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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	**Inter-agency Coordinating Committee for Sao Tome and Principe**
Country	**Sao Tome e Principe**
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	**low-income**

Applicant Type X ☐ CCM ☐ Sub-CCM ☐ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☐	HIV1	***" Strengthening the HIV/AIDS epidemic response in Sao Tome e Principe"/Complement***	☐
☐	Tuberculosis[1]	**Reinforcement of nationa response to tuberculsis epiidemic**	**X**
☐	Malaria		☐

Currency X USD or ☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

1 In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. ***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/*

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: **Membership details of CCMs or Sub-CCMs**

Complete the following sections for each disease included in Round 8:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the *Round 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on These decisions are available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

ROUND 8 – Tuberculosis

1 FUNDING SUMMARY AND CONTACT DETAILS

1.1 Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	$356,624.0	$211,840.0	$328,028.0	$317,531.0	$315,134.0	$1,529,157.0
Tuberculosis	**$ 664,574.0**	**$468,340.0**	**$822.609.0**	**$326,177.0**	**$327,118.0**	**$2,608,818.0**
Malaria						
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 8 Funding Request ➔:	**$4,137,993.0**

1.2 Contact details

	Primary contact	Secondary contact
Name	Dr. Alzira S. Silva do Rosário	Dr. Vilfrido Santana Gil
Title	NAP Coordinator	Coordinator
Organization	Ministry of Health	Global Fund Unity/UNDP Sao Tome
Mailing address	Bairo Ponta Mina- S.Tome	B.P. 109, Avenue des Nations Unies, São Tome et Principe
Telephone	+239 221 650/ 221099 / 903627	+239 221122 / 221123 / 904649
Fax	+239 221 227	+239 222 198
E-mail address	alzirarosario@hotmail.com	vilfridogil@hotmail.com
Alternate e-mail address		vilfridogil@undp.org

1.3 List of Abbreviations and Acronyms used by the Applicant

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

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

SB	**Sub-recipient**
STI	**Sexually Transmitted Infections**
STP	**Sao Tome and Príncipe**
SHP	**Sexual Health Program**
TB	**Tuberculosis**
TB NP	**Tuberculosis National Program**
UNAIDS	**United Nations Aids Program**
UNDP	**United Nations Development Program**
UNFPA	**United nations population Fund**
UNICEF	**United Nations Children's Fund**
UN	**United Nations**
USD	**United States Dollar**
VCT	**Voluntary counseling and testing**
WB	**World Bank**
WFP	**World Food Program**
WHO	**World Health Organization**
	[use "Tab" key to add extra rows if needed]

ROUND 8 – Tuberculosis

2 APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is now set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1 Members and operations

2.1.1 Membership summary

	Sector Representation	Number of members
☐	Academic/educational sector	0
X	Government	9
X	Non-government organizations (NGOs)/community-based organizations	5
X	People living with the diseases	2
☐	People representing key affected populations2	0
X	Private sector	2
X	Faith-based organizations	1
X	Multilateral and bilateral development partners in country	13
☐	Other *(please specify):*	---
	Total Number of Members: *(Number must equal number of members in 'Attachment C"3)*	32

2 Please use the Round 8 Guidelines *definition of* key affected populations.

3 ***Attachment C*** *is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/8/AttachmentC_en.xls*

2.1.2 Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):

(a)	Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐	No	**X**	Yes
(b)	Is there continuing active membership of people living with and/or affected by the diseases**.**	☐	No	**X**	Yes

2.1.3 Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

Among the CCM members, some of them have experience in managing health services from different components. For elaboration of the present proposal, CCM counted with technical assistance of experts on health system and laboratory, from an inter-countries team of the WHO.

Representative from the reference and district laboratories, Pharmaceutics Sector, Human Resources, Health Ministry information System, Monitoring- evaluation Sector of the National Endemic Center were present at the process, they participated in the analysis of situation (strengths, weaknesses and opportunities) and identified priorities toward elaboration of this National Proposal.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- The factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

Among the CCM members, there are experts on gender equality subjects, for instance the UNFPA representative. On the other side, a big number of these members have participated in two training sessions on gender equality, organized at national level.
Sensitization on gender awareness: Recognizing in fact that a program adapted to gender issues (essentially HIV/AIDS) requires different approaches among women and men, boys and girls. CCM members are invited to comment their aptitudes and global experiences on gender issues ; taking in account the gender issues while analyzing the program's weaknesses and gaps, and how to improve this proposal by integrating gender equality concerns.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sartorial program design.

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

ROUND 8 – Tuberculosis

2.2 Eligibility

2.2.1 Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.

☐	Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
X	Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below***.

2.2.2 Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*

The application process and presentation of proposal was open and transparent. A reference term with clear criteria for application evaluation was elaborated, recorded on CD together with documents of reference and available for those who are interested. The process was diffused by CCM on April15th, 2008, by announces on TVS, National Radio and News-Papers (annex No. 25) For 3 weeks, encouraging all the interested people from public or private sectors, NGO, PLHIV to participate and submit their request to be integrated in the National CCM proposal.

CCM received 7 applications for HIV/AIDS: 3 from NGO, 1 from Work Union, 1 from traditional healers, 1 from Justice ministry and 1 from the community based organization. No proposal was submitted for tuberculosis.

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*

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

All the applications were related to AIDS component. From. The 7 applications, 4 of them had better punctuation, following the pre-established criteria, and were accepted (see evaluation table, annex 27).

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

In absence of tuberculosis proposal, MCC decided in the meeting on May 7th to orient national team to elaborate a proposal taking in consideration consensual priorities retained by integrating into elaboration process, representatives from the national program of fighting against tuberculosis, sanitary districts and NGOs.

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

A letter was addressed to different partners of the fighting against HIV/AIDS and Tuberculosis, CCM members and not members, to identify their representatives in the process of elaboration of national proposal. The public health professionals, district representatives and NGO, representatives of PLHIV, representatives from finance ministries and education, CCM members and not members, could participate direct or indirectly in various work sessions.	
(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***Report of Meeting, CCM April 14th (annexe n 002/2008)***

2.2.3 Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.	
Periodic meetings are organized by CCM for analysis of activities, its implementations and respective funding allocation.	
(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.	
Supervision of the current subsidizing performance for malaria and AIDS are defined in the CCM regulation (annex 8)	

2.2.4 Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*	
During the CCM meetings held to discuss the overall strategy and to introduce some of the details of the proposal UNDP has been selected as the PR by concensus of all due to the lack of capacity of both management and procurement needs of the other potential candidate, the CNE to undertake the complex managerial activities required in a GFATM award. The decision was also supported by the good performance of UNDP till today with both malaria and aids grant.	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***Verbal Process n. 007/2008*** ***June 27th 2008***

ROUND 8 – Tuberculosis

2.2.5 Principal Recipient(s)

Name	Disease	Sector**
PNUD	HIV	
PNUD	TUB	

[use "Tab" key to add extra rows if needed]

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

2.2.6 Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.

In Sao Tome and Principe, it was still not possible to identify two principal beneficiaries to manage a single project simultaneously.

UNDP is the only principal beneficiary, elected by CCM consensus since 2005. This is due to performance of this institution as it was described in point 2.2.4. Till this time both government and not government sectors were still not identified since all the conditions required to be principal beneficiary are not in place. UNDP has already started preparing a government sector (e.g. National Endemic Center) to be able to assume a principal beneficiary role in the future. However, this sector didn't still reveal enough capacity to play this role.

2.2.7 Managing conflicts of interest

(a)	Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	☐ Yes ***provide details below*** **X** No ➔*go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☐ **Yes** ***[Insert Annex Number]***

2.2.8 Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	**X** Yes

ROUND 8 – Tuberculosis

3 PROPOSAL SUMMARY

3.1 Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	July 2009	July 2014

3.2 Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 8 tuberculosis proposal?

☐ Yes *(go first to (b) below)*

☉ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/en/apply/call8/other/#5*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

São Tomé and Príncipe's fiscal cycle follows the calendar year, so it starts on January 1 and ends on December 31.

The timetable for the implementation and reporting of activities takes this schedule into account. This fiscal cycle was kept in mind during the development and implementation of Rounds 4 and 7 for malaria and Round 5 for AIDS, which are currently running.

Planning for the implementation of this R8 proposal follows the same concept inasmuch as the activities are scheduled to start on July 1, 2009. The activities that are to be funded by the government and other partners beginning in January will be launched. The program results will be available each quarter and only the impact indicators will be presented in line with the calendar year.

3.4 Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis occur through a program-based approach?

☉ Yes. Answer s.3.4.2

☐ No. ➔ *Go to s.3.5.*

3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?

☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common***

funding mechanism.

No. Do not complete s.5.5

3.5 Summary of Round 8 Tuberculosis Proposal

Provide a summary of the tuberculosis proposal described in detail in section 4.

Prepare after completing s.4.

Strengthening of the national TB response

The goal of this proposal is to help establish in São Tomé and Príncipe a functional NTCP (c) capable of caring for the vast majority of the country's current tuberculosis patients as called for in the 2007-2011 strategic plan adopted in 2007.

Thus the overall objective is to reduce morbidity and mortality linked to tuberculosis. Specifically, four goals have been identified:

Goal 1: To work to expand an effective DOTS strategy by:

- Setting up CDTs (Tuberculosis Diagnosis & Treatment Centers) in all 7 districts (4 the first year and 3 the second year). This effort would use infrastructure and staff already in place in the districts through training and retraining for the health professionals in these districts, the provision of laboratory reagents and consumables, management tools and the resources to supervise the laboratories, monitoring/evaluation and quality control.
- Establishing the LNR (National Reference Laboratory) by refurbishing, adapting and outfitting the lab at HAM (Dr. Ayres de Menezes Hospital) for culture and susceptibility testing, quality control and provision of reagents and consumables including culture media and susceptibility tests, training for 2 of the HAM technicians in doing cultures and susceptibility tests in a Portuguese-speaking country.
- Ensuring the availability of the first- and second-line medications, distributing them to the CDTs, assigning staff, and training in management of drug stocks.
- Setting up an effective TB monitoring and evaluation system as part of the CNE's (National Center for Endemic Diseases) Monitoring and Evaluation Unit which handles the monitoring and evaluation of malaria and HIV/AIDS.
- Strengthening the program's managerial and supervisory capabilities by assigning some human resources to the central unit, providing equipment required for operation and handling supervision.
- Building staff capabilities by organizing both on-site and off-site training and retraining in appropriate fields for the various categories of professionals.

Goal 2: To fight TB/HIV co-infection, MDR-TB, and take on other challenges by:

- Setting up a system for TB/HIV cooperation.
- Establishing activities intended to lessen the TB load among persons living with HIV/AIDS through more aggressive identification of cases of TB in the HIV counseling and screening centers by systematically using the algorithm for suspect cases and the reference form for the CDVs (Voluntary Screening Centers) and CDTs developed for this purpose.
- Preventing and fighting multidrug resistant tuberculosis (MDR-TB) through care that includes provisions to support the estimated 38 MDR-TB patients.

Goal 3: To help strengthen healthcare systems by implementing the practical approach to respiratory health (APSR) by:

- Conducting a survey in the districts, developing national APSR directives and training materials, training doctors and nurses, developing a plan to expand implementation of the initiative, and ensuring the supply of equipment and drugs.

Goal 4: To give persons suffering from TB and their communities the ability to take action by conducting a KAP survey during the 1st and 5th years, the development of a Program Communication and Social Mobilization (PCSM) plan and an effort to increase awareness-raising activities, community-based communications and social mobilization efforts that target primarily young people and are led by NGOs with the involvement of community health workers in the provision of care.

ROUND 8 – Tuberculosis

The total amount requested is USD **2,608,818.00** and this would be put to use as follows: USD 1,132,914.00 for the first two years (USD 664,574.00 for Year 1 and USD 468,340.00 for Year 2), and a total of USD 1,475,904.00 for the last three years.

4 PROGRAM DESCRIPTION

4.1 National programme and strategy

(a) Briefly summarize:

- the current tuberculosis national programme or strategy;
- how the strategy responds comprehensively to current epidemiological situation in the country; and
- the improved tuberculosis outcomes expected from implementation of these programme or strategy.

The Strategy and National Program to Fight TB

São Tomé and Príncipe's National Program to Fight TB (NTCP) was established in 1993 with the technical support of Medicus Mundi. Each year, it notified an average of 150 cases of all forms of tuberculosis. In 2006, the WHO estimated the incidence and prevalence of cases of all forms to be 103 and 252 per 100,000 population respectively, and the incidence of smear-positive (S+) cases at 46 per 100,000. For the same year, 153 cases of all forms of TB were notified including 36 S+ cases for an S+ PTB detection rate of 50%. For the 2005 cohort of S+ PTB cases (49 cases), the recovery rate was 98% (just 1 death representing 2%). These figures should be regarded with some reservations given the current weakness of the program. HIV/AIDS appeared in population in 1989. The prevalence of HIV is estimated at 1.5% (2005 National AIDS Program study of seroprevalence of HIV among pregnant women). Among TB patients, it increased rapidly from 1.9% in 2006 to 8.6% in 2007 (data from the national AIDS and TB programs).

The way that TB patient care is currently organized is archaic. It is highly centralized with a single diagnostic and treatment center at the national hospital in the capital city of São Tomé. X-rays are requested systematically for all patients, some of whom must pay for them. Sputum smears and treatment are free. A short 6-month 2RHZE/4RH regimen is used for all new patients and an 8-month course of 2SRHZE/1RHZE/5RHE is used for retreatment. Hospitalization is required for all patients throughout the intensive phase of treatment, the annual average cost of which is USD 382,468. During the continuation phase, which is self-administered and unsupervised, monthly doses are provided directly to the patients. The anti-TB drugs were purchased by the WHO each year until 2007. This is now handled by the NGO called Valle Flor. The drugs are stored by the National Medication Repository (FNM, a central storage facility for vital drugs including those for AIDS, malaria and TB). Portions of the stockpile are sent to the hospital and distributed as directed by the head of the National Program to Fight TB. Patients who come from all regions of the country for diagnosis and treatment must bear substantial costs when their income is already quite meager. Patients are offered neither supervision nor support after they leave the hospital, to which they must return each month for their rations of medications, and testing. Since 2006, several MDR cases have been identified and there are currently 4 MDR-TB patients under care. Three are currently undergoing treatment, and the fourth has not been able to buy the medications, which must be purchased by the family.

Since 2007, the National Program to Fight TB's central unit, which until this year had only one doctor (the head of the Program himself) and no infrastructure, has been connected with the National Center for Endemic Diseases (CNE) which also handles the programs for malaria and HIV/AIDS, among others. This integration will make it possible to share common services, e.g., the services of the monitoring and evaluation unit, communications services for behavior modification, and administrative services.

Aware that the steps being taken to fight TB might be in jeopardy, in 2006 the government developed a national anti-TB policy and a strategic plan for 2007-2011 based on the new Stop TB Strategy and the 2006-2015 Global Plan to Fight TB from the Stop TB Partnership. The long-term objective of this national anti-TB policy and strategy, adopted by the government in 2007, is to make São Tomé and Príncipe a TB-free island, offering quality diagnostics and care to the entire population thanks to the establishment and implementation of an effective anti-TB program that is based on the DOTS strategy, properly resourced, accepted by the population, implemented in the context of a functional healthcare system, and supported by the community.

The overall goal defined in these documents is to reduce the morbidity and mortality associated with TB in São Tomé and Príncipe, and more specifically, to detect 70% of the smear-positive cases of TB and to cure 85% of them by 2011. The following results are expected: i) improved program coverage; ii) improved TB detection and recovery; iii) improved drug acquisition and management; iv) improved

monitoring and evaluation; v) improved care for persons living with HIV/AIDS and stricken with TB or MDR-TB; vi) improved medical response; vii) improvement in terms of advocacy, communication, social mobilization and capacity building.

The current response to the epidemiological situation
Under the current program as described above it is not possible to identify and treat all cases of TB, or, in particular, to offer patients effective care that makes it possible to reduce the prevalence of TB mortality. Decentralizing and integrating the fight against TB is an urgent need in the country, particularly because we already have some important assets in this regard: the primary healthcare program covers the entire country, all districts have doctors and laboratories with sufficient staff, especially microscopists, who were deployed in the fight against malaria and who are currently underutilized due to the retreat of that disease. Implementing the strategic plan is the best response to the current epidemiological situation with regard to TB in São Tomé.

Results expected from this proposal
The goal of this proposal is to reduce the morbidity and mortality of TB by 2013 in compliance with the MDGs and the Stop TB Strategy. Four of the six Stop TB Strategy goals have been adopted: 1) Work to expand and improve a solid DOTS strategy; 2) Fight against TB/HIV co-infection, MDR-TB, and confront other challenges; 3) Help strengthen the healthcare system by implementing the practical approach to respiratory health (APSR); and 4) Give TB patients and their communities the ability to act through behavior modification communications (CCC): advocacy, communications and social mobilization, and the involvement of communities in TB care (Community DOTS).

Implementing the actions and interventions called for in this project will make it possible to have a functional National Program to Fight TB in place, one which has: human resources at the central level; diagnostic and treatment centers in all seven districts in the country; healthcare stations and centers that detect suspect TB cases and provide care for confirmed cases as close as possible to the patient's home and at the least possible expense to the patient; trained staff; an effective monitoring and evaluation system integrated into the one already in place for AIDS and malaria; coordination and fruitful collaboration with all partners.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7 proposal when the document was last submitted, and the Global Fund will obtain this document from our Round 7 files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

	Document	Proposal Annex Number	Page References
☑	National Health Sector Development/Strategic Plan	Annex 1	pp 10-27
☐	National Tuberculosis Control Mid Term Strategy or Plan	not available	
☑	National Tuberculosis Guidelines (medical and laboratory)	Annex 2	pp 12-52
☐	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	not available	
☑	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	Annex 3, Dr. Wembanyama's mission report	pp 1-11
☐	National Monitoring and Evaluation Plan (health sector,	not available	

disease specific or other)

☑ National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services	Annex 4	pp 23-26
National poverty reduction strategy	Annex 5	pp 24 and 49 and 83-85
PNDS 2001-2005	Annex 18 Round 7 MAL	PP 74-76

4.2 Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

☉ Whole country ☐ Specific Region(s) ***If so, insert a map to show where* ☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

***** Paste map here if relevant***

(b) **Size of population group(s) targeted in Round 8**

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	157,848	National Statistics Institute, National population growth, 2002-2009	2008
Women > 25 years	28,722	National Statistics Institute, National population growth, 2002-2009	2008
Women 19 – 24 years	7,762	National Statistics Institute, National population growth, 2002-2009	2008
Women 15 – 18 years	9,493	National Statistics Institute, National population growth, 2002-2009	2008
Men > 25 years	25,706	National Statistics Institute, National population growth, 2002-2009	2008
Men 19 – 24 years	7,629	National Statistics Institute, National population growth, 2002-2009	2008
Men 15 – 18 years	9,583	National Statistics Institute, National population growth,	2008

(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
		2002-2009	
Girls 0 – 14 years	34,230	National Statistics Institute, National population growth, 2002-2009	2008
Boys 0 – 14 years	34,723	National Statistics Institute, National population growth, 2002-2009	2008
Other **: ***Refer to the Round 8 Guidelines for other possible groups*			
Other **:			
Other **:			[*use "Tab" key to add extra rows if needed*]

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated tuberculosis patients - shown as number per 100,000 population (*all ages)*	153 cases of TB (all forms expected) i.e., 103/100,000	Global TB Control WHO Report 2008	2006
Female tuberculosis patients > 25 years	9 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Female tuberculosis patients 19 – 24 years	3 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Female tuberculosis patients 15 – 18 years	1 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Male tuberculosis patients > 25 years	17 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Male tuberculosis patients 19 – 24 years	4 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Male tuberculosis patients 15 – 18 years	2 new S+ TB cases notified	Global TB Control WHO Report 2008	2006
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	153 cases of all TB forms notified 99/100,000	Global TB Control WHO Report 2008	2006
Tuberculosis patients all forms tested for HIV (rate among	8.6% of TB patients (all forms) were HIV+	National TB and AIDS Programs	2008

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
notified)	in 2007		
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	72 46/100,000	Global TB Control WHO Report 2008	2006
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	36 23/100,000	Global TB Control WHO Report 2008	2006
Case detection rate of new smear-positive cases	50%	Global TB Control WHO Report 2008	2006
Estimated number of multi-drug resistant cases of tuberculosis	not available		
Notified number of multi-drug resistant cases bacteriologically confirmed	4 presumed MDR-TB cases identified and being treated	National Program to Fight TB	2008
Treatment success rate of new smear-positive cases	98% - statistic not reliable due to poor status of current National Program to Fight TB	Global TB Control WHO Report 2008	2005
Defaulter and transfer rate of new smear-positive cases	0	Global TB Control WHO Report 2008	2005
Estimated number of girl (0 – 14 years) tuberculosis patients all forms	8 cases of TB (all forms) estimated (5%) 5/100,000	Global TB Control WHO Report 2008	2006
Notified number of girl (0 – 14 years) tuberculosis patients all forms	1 girl S+ TB case notified in 2006; the number for all forms of TB is not available	Global TB Control WHO Report 2008	2006
Estimated number of boy (0-14 years) tuberculosis patients all forms	8 cases of TB (all forms) estimated (5%) 5/100,000	Global TB Control WHO Report 2008	2006
Notified number of boy (0 – 14 years) tuberculosis patients all forms	0 boy S+ TB cases notified in 2006	Global TB Control WHO Report 2008	2006
Other**: ***Refer to the Round 8 Guidelines for other possible groups*			
Other**:			
Other**:			[*use "Tab" key to add extra rows if needed]*

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[4] who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

- the main weaknesses in the implementation of current tuberculosis program or strategy;
- how these weaknesses affect achievement of planned national tuberculosis outcomes; and
- existing gaps in the delivery of services to target populations.

Weaknesses in the implementation of the current strategy

The main weaknesses in the implementation of the current program are:

1. The population has insufficient access to quality diagnostic and care services (DOTS)

TB diagnosis and treatment is too centralized. They are conducted in a single hospital (the Central Hospital of São Tomé) where all patients must go. A single laboratory at the HAM hospital conducts all sputum smear tests. Patients are hospitalized during the entire intensive phase of treatment, far from their families. Maintenance phase follow-up treatment is a poorly conducted. There is no supervision. The ability to manage medications and consumables is weak. Supervision and monitoring/evaluation are not in place. The National Reference Laboratory is not capable of conducting culture tests or susceptibility tests because the current facilities are not set up for cultures or susceptibility tests and they lack trained staff.

2. Lack of trained staff

Despite the availability of human resources in the seven districts (doctors, nurses, lab assistants, pharmacy technicians, microscopists) these human resources have not been trained in the new strategy of TB care. The training school for skilled healthcare workers that is responsible for training nurses, lab assistants and others does not teach TB care done in accordance with the DOTS strategy in its training curriculum. At the central level the capacity for managing, monitoring and evaluating TB care in accordance with the new strategy is also insufficient.

3. Insufficient monitoring and evaluation

The system for routine monitoring of patients is weak, which results in a lack of information about what happens to patients later on. The records and notification system is deficient. Data on hospitalized patients are collected by nurses from the Pneumophtisiology department, and are retrieved by the program Director who himself does the analysis and writes the quarterly reports. The lack of periodic monitoring surveys should also be noted.

4. Insufficient administrative and supervisory capacity

Affiliated with National Center for Endemic Diseases (CNE), the National Program to Fight TB (NTCP) does not have sufficient human resources with well-defined tasks to monitor the implementation of the national anti-TB strategy, particularly as regards the component of care, and monitoring and evaluation. Despite the availability of infrastructure, the NTCP does not have the financial or logistical means (including transportation) to ensure its operation. The program's technical documentation is not current and supervisory visits are not being conducted.

5. Insufficient care for TB/HIV co-infection and MDR-TB

There is no formal framework for coordination between the two programs and the actions aimed at reducing HIV morbidity in TB patients and TB among persons living with HIV are insufficient. MDR

[4] Please refer back to the definition in s.2 and found in the *Round 8 Guidelines.*

patients do not have access to diagnostic exams and care.

6. **Insufficient community involvement in information and awareness-raising campaigns, as well as in TB care**

There is no plan for communications and social mobilization. The partnership for the fight against TB is insufficient and the involvement of NGOs, the community and the private sector in carrying out these activities is weak.

Due to all of these weaknesses, the program's results in terms of the detection rate and recovery rate are insufficient. Care for patients is medically inadequate and socially burdensome for the patients who are forced to deal with enormous expenses when they are already in a vulnerable situation.

In short, given that the National TB Plan has not been functional, all of the weaknesses identified here constitute shortcomings that must be addressed at every level of services provided to the target populations, specifically the men, women and children in this country who carry TB whether or not it is associated with HIV.

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect tuberculosis outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and tuberculosis outcomes (e.g.: PAL services), but perhaps not also malaria and tuberculosis programming and service delivery.*

The health system is subject to a certain number of organizational, structural and operational requirements that affect the results of the National Program to Fight TB. The main ones are summarized below:

Leadership and Governance: the process of reform begun in 2000 with the drafting of strategic documents such as the National Health Policy (NACP), the 2001-2005 National Health Development Plan (PNDS) and the Healthcare Map has encountered implementation bottlenecks due to institutional instability. The 2001-2005 PNDS is still the document of reference, and the primary strategic components have not been implemented. No evaluation has been conducted on the PNDS. The laws for the most part date from before independence, and regulations are restrictive.

Human Resources: a shortfall of qualified healthcare workers and the uneven geographical distribution of existing staff, to the detriment of the healthcare units in the districts, are noteworthy. The substandard valuation of these human resources (low salaries, lack of promotion or professional advancement) is a demotivating factor for these workers, which leads to a brain drain toward more attractive sectors or abroad. The lack of any HR development plan in the healthcare area should also be pointed out.

Healthcare Funding: despite the efforts of the government, the funding of healthcare programs is dependent on external assistance. Currently, the budget allocated to the healthcare sector is approximately 10% of the State's budget as against the 15% promised by the heads of state during the Abuja 1 and Abuja 2 summits in 2001 and 2006 respectively. This substantial dependence on external resources could put the ability to continue actions taken in the effort to implement certain projects at risk. Noteworthy are the lack of precise information on the costs of healthcare and the dearth of legislation on healthcare funding.

Services: since 2001, universal access to healthcare services and integrated care have been adopted as basic principles. At this stage, 70% of the population has access to a healthcare facility less than one hour away. However, geographical and financial roadblocks to access exist and this is even more apparent for the residents of the island of Principe who must travel 12 hours by boat, and for those who live in the more remote districts, Lembá and Caué in particular, where the poverty rates are also the highest. Generally speaking, the infrastructure and equipment are poorly suited to needs, and a lack of standardization or any maintenance policy accounts for the recurring breakdowns. Diagnostic services as well as laboratories and radiology are weak and unstructured. There is a shortage of normative and procedural documentation; what does exist is not properly distributed, and thus not widely used by staff.

Medicinal products and management of purchasing and inventory: the percentage of the population with access to vital, high-quality drugs at an affordable cost is not yet known due to limitations in the pharmaceutical sector. Current strategies and legislation are inadequate. Insufficient epidemiological data and poor management capabilities impact the quantification of needs in terms of pharmaceutical products, and the management of purchasing and inventory. On the other hand, the fact that there is a variety of sources but no coordination leads to frequent depletion of inventories of drugs, reagents and other strategic inputs for certain programs and services with negative consequences for the quality of patient care. The storage and distribution capabilities of the National Medication Repository (FNM) are insufficient. Peripherally, the problem of supply, storage and management of drugs and medicinal products is actually both an infrastructure problem and a management capacity problem. Quality control for drugs, reagents and other strategic inputs is nonexistent.

National Health Information System: the National Health Information System is experiencing difficulties associated with i) leadership; ii) organization; iii) a complete lack of directives; iv) insufficient training of healthcare workers in data collection and processing; v) frequently running out of data collection forms and insufficient means of transmission; vi) irregular and insufficient supervisory visits. These shortfalls impact the quality of monitoring/evaluation, and lead to gaps in real-time information needed for decision-making. Due to weaknesses in the national health information system, various programs and services (sexual and reproductive health, malaria and AIDS), in order to meet their own information needs for management purposes, have developed their own data collection and reporting systems with very poor coordination among themselves. In addition, there is no drug monitoring system.

Operational research: operations research is uncommon and any results are little used. The practical approach to respiratory health (APSR) although respiratory illnesses account for 50% of the morbidity in the health districts.

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect tuberculosis outcomes.

Leadership and Governance

- Steps taken by the Ministry of Health

A technical team was named to lead the evaluation of the 2001-2005 National Health Development Plan (PNDS) and to draft the second generation plan. Support missions to the country were conducted in 2007 in order to restructure the Ministry of Health and to evaluate the organizational framework of the National Center for Endemic Diseases and to propose a new operational structure in order to address the mission of "organizing and coordinating the monitoring, prevention and fight against endemic diseases, diseases at high risk of becoming epidemic, and infectious diseases that impact public health". Documents specifying the organization and operation of the management, departments and program will be revised as a result in order to strengthen the leadership and coordination among the various branches of the Ministry of Health.

Human resources

- Steps taken by the government

New skilled workers (nurses, lab assistants, statistical technicians, dispensing technicians) have been trained by the skilled health worker training school, the Institut Victor Sa Machado, and assigned by the government to health units including the districts. These skilled workers will be retrained and will participate in the decentralization of the fight against TB.

Government workers received a pay increase in 2007, but it is still insufficient to cover basic monthly needs.

A human resources development plan is scheduled to be drafted in 2008.

- Steps taken by partners

Training provided for the head of the program in TB program management.

Healthcare funding

- Steps taken by the government

Training for managers at the central and district levels in financial management with an eye to improving their financial absorption capacity.

- Steps taken by partners

Training conducted by the WHO at the central and district levels on conducting surveys on the national health accounts

Services

- Steps taken by the government and partners

To improve access to diagnostic and treatment services for the most distant populations, in 2008 the government signed an agreement with NGO Valle Flor in the context of the implementation of "Project Health for All" to extend its coverage to the districts of Caué and Principe island. As a part of this, a radiology department will be set up in the second half of 2008 and there are also plans to improve laboratory services. Another goal of this project is to improve healthcare infrastructures. The other five districts, including Lembá, have already received assistance in the context of the implementation of this project since 2005.

Healthcare centers and stations have also been refurbished and equipped as a part of the implementation of an aid project for the social sectors funded by the World Bank.

Medicinal products, and purchasing and inventory management

- Steps taken by the government and partners

A study was conducted in the first quarter of 2008 in public and private facilities and in households to determine the percentage of the population that has access to high-quality, vital medications at an affordable cost, and to gather data to help define policy and national strategies.

An Executive Order on the organization of the 12th Institutional Government defined the National Medication Repository (FNM) as the national clearinghouse for the purchase of medications and medicinal products.

The National Health Information System

A Health Demographics Survey (EDS) will be conducted in the third quarter of 2008 to update national health statistics.

As a part of the implementation of projects from the Global Fund's Round 4 for malaria and Round 5 for AIDS, the CNE's Monitoring and Evaluation Unit has been strengthened by recruiting and training more staff.

4.4. Round 8 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current tuberculosis epidemiology and identified weaknesses and gaps from s.4.2.2 and 4.3.

Note: All health systems strengthening needs that are most effectively responded to on an tuberculosis disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No:	1. Extension of quality DOTS strategy	Historical		Current		Country targets			
Intervention	Number of TB diagnostic centers in the 7 districts and the HAM	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		1	1	1	6	8	8	8	8
B: Extent of need already planned to be met under other programs		1	1	1	1	1	1	1	1
C: Expected annual gap in achieving plans		0	0	0	5	7	7	7	7
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			5	7	7	7	7

Priority No:	1. Extension of quality DOTS strategy	Historical		Current		Country targets			
Intervention	Number of reference laboratories doing cultures and susceptibility testing	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		0	0	0	0	1	1	1	1
B: Extent of need already planned to be met under other programs		0	0	0	0	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	0	1	1	1	1
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	1	1	1	1

ROUND 8 – Tuberculosis

Priority No:	1. Extension of quality DOTS strategy	Historical		Current		Country targets			
Intervention	Number of new S+ cases diagnosed	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		36	60	51	57	63	65	66	66
B: Extent of need already planned to be met under other programs		36	60	51	44	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	13	63	65	66	66
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			13	63	65	66	66

Priority No:	The fight against TB/HIV co-infection	Historical		Current		Country targets			
Intervention	Number of TB patients tested for HIV and given care	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		153	93	113	127	140	144	147	147
B: Extent of need already planned to be met under other programs		NA	93	113	127	140	0	0	0
C: Expected annual gap in achieving plans		NA	0	0	0	0	144	147	147
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			0	0	144	147	147

Priority No:	Helping to strengthen the healthcare system	Historical		Current		Country targets			
Intervention	Number of districts offering APSR	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target *(from annual plans where these exist)*		0	0	0	0	0	1	4	7
B: Extent of need already planned to be met under other programs		0	0	0	0	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	0	0	1	4	7
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			0	0	1	4	7

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 8 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, program work area (or, "service delivery area (SDA)"), and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*

Where there are planned activities that benefit the health system that can easily be included in the tuberculosis program description (because they predominantly contribute to tuberculosis outcomes), include them in this section only of the Round 8 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 8. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 8 Guidelines (s.4.5.1.) for information on this choice.*

The goal of this proposal is to help put a functional National Program to Fight TB (NTCP) in place in the Republic of São Tomé capable of caring for the vast majority of the country's TB patients in accordance with the 2007-2011 strategic plan drafted in 2006. The proposal centers on four goals, the primary activities of which are described below:

1. To continue to extend and improve a quality DOTS strategy.

2. To fight TB/HIV co-infection, MDR-TB, and confront other challenges.

3. To help strengthen the healthcare systems by putting in place the Practical Approach to Respiratory Health (APSR).

4. To give persons stricken with TB and their communities the ability to act.

The goals, Service Delivery Areas (SDAs) and activities are connected as follows:

Goal 1: To continue to extend and improve a quality DOTS strategy:

Given the unique situation of São Tomé and Príncipe (isolated, far from the continent), and the availability of numerous capable healthcare facilities (healthcare centers and stations) with staff and equipment already in place, who are handling the business of primary care in a well-organized fashion, and who have already taken part in the activities of the sexual and reproductive health program, provide effective care for malaria, and currently also assist in providing care for HIV/AIDS, the process of decentralizing and integrating the fight against tuberculosis will take advantage of these same structures. The primary healthcare program, centered on the health district, was launched in 1981. It was reinforced beginning in 2005 as part of the "Health For All" initiative with the technical and financial support of an NGO (the Institut Marques de Valle Flor). Some bilateral partnerships come up international NGOs and institutions of the United Nations (such as the WHO, UNPF, and UNICEF) support the districts in the context of their own programs. Recently, the social sector support project (PASS) funded by the World Bank has been helping to improve primary healthcare and strengthen the health districts.

SDA 1.1 Improvement in diagnostics:

This will be done by putting DOTS services in place in 4 districts the first year and the 3 other districts the second year, in addition to the current center.

1.1.1 Extending the network of diagnostic centers

The choice of these districts is based on the criteria of distance, population and availability of human resources and equipment. The districts concerned are:

- Agua Grande, home to the capital, with a population of 58,329, which has a healthcare center staffed by doctors (the Agua Grande general clinic, which attracts a substantial outpatient clientele) and for healthcare stations staffed by nurses. This district is also home to the central hospital where the two reference facilities are located: the Pneumophtisiology department (reference clinic) and the central

laboratory (the National Reference Laboratory, or LNR).

- The second most densely populated district is Me Zochi, with a population of 38,480, located just 7 km from the capital.

- The two other districts identified are Lemba, 27 km from the capital with a population of 11,855, and the island of Principe which has a population of only 6292 and is located some 150 km away, a trip that takes 12 hours by boat. These four districts account for 80% of the population.

The districts that will come into play in the second year are: Lobata, located 12 km from the capital with 15,808 inhabitants, Cantagalo, 20 km away with 14,437 inhabitants, and Caué with a population of 5618 located some 80 km away from the capital. The healthcare centers in all of these districts each have at least one doctor handling general consultations as well as a laboratory with at least 2 microscopes, between 1 and 4 lab technicians, and 1 or 2 microscopists who have been trained in the diagnosis of malaria, but who are currently underutilized due to the drastic reduction in the prevalence of that disease thanks to the effective anti-malaria program implemented with the support of several partners including the Global Fund (Round 4 and Round 7). These microscopists will be in charge of handling the microscopic examination of sputum smears for suspect cases of TB.

In all these healthcare centers, which will become DOTS centers, outpatient consultations are conducted by doctors including the District Managing Physician who is also the top official in charge of healthcare for the district. This Managing Physician will be the TB coordinator. These doctors are the ones who will handle selecting suspect cases and sending them to the laboratory for microscopic examination. The TB coordinator will handle care for diagnosed TB patients, will maintain the case registry and files, do the quarterly reports and order medications. To further reduce travel problems for patients, nurses from healthcare stations and community health workers will be involved in the selection of suspect cases and taking sputum samples of laboratory. This activity will be described in more detail in the “community involvement” section (Goal 4).

The district laboratories are all in good condition and are well equipped thanks to the “Health for All” project. Therefore the facilities will not need to be refurbished and microscopy equipment will not need to be provided. Supplies of reagents and consumables will be provided for the four laboratories in the four districts that will start up the first year along with the HAM hospital, and then for all seven districts and the hospital beginning in the second year, up through the end of the project.

Since facilities already in place will be used, the support provided will focus on training (included under SDA 1.5 on human resources), the supplying of reagents and lab consumables, management tools, resources for supervising the laboratories, monitoring/evaluation and quality control.

- 1.1.1.1 Organizing a 5-day workshop for adapting the laboratory microscopy guide (1 facilitator and 15 participants);
- 1.1.1.2 Printing 50 copies of the lab guide and make them available to the 7 CDTs and the HAM;
- 1.1.1.3 Organizing 2 retraining sessions for the lab assistants and microscopists, including 1 5-day session in Q4 of Year 1 and another in Q1 of Year 2 (SDA 1.5).
- 1.1.1.4 Supplying the 7 CDTs and HAM with sufficient standard laboratory consumables to screen 11,428 suspect TB cases over 5 years, broken down as follows: Year 1 (2067), Year 2 (2282), Year 3 (2328), Year 4 (2365), Year 5 (2386);
- 1.1.1.5 Providing for the maintenance of the microscopy laboratories (7 districts and HAM) for 5 years.

1.1.2 Establishment of the National Reference Laboratory (NLR)

The central laboratory for the HAM hospital is currently the only lab qualified to conduct microscopic sputum examinations and this will be the reference lab for the NTCP. It will be in charge of training and microscopists, the quality assurance program (QA), and supervising the network of peripheral labs. Although staffing is sufficient, the current facility is not suitable for doing cultures or susceptibility testing. The hospital administration has agreed to provide space that can be renovated and equipped for this purpose. This project of setting up the NLR will take place in the third year of the program and will include the following components:

- 1.1.2.1 Training 2 HAM technicians over 3 months in doing cultures and susceptibility tests in a Portuguese-speaking country during Q1 of the third year (SDA 1.5);
- 1.1.2.2 Refurbishing the HAM laboratory and so cultures can be done (Q1 of the third year);

- 1.1.2.3 Providing the HAM laboratory with standard equipment for solid media cultures in the third year;
- 1.1.2.4 Providing the HAM laboratory with reagents for solid media cultures and susceptibility testing, Year 3 (1782), Year 4 (1782), Year 5 (1782).
- 1.1.2.5 Performing culture examinations for suspect MDR cases at the Cameroon Pasteur Institute in Yaoundé in Year 1 and Year 2 (including DHL, culture + susceptibility test + service fees)
- 1.1.2.6 Procuring reagents and consumables to conduct smears, cultures and susceptibility tests for monitoring 38 MDR-TB cases over 5 years (included in activity 1.1.2.3);
- 1.1.2.7 Providing funds for the services of the HAM laboratory for verifying all positive slides and 10% of the negative slides from the microscopy labs in the districts during the 5 years of the project;
- 1.1.2.8 Providing for external quality evaluation of the LNR (supranational laboratory), once per year for 5 years;
- 1.1.2.9 Providing for maintenance of the culture laboratory beginning in Year 2;
- 1.1.2.10 Providing funds for lung x-rays for 325 S- patients (43 in Year 1; 52 in Year 2; 63 in Year 3; 76 in Year 4 and 9 in Year 5).

Training for the 2 HAM technicians in doing cultures and susceptibility tests will take place during the second year in a Portuguese-speaking country such as Mozambique. This activity will last 6 months and is included in SDA 1.5 which covers all training.

Until the culture laboratory is set up, these examinations will be done at the Cameroon Pasteur Institute in Yaoundé where samples for suspect cases of MDR-TB will be sent.

The microscopy laboratory culture and quality assurance program (with verification of all positive slides in 10% of negative slides) will be put into place as the functionality of the various laboratories comes on line.

The lung x-rays, an important part of diagnostics for S- TB cases, is currently requested systematically for all patients. This constitutes another additional expense for these patients who were already struggling financially. So these x-rays should be funded in the context of this project so that it is free for patients.

SDA 1.2 Strengthening the drug procurement and management system

Treatment will be primarily on an outpatient basis, which constitutes an innovation compared with previous practices. Treatment supervision will be conducted both by healthcare staff and community workers. Treatment schedules will run for either 6 months (2RHZE/4RH for all new cases of S+, S-, and EPTB) or 8 months (2SRHZE/1RHZE/5RHE for retreatment cases). 4FDCs will be introduced. Currently, only RH is available in combined form.

1.2.1 Purchasing and management of supplies

Until 2007, anti-TB drugs were ordered by the WHO from the IDA. As part of this project drugs, reagents and laboratory consumables will be purchased by the PR from the GDF.

- 1.2.1.1 Providing first-line drugs to the CDTs for treatment of a total of an estimated 437 cases of all forms of TB in adults (category I and III) over 3 years (Year 3 144 cases, Year 4 146 cases, Year 5 147 cases);
- 1.2.1.2 Providing first-line drugs for a total of 32 cases in adults undergoing retreatment (category II) during the 5 years;
- 1.2.1.3 Providing drugs for the treatment of 13 children Years 1 and 3;
- 1.2.1.4 Handling transportation, insurance, storage and distribution of drugs, reagents for cultures and susceptibility tests;
- 1.2.1.5 Acquisition of inventory management software for the National Medication Repository (FNM) in the first year;
- 1.2.1.6 Purchasing equipment: 200 peak flow meters, 10 spirometers
- 1.2.1.7 Providing medications: salbutamol spray and beclometasone (units are considered in SDA 1.2)
- 1.2.1.8 Acquisition of 8 computer systems (computers, uninterruptible power supplies, printers) for managing pharmacy inventories at the CDTs (7 for the districts, 1 for the NTCP) in Year 3;
- 1.2.1.9 Training for 9 pharmacy managers in using the software to manage drug inventories (7

for the CDTs, 1 for the HAM and 1 for the NTCP), Year 1 (SDA 1.5);
- 1.2.1.10 Acquisition of second line drugs for 38 MDR patients (6 in Year 1, 7 in Year 2, 8 in Year 3, 8 in Year 4 and 9 in Year 5).

Drug requirements are quantified under several headings: for new cases of all forms of TB in adults (categories I and III), for adults undergoing retreatment (category II), for children, and a 100% emergency stock which is added to the first year. The number of patients to treat has been estimated using projections done by the WHO for São Tomé using the WHO planning and budgeting tool (see page Epidemiology) based on the number of cases notified in 2006 and assuming that 50% of the cases were identified. For first-line drugs, GDF kits will be used for the 3 categories of patients (Stop TB cat I + III Patient Kit A and Stop TB Cat II Patient Kit A1, ref. page First line drugs).

1.2.2 Storage of drugs

Drug supplies are managed by the National Medication Repository (FNM) which manages the essential vacations including those for AIDS and malaria. Anti-TB drugs are stored in its warehouses. The agency does not have sufficient staff and its facilities have become cramped. The NTCP will help improve the FNM's ability to manage, store and distribute medications by:

- 1.2.2.1 Refurbishing the FNM facilities and providing them with additional shelving to warehouse additional anti-TB drugs and laboratory consumables;
- 1.2.2.2 Hiring a full-time administrative assistant for Years 1, 2, 3, 4 and 5.
- 1.2.2.3 Purchasing a freezer where reagents and culture media can be stored
- 1.2.2.4 Supporting the operation of the FNM’s electrical generators (fuel)

1.2.3 The distribution of drugs

The districts will be supplied with medications based on the quarterly report, which must be submitted with the order. The order must be approved by the head of procurement for the NTCP. Logistical support will be provided in the distribution of the medications.

- 1.2.3.1 Distribution of drugs and microscopy reagents to the CDTs once per quarter for Years 1, 2, 3, 4 and 5.

SDA 1.3 Monitoring/evaluation

This is one of the weak points of the current program. Until 2005, what happened to patients after they left the hospital at the end of the intensive phase of treatment was not known because they returned to their original districts and were left to themselves without any follow-up. Only the most motivated patients came back for their checkups. There was no system for routine monitoring of these patients, so what happened to them was not known. It was only beginning in 2005 that it became possible to obtain a patient cohort analysis.

So it is now urgent that a routine monitoring/evaluation system that uses the notification and reporting system and the monitoring/evaluation indicators recommended by the Stop TB Partnership be put in place. This system will be integrated into what is already in place at the CNE (the National Center for Endemic Diseases: AIDS, malaria and TB) until such time as a national health information system is put in place by the Ministry of Health.

- 1.3.1.1 Organizing a workshop to draft a monitoring and evaluation plan (workshop for 15 persons over 5 days) in Year 1;
- 1.3.1.2 Organizing a 3-day workshop to revise the guide and data recording and reporting forms, Year 1;
- 1.3.1.3 Printing 5000 copies of the record sheets and 5000 copies of patient files, Year 1 (SDA 1.4);
- 1.3.1.4 Organizing 4 quarterly supervisory visits from the central level to the CDTs and the HAM each year during Years 1, 2, 3, 4 and 5 (SDA 1.4);
- 1.3.1.5 Providing the Pneumology departments at the HAM and the CDTs with tools to manage MDR-TB cases (record, guides, patient files).
- 1.3.1.6 Organizing a workshop to standardize the monitoring and evaluation tools and choosing the indicators for the 3 diseases, i.e., TB, AIDS and malaria, to be included on the CNE’s M&E grid, Year 2;
- 1.3.1.7 Acquisition of data software, Year 1;

- 1.3.1.8 Training managers in the use of the data software (15 persons over 5 days), Year 1.

1.3.1 Workshop to revise the recording and reporting materials, Year 1

A workshop will be organized during the first year of the project to revise the NTCP's technical guide and the recording and reporting forms to bring them into compliance with R&R for the Stop TB Partnership which takes into account the six elements of the new Stop TB Strategy. These documents must be completed, printed up and distributed so they can be used in routine monitoring of the NTCP's activities.

A workshop to standardize the monitoring/evaluation tools and choice of indicators for the 3 diseases (TB, malaria, AIDS) to be included in the CNE's M&E grid will be organized during the **second year.**

SDA 1.4 Program supervision and management

1.4.1 Strengthening the NTCP

Since 2007, the central unit of the National Program to Fight TB (NTCP) has been connected to the National Center for Endemic Diseases (CNE) which includes programs to control AIDS, malaria, TB and other transmissible and non-transmissible diseases. This has allowed the NTCP to improve its managerial capacities by using resources available at the CNE. As a part of this project, the NTCP should profit from a strengthening of its resources, both in terms of staff and equipment, for the operation of the central unit (computers, Internet access, etc.). Staff at the CNE will be trained to handle TB activities (see training listed under section 1.5.3). The following activities are planned:

1.4.1.1 Staff

The following staff should be hired in order to augment the staff of the NTCP:
1.4.1.1.1 Allocation of a monthly subsidy for the NTCP coordinator for 5 years.
1.4.1.1.2 Hiring 1 nurse for 5 years (SDA 1.5)
1.4.1.1.3 Hiring 1 administrative assistant for 5 years (SDA 1.5)
1.4.1.1.4 Hiring 1 driver for 5 years (SDA 1.5)
1.4.1.1.5 Assigning 1 professional to the monitoring and evaluation unit for the 5 years that the project is put in place

1.4.1.2 Equipment

1.4.1.2.1 Equipping the NTCP's central unit with 2 computer systems (computers, uninterrupted power supplies, printers), 1 laptop, 1 DataShow, 1 photocopier, the first year;

1.4.1.3 The tools

1.4.1.3.1 Printing up 100 copies of the TB technical guide, Year 1;
1.4.1.3.2 Reproducing 100 copies of the MDR patient monitoring sheets, Year 2;
1.4.1.3.3 Printing up 50 copies of the laboratory guide and making them available to the 7 CDTs and the HAM;
1.4.1.3.4 Printing up 15,000 copies of the record sheets and 15,000 copies of the patient files, Year 1;
1.4.1.3.5 Setting up a work group to draft the supervision guide (10 days of group work for 5 people);
1.4.1.3.6 Setting up a work group to draft the home care patient monitoring sheets (5 days x 5 people);
1.4.1.3.7 Reproducing and distributing 100 copies of the care directives for drug-resistant TB

1.4.1.4. National-level staff meetings

1.4.1.4.1 Organizing an annual TB control activity assessment meeting, beginning in Year 1;
1.4.1.4.2 Organizing semiannual meetings from Year 1 to Year 5.

1.4.1.5 District-level staff meetings

1.4.1.5.1 Holding 1 coordinating meeting per quarter per district per year.

1.4.1.6 Supervision

1.4.1.6.1 Organizing 1 supervisory visit per quarter from the central level to the CDTs and the HAM each year for 5 years.

1.4.1.7 Transportation

1.4.1.7.1 Acquisition of 1 all-terrain 4x4 vehicle for the NTCP;
1.4.1.7.2 Providing the NTCP's vehicle for 5 years;
1.4.1.7.3 Providing maintenance for the vehicle for 5 years;
1.4.1.7.4 Equipping the 7 district laboratories (4 the first year and 3 the second year) with standard laboratory microscopy equipment (1 lab 7651, without binocular microscope (USD 1528)).

Special emphasis will be placed on supervision, given the size of the country and the number of patients expected. All supervision at the central level must be conducted at least once per quarter. Supervision will begin within three months following the initiation of the activities. Special attention will be paid to labs and the selection of suspect TB cases.

The supervisory team of the CNE (into which the NTCP coordinator will be integrated), the doctor in charge of care for the National AIDS Program and the LNR's lab technicians will handle providing central-level supervision of the districts. A vehicle will be provided at the central level for this purpose.

District level supervision of healthcare stations will be built in to the supervision area in place for these facilities. Suitable training will enable these teams to conduct the TB supervision that they will be asked to do. A TB supervision guide will be drafted and distributed.

SDA 1.5 Human resources development

Proper staffing levels and the right skill sets are vital for the implementation of all of the programs activities. While staffing in the districts may be sufficient, it is not at the central level. Job descriptions will be rewritten along with clear definitions of responsibilities and tasks, and a document for this purpose will be drafted as a part of the restructuring of the CNE to include tasks associated with TB. The following actions will need to be completed in the context of this project:

1.5.1 Revision of tasks

1.5.1.1 Organizing the workshop to rewrite job descriptions and define responsibilities and tasks for the teams from the districts, the CNE and the HAM in the context of caring for TB, Year 1;

1.5.2 *Hiring:*
1.5.2.1 One full-time doctor for 5 years
1.5.2.2 One full-time nurse for 5 years
1.5.2.3 One full-time administrative assistant for 5 years
1.5.2.4 One full-time driver for 5 years
1.5.2.5 Assigning 1 professional for the monitoring and evaluation unit for the 5 years of project implementation

1.5.3 *Technical assistance:*

Given that nothing has yet been done in terms of putting in place a DOTS program that complies with the Stop TB Strategy, technical assistance will be required to support the drafting of technical and training documents, training for trainers, the establishment of the LNR (cultures and susceptibility tests), launching the APSR, TB/HIV, MDR-TB, and mobilization of the community.

1.5.3.1 Hiring an international consultant to revise the NTCP's technical guides, to adapt the recording and reporting forms to comply with the Stop TB Partnership's R&R, and training, for 104 days, Year 1;

1.5.3.2 Hiring an international consultant to develop the configuration and training strategy, for 21 days, Year 1;

1.5.3.3 Hiring an international consultant to support trainer training for TB, TB/HIV and MDR TB, for 16 days, Year 1;

1.5.3.4 Hiring an international consultant to support analysis of the MDR TB situation and drafting the MDR-TB Infection Control Plan, Year 2;

1.5.3.5 Hiring an international consultant to support analysis of the APSR situation and development of the guides (1 person for 1 week, twice), Year 3;

1.5.3.6 Hiring an international consultant to set up the national reference laboratory (LNR) for cultures and susceptibility tests, Year 3.

1.5.4 Training

Implementing the activities required for this expansion/decentralization of the DOTS services and improvement of care will require training for all categories of staff who will be involved, and retraining as time goes on. Training for trainers will be organized to handle successive training sessions. The District Managing Physicians will handle the training of nurses and community health workers in their district.

The following training sessions will be organized:

1.5.4.1. Training for 15 trainers in 1 5-day session on all aspects of the Stop TB Strategy including TB/HIV, Year 1;
1.5.4.1.1 Organizing 1 internal training program in English over 6 months, 14 people, in the first 2 years;
1.5.4.1.2 Organizing the consolidation of internal training in English in an English-speaking country for the 2 best participants, for 1 month (training consolidation abroad will take place in the first 2 years)
1.5.4.2. Training for 12 trainers in behavior modification communication (CCC) for CNE and NGO managers in 1 3-day session, Year 1;
1.5.4.3. Training for 15 trainers for APSR in 1 3-day session, Year 3;
1.5.4.4. Retraining for 16 lab assistants and microscopists in conducting microscopic examinations during 2 5-day sessions, i.e., 8 in Year 1 and 8 in Year 2 at the HAM;
1.5.4.5. Organizing 7 3-day training sessions for district nurses on the Stop TB Strategy including TB/HIV aspects, specifically 4 sessions in Year 1 and 3 in Year 2;
1.5.4.6. Organizing 8 3-day sessions for public and private doctors and HAM nurses on the Stop TB Strategy including TB/HIV aspects, years 1 and 2;
1.5.4.7. Organizing 1 3-day training session for HAM nurses on the Stop TB Strategy including TB/HIV aspects, Year 1;
1.5.4.8. Training for 9 pharmacy managers (7 from the CDTs, 1 from HAM and 1 from the NTCP) on using software to manage drug inventories, Year 1;
1.5.4.9. Training for 2 technicians over 3 months in doing cultures and susceptibility testing in a Portuguese-speaking country, Q1 of Year 3;
1.5.4.10. Training for 15 trainers in MDR-TB, Year 2;
1.5.4.11. Organizing 3 3-day sessions for training on caring for MDR-TB, specifically 1 session for 20 doctors in Q1 of Year 2, 1 session in Q3 for 20 nurses, and the third in Q2 of Year 3;
1.5.4.12. Organizing 13 day training session for district nurses in caring for TB patients in the community (15 participants x districts x 3 days).
1.5.4.13. Organizing 3-day training sessions for 105 community health workers in the districts on caring for TB patients in the community, i.e., 60 in Year 3 and 45 in Year 4;
1.5.4.14. Training on TB for 25 journalists from various media in 1 4-day session in Year 1;
1.5.4.15. Training for 25 NGO and CBO activists on behavior modification communications (CCC) actions in the community, Year 1.

In all of these training sessions TB/HIV co-infection will be discussed. Accordingly there will not be any training on co-infection specifically. These activities will be initiated in each district immediately after the training of the doctors and lab technicians and supplies of drugs, reagents, consumables and tools are in place.

Goal 2: Fighting TB/HIV co-infection, MDR-TB and confronting other challenges

SDA 2.1 TB/HIV

Collaboration in the fight against TB/HIV co-infection

Collaboration on TB/HIV issues is still weak, although some collaborative activities are currently being conducted by the NACP which received funding from the Global Fund (Round 5). This involves systematically offering HIV counseling and screening to TB patients, systematically checking for TB among persons living with HIV and making ARVs and Cotrimoxazol available to TB patients. The National Strategy to Control TB plans to strengthen this collaboration in an effort to improve care for TB and HIV/AIDS patients.

As part of this proposal, plans call for putting in place all of the activities recommended by the WHO in the "current policy of TB and HIV collaboration" which includes three main components: setting up a mechanism for collaborating, initiating activities intended to reduce the occurrence of TB among persons living with HIV and that of HIV among TB patients.

Connecting the programs against TB, HIV/AIDS and malaria all to the CNE, and bringing their central units together in the same facility, supports this collaboration.

2.1. 1 *Setting up a mechanism for collaborating on TB/HIV:*

2.1.1.1 Organizing a 5-day workshop to work out the context for collaboration, define the RDTs and road map for the TB/HIV coordination committee, Year 1 (15 people for 5 days);
2.1.1.2 Printing up 100 copies of the "framework for TB/HIV collaboration", Year 1;
2.1.1.3 Distributing the "framework for TB/HIV collaboration" to the CDVs, CDTs, healthcare centers and stations, the HAM, NGOs and community health workers, Years 1 and 2;
2.1.1.4 Organizing a 3-day joint TB/HIV planning workshop for 25 participants where they will agree on specific TB/HIV activities, Year 1;
2.1.1.5 Organizing quarterly coordination meetings each year beginning in Year 2;

The TB/HIV training guide will be included in the training modules for the expansion of the DOTS as called for in the Stop TB Strategy.

2.1. 2 *Initiating activities intended to reduce the occurrence of TB among persons living with HIV/AIDS*
2.1.2.1 Providing for the distribution of the algorithms for suspect cases and reference forms to the CDVs and CDTs.

2.1.3. *Initiating activities intended to reduce the occurrence of HIV/AIDS among TB patients*
2.1.3.1 Providing for the screening of 516 TB patients in Years 3, 4 and 5;
2.1.3.2 Providing for the prophylaxis (using Cotrimoxazol) of an estimated 516 TB patients in Years 3, 4 and 5;
2.1.3.3 Providing for the ARV treatment of the estimated 73 TB patients eligible in Years 3, 4 and 5;
2.1.3.4 Providing for the purchase of condoms for 516 TB patients over 5 years.

The NACP has been conducting TB/HIV activities since 2006 with funding from Round 5 of the Global Fund, which should continue until 2011. These activities include: systematic screening of TB patients for HIV, Cotrimoxazol prophylaxis, ARV treatment for eligible patients and the distribution of condoms to TB patients. Continuing these activities is the objective of this SDA.

Training sessions are planned for staff and the community as indicated in SDA 1.5, along with behavior modification communications (CCC) sessions and preventing HIV which are included in SDA 4.1.

As with the other aspects of the DOTS program, monitoring/evaluation, supervision, health education and communications regarding TB/HIV collaboration will be conducted after the appropriate training.

SDA 2.2 MDR-TB

Preventing and fighting multi-drug-resistant tuberculosis (MDR-TB)

Although the number of patients is limited, the problem of MDR-TB must be taken into consideration. Currently in 2008, there are four presumed MDR-TB patients to be treated. Three of these are being treated with second line drugs; the fourth has not yet obtained the drugs, especially the Amikacine, which are not immediately available in São Tomé. The regimen being administered is Amikacine, Ethionamide, Ofloxacine, Pyrazinamide, Ethambutol for three months followed by Ethionamide, Ofloxacine, Ethambutol for 18 months. The medications were purchased by Valle Flor but some problems have been encountered in obtaining some of them, particularly the Amikacine, which a church helped obtain for 2 patients, another patient's family was able to buy the drugs, and the fourth is not being treated because he has not been able to find the Amikacine.

Given the need to be able to provide care for all cases of tuberculosis in the country, including these MDR-TB cases, this proposal calls for putting in place the resources to fight MDR-TB. To this end, the following activities will be undertaken:

2.2.1.1 Organizing a 5-day workshop to analyze the situation and draft a plan to fight MDR-TB in Year 2 with the support of an MDR-TB expert;
2.2.1.2 Organizing a workshop to adapt the technical guide for MDR-TB care in Year 2;
2.2.1.3 Training 15 trainers on MDR-TB, Year 2 (SDA 1.5)
2.21.4 Reproducing 100 copies of monitoring sheets for MDR patients, Year 2 (SDA 1.5);
2.2.1.5 Refurbishing 1 hospital room in the HAM hospital for pneumophtisiology, Year 3;
2.2.1.6 Equipping the pneumophtisiology hospital room in the HAM hospital, Year 3;
2.2.1.7 Acquiring the second line medications for 38 MDR-TB patients over 5 years;
2.2.1.8. Supporting the Green Light Committee initiative;
2.2.1.9. Providing nutritional support for the 38 patients;
2.2.1.10 Providing facilities with 5000 filter masks (model FFP2) for 5 years (pneumology department staff, patients, visitors);
2.2.1.11 Acquiring 2500 surgical type masks for the 38 MDR-TB patients.

The situation will be analyzed in Year 2 of the project with the support of an MDR-TB expert in order to determine the programmatic and clinical aspects that need to be instituted for effective care of MDR-TB cases, including the development of a plan to fight infection. The provision of care for the 50 MDR-TB patients can be broken down as follows: 4 in Year 1, 7 in Year 2, 10 in Year 3, 13 in Year 4, and 16 in Year 5. This care includes a 4-month intensive phase and an 8-month continuation phase.

The 2nd-line drugs (regimen above) for the 38 patients will be purchased in the context of this project after the Green Light Committee approves the MDR-TB care project that will be drafted in the Year 1. Support for the Green Light Committee initiative is justified in order to ensure regular monitoring of the implementation of this proposal. One room in the Pneumophtisiology Department at the HAM hospital will be renovated and equipped for the hospitalization of patients who will require it until they are negative, or for about the first 6 months of treatment. Anti-infection measures will be put in place. Once released from the hospital, these patients will be monitored using the usual monitoring system of the program, for which the staff will have received all necessary training. Nutritional support and incentives (revenue-generating activities, or returning to work, depending on the case) in order to foster the re-entry of these patients into the workforce will be provided as a part of this project. Monitoring/evaluation, supervision, health education, and communications regarding MDR-TB care will be conducted in a similar fashion to the other aspects of the DOTS program after appropriate training.

Goal 3: Helping to strengthen the healthcare systems by implementing the Practical Approach To Respiratory Health (APSR)

SDA 3.1 The Practical Approach To Respiratory Health (APSR)

On São Tomé and Príncipe, in all healthcare facilities, respiratory pathologies have become the primary cause of morbidity and account for about 50% of the reasons for consultations. Care for these patients is not streamlined. The implementation of a global and systematic approach to care for these patients who present respiratory symptoms at primary healthcare facilities will improve the quality of patient care, increase the TB detection rate and improve the quality of diagnosis and treatment. Bringing this approach to São Tomé and Príncipe as a part of this proposal will not only improve the care provided to patients in general but will also improve the care of TB patients.

The Ministry of health is going to set up a national working group (GTN) which will steer all activities involved in introducing this approach. This group will include all main partners: the TB, HIV/AIDS, and malaria programs, the Health for All project, the WHO, clinicians from the HAM hospital, the District Managing Physician, instructors from the school of healthcare. This group will carry out the following activities:

3.1.1 Conducting a study to analyze the situation in the Agua Grande district (a team of 3 investigators will work for 1 week to gather data);

3.1.2 Organizing a 7-day workshop to draft the national APSR directives;

3.1.3 Organizing a consensus workshop on these tools (25 participants for 1 day);

3.1.4 Training staff: doctors and nurses for 3 days in Year 3 (SDA 1.5);

3.1.5 Organizing a workshop to draft the expansion plan for implementing the initiative (6 days, GTN 12 people);

3.1.6 Procuring equipment: 200 peak flow meters and 10 spirometers;

3.1.7 Procuring medications: salbutamol spray and beclometasone (units are considered in SDA 1.2)

These activities will begin in Agua Grande in the third year of the project and will be expanded to the other districts in 2 years.

External technical assistance will be required during the situational analysis, the drafting of the directives and training materials, ended during the training of the trainers. This is discussed in SDA 1.5 (Human Resources Development).

Goal 4: Giving persons stricken with tuberculosis and their communities the ability to act

The successful implementation of the goals and activities called for in this proposal require intensive efforts in the areas of awareness-raising, communications and social mobilization. These efforts will make it possible to fight discrimination and the stigmatizing of TB patients, to give patients the ability to act, to mobilize resources and also to achieve the desired results in terms of detection rates and patient recovery.

SDA 4.1 Advocacy, awareness-raising, communications and social mobilization

The CNE includes a behavior modification communications (CCC) unit. This unit, along with the NGOs, will be tasked with establishing an effective program of awareness-raising, communications and social mobilization that is coordinated with similar efforts in the programs for AIDS, malaria and other diseases that fall under the CNE. To this end, intensive actions will be undertaken, only some of which are listed here.

4.1.1 General activity management

4.1.1.1 Recruiting an NGO to conduct 1 KAP survey in Year 1 and a second in Year 5;

4.1.1.2 Organizing a national meeting of the presentation of the results, Year 1;

4.1.1.3 Hiring an international consultant to draft the communications plan, directives, and communications and awareness-raising materials for a 21-day period in Year 1;

4.1.1.4 Organizing a 5-day workshop to draft the communications plan, directives, and communications and awareness-raising materials for 15 participants, Year 1;

4.1.1.5 Printing 100 copies of the communications plan and 100 copies of the communications directives

4.1.1.6 Assembling 5000 communications kits (5000 posters, 5000 brochures, 100 banners (20 x 5 years), 5000 T-shirts, 5000 caps, 5 videos and 5 giant signs)

4.1.1.7 Producing and broadcasting 10 advertisements for radio and TV and newspapers from Year 1 to Year 5;

4.1.1.8 Organizing a trip to the Parliament to lobby politicians, and government officials and opinion leaders to strengthen the interest generated in TB and to mobilize additional local resources;

4.1.1.9 Organizing World TB Day at the national and district level Year 1 to Year 5;

4.1.1.10 Organizing 140 communications sessions in the communities of the 7 districts (1 per quarter per district) with distribution of awareness-raising materials, and the presentation of videos, plays and sketches produced for this purpose, from Year 1 to Year 5;

4.1.1.11 Organizing 35 communications sessions in secondary schools (1 session per year per district);

4.1.1.12 Organizing 5 communications sessions in churches (once per year);

4.1.1.13 Organizing 5 communications sessions in military garrisons (once per year);

4.1.1.16 Organizing 5 communications sessions in the prison (once per year);

4.1.1.17 Organizing 1 intermural contest in schools on the subject of TB, once per year per district;

4.1.1.18 Organizing 1 television show per quarter on the subject of TB.

Having access to various channels of awareness-raising and communications will be an opportunity to broadcast messages about TB throughout the population. Young people will be a preferred target for these actions. Organizing a contest in the schools is an excellent opportunity to reach this target group. Plans to organize World TB Day in the seven health districts are included in the spirit of decentralizing these activities.

As a part of implementing this SDA, 1 NGO will be hired to conduct a KAP survey when the implementation of this proposal begins in order to analyze the situation and evaluate communications needs. A second survey will be conducted in Year 5 for the purposes of evaluation. Preparing this survey, drafting the survey documents and the specific calendar for rolling it out will be determined by the CCC team. It will be conducted in 1 month and will cover all seven districts.

After the survey data is processed, a national meeting will be organized for the presentation of the results. An international consultant will be hired to draft the communications plan, and the communications and awareness-raising directives and materials.

No additional staff will be hired. Workers from the CCC unit in the NGOs will be responsible for coordinating and conducting the actions involved in awareness-raising, communications and social mobilization in accordance with the communications plan that will be drafted.

All the training has been listed in SDA 1.5 under Goal 1. Contracts will be signed with the NGOs to govern the execution of these activities.

Awareness raising activities will include lobbying politicians, government officials and opinion leaders to strengthen the interest generated in TB and to mobilize additional local resources, organizing the five World TB Days and other awareness raising activities mentioned above, including the visit to Parliament.

Communications activities will include producing and broadcasting ad campaigns that will run in all of the media (radio, TV, print) according to the calendar laid out in the communications plan. Conferences in the schools (1 session per year per district), the churches (once per year), military garrisons (once per year), the prison (once per year) and in the communities will be organized and will include distribution of awareness raising materials, presentation of videos plays and sketches produced for this purpose.

SDA 4.2 Community participation in TB care

In this proposal, special emphasis has been placed on providing anti-TB care focused on the patient within a highly decentralized/integrated framework. In this spirit, a section is devoted to community involvement in the care and prevention of TB. This community participation is intended to: i) improve patient access, either economically or geographically, to TB diagnostic and treatment services; ii) improve identification of suspect cases and directing them to diagnostic centers, as well as patient transport procedures, when necessary; iii) improve the rate of patients actually following their treatment, and reduce stigmatizing. To successfully complete this action, a broad partnership will be set up between the healthcare services and civil society.

The CCC unit of the CNE will steer community involvement un the supervision of the head of the NTCP and with the close collaboration of civil society organizations. The following actions will be taken:

4.2.1.1 Organizing a 5-day workshop to develop the community involvement policy and plan for the fight against TB, Year 3;

4.2.1.2 Organizing a 5-day workshop to draft technical documents specifically designed for the community, Year 3.

Training for healthcare staff, community workers and all stakeholders was discussed in Goal 1, SDA 1.5.

Incentives to motivate community workers will be provided, such as transportation expenses for awareness-raising, transport for sputum samples and searching for patients who are lost to follow-up.

4.5.2. Re-submission of Round 7 (or Round 6) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

National officials believe that as a part of reducing poverty on São Tomé and Príncipe and achieving the MDGs, the fight against TB must hold an important place and that all TB patients, regardless of number, must receive treatment under the best possible conditions. This is why the decision was made to submit a new proposal in an effort to obtain the resources that will make it possible to strengthen the National Program to Fight TB, and to a certain extent the healthcare system generally, and will offer greater accessibility to care for all patients presenting respiratory symptoms, which currently make up 50% of the demand for care in basic healthcare facilities. The additional resources that this proposal will provide will supplement those provided by the government and other partners on the ground.

For this proposal, the guiding principle as the document was drafted was the desire to put in place a DOTS program that complies with the Stop TB Strategy and the global plan for 2006-2015 with the objective of achieving the MDGs. For the budgeting process, the WHO tool that was developed for the global plan was widely used. For local costs (training, workshops, supervision, etc.) the schedules of rates from the local Global Fund management group were used.

Given that integration and decentralization are the project's guiding principles, no construction projects are planned. The infrastructure, equipment and staff already in place will be used at all levels. One renovation project, needed to establish the LNR, is included because having an LNR within the country is absolutely necessary. This LNR for mycobacteria will be a unit of the general LMR which is currently being put in place and will be used for all diseases, AIDS in particular.

Altogether, this proposal, if it is funded, will make a major contribution to the improvement of healthcare on São Tomé and Príncipe. While the number of TB patients here may be relatively small, it still represents a quantity of human suffering and misery that can and must be relieved.

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

This activity plan is inspired by the needs outlined in the strategic plan as well as the accumulated experience gained by implementing the other components funded by the Global Fund, in particular R4 for malaria and R5 for AIDS.

The result of the malaria program, with its numerous partners and excellent coordination under the leadership of the Minister of Health, was a substantial reduction in morbidity and mortality from malaria.

In addition, the result of the implementation of R5/AIDS and the contributions of other partners was a strengthening of the NACP organization and its ability to implement activities. There has been a clear increase and intensification of activities, both those directly related to healthcare and otherwise. Screening and PMTCT were decentralized public down to the level of health stations in the districts, while it is now possible for persons living with HIV to receive ARV treatment in five of the district health centers. The systematic screening of TB patients, the availability of Cotrimoxazol prophylaxis and condoms, and the availability of ARV treatments for eligible patients also inspired us as this proposal was drafted.

The constraints identified with regard to the two grants currently being implemented or as follows: limitations of the local market in terms of procuring a very wide variety of necessary materials, the administrative inadequacies of several sub-recipients, the weaknesses of the current healthcare system and in particular the shortcomings of the monitoring and evaluation system.

The activities of this proposal bear in mind the shortcomings identified in the national strategic plan and listed above; these will be addressed through:

- strengthening the NTCP
- extending the national coverage of the quality DOTS program to the 7 districts

- bringing the diagnostic laboratories at the district and the national-reference levels up to standard
- procurement of first- and second-line drugs
- Refurbishing and equipping the Pneumophtisiology department to provide care for MDR-TB patients.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available tuberculosis diagnosis treatment and care and support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the response between these key population groups).*

The national strategy for gender equality and fairness is a frame of reference and contains a strategic orientation that points to improvement in the general and reproductive health of women, men and adolescents. One of the goals of this strategic orientation is to "ensure that the healthcare sector takes into account the different general and reproductive healthcare needs of men, women and adolescents". The strategies laid out to reach these objectives are as follows: (i) a broad program of information and awareness raising among the target groups; (ii) social mobilization of the populations, and (iii) lobbying leaders and decision makers for active support for the improvement of general and reproductive healthcare for women and adolescents. Going forward, these strategies will need to be applied in the implementation of TB program.

In view of the HIV/AIDS-TB connection, the trend toward more women being affected by the AIDS epidemic, the greater of vulnerability of women compared to men, and the higher rate of illiteracy among women, it will be necessary in the course of implementing a program to: retrain all staff involved in the program in gender issues, whether at the level of the districts or the healthcare facilities; integrate the gender approach in all interventions whether at the Central, District or healthcare facility level; improve the level of information that women, adolescents and men have regarding risk factors and vulnerability. Accordingly, in all actions focusing on advocacy, social mobilization, information and communications, the specific needs of men, women and adolescents, as well as populations in rural areas and the Principe Region, will be taken into account.

The effort will also be made to disaggregate all data by sex, age and urban/rural area, so that epidemiological trends can be seen and appropriate compensatory measures can be taken.

Regarding community involvement in TB care, it will be necessary to see that women and men are equally involved.

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

Question 4.3.2 identified significant weaknesses in the country's healthcare system that impact TB care. These weaknesses concern healthcare staff, services, medicinal products and the management of purchasing and inventories, and the healthcare information system (SIS). To moderate the effect of these weaknesses, this proposal has identified the following activities:

Healthcare staff: this proposal calls for hiring 1 doctor, 1 administrative assistant, and 1 driver and will retrain lab assistants and microscopists in the screening and care of TB patients and healthcare facilities

in the districts (Goal 1, SDA 1.5).

Services: improving geographical access to a quality diagnostic service is one of the major components of this proposal (SDA 1.2): increasing the number of CDTs from 1 to 8, refurbishing and upgrading the technical equipment in existing facilities, in particular the LNR and the Pneumophtisiology department, the provision of materials and reagents for cultures and susceptibility testing.

Medicinal products and management of purchasing and inventories: support for the government's budget through the regular supply of first-line medications obtained through the GDF and second-line medications obtained through this proposal; the acquisition of software for managing inventories at the FNM pharmacy, the CDTs and the NTCP, along with corresponding training for users (SDA 1.2).

The National Healthcare Information System: the weaknesses will be partially compensated by the use of software for managing NTCP data. The NTCP's monitoring/evaluation system makes it possible to send data from the districts to the central level each quarter. So data transmission problems due to the SIS not operating properly will not affect the NTCP. The training of private-sector staff, along with semiannual meetings organized between the NTCP and the private sector, as well as opening CDTs in healthcare units will help improve the completeness and quality of the data gathered.
The availability of management tools like the register, guides and patient files will make it possible to include all facilities in the system for the routine collection of TB-related data.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

This proposal has connections with Round 5-HIV/AIDS, specifically as regards the TB/HIV SDA in the implementation of activities intended to reduce the occurrence of HIV/AIDS among TB patients. Since 2006, Round 5 funding has ensured the availability of counseling and screening for TB patients and Cotrimoxazol prophylaxis. These activities will be broadened to the TB diagnostic and treatment centers and the continuation will be handled by the NACP, just like ARV treatment for eligible TB patients. The same is true for the laboratory assistants already trained in microscopy as a part of that Round who will be retrained for the installation of microscopy labs in the districts.

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

This proposal also has links with the Health for All Project run by the NGO Valle Flor. The goal of that project is to guarantee the quality of universal services and of an integrated package of healthcare (prevention, treatment, and promotion) in São Tomé and Príncipe's seven health districts.

Health for All, which runs for 4 years, should have the following results: i) a structured and functional network of healthcare facilities; ii) integrated patient care; iii) trained district managers; iv) strengthened IEC activities; v) promoting activities for water and sanitation; and vi) improved managerial capacities. To achieve the results, the following actions will be undertaken: functional restructuring of infrastructure and addition of equipment, consumables for diagnostics, drugs and medicinal products. As a part of providing care, the prevention and control of diseases linked to poverty will receive special attention.

As part of the implementation of this proposal, the NGO will provide for the maintenance of the district laboratories, the acquisition of first-line medications (categories I, II and III) and second-line medications for TB until 2011. It also calls for setting up a radiology department in the healthcare facility located in the capital of Ile de Principe. TB suspects will receive x-rays for free. Beginning in 2011, funding from this proposal will be used for the purchase of medications.

The WHO helps train persons involved in the fight against TB and takes care of the experts involved in the implementation of the biennial Work Plans. The WHO also provides funding to the NTCP in the following amounts: USD 31,828 for 2008-2009 and an estimated USD 21,828 for 2010-2011.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

No financial or nonfinancial contribution is expected for this period from the private sector. The CCM will be conducting advocacy actions in the private sector during the term of the proposal to obtain their participation, and the results will be reported systematically.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?)* ➔	Not applicable

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	Contribution Description (*in words*)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach contact, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved tuberculosis service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available.*

Integrating the NTCP into the CNE has made it possible to have access at the central level to the human resources and equipment needed to conduct the managerial, supervisory and monitoring/evaluation activities involved in the fight against tuberculosis (CNE organization chart included in annex).

The decentralization and integration of the activities involved in the fight against tuberculosis at the district level entail the use of human resources and equipment already in place not only for the fight against TB but also for the selection of suspect cases (general practitioners from the healthcare center), and the diagnosis (a well-equipped and well-staffed multipurpose laboratory is in place) and treatment of patients (nurses from the healthcare centers and stations). Anti-TB drugs will be managed along with other essential medications in the pharmacy of the healthcare center. To make treatment available as close as possible to the homes of patients, healthcare stations with nurses, the NGOs, and the community (community-based organizations, community healthcare workers) will take part in the treatment and monitoring of patients as described in SDA 4.2. The “healthcare district”, which is the linchpin of the country's healthcare system, has received a boost not only from the social sector support project (PASS) funded by the World Bank, but also from the Health for All Project run by the NGO Valle Flor.

The major contribution of this proposal to getting results will be securing the financial resources used to fund, among other things:

- training for staff already in place: successive training sessions at the national, district and community levels;
- the procurement of drugs and reagents;
- supervision;
- drafting the required technical documents;
- monitoring/evaluation;
- awareness-raising/communications/social mobilization.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal’s strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

Aware of the magnitude of poverty on São Tomé and Príncipe, in 2002 and the government developed and adopted a national poverty reduction strategy which stipulates, as regards healthcare, that emphasis will be placed on qualitative improvement in the health of the people and their well-being. This proposal is part of the strategic focus of promoting good governance to reduce poverty in the medium and long term through the need to adapt the policy of decentralization, and reorganization of the local and regional administration by strengthening the abilities of the health districts to manage cases of the major endemic diseases, TB in particular. In addition, this proposal contributes to improving the nutritional health of the groups most at risk, by providing nutritional support to patients suffering from TB/HIV co-infection. Moreover this proposal also fits with the strategy of fighting poverty in order to enable the implementation of the national policy to fight tuberculosis, which aims to reduce risks from the disease and to promote fair and universal access to the actions and services that promote, protect and reestablish individual

health by taking into consideration the factors likely to determine and condition the general health status of the people of São Tomé and Príncipe. This proposal also helps to guarantee access to specialized care by building the capacities of the laboratory at the Dr. Ayres de Menezes Hospital in terms of conducting culture examinations on site. It also fits with the strategic objective of establishing the conditions necessary for the population to exercise independence in adopting the attitudes, behavior and practices that help to improve and reserve good health by promoting social mobilization, information and health education

The national health policy described in the National Health Development Plan (PNDS) for 2001-2005, while recognizing the social nature of healthcare services as a factor in development, social justice and the fight against poverty, set seven specific goals including one dealing with undertaking actions that promote the fight against the diseases most responsible for morbidity and mortality in the country (see pp 24, 49). These diseases include malaria, AIDS and tuberculosis which, pursuant to the 2001 Declaration of African Heads of State and Government in Abuja, all African states considered to be poverty-based diseases.

The efforts of programs fighting malaria, HIV/AIDS and tuberculosis help reduce morbidity and mortality from these diseases, which in turn promotes economic development. The programs for malaria and HIV/AIDS have already received grants from the Global Fund (R4 and R5, respectively) which have allowed them to make appreciable progress toward reaching the MDGs. As a result, joint TB/HIV activities have been possible, including systematically offering HIV testing to TB patients after counseling, treatment with ARVs for co-infected TB patients who need them, and screening for TB among persons living with HIV. The funding received based on this proposal will help achieve the MDGs and the objectives of the Stop TB Partnership, while at the same time strengthening the fight against TB/HIV co-infection, care for MDR-TB patients, and community involvement in the fight against TB.

This request is perfectly in line with the Stop TB Strategy and the Global Stop TB Plan to which this country subscribes and which has served as a basis not only for drafting the national anti-TB policy and the 2006-2011 strategic plan, but this proposal as well. The implementation of this proposal will make it possible to develop a broader partnership involving healthcare staff, NGOs and the communities (community-based organizations, community health workers, opinion leaders) in an effort to improve the quality of care for all TB patients in the country. This care will take into account all relevant aspects, including TB/HIV co-infection and multi-drug-resistant TB.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national tuberculosis outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

The National Health Information System (SIS) is not very functional but efforts are being made by the Ministry of Health to get it up and running. Without such a system, programs and services have had to set up their own system to meet their needs for data for planning, monitoring and evaluation. For example in 2007, as part of its institutional reinforcement, the CNE acquired a monitoring and evaluation unit and the anti-malaria and AIDS programs are already benefiting from its services.

An evaluation conducted recently in the context of the implementation of these two programs identified the strengths and weaknesses of the monitoring and evaluation system that the CNE put in place for these two diseases. The system's strengths were the following:

- having monitoring and evaluation plans that are in tune with the national strategies for these two diseases;
- operational data collection facilities for the district's (district epidemiology managers)
- development of an integrated approach among all players (public and private sectors and the NGOs) at the various levels for the two diseases;
- organization of monthly meetings for analyzing and validating the data;
- increasing staffing levels at the central and district levels.

In spite of these strengths, the evaluation also found some weaknesses with the system, in particular:

- the results of the implementation are not sufficiently distributed;
- the reporting system for services is still weak and does not eliminate double reporting;
- a lack of indicators on the socioeconomic situation, and tools for evaluating customer satisfaction;
- reports are not produced on time.

The NTCP's current monitoring and evaluation system is weak. It operates at two levels:

- the peripheral level (districts) where the main activity is data collection done by the district epidemiology managers. These data (the number of cases notified) are sent to the epidemiology department at the Healthcare Directorate where monthly epidemiological reports are drafted, without any coordination with the NTCP;
- the HAM level, where data are collected by nurses from the Pneumophtisiology department and then later retrieved from the register by the Director of the NTCP, who himself then writes the quarterly reports;
- supervisory visits, conducted by the NTCP manager, are nearly nonexistent. There are no data validation sessions.

The primary weaknesses of the NTCP's M&E system are:

- it is unstructured;
- there is no monitoring and evaluation plan that is in line with the national anti-TB strategic plan;
- the system is inadequate in terms of electronic data management;
- supervisory visits are insufficient;
- reports are often incomplete and late.

These weaknesses will be addressed once the NTCP is effectively integrated into the CNE.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

All of the results and indicators of this proposal will be input using the CNE information system already in place.
The screening and treatment centers (CDTs) that make up the first level of data collection on morbidity and mortality associated with tuberculosis will have management tools revised in compliance with the WHO recommendation. At this level those tools include: the TB declaration register, the laboratory register, treatment forms and drug order forms, and the quarterly reports on screening and treatment results. Once compiled and analyzed the data will be sent on a quarterly basis to the Central Monitoring and Evaluation Unit of the CNE, where the national level quarterly and annual reports are drafted.
So the schedule for collecting and monitoring data is as follows:

- data are collected monthly at the health center and sent to the district CDTs
- data are collected monthly from the pneumophtisiology department and sent to the monitoring and evaluation unit of the CNE
- data are collected monthly from the LNR and sent to the monitoring and evaluation unit of the CNE
- data are collected monthly from the FNM and sent to the monitoring and evaluation unit of the CNE
- data are collected monthly from activities conducted by the NGOs and the Community health workers and are sent the District Managing Physician and the monitoring and evaluation unit of the CNE
- the districts compile and analyze the data on a quarterly basis
- the Pneumophtisiology department at the HAM compiles and analyzes the data on a quarterly basis
- the LNR compiles and analyzes the data on a quarterly basis
- the FNM compiles and analyzes the data on a quarterly basis
- the CNE compiles and analyzes the data on a quarterly basis and sends them to the WHO

The other data sources are primarily:

- the annual LNR activity report
- the annual report on the country's health situation
- the general census on population and housing
- the WHO's global TB report

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

Improvements in the monitoring and evaluation system included in this proposal are as follows:

Information system

In this proposal, shortcomings in the information system that might interfere with impact measurement are taken into account by:

- the reproduction and distribution of data management tools
- drafting patient monitoring forms
- acquiring data software
- training in the use of data software

These activities make it possible to strengthen reporting of the data that make up the national system.
The PR's management unit already has very substantial experience in collecting and analyzing data and generating reports, but it does not have a training plan to strengthen data management capacities for sub recipients and especially to avoid double counting at service delivery points. Quality control is not in place.

Supervision

The following actions will be taken to compensate for the known weaknesses in the monitoring and evaluation system:

- NTCP will organize quarterly supervisory visits.

Communications

To get the data for the report expeditiously, the community health workers and the *RDE*s will use the transportation provided to them as a part of the various programs. To improve communication as well, this proposal calls for strengthening the NTCP by acquiring a vehicle.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	UNDP
Address	UNDP, Avenue des Nations Unies, São Tomé et Principe POB 109 , São Tomé Tel : 00 239 221 122

FAX : 00 239 222 198

Email : antonio.viegas@undp.org

Given that the CCM has decided that the PR for this project will be the UNDP, that organization will apply the same management methods that have already been proven in the implementation of the credits allocated to Round 4 of the malaria program and Round 5 of the AIDS program. Last year that good performance was an argument in favor of choosing the UNDP as PR for Round 7 awarded to the malaria program, as no other institution among the NGOs and government services was in a position to compete against it, even up to the present.

PR 2 [Name]

Address [street address]

[Description]

PR 3 [Name]

Address [street address]

[Description]

➔ ***Copy and paste tables above if more than three Principal Recipients***

4.9.2 Sub-Recipients

(a) Will sub-recipients be involved in program implementation?

- ☉ Yes
- ○ No

(b) **If no**, why not?

(c) **If yes**, how many sub-recipients will be involved?

- ☉ 1 – 6
- ○ 7 – 20
- ○ 21 – 50
- ○ more than 50

(d) Are the sub-recipients already identified?
(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)

- ○ Yes

[Insert Annex Number for list]

- ☉ No

Answer s.4.9.4. to explain

(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program

delivery at the sub-recipient level, please explain why.

MAXIMUM TWO PAGES

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

The selection of sub-recipients is not altogether complete, but it is assumed that most of the current SRs from R4/Malaria and R5/AIDS will work in the TB program since the results of their services have been satisfactory up to the present. Several new SRs will be considered as potential candidates for the various activities after a committee made up of the PR, CNE and WHO evaluates their abilities.

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

The SR that will be in charge of procurement and distribution of drugs and laboratory products will operate based on purchasing specifications provided by the NTCP using an operational action plan. The RP, the SR and the NTCP will take part in the call for tenders process. Monthly follow-up meetings are scheduled. All of this is set out in the context of joint action set up as a partnership agreement between the PR and the SR.

The PR will delegate the implementation of planned technical activities to the yet to be determined SRs, and will be conducting supervision on the quarter the basis. In this way, results will determine future disbursements.

Support from partners in project implementation

For the implementation of activities, the WHO will provide the assistance of its technical staff on the biennial plans with the country.
The Health for All Project will provide 1st-line medications until 2010.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

The implementation of this proposal presents some problems in terms of professional skill sets, given the shortage of adequate training for healthcare staff, NGOs and community health workers in the area of TB management.

This proposal calls for strengthening capacities of the primary players involved in TB patient care including those with TB/HIV co-infection and MDR-TB. This involves staff from the districts, the pneumophtisiology department at the HAM, the reference laboratories and the FNM.

The NTCP will be strengthened to obtain better performance in the management of TB cases. Needs in terms of assistance have been identified based on a situational analysis and international consultants will be hired in accordance with international “call for tenders” procedures.

As a part of the implementation of this proposal, the following technical assistance is planned:

- One external project for monitoring/evaluating the implementation of the activities funded by the Global Fund. This will make it possible to identify problems and solutions in this area;
- Training in the estimation of needs in terms of second-line drugs;
- Training in the use of software for managing anti-TB drug inventories;
- Hiring an international consultant to revise the directives on care for MDR-TB patients.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?

☐ **No**
➔ ***Go to s.4B if relevant, or direct to s.5.***

☒ **Yes**
➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Ministry of Health, Healthcare Directorate (National Medication Repository (FNM))	Sub-recipient	☐ Yes ☒ No
Intellectual property rights	NA	NA	☐ Yes ☒ No
Quality assurance and quality control	Pharmaceutical Dept of Healthcare Directorate	Agent in charge of Pharmaceutical Inspection	☒ Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	UNDP	PR	☐ Yes ☒ No
Product selection	NTCP	Sub-recipient	☐ Yes ☒ No
Management Information Systems (MIS)	M&E unit of CNE and National Medication Repository (FNM)	Agent in charge of M&E Sub-recipient	☐ Yes ☒ No
Forecasting	NTCP	Sub-recipient	☐ Yes

			☉	No
Procurement and planning	UNDP	PR	○	Yes
			☉	No
Storage and inventory management *More details required in s.4.10.4*	National Medication Repository (FNM)	Sub-recipient	○	Yes
			☉	No
Distribution to other stores and end-users *More details required in s.4.10.4*	National Medication Repository (FNM)	Sub-recipient	○	Yes
			☉	No
Ensuring rational use and patient safety (pharmacovigilance)	Pharmaceutical Dept of Healthcare Directorate	Agent in charge of monitoring rational use of medications at Ministry of Health level	☉	Yes
			○	No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
National Medication Repository (FNM)	Sub-recipient	**(USD 213,321.30) for 2007**

[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

This proposal relies on the existing national-level procurement system for vital drugs. Thus the national medication repository (FNM) will play the role of supply and distribution agent. The system is currently being strengthened as part of the implementation of the Global Fund's Round 4/Malaria and Round 5/HIV/AIDS projects.

As a part of this effort an administrative assistant has been hired to support the FNM in supervising and controlling the inventory of pharmaceutical and medical products. The pharmaceutical and medical products that will be acquired in the context of this proposal will be integrated into this system.

There currently is no drug monitoring system and this is one of the weaknesses of the national pharmaceutical sector. To better understand the situation, the Ministry of Health conducted a first evaluation in 2007 at the institutional level on the structure and process involved. A second evaluation on access to vital drugs and the rational use of medications is underway. The factual data obtained from these two studies will serve as the basis for defining a national pharmaceutical policy and the implementation strategy.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

- [x] National medical stores or equivalent
- [ ] Sub-contracted national organization(s) *(specify)*
- [ ] Sub-contracted international organization(s) *(specify)*
- [ ] Other: *(specify)*

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

Regarding infrastructure and logistics, the FNM has two large warehouses, outfitted with shelving that allows for storing a maximum of products, and their ideal arrangement vertically. These facilities are able to absorb the additional volumes planned for. Plans also call for hiring an administrative assistant and assistance with fuel, to run the generators when the electricity goes out, as it very often does in this country, and to distribute medications.

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

Currently the both the district health facilities and the HAM are supplied by the FNM. So the entire population has access to medications through these healthcare facilities. Services and programs that need medications from the FNM withdraw them by their own means.

This proposal calls for purchasing and distributing 1st- and 2nd-line anti-TB drugs for TB patients, including MDR-TB cases, as well as lab consumables and reagents, over the last 3 years.

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-Tuberculosis' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-Tuberculosis' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	☉ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.* ☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the HIV or malaria proposal*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

Clarified table 5.1.

➔ *Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.*

Analyse des écarts financiers *(même devise qu'en couverture du Formulaire de proposition)* **Remarque : ➔ Ajustez les en-têtes des tableaux** (autant que nécessaire) **d'années calendaires en exercices budgétaires (par ex., fin EB 2007 ; etc.) pour aligner la planification annuelle sur les exercices budgétaires**								
	Réelles		**Prévues**		**Estimées**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Le financement d'un programme Tuberculose doit permettre de fournir des services de diagnostic, de traitement, de soins et de soutien complets aux populations ciblées								
Ligne A ➔ Indiquez les montants annuels	$ 330,407	$94, 770	$86,784	$935,964	$ 583,550	$883,454	$389,822	$392,563
Ligne A.1 ➔ Total pour la durée de la demande de financement de la série 8 *(besoin total sur la durée de la proposition de série 8)*								**$3,186,353**
Ressources actuelles et futures pour répondre aux besoins financiers								
Source nationale **B1** : Prêts et allégements de dette (*indiquez le nom du bailleur de fonds)*	0	0	0	0	0	0	0	0
Ressource nationale **B2** : Sources de financement nationales	$192,222.0	$146,937.0	$260,097.0	$249,297.0	$93,117.0	$41,997.0	$43,797.0	$45,597.0
Ressource nationale **B3** : Contributions du secteur privé (national)				0	0	0	0	0
Total des entrées de la Ligne B ➔ Total des ressources NATIONALES (allègements de dette inclus) actuelles et prévues :	$192,222.0	$146,937.0	$260,097.0	$249,297.0	$93,117.0	$41,997.0	$43,797.0	$45,597.0

ROUND 8 – Tuberculosis

Analyse des écarts financiers *(même devise qu'en couverture du Formulaire de proposition)*

Remarque : ➔ Ajustez les en-têtes des tableaux (autant que nécessaire) **d'années calendaires en exercices budgétaires (par ex., fin EB 2007 ; etc.) pour aligner la planification annuelle sur les exercices budgétaires**

	Réelles		Prévues		Estimées			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Ressource extérieure **C1** (OMS)	$35,453.0	$25,453.0	$20,914.0	$10,914.0	$10,914.0	$10,914.0	$10,914.0	$10,914.0
Source extérieure **C2** (Valle Flor)	0	7934	7934	7934	7934	7934	7934	7934
Ressource extérieure **C3** Contributions du secteur privé (international)				0	0	0	0	0
Total des entrées de la Ligne C ➔ Total des ressources EXTÉRIEURES (subventions du Fonds mondial exclues) actuelles et prévues :	**$35,453.0**	**$33,387.00**	**$28,848.0**	**$18,848.0**	**$18,848.0**	**$18,848.0**	**$18,848.0**	**$18,848.0**
Ligne D : Montant annuel de toutes les subventions du Fonds mondial existantes pour la même maladie : Incluez les montants non approuvés de "Phase 2" en tant que montants "prévus" dans les années correspondantes	**0**	**$3,245.0**	**$3,245.0**	**$3,245.0**	**$3,245.0**	**0**	**0**	**0**
Ligne E ➔ Total des ressources actuelles et envisagées (c-à-d. Ligne E = total Ligne B + total Ligne C + total Ligne D)	**$227,675.0**	**$183,569.0**	**$292,190.0**	**$271,390.0**	**$115,210.0**	**$60,845.0**	**$62,645.0**	**$64,445.0**

Calcul des écarts en ressources financières et synthèse du financement total demandé dans la série 8 ***(joindre un budget détaillé)***

ROUND 8 – Tuberculosis

Analyse des écarts financiers *(même devise qu'en couverture du Formulaire de proposition)*

Remarque : ➔ Ajustez les en-têtes des tableaux (autant que nécessaire) **d'années calendaires en exercices budgétaires (par ex., fin EB 2007 ; etc.) pour aligner la planification annuelle sur les exercices budgétaires**

	Réelles		Prévues		Estimées			
	2006	2007	2008	2009	2010	2011	2012	2013
Ligne F ➔ Total de l'écart de financement (c.-à-d. Ligne F = Ligne A - Ligne E)	$ 102,732	- $ 88,799	- $ 205,406	$664,574	$ 468,340	$ 822,609	$327,177	$ 328, 118
Ligne G = Demande de financement Tuberculose de la série 8 *(même montant que dans le tableau 5.3 pour cette maladie)*				$ 664,574	$ 468,340	$ 822,609	$ 326,177	$ 327,118

Partie H - Calcul du "partage des coûts" pour les candidats à revenu moyen inférieur et à revenu moyen supérieur

Pour la série 8, la demande de financement maximum totale pour la tuberculose dans la Ligne G correspond à :

*(a) Pour les **pays à revenu moyen inférieur**, un montant tel que la contribution totale du Fonds mondial (toutes subventions) au programme national ne dépassant pas 65 % des besoins en financement du programme national de lutte contre la maladie sur la durée de la proposition ; et*

*(b) Pour **les pays à revenu moyen supérieur**, un montant tel que la contribution totale du Fonds mondial (toutes subventions) au programme national ne dépassant pas 35 % des besoins en financement du programme national de lutte contre la maladie sur la durée de la proposition.*

Ligne H ➔ Calcul du partage des coûts en pourcentage (%) du financement total du Fonds mondial

Partage des coûts = $\frac{\text{(total des entrées de la Ligne D sur la période 2009-2013 + total de la Ligne G) X 100}}{\text{Ligne A.1}}$

% Non Applicable

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensues that government, non-government and community needs were included to ensure fully implementation of country's tuberculosis program and strategy.

Needs were calculated based on the national TB control strategy for 2007-2011. It must be noted that the strategic plan does not account for costs related to human resources, either in place or those to be hired. Other fixed costs like water, electricity, office consumables, transportation, and communications, as well as social mobilization – a component critical to the success of this program – are not explored in detail in this document.

For the basic national data, the high cost of hospitalization paid for by the government as a result of not implementing the DOTS strategy was considered; thus the trend is expected to reverse with the implementation of this proposal.

Budgeting for this proposal did take into account the needs of the governmental sectors like the NTCP, the FNM and the health districts. The needs of the NGOs that will be entailed in implementing this proposal were also taken into account, especially those related to building human resource capacities through training in order to properly carry out the program's activities.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

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

The fight against TB is one of the nation's top disease-fighting priorities and is included in the National Poverty Reduction Strategy (SNRP) as well as documents such as the 2007-2010 policy option which is one of the fundamental documents used for drafting the government budget each year. Resources coming from debt reduction are by law directed first to the social sectors, specifically education and health. The government is making a substantial contribution in the context of this proposal for patients which does not have to be paid back. Care for hospitalized patients is free. Activities sponsored by the World Bank as part of the social secteur support project (PASS) fall within the context of debt reduction. These activities will make an indirect contribution to the implementation of this project because the district infrastructures that are refurbished and equipped (notably the healthcare centers and stations and a few community stations) will be used in the course of this project, as will the computer workstations made available to the district teams and the transportation provided for patient referrals. The NTCP did not receive direct funding for these activities as a part of debt reduction.

To ensure that the nation's resources are used transparently, fairly and in a way that can guarantee the implementation of treatment strategies, diagnostics and care at the national and district levels, a "Big Options" government plan and a request for corresponding funds to implement it, have been submitted to the Parliament. Once approved, the funds will be made available to the central, regional and district levels so they can implement their annual programs. The government must systematically send a copy of its annual technical and financial report to the National Audit Office.

The goal of this project is to extend the government's efforts to expand the DOTS strategy and improve service coverage for diagnosis and treatment. The population of the seven districts is taken into account. This approach will make possible quality care for patients as close as possible to where they live. The SRs will send technical and financial reports on implementation to the PR and regular

audits are planned.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1
Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time)*. Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).
During the term covered by this proposal, some changes are expected which will result in reduced contributions from external sources. In 2011, funding for the Health for All Project, provided by the Portuguese Cooperative and implemented by the NGO Valle Flor, will come to an end, ending with it 1st-line drug funding and support for the districts. In fact, as this proposal was being planned, attention was focused on avoiding delays that could create problems for the implementation of activities and the provision of care to patients. To avoid this problem, the drug procurement process, previously handled by the Health for All Project, should start in the third quarter of 2009, to ensure that medications are available before the end of the Health for All Project.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

ROUND 8 – Tuberculosis

5.3. Summary of detailed budget by objective and service delivery area

Clarified table 5.3.

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	SDA 1.1	48,259.00	54,302.00	363,877.00	23,192.00	23,329.00	512,959.00
1	SDA 1.2	76,983.00	30,765.00	84,620.00	46,589.00	47,394.00	286,351.00
1	SDA 1.3	11,270.00	4,285.00	-	-	-	15,555.00
1	SDA 1.4	96,100.00	44,625.00	20,716.00	20,716.00	20,716.00	202,873.00
1	SDA 1.5	159,282.00	125,697.00	87,495.00	31,050.00	27,000.00	430,524.00
2	SDA 2.1	6,332.00	3,720.00	3,216.00	3,216.00	3,216.00	19,700.00
2	SDA .2.2	102,763.00	108,246.00	134,165.00	103,714.00	103,763.00	552,651.00
3	SDA 3.1	77,800.00	26,800.00	44,050.00	26,800.00	26,800.00	202,250.00
4	SDA 4.1	85,785.00	69,900.00	76,900.00	71,900.00	75,900.00	380,385.00
4	SDA 4.2	-	-	8,570.00	-	-	8,570.00
	[use "Add Extra Row Below" from "Table" menu in Microsoft Word menu bar to add as many additional rows as required]						
Round 8 tuberculosis funding request:		664,574.00	468,340.00	822,609.00	326,177.00	327,118.00	2 ,608,818.00

ROUND 8 – Tuberculosis

5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	36,600	36,600	40,800	40,800	40,800	195,600
Technical and Management Assistance	25,630	10,270	15,270	0	0	51,170
Training	145,556	119,466	133,775	32,050	28,000	458,847
Health products and health equipment	152,110	107,350	103,707	76,685	76,824	516,676
Pharmaceutical products (medicines)	52,536	53,962	61,410	61,410	61,772	291,090
Procurement and supply management costs	45,718	43,089	81,030	29,986	30,427	230,250
Infrastructure and other equipment	52,800	0	281,650	0	0	334,450
Communication Materials	66,900	69,900	71,900	71,900	71,900	352,500
Monitoring & Evaluation	76,113	25,226	30,886	11,116	15,116	158,457
Living Support to Clients/Target Populations	263	461	165	214	263	1,366
Planning and administration	10,348	2,016	2,016	2,016	2,016	18,412
Overheads	0	0	0	0	0	0
Other: *(Use to meet national budget planning categories, if required)*	0	0	0	0	0	0
Round 8 tuberculosis funding request (*Should be the same annual totals as table 5.2*)	664,574	468,340	822,609	326,177	327,118	2,608,818

5.4.1. Overall budget context

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

The cost categories with significant variations are pharmaceutical products, medical equipment, and training.

Setting up the district laboratories during the first two years with the acquisition of equipment for the seven districts and setting up the culture laboratories by equipping the HAM laboratory in the third year explains this variation.

As for training, that is focused in the first three years. The first two years are devoted to training, to ensure that resources are ready to take on the challenge of extending DOTS coverage, including doctors, nurses and the managers who will have to address social mobilization.

An important variation in the totals in the third year is explained by costs in the following categories: infrastructure and other equipment, medicinal products and training. Implementing laboratories by refurbishing and equipping the HAM laboratory and training to HAM technicians for 1 month in a Portuguese-speaking country on cultures and susceptibility testing. This is also planned for infrastructures for the care of MDR-TB patients and support from the Green Light Committee.

5.4.2. Human resources

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

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

For this proposal the "human resources" category accounts for only about 7.5% of the total cost of the project.

5.4.3. Other large expenditure items

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

➔ *Attach supporting information as a clearly named and numbered annex*

5.5. Funding requests in the context of a common funding mechanism

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

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
NA
5.5.2. Measuring performance How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
5.5.3 Additionality of Global Fund request Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.*
NA

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 8

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 8 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions

Down load 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 8 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Tuberculosis Proposal checklist

Section	Document description	Annex Number
4.5.1	List of microscopy lab consumables	Annex 6
4.5.1	List of standard equipment for microscopy lab	Annex 7
4.5.1	List of equipment for the HAM culture lab	Annex 8
4.5.2	WHO STOP TB Planning and Budgeting for TB control	Annex 9

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Sao Tome and Principe
Disease:	Tuberculosis
Proposal ID:	Strengthening of national response to TB

Program Goal, impact and ouctome indicators

	Goals
1	Reduce tuberculosis morbidity and mortality in Sao Tome and Principe to meet the MDG and objectives of the Stop TB partnership
2	
3	
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	TB prevalence rate	345/100000	1990	WHO 2008 report					172/100000	The baseline indicator represents the estimation from WHO for the country as per the WHO 2008 report. In order to have the real data, a prevalence survey is planned in year 3.
outcome	Case detection rate: new smear positive TB cases	36/72	2006	WHO 2008 report	75%	85%	90%	95%	100%	Calculated on the basis of estimates from WHO 2008 report.
outcome	Treatment success rate: new smear positive TB cases	98%	2006	WHO 2008 report	98%	98%	98%	98%	98%	this indicator will need to be revised every year according to the real number of patients healed.
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* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Objective 1: Carry out expanding and improving a high-quality DOTS strategy	
2	Objective 2: Fighting TB/HIV co-infection, MDR-TB and confronting other challenges	
3	Objective 3: Contribute to strengthening the health system by setting up the practical approach to lung health (APSR)	
4	Objective 4: Give TB patients and communities the ability to act.	
5		
6		
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Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Sao Tome and Principe
Disease:	Tuberculosis
Proposal ID:	Strengthening of national response to TB

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	Improving diagnosis	Number of district laboartories qu' efectue l' examen microscoipique de crachat	0	2008	R&R TB system, quarterly reports	2	2	2	1	0	0	0	Y	Y	N - not cumulative	UNDP	quarterly reports
1.2	Improving diagnosis	number of district laboratories which participated in at least 4 external quality control tests of smear test microscopes.	0	2008	R&R TB system, quarterly reports	2	4	6	7	7	7	7	Y	Y	Y - cumulative annually	UNDP	quarterly reports
1.3	M&E	number of districts who send their reports by the deadline in line with national regulations.	0	2007	R&R TB system, quarterly reports	2	4	6	7	7	7	7	Y	Y	Y - cumulative annually	UNDP	quarterly reports
1.4	Procurement and supply management (First line drugs)	number of units managing cases of tuberculosis which have said that they are out of stock in first or second line drugs leading over the years to an interruption in treatment compared to the total number of units	1	2007	R&R TB system, quarterly reports	0	0	0	0	0	0	0	Y	Y	Y - over program term	UNDP	yearly reports
1.5	M&E	% of monitoring visits carried out with documented reports compared to the number of visits planned over one year	0	2008	R&R TB system, quarterly reports	5/6 (83%)	5/6 (83%)	100%	100%	100%	100%	100%	Y	Y	Y - over program term	UNDP	quarterly reports
1.6	M&E	Usage of monitoring list (o/n)	n	2008	R&R TB system, quarterly reports	O	O	O	O	O	O	O	Y	Y	Y - over program term	UNDP	quarterly reports
1.7	HSS: Health Workforce	% of health establishments having at least one person in their staff who can treat tuberculosis patients	1/32	2008	R&R TB system, quarterly reports	**19/32**	**19/32**	**32/32**	**32/32**	**32/32**	**32/32**	**32/32**	Y	N	Y - over program term	UNDP	yearly reports
1.8	Improving diagnosis	% of facilities in health establishments which have carried out at least one transport of spit samples to districts	0	2008	R&R TB system, quarterly reports	**15%**	**25%**	**35%**	**50%**	**75%**	**85%**	**95%**	Y	N	Y - over program term	UNDP	yearly reports
2.0	TB/HIV	Number of TB patients who are benefiting from HIV screening	40%	2007	R&R TB system, quarterly reports	80%	98%	98%	98%	98%	98%	98%	Y	Y	Y - cumulative annually	UNDP	yearly reports
2.1	TB/HIV	Number of TB patients who are benefiting from prophilaxy with co-trimoxazole	100%	2008	R&R TB system, quarterly reports	100%	100%	100%	100%	100%	100%	100%	Y	Y	Y - over program term	UNDP	yearly reports
2.2	TB/HIV	Number of health establishments and or meeting places implementing measures against tuberculosis (administrative and environmental measures in line with national regulations)	0	2008	R&R TB system, quarterly reports	**19/32**	**19/32**	**32/32**	**32/32**	**32/32**	**32/32**	**32/32**	Y	Y	Y - over program term	UNDP	yearly reports
3.0	PAL (Practical Approach to Lung Health)	Number (%) of establishments with activities in this area	0	2008	Système d'E&R (enregistrement et reporting) relatif à la tuberculose, rapports trimestriels	0	0	0	0	5/32	13/32	28/32	Y	Y	Y - over program term	UNDP	reports, surveys
3.1	PAL (Practical Approach to Lung Health)	number (%) of cases of lung diseases amongst ambulatory patients who are managed correctly in health establishments (in the national health information system)	0	2008	R&R TB system, quarterly reports	0	0	0	0	50%	75%	95%	Y	N	Y - over program term	UNDP	
																UNDP	
4.0	ACSM (Advocacy, communication and social mobilization)	% of people who have a correct knowledge of TB	ND	2008	R&R TB system, quarterly reports	etude				50%		80%	Y	N	Y - over program term	UNDP	
4.1	ACSM (Advocacy, communication and social mobilization)	number of patient charts distributed	0	2008	TB treatment card	0	0	0	100%	100%	100%	100%	Y	N	Y - over program term	UNDP	
4.2	ACSM (Advocacy, communication and social mobilization)	number of communities having benefited from BCC sessions (Behavior Chance Communiation)	0	2008	R&R TB system, quarterly reports	30	30	30	30	120	120	120	Y	Y	Y - over program term	UNDP	reports
4.3	Community TB care	number and % of case management in the community during the entire period of treatment	0	2008	R&R TB system, quarterly reports				25%	50%	75%	80%	Y	Y	Y - over program term	UNDP	YEARLY REPORTS
4.4	Community TB care	number (%) of community health posts which have raised anomalies within their diagnosis services	0	2008	R&R TB system, quarterly reports	0	25%	35%	45%	50%	75%	80%	Y	N	Y - over program term	UNDP	
4.5	Community TB care	number of community health posts which are organizing TB awareness-raising sessions	0	2008	R&R TB system, quarterly reports	0	25%	35%	45%	50%	75%	80%	Y	N	Y - over program term	UNDP	