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

PROPOSAL FORM – ROUND 10
SINGLE COUNTRY APPLICANT

SECTIONS 1-2

Deadline for submission: 20 August 2010, 12 Noon CET

Applicant Name	COUNTRY COORDINATING MECANISM SAO TOME AND PRINCIPE		
Country	Sao Tome and Principe		
Income Level → *Refer to Annex 1 in the Round 10 Guidelines*	Low Income		
Applicant Type	X ☐ CCM	☐ Sub-CCM	☐ Non-CCM
If your country is also part of a Round 10 multi-country proposal, indicate for which disease(s)	☐ HIV	☐ Tuberculosis	☐ Malaria
Currency	X ☐ USD	☐ Euro	

Disease		Title	Does the proposal include cross-cutting health systems strengthening interventions? → *Indicate yes or no and Include sections 4B and 5B in one proposal only*	Is this being submitted as a consolidated disease proposal? → *Indicate yes or no*
HIV → *Choose either Regular or MARPs reserve*	X ☐ Regular	**Strengthening the HIV/AIDS epidemic response among vulnerable groups and Most-at-risk population in Sao Tome and Principe**	*NO* → *Cannot submit request for cross-cutting health systems strengthening with a MARPs reserve proposal*	**NO**
	☐ MARPs Reserve			
Tuberculosis				
Malaria				

IMPORTANT NOTE:

We strongly recommend applicants use the information below as an essential reference while completing the Proposal Form and other application documents. It is very important to carefully read each section in the Round 10 Guidelines at the same time as filling out the proposal and other application documents in order to submit a complete application. All other Round 10 documentation is available on the Global Fund's website.

MANDATORY SECTIONS OF THE PROPOSAL FORM:

A) Complete sections 1-2 only once per applicant[1]

Section 1 Funding Summary and Contact Details

Section 2 Applicant Summary and Eligibility

- Membership Details (CCM or Sub-CCM)
- Eligibility Form (if applicable)

B) Complete sections 3-5 once for each disease proposal[2]

Section 3 Proposal Summary

Section 4 Program Description

- Performance Framework **or** Consolidated Performance Framework
- Pharmaceutical and Health Products List (if applicable)
- Work Plan

Section 5 Funding Request

- Detailed Budget

OPTIONAL SECTIONS OF THE PROPOSAL FORM:

If relevant, complete sections 4B and 5B only once per applicant and include with only one disease proposal

Section 4B Cross-cutting health systems strengthening interventions

Section 5B Cross-cutting health systems strengthening funding

[1] The applicant only needs to submit a single section 1-2 as part of the application, even when applying for multiple diseases.
[2] The applicant needs to submit a section 3-5 for each disease proposal submitted.

ROUND 10

SECTION 1: FUNDING SUMMARY AND CONTACT DETAILS

1.1 Funding summary

Disease	Round 10 Funding Request					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	$ 669 568	$ 610 284	$ 460 656	$ 368 584	$ 367 621	$ 2 476 713
Tuberculosis						
Malaria						
Cross-cutting HSS interventions → *Insert disease name*						
					Total Round 10 Funding Request	$ 2 476 713

1.2 Contact details

	Primary contact	Secondary contact
Name	Mme Angela dos Santos Ramos José da Costa Pinheiro	Dr. Alzira S. Silva do Rosário
Title	Chairman CCM Sao Tome and Principe	NAP Coordinator
Organization	Ministry of Health	Ministry of Health
Mailing address	BP: 23 , S.Tome	Bairo Ponta Mina- S.Tome
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1.3 List of Abbreviations and Acronyms used by the Applicant	
Acronym/ Abbreviation	**Definition**
	→ use "Tab" key to add extra rows if needed

Acronym/ Abbreviation	Meaning
AIDS	Acquired Immunodeficiency Syndrome
ALISEI	NGO (result of a merger between the Nuova Frontiera & Cidis Associations)
ARV	Anti-Retroviral
ASPF	Sao Tome Association for family planning
ASC	Health Community Agent
BCC	Behavior Change Comunication
Caritas	Catholic Church NGO for social relief
CAP	Behavior Attitude and Practice
CBOs	Community Based Organizations
CST	National Telecommunication Company
CCM	Country Coordinating Mechanism
CNLS	National Commission of Fight Against AIDS
CSW	Commercial Sex Workers
FNM	National Fund of Medicines
FONG	National Federation of non-Governmental organizations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross of National Product
HAART	Highly Active Anti-Retroviral Therapy
HAM	Hospital Ayres de Menezes
HC	Health Centers
HIS	Health Information System
HIV	Human Immunodeficiency Vírus

HIPC	**Highly Indebted Poor Country**
INE	**National Institute of Statistic**
IEC	**Information Education and Comunication**
IPAD	**Portuguese Institute for Support for Development**
IPPF	**International Planning Partners Federation**
IRS	**Intradomicile Residual Springing**
KAP	**Knowledge, Attitudes, Practices**
LLN	**Long lasting net**
M&E	**Monitoring and Evaluation**
MDG	**Milleniun Desenvolopment Objective**
MoH	**Ministry oh Health**
NAP	**National AIDS Program**
NGOs	**Non Governmental Organizations**
NSP	**National Strategic Plan**
NHIS	**National Health Information System**
NHS	**National Health System**
OI	**Opportunistic Infections**
ONTSTP	**National Workers Organization of Sao Tomé & Príncipe**
OBC	**Community Based Organization**
PASS	**World Bank Project for Social Sector Support**
PLWHA	**People living with HIV/AIDS**
PMCT	**Prevention of mother-to-child transmission**
PNLT	**National Program of Tuberculosis**
PEP	**Post-Exposition Prevention**
PRSP	**Poverty Reduction Strategic Plan**
PPTE	**Debt Pardoning**
PR	**Principal recipient**
Palaiés	**African women selling local products as retailer in the African streets or traditional markets for subsistence**

RHS	**Reproductive Health Services**
RDE	**Epidemiologic District Responsible**
SDA	**Service deliver area**
SB	**Sub-recipient**
STI	**Sexually Transmitted Infections**
STP	**Sao Tome and Príncipe**
SHP	**Sexual Health Program**
TB	**Tuberculosis**
TB NP	**Tuberculosis National Program**
UNAIDS	**United Nations Aids Program**
UNDP	**United Nations Development Program**
UNFPA	**United nations population Fund**
UNICEF	**United Nations Children's Fund**
UN	**United Nations**
USD	**United States Dollar**
VCT	**Voluntary counseling and testing**
WB	**World Bank**
WFP	**World Food Program**
WHO	**World Health Organization**

SECTION 2: APPLICANT SUMMARY AND ELIGIBILITY

CCM applicants	Sub-CCM applicants	Non-CCM applicants
→ *Complete sections 2.1 & 2.2* → *Delete sections 2.3 & 2.4*	→ *Complete sections 2.1, 2.2 & 2.3* → *Delete section 2.4*	→ *Complete section 2.4* → *Delete section 2.1, 2.2 & 2.3*

2.1 Members and operations

2.1.1 Membership summary → *tick the relevant box*

Sector Representation	Number of members
X ☐ Academic/educational sector	1
X ☐ Government	8
X ☐ Non-government organizations (NGOs)/community-based organizations	7
X ☐ People living with the diseases	2
☐ People representing key populations[3]	0
X ☐ Private sector	2
X ☐ Faith-based organizations	1
X ☐ Multilateral and bilateral development partners in country	12
☐ Other → *specify*	
Total Number of Members: → *Must equal the number of members in the Membership Details form*[4]	33

[3] See the definition of key populations found in the Round 10 Guidelines.

2.1.2 Broad and inclusive membership Since your last eligible application to the Global Fund:		
(a) Have there been any changes in members since the last time the CCM (or Sub-CCM) was determined eligible?	X ☐ No → *go to section 2.1.2 (c)*	☐ Yes → *go to section 2.1.2 (b)*
(b) If 'Yes' in part (a), describe in the space below how those new members were selected.		
ONE PAGE MAXIMUM		
(c) Is there continuing active membership of people living with and/or affected by the diseases?	☐ No	X ☐ Yes
(d) Is there continuing active membership of both males and females and/or any improvement toward gender balance among members?	☐ No	X ☐ Yes

2.1.3 Member knowledge and experience in cross-cutting issues
(a) Health Systems Strengthening: Describe the capacity and experience of the CCM (or Sub-CCM) on health systems strengthening issues
Among the CCM members, some of them have experience in managing health services from different components. In evaluating the impact of health system problems on the programs and outcomes for the three diseases, as well as its experience in this matter, the CCM will admit as a resource person, any individual or corporation that it deems necessary in light of his/her competences or action in the furtherance of CCM goals. The National Health Information System Department (HIS), and UNDP, PR unit will be specifically requested by the CCM to deal with all health system issues and the outcomes of the three diseases. Representative from the reference pharmaceutics Sector, warehouse, Human Resources, IEC, Health Ministry information System, Monitoring- evaluation Sector of the National Endemic Center were present at the process, they participated in the analysis of situation (strengths, weaknesses and opportunities) and identified priorities toward elaboration of this round. For elaboration of the present proposal, CCM counted with technical assistance of experts on the health system, laboratory, particularly on HIV strategic information and planning and assessment of essential drugs logistical, from inter- country team of WHO.,

(b) Gender**:** Describe the capacity and experience of the CCM (or Sub-CCM) in gender and also issues concerning sexual orientation and gender identities.

- Expertise and skills in methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- Comprehensive knowledge of the factors that make women and girls and sexual minorities vulnerable such as harmful gender norms, behavior, attitudes and practices that underlie the differentials in the spread of HIV (e.g. gender based violence, discrimination and stigma, sexual female mutilation, early marriage, masculinity, etc).

Furthermore, among the CCM members, there are Experts on gender equality subjects, for instance the UNFPA representative. On the other side, a big number of these members have participated in two training sessions on gender equality, organized at national level.

CCM members are invited to comment their aptitudes and global experiences on gender issues ; taking in account the gender issues while analyzing the program's weaknesses and gaps, and how to improve this proposal by integrating gender equality concerns.

However we think is still necessary to strengthen the capacity of the CCM in gender and HIV.

(c) How many members of the CCM (or Sub-CCM) have considerable expertise in one or both of the areas described in section 2.1.3 (b)?	*→health system: 37%; Gender: 48,6%* *Both: 17%*

(d) Multi-sectoral planning**:** Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.

Multi-sectorial approach is used at national level for analyzing problems and elaboration of strategic plan of fighting against malaria, AIDS and Tuberculosis. CCM members are always represented by their colleagues in different exercises of analysis and Monitoring-Evaluation planning

Besides, STP CCM took responsibility on GF R4 on course, in accordance with a multisectorial approach, involving governmental departments, private sector and several civil society organizations. This is related to Malaria R4 and R7, HIV R5 and Tuberculosis R8.

2.2 Eligibility

2.2.1 Application history	
X Recently applied for funding in Round 8, or Round 9, or RCC Waves 5-8 and was determined eligible	→ *Complete sections 2.2.2 to 2.2.7*
☐ Last applied for funding before Round 8 or RCC Wave 5	→ *Complete Eligibility Form* → *Complete sections 2.2.5 to 2.2.7* → *Do not complete sections 2.2.2 to 2.2.4*
☐ Determined ineligible at last application	→ *Complete Eligibility Form* → *Complete sections 2.2.5 to 2.2.7* → *Do not complete sections 2.2.2 to 2.2.4*

2.2.2 Proposal development process

(a) Describe the process used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, at the national, sub-national and community levels, as well as from key populations, where applicable.

→ *Explain the process for each disease proposal in the application*

The proposal development process encompassed technical inputs from a range of stakeholders including non-CCM members (representatives of public and private sectors and CSOs). The process involved a series of stakeholders meetings.

The application process and presentation of proposal was open and transparent. A reference term with clear criteria for application evaluation was elaborated, recorded on CD together with documents of reference and available for those who are interested. The process was diffused by CCM on April15th, 2008, by announces on TVS, National Radio and News-Papers for 3 weeks, encouraging all the interested people from public or private sectors, NGO, PLHIV to participate and submit their request to be integrated in the National CCM proposal. The CCM received 7 applications for HIV/AIDS: 3 from NGO, 1 from Work Union, 1 from traditional healers, 1 from Justice ministry and 1 from the community based organization. No proposal was submitted for tuberculosis.

Even Round 10 is a re submission of Round 9 proposal the development process was enhanced through a stakeholders workshop, to respond the TRP weakness..

(b) Describe the process used to transparently review the submissions received for possible integration into the proposal.

→ *Explain the process for each disease proposal in the application*

The process to analyze applications for eventual integrating into the national CCM program was made by using punctuations based on pre-established criteria by an exam committee. These are : (1)Accordance with documents of national and sectoral references (2) the content of proposal (3) participation of people living with the disease, (4) reinforcement of health system.

All the applications were related to AIDS component. From the 7 applications, 4 of them had better punctuation, following the pre-established criteria, and were accepted (see evaluation table)

CCM in its session of May 7th, analyzed the list of candidates approved by the exam team and advised to introduce them into the national proposal.

(c) Describe the process used to ensure the input of people and stakeholders other than CCM (or

Sub-CCM) members in the proposal development process.

→ *Explain the process for each disease proposal in the application*

A letter was addressed to different partners of the fighting against HIV/AIDS and Tuberculosis, CCM members and not members, to identify their representatives in the process of elaboration of national proposal. The public health professionals, district representatives and NGO, representatives of PLHIV, representatives from finance ministries and education, CCM members and not members, could participate direct or indirectly in various work sessions

The CCM (May 20, 2009) and 8th july 2010 meeting minutes and notes demonstrate how the CCM decided to solicit review of the draft proposal ensuring the contribution of a broad range of stakeholder through sending proposal by e-mail and hard copies to relevant personnel (CCM and non-CCM members)..

(d) Attach a signed and dated version of the minutes of the meeting(s) at which the CCM (or Sub-CCM) members decided what to include in each disease proposal.	*Annex 8* → *insert annex number*

2.2.3 Process to oversee program implementation

(a) Describe the process used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

ONE PAGE MAXIMUM

Supervision of the current subsidizing performance for AIDS, Tuberculosis and Malaria are defined in the CCM regulation.

The CCM decided that HIV technical subcommittee to oversee the development of the GFATM proposal of HIV component for round 10). This document demonstrates how the CCM decided to revised R9, and developed the proposal on HIV components for Round 10 call. The HIV technical subcommittee of CCM had meetings during proposal development and obtained valuable inputs from members and also UNAIDS, UNICEF, WHO, UNFPA, FAO, HIV+ NGO, PLWA and others.

The HIV technical subcommittee of CCM also formed a Core Group for day-today work on proposal and presented to the HIV Technical Sub Committee.. The proposal developed based on gap analysis and consultations with wide range of stakeholders including Government-MOH, NGOs, UN agencies, CCM members and national & international NGOs , technical experts and donors including comments from TRP. This proposal received inputs from stakeholders and finalized the proposal

Similarly following the decision of CCM, the technical sub-committee of HIV has prepared the proposal for the HIV component. The technical sub-committee for HIV is headed by the Coordinator of PNLS, and experts from various disciplines (clinicians, epidemiologist, programme management, and financial experts) are included as members. According to the decision of CCM, a core working group was constituted to prepare the draft proposal. This proposal was reviewed and finalized in the technical sub-committee meetings. The proposal was shared with NGO and received inputs from them. Support from WHO IST AC/AIDS (strategic information, and strategic planning), an UNAIDS International consultant provided technical support during preparation of the HIV proposal.

(b) Describe the process used by the CCM (or Sub-CCM) to oversee program implementation.

The 'Structure and Functions of the Sao Tomé National Coordinating Mechanism' and the 'Operations Manual' provide guidance on the process of ensuring a wide range of stakeholder involvement, including non-CCM members in grant oversight processes.

- The CCM Executive Committee is mandated to invite technical Experts of PNLS, SIS or resource persons for information or Expert opinion on areas of its mandate. Under Tier 2 of the CCM structure, the Technical Coordinating Team (TCT) and TWGs provide programmatic and management oversight of the GF grants. They work with various stakeholders in the field who are non-TNCM members such as CSOs (including FBOs), and the private sector.
- The established system of representation by constituency provides a number of forums from

national level to district level to discuss, question input into the ongoing oversight programme implementation

- At district level there are council multi-sectoral HIV and AIDS Committees and discussion on ongoing programmes is a standing agenda on quarterly basis
- All constituencies have their schedule of meetings with extensive discussion on particular issues related to ongoing programmes

Periodic meetings are organized by CCM for analysis of activities, its implementations and respective funding allocation.

2.2.4 Process to select Principal Recipient(s)

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal.

→ Explain the process for each Principal Recipient for each disease

ONE PAGE MAXIMUM

The CCM conducted with the various national and international partners of the United Nations System, of the multilateral and bilateral cooperation, the NGOs and the state institutions a concertation to assess the capacities of a possible Principal Recipient in light of the World Funds recommendations and guidelines. At the end of the consultations marked by a spirit of efficiency and objectivity, the national and international partners reached a consensus that enabled the suggestion of the renewal of PNUD as Principal Recipient (PR). This choice was ratified through a CCM members-wide consensus during the meeting of the 18 th august 2010

During the CCM meetings the UNDP has been once selected as the PR by consensus of all due to the lack of capacity of both management and procurement needs of the other potential candidate, the CNE to undertake the complex managerial activities required in a GFATM award. The decision was also supported by the good performance of UNDP till today with both malaria and aids grant..

UNDP as PR is an instance that enjoys management autonomy with a compatibility of a private nature. This instance manages the main fundings dedicated to the three pathologies (HIV/AIDS, Malaria and Tuberculosis) notably fundings from the GFTAM 5 Round. It acquired solid management capacities and a management experience with transparent and efficient procedures. The LFA assessment reports on the performances also confirm the acquisition of skills that still need to be reinforced.

For round 10 as in round 9, it is identify two PR to manage a project simultaneously. Now, the Civil Society is in the beginning for a skills transfer to institutions of the country.

The supervision of the program's implementation will be ensured by the CCM through its technical bodies as per their missions specifications described in the internal regulation.

(b) Attach the signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) members nominated the Principal Recipient(s) for each disease.	ANEX 9

2.2.5 Non-implementation of dual track financing

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

NOT APLICABLE

2.2.6 Managing conflicts of interest	
(a) Are the Chair and/or Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the disease proposals in this application?	☐ Yes *→ go to (b) and then section 2.2.7* X ☐ No *→ go to section 2.2.7*
(b) If yes, attach the plan for the management of actual and potential conflicts of interest.	*→ insert annex number*

2.2.7 Proposal endorsement by members	
The Membership Details form has been completed with the signatures of all members of the CCM (or Sub-CCM)	X ☐ *→ Tick this box to confirm that the Membership Details form, with signatures, is attached to the application*

2.3 Sub-CCM applicant further details

2.3.1 Status of Sub-CCM		
(a)	Does the Sub-CCM operate under the authority of the CCM to focus on a particular region or issue?	☐ Yes → *answer sections 2.3.2 and 2.3.3*
(b)	Does the Sub-CCM claim an independent basis to operate without oversight of the CCM?	☐ No → *answer sections 2.3.2 and 2.3.4*

2.3.2 Rationale
Why does a Sub-CCM approach represent an effective approach in the circumstances of your country?
NOT APPLICABLE

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

2.3.4 Justification of independence of Sub-CCM
Explain how the Sub-CCM has a right to operate without endorsement from the CCM.
NOT APPLICABLE

2.4 Non-CCM applicants

2.4.1 Sector of work → *check one box only*	
☐	Academic/educational sector
☐	Government
☐	Non-government organization (NGO)/community-based organizations
☐	People living with the diseases
☐	People representing key populations[5]
☐	Private sector
☐	Faith-based organizations
☐	Other: → *specify*

2.4.2 Justification for Non-CCM proposal		
(a) Identify the main justification for submitting a Non-CCM proposal → *check one box only:*		
(i)	Country in conflict, facing a natural disaster or in a complex emergency situation	☐ Yes → *go to section 2.4.3*
(ii)	Country that suppresses, or has not established partnerships with civil society and non-governmental organizations, which may include, but is not limited to, key populations	☐ Yes → *complete (b) below and go to section 2.4.3*
(iii)	State without a legitimate government, and not being administered by a recognized interim administration	☐ Yes → *go to section 2.4.3*
(b) If (ii) applies: Describe, chronologically, all attempts by the Non-CCM to communicate with the CCM on the inclusion of the Non-CCM proposal's activities in the larger CCM proposal.		
NOT APPLICABLE		
(c) Describe how the Non-CCM will be able to implement the proposal and achieve the outputs/outcomes when the CCM has not supported the proposal.		
NOT APPLICABLE		

[5] See the definition of key populations found on page 3 of the Round 10 Guidelines.

2.4.3 Expected benefit of proposal
Describe how the proposal addresses gaps in the existing country efforts for HIV, tuberculosis, and/or malaria as relevant.
NOT APPLICABLE

2.4.4 Non-CCM knowledge and experience in cross-cutting issues	
(a) Health Systems Strengthening: Describe the capacity and experience of the Non-CCM on health systems strengthening issues.	
NOT APPLICABLE	
(b) Gender: Describe the capacity and experience of the Non-CCM in gender issues and also issues concerning sexual orientation and gender identities. The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that effective programming requires: • Expertise and skills in methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and • Comprehensive knowledge of the factors that make women and girls and sexual minorities vulnerable such as gender harmful norms, behavior, attitudes and practices that underlie the differentials in the spread of HIV (e.g. gender based violence, discrimination and stigma, sexual female mutilation, early marriage, masculinity, etc).	
NOT APPLICABLE	
(c) How many members of the Non-CCM have considerable expertise in one or both of the areas described in 2.4.4 (b)?	→ *insert number*
(d) Multi-sectoral planning: Describe the capacity and experience of the Non-CCM in multi-sectoral program design.	
Not aplicable	

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

2.4.6 Signature by authorized representative of Non-CCM applicant		
Position	**Printed Full Name**	**Signature**
		→ *use "Tab" key to add extra rows if needed*

Section 2: Eligibility		List annex name and number
CCM and Sub-CCM applicants only		
2.2.2(a)	Process used to invite submissions for possible integration into each disease proposal	**ANNEXE 1**
2.2.2(b)	Process used to review submissions for possible integration into each disease proposal	**ANNEXE 2**
2.2.2(c)	Process used to ensure the input of a broad range of stakeholders in the proposal development process	**ANNEXE 3**
2.2.3(a)	Process to oversee grant implementation by the CCM (or Sub-CCM)	**ANNEXE 4**
2.2.3(b)	Processes used to ensure the input of a broad range of stakeholders in grant oversight process	
2.2.4(a)	Process used to select and nominate the Principal Recipient(s) for each disease proposal	**ANNEXE 5**
2.2.6	Conflict of Interest policy	**NA**
2.2.7	Minutes of the meeting at which the proposal was finalized and endorsed by the CCM (or Sub-CCM)	**ANNEXE 6**
2.2.7	Endorsement of the proposal by all CCM (or Sub-CCM) members	**Membership Details Form (ANNEXE7)**
Sub-CCM applicants only		
2.3.3 *CCM Endorsement*	Process used to show that the CCM reviewed and endorsed the proposal	NA
2.3.4	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM	NA
Non-CCM applicants only		
2.4.1	Documentation describing the organization, and the key governance arrangements, and a summary of the main sources and amounts of funding	NA
2.4.2(a)	Documentation justifying the exceptional circumstance for submitting a Non-CCM proposal	NA
2.4.2(b)	Documentation of communication to the CCM for consideration of the proposal	NA

PROPOSAL FORM – ROUND 10
SINGLE COUNTRY APPLICANT

SECTIONS 3-5: HIV

3. PROPOSAL SUMMARY

3.1 Transition to a single stream of funding (a) Select only one of the three options:	☐ Option 1: Transition to a single stream of funding by submitting a consolidated disease proposal *→ go to section 3.1 (b)* **Relevant sections are marked in RED throughout the proposal form**
	☐ Option 2: Transition to a single stream of funding during grant negotiation *→ go to section 3.1 (b)* **Relevant sections are marked in RED throughout the proposal form**
	X ☐ Option 3: No transition to a single stream of funding in Round 10 **Relevant sections are marked in RED throughout the proposal form**
(b) For options 1 or 2, list the grant numbers.	*→ insert relevant grant numbers*

3.2 Duration of Proposal	**Planned Start Date**	**To**
Month and year:	January 2012	December 2016

3.3 Alignment to in-country cycles

Describe:

(a) how the proposal duration was selected in section 3.2 and how it contributes to alignment with the national fiscal cycle(s), programmatic reporting, or in-country program reviews; and
(b) the systems in place for regular national program reviews and evaluations (including Operations and Implementation research).

The fiscal year of Sao Tome and Principe coincided with civil year. It starts on January first and end on December. The chronologic implementation of activities presented on this proposal took this into account,

as we did for the proposals on malaria (round 4 and 7), HIV (round 5) and tuberculosis (round 8). Therefore, the implementation of this proposal is planned to begin in January 2012, in order to allow for enough time to complete the grant negotiation and all procedures required for the signature of the contract with the principal recipients and sub-recipients. Activities planned to be funded by government and other partners will enter in execution by January. The programmatic results will be available by semester and only indicators of impact will be presented based on civil year.

3.4 Summary of Round 10 Proposal

Provide a summary of the HIV proposal.

- This proposal seeks to expand de coverage and impact of HIV interventions through: Expanding HIV testing and counseling, targeting de prevention of sexual transmission of HIV, particularly among those most at risk and most vulnerable, exploiting the role of antiretroviral drugs in HIV prevention, optimizing HIV/AIDS treatment for children, adolescents and adults, delivering comprehensive programmes for most-at-risk populations: sex workers, men who have sex with men and patients with STI as well as PLWA and partners
- This proposal integrates programmes and services seeking to eliminate mother-to-child transmission of HIV, Link HIV and TB services, addresses HIV and viral hepatitis co-infection on PLWA, as well as hepatitis B among health care workers most at risk for occupational exposure. In addition, it promotes positive prevention for people living with HIV.
- The implementation of the proposed interventions will contribute to build a sustainable health system in São Tomé e Príncipe, through strengthening the health information system to, better monitor responses to HIV/AIDS, expanding human resource capacity, improving safety of health services, as well as Improving the efficiency, quality, effectiveness and equitable coverage of HIV services and programmes. In addition, it will contribute to creating supportive environments for HIV responses through addressing HIV stigma and discrimination in the health sector and promoting gender mainstream.

This proposal is in line with STP national systems and strategies. Priorities were drawn from national strategic plans and priorities, especially form the AIDS National strategic plan. Its development was on inclusive mode, with participation of different implement partners, such as TB program, reproductive health, different NGOs and PLWA, aiming for potentiating synergy among implementer partners and donors.

- Its has one Goal: **To Decrease the Morbidity Mortality of HIV infection among people living with HIV/AIDS in São Tomé and Príncipe**

Its activities is distributed through **5 objectives and 16 SDAs** as follows**.**

Objective: 1 To significantly reduce the sexual transmission of HIV infection in STP

- SDA-1: Testing and Counseling
- SDA-2: STI Diagnose and Treatment
- SDA.3 BCC Mass Media
- SDA-4: BCC Community outreach and Most-at-risk population
- **SDAS-5: Condoms**

Objective 2 – Reduce morbidity, mortality and improve the quality of life of HIV infected patients, their partners and families and support orphans

- SDA-6: Antiretroviral Treatment (ARV) and Monitoring
- SDA.7: Prophylaxis and Treatment for Opportunistic Infection
- SDA-8: TB/HIV - Provide state of the art prophylaxis and treatment for patients co-infected with TB and their contactants
- SDA –9: Care and Support for the chronically ill
- SDA.10: Support for Orphans and Vulnerable Children

Objective 3 – Eliminate mother-to-child HIV transmission in São Tomé & Principe

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- SDA-11: PMTCT

Objective 4: to prevent parental transmission of HIV infection and other blood borne infection

- SDA.12: Blood Safety and Universal Precaution

Objective 5: To increase institutional capacity of the National AIDS Program/Ministry of Health and Civil Society

- SDA.13: Program Management and Administration
- SDA.14 Information system
- SDA.15 Strengthening of Civil Society and Institutional Capacity building
- SDA 16 – General management services. Contribution GMS-PR
- The total amount requested is $ 2,476,713 whose mobilization answers the following scheme: $ 1,279,852 for the first two years and $ 669,568 for year one and $ 610,284 for two years. And for the last three years the value of $ 1,196,861.

4. PROGRAM DESCRIPTION

4.1 National program

Describe:

(a) current HIV national prevention, treatment, and care and support strategies;

(b) how these strategies respond comprehensively to current epidemiological situation in the country; and

(c) the improved HIV outcomes expected from implementation of these strategies.

After evaluation in 2008 of the implementation of the strategic plan 2004-2008, a new plan was set for the period 2011-2015. The priority strategic axes are: 1- Prevention of new infections; 2-cCunseling and Testing; 3- Care and support of HIV infected individuals; 3- Protection, assistance and socio-economic support of PLWHA and those affected; 4- Coordinating the multi-sectoral partnership and resources mobilization; 5- Strategic management of information and research.

The HIV prevention strategy combines:

1-Communication for behavior change through interventions directed to general population through mass media and telephone (Toll free Hotline).
2-Education and information on sexual and reproductive health
3- Prevention of HIV and other STI
4- Promotion of values and moral education among young people on schools and out of school
6- Peer education and other prevention interventions targeting most-at-risk populations: sex workers and clients, MSM, patients with STIs and PLWHA.
7- Social marketing of condoms, free condom distribution, across the country on both, health services and out of health services hot spots (393 spots) at the level of communities, bars, nightclubs, hotels, work place, among others, in both, urban and rural areas
8- Diagnosis and treatment of sexually transmitted infections, through syndromic approach management, at all health centers and clinics, free of charge.

HIV counseling and testing: HIV voluntary and counseling is one of the key strategies of the AIDS program with impact on prevention and treatment. Services providing HIV VCT are available in all health services, including health posts, health centers, reproductive health services and Hospital. NGOs also provide VCT out of Health sector, in urban and rural areas. HIV testing among women and tuberculosis patients is high. Among males, the uptake of HIV test remains low and it is a matter of concern. The provider-initiated testing and counselling strategy will start soon to be implemented, coupled with the already available client initiated HIV VCT.

The strategy for HIV prevention of mother-to-child transmission (PMTCT), combines:

Integration of PMTCT activities in all reproductive health and prenatal care services, at every Health District. (2) Care and primary prevention (safe sex); (3) family planning, (4) promotion of VCT, including partners (5) integral health management of the mother and child (psychological, social, nutritional and medical) The PMTCT interventions available comprises HIV VCT, ARV prophylaxis for the mother (triple therapy) and exposed infant (AZT), provision of infant formula, administration of cotrimoxazole for the infant.

Treatment care and support to PLWA: is structured based on the integrated management of diseases of children, adults and adolescents in matters of HIV and AIDS (PCIMAA) in all health units. It combines the diagnosis and treatment of opportunistic infections, treatment of co-infection HIV/TB, ARV treatment, nutritional support, psychosocial assistance, the organization of aid compliance and continuity of care including home visits. First and second line ARV treatment is available, as well as immunologic monitoring. Patients with HIV/TB are screened for HIV. Co-infected patients receive ARV treatment and cotrimoxazole. Screening with PPD will start soon, as well as INH prophylaxis. Screening for hepatitis B is planned to be included on the case management of PLWA.

Safety of transfusions through the promotion of voluntary blood donation and ensuring screening for four markers of the blood-borne diseases (HIV, HBV, HCV, Syphilis) of all donated blood; availability of post exposure prophylaxis at all levels of health system to be provide to health professionals and victims of rape; adequate management of biomedical waste

The National Strategy for 2011 - 2015, takes into account the epidemiologic context of the epidemic in Sao Tome and Principe and its strategic priorities define interventions targeted to both the general population and most at risk populations, particularly: sex workers and clients and men who have sex with men. Men within the age range of 30-34 years, because of the high prevalence are also prioritized; the catwalks populations are characterized by their geographic mobility (taxi drivers, bikers, sailors ...). the vulnerable populations: that the social situation are exposed to infection by HIV. They are the orphans and vulnerable children, women of childbearing age (especially the low level of education), youth aged 15-19.

The implementation of these strategies is expected to:

1-Decrease significantly the sexually transmission of HIV infection

2-Ddecrease sexually transmitted infections

3- Eliminate HIV mother-to-child transmission

4- Increase the safety of blood transfusions

5- Decrease morbidity and mortality of HIV/AIDS and tuberculosis

6- Improve the quality of life of PLWA

7- Strengthen the NAP capacity on strategic management of information and research

8- Strengthen the institutional capacity of the National AIDS program and partners from civil society to on prevention for most at risk populations as well as on program monitoring and evaluation

9- Increase the engagement of civil society and communities on the fight against AIDS epidemic

10- Strengthen the multisectoral coordination with strong involvement of communities on the decentralization process;

11- strengthen the health information system to, better monitor responses to HIV/AIDS

12- improve the strategic information system and research, which will allow for better understanding of the epidemic in STP,

13- improve the planning effectiveness and the most efficient and evidence-based monitoring and evaluation activities

4.2 Epidemiological profile of target populations

(a) Describe the current epidemiological profile of the target populations, and how this profile is changing with respect to HIV.

São Tomé and Príncipe is Africa's smallest economy and one of the poorest countries in the world. The per capita income of US$424 places the country below the average for Sub-Saharan Africa. Approximately 54 percent of its population of 163.874 is poor and 15 percent live in extreme poverty. The country ranks 131 out of 182 countries in the 2009 UNDP Human Development Index. Life expectancy is 67 years and adult literacy rate is estimated at 83%.

The first AIDS case was reported in 1990 and since then, 390 cases have been identified by the Ministry of Health (MoH) , with occurrences in all country's health districts. The majority of cases are associated to heterosexual transmission, mostly heterosexual. Projections made using the Spectrum software indicate a estimated number of 1.050 people living with HIV/AIDS in São Tomé e Príncipe by 2010.

The HIV epidemic in STP shows characteristics of both generalized and concentrated epidemics, what may indicate it is transitioning from concentrated to generalized one. According to the DHS conducted in 2008/2009, the prevalence of HIV infection in the general population aged between 19-49 years old is 1.5%, a pattern of generalized epidemics. Over all, in the DHS, the prevalence found among men (1.7%) is higher than among women (1.3%), a pattern characteristic of countries where the epidemic still concentrated in high-risk groups. This findings are reinforced by the data from sentinel surveillance that found a low prevalence (0.6%) among pregnant women, a high prevalence among sex workers (4.2%) and 0% among conscripts (young men presenting for mandatory service on army). According to the DHS data, among men, prevalence hits its peak between 30-34 years old (6.1%) and among women between 35-39 years (2.4%) and 40-45 years (2.4%). The DHS was powered to discriminate between urban (2.1%) and rural (2.4%) regions, as well as to determine the prevalence for the Príncipe region (2.2%). No relationship was observed between wealth and HIV infection. As expected, prevalence was higher among those who reported no schooling. Among those, it is higher among women than men. As in other countries among those aged 20-24 years, women (1.0%) are far more likely to be infected than young men (0.6%), reflecting early marriage and sex activity among women than men. The epidemiologic data from the autonomous region of Príncipe indicate that the epidemic in this region is spreading faster than in São Tomé, and is a matter of concern. According to the DHS data, the HIV prevalence was found to be 2.2%. Among those women who reported no schooling at all, HIV prevalence was 4.0%, while among men in the same situation it was 2.3%.

(b) Do the activities in the proposal target:

X Whole country	☐ Specific geographic region(s)	☐ Specific population group(s)

→ *Paste map here if relevant (see Guidelines)*

(c) Size of target population(s) → *If national data is disaggregated differently then type over the categories proposed*			
Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	163.874	Institut National de la Statistique	24/01/2008
Females > 25 years	29.862	Institut National de la Statistique	24/01/2008
Males > 25	26.623	Institut National de la Statistique	24/01/2008
Females 20-24	8.075	Institut National de la Statistique	24/01/2008
Males 20-24	7.906	Institut National de la Statistique	24/01/2008
Females 15-19	9.873	Institut National de la Statistique	24/01/2008
Males 15-19	9.929	Institut National de la Statistique	24/01/2008
Females 10 – 14 years	11.183	Institut National de la Statistique	24/01/2008
Males 10 – 14 years	11.374	Institut National de la Statistique	24/01/2008
Females 5-9 years	11.855	Institut National de la Statistique	24/01/2008
Males 5-9	12.070	Institut National de la Statistique	24/01/2008
Females 0-4	12.527	Institut National de la Statistique	24/01/2008
Males 0-4	12.507	Institut National de la Statistique	24/01/2008
Other: → *specify*			→ *use "Tab" key to add extra rows and insert more population groups if needed*

(d) HIV epidemiology of target population(s) → *If data is disaggregated differently then type other the categories suggested and enter your own population group*			
Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV *(all ages)*	1050	PNLS, projection spectrum	Mai 2010
Females living with HIV > 25 years	410	PNLS, projection spectrum	Mai 2010
Males living with HIV > 25 years	350	PNLS, projection spectrum	Mai 2010
Females living with HIV 20 – 24 years	76	PNLS, projection spectrum	Mai 2010
Males living with HIV 20 – 24 years	35	PNLS, projection spectrum	Mai 2010
Females living with HIV 15 – 19 years	31	PNLS, projection spectrum	Mai 2010
Males living with HIV 15 – 19 years	15	PNLS, projection spectrum	Mai 2010

Pregnant females living with HIV >25 years	4	PNLS, projection spectrum, ajustada	Mai 2010
Pregnant females living with HIV 20-24 years	6	PNLS, projection spectrum, ajustada	Mai 2010
Pregnant females living with HIV 15-19 years	36	PNLS, projection spectrum, ajustada	Mai 2010
Females 10–14 years living with HIV	9	PNLS, projection spectrum	Mai 2010
Males 10-14 years living with HIV	10	PNLS, projection spectrum[1]	Mai 2010
Females 5-9 years living with HIV	15	PNLS, projection spectrum	Mai 2010
Males 5-9 years living with HIV	16	PNLS, projection spectrum	Mai 2010
Females 0–4 years living with HIV	18	PNLS, projection spectrum	Mai 2010
Males 0-4 years living with HIV	19	PNLS, projection spectrum	Mai 2010
Other: *→ specify*			*→ use "Tab" key to add extra rows and insert more population groups if needed*

4.3 Major constraints and gaps in disease, health, and community systems

4.3.1 HIV program

Describe:

(a) the main weaknesses in the implementation of current HIV strategies;
(b) existing gaps and inequities in the delivery of services to target populations; and
(c) how these weaknesses affect achievement of planned national HIV outcomes.

Prevention: 1- Lack of data, access and technical capacity to work on prevention focused on MSM population. It true for both NAP and NGOs; 2-Limited access to sex workers and limited technical capacity to develop effective prevention work focused on this population; **Condoms:** 1- insufficient on the NGO in charge to keep all points (393) adequately supplied. 2-Data on female condom acceptability is not available, 3- limited material advertising distribution and promoting condom use. **Testing and Counselling:** HIV test uptake remains low among men. According to the DHS 2008/2009 data, while 65% of women in reproductive age are already aware of their HIV serostatus while only 37% men do. **STI Diagnose and Treatment:** Weaknesses identified in this area are 1- Drugs for treatment of STI are free of charge only for HIV infected patients. 2- STI services are mostly providing care to women. 3- stock-out periods of STI drugs. **PMTCT:** In 2009, 6.285 pregnant women up took HIV VCT. The major weaknesses related to PMTCT is the high rate of lost to follow up of HIV infected pregnant women identified during prenatal care. In 2009, 24 (63%) out of 37 HIV pregnant women were identified. Because of the high rate of lost to follow up, only 14 among 24 found to be HIV infected, effectively received antiretroviral drugs for PMTCT. This high rate may be associated to the high level of stigma and discrimination in STP. **Care and support:** 1- patients continue to be diagnosed very late, 2- ARV treatment is decentralized to the level of Health centers, but not to the level of health posts. 3- Treatment monitoring is limited. Viral load exams and resistance testing are not available. 4- lack of early diagnosis of HIV infection for infants born to HIV infected mothers; 5- lack of capacity for kaposi's sarcoma, treatment; 6- HIV infected patients are not screened for latent tuberculosis; 7- patients are not screened for hepatitis B; 8- support provided to orphans is limited to provision of school tuition, out fits and

[1] Dados ajustados do spectrum utilizando como referencia a estrutura percentual por idade dos casos notificados em 2009

supplies. **Blood Safety:** 1- Blood bank physical facility is in bad condition; 2- the proportion of family/replacement blood donors still very high; 3- the service is operated by technicians with low capacity on hemotherapy, 4- the hospital lacks a hemotherapy committee and surveillance of transfusion adverse reactions; 6- physicians do not follow good practices on hemotherapy. **Universal Precautions:** Post exposure prophylaxis is already available in STP, on the reach of all health worker up to the district level. In addition, NAP staff carried out a number of trainings attended by a high proportion of health care workers of STP, on universal precautions and occupational post exposure prophylaxis. In 2009, only 5 health care workers looked for this prophylaxis. Currently there is no system defined to register occupational exposure and the actual number of accidents is unknown. Prevelence of Hepatites B is as high as 13, 6%, hepatitis B treatment is not available. Despite of this, Hep B vaccination is not available to health care workers. **NAP management capacity:** 1- NAP permanent staff is small and needs to be supported with members hired through the Global Fund funds; 2-Technical capacity on monitoring and evaluation is limited; 3 – M& E system needs to be reviewed as well as its tools; 4- Institutional capacity to work with MSM and sex workers is lacking; 5- opportunities for technical update on care management and ARV therapy for the central level staff are limited in-country; 5- Civil Society capacity on M&E is very limited.

4.3.2 Health Systems

Describe the main weaknesses of and/or gaps in health systems that affect HIV outcomes.

The health system in São Tomé and Príncipe is almost exclusively assured by public structures organized on two levels: the central level, which is of national scope, based on more complex health care provided by the Ayres de Menezes Hospital; and the district level, coinciding with the administrative division of the territory, based upon primary health care. The latter is, for its part, comprised of three levels: District Health Centres (6 units), Local Health Centres (28 units) and Community Health Centres (17 units). The private sector is practically non-existent, except for a very small number of "clinics" in the capital. Healthcare in São Tomé and Príncipe is afflicted by serious structural problems, aggravated by the context of generalized poverty, poor nutrition, lack of basic sanitation and drinking water, illiteracy, and poor awareness of healthy living habits.

The main weaknesses and gaps that affect the results in the fight against HIV are as follows:

1. Insufficient Financing of Health System: - The proportion of Budget allocated to Health represents only 11% (2009) against 15% recommended. Most of this budget is for expenditure on administration (staff salaries, office consumables, payment of water and energy, maintenance of buildings and equipments, among others). Unfortunately, frequently the planned investment is not executed, resulting in an insufficiently funding level. The budget allocated to the "Centro Nacional de Endemias" (CNE) the Ministry of health body to which AIDS, Tuberculosis and Malaria programs a part of, represents only 2%. This proportion from a small overall budget is clearly insufficient to face escalating costs to fight all endemic diseases affecting São Tome& Principe. Even worse is the fact that the amount is not clearly allocated to each program, what makes the request for funds from programs very vulnerable. Moreover, as usually in the public sector in STP, most of the times, funds not released timely and activities relying sole on it are severely affected and many times not executed. The Country lacks a policy of Health System focused on facilitating the access to care. Moreover, the current policy of cost recovery on health services severely affects the access of those more vulnerable, that is the case of a high proportion of PLWA .Cost recovery incur on consultation and any exam ordered by the physicians. **2. Insufficiency of qualified human Resources on Health Sector**: This is a serious constraint faced by the country and represents a barrier for decentralization of care and management of Health services in all level. This affects directly the implementation of HIV/AIDS prevention and care intervention, as well as the program management, mostly on monitoring and evaluation. The country lacks specialist in many areas. Cancer treatment for instance is not available in the country. The main causes are inadequacy of basic training for new staff, insufficient training in the management of public health programs, the frequent changes of staff already trained in the national health service, drain boards for the most attractive sectors, which is associated to an unequal distribution of human resources at the expense of districts. Lack of qualified human resources is the current main barrier to improve laboratory support for clinical care. This is the case of virological monitoring of ARV treatment and diagnose of HIV infected children. The diagnosis of HIV infection, as well as hepatitis and syphilis relies on rapid tests. The unavailability or

high cost of equipment maintenance is also an important barrier for adequate care. Lack of personnel with skills on drug and medical products some times result in periods of out of stock on drugs and kits.
3. Leadership and Good Governance: • Some strategic documents and regulations of the health sector have become outdated or are missing including the national health policy, the national health development plan, the plan for human resource development in the field of health, politics and financing plan for the sector.
4. Health Information System is weak: This is a barrier for good planning, monitoring and evaluation Given this insufficiency, each program and project develops its own sub-system to respond to their needs

4.3.3 Community Systems

Describe the main weaknesses of and/or gaps in community systems that affect HIV outcomes.

The health system in São Tomé and Príncipe is almost exclusively assured by public structures. The country still lacks a strategy to guide community-based activities and mechanisms for engaging communities. Community based organization (CBO) are only few and in general, not involved in providing health care. Activities implemented by these organizations usually are to advocacy, awareness and VCT. More recently, with funds from Global Fund HIV/AIDS Round 5, partnership with CBO was established to implement out reach and prevention work focused on sex workers community. Also, partnership were also developed to increase the coverage of HIV VCT and peer education. Regarding PLWHA, due to the high level of stigma and discrimination, their avoid to disclose their HIV serostaus. In the last year the First Association of PLWA was finally established as an association within the country´s legal framework. This was a landmark, acomplished by PLWA and Medicos do Mundo. Activities of this association still limited to participation in radio programs and collaboration with the NAP in the operation of the Linha verde, the Toll-Free Hotline that provides HIV/AIDS information through tepephone(initiative funded by the private sector through the CST). Most of the CBO lack management and fiancial capacity and skills on prevetion focused on most at risk population is lacking. This brings a problem for the data provided by these organizations for the NAP regular reports.

4.3.4 Efforts to resolve weaknesses and gaps

Describe what is being done, and by whom, to respond to health and community system weaknesses and gaps that affect HIV outcomes, as outlined in sections 4.3.2 and 4.3.3.

The São Tome & Príncipe Government has taken steps to improve the financing of Health Sector. A survey about costs related to health services was conducted in 2007 to establish in average the national health account and identify the range of expenses related to health in medium term. In addition, staff at the central and district levels were trained in financial management in order to improve their management skills and increase the efficiency of the funds already allocated to the Health system. Also in this field, the country was supported by the WHO, which organized a training for staff in central and district levels on nation health account. Regarding insufficiency of qualified human resources the new health staff hired by the government (nurses, laboratories, statistics, and pharmacy technicians) are being trained by the training school of health. These new staff are being integrated to the public health services at district level. A technical team was nominated to conduct the NPSD 2001-2005 evaluation and to elaborate a plan of second generation. In 2009, a new situation analysis was made in order to elaborate a new human resources plan.
The Health Demographic Survey (SDS) conducted during 2008- 2009 provided important data for the country´s Health indicators framework. Within the framework of project implementation of 4th Round Global Fund for malaria, and 5th for HIV AIDS, the monitoring and evaluation unity of the CNE, was strengthened with staff training on M&E. The WHO and UNAID also contributed to the NAP staff capacity building providing training on the use of EPP and Spectrum softwares, and now estimation of important parameters can be locally. It is an important achievement in the field of HIV/AIDS monitoring and evaluation. .In addition, one staff from the NAP was specifically trained on UNGASS data monitoring, improving the country capacity to provide quality data on its reports.

In collaboration between, Brazil, US and STP, investments are being made on the Health System that will significantly contribute for the M&E of AIDS, TB and Malaria programs.
Regarding weaknesses on community systems, we have been working to strengthen the Civil Society institutional capacity. In the current Round 10 funds are allocated to build capacity on NGOs to work with two most at risk population sex workers and men who have sex with men. In addition, the NGos are included in our activities of monitoring and evaluation. NOGs will participate in the review process as well as in the trainings. We believe that these activities will contribute to improve their institutional capacity and as result the country response to the HIV/AIDS epidemic. The regular meetings on monitoring and evaluation to be held twice a year with participation of all NAP partners on implementation and CCM members. We believe that will contribute for the empowerment of the community members. In addition, we highlight that community members will be trained jointly with health care workers to do out reach work under the coordination of health districts. It will contribute to decrease the lost to follow up of HIV infected pregnant women, currently very high

4.4 Proposal strategy

Complete this version of section 4.4.1 if the applicant selected option 2 or 3 in section 3.1 of the Proposal Form

Option 2 = Transition to a single stream of funding during grant negotiation
Option 3 = No transition to a single stream of funding in Round 10

4.4.1 Interventions

→ This section should be completed in parallel with the Performance Framework and detailed budget and work plan

Describe the objectives, service delivery areas (SDA), and activities of the proposal. **The description must be organized in that exact order and the numbering system must match the Performance Framework, detailed budget and work plan.**

The description must reference:
(a) who will implement each area of activity (e.g. Principal Recipient, Sub-recipient or other implementer); and
(b) the targeted population(s).

Objective: 1 To significantly reduce the sexual transmission of HIV infection in STP

HIV testing and treatment are now, more then ever, viewed as an important tool for prevention. People when aware of their HIV status are more prone to adhere to HIV prevention interventions. In addition, early diagnosis is pivotal for timely initiation of ARV treatment. Even more, ARV treatment reduces viral load and infectiousness. The number of people who uptake HIV, have been increasing along the last years, a large parte reflecting VCT on prenatal care. Among males, the uptake of HIV test remains low and it is a matter of concern. According to the DHS 2008/2009 data, 65% of women in reproductive age are already aware of their HIV serostatus while only 37% men do. The HIV test uptake in the last 12 months among adults aged between 15-49 years old was 31,4% and 22.8%, for females and males respectively. According to the DHS, the HIV prevalence is higher among men than among women, except among those aged 20-24 years, in which women (1.0%) are far more likely to be infected than men (0.6%). Among men, the prevalence hits its peak between 30-34 years old (6.1%) and among women between 35-45 years (2.4%). In this context, the implementation of the strategy of provider-initiated testing and counselling will be critical to achieve the goals of earlier diagnosis and treatment in order to avoid progression of the HIV disease and reduction of HIV sexual transmission. This strategy will be coupled with the already available client initiated HIV VCT. In order to allow for adequate supervision, M&E of benefits and adverse events, ensuring that principles of counselling, consent and confidentiality will be properly adhered to, the implementation will be phased. It will start in the Central Hospital in São Tomé and the Inpatient unit at Principe island and then scaled down to health centres with inpatient units, those providing STI treatment and after then to other health services. In adopting this strategy, we can foresee an increase on the demand for care and ARV treatment. However, because we have been successful in training health care workers from most of health services on HIV/AIDS care, we believe we will be able to, adequately handle the increased demand this strategy may bring.

The risk of HIV transmission is increased in the presence of other sexually transmitted infections. Therefore, adequate STI treatment is a key strategy in reducing the spread of HIV infection. The comprehensive management of STI involves reducing the incidence of STI, by preventing transmission through the promotion of safer sex, making condoms widely available, and reducing the prevalence of curable STI through early and effective case finding and treatment, including treatment of the partners. Currently, only HIV infected patients can receive drugs to treat STI free. For those who need to purchase the drugs, lack of resources may defer them to look for adequate treatment, increasing their risk of acquire/transmit HIV infection. Therefore, in order to guarantee promptly access to STI diagnosis and treatment, we are including on this proposal the cost of STI drugs to have health services providing treatment at no cost for patients. We expect that availability of free drugs will be an attractive for men to seek care at health services, representing a valuable opportunity for HIV VCT.

Sex workers: In São Tomé & Príncipe Sex Workers holds the highest prevalence of HIV infection (4.2%)**,** being one of the major drivers of the epidemic. Sex work stills heavily stigmatized, what makes this population very difficult to reach. In the 3 years, with GFATM round 5 resources, the NAP established a partnership with ALISEI (NGO), to work with this most-at-risk population. An assessment was conducted to obtain information about sex work settings and their social context in order to guide the design and implementation of interventions. Over all 100 female sex workers were assessed and professionals from all districts, including from Principe, could participate. Interviews, gynaecologic examination and HIV VCT free of charge were offered to them. Some of them were trained to be peer educators. This assessment, although initial, sheds light on problems that sex workers face in their lives, and make them vulnerable to HIV infection. They are not a homogeneous group, but come from a diverse range of backgrounds, and can differ greatly in the lives that they lead and the levels of risk they face can be different. Despite this diversity, most of them share factors of vulnerability such as social and economic positions. All these factors, combined with stigmatization, contribute to their high vulnerability to HIV. Under the leadership of ALISEI, a strategic plan was developed and will be validated in the next months in workshops with major stakeholders. The interventions here proposed are based on the mentioned strategic plan and aims primarily to increased availability of condoms and level of correct condom use, and safer sex amongst sex workers and their clients, as well as promote good health care and health seeking behaviour, including STI treatment and HIV testing and empowerment of these women. This is a priority population for female condoms provided by our partner UNFPA. Needless to say that besides HIV prevention, this population is also in need of treatment, care and social support. Peer

education is the cornerstone of the strategy for this setting. The educative activities to be implemented will promote solidarity, empowerment and enable them to reach more of their peers and share their knowledge on HIV prevention and care and other health matters, such as reproductive health. As the work progress, sex workers themselves will be empowered to identify and prioritize other health and social needs. Progressively, other stakeholders will be involved, such as owners and managers of bars, hotels and brothels. Educative activities will also include promotion of human rights and stigma reduction. Health care workers from reproductive health services will be sensitized and trained to provide care in a judgeless attitude. Sex Workers will be linked to income generating programs and other poverty reduction initiatives, which will offer them some opportunities to leave the profession, if they want to do so. During this work, the team of ALISEI indentified the need to improve their own staff technical capacity to work with this population. International technical assistance is therefore, requested. This capacity building will also benefit the NAP and NGOs, expanding the country's capacity to prevent HIV on this high risk and vulnerable population.

Men who have sex with men: In STP, because of the high level of stigma and discrimination against homosexuality, men who have sex with men live in clandestinely, have no visibility and are very difficult to reach out. This is a phenomenon throughout Africa, known to be a major contribution for the spread of HIV infection. So far, we have no access to this high-risk population but are fully committed to fill this GAP. The strategy for this population will be similar to the one implemented for sex workers, that is, partnership with civil society, situation analysis and development of a strategic plan for STP in this field.

Especial attention is need to those non-scholarized, especially in rural areas. Flip charts will be produced with pictures instead of text, to be used by community educators and health care workers to educate those that can not read.

Condoms: Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. The condom programming in STP takes into account that effective condom promotion should target not only the general population, but also people at higher risk, especially women, young people, sex workers & clients, MSM. In order to facilitate condom uptake, they are available at no cost, in every health service as well as in non-traditional outlets, such us bathrooms, walk-ways, hotels, bars, discos, totalizing 393 points where condom dispensers are located. The estimated condom need of STP is 4.824.600 of units per year, for an sexually active population of 89.000 people. In 2009, a total of 1.485.888 condoms were distributed. Distribution points are expected to reach 530 by the end of 2013. Currently, some problems in the supply channel of points out of health services were identified and the supply of rural areas will be decentralized to Health Districts, taking advantage of the motorcycles and fuel that will be provided to Districts by the Malaria Global Fund grant. So far, lubricants are not available for distribution. Because condom breakage is more common when lubrication is insufficient, lubricant sachets will be made available for those who would need it. It is an important asset on the prevention among MSM. UNFPA will provide the entire need of male condoms through out the 5 years of proposal implementation. Acceptability of female condoms will be assessed in an study planned to be conducted in 2011. Therefore, we will not, at this point, request resources to purchase female condoms, neither male condoms.

SDA-1: Testing and Counseling

Activity-1: Develop a plan and guidelines for introduction of the provider initiated HIV testing

Target population: 89.000 adults

PR and Implementer in charge: UNDP, NAP, Health Districts, Central Hospital, ISVSM

Activity-2: Provide training to 180 physicians, nurses and other health care workers on HIV counseling and testing and on provided initiated testing approach (3X20 participants:y1, y2, y3)

Target population: 60 health care workers trained each year and 180 by the end of the third year

PR and Implementer in charge: UNDP, NAP, ISVMS

Activity-3: Purchase, store and distribute 177.000 HIV test to Health Services and NGOs for 5 years (21.000 Y-1; 28.000 Y-2; 36.000 Y-3; 44.000 Y-4; 48.000 Y-5)

Target population: total country's population

PR and Implementer in charge: UNDP, FNM,NAP, Health Districts, Central Hospital

Activity-4: Develop, print and distribute communication material to stimulate HIV test uptake by the sexually active population specially men (posters and flyers)

Target population: 89.000 adults

PR and Implementer in charge: UNDP, NAP, CNES

SDA-2: STI Diagnose and Treatment
Activity-1: Refresh of STI Syndromic Approach training - 180 health care workers (2nd and 3rd Y)
Target population: 89.000 adults
PR and Implementer in charge: UNDP, NAP, ISVSM
Activity-2: Purchase, store and distribute drugs for STI treatment free of charge to health services at the 7 health districts
Target population: 89.000 adults
PR and Implementer in charge: UNDP, FNM, NAP
Activity-3: Distribute free of charge condoms (budget on SDA.4)
Target population: 89.000 adults
PR and Implementer in charge: UNDP, NAP, Health Districts
Activity-4:Counseling and HIV testing, under the provider initiated approach in all services providing STI care **(budget on SDA1.3)**
Target population: 89.000 adults
PR and Implementer in charge: UNDP, NAP, Health Districts

SDA.3 BCC Mass Media
All Mass Media activities (safe sexual behaviour, stigma and discrimination mitigation, among others, **will be supported by UNICEF**

SDA-4: BCC Community outreach and Most-at-risk population
Activity-1: sensitization and capacity building for Health Care workers, policemen, owners of bars and brothels, regarding sex workers
Activity-2: Provision of condoms to SW and clients (budget on SDA.5)
Activity-3: Peer education on HIV prevention: sex workers, clients, bar owners, among others
Activity-4 Develop educative materials focusing prevention for sex workers, MSM, STI patients,
Target population: 38.000 sex Workers (estimated based on access to 100 in 2008/2009)
PR and Implementer in charge: IMVF, ALISEI, NAP, CNES
Activity-5 Financial support to income generating programs to include SW among its beneficiaries
Target population: 300 Sex Workers (estimated based on access to 100 in 2008/2009)
PR and Implementer: IMVF, ALISEI, NAP
Activity-6: Situation analysis and strategic plan for intervention on MSM population (2nd Year)
Target population: no data available to estimate
PR and Implementer: IMVF, ALISEI,NAP
Activity-7 training for selected MSM to implement peer education activities on the Field of HIV prevention and care (3^{rd} , 4^{th}, 5^{th} years)
PR and Implementer: IMVF, ALISEI,NAP
Activity-8 Youth education on HIV/AIDS – costs covered by UNFPA

SDAS-5: Condoms
Activity-1: distribute condoms purchased by UNFPA for 5 years.
Target population: 89.000 adults
PR and Implementer in charge: UNDP, FNM, NAP
Activity-2: Increase the number of points of condoms distribution **from 393 to 513 by the end of year 4**, and improve the logistic of supplying the distribution points
Target population: 89.000 adults
PR and Implementer in charge: IMVF, ALISEI,NAP, Health Districts
Activity-3 Develop, print and distribute flyers and posters with prevention messages promoting condom use and informing where condoms can be obtained for free
Target population: 89.000 Adults
PR and Implementer in charge: IMVF,ALISEI,NAP,CNES
Activity-4 purchase, store and distribute Lubricants (10% number Condoms)
Target population: 89.000 adults

PR and Implementer in charge: UNDP, FNM, NAP

Objective 2 – Reduce morbidity, mortality and improve the quality of life of HIV infected patients, their partners and families and support orphans

Since 2005, **ARV treatment** has been implemented in collaboration with Brazil. Since then, Brazil donates most of the first line drugs, as well as drugs for PMTCT. The Institute Marques de Valle Flor (IMVF), though the project "Health for All" donates Triomune. From 2008 on, thanks to GFATM, we could incorporate other ARV necessary for treatment modifications, including efavirenz for HIV/TB co-infected patients, pediatric formulation of ARVs, as well as opportunistic infection drugs. Funds requested on this proposal will secure the continuation of the support for ARV treatment (adults and children), including second line drugs, **treatment of opportunistic infection and immunologic monitoring**. Brazil and IMVF will maintain their contributions. As of July 2010, 363 patients are on follow up with 185 patients on ARV. The improvement of access to ARV and other care interventions resulted in significant reduction on mortality rates from 22% in 2005 to 2.3% in 2009. Although these results are encouraging, patients continue to be diagnosed on late disease stage. Therefore, the provider initiated HIV VCT (see Objective 1) will be a key intervention to improve care outcomes and prevention. Because we have already trained health care workers from most of the health services in 6 of 7 health districts, we believe we have capacity to accommodate an increased demand for care and ARV treatment. Therefore, it is feasible to introduce the higher threshold (< 350 CD4 cells/mm3) to initiate treatment, as recommended by WHO, without compromising the treatment of those more severely ill. Moreover, we plan to, progressively make available HIV care closer to patient home, what will facilitate both, the patient access to the health facility and access of the health team to the patient. Currently, we lack capacity to treat patients with kaposi's sarcoma, the most common neoplasia affecting in HIV infected patients in Africa and funds are being requested to fill this GAP. Currently, we already have both **adults and children on second line treatment.** So far, viral load monitoring is not available and switch of treatment is based on clinical/immunological criteria of failure. This represents high risk of development of virus resistance to ARV. According to the DHS, the **prevalence of hepatites B in our population can be as high as 13% among males**. Because some ARV are also active on hepatitis B virus, we will introduce screening for Hep B antigen as a routine for HIV patients. Those co-infected will be started on schemas containing tenofovir+lamivudine, in order to minimize development of hepatitis B virus resistance. We will vaccinate all HIV infected patients for Hepatitis B. Because Hepatitis B serology would be very costly, vaccine will be given to all negative on Hepatitis antigen rapid test.

If left without effective ARV treatment, half of HIV infected children will have died by two years of age. WHO recommends that infant and children < 2 years of age should be started on ARV treatment immediately upon HIV diagnosis. Unfortunately, early diagnosis for infants born to HIV infected women is not available. We expect to fill this gap when the Public Health Laboratory that will be established in partnership with the Brazilian government start to operate. Discussions were conducted and this laboratory will be able to run exams for TB (culture, speciation and others).In this future this lab will be able to run diagnosis for opportunistic infections, viral load monitoring and early infant diagnosis. It is expected that this lab will be on operation by 2012. .

From a public health perspective, people living with AIDS make up the most important group to address with HIV prevention strategies, because of the great impact on the transmission of HIV. We will train our teams providing care to PLWA to provide counselling for behaviour change and couples counselling. HIV infected patients will be stimulated to bring their partners and counselling and HIV testing will be offered to them. Currently, we provide STI free treatment only to HIV infected patients. We will extend this benefit also to other individuals. These interventions will be even more important as we expand the identification of HIV infected people through implementing the provider initiated testing. We expect that free STI treatment will contribute to attract more men to health services.

Tuberculosis is the most frequent O.I and the major cause of death among our patients. Along the last year we have been increasing our collaboration with the TB program that is now gaining better infrastructure thanks to the Round 8 Grant. We can mention forecasting of kits, reagents and drugs, as well as planning and conduction of training programs. Important to highlight that, health care workers teams that provide care for HIV, TB and Malaria patients are the same. Treatment of TB will soon be decentralized coupled with DOTS implementation. We will train the teams at the district level to work in an integrated approach to cover the integral health care needs of the patients under their care, including

outreach of patients lost to follow up irrespective of the program they participate. In addition they will be trained to better register and collect data included in the M&E framework of both programs. Working under the integrated approach concept, we will be able to start ARV treatment earlier as well as to screen the HIV/TB patient's partners for HIV earlier.

SDA-6: Antiretroviral Treatment (ARV) and Monitoring
Activity-1: Purchase, store and distribute ARV for first and second line treatment (includes PMTCT – 37 women and infant per year) - (excluding those donated by IMVF and Brazil)
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, FNM, NAP
Activity-2: Purchase, store, distribute, reagents for 4.014 CD4 count for 5 years (669 year 1, 532 year 2)
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, FNM, NAP
Activity-3: Decentralize ARV treatment to 30 health services up to the level of health posts
Target population: 1.050 PLWA

- treatment on 30 health services by Y3, Y4, Y5 (14-Y1; 22-Y2)
- number of patients on ARV treatment: 255-Y1; 296-Y2; 338-Y3; 352-Y4; 365-Y5
- number of patients on second line: 26-Y1; 31-Y2; 36-Y3; 41-Y4; 46-Y5

PR and Implementer in charge: UNDP,NAP, Health Districts

SDA.7: Prophylaxis and Treatment for Opportunistic Infection
Activity-1: Purchase, store and distribute drugs to treat and prevent opportunistic diseases
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, FNM, NAP
Activity-2: Update the ARV & O:I management guidelines and conduct update training with international technical assistance
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, WHO, NAP, ISVSM
Activity-3: 1 month of training for 1 physician on Kaposi's sarcoma management in Mozambique **– Y-1**
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, NAP, Central Hospital
Activity-4: Screen all HIV infected patients for hepatitis B
Target population: 1.050 HIV infected patients
PR and Implementer in charge: UNDP,NAP, Health Districts

SDA-8: TB/HIV - Provide state of the art prophylaxis and treatment for patients co-infected with TB and their contactants
Activity-1: screen HIV infected patients for TB and administration of INH for those with PPD > 5 mm (purchase of INH and PPD test included in the tuberculosis GFATM round 8 grant)
Activity-2: screen all tuberculosis patients for HIV infection and provide ARV treatment with efavirenz, starting within the 4 weeks of TB treatment and cotrimoxazol administration irrespective of CD4 count (Efavirenz and cotrimoxazole budgeted on SDA-1)
Target Group: 120 TB patients per year
PR and Implementer in charge: UNDP, NAP, NTBP

SDA –9: Care and Support for the chronically ill
Activity 1 – Purchase and distribute water filter for HIV infected patients
Target population : all HIV/AIDS infected patients (446 Y1, 488 Y2, 548 Y3, 584 Y4, 610 Y5)
PR and Implementer in charge: UNDP, FNM, NAP, Health Districts
Activity-2 : Provide monthly supply of food for HIV/AIDS, including pregnant women
Target population : 223-Y1, 244-Y2, 274-Y3, 292-Y4, 305-Y5 patients
PR and Implementer in charge: IMVF, Red Cross, WFP
Activity-3: Provide training for 36 (12 per training) health care workers (physicians, nurses and technicians) on prevention for positives, behaviour change and couples counselling –Y-1 and Y-2
Target population: 1.050 PLWA

PR and Implementer in charge: UNDP, NAP, Health Districts, ISVSM
Activity-4: Provide training each year for 60 health care workers (20 in each training) on integral management approach for health teams working on 37 services of 7 Health Districts providing care to HIV infected patients, tuberculosis patients, Sexually Transmitted Infections, malaria, prenanatal care and reproductive health and PMTCT - **second and third years**
Target population: 1.050 PLWA
PR and Implementer in charge: UNDP, NAP, Health Districts, Central Hospital, ISVSM
Activity -5: Provide counselling and HIV testing to partners of HIV infected patients (bugeted on SDA.1)
Target population : 223-Y1, 244-Y2, 274-Y3, 292-Y4, 305-Y5 patients
PR and Implementer in charge: UNDP,NAP, Health Districts

SDA.10: Support for Orphans and Vulnerable Children
Activity-1 : Provide financial support for school tuition fees and school materials to orphans
Target population : orphans 40-Y1, 45-Y2, 50-Y3, 50-Y4, 50-Y5
PR and Implementer in charge: IMVF, Caritas
Activity-2 : Provide monthly supplies of food to orphans and their families
Target population : Orphans 40-Y1, 45-Y2, 50-Y3, 50-Y4, 50-Y5. (budget on SDA.9)
PR and Implementer in charge: IMVF, Red Cross

Objective 3 – Eliminate mother-to-child HIV transmission in São Tomé & Principe
In the last 5 years, the coverage of PMTCT interventions increased significantly. Data provided by the NAP monitoring system and DHS 2008/2009, indicate that uptake of HIV VCT during prenatal care is high. In 2009, 6.285 pregnant women up took HIV VCT. The estimated number of HIV infected pregnant women delivering each year in STP is 37. In 2009, 24 (63%) out of 37 HIV pregnant women were identified. Currently, the full package of PMTCT interventions and trained health care workers are available in 8 referral centres in all 7 Health Districts and at the Central Hospital. Despite of this, in 2009, because of the high rate of lost to follow up, only 14 among 24 found to be HIV infected, effectively received antiretroviral drugs for PMTCT. In order to curb this situation we have identified the need to establish a better provider-client relationship, in order to provide them more and better information and support to help them to cope with the HIV infection diagnosis and all issues related to it such us, HIV status disclosure, recommendation to not breastfeed, and fear of stigma and discrimination. In this sense, we will invest more effort on training for the health team and community members on each district to deliver outreach and social support interventions to HIV infected pregnant women, their infants and family. Every women testing HIV positive will be assigned to one health care team in accordance with their residence location or preference. This health team will be in charge of following the assigned mother-infant pair during pregnancy and after birth. Among the tasks of each team will be included: issues related to prevention of HIV infection transmission, especially MTCT, safe infant feeding, including the correct preparation of infant formula and administration of cotrimoxazole for the infant, among others. Home visits will be performed in the case of missing appointments. The team will also provide information and guidance about how to access nutritional support from Red Cross Cruz. If any woman decides to breastfeed her infant, she will be instructed to exclusive breastfeed and kept on ARVs.
SDA-11: PMTCT
Activity 1 – HIV VCT for pregnant women and their partners in every prenatal care service and at the central Hospital (Kits on the budget on SDA.1)
Target population: 6.300 pregnant women
PR and Implementer in charge: UNDP, NAP, FNM, Central Hospital
Activity 2 – ARV Prophylaxis for women and their infants (drugs budgeted on SDA.6)
Target population: 37 pairs of women and infant per year
PR and Implementer in charge: UNDP, FNM,NAP, Health Districts, Central Hospital
Activity 3 - Cotrimoxazole to infants born to HIV infected women
Target population: 37 infant born to HIV infected women per year (budgeted on SDA.7)
PR and Implementer in charge: UNDP, FNM,NAP, Health Districts, Central Hospital
Activity 4 – Provide infant formula to infants born to HIV infected women
Target population: 37 HIV exposed infant per year
PR and Implementer in charge: UNDP, FNM,NAP, Health Districts, Central Hospital

Activity 5 – Training for health care workers and community members, including birth attendants, to enable them to do outreach work, social support, as well as to deliver health education interventions
Target population: 37 pregnant women and infants
PR and Implementer in charge: UNDP, NAP, ISVSM, Health Districts, Central Hospital
Activity 6- Outreach and support home visits for pregnant women and infants
Target population: 37 HIV infected pregnant women and exposed infants per year
PR and Implementer in charge: UNDP, FNM,NAP, Health Districts, Central Hospital

Objective 4: to prevent parental transmission of HIV infection and other blood borne infection

Transfusion of blood is a life saving treatment. Nevertheless, people have an increased risk of acquire HIV and other infections, through transfusions of blood that have not been collected and tested correctly. In STP, there is only one blood bank, located at the Central Hospital. In 2006 the national policy for blood transfusion and a strategic plan was developed., but we still struggling to implement it because of lack of human resources, lack of technical capacity and equipments. Despite of this, thanks to the GFATM Round 5 Grant, since 2007, 100% of blood is HIV screened. Since 2009, 100% was reached also for hepatitis B, C and Syphilis. Currently, the Blood bank's physical facility is in bad condition and need at least some renovation to guarantee adequate bio safety and minimal comfort and confidentiality for workers and donors. In the last years, the proportion of paid donors decreased, but the proportion of family donors remains high. Therefore, it is important to continue to implement efforts to move towards voluntary blood donation. This work will be performed by UNDABESA an NGO that supports our blood bank educating the public, motivating and recruiting them as donors. Informative/educative communication materials for potential blood donors will be developed, focusing on self identify if they comply with criteria for blood donation and self-exclude when adequate. It is very clear that a number of transfusions currently prescribed were not essential and could be avoided. Therefore, we will sensitize and train physicians to avoid unnecessary transfusions and increase the use of blood substitutes.

Although the risk of acquiring HIV infection through an accidental exposure is low, it can not be neglected. Therefore, in order to protect health care workers from acquiring infections in health-care settings it is critical that they be trained to comply with infection control recommendations in handling sharps is the mainstay in the prevention of occupational HIV infection. In addition, availability of post exposure prophylaxis (PEP) is crucial to have health care workers confident that performing their duties will not endanger their lives or the lives of people with whom they interact. Availability of PEP, coupled with training and sensitization of health-care workers are essential to avoid stigma and discrimination against PLWA receiving care in health services.

According to the DHS, the **prevalence of hepatites B in our population can be as high as 13% It poses a burden to health care worker who are under the risk of occupational exposure. Hepatitis B vaccination for this population is not available. Therefore**. We will vaccinate all Health care workers (631) starting with those working in emergency room and surgical department. Hepatitis B. Because Hepatitis B serology would be very costly, vaccination will be given without it.

A key consensus at the 2005 Joint International Labour Organization/World Health Organization Technical Meeting for the Development of Policy and Guidelines regarding occupational and non-occupational HIV-PEP was that HIV-PEP must be part of comprehensive HIV prevention, occupational health, and post-rape care service policies. Services must be provided as part of a comprehensive prevention package that emphasizes primary prevention.

SDA.12: Blood Safety and Universal Precaution

Activity- 1: Establish the transfusion committee and system for transfusion adverse reactions surveillance
Activity- 2: Training for health care workers on good practices on hemotherapy Y-1 and Y- 3
Target population: 163.432 inhabitants
PR and Implementer in charge: UNDP, NAP, Health Districts, Central Hospital, ISVSM
Activity-3: Short-term training in Portugal or Brazil for 1 nurse and 1 technician on hemotherapy
Target population: 163.432 inhabitants
PR and Implementer in charge: UNDP, Blood Bank, NAP
Activity- 4: Purchase kits and reagents in to guarantee 100% of blood donors are screened for HIV,

syphilis, hepatitis B and C (includes HepB test for HIV infected patients budgeted on SDA.9)
PR and Implementer in charge: UNDP, FNM, Blood Bank
Activity-5: Purchase 10% of total need of 1.200 bags for blood collection per year
PR and Implementer in charge: UNDP, NAP, Blood Bank
Activity-6: Small renovation of the blood bank facility –Blood Bank
PR and Implementer in charge: UNDP, NAP, Blood Bank
Activity- 7: Purchase equipments & furniture for blood bank (2 fridges, 2 chairs for blood collection
Target population: 163.432 inhabitants
PR and Implementer in charge: UNDP, Blood Bank
Activity-8 :educative and advocacy activities to recruit and fidelize voluntary blood donors
Target population: 163.432 inhabitants
PR and Implementer in charge: IMVF, UNDABESA, NAP, Blood Bank
Activity- 9: Refresh Training for Health care workers on universal precaution -Y-2 and Y- 4
Target population: 163.432 inhabitants
PR and Implementer in charge: UNDP, NAP, Health Districts, , Central Hospital, ISVSM
Activity 10: Selection of services & training on care for occupational exposure and sexual abuse
PR and Implementer in charge: UNDP, NAP, Health Districts, Central Hospital, ISVSM
Activity-11: Secure ARV drugs, HIV and hepatitis test kits for occupational exposure and sexual violence victims and hepatitis B vaccine for all health care workers (631) (budgeted on objective 1 and 2)
PR and Implementer in charge: UNDP, FNM, Blood Bank
Activity- 12: Develop a system for surveillance of occupational exposure – Year 2
Target population: 500 health care workers
PR and Implementer in charge: UNDP, NAP

Objective 5: To increase institutional capacity of the National AIDS Program/Ministry of Health and Civil Society

SDA.13: Program Management and Administration
Activity-1: purchase of office and computer supplies for NAP
Activity-2: purchase of 8 desktops, 2 laptops, 01 scanner and 02 video-projectors (50% first year and 50% on year 4) for NAP operation
Activity-3: purchase of 1 copy machine for NAP
Activity-4 :purchase 01 vehicle for supervision visits – Year 3
Activity-5: support for salaries of 5 staff members (1 nurse, 1 physician, 1 Informatics technician, 1 staff for monitoring and evaluation, 1 administrative assistant)
Activity-6: subsidies for NAP collaborators (01 Director, 01physician,01 epidemiologist,01 psychologist, 02 nurses, 3 hotline lay staff, 02 laboratory technicians)
Activity-7: air ticket, perdiem and registration costs for participation of NAP technical staff and partners on 2 international meetings for updating and exchange of experiences **per year**
Activity-8: air tickets & perdiem for supervisions in Principe island (2 staff on each travel per year)
Activity-9: car fuel and perdiem for 02 staff for 4 supervision visits per year to 7 Health Districts
Activity-10: Translation costs: (U$ 5.000 per year)
Activity-11: car fuel to health districts supervision to the health services
PR and Implementer in charge: UNDP,NAP, Health Districts

SDA.14 Information system

Activity-1: Review of M&E framework and development of manual, tools, and training
Technical assistance for 45 days of work (review M&E framework & Tools, develop a Manual & training
PR and Implementer in charge: UNDP,WHO,NAP,ISVSM
Activity-2- monitoring & evaluation meetings (two per year) (30 participants -2 days)
PR and Implementer in charge: UNDP, NAP,
Activity-3: training for M&E partners on the reviewed system & use of the data collection tools
PR and Implementer in charge: UNDP,WHO,NAP
Activity-4: printing and distribution on M&E manual to governmental and non-governmental partners

Target population: 80 partners
PR and Implementer in charge: UNDP,WHO,NAP
Activity-5: Support the sentinel surveillance annual studies
Purchase kits, tubes, needles, labels, transportation bags, diesel, subsides for laboratory and field staff on sentinel sites, and for transportation of sex workers participating on surveys
PR and Implementer in charge: UNDP,WHO,NAP
Activity –6: Partially support the Demographic and Health Survey of 2014 (U$ 100.000)
PR and Implementer in charge: UNDP, NAP

SDA.15 Strengthening of Civil Society and Institutional Capacity building
Activity-1: subside for 1 project manager
Activity-2: office and informatics equipments, and management costs
Activity-4: 15 days of consultancy for capacity building on HIV prevention for sex workers for NGOs and NAP staff
Activity-5: 15 days for capacity building on HIV prevention for MSM for NGos and NAP program and design and planning of the situation analysis study on MSM
Activity-6: 15 days of consultancy during the execution of the MSM situation analysis study
PR and Implementer in charge: IMVF, WHO,NAP, ALISEI and other NGOs

SDA 16 – General management services.
Contribution GMS-PR

Complete this version of section 4.4.1(a) (b) and (c) if the applicant selected option 1 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal

4.4.1 Interventions

→ This section should be completed in parallel with the Consolidated Performance Framework and detailed budget and work plan

(a) Overview of programmatic activities

Describe the objectives, service delivery areas (SDA), and activities of the consolidated disease application. **The description must be organized in that exact order and the numbering system must match the Consolidated Performance Framework, detailed budget and work plan.**

The narrative description of the Round 10 interventions should reflect all objectives, service delivery areas (SDAs), and activities in the Round 10 consolidated disease proposal, but distinguish between what programming is being continued from existing grants versus new programming for Round 10.

The description must identify:
(1) who will implement each area of activity (e.g. Principal Recipient, Sub-recipient or other implementer);
(2) the targeted population(s);
(3) what changes in implementation and/or the targeted population(s) have occurred, if any, for those elements which are from existing grants and continuing in this consolidated disease proposal;
(4) any links between the existing grant activities to be continued in the consolidated disease proposal, as these activities previously existed in separate grants;
(5) any links between the proposed activities and existing Global Fund grants for other diseases or HSS; and
(6) how duplication will be avoided if there are linkages identified in points (4) and (5) above.

Not applicable

(b) Changes to existing SDAs, programmatic activities, indicators and targets

In the table below, list the SDAs and activities of existing grants consolidated within the Round 10 consolidated disease proposal. Explain whether each SDA and activity from an existing grant will be included in the Round 10 consolidated disease proposal by indicating an increase in scale, decrease in scale, continuation without change, or discontinuation. Provide justification for any proposed changes or discontinuation.

→ The proposed changes should be clearly and systematically reflected in the Consolidated Performance Framework

Round #	Service Delivery Area (SDA)	Activity	Proposed change	Justification for change
→ use "Tab" key to add extra rows				

(c) Changes to existing impact or outcome indicators and targets

Describe any major changes in indicators and targets that may have occurred due to the programming described above in sections (a) and (b) and that is supported by the Consolidated Performance Framework. In particular, if there has been discontinuation or change in indicators or if targets have been changed between previous grants and the Round 10 proposal, describe why this has occurred.

Not applicable

4.4.2 Addressing weaknesses from a previous category 3 proposal

If relevant describe how the weaknesses identified in the TRP Review Form of a previous category 3 proposal have been addressed.

Weakness	Response
Round 8:Epidemiological data are scarce and there is no situation analysis to support the proposed activities **Round 9: There remains a very weak understanding of the epidemiology of the HIV/AIDS epidemic, although it is stated that there will be studies in 2010 and 2012. The same issue was pointed out in Round 8 as a major weakness. It is therefore very difficult to justify the proposed interventions. The proposal has a plethora of interventions, lacks focus, and is unlikely to have much of an impact.** **Round 9: The proposal seeks to focus on highly vulnerable groups; however many of the proposed interventions are more appropriate for a generalized epidemic. There is no in-depth discussion on how these groups will be accessed and the reasons for their vulnerabilities.**	For the preparation of this proposal, data were gathered from different sources of reliable data, such us, the demographic health survey conducted during 2008/2009, sentinel surveillance on pregnant women and sex workers. Additionally, estimations were made with the use of the Spectrum software for the number of people living with HIV/AIDS, pregnant women and HIV/AIDS orphans, number of individuals in need of ARV treatment until, 2015. Moreover, programmatic data, including data from implementer partners, collected under the umbrella of the NAP current monitoring and evaluation framework were also gathered. Behavior data now available are broader and includes information for sex workers, a pivotal most at risk population in our epidemiological context. The DHS also provided reliable key data for prevention such us, rate of HIV test uptake, knowledge of HIV serostatus, condom use, number of partners among other. Therefore, we believe that the epidemiologic and program performance data we present in this round 10 proposal support the strategies and interventions prioritized to be funded by Global Fund. Funds requested in this proposal will contribute to strengthen our capacity to conduct key epidemiologic studies in order to have data about how the epidemic is evolving among the most at risk population in our country. A more detailed information will allow the NAP and other partners to better know the epidemic in STP and better monitor the country response to the epidemic
Round 9: No proper rationale provided	They had been taken measured to

for selecting UNDP as the Principal Recipient instead of a national body	improve the managemental capacity of " Centro National de Endemias" , so that this governmental institution assumed the leadership as PR. However, its functioning was not considered still adjusted when evaluated for the LFA in a recent visit. Currently it was not possible to identify any institution of the prepared Health department to play this role. In face of this situation, a public call for presentation of proposals for the Global one launched and as Beneficiary Deep Main performance as Beneficiary of a Main one were selected, the Institute Mark of Valle Flower. This Institute will go to share with the PNUD, the administration of the resources of the proposal of R10, executing all the activities related with the Civil Society.	
Round 9: The budget has quadrupled since the Round 8 submission with very modest outcomes. For example, the percentage of young women and men who have had sexual intercourse before the age of 15 decreasing from a baseline of 60 percent to an end line of 58 percent over 5 years; considering that the 15-25-year-old population stands at 33,867, this would indicate that less than 700 people actually changed behavior (when US$ 600,000 is allocated to generalized behavior change communication). **· Round 9: The behavior change communication activities appear particularly inappropriate for the type of epidemic, with only 18 percent of the behavior change communication budget going to most-at-risk groups, and 82 percent going to the general population**	The proposal and the budget were reviewed. We have discussed with our partners and it was agreed that **UNICEF** would take the charge of the cost of mass media communication for the general population. Therefore, only communication activities for most at risk populations are included in the budget.	
Round 8: Although the proposal has a M&E plan, it needs elaboration **Round 8: The proposal does not indicate any activities to build the infra-structure to improve the performance of the STI/HIV Program**	The performance framework was completely and carefully reviewed. In the Round 10 proposal, indicators related to condom use were included. It was possible because since the last submission, we received the results from the DHS	

	Round 9: The performance framework is very weak, particularly the impact indicators which do not adequately reflect the key activities. For example, there is a big focus on condom distribution (to reach 3 million per year by year 5, or 34 per adult over 15 per year) with no indicator on condom use	conducted in 2008/2009, which report was not available by the time of the round 9 proposal preparation. Now we have some baseline data about condom use and expect to have similar quality data from the next DHS to be conducted in 20014. Besides condom use, the DHS also provided reliable key data for prevention such us, rate of HIV test uptake, knowledge of HIV serostatus, condom use, number of partners among other. These data are now being incorporated as baseline for our performance frame worker. Funds requested in this proposal will contribute to strengthen our capacity on monitoring evaluation will allow us to keep the process of improvement of the capacity of NAP and health districts on monitoring and evaluation.	
	Round 9: There is a mention of male commercial sex workers and a lack of framework to protect sexual minorities; however, there is no discussion specifically of men who have sex with men and their vulnerabilities to HIV/AIDS.	This is a very difficult field to work due to high stigmatization and discrimination. However, we are fully committed to overcome these barriers and learn how to work with this high-risk population. To correct this weakness, in this Round 10, we are requesting funds to conduct a situation analysis of the MSM community on STP, based on the successful experience we had in the Sex Workers field with the NGO ALISEI. Funds are being requested for capacity building and we expect to be able to initiate the prevention work focused on MSM soon.	
	Round 9: There is a mention of the introduction of female condoms but there is no discussion of how they will be introduced or their acceptability	On this Round 10, funds are being requested exclusively for male condoms. Female are already provided by the authorities with the support of UNFPA in a pilot project. We will take advantage of this provision to pilot the acceptability of female condoms among sex workers in partnership with the NGO which is developing the prevention work with sex workers and partnership with health services, for pilot its acceptability among HIV infected women. No cost will be charged to Global Fund	
	Round 9: There is a poor description of how this proposal will coordinate with other funding streams identified	Unfortunately, we do not have many sources of financing for HIV/AIDS. They are, basically, UN agencies, the governments of Brazil and Portugal. Therefore, it is not difficult to co-ordinate with our partners. In the preparation of this proposal, as, the quarrels they had been always carried through with our partners to	

	decide what she would be covered per item of them and that would be enclosed in this 10 Round Proposal, preventing duplications and confusions	
Round 9: It is not clear how the capacity of health facilities to provide necessary services will be strengthened. Infrastructure improvements proposed in response to the weaknesses identified by the TRP in the Round 8 proposal are limited to the national AIDS control program and some laboratory equipment.	On this round, we clearly describe how the capacity of both central level (NAP) and Health services (at District level) will be strengthened. In this regard it is important to highlight1- the training of the health teams at the district level to implement the integrated approach on health of the patients; 2- secured financial resources on the proposal budget to cover, car fuel for transportation during visits, office supplies; 3- participation on the capacity building activities requested for prevention among sex workers and MSM, requested on; 4- participation on the training on monitoring & evaluation to be conducted after the review of the M&E framework and data collection system. In addition, the services at the district level will benefit from resources from the malaria and tuberculosis global fund grants, such as motorcycles and fuel (malaria round 7) that will allow for adequate channel of condoms to distribution points out of the health services.	
Round 9: The approach to tuberculosis/HIV/AIDS co-infection is an important element, but poorly developed	As in other developing countries, in STP tuberculosis is the leading cause of death among HIV infected patients. Among tuberculosis patients, 12% are HIV infected. The TB Program recently got a Global Fund Grant Round 8 and a set of interventions are being implemented such as decentralization of treatment to districts, DOTS, improvements on diagnosis, especially of baciloscopy at the level of districts, among others. This proposal has strong connections with Round 8 Tuberculosis, specifically regarding TB/HIV on interventions intended to reduce the progression of HIV disease on tuberculosis patients and prevention of tuberculosis among HIV infected patients on follow up, through administration of isoniazide. Since 2006, with Round 5 funding availability of counseling and screening for TB patients and Cotrimoxazole prophylaxis has been assured. Currently, VCT for TB is concentrated on the central hospital, because all patients with TB currently are hospitalized. The PNLCT is preparing the ground for decentralization of TB treatment	

		to the district level. Therefore, VCT for TB patients will need to be conducted at the health services. Although we already have this capacity at the district, level, careful supervision will be implemented in order to guarantee the high level of HIV screening this population. The TB program will take advantage of the technician trained on TB microscopy with HIV round 5 grant resources 21 Since 2008, efavirenz is available through Global Fund resources, to all TB/HIV co-infected patients. On this round 10th proposal, funds will provide tuberculin test (PPD) and INH prophylaxis for those with reaction ≥ 5mm. The AIDS and TB National Programs are already working in collaboration. This partnership allows for joint planning of trainings, purchase of drugs, health services supervisions and home visits. We believe that this strengthened partnership will allow the tuberculosis program to find more cases and contacts of smear positive patients and the AIDS Program will to diagnose more HIV infections among partners of TB patients. Both programs will also be benefited by a higher adherence to treatment and completion of TB treatment with cure, decreasing morbidity and mortality and the risk of resistance development to TB drugs and ARV drugs.	

4.4.3 Lessons learned from implementation experience

How do the implementation plans and activities described in 4.4.1 above draw on lessons learned from program implementation (from either Global Fund financed or non-Global Fund financed programs)?

The National AIDS program has been coordinating the national response to HIV/HIV epidemic since it was established back to 1987 and its team has gained considerable experience along the years. In addition, with the submission made by the country to the Global Fund Round 5 and subsequent implementation, the country learned a new way to address the epidemic of HIV / AIDS from a strategic alliance between the Government, Civil Society and International Cooperation .

Among the lessons learned are:

1- Knowledge about the epidemic is strategic for a strong country response.

2. The fight against HV/AIDS is an axis of integration of international cooperation resources from various bilateral and multilateral sources, and requires a careful and efficient management.

3. The district health scenario is a prime setting for action on implementation of successful actions in combating the HIV/AIDS epidemic;

4. The Monitoring and Evaluation system is an essential and important support for the process of decision making

5. Increase coverage of knowledge of HIV status by the general population is an element that contributes to reducing stigma and discrimination.

6. It is possible to organize the distribution of condoms at the national level under the responsibility of a members of Civil Society and with the participation of numerous public and private actors.

7. It is not enough to test pregnant women, it is essential to identify effective strategies to reduce the number of women infected "lost" by the program.
8. Most at risk populations such as sex workers can be accessed when working with community partners, strengthening both NGOs and NAP capacity

9. Health workers progressively lower levels of stigma and discrimination against infected people to the extent they receive information and training.
10. Cost of STI is a barrier to adequate treatment
11. Having a functional logistics of health products, is essential to increase the confidence of the population on Health services
12. The services of sexual and reproductive health are important ally for PMTCT.
13. Men, because of the role they play in the epidemic, need a particular approach in terms of making counseling and voluntary testing attractive to them

4.4.4 Enhancing TB/HIV collaborative activities

Describe:

(a) how the proposal will contribute to strengthening TB/HIV collaborative activities; and
(b) the collaboration between the National TB program and the HIV services of your country.

As in other developing countries, in STP tuberculosis is the most frequent opportunistic infection and the leading cause of death among HIV infected patients. Among tuberculosis patients, 12% are HIV infected. This proposal has strong connections this Round 8 TB Grant implementation, specifically regarding TB/HIV on interventions intended to reduce the progression of HIV disease on tuberculosis patients and prevention of tuberculosis among HIV infected patients on follow up, through administration of isoniazide.

Since 2006, with Round 5 HIV/AIDS Grant, HIV VCT as well as Cotrimoxazole prophylaxis is available for patients with tuberculosis with high coverage. Currently, VCT for TB is concentrated on the central hospital because, currently, all patients with TB stay in hospital for at least some weeks. The Tuberculosis program is now preparing the ground for decentralization of TB treatment to the district level. Therefore, VCT for TB patients will also be performed at the health services at District level. Although we already have this capacity at District level, careful supervision will be implemented in order to guarantee the current high level of HIV screening this population. The TB program will take advantage of the 40 technician trained on TB microscopy with HIV round 5 grant resources. Since 2008, efavirenz is available through Global Fund resources, to all TB/HIV co-infected patients.

On this round 10th proposal, funds will provide tuberculin test (PPD) and INH prophylaxis for those with reaction ≥ 5mm. Along the last year we have been increasing our collaboration with the TB program that is now gaining better infrastructure thanks to the Round 8 Grant. We can mention forecasting of kits, reagents and drugs, as well as planning and conduction of training programs. Important to highlight that, health care workers teams that provide care for HIV, TB and Malaria patients are the same. Treatment of TB will soon be decentralized coupled with DOTS implementation. Patients will then, be able to get both ARV and TB drugs at the same health service. We will train the teams at the district level to work in an integrated approach to cover the integral health care needs of the patients under their care, including outreach of patients lost to follow up irrespective of the program they participate. In addition they will be trained to better register and collect data included in the M&E framework of both programs. Working under the integrated approach concept, we will be able to start ARV treatment earlier as well as to screen the HIV/TB patient's partners for HIV earlier. We believe that this strengthened partnership will allow the tuberculosis program to find more cases and contacts of smear positive patients and the AIDS Program will be able to provide HIV VCT to partners of HIV patients with TB and prevent HIV transmission among discordant couples. Both programs will also benefit by a higher adherence to treatment and completion of TB treatment with cure, decreasing morbidity and mortality and the risk of resistance development to TB drugs and ARV drugs.

4.4.5 Enhancing social and gender equality

Using specific references to objectives, SDAs, and activities included in section 4.4.1, explain how the Round 10 interventions address issues related to social and gender equality and confirm that these items have been properly costed in the budget.

To ensure social equity and gender this proposal prioritize high-risk groups and vulnerable particularly sex workers, youth out of school, non-scholarized individuals **(Objective 1 SDA.1** (Act 1, Act 2, Act 3, ACT 4), though implementing the provider initiated HIV VCT, making available communication materials, Income generating activities will be made available to PLWA and sex workers **(Objective 1.SDA.4, Act 5).** Availability of condoms and STI treatment at no cost to patients will increase access to those social vulnerable to these treatment **(objective 1, SDA. 2, Act 1, Act 2, Act 3, Act 4).** Capacity building on NAP and NGOs to work with sex workers and MSM will increase access of these socially vulnerable population to key prevention and care interventions **(Objective 5: SDA.15 Act 5, Act 6).** Income generating activities for PLWA and sex workers will contribute to decrease the social vulnerability of these groups **(Objective 1, SDA. 5, Act 5).** The weaknesses identified in section 4.3 - coverage of HIV testing in men, and poor access to services in the male population of STI, late diagnose of HIV infection of infant born to HIV infected women mothers, limited access to the support of orphan children are being addressed, as stated above, as well as the needs of sexual minorities such us MSM. The proposal also addresses the needs of impoverished populations especially those non-scholarized though production of HIV/AIDS educative materials targeting them. The decentralization of ARV treatment to 80% of health services operating in the country will increase access to treatment of those social vulnerable, a large piece of HIV/AIDS patients. **(Objective 2, SDA.6, Act 3).**
In STP, poverty deeply affects a large proportion of sex workers.

4.4.6 Partnerships with the private sector

Describe how contributions related to: (i) co-investment from the private sector, and (ii) donated goods or services, will add value to the planned outcomes of the proposal. Make specific reference to the associated objectives, SDAs, or activities to which they are linked.

In 2007, an innovative information service was launched to provide to the public reliable information on HIV/AIDS prevention and care. The service is a tollfree hotline - **Linha Verde** (Green line). Provided free of cost by the **"Companhia Santomense de Telecomunicações - (CST)",** the toll-free line is operated by people living with AIDS, who were previously trained by the National AIDS Program staff. The NAP also provides space on its facilities as well as daily supervision. With an average of 8.7 calls per day, the service operates from Monday to Friday from 8:00 am to 5:00 PM. The service keeps brief statistics about questions calls of the calls and register the issue of each question. One of the advantages of the service is the fact that people can call anonymously. It is even more valuable in an environment of stigmatization that still a reality in São Tomé & Principe. The service also provides information about where to go to get condoms, VCT, STI and AIDS treatment and care. Data collected by the toll free hotline (**Linha Verde**), are being analyzed contribute to the communication material to be developed for prevention of HIV/AIDS and STI. The CST also provided funds to develop a website where HIV/AIDS information and activities on the field can be obtained. Currently, negotiations are ongoing with CST to implement a MSN message delivery service in partnership with NAP. This initiative will take advantage of the high coverage of mobile services in São Tomé and Principe, where 90% of the population has access to a mobile phone.
The private sector will benefit from the training and capacity building provided to health care workers (they in general have more than one job and some combine, public and private positions).

Only complete section 4.4.7 if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form, DO NOT COMPLETE section 4.4.7 if the applicant selected Option 1 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal
Option 2 = Transition to a single stream of funding during grant negotiation
Option 3 = No transition to a single stream of funding in Round 10

4.4.7 Links to other Global Fund resources

Describe in the table below the linkages between this Round 10 proposal and existing Global Fund resources. It is important to list the SDAs and activities as outlined in the current proposal in the left hand column, add a description as to how they relate to previous grants in the middle two columns, and then outline how the Round 10 proposal specifically addresses this in the right-hand column.

Key SDA and activity as proposed in the Round 10 proposal	Existing grants		Round 10 Proposal
	ROUND 5 VIH	*ROUND 8 TB*	
1. SDA : **Testing and Counseling**			
1.1.1 Activity: Develop a plan and guidelines for introduction of the provider initiated HIV testing	**No**		The provider initiated HIV testing is part of an strategy to increase testing and counselling
1.1.1.1 Activity: Work session to develop the plan and guidelines			
1.1.1.2 Activity: Workshop for plan and guidelines validation			
1.1.1.3 Activity: Printing of the plan and guidelines (200 copies)			
1.1.2 Activity: Training of 180 health care workers on HIV counseiling and testing approach	**No**		The provider initiated HIV testing is part of an strategy to increase testing and counselling
1.1.2.1 Activity: Training of 160 physitians, nurses and other health care workers on HIV counseiling and testing approach in ST			
1.1.2.2 Activity: Training of 20 physitians, nurses and other health care workers on HIV counseiling and testing approach in Principe			
1.1.3 Activity: 177,000 HIV test kits purshase	**Yes**		The provider initiated HIV testing is part of an strategy to increase testing and counselling

1.1.4 Activity: 177,000 HIV test kits storage & distribution	**Yes**		The provider initiated HIV testing is part of an strategy to increase testing and counselling
1.1.5 Activity: Develop, print and distribute communication material to stimulate HIV test uptake by the sexually active population specially men (posters and flyers)			
2. SDA:**STI Diagnose and Treatment**			
1.1.6 Activity: Training/refresh of 160 health care workers on STI syndromic approach in ST			
1.1.7 Activity: Training/refresh of 20 health care workers on STI syndromic approach in Principe			
1.1.8 Activity: STI drugs purshase	**Yes**		
1.1.9 Activity: STI drugs storage and distribution	**Yes**		
1.1.10 Activity: Distribute free of charge condoms (costs covered by UNFPA)	**Yes**		**Health district will be in charge of distribution on district and community level with participation of the health community workers**
1.1.11 Activity: Counseling and HIV testing, under the provider initiated approach in all services providing STI care (budget on SDA1-testing and counseiling)	**No**		The provider initiated HIV testing is part of an strategy to increase testing and counselling
3. SDA **:BCC Mass Media**			
1.1.12 Activity: All Mass Media activities (safe sexual behaviour, stigma and discrimination mitigation, among others, **will be supported by UNICEF)**	**Yes**		
4. SDA **:BCC Community outreach and Most-at-risk population**			

1.1.13 Activity: Provide activities of sensitization and capacity building for Health Care workers, policemen, owners of bars and brothels **in ST**	**No**		Provide activities of sensitization and capacity building for Health Care workers and others will be involved to approach the most-at-risk population
1.1.14 Activity: Provide activities of sensitization and capacity building for Health Care workers, policemen, owners of bars and brothels **in Principe**	**No**		Provide activities of sensitization and capacity building for Health Care workers and others will be involved to approach the most-at-risk population
1.1.15 Activity: Provision of condoms to be distributed free of charge to SW and their clients (costs covered by UNFPA)	**Yes**		
1.1.16 Activity: Peer education on HIV prevention activities involving sex workers, clients, bar owners, among others	**Yes**		Peer education activities will have a wide approach, instead of be limited to SW
1.1.17 Activity: Develop educative materials **(posters)** focusing prevention for sex workers and clients, MSM, STI, rural population promoting condom use and informing where condoms can be obtained for free			
1.1.18 Activity: Develop educative materials **(flyers)** focusing prevention for sex workers and promoting clients, MSM, STI, rural population condom use and informing where condoms can be obtained for free			
1.1.19 Activity: Financial support to income generating programs to include SW among beneficiaries	**No**		This initiative take part of a new approach to the SW social situation
1.1.20 Activity: situation analysis and strategic plan for intervention on MSM population (2nd Year)	**No**		This initiative take part of a new approach to the MSM social situation
1.1.21 Activity: Training for selected MSM to implement peer education activities on the Field of HIV prevention and care (3rd 4th and 5th years)	**No**		This initiative take part of a new approach to the MSM social situation
1.1.22 Activity: Elaboration & reproduction of 500 forms for registration of transfusion (Y1-Q1) and			

120 to system for surveillance of occupational exposure (Y2-Q1)			
1.1.23 Activity: Develop flips charts for use of health care workers and community members on education of non schoolarized population			
5. SDA: **Condoms**			
1.1.24 Activity: Purchase, store and distribute 14 million male condoms in 5 year costs covered by UNFPA	**Yes**		Number of condoms distributed will be increased
1.1.24.1 Activity: Purchase, of 1,834,000 male condoms-costs covered by UNFPA	**Yes**		Number of condoms distributed will be increased
1.1.24.2 Activity: Store and distribute 1,834,000 male condoms-costs covered by UNFPA	**Yes**		Number of condoms distributed will be increased
1.1.25 Activity: Increase the number of points of condoms distribution **from 393 to 513 by the end of year 4**, and improve the logistic of supplying the distribution points			
1.1.26 Activity: Develop, print and distribute **flyers and posters** with prevention messages promoting condom use and informing where condoms and lubricants can be obtained for free (budget on SDA.4-BCC Community Outreach and schools)			
1.1.27 Activity: Purchase Lubricants (10% number Condoms)			
1.1.28 Activity: Store and distribute Lubricants (10% number Condoms)			
1.1.29 Activity: Regularly supply the distributions points with condoms (fuel)			
6. SDA: **Antiretroviral Treatment (ARV) and Monitoring**			
2.1.1 Activity: Purchase, store and distribute ARV drugs suitable for first and second line treatment (includes PMTCT – 37 women and infant per year) - (excluding those donated by IMVF and Brazil)	**Yes**		

2.1.1.1 Activity: Purchase of ARV drugs suitable for first line treatment			
2.1.1.2 Activity: Purchase of ARV drugs suitable for second line treatment			
2.1.1.3Activity: Store and distribute ARV drugs suitable for first and second line treatment			
2.1.2 Activity: Purchase, store and distribute kits and reagents for 4.014 CD4 count for 5 years (669 year 1, 532 year 2)	**Yes**		
2.1.2.1 Activity: Purchase kits and reagents for 4.014 CD4 count for 5 years (669 year 1, 532 year 2)			
2.1.2.2 Activity: Store and distribute kits and reagents for 4.014 CD4 count for 5 years (669 year 1, 532 year 2)			
2.1.3 Activity: CD4 count machine maintenance Y1, Y3, Y5	**Yes**		
2.1.4 Activity: Air ticket to specialist in CD4 count machine maintenance			
7. SDA**: Prophylaxis and Treatment for Opportunistic Infection**			
2.1.5 Activity: Purchase drugs to treat and prevent opportunistic diseases	**Yes**		
2.1.6 Activity: Store and distribute drugs to treat and prevent opportunistic diseases	**Yes**		
2.1.7 Activity: International consultant to update the ARV & IO management guidelines			
2.1.7.1 Activity: Air ticket to international consultant to update the ARV & IO management guidelines			
2.1.7.2 Activity: Per diem to international consultant to update the ARV & IO management guidelines			
2.1.7.3 Activity: Honorarium to international consultant to update the ARV & IO management guidelines			
2.1.8 Activity: Update the ARV & OI management guidelines and conduct update training			

2.1.9 Activity: Training for 1 physician on Kaposi's sarcoma management in Mozambique (1 month) **– Y-1**			
2.1.10 Activity: Purshase Hepatites B vaccin			
2.1.11 Activity: Per diem in Mozambique, 1 month			
2.1.12 Activity: Screen all HIV infected patients for hepatitis B (budget on SDA.12)			
8. SDA**: TB/HIV - Provide state of the art prophylaxis and treatment for patients co-infected with TB and their contactants**			
2.1.13 Activity: Screen HIV infected patients for TB with PPD	**No**		Improve the co-infection approach
2.1.14 Activity: screen all tuberculosis patients for HIV infection and provide ARV treatment with efavirenz (Efavirenz and cotrimoxazole budgeted on SDA-1)	**Yes**		
9. SDA**: Care and Support for the chronically ill**			
2.1.15 Activity: International consultancy to adapt guidelines on Inetragted care Management Adult and Adolescent (2 weeks; Same cost like in activity 2.1.7)			
2.1.16 Activity: Purchase water filter for HIV infected patients			
2.1.17 Activity: Distribute water filter for HIV infected patients			
2.1.18 Activity: Provide monthly supply of food for HIV/AIDS, including pregnant women	**No**		Improve the support approach
2.1.19 Activity: Training for 60 health care workers on integral management approach	**No**		Improve the management approach
2.1.20 Activity Training for 36 health care workers on prevention for positives, behaviour change and couples counselling –Y-1 and Y-2			
2.1.21 Activity: Provide counselling and HIV testing to partners of HIV infected	**No**		Improve the testing approach

patients (bugeted on SDA.1)			
10. SDA: Support for orphans and vulnerable children			
2.1.22 Activity: Provide financial support for school tuition fees and school materials to orphans	**Yes**		
2.1.23 Activity: Provide monthly supplies of food to orphans and their families(budget on SDA.9)	**No**		Improve the support approach
11. SDA: PMTCT			
3.1.1 Activity: HIV VCT for pregnant women and their partners in every prenatal care service and at the central Hospital (Kits on the budget on SDA.1)			
3.1.2 Activity: ARV Prophylaxis for women and their infants (drugs budgeted on SDA.6)	**Yes**		
3.1.3 Activity: Cotrimoxazole to infants born to HIV infected women (drugs budgeted on SDA7)	**Yes**		
3.1.4 Activity: Provide infant formula to infants born to HIV infected women	**Yes**		
3.1.5 Activity: **T**raining for health care workers and community members, including birth attendants, to enable them to do outreach work, social support, as well as to deliver health education interventions	**No**		Improve the outreach and social support approach
3.1.5.1 Activity: **T**raining for health care workers and community members, including birth attendants, to enable them to do outreach work, social support, as well as to deliver health education interventions in ST			
3.1.5.2 Activity: **T**raining for health care workers and community members, including birth attendants, to enable them to do outreach work, social support, as well as to deliver health education interventions in Principe			
3.1.6 Activity: Outreach and support home visits for pregnant women and infants	**Yes**		
12. SDA:Blood safety and universal precaution			
4.1.1 Activity: Establish the transfusion committee and system for transfusion adverse reactions surveillance	**No**		Improve security of Blood safety transfusion

(including elaboration and reproduction of 500 forms-see SDA4)			
4.1.2 Activity: International consultancy in hemotherapy (2 weeks; Same cost like in activity 2.1.7)			
4.1.3 Activity: Training for health care workers on good practices on hemotherapy Y-1 and Y- 3			
4.1.4 Activity: Short-term hands on training in Portugal or Brazil for 1 technician on hemotherapy: Air ticket to Portugal or Brazil			
4.1.5 Activity: Short-term hands on training in Portugal or Brazil for 1 technician on hemotherapy: Air ticket to Portugal or Brazil			
4.1.6 Activity: Purchase kits and reagents in to guarantee 100% of blood donors are screened for HIV, syphilis, hepatitis B and C	**No**		Improve security of Blood safety transfusion
4.1.6.1 Activity: kits and reagents purshase			
4.1.6.2 Activity: kits and reagents storage & distribution			
4.1.7 Purchase 10% of 1.200 bags for blood collection per year	**Yes**		
4.1.8 Activity: Small renovation of the blood bank facility –Blood Bank			
4.1.8.1 Activity: Broadcast to select construction enterprise			
4.1.8.2 Activity: Contract selected construction enterprise			
4.1.9 Activity: Purchase equipments and furniture to improve the blood bank infra-structure (2 fridges with temperature register, 2 chairs for blood collection and other furniture –Blood Bank	**No**		Improve security of Blood safety transfusion
4.1.9.1 Activity: Purchase 2 fridges with temperature register			
4.1.9.2 Activity: Purchase 2 chairs for blood collection			

4.1.9.3 Activity: Educative and advocacy activities to recruit and fidelize voluntary blood donors			
4.1.10 Activity: Refresh Training for Health care workers on universal precaution -Y-2 and Y- 4	**Yes**		
4.1.11 Activity: Selection of services in each district to provide care to victim of occupational exposure to HIV and sexual abuse and provision of training for the team	**No**		Improve the provision of care to victim of occupational exposure
4.1.12 Activity: Secure ARV drugs, HIV and hepatitis test kits for victims of HIV occupational exposure and victims of sexual violence (budgeted on objective 1 and 2)			
4.1.13 Activity: Develop a system for surveillance of occupational exposure – Year 2 (elaboration na reproduction of 120 forms-see SDA4)	**No**		Improve the knowledge of occupational exposure
13. SDA:Programme management and Administration cost			
5.1.1 Activity: purchase of office and computer supplies (50% first year and 50% on year 4) for NAP operation	**Yes**		
5.1.1.1 Activity: 8 desktops + 8 UPS			
5.1.1.2 Activity: Copy machine			
5.1.1.3 Activity: 2 laptops			
5.1.1.4 Activity: 01 scanner			
5.1.1.5 Activity: 2 video-projectors			
5.1.2 Activity: purchase 01 vehicle for supervision visits – Year 3	**Yes**		
5.1.3 Activity: Broadcast to select 1 driver, Y3			
5.1.4 Activity: Driver recruitment			
5.1.5 Activity: Car insurance			
5.1.6 Activity: Car maintenance			

5.1.7 Activity: support for salaries of 4 staff members (1 nurse, 1 physician, 1 administrative assistant, 1 driver)	**Yes**		
5.1.8 Activity: Broadcast to select 1 informatic technicien, 1 technicien in M&E	**No**		
5.1.9 Activity: Recruitment of 1 informatic technicien, 1 technicien in M&E			
5.1.10 Activity: Work assurance (Van Breda) for NAP staff (7)			
5.1.11 Activity: subside for NAP collaborators (program director, 01 physician, 01 epidemiologist,01 psychologist, 02 nurses, 3 hotline staff, 02 laboratory technicians)	**Yes**		
5.1.12 Activity: Air ticket for participation of NAP technical staff and partners on 2 international meetings for updating and exchange of experiences **per year**			
5.1.13 Activity: Perdiem and registration costs for participation of NAP technical staff and partners on 2 international meetings for updating and exchange of experiences **per year**			
5.1.14 Activity: Air tickets&perdiem for supervisions in Principe island (2 staff on each travel per year)			
5.1.14.1 Activity: Air tickets for supervisions in Principe island (2 staff on each travel per year)			
5.1.14.2 Activity: Perdiem for supervisions in Principe island (2 staff on each travel per year)			
5.1.15 Activity: Perdiem for 02 staff for 4 supervision visits per year to 7 Health Districts			
5.1.16 Activity: car fuel for 02 staff for 4 supervision visits per year to 7 Health Districts			
5.1.17 Activity: car fuel to health districts supervision to the health services			
5.1.18 Activity: Translation costs: (U$ 5.000 per year)			

5.1.19 Activity: Subside for FNM collaborators			
5.1.20 Activity: Broadcast to select 1 national program officer			
5.1.21 Activity: Recruitment national program officer			
14: SDA: Information system			
5.1.22 Activity: Review of M&E framework and development of manual, tools, and training			
5.1.22.1 Activity: International consultancy to review of M&E framework and development of manual, tools, and training			
5.1.22.2 Activity: Air ticket			
5.1.22.3 Activity: Perdiem to ITA			
5.1.22.4 Activity: Honorarium to ITA			
5.1.22.5 Activity: Training to NAP and Health Districts staff as well as NGO and other implementer partners on data collection			
5.1.23 Activity: Monitoring & evaluation meetings (two per year) (30 participants -2 days)			
5.1.24 Activity: surveillance annual studies			
5.1.25Activity: Partially support the Demographic and Health Survey of 2013 (U$ 100.000)	**No**		Improve the knowledge of socio-demographic features related to HIV epidemic model
15 SDA: Strengthening of civil society and institutional capacity building			
5.1.26 Activity: 1 staff member of second principal recipient (1project manager)	**No**		Improve the institutional capabilities of 2nd PR
5.1.26.1 Activity: Project manager selection			

5.1.26.2 Activity: Subsidy to project manager			
5.1.27 Activity: office and informatics equipments, and management costs			
5.1.27.1 Activity: 1 desktops + 1 UPS			
5.1.27.2 Activity: Copy machine			
5.1.27.3 Activity: 01 scanner			
5.1.27.4 Activity: 1 Printer			
5.1.28 Activity: 15 days of consultancy for capacity building on HIV prevention for sex workers for NGOs and NAP staff			
5.1.28.1 Activity: ATKT			
5.1.28.2 Activity: Per diem for consultant			
5.1.28.3 Activity: Honorarium to consultant			
5.1.29 Activity: 15 days for capacity building on HIV prevention for MSM for NGos and NAP program and design and planning of the situation analysis study on MSM			
5.1.29.1 Activity: ATKT			
5.1.29.2 Activity: Per diem for consultant			
5.1.29.3 Activity: Honorarium to consultant			
5.1.30 Activity: 15 days of consultancy during the execution of the MSM situation analysis study			
5.1.30.1 Activity: ATKT			
5.1.30.2 Activity: Per diem for consultant			
5.1.30.3 Activity: Honorarium to consultant			
5.1.31. Activity: ITA to capacity building of new 2nd PR on project management by GF rules (2 month)			

5.1.31.1 Activity: ATKT			
5.1.31.2 Activity: Per diem for consultant			
5.1.31.3 Activity: Honorarium to consultant			
5.1.32 Activity: Management Cost			
5.1.33 Activity: Executive desk			
5.1.34 Activity: Supply			
5.1.35 Activity: Executive chair			
5.1.36 Activity: Visitor/normal chair			
5.1.37 Activity: Executive office cabinet			
16: SDA:Contribution GMS-PR			
5.1.38 Activity: GMS (FSA 7%)-PR			

4.4.8 Links to non-Global Fund resources

Describe whether the Round 10 interventions (e.g. goals, objectives, SDAs, and activities) listed in section 4.4.1 have linkages to programs financed through non-Global Fund resources. If such linkages exist, list the non-Global Fund financed programs and their activities, and explain how the proposal complements those programs and activities. In addition, explain how the Round 10 interventions do not duplicate existing programs and activities supported by non-Global Fund resources.

IMVF: This proposal will be implemented in close collaboration with the "Health for All Project" run by the NGO "Instituto Marquês de Valle-Flôr"(IMVF). The goal of that project is to guarantee the access to primary health care, at the level of district and local health centers. It includes access to laboratory exams in every one of the 7 Health Districts, such as hematology and biochemistry, which are important for monitoring of adverse events on patients on antiretroviral therapy. Each one of the 7 District or Local Health Centre set up by the IMVF has a target population of 4,415 inhabitants on average. Among the expected results for the "Health for All project" are: i) a structured and functional network of healthcare facilities; ii) integrated patient care; iii) trained district managers; iv) strengthened IEC activities; v) promoting activities for water and sanitation; and vi) improved management capacities. To achieve the results, the following actions will be undertaken: functional restructuring of infrastructure and addition of equipment, consumables for diagnostics, as well as medicines. Regarding HIV/AIDS, the IVMF provides to the NAP the TRIOMUNE that is a fixed dose combination of stavudine, lamivudine and nevirapine. **(Objective 2, SDA.6; SDA.9)**

UN Agencies:

UNICEF: will cover the costs of Mass Media Communication (UNICEF) - stigma and discrimination mitigation, prevention among general population and youth (peer education),

UNFPA: will cover cost of condoms (2,8 million of male condoms per year for 5 years; 1.500 female condoms – until the results of female condom acceptability study are available, full financing of the female condom acceptability study) and gender equity activities**. (Objective 1, SDA.5, SDA.4). The cost of condoms represented a large piece of the budget of the proposal presented on round 9.**

WFP: will cover costs of nutritional support for patients on ARV treatment. **(Objective 2, SDA. 9).**

The Brazilian Government provides most of the antiretroviral drugs necessary for first line treatment, as well as for prophylaxis of mother-to-child transmission. **(Objective 2, SDA.6; Objective 3, SDA.1);** The Brazilian government is also providing support for the Health System providing computers and training on epidemiology. This will be a major contribution for the M&E of this proposal. Equipments are already in place and in-country, training will start in the next few months. **(Objective 5, SDA.14)** In addition, the Brazilian cooperation will build a new laboratory for TB diagnostic that will allow for cultures and resistance testing. We believe that, in the future, this laboratory structure will also be able to hold the viral load monitoring and infant early HIV infection diagnostic. **(Objective 3, SDA.6, SDA.8; Objective 3 SDA.11).**

Compania São Tomense de Telecomunicações (CST): will cover the cost of the Toll-Free- HIV/AIDS information Hotline, and delivery of SMS messages through mobile phone **(Objective 1: SDA.4)**

4.4.9 Strategy to mitigate unintended consequences of additional program support on health systems

Describe:

(a) the potential risks and unintended consequences on health systems that may result from the implementation of the proposal; and
(b) the proposed strategy for mitigating these potentially disruptive consequences.

Expansion of HIV testing: The expansion of the HIV testing through the « provider initiated testing strategy » is associated to a risk of problems with confidentiality of test results. In order to prevent such problems, we plan to implement this strategy in a phased mode, allowing for adequate supervision, monitoring and evaluation of benefits and adverse events. Principles of counselling, consent and confidentiality will be assured. Another potential risk of this strategy would be lack of capacity to handle the increase on the demand for care and treatment it may bring. However, because in the last 5 years, we have been successful in training physicians and other health care workers that now are able to provide HIV/AIDS care in all 7-health districts, we believe we will be able to any increased demand for care this strategy may bring. The same is true for the decision to start treatment when CD4 count below 350 cells/mm3 instead of current threshold of 200 cells/mm3.

HIV Screening for Tuberculosis patients: Currently, VCT for TB is concentrated on the central

hospital because, all patients with TB stay in hospital for at least some weeks. The Tuberculosis program is now preparing the ground for decentralization of TB treatment to the district level. Therefore, VCT for TB patients will progressively need to be performed at the health services at District level. There is a risk of decrease of the current high coverage of HIV screening among these patients. To avoid this, although we already have this capacity at District level, we will keep the screening under close supervision to timely intervene if the level of coverage decreases.

Availability of data for important data for indicators of impact and out come as well programmatic will depend on the next round of the DHS. The DHS is an expensive survey that mobilize local and international funds. The largest part is internationally funded. A risk do exist that lack of external funding may delay or definitely impair the execution of the survey. In order to decrease this risk, we have already started to advocate for it. In addition, U$ 100.000 will be secured in the proposal budget to contribute to the local costs of the survey (total cost of DHS 635.424).

4.5 Program Sustainability

4.5.1 Strengthening capacity and processes in HIV service delivery to achieve improved health and social outcomes

Describe how the proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes.

➔ *If available, refer to country evaluation reviews*

➔ *Support explanation with excerpts from documents that the country has adopted, identifying the source, such as a National Disease Strategy*

Activities of this proposal will significantly contribute to improve the quality and coverage of HIV service, but also to the general health care, benefiting patients of all diseases. Among the activities that will build capacity we highlight:

1- training of health care workers: on provider initiated HIV VCT strategy, Kaposi´s sarcoma management, integrated health approach,

2- technical assistance to NGOs on prevention focused on most-at-risk populations (sex workers and MSM),

3- technical assistance to review the NAP´s monitoring and evaluation framework and tools, institutional capacity of both government and civil society institutional capacity will be strengthened

4- Training of community health workers to join the health team at the district level on activities focused for instance on increasing the retention of HIV infected pregnant women on care, through out reach work and other support interventions.

This proposal will continue to the process, initiated on round 5 GF grant, of strengthening the NAP capacity to coordinate, supervise, monitor & evaluate the STO response to HIV/AIDS epidemic, including public, private sectors and civil society and community system.

Similarly the health districts will be strengthened both at the level of institutional and human resources, with supply of reagents, consumables and drugs in the prevention, treatment, care and support, educative material. Moreover, this proposal seeks to strengthen the HIV VCT, home visits and implement improved management of cases of AIDS, STIs and tuberculosis, with the introduction of free drugs for all patients with STIs and INH. The proposal also will strengthen the capacity of Health districts, to conduct supervisions to health services under its responsibility, as well as on monitoring and evaluation. The private system also will be strengthened as the training of doctors will be included in the private sector.

4.5.2 Alignment with broader developmental frameworks

Describe how the proposal's strategy aligns with broader developmental frameworks such as:

- Poverty Reduction Strategies;
- The Highly-Indebted Poor Country (HIPC) initiative;
- The Millennium Development Goals;
- An existing national health sector development plan; and
- Any other important initiatives.

The interventions to be implemented with funds requested in this proposal will contribute to the achievement of the following Millennium Development Goals (MDG):

Goal 1 Eradicate extreme poverty and hunger: linking PLWA and at risk of HIV infection to income generate programs, providing nutritional support to orphans and people living with HIV/AIDS.(SDA. In addition, with improved quality of life resulting from care and ARV treatment, adults will be able to continue to work and earn an income **(SDA.6; SDA.7; SDA.8; SDA.9;SDA.10);** through in income generating opportunities for PLWA and sex workers **(SDA.4)**

Goal 2 Achieve universal primary education: providing support orphans with tuition fees and school books and other materials as well as providing nutritional support to them and their families **(SDA.10);**

Goal 3 Promote gender equality and empower women: activities on (SDA-4) targeting sex workers, will empower women, through education on sexual health, HIV prevention, and participation in income generating opportunities that will provide business skills and small start up money. This may contribute to reductions in the numbers of sexual partners, as many of those assessed reported poverty as the main reason for working in the sex business. In addition, may increases condom use by reducing gender inequalities. by creating conditions to increase access to STI services and test for men. Moreover, women in rural areas will benefit from HIV/AIDS educative material developed focusing non-scholarized population**. (SDA.4)**

Goal 4 Reduce child mortality: Through prevention of mother-to-child transmission, through ARV & O.I & food supply; treatment for the mother **(SDA:11, SDA.9, SDA.6, SDA.7); Goal 5 Improve Maternal Health:** VCT during pregnancy, HIV/AIDS care and support. Improving the safety of the blood transfusions (bleeding is common among postpartum) **(SDA.12). Goal 6 Combat HIV/AIDS, malaria and other diseases:** all activities included in this proposal will directly contribute to achieve this goal.

The interventions to be implemented with funds requested in this proposal will also contribute to the achievement of the following Poverty Reduction Strategies (PRS) goal: Developing human capital by improving social conditions and promote the well-being of the population.

By strengthening the institutional capacity of NAP and health districts and particularly in accelerating prevention interventions with particular emphasis on mother to- child transmission, ensuring access to ARVs and combating stigma

4.5.3 Improving value for money

Explain how the program that the proposal contributes to represents good value for money. Specifically, given the context of the epidemic in the country and the definition of value for money provided in the Guidelines, describe how the key interventions in the proposal represent the best balance of costs and effectiveness, with consideration to the desired achievement of both short and long term impacts.

We have been doing our best to make every cent donated to our contry return in benefits to our population. On deciding about what strategies and interventions to prioritize we have based our decisions on the best evidence available to the moment, always following WHO and other UN agencies guidelines.

This proposal seeks to expand de coverage and impact of HIV interventions through: Expanding HIV testing and counseling, targeting de prevention of sexual transmission of HIV, particularly among those most at risk and most vulnerable, exploiting the role of antiretroviral drugs in HIV prevention, optimizing HIV/AIDS treatment for children, adolescents and adults, delivering comprehensive programmes for most-at-risk populations: sex workers, men who have sex with men and patients with STI as well as PLWA and partners. It integrates programmes and services seeking to eliminate mother-to-child transmission of HIV, Link HIV and TB services, addresses HIV and viral hepatitis co-infection on PLWA, as well as hepatitis B among health care workers most at risk for occupational exposure. In addition, it promotes positive prevention for people living with HIV. The implementation of the proposed interventions will contribute to build a sustainable health system in São Tomé e Príncipe, through strengthening the health information system to, better monitor responses to HIV/AIDS, expanding human resource capacity, improving safety of health services, as well as Improving the efficiency, quality, effectiveness and equitable coverage of HIV services and programmes. In addition, it will contribute to creating supportive environments for HIV responses through addressing HIV stigma and discrimination in the health sector and promoting gender mainstream. Therefore, we are confident that this is a good value for the money.

Finally, not all benefits of Global Fund resources are bringing to São Tomé and Príncipe population are measurable. There are changes to local levels because behind the numbers are the personal realities – individual lives changed, hope given, confidence raised for a life of dignity and control over ones future. This kind of aid is effective and it is for the long-term.

4.6 Monitoring and Evaluation System

4.6.1 Impact and outcome measurement systems

Describe the impact and outcome measurement systems, including strengths and weaknesses, used to measure achievements of the national disease program at impact and outcome level.

In general terms, the realization of Demographic and Health Surveys (DHS, 2008-2009) is a main progress made by the PNLS to improve these system. In fact, this study is now days a key information to guide the social response to fight the epidemic. Further, prior to the availability of data from IDS, various researches conducted by the Ministry of Health / UNAIDS (2005, HIV and Syphilis in pregnant women), WHO (2009, HIV and syphilis in pregnant women), UNDP (2001, Profile of poverty in STP), UNICEF (2009, Situation of women and children in STP)), Alisei (2010: Strategic Plan to address the most at risk group of sex workers, and 2007: diagnosis of the situation of sex workers) and other, helping the better understanding of social demographic characteristics of patients with HIV / AIDS and how epidemic model in the country is evolving.

In summary, the strengths and weaknesses identified in the system to measure impacts and outcome are the following:

Forces	Weaknesses
• Availability of a national monitoring and evaluation plan with key indicators; • Satisfactory collaboration with other programs of the Ministry of Health (Reproductive Health and Tb); • Data Organization at central and district levels; • Existence of skilled technicians for collecting the information; • Engagement of partners both bilaterally and multilaterally in straightening the M&E system; ; • Annual Survey of HIV prevalence in risk groups through the installation of sentinel sites; • Availability of tools to gather information and reporting; • Existence of some mechanisms for sharing and dissemination of information.	• Poor functioning of the National Comission to Fight HIV/AIDS and weak participation of other sectors in the fight against HIV / AIDS • Poor use of the data available to face on the epidemic and with agenda of HIV/AIDS research. • Insufficient epidemiological programmatic information. • Weak dates promptitude and completeness coming from district report • Insufficiency of the epidemiological surveillance system (late arrival notification of AIDS cases in the sector of epidemiological surveillance; • Lack of computer equipment and safety measure of the base dates; • Lack of guidelines on epidemiological surveillance of HIV / AIDS;

4.6.2 Impact and outcome measurement

(a) Has impact and/or outcome data been collected in the last 2 years?	X Yes → *answer section 4.6.2 (b)*	☐ No → *go to section 4.6.2 (c)*	(b) What was the source(s) of the measurement?	→ *insert source (large scale surveys, demographic surveillance, vital registration systems, other)*

(c) It is important to guarantee that there are systems in place to measure all impact and outcome indicators in the performance framework. In order to do this, fill in the table below, fully describing all planned surveys, surveillance activities and routine data collection in country used to measure impact and outcome indicators relevant to the proposal. Add rows as needed.

Data Source	Funding	Years of Implementation					Impact/Outcome Indicators relevant to the proposal to be measured by data source
		2011	2012	2013	2014	2015	
Source 1 *(demographic and health survey*	Total cost					**635.424**	
	Secured funding amount and funding source					**0**	
	Funding gap					**635.424**	
	Round 10 funding request for Source 1					**100.000**	
Source 2 *(behavior surveillance Survey)*	Total cost		**35**			**35**	
	Secured funding amount and funding source						
	Funding gap		**35**			**35**	
	Round 10 funding request for Source 2		**35**			**35**	
Source 3 *(specific report)*	Total cost		**2.0**	**2.0**	**2.0**	**2.0**	
	Secured funding amount and funding source						
	Funding gap		**2.0**	**2.0**	**2.0**	**2.0**	
	Round 10 funding request for Source 3		**2.0**	**2.0**	**2.0**	**2.0**	

4.6.3 Links with the National M&E System

(a) Describe how the monitoring and evaluation (M&E) arrangements in the proposal (at the Principal Recipient, Sub-recipient, and other levels) use existing national indicators, data collection tools and reporting systems including reporting channels and cycles.

The M&E system which will be used by the Principal Recipients and Sub Recipients mentioned in this proposal use the National System of M&E which is based on the Health National Information System and the specific diseases information system. The National M&E is briefly described below:
The National AIDS Program coordinates the monitoring and evaluation system, in close collaboration with the epidemiology unit of the CNE (National Center for Endemic Diseases). NAP and CNE monitoring and evaluation unit are working closely on data harmonization and integration, as well as with Districts Epidemiological assistants. These assistant at the level of districts are in charge of data collection on health services. NGOs and other non-health structures also take part on this process of data harmonization and integration. The coordination between CNE, Health Districts and Civil Society and other implementer partners are part the M&E lead by the MOH.
Different sources of information provide data to the M&E system: the traditional diseases information system, specific reports to addressed specific needs (stoke out, for instance), medical records, reports prepared by NGOs, health services registries, among others. Other important data come from UN agencies and bi-lateral partners. Data generated by surveys and scientific research are also obtained from the institution in charge, for instance, the data from the Demographic and Health Survey (2008-2009).
In general, the data collection system uses standardized forms to registry and consolidates the data at level of health post and districts as well as in a specific format report prepared by the Sub recipients. The FIRST level of information is collected from the records, or books or forms on use by the implementation structures to document their activity. The information gathered at this level is compiled in standard formats. Data is sent each month to the Head of Health District, that are in charge of data consolidation.

The SECOND level is represented by the Directorate of Health District, that receives the data from routine reports coming from health facilities and communities, which support HIV/AIDS activities at the level of district. The District Monitoring and Evaluation Unit compiles data and sends it every month/quarters to the monitoring and evaluation unit of the National AIDS Program at the National center for Endemic Diseases.
The THIRD level is represented by the NAP/CNE/Epidemiology/MoH Unit / MOH, that receives and processes these data. Regularly, this Unit releases a report with epidemiological and programmatic results.

(b) Are all of the M&E arrangements planned for the proposal using the national M&E system?	X ☐ Yes *→ go to section 4.6.4*	☐ No *→ continue to section 4.6.3 (c)*

(c) If no, explain why not and list any service delivery areas (SDAs) and/or activities that will not be monitored through the national M&E system.

ONE PAGE MAXIMUM

4.6.4 Strengthening monitoring and evaluation systems

(a) Has a multi-stakeholder national M&E assessment been recently conducted (in last 2 years)?	X ☐ Yes *→ continue to section 4.6.4 (b)*	☐ No *→ go to section 4.6.5*
(b) If yes, has a costed M&E action plan been developed or	X ☐ Yes	☐ No

updated to include identified M&E strengthening measures?	*→ continue to section 4.6.4 (c)*	*→ go to section 4.6.5*

(c) Describe whether the proposal is requesting funding for any M&E strengthening measures. These strengthening measures may have been identified through a national M&E assessment or any other relevant evaluation or review process.

This proposal requests funding for the strengthening of monitoring and evaluation system according with the following initiatives addressed to the NAP, Health Districts and NGOs:
Technical assistance for 45 days of work :

- review the monitoring and evaluation framework & data collection tools
- develop a M&E data collection manual & collection tools
- train NAP and Health district staff, NGOs, and other implementation partners on the reviewed M&E data collection tools

To organize 02 monitoring & evaluation meetings per year
To print and distribute M&E manual & data collection tools to implementation partners
To design and conduct sentinel surveillance annual studies: development and printing behaviour questionnaires and data collection forms; kits, tubes, needles, labels, transportation bags, diesel, subsides for laboratory and field staff on sentinel sites, and for transportation of sex workers and MSM participating on RDS surveys (Sex workers, MSM).
To partially fund the Demographic and Health Survey of 2015 (U$ 100.000 – total cost of 635.424).

4.7 Implementation Capacity

4.7.1 Principal Recipient(s)

Describe the technical, managerial and financial capacities of each Principal Recipient (PR) to manage and oversee implementation. Include any anticipated limitations to strong performance and refer to any existing assessments of the PR, other than Global Fund reporting mechanisms.

→ Copy and paste tables below if there more than three Principal Recipients

PR 1 Name	UNDP SAO TOME AND PRINCIPE	**Sector**	
Street Address	UNDP, Avenue des Nations Unies, Sao Tome et Principe POB 109 , Sao Tome Tel : 00 239 221 122 FAX : 00 239 222 198 Email : antonio.viegas@undp.org		

As long as the PR elected will be UNDP, which is the same one that is already working on the implementation of malaria grant (round 4) and AIDS grant (round 5) procedures and managerial issues will remain the same, with the Global Fund Unit working at UNDP and following the financial and procurement processes of UNDP . The implementation of the grant will be as follow: the SRs selected will make a joint planning of the annual (divided by quarter) work plan. After the signature of the contract the money will be transferred quarterly to each SR, according to the activities planned and their performance from the previous quarter. Regular meeting with PR and SR and supervision visits (technical and financial) from the PR will take place. Conjointly, the SRs and PR will discuss the best solution to deal with some issues. Also the PR will assess regularly the performance of the SR and if there a risk of any constraint, the PR will anticipate (preparing a strategy) to overcome or to avoid the issue. Quarterly the SR will send a report from previous quarter to allow the PR to prepare its report to the Global Fund, moreover, the report will be used to assess the SR to identify the weaknesses and will propose in any case, if possible, the strategy to reinforce the SR. It was discussed at the CCM and it was agreed upon that the CNE, the other potential PR, has not yet the capacities to overtake the management of the project. UNDP is working to strengthen the capacities of the CNE and in the future they will be able to take over. Some measures have been taken regarding this issue like the creation of the Monitoring & Evaluation Unit, or the acquisition of a generator for the CNE. An assessment of the CNE staff has been conducted in order to identify any possible gaps within the CNE in order for it to be reinforced. The Human Resources aspect has also been considered in the past and there are some plans to continue working on that side. According to the performance, the nominated PR has had good management record, viewed as consistent, transparent and effective. In order to consolidate his management performance, the PR has taken some action, in nominating a full time Coordinator for some related areas to follow all the processes of their project. The experience of UNDP as a PR has been satisfactory till today. Both programs are qualified as B1according to the GF criteria what is by itself a good indicative to CCM members

PR 2 Name	Instituto Marquês de Valle Flôr (IMVF)	**Sector**	
Street Address	Headquarters: Rua de S. Nicolau, nº 105, 1100-548 Lisbon, PORTUGAL Bairro 3 de Fevereiro, P.B. 280 Democratic Republic of São Tomé and Principe		

The Instituto Marquês de Valle Flôr (IMVF) is a Non-Governmental Development Organization (NGDO) whose mission is to promote socio-economic and cultural development in Portuguese-speaking countries. To achieve its proposed mission the IMVF is guided by the following set of values that express its identity:

· Social, political, economic and gender Equality;

· Rigour in the management and execution of the projects and programs;
· Spirit of Partnership based on sharing resources and responsibilities with local, national and international partners;
· Sustainability of the actions, based on the involvement and empowerment of the communities that benefit from the projects, and making them co-responsible.

IMVF, founded on 1 August 1951, has today more than 50 years of history and work developed at the service of the underprivileged population. At the beginning of its activity IMVF was mainly oriented to scientific investigation and to the improvement of the socio-economic conditions of the former Portuguese colonies mainly on the Island of São Tomé. When Portugal joined the EEC on 1985, new partnerships were started and the activity of the Institute extended to Projects in the areas of Cooperation and Education for Development, as well as Humanitarian Aid. Geographically, IMVF works in all the Portuguese- speaking countries. Due to the relevant services rendered throughout its existence IMVF was awarded, in June 1995, the "degree of honorary member of the Order of Merit", by initiative of His Excellency the President of the Portuguese Republic.

- The institute is presently responsible for the management of about 40 projects, covering the areas of Cooperation, Development Education and Humanitarian Aid. The Cooperation projects are developed in the Portuguese speaking-countries and aim to help eradicate poverty and achieving the Millennium Development Goals

The IMVF is member of several networks that voice the NGO sector, being it through the celebration of cooperation protocols with various national and international partners, or through the participation in debate spaces and the information diffusion on development related issues, like the Portuguese NGDO Platform, CONCORD and Oneworld.

IMVF is a Foundation that relies on the Board of Administration, Board of Directors and Council of Auditors to run its varied set of activities and projects. The IMVF projects are co-financed by the Institute own funds, European Commission, Portuguese Institute for Development Assistance (IPAD), World Bank, Calouste Gulbenkian Foundation, United Nations Agencies, Municipalities, amongst others.

IMVF is working in São Tomé and Príncipe since 1989. This means a 20 years long work in the country, mainly in the sector of Health. During these years, preventive and primary care Projects were tackled targeting a Sustainable Development Model depending mainly on National technical capacities.

In 2007, the Portuguese Institute for Development Assistance (IPAD), made a very positive evaluation on the Project "Health for All", which aims improving the quality and promoting the sustainability of the preventive, primary and medical assistance health care in São Tomé and Principe, including fight against poverty diseases. The external evaluation revealed the high degree of efficacy and efficiency of the Project mentioning that its activities clearly contribute in reducing poverty and in achieving the Millennium Development Goals through the strengthening of the health services specially benefiting the poorest and most vulnerable.

Due to the successful results of the Project "Health for All", outlined in a retrospective study covering 20 years of work in the Health Sector in São Tomé and Príncipe, IMVF was distinguished, in April 2009, with the Honorable Mention of the Bial Awards 2008, in a ceremony presided by His Excellency the President of the Portuguese Republic.

Actually, IMVF in implementing the Project "Health for All -Extension and Consolidation", covering the period from 2008 to 2011. This Project maintains the same goals of the previous one but at a national level (all the Districts are now covered by the Project, including the Island of Principe) and broadens its activities with some specialities like gynaecology and obstetrics, internal medicine, surgery and paediatrics amongst others

By 2009, emerging medical needs made clear the necessity to reinforce the provision of specialized secondary and tertiary health care at São Tomé's Central Hospital. As a response the Health for All: Medical Specialties was put in place. Being complementary to the Health for All: Extension and Consolidation, this Project seeks to implement an approach that will allow swifter and more suitable solutions for integrated care provision, the decrease in the number of evacuation of patients to Portugal for assistance and the promotion of local competences. The impact of the project on the national population's quality of life will necessarily be positive, as it will bring medical care, which was unavailable up till now.

On the other hand, the sequence of medical specialists and experts' missions will decisively contribute to a reduction in the number of patients in an advanced critical state, as it will allow for more regular and proficient assistance to the population. The recurrent presence of these international experts will also provide the medical staff in São Tomé and Principe updating opportunities in assessment, follow-up and stabilization of critical situations. This Project will improve the working conditions and greatly increase the capacity to provide health care in the country by providing up-to-date and specialized equipments and materials. Moreover, the Project foresees the use of telemedicine technology as a component of the utmost importance. It can break the isolation to which the country and the medical practice have been submitted and incorporate them in a network of up-to-date and specialized assistance. This tool, therefore, represents valuable on-distance support, with obvious advantages for the monitoring, training, technical assistance and capacity building of the local technical staff's.

Monitoring and evaluation procedures have been transversal to IMVF intervention in the country, since the beginning. Alike IMVF previous interventions this Project includes constant epidemical surveillance at all national health facilities and centers, as well as the collection, analysis and follow-up of national health statistics. Evaluation and monitoring of project's outcomes and impacts on national health indicators is, therefore, a cross-cutting component of the Project allowing better planning and activities' redirection, whenever necessary.

PR 3 Name		**Sector**	
Street Address			
→ *Description*			

4.7.2 Sub-recipients				
(a) Will Sub-recipients be involved in implementation?	X☐ Yes → *go to section 4.7.2 (c)*			
	☐ No → *go to section 4.7.2 (b)*			
(b) If no, why not?				
HALF PAGE MAXIMUM				
(c) If yes, how many Sub-recipients will be involved?	☐ 1-6	X☐ 7-20	☐ 21-50	☐ 50+
(d) Are all Sub-recipients already identified?	X☐ Yes → *go to sections 4.7.2 (e) and (f)*		☐ No → *go to section 4.7.3*	
(e) List the identified Sub-recipients and describe: • The work to be undertaken by each Sub-recipient; • Past implementation experience of each Sub-recipient; • Any challenges that could affect performance of each Sub-recipient as well as a mitigation strategy to address this.				
The key SR under UNDP supervision will be the National AIDS Program (PNLS=NAP) and the National Drug Fund (FNM). NAP is an institution of the Ministry of Health created in 1987, in charge of coordination of actions to fight HIV/AIDS at national level. The NAP is also the main SR of R5 grant since 2006, with a good performance, which had contributed to classification in A1 category of the Global Fund performance framework assessment. In addition, the NAP has also, been implementing				

projects funded by the Word Bank. This SR has been strengthened by the R5 proposal, with personnel, training and equipment, which place the NAP in a better position to implement this new proposal. However, there are weakness/challenges that must be overcome, as in M&E system and planning. In order to overcome these weaknesses, funds for short training courses, technical assistances, acquisition of equipment, support for supervision activities, among others, under the objective number 4.
In the implementation of R10, the WHO will be in charge of coordinating and implementing the technical assistance in different areas identified as priorities, namely: the strengthening of strategic information, developing guidelines, the plan, training for the introduction of the provided initiated HIV counseling, and testing strategy. In addition, WHO will coordinate updating of guidelines on STIs and PMTCT, the training of the staff and monitoring the ARV resistance.
WHO is the specialized agency of the United Nations system to Health. It has expertise in several areas of the fight against AIDS that support partners in improving the national response, using the expertise available in three levels of the organization, namely: headquarters, regional and national level.
However to implement such measures, the local team of WHO should be strengthened with an NPO which will coordinate, monitor and assess the technical assistance mobilized under this project.
FNM is an institution, with more than 15 years of experience, is responsible to centralizes stocks and distributes medicines and consumables for the national health service. This government institution is a sub-recipient for all 3 rounds Global Fund grants, since 2005, with performance that have been improved along the proposal implementation. However, adequate and timely forecasting, as well as the management of stock continuing to have weaknesses. To minimize these weaknesses, these activities will be performed in partnership. Under the coordination of UNDP, FNM and NAP will, jointly forecast the needs of pharmaceutical and medical products. The supervision will be strengthened and accountability will increase, with benefits to better performance of the health system.
All the sub recipients have some experience in fighting this epidemic since the same has been developing actions in this area together with other partners beside the Global Fund project/National AIDS Program, (NMF), NGOs, Caritas, National Red Cross and ALISEI. The institutions can be considered as main Sub-Recipients

- **NAP/Ministry of Health**
- **WHO**
- **Reproductive Health Services (PSR) – for PMTCT**
- **Fundo Nacional de Medicamentos (FNM)**
- **ISVSM (Instituto Superior Vitor Sá Machado)**
- **7 Health Districts (Agua Grande, Me-Zochi, Cantagalo, Lobata, Lembá, Cauê e Região Autónoma do Príncipe)**
- **UNDP – procurement of drugs, kits & reagents, and other goods and supplies**

NAP is a body of the Health Ministry created in 1987, in charge of coordination of actions of the fight against HIV/AIDS at the national level. **FNM** is an institution that centralizes stocks and distributes medicines and consumables for the national health service. This sub-recipient is involved in the Global Fund Proposal approved for STP (4th Round of malaria and 5th Round of HIV AIDS and was identified in proposal more recently submitted.
Health Districts will be in charge of supervisions to health services, supplying condom to dispensers on distribution points out of health sector
IMVF, Civil Society PR
The sub-recipients were selected based on their previous experience and implementation capacity. The tasks they are going to undertake are major and rooted in their constituency. Referring to Annex number 1 we can clearly verify that the entities were selected upon the basis of their experience and capacity in implementing the necessary tasks that will be demanded. This is clearly identified in the right sided column in front of the identified sub-recipients (Primary areas of work).
The NGO ALISEI has developed social health projects including HIV/AIDS, since 1998. It is one of the major partners in fighting against HIV/AIDS, where actions have been developed especially in the matters of information and awareness in the population, particularly with sex workers, condom promotion and its social marketing. They also collaborate with NAP in the area of support materials for information and awareness as well as in the organization of massive activities.

On this Round:
1- **Alisei** will be in charge of the SDA.X BCC community and most at risk population, that includes the activities focused on sex workers and men who have sex with men
2. **Caritas** – will continue to provide support for orphans
3. **Red Cross** - will be in charge of income generating activities focused on PLWA and sex workers. This organization will also be in charge of providing the nutritional support for PLWA

(f) If the private sector and/or civil society are not involved as Sub-recipients in implementation, or only involved in a limited way, explain why.

HALF PAGE MAXIMUM

4.7.3 Sub-recipients to be identified

Describe:

(a) why some or all of the Sub-recipients are not already identified; and

(b) the transparent, time-bound process that the Principal Recipient(s) will use to select Sub-recipients and not delay program performance.

Not applicable

4.7.4 Coordination between or among implementers

Describe:

(a) how coordination will occur between multiple Principal Recipients if there is more than one nominated Principal Recipient for the proposal; and

(b) how coordination will occur between each nominated Principal Recipient and its respective Sub-recipient to ensure timely and transparent program performance.

Par beyond the coordination that will be made at the level of the CCM in the implementation of this proposal, the main beneficiaries will hold regular meetings to monitor the implementation of interventions. Moreover each PR will arrange the meetings coordination with they sub recipients.

Clarified Section 4.7.5.

4.7.5 Strengthening implementation capacity

(a) The applicant is encouraged to include a funding request for management and/or technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan based on the indicative percentage range in the Guidelines. In the table below provide a summary of the TA plan.

→ Refer to the Strengthening Implementation Capacity information note for further background and detail

Management and/or technical assistance need	Management and/or technical assistance activity	Intended beneficiary of management and/or technical assistance	Estimated timeline	Estimated cost *→ same as proposal currency*
Prophylaxis and treatment for opportunistic infections	**International consultant to update the ARV & IO management guidelines**	**National AIDS Program (NAP)**	**Year -2 (2 Weeks) and Year 3 (2 Weeks)**	**15,780**
Adaptation of the guidelines on Integrated care Management	**International consultancy to adapt guidelines on Integrated care Management Adult**	**National AIDS Program (NAP)**	**2 weeks in Y1**	**7,890**

Adult and Adolescent	and Adolescent (2 weeks; Same cost like in activity 2.1.7)			
Blood safety and universal precaution	International consultancy in hemotherapy	Unit of hemotherapy/HAM	Year – 1(2 weeks) and Year 3 (2 Weeks)	15,780
Management of all technical assistance	Recruitment national program officer (local staff)	All Global Fund Grants in STP	All 5 years	165,000
HSS: Information system	International consultancy to review of M&E framework and development of manual, tools and training	NAP ; health districts; and hospitals	Year 1(45 days)	20,075
Strengthening of civil society and institutional capacity building	International consultancy for capacity building on HIV prevention for sex workers for NGOs and NAP staff	NGOs and NAP	Year 1 (2 weeks)	7,890
Strengthening of civil society and institutional capacity building	Capacity building on HIV prevention for MSM for NGOs and NAP program and design and planning of the situation analysis study on MSM	NGOs and NAP	Year 1(2 weeks)	7,890
Strengthening of civil society and institutional capacity building	Consultancy during the execution of the MSM situation analysis study	NAP	Year 1 (2 weeks)	7,890
Strengthening of civil society and institutional capacity building	ITA to capacity building of new 2nd PR on project management by GF rules	new 2nd PR	Year 1(2 months)	26,100

(b) Describe the process used to identify the assistance needs listed in the above table.
The process of identifying these needs has gone through three stages: **I. During the workshop to analyze the situation for the elaboration of a National Strategic Plan HIV/AIDS, 2011 – 2015, which took into account some of the weaknesses identified during the evaluation at mid-term strategic plan 2004-2008** **II. During the workshop for the development of the R10 proposal which took into account the needs included in the "National Strategic Plan HIV/AIDS, 2011-2016" and identified other.** **III. After the selection of "BP number 2, based on the discussions presented by the same during the preparation of the proposed R10.**
(c) If no request for management and/or technical assistance is included in the proposal, provide a justification below. Or, if the funding request is outside the indicative percentage range, provide a justification below.
The percentage (3-5%) indicate by the GF was exceeded because: *I.* **Most of the technical assistance identified is international due to the lack of local experts in the areas needed. As is well-known the international consultancies cost more than the local consultancies. For instance: the country doesn't have local experts available to design and analysis the study about MSM and to improve the capabilities of the ONGs available to work in this topic.** *II.* **In this component was included the management cost.** **II.1 the cost of technical assistance is just 4% (if from the total amount of $ 266,405 that corresponds technical and management assistance in our budget we take out $165,000 that correspond the cost with national program officer the result will be $101,405. For more details please be so kind see in our budget activity number 5.1.21 and sheet "summary"- technical and management assistance).**

4.8 Pharmaceutical and Other Health Products

4.8.1 Scope of Round 10 proposal	
Does the proposal seek funding for any pharmaceutical and/or health products?	X ☐ Yes → *go to section 4.8.2*
	☐ No → *skip the remainder of section 4.8*

4.8.2 Table of roles and responsibilities			
Function	Name of the organization(s) responsible for this function	Role of the organization(s) responsible for this function	Does the proposal request funding for additional staff or technical assistance? *→ indicate Yes or No*
Procurement policies, systems, and planning	National Aids Program and National Found Drugs	**National Aids Program** - Definition of protocol treatment - Definition of renewable energy supply drugs (Estimate of needs, Programming distribution) - Supervision of consumption and quality storage and its management **National Found Drugs** - Storage, distribution, supervision - Training Workshops - Reporting	**NO**
Intellectual property regulations	**NA**		
Quality assurance and quality control	**National Aids Program**	External quality control (harvesting and shipment of samples)	**NO**
Management and coordination *→ more details required in section 4.8.3*	National Found Drugs	FNM-1: (Management) -Clearance of drugs and consumables -STORAGE, distribution, supervision - Produce regular reports 2-PNLS: (Management and Coordination) - Estimate of needs, Programming distribution - Supervision of consumption and quality storage and its management	**NO**

Product selection (e.g. PMTCT and pediatric HIV care)	National Aids Program	Selection of products in accordance with Protocol National	**NO**
Management Information Systems (MIS)	National Found Drugs	**National Found Drugs** - Management Information System **National Aids Program** - Definition of criteria for development of the system (annual evaluation system	**NO**
Forecasting	National Aids Program	Forecast of needs based on the prevalence of the disease, recording incidents and behavior of the stock	**NO**
Storage and inventory management *→ more details required in section 4.8.4*	National Found Drugs	Registration and completion of sheet storage - Organisation of national base stock - Provision of regular reports on the situation of stock	
Distribution to other stores and end-users *→ more details required in section 4.8.4*	National Found Drugs	Distribution of medicines and other consumables to the Health Districts	**NO**
Ensuring rational use and patient safety	National Aids Program	Monitoring and evaluation of ARV treatment, other consumables and non-consumables	**NO**
Pharmacovigilance	National Aids Program	WHO, Support in defining guidelines; its monitoring and evaluation, training of staff	**Yes**
Drug resistance Surveillance	National Aids Program	PNLS-resistance performance of studies of primary, secondary, implementation of early warning indicators (IAP)	**YES**

		- WHO: Support for situation assessment, definition of policy and protocol, training of staff	

4.8.3 Past management experience

Describe the past experience of each organization that will be involved in managing pharmaceutical and other health products.

Organization name	Short description of management experience	Total value procured during last financial year → *same currency as proposal*
UNDP	The UNDP has experience in procurement of medicines including several rounds of R4 Malaria, AIDS R5, R7 MAL, and R3 TB	
NMF	The NFM has experience in both the import of essential drugs at national level in storage and distribution of medicines	
NAP	The NAP has experience in the estimation of needs for drugs (ARVs and consumed in the laboratory), in monitoring and tracking of resource use	
→ *use the 'Tab' key to add extra rows*		

4.8.4 Alignment with existing systems

Describe how the proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance and drug resistance surveillance systems. If existing systems are not used, explain why.

ONE PAGE MAXIMUM

The project is managed by UNDP Managing Unity that supports the FNM and CNE. The CNE equally represents the National Anti-malarial Program (PNLP). There is a coordinating circuit between these different entities, and the periodical meetings are carried out every quarters.

The pharmaceutical products of 1st line are managed by the UNDP and 2nd line products are managed by the government. In a recent future the both pharmaceutical products will be managed by the UNDP.

The quality control of the products will be external and this round plans to assure an assistance to set up a sample preparation procedure and training on the same subject.

This grant equaly plans to support the evaluation and study of an operationalization plan to create a national pharmaceutical regulator sector.

To face this deficit, the managing unity previews a reinforcement of its staff (national or international pharmacist/ logistician (logistic).

4.8.5 Storage and distribution systems	
(a) Which organization(s) have primary responsibility to provide storage and distribution services under the proposal? *→ tick the corresponding boxes to the right and enter the name of the organization(s)*	X ☐ National medical stores or equivalent
	→ specify
	☐ Sub-contracted national organization(s)
	→ specify
	☐ Sub-contracted international organization(s)
	→ specify
	☐ Other:
	→ specify

(b) For storage partners, what is each organization's current storage capacity for pharmaceutical and health products? If the proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The FNM is responsible for storage and distribution of ACT and RDT purchased by this grant and destinated to the districts and all dispensaries in the country as well as the pharmaceutical product purchased by the government. The actual (current) capacity is 1035 m^3 so it is very limited. The arrival of a new grant requires an extending of its real capacity at least to 2000 m^3. With this proposal around 750 m3 will be build under this proposal.

The CNE is responsible for the storage of bed nets distributed in campaigns. CNE manages equally the microscope consumable. This entity needs to reorganize its storage (arrangement in shelves, articles identification)

Its storage capacity is greatly outdated and needs an urgent extension and modernization. This real capacity of 330 m^3 must turn into a minimum of 1000 m^3 for a good perspective of storage all the articles expected.

(c) For distribution partners, what is each organization's current distribution capacity for pharmaceutical and health products? If the proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The current applied distribution system is a pulling system. The dispensaries pass the command of their products to the districts and go take it on their own. The districts pass the command to the FNM and use their own vehicle as transport. The distribution is a big point in the country supply system (adequate vehicle, functional, no carburant problem). The good point of the country in relation to FNM is the delivery in maximum 2 hours after having received the command.

However, for longer development of this distribution performance, a supply and distribution national plan must be created. And each district must have its own plan for supply and distribution of pharmaceutical and medical products.

4.8.6 Pharmaceutical and health products for initial two years

Complete the Pharmaceutical and Health Products List and list all of the products that are requested to be funded through the proposal.

If the pharmaceutical products included in the Pharmaceutical and Health Products List are not included in the current national, institutional or World Health Organization Standard Treatment Guidelines (STGs), or Essential Medicines Lists (EMLs), describe below the STGs that are planned to be utilized, and the rationale for their use.

Applicants are invited to justify the prices based on either the range provided in the Unit Costs for Selected Key Health Products information note or with another published international reference source. If the provided price is out of range, provide justification. Also, if local legislation is preventing access to low cost prices through local manufacturers or similar mandates, clarification should be provided as well as a plan for addressing such barriers over the life of the proposal.

ONE PAGE MAXIMUM

The pharmaceutical and health products included in the provisional list (Annex B) for which fund are being requested in this proposal, are presently in the Directive Therapeutic national standard (DTS), except for Vinblastine (Velba) to IO (kaposi) that will be included in the Directive on th enext review of the National Executive (National Therapeutic Protocol). All products will be ordered from the list of WHO essential medicines (LME).
DTS will be used to elaborate the National Therapeutic Protocol in 2005 based on WHO guidelines, and revised in 2007.The new review, to be made in the following months willincorporate the new WHO recommendations. The Protocol is available on all services providing care for PLWHA. The PNLS carries out quarterly monitoring of compliance. Besides this, there is a therapeutic technique Committee of AIDS that follows, nationally, the prescription of ARVs.
Unit prices for pharmaceutical products were taken from the manual "Price Indicator" IDA (publication October 2008). The cost of pharmaceuticals for the first two years were made based on the estimations of existing patients, calculated on the Spectrum.
The PLWHA have access to free pharmaceuticals in accordance with Decree Law 90/91 which defines gratuituidade for chronic diseases, including HIV.

4.8.7 Multi-drug resistant tuberculosis

Is the provision of treatment of multi-drug resistant tuberculosis included in this HIV proposal as part of TB/HIV collaborative activities?	☐ Yes *→ include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services*
	X ☐ No *→ do not include the Green Light Committee costs*

5. FUNDING REQUEST

The Round 10 Guidelines contain different guidance for sections 5.1 and 5.2 depending on whether the applicant selected Option 1, 2 or 3 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal

Option 2 = Transition to a single stream of funding during grant negotiation

Option 3 = No transition to a single stream of funding in Round 10

5.1 Financial Gap Analysis

Section D and H of the Gap Analysis table below must be completed differently depending on whether applicant selected Option 1, 2 or 3 (see above)

→ Summary Information provided should be described further in sections 5.1.1 – 5.1.3
→ Currency must be the same as identified on the proposal cover page
→ Adjust the years as necessary in the table from calendar years to financial years to align with national planning and fiscal periods

Financial gap analysis								
	Actual		Planned		Estimated			
	2009	2010	2011	2012	2013	2014	2015	2016
SECTION A: Funding needs for the full national HIV program								
LINE A *→ Provide annual amounts*	8 000 000	10 000 000	10 000 000	10 000 000	10 000 000	10 000 000	10 000 000	10 000 000
LINE A.1 *→ Indicate the amount of the funding need for the full national HIV program over the full term of the Round 10 proposal*								
SECTIONS B, C AND D: Current and planned resources to meet the funding needs of the full national HIV program								
Section B: Domestic								

Financial gap analysis								
	Actual		Planned		Estimated			
	2009	2010	2011	2012	2013	2014	2015	2016
Domestic source **B1**: Loans and debt relief → *provide name of source here*								
Domestic source **B2** National funding resources	100 000	200 000	200 000	200 000	200 000	200 000	200 000	200 000
Domestic source **B3** Private sector contributions (national)				0	0	0	0	0
LINE B: Total current & planned DOMESTIC resources → *Total of Section B entries*	100 000	200 000	200 000	200 000	200 000	200 000	200 000	200 000
Section C: External (non-Global Fund)								
External source **C 1** (*EU*)	20 000	20 000	20 000	20 000	20 000	20 000	20 000	20 000
External source **C 1** (*FAO*)	94 673	94 673	94 673	94 673	94 673	94 673	94 673	94 673
External source **C 1** (*UNFPA*)	100 000	100 000	100 000	100 000	100 000	100 000	100 000	100 000

ROUND 10 – HIV

Financial gap analysis								
	Actual		Planned		Estimated			
	2009	2010	2011	2012	2013	2014	2015	2016
External source **C 2** (*UNICEF*)	61 000	61 000	61 000	61 000	61 000	61 000	61 000	61 000
External source **C 3** (*WHO*)	100 000	100 000	100 000	100 000	100 000	100 000	100 000	100 000
External source **C 1** (*UNAIDS*)	20 000	20 000	20 000	20 000	20 000	20 000	20 000	20 000
External source **C 1** (*UNDP*)	10 000	10 000	10 000	10 000	10 000	10 000	10 000	10 000
External source **C 1** (*WORLD BANK*)	1 455 500	610 216	309 500	1 000 000	0	0	0	0
External source **C2** (*Brasil Cooperation*)	50 000	50 000	50 000	50 000	50 000	50 000	50 000	50 000
External source **C3** Private sector contributions (International)								
LINE C: Total current & planned EXTERNAL (non-Global Fund) resources → *Total of Section C entries*	1 911 173	1 065 889	765 173	1 455 673	455 673	455 673	455 673	455 673

ROUND 10 – HIV

Financial gap analysis								
	Actual		Planned		Estimated			
	2009	2010	2011	2012	2013	2014	2015	2016
Complete this version of Section D if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form: **Section D: External (Global Fund)** ➔ *Insert additional lines below if there are more than two existing HIV Global Fund grants*								
Complete this version of Section D if the applicant selected Option 1 in section 3.1 of the Proposal Form: **Section D: External (Global Fund)** ➔ *Insert additional lines below if there are more than two existing HIV Global Fund grants*								
LINE D: Total current & planned EXTERNAL (Global Fund) resources *→ Total of Section D entries*	272 932	216 752	447 026	304 934	106 618			
LINE E : Total current and planned resources *→ Line E = Line B + Line C + Line D*	2 284 105	1 482 641	1 412 199	1 960 607	762 291	655 673	655 673	655 673
Calculation of gap in financial resources and summary of total funding requested in Round 10 *→ must be supported by detailed budget*								

ROUND 10 – HIV

Financial gap analysis								
	Actual		Planned		Estimated			
	2009	2010	2011	2012	2013	2014	2015	2016
LINE F: Total funding gap Line F = Line A – Line E	5 715 895	8 517 359	8 587 801	8 039 393	9 237 709	9 344 327	9 344 327	9 344 327
LINE G: Round 10 HIV funding request *→ must be same amount as requested in tables 1.1, 5.3, 5.4 and detailed budget for this disease*				**669 568**	**610 284**	**460 656**	**368 584**	**367 621**

Part H – Cost Sharing calculation for Lower-middle income and Upper-middle income applicants

In Round 10, the total maximum funding request for HIV in Line G is:

(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program being not more than 65% of the national disease program funding needs over the proposal term; and

(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program being not more than 35% of the national disease program funding needs over the proposal term.

Line H = Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

Complete this cost sharing calculation if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form:

$$\text{Cost sharing} = \frac{(\text{Total of Line D amounts for proposal period} + \text{Total of Line G amounts}) \times 100}{\text{Line A.1}}$$

Complete this cost sharing calculation if the applicant selected Option 1 in section 3.1 of the Proposal Form:

$$\text{Cost sharing} = \frac{(\text{Total of Line D1 amounts for proposal period} + \text{Total of Line G amounts}) \times 100}{\text{Line A.1}}$$

%

5.1.1 Explanation of financial needs and additionality of Global Fund financing

Describe how the annual amounts were:

(a) developed;
(b) budgeted in a way that ensures that government, non-government and community needs were included to reflect implementation of the country's malaria program strategies; and
(c) developed in a way that demonstrates the funding requested in the proposal will contribute to the achievement of outputs and outcomes that would not be supported by currently available or planned domestic resources.

ONE PAGE MAXIMUM

The annual amounts were taken from the re-costed (May 2008, see gap analysis report on Sao Tomé HIV/AIDS and STI Strategic Plan (NASP) 2004-2008 with an extension in 2009. The estimation of resource requirements for implementing the Sao Tomé National HIV/AIDS and STI Strategic Plan (NASP) 2010-2014 will be accomplished by use of the Resource Needs Model (RNM) next year.

In this proposal, the necessities were calculated based on the National Strategic Plan (NSP) 2004-2008 for HIV/AIDS and its extension to 2009. We remark that some activities in the present proposal were included in the above mentioned NSP, but not yet accomplished because of the lack of funds availability. Unit costs from all these sectors were harmonized to take into account the specificities of the implementation platforms that these sectors may present. The unit cost of delivering the service was therefore determined based on service provider experiences.

The costs were developed taking into account the population in need of the services, the targets that were set and the unit cost to deliver the service. The following steps were followed:

1. Key services necessary to achieve the results and targets specified in the NASP were identified
2. The population in need of the service based on demographic data was determined with a focus on PLWA. The cost category “Living Support to Clients/Target Populations” is 21.91% of the grant.
3. Appropriate level of coverage of the services for each year was determined based on universal targets and capacity assessments.

The budget for this proposal is based in the needs of the governmental sectors like National AIDS Program, National Drugs Fund and the Health districts. The NGOs needs (such as strengthening of capacity building for example) were also taking into consideration in this proposal.

5.1.2 Domestic funding

→ corresponds to LINE B in Table 5.1

Describe the processes used in country to:

(a) prioritize domestic financial contributions to the national HIV program including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget; and
(b) ensure that domestic resources are used efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

ONE PAGE MAXIMUM

As mentioned previously, the Government of Sao Tomé and Principe is committed to scaling-up and sustaining HIV/aids prevention and treatment, with the vision to move towards elimination of the disease. Fight against AIDS is included into the national priorities of the National Strategy for Poverty

Reduction (NSPR) and into the documents like Political Option 2007-2010. TB control is among the national priorities included in the grand scheme diseases control, integrated in the National Strategy for Poverty Reduction SNRP as well as in documents such as politic option 2007-2010, that represents the basis for the National Budget elaboration.

To guarantee that the national funds are used with transparence and equity and to assure an execution of the treatment strategy, diagnosis and care at the national and districts levels, one proposal of the Governmental Bigs Plan Option and one proposal of the National Budget are presented in the Parliament for approval.

5.1.3 External funding

→ corresponds to LINE C in Table 5.1

Describe:

(a) any changes in contributions anticipated over the proposal term and the reason for any identified reductions in external resources over time; and
(b) any current delays in accessing the external funding identified in Table 5.1 that should be explained, including the reason for the delay, and plans to resolve the issue(s).

ONE PAGE MAXIMUM

The level of external funding presented in Line C is based on the UNDAF current knowledge and discussions with partners/donors. Sao Tomé and Principe – partly due to its commitment to scaling-up HIV prevention and control interventions – benefits from a very strong partnership for its fight against HIV/AIDS. This partnership includes a number of international organizations, e.g. (EU, 20 000 USD in 2008), (UNFPA, 100 000 in 2008), (UNICEF, 61 000 USD), (UNDP, 10 000 USD in 2008), donors (e.g. Brazil Cooperation, and various non-governmental organizations (e.g. MDM, ALISEI). Based on this strong partnership and as explained in **4.6.2.**, Sao Tomé and Principe is not requesting 100% of the identified gaps related to **SDA in 4.5.1**, as it anticipates some of the gap will be covered by contributions of this partnership. This proposal seeks to address these gaps and constraints and avoid duplication as following:

- **The World Food Program (WFP) (94 673 USD in 2008).** has been supporting AIDS patients with food. The counter part required from that component refers to second-line ARV from 2011 since the same is assured in the 5th Round proposal of the Global Fund, which will approximately end in 2010. Actions related to home care and psycho-social support as well as for stigma reduction counts as support from government. However, this is almost insignificant. It is expected that the reinforcement of these actions be provide by this proposal.
- The support of **WHO (100 000 USD in 2008** through its bi-annual plans and the government for elaboration of norms, personnel training and supply of some reagents.**WHO)** is to reduce the transmission of blood born diseases, including HIV, hepatitis and syphilis.
- **UNAIDS (20 000 USD in 2008)** contribute for a wide coverage of activities for vulnerable groups (e. g. women, CSWs and OVC). This support for maintenance of about PMTCT, posts of preservatives distribution and social marketing that have been funded to support social sector/ world Bank which funding will end in 2010. Actions partly related to sex workers funded by Global Fund till 2011, had a reinforcement from UNAIDS, in 2008 by the fund for programmatic acceleration.
- **The World Bank funding (610,216 USD in 2008)** under PASS program which has been assisting Sao Tomé and Principe since 2004. The development objective of the proposed Social Sector Support Project (PASS) is to contribute to improving the delivery of basic health and education services, which implies a focus on greater equitable access, better quality, and improved local governance of services. The key performance indicators will be improvements in health and education outcomes within the framework of the Millennium Development Goals (MDG). These include key indicators that measure performance in the delivery of basic education and health services as well as indicators showing performance in HIV/AIDS, Malaria

and local governance of services. The proposed PASS includes the following 4 components: (i) Improved delivery of basic education services; (ii) Improved delivery of basic health services; (iii) Addressing cross-cutting issues: HIV/AIDS and Malaria; and (iv) Project Management and Coordination. Health Information system. The project until 2010 will support the health information system through training, TA and equipment for the establishment of a basic system in which information on key sectoral indicators regularly flows from the facilities to the center and feedback on the information is provided. The proposal proposes TA and equipment to a functional National Health Information System (SIS). Other efforts to address obstacles to service access and constraints on programme implementation are as outlined in sections 4.5.1 of this proposal.

Brazil Cooperation (50 000 USD in 2008). During the course of this proposal implementation, we will expect some modifications. For example, the project Health for All, with the financing of the Portugal Cooperation will end in 2011. So in this case that represents a reduction of the external contribution to the National Health System and adjustments will be needed.

5.2 Detailed Budget

Instructions for completion of the detailed budget:

→ For guidance on the level of detail required (or for a template) refer to the budget information available in Section 5.2 of the Guidelines

1. Submit a detailed budget in Microsoft Excel format.
2. Ensure that this detailed budget is consistent in numbering with the Round 10 interventions in section 4.4.1 of the Proposal Form, the Performance Framework, and the detailed work plan.
3. From the detailed budget, prepare table 5.3, the summary by objective and service delivery area.
4. From the detailed budget, prepare table 5.4, the summary by cost category.
5. Do not include a request for CCM or Sub-CCM funding in this Round 10 proposal. Requests for funding are available through a separate application. The application is available at: http://www.theglobalfund.org/en/ccm/

5.3 Summary of Detailed Budget by Objective and Service Delivery Area

→ Use the same objective and SDA numbering as the description in section 4.4.1, the Performance Framework, and the detailed budget and work plan.
→ Annual totals at the end of this table must equal annual totals in the detailed budget and tables 1.1 and 5.4

Objective number	Service delivery area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Testing and Counseling	32 705	37 940	47 180	50 820	55 440	224 085
1	STI diagnosis and treatment	3 312	12 161	10 047	4 447	4 447	34 414
1	BCC – Mass media	0	0	0	0	0	0
1	BCC - community outreach and Most-at-risk population	15 660	11 114	13 600	13 600	7 200	61 174
1	Condom	10 800	7 338	6 185	5 031	3 877	33 230
2	Antiretroviral treatment (ARV) and monitoring	22 990	16 127	25 996	18 925	28 959	112 997
2	Prophylaxis and treatment for opportunistic infections	90 350	65 106	32 933	13 459	13 459	215 308
2	TB/HIV	1 262	176	176	176	176	1 967
2	Care and support for Most-at-risk population	78 024	89 114	4 000	0	0	171 138
2	Support for orphans and vulnerable children	20 160	22 680	25 200	25 200	25 200	118 440
3	PMTCT	37 202	37 202	36 232	36 232	36 232	183 100
4	12-Blood safety and universal precaution	62 513	19 873	23 363	19 873	11 873	137 494
5	Program management and administration cost	146 428	130 428	184 508	135 608	135 608	732 578

ROUND 10 – HIV

Objective number	Service delivery area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
5	HSS: Information system	33 575	111 500	11 500	11 500	11 500	179 575
5	Strengthening of civil society and institutional capacity building	70 784	9 600	9 600	9 600	9 600	109 184
5	Contribution GMS-PR	43 804	39 925	30 136	24 113	24 050	162 028
Round 10 HIV funding request:		669 568	610 284	460 656	368 584	367 621	2 476 713

5.4 Summary of Detailed Budget by Cost Category

→ Summary information provided in the table below should be described further in sections 5.4.1 to 5.4.3
→ Annual totals at the end of this table must equal annual totals in the detailed budget and tables 1.1 and 5.3

Cost Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	85 339	85 339	87 739	87 739	87 739	433 896
Technical and management assistance	102 845	48 780	48 780	33 000	33 000	266 405
Training	76 540	53 300	50 500	31 700	23 300	235 340
Health products and health equipment	194 452	168 340	75 638	75 616	80 977	595 023
Pharmaceutical products (medicines)	8 655	10 175	10 545	10 836	11 128	51 338
Procurement and supply management costs	17 484	17 679	11 656	12 325	12 773	71 918
Infrastructure and other equipment	35 614	600	49 300	600	600	86 714
Communication materials	14 983	5 476	4 308	9 154	2 000	35 920
Monitoring & Evaluation	24 131	122 781	20 311	20 311	20 311	207 846
Living support to clients/target populations	50 369	52 889	55 409	55 409	55 409	269 486
Planning and administration	6 800	5 000	6 000	6 000	6 000	29 800
Overheads	52 357	39 925	40 469	25 893	34 383	193 027
Other (specify):						
Round 10 HIV funding request:	669 568	610 284	460 656	368 584	367 621	2 476 713

5.4.1 Overall budget context

Describe any significant variations in cost categories by year, or significant five year totals for those categories.

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Human resources represents a large proportion of Sao Tomé and Principe's proposed Round 10 budget (18 %). The main raison is a personal staff cost of the new second PR.

The technical and management assistance cost category represents an important amount because during the proposal considerable amount of budget is needed to coordinate all international technical assistance of all four Global Fund Grant ins the country by new recruited staff from SR-OMS.

Clarified Section 5.4.2 (b)

5.4.2 Human resources

(a) Describe how the proposed financing of salaries, compensation, volunteer stipends, or top-ups will be consistent with agreed in-country salary frameworks, such as national salary or inter-agency frameworks.

→ Attach supporting information as evidence, including draft documents where applicable

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The Salary to volunteers which will implement outreach activities among high risk groups and PLWHA. Volunteer's fee was calculated based on target group size and planed coverage and also previous experience of GFATM, Round 5. The Salary level was indicated based on minimum level of existing salaries in Sao Tomé and Principe for volunteers ($ 150). The functional obligations of volunteers will include

1) motivation of high risk group representatives to utilize HIV prevention services;
2) motivation of high risk group representatives to utilize harm reduction services;
3) Strengthening of Adherence to ARVT;
4) Strength of PMTCT coverage;
5) Distribution of condoms, IEC materials;
6) Inter Personal communications on Behaviour Change Communications;
7) Consulting and Testing services;
8) Referral to STI diagnostic and treatment

The other salaries:

- Salary of coordinators and accountants of NGOs implementing the project. The functional obligations of volunteer will include 1) Realization of HIV prevention programs ; 2) Control and Monitoring of work of volunteers; 3) Reporting system to PR; 4) Reporting for materials received to be distributed among vulnerable groups.
- Salary of Managers of NGO which will work about strengthening capacity of their institution
- Salary of M&E specialists

Also salaries of consultants on development of educational manuals, conduction of trainings, establishment of computer programs, implementation of M$E projects, Project Implementation Unit, and International Technical Assistance were included and determined being calculated in accordance with NAP and National HIS.

(b) In cases where human resources represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

→ Attach supporting information as evidence, including draft documents where applicable

(i) this budget calculation over the initial two years is based in the salary and subsidy paid in HIV Grant STP-506-G02-H. But in this proposal we established a harmonization with others Global Fund Grants in STP relative salaries and subsidies. Attached you can see copies of staff contracts and vouchers of subsidy paid to NAP staffs;

(ii) the method of calculating the anticipated costs over years three to five is the same in the initial two years; and

(iii) extent human resources spending with the NAP staffs give then more motivation. This motivation will contribute to better service delivery based in the performance. This motivation will also contribute to better organization of the services and their monitoring at central level, health districts level and central hospital.

5.4.3 Other large expenditure items

If 'other' cost categories represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts; and (ii) explain how this contribution is important to implementation of the national HIV program.

→ Attach supporting information as evidence, including draft documents where applicable

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Apart from reference documents proposed by GFATM-Geneva, we have used the financial data of GF projects management unit (PMU) for unity cost of certain items in the budget. Rehabilitations, human resources cost, training costs and consultancy costs estimates. is presently implementing round 5 Sao Tomé and Principe Global Fund HIV/AIDS projects, we therefore used these informations for certain budget lines.

5.4.4 Measuring service unit cost and cost effectiveness

Provide the following:

(a) where available, estimates of recent average service delivery unit costs at the program-level for key services with an explanation of how the estimates were developed;
(b) estimates of the expected average service delivery unit costs for key services that are included in the proposal; and
(c) a description of how key service delivery unit costs will be measured at the program-level, over time throughout the lifecycle of the grant.

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NA

5.5 Funding Requests in the Context of a Common Funding Mechanism

→ In this section, common funding mechanism refers to situations where all funding is contributed into a common fund for distribution to implementing partners

5.5.1 Common funding mechanism	
If the country's response to HIV is through a program-based approach, does the proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes *→ complete all of section 5.5*
	X ☐ No *→ do not complete section 5.5*

5.5.2 Operational status of common funding mechanism

Describe the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

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NA

5.5.3 Measuring performance

Describe how program performance helps determine financial contributions to the common fund.

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NA

5.5.4 Additionality of Global Fund request

Describe how the funding requested in the proposal will contribute to the achievement of outputs and outcomes that would not be supported by current or planned resources available to the common funding mechanism.

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NA

CHECKLIST

Section 3 and 4: Proposal Summary and Program Description		Document attached? → *mark an 'X' if attached*	List document name and number
4.1	National Health Sector Development / Strategic Plan		
4.1	National HIV Control Strategy and/ or Costed Implementation Plan		
4.1	Sub-sector policies that are relevant to the proposal (e.g. national or sub-national human resources policy, norms and standards, gender policies/strategies and plans, policies on community or CSO partnerships with government health or other systems)		
4.1	Most recent self-evaluation reports/technical advisory reviews, including any epidemiology report directly relevant to the proposal		
4.1	National Monitoring and Evaluation Plan (e.g. health sector, disease-specific, or other)		
4.1	National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need.		
4.1	Most recent bio-behavioral surveillance of key population(s)		
4.1	National report on gender specific operational research and any gender analysis/assessments that might have been undertaken of the HIV response		
4.1	National pharmacovigilance policy		
4.2 (b)	Map if proposal targets specific region/population group		
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists)		
4.4	Document(s) that explain basis for coverage targets		
4.4.1	**A completed Performance Framework (mandatory)**		**Performance Framework**
4.4.1	**A detailed work plan (mandatory)**		**work plan**
4.4.2	A copy of the Technical Review Panel (TRP) Review Form from Round 8 or 9, if relevant		
4.6.1	A recent evaluation of the Impact Measurement Systems as relevant to the proposal (if one exists)		

4.7.1	A recent assessment of the Principal Recipient capacities (other than Global Fund Grant Performance Report)		
4.7.1	Documents describing the organization, such as official registration papers, summary of recent history of organization, management team information *→ only for Non-CCM applicants*		
4.7.2	List of Sub-recipients already identified (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)		
4.8.6	**A completed HIV Pharmaceutical and Health Products List** *→ only mandatory if applicant is procuring these products*		
Section 4B: Cross-cutting HSS (only one per country's application)		**Document attached?** *→ mark an 'X' if attached*	**List document name and number**
4B.2	**A completed separate cross-cutting HSS Performance Framework (mandatory, if applicable)**		**Performance Framework**
4B.2	**A detailed separate cross-cutting HSS work plan (mandatory, if applicable)**		**work plan**
Section 5: Funding Request		**Document attached?** *→ mark an 'X' if attached*	**List document name and number**
5.2	**A detailed budget (mandatory)**		**detailed budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal		
5.4.3	Information on basis of costing for 'other' cost category items		
5.5.1	Documentation describing the functioning of the common funding mechanism *→ only include if there is a common funding mechanism*		
5.5.2	Most recent assessment of the performance of the common funding mechanism *→ only include if there is a common funding mechanism*		

Section 5B: Cross-cutting HSS Funding Request		Document attached? → *mark an 'X' if attached*	List document name and number
5B.1	**A separate cross-cutting HSS detailed budget (mandatory, if applicable)**		**detailed budget**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)		
5B.4.3	Information on basis of costing for 'other' cost category items		
Other documents relevant to sections 3, 4 and 5 attached by applicant		**Document attached?** → *mark an 'X' if attached*	**List document name and number**

PROPOSAL FORM – ROUND 10
SINGLE AND MULTI-COUNTRY APPLICANT

Performance Framework: Indicators, Targets and Periods Covered

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

HIV

Program

Country:	Sao Tome e Principe
Disease:	HIV/AIDS
Proposal ID:	

Program

Goals:

1	**To decrease morbidity and mortality of people living with HIV/AIDS, vulnerable groups and Most-at-risk populations.**
2	

Impact indicator number	Impact indicator formulation	Baseline			Targets							Comments*
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5	
1	% of young women and men aged 15-24 who are HIV infected	1.60	2009	DHS/DHS+ (Demographic and Health Survey)	1.60		1.60		1.60	1.60	1.60	This indicator will be obtained during the period from Centines Surveillance Sites in antenatal clinics
2	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	87.8	2009	PNLS REPORT	90		92		93	94	95	
3	% of infants born to HIV infected mothers who are infected	12	2009	PNLS REPORT	9		7		6	4	2	
4	Please select…			Please select…								

Outcome indicator number	Outcome indicator formulation	Baseline			Targets							Comments*
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5	
1	% of women and men aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	57	2009	DHS/DHS+ (Demographic and Health Survey)			60				70	A DHS is planned for the year Y3/2014. We will request technical assistance Y1 to identify alternative to obtain data for the intermediate period.
2	% of female and male sex workers reporting the use of condom with their most recent client	ND		Please select…			60				80	The data is not avalilable but the sex workers situation diagnosis (2007) state that 95.24% know the preservative as a prevention measure to avoid be inbfected by HIV. Behaviors questions related to this issue wil be including in a Sentinel Survey.
3	% of women and men aged 15-49 expressing accepting attitudes towards people with HIV	15	2009	DHS/DHS+ (Demographic and Health Survey)			25		25	30	35	A DHS is planned for the year Y3/2014. We will request technical assistance Y1 to identify alternative to obtain data for the intermediate period.
4	Please select…			Please select…								
5	Please select…			Please select…								
6	Please select…			Please select…								

* please specify source of measurement for indicator in case different to baseline source.

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objectives:																
1	To significanthly reduce the sexual transmission of HIV infection in STP																
2	Reduced morbidity, mortality and improve the quality of life of HIV infected patients, their partners and families, and support orphans.																
3	Eliminate mother-to-childHIV transmission																
4	To prevent parenteral transmission of HIV infection and other blood borne infection																
5	To increase institucional capacity of the National AIDS Program / Ministry of Health Civil Society																
6																	

Indicator Number	Objective Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for years 1 and 2				Annual targets for years 3, 4, and 5			Tied to	Targets cumulative Y-over program term Y-cumulative annually N-not cumulative	Baselines included in targets (Y/N)	Top 10 indicator	DTF: Name of PR responsible for implementation of the corresponding activity	Comments
				Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5						
1	1	BCC - community outreach and most at risk population	Most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (%)	ND		Please select…				80			95	National Program	Y - over program term	N	Top 10	IMVL	The date is not avalilable but according with the sex workers situation diagnosis (2007) state that 95.24% know the preservative as a prevention measure to avoid be infected and know that sex without condom (87,3%) it is a main way to be infected.
2	1	Testing and Counseling	Women and men aged 15 - 49 years who received an HIV test in the last 12 months and who know their results (%)	29	2009	DHS/DHS+ (Demographic and Health Survey)				35	40		45	National Program	N - not cumulative	N	Top 10	UNDP	Partially financed by GF
3	1	Testing and Counseling	People who received testing and counseling services for HIV and received their test results (#)	38,105	2007 - 2009	PNLS REPORT		12000		14000	16000	18000	20000	National Program	N - not cumulative	N	Not Top 10	UNDP	Partially financed by GF
4	1	STI diagnosis and treatment	Number of patiens with STIs at health care facilities who are appropriately treated	5,075	2009	PNLS REPORT		6000		6500	7000	7500	7500	National Program	N - not cumulative	N	Not Top 10	UNDP	Fully suported by GF
5	1	STI diagnosis and treatment	Percentage of facilities with no reported stock out lasting more than 1 week of recommended STIs drugs durign the past three months	100	2009	PNLS REPORT		100		100	100	100	100	National Program	N - not cumulative	N	Not Top 10	UNDP	Fully suported by GF
6	1	Condom	Number of procured male condoms distributed to health facilities and NGOs	2,337,072	2009	PNLS REPORT		1834000		2205840	3320064	3320065	3320066	National Program	N - not cumulative	N	Top 10	IMVL	Partially financed by GF
7	1	BCC - community outreach and schools	Number of leaders among sex workers trained as peer counsellors on HIV and Sti prevntion	63	2009	PNLS REPORT		20		40	60	80	100	National Program	Y - cumulative annually	N	Not Top 10	IMVL	Fully suported by GF
8	2	Antiretroviral treatment (ARV) and monitoring	Health facilities that offer antiretroviral therapy (prescribe and/or provide clinical follow-up) (%)	21	2009	PNLS REPORT		40		60	80	80	80	National Program	Y - cumulative annually	N	Not Top 10	UNDP	Partially financed by GF
9	2	TB/HIV	Adults and children newly enrolled in HIV care who start treatment for latent Tb infection (Isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period (#, %)	0	2009	PNLS REPORT		15		20	25	30	35	National Program	Y - cumulative annually	N	Not Top 10	UNDP	Fully suported by GF
10	2	Antiretroviral treatment (ARV) and monitoring	Number of people with advanced HIV+ infection recieving ARV treatment according to national guidelines	159	2009	PNLS REPORT		218		255	296	338	352	National Program	Y - cumulative annually	N	Top 10	UNDP	Partially financed by GF
11	2	Prophylaxis and treatment for opportunistic infections	Number of HIV+ patiens receiving prophylaxis for Ois	57	2009	PNLS REPORT		59		66	71	49	58	National Program	N - not cumulative	N	Not Top 10	UNDP	Fully suported by GF
12	2	TB/HIV	Percentage of Tb+ patients in health facilities receiving HIV test, results and post test counselling	100	2009	PNLS REPORT		100		100	100	100	100	National Program	N - not cumulative	N	Top 10 equivalent	UNDP	Partially financed by GF
13	2	Support for orphans and vulnerable children	Number of orphans receiving support for school materials ans clothes	30	2009	CARITAS REPORT		35		40	45	50	55	National Program	Y - cumulative annually	N	Top 10	IMVL	Fully suported by GF
14	3	PMTCT	Infants born to HIV-infectd women starting on co-trimoxazole prophylaxis within 2 months of birth (%)	100	2009	PNLS REPORT		100		100	100	100	100	National Program	N - not cumulative	N	Top 10 equivalent	UNDP	Fully suported by GF; This percentagem relate to those being followed in health services
15	3	PMTCT	Number of positive pregnant women who received complete course of ARVs	11	2009	PNLS REPORT		15		20	25	28	30	Please select…	N - not cumulative	N	Top 10 equivalent	UNDP	Partially financed by GF
16	3	PMTCT	Percentagem of pregnant women in antenatal clinics receivibg HIV test, results and post test counselling	98	2009	PNLS REPORT		98		98	98	98	98	National Program	N - not cumulative	N	Not Top 10	UNDP	Partially financed by GF
17	4	Blood safety and universal precaution	"% of blood units transfused in the last 12 months that have adequately screened to hepatitis C, HBS, HIV according with the national or WHO guidelines	1	2009	PNLS REPORT	100%	100%	100%	100%	100%	100%	100%	National Program	N - not cumulative	N		UNDP	Fully suported by GF

Related to the activities link to the SDAs 09 and 15 we prefer do not have and indicator in the PF and instead of its use as evidence the training and consultancy reports which can be verified by the LFA.
In the case of the SDA 12 the omission was an error. You can check the indicator related to this issue in the PF updated. The indicator proposal is the same that the HIV/R10 had: "% of blood units transfused in the last 12 months that have adequately screened to hepatitis C, HBS, HIV according with the national or WHO guidelines".