PROPOSAL FORM

FIFTH CALL FOR PROPOSAL

The global fund to fight AIDS, Tuberculosis and Malaria is issuing its fifth call for proposals for grant funding. The proposal form should be used to submit proposals to the global Fund. Please read the accompanying Guidelines for proposal carefully before filling out the proposal form.

Timetable: fifth round

Deadline for proposal submissions	10th June 2005
Board consideration of recommended Proposals	28th -30th September 2005

Resources available: fifth round

As of the date of the Fifth Call for Proposals, US$ 300 million is available for commitment for the Fifth Call for Proposals. It is anticipated that additional resources will become available prior to the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website. Any information submitted to the Global fund can be made publicly available.

Geneva, 17 March, 2005

1 Eligibility

Proposal Title	SUPPORT FOR STRENGTHENING AND EXTENSION OF THE FIGHT AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA IN DRC
Name of applicant	National country coordination mechanism of the Global fund in the fight against AIDS, Tuberculosis and Malaria in DRC, CCM-DRC
Country	Democratic Republic of Congo

Type of application

- ☒ CCM - National country coordinating mechanism
- ☐ Sub-National country coordinating mechanism
- ☐ Regional coordinating mechanism (including Small Island Developing States)
- ☐ Regional Organisation
- ☐ Non-Country Coordinating Mechanism

[Please tick one of the boxes to categorize your application type; refer to Guidelines for Proposal, Section II, paragraphs C1 to C4.]

Proposal Components

- ☒ HIV/AIDS[1]
- ☒ Tuberculosis[2]
- ☒ Malaria
- ☒ Health system strengthening

[Please tick one of the boxes to categorize your application type; refer to Guidelines for Proposal, Section III, A.]

Currency in which the proposal is submitted

- ☒ USD
- ☐ Euro

[1] **In cases where HIV/AIDS is the main vector of the tuberculosis epidemic, HIV/AIDS 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/***.

[2] **In cases where HIV/AIDS is the main vector of the tuberculosis epidemic, HIV/AIDS 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 Eligibility

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

[Countries classified as "lower-middle-income" or "upper-middle-income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals, section II.A.).

Country	**CONGO (DEMOCRATIC REPUBLIC)**

☒ Low income
☐ Lower-middle-income [see paragraph 1.1 below]
☐ Upper-middle-income [see paragraph 1.1 below]

[See the Guidelines for Proposals, Appendix 1. For proposals from multiple countries, complete the above referenced information separately for each country.]

1.1 Lower-middle-income and upper-middle-income country

[Sections 1.1.1 and 1.1.2 must be filled out for these two categories; without this information, this proposal will not be considered for financing.]

1.1.1 Counterpart financing and greater reliance on domestic resources

[For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section II.A.
The field "Total requested from the Global Fund" in the table below should match the request in sections 5.1]

Tableau 1.1.1 - Counterpart financing and greater reliance on domestic resources

Financing sources	**In EUR / USD**				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested from the Global Fund (A) [from Table 5.1]					
Counterpart financing (B) [linked to the interventions for which funds are requested under (A)]]					
Counterpart financing as a percentage of: B/A x 100 = %					

1.1.2 Poor or vulnerable populations

1 Eligibility

Describe how these populations have been identified, and how they will be involved in planning and implementing the proposal (2–3 paragraphs).

1.2 CCM functioning - eligibility criteria

[*To be eligible for funding National/Sub-National/Regional (C)CM applications have to meet the requirements outlined in 1.2.1 to 1.2.3.][Question not applicable for Non-CCM applications*]. *[Question not applicable for Non-CCM applications]*

1.2.1	**Demonstrate CCM membership of people living with and /or affected by the diseases***. [This may be done by demonstrating corresponding CCM membership composition in section 3.6.3 'Membership Information']*
	The CCM DRC includes a representative for persons living with HIV/AIDS, member of the organisation « Network of persons living with HIV », RCP+ and a representative of persons suffering from tuberculosis, cured tuberculosis patients member of the NGO « Club Amis de Damien ». Given the fact that malaria affects the whole population all CCM members are thus considered as affected by this disease. For further details please refer to the list of CCM members given in 3.6.3

1.2.2	**Provide evidence that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a documented, transparent process developed within each sector.** ***[Please summarize the process and attach documentation as an appendix]***
	The members of the CCM have been chosen at the start by the different partners involved in the fight against the three diseases on the initiative of the Health Minister who is also the President of the CCM. The CCM has asked the non-governmental sector to officially appoint its representatives for the CCM in order to ensure transparency and to formalize the procedure. The organizations involved have thus transmitted the appropriate documents for the appointment of their respective members which have been prepared by their competent administration representatives, namely the board of directors of NGOs. (Appendix 1, documents pertaining to the appointment of the CCM members by their respective organizations).

1.2.3	**Describe and provide evidence of a documented and transparent process to:**
	a) Solicit submissions for possible integration into the proposal *[please summarize and attach documentation as an appendix]*
	The administrative, financial and technical procedure handbook (preliminary) of the CCM-DRC (Appendix 3) defines, in paragraph 7.2, two methods of elaboration of proposals for the implementation of a work frame with the partners coming from the Task Forces. In relation to the drawing up of the present proposal, the CCM has, through its Technical Secretary office, developed Terms of references which have been submitted for the approval of the CCM bureau. A call for proposal has been made for the period between 17.03.2005 to 18.04.2005. This period has been extended to the 29.04.2005 following a decision made by the general assembly. The documents pertaining to this can be found in Appendix 2.
	b) Review submissions for possible inclusion in the proposal *[Please summarize and attach documentation as an appendix]*

1 Eligibility

Following the call for proposal by the CCM throughout the country, several stake holders have transmitted various proposals to the Technical Secretary office which have been put at the disposal of the committee of experts gathered for this purpose. This committee has held a workshop from the 04.05.2005 to the 10.05.2005 to analyse and integrate the received proposals in order to prepare a single CCM proposal: 23 proposals have been received comprising 16 on AIDS, 6 on Malaria and 1 for health system strengthening.
This committee is composed of persons issued from different multilateral cooperation organizations (WHO, UNDP, European Commission), bilateral cooperation organizations (GTZ, CDC), national (Ligue Nationale Antituberculeuse et antilépreuse du Congo, Conseil National des Ong de la Santé, Union Baptiste Suédoise, Eglise du Christ au Congo / IMA) and international NGOs (Fometro, Damien Foundation, DWB/Belgium), Ministry of Health (NPMC, NPAC, NTP, PNTS, SSP Department, Department of the struggle against diseases, Partnership Department), PNMLS, University (Public Health schools) and independent groups.

The committee has redefined the main intervention areas in relation with the strategic plans of specific programs aimed at fighting the diseases while keeping consistency between the various components.

In Appendix 4, please find the final report of the workshop for the analysis and integration of the proposals of the CCM DRC for submission at the GF's 5th call for proposal.

c) Nominate (the) Principal Recipient(s) and oversee program implementation *[please summarize and attach documentation as an appendix]*

The nomination procedure of the PR and monitoring and evaluation of the interventions is described in the Handbook of administrative, financial and technical procedures of the CCM (Appendix 3). This is only a preliminary handbook. The final procedure handbook will be made available to the Global Fund as soon as possible. The procedure described in this handbook includes a major interest campaign throughout the whole country and an evaluation of the candidates based on the criteria defined in the procedure handbook.
The change in PR requires, to date, an evaluation procedure that the CCM cannot achieve within the granted deadline.
In these conditions, and taking into account the above mentioned reasons, the CCM has decided to renew the UNDP as PR :

- The procedure implemented by the UNDP as PR since the start of the year has developed well and the results obtained, as far as the delay is concerned, for the start of the funded Grants are quite positive, based on the assessment published in the Newsletter / GF of the month of may 2005.
- The status of post war countries which campaign to use the UNDP as PR cannot be considered as obsolete in the case of the DRC.

The decision of the CCM is thus justified by the progress noted with the current PR and the fact that the procedure of identification of national PRs, which is under way, is not over yet. The CCM is going forward with the identification of national PRs while still proposing the actual PR so as to be able to implement the necessary mechanism for the transfer of expertise.

3 Type of application

2.1 Executive Summary

[Please include quantitative information, where possible (4–6 paragraphs total)]:

2.1.1	**Briefly describe the (national) disease context, existing control strategies and programs as well as program and funding gaps. *Explain how the proposed interventions complement existing strategies and programs, particularly where funding from the Global Fund has been received or approved.***
2.1.2	Describe the overall strategy by referring to the goals, objectives and service delivery areas for each component, including expected results and associated timeframes. Specify for each component the beneficiaries and expected benefits (including target populations and their estimated number)**.**
2.1.3	If there are several components, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities (by synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact*).*
2.1.4	Indicate whether the proposal is to scale up existing efforts or initiate new activities. ***Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal*.**

The DRC is the third biggest country in Africa and has a population of 60 million people yet it also holds some sad records: ranked in the 168th position out of 177 for the human development index, HDI (UNDP 2004), 5th in Africa and 11th in the world amongst the 22 countries which account for 80 % of tuberculosis cases (Global.), 8th in the world amongst the countries which carry the burden of HIV/TB co–infection (TB/HIV, WHO/COS/TUB/2002.311). There is a widespread HIV epidemic in the DRC. The mean prevalence is around 4.5 % with a range of 1.7 % in the western Kasaï province to 7 % in Katanga (NPAC, 2004). The DRC is amongst the 27 countries considered « of highest priority, which are in great need of the consideration of the rest of the world ».

While in the 1980s the DRC, the then Zaïre Republic, had a health system capable of facing various health problems the situation has drastically changed and nowadays the system has totally disintegrated.

Taking into account the success of the program of the fight against tuberculosis whose activities have been integrated in the primary health services since the 1980s, interventions concerning HIV/AIDS and Malaria control will be made within the same geographical areas so as to have a real impact on the health of the population.
The health zones considered by the present proposal are those that are covered by a global support. The grants requested by the present proposal will give long lasting results in a spirit of close collaboration and complementarity between the different partners.

For Tuberculosis

2.1.1 National context and current situation of tuberculosis

3 Type of application

The NTP is making progress despite the difficult political, economic and social environment. Even if we have not yet started to control the tuberculosis epidemic, we have nevertheless had some good results. Between 1996 and 2004 the DOTS therapeutic coverage has increased from 30 % to 75%, the rate of detection of TPM+ patients has increased from 35% to 70% and the rate of treatment success has increased from 50% to 81%. These results have been obtained thanks to the contribution of the permanent partners for the implementation of the program (Fondation Damien, TLMI, ALM, UBS, LNAC, ALTI), of the technical support partners (WHO, IUATLD, CDC) and the financial partners (USAID, TBCTA, GDF, GF, CTB, UE, DGCD). Strength of the program, apart from the partnerships, is the integration of the NTP in the basic health care (national health policy), with staff at the national and intermediary levels who are more or less stable. Its integration in the primary health system is the basis for it being a long term scheme.

Control strategies and existing programs

Since 1996, the PNT has adopted the DOTS strategy of the WHO to implement its activities. In order to support these strategies a master plan for development for 2001-2005 was drawn up in the year 2000. Out of a global budget of 42.7 millions dollars for this master plan, the government has dispatched 94% to its support partners including 7 973 004 dollars granted by the Global fund at the 2nd Round, which represents 19% of the budget. On the other hand, the second phase (3rd year) of the support of the Global fund has been validated by the board of administration of the Global fund. The agreements with the GDF have allowed the country to procure first class anti-tuberculosis medicines for 2/3 of the needs of the NTP since 2002, the other 1/3 has been provided by the other partners. This joint program with the Global Drug Facility will end in 2006

Program and Financial gaps

After global analysis made by the NTP during the External Revue in February 2005 we have noted that the low level of the performances (weak rate of cure and detection) in structural coordinations devoid of structural support and in the major coordinations where supervision and monitoring are difficult to make and where there are insecurity concerns. The present proposal will serve to reinforce the achievements of the DOTS and the social mobilisation. We also consider, with the collaboration of the NPAC, to extend our care to TB co-infected with HIV with the implementation of the VSC in health care centers for the diagnosis and treatment of tuberculosis and antiretroviral therapies for eligible patients. Particular emphasis will also be put on the monitoring and care of multi-drug-resistant TB cases which have been identified as a major problem in big cities during the External Revue. On the other hand, as the contract with the GDF ends at the end of year 2006, 766 746 antituberculosis cures are also requested in this project. The traditional partners will finance 1/3 of the requirements in drugs

From a financial point of view this project submitted to the Global Fund is part of our new Strategic Plan 2006-2010 developed after the previous external evaluation. The global amount for this plan for a period of five years is 112 570 288 USD, due to the high cost of antiretroviral drugs. Some traditional partners have already announced their participation for an amount of 25 552 860 USD and the grants requested from the Global fund in this project is of the order of 42 872 811 USD (1/3 of the plan), which means that we will be faced with a deficit of 44 144 617 USD which will have to be funded over the next five years

2.1.2 Goals, Objectives and service delivery

The main goal of this program is to reduce the morbidity and the mortality due to

TB and TB-HIV co-infection in the Congolese population.

To attain this goal from now to 2010, five service delivery areas of have been selected:

1. **Prevention** :

- To increase the level of detection from 70% to 75% by extension of the DOTS coverage: by fragmenting the largest coordinations and by increasing the number of health diagnosis centers and treatment for TB (HCDT) from 991 to 1545 centers dispatched between the public, private and confessional sectors.

2. **Treatment of TB cases** : Increase the level of success from 81% to 85% in new TPM+ patients and increase the access to second line drugs from 200 to 7 011 expected multi-drug-resistant patients.

3. **TB/HIV collaboration** :

- To hold collaboration meetings between the TB and AIDS programs
- To provide VSC services to all expected tuberculosis patients (691 484 cases)
- provide cure to the 20 745 expected co-infected patients during their antituberculosis treatment:

4. **Advocacy, communication and social mobilisation**

a) To improve advocacy to opinion leaders and current and future partners in order to perpetuate the project

b) To increase awareness of TB, AIDS, Malaria, Health and Development through radio and television programs in each Province.

c) To mobilize individuals, families and the community in the prevention and treatment of TB patients, co-infected TBs and multi-drug-resistant TB, and to fight stigmatisation.

5. **Strengthening of the institutional capabilities**

a) To guarantee stability of the health care professionals by providing continuous training during employment, to pay them on the basis of efficiency with individual performance based contracts.

b) To improve the monitoring and coordination of the activities of the fight at the intermediary level by decreasing the geographic intervention range (fragmentation of the largest coordinations)

The recipients are: tuberculosis patients estimated at 691 484 cases, multi-drug-resistant TB patients estimated at 7011 cases, co-infected patients estimated at 207 445 cases including 20 745 who will be put under ARV during the antituberculosis treatment in the health centers; children under the age of five whose mothers are tuberculosis patients, the Congolese population and the staff of the health system. The main expected benefits are: better access to these services by patients and the general population, easy access to secondary drugs for multi-drug-resistant patients, easy access to VSC and ARVT for TB patients, decrease stigmatization towards TB and TB-HIV patients and increase public awareness, the number of diagnosed HIV cases and increase in health care

2.1.3 Expected synergies from the combination of different components

Synergy with the (AIDS/HIV) and NPMC (Malaria):

For the period between 2006-2010 the program expects to procure health care to 691 484 TB patients (all forms) from 515 health zones including 207 445 co-infected patients, if we consider the seroprevalence of TB patients estimated at 30% who will be treated with ARV between 2006 and 2010. The collaboration between the NTP and NPAC programs is under way: the harmonization of the strategies and information media has been one of the results of the workshops held to this effect with the support of the WHO, NCU and CDC.

Several initiatives for caring of co-infected patients are under way in several ZS across the country with the partners of the NTP and of the NPAC, including USAID, NCU/CDC, and WHO. With this proposal the integration of the activities of the TB-HIV co-infection in health centers will allow a fast up-scaling to the 3x5 initiative in DRC. This integration will allow for a better quality of life and will

contribute to increase the life expectancy of AIDS patients. The NTP expects that 20 745 co-infected TBs will necessitate cure with ARV while being treated with anti-tuberculosis drugs (10% of the co-infected); the rest of the patients being cared for by the NPAC after being cured of TB. The supervision for the monitoring and evaluation of the co-infection will be taken in charge jointly by the two programs. Material and laboratory reagents will be provided to health centers which deal with tuberculosis but which also detect and provide treatment for other diseases, particularly Malaria which represents the principal cause of morbidity and mortality in our communities. In the present proposal, the « Malaria » component has taken into account the allocation places of theses materials (microscopes) for the extension of its struggle program.

Synergy with the Reinforcement of health care services component :

The surplus work in the tuberculosis diagnosis and treatment centers will necessitate an increase in staff and an increase in overtime which justifies the application for financial support for the service providers in order to motivate them for better work and stability. All the aspects of the management of the human resources of the health zones, namely the continuous training during employment and motivation bonuses have been evaluated and described in the component which deals with the « Strengthening of health services » of the present proposal. Furthermore, the health care being integrated in the same centers which will also deal with patients suffering from Malaria and/or AIDS, this financial incentive will not only benefit the three programs but also the whole minimal activity package provided by the health centers to the general population.

2.1.4 Scale up of existing programs and initiation of new activities

This proposal is at the same time a scale up of existing projects and an initiation of new activities. This proposal is the logical continuation of the proposal financed in the 2nd Round of the Global fund, the 2nd phase of which has been accepted. The present program will reinforce routine activities which are supported by the traditional partners of the NTP as well as innovative activities introduced thanks to the previous financial support of the Global Fund, in particular in favour of advocacy and community involvement.
Pilot projects to provide health care for TB-HIV patients in Kinshasa have been initiated. The lessons learned from these projects will lastly be used to extend this project at the national level, including:

- the VSC works best when implanted in TB diagnosis and treatment centers,
- these rapid tests can be performed in the health centers with simple equipment,

The program thus proposes to introduce, as innovation and in close collaboration with the NPAC, the ARVT on top of the VSC in TB patients and to extend all its activities to other non covered zones of the country.
The community-based DOTS strategy initiated in Kinshasa and lower Congo (coordinations which had a high drop out rate at the start) has lead to an increase in the number of cures in the coordinations. This strategy will also be extended throughout the country and applied to co-infected patients under ARV.
Currently, health care to multi-drug-resistant TB patients is provided only in Kinshasa. The NTP plans to extent this to each and every province.
The advocacy, communication and the social mobilization which have already started will be reinforced in all the coordinations. Health programs on HIV/AIDS, TB, Malaria will be jointly organized and aired on several provincial radio and television channels

The global cost for this component is 36 234 565.00 USD for 5 years.

For Malaria

Malaria is a main public health concern in DRC. It is the first cause of morbidity and mortality in particular amongst children under the age of 5 and pregnant

women. The annual estimated number of Malaria cases is 10 060 000 in the Democratic Republic of Congo. Children under the age of 5 pay a heavy price as they account for approximately 59 to 86 % of all cases. According to MICS II (2001), the prevalence of the fever in children under 5 years of age is 41 % and every child in this age group suffers from about 6 to 10 Malaria fevers per year (survey made by PEV/LMTE, 1998).

Only 52 % of the children suffering from malaria are treated with Sulfadoxine-Pyrimethamine. 85% of blood transfusion in paediatric units of Kinshasa hospitals are due to malaria and 3 out of 10 hospital beds, in this same city, is occupied by malaria-suffering patients.

The strategy of the National Program to fight Malaria is composed of six points which are :

(i) prevention of Malaria by promoting the use of mosquito screens impregnated with insecticides,
(ii) care for the diseased at the community level and public and private health care centers ;
(iii) intermittent preventive treatment in pregnant women and purification of the interior and exterior of housing,
(iv) epidemiologic control, monitoring and evaluation of the activities ;
(v) institutional capacity-building ;
(vi) Reinforcement of the partnership for the mobilization of human, material and financial resources and the coordination of the interventions.

The ongoing programs allow 60 % coverage with impregnated screens, to provide reasonably good health care to 80 % of Malaria cases in the health zones and 20 % in the community of 188 out of 515 health zones that exist in DRC. These programs are funded by the Global fund (3rd round), UNICEF, WHO, USAID, the African development Bank and the CDC-Atlanta. The proposed interventions of the present component will allow the extension of these coverages to 65 new health zones.

The aim of this component is to contribute to reduce by 20 % the morbidity and the mortality linked to Malaria in DRC, in particular in pregnant women and children under the age of five. In order to achieve this aim we have to reach three goals. Namely :

1. To extend the interventions for Malaria prevention with the use of MSII and ITP in the 65 ZS.
2. To improve health care provided to children under the age of five suffering from Malaria and pregnant women in the 65 ZS.
3. To ensure the monitoring and evaluation of the project

The expected results are :

(i) 60% of children under the age of five and pregnant women sleep under MSII,
(ii) 60% of pregnant women in the health institutions are provided with ITP and
(iii) 80% of children under the age of five are provided with an adequate and effective anti-malaria treatment in health institutions.

The main areas of service delivery are, for the first objective, the prevention of Malaria by the use of insecticide-impregnated screens, intermittent preventive treatment in pregnant women and the purification of the interior and exterior of housing. The service delivery areas in the second objective are the treatment of Malaria in health institutions with ACT and Quinine, the treatment of Malaria at home with ACT, diagnosis with microscopes, quality control of the drugs and the monitoring of drug resistance.

Main recipients: The proposal concerns 65 health zones and the target

groups are children under the age of five and pregnant women. There are 1 813 136 children under the age of five and 362 627 pregnant women.

Synergy: There is a synergy between this component and the HIV/AIDS, Tuberculosis and the health system strengthening components. The latter proposes to contribute to provide health care to HIV/SIDA, Malaria and Tuberculosis cases by implementing a theoretical and practical training based on the universities. To this end, the component proposes interventions which will contribute to stabilizing the primary staff in the struggle against the three diseases, the creation of a coordinating cell for the training centers in every public health school in the country, etc.

85% of blood transfusions in children under the age of five are due to malaria. The improvement of the safety procedures during blood transfusion will reduce the risk of HIV transmission by this means. Pregnant women with HIV will receive an additional dose of SP during ITP. Diagnosis of tuberculosis and malaria is done under the microscope by the same technician: the improvement of the health institutions with laboratory equipments such as microscopes and light sources will be done for the two structures in the two components.

This project is an extension of the coverage financed by the 3rd round of the Global fund and the other above mentioned partners. Free distribution of MSII to targets in certain ZS has allowed significant coverage. This element has been integrated in the new proposal and finds its rationale in the widespread poverty which characterizes our country following the war. The main novelties are drug quality control and the monitoring of drug monitoring to support the new policy, the distribution of MSII at the same time as Vitamin A and Mebendazole distribution and during the anti-measles vaccination campaign.

The global cost for this component is of the order of **32 000 491.75** USD for five years

For AIDS

2.1.1. The prevalence of AIDS range from 1.7 to 7% in the adult population in the 15 to 49 age group with variations according to different provinces. (NPAC: 2003-2004; Survey of the seroprevalence of HIV by sentry sites). The mean prevalence is around 4.5 % (4.2% according to the UNAIDS 2004 report). The impact of the epidemic is aggravated by the social and political crisis in which more than a million children under the age of 15 have lost one or both parents since 1990.

The number of PLHIV (0-49 years) in 2004 is estimated at 2 610 000 with a sex ratio Women/Men for HIV infection of 1.1 ; the prevalence of HIV in tuberculosis adult patients is 45 % ; the number of persons at an advanced stage requiring treatment is 338 700;

The national strategic plan (1999-2008) defines three major strategic intervention lines: prevention, providing care and reducing the impact. These three intervention lines will become operational in 13 intervention areas. (See national Strategic plan in Appendix P50-57).

The analysis and the implementation of the strategic plan show that progress has been made in the last few years as evidenced by the numerous results obtained thanks to the support of the government and its partners.

2.1.2. The present proposal to the Global Fund will allow the strengthening and the extension of the prevention activities and especially to allow a greater number of persons to have access to antiretroviral drugs keeping in mind the national ARV extension plan elaborated in the global initiative 3 by 5 thanks to the support of the WHO and UNAIDS. This plans aims, between now and 2009, to ensure that 235 146 people will have access to antiretroviral medicines (which corresponds to a coverage of 69%). The total budget for this plan is of the order of 315 178 496 USD and the available funds amounts to 68 781 655 USD (which will allow us to treat 63 695 patients). There is a gap of 246 396 839 USD (that is to say 171 451 PLHIV)

3 Type of application

The aim of the present proposal is to contribute to the reduction of the morbidity and mortality due to HIV/AIDS in DRC.

Goals :

1. To reduce the risk of HIV transmission in vulnerable groups in the 100 health zones covered by the program
2. To ensure access to antiretroviral treatment to 64 654 PLHIV from now until 2010 which will represent an increase of 2 %
3. to reinforce monitoring and evaluation of the program of struggle against HIV/AIDS

Services delivery and expected results :

For the goal: to reduce the risk of transmission of HIV in vulnerable groups in 100 health zones covered by the programs by providing CCC programs by mass media, promiscuity CCC, prevention of the transmission from mother to child, blood transfusion safety and general precautions, post exposition prophylaxis (PEP), universal precautions and advice and voluntary screening of HIV/AIDS, the expected outcome will be an increase in the number of tests in the voluntary screening centers and centers for counselling, the prevention of new cases.

For the goal : to ensure by 2010 access to medical care and antiretroviral treatment to 64 654 PLHIV representing 2% additional PLHIV by providing the following services : Prophylaxis and treatment for opportunistic infections, antiretroviral treatment and monitoring, home palliative care, strengthening of the social network, operational research, monitoring of drug resistance, care and support orphans as well as for vulnerable children, the expected outcomes are: improvement in the life expectancy and the quality of life of PLHIV, improvement in the acceptance and observance of treatment, reduction of risk and the vulnerability of VOC and AP.

Recipients and their benefits :

-young people in the age group (10-24 years), risk-specific exposed groups such as sex professionals and their clients will have the following benefits : a wider access to prevention services including voluntary screening and counselling, vulnerability reduction, access to reliable information to improve practice and a better participation in the implementation of the interventions by targeting these interventions ;

- voluntary blood donors : free access to blood products and its derivatives for them and their families when the need arises, free condoms, to provide health care to them in case of HIV infection.
- Recipients of blood transfusion especially women and children : safe blood transfusion ;
- sexually abused women and the health staff : reduction of HIV/AIDS transmission risk and protection ; - general population : to acquire adequate information and practices against HIV/AIDS, decrease in the stigmatization towards PLHIV ;
- Pregnant women and new-born babies: to reduce the risk of transmission, knowledge of the serological status, protection of couple's life, access to an adequate health care if necessary.
- the PLHIV (64654) : improvement in life expectancy and the quality of life through adequate health care, vulnerability reduction and reduction of stigmatization,
- The AP, orphans and vulnerable children: strengthening of health and social care and decrease in the risk and vulnerability.

HIV/TUB : through health care to HIV/TUB co-infected persons (45 to 65 % of the PLHIV), the present program allows

(i) to increase the number of persons who are aware of their serological status towards HIV and who can take the necessary precautions in case of need,
(ii) to increase the number of persons who have access to health care particularly ARV,
(iii) to strengthen the capability of health structure staffs,

(iv) to strengthen the health system (providing equipment),
(v) to reinforce the collaboration between the NPAC and the NTP

2.1.3. With the Tuberculosis component: this component ensures that HIV-TUB co-infectants (45 to 65% of the PLHIV) receive adequate treatment.
With the strengthening of the health system component, this component ensures the training of the staff and pays the motivation bonuses of the HZ.
With the Malaria component, this component ensures intermittent presumptive treatment with sulfadoxine –pyrimethamine to pregnant HIV+ women at the PMCT sites.

2.1.4. New activities :
- post exposition prophylaxis for health staff and sexually abused women
- to provide widespread health care to co-infected HIV/Tub patients
- strengthening of the local NGO networks and of the PLHIV
The other services provided are extension of the existing interventions
The budget for the component is of the order of **117 823 806.78 USD.**

Strengthening of the health system

The health system of the Democratic Congo Republic show some weaknesses in the struggle against HIV/AIDS, Malaria and Tuberculosis, examples of such weaknesses are: insufficient number of trained staff (for ARV treatment, Malaria and Tuberculosis), weak motivation of the staff which accounts for the weak turn-over and employment instability, unfair distribution of staff between rural and urban areas, the dilapidated state of the infrastructures and sanitary equipments following plunder and the armed conflict and the weak funding of the health system by the Congolese government), the weakness of the monitoring and evaluation system which causes lack of information for decision making as well as the insufficient coordination between the many partners in the struggle against these three diseases. In the current configuration, the structures caring for the PLHIV, the AP, tuberculosis patients and pregnant women do not provide quality services which mean that there is a lack of an adequate environment to efficiently fight against the development of drug resistance, stigmatization and discrimination towards the recipients.

As for HIV/AIDS, the NPAC in its extension plan for the treatment by ARV developed with the 3 by 5 initiative of the WHO, estimates that 5000 people are now treated with antiretroviral treatment. The number of PLHIV eligible for the treatment by ARV range from 350 000 to 520 000 people across the country which represents 15% to 20% of the infected persons. To date, only 5200 persons are under ARV, which represents only 1.2% of eligible persons. We plan to increase this number to only 235 146 during the next five years. As things are going on currently, it will take years to attain the coverage goals expected with the start of the activities of the struggle against HIV/AIDS. This is a major challenge for the country and involves reaching a greater number of infected persons and to provide them with at least minimal health care.
We have the same problems concerning tuberculosis and malaria where we can observe a vertical effect of the training of service providers even in peripheral areas.

The aim of this proposal is to contribute to the improvement of health care quality of HIV/AIDS cases including malaria and tuberculosis cases by setting up a standard and permanent practical and theoretical training program based on the universities. The ministry of health has taken the initiative to work with the ministry of higher education for a partnership where the benefits of the educational environment, the infrastructures of the clinics and laboratories, the administrative know-how as well as the respect and consideration provided by the universities to the recipients and to the public represent major assets which will accelerate and extend the coverage. To these benefits we can add the

geographical coverage of national universities and technical schools which will support health care in the private as well as in the public sector; this will allow the systematic increase in accessibility, in community support and will also allow the improvement of the quality of health care services of these three diseases. For this health care service which will be carried out according to the national and international standards and regulations, the drugs will be provided by the three national programs involved.

This collaboration will result, in the next five years, in the creation of 7 centers which will be able to train at least 6 400 health service providers who are members of the multidisciplinary teams in the health care for the 3 diseases in the health structures as well as in the community. These centers will also be regarded as models and will provide consultative services to community health agents. They will also allow the monitoring and evaluation of the activities including the implementation of operational research projects and to set up better strategies for the struggle against these three diseases in the community as well as in health centers. This system will mean that data can be collected, analyzed and synthesized on the activities of all the components.
To stabilize employment of trained staff and to fight brain drain which is detrimental to the quality and quantity of health care provided by the health system, we propose to, one hand, improve working conditions of service providers who will benefit from support by external experts through the VSAT communication system and the referral system and by the implementation of a motivation system in the form of a performance contract which will be signed by the service provider and the training center.
Thanks to the use of the VSAT communication technology, the system will be able to establish an efficient partnership with universities and education centers in Europe, North America and Asia, as well as with the medical associations and the experts in the fields of treatment, training and monitoring and evaluation as well as research.

These 7 training sessions, which have been developed in the universities, will be held by the medical teaching staff in partnership with provincial hospitals which are under the management of the ministry of health, some technical schools, community groups of struggle against HIV/AIDS and the teams in the health zones. The national programs for the monitoring of the diseases (HIV, malaria and TB) will provide technical support to the centers with the participation of public health schools of Kinshasa and Lubumbashi.

A national coordination cell will be set up to facilitate collaboration between the PR, the different recipients, the CCM, the CNMLS as well as other protagonists involved in the struggle against the three diseases. At the level of each center there will also be a local coordination cell for the activities.

To set up these activities a global amount of 33 356 411.25 USD is required for a 5 year period.

2.2 Component and Funding Summary

Table 2.2 – Total Funding Summary

	Total funds requested in Euro / US$					
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
HIV/AIDS	32 527 257.82	17 906 543.53	38 293 216.53	14 644 099.46	14 452 689.45	117 823 806.78
Tuberculosis	6 838 412.00	7 915 022.00	8 161 919.00	6 543 699.00	6 775 513.00	36 234 565.00

3 Type of application

Malaria	**9 576 447.62**	**7 982 376.62**	**7 413 746.27**	**3 414 060.62**	**3 613 860.62**	**32 000 491.75**
Health systems strengthening	9 501 153.58	5 374 488.29	5 858 336.46	6 311 216.46	6 311 216.46	33 356 411.25
Total	58 443 271.02	39 178 430. 44	59 697 218.26	30 913 076.04	31 153 279.53	219,415,274.78

Table 3 – Type of Application

Type of proposition:	
☒ National Country Coordinating Mechanism	*go to section 3.1*
☐ Sub-National country coordinating mechanism	*go to section 3.1*
☐ Regional Coordinating Mechanism (including Small Island States)	*go to section 3.1*
☐ Regional Organisation	*go to section 3.1*
☐ Non national coordinating mechanism	*go to section 3.1*

[Complete section 3 as appropriate. Please note that - without these details and in particular the information requested in section 3.6 the proposal cannot be reviewed.]

3.1 National Country Coordinating Mechanism

Table 3.1 – National CCM: Basic Information

Name of National CCM	Date of Composition
CCM – RDC	February 27, 2002

3.1.1	**3.1.1 Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs). *[For example, a decision-making mechanism, constituency consultation processes, structure of sub-committees, frequency of meetings, implementation supervision, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]***
	The CCM functions by ministerial decree N° 1250/ CAB/ MI/ S/ CJ/ 15 of 3rd May 2003 of the Ministry of Health, defining the creation of the CCM (Appendix 8) as well as its internal rules and regulations (Appendix 9). The CCM is composed of three bodies : • The general assembly which is the deliberation body composed of all

the members of the CCM /RDC,

- The Bureau, the body which deals with the orientation and driving forward projects, composed of six members including one representative of civil society, 2 from the government sector and 3 from bi and multilateral cooperation.
- The technical secretariat, a body whose principal role is to prepare technical and administrative dossiers, to implement CCM activities as well as the production and filing of the technical and administrative documents of the CCM, is composed of the directors of the three national programs and field partners involved in the struggle against the diseases.

The technical secretariat, as well as the three Task Forces which are hereby represented, constitute the permanent dialogue framework between the different field workers.

The president of the CCM is also a member of the National multisectorial Board of AIDS control and sits in this committee with two other members of the CCM. In this context, there is a regular harmonisation of the interventions with the Multi country Aids Program (MAP) financed by the world bank. A workshop for the harmonisation of the interventions of the two programs in the country has been organized from 02 to 05.10.2004.

A commission for monitoring and evaluation is implemented by the General assembly of the CCM to ensure the monitoring of the interventions of the Global fund.

In the decision making process, the Technical secretariat generally meets twice a month, prepares all technical and administrative dossiers and forwards them to the CCM bureau. The latter meets on the first Wednesday of each month and decides which actions have to be taken and submits the dossiers to the General Assembly for analysis and/or approbation, depending on the subject matter.

4 meetings of the General assembly, 11 meetings of the Bureau, 22 meetings of the Technical Secretariat and 5 meetings of the technical Commissions have been held in the course of the year 2004. In the first quarter of 2005, one meeting of the General assembly has been held, as well as 3 meetings of the Bureau, 3 meetings of the Technical Secretariat and 5 meetings of the technical Commissions.

Decisions are made by consensus or by a majority of votes. The CCM members are regularly notified of the activities of the CCM and contacts with the Global Fund, essentially by e-mails and during the meetings.

3.2 Sub-national CCM

Table 3.2 – Sub-National CCM: Basic Information

Name of sub-national CCM	Date of Composition
N/A	

3.2.1 Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) *(2 paragraphs)* .*[For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]*

N/A

3.2.2 Explain why a Sub-National CCM has been chosen *[1 paragraph].*

N/A

3.2.3* Describe how this proposal is consistent with and complements national strategies and/or the National CCM plans e *[1 paragraph].

N/A

3.3 Regional coordinating mechanism (including Small Island Developing States)

Table 3.3 – National CCM: Basic Information

Name of Regional CCM	Date of Composition

2.1 Executive Summary

N/A

3.3.1 Explain why a Regional Coordinating Mechanism has been chosen *[1 paragraph]*.

N/A

3.3.2 Describe how this proposal is consistent with and complements national strategies and/or the Regional Coordinating Mechanism plans. Provide details of how it would achieve results that would not be possible with national approaches only. *[1 paragraph]*.

N/A

3.4 Regional Organizations

Table 3.4 – Regional Organization: Basic Information

Name of Regional Organization
N/A

3.2.3 Rationale

Describe how this regional proposal complements the national plans of each country involved and how it would achieve results that would not be possible with national approaches only.

N/A

3.3 Non-Country Coordinating Mechanism

Table 3.5 – Non-CCM Applicant: Basic Information

Name of Non-CCM applicant
N/A

2.1 Executive Summary

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

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

3.3.4 Rationale for applying outside an existing CCM

Non-CCM proposals are not eligible unless they satisfactorily explain that they originate from one of the following:

1. *Countries without legitimate governments;*
2. *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*
3. *Countries that suppress or have not established partnerships with civil society and NGOs..*

3.3.4.1 Describe which of the above conditions apply to this proposal (*3–4 paragraphs)*.

N/A

3.3.4.2 Describe any attempts to contact the CCM and provide documentary evidence as an appendix *(2 paragraphs)*.

N/A

3.3.5 Non-CCM proposals from countries in which no CCM exists

[Describe how the proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy) (3–4 paragraphs). Provide evidence (e.g., letters of support) from relevant national authorities in an appendix.]

N/A

2.1 Executive Summary

3.3.6 ***All non-CCM proposals should include as appendices additional documentation describing the organization, such as:***

- *statutes of organization (official registration papers);*
- *a summary of the organization, including background and history, scope of work, past and current activities;*
- *reference letter(s);*
- *main sources of funding.*

3.4 Proposal Endorsement and Membership Section

3.4.3 Representation

Table 3.6.1 – National/Sub-National/Regional (C) CM Leadership Information
(not applicable to Non-CCM and Regional Organization applications)

	President	Vice-president
Name	Emile BONGELI YEIKELO YA ATO	SIDIKI COULIBALY
Title :	Health minister	UNFPA Representative in DRC
Postal address	B.P 3088 KIN 1	
Telephone	+ 243 98911240	+ 243 81,994 72 92
Fax		
e-mail address	bongelien@yahoo.fr	Sidiki.coulibaly@undp.org; sidiki@unfpa.org

3.4.4 Contact information

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

Table 3.6.2 – Non-CCM Applicants and Regional Organizations: contact information
(not applicable to National/Sub-National/Regional (C)CM applications)

	Primary contact	Secondary contact
Name		
Title :		
Organization	N/A	
Postal address		
Telephone		
Fax		
e-mail address		

3.4.5 Membership information

[Applicable to submissions from National/Sub-National/Regional (C)CMs. Not applicable to Non-CCM Applicants and Regional Organization applications. One of the tables below must be completed for each national/Sub-National/Regional (C)CM member.]
[To be eligible for funding National/Sub-National/Regional (C)CMs must demonstrate evidence of membership of people living with and /or affected by the diseases.]

Table 3.6.3 – National/Sub-National/Regional (C)CM Member Information

National/Sub-National/Regional (C)CM member details			
Member 1			
Agency/organization	MINISTRY OF PLANNING	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Mbalq Sungu	Member of the CCM since	27 – FEV – 2002
Title in agency	Head of the health division	Fax	
e-mail address	mbalasungu@yahoo.fr	Telephone	+ 243 81,518 6019
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member and recording secretary of the follow-up - assessment commission of the CCM	Postal address	
Member 2			
Agency/organization	FINANCE MINISTRY	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people*	Government	Sector represented	GOVERNMENT

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Mr. Benoît Mutambay	Member of the CCM since	26 – NOV – 2004
Title in agency	Researcher	Fax	00 243 33 232
e-mail address	benoîtkkmut@yahoo.fr	Telephone	+ 243 99 44 350
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the monitoring and evaluation committee, technical support in removing the taxes on goods specifically destined for use in Malaria control.	Postal address	
Member 3			
Agency/organization	DRC ARMED FORCES	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Tchala Muaku	Member of the CCM since	27 – FEV – 2002
Title in agency	Technical Director of the Medical Department	Fax	
e-mail address	dotchafely@yahoo.fr	Telephone	+ 243 98,313 366
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 4			
Agency/organization	NATIONAL POLICE	Web site	

Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Joe Kamanga	Member of the CCM since	27 – FEV – 2002
Title in agency	Cmd 2nd Medical service	Fax	
e-mail address	Joe_kamanga@yahoo.fr	Telephone	+ 243 81,504 186
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 5			
Agency/organization	UNDP	Web site	www.undp.org
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	UN Agency	Sector represented	Multilateral Development Partner
Name of representative	Mr. Roberto Garcia	Member of the CCM since	JAN – 2005
Title in agency	Principal Coordinator of the PNUD / FM	Fax	
e-mail address	Roberto.garcia@undp.org	Telephone	+ 243 81 961 24 91
Main role in the Coordinating Mechanism and the proposal development	Member, Implementation Coordinator of the three financed components.	Postal address	

(proposal preparation, technical input, component coordinator, financial input, review, other)			
Member 6			
Agency/organization	WHO	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	UN Agency	Sector represented	Multilateral Development Partner
Name of representative	Mr. Léonard Tapsoba	Member of the CCM since	27 – FEV – 2002
Title in agency	RESIDENT REPRESENTATIVE	Fax	
e-mail address	tapsobal@cd.afro.who.int	Telephone	+ 243 81 700 64 00
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the CCM, Technical support	Postal address	
Member 7			
Agency/organization	UNAIDS	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	UN Agency	Sector represented	Multilateral Development Partner
Name of representative	Mr. Pierre Somse	Member of the CCM since	27 – FEV – 2002

2.1 Executive Summary

Title in agency	Coordinator	Fax	
e-mail address	Somse.pierre@undp.org	Telephone	+ 24381 882 36 17
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Technical support in the preparation of the proposal	Postal address	
Member 8			
Agency/organization	UNICEF	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	UN Agency	Sector represented	Multilateral Development Partner
Name of representative	Anthony Bloomberg	Member of the CCM since	27 – FEV – 2002
Title in agency	RESIDENT REPRESENTATIVE	Fax	
e-mail address	abloomberg@unicef.org	Telephone	+ 243 81,880 1815
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 9			
Agency/organization	EUROPEAN COMMISSION	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people*	Bilateral Donor	Sector represented	Multilateral and Bilateral Development Partners

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Ms. Nancy Vanhaverbeke - Merckx	Member of the CCM since	27 – FEV – 2002
Title in agency	Head of the health department	Fax	+ 873 762 067 591
e-mail address	nancy.vanhaverbe-merckx@cec.eu.int	Telephone	+ 243 81894 6702
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	4th Vice – President	Postal address	B.P. 2699 KINSHASA
Member 10			
Agency/organization	USAID	Web site	www.usaid.gov/cg
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Bilateral Development Partner
Name of representative	Mr. Robert G. Hellyer	Member of the CCM since	27-Fev-2002
Title in agency	Director of USAID	Fax	00 243 880 32 74
e-mail address		Telephone	+ 243 81 700 7194 + 243 81 700 7194
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)* **Name of representative**	2nd Vice – President Mr. Robert G. Hellyer	Postal address Member of the CCM since	USAID/Kinshasa Unit31550, APO AE 09828-1550 27-Fev-2002
Member 11			
Agency/organization	G T Z	Web site	

2.1 Executive Summary

Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Bilateral Development Partner
Name of representative	Mr.Eric Verschueren	Member of the CCM since	2004
Title in agency	Principal Technical Advisor	Fax	
e-mail address	Eric.verschueren@gtz.de	Telephone	+ 243 98 229 555
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the pilot committee, Support to the functioning of the CCM and organization of the application process	Postal address	
Member 12			
Agency/organization	C D C	Web site	www.cdc.gov/nchctp/od/gap
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Bilateral Development Partner
Name of representative	Ms Karen Hawkins Reed	Member of the CCM since	2004
Title in agency	Chief of party	Fax	1-413 – 376 – 0619
e-mail address	khawkins@cdcrdc.org	Telephone	+ 243 817004029
Main role in the Coordinating Mechanism and the proposal development	Member, technical support to CCM activities	Postal address	

(Proposal preparation, technical input, component coordinator, financial input, review, other)			
Member 13			
Agency/Organization	BELGIAN EMBASSY	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Multilateral and Bilateral Development Partners
Name of representative	Mr. Fraipont Flory	Member of the CCM since	
Title in agency		Fax	
e-mail address	flory.fraipont@btcctb.org	Telephone	+ 243 987 0955
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	B.P. 899 KIN 1
Member 14			
Agency/organization	FRENCH EMBASSY	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Bilateral Development Partner
Name of representative	Mr. Pierre Laye	Member of the CCM since	27 – FEV – 2002
Title in agency	Health chief	Fax	

e-mail address	Pierre.laye@diplomatie.gouv.fr	Telephone	+ 243 81 700 57 28
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 15			
Agency/organization	DAMIEN FOUNDATION	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	NGOs/Community-Based Organizations
Name of representative	Mr. Pamphile Lumbamba	Member of the CCM since	27 – FEV – 2002
Title in agency	Medical Director and Representative	Fax	
e-mail address	plubamba@ic.cd	Telephone	+ 243 81 81 81 39389
	Member, technical support in setting up the tuberculosis component	Postal address	
Member 16			
Agency/Organization	CNOS	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	NGOS/Community-Based Organisations
Name of representative	Mr. Nestor Mukinay	Member of the CCM	27 – FEV – 2002

		since	
Title in agency	National President	Fax	
e-mail address	cnosrdc@yahoo.fr	Telephone	+ 243 81,517 36 24
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	3rd Vice President	Postal address	B.P. 15205 KINSHASA 1
Member 17			
Agency/organization	FORUM AIDS	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO/Community-Based Organisations	Sector represented	NGOs/Community-Based Organisations
Name of representative	Mr. Georges Engwanda	Member of the CCM since	27 – FEV – 2002
Title in agency	Vice – President	Fax	
e-mail address	georgesengwanda@yahoo.fr	Telephone	+ 243 98 244 608
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 18			
Agency/organization	L N A C	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people*	NGO/Community-Based Organisations	Sector represented	NGOs/Community-Based Organisations

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Mme Ghislaine Tshitenge	Member of the CCM since	27 – FEV – 2002
Title in agency	Administrator	Fax	
e-mail address	ghilsmabel@yahoo.fr	Telephone	+ 243 81 4526317
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 19			
Agency/organization	RCP +	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	NGOs/Community-Based Organisations
Name of representative	Mr. Aimé Mambu Mpaka	Member of the CCM since	27 – FEV – 2002
Title in agency	2nd Vice President	Fax	
e-mail address	apamazoa@yahoo.fr	Telephone	+ 243 81 700 57 28
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 20			
Agency/organization	FEDERATION DES ENTREPRISES DU CONGO F E C	Web site	

Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	PRIVATE SECTOR	Sector represented	PRIVATE SECTOR
Name of representative	Mr. Marc Atibu Saleh	Member of the CCM since	27 – FEV – 2002
Title in agency	Director	Fax	
e-mail address	marcatibu@yahoo.fr	Telephone	+ 243 98 114 372
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 21			
Agency/organization	A N E P	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Luzaza Ndongo	Member of the CCM since	27 – FEV – 2002
Title in agency	Focal Point / AIDS	Fax	
e-mail address	yazadongo@hotmail.com	Telephone	+ 243 81 517 10 42
Main role in the Coordinating Mechanism and the proposal development	Member	Postal address	

(Proposal preparation, technical input, component coordinator, financial input, review, other)			
Member 22			
Agency/organization	PUBLIC HEALTH SCHOOL	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERMENT
Name of representative	Prof Munyanga	Member of the CCM since	27 – FEV – 2002
Title in agency	Director	Fax	
e-mail address	munyangam@yahoo.fr	Telephone	+ 243 99 42798
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 23			
Agency/organization	CATHOLIC CHURCH	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Religious confession	Sector represented	Religious/faith-based organization
Name of representative	Mr. Zacharie Beya	Member of the CCM since	27 – FEV – 2002
Title in agency	Assistant General secretary	Fax	

e-mail address	conf.episc.rdc@ic.cd	Telephone	+ 243 81 518 6019
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 24			
Agency/organization	EGLISE DU CHRIST AU CONGO	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Religious Confession	Sector represented	Religious/faith-based organization
Name of representative	Mr. Roger Bokandenga	Member of the CCM since	27 – FEV – 2002
Title in agency	Project Coordinator AIDS/Urban Synod	Fax	00 243 88 387 – 12 34 961
e-mail address	bokandenga@yahoo.fr	Telephone	+ 243 81,520 27 35
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 25			
Agency/Organization	KIMBANGUSITE CHURCH	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people*	Religious Confession	Sector represented	Religious/faith-based organization

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Mr. Jean Paul Divengi	Member of the CCM since	27 – FEV – 2002
Title in agency	President of the Commission for the struggle against the disease	Fax	
e-mail address	jpdnzambi@yahoo.fr	Telephone	+ 243 81812 84 8
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 26			
Agency/organization	MUSLIM COMMUNITY	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Religious Confession	Sector represented	Religious/faith-based organization
Name of representative	Mr. Gamal Sheih Lumumba Bin Ramazani	Member of the CCM since	27 – FEV – 2002
Title in agency	President	Fax	
e-mail address	islamrdc@yahoo.fr	Telephone	+ 243 99,540 79
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 27			
Agency/organization	SALVATION ARMY	Web site	
Type	Religious Confession	Sector	

(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	Religious/faith-based organization
Name of representative	Mr. David Nku Imbie	Member of the CCM since	17 NOV – 2004
Title in agency	Medical director and doctor	Fax	
e-mail address	davidnku@salvos.com	Telephone	+ 243 99 28 511
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical support to the CCM	Postal address	
Member 28			
Agency/Organization	BOARD OF THE EGLISES DE REVEIL	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Religious Confession	Sector represented	Religious/faith-based organization
Name of representative	Mr. Kankienza Mwana Mbo	Member of the CCM since	27 – FEV – 2002
Title in agency	National President	Fax	
e-mail address	lemire@yahoo.fr	Telephone	+ 243 99 81 274
Main role in the Coordinating Mechanism and the proposal development	Member	Postal address	

(Proposal preparation, technical input, component coordinator, financial input, review, other)			
Member 29			
Agency/Organization	INTER-UNION	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	non governmental organisation	Sector represented	non governmental organisation
Name of representative	Mr. Kibiswa	Member of the CCM since	27 – FEV – 2002
Title in agency	President	Fax	
e-mail address	naupesskib@yahoo.fr	Telephone	+ 243 81,508 41 52
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	
Member 30			
Agency/Organization	RESEARCH AND PLANNING DEPARTMENT/ MINISTRY OF HEALTH	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Jacques Wangata	Member of the CCM since	27 – FEV – 2002

2.1 Executive Summary

Title in agency	Director	Fax	
e-mail address	bepsante@ic.cd	Telephone	+ 243 81,700 54 63
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Coordinator for the technical secretariat, coordinator for the drawing up of the proposal.	Postal address	
Member 31			
Agency/Organization	P N M LS	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Baudouin Matela	Member of the CCM since	OCTOBRE – 2004
Title in agency	National coordinator	Fax	
e-mail address	baudouinmatela@yahoo.fr	Telephone	+ 243 99 52 16 1
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the technical secretariat	Postal address	
Member 32			
Agency/Organization	N P M C	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people*	GOVERNMENT	Sector represented	GOVERNMENT

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Mr. Benjamin Atua	Member of the CCM since	30 – DEC – 2003
Title in agency	Director	Fax	
e-mail address	amatindii@yahoo.fr	Telephone	+ 243 98 21 72 43
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat	Postal address	
Member 33			
Agency/Organization	N T P	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Etienne Bahati	Member of the CCM since	27 – FEV – 2002
Title in agency	Director	Fax	
e-mail address	Pnt-rdc@ic.cd	Telephone	+ 243 98 226 617
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the technical secretariat, technical support for the development of the Tuberculosis component	Postal address	
Member 34			
Agency/organization	TASK FORCE AIDS	Web site	

2.1 Executive Summary

Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	UN Agency	Sector represented	Multilateral Development Partner
Name of representative	Mr. Pascal Milenge	Member of the CCM since	27 – FEV – 2002
Title in agency	NPO H I V	Fax	
e-mail address	Milengep@cd.afro.who.int	Telephone	+ 243 81 700 64 00
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the technical secretariat and president of the monitoring and evaluation committee	Postal address	
Member 35			
Agency/Organization	TASK FORCE MALARIA	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Donor	Sector represented	Bilateral Development Partner
Name of representative	Mr. Willy KABUYA	Member of the CCM since	27 – FEV – 2002
Title in agency	Coordinator	Fax	
	wkabuya@msh.com	Telephone	+ 243 98 160 862
Main role in the Coordinating Mechanism and the proposal development	Member of the Technical Secretariat	Postal address	

(Proposal preparation, technical input, component coordinator, financial input, review, other)			
Member 36			
Agency/Organization	NATIONAL AIDS CONTROL PROGRAM	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	GOVERNMENT	Sector represented	GOVERNMENT
Name of representative	Mr. Jack KOKOLOMAMI	Member of the CCM since	27 – FEV – 2002
Title in agency	Director	Fax	
e-mail address	Pajack70@yahoo.fr	Telephone	+ 243 9956118
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member of the Technical Secretariat	Postal address	
Member 37			
Agency/organization	TASK FORCE TUBERCOLOSIS	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	GOVERNMENT
Name of representative	Mr. Gérard Kaboto	Member of the CCM since	27 – FEV – 2002
Title in agency	Project Director	Fax	
e-mail address		Telephone	243 99 44 886
Main role in the	Member of the Technical	Postal	

Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Secretariat	address	
Member 38			
Agency/organization	CLUB AMIS DE DAMIEN	Web site	
Type *(academic/educational sector; government; non governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	non governmental organisation
Name of representative	Mr. Maxime Lunga Nsumbu	Member of the CCM since	10 – MAI - 2005
Title in agency	President	Fax	
e-mail address	Cad_rdc@yahoo.fr	Telephone	+ 243 81,519 0 773
Main role in the Coordinating Mechanism and the proposal development *(Proposal preparation, technical input, component coordinator, financial input, review, other)*	Member	Postal address	

3.6.4. National/Sub-National/Regional (C)CM Endorsement of Proposal

[[[Please note: The entire proposal, including the signature page, must be received by the Global Fund Secretariat before the deadline for submitting proposals. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an appendix to this proposal.]

PROPOSAL TITLE: SUPPORT FOR STRENGTHENING AND EXTENSION OF THE FIGHT AGAINST AIDS, TUBERCULOSIS AND MALARIA IN DRC

"We, the undersigned, hereby certify that we have participated in the proposal development process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. If the proposal is approved we further pledge to continue our involvement in the Coordinating Mechanism during its implementation."

Table 3.6.4 – National/Sub-national /Regional (C)CM Endorsement

Agency/organization	Name of representative	Title :	Date	Signature
MINISTRY OF HEALTH	Mr. Emile Bongeli Yeikelo Ya Ato	Minister		
UNFPA	Mr. Sidiki Coulibaly	Resident Representative in DRC		
MINISTRY OF PLAN	Mr. Mbala Sungu	Head of the health division		

FINANCE MINISTRY	Mr. Benoît Mutambay	Chargé d'Etudes		
DRC ARMED FORCES	Mr. Tchala Muaku	Technical Director of the Medical Department		
NATIONAL POLICE	Mr. Joe Kamanga	Cdt 2nd Medical service		
UNDP	Mr. Roberto Garcia	Principal GF Coordinator		
WHO	Mr. Léonard Tapsoba	Resident Representative in DRC		
UNAIDS	Mr. Pierre Somse	Coordinator		
UNICEF	Mr. Anthony Bloomberg	Resident Representative in DRC		
EUROPEAN COMMISSION	Ms. Nancy Vanhaverbeke Merckx	Head of the health department		
USAID	Mr. Robert G. Hellyer	Director of USAID		
G T Z	Dr. Eric Verschueren	Technical Consultant Principal		
CDC	Ms. Karen Hawkinds Reed	Chief of party		
BELGIUM AMBASSY	Mr. Fraipont Flory	Officer in charge of the International Service		
French Embassy	Mr. Pierre Laye	Cooperation Associate		
DAMIEN FOUNDATION	Mr. Pamphile Lubamba	Medical Director and Representative		
CNOS	Mr Nestor . Mukinay	National President		
FORUM AIDS	Mr. Georges Engwanda	Vice President		
LNAC	Mme Ghislaine Tshitenge	Administrator		
RCP +	Mr. Aimé Mambu Mpaka	2nd Vice President		

FEDERATION DES ENTREPRISES DU CONGO	Mr. Marc Atibu Saleh	Director		
A N E P	Mr. Luzaza Ndongo	Focal Point / AIDS		
PUBLIC HEALTH SCHOOL	Mr. Munyanga	Director		
CATHOLIC CHURCH	Mr. Zacharie Beya	Assistant General secretary		
EGLISE DU CHRIST IN CONGO	Mr. Roger Bokandenga	Coordinator AIDS/Synode Urb.		
KIMBANGUISTE CHURCH	Mr. Jean Paul Divengi	President of the CKLM		
MUSLIM COMMUNITY	Mr. Gamal Sheih Lumumba	President		

SALVATION ARMY	Mr. David Nku	MEDICAL DOCTOR AND DIRECTOR		
BOARD OF THE EGLISES DE REVEIL	Mr. Kankienza Mwana Mboo	President		
INTER-UNION	Mr. Kibiswa	President		
DEPARTMENT OF STUDIES AND PLANIFICATION	Mr. Jacques Wangata	Director		
NATIONAL PROGRAM FOR AIDS CONTROL	Mr. Baudouin Matela	National Coordinator		
NATIONAL PROGRAM FOR THE STRUGGLE AGAINST MALARIA (NPMC)	Mr. Benjamin Atua	Director		
NATIONAL PROGRAM FOR THE STRUGGLE AGAINST TUBERCULOSIS (N P T)	Mr. Etienne Bahati	Director		
NATIONAL PROGRAM FOR AIDS CONTROL	Mr. Jack Kokolomami	Director		
TASK FORCE AIDS	Mr. Pascal Milenge	NPO HIV		
TASK FORCE MALARIA	Mr. Willy Kabuya	Coordinator		
TASK FORCE T B C	Mr. Gerard Kaboto	Project Director		
CLUB AMIS DE DAMIEN	Mr. Maxime Lunga Nsumbu	President		

Table 3.6.4 – National/Sub-national /Regional (C)CM Endorsement

3.6.5 CCM Endorsement Details for Applications from Regional Organizations:

[Regional Organizations must receive the agreement of the full CCM membership of each country in which they wish to work.]

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

Table 3.6.5 – Regional Organization Endorsement

Names of CCM	Country	Attachment number
	N/A	

4 Components section

4.1. Identify the Component Addressed in this Section

☐ HIV/AIDS[3]
☒ Tuberculosis[4]
☐ Health systems strengthening

4.1.1. Indicate the Estimated Start Date and Duration of the Component

[Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the proposal form), as well as the fact that generally funds are not made available for a minimum of two months following Board approval. Approved proposals must have a start date within 12 months of proposal approval.]

Table 4.1.1 – Proposal Start Time and Duration

	From	To
Month and year:	**JANUARY 2006**	**DECEMBER 2010**

4.2. Contact Persons for Questions Regarding this Component

[Please provide full contact details for two people; this is necessary to ensure fast and responsive communication. These contacts need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr Jacques WANGATA	Dr Etienne BAHATI
Title :	DIRECTOR	DIRECTOR
Organization	RESEARCH AND PLANNING DEPARTMENT (SPD)	NATIONAL PROGRAM FOR THE STRUGGLE AGAINST TUBERCULOSIS (N T P)
Postal address		
Telephone	243 99 217 59	243 98 22 6617
Fax		
e-mail address	Wangata2@yahoo.fr	Pnt-rdc@ic.cd

[3] **In cases where HIV/AIDS is the main vector of the tuberculosis epidemic, HIV/AIDS 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/***.

[4] **In cases where HIV/AIDS is the main vector of the tuberculosis epidemic, HIV/AIDS 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/***.

4.3. National Program Context and Gap Analysis for this Component

[The context in which proposed interventions will be implemented provides the basis for reviewing this proposal. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies, broader development frameworks, and resource availability and gaps needs to be clearly documented.]

4.3.1. Epidemiological and Disease-Specific Background

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

An estimation made by the WHO reveals that, in 2003, the annual incidence of TPM+ in DRC was of 160 cases for 100 000 inhabitants. The RDC is one of the 22 countries in the world where TB infection is the highest. The RDC is ranked 5th in Africa and 11th in the world (Global Tuberculosis Control, WHO/HTM/TB/2005.349). The number of TPM+ cases reported by the government has been constantly increasing since 1987. The number of new TPM+ cases has risen from 15 000 in 1987 to 62 519 in 2004. This increase is partly due to the HIV infection whose mean prevalence is of 4.5% (NPAC, 2003) which means that the RDC is one of the countries in which there is a widespread HIV epidemic. The prevalence of HIV infection in tuberculosis patients is of the order of 30 % (45% in the pilot Project TB-VIH of Kinshasa, 2004; and 17% in the UNC or the same period). In DRC, there is an estimated 36 000 deaths due to TB each year, in which 28% is attributable to HIV (Corbett et al. 2003). The WHO estimates that the DRC is ranked 8th among the countries which have the heaviest burden of TB/HIV co-infectants (WHO/CDS/TB/2002.311). The greatest number of TB cases is reported in big cities. In Kinshasa alone there are a reported 20% of all the TB cases in the country (See Appendix TB-02). More than 85 % of the new infectious cases are reported in the 15 to 54 age group, with predominance in the male population. Active adults are therefore the most affected by TB.

Even with the difficult political, economic and social contexts which have prevailed since 1990 (civil war and insecurity), the NTP has had some good results in the struggle against TB thanks to the high level of decentralization of the program, its integration in the primary health care, the support of traditional partners and to the stability of our staff at the central and intermediary levels. The number of positive reported smears has risen from 42 cases out of 100 000 in 1987 to 98 cases out of 100 000 in 2003, compared to the 160 cases expected by the WHO. The rate of detection of new TPM+ patients has risen to 28 % in 1987 to 70 % in 2004. The results obtained in the treatment of new cases of TPM+ show that the rate of success has risen from 26 % in 1996 (year of introduction of the short schemes) to 81 % in 2004, while the number of drop outs has decreased to 6 % for the same period (source: NTP report - 2004, not published). These results vary from one area to another. Low coverage and insecure zones as the Ituri region show low performances which reduce the national mean. Detection is low in certain provinces where social stigmas and false beliefs persist. Drop out rates amongst TPM+ patients is around 46% in Ituri where there is a high risk of the development of resistance due to interruption in treatment and population movements. In 2003, the WHO estimated that the prevalence of multi-drug resistant patients amongst new cases was around 1.5% (Global Tuberculosis Control, WHO/HTM/TB/2005.349).

Since 2004, the PNT has chosen a 6 month treatment scheme for the new cases and an 8 month scheme for re-treatment cases. The medications chosen are :

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

The support of the GDF which has been granted to the Congolese government since 2002 to cover one third of the need for anti-tuberculosis medicines, will end at the beginning of 2006. One of the purposes of the present proposal is to ensure procurement of anti-tuberculosis

medicines for the coming years.
Concerning the resistance to anti-tuberculosis drugs, a 1998 Kinshasa survey showed that multi-drug resistance in patients who have never received treatment is of the order of 2.2 % while 22.9 % was found in TB treated cases.

The scheme of treatment for multi-drug resistant TB has been standardized by the program since 2004, in accordance to the guidelines of the WHO and Green Light Committee. The Ministry of Health has applied for an accreditation for the latter. The chosen schemes are as follows :

- Intensive phase: 6 month of K.O.Pr.Z.E.
- Continuation phase: 18 months of Pr.O.Z

In the case of TB co-infectants, the following treatment schemes, proposed by the NPAC has also been adopted by the NTP:

- For the 1st line (patients under anti-tuberculosis medicines with Rifampicine): d4T + 3TC +EFV

In the event of neuropathies, the d4T may be replaced by AZT.

- For the 2nd line : ABC + ddl + LPV/r

4.3.2. Health Systems, Disease-Control Initiatives and Broader Development Frameworks

[Proposals to the Global Fund should be developed based on a comprehensive review of the capacity of health systems, 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.]

a) Describe the (national) health system, including both the public and private sectors, as relevant to fighting the disease in question.

The DRC was one of the first African countries to apply the Alma Ata resolutions (1978) and to adopt the strategy of Primary Health Care. At an administrative level, the country is divided into 11 provinces. From a sanitary point of view, as from 1985, the country has been subdivided into 306 health zones (equivalent to the sanitary district of the WHO), and is now subdivided into 515 zones, most of which are functional.
The health zone is the operational unit of the whole health system. It cares for about 100 000 inhabitants in rural zones and 200 000 to 300 000 in urban areas. It is consisted of a General referral Hospital (GRH) and from 10 to 20 health centers (HC). The area covered by each health center has a diameter of 5 to 8 km.
The community, organized in development committees of each health zone, is involved in the functioning of the system. Recovery of cost from the community is low (about 15%) and does not allow self-financing of the health structures. The health centers belong to the state, to religious-based organizations, to private and public enterprises as well as individuals. These centers, however, provide health care to the whole population without distinction. The private structures are profit making businesses.

In the case of the struggle against TB, the program is based on the primary health model, that is, it is organized at three levels, each with a specific role:

The central level has a normative role of planning, resource mobilization, plea and coordination of the fight in the whole country.

The intermediary level, represented by the provincial coordinations which provide technical support and coordination for the activities of the struggle against TB in the health zones. A TB coordination is a state structure linked with the struggle against Leprosy in DRC. It is called TB Leprosy coordination. It is made up of around 20 to 30 Health Zones.

The peripheral level is constituted of Health Zones (HZ) which consist of health centers, some of which have integrated the screening and the treatment of tuberculosis named HCDT. Each HZ possesses around two HCDT. The HCDT is the operational level where the guidelines on health care for tuberculosis patients is applied.

Health care in the HCDT is organized into two levels:

❖ The first level is a network of health centers which aims at providing the general

population a minimal activity package (MAP) related to providing health care to tuberculosis patients with the participation of the community;

❖ The second level is the General Hospital (GH) which offers an additional package of referral health care (APC).

The two levels are related to each other by a referring and counter-referring system.

Some private health centers care for TB patients for diagnosis and treatment as for example public and Para governmental companies. All the other centers direct the suspected TB cases to the HCDT. The main reason is the shortfall in earnings for these profit making structures while under DRC law, free TB treatment is provided.

In 2005, the NTP operates with a central unit, the national TB bureau (NTB), a national referral laboratory (NRL), 20 provincial coordinations and 20 referral provincial laboratories. The latter cover all the Health Zones which have integrated the struggle against TB (515) and 991 diagnosis and treatment centers for TB treatment. A rural HCDT covers more than 2000 Km² and serves around 50 000 inhabitants while an urban HCDT is more condensed with a population varying between 50 000 to100 000 inhabitants.

Human Resources at the NTP:

The structure comprises two medical doctors, two pharmacists, six laboratory technicians, two administrators, three social workers. The External Revue has made strong recommendations to hire more staff considering the dimensions of the country and to improve field efficiency.

The intermediary level comprises in general one medical doctor, 2 lab technicians, 1 supervisor nurse, 1 administrator and 1 social worker.

At the level of the Health Zones, the central bureau is composed of, in general, one medical doctor who is also head of the zone, one administrator, one or two nurses and a social animator. There also exists at this level, a referral structure which is the General referral Hospital, headed by a director-doctor.

The HCDT is composed of 2 to 5 nurses, 1 or 2 lab technicians, apart from the General referral Hospital where there is more staff with at least one medical doctor.

The human resources of the public sector and of the faith-based organizations are paid by the government and in certain structures they even benefit of the motivation bonus awarded by some partners.

The staff of the private sector are paid by the owner.

In the context of community participation, the Health centers collaborate with the Community relays (at least 15 per HCDT).

For all of the activities, out of the 20 existing provincial coordinations, only 15 of them benefit from a financial support of the partners which are mostly international NGOs. This support enables them to cover functioning costs. However, 4 coordinations receive little support due to their vast dimensions and this does not allow for much support for the stakeholders.

All the partners gather around the Program in the tuberculosis Task Force which provides a framework for dialogue and harmonisation of the interventions in the fight against Tuberculosis in DRC.

(Appendix TB-04 : partners)

The Health Information System (HINS) in DRC.

The HINS exists in all health structures. Information is collected at the operational level of the activity, that is the HC in the HZ by the tools set up: patient forms, registers, report forms. This information is centralized each month in the HZ and forwarded, every three months, to the provincial district. In the monitoring of potentially epidemic diseases, epidemiological data on these diseases is transmitted once a week.

There is a specific rate of collection and transmission of information for specialized programs even though the data is registered daily. For Tuberculosis, data is collected quarterly and the data is collected at the level of the HCDT on a form and sent to the Health zone where it is centralized and transmitted to the coordination which, in turn, centralize and analyze the data of the Health zones under its jurisdiction and send it to the national bureau.

The data is centralized at all levels by the HCDT, analyzed and a feedback is sent to the senders for use.

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

The main goal of this program is to reduce the morbidity and the mortality caused by TB by providing health care to 100 % of microscope-based diagnosed patients by increasing treatment success to 85 % and the rate of detection to 75 % of expected tuberculosis cases from microscopic analysis, by extending the DOTS strategy to 100 % of the population.

To this aim the NTP has as a general goal to provide health care, in priority, to infectious tuberculosis patients and to cure them. The specific goals of the NTP are the same as those of the WHO and the initiative Stop to Tuberculosis, namely:

- To increase detection of TPM+ cases to 75 % of expected patients until 2010 in DRC
- To increase treatment success rate to 85 % of treated cases in DRC
- To provide VSC services to all TB patients (691 484) and TARV to 82 995 expected eligible co-infected.
- To increase access to second line drugs for multi-drug-resistant TB patients from 200 to 7011.
- To reinforce advocacy, communication and social mobilisation in disease control.
- To enhance the capabilities and competence of the central unit of the NTP and health care providers at all levels.

And to reach these goals, the DOTS strategy was adopted in 1996. On the operational level, the elements of the strategy are applied in this manner :

1. <u>The political commitment</u> can be found in the creation of the NTP, by the fact that the government has provided infrastructures and human resources, the creation of the tuberculosis Task Force, tax exemptions and salaries.
2. <u>Quality controlled diagnosis under the microscope</u>
   The diagnosis is done by microscopic examination on the basis of direct Ziehl examinations. Regular quality control of these tests is done. The program financed by the Global Fund has allowed the DRC to improve the tools by providing microscopes to 800 HCDT in the first phase of the 2nd Round. 200 additional microscopes were also bought by the implementation partners during the same period. Besides providing training to 1240 lab technicians we also provided to 991 HCDT with the necessary reagents and small lab materials. With the present proposal, the PNT wishes to provide 554 HCDT with quality microscopes and anticipate the renewal of 150 microscopes, if the need arises, as well as small lab materials and equipments and reagents for 1545 HCDT.
   For TB co-infected patients, NPAC algorithms adapted according to the guidelines of the WHO have been developed and introduced in the program handbook (IATP-4).
3. <u>Short term treatment under direct supervision</u> :
   In the health centers patients are under DOT (directly observed treatment). During the first two months (intensive treatment phase) they visit the closest health center each day to take their tablets in front of the medical staff. In the continuation phase, they are given tablets for one week which they must swallow at home in front of a sponsor. Community DOTs are also held in the towns of Kinshasa and Matadi. The patient is supervised at home by members of the community (cured tuberculosis patients, family member or a community leader) to ensure that he takes his pills. Mechanisms are set up to bring drop outs back into the fold (bill book, sponsoring of the treatment, etc).
   Concerning multi-drug-resistant TB, standardized schemes have been chosen following the guidelines of the WHO and the Green Light Committee in this matter and written in the health care Guide with particular emphasis on the DOTS Plus strategy since 2004. An application for approval by the NTP at the said institution has been made and we are waiting for an answer.
4. <u>To provide continuous and regular</u> supply of drugs and laboratory furniture.
   The agreements with the GDF have allowed the country to procure first-line anti-tuberculosis medicines for 2/3 of the needs of the PNT since 2002, the other 1/3 has been provided by the other partners. This program with the GDF ends in 2006. Financial support obtained from the Global fund and the other partners has allowed the distribution of these drugs from the central level towards the health centers.

In the future, continuous advocacy towards the opinion leaders in the government will allow this funding to be continued. In the present proposal, the same implementation partners have agreed to provide one third of the need in drugs as in the past and to ensure the monitoring - evaluation for half of the activities.

5. The information system used in the program is in line with the WHO and the International Union Against Tuberculosis and Respiratory diseases (IUATLD) guidelines.
   Printing of this information media has been in part financed by the USAID and the Damien foundation. A software of databases has been elaborated thanks to the funding of the Global fund and has been placed at the national bureau and the coordinating provincial bureaus. It is now being tested.
   The components of the DOTS strategy mentioned above are implemented by the NTP with the help of our partners (Fondation Damien, TLMI/SP, ALM, USAID, UBS, and IUATLD).
   The support of the Global fund will also be used to strengthen the capabilities of the institutions and the competence of the service providers involved in the program. Training sessions have been organized for medical staff and community workers.

   Advocacy, Communication and Social Mobilization:
   Mobilization activities have allowed the involvement of the community. Appropriate messages have been diffused in the community and the social mobilization and communication capabilities of national and provincial stakeholders are being reinforced. In the context of Global fund support; messages to raise the awareness have been diffused on roadside billboards, in television and radio spots, in micro programs, in sketches, in posters and circulars as well as in the image boxes. The World Tuberculosis Day (WTD) has been celebrated and radio and television programs have been organized through all the coordinations with the participation of USAID and the other partners of the program.

   The activities of collaboration of TB-VIH:
   The collaboration between the NTP and NPAC programs is under way: the harmonization of the strategies and information media has been one of the results of the workshops held to this effect with the support of the WHO, UNC and CDC. Several initiatives for caring of co-infected patients are under way in several HZ across the country by the partners of the NTP and of the NPAC, including USAID, UNC/CDC, and WHO.
   The WHO, with funding from USAID, has started in 10 health centers and 3 Health zones in Kinshasa, the health care providing package for HIV in co-infected patients and foresees to extend this in 4 other towns, while the IUATLD, with the help of the European Commission and USAID, will start providing health care in two provinces.

   Monitoring and Evaluation
   NTP External Review
   From the 10th of February to the 25th, 2005, the PNT has been subject to an External Review by international (WHO, IUATLD, USAID, CDC) and national experts on the initiative of the Ministry of Health.
   The workgroup was composed of 12 international consultants and of 58 national consultants who have visited 7 provinces including 21 Health zones, 42 HCDT, 17 medical schools, 7 central departments and 14 NGOs.
   The WHO and the IUATLD are involved in the technical support to update the guidelines and evaluate the program.

   In appendix TB-05 can be found, the list of the appraisers as well as the recommendations of the External review.

   The support of the government consists in mobilizing the financial resources, to provide the NTP with the necessary infrastructures and human resources.

c) Describe the role of AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or sector-wide approaches. Outline any links to international initiatives such as the WHO/UNAIDS '3-by-5 Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

TB is a disease with strong links to poverty and which induces and/or worsens poverty. The loss of one day's work has major consequences on the family income and the country's productivity. TB causes the lost of three to four month's work and approximately 20 to 30% of the family income (WHO, 2000). TB affects the most productive layer of the DRC population. Indeed, more than 85% of tuberculosis patients are in the 15 to 54 age group. In a decayed political, social and economic context, where unemployment levels are high, most of the population survive by informal means.
By controlling this disease, the program contributes to the reduction of poverty as early screening and effective treatment is a social security and preventive measure: the patient can carry on with his daily life without contaminating people around him. The aim is to reverse the actual trend of the tuberculosis endemic by using as indicators the number of cases of death linked to TB and the proportion of TB cases detected and treated with the DOTS strategy. And this constitutes one of the development goals for the millennium. A cured patient can return to work and be productive for his family and his country; the transmission chain is broken.
In the context of the « Stop Tuberculosis » initiative the DRC has signed in the year 2000 the "Amsterdam Declaration" during the Ministerial conference of the 22 most affected countries. The goal of this initiative was to strengthen the political involvement of the governments and of the international community with the aim of mobilizing the necessary resources to more efficiently fight against Tuberculosis. The government has also signed agreements with the GDF for the supply of first line anti-tuberculosis drugs to the country which is then freely distributed to patients.

The government plans to give some of the funds mobilized in the Very Poor and Indebted countries (HIPC) to buy anti-tuberculosis drugs.
Each year, the NTP is monitored by the WHO and the IUATLD in the technical support field.
On the other hand, the General Health Secretary of the DRC has been invited to the administrative Board of the Partnership Halt to TB in May 2005 in Addis-Abeba which has validated the action plan for 2006-2007 (see Appendix TB 06, WHO press release).

4.3.3. Financial and Programmatic Gap Analysis

[Interventions included in the proposal should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionally should be described Use Table 4.3.3.a to provide in summarized form all the figures used in sections 4.3.3.1 to 4.3.3.3.]. [For health systems strengthening components the financial and programmatic gap analysis needs to provide information relevant to the proposed health systems strengthening intervention(s).]

4.3.3.1 Detail current and planned expenditures from all relevant sources, whether domestic, external or from debt relief, including previous grants from the Global Fund.

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources. Indicate duration and amount, and ensure that the amount for domestic sources is consistent with Table 1.1.1]

Following our 2001-2005 strategic plan which is being evaluated, the global budget is of the order of 42 000 000$, this sum has been covered by national as well as foreign contributions.
Concerning the national sources, the government has contributed a sum of 2 200 000$ and the European Union via the LNAC a sum of 455 000$ while the external sources are constituted by our implementation partners and dormant partners as follows:
Dormant partners :
- USAID: 3 000 000$

- DGCD/CTB: 3 117 500$ (Belgian cooperation)
- GDF: 4 200 000$
- GFTM: 6 410 000

Set up partners :
- Damien Foundation: 15 500 000$
- TLMI : 2 140 000$
- WHO : 1 010 000$
- ALTI : 200 000

The expenses for the 2006-2010 strategic plan are estimated at 112 570 288 dollars.
The sources of funding are the same but for the GDF the funding ends in 2006; out of this global sum, the budgets of our partners cover 25 552 860 dollars for the first three years, that is 22 % of the total budget; which leaves us with a gap of 87 017 428 dollars which has to be found. It is also to be noted that the introduction of the ARV and the VSC in our budget for co-infected tuberculosis patients is the rationale for the increase in the budget, given that the NPAC covers only 300 Health zones.

4.3.3.2 Provide an estimate of the costs of meeting overall (national) goals and objectives and provide information about how this costing has been developed (e.g., costed national strategies).

The external Review of the NTP which is being held in the month of February of this year, on the demand of the government of the DRC and under the coordination of the WHO has done a complete and independent analysis of all the aspects of the tuberculosis program of the DRC in the view of making the necessary recommendations for the improvement of the performance of the NTP.
After analysis of the different aspects of the program, the following objectives have been chosen amongst others :
1) Prepare specific recommendations to improve the performances of the NTP
2) Propose the main ideas of the development plan of the NTP for 2006-2010
This forum which had gathered all the partners of the NTP has allowed the evaluation the needs and to estimate the cost of the proposed improvements.
The opportunity given by the present proposition has also lead the CCM-RDC to organize a TB-VIH-Malaria workshop in the course of the month of may. This will give the opportunity for the NTP and its partners to refine their action plan and to harmonize with the other partners of the Ministry of Health.
Finally, it is noteworthy that the external expertise on advocacy, communication and social mobilization proposed by the Partnership Halt to TB that has helped us in this particular area to estimate our needs and set out our budget.

The rationale for the following estimations per goal can be found in Appendix TB-07
1°goal : Detection
- Reagents and consumables (slides, cuspidor, small materials) :
  Rationale for the calculation: a total of 9 126 164 examinations will be done during the next five years.
  The first year 1 149 984 samples to be examined in the health centers.
  (rationale : 864 000 examinations done in 2003),
  The increase rate is of the order of 10 % per annum. Provision has been made for 30% with an additional 15% for transportation costs. To this should be added the sum needed for quality control of 111 240 samples per annum. Examination cost per unit is estimated at 0.395$.
- Microscopes: the DOTS coverage makes provision for 1545 HCDT. Given that each HCDT must have at least one microscope, the existing project financed by the Global fund (2nd round) anticipates 800 microscopes to which should be added 200 microscopes of the other partners, the Gap being of 545 microscopes. The NTP proposes to have 154 microscopes in reserve to replace broken ones, which means that 699 microscopes should be provided. Unitary cost is 1250$.
- The TOP lamps: they will be bought for each microscope at 100$/ each for 699 units (it is a light source used to make microscope readings in the absence of electricity).

- 8 fluorescence microscopes will be bought: 6000$ /unit, transportation and spare parts included, for the large diagnosis centers in the country and the coordinations which have to ensure quality control.
- 8 microscopes for training for the new coordinations: 4000$/unit, transportation and spare parts included.
- Creation of 4 new coordinations: 250 000$/annum for the functioning of one coordination.
- Training: NTP staff will have access to national and international courses as well as advanced training periods and participation in international conferences. Average cost for an international course: 5000$/month and 130$ per day at the national level.
- Supervision : the national level organizes 5 types of visits (Medical doctors, Lab technicians, Administrator, Social worker) per quarter at the cost of 1800$ for 10 work days, transportation included. The coordinations organize 4 types of visits (Medical doctors, Lab technicians, Administrator, Social worker) to the HZ/HCDT for a daily cost of 40$. The Health zones organize a monthly visit to each HCDT for a daily cost of 10$. The vehicles and motorcycles will be bought for 13 coordinations and two motorcycles per coordination
- Technical assistance: an internal and external assistance is anticipated. The cost of the external assistance which comprises 15 days of field services and 5 days for report writing is evaluated at 10 300$. The internal assistance (national) is evaluated at 5 750$ for the same period of services.

2° goal : Treatment

- For five years 766 746 Cures for 691 484 TB patients. The number of patients is calculated from the data obtained in 2004 (10% increase for 2004 to estimate the number of cases for 2005) followed by an annual increase of 10% made by the experts of the external review of the NTP. The cost per cure is 17$ including national and international shipping. To this is added security provision for one year. The sum is 11 553 305$, one third of which will be supported by the traditional implementation partners.

- a technical assistance is anticipated in the same conditions as in goal 1

3° goal : TB-HIV

- VSC services will be integrated in all HCDT. The integration cost is supported by the NPAC in 300 HZ and the NTP in 215 HZ. In the same way, the 207 445 co-infected patients will be treated with cotrimoxazole and 11 445 will be put under ARV during their anti-tuberculosis cure, on the NPAC budget. The sum of 6 638 246$ budgetized by the NTP for the ARV of 8 299 patients is paid on the NPAC budget. Condoms will also be provided by the NPAC.
- But the NTP will have to intervene in the training of all the TB stakeholders for TB-HIV health care as it is well acquainted with the field and targets. We will have to train all the TB coordination teams and those of the health zones as well as all the nurses and lab technicians of the health centers. On the basis of the lengthy experience of the NTP, these trainings must be maintained as retraining programs to enable service providers to attain perfection in this new task and also as a stimulus for exchanging experiences.

4° goal : multi-drug-resistant TB

- for second line drugs 7 011 cures are anticipated starting from a 1.5% occurrence of MDR cases in tuberculosis patients with a positive microscopic examination. The cost of the cure is estimated at 615$. However the purchase will be done through the Green Light Committee when the program will be accredited.
- rehabilitation : the national reference Laboratory will be rehabilitated for 110 000$
- Consumables for the culture of mycobacteria and molecular biology tests for multi-drug resistance for 82 308$ per annum.

5° goal : Advocacy, Communication and social mobilization :

- creation of a secretariat Stop Tuberculosis (Stop TB RDC) : 10 000$ for the rehabilitation of the premises, 5 000$ for its equipment and 150 000$ functioning cost at 30 000$ per annum
- 135 press briefings anticipated for 5 years. At the central level 5 press briefings at 500 dollars per press briefing. At the provincial level 130 press briefings at 300$ per press briefing.

- 20 liaison bulletins published over five years at the cost of 24 600$ per bulletin.
- Tests, distribution and copying sessions for the new educational audiovisual media will be organized over 5 years: that is 3 tests at 3 000$ per test; 3 copies at 500$ per copy; 17 distributions at 5 000$ per distribution.
- Tests, copying and distribution sessions for revised educational audiovisual and script visual media will be organized over 5 years : that is 2 tests at 6 000$ per test ; 2 copies at 10 500$ per copy and 2 distributions at 7 000$ per distribution
- Sessions of copying and distribution of the social Mobilisation guide and of the training Module will be organized over 5 years : that is 3 sessions for the guide at 15 200$ per session and 3 sessions for the Module at 14 600$ per session
- Sessions of copying and distribution of guidelines for social mobilization will be organized over 5 years : that is 2 copies at 5 000$ per copy and 2 distributions at 2 600$ per distribution
- 10 awareness sessions for media professionals will be organized over five years at 9 780$ per session
- 19 advocacy visits will be organized over five years at 2 000$ per visit
- 5 ambassador-spokesmen networks for the partnership created for five years at 1000$ per network
- 5 World Tuberculosis Day (WTD) will be organized over 5 years at 2 500$ per coordination and 20 000$ for the central level.
- Purchase of 26 mobile units at the cost of 30 000$ per mobile unit (vehicles, speed boats or motorcycles…)
- 24 832 awareness sessions for the community leaders of the CBO will be organized over 5 years at 50$ per session
- 23 175 CBO organizers will be trained, equipped and motivated twice in 5 years at 151$ per organizer
- 6180 consultations and information exchanges in the HCDT on the control of TB/HIV co-infection will be organized during 4 years at 50$ per meeting
- 520 awareness sessions of specific groups by peer educators will be organized during 4 years at 100$ per session
- 432 consultation meetings between the traditional practitioners and communication and health professionals will be organized during 4 years at 100$ per meeting
- 1 social Mobilization action plan will be elaborated at the central level at a cost of 5900$ and 10 300$ for the external technical assistance (see next goal on the strengthening of the institutional capabilities for the elaboration workshop).
- 3 sessions for the training of teachers will be organized over 5 years at 34 290$ per session

6° goal: strengthening of the institutional capabilities and the skills of the human resources.

- The partnership meetings: 20 meetings planned at the rate of one meeting per quarter at a cost of 500$ per meeting.
- Workshops for the elaboration of several guides, educational media and modules: 28 workshops are anticipated over 5 years at a cost of 15 000$ per workshop. However, for the social mobilisation workshop the cost varies according to the number of participants (see table in appendix).
- Meetings for data validation: 11 535 meetings will be held. 10 300 at the level of the health zones for a cost of 50$ per meeting. At the district level 1 120 meetings with a supplementary 1000$ for the additional day. At the provincial level 130 meetings at a cost of 15 000$ per meeting and the national level 5 meetings at a cost of 50 000$ per meeting. For the members of the community 30 900 meetings anticipated at a cost of 50$ per meeting in each HCDT,
- 20 meetings of the task force anticipated at the national and provincial levels for a cost of 500$ per meeting. the same is true for the TB/HIV control committees
- For the Green Light Committee: 10 meetings will be held over the five years at 500$ per meeting.
- Payment to staff will be made by considering the efficiency of each and everyone with the signature of the performance contract. See Appendix TB-08: details on the NTP budget.
  that is a total of 36 234 565 dollars

4.3.3.3 Provide a calculation of the gaps between the estimated costs and current and planned expenditures.

Table 4.3.3 - Financial Contributions to National Response

	Financial contributions in Euro / US$						
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
National (A)							
External (B)			7 772 040	5 370 333	4 599 087	3 839 656	3 971 744
External source 1 USAID			875 000				
External source 2 WHO			300 000				
External source 3 DAMIEN FOUNDATION			3 290904	3 462 697	3 528 451	3 549 020	3 681 108
External source 4 UBS			140 425	113 125	185 225	144 625	161 425
External source 5 ALM			290 636	290 636	290 636	290 636	290 636
External source 6 DGCD/CTB			2 235 500	837 000			
External source 7 IUATLD / EU			780 000	780 000	780 000		
Total resources available (A+B)			7 772 040	5 370 333	4 599 087	3 839 656	3 971 744
Total need (C)			**25 325 652**	**23.900.946**	**20 622 812**	**21 682 359**	**21 038 520**
Unmet need (C) – (A+B)[			17553612	18530613	16023725	17842703	17066776

4.3.4 Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this is the case.

The NTP has been working for a number of years with the so-called traditional partners which are either implementation partners (Damien foundation, TLMI, ALM, ALTI, UBS, Sanru, faith-based NGOs, Solidarité Protestante, LNAC), or technical support partners (WHO, IUATLD, APEFE), or dormant partners (USAID, TBCTA, GDF, GF, CTB, EU). But the implementation partners are also the dormant partners of the coordinations they sponsor. The resources brought by these partners are not sufficient, in particular for the supply of drugs and laboratory materials. The funds awarded by the GF will complement these and help in improving coverage and performances of the program as well as to finance new initiatives which consist of providing health care for co-infection and multi-drug-resistances. Each traditional partner has guaranteed funding proposals for the 2006-2010 strategic plans. The guarantee of complementarity is based on the following :

- Each implementation partner has, for a number of years, a well defined sphere of action and a certain number of coordinations under their responsibility which has been decided at the TB forum. The budget propositions are drawn from the respective existing action plans of the provincial coordinations and of the central unit which has been elaborated and submitted to the said partners and approved by them, including the Damien Foundation (and the DGCD), the UBS, the CTB, amongst others..
- Our partners have participated in all the stages of the elaboration of the 2006-2010 strategic

plans as well as the present proposal.

- The NTP partners have never withdrawn from the country in spite of all the social tensions due to the war and the ensuing insecurity. That's why they are called " traditional partners."
- The partners also participate in the supervisions, monitoring and evaluation of the program.
- The partners have signed conventions with the Ministry of Health.

It is also to be noted that the traditional implementation partners in DRC have been working in the country, in the control of TB and leprosy, which still represent a public health concern, for over 30 years. They intend to meet the challenge of controlling these two epidemics on a humanitarian basis and they surely will not withdraw from this program now that they have additional support for their long term efforts.

The partners are involved in this proposition for the running (monitoring, evaluation, salaries) for half of the cost and for one third of the first line medicines.

4.4 Component Strategy

4.4.1 Description and justification of the program strategy

[This section must be supported by a summary of the Program Strategy section in tabular form.

- *Tables 4.4a and b (following section 4.4.1) are designed to help applicants clearly summarize the strategy and rationale behind this proposal. For definitions of the terms used in the tables, see Appendix A. (See Guidelines for Proposals, section V.B.2, for more information.)*
- *In addition, please also provide a detailed quarterly work plan for the first 12 months and an indicative work plan for the second year. These should be attached as an appendix to the proposal form.]*

Note: Narrative information in section 4.4.1 should refer to Tables 4.4a and 4.4b, but should not consist merely of a description of the tables.]

- *See Appendices TB-09 (Planning 01) and TB-10 (Planning 02-Moso)*

See also Appendix TB-03: strategic plan of the NTP-DRC 2006-2010

Table 4.4a. Goals and Impact Indicators over Life of Program

Goal n°	Goal over 5 years
1	Reduction of the morbidity and mortality burden due to TB and TB/HIV co-infection in the Congolese population from now to 2010.

Goal n°	Impact indicator	Baseline			Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Source and comments
		Value	Year	Source						
1a	Increase in the screening of TB patients with positive smears	**62 519 (70%)**	**2004**	**NTP**	**66 678 (72%)**	73%			**124 372 (75%)**	NTP report (Hypothesis: TPM+ frequency estimated at 160/100 000 (WHO, 2005), the improvement in the DOTS coverage will increase the rate of screening).
1b	Increase in the success rate of treatment of new TB patients with positive smears.	**81%**	**2004**	**NTP**	**83%**	84%			**85%**	NTP report.
1c	Reduction of the number of TB-related deaths in new TB cases with positive smears per year.	**3411 / 54 090 (7%)**	**2003).**	**NTP**	**6%**	6%			**< 5%**	NTP report.

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[Impact indicators are not normally measured every year, and values for targets do not need to be entered for every year. It is advisable to refer to the list of coverage indicators provided in Appendix A.]

Tableau 4.4b. Objectives, Service Delivery Areas and Coverage Indicators over Life of Program

Program objectives over five years		
Objective n°	**Objective description**	**Link to goal by number**
1	To increase detection of TPM+ cases to 75 % of expected patients until 2010 in DRC	1
2	To increase treatment success rate to 85 % of treated cases in DRC	1
3	To provide VSC services to all TB patients (691.484) and ARVT to the 207 445 expected co-infectants (mean value of 30% HIV seropositivity amongst TB patients).	1
4	To increase access to second line drugs for multi-drug resistant TB patients.	1
5	To strengthen the plea, communication and social mobilization in the control of TB and TB-HIV co-infection.	1
6	To enhance the capabilities and competence of the central unit of the NTP and health care providers at all levels.	1

Objective n°	Service delivery area	Directly tied	Indicator description[5]	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
				Value	Year						
1a	*Prevention (IP1)*	No	Number and % of new TB with positive smears recorded versus the number of expected cases per annum.	62519 cases (70%)	2004	72%	73%			75%	Per annum
1b		Yes	Number and % of people concerned by the CCC	NA	2004						2006 and 2010 surveys
2a	*Treatment (IT2)*	No	% of NC-TPM+ recorded among all TB forms	62519 cases (65%)	2004	65%	65%			65%	Per annum
2b		No	% of NC-TPM+ recorded versus the expected total	70%	2004	72%	73%			75%	Per annum
2c		No	Number and % of NC-TPM+ during a certain period which have been treated plus number of those who have finished their treatment (rate of success)	42734 cases (81%)	2004	82%	83%			85%	Per annum
2d		No	Number and percentage of recorded new positive TB smears under DOTS which are now at the end of the initial phase of treatment	93%	2004	95%	95%			95%	Per annum
3a	*The activities of collaboration of TB/VIH:*	No	Number of TB patients who benefit from counselling and voluntary HIV screening	NA	2004	50%	60%			90%	Per annum
3b		No	Number of recorded TB patients who are seropositive	NA	2004	45%	45%			45%	Per annum
3c		No	Number of seropositive TB patients who have started a TARV during or at the end of TB treatment	NA	2004	20%	20%			20%	Per annum

[5] Only the highest level indicators (Level 3: number of persons affected).

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Objective n°	Service delivery area	Directly tied	Indicator description[6]	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
3d	*The activities of collaboration of TB/VIH:*	*No*	Number of diagnosis and TB treatment health centers which provide simultaneous TB and HIV services (VSC routinely integrated, ARVT)	**10**	**2004**	**100**	**200**	**300**	**350**	**400**	*ANNUAL*
3e		*No*	Number of diagnosis and TB treatment health centers which provide condoms.	*NA*	*2004*	*100*	*200*	*300*	*350*	*400*	*ANNUAL*
4a	*Treatment of TB-MR*	*No*	Number and % of diagnosed and treated MDR-TB patients	*200*	*2004*	*350*	*1000*			*7011*	*ANNUAL*
4b		*Yes*	Number and % of MDR-TB patients who have a negative culture at the end of 6 month treatment	*NA*	*2004*	*50%*	*55%*			*65%*	*ANNUAL*
4c		*Yes*	Number and % of cured MDR-TB patients	*NA*	*2004*	*50%*	*55%*			*65%*	*ANNUAL*
4d		*Yes*	Number and % of MDR-TB patients having abandoned the treatment	*NA*	*2004*	*50%*	*30%*			*10%*	*ANNUAL*
5a	*Social Mobilization*	*No*	Number of community organizations involved in the prevention and treatment activities of TB (HIV/TB)	*60*	*2004*	*100*	*200*			*500 out of 1500 (30%)*	*ANNUAL*
5b		*Yes*	Number of new pulmonary positive TB patients who reports observing the posology in accordance with the national TB program	*NA*	*2004*	*30%*	*50%*			*90%*	*CAP SURVEY*
5c		*No*	Number of active community relays in TB activities	*4 094*	*2004*	*4 500*	*5 500*			*7 500*	*ANNUAL*

[6] Only the highest level indicators (Level 3: number of persons affected).

4 Components

TUBERCULOSIS

Objective n°	Service delivery area	Directly tied	Indicator description[7]	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
6c	Support Environment	No	Percentage of centers which have not reported any under stocking of drugs and of laboratory furniture	91%*	2004	92%	94%	96%	98%	100%	Bi annual
6d		No	Number of people who have received continuous training during the course of the year	106	2004	158	76				(Central and intermediary levels)
6 e		No	Number of people trained according to the national guidelines	4 547	2004	7 995	5 254				(operational level)
6f		No	Number of sites which are regularly supervised		2004	991	1291				Per annum
6g		No	Number and percentage of sites which submit complete reports on-time		2004	991	1291				Per annum
6h		Yes	Number of people trained for stock and supply management	0	2004	1	1				Per annum
6i		Yes	Number of people trained to the research methods	1	2004	8	8				Per annum
6j		Yes	Number of sites with applied research according to the national plan and procedures	2	2004	4	3				Per annum
6k		Yes	Existence of applied research protocol on TB at the national level	3	2004	4	3				Per annum
6l		Yes	Number of surveys done on the effects of TB which are known and published	Ongoing	2004	4	3				Per annum

** CAP Survey Kinshasa (2004)*

[It is advisable to refer to the list of coverage indicators provided in Appendix A.] However, if the service delivery areas and indicators do not adequately reflect the proposed strategy, they may be expanded.]

[7] Only the highest level indicators (Level 3: number of persons affected).

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

The main goal of this program is to reduce the morbidity and the mortality due to TB and due to TB-HIV co-infection in the Congolese population.
To attain its goal, the program has the following objectives:

- To diagnose 75% of tuberculosis patients with expected positive microscope analysis;
- To cure 85 % of the treated patients;
- To extend the DOTS coverage to 100% of the population ;
- To improve access to VSC for TB patients and to ARVT for the co-infected.
- Advocacy, communication and social mobilization for TB control.

The present program will strengthen the routine activities supported by the traditional partners of the NTP as well as innovative activities introduced thanks to the previous Global fund support. This program also aims at introducing VSC and ARVT to all tuberculosis patients and to extend all its activities to areas in the country where there is a low coverage. The main areas of service delivery are :

- The prevention (early diagnosis)
- Treatment of TB and multi-drug resistant patients
- Collaboration between TB/HIV (VSC and ARVT);
- The advocacy, communication and social mobilisation (social participation)
- Health system strengthening

Intervention area 1 : Prevention

Specific goal:
(1) To increase from 70% to 75% the rate of detection of expected TPM+ cases.
We have now attained a percentage of detection of 70 % (2004) thanks to the improvement of the diagnosis with the new microscopes, training and supervision as well as the other support activities that the NTP has received with the support of the GF and the traditional partners of the program. We want to maintain and consolidate these achievements. By increasing the number of centers from 991 to 1545 we hope to improve our detection percentage to 75% by bringing these centers closer to the population and by increasing the awareness to the disease. The supervisions, objective-driven training, quarterly and annual monitoring and evaluation will allow the improvement of the performances and the achievement of this goal.

Intervention area 2 : Treatment (TB and MDR)

Specific goals:

1. **To increase from 81% to 85% the success rate of the treatment of TPM+ tuberculosis patients to whom health care is provided;**
2. **To increase access to second line drugs of multi-drug resistant TB patients from 200 to 7011.**

(1) We will have to supply two thirds of the need in anti-tuberculosis drugs required to cure TB patients under DOTS. The drugs used in the national program are currently supplied by the GDF. The latter will cease to supply these drugs in 2006 and the traditional partners of the NTP will take over as suppliers. The need for anti-tuberculosis drugs has been estimated by the experts, during the external review of the NTP, at 766 746 cures for the period 2006 to 2010 (Need for safety stock). To avoid under stocking the NTP has decided to have a security stock representing one year stock at the national depot, 6 months at the provincial level, 3 months at the health zone levels and 1 month at every TB center.

(2) We propose to extend health care for multi-drug-resistant chronic patients throughout the whole country. A total of 7 011 cures will be necessary to cover the needs in second line drugs for the period 2006 to 2010. The guidelines have been elaborated in 2004 according to the standards decreed by the Green Light Committee and an application for accreditation has been deposited in that sense (See Appendix TB-11). Seven additional laboratories in the country (to be added to the 4 labs of the 2nd Round) will be provided with culture materials in the aim of reducing the transfer of these infectious patients, who represent a danger of propagation of the multi-drug resistance for the national as well as the international community.

Intervention area 3: TB/HIV Collaboration.

Specific goal:

(1) Provide VSC services to all TB patients

(2) To put diagnosed and eligible TB/HIV patients under ARVT.

In the context of the strengthening of the collaboration activities between the NTP and the NPAC, routine VSC and ARVT will be introduced in the TB centers across the country.

The NPAC has started the activities anticipated in the 3rd Round of the GF as well as those funded by the MAP/World Bank for a period of 5 years. We estimate that in 2006 we will have laid the basis of a collaboration of the activities with the NTP. We thus start with 300 health zones where VSC will be available with the NPAC budget and we anticipate strengthening it in 215 health zones with 645 complementary VSCs at the HCDT level. Taking into consideration the 3 by 5 initiative, we plan to make available to the NPAC the experience acquired with the Tuberculosis program which is well implanted in the health structures of the country. Starting with all the efficient HCDT which are primarily general referral hospitals and referral health centers, the NTP will be involved in making available the tools for diagnosis and providing its field experience to the NPAC for a rapid up-scaling. Starting with the 2004 projections (a 10% increase each year) we expect, for the 2006 to 2010 period, nearly 691 484 cases of TB. The surveys held in Kinshasa in 2004-2005 have shown a seropositivty prevalence rate of 45% in tuberculosis patients and 17% in others in the same town; that's how we calculate a mean value of 30% amongst the tuberculosis patients and we anticipate to put under treatment 10% of the tuberculosis patients during their anti-tuberculosis treatment while the other 90 % will be treated after their anti-tuberculosis treatment. We anticipate to manage 20 745 co-infected TB patients already under ARV.
All the HCDT chosen for VSC will have to undergo an evaluated of their VSC premises and we anticipate 1545 HCDT with the appropriate VSC premises and laboratories. Priority will be given to HCDT which report more than 100 tuberculosis patients per year, GRH and RHC.

Intervention area 4: Advocacy, communication and social mobilization.

A. Advocacy
B. COMMUNICATION
C. SOCIAL MOBILIZATION

The goal of this intervention area is to improve social participation in providing health care for TB and TB-HIV and patients. See the details of the plan in Appendix TB-10: Planning 02 Moso.

Studies done in Southern Africa (Wilkinson, 1995; Connolly, 1999, Banerjee, 2000) have shown the benefits of the involvement of the community in the therapeutic care of tuberculosis patients. The results of the surveys in Kinshasa and in Bukavu show that the involvement of the community in the caring of tuberculosis patients is in general weak. Their involvement in the supervision of medication (community DOT) has been confirmed by only 7% of patients. The current program wants to improve

community participation in caring for TB and TB-HIV patients in order to reduce the social stigma linked with these two diseases and to increase the number of people being cured. This program also emphasizes on the role of community members to improve the acceptance of the treatment. The NTP will be able to cover 100 % of the population by delegating its awareness and detection of suspected cases activities to members of the community.

We must also encourage diffusion of the life experiences of cured tuberculosis patients and community relays to be able to reach as many people as possible.

Intervention area 5 : Institutional capacity-building

Specific goal:
(1) To increase the DOTS from 75% to 100% from now to 2010.
(2) Improve the institutional capabilities and the technical skills of service providers.
In the context of this proposal we will aim at increasing or improving the existing HCDT coverage by the extension of the screening in private structures and in prisons as well as bringing together the managerial staffs of the HCDT by the splitting of the four largest and most geographically inaccessible TB coordinations into eight coordinations comprising between 10 to 20 zones each. This will improve the management by regular close supervisions. An additional 554 quality microscopes will be needed for the new HCDT including the private structures to be integrated. We must also provide training and retraining of the technicians as well as support in the form of reagents and consumables which will ensure the success of this goal.
Furthermore, quality control of the Ziehl slide smears will be done on line to decrease discrepancies between the results of the HCDT and those of the testing laboratories.

Training of all the health service providers as well as all the NTP managers is a must for this activity. The supervision, monitoring and evaluations must be done on a regular basis so as to integrate these new activities into primary health care.
In this view, the structures of the health districts will be put in good use as coordination auxiliaries. Their equipment and managerial staff constitute a motivation in favour of the proximity policy in the management of the basic structures as well as in data collection and analysis and on time feedback. Currently there are 56 sanitary districts and less than a quarter of them are functional; we will have to strengthen the rural districts in the context of the HINS so as to maximize their involvement in the control of Tuberculosis and HIV-AIDS. Quarterly meetings at the level of the health districts are anticipated to this end.
We also anticipate training and retraining sessions and participations in forums and international congresses for the managers of the national bureau and the provincial coordinations. At the provincial level, the same meetings will be held each quarter in the scope of the monitoring process.
To improve the management of the program, we anticipate, once a year, financial audits and external technical consultations.

PERFORMANCE CONTRACTS

In the present proposal there is a significant chapter on the performance contract to motivate the health staff. As mentioned earlier, most of the health centers belong to the state. The government has been in a transition crisis since 1990 with the consequence of a brain drain, in particular, in the medical field. We have noted the instability of the staff due to the low wages paid by the government and this is detailed in the problem description given in the appendix. We have to train new staff each year because those who are trained move elsewhere. In order to retain and stabilize the staff which have a good productivity we have decided to award a bonus based on performances. The addition of seropositive patients who seek treatment for TB will increase the work burden of the owners and administrators of the centers

to the point of asphyxiation. This is the main reason why private clinics have not participated in the program. For a country ranked 168th out of 177, based on the human development index, HDI (UNDP 2004), and worse, which appears in the list of the 27 countries «of highest priority which needs the attention of the rest of the world» according to the same report, it is our role to motivate and to stimulate those who provide health care to these sick persons who do not pay for the health care they receive and to all those who militate against the stigmatization of these patients. It is worth encouraging the good results obtained so far by the stake holders.
We hope that the new election campaign will bring good governance to a potentially rich country such as the DRC. The health system could become one of the priorities of the new leaders with the help of the international community and successful advocacy which have been implemented at the base.

Il is evident that the civil servants receive a salary from the government and that staff of the NGOs and those of the non profit private sector are also paid. But the very low salaries of the civil servants will not allow us to reach the ambitious goals that we are after because the implementation of tuberculosis and HIV/AIDS control requires enormous efforts and self-sacrifice from the staff on whose shoulders rest the burden to lessen the sufferings of these patients when it is not possible to cure them.
In this context, we have anticipated that a bonus should be awarded to all the staff from the central unit to diagnosis and treatment health centers. It will represent 50 % of the actual amount, the rest being provided by the other partners of the program. In appendix TB-08, the rationale for the calculation of these bonuses. We propose the bonus for the 1545 health centers comprising two nurses and a lab technician per structure. At the level of the health zones, 149 of them benefit from a global support of some silent partners in the context of the projects MEPRR (multisectorial emergency program for rehabilitation and reconstruction), USAID and the Belgian cooperation. The NTP requests support for the remaining 336 zones for a head of zone doctor, a medical doctor-director of the general hospital and a supervisor nurse per health zone. At the intermediary level the salaries of the staff are paid by the traditional partners of the program. At the central level, all the technical staff have been considered at 50 % as described above.
A performance contract will be developed to ensure that all those concerned do what they are paid for according to their job description. Examples of such contracts can be found at some silent partners (Belgian technical cooperation, multisectorial emergency program for rehabilitation and reconstruction) who have had some good results.

D. **STRENGTHENING OF THE CAPABILITIES AND MONITORING / EVALUATION**

- **Specify the recipients of the proposition for each component and the advantages they will benefit from**

For providing health care to patients under treatment, the recipients are all the patients diagnosed and put under treatment over 5 years, from 2006 to 2010, and estimated at 691 484 including 70% of TPM+ (Koch's bacillus spitters).
For case diagnosis and microscopy quality control, the recipients are all suspected patients, diagnosed primary and secondary tuberculosis (chronic multi-drug resistant), whose number is estimated at more than 3 200 000 people who are in need of bacilloscopy (15% of positive Ziehl examination), from 2006 to 2010. For the advocacy, the recipients are the opinion leaders and our current supporters.
For TB-HIV collaboration, it will concern all the 691 484 tuberculosis patients who will be given VSC, as well as 30% (estimated prevalence of HIV/AIDS amongst tuberculosis patients) of them who will be given ARV.
For the social mobilization by the IEC, the recipients are the general population, and in particular school children, students, youth associations. Next we have those who popularize messages (educators, journalists, leaders of the various mass

associations) of all levels, particularly from the periphery to the health centers and finally the managers of the national bureau (IEC cell) and provincial coordinations.
For the strengthening of the technical know-how and the institutional capabilities, the recipients are the managers of the national bureau and the provincial coordinations, the central bureaus of the health zones, the general referral hospitals and the health centers with their laboratories.
Finally, the 168 million Congolese in general and particularly the 12 million children under the age of 15 will benefit from a safe environment if we succeed in reducing the contamination by reducing the number of carriers of the TB bacillus.

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

The goal pursued by this proposition is to reduce the burden of mortality and morbidity and the TB-related deaths and lies in the context of the reduction of poverty, one of the main objectives of the millennium.
To reach this goal five areas of service delivery have been chosen namely TB prevention by early diagnosis, treatment of all diagnosed patients, provide health care to co-infected TB/HIV patients and the treatment of multi-drug resistant TB, and finally the plea, communication and social mobilization for increase community participation and the appropriation of TB control.

The essential problems identified from the analysis of the situation (see Appendix TB-12: problem tree and Appendix TB-13, Objectives tree) concern the increasing number of infectious tuberculosis patients during the past 15 years (see also graph given in appendix TB-14) as well as the increase in the number of multi-drug-resistant cases amongst them. We must also keep in mind the results of the Kinshasa survey which found that 45% of TB patients are co-infected with HIV on one hand, and on the other that the ignorance of the population strengthens stigmatization of these patients. Finally, it is evident that the drugs needed to provide health care for TB patients, chronic TB patients and co-infected patients, are currently in shortage in spite of all the efforts of our traditional partners. The social and political context of the DRC does not help the service providers who have worked as volunteers up to now and we will have to provide financial motivation to these people to help them carry on.
The program wishes to carry out the following activities :

- to increase the HCDT from 991 to 1545 (private sector and prisons included) and to provide them with microscopes, reagents and laboratory materials
- To increase the number of coordinations from 22 to 26 and to equip them with the necessary logistics to carry out their management of TB centers. The low performances noted in some large coordinations justify this need.
  - To procure primary anti-tuberculosis drugs for patients who will be cared for in the 1545 HCDTs distributed in all the health zones in the country.
  - To decentralize the diagnosis of multi-drug resistant TB by providing health care for all the multi-drug-resistant TB cases in the country in the 16 sites, including 5 in Kinshasa, with second line medicines and in accordance with the standardized schemes approved by the Green Light Committee.
  - In collaboration with the NPAC, to allow all diagnosed tuberculosis patients to have access to VSC for HIV and to provide ARV to co-infected patients in addition to prevention by condoms and providing health care for opportunistic infections.
  - To train all care providers and to retrain them regularly.
  - To regularly supervise all health care providers.

Given that 30% of tuberculosis patients are co-infected and that this status causes

numerous deaths amongst tuberculosis patients, the program will facilitate the national plan of the NPAC for VSC and ARV by getting involved in all TB/HIV co-infection activities at the baseline where there are the foundations thanks to the coordinations and their extensive field experience.

[For health systems strengthening components only:]

4.4.1.3 Describe in detail how the proposed objectives and service delivery areas are linked to the fight against the three diseases. In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. To demonstrate the contribution of the proposed health systems strengthening intervention(s) in fighting the disease(s) include at least three disease relevant indicators with a baseline and annual targets over the life of the program. *[This may be done in form of an appendix based on the format of table 4.4.b.]*
Clearly explain why the proposed health systems strengthening activities are necessary to improve coverage in the fight against the three diseases. [When completing this section, applicants should refer to the Guidelines for Proposals, section III.B. &F.*]*

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

The target groups of the NTP are: the suspected TB cases, TB patients, cured TB patients, co-infected TB/HIV patients, multi-drug-resistant TB patients, people living with HIV (PLHIV) and the members of the community as well as the health care staff who are confronted daily with the reality of tuberculosis in their work. In Kinshasa, cured tuberculosis patients have formed an association called «Club des Amis de Damien (CAD)" to give assistance to TB patients in the course of their treatment in order to fight stigmatization as well as to improve their adherence to the treatment (DOTS).
During the external review of the NTP, the officers in charge of the 21 health zones, the service providers of the 42 TB health centers, teachers from the 17 medical schools, the managers of 7 departments of the ministry of health and 14 national and international NGO stakeholders involved in Tb control have been visited and have also participated as appraisers. The strategic plan which has been drawn from this Review is thus the work of all the targets recipients of the program. The president of the CAD has been greatly involved in the social mobilization component as member of the TB Task Force. In the DRC provinces, cured TB patients are also members of the Task Force. In the implementation of the activities, family members of TB patients act as sponsor to accompany the patients during treatment. The survey carried out by the Public Health School of Kinshasa on co-infected patients in the pilot centers has lead to the choice of on-site VSC as proposed in the present project. This is to underline the fact that even the opinion of co-infected patients have been taken into account in this proposal.

4.4.1.5 Provide estimates of how many of those affected are women, how many are young people, how many are living in rural areas. The estimates must be based on a serious assessment of each objective.

The total number of new expected TPM+ between 2006 to 2010 is about 518 613 patients, taking into account a 10% increase per annum which represents our national mean value. Knowing that 66% of diagnosed patients in 2004 come from rural diagnosis and treatment TB centers, we report this percentage on the 2006-2010 total and we find 342 284 TPM+ cases. Youths in the 0-24 age group represent 27% of patients amongst the TPM+, while women represent 47% against 53% men. These targets are the same for all our objectives as the diagnosed patient will be treated and will have access to VSC and ARV. But this calculation takes only the TPM+ patients into account as we do not have this indicator for all the forms of Tuberculosis.

	Estimated percentage of affected persons:		
	Women	Youths (0-24 years)	in rural areas
To increase detection of TPM+ cases to 75 % of expected patients until 2010 in DRC	160 874 (47% of TPM+)	92 417 (27% of TPM+)	342 284 (66% of TPM+)
To increase treatment success rate to 85 % of treated cases in DRC	136 743 (TPM+)	78 554 (TPM+)	290 941 (TPM+)
To provide VSC services to all TB patients (691 484) and ARVT to 207 445 expected eligible co-infected patients (30 % seropositivity).	160 874 (47% of TPM+)	92 417 (27% of TPM+)	342 284 (66% of TPM+)

4.4.1.6 Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. This should provide reviewers with a clear understanding of what activities are proposed, how these will be implemented, and by whom.

See table in Appendix TB-09 and TB-10 : planning

4.4.1.7 Outline whether these are new interventions or existing interventions that are to be scaled up, and how they link to existing programs.

(1) It is primarily an extension of the geographical and demographical coverage from 75 to 100%) of an existing intervention: the DOTS strategy has been introduced in 1995 but some areas are not yet covered. The delimitation of the new coordinations and the increase in the number of new TB diagnosis and treatment health centers from 991 to 1545 will mean that the diagnosis and treatment will be as near as possible to the population and will improve DOTS coverage. Furthermore, social mobilization and an information campaign have been introduced in 2004 with the first support of the Global fund and must be extended to the peripheral zones.
(2) The introduction of VSC and ARVT activities for TB patients is a new intervention for the Congolese national program which considers control of HIV/TB co-infection as a necessary condition to curb the tuberculosis endemic.

4.4.2 Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the Global Fund grant period.
Given the political, social and economic context (war, political instability), it is difficult to make projections on the perpetuation of the activities. However, the trained staff, the supplied equipment and the strengthened primary health care policy constitute important achievements which can guarantee the perpetuation of the project to its term. This perpetuation will also depend on the support of the traditional partners and the commitment of the government, and the advocacy activities which have already started since 2002 and which forms part of this project and have, as a main objective, to maintain and increase the commitment of the government and the stakeholders of the public and private civil society in DRC. The HIPC initiative also constitutes an important opportunity to mobilize for the perpetuation at the end of the war and after the elections.

4.4.3 Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities (2 paragraphs).
Concerning program management, there is no gender inequities for the managerial positions. Epidemiological data show that the sex ratio has been of the order of 1.1 in this country for several years. This means that there are more women suffering from TB than men. However, in war zones where conflict has continued for a long time the sex ration is 1.8, that is one man for two sick women. The turmoil caused by war prevents women reaching health services. The advocacy, communication and social mobilization activities must be intensified in these regions in order to improve the diagnosis of tuberculosis women. The under notification of women as noted in 2004 (48% amongst TB cases with positive smears reported) can also be explained by the fact that the access of women to the health services is not favoured by certain beliefs and customs of the country. The current project emphasizes on social mobilization and struggle against stigmatization which will help improve the access of women to health services.

4.4.4 Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases (1–2 paragraphs).
Tuberculosis is an integrated program as described above. This means that TB patients are diagnosed and treated in the same health centers as other patients. It is in these centers that we want to integrate counselling and voluntary screening of HIV in TB patients to whom health care is provided. But we have to learn the lessons of the operational researches of the PHC of Kinshasa (experience from the UNC-DRC pilot project) which have shown that routine VSC options (opt out) and on-site are preferred to out-site VSC. This will repress exclusion and discrimination towards persons living with HIV. According to the same study, the patients have preferred «not to be heard» and «not to be seen» during counselling. This is why it is necessary to rehabilitate the VSC rooms on site. The advocacy, communication and social mobilization activities have, as an objective, to create a non-discriminatory environment.

4.4.5 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) (1–2 paragraphs).
Treatment for tuberculosis has been free across the whole country since 2002 following a

	decision made by the Minister of Health. In the present proposal, we propose that all tuberculosis patients have access to a VSC to allow detection of seropositivity amongst them and to provide health care to them. For this reason we have solicited the integration of the VSC package in all diagnosis and treatment TB health centers in addition to those contained in the current extension plan of the NPAC so as to respect equity principles.

4.5 ***Monitoring and Evaluation (M&E)***

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

4.5.1 Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.
1. Program monitoring - The NTP has its own information system, inspired from the one proposed by the WHO and the UNION and which utilises information media (administrative and epidemiologic) detailed in the program Guide and which is in accordance with the ministry of health's system. - Monitoring frequency is quarterly for epidemiological and laboratory data as well as data on drug management and other inputs for the diagnosis and health care provided to the patients. Epidemiological data coming from the HCDT (991) are validated on a quarterly basis at the intermediary level (22) between the provincial coordination team and the managers at the central bureaus of all the health zones which are concerned with disease control. All these data synthesized, analyzed and commented, by each provincial coordination, are synthesized quarterly at the national level. A feed-back is sent from the superior level to the level from where the data came from. There is an annual publication by the national level after analysis and comments by the main program indicators. The supervisions, spread on the whole quarter and planned at all levels of the system strengthen this quarterly monitoring. These supervisions are put in a time chart which has been chosen by all the set up partners in a forum - In this Global Fund project we anticipate to add four provincial coordinations, which will be derived from fragmented large coordinations, and to add 554 HCDT. These structures will automatically be integrated in the existing information system. Furthermore, to address the problems of promptness and completeness of data which we have currently, we anticipate in this project to improve the quality and volume of communication particularly between the intermediary and central levels by using the computer and internet at these various levels of the health system with an important budget. The strengthening of the expertise of the staff in this field is described in the training section, of the diffusion of ATIP IV (guidebook of the program) and the distribution of information media to a large scale over 5 years thanks to the financial support of the Global Fund as well as that of other partners. 2. Evaluation of the program - The evaluations are not routine and are often carried out at the end of a project of the intermediary level (European Union projects, Belgian Cooperation …) or national level (USAID, External Review of the Program). We did our first external evaluation of the NTP in February 2005, with the financial contribution of the Global Fund (2nd round), and we now wish to carry out this evaluation systematically every 5 years. We anticipate funding the next one, in 2010, with this project submitted to the Global Fund - In addition to this evaluation of the whole NTP, we have anticipated to complete these global evaluations by annual evaluations of some provincial coordinations to improve the level of performance of the intermediary level by anticipating every year an external evaluation of three provincial coordinations which will add up to the anticipated two coordinations which will be financed by other partners. - The evaluation of the achievements of the program is done indirectly by occasional surveys on the prevalence of multi-drug-resistance. We have already done this once, in 1998 only in the Kinshasa province, with the outcome mentioned above (see mdr,

	page). We are going to do this survey again in July 2005, in Kinshasa and in the lower Congo province. In the present project we anticipate to make a survey in all the provinces in 2010; this will allow us to have a complete and global image of the multi-drug resistance in DR Congo.
4.5.2	Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.

4.6 ***Procurement and Supply Management***

4.6.1 In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country] [When completing this section, applicants should refer to the Guidelines for Proposals, section V.B.5.] Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

Procurement Management (acquisition, storage, distribution and use)
Background

As mentioned above, even for the procurement the NTP is organized according to the national health policy and is integrated in the primary health care (national strategies).

Before 1981, no particular structure was organized for the procurement of anti-tuberculosis drugs in DRC. Procurement of drugs was done through a state-run structure centralized in Kinshasa (DCMP) which supplied all the hospitals in the country with drugs light materials and equipments. The anti-tuberculosis drugs and the reagents were included and were made available at the sanatorium where all tuberculosis patients were treated.

As from 1988 the procurements are organized, on a regular basis in Kinshasa, by the National Congolese League against Tuberculosis NCLAT, the faith-based organizations and the private sector. Inside the country, procurement is ensured by the partners (Damien Foundation, TLMI, ALM, ALTI, and FOPERDA) through the provincial coordinations they support.

In 2002, the GDF signed a three year support convention with the government for first line tuberculosis drugs. This will give the program the opportunity to organize the management of anti-tuberculosis drugs for the first time, by centralizing the procurement of all (partners and GDF) at the central unit. This convention ensures that the GDF will supply 2/3 of the country's needs, the remaining 1/3 being supplied by the other partners. To date, everything has gone on as planned and the convention ends in 2006!

In 2003, the World bank has provided the NTP with second line anti-tuberculosis drugs (mdr).
Thus the NTP currently manages all the anti-tuberculosis drugs in the country in close collaboration with the partners in a Task-force committee named PATIMED.

Implementation framework :

To reach its goals (regular procurement of quality drugs accessibility of anti-tuberculosis drugs to all TB patients and rational use) the NTP has prepared an implementation framework

- by firstly implementing a management committee of anti-tuberculosis drugs named <PATIMED> which is the dialogue structure where all implementation partners, the national tuberculosis bureau and the ministry of health through the Department of medical stores and drugs meet to establish the forecast, to harmonize the distribution, the monitoring and management as well as the supervision Timetable; in brief, a framework to help in drugs management through the NTP health structures.
- secondly, by elaborating a management guide for anti-tuberculosis drugs also named < guide PATIMED>, to help the administrators
  in the monitoring of the standards for a good practice of drugs management
- Training and retraining sessions are held and anticipated in the project. They will be strengthened by regular supervisions by the staff responsible for anti-tuberculosis drug management and use of drugs at all levels

Procurement and Supply Management

2/3 of the anti-tuberculosis drugs are bought by the GDF and the traditional partners contribute the other 1/3. The GDF and traditional partners all pass through the Foundation for the call for tenders, the purchase and transportation up to entry in the country. There are two entry sites: Kinshasa for all the procurements of the partners. Procurements from the GDF have two entry sites, Kinshasa for the 13 coordinations situated in the west of the country and at Goma for those in the east.

The storage in Kinshasa and in Goma is ensured by the Central Unit and the Damien Foundation (depot belonging to the NTP and the Damien Foundation). Since 2003, the distribution from these central depots of Kinshasa and Goma to the coordinations is ensured by the UNDP with the budget of the Global Fund (2nd round). The distribution of anti-tuberculosis drugs by the provincial coordinations is ensured by the health zones which come to pick their requisition in the coordinations, or this takes place during the supervisions of the intermediary level staffs. The frequency of distribution at this level is quarterly and every coordination has a small depot where they store about six month's stock. The Health zones store a three-month stock and supply the health structures on a monthly basis. The drugs are distributed freely to the patients

4.6.2 Procurement Capacity

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

- ☐ PR only
- ☐ Sub-recipients only
- ☒ Both

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

The GDF and the partners have just bought medicines for a sum of 1 687 156 $ including 1 297 823 USD by the GDF and 389 333 USD by the partners (Damien Foundation, TLMI, ALM…). The quantity of drugs is given below.
$R_{150}H_{75}Z_{400}E_{275}$: 14 456 000
$R_{150}H_{75}Z_{400}$: 11 162 000
$E_{400}H_{150}$: 1 776 000
$R_{150}H_{75}$: 54 965 000
$R_{150}H_{150}$ 1 127 000
EMB_{400}: 3 167 000
SM: 859 850
Paediatric forms:
$R_{60}H_{30}Z_{150}$: 1 927 000
$R_{60}H_{60}$: 928 000
$R_{60}H_{30}$: 300 000

4.6.3 Coordination
a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.
To this date where the country has the support of the GDF for first line anti-tuberculosis drugs, 66% of the cost is covered by the GDF and 34% by the other partners (Government, FD, ALM, TLMI)
b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal *(1 paragraph)*.
The GDT grant began in 2003 for a period of 3 years; the NTP has been awarded a 1 year extension which will end in 2006. This extension will allow the connection with the expected 5th round of the Global Fund grant. However, the traditional partners including the government, the Damien Foundation and the ALM are still financing the procurement of anti-tuberculosis drugs for one third of the country's needs

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4.6.4 Supply Management (Storage and Distribution)	
a) Has an organization already been nominated to provide the supply management function for this grant?	☒ Yes ➔ continue ☐ No ➔ go to 4.7.5

b) b) Indicate, which types of organizations will be involved in the supply management of drugs and health products *[If more than one of these is ticked, describe the relationships between these entities (1 paragraph)]*

- ☐ National medical stores or equivalent
- ☐ Sub-contracted national organization(s) (specify which one[s])
- ☐ Sub-contracted international organization(s) (specify which one[s])
- ☐ Other (specify)

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

The storage capacity of the NTP is of the order of 2 028m^3 at the central level (including 1500m^3 for the central unit, 120 m^3 for the Damien Foundation and 1008 m^3 for the depot in Goma), the storage capacity of the coordinations is estimated globally at 2640m^3

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

Drugs and other laboratory supplies are distributed at least twice a year to the coordinations from Goma for the eastern coordinations (that is 6) and from Kinshasa for the western coordinations (16). The coordinations transport them to the health zones either monthly or quarterly depending on the distance and transportation difficulties. The central unit store a 6 month's stock and 3 month's at the coordination level. The geographical coverage as compared to the CPLT is total. The same is true for the population covered if the network system is taken into consideration with one HCDT for at least 4 THC. Distribution of ARV to the co-infected patients can be done concomitantly with the NPAC, through the central purchase and distribution pathway : FEDECAM for the western part of the country and ASRAMES for the eastern part

[For tuberculosis and HIV/AIDS components only:]

4.6.5 Does the proposal request funding for the treatment of multi-drug-resistant TB?	☒ Yes ☐ No

An application has already been elaborated with the DOTS plus development program. However, we are still waiting for a formal approval. Please find enclosed the application as well as our development plan of the project for providing health care for multi-drug-resistant TB in DRC.(see Appendix TB-11)

[If yes, applicants should be aware 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. If not, a Green Light Committee application form must be completed and included with this proposal (see Appendix).]

4 Components

4.7 ***Technical 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 Technical Review Panel Clarifications, development of M&E or Procurement Plans, etc.]

4.7.1 Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.
Technical assistance is needed for capacity-building at all the steps of this project and at all levels. Indeed, we are currently implementing the 2nd Round of the Global fund. The start of the activities has greatly delayed because of a lack of knowledge of the functioning mechanisms of the Global fund. To accelerate the implementation of the current project and to comply with the requirements we would like to have the help of a technical assistant for every critical step. We thus anticipate 4 international consultancies for the first year in the following areas: 1°) rehabilitation of the premises of the coordinations, of the laboratories, of the pharmaceutical depots and the VSC as well as their equipments; 2°) advocacy, communication and social mobilization; 3°) organisation of studies, surveys and staff training, and finally 4°) procurement of first and second line anti-tuberculosis medicines and laboratory products. . It is clear that concerning the procurement of anti-tuberculosis medicines, the Damien Foundation has the necessary expertise and we could thus turn to them for advice in this area. We consider that technical assistance is indispensable for such a vast country and this will allow us to concentrate on more technical aspects. The number of services provided is enormous and we would like them to be up to standard and rapid at the same time. That's why we need short term technical assistance.

5 Budget

5

[Please note that this section is to be completed for each component. "Throughout, 'year' refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.

Financial information can be provided either in Euro or USD, but must be consistent throughout the proposal. Please clearly state denomination of currency.]

All budget breakdowns requested in the following sections are to be provided as an attachment to the hard and soft (electronic) copies of the proposal form.

5.5 *Component Budget*

[The budget should be broken down by year and budget category. The budget categories and allowable expenses within each category are defined in detail in the Guidelines for Proposal, section V.B.7. Costs that do not fall within the above-mentioned categories can be allocated under 'other' but must be specified. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.]

Table 5.1 – Funds Requested from the Global Fund

	Funds requested from the Global Fund (in Euro/USD)					
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	264 024	264 200	266 200	260 024	254 200	1 308 648
Infrastructure and equipment	912 700	946 450	1 807 100	65 700	31 200	3 763 150
Training	277 476	262 000	270 000	260 736	252 000	1 322 212
Commodities and products	1 196 506	1 279 820	1 071 726	1 031 726	1 031 726	5 611 504
Drugs	2 350 941	2 576 917	2 825 748	3 098 818	3 399 592	14 252 016
Planning and administration	1 351 185	1 179 955	1 442 265	1 200 815	1 220 815	6 395 035
Other : Social Mobilization	331 080	1 405 680	633 380	625 880	585 980	3 582 000
Total funds requested from the Global Fund	6 683 912	7 915 022.00	8 316 419	6 543 699.00	6 775 513.00	36 234 565.00

The component budget must be accompanied by a detailed year 1 and indicative year 2 work plan and budget. This should reflect the main

headings used in section 4.4. (component strategy) and should meet the following criteria (please attach this information as an appendix):

a) *They should be structured along the same lines as the component strategy—i.e., reflect the same goals, objectives, service delivery areas and activities.*
b) *should be detailed for year 1 and indicative for year 2, stating all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.2*
c) *should provide more summarized information and assumptions for the balance of the proposal period (year 3 through to conclusion of proposal term).*
d) *should be integrated with a detailed work plan for year 1 and an indicative work plan for year 2.*
e) *should be fully consistent with the summary budgets provided elsewhere in the proposal, including those in this section 5.*

5.5.1 Breakdown by Functional Areas

[Provide the budgets for each of the following three functional areas—monitoring and evaluation; procurement and supply management; and technical assistance. In each case, these costs should already be included in Table 5.1. Therefore, the tables below should be subsets of the budget in Table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in Table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).)]

Monitoring and Evaluation

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

Table 5.1.1a – Costs for Monitoring and Evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in Euro/US$)					
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and evaluation	1 274369	1 377175	1492345	1 474719	1 468895	7 087503

Procurement and Supply Management

5 Budget

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

Table 5.1.1b – Costs for Procurement and Supply Management

	Funds requested from the Global Fund for procurement and supply management (in Euro/USD)					
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and Supply Management	257792	283412	311597	342595	376697	3872093

Technical assistance:

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

Table 5.1.1.c – Costs for Technical Assistance

	Funds requested from the Global Fund for technical assistance (in Euro/USD)					
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Technical assistance:	84 800	84 800	84 800	84 800	84 800	424 000

5 Budget

5.5.2 Breakdown by Service Delivery Area

[Please estimate the percentage allocation of the annual budget over service delivery areas. The objectives and service delivery areas listed should resemble, as closely as possible, those in Table 4.4b.]

Table 5.1.2: Estimated Budget Allocation by Service Delivery Area and Objective.

		Year1	Year 2	Year 3	Year 4	Year 5	Total
Value per year		**6 683 912**	**7 915 022.00**	**8 316 419**	**6 543 699.00**	**6 775 513.00**	**36 234 565.00**
Goals :	**Service delivery area**	**Estimated percentage of budget**					
To increase detection of TPM+ cases to 75 % of expected patients until 2010 in DRC	**Prevention**	**37%** (2474253)	**35 %** (2803707)	**45%** (3764343)	**33%** (2148443)	**31%** (2148443)	**37%** (13339189)
To increase treatment success rate to 85 % of treated cases in DRC	**Treatment**	**32%** **2129128**	**26%** **2044714**	**25%** **2115295**	**35%** **2322005**	**36%** **2476904**	**30%** **11088106**
To provide VSC services to all TB patients and ARVT to eligible co-infected patients.	**TB/VIH Collaboration activities**	**9%** **632 398**	**8%** **649 458**	**8%** **689 938**	**3%** **223 488**	**4%** **244 488**	**(7%)** **2 489 801**
To increase access to second line medicines for multi-drug-resistant TB patients.	**Treatment of multi-drug-resistant TB**	**16%** (1 067 053)	**13%** (1 011 433)	**13%** (1 113 463)	**19%** (1 223 883)	**19%** (1 319 577)	**16%** (5 735 409)
Advocacy, Communication and Social Mobilization:		**< 5%** (331080)	**18%** (1405680)	**(7%)** (633380)	**9%** 625880)	**8%** (585980)	**10%** (3582000
Total		**100%** **6 683 912**	**100%** **7 915 022.00**	**100%** **8 316 419**	**100%** **6 543 699.00**	**100%** **6 775 513.00**	**100%** **36 234 565.00**
Total		100%	100%	100%	100%	100%	

5.5.3 *Breakdown by Partner Allocations*

[Indicate in Table 5.1.3 below how the requested resources in Table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.]

Table 5.1.3 – Partner Allocations

	Fund allocation to implementing partners				
	Year1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector	4.0%	1.4%	(0.7%)	0.8%	(3.7%)
Government	27.6%	(28.7%)	31.8%	< 35.5%	33.8%
Non governmental/ community-based org.	12.6%	11.6%	9.8%	11.2%	10.5%
Non governmental/ community-based org.	1.6%	2.1%	1.8%	2.4%	1.9%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria	0.0%	0.0%	0.0%	0.0%	0.0%
Private sector	0.0%	0.0%	0.0%	0.0%	0.0%
Religious/faith-based organizations	0.0%	0.0%	0.0%	0.0%	0.0%
Multi-/bilateral development partners	(15.7%)	19.4%	17.3%	< 0.5%	0.0%
Others : GDF	< 38.5%	36.9%	38.6%	49.6%	50.1%
Total	100%	100%	100%	100%	100%

5 Budget

5.6 ***Key Budget Assumptions for requests from The Global Fund***

[Unit costs and volumes must be fully consistent with the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.]

5.6.1 Drugs
a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please attach appendix).* b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please attach appendix).* c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. (Please attach appendix).
a) Add to the ATB price list **b) : for primary drug, the cost is 8 733 856$ and for the secondary drug the total cost is 5 103 148$** **c) Equipment cost, see calculation rationale to be included**

5.6.2 **Human resources costs** *In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1–2 paragraphs). (Please attach appendix).*
Human resources represent 2% of the budget and is limited to staff of the central level as those of the intermediary level are paid by the traditional partners and those of the periphery level, for several health zones, are paid in the framework of the global supports (World bank financing, African development bank, European union, international NGO, etc.) However, the periphery workers who work in the health zones do not benefit from the global support and are included in the bonuses of the component « Strengthening of the health systems ».
See rationale for the calculation of the proposed bonuses Appendix TB-08 : budget details

5.6.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years *(1–2 paragraphs). (Please attach appendix).*

Cost of equipments see Appendix TB-09 and TB-10 : planning for year 1 and 2