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

PROPOSAL FORM

FIFTH CALL FOR PROPOSALS

SAO TOME & PRINCIPE HIV/AIDS PROPOSAL

Strengthening the HIV/AIDS epidemic response in Sao Tome & Principe

June 2005

Table of Contents

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ALISEI	NGO (result of a merger between the Nuova Frontiera & Cidis Associations)
ANC	Antenatal Care
ARV	Anti-Retroviral
ASPF	Sao Tome Association for family planning
Caritas	Catholic Church NGO for social relief
CBOs	Community Based Organizations
CCM	Country Coordinating Mechanism
CSW	Commercial Sex Workers
DOT	Directly Observed Therapy
ELISA	Enzyme Linked Immunno Assay
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
HIV	Human Immunodeficiency Virus
INE	National Institute of Statistic
IPAD	Portuguese Institute for Support for Development
IPPF	International Planning Partners Federation
KAP	Knowledge, Attitudes, Practices
M&E	Monitoring and Evaluation
WB	World Bank
MoH	Ministry oh Health
NAP	National AIDS Program
NGOs	Non Governmental Organizations
NHIS	National Health Information System
NHS	National Health System
OI	Opportunistic Infections
PASS	World Bank Project for Social Sector Support
PLWHA	People living with HIV/AIDS
SHP	Sexual Health Program
PMTCT	Prevention of mother-to-child transmission
PNLT	National Program of Tuberculosis
PRSP	Poverty Reduction Strategic Plan
RHS	Reproductive Health Services
HIS	Health Information System
STI	Sexually Transmitted Infections
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
USD	United States Dollar
VCT	Voluntary counseling and testing
WBank	World Bank
WFP	World Food Program
WHO	World Health Organization

1 1 Eligibility

Proposal title	Strengthening the HIV/AIDS epidemic response in Sao Tome & Principe
Name of applicant	
Country/countries	Sao Tome & Principe

Type of application:

- ☒ **National Country Coordinating Mechanism**
- ☐ Sub-National Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including Small Island Developing States)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism

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

Proposal components

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

[Please tick the appropriate box or boxes for your proposal target; refer to Guidelines for Proposals, section III, A.]

Currency in which the Proposal is submitted

- ☒ US$
- ☐ Euro

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

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

[Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.]
[Countries classified as "lower-middle-income" or "upper-middle-income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals, section II.A.).]

Country/countries	Sao Tome & Principe

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

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

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

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

1.1.1 Counterpart financing and greater reliance on domestic resources

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

Table 1.1.1 – Counterpart Financing and Greater Reliance on Domestic Resources

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

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

1.2 CCM functioning - eligibility criteria

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

1.2.1	Demonstrate CCM membership of people living with and /or affected by the diseases. *[This may be done by demonstrating corresponding CCM membership composition in section 3.6.3 'Membership Information.']*
	The PLWHIV are the new member in the CCM. As the stigma is very high in the country it is very difficult to find PLWHIV to be available to integrate the CCM proposal. Therefore the PLWHIV that are integrated in the proposal were done by voluntary basis. However these people are not yet prepared to be disseminated as PLWHIV. Please see section 3.6.3."Membership information".

1.2.2	Provide evidence that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a documented, transparent process developed within each sector. *[Please summarize the process and attach documentation as an annex.]*
	The CCM was established on year 2000 and have been reinforced for the previous Global Fund proposal submission and now for this fourth for the HIV/AIDS proposal submission. Therefore the NGO in the CCM are not new. In São Tome and Principe, there is a National Federation of NGO (FONG) on which all the NGO are affiliated. The NGO are represented by this Federation, by National Red Cross & the National Labor organization, by the head of these NGO. The head of these NGO are elected by their members.

1.2.3	Describe and provide evidence of a documented and transparent process to:
a)	Solicit submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
	The PLWHIV are the new member in the CCM. As the stigma is very high in the country it is very difficult to find PLWHIV to be available to integrate the CCM proposal. Therefore the PLWHIV that are integrated in the proposal were done by voluntary basis. .....
b)	Review submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
	The composition of the CCM is the same concerning the posts.However , some names have changed due to new appointments
c)	Nominate (the) Principal Recipient(s) and oversee program implementation *[please summarize and attach documentation as an annex.]*
	The PR was nominated by consensus in the CCM meeting

2.1 Executive Summary

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

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

Sao Tome & Principe is a small island state within the lower income bracket of African nations with a population of 148,968 inhabitants (66.6% under 25 years), 53.8% living in poverty. HIV prevalence among pregnant women increased from 0.1% in 2001 to 1.5% in 2005. As of 2004, 157 cumulative AIDS cases have been reported. The estimated number of PLWA is 1,020 (age range 15 – 49 years) and around 200 patients are severely ill. Currently, there are 37 HIV infected patients being monitored, 18 receiving ARV treatment. Dissemination of HIV/AIDS prevention information is still relatively low. Knowledge about safe sexual behaviors is low. Condom use is low (men- 40.7% and women-13.8%). School drop out is especially high among youth aged 13-17 years old. School attendance among this grouping of adolescents is only 25.3%. The HIV prevalence among TB patients tested in 2004 was 10%. Currently, the TB diagnosis is limited to the central hospital laboratory. The Central Hospital's Blood Bank relies mainly on blood donors provided by individual family members of interned patients. Blood is not at all tested for hepatitis C or malaria. Health care workers have never been trained on safety precautions. And the disposal of needles and sharp instruments is highly inadequate. Post exposure with antiretroviral drugs is not available. The only laboratory in the country running HIV diagnosis examinations lacks adequate infrastructure and is very poorly equipped.

The major **Goal** of this proposal is: To contribute to reversing the spread of the HIV/AIDS Pandemic in Sao Tome & Principe and limit its negative impact on the nations development."

Five(5) key objectives have been identified to include:

1- Preventing sexual transmission of STI/HIV among vulnerable people

2. Reducing the transmission of blood born diseases, including HIV, hepatitis and syphilis

3- Preventing of Mother-to-Child Transmission

4- Improving the quality of life and decrease the morbidity and mortality of people living with HIV/AIDS and their families

5- Increasing institutional capacity of the National Aids Program and Non-Governmental Organizations

The Key services delivery areas will include 1- Youth education, focusing on youth out of School, 2- Information and education for commercial sex workers, 3- Voluntary counseling and testing (VCT), 4- Condom Distribution, 5- Treatment of Sexually Transmitted disease through syndromic approach, 6- Blood safety, 7- Universal precautions, 8 - Prevention of HIV Mother-to-Child HIV Transmission, 9- Prophylaxis and Treatment of Opportunistic Infections, 10- Antiretroviral Treatment and Monitoring, 11- Support for the chronically ill and orphans, 12- Stigma Reduction, 13- Strengthening the civil society, Strengthening the institutional capacity of

the NAP/CCM/NGOs

Over the years, a strong partnership has been developed with the varied agencies of the United Nations, bilateral partners, and other donors to implement activities related to HIV/AIDS prevention and care.. Therefore, we are at a stage of scaling up some interventions such us HIV VCT, condom distribution, antiretroviral therapy and PMTCT, management of STI through a symptomatic approach. This proposal also includes intervention that will be new, such as, the treatment and prevention of opportunistic infections, antiretroviral therapy monitoring, prevention interventions focusing on commercial sex workers and youth out of school, income generating activities and interventions aimed at reduction of stigma and discrimination. Monitoring and evaluation activities will also be improved. Capacity building activities in this field are included in this proposal that seeks to increase the autonomy of national staff technical in this field. Capacity building activities for NGOs are also new interventions that will be made possible through financial resources requested in this grant application. We will optimize the use of human resources and technical capacity available not only in the government but also in the NGO's, bilateral/multi-lateral partners, UN agencies, the private sector and local communities.
The main results in implementing this proposal will be:

- Increased knowledge about HIV prevention and appropriate sexual behavior among **3.669** young people out of school (15 – 19 years) covering 7districts within the country by Year 3.
- **70 commercial sex workers** exposed to outreach activities conducted by trained peer counselors with increased knowledge about safe sexual practices, HIV/AIDS, VCT, STI and contraception. They will be empowered to practice safe sex with clients and intimate partners.
- HIV Voluntary Counseling and Testing will be provided in 29 health care facilities (7 health centers and 1 hospital and 21 health posts) distributed among 7 districts (health districts). These services will provide HIV VCT to pregnant women, patients diagnosed with STI and patients with tuberculosis.
- Condom distributed at no cost for the population will be available in 29 health care facilities (7 health centers, 21 health posts and Ayres de Menezes hospital (including HIV care referral center and VCT service) distributed on the 7 districts of the country (health districts). Increased availability of condoms in the country distributed through NGOs and health services – from 560,000 in 2005 to **1,350,000 by the 5th year** (900,000 by the 2nd year).
- diagnosis and treatment of STI through syndromic approach will be provided by trained health care workers in 29 health care facilities (7 health centers and 1 hospital and 21 health posts) distributed on the 7 districts of the country (health districts) access to STI diagnosis and treatment through Syndromic Approach in the 7 districts of the country.
- **75% of STI** patients treated at health services tested for HIV infection by 5 year (50% by 2nd year)
- **1,500 patients** per year will be treated for STI at health services by 5th year **(1,000 by 2nd year)**
- Increased voluntary blood donors' rate from < 5% to **30%** by the 5th year (10% by the 2nd year)
- **100% of transfused blood** will be tested for Hepatitis C by the 2nd year.
- **60 health care workers** each year will receive training on universal precautions
- **100% of the 29 health care services** will have adequate disposal for needles and other sharp instruments by the 2nd year
- Post exposure prophylaxis will be available 24 hours at Ayres de Menezes Hospital by 2nd year.
- Increased rate of pregnant women tested for HIV from 20% to **85%** by the 5th year (**65%** by the 2nd year)
- Increased coverage rate of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT according to National/WHO guidelines from < 5% (2) to **60% (50)** by the 5th year [being **30% (25)** by the 2nd year)
- Increased coverage of infants born to HIV infected women receiving ARV prophylaxis, from < 5% to **85%** (70) by the 5th year [45% (38) by 2nd year]
- Availability of infant formula to 100% of infants whose mother's choose to not breastfeed.
- **100%** of patients diagnosed with HIV infection on WHO stage II, III, and IV will have access to prophylaxis and treatment of OI by the 2nd year (includes all patients HIV infected diagnosed with tuberculosis).
- **330** patients by the 5th year will be on prophylaxis for opportunistic infections.
- **29** health services with installed capacity to perform sputum smear microscopy by 5th year.
- **120** community health care agents sensitized about tuberculosis and HIV infection by 5 year (60 by 2nd year)
- **100%** of patients HIV infected diagnosed with tuberculosis will be tested for HIV by 5th year.
- **330** patients by the 5th year will be on antiretroviral treatment
- **104 PLWHA/orphans families/caregivers** will be supported with income generating activities by 5th year (34 by 2nd year)
- **All PLWHA/orphans their families/caregivers** identified will receive nutritional support from the World Food program
- **All HIV infected pregnant women diagnosed** will receive nutritional support from the World Food program
- **100** orphans will be supported with school materials and clothes (45 by 2nd year).
- Institutional capacity will be strengthened through the development of a System of Monitoring &

Evaluation, and through increasing the availability of NAP staff with adequate skills and capacity to conduct supervisions of activities being conducted on field by health care workers and other partners, mainly NGOs, collect and analyze epidemiological and other relevant data, including KAP studies.

Best practices and innovative aspects of the proposal

The elements of innovation in this proposal are seen in its deliberate attempts to ensure south-south collaboration between Sao Tome & Prince and Brazil. Both nations share several common features which include among others, the use of Portuguese as a national language and common historical and cultural links. A commonly shared political vision through the political compact of the CPLP group of Portuguese speaking nations has ensured the need for greater economic and social interaction between the two nations. Sao Tom & Principe believes that as a nation it can build on the successful Brazilian experience of overcoming barriers usually faced by developing countries to implement HIV/AIDS prevention and care programs and boost the Sao Tome & Principe response to the AIDS pandemic. The interventions included in this proposal were chosen among recognized "best practices" and relevant to Sao Tome & Principe's specific realities.

2.2 Component and Funding Summary

Table 2.2 – Total Funding Summary

	Total funds requested in Euro / US$					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	337,014.80	247,202.85	277,467.48	269,272.00	354,203.16	1,485,160.29
Tuberculosis						
Malaria						
Health systems strengthening						
Total	337,014.80	247,202.85	277,467.48	269,272.00	354,203.16	1,485,160.29

3 Type of Application

Table 3 – Type of Application

Type of application:		
☒	National Country Coordinating Mechanism	→*go to section 3.1*
☐	Sub-National Country Coordinating Mechanism	→*go to section 3.2*
☐	Regional Coordinating Mechanism (including Small Island States)	→*go to section 3.3*
☐	Regional Organization	→*go to section 3.4*
☐	Non-Country Coordinating Mechanism	→*go to section 3.5*

[Complete section 3 as appropriate. Please note that - without these details, and in particular the information requested in section3.6 the proposal cannot be reviewed.]

3.1 National Country Coordinating Mechanism

Table 3.1 – National CCM: Basic Information

Name of National CCM	Date of Composition
Inter Agency Coordinating Committee of Sao Tome & Principe	03/10/2000

3.1.1	Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs). [For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]
The National CCM of STP currently has 24 members that generally convene four (4) times per year as a single body at the Ministry of Health premises. Additional meetings are scheduled as needed to consider special issues. The general role of the CCM is to assist the Ministry of Health with the formulation of health policies, and resource mobilization. The CCM was initially established on October 10, 2000 with 13 original members. In October of 2002, the CCM was expanded to include 10 new members. The IACC was added as an additional partner at that time. Most recently the CCM has been involved in the implementation of expanded immunization programmes funded among other key partners that include Government, the UN agencies, bilateral groups, NGO's and the Gates Foundation. The CCM has a simple organizational structure with a President, Vice-President, Secretariat and various technical groups that are formed, as needed from among the CCM members. In 2005, a representative of people living with HIV/AIDS was included as a CCM Member.(See earlier note) Decisions are generally derived by consensus after careful and exhaustive consideration by all technical partners and inputs as required. External technical experts or consultants are sometimes called in to provide advice on key areas. The CCM convened several times during the development of this proposal to review draft plans and to provide final approval. Meetings will be convened during the resource mobilization and implementation phases to provide direction and oversight after receiving briefs on the status and progress of activities. Meetings will also be convened to provide oversight on the monitoring and evaluation process as results become available. Public, privates institutions, NGO and PLWA CCM's member's are also NAC's member linked through the Executive Secretariat.	

3 Type of Application

3.2 Sub-National Coordinating Mechanism

Table 3.2 – Sub-National CCM: Basic Information

Name of Sub-National CCM	Date of Composition

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

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

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

3.3 Regional Coordinating Mechanism (including Small Island Developing States)

Table 3.3 – Regional Coordinating Mechanism: Basic Information

Name of Regional CM	Date of Composition

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

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

3 Type of Application

3.4 Regional Organizations

Table 3.4 – Regional Organization: Basic Information

Name of Regional Organization
not applicable

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

3.5 Non-Country Coordinating Mechanism

Table 3.5 – Non-CCM Applicant: Basic Information

Name of Non-CCM applicant
no applicable

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

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

3.5.2 Rationale for applying outside an existing CCM

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

1. *Countries without legitimate governments;*
2. *Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or*
3. *Countries that suppress or have not established partnerships with civil society and NGOs.*

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

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

3 Type of Application

3.5.2.3 Non-CCM proposals from countries in which no CCM exists
[Describe how the proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy) (3–4 paragraphs). Provide evidence (e.g., letters of support) from relevant national authorities in an annex.]

3.5.3 All non-CCM proposals should include as annexes additional documentation describing the organization, such as:

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

3.6 Proposal Endorsement and Membership Section

3.6.1 Representation

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

	Chairperson	Vice Chairperson
Name	**Dr. Alberto Manuel dos Santos**	**Dr. Jose Manuel Carvalho**
Title	**Minister of Health**	**Coordinator of Health Care Department**
Mailing address	**Ministry of Health, P.O.Box 23 S.Tome and Principe**	**Ministry of Health, P.O.Box 23 S.Tome and Principe**
Telephone	**+239 241 201**	**+239 242 000**
Fax	**+239 221 306**	**+239 242009**
E-mail address	**msaude@cstome.net**	**hilarcarvalho@hotmail.com**

3.6.2 Contact information

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

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

	Primary contact	Secondary contact
Name	Dr. Alzira do Rosario	Dr. Claudina Augusto Da Cruz
Title	Director of National HIV/AIDS Programme	WHO focal person for HIV/AIDS
Organization	Ministry of Health	WHO

3 Type of Application

Mailing address	Ministry of Health, P.O.Box 23 S.Tome and Principe S. Tome and Principe	WHO, United Nations Av. Sao Tome, P. O. Box 281 Sao Tome and Principe
Telephone	+239 242000	+239 222957
Fax	+ 239 221 306	+239 221 766
E-mail address	internet@cstome.net alzirarosario@hotmail.com	ccruz.who@undp.org claudinacruz@hotmail.com

3.6.3 Membership information

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

3.7 Proposal Endorsement and Membership Section

3.7.1 Representation

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

	Chairperson	Vice Chairperson
Name	**Dr. Alberto Manuel dos Santos**	**Dr. Jose Manuel Carvalho**
Title	**Minister of Health**	**Coordinator of Health Care Department**
Mailing address	**Ministry of Health, P.O.Box 23 S.Tome and Principe**	**Ministry of Health, P.O.Box 23 S.Tome and Principe**
Telephone	**+239 241 201**	**+239 242 000**
Fax	**+239 221 306**	**+239 242009**
E-mail address	**msaude@cstome.net saudefor@cstome.net**	**hilarcarvalho@hotmail.com**

3.7.2 Contact information

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

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

	Primary contact	Secondary contact
Name	Dr. Alzira do Rosario	Dr. Claudina Augusto Da Cruz
Title	Director of National HIV/AIDS Programme	National Officer Programme HIV/AIDS
Organization	Ministry of Health	WHO

3 Type of Application

Mailing address	Ministry of Health, P.O.Box 23 S.Tome and Principe S. Tome and Principe	WHO, United Nations Av. Sao Tome, P. O. Box 281 Sao Tome and Principe
Telephone	+239 242000	+239 222957
Fax	+ 239 221 306	+239 221 766
E-mail address	internet@cstome.net alzirarosario@hotmail.com	ccruz.who@undp.org claudinacruz@hotmail.com

3.7.3 Membership information

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

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

National/Sub-National/Regional (C)CM member details			
Member 1			
Agency/organization	Ministry of Health	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	
Name of representative	Dra Idalecio Aguiar	CCM member since	
Title in agency	Director of Planing, Adminstration and Finances	Fax	00 239 221306
E-mail address	msaude@cstome.net	Telephone	00 239 241200
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Ministerio da Saude POBox 23 Sao Tome &Principe
Member 2			
Agency/organization	Ministry of Health	Website	
Type *(academic/educational sector; government; nongovernmental and*	Gouvernment	Sector represented	

3 Type of Application

community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Dra Maria da Conceicao	CCM member since	
Title in agency	Director of the Centre for Endemic Diseases	Fax	00 239 221227
E-mail address	malarstp@cstome.net	Telephone	00 239 221099
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Ministerio da Saude PO Box 23 Sao Tome & Principe

National/Sub-National/Regional (C)CM member details

Member 3

Agency/organization	Ministry of Health	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	
Name of representative	Dra Alzira do Rosario	CCM member since	
Title in agency	Director of National AIDS Programme	Fax	00 239 221306
E-mail address	internet@cstome.net alzirarosario@hotmail.com	Telephone	00 239 242000
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Ministerio da Saude PO Box 23 Sao Tome & Principe

Member 4

Agency/organization	WHO	Website	
Type	Multilateral Development partners	Sector	

3 Type of Application

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Dra Claudina A.Cruz	CCM member since	
Title in agency	WHO focal person for HIV/AIDS, TB	Fax	+239 222957
E-mail address	ccruz.who@undp.org claudinacruz@hotmail.com	Telephone	+239 221 766
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	WHO Immeuble des Nations Unies Avenue des Nations Unies BP 287, Sao Tome
Member 5			
Agency/organization	Ministry of Planning and Finance	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	
Name of representative	Manuel Filipe Moniz	CCM member since	
Title in agency	Coordinator planning and investment	Fax	+239
E-mail address	dgplaneamento@cstome.net	Telephone	+239 222121
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	tecnical input	Mailing address	Ministerio da Saude PO Box 23 Sao Tome
Member 6			
Agency/organization	Ministry Education and Culture	Website	
Type	Government	Sector	

3 Type of Application

(academic/educational sector, government, nongovernmental and community-based organizations, people living with HIV/AIDS, tuberculosis and/or malaria, the private sector, religious/faith-based organizations, multi-/bilateral development partners)		represented	
Name of representative	Maria de Fatima Sousa Leite	CCM member since	
Title in agency	Coordinator planning and investment	Fax	
E-mail address	msaude@cstome.net	Telephone	+239 225691
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Ministerio da Saude PO Box 23 Sao Tome e Principe
Member 7			
Agency/organization	Social Communication	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations, people living with HIV/AIDS, tuberculosis and/or malaria, the private sector, religious/faith-based organizations, multi-/bilateral development partners)*	Government	Sector represented	
Name of representative	Eugenia do Sacramento Menezes Alamão	CCM member since	
Title in agency	Director	Fax	
E-mail address	msaude@cstome.net	Telephone	+239 221538
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical imput	Mailing address	Ministerio da Saude PO box 23 Sao Tome & Principe
Member 8			
Agency/organization	UNDP	Website	
Type	Multilateral Development partners	Sector represented	

3 Type of Application

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Christian Lehembre	CCM member since	
Title in agency	UNDP Resident Representative	Fax	+239 222198
E-mail address	Registry.st@undp.org Christian.lehembre@undp.org	Telephone	+239 221122 +239 221123
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	UNDP United Nations Building Avenue des Nations Unies BP 109 SAO TOME
Member 9			
Agency/organization	WHO	Website	
Type *(academic/educational sector, government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multilateral Development partners	Sector represented	
Name of representative	Dr Teresa Araujo	CCM member since	
Title in agency	WHO Contry Representative	Fax	+239 222198
E-mail address	tearaujo.who@undp.org	Telephone	+239 221122
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	WHO United Nations Building Avenue des Nations Unies BP. 287, SAO TOME
Member 10			
Agency/organization	UNICEF	Website	
Type	Multilateral Development partners	Sector	

3 Type of Application

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Batilloi Warritay	CCM member since	
Title in agency	Head of Mission	Fax	+239 222 477
E-mail address	bwarritay@unicef.org	Telephone	+239 221 634
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	UNICEF United Nations Building Avenue des Nations Unies BP 404 . SAO TOME
Member 11			
Agency/organization	UNFPA	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multilateral Development partners	Sector represented	
Name of representative	Dr Victoria D'Alva	CCM member since	
Title in agency	UNFPA Country Representative	Fax	+239 221924
E-mail address	victoria.dalva@undp.org	Telephone	+239 221529
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical imput	Mailing address	UNFPA United Nations Building Avenue des Nations Unies BP 952 . SAO TOME
Member 13			
Agency/organization	African Development Bank	Website	
Type	Multilateral Development partners	Sector	

3 Type of Application

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Dr Helder Costa Neto	CCM member since	
Title in agency	Programme Coordinator	Fax	+239 222198
E-mail address	helder.neto@undp.org	Telephone	+239 221122
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	African Development Bank United Nations Building Avenue des Nations Unies BP 952 . SAO TOME
	Member 12		
Agency/organization	Portuguese Cooperation	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Development partners	Sector represented	
Name of representative	Antonio Machado	CCM member since	
Title in agency	Officer Cooperation of Portuguese Embassy	Fax	+239 221190
E-mail address	eporcoop@cstome.net	Telephone	+239 221130
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Av. 12 de Julho PO box 713, Sao Tome and Principe
	Member 13		
Agency/organization	French Cooperation	Website	
Type	Bilateral Development partners	Sector	

3 Type of Application

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Danielle Robin	CCM member since	
Title in agency	Representative French Embassy	Fax	+230221792
E-mail address	danielle.robin@diplomatic.gouv.fr	Telephone	+239 222266
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Bairro da Quinta de Santo António Pobox 115 Sao Tome
Member 14			
Agency/organization	American Cooperation	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Bilateral Development partners	Sector represented	
Name of representative	Nelson de Assuncão	CCM member since	
Title in agency	Economical commerce Assistent	Fax	+239 223406
E-mail address	jpinto@sto.ibb.gov nassuncao@sto.ibb.gov	Telephone	+239 223400
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Voice of America Pinheira, PO Box 522, Sao Tome and Principe
Member 15			
Agency/organization	Taiwan Cooperation	Website	
Type	Bilateral Development partners	Sector	

(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)		represented	
Name of representative	Lay Seng Jung	CCM member since	
Title in agency	Secretary of Embassy	Fax	+239
E-mail address	rocstp@cstome.net	Telephone	+239 222671
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Av. Marginal 12 de Julho, PO Box, 839 Sao Tome and Principe
Member 16			
Agency/organization	Red Cross of STP	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non Governmental and Community – based organizations	Sector represented	
Name of representative	Paulo Rosario das Neves	CCM member since	
Title in agency	Agency representative	Fax	+239 222469
E-mail address	cvstp@cstome.net	Telephone	+239 222305
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Av.12 de julho n. 11 Bp 96 Sao Tome e Principe
Member 17			
Agency/organization	Rotary Club	Website	
Type *(academic/educational sector; government; nongovernmental and*	Non Governmental and Community – based organizations	Sector represented	

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community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Eugenio Silva	CCM member since	
Title in agency	Vice President	Fax	+239 222477
E-mail address		Telephone	+239 221634
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	????????????
Member 18			
Agency/organization	Chamber of Commerce, Industry, agriculture, and Services	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	The Private Sectors	Sector represented	
Name of representative	Abilio Afonso Henriques	CCM member since	
Title in agency	President	Fax	+239 221409
E-mail address	ccias@cstome.net	Telephone	+239 222723
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	
Member 19			
Agency/organization	NGO Federation of STP	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people*	Non Governmental and Community – based organizations	Sector represented	

3 Type of Application

living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Dr Dulce Braganca Gomes	CCM member since	
Title in agency	President	Fax	……
E-mail address	fong@cstome.net	Telephone	+239 226754
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Secretariat	Mailing address	Bairro Quinta de Santo António N. 817 PO Box 1029 Sao Tome and Principe
Member 20			
Agency/organization	Caritas of STP	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non Governmental and Community – based organizations	Sector represented	
Name of representative	Maximo Queiroz do A. Aguiar	CCM member since	
Title in agency	President	Fax	+239 222565
E-mail address	caritas_stp@cstome.net	Telephone	+239 222565
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	
Member 21			
Agency/organization	Catholic church	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or*	religious/faith-based organizations	Sector represented	

3 Type of Application

malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Julia Gaspar	CCM member since	
Title in agency	Director of home's Sisters	Fax	
E-mail address		Telephone	+239 222604
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical imput	Mailing address	Bp 189 Sao Tome and Principe
Member 22			
Agency/organization	Inter Sindical	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non governmental and community-based organizations	Sector represented	
Name of representative	Joao Tavares	CCM member since	
Title in agency	President	Fax	+239 226603
E-mail address	onstpbis@cstome.net	Telephone	+239 222431
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	Rua de Cabo Verde PO Box 8 Sao Tome and Principe
Member 23			
Agency/organization	PLHIV	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or*		Sector represented	

3 Type of Application

malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)			
Name of representative	Sonia	CCM member since	
Title in agency		Fax	
E-mail address	Sonia_fofa@hotmail.com	Telephone	+239 242000
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	
Member 24			
Agency/organization	PLHIV	Website	
Type *(academic/educational sector; government, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*		Sector represented	
Name of representative	Fernando	CCM member since	
Title in agency	ferdinando90@hotmail.com	Fax	+239
E-mail address		Telephone	+239 242000
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	

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

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

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

PROPOSAL TITLE: Strengthening the HIV/AIDS epidemic response in Sao Tome & Principe

PROPOSAL TITLE: Strengthening the Sao Tome & Prince Response to the HIV/AIDS epidemic

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

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

Agency/organization	Name of representative	Title	Date	Signature
Ministry of Health	Alberto dos Santos	Minister of Health	30/05/05	
Ministry of Health	Jose Manuel Carvalho	Director of Health Services	30/05/05	
Ministry of Health	Dr Idalecio Aguiar	Director of Planning, Administration and Finances	30-5-05	
Ministry of Health	Maria Conceicao Ferreira	Director of the Centre for Endemic Diseases	3/05/05	
Ministry of Health	Alzira do Rosario	Director of National AIDS Programme	30/5/05	
WHO	Claudina A.Cruz	WHO focal person for HIV/AIDS	30-5-05	
Ministry of Planning and Finance	Manuel Filipe Moniz	Coordinator: Planning and Investment	3/06/05	
Ministry of Culture and Education	Ma de Fatima Leite Sousa Almeida	Technical officer for Planning and Investment	3/6/05	
Social Communication	Eugenia Sacramento Menezes C. Alamão	Director	3/06/05	
UNDP	Christian Lehembre	UNDP resident representative	30-5-05	
UNICEF	Batilloi Warritay	Officer-in-Charge	30-5-05	
WHO	Teresa Araujo	WHO Country Representative		
UNFPA	Victoria Menezes	UNFPA Country Representative	30-5-05	
African Development Bank	Helder Costa Neto	Programme Coordinator	30-05-05	
Portuguese Cooperation	Antonio Machado	Head of Mission	03.06.05	
French Cooperation	Dannielle Robin	Representative from the French	03.06.05	

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China Taiwan Cooperation	Lay Seng Jung	Secretary of Embassy	02/06/05	
American Cooperation	Ronald D Johnson	Third Secretary of Embassy	02/06/05	
Red Cross of STP	Paulo Rosario das Neves	Agency Representative	30.05.05	
Rotary Club	Eugenio Silva	Vice President	30.05.05	
Intersindical	Joao Tavares	President	02/06/05	
Catholic Church	Fernanda Morais Pinto	Director of Sister's Home	03/6/05	
Caritas of STP	Maximo Aguiar	President	30.05.05	
NGO Federation of STP	Dulce Braganca Gomes	President	03/06/05	
Chamber of Commerce Industry and Services	Abilio Afonso Henriques	President	3/06/05	
PLWHIV			03/06/05	
PLWHIV			03/06/05	

247600
903100

3.6.5 CCM Endorsement Details for Applications from Regional Organizations:

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

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

Table 3.6.5 – Regional Organization Endorsement

Names of CCM	Country	Attachment number

4 Components Section

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

4.1 Identify the Component Addressed in this Section

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

4.1.1 Indicate the Estimated Start Time and Duration of the Component

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

Table 4.1.1 – Proposal Start Time and Duration

	From	To
Month and year:	January 2006	December 2010

4.2 Contact Persons for Questions Regarding this Component

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

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Alzira do Rosario	Claudina Augusto da Cruz
Title	Director of National HIV/AIDS Programme	NPO/HIV,
Organization	Ministery of Health	WHO
Mailing address	Ministery of Health, PO Box 23 S. Tome and Principe S. Tome	WHO, United Nations, PO Box 201 Sao Tome and Principe
Telephone	+239 242000	+239 222957
Fax	+239 221306	+239 221766
E-mail address	internet@cstome.net alzirarosario@hotmail.com	ccruz.who@undp.org claudinacruz@hotmail.com

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

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

4.3 National Program Context and Gap Analysis for this Component

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

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

Sao Tome & Prince is a small island state and lower income country located in the Guinea Gulf,Central Africa. The country's total land territory is 1001 km2 distributed between two islands, Sao Tome (859km2) and Principe (142 km2), 150 km apart from each other. The country's independence from Portugal was on July 12th of 1975. The total population has over the years gone from 64,000 inhabitants in 1975 to 148,968 in 2005, in accordance with projections made by the National Institute of Statistic (INE) and based on 2001 National Census (Growth rate of 1,6%). The male population account for 49% of the population and 51% are female. The population is significantly youthful with , 42.1% of this number aged between 0 and 14 years; 60.9% is between 15 and 49, and only 4.3% being 65 and above. Overall, 66.6% of the population is younger than 25 years old, with an age pyramid that has a wide base and a small apex, illustrating a high fertility and birth rate as well as a rather high mortality rate, producing a large population of young people and very few older people. Overall, 55.1% of the economically active population live in urban areas. By 2001, 53.8% of the population was living under the poverty threshold of 1 USD per day. The economically active population is primarily engaged in agriculture and fishing. In the UNDP Human Development Report 2004 Sao Tome & Principe is ranks 123rd. (UNDP 2004). Following the structural adjustment programme adopted on 1997, the socio-economic situation has deteriorated in the country.

The country's main socio-economic indicators 2001, are as follow:

Expenditure on health per capita: 25 USD
Life expectancy at birth: 63.9 years
Infant mortality rate: 57.6/1000
Maternal mortality: 122/100.000
Fertility rate: 4.7%
Education rate: 80% (adult pop)
GNP: ~ 407 USD per capita
55.7% of the families are headed by women
Population living in poverty: 53.8% (15.1% in extreme poverty)
11.8% of the population have never attended school
Access to canalized water: 19.6% (in average, 80% of the population have access to water)
Schooling rate among adults: 80.7%

In ST&P HIV infection surveillance was started in 1989, when the first HIV sentinel study was conducted. At the time, 458 pregnant women 0.7% were found to be HIV infected. Prevalence studies conducted among pregnant women in 2001 and 2005 have found an HIV prevalence of 1.0% and 1.5% respectively. The AIDS case reporting was started in 1990 and since then, 157 AIDS cases have been reported to the Ministry of Health. However, under-reporting is considered to be high. So far, 48.4% of this number have already died. As in other African countries, heterosexual transmission (87.3%) is, by far, the most common transmission route in ST&P. Blood transfusion accounts for 4.5% of the reported cases. The age group between 30 and 49 years is the most affected. Most of the cases occurred among urban population mostly from Agua Grande and Me Zochi, the most affected districts with 56.7% and 18.5% of the AIDS cases reported respectively. It is estimated that there are around 1.020 people living with HIV AIDS in the country among the population aged between 15 – 49 years. In 2004, the HIV infection prevalence among blood donor was found to be 2.5%. From November to April, 44 HIV/AIDS were identified,

7 have died in this period and, currently, there are 37 HIV infected patients being monitored. 18 on ARV treatment.
The situation regarding sexual behavior is worrisome. In a KAP study conducted by the NGO (ALISEI) 30% of women interviewed reported that their partner had another sexual partner. In 2000, 20% of the pregnant women presented at health clinics had evidence of STI during gynecologic exam.
There is a lack of information and knowledge about safe sexual behavior. Condom use among men was reported to be 40.7% and 13.8% among women (KAP 2001, RHP).
The country's high fertility rate is due, among other causes, to precocious sexual activity, an open ended concept of marriage and a low rate of contraceptive use. Teenage pregnancy is becoming an issue of grave concern. This situation has resulted in a significant school dropout problem among girls, further enhancing extreme poverty and inequality. In accordance with data from a study conducted among youth out of school, conducted in 2001 by the Ministry of Education, Culture and Sports, 20% of youth below 17 years old were reported to have an active sexual life. The same study found 37.5% of female adolescent between 15 and 17 years reported a voluntary interruption of pregnancy. In the same year, at the Hospital Ayres de Menezes, 580 women hospitalized were as a result of complications due to abortion, Ten 10% occurred among women younger than 17 years old. Abortion complications are among the three most frequent causes of mortality among women.

In addition to a low global rate of attendance to school (45%), school drop out is especially high among youth aged 13-17 years old. In that age range school attendance is only 25.3%. Infant labor between children aged between 10-17 years reaches 8.3% and 78.3% when the age range of 15-17 years is considered acceptable.
Tuberculosis is a public health problem in ST&P. The number of TB cases increased considerably between 2001 and 2004, the annual number of TB cases reported went from 70 to 153 in 2004 (MS 2003). The HIV prevalence among those tested in 2004 was 10%. Currently, the TB diagnosis is limited to the central hospital laboratory, the only facility where sputum smear microscopy is performed. Certainly it is fueling the TB epidemic in ST&P due to the delay in the diagnosis and treatment of infectious cases. As a result of late diagnosis of both tuberculosis and HIV infection, tuberculosis is a recognized cause of death among HIV infected patients. In addition co-infected patients frequently develop other opportunistic infections before having their HIV infection diagnosed, indicating lost opportunities to diagnose HIV infection by the time of a TB diagnosis.
Given the close links between anemia, malaria and malnutrition, blood transfusions are very frequently prescribed, increasing the risk of the population living in ST&P to being infected by blood borne diseases. In spite of it, blood transfusion relies mainly on blood collected from family members or from donors provided by the patient's family. By 2004, less than 5% of the 2,800 blood transfusions were made with blood voluntary donated. In 2004, a prevalence of 2.6% of HIV infection was found among blood donotion candidates. In this population, prevalence of hepatitis B antigen was 9.8% and 1.6% for syphilis. So far, blood donors are not at all tested for hepatitis C and malaria is only verified when the blood donor candidate reports fever. Therefore the risk of malaria transmission from asymptomatic carriers is high. In addition physicians normally prescribe the use of all blood received rather than blood components. Health care workers have not been trained on Universal Safety Precautions and post exposure prophylaxis with antiretroviral drugs is not available to them. An association called UNDABESA was established in 2002 with the main purpose of stimulating volunteer blood donation in ST&P. However, lack of resources to mobilize the population has extensively limited its activities. The blood bank's laboratory at Ayres de Menezes Hospital the only laboratory in the country running HIV diagnosis exams. Are being run under minimal standards for the performance of quality basic blood donors screening and HIV diagnosis.

Poverty, unemployment, high internal mobility and migration, lower education level, high prevalence of STI's and a high number of sexual partners, taboos and high level of stigma and discrimination against HIV/AIDS affected persons are the major identified barriers to HIV/AIDS prevention in ST&P. This therefore poses a risk of rapid dissemination of HIV infection in the country. It is anticipated that the activities related to future petroleum exploitation will increase in the coming years and could bring a high number of workers

from abroad increasing the risk of the pandemic spread.

The interventions proposed in this proposal were chose based on an extensive process of field assessments made in the last 4 years regarding HIV/AIDS and reproductive health. These assessments and studies provided data for the development of the National STD/AIDS Strategic Plan (2004/2008) and for the development of the proposal here presented. In addition to the National Strategic Plan (2004/2008) a number of documents were consulted which include::

Situation of HIV/AIDS Orphans in São Tome & Prince. Ângelo Soares de Ceita & Teodora de Souza/Socióloga. UNICEF August 2004

Situation Analysis of Population and Gender in Sao Tome & Prince - Ministry of Planning and Finance – January 2004.

Strategy for the Cooperation with São Tome & Prince – 2005/2009. World Health Organization – March 2005.

National Policy to Fight AIDS – Ministry of Health – April 2003.

Mission to Develop an Action Plan for the Prevention of HIV Infection Mother-to-Child Transmission. Pr. Francois René TALL – WHO/AFRO Short term consultant - November 2001

Strategy to Gender Equality in São Tome & Prince. September 2004.

Report – Mission of Assistance to ST&P for Training of laboratory Technicians on HIV/AIDS and the Development of a National Program of Quality Assurance. October 2004.

Milenium Development Goals – ST&P Report July 2004.

Knowledge, Atitudes and Practices (KAP) Study regarding Sexual and Reproductive Health of Adolescents and Youth out of School System in Sao Tome & Prince. Maria Helena Menezes da Costa Neto – Ministry of Education, Culture, Youth and Sports. February 2002

National Institute of Statistic Republica Democrática de S. Tomé e Príncipe
III National Census of Population and housing - 2001

Sanitary profile of the Republica Democrática de S. Tomé e Príncipe. WHO/ST&P. December 2004

Along the years we have developed a strong partnership with different UN agencies, bilateral cooperation and other donors to implement activities related to HIV/AIDS prevention and care. Therefore, we are in a stage to scaling up some interventions such us HIV VCT, condom distribution, antiretroviral therapy and PMTCT, management of STI through syndromic approach. This proposal also includes intervention that will be new such as prevention interventions focusing commercial sex workers and youth out of school, income generating activities and interventions focusing reduction of stigma and discrimination. Monitoring and evaluation activities will be improved and capacity building activities in this field are included in this proposed seeking to increase the national staff technical autonomy on this field. Capacity building activities for NGO are also new interventions that will be made possible through financial resources requested in this grant application.

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

[Proposals to the Global Fund should be developed based on a comprehensive review of the capacity of health systems, disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases.]

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

The ST&P health policy recognizes the social nature of health care as an important factor for development and social justice and fight against poverty. The health reform

started in 1998 a National policy on Health was developed and the National Development Sanitary Plan was developed in 2000. It integrates Health under the Development having equity, integrality and universal access as main principles. The plan includes the decentralization as one of the main strategies to be implemented and complimented by public and private sectors as well as population participation on cost recovery. Political instability and frequent changes on the Ministry of Health is one of the main barriers for the continued implementation of the National Policy on Health.
The country is divided on 7 health districts, 6 in Sao Tome and 01 in Principe. Health care facilities are available in the 7 districts of the country. There is only one hospital but 3 other district health centers can also hospitalize patients. Overall, in addition to the hospital there are 7 health centers (3 with hospitalization capacity), 21 primary care unit (health post) and 21 community health centers (coordinated and staffed with volunteers from the community). This distribution of health care services is an opportunity to reach out the population with HIV/AIDS care and prevention interventions. However, because of lack of resources access to these services are still limited in ST& P. Human resources working in the health sector are quite scarce. In average there are 5 physicians, 12 Nurses, 7 dentists, 01 pharmacist and 37 midwives per each 10.000 inhabitants.
There are secondary level school to prepare health care workers was established in the country and all university level training must be done out of the country. The country investment on health went from 8% of the GNP, in 2002 to 19% in 2004, indicating the commitment of the government with the improvement of the public health sector.

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

The National AIDS Program was established in 1987. Since then the intervention have been implemented in partnership with Government, civil society, and development partners.
Among the interventions implemented so far we can highlight:

1- the implementation of a school program of sexual education since 1988
2- the implementation of HIV serology at the Blood´s Bank laboratory – with the support of the WHO (1989)
3- the first project of STI control – with financial support from Medicos do Mundo (1992/94)
4- Establishment of counseling centers at two school (Gabinetes de Escuta) – (2001), in partnership with UNFPA
5- Development of the National Strategic Plano n HIV/AIDS for 2004/2008
6- Development of the Ministry of Health Sectorial Plan for HIV/AIDS (2003)
7- Condom promotion and distribution
8- The establishment of the UNDABESA
9- Establishment of one HIV VCT service managed by the NGO Medicos do Mundo using HIV rapid testing
10- Training of trainers on management of STI through syndromic approach
11- The establishment of a referral center for HIV/AIDS patients at the Ayres de Menezes Hospital with a team trained in Brazil (2004)
12- Implementation of antiretroviral therapy and prevention of PMTCT activities (HIV VCT and ARV Prophylaxis)

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

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It is well known that diseases like Malaria, Tuberculosis and AIDS are closely related to poverty. The HIV/AIDS pandemic not only causes poverty: it is also fuelled by it. ST&P is among the least developed countries. The proportion of the population living in poverty went from 36% in 1987 to 53.8% in 2001, being 15.1% in extreme poverty. Deaths caused by malnutrition account for 15% of infant mortality among the under five population and anemia is very common, affecting nearly 60% of the population. The difficult socioeconomic situation resulted in an intense rural exodus and to an accelerated urbanization. Around 30% of ST&P families are headed by women and are significantly poorer than those headed by man. The situation has worsened with the increase in the country's external debt and the adoption of a structural adjustment in 1987. In spite of the improvement of some macro-economical indicators, the country's situation in terms of external debt increased from USD 172 millions to USD 310 millions in 2002, 6 times the country's GNP. In December 2000, the country met the minimal requirements to benefit from HIPIC and since 2001 is benefiting from part of its external debt to implement activities on Health and education and infrastructure.
By scaling up the response to the HIV/AIDS epidemic in ST&P the government, in partnership with all concerned stakeholders will be able to make headways toward the achievement of the Millenium Development Goals(MDG). This proposal will directly contribute to the attainment of MDG of combating HIV/AIDS, malaria, and other diseases and specifically to MDG target of halting and beginning to reverse by 2015 the spread of HIV/AIDS. Moreover, through the components related to improving the income and nutritional needs of PLWHA and their families, it will contribute to the achievement of MDG target of halving, between 1990 and 2015, the proportion of people whose income is less than one dollar a day, and MDG target of reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio since an important component concerns HIV+ pregnant women. The proposal as a whole will also have a positive impact towards the achievement of MDG 3 and MDG 4 and 5 through the implementation of interventions to prevent MTCT.
In this proposal there are different links to "3-by-5" initiative,
Identifying the better use of different "entry points" (tuberculosis, PMTCT, STI) to identify people who need ART and refer them for therapy.
Simplifying HIV testing (rapid test Determine)
Standard first- and second-line ARV treatment regimens
Standard laboratory to monitor patients HIV infected in order to determine those in need of ARV treatment and to monitor antiretroviral therapy and HIV/AIDS diagnostic support
Implementing an strategy of building capacity of all health care workers in order to optimize the use of the scarce human recourses available in the country to delivery adequate prevention and care services to patients presenting a STI, HIV infected patients and population vulnerable to STI and HIV/AIDS.

4.3.3 Financial and Programmatic Gap Analysis

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

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

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

Please see table 4.3.3

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4.3.3.2 Provide an estimate of the costs of meeting overall (national) goals and objectives and provide information about how this costing has been developed (e.g., costed national strategies).
We have the cost of meeting the overall national goals for the period of 2004/2008 and in totalize USD 4,776,500. This costing was estimated based on our strategic plan for 2004/2008 (please see the annex)

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

Table 4.3.3 - Financial Contributions to National Response

	Financial contributions in Euro / US$						
	2004	2005	2006	2007	2008	2009	2010
Domestic (A)	35, 680	37,464	39,519	41,514	43,589	45,768	48,056
External (B)	**335,372**	**469,448**	261,558	349,300	349,300	287,742	287,742
External source 1 (World Bank project – PASS)	0	115,325	61,558	61,558	61,558		
External source 2 (WHO)	49,250	49,250	20,000	20,000	20,000	20,000	20,000
External source 3 (UNAIDS)		87,873					
External source 4 (UNICEF)	3,000		50,000	50,000	50,000	50,000	50,000
External source 5 (WFP)	0	0	80,000	167,742	167,742	167,742	167,742
External source 6 (Medicos do Mundo)	0	50,000					
External source 7 (Glaxo Smith Kline Foundation)		39,000					
External source 8 (IPPF)	0	10,000					
External source 9 (European Community)		52,000					
External source 10 (Brazilian Cooperation)*	166,172						
External source 11 (IPAD)	66,950						
External source 12 (FONG)		16,000					
External source 13 (UNFPA)	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Total resources available (A+B)	**371,052**	506,912	301,077	390,814	392,889	333,510	**335,798**
Total need (C)	836,000	1,155,000	986,000	878,500	921,000	900,000	900,000
Unmet need (C)- (A+B)	**464,948**	**648,088**	**684,923**	487,686	528,111	566,490	**564,202**

* Cost of antiretrovirals not included

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

This proposal was developed jointly by all the partners involved in the ST&P fight against the HIV/AIDS epidemic, including donors and international agencies. The need of continued support from the partners we have so far is very clear and all of them are deeply committed to continue to maintain the level of support in such a way that resources obtained from Global Fund will not replace the financial contribution the country is receiving. Instead, Global Fund resources will allow ST&P to scale up existing intervention and to implement activities in areas presently uncovered. In additional, the government is committed to progressively increase the resources available to HIV/AIDS. The government will make CCM and civil society fully informed about the level of support provided by its own budget and by each partner facilitating the control by civil society. Also, CCM have decided to lunch a news letter to regularly provide information about implementation of HIV/AIDS a Malaria proposal activities and how resources from Global Fund are being spent.

4.4 Component Strategy

4.4.1 Description and justification of the program strategy

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

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

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

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

Goal No.	Goals over five years
# 1	To contribute to reverse the current progression of HIV epidemic and its impact on Sao Tome and Prince
#	
#	

Goal No.	Impact indicator	Baseline			Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Source and comments
		Value	Year	Source						
# 1	Reduced HIV-1 seroprevalence among pregnant women	1.5%	2005	Cross sectional study HIV-1 seroprevalence among pregnant women					1.5%	Cross sectional study HIV-1 seroprevalence among pregnant women By 2005, the epidemic is on the rise. The proposal implementation time (5 years) will not be enough to achieve a decrease in the HIV-1 prevalence in our population. However, we believe we will be able to achieve a trend of estabilization
#										
#										

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

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

Program objectives over five years											
Objective No.	Objective description										Link to goal by number
#1	To Prevent sexual transmission of STI/HIV among vulnerable people										#1
#2	To Reduce the transmission of blood born diseases										#1
#3	To Prevent HIV Mother-to-Child Transmission (PMTCT)										#1
#4	To Improve the quality of life and decrease the morbidity and mortality of people living with HIV/AIDS and their families										#1
#5	To Increase institutional capacity of the National Aids Program and Non-Governmental Organizations										#1
Objective No.	Service delivery area	Directly tied	Indicator description	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
				Value	Year						
#1	Youth education	Yes	% youth out of school exposed to HIV/AIDS prevention intervention	TBN	2005	20%	30%	40%	50%	65%	Yearly
#1	Information and education for specific group	Yes	N° of commercial sex workers exposed to outreach programs	0	2005	20	30	40	50	70	Yearly
#1	Condom distribution	Yes	N° of condom distributed in the country	560,000	2004	750,000	900,000	1,050,000	1,200,000	1,350,000	Yearly
#1	STI Diagnosis and Treatment	Yes	N° of health facilities with at least two health care workers diagnosing and treating STI using syndromic approach	1	2005	4	7	14	21	29	Yearly
#1	Voluntary counseling and testing	No	% of health facilities with at least two health care worker able to adequately delivery HIV VCT	7	2005	14	21	29	29	29	Yearly
#2	Blood safety	Yes	% of transfused blood with a complete screen for hepatitis C	0%	2005	30%	100%	100%	100%	100%	Yearly
#2	Blood safety	Yes	% of Blood transfusions made with blood donated voluntary	< 5%	2005	5%	10%	15%	20%	30%	Yearly
#2	Universal Precautions	Yes	N° of health care workers who have participated in	0	2005	60	60	60	60	60	Yearly

			training on universal precautions in the referred year								
#3	Prevention of HIV Mother-to-Child Transmission	No	N° of HIV + pregnant women who receive a complete course of ARV to PMTCT according to national /WHO guidelines in the referred year	2	2005	12	25	30	40	50	Yearly
#3	Prevention of HIV Mother-to-Child Transmission	No	% of pregnant women tested for HIV during antenatal care	20%	2005	40%	65%	75%	80%	85%	Yearly
#4	Antiretroviral Treatment and Monitoring	Yes	N° of HIV Patients receiving ARV in accordance with National/WHO guidelines(new patients each year)	18	2005	40	50	60	70	70	Yearly
#4	Prophylaxis and Treatment for Opportunistic infections	Yes	N° of HIV Patients receiving prophylaxis for OI (new patients)	18	2005	40	50	60	70	70	Yearly
#4	Support for the chronically ill	Yes	N° of PLWHA families trained and supported for a income generating activity	0	2005	12	25	30	35	45	Yearly
#4	Support for orphans	Yes	N° of family with orphans receiving support	0	2005	12	24	40	50	65	Yearly
#4	Stigma reduction	Yes	N° of mass media campaign disseminated to sensitize the general population	0	2005	3	3	3	3	3	Yearly
#5	Strengthening the civil society	Yes	N° of NGO and youth associations participating in capacity building activities	0	2005	12	12	12	12	12	Yearly
#5	Strengthening the institutional capacity of NAP	Yes	System of Monitoring & Evaluation established	0	2005	01					2nd year

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

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

Goal

To contribute to reverse the progression of HIV/AIDS Epidemic in Sao Tome & Prince and its impact on the country development .

Objectives

1. Preventing sexual transmission of STI/HIV among vulnerable people

Key Service delivery areas:

- ***Youth education:*** improving in the young people (15 – 19 years) out of school, knowledge and opportunities to be informed about HIV/AIDS issues.
  - Increased knowledge about HIV prevention and awareness about a healthy sexual behavior among **3.669** of young people out of school (15 – 19 years) covering the 7 distrits with the country by the 3 year.
- ***Information and education for specific group:*** improving information and education of sex workers concerning HIV/AIDS and STDs and access to condoms and HIV Voluntary counseling and testing. Out reach activities will be implemented in the 7 distrits in the country.
  - **70 commercial sex workers** exposed to outreach activities conducted by peer counselors trained with activities funded by this proposal by the 5th year (30 by the second year), with increased knowledge about safe sexual practices, HIV/AIDS, STI and contraception. They will be strengthened to practice safe sex with clients and intimate partners.
  - Commercial sex workers with increased access to condoms, STI treatment, HIV VCT and contraceptives.
  - Health care workers sensitized to provide better care to commercial sex workers.
- ***Voluntary counseling and testing (VCT):*** HIV Voluntary Counseling and Testing will be provided in 29 health care facilities (7 health centers and 1 hospital and 21 health posts) distributed on the 7 distrits of the country (health districts). These services will provide HIV VCT to pregnant women, patients diagnosed with STI and patients with tuberculosis.
  - Increased access to HIV VCT in health services provided by trained health care workers – from 7 health services in 2005 **to 29 services by 5th year (21 by the 2nd year)**
- ***Condom Distribution:*** Condom distributed at no cost for the population will be available in 29 health care facilities (7 health centers, 21 health posts and Ayres de Menezes hospital (including HIV care referral center and VCT service) distributed on the 7 districts of the country (health districts).
  - Increased availability of condoms in the country distributed through NGOs and health services – from 560,000 in 2005 to **1,350,000 by the 5th year** (900,000 by the 2nd year).
  - Increased number of condoms distributed to people with STI and PLWHA in the health facilities of the 7 distrits of the country.
- ***Treatment of Sexually Transmitted disease:*** diagnosis and treatment of STI through syndromic approach will be provided by trained health care workers in 29 health care facilities (7 health centers and 1 hospital and 21 health posts) distributed on the 7 distrits of the country (health districts) access to STI diagnosis and treatment through Syndromic Approach in the 7 distrits of the country.
  - **75% of STI** patients treated at health services tested for HIV infection by 5 year (50% by 2nd year)

- **29 health services** with at least two HCW trained on syndromic approach providing diagnosis and treatment of STI, including provision of drugs free of charge for patients by 5th year (7 by 2nd year)
- **1,500 patients** per year will be treated for STI at health services by 5th year **(1,000 by 2nd year)**

2. Reducing the transmission of blood born diseases, including HIV, hepatitis and syphilis

Key Service delivery area:

- ***Blood safety:*** Increasing the access to safe blood transfusions in all 7 distrits of the country
  - Increased voluntary blood donors' rate from < 5% to **30%** by the 5th year (10% by the 2nd year)
  - **100% of transfused blood** will be tested for Hepatitis C by the 2nd year
- ***Universal precautions:*** Improving knowledge about universal precautions and their use among the health workers and making available to them post exposure prophylaxis with antiretroviral drugs.
  - **60 health care workers** each year will receive training on universal precautions
  - **100% of the 29 health care services** will have adequate disposal for needles and other sharp instruments by the 2nd year
  - Post exposure prophylaxis will be available 24 hours at Ayres de Menezes Hospital by 2nd year

3- Prevention of Mother-to-Child Transmission

Key Service delivery area:

- **Prevention of Mother-to-Child HIV Transmission:** HIV VCT will be provided in all settings providing antenatal care and at maternity for those not tested during pregnancy. Prophylaxis with antiretroviral will be available to all HIV infected pregnant women as well as for their infants. Breast milk substitution (infant formula) will be provided to those who choose to not breastfeed.
  - Increased rate of pregnant women tested for HIV from 20% to **85%** by the 5th year **(65%** by the 2nd year)
  - Increased coverage rate of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT according to National/WHO guidelines from < 5% (2) to **60% (50)** by the 5th year [being **30% (25)** by the 2nd year)
  - Increased coverage of infants born to HIV infected women receiving ARV prophylaxis, from < 5% to **85%** (70) by the 5th year [45% (38) by 2nd year]
  - Availability of infant formula to 100% of infants whose mother's choose to not breastfeed.

4- Improve the quality of life and decrease the morbidity and mortality of people living with HIV/AIDS and their families

Key Service delivery area:

- **Prophylaxis and Treatment of Opportunistic Infections:** increase access of HIV infected patients to adequate prevention and treatment of opportunistic infections in accordance with the national/WHO guidelines. Patients co-infected with TB and HIV will have access to cotrimoxazole and adequate antiretroviral treatment. Patients with HIV infection will have access to prophylaxis with NIH when needed.
  - **100%** of patients diagnosed with HIV infection on WHO stage II, III, and IV will have access to prophylaxis and treatment of OI by the 2nd year (includes all patients HIV infected diagnosed with tuberculosis).
  - **330** patients by the 5th year will be on prophylaxis for opportunistic infections (130 by 2nd year)
  - **29** health services with installed capacity to perform sputum smear microscopy by 5th year (7 by 2nd year)

- **120** community health care agents sensitized about tuberculosis and HIV infection by 5 year (60 by 2nd year)
- **100%** of patients HIV infected diagnosed with tuberculosis will be tested for HIV by 5th year (75% by 2nd year)

- **Antiretroviral Treatment and Monitoring:** Providing ART and monitoring to **330** HIV/AIDS Patients in accordance with the national/WHO guidelines
  - **330** patients by the 5th year will be on antiretroviral treatment (**130** by 2nd year)
- **Support for the chronically ill and orphans:** PLWHA/orphans families/caregivers will be supported with income generating activities, clothes, school materials and nutritional support
  - **104 PLWHA/orphans families/caregivers** will be supported with income generating activities by 5th year (34 by 2nd year)
  - **All identified PLWHA/orphans their families/caregivers** will receive nutritional support from the World Food program
  - **All HIV infected pregnant women diagnosed** will receive nutritional support from the World Food program
  - **100** orphans will be supported with school materials and clothes (45 by 2nd year).
- **Stigma Reduction:** activities to reduce HIV/AIDS stigma will cover community health agents, NGO, businessmen, health care workers and youth.

5- Increase institutional capacity of the National Aids Program and Non-Governmental Organizations

Key Service delivery area:

- **Strengthening the civil society:** NGO will participate in capacity building activities related to HIV/AIDS prevention, care, human rights and stigma reduction. Capacity building on management of projects will also be provided to them.
- **Strengthening the institutional capacity of the NAP:** institutional capacity will be strengthened through the development of a System of Monitoring & Evaluation, and through increasing the availability of NAP staff with adequate skills and capacity to conduct supervisions of activities being conducted on field by health care workers and other partners, mainly NGOs, collect and analyze epidemiological and other relevant data, including KAP studies.

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

Each one of the elements included in this proposal bring added value to each other and all can results in synergic actions for a broader impact.
Developing and increasing availability of HIV VCT up to the level of health posts facilities is a means to expand the access of pregnant women, tuberculosis patients and vulnerable or high risk people (sexual workers, people with STI), to HIV testing and increase their awareness about HIV. This increased awareness coupled with prevention counseling is a catalyst way to promote a sexual behavior change as well as a strategy to reduce stigma related to PLWA, a major problem in ST&P. The expansion of HIV VCT will contribute to promote public discussion, information sharing and education with increasing knowledge about HIV infection its prevention.
The components pertaining to youth and to support for income generation activities are also interventions that will significantly contribute toward reducing

stigma. The youth component, through the engagement of youth and community associations, will focus on the knowledge about HIV/AIDS issues, life skills, and reducing stigma about PLWHA. Young people in this component will be taught the importance of postponing sex, remaining faithful to one partner, using condoms and avoid drug use. The income generation component will allow PLWHA to have improved economic means and a rightful integration in the society. It is expected that reduction of stigma will in turn bring an increasing request of VCT and treatment.
It is clear that the treatment of OI and with ARV drugs can decrease the morbidity and mortality of PLWHA improving the life quality and the economical aspect (income) of families of PLWHA. The proposal also encompasses the relationship between the broader aspect of treatment and testing of TB patients.
All activities targeting health staff (training on HIV/AIDS, tuberculosis, PMTCT, M&E) will boost the health sector capacity to better meet the need of the population of ST&P. Besides expanding and improving the HIV/AIDS prevention and care services available to the ST&P population, these activities will also contribute to improve antenatal care services, reduce maternal mortality.
The establishment of an association of PLWA will be crucial to empower them to implement advocacy strategies which will help reduce stigmatization

[For health systems strengthening components only:]

4.4.1.3 Describe in detail how the proposed objectives and service delivery areas are linked to the fight against the three diseases. In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. To demonstrate the contribution of the proposed health systems strengthening intervention(s) in fighting the disease(s) include at least three disease relevant indicators with a baseline and annual targets over the life of the program. *[This may be done in form of an annex based on the format of table 4.4.b.]*

Clearly explain why the proposed health systems strengthening activities are necessary to improve coverage in the fight against the three diseases. *[When completing this section, applicants should refer to the Guidelines for Proposals, section III.B.&F.]*

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

The Country Coordinating Mechanism for the Global Fund proposal provides the space which empowers the active participation of all groups of society associated with the fight against the HIV/AIDS epidemic, PLWA are represented in the CCM but they were concerned about the disclosure of their HIV *serostatus* and could be not be officially nominated as CCM members. However, they have fully discussed this proposal during its development in a meeting with the working group when they had opportunity to give their input about strategies and activities planned. The level of stigma is very high in our society. We expect that with the implementation of this proposal we will be able to progressively decrease the stigma associated to HIV/AIDS in our society and increase the capacity of PLWA to participate in all level of decisions about the ST&P response to the HIV/AIDS epidemic. Overall a number of NGOs will be strengthened to participate in the implementation of the proposal. All the groups represented in this mechanism participated in the definition of the proposal and will contribute to its implementation, execution, monitoring and evaluation. Sex workers will participate in workshops and in peer training in their work areas.

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

Table 4.4.1.5 Objectives

	Estimated percentage of people reached who are:		
	Women	Youth	Living in rural areas
Objective 1	1.Youth education; 49% 2.Sex worker : ND 3.HIV voluntary counseling and testing: a) STI: 51% b) Tb patients:25% c) PLWHIV: 47%	1. Youth education; 100% 2.Sex worker : ND 3.HIV voluntary counseling and testing: a) STI: 20% b) Tb patients: 10% c) PLWHIV:	1. 1.Youth education; 45% 2.Sex worker : ND 3.HIV voluntary counseling and testing: a) STI: 45% b) Tb patients: 40% c) PLWHIV: 45%
Objective 2	1.PMCT: 100% 2. health care workers trained : 60%	1.PMCT: 16% 2.heath care workers trained : 0%	1.PMCT: 45% 2. heath care workers trained : 15%
Objective 3	1.HCW trained : 60%	1. HCW trained: 0%	1. HCW trained: 15%
Objective 4	1. PLWHIV/families participate in income generation activities: 47% 2.PLWHIV/orphans:29%	1. PLWHIV/families participate in income generation activities: 47% 2.PLWHIV/orphans:100%	1. PLWHIV/families participate in income generation activities:45% 2.PLWHIV/orphans:36%
Objective 5	1. 51%	1.23%	1. 45%

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

1. Preventing sexual transmission of STI/HIV among vulnerable people

Key Service delivery areas:

- ***Youth education:*** improving in the young people (15 – 19 years) out of school, knowledge and opportunities to be informed about HIV/AIDS issues.
  - Increased knowledge about HIV prevention and awareness about a healthy sexual behavior among 3.669 of young people (15 – 19 years) covering the 7 regions with the country by the 3 year.

Promoting behavior change is a critical facet of HIV/AIDS prevention, care, and support interventions and remains the major means of preventing HIV infection. In developing countries, recent data indicate that about half of all new HIV infections are among youth aged between 15 and 24 year. This age group also has the highest incidence of STI. Thus, the risk behavior of today's youth will shape the course of the AIDS pandemic in the future. Programs for young people can help them adopt safe behaviors. But in some situations—such as early sexual activity and early marriage due to poverty—young people are forced into unsafe sex and need programs and policies designed to helping them choose safe behavior. ST& P has a population with young structure, 42.1% of the population is between 0 and 14 years of age; 60.9% is between 15 and 49, and only 4.3% is 65 or older. Overall, 66.6% of the population is younger than 25 years old, with an age pyramid that has a wide base and a small apex, illustrating high fertility and birth rates as well as a rather high mortality rate, producing a large population of young people and very few older people.

In spite of high rate of school attendance for the infants aged between 6-14 years, after that age, school drop out increases significantly resulting in an overall rate of school attendance is around 45%, school drop out is especially high among youth aged 13-17 years old that have school attendance rate of only 25.3%. Infant labor between children aged between 10-17 years reaches 8.3% and 78.3% on the age range of 15-17 years.

4 Components Section

The Ministry of Education has conducted a KAP study among youth aged between 12-24 years out of school for at least one year. The study population was selected based on a probabilistic multistage sample with a sample size of 592 individuals of both genders, including urban and rural population. This study found that for youth out of school in ST&P, peers holding information have a strong influence under adolescents. Among those aged between 18-24 years, 55.6% of women and 85.7% of men have trained peers as a preferred source of information about sexual health. It was found that sexual activity initiation occurs early for both males and females. Among those who reported to be sexually active, first sexual relationship occurred between 15-17 years for 57.1%.

Data about condom use among first intercourse is also a matter of concern. For youth out of school aged: 15-17 years only 10.5% of women and 29.2% of men reported condom use in the first intercourse. A very low proportion reported to always use Condom, being 11.1% among males between 15-17 years. The proportion of those that never have used condoms in spite of being sexually active was 24.6% among male and 73.6% among female aged 15-17 years.

Among those aged between 15-17 years, 16% of females and 3% of males are already living with a partner as married. Knowledge about sexually transmitted diseases was found to be very low and the large majority could not point out a sign or symptom of a STI. It is also worrisome that 36.1% of women and 30.1% of men aged between 15-17 years and 63.9% and 68.7% of those aged between 18-24 years reported to believe that pregnancy is the only risk of a sexual intercourse without condom.

Regarding income generating activities, 68% of females and 43.3% of males are not involved in any income generating activity, in spite of being out of the educational system. Unemployment among youth account for 60% of the overall unemployment.

Youth attending school are already covered with interventions focusing reproductive health and prevention of STI and HIV infection implemented by teachers and peer counselors. In partnership with UNFPA, two centers located at Liceu Nacional (Agua Grande) and Escola secundária de Trindade (Mezochi) were established in schools in order to provide youth with information on reproductive health and prevention of STI and HIV. At these centers male condoms are distributed and youth can be counseled and referred for HIV testing. These centers are daily visited by adolescent looking for condoms, games, and information and education activities related to SRH (sexually reproductive health) and counseling about different problems experienced by youth. Although the activities of these centers are not limited to youth attending school, access of youth out of schools to activities provided by them is limited.

Because of the context described above we choose youth out of school as a priority population for interventions to be covered with resources from this proposal.

The Youth associations, the Ministry of Youth and Sports as well as the Ministry of Education & culture and the Sexual Health Program will be the key partners to implement these activities.

Youth peer leaders will be identified and trained to delivery information and education to their peers. They will be stimulated to conduct dramatization, talks, radio programs, peer education, activities of information, and education focusing youth out of school. IEC materials focusing this population will be developed, printed and made available to youth trained as peer counselors and youth associations. This group will be actively involved on the development of this educative material. At the end of each peer counselors training a plan of action will be developed by each one and their activities will be supervised continuously by the team of trainers. As a way to stimulate youth association to be actively engaged in these activities once a year, on the AIDS awareness day (December 1st) two youth association will be awarded based on their performance regarding HIV/AIDS youth education.
In partnership with NGOs, Youth Association, Ministry of education & culture, Ministry of youth & Sports, and Commercial Chamber of ST&P entertainment activities such as projections of videos and films will take place at the city's only theater. Also, sports activities that usually engage a large number of youth will be organized in partnership with the Ministry of youth & Sports during these activities messages related to issues related to HIV/AIDS including safe sexual behavior will be delivered.

In addition, the UNICEF vehicle that is equipped with communication equipments adequate to delivery messages to big audiences will delivery prevention messages at youth main gathering places such as the open market and places were youth play soccer, basketball and other games. The messages to be delivered will be created with the participation of youth engaged in the peer counselor's activities.

Main activity	Indicator	Implementing partners
Identify youth leaders among youth association	N° of peer counselors trained	Youth Association and Ministry of youth & Sports
Peer counselors training	N° of peer counselors trained	NGO, Youth Association, Ministry of Education & culture, Ministry of Youth & Sports and UNFPA
Organizing formal and informal meetings with youth about STI, HIV/AIDS issues	N° of meeting organized and number of participants	NGO Youth Association, Ministry of education & culture, Ministry of youth & Sports and UNFPA
Organizing community initiatives concerning IST, HIV/AIDS issues	N° initiatives organized involving the community	NGO, Youth Association, Ministry of education & culture, Ministry of youth & Sports and Commercial Chamber of ST&P
Developing and distributing simple Information materials	N° of HIV/AIDS educative materials developed N° of HIV/AIDS educative materials distributed	NGO, Youth association and Ministry of education & culture, Ministry of youth & Sports and UNFPA
Delivery of prevention messages at youth main gathering places (by mobile vehicles)	N° of days when messages were disseminated	NGO, Youth Association, Ministry of education & culture, Ministry of youth & Sports, UNICEF
Supervision of Peer counselors activities	N° of supervision activities carried out over N° of supervision activities planned	SHP and NAP

- ***Information and education for specific group:*** improving information and education of sex workers concerning HIV/AIDS and STDs and access to condoms and HIV Voluntary counseling and testing. Out reach activities will be implemented in the 7 districts in the country.
  - **70 commercial sex workers** exposed to outreach activities conducted by peer counselors trained with activities funded by this proposal by the 5th year (30 by the second year), with increased knowledge about safe sexual practices, HIV/AIDS, STI and contraception. They will be strengthened to practice safe sex with clients and intimate partners.
  - Commercial sex workers with increased access to condoms, STI treatment, HIV VCT and contraceptives.
  - Health care workers sensitized to provide better care to commercial sex workers.

The Sex industry is one the factors driving the spread of HIV epidemic. Although we do not have data regarding HIV infection among commercial sex workers in ST&P, In general, rates of HIV infection and transmission observed in commercial sex workers are far in excess of the levels found in the rest of the population. Frequent sexual contacts with multiple clients, who will in turn carry the virus to their spouses, high rates of sexually transmitted infections and a scarce use of protection, are just a few factors that explain why CSW constitute one of the highest-risk groups for HIV/AIDS infection.
Female poverty is a major factor that drives women, young and old, into risky behavior, including commercial sex work, survival sex and dependence on multiple partners. There is research that indicates that the poorer the sex worker, the less likely she is to ask for or insist on using a condom. Competition among commercial sex workers means that those who demand safe sex may be forced out of the market. The poor socio-economic situation across most of ST&P has pushed many women into the sex

trade. It is believed that initiatives targeting commercial sex workers and their partners can have an enormous impact on the HIV epidemic due to the number and frequency of sexual partner change and reported unprotected sex acts. Currently, needs of commercial sex workers regarding HIV prevention and care services are not assessed and they are not receiving any kind of prevention intervention designed to them. However, a rapid field assessment made by the National AIDS Program Staff indicated that this population seems to have the Sexual Health Program at Agua Grande as the main source for condoms. In this brief assessment it was possible to identify that some of these women are engaged on unsafe sexual practices and wrong perception about the correct use of condoms. Also, some of them revealed that although they do use condoms with clients, they do not use it in their most intimate relationships.

It is planned to have in the second semester of 2005 an international consultant skilled on implementing activities focusing the population of commercial sex workers working with the National AIDS Program, Sexual Health Program and NGOs in order to train them to implement field activities focusing this population.

For the implementation of the activities of this proposal component a NGO will be selected among those trained during the expert consultancy above described. This NGO will be supported with Global Fund Resources to implement activities focusing commercial sex workers. The method of focus group will be used to identify leadership among CSW and to assess their main needs regarding HIV/AIDS Prevention. After the training, the peer counseling activities implemented by this group will be supervised by the selected NGO as well as by the NAP. The NGO and NAP will work together to carry out activities focusing health care workers from the Sexual Health Program in order to sensitize them about the needs of commercial sex workers.

Main Activities	Indicators	Implementing Partners
Identify leadership among sex workers in focus group discussions	N° of leaders identified among sex workers	NGO, NAP
Training peer counselors about HIV/AIDS issues, including availability of condoms, VCT, STI treatment and contraceptives.	N° of sex workers' peer counselors trained	NGO, NAP and SHP
Out-reach activity to contact sex workers with the help of peer counselors trained	N° of sex workers contacted by peer counselors	NGO, NAP and SHP
Sensitization of Health care workers about CSW needs	N° of HCW who participated in sensitization activities	NGO, NAP and SHP

- ***Voluntary counseling and testing (VCT):*** HIV Voluntary Counseling and Testing will be provided in 29 health care facilities (7 health centers and 1 hospital and 21 health posts) distributed on the 7 districts of the country (health districts). These services will provide HIV VCT to pregnant women, patients diagnosed with STI and patients with tuberculosis.
  - Increased access to HIV VCT in health services provided by trained health care workers – from 7 health services in 2005 **to 29 services by 5th year (21 by the 2nd year)**

Early knowledge of HIV infection is now recognized as a critical component in controlling the spread of HIV infection. Many infected persons decrease behaviors that transmit infection to sexual partners once they are aware of their HIV+ status. On the contrary, unaware HIV infected persons do not reduce risky behaviors. In addition, certain prevention counseling approaches can be effective in reducing high-risk behaviors and new sexually transmitted infections. Knowledge of HIV status is thus a critical HIV prevention strategy and essential for entry into care. Increasing access to HIV VCT in Sao Tome & Prince will be one of our main strategies to control the HIV/AIDS epidemic in the country. Nowadays, availability of HIV counseling is very limited in Sao Tome & Principe because except for VCT services provided by one NGO - Medicos do Mundo - HIV test is only provided for a fee. Because of lack of financial resources, many people do not go for HIV testing even when prescribed, including pregnant women.

In order to increase access to VCT the provision of HIV rapid test to health care units up to the level of health posts is of utmost importance. To achieve this goal, we have choose the Determine HIV rapid test once this kit does not requires the availability of a cold chain. Confirmation test will be done with the use of other rapid test, Genie II, it requires cold chain and available only at the Ayres de Menezes Hospital. Following WHO strategy II we will made available ELISA for those patients with HIV rapid test positive and not presenting symptoms (asymptomatic patients).

The NGO Medicos do Mundo established a service to provide HIV VCT using HIV rapid test In 2002 and have developed experience on providing HIV VCT in ST&P. This NGO will be our main partner in the scaling up of HIV VCT. Starting in 2005, training of health care workers on HIV VCT will be implemented with financial resources provided by the World Bank project called PASS (Projeto de Apoio ao Setor Social). During these trainings, Health Care Workers will be trained on how to provide prevention counseling, including how to educate clients on condom use. HIV VCT services will be expanded to health services structures located in each one of the country's regions at health centers and health posts. Initially HIV VCT using rapid tests will be made available in each one of the 7 Health Care Centers and then will be expanded to health posts. HIV VCT will be especially focused on pregnant women, TB patients and patients with STI. Regarding financial resources to purchase HIV test kits, the PASS budget will cover the pregnant women screening with Determine Test from 2005 to 2008. Because of it we are requesting from Global Fund resources to cover confirmatory HIV tests during this period. Global funds resources will cover HIV VCT for patients with STI and tuberculosis.

Main Activities	Indicators	Implementing Partner
Training sessions for HCW	N° of HCW trained on VCT	Medicos do Mundo, NAP and SHP
Procurement and provision of HIV rapid test kits to Health Care Services in the 7 districts of the Country	N° of health services without shortage of HIV Rapid test kits in the last 3 months	PR(UNDP) and Ministry of Health
	N° of health care services providing HIV voluntary counseling and testing in each region of the country	Health Care Services, SHP, NAP,TB NP
	N° of patients who have received HIV counseling and rapid testing on health care services	Health Care Services,SHP, NAP,TB NP

- ***Condom Distribution:*** Condom distributed at no cost for the population will be available in 29 health care facilities (7 health centers, 21 health posts and Ayres de Menezes hospital (including HIV care referral center and VCT service) distributed on the 7 districts of the country (health districts).
  - Increased availability of condoms in the country distributed through NGOs and health services – from 560,000 in 2005 to **1,350,000 by the 5th year** (900,000 by the 2nd year).
  - Increased number of condoms distributed to people with STI and PLWHA in the health facilities of the 7 districts of the country.

Condoms are the only device currently available that protects against the sexual transmission of HIV, and they are a mainstay of HIV prevention programs. The male latex condom is the single most efficient technology available to reduce the sexual transmission of HIV and other sexually transmitted infections. Male condoms are currently a barrier method widely available. Unfortunately there are many cultural, gender, economic, and service-delivery barriers that impede the wide and consistent use of barrier methods for HIV/STI prevention, including lack of adequate number of condoms made available to the population specially to those under higher risk of acquiring/transmitting HIV infection such us patients with STI and/or HIV infection and commercial sex workers.
Currently condoms distributed in ST& P are provided in its majority by UNFPA and distributed by Sexual Health Program together with other contraceptives. In 2004, 400.000 condoms were made available by UNFPA. Additional condoms are also made available by two NGOs - Medicos do Mundo and Associação de Planeamento Familiar (ASPF). It is projected that, overall, 560,000 condom units will be distributed in the country in 2005. A demand for a higher number of condoms already exists and there is a gap between supply and demand. Our capacity to distributed condoms coupled with adequate prevention counseling and education about the correct use of condoms is increasing progressively and will

significantly be increased with the trainings that will be carried out covering health care workers and NGOs.

Main activity	Indicator	Implementing partners

	Providing diagnosis and treatment of STI	N° of patients treated for STI at Health centers and health posts	NAP and SHP
1.4.3.	Providing HIV VCT to patients diagnosed with STI	% of STI patients treated at health services receiving HIV VCT	Medicos do Mundo, SHP, NAP

2. Reducing the transmission of blood born diseases, including HIV, hepatitis and syphilis

Key Service delivery area:

- ***Blood safety:*** Increasing the access to safe blood transfusions in all 7 districts of the country
  - Increased voluntary blood donors' rate from < 5% to **30%** by the 5th year (10% by the 2nd year)
  - **100% of transfused blood** will be tested for Hepatitis C by the 2nd year
- ***Universal precautions:*** Improving knowledge about universal precautions and their use among the health workers and making available to them post exposure prophylaxis with antiretroviral drugs.
  - **60 health care workers** each year will receive training on universal precautions
  - **100% of the 29 health care services** will have adequate disposal for needles and other sharp instruments by the 2nd year
  - **Post exposure prophylaxis** will be available 24 hours at Ayres de Menezes Hospital by 2nd year

Blood safety

Because of anemia related to malaria and malnutrition blood transfusion are very frequently prescribed, increasing the risk of the population living in ST&P of acquiring blood borne diseases. In average, ST&P inhabitants have 2 or three malaria episodes per year and women and children are the most affected. In spite of it, blood transfusion relies mainly on blood collected from family members or from donors paid by patient's family. By 2004, less than 5% of blood transfused was collected from voluntary blood donation. An association called UNDABESA was established in 2002 with the main purpose of stimulating volunteer blood donation in ST&P. However, lack of resources to mobilize the population strongly limits the activities of this institution.

Regarding VCT, there is an identified need to provide VCT training to blood bank staff in order to improve their capacity to provide pre and post test counseling to blood donors. Currently, because the blood bank staff lacks adequate skills on HIV VCT, blood donors found to be HIV infected are referred to be counseled by the Medicos do Mundo at their VCT facility. In result of it many patients do not go there and do not get adequate information about their serostatus or how to prevent the transmission of HIV infection to other.

Under the cooperation with the Portuguese Government the Blood Bank is receiving technical support from the Portuguese Institute of Blood. During the first semester of 2005 Blood bank technicians were trained about how to separate different components of blood in order to allow better use of the blood available and to reduce the risk to transmit of blood born diseases through transfusion. Another period of technical support is planned for the second semester of 2005 when physicians will start to be trained on adequate use of blood products. It is also expected that under this technical cooperation the blood bank will be able to develop a protocol for selecting blood donors. Also, the laboratory technician in charge for the blood bank laboratory will be trained in Brazil on haemotherapy and HIV diagnosis in June/July 2005.

The laboratory of the blood bank at the Ayres de Menezes Hospital is in charge for all exams necessary for blood donors screening as well as for all serology provided to the ST&P population, including HIV and syphilis serology. Unfortunately it lacks adequate space and equipments to run with required quality the volume of testing needed by the country. Therefore, we are requesting funds to renovate space and equipment of this laboratory facility located at the Ayres the Menezes Hospital.

Behavioral interventions, including simple interventions, appear to be effective in changing physician transfusion practices and reducing blood utilization. Therefore during the implementation of this proposal we will continually provide training on this issue to physicians in order to decrease unnecessary blood transfusions.

The Portuguese cooperation provides most of the kits and reagents required for screening blood donors. In this proposal we are requesting only around 30% of the total needs of these products in order to prevent periods out of the stock.

Main Activities	Indicator	Imlementing Partners
Renewing of the central serology laboratory infrastructures	Central laboratory infrastructure renewed	PR(UNDP), Blood Bank
Acquisition and provision of equipment to the Blood's Bank Laboratory	Blood's Bank with adequate equipment to run serology exams in operation	PR(UNDP), Blood Bank(HAM)
	Blood Bank with adequate capacity to store blood products, diagnosis kits and reagents	PR(UNDP), Blood Bank(HAM)
Acquisition and provision of blood bags and test kits for infectious disease (HIV, VDRL, HBV, HCV),	N° of test kits procured over planned	PR(UNDP)
	N° of blood bags procured over planned	PR(UNDP), Blood Bank
Provide light meal to volunteer donors after blood donation	N° of volunteer donors provided with meal after blood donation	HAM, Blood Bank
Training Physicians about adequate use of blood products	N° of physicians trained	Ministry of Health
Supporting voluntary blood donors' association (UNDABESA) to sensitize people about the importance of voluntary blood donation	N° of out-reach activities held to sensitize community	UNDABESA and Ministry of Health
Continue the participation on the program of External Control of Quality provided by the Portuguese Institute of Blood	Participation in Annual Quality External Control Program	Ministry of Health and Portuguese Cooperation

Universal Precautions and Adequate Management of Hospital Waste

Improving the safety of injections is an important component of universal precautions.
Clear guidelines and training are amongst the most effective ways to reduce the transmission of HIV and other blood-borne diseases, and to improve the delivery of care to patients.
Health care worker protection is an essential component of any strategy to prevent discrimination against HIV infected patients by health care workers. If health care workers feel they can protect themselves from HIV infection, they can provide better care. Although this kind of infection account for a minority of HIV infections, health care procedures represent a highly preventable source of HIV infection. Among health care associated sources of infection, unsafe injections are of particular concern, accounting for an estimated 3.9% to 7.0% of new infections worldwide. Health care workers of ST&P have never received training on universal precautions and do not have a guideline available about how to protect them self and patients about HIV transmission in the health care settings. In addition, post exposure prophylaxis is not available to them. Lack of training, lack of a safe working environment regarding HIV infection contributes to persistence of discrimination and stigma against HIV infected patients in health care settings.

Availability of adequate containers will allow the discard of contaminated sharps in puncture and liquid proof containers that will be later closed, sealed and destroyed before completely full.
A guideline about occupational exposure will be developed as well as educative materials to be placed at health facilities. Universal precautions will be integrated in all health care workers training, which will be provided on a regular basis in health care worker in-service education. Health care workers will also be trained/educated in reducing unnecessary invasive procedures.

Post Exposure Prophylaxis (PEP) - short-term antiretroviral use to reduce the likelihood of HIV infection after potential occupational exposure will be made available as a comprehensive universal precautions package to reduce staff exposure to infectious hazards at work.
The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in health care workers and it is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace.
Prevention of exposure remains the most effective measure to reduce the risk of HIV transmission to health workers. The priority must be to train health workers in prevention methods (universal precautions) and to provide them with the necessary materials and protective equipment. An institutional guideline for Universal Precaution and PEP will be in place. HIV testing, counseling and antiretrovirals will also be made available. The training program on universal precautions and thereby reducing the incidence of health worker exposure to HIV will be an important step to containing the cost of providing PEP.

Main Activities	Indicator	Implementing Partners
Training Health Care Workers on Universal Precautions	N° of HCW trained on Universal Precautions	TB NP
Provision of equipments for adequate disposal of needles and syringes	Inpatient Unit wards with adequate disposal of needles and syringes	PR (UNDP)
Production of technical and educative material for HC Workers about universal precautions	Guideline for Universal precautions and PEP available	HAM, NAP, Ministry of Health
	Educative materials about universal precautions available at health services	HAM, NAP, Ministry of Health
Provision of PEP for occupational exposure	PEP for occupational exposure available at HAM 24 hours a day	HAM, NAP

3- Prevention of Mother-to-Child Transmission

Key Service delivery area:

Prevention of Mother-to-Child HIV Transmission: HIV VCT will be provided in all settings providing antenatal care and at maternity for those not tested during pregnancy. Prophylaxis with antiretroviral will be available to all HIV infected pregnant women as well as for their infants. Breast milk substitution (infant formula) will be provided to those who choose to not breastfeed. However the activity will not interfere with coverage already obtained of the exclusive breastfeed (6 months).

- Increased rate of pregnant women tested for HIV from 20% to **85%** by the 5th year (**65%** by the 2nd year)
- Increased coverage rate of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT according to National/WHO guidelines from < 5% (2) to **60% (50)** by the 5th year [being **30% (25)** by the 2nd year)
- Increased coverage of infants born to HIV infected women receiving ARV prophylaxis, from < 5% to **85%** (70) by the 5th year [45% (38) by 2nd year]
- Availability of infant formula to 100% of infants whose mother's choose to not breastfeed.

Implementation of PMTCT programs has recently become a realistic possibility in resource-poor countries. In Sao Tome & Principe, a recently conducted cross-sectional study (2005) found a seroprevalence of 1.5% among pregnant women. The projected number of pregnancies and deliveries in ST&P for 2006 is respectively, 5.380 and 5.680. It is estimated that around 84 HIV infected women deliver each year in the country, most of them unaware about their HIV infection. The implementation of a national program for PMTCT is therefore a national public health priority.
HIV VCT will be provided in all settings providing antenatal care and at maternity for those not tested during pregnancy. Prophylaxis with antiretroviral will be available to all HIV infected pregnant women as well as for their infants. Breast milk substitutes (Infant formula) will be provided to those who choose to

not breastfeed, coupled with educative interventions and home visits.
Currently VCT is only being provided to pregnant women attending antenatal care at few antenatal care services. In result, by now, no more than 20% of the pregnant women are having access to HIV VCT. Another significant barrier is that HIV test is not free of charge and many women can not pay it cost.
Initial training on VCT was provided to at least one health care worker in 7 health centers providing antenatal care in the country. However, the number of HCW skilled to provide VCT must be increased in order to increase the HIV test coverage among pregnant women. In order to achieve it training programs will be implemented in order to have a higher number of health care workers adequately trained to provide VCT. We would like to let clear that we are not asking for funds for this training because this cost will be by the World Bank project "Projeto de Ação para o Setor Social" (PASS) – Project for Social Sector – The same project will cover HIV rapid test kits for pregnant women during 2005, 2006 and 2007.
In ST&P most deliveries occurs at hospitals what open a window of opportunity to provide VCT to women who, for any reason, have not undergone VCT during pregnancy. For this purpose, all nurses working in the delivering unit will be trained to provide HIV VCT.

Prophylaxis with ARV: HIV infected women on WHO stage II, III and IV will receive triple drug combination (AZT+3TC+NVP). Women not needing antiretroviral treatment will receive zidovudine during pregnancy and *intrapartum*. Infant born to HIV infected will also receive zidovudine since birth and until six weeks of life coupled with cotrimoxazole. Drugs are already available in the country and currently one pregnant women is receiving antiretroviral drugs for prophylaxis.

Infant feeding: women will be informed about infant feeding modalities and in conjunction with their health care providers will make an informed decision about how to feed their babies. Infant formula will be made available to those who chose it and especially to those presenting advanced disease (stage III and IV). Women choosing infant formula feeding will be intensively educated about infant formula preparation, including hygiene care among other issues. Trained staff will carry out home visits to assess administration of zidovudine and infant formula preparation also assessing other needs the families may have. Home visits will begin before delivery in order to allow a more accurate assessment of family needs. Within the first 6 weeks (zidovudine administration period), home visits will be made in a weekly basis. Extra visits may be programmed if a need is identified. Thereafter visits will be conducted in a monthly base up to six months of age.
Women's health care: once diagnosed, HIV-infected pregnant women will be evaluated (clinically and laboratory exams with confirmation test) and assessed about their need of antiretroviral and opportunistic infection treatment at the referral center at the Ayres de Menezes Hospital in Agua Grande. After delivery, women will continue to be followed up at the referral center, where they will be able to receive ARV (refill) and condoms for free. The health care workers from primary care units will receive training on how to manage ARV most common side effects, in order to provide emergency care to patients on ARV treatment, especially those presenting allergy reactions to nevirapine.

The implementation of the PMTCT in Sao Tome & Prince will empower women, improve antenatal care, and increase HIV diagnostic capacity and identification of HIV infected women.

Most of the antiretroviral drugs needed for this component will be provided by the Brazilian Government under the cooperation agreement signed in 2004 (Program of International Cooperation – PCI). **So, we are requesting only funds to purchase nelfinavir (PI) for pregnant women presenting adverse events to nevirapine.** Women starting nelfinavir during pregnancy will continue to use this drug after delivery.

The World Food Program will provide food supplementation to all HIV infected pregnant women that will be distributed by a NGO to be contracted (see objective 4).

Main Activities	Indicator	Implementing Partners
infected pregnant women	prophylaxis with ARV	
Provision of prophylaxis with ARV to infants born to HIV infected women	N° of infants born to HIV infected pregnant women who received ARV prophylaxis	NAP,SHP,HAM
Acquisition and provision of artificial milk for	Central hospital and outpatient care center without	PR(UNDP) and NAP

Acquisition and provision of artificial milk for newborns delivered by HIV+ women with advanced disease	Central hospital and outpatient care center without out of stock of infant formula in the last 6 months	PR(UNDP) and NAP
Provision of infant formula to infants born to HIV infected women	N° of infants born to HIV infected women who received infant formula without interruption	PR(UNDP), NAP,SHP,HAM
Home visits to families with infants born to HIV infected women	N° families with infants born to HIV infected women	NAP,SHP,HAM

4- Improve the quality of life and decrease the morbidity and mortality of people living with HIV/AIDS and their families

Key Service delivery area:

- **Prophylaxis and Treatment of Opportunistic Infections:** increase access of HIV infected patients to adequate prevention and treatment of opportunistic infections in accordance with the national/WHO guidelines. Patients co-infected with TB and HIV will have access to cotrimoxazole and adequate antiretroviral treatment. Patients with HIV infection will have access to prophylaxis with NIH when needed.
  - **100%** of patients diagnosed with HIV infection on WHO stage II, III, and IV will have access to prophylaxis and treatment of OI by the 2nd year (includes all patients HIV infected diagnosed with tuberculosis).
  - **330** patients by the 5th year will be on prophylaxis for opportunistic infections (130 by 2nd year)
  - **29** health services with installed capacity to perform sputum smear microscopy by 5th year (7 by 2nd year)
  - **120** community health care agents sensitized about tuberculosis and HIV infection by 5 year (60 by 2nd year)
  - **100%** of patients HIV infected diagnosed with tuberculosis will be tested for HIV by 5th year (75% by 2nd year)

Prophylaxis and Treatment of Opportunistic Infections

It is estimated that 30-70% of deaths among HIV infected patients worldwide are due to opportunistic infections. Opportunistic diseases are also significantly associated with morbidity among this population. Due to limited availability of diagnostic facilities, information on the etiology, incidence and prevalence of OIs in HIV infected adults and children in resource poor settings are scarce. However, data available so far indicate that the spectrum of opportunistic infection seen in resource-poor settings is somewhat different with a predominance of bacterial, *Mycobacterium tuberculosis, non-typhi salmonellae, Cyclospora cayetanensis, Isospora belli* and *Cryptosporidium parvum*. Patients co-infected with tuberculosis are at particularly high risk of death as a consequence of opportunistic infections. On other hand, prevalence of HIV infection among patients with tuberculosis uses to be high. In ST&P it is estimated to be around 10%, but data about it still limited. Mortality among these patients is high despite effective treatment for tuberculosis. Although the spectrum of HIV –related illness in resource poor-countries may differ from that in industrialized countries, many of these OIs could be prevented through the use of cotrimoxazole. Access to drugs to prevent and treat OIs is a major problem in addressing the HIV/AIDS epidemic in developing world. This is the case of ST&P where treatment for most OI and malignancies is not available. Therefore, in order to reduce morbidity and mortality among our patients we are requesting resources to purchase these drugs.

There is increasing body of evidence regarding the benefit of cotrimoxazole in HIV infected adults and children in resource limited settings. Therefore, regarding primary prophylaxis for OIs our priority will be to provide cotrimoxazole to all symptomatic patients including patients developing tuberculosis. Cotrimoxazole will also be provided to patients with a total lymphocyte count below 1.200 cellsmm3, presenting or not sign and symptoms related to HIV infection and to patients diagnosed with PCP as a secondary prophylaxis.

All infants born to HIV infected mothers will also be provided cotrimoxazole on adequate dosing

until HIV infection is ruled out. HIV infected children will also be provided cotrimoxazole because there are evidence that daily administration of this drug can reduce mortality by 43% and hospital admission rate by 23%.

HIV and TB

This proposal was developed in order to allow the TB and HIV programs to work synergic, exploring the full potential of the resources available to each program in order to decrease the morbidity and mortality among TB/HIV co-infected patients as well as decrease the transmission of TB in the population. Currently, the TB diagnosis is limited to the central hospital laboratory where is located the only laboratory in the country where TB diagnosis (sputum smear microscopy) is performed. Certainly it is fueling the TB epidemic in ST&P due to the delay in the diagnosis and treatment of infectious cases. Therefore, we will implement the districts small laboratories located in the health centers to do sputum smear microscopy in order to have the infectious TB diagnosed early in the course of the disease. This strategy will take advantage of the funds made available by the Global Fund to fight malaria in Sao Tome through the malaria proposal to purchase optical microscopes. The same team of laboratory technicians, working in the health care centers and health posts located in all districts will be trained to do sputum smear microscopy. The central laboratory will have its technicians trained in order to establish a simple quality control program of TB diagnosis (sputum smear microscopy) performed at the peripheral level. These technicians will also be in charge of training of new technicians and to re-train based on the results of the sputum smear microscopy quality control program.

In spite of all efforts, most HIV/TB co-infected patients still being diagnosed on an advanced stage of disease and special efforts are required to systematically detect cases at an early stage. For this, health care providers will be sensitized about TB and about use of sputum smear microscopy for case detection. Special attention is devoted to patient care in order to conduct treatment of co-infected in a coordinated manner optimizing efforts to achieve better adherence to TB and antiretroviral treatment. People infected with HIV will be screened for TB, treated if they have active disease, and offered isoniazid preventive therapy as needed.

All patients diagnosed with TB will be counseled and offered an HIV test. Patients co-infected will have access to PCP prophylaxis and patients diagnosed with HIV infection will have access to INH prophylaxis when needed. This sputum smear microscopy service will be available and accessible to the whole population including the poorest sections of the community. At the referral hospital chest X ray will be available as an additional diagnostic tool.

In order to improve patient adherence to treatment, each patient diagnosed with TB and HIV will be stimulated to indicate one family member or friend, to be fully aware about his/her HIV serological status and willing to help him to comply with follow up and adherence to TB and ARV treatment. This person will contribute to reinforce the patient motivation to continue treatment and counter the tendency of some to interrupt treatment. When this person is not available, a community health agent or a NGO volunteer will be asked to support this person during his treatment. The capacity of community health agents and NGO volunteers to provide this kind of support will be developed through sensitization and skills building activities planned to take place in the coming years starting in the second semester of 2005.

Patients co-infected with TB and HIV will be treated with standardized short-course chemotherapy, containing rifampicin and will be managed under direct observation treatment. It will ensure adequate adherence to TB and ARV treatment and avoid emergence of drug-resistant forms both for TB and HIV.

Patients diagnosed with TB will not be started immediately on HAART. Antiretroviral treatment of these patients will be deferred by at least 4 weeks in order to not disturb patient's adherence to TB treatment. However, co-infected patients will be started on cotrimoxazole since the beginning of TB treatment. First line ARV therapy for these patients will be a combination of AZT, 3TC and Efavirenz.

Main Activities	Indicator	Implementing

for symptomatic patients	prophylaxis for OI	HAM, TB NP
Decentralization of sputum smear microscopy	N° of laboratory technicians trained on sputum smear microscopy	NAP, TB NP, HAM
	N° of Health centers performing sputum smear microscopy	TB NP
Provision of HIV VCT to patients diagnosed with tuberculosis	% of patients diagnosed with tuberculosis HIV tested	TB NP and NAP
Sensitization of community health agents on TB and HIV issues	N° of community health agents participating on sensitization TB and HIV activities	TB NP, NAP

- **Antiretroviral Treatment and Monitoring:** Providing ART and monitoring to **330** HIV/AIDS Patients in accordance with the national/WHO guidelines

330 patients by the 5th year will be on antiretroviral treatment (**130** by 2nd year)

ARV therapy prolongs and improves the quality of a person's life and pilot projects have demonstrated that ARV therapy can be successfully and responsibly delivered even in resource poor settings. In order to facilitate the implementation and the scaling up of the ARV program, we will use standardized ARV first and second line regimens. All patients will be evaluated and followed by the HIV/AIDS referral center recently established at the Hospital Ayres de Menezes, the Sao Tome & Prince main hospital. The team working in this referral center was trained in Brazil in 2004.

We have chosen the ARV regimens based on the WHO ARV Guidelines. First line regimens will be those composed by 2 NRTI and one NNRTI. Most HIV infected women are in childbearing age and will be preferable initiated regimens containing nevirapine while efavirenz will be the choice for patients receiving tuberculosis treatment. Pregnant women and other patients with high CD4 will not be started on nevirapine because of the reported high risk of hepatotoxicity. ZDV/3TC and d4T/3TC will be the backbone of regimens for both adults and children to be adopted for the implementation of ARV treatment program in ST&P. Adults: patients with WHO stage II, III and IV or presenting total lymphocyte count < 1.200 cells/mm3 will be the prioritized population to receive ARV treatment

Children: for children over 18 months old who are HIV- antibody positive, ART will be offered if they have WHO stage III HIV disease (i.e. clinical AIDS). For those older children with WHO stage I or II HIV disease, ART will be recommended if the CD4 percentage will be available.

TB patients: patients with HIV advanced disease with high risk of disease spread and death during the period of TB treatment will be evaluated to start ARV treatment after few weeks of TB treatment instead of waiting until completion of TB treatment. Efavirenz will be the first line regimen for patients receiving TB treatment.

All symptomatic patients (WHO stages II,III, IV) will also be prescribed prophylaxis with cotrimoxazole.

Treatment failure: initially, treatment failure will be mainly evaluated clinically. However, we estimate that by the end of the first year or at latest by the second year of proposal implementation we will be able to add CD4/CD8 count to patient monitoring. We are trying to establish cooperation with an institution in Portugal where we will be able to send serum in batches for viral load measurement. Considering the complexity of running HIV viral load and the number of exams we will need, it is our understanding that it will be more cost-effective to store the samples and send it in batches to a referral laboratory in Portugal or to a Regional laboratory. Another reason to do so is the difficult to get maintenance for medical and laboratory equipments in our insular country.

Adherence: Before starting treatment each patient will receive extensive counseling and education about the importance of adherence and consequences of non-adherence. Each one will be asked to indicate one family member or friend, to be fully aware about his/her HIV serological status and willing to help him to comply with follow up and adherence to treatment. Difficulties to disclosure HIV status to family members may be a significant barrier to adherence to ARV treatment. To decrease this barrier health care provider will be available to support each patient in the process of disclosure of HIV serostatus to partners, family and/or close friends. When a family member or close friend could not be appointed by the patient, a NGO volunteer may be asked to collaborate with patient adherence. The capacity to provide this kind of support will be developed through sensitization and skills building activities planned to take place in the coming years, starting in the second semester of 2005.

Under the bilateral cooperation with the Brazilian Government, ST&P is receiving anti-retroviral drugs and technical support to implement HIV diagnosis and antiretroviral therapy program. In accordance with

the signed agreement Brazil will provide the antiretroviral drugs listed below to all patients needing treatment in ST&P:
~~AZT+3TC/AZT 100 mg/IV AZT/AZT syrup/Lamivudine syrup/D4T 30 and 40 mg/3TC 150 mg/ddI 25 and~~ 100 mg/Nevirapine 200 mg/Indinavir 400 mg/Ritonavir 100 mg.
Provision of Pediatric drug formulation, excluding PMTCT, is not included in this agreement. Besides the providing ARV drugs, Brazil is also providing technical assistance through both making available an expert on ARV therapy to work with the national team to plan and implement the antiretroviral treatment program in ST&P and providing hands on clinical training in Brazil. This cooperation started in 2004 and we are ready to scale up our treatment program
Therefore, we will need to purchase only ARV to treat patients with tuberculosis (Efavirenz), patients intolerant or failing first line ARV treatment and ARV drugs to provide post exposure prophylaxis to Health Care workers. So, we are asking financial resources to purchase, efavirenz(Sustiva), ~~lopinavir/ritonavir (Kaletra), nelfinavir (for pregnant women intolerant to nevirapine), AZT+3TC~~+Nelfinavir for occupational post exposure prophylaxis and for pediatric treatment(first and second line regimens).

Like TB treatment, ARV treatment and monitoring laboratory exams as well as drugs to prevent and treat opportunistic infections will be available free of charge to all patients.

Main Activities	Indicator	Implementing Partners

adequate school materials and clothes	receiving support for school materials and clothes	

The impact of HIV/AIDS on individuals, families, communities and societies goes far beyond physical illness and death; it encompasses socioeconomic effects, including increased poverty and hunger; demographic effects, such us increase in orphans and vulnerable children [OVC]; community effects, such as caregiver burn-out and AIDS-related isolation. Extended family networks play an important role in the care of orphans and vulnerable children, but many of these families live in extreme poverty. Many households' capacity to support and care for OVC is precarious. The extent of poverty is widespread, and many factors increase households' economic vulnerability, including death, illness, a lack of assets, and households headed by women and elderly people. Therefore, intervention focused on social support to mitigate the HIV/AIDS epidemic impact on vulnerable population such us orphans and their caregivers and HIV infected patients living in poverty, are of crucial importance.
We will implement two kinds of interventions focused on this vulnerable population, provision of food and provision of access to income generating activities. The World Food Program has already made a commitment to provide food for all HIV infected pregnant women, HIV infected patients, orphans and their families/caregivers. The Ministry of Education has already agreed to not charge school and transportation fees for the orphans. Therefore, we are requesting additional funds to cover school materials and clothes for orphans. For this component we are also requesting funds to cover operational costs of providing food to PLWA that will be done by a NGO. The NGO will be chosen by a BID to be conducted by PR (UNDP).

- **Stigma Reduction:** activities to reduce HIV/AIDS stigma will cover community health agents, NGO, businessmen, health care workers and youth.

Stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. They deter individuals from finding out about their HIV status and inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves.

The level of stigma in ST&P is very high. A high proportion of the population believes HIV infected people, in spite of their clinical status, should not continue with activities like attending school or work. PLWA have identified the need to sensitize the population about HIV/AIDS and human rights as the highest priority for the improvement of their quality of life.

Experience teaches that a strong movement of people living with HIV (see objective 5.1.1) that affords mutual support and a voice at local and national levels is particularly effective in tackling stigma. Moreover, the presence of treatment makes this task easier too: where there is hope, people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status, and to seek care if necessary.

Communities are key stakeholders in HIV/AIDS programs, with the potential to make major contributions to the success of prevention, care, and support efforts. We expect that the training of NGO and sensitization of community health agents will galvanize broader community attention to affected groups decreasing stigma and discrimination and contribute to enhance access to services.
Initiating in the second year, funds will be made available to NGO to fund projects focusing stigma reduction. The PR will launch a call for proposals and an external committee with broad representation will select the projects to be funded with GFATM HIV/AIDS proposal.

Main Activities	Indicator	Implementing Partners
Dissemination positive messages about PLWA and human rights on mass media (radio and television)	N° of messages disseminated through mass media vehicles each year	NAP, NGOs
Training of NGO members to fight stigma and discrimination	N° of NGO members who received training to fight stigma and discrimination	NAP
Selection NGO projects	N° of projects funded	PR(UNDP), CCM

focusing stigma reduction (for funding)		
Dissemination of messages focusing businessmen	N° of Issues of the Commerce Chamber's Newsletter with published articles about HIV/AIDS	Chamber of Commerce, NAP, NGOs and other partners in the fight against HIV/AIDS
Sensitization of community health agents about HIV/AIDS	N° of community health agents participating in activities of sensitization	NAP and NGOs

5- Increase institutional capacity of the National Aids Program and Non-Governmental Organizations

Key Service delivery area:

- **Strengthening the civil society:** NGO will participate in capacity building activities related to HIV/AIDS prevention, care, human rights and stigma reduction. Capacity building on management of projects will also be provided to them.
- **Strengthening the institutional capacity of the NAP:** institutional capacity will be strengthened through the development of a System of Monitoring & Evaluation, and through increasing the availability of NAP staff with adequate skills and capacity to conduct supervisions of activities being conducted on field by health care workers and other partners, mainly NGOs, collect and analyze epidemiological and other relevant data, including KAP studies.

Strengthening the civil society

Communities are key stakeholders in HIV/AIDS programs, with the potential to make major contributions to the success of prevention, care, and support efforts. However, the civil society often does not have the necessary representative structures or administrative capacity to participate effectively and need training. Often, community representatives are not empowered to be effectively involved in decision-making process that affects them. Many NGOs did not have enough resources or technical and managerial skills. This proposal seeks to increase NGO capacity to effectively participate in the country's response to the HIV/AIDS epidemic through providing them technical and financial support.
Currently ST&P does not have any organization of People Living with AIDS. However, there is an indication that some patients may be willing to take the leadership to found the first organization of PLWA in ST&P. We have budgeted resources to support this initiative during the implementation of this proposal. The organization of PLWA will crucial to raise awareness of HIV-associated human rights issues and to advocate that they be given due consideration in all aspects of AIDS policy and programming

Main Activities	Indicator	Implementing Partners
Provide training to NGO regarding prevention interventions and human rights	N° of NGO members participating in the trainings	FONG
Provide NGO with training on project management	N° of NGO participating in the trainings	School of Professional Training, FONG
Support the establishment of an Association of PLWA	Association of PLWA established	FONG and NAP

Strengthening the institutional capacity of the NAP

Monitoring and evaluation are essential to determining whether programs are reaching target populations and accomplishing their objectives. It also helps with refining interventions for maximum impact, tracking increasing access to services. However lack of technical capacity and resources is hindering action in this crucial area in ST&P. This Proposal seeks to strengthen the country's capacity to collect and analyze HIV/AIDS AIDS data used to support planning and monitoring. We expect that with the aid of a expert on

M&E and participation of all partners involved in the fight against HIV/AIDS we will be able to build one agreed monitoring and evaluation system that provides a single mechanism to account for various funding arrangements, monitors AIDS program effectiveness, and provides the strategic information needed to adjust the action framework. The involvement of all partners, including NGO and community level participants will be crucial.
We will build on existing efforts and address key monitoring and evaluation information gaps. We will use standardized indicators in order to be able to compare our data with those from other countries in many critical areas such us AIDS awareness levels, availability of prevention and treatment services, reduction of risk behavior. The monitoring and evaluation component of this proposal will take advantage of the structure that is being established by the Malaria Global Fund Proposal (already funded). With resources from the Malaria proposal, computers are being purchased for health units at the district level. These computers will also be used for M&E activities related to HIV/AIDS and STI.

The increase in the number of staff available for supervision of health care services will be a crucial step in order to better monitor the activities being implemented in the field. Therefore, the NAP team will be strengthened with three new professionals – a nurse, a driver and an administrative assistant. The purchase of a car will be of fundamental importance to allow timely transportation of the NAP staff for field supervisions and to collect data relevant for monitoring.

HIV/AIDS surveillance will be improved with the addition of key sources of data such us sentinel surveillance (pregnant women), STI data, data about exams use for screening blood donors, household and behavioral surveys, death registers, and active AIDS case finding activities that will be conducted in death certificates, and from charts of hospitalized patients.

During this proposal implementation period, three KAP surveys will be conducted to obtain baseline data and follow up, in order to contribute to the evaluation of this proposal implementation. In the first year KAP survey a among adult population will be conducted assessing level of stigma, sexual behavior, condom use, access to services related to STI, HIV/AIDS, among other data relevant for this proposal.

It is important to highlight that UNFPA will conduct a KAP study among youth out of school during the second semester of 2005 and it is why we will not need to conduct a KAP study to obtain baseline data for the youth component of this proposal.

Adult and youth out of school KAP study will be conducted again in the 3rd year and in the 5th year of the proposal implementation.

Because a cross sectional seroprevalence study among pregnant women was conducted in 2005, a new cross-sectional study seroprevalence study will be conducted in the third and 5th year to track the HIV prevalence along the time.

Main Activities	**Indicator**	**Implementing Partners**
Hiring a M&E expert	Expert on M&E hired	PR(UNDP)
Hiring additional staff to NAP(1 nurses, 1 driver and 1 administrative assistant)	Additional staff hired	PR(UNDP)
Training the NAP AND Partners on M&E	N° of training sessions on M&E	M&E expert
	N° of NAP staff and partners who have attended M&E training sessions	NAP
Procurement of a car for supervision	Car available for supervision and home visits	PR(UNDP)
Procurement of equipments for NAP	Nap Office equipped	PR(UNDP)
Implement health services supervision activities	% of health services supervised at least two times per year	NAP
Implement monthly active AIDS case finding activities	Active case finding activities implemented	NAP

Implementation of KAP studies	N° of KAP studies implemented as planned	NGO, UNFPA, NAP, INE	
Implementation of HIV seroprevalence studies	N° of HIV seroprevalence studies implemented as planned	NAP, SHP, INE	
Data collection at health care services (M&E) - 7 districts - 4 X year	% of data collection performed as planned	NAP	

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

Along the years we have developed a strong partnership with different UN agencies, bilateral cooperation and other donors to implement activities related to HIV/AIDS prevention and care. Therefore, we are in a stage to scaling up some interventions such us HIV VCT, condom distribution, antiretroviral therapy and PMTCT, management of STI through syndromic approach. This proposal also includes intervention that will be new such as prevention interventions focusing commercial sex workers and youth out of school, income generating activities and interventions focusing reduction of stigma and discrimination. Monitoring and evaluation activities will be improved and capacity building activities in this field are included in this proposed seeking to increase the national staff technical autonomy on this field. Capacity building activities for NGO are also new interventions that will be made possible through financial resources requested in this grant application.

Key services not available:

- Interventions focusing commercial sex workers
- Support for orphans
- Strengthening of civil society
- Fight against stigma and discrimination
- Screening of Blood donors for hepatitis C

Key services already being implemented but not currently available at sufficiently wide scale:

- Information, Education and Communication
- Youth out school education
- Condom distribution
- HIV VCT
- PMTCT
- STI diagnosis and treatment
- Blood safety, universal precautions
- Treatment and prophylaxis for OI
- ART treatment and monitoring
- Income generating activities available to patients/orphans and their families/caregivers

Please see more details in the section 4.4.1.6 where the goals, service areas and activities are fully described.

4.4.2 Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the Global Fund grant period.

The Funds that will be made available by the Global Fund will allow ST&P to build in the country the capacity to fight HIV/AIDS in the governmental and non-governmental sector. This process of capacity building will empower all partners to expand and qualify the services and interventions they are providing. Although we expect that along the 5 years of this proposal implementation the ST&P government will progressively increase the resources allocated to fight the HIV/AIDS epidemic, due to our economic situation we

expect that a significant proportion of the activities to be implemented with GFATM financial resources will depend on our capacity to mobilize resources from our partners. We expect that the NGO capacity building implemented during the next five years will allow them to raise funds for their main activities.

4.4.3 Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities *(2 paragraphs)*.

The primary determinants of the evolution of the epidemic in ST&P are to a large extent associated with the level of social development. The extreme vulnerability of women and youth with low economic capacities can be seen. Women's rights in society are not sufficiently recognized, particularly within the family unit. The income of youth is uncertain, unemployment level is high being difficult for youth to enter in the labor market, which aggravates poverty and may predisposes them to have early sexual relations and in certain level may contribute for have young women engaged on prostitution, which entails important factors of vulnerability to STI and HIV/AIDS.
The project aims to reduce the current power gaps between men and women with respect to making decisions about sexual practices, with special emphasis on the young population in order to encourage changes in attitudes and responsible behaviors. A large number of planned activities in the IEC strategy seek to empower women, especially among youth, women heads of households and commercial sex workers, groups targeted for participation in workshops on the promotion and knowledge of human rights and gender equality, negotiating techniques for using condoms, facilitating effective couples communication and promotion of condom use.

4.4.4 Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases *(1–2 paragraphs)*.

Dissemination of mass media campaign about HIV/AIDS will contribute to promote public discussion, information sharing and education with increasing knowledge of the people about the consistency of the disease burden and the impact on the economic and social aspects. By increasing access to life saving antiretroviral treatment PLWA will contribute to a better quality of life of PLWHA encouraging more people to get tested, to seek treatment and finally to reduce stigma. Stigma will likewise be reduced by interventions focusing youth, health care workers and community health agents and the support for income generating activities. The income generation component will allow PLWHA to have improved economic means and a rightful integration in the society. The establishment of an association of PLWA will be crucial to empower them to implement advocacy strategies which will help reduce stigmatization

4.4.5 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) *(1–2 paragraphs)*.

Because the country small population, we believe we will be able to provide a quite good access to prevention and care services to both urban and rural population in the 7 regions of the country. Regarding antiretroviral treatment the agreement signed with the Brazilian government foresee the provision of antiretroviral drugs to achieve a high coverage of treatment.

4 Components Section

4.5 Program and financial management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals; section V.B.3, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.]

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

[Every component of your proposal can have one or several Principal Recipients. In Table 4.5.1 below, you must nominate the Principal Recipient(s).]

4 Components Section

Table 4.5.1 – Implementation Responsibility

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone and fax numbers, e-mail address**
United Nations Development Programme(UNDP)	Resident Coordinator	Mr Christhian Lehembre	UNDP, Av. Des Nations Unies-S. Tome, PO Box 109, S. Tome e Principe Fax: 239 222 198 Phone: 239 221 122 Email: registry.st@undp.org

4.5.2 Describe the process by which the CCM, Sub-CCM or Regional CM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was/were nominated should be included as an annex to the proposal. If there are multiple Principal Recipients, questions 4.5.3 – 4.5.6 should be repeated for each one.] [Question not applicable to Non-CCM and regional Organization applications].

The UNDP was chosen by consensus to act as the Principal Recipient. No other organization in STP has the ability to manage large-scale procurement as efficiently and in compliance to international standards.

4.5.3 Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).]

The primary qualification of this task is transparency of their management procedures and their compliance with international standards. The UNDP also has experience in managing funds for UNAIDS in Sao Tome for a project on voluntary counseling and screening for follow-up of HIV positives and those AIDS. This organization has already demonstrated the capacity and expertise required to meet the global Funds requirement for coordination and management.

4.5.4	Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes
		☐ No

4.5.5 If yes, provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous Global Fund grants *(1–2 paragraphs).*

The UNDP is already administrating the malaria proposal funds that totalize USD1,941,359.00 (one million nine hundred forty one thousand three hundred fifty nine United States Dollars) for two years period. The total Global Fund Grant for five year for the malaria component is up to USD 3,484,859.00. The contract was signed on February 17, 2005 and the implementation of the proposal has just began. So, it is not possible to provide, by this time, an evaluation about the performance of UNDP administrating GFATM funds. However, the report of the first visit of LFA, after starting the implementation of the program, was positive.

4.5.6 Describe other relevant previous experience(s) that the nominated Principal Recipient has had:
[Please describe in broad terms the relevant programs, as well as their objectives, key implementation challenges and results (2–3 paragraphs).]
The UNDP, PR, in this Country have a large experience administrating extra-regular UNDP fund. In the last two years, more then 2.5 millions USD have been managed by the UNDP country office from the various partners, bilateral (UK;USA; Netherlands, France & STP) and multilateral (UNDP, GEF & African Development Bank). Some of these projects are the following: (i) National forum of political consensus-USA (ii) platform for sharing-UK (iii) Integration of girls in order to empowerment them, "platform for sharing"-UNFIP (iv) Human resources management-ADB (v) Environment management UN Convention-GEF (vi) Election control mechanism-UNDP/HQ.

4.5.7 Describe the proposed management approach and explain the rationale behind the proposed arrangements.
[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (2–3 paragraphs).]
The responsibility to starting the project proposal came from the MOH, acting through the CCM. After the approval of the work plan by the CCM, including the implementation responsibility of each SR, the UNDP as a PR will make the following arrangement:1-signed the contract with each of the SR defining the role, procedure and respective deadline to implement the work plan; 2-The SR will be supervised regularly by the Global Fund Unity of the PR in order to assure that the activities are well performed and done as planed; 3-The PR will establish a plan to reinforce, progressively, each SR on these weaknesses identified during the supervision process; 4-At least, quarterly, the PR will submit to the CCM the technical and financial report that show the progress on the implementation of the Program and to be approved or take the due decision when needed;5-All the work plan and demand of next disbursement will be submitted by the PR to the CCM to be approved. *Note:(i) the UNDP have set up a new technical/financial Unity to deal specifically with the Global Fund projects in the country (ii) For the situation where other UN agencies have advantages in term of specialized experience and expertise (ex. WHO; UNICEF) such agencies will be consulted (iii) UNDP HQ have signed (and are in the process to be signed) accords that reinforce and make more operational the administration of these projects (ex: for use of well established procurement agent as IAPSO& periodicity of financial audit).*

4.5.8 Are sub-recipients expected to play a role in the program?	☒ Yes → go to 4.5.9
	☐ No → go to 4.6

4.5.9 How many sub-recipients will be, or are expected to be, involved in the implementation?	☒ 1-5
	☐ 6-20
	☐ 21 – 50

	☐ more then 50

4.5.10 Have the sub-recipients already been identified?	☐ Yes → go to 4.5.11 - 4.5.13
	☒ No → go to 4.5.14 & 4.5.15

4.5.11 Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.); *(2–3 paragraphs).*

4.5.12 Where sub-recipients applied to the CCM, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal *(1–2 paragraphs).*

4.5.13 Describe the relevant technical, managerial and financial capabilities of the sub-recipients. *[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (e.g., capacity-building, staffing and training requirements, etc.).]*

4.5.14 Describe why sub-recipients were not selected prior to submission of the proposal.
Currently there are some NGOs working in the HIV /AIDS field but we have already identified the need to offer them capacity building opportunities before they can compete for funds that will be made available through this proposal. Therefore, sub-recipients will be selected in a public BID implemented by the principal recipient after the capacity building process.

4.5.15 Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process *(1–2 paragraphs).*
Sub-recipients will be selected in a public BID implemented by the principal recipient after the capacity building process. Technical aspects and the cost of the proposal will be the main factors to be considered for the selection of the sub-recipients. A selection committee with broad representation will be appointed by the principal recipient after the agreement of the CCM.

4.6 Monitoring and Evaluation (M&E)

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

4.6.1	Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.
	We will build on existing efforts and address key monitoring and evaluation information gaps. We plan to use standardized indicators in order to be able to compare our data with those from other countries in many critical areas such us AIDS awareness levels, availability of prevention and treatment services, reduction of risk behavior. The monitoring and evaluation component of this proposal will take advantage of the structure that is being established by the already funded and on implementation Malaria Global Fund Proposal. The data regarding the implementation of these proposal activities as well as the KAP and seroprevalence studies results will significantly increase our capacity to track the trends of the epidemic and to determining whether we are reaching the target populations and accomplishing the established objectives. It will also increase our capacity to refine interventions for maximum impact and tracking access to services.

4.7 Procurement and Supply Management

[In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country]. [When completing this section, applicants should refer to the Guidelines for Proposals, section V.B.5.]

4.7.1	Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.
	Generally when commodities and equipment are to be requisitioned, price quotations are requested from at least three suppliers. Price, delivery costs and delivery timeframe are considered for each of these bids is considered before deriving a procurement decision. Both local (in STP) and central (in New York) committees (in STP) and central committees have been established to consider procurement decisions when necessary (depending on the scale of the requisition). Bids totaling less than 5,000 USD can be processed within the local UNDP office without the involvement and approval of any committee. Requisitions totaling between 5,000 and 100,000 USD will require the review and approval of the local committee. Requisitions totaling more than 100,000 USD require the involvement of a committee based at UNDP headquarters in New York. UNDP has the capacity and structure to handle procurement requirements according to international standards.

4.7.2 Procurement Capacity
a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products? ☒ Principal Recipient only ☐ Sub-recipients only ☐ Both
b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency

4.7.3 Coordination
a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.
b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal *(1 paragraph)*.
Under the bilateral cooperation with the Brazilian government, ST&P is receiving anti-retroviral drugs and technical support to implement HIV diagnosis and antiretroviral therapy program. In accordance with the signed agreement Brazil will provide the antiretroviral drugs listed below to all patients needing treatment in ST&P: AZT+3TC/AZT 100 mg/IV AZT/AZT syrup/Lamivudine syrup/D4T 30 and 40 mg/3TC 150 mg/ddI 25 and 100 mg/Nevirapine 200 mg/Indinavir 400 mg/Ritonavir 100 mg. The Portuguese bilateral cooperation is providing us technical support in the field of laboratory, including quality assurance. The Portuguese cooperation also provides most of the kits, reagents and consumables required for the operation of the blood bank. UNFPA provides yearly 300,000 – 400,000 units of condoms through Sexual Health Program and the World Food Program is committed to provide food support for HIV infected pregnant women, HIV/AIDS patients and orphans and their families/caregivers. WFP will provide food support to HIV/AIDS Patients, HIV Infected pregnant women and orphans and their families/caregivers Therefore, we will need to purchase only ARV to treat patients with tuberculosis (Efavirenz), patients intolerant or failing first line ARV treatment and ARV drugs to provide post exposure prophylaxis to Health Care workers. So, we are asking financial resources to purchase, efavirenz(Sustiva), lopinavir/ritonavir (Kaletra), nelfinavir (for pregnant women intolerant to nevirapine) and AZT+3TC+Efavirenz (post exposure prophylaxis).

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

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

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

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

Fundo Nacional de Medicamentos (FNM) is a drug procurement, storage and distribution body established by the Ministry of Health, is in charge of storing and distributing drugs to health services. By the occasion our malaria proposal was approved the FNM was inspected by the LFA and approved it for the storage of malaria drugs to be procured with Global Fund resources. For this proposal, drugs test and supplies once purchased by the Principal Recipient and received in the country will be stored at FNM and from there distributed to the health services.

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

The country's health services are quite well distributed covering the 7 regions of the country. Because of the small territory of our country, the time of travel from most part of the country is quite reasonable (1- 2hours)Because prevention and services will be decentralized to the level of districts the population from all regions, including urban and rural population will have wide access to them.

[For tuberculosis and HIV/AIDS components only:]

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

[If yes, applicants should be aware that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made. If not, a Green Light Committee application form must be completed and included with this proposal (see AnnexB).]

4.8 Technical Assistance and Capacity-Building

[Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including Technical Review Panel Clarifications, development of M&E or Procurement Plans, etc.]

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

Along the years we have developed a strong partnership with different UN agencies, bilateral cooperation and other donors to implement activities related to HIV/AIDS prevention and care. Therefore, we are in a stage to scaling up some interventions like condom distribution, antiretroviral therapy and PMTCT and read to start new interventions such those focusing the vulnerable group of commercial sex workers and youth out of school.
We identify the need to continue to receive technical support on HIV care and it is already included in the bilateral cooperation with Brazil. If needed we can also request from Brazil support on the logistic of drugs for STI.

As HIV/AIDS care is a very dynamic field we have included in the budget resources to allow one NAP staff engaged on clinical care to go abroad for training every two years. We also anticipate the need to receive technical support to build capacity on the NGO field.

Although some NGO are already working on HIV/AIDS field in ST&P, there is a clear need to provide them opportunities to build capacity to qualify their work. For instance, we do not have even one NGO poised to work of high risk population such us the commercial sex workers. Regarding this we expect to start in 2005 the process of building capacity NGO capacity to work with this population with funds from UNAIDS. Also, most NGOs operating in ST&P lack skills required to develop competitive proposals seeking to raise funds frequently made available internationally. They also need to strengthen their management capacity. Regarding this, we expect that the School of Professional Training – a non-profit organization operating in ST&P - that is already providing training on management of small business focusing in income generating activities for vulnerable population will be able to provide support on this field. This training is already included in the proposal budget.
Stigma and discrimination is a major problem in our country and is a recognized barrier for HIV prevention and care. With resources provided by Global Fund we expect to hire an international expert on the field of human rights and advocacy to expand the building capacity opportunities to ST&P NGO (included in the budget).
With no doubts, our major need regarding the implementation of this proposal is on monitoring and evaluation. Our installed capacity in this field is low and when combined with the few skilled human resources available in the country this problem became even worse. In order to overcome this constrain we plan to have the support of an international consultant during the first two years of implementation and resources for it are included in the budget. In order to optimize the use of human resources available in the country we will implement M&E activities jointly with the team working in the GFATM malaria component (already funded and in implementation). These efforts will also take advantage of the availability of vehicular support.

5 Budget Section

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

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

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

5.1 Component Budget

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

Table 5.1 – Funds Requested from the Global Fund

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	30,100	55,100	5,100	5,100	5,100	100,500
Infrastructure and equipment	123,920	4,000	6,800	4,000	2,000	140,720
Training	50,614	46,717	34,218	35,428	34,058	201,035
Commodities and products	59,132.80	60,390.05	76,514.40	97,477.40	106,599.40	400,114.05
Drugs	17,795	32,682.80	56,025.08	72,899.60	102,410.76	281.783,24
Planning and administration	32,153	14,203	61,695	15,457	61,875	185,383
Other (please specify)	23,300	34,110	37,115	38,940	42,160	175,625
Total funds requested from the Global Fund	337,014.80	247,202.85	277,467.48	269,272	354,203.16	1,485,160.29

The component budget must be accompanied by a detailed year 1 and indicative year 2 workplan and budget. This should reflect the main headings used in section 4.4. (component strategy) and should meet the following criteria, (please attach this information as an annex):

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

5 Budget Section

5.1.1 Breakdown by Functional Areas

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

Monitoring and evaluation:

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

Table 5.1.1a – Costs for Monitoring and Evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and evaluation	52,370	65,700	54,830	13,830	55,850	242,580

Procurement and supply management:

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

Table 5.1.1b – Costs for Procurement and Supply Management

	Funds requested from the Global Fund for procurement and supply management (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement and supply management	2,500	2,600	2,600	2,600	2,600	12,900

5 Budget Section

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

Table 5.1.1.c – Costs for Technical Assistance

	Funds requested from the Global Fund for technical assistance (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical assistance	32,800	55,000	0	0	0	87,800

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5.1.2 Breakdown by Service Delivery Area

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

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

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Value per year		337,014.80	247,202.85	277,467.48	269,272.00	354,203.16	1485,160.29
Objectives	Service delivery area	Estimated percentage of budget					
Objective 1	Service delivery area 1	3,44%	3,70%	4,99%	4,44%	3,48%	20,05%
	Service delivery area 2	1,94%	1,03%	0,49%	0,43%	0,32%	4,21%
	Service delivery area 3	0,45%	0,65%	1,09%	4,20%	3,51%	9,90%
	Service delivery area 4	4,47%	6,82%	11,97%	13,05%	10,84%	47,42%
	Service delivery area 5	3,44%	5,67%	10,76%	9,10%	6,74%	35,72%
Objective 2	Service delivery area 1	27,92%	7,23%	9,39%	8,66%	6,99%	60,20%
	Service delivery area 2	4,65%	1,49%	1,67%	1,49%	1,17%	10,48%
Objective 3	Service delivery area 1	1,99%	3,10%	4,95%	5,43%	4,69%	20,14%
Objective 4	Service delivery area 1	3,40%	3,08%	6,32%	3,57%	3,52%	19,89%
	Service delivery area 2	8,41%	5,41%	15,91%	21,87%	25,54%	77,15%
	Service delivery area 3	5,79%	7,62%	11,35%	12,03%	10,20%	46,99%
	Service delivery area 4	2,99%	5,95%	8,11%	7,23%	5,66%	29,95%
Objective 5	Service delivery area 1	6,40%	4,07%	4,09%	3,64%	2,85%	21,05%

	Service delivery area 2	24,45%	17,52%	21,15%	1,91%	15,22%	79,52%
Total:		100%	100%	100%	100%	100%	

5.1.3 Breakdown by Partner Allocations

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

Table 5.1.3 – Partner Allocations

	Fund allocation to implementing partners (in percentages)				
	Year 1	Year 2	Year 3	Year 4	Year 5
Academic/educational sector	0	0	0	0	0
Government	79%	79,5%	81,5%	81,5%	67,5%
Nongovernmental/ community-based org.	14%	9%	24%	8%	24%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria	1%	0,5%	0,5%	0,5%	0,5%
Private sector	5%	10%	8,5%	9%	7%
Religious/faith-based organizations	0	0	0	0	0
Multi-/bilateral development partners	1%	1%	1%	1%	1%
Others (please specify)					
Total	100%	100%	100%	100%	100%

5.2 Key Budget Assumptions for requests from The Global Fund

Without limiting the information required under section 5.1, please indicate budget assumptions for year 1and year 2 in relation to the following:

5 Budget Section

5.2.1 Drugs, commodities and products

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

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please attach annex).*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. (Please attach annex).

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please attach annex).*

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

5.2.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over *(1–2 paragraphs). (Please attach annex).*

The higher proportion of resources allocated to human resources relates mainly to the cost of international consultants in the field of monitoring and evaluation and for NGO capacity building. It is important to point out that in all the cases the international consultants will train local staff and NGO members in such a way that the country will get some autonomy to continue to implement the activities related to the consultancy. Other financial resources allocated to human resources will be crucial to strengthen NAP capacity to do home visits and activities essential to monitoring and evaluation

5.2.3 Other key expenditure items

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

Regarding equipments we made our budget based on prices available on UNICEF catalog, IDLA and WHO source of drugs prices. The renovation of the laboratory facility was based on an estimation per m2 considering the prices currently practiced in ST&P.