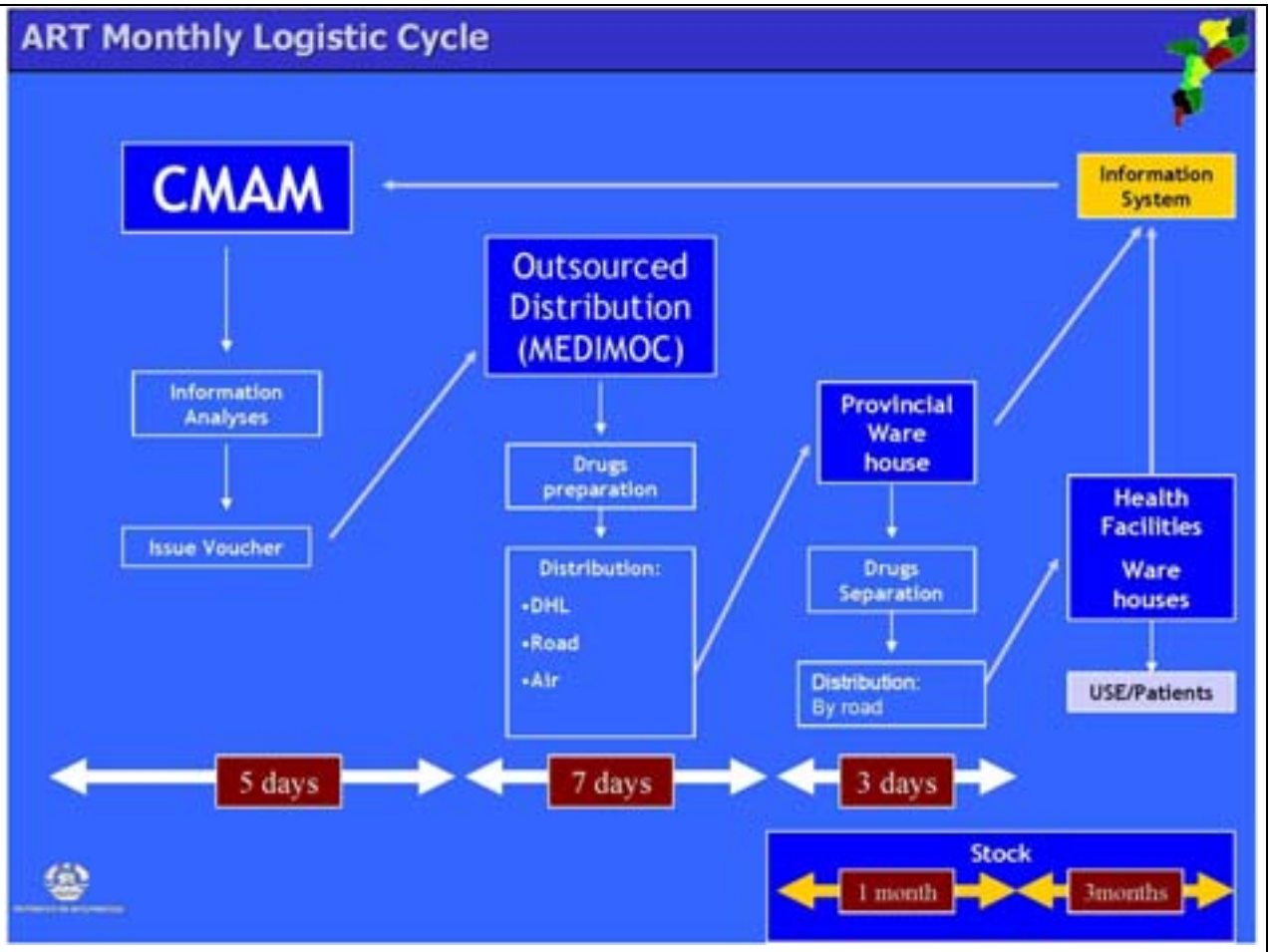

Currently, the NHS through CMAM provides ART drugs to the entire health system, including the facilities where international NGOs like HAI, MSF, S.Egidio and ICAP operate. Around 80% of the ARV drugs are delivered in NHS health facilities directly managed or otherwise supported by NGOs.

4.10.5 Pharmaceutical products selection

Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use.

In section 5.4.1, Applicants are requested to complete '**Attachment B**' **to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.

See Attachment B

4 Component Section *Tuberculosis*

[For tuberculosis and HIVAIDS components only:]

4.10.6 Multi-drug-resistant tuberculosis		
Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	☒	Yes
	☐	No

If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted 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 4.10.6.

Applicants should also ensure that for each year of the proposal term, an amount equivalent to US$ 50,000 should be transparently budgeted in section 5 of the proposal for contribution towards fees incurred by the Green Light Committee. *Applicants should note that this money must be reserved for the Green Light Committee and can not be transferred for other implementation activities.*

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 and training

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 strengthen national capacity, capacity of Principal Recipients and sub-recipients, as well as any target group. Ensure that these activities are included in the detailed budget in section 5.

A. NATIONAL CAPACITY BUILDING AND TRAINING

Human resources

As mentioned, human resource shortages, endemic in all of sub-Saharan Africa, create a significant bottleneck for expansion of activities on all levels in terms of overall numbers of staff and their skills. Therefore, we propose to enhance coverage of targeted human resource strengthening on all levels:

1. **district-level** through community based DOTS volunteers and additional district level trainings as well as enhanced supervision of laboratory and health care workers;

2. **provincial level** with the continuity of support for existing TB/HIV coordinators, nomination of focal points for PAL, and intensive training of new regional laboratory staff to be recruited;

3. **central level** with additional staff as follows: a.*) specific to TB* including M&E, TB/HIV coordination, operational research coordination and b.) *for broader health strengthening for infectious disease control* with additional staff for drug supply and management (pharmacist), and human resource development coordination— these staff will dedicate part of their time to TB and the remaining time to other communicable diseases.

The human resource development coordinator will be responsible for developing and implementing a human resource strengthening plan including a TB component for all levels (district, regional and national). In addition, other TB Control partners have proposed to hire additional staff to minimize human resource constraints including, for example, a data analyst proposed to be recruited by the CDC to increase capacity for TB surveillance and monitoring on the national level. Further, upon GLC approval, additional staff will be trained to provide intensive patient support services for DOTS Plus patients.

External technical assistance will also be requested as described in the subsequent section (4.11.2).

Diagnostic capacity

Detection of smear-positive, smear-negative, extra-pulmonary and multi-drug-resistant TB all remain a significant challenge. We propose to address these constraints with additional infrastructure and training as follows:

1. Laboratory infra-structure strengthening to address scaling up the provision of high quality DOTS with assurance of well-equipped peripheral microscopy laboratories (particularly in underserved areas), culture and drug susceptibility testing as well as a new DOTS-Plus project. All of these infrastructural strengthening initiatives will be accompanied with appropriate trainings;
2. Development of algorithms and training to increase the diagnosis of smear-negative and extra-pulmonary TB (in adults and children) including significant training in radiographic techniques and interpretation among children and HIV infected persons as well as additional radiographic equipment.

Again, TB control partners will further support these endeavors with their own funds such as extensive national and regional laboratory strengthening provided by CDC and TBCAP. External technical assistance will also be requested as described in the subsequent section (4.11.2).

B. PRINCIPAL RECIPIENT CAPACITY BUILDING AND TRAINING

Financial capacity constraints

In November 2006, the existence of constraints in MOH's financial management were noted. Some of the capacity constraints have already been addressed with actions described in this document. A committee has been nominated to draft a restructuring plan for the DAF, with emphasis on financial management and reporting. Incentives are put in place to enhance recruitment and retention of DAF staff. DANIDA has agreed to support technical assistance for a period of 2 years.

GF financial management. The GF is channeled through the PROSAUDE common fund. It does not follow procedures different from those that are part of the PROSAUDE regulations. The common fund has the advantage of pooling precious resources to address multiple disease control interventions simultaneously and reduces transaction costs. It also creates an economy of scale; so, money is available for activities prior to receipt of anticipated funds without having to borrow money with interest charges. The planned decentralization of spending to provincial governors gives such governments more flexibility in disseminating funds. Further, greater transparency will be sought and financial tracking of monies from the central to the district level.

Performance-based monitoring, evaluation and reporting

The monitoring, evaluation and reporting system for activities tied to monies spent and established indicators which was utilized in Round 2 TB, has room for improvement. For Round 2 TB, reporting for some indicators was not achieved by the dates of established deadlines. We propose to greatly increase support for monitoring and evaluation through additional staff recruitment, both local and international, and training. The development of the Performance Assessment Framework (PAF) referred to earlier, aims to streamline reporting on key indicators and eliminate the need for MOH to report to donors bilaterally.

C. SUB-RECIPIENT CAPACITY BUILDING AND TRAINING

Delays in disbursements from Round 2 TB lead to corresponding delays in implementation for some sub-recipients. Increased efforts will be made to provide sub-recipients with timely disbursements of anticipated funds. Health Alliance International (HAI) will be a designated sub-recipient of this funding proposal. HAI has strong leadership and dedicated staff with a proven track record in project implementation. Such an NGO and others may be utilized to increase the country's capacity to implement activities which the MOH would not be able to perform alone. The proposed STOP TB Mozambique Partnership will also be utilized to routinely inform TB control partners how to apply for monies for TB control activities as well as the funds available and those already dispersed.

D. TARGET GROUP CAPACITY BUILDING AND TRAINING

Persons living with HIV/AIDS, children, prisoners, miners are particularly vulnerable to TB in Mozambique but interventions have been inadequate to address the TB epidemic which affects them more than others

without such characteristics. We will increase coordination with HIV/AIDS programmes through appointment of TB/HIV focal points in all provinces. We will also increase coordination with broader non-TB sector partners in order to reach these target groups with the appointment of a Risk Group Coordination Focal Point on the central level. Finally, such target groups are often marginalized in society which may lead to delays in diagnosis and poor treatment adherence. We will further invite persons who have been or are living with TB, or organizations representing them, to participate in a dialogue with open invitation to join the Stop TB Mozambique partnership. People who have been or who are living with TB will, or representatives of organizations representing TB patients, will also be given the opportunity to participate in national and international workshops and conferences to increase the awareness of their specific concerns with the national and global TB control community. Such workshops and conferences may also increase overall awareness among TB patient groups and a sense of solidarity among TB patients.

4.11.2 Technical and management assistance

(a) **Needs Assessment**

Describe any needs for technical assistance, including assistance to enhance management capabilities to support the attainment of the planned outputs and outcomes under this proposal. Where relevant, link your response in this section to the potential capacity constraints of the Principal Recipient and/or other implementing partners under this proposal. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, in section 5).* ***In your description, identify the process by which needs were assessed and evaluated****.*

Several areas of the TB Programme can benefit from strengthening. These areas include M&E, human resource, drug management, laboratory and radiologic diagnosis. The SRL support to DRS is needed; the establishment of a drug management supply system; the establishment of a MDR TB monitoring system and the installation of TB Electronic Register all need technical assistance. International assistance needs include an M&E `expert, a drug supply management expert, MDR/TB expert, expert in radiology and expert to provide assistance on guidelines for culture and SST, laboratory on site capacity building and laboratory hands on assistance and training.

An agreement has been reached with WHO/ STOP TB, for the recruitment of four international providers of technical assistance to strengthen the management capacity of the National TB Programme. . One will be based at the central level and one in each of the regions (North, Centre, South).

(b) **Planned sources and mechanisms for procurement of services**

Describe how technical and management assistance is planned to be obtained during the proposal term in a transparent and efficient manner. In particular, identify whether local, national and/or international assistance will be obtained, the scheduled timeframe (short term or longer term) and the rationale for this approach. Also describe how the provision of the planned assistance will contribute to long term increased capacity to respond effectively to the disease.

As far as possible Technical Assistance would be sourced in the following order: subregional, then regional and then international, to make technical assistance contextual and affordable. An expert from the sub-region would have a better appreciation of challenges and issues related to sustainability. Experts would be sourced with the support of WHO, Royal Netherlands Tuberculosis Foundation (KNCV)and other technical partners in TB.

International assistance consists of M&E `expert (long term), drug supply management expert, MDR/TB expert, expert in radiology and expert to provide assistance on guidelines for culture and SST, laboratory on site capacity building and laboratory hands on assistance and training.

The planning, management, procurement and skills transfer for technical assistance would be enhanced

by the 6 activities below.

1. Inauguration of Technical Assistance Committee to effectively manage procurement and utilization of TA.
2. Development of Annual TA procurement plan so all TAs and their local counterparts/institutions are identified 3 months prior arrival
3. Draft TORs for all Technical Advisers and Local Counterparts
4. Committee to Select all TA and Local Counterparts from a shortlist of three applicants, when ever possible, with interviews where appropriate.
5. Approve workplan for each Technical Adviser/expert
6. Local Counterparts to write individual POA
7. Each TA to follow up local counterpart implementation of POA
8. Annual assessment of TA using the attainment of relevant skills and attitudes of the national counterpart (individual and institutional) as the key item in the performance appraisal of the Technical Advisers

Under operations research, international universities and NGOs would be twinned with national universities and NGOs to implement the research, and again the same six steps above would be applied.
.
The intensive technical assistance will contribute to increased capacity because it would be well managed, and would thus deliver its outputs. The M&E expert would review forms, train staff and ensure that data for all areas, particularly TB/HIV/ MDR/TB etc are all adequately reported and analysed. The drug expert would ensure there is no drug stock outs. Laboratory and diagnostic capacity would be improved.

Each Technical Adviser/Expert would have a carefully selected national counterpart, whose capacity they would build. The attainment of relevant skills and attitudes of the national counterpart would be key items in the annual performance assessment of the Technical Advisers. These national counterparts would ensure follow up, and future capacity building of fellow Mozambicans, so that investments made in these areas would be sustained. Also the networks to be established between the Technical Advisers and their national counterparts/institutions would continue to enhance knowledge exchange and build capacity, long after the formal assistance would have ended.

5 Component Budget *Tuberculosis*

5. Tuberculosis Component Budget - Overview and general guidance

This section 5 is where Applicants detail their funding request which is summarized in table 1.2. **Section 5 must be completed for each disease component included in your proposal**.

For Round 7, section 5 has been restructured to adopt the following order:

1. **prepare a detailed component budget** (section 5.1);
2. from that detailed budget, **prepare a summary by objective and service delivery area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. then provide details about **key budget assumptions** (section 5.4).

Funding to be contributed through a common funding mechanism
If part or all of the funding requested for this component is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.5)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds within the common funding mechanism; **and**

(b) provide, as an annex to your proposal, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Component Budget

A detailed per-disease component budget covering the proposal period must be attached as an annex to your 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 5.1):*

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

(b) It should cover the full term of the proposal, and:
*(i) be **detailed for year 1 and year 2**, with financial information broken down by **quarters for the first year, and at least half yearly for the second year**;*
(ii) provide summarized information and assumptions for the balance term of the proposal period (year 3 and beyond).

*(c) It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

*(d) 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).*

(e) Details on HSS Strategic Actions should be clearly identified.

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

5 Component Budget *Tuberculosis*

5.2 Summary by objective and service delivery area

Please provide a breakdown of the annual budget by objective service delivery area (SDA) derived from your detailed component budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total).

The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category).

Table 5.2: Budget breakdown by service delivery area and objective.

5.2 Summary by objective and service delivery area

Please provide a breakdown of the annual budget by objective service delivery area (SDA) derived from your detailed component budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total).

The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category).

Table 5.2: Budget breakdown by service delivery area and objective.

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*					
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1	SDA 1.1 Improving Diagnosis	189.027	328.525	217.824	202.469	227.404	1.165.249
1	SDA 1.2 Improving Diagnosis	189.027	328.525	217.824	202.469	227.404	1.165.249
1	SDA 1.3 Standardized treatment with supervision and patient support (DOT)	77.569	70.289	77.569	45.340	77.569	348.336
1	SDA 1.4 Drug procurement and supply management quality	1.188.466	1.479.017	2.358.312	2.727.800	3.194.624	10.948.220
1	SDA 1.5 Monitoring and evaluation system	79.170	70.170	115.090	70.170	115.090	449.690

1	SDA 1.6 Program management and supervision	12.000	67.920	0	0	0	79.920
1	SDA 1.7 Human Resources	2.817	0	0	0	0	2.817
1	SDA 1.8 Political commitment	96.614	95.450	84.450	95.450	84.450	456.414
2	SDA 2.1 Scaling up the implementation of TB/HIV Activities	32.050	32.050	32.050	32.050	32.050	160.250
2	SDA 2.6 Strengthen case management and surveillance of MDR/XDR TB	123.867	283.298	193.040	150.834	149.794	900.832
2	SDA 2.8 Address High Risk Groups	533	7.890	773	240	773	10.210
3	SDA 3.1Health system strengthening (beyond TB)	33.380	542.000	192.000	492.300	492.300	1.751.980
3	SDA 3.2 PAL	3.000	31.550	58.300	89.850	58.300	241.000
4	SDA 4.1 PPM	0	0	0	0	0	0
5	SDA 5.1 Supportive environment: Advocacy, Communication and Social Mobilization (ACSM)	0	93.276	4.800	0	0	98.076
5	SDA 5.2 Supportive environment: Advocacy, Communication and Social Mobilization (ACSM)	0	0	0	0	0	0
5	SDA 5.3 Community TB care	624.047	571.625	527.625	571.625	527.625	2.822.545
5	SDA 5.4 Community TB care	0	0	0	0	0	0
5	SDA: 5.5 Patients charter	0	54.752	54.752	54.752	54.752	219.008
6	SDA 6.1 Programme-based operational research	0	27.400	45.544	45.544	45.544	164.032
Total of funds requested from the Global Fund:		2.651.567	4.083.736	4.179.952	4.780.893	5.287.680	20.983.828

5 Component Budget *Tuberculosis*

5.3 Summary by cost category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your detailed component budget (section 5.1)*

(a) Different from Round 6, the cost categories in table 5.3 have been expanded to provide greater clarity between different cost categories.

(b) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(c) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

Table 5.3 – Budget breakdown by cost category

(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)

Use the "TBTable53Line" button  *in the standard toolbar to insert row at the end of table*	**Breakdown by cost category** *(same currency as in section 1.1 of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	43.500	51.000	54.000	354.300	354.300	857.100
Technical Assistance	97.050	126.526	91.600	111.600	107.550	534.326
Training	307.214	416.730	349.780	421.330	349.780	1.844.834
Health products and Health Equipment	302.647	862.671	547.492	567.463	609.160	2.889.433
Medicines and pharmaceutical products	904.405	1.034.224	1.766.217	2.053.590	2.346.710	8.105.146
Procurement and supply management costs	147.986	278.367	391.887	450.712	582.519	1.851.470
Infrastructure and other equipment	106.111	430.826	113.351	18.131	70.961	739.378
Communication Materials	178.903	231.828	197.891	179.979	197.891	986.493

5 Component Budget *Tuberculosis*

Monitoring & Evaluation	489.022	568.117	579.486	528.566	579.486	2.744.677
Living Support to Clients/Target Populations	0	0	0	0	0	0
Planning and administration	74.729	83.448	88.248	95.223	89.323	430.971
Overheads	0	0	0	0	0	0
Other: *(To be further defined to meet national budget planning categories)*	0	0	0	0	0	0
Total funds requested from Global Fund	2.651.567	4.083.736	4.179.952	4.780.893	5.287.680	20.983.828

5.4 Key budget assumptions

The detailed component budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for year 1 and year 2 in relation to three key areas.

5.4.1 Pharmaceuticals and other health products and equipment

Applicants must complete Attachment B to this Proposal Form *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1 and 2 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.***
Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.

(a) **Provide a list (by generic product name) of anti-tuberculosis medicines** to be used in years 1 and 2 (**including for multi-drug resistant tuberculosis**), and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
(Please complete table B.1 in Attachment B to the Proposal Form.)

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(c) Provide **the total cost** for all other medicines to be used over years 1 and 2. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

Information on appropriate unit costs is available at, for example:

- *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2005, http://www.who.int/medicines/areas/access/med_prices_hiv_aids/en;
- Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mas/mns.htm);
- *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/what_msh_does/cpm/index.html*); and*
- *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility http://www.stoptb.org/gdf/drugsupply/drugs_available.asp.)*

Provide any additional information on unit costs below

Tables 5.2 and 5.3 shows the breakdown of the proposed budget by objectives and SDA's and by cost categories totaling $21,390,945 for the five year Round 7 proposal term.

MEDICINES

As indicated in Attachment B all medicines proposed to be purchased with Global Fund funds are included in the WHO Essential Medicines List and the National TB Treatment Guidelines. The current version of the National Medicines List, dated 1999 (Formulário Nacional de Medicamentos) is under revision and will incorporate the anti-tuberculosis Fixed Dose Combinations according to approved TB treatment standard guidelines

The first line medicines have been purchased through the national channels with the

involvement of the GDF which supported the introduction of the 4 medicines fixed dose combination. Mozambique has defined a national treatment guideline for MDR-TB and implemented it in a small scale in last two years. A protocol for MDR-TB was prepared and submitted to the GLC and still under negotiations. The current proposal budgets for 2nd line TB treatment according to suggested USD 3.000 per patient by the GLC and just from the third year of the proposal. The definition of actual medicines and quantities of each will be decided only after the protocol is approved. The present 2nd drugs used by TB Program will continue to be purchased through the national mechanisms, using other sources of funding, to ensure that the patients that started treatment will continue to be assisted. The 1st line medicines were costed based on the unit prices indicated in the GDF website. Only the Rifampicin 150mg unit price was based on the import price obtained by CMAM/MEDIMOC (medicines and heath products national Procurement Agency for the Ministry of Health).

HEALTH PRODUCTS

In this category the auto-disabling syringes with integrated needle are the largest item programmed to be bought with Round 7 funding. The unit costs used is the one indicated in the GDF web-site. The sputum containers another key health product for the TB Program, are not included in this budget because they will continue to be purchased under the general laboratory funds from State Budget and Health Common Fund.

HEALTH EQUIPMENT

It is programmed that 2 stationary chest X-Ray machines will be bought every year of the proposal to improve TB diagnostic capacity at peripheral areas. The unit cost of the equipment including its installation was furnished by the Investment Management Unit of the Ministry of Health (GACOPI) based on a recent international tender.

A MIGT is programmed to be installed in the NRL during the second year of the proposal with the aim to improve the MDR-TB management and build national laboratory capacity in this domain. The estimated costs of the equipment and its normal running costs is based on a recent quotation obtained from the supplier.

5.4.2 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 client/target population level, and how these salaries will be sustained after the proposal period is over. *(**Maximum of half a page**).*

(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)

In the first two years of the proposal the human resources costs represents less then 3% of the total proposal annual costs. It covers basically the contracting of additional staff to improve medicines supply management systems and a TB related human resources management expert.

5.4.3 Other key expenditure items

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

Infrastructure and other equipment represents about 12% of the total budget of year one and decreases to less then 3% in the remaining years of the proposal.

Incubators for the NRL and future regional laboratories were identified as a major need to increase culture for sensibility testing, therefore two incubators for each laboratory was programmed for the first two years at an average cost of USD 6.390,65 each

In this category purchase of 100 motorbikes in year one represents the single major investment with the objective to ensure adequate supervision activities at district level as well as patient and contacts tracking by TB supervisor at the health facility level. A programmed monthly visit to CBO's at district level by the district TB supervisor is envisaged as part of a general strengthening of DOTs in the country.

Communication materials in year one and two of the proposal is mostly linked to the production of TB awareness campaign materials involving production and broadcast of radio spots as well as flyers distributed to patients and relatives and posters in the health facilities. Production of video materials to be disseminated all over the country supporting TB awareness and promotion of DOT's is also included.

1000 bicycles would be purchased in year 1, and 200 would be purchased in year 2 for the Community DOTs volunteers.

There are no renovation of health facilities/laboratories or purchase of microscopes or purchase of vehicles in this two year budget because they are being provided by other sources of funding.

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. 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.

Section 4: Component Strategy – Tuberculosis		**Attachment Number to proposal**
4.3.1	Documentation relevant to the national disease program context. 1. Health Sector Strategic Plan 2. National TB Strategy 3. Draft Strategic Plan Laboratories	 1 2 4 5

	4. Draft Human Resources Development Plan 5. Government 5 year plan 2005-2009 6. Health Policy Declaration 7. Annual Operational Plan (POA) 2007 8. WHO Expert Review of TB Programme, 2006 9. Medium Term Expenditure Framework (MTEF) 2008-2010	6 7 9 10 32
4.3.5(c) *(**only** if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism. 1. SWAp Memorandum of Understanding 2. SWAp Code of Conduct 3. Annual Operational Plan 2007 4. SWAP TOR 5. Annual Joint Review Report 6. Plan for Harmonisation of the CCM with existing coordination mechanisms	 8 33 9 29 30 31
4.3.5(d) *(**only** if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism. Common Fund Audit Report	 11
4.6	**A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**.	**Attachment A – Tuberculosis**
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	15
4.6	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals.	14
4.8.3 (c)	List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**)	18 16a 16b
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	NA
Section 5: Component Budget – Tuberculosis		**Attachment Number to proposal**
5.1	**Detailed component Budget**	21
5.1	Details of cross-cutting HSS amounts (if not clearly	25

(if HSS strategic actions are included – see section 4.4.2)	identifiable from the detailed component budget).	
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	**Attachment B – Tuberculosis**
5.4.2	Human resources costs.	22
5.4.3	Other key expenditure items.	23
5.1 – 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	9
Other documents relevant to sections 4-5 attached by Applicant:		**Attachment Number to proposal**
4.3.3a	Community Involvement Strategy a. Community Involvement Strategic Plan b. List of Participants at June 2007 Community Involvement Meeting c. Agenda of June 2007 Community Involvement Meeting d. Health Ministers Note to June 2007 Community Involvement Meeting	 13a 13b 13c 13d
4.3.3a	Draft Strategic Plan for Health Laboratories	4
4.3.3a	Human Resource Plan	5
4.3.3a	Accelerated Human Resource Plan	26
4.3.3a	Governments 5 year Programme	19
4.3.3a	Map of Mozambique	27
4.3.3b	Poverty Reduction Strategy (PARPA II)	3
4.3.3b	Health Policy Declaration	7
4.6.3a	Proposed Future NGO Partners and their SDAs Proposed geographic (central and provincial) level participation by other NGOs.	16a 16b
4.6.3b	Photograph of Bicycle Ambulance	17
4.8.3	Methodology of selecting sub-recipients 24a. Newspaper advert	 24a

	24b. Email of newspaper advert 24c. Minutes of CCM Meeting on 13 February 2007 to agree on EOIs and selection criteria 24d. Minutes of CCM meeting of 3 April 2007 to select sub-recipients and principal recipients. 24e. Matrix with classification of EOIs by sub-committee of the CCM.	24b 24c 24d 24e
5.1	Laboratory Reagents and materials	28

Please note: There are no attachments with numbers 12, 19 and 20

TB Attachment A to the Proposal Form

Program Details

Country:	**Mozambique**
Disease:	**Tuberculosis**
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	To reduce the prevalence, morbidity, and mortality due to tuberculosis in line with the MDGs by 2020
2	

Impact and outcome Indicators	Indicator formulation	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
outcome	detection rate of new smear-positive TB cases under DOTS	49%	2005	WHO Report 2007	53%	56%	59%	62%	65%	annual, NTP statistics
outcome	success rate of new smear-positive TB cases under DOTS treatment	77%	2004	WHO Report 2007	80%	81%	81%	82%	83%	annual, NTP statistics
Outcome	defaulter rate of new smear-positive TB cases under DOTS	7%	2004	WHO Report 2007	7%	6%	6%	5%	5%	annual, NTP statistics

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To increase the detection and cure rate by expanding DOTS	
2	To address TB/HIV, MDR-TB and other challenges	
3	To strengthen health systems	
4	To engage all care providers	
5	To empower people with TB and communities	
6	Use evidence-based methods to evaluate health benefits of interventions	
7		

TB Attachment A to the Proposal Form

Program Details

Country:	**Mozambique**
Disease:	**Tuberculosis**
Proposal ID:	

Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5				
1.1	Improving diagnosis	Number of laboratory technicians trained in microscopy	80	2006	NTP annual report	40	80	40	80	80	80	80	Y	N	N - not cumulative	
1.2	Improving diagnosis	Number of clinicians trained in TB management incl TB/HIV	80	2006	NTP annual report	40	80	40	80	80	80	80	Y	N	N - not cumulative	Every six months an internal assessment will be conducted to identify key constraints to project completion and solutions will be implemented in order to ensure 4 labs are rehabilitated / upgraded each year
2.1	Scaling up the implementation of TB/HIV activities	Percent of registered TB patients counselled and tested for HIV	24%	2006	R&R TB system	52.5%	60.0%	72.5%	75.0%	85.0%	90.0%	95.0%	N	N	N - not cumulative	
2.2	Scaling up the implementation of TB/HIV activities	Number of HIV+ TB patients receiving cotrimoxazole preventive therapy	1058	2006	R&R TB system	5000	10000	7000	14000	18000	22000	26000	N	N	Y - cumulative annually	
2.3	Scaling up the implementation of TB/HIV activities	Number of HIV+ registered TB patients who begin or continue ART during or at end of TB treatment	2613	2006	R&R TB system	3700	5000	6200	7500	10000	12500	15000	N	N	Y - cumulative annually	
2.4	Scaling up the implementation of TB/HIV activities	Number of newly diagnosed HIV+ people given treatment for LTBI	109	2006	Information from ART treatment centers	250	500	375	750	1000	1500	2000	N	N	Y - cumulative annually	Measured every 6 months
2.5	Scaling up the implementation of TB/HIV activities	Number of patients enrolled in ART treatment clinics who are regularly screened for TB	706	2006	Information from ART treatment centers	750	1500	1500	3000	6000	12000	24000	N	N	Y - cumulative annually	
2.6	Strengthen case management and surveill. of MDR/XDR-TB	Percent of MDR-TB suspects who are confirmed (DST) MDR-TB cases	N/A*		NRL	3.0%	5.0%	6.5%	8.0%	8.5%	9.0%	9.5%	N	N	Y - cumulative annually	
2.7	Strengthen case management and surveill. of MDR/XDR-TB	number of MDR-TB patients diagnosed and treated	129	2006	NRL	50	100	75	150	200	275	350	N	N	Y - cumulative annually	
5.1	Supportive environment: Advocacy, Communication and Social Mobilization (ACSM)	Number of IEC talks performed	2080	2006	Provincial data collection system	2000	4000	3000	6000	8000	9000	10000	N	N	Y - cumulative annually	
5.2	Supportive environment: Advocacy, Communication and Social Mobilization (ACSM)	Number of IEC radio spots emitted	78	2006	Provincial TB data collection system	500	1000	750	1500	2000	2000	2000	Y	N	Y - cumulative annually	
5.3	Community TB care	Number of volunteers trained for CB TB Care	1395	2006	Provincial TB data collection system	500	1000	500	1000	1000	1000	1000	N	N	Y - cumulative annually	
5.4	Community TB care	Reporting units implementing CTBC activities	0**	2006		40	85	55	110	169	169	169	N	N	Y - cumulative annually	
	* This baseline is not available; the targets for 2008-2012 are very rough estimates															
	** Implementation of CTBC care started in 2007															