PROPOSAL FORM

SIXTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Sixth Call for Proposals for grant funding. This Proposal Form should be used to submit proposals to the Global Fund. **Please read the accompanying Guidelines for Proposals carefully before filling out the Proposal Form**.

Timetable: Sixth Round

Deadline for submission of proposals: 3 August 2006
Board consideration of recommended proposals: 31 October - 3 November 2006

Resources available: Sixth Round

As of the date of the Sixth Call for Proposals, the funding available for this Call is forecast to be in the range of US$ 0 to US$ 565 million, depending mainly on the amount and timing of new pledges to the Global Fund. The amount forecast to be available will be updated on the Global Fund website.

Geneva, 5 May 2006

Index

PROPOSAL SECTIONS FOR COMPLETION BY APPLICANTS

ATTACHMENTS TO THE PROPOSAL FORM FOR COMPLETION BY APPLICANTS

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

B. Preliminary Procurement List of Drugs and Health Products

A list of all annexes to be attached to the Proposal Form by the applicant can be found at the end of sections 3 and 5 the Proposal Form

OTHER REFERENCE DOCUMENTS FOR APPLICANTS

(These and other documents are available at http://www.theglobalfund.org/en/apply/call6/documents/)

Country Coordinating Mechanisms:	The Global Fund's Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility (**CCM Guidelines**)
Monitoring and Evaluation:	Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**)
Procurement and Supply Management:	The Global Fund's "Guide to Writing a Procurement and Supply Management Plan" (**PSM Guide**)

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Guidelines for Proposals (Sixth Call for Proposals)
   - A complete copy of this Proposal Form
   - The Attachments to this Proposal Form.

2. Please read the accompanying **Guidelines for Proposals** before filling out this Proposal Form.

3. For detailed information on how to use the electronic version of the Proposal Form, please see Attachment 4 to the Guidelines for Proposals.

4. In **this Proposal Form** further guidance for completing specific sections is also included in the Form itself, printed in *blue italics*. Where appropriate, indications are given as to the approximate length of the answer. Please try to respect these indications.

5. To **avoid duplication of effort**, we recommend you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

6. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are sending a fully completed proposal.

7. **Attach all documents** requested throughout the Proposal Form.

8. Consult our "Frequently Asked Questions" link: *http://www.theglobalfund.org/en/apply/call6/*

Please note that any information submitted to the Global Fund may be made publicly available.

WHAT IS DIFFERENT COMPARED TO ROUND 5?

The main difference compared to the Round 5 Proposal Form is that **Health Systems Strengthening** is no longer a separate component. It is important to recognize that applicants can still apply for funding for health systems strengthening activities by including such activities in the specific disease components.

In other respects the Round 6 Proposal Form is similar to the Round 5 Proposal Form, and changes have mainly been made for the purpose of improved clarity and presentation.

1 Proposal Overview

1.1 General information on proposal

Applicant Name	Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB control and Prophylaxis Programmes (CCM on TB/AIDS)
Country/countries	Republic of Moldova

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

- ☒ National Country Coordinating Mechanism
- ☐ Sub-national Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including small island developing states)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

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

	Component	Title
☒	HIV/AIDS[1]	Scaling up Access to Prevention, Treatment and Care under the National Program for Prevention and Control of HIV/AIDS/STI 2006-2010
☒	Tuberculosis[1]	Strenghtening tuberculosis control in the Republic of Moldova
☐	Malaria	

Currency in which the Proposal is submitted

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

- ☐ US$
- ☐ Euro

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

1 Proposal Overview

1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding component budget in table 5.1.

Table 1.2 – Total funding summary

Component	Total funds requested (Euro / US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	3,645,486	2,765,586	2,864,861	3,164,584	3,500,194	15,940,711
Tuberculosis	3,359,837	2,427,053	2,194,573	2,075,021	1,920,149	11,976,633
Malaria	0	0	0	0	0	0
Total	7,005,323	5,192,639	5,059,434	5,239,605	5,420,343	27,917,344

1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* (Euro / US$)
HIV/AIDS		
Tuberculosis		
Malaria		
HSS/Other	GF Round 1	11,719,047.00

* *Aggregate all past grants, including approved but as yet unsigned amounts. These amounts should include Phase 2 where this has been approved/signed. For more detailed information, see the Guidelines for Proposals, section 1.3.*

2 Eligibility

Only those Proposals that meet the Global Fund's eligibility criteria will be reviewed by the Technical Review Panel.

Eligibility is a multi-step process that depends on the income level of the country (or countries) applying for funding and, in some cases, disease burden.

Please read through this section carefully and consult the Guidelines for Proposals, section 2, for further guidance on the steps to be followed by each applicant.

2.1 Technical eligibility

2.1.1 Country income level

*Please tick the appropriate box in the table below. **For proposals from multiple countries**, complete the referenced information separately for each country (see the Guidelines for Proposals, section 2.1).*

Country/countries	Republic of Moldova

☒	Low-income	➔ *Complete section 2.2 only*
☐	Lower-middle income	➔ *Complete sections 2.1.2, 2.1.3 and 2.2*
☐	Upper-middle income	➔ *Complete sections 2.1.2, 1.2.3, 2.1.4 and 2.2*

2 Eligibility

2.1.2 Counterpart financing and greater reliance on domestic resources

Please enter information on counterpart financing in table 2.1.2 below if the country(ies) listed above are classified as Lower-middle income or Upper-middle income.

Non-CCM Applicants do not have to fulfill the counterpart financing requirement.

The table should be filled in for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.1.2.

***Important note:** The field "Total requested from the Global Fund" in table 2.1.2 below should equal the request in section 5 and table 5.1 for each corresponding component.*

Table 2.1.2 – Counterpart financing

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
HIV/AIDS	**Total requested** from the Global Fund **(A)** [from table 5.1]	3,645,486	2,765,586	2,864,861	3,164,584	3,500,194
	Counterpart financing (B) [linked to the disease control program]	2,139,111	1,200,000	1,300,000		
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	36.98%	30.26%	31.21%	0.00%	0.00%

2 Eligibility

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Tuberculosis	**Total requested** from the Global Fund **(A)** [from table 5.1]	3,359,837	2,427,053	2,194,573	2,075,021	1,920,149
	Counterpart financing (B) [linked to the disease control program]	516,930	0	0	0	0
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	13.33%	0.00%	0.00%	0.00%	0.00%

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro / US$)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
Malaria	**Total requested** from the Global Fund **(A)** [from table 5.1]	0	0	0	0	0
	Counterpart financing (B) [linked to the disease control program]					
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**	**!Zero Divide**

2 Eligibility

2.1.3 Focus on poor or vulnerable populations

*All proposals from Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or vulnerable population groups. Proposals may focus on both population groups but **must** focus on at least one of the two groups. Complete this section in respect of each component.*

Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal *(Maximum half a page per component).*

2.1.4 High disease burden

Proposals from Upper-middle income countries must also demonstrate that they face a very high current disease burden. Please enter such information in the section below in respect of each component. Please note that if the applicant country falls under the "small island economy" lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Attachment 1 to the Guidelines for Proposals).

Confirm that the country(ies) is(are) facing a very high current disease burden, as evidenced by data from WHO and UNAIDS. *(Please see the Guidelines for Proposals, section 2.1.4 for more information on the definition of high disease burden.)*

2.2 Functioning of Coordinating Mechanism

To be eligible for funding, all applicants, other than Non-CCM Applicants and Regional Organizations must meet the Global Fund's minimum requirements for Coordinating Mechanisms.

For additional information regarding these requirements, see:

- *The Guidelines for Proposals, section 2.2 and*
- *The CCM Guidelines.*

Please note that your application must provide documentation to show how the applicant meets these minimum requirements. You will be asked to re-confirm this in the Checklist at the end of section 3.

2.2.1 Broad and inclusive membership
a) People living with and/or affected by the disease(s) Provide evidence of membership of people living with and/or affected by the disease(s). *(This may be done by demonstrating corresponding Coordinating Mechanism membership composition and endorsement in table 3B1.2, and 3B.1.3 in section 3B of the Proposal Form.)*
People living with HIV/AIDS are represented in CCM on TB/AIDS as of 2005, when the CCM extended its functions from the oversight of Global Fund to Fight AIDS, Tuberculosis and Malaria and World Bank financed programmes to the oversight and monitoring of National Programmes on TB/HIV/AIDS/STI. The nongovernmental sector delegated representatives for the CCM decisional and operational levels during the Forum of NGOs working in TB and AIDS, which took place in April, 4th, 2005, including representatives of people living and/or affected by the disease. The transparecy of the process was ensured by observers from CCM and International organizations and by an open voting. The candidates

selected through the voting procedure at the NGO forum became official members of the CCM through the Government decision nr. 825 from the 3rd of August 2005.
See Attached.
Annex 1/CCM. Government decision Nr. 825 from the 3rd of August 2005 regarding the CCM Terms of Reference (Rom. and Eng.);
Annex 2/CCM. Minutes and decisions of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB;
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006;
Annex 9/CCM. Minutes of the CCM meeting from March 2006;
Annex 11/CCM. CCM membership list, also available on the webpages: www.ccm.md and www.aids.md;
Annex 14/CCM. Minutes of the extended meeting of the Technical Working Group on HIV/AIDS;
Annex15/CCM. Minutes of the extended meeting of technical working groups on TB;
Annex 16/CCM. Minutes of the meeting of the local technical review committees

b) Selection of non-governmental sector representatives

Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.

(Please summarize the process and, for each sector, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the applicable annex number.)

Each CCM member represents a constituency. All nongovernmental sector representatives in the CCM are leaders of networks, unions or NGO facilitator organizations: Soros-Moldova Foundation - NGOs working in HIV/AIDS prevention with vulnerable groups (NGO facilitator); "Tineri si Liberi" – leader of the Social Network (includes AIDS network – information available on www.retea-sida.md); NGO"Credinta" – organizations of people living with HIV/AIDS in Moldova; AIHA - NGOs active in TB; and Red Cross Society in Moldova represents the network of branch organizations throughout Moldova.
The nongovernmental sector selected their representatives for the CCM decisional and operational levels in a democratic and transparent way during the Forum of NGOs working in TB/AIDS fields in April, 4th, 2005, including representatives for people living and/or affected by the disease. See Annex 2 and Annex 8. All NGOs members were approved through the Government decision nr. 825 from the 3rd of August 2005. See Annex 1.
The representatives of international organizations have been delegated to CCM through a UN Theme Group on HIV/AIDS resolution in 2002. See Annex 18.
See Attached:
Annex 1/CCM. Government decision Nr. 825 from the 3rd of August 2005 regarding the CCM Bylaws;
Annex 2/CCM. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB;
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent;
Annex 18/CCM. Minutes of the UNTG on HIV/AIDS from 2002.

2.2.2 Documented procedures for the management of conflicts of interest

Where the Chair and/or Vice-Chair of the Coordinating Mechanism are from the same entity as the nominated Principal Recipient(s) in this proposal, describe and provide evidence of the applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest arising in regard to the applicant's operations or responsibilities.

(Please summarize and attach the policy as an annex. Please indicate the applicable annex number.)

Annex 3/CCM. Policy of conflicts of interests in Republic of Moldova

2 Eligibility

2.2.3 Documented and transparent processes of the Coordinating Mechanism

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

Please describe and provide evidence of the CCM's documented, transparent and established:

a) Process to solicit submissions for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

The decision to apply to the VI round of the Global Fund to fight AIDS, tuberculosis and Malaria was taken during the CCM meeting from the 11th of May 2006. See Annex 7 and Annex 4. The same meeting approved the Development and Approval Mechanism of the Grant Proposal to Global Fund by Republic of Moldova Following the agreed mechanism, the draft proposals were developed by the CCM Technical Working Groups (TWG)., widely and multisectorally represented: representatives of governmental institutions, NGOs, multilateral and biletaral organizations, (the TWG were approved at the CCM meeting from March 2006. See Annex 5.). CCM has 10 functional TWG: 5 - in HIV/AIDS field; 4 – in TB field; one common TB/AIDS– monitoring and evaluation. Every group in HIV/AIDS field has representatives of people living/or affected by the disease (See Annex 8).
The consultation process may be followed in its dynamics on www.aids.md and the results of the discussions are posted on www.ccm.md. Also, information about the sites and solicitation of submissions was published in "Moldova Suverana" newspaper (Romanian language) and "Economiceskoie obozrenie" newsletter (Russian language) at the end of May 2006 (See Annex 6). The information was published in the CCM Info Bulletin (Annex 6). UNAIDS Moldova offered support to incorporate the proposals from the TWG into the national one on the HIV/AIDS component, whereas AIHA Moldova – on Tuberculosis. In parallel, the draft proposals summitted by the TWG were revised in 2 extended meetings of the technical working groups for both TB and HIV/AIDS components (See Annexes 14 and 15).The consolidated proposals were reviewed, discussed and approved by 2 local technical review committees (one for TB and one for HIV/AIDS - responsible chiefs of the TWG, international organizations representatives, PLWA, NGO, representatives from Transnistria region. See Annex 16.
See attached.
Annex 4/CCM. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed;
Annex 5/CCM. CCM decision from March 2006. Approval of TWG;
Annex 6/CCM. The text of CCM information of Global Fund process in the newspapers;
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006.
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent
Annex 14/CCM. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS;
Annex 15/CCM. Minutes on the meeting of the extended meeting of the TWG on TB;
Annex 16/CCM. Minutes on the meeting of the local technical review committees.

b) Process to review submissions received by the CCM for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

The proposal to the Global Fund was developed though the CCM TWG. There are a total of 10 TWG: 5 on HIV/AIDS, 4 on TB and 1 mixed on M&E. The membership of the TWG was approved at the CCM meeting from March 2006. See Annex 5. The TWG are widely and multisectorally represented and are focused on key area objectives. Every group in HIV/AIDS field has representatives of people living/or affected by the disease. See Annex 8. Each of the TWG received submissions, reviewed them, and developed drafts based on the key areas under the National HIV/AIDS/STI/TB Programs. Also, in order to ensure transparency and communication among stakeholders, all submissions, all drafts developed and discussed by the TWG, as well as all the meetings scheduled for discussion have been posted on http://www.aids.md/coordination/consultation/.
The draft proposals of TWG were reviewed in 2 meetings of extended TWG representativeness: one for TB and one for HIV/AIDS components. See Annexes 14 and 15. All the revised proposals were incorporated in a consolidated document with the assistance of UNAIDS Moldova (HIV/AIDS/STI

component) and AIHA (TB component). The consolidated proposals were reviewed, discussed and approved by the 2 local technical review committees (one for TB and one for HIV/AIDS), which include leaders of the TWG, international organizations, PLWA, NGO, etc. See Annex 16.
See attached:
Annex 5/CCM. CCM decision from March 2006. Approval of TWG;
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent
Annex 14/CCM. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS;
Annex 15/CCM. Minutes on the meeting of the extended meeting of the TWG on TB;
Annex 16/CCM. Minutes on the meeting of the local technical review committees

c) Process to nominate the Principal Recipient(s) and **oversee** program implementation.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

Under the previous 5-year Global Fund grant, the managemement and disbursement of fund was carried out through one national organization – Project Coordination, Implementation and Monitoring Unit, Ministry of Health and Social Protection. According to its status, the Unit is subjected to the Ministry of Health and Social Protection and is under the oversight of the CCM.
The discussions related to the principal recipient were held at the CCM meeting from the 11th of May 2006. The detailed discussion is described in the minutes of the CCM meeting from the 11th of May 2005. See Annex 7. It was decided that the principal recipient will remain the Ministry of Health and Social Protection through Project Coordination, Implementation and Monitoring Unit. See Annex 4.
See attached:
Annex 4/CCM. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed.
Annex 7/CCM. Minutes of the CCM meeting from the 11th of May 2006..

d) Process to ensure the input of a broad range of stakeholders, including CCM members and non-CCM members, in the proposal development process and grant oversight process.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

A broad range of stakeholders, represented in the CCM through technical working groups (TWG) developed the drafts of the proposal. The operational level of CCM is functional through 10 TWG: 5 – in HIV/AIDS field and 4 in TB field, 1 mixed on M&E. TWG members are representing different constituencies: government, nongovernament, academic and international organizations, as well as from different regions of the country, including Transnistria region. See Annex 8.
TWG members were responsible to analyse and discuss the proposals submitted by non CCM members. The non CCM members (representatives of private, religiouse, academic, civil society members, mass media) were invited by CCM Secretariat to participate at the elaboration of the proposal through mass media. See Annex 6. The technical working groups met for several times in order to discuss and develop the drafts proposals. All the summaries of the meetings were placed on http://www.aids.md/coordination/ccm/ and www.ccm.md.
See attached:
Annex 6/CCM. The text of CCM information of Global Fund process in the newspapers
Annex 8/CCM. List of CCM Technical working groups members and the institutions they represent

3A Applicant Type

This section contains information on the applicant. Please see the Guidelines for Proposals, section 3A, for more information regarding the nature of different applicants.

All Coordinating Mechanism Applicants *(whether national, sub-national, regional (C)CMs) and Regional Organizations* ***must also*** *complete section 3B of this Proposal Form and provide the documented evidence requested.*

Non-CCM Applicants *do not complete section 3B. These applicants must fully complete section 3A.5 of this Proposal Form and provide documentation as an attachment to this proposal supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism structure.*

3A.1 Applicant

Table 3A.1 – Applicant

Please tick the appropriate box in the table below, and then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table.

National Country Coordinating Mechanism	☐ *complete sections 3A.2 and 3B*
Sub-national Country Coordinating Mechanism	☐ *complete sections 3A.3 and 3B*
Regional Coordinating Mechanism (including small island developing states)	☐ *complete sections 3A.4 and 3B*
Regional Organization	☐ *complete section 3A.5 and 3B*
Non-CCM Applicants	☐ *complete section 3A.6*

3A Applicant Type

3A.2 National Country Coordinating Mechanism (CCM)

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

Table 3A.2 – National CCM: basic information

Name of national CCM	**Date of composition** (yyyy/mm/dd)
Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes	2005/08/03

3A.2.1 Mode of operation

Describe how the national CCM operates. In particular:

- **The extent to which the CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the CCM, and a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number.)

The Country Coordination Mechanism of the National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes (hereinafter CCM) was approved through the Government Decision nr.825, from the 3rd of August 2005. It represents the successor of the CCM for monitoring the TB/AIDS programme, financed by the Global Fund to fight AIDS, TB and Malaria and the World Bank, created in March 2002.

The CCM plays a leading role in coordinating and implementing the country's multisectoral response to the epidemics since its establishment in 2002 and currently counts 22 members: 9 from governmental constituency, 5 – nongovernmental sector, including people living with HIV, 8 – donor, multilateral and bilateral development agencies. See Annex 1.

The CCM aims to contribute to the effective implementation of the National Program for Prevention of HIV/AIDS and the National Program on TB Control, acting as a nexus point for coordinating and overseeing donor financing in support of the national commitment and priorities to fight HIV/AIDS/STIs and TB. CCM has assumed oversight responsibilities for programs funded by the World Bank, the Global Fund, USAID, Swedish governments, and UN agencies ensuring harmonized approach towards achieving the national program goals and Moldova's health-related MDGs. The CCM is an integral part of the "Three Ones" system in the country serving as the national HIV/AIDS and TB coordinating body. CCM approves the national documents elaborated by technical working groups. See Annex 5 and 9. The CCM members meet at least 4 times a year (or more frequently if needed).

The members of the nongovernment sector were selected for both decisional and operational levels through a transparent and democratic process, during the NGO Forum of the nongovernmental organization working in the TB/AIDS field. See Annex 2.

The CCM's structure is organized on three levels: decisional (22 representatives), coordination (CCM Secretariat), and operational (10 technical working groups). The technical working groups (5 active in HIV/AIDS field, 4 in TB field and 1 mixed monitoring and evaluation TB/AIDS) are responsible to assess the needs in their specific areas, to identify solutions, to develop drafts of the national documents, strategies and policies. The technical working groups are widely represented, including nongovernment sector, governmental and international ones, as well as representatives from different regions of the country, including Transnistria.

3A Applicant Type

The Secretariat of the CCM (supported financially by World Bank and UNAIDS) is responsible for the coordination and information activities, as well as facilitating the nation wide consultancy processes, and CCM meetings: information on the CCM processes and news is mostly shared through email, via a daily online newspaper to every CCM member. CCM members are always asked to distribute the materials to their constituencies. There is also a printed quaterly newspaper "CCM Informational Bulletin" distributed to a large range of beneficiaries. See Annex 17. UNAIDS office is providing information related to Global Fund processes via the online daily news distributed through email to a wide range of stakeholders.

In the course of grant implementation the CCM has been contributing to the efficient implementation of the grant in different ways: from timely addressing the implementation constraints, considering and endorsing proposals for utilization of program savings realized due to efficient procurement processes to harmonizing coordination with partners.

See attached:

Annex 1/CCM. CCM Nr. 825, Government decision from the 3rd of August 2005 regarding the CCM Bylaws;

Annex 2/CCM. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB.

Annex 5/CCM CCM decision from March 2006. Approval of TWG;

Annex 9/CCM. Minutes of the CCM meeting from March 2006;

Annex 12. CCM Info Bulletin sample;

Annex 17/CCM. List of Informational Bulletin beneficiaries;

Annex 19/CCM. The diagram setting out the interrelationships between main key actors.

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.3 Sub-national Country Coordinating Mechanism

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

Table 3A.3 – Sub-national CCM: basic information

Name of sub-national CCM	**Date of composition** (yyyy/mm/dd)

3A.3.1 Mode of operation

Describe how the sub-national CCM operates. In particular:

- **The extent to which the sub-national CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the sub-national CCM, and a diagram setting out the interrelationships between all key actors as an annex to this proposal. Please indicate the appropriate annex number.)

3A.3.2 Rationale

a) Explain why a sub-national CCM has been chosen. *(Maximum of half a page.)*

b) Describe how this proposal is consistent with and complements the national strategy for responding to the disease and/or the national CCM plans. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.4 Regional Coordinating Mechanism (including small island developing states)

For more information, please refer to the Guidelines for Proposals, section 3A.4, and the CCM Guidelines.

Table 3A.4 – Regional Coordinating Mechanism: basic information

Name of regional Coordinating Mechanism (RCM)	**Date of composition** (yyyy/mm/dd)

3A.4.1 Mode of operation

Describe how the RCM operates. In particular:

- **The extent to which the RCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country; and
- **How it coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, or the national strategies of small island developing states who do not have their own national CCM or other national coordinating body.)
- **The RCM's governance structure and processes,** and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the RCM, and a diagram setting out the interrelationships between key actors across the included countries as an annex to this proposal. Please indicate the appropriate annex number.)

3A.4.2 Rationale

a) Explain why a RCM approach has been chosen. *(Maximum of half a page.)*

b) Describe how this proposal is consistent with and complements the national strategies of countries included and/or the national CCM plans. *(Maximum of half a page.)*

c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

3A Applicant Type

d) Explain how the RCM represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes of the RCM. *(Maximum of half a page.)*

➔ *After completing this section, complete section 3B.1.*

3A Applicant Type

3A.5 Regional Organizations (including Intergovernmental Organizations and International Non-Government Organizations)

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

Table 3A.5 – Regional Organization: basic information

Name of Regional Organization
Sector represented by the Regional Organization

3A.5.1 Mode of operation

In addition to answering the sections below, Regional Organizations should provide, as additional annexes to this proposal documentation describing the organization, such as:

- *Statutes, by-laws of organization (official registration papers); and*
- *A summary of the main sources and amounts of funding.*

Describe how the Regional Organization operates. In particular:

- The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects; and
- **The coverage and past experience** of the Regional Organization's operations. *(Maximum of half a page.)*

3A.5.2 Rationale

a) Explain why a Regional Organization has been chosen and the added value of the proposed regional approach beyond the national response of individual countries. *(For example, address cross-border or regional issues. Maximum of half a page.)*

b) Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. *(Maximum of half a page.)*

c) Provide details of how this proposal will achieve cross-border or multi-country outcomes that would not be possible with only national approaches. *(Maximum of half a page.)*

3A Applicant Type

d) Explain how the Regional Organization represents a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)*

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

3A Applicant Type

3A.6 Non-CCM Applicants

*Non-CCM proposals are **only eligible for funding under exceptional circumstances listed in section 3A.6.2 below**. For more information, please refer to the Guidelines for Proposals, section 3A.6.*

In addition to answering the sections below, all Non-CCM proposals should include as annexes additional documentation describing the organization, such as: statutes and by-laws of organization (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization; a summary of the organization, including background and history, scope of work, past and current activities; and a summary of the main sources and amounts of existing funding.

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

Name of Non-CCM Applicant	
Street address	

	Primary contact	**Secondary contact**
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

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

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

3A Applicant Type

3A.6.2 Rationale for applying outside a Coordinating Mechanism

a) Non-CCM proposals are **only eligible** if they satisfactorily explain that they originate from one of the following:

i) Countries without legitimate governments;

ii) Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or

iii) Countries that suppress, or have not established partnerships with civil society and NGOs.

Describe which of the **above conditions** apply to this proposal. (*Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.2 for further information.)*

b) Describe your organizations **attempts to include this proposal in the relevant CCM's final approved country proposal** and the responses, if any, from the CCM. *(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM (national, sub-national or regional) as an annex to the proposal.)*

*If this Non-CCM proposal originates from a country in which no CCM exists (for example, a small island developing state), please **also** complete section 3A.6.3.*

3A.6.3 Consistency with national policies

Describe how this proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy). *(Maximum of one page. Provide evidence (e.g., letters of support) from relevant national authorities in an annex to the proposal.)*

➔ *After completing this section, complete section 4.*

3B Proposal Endorsement

3B.1 Coordinating Mechanism membership and endorsement:

All national, sub-national and regional Coordinating Mechanisms must complete this section. Regional Organizations must complete section 3B.2.

National/Sub-national/Regional Coordinating Mechanisms

3B.1.1 Leadership of Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information
(not applicable to Non-CCM and Regional Organization applicants)

	Chair	Vice Chair
Name	Ion Ababii	Viorelia Moldovan-Batrinac
Title	Minister of Health and Social Protection	Deputy Minister of Youth and Education
Organization	Ministry of Health and Social Protection	Ministry of Youth and Education
Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova	1, Piata Marii Adunari nationale str, Chisinau, Republic of Moldova
Telephone	+ 373 22 72 99 07	+ 373 22 23 34 22
Fax	+373 22 73 87 71	NA
E-mail address	silmunt@mednet.md	preuniversitar@edu.md

3B Proposal Endorsement

3B.1.2 Membership information

Please note that to be eligible for funding, national/sub-national/regional Coordinating Mechanisms must demonstrate evidence of membership of people living with and/or affected by the diseases. It is recommended that the membership of the CCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1, and the CCM Guidelines.

*The table below must be completed for **each** national/sub-national/regional Coordinating Mechanism **member**, and the table will therefore need to be extended to cover numerous members.*

Use the "Add_Member" button**  **in the standard toolbar.

*Under "**Type**", please specify which sector the CCM member represents: academic/educational; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; or multi-/bilateral development partners in country.*

Table 3B.1.2 – National/sub-national/regional (C)CM member information

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Health and Social Protection	Website	www.ms.md
Type	Government		
Name of representative	Ion Ababii	CCM member since	2005, the entity from 2002
Title in agency/organization	Minister of Health and Social Protection	Fax	+373 22 73 87 71
E-mail address	silmunt@mednet.md	Telephone	+ 373 22 72 99 07
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	CCM Chair (strategic overview, ensuring synergies, overall coordination and approval etc.)	Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Youth and Education	Website	www.edu.md
Type	Government		
Name of representative	Viorelia Moldovan-Batrinac	CCM member since	2005, the entity from 2002
Title in agency/organization	Deputy Minister of Youth and Education/Ministry of	Fax	+373 22 23 35 15

3B Proposal Endorsement

	Youth and Education		
E-mail address	preuniversitar@edu.md	Telephone	+ 373 22 23 34 22
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Vice Chair (review and approval)	Mailing address	1, Piata Marii Adunari nationale str, Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Finance	Website	NA
Type	Government		
Name of representative	Ion Chicu	CCM member since	2006, the entity from 2002
Title in agency/organization	Vice Minister of Finance	Fax	+ 373 22 22 82 27
E-mail address	NA	Telephone	+373 22 24 37 26
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, financial input	Mailing address	7, Cosmonautilor str. Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Justice	Website	NA
Type	Government		
Name of representative	Nicolae Esanu	CCM member since	2002
Title in agency/organization	Vice - Minister of Justice	Fax	NA
E-mail address	NA	Telephone	+373 22 20 14 18
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator,*	member, reviewed and approved the proposal	Mailing address	82, 31 August 1989 street. Chisinau, Republic of Moldova

3B Proposal Endorsement

financial input, review, other)			
Member			
Agency/organization	AIDS Centre	Website	NA
Type	Government		
Name of representative	Stefan Gheorghita	CCM member since	2005
Title in agency/organization	Prime-vice Director, AIDS Centre	Fax	+ 373 22 72 97 25,
E-mail address	naac@sanepid.md	Telephone	+ 373 22 46 92 95, + 373 22 46 94 43
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at proposal preparation, review, approval	Mailing address	7/1 Studentilor str. MD 2020, Chisinau, Republic of Moldova
Member			
Agency/organization	Swedish International Development Cooperation Agency /Sida	Website	www.sida.se
Type	bilateral development agency		
Name of representative	Hans Lundquist	CCM member since	2005
Title in agency/organization	First Secretary, Embassy of Sweden, Head of Sida	Fax	+ 373 22 23 29 85
E-mail address	office@asdi.md, hans.lundquist@asdi.md	Telephone	+ 373 22 23 29 83
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, technical input, proposal review and approval	Mailing address	108/1, 31 August 1989 str. MD 2005 Chisinau, Republic of Moldova

3B Proposal Endorsement

Member			
Agency/organization	Ministry of Internal Affairs	Website	NA
Type	Government		
Name of representative	Valentin Zubic	CCM member since	2005, the entity from 2002
Title in agency/organization	Vice Minister of Internal Affairs	Fax	NA
E-mail address	NA	Telephone	+ 373 22 25 53 42
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	member, approved the proposal	Mailing address	75, Stefan cel Mare str, Chisinau, Republic of Moldova
Member			
Agency/organization	World Bank	Website	www.worldbank.org.md
Type	multilateral development agency		
Name of representative	Edward Brown	CCM member since	2002
Title in agency/organization	Country Manager	Fax	+ 373 22 23 70 53
E-mail address	ecorman@worldank.org	Telephone	+ 373 22 23 35 65
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, review and approval of the proposal	Mailing address	76/6, Sciusev str., MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	UN	Website	www.undp.org
Type	multilateral development agency		
Name of representative	Bruno Pouezat	CCM member since	2002
Title in agency/organization	UN Resident	Fax	+ 373 22 22 00 41

3B Proposal Endorsement

	Coordinator in Moldova		
E-mail address	registry.md@undp.org, bruno.pouezat@undp.org	Telephone	+ 373 22 22 00 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	member, reviewed and approved the proposal	Mailing address	MD 2012, 131, 31 August 1989 str, Chisinau, Republic of Moldova
Member			
Agency/organization	UNICEF	Website	www.unicef.org
Type	Multilateral development agency		
Name of representative	Ray Virgilio Torres	CCM member since	2005, the entity from 2002
Title in agency/organization	UNICEF Representative in Moldova	Fax	+ 373 22 22 02 44
E-mail address	chisinau@unicef.org	Telephone	+ 373 22 22 00 34
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal	Mailing address	131, 31 August 1989 str, MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	WHO	Website	www.who.int
Type	Multilateral development agency		
Name of representative	Pavel Ursu	CCM member since	2002
Title in agency/organization	Head of WHO Country Office in Moldova	Fax	+ 373 22 23 73 46
E-mail address	pursu.who@un.md	Telephone	+ 373 22 23 73 48
Main role in the Coordinating Mechanism and the proposal development	CCM member, reviewed and approved the proposal.	Mailing address	27 Sfatul Tarii str. MD 2012, Chisinau,

3B Proposal Endorsement

(proposal preparation, technical input, component coordinator, financial input, review, other)			
Member			
Agency/organization	UNAIDS	Website	www.aids.md
Type	multilateral development agency		
Name of representative	Gabriela Ionascu	CCM member since	2002
Title in agency/organization	UNAIDS Programme Coordinator in Moldova	Fax	NA
E-mail address	gabriela.ionascu@un.md	Telephone	+ 373 22 22 00 45, + 373 691 23 392
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member. Prepared, reviewed, provided technical assistance, financial input, coordinated, approved the proposal	Mailing address	131, 31 August 1989 str. MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Soros-Moldova Foundation	Website	www.soros.md
Type	Nongovernmental organization		
Name of representative	Victor Ursu	CCM member since	2002
Title in agency/organization	Executive Director	Fax	+ 373 22 27 05 07
E-mail address	vursu@soros.md	Telephone	+ 373 22 27 02 32, + 373 22 27 00 31
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	NGO facilitator. Reviewed and aproved the proposal. Th eorganization provided assistance in preparing, coordinating with Harm Reduction network, reviewing the proposal.	Mailing address	32, Bulgara str. MD 2021, Chisinau, Republic of Moldova
Member			
Agency/organization	USAID	Website	www.usaid.org
Type	Bilateral Development Agency		

3B Proposal Endorsement

Name of representative	Diana Cazacu	CCM member since	2002
Title in agency/organization	USAID/Moldova Project Manager	Fax	+ 373 22 23 72 77
E-mail address	dcazacu@usaid.gov	Telephone	+ 373 22 20 18 16
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal	Mailing address	57/1 Banulescu Bodoni str, Chisinau, Republic of Moldova
Member			
Agency/organization	AIHA	Website	www.aiha.com
Type	NGOs/Community-Based Organisations, representative of TB NGOs in the country		
Name of representative	Viorel Soltan	CCM member since	2005
Title in agency/organization	Chief of party / Project Director	Fax	+ 373 22 22 67 37
E-mail address	viorel@aiha.moldnet.md	Telephone	+ 373 22 27 93 80
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at proposal preparation, review, technical input, approval.	Mailing address	29/1, Armeneasca str. MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Project Coordination, Implementation and Monitoring Unit of the Ministry of Health	Website	NA
Type	Government		
Name of representative	Victor Volovei	CCM member since	2002
Title in agency/organization	Director Executive, Project Coordination Unit	Fax	+ 373 22 23 87 51
E-mail address	vvolovei@ucimp.md	Telephone	+ 373 22 23 87 51

3B Proposal Endorsement

Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal. Provided technical input	Mailing address	101, Sciusev str. MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Young and Free: Training Resource Centre	Website	www.retea-sida.md
Type	NGO		
Name of representative	Antonita Fonari	CCM member since	2005
Title in agency/organization	Executive Director	Fax	+ 373 22 567 551
E-mail address	presedinte@retea-social.md, secretariat@retea-sida.md	Telephone	+ 373 22 567 551
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, AIDS Network. particiapted at proposal preparation, review and coordiantion with AIDS network (around 40 NGOS)	Mailing address	C/P 3036, MD 2072, Chisinau Moldova Chisinau, Republic of Moldova
Member			
Agency/organization	Red Cross Society in RM	Website	http://www.icrc.org/
Type	GOs/Community-Based Organisations		
Name of representative	Larisa Birca	CCM member since	2005
Title in agency/organization	Chair	Fax	+ 373 22 72 58 24
E-mail address	crucearosie@moldnet.md	Telephone	+ 373 22 72 96 44
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, reviewed and approved the proposal	Mailing address	67 a, Asachi str. Chisinau, Republic of Moldova

3B Proposal Endorsement

Member			
Agency/organization	Credinta Association	Website	www.aidsmd.narod.ru
Type	People living with HIV/AIDS		
Name of representative	Igor Chilcevschii	CCM member since	2005
Title in agency/organization	Chair	Fax	+ 373 22 43 81 35
E-mail address	credinta@hotmail.ru	Telephone	+ 373 22 43 81 35, + 373 22 44 65 10
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, participated at the elaboration, preparation, review and approval of the proposal	Mailing address	C/P 2839, MD 2068, Chisinau Chisinau, Republic of Moldova
Member			
Agency/organization	UNFPA	Website	www.unfpa.org
Type	Multilateral development Agency		
Name of representative	Boris Gilca	CCM member since	2005
Title in agency/organization	Programme Coordinator	Fax	+ 373 22 21 40 03
E-mail address	boris.gilca@un.md, boris@unfpa.org	Telephone	+ 373 22 22 00 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member . Participated at proposal development, review and approval	Mailing address	UN House, 4th floor, 31 August 1989, N 131 street MD 2012, Chisinau, Republic of Moldova
Member			
Agency/organization	Government of Republic of Moldova	Website	www.gov.md
Type	Government		
Name of representative	Rodica Scutelnic	CCM member since	2006, the entity from

3B Proposal Endorsement

			2002
Title in agency/organization	Senior Consultant, Social Development Department, State Chancellory	Fax	+ 373 22 250 447
E-mail address	rchimirciuc@yahoo.com	Telephone	+ 373 22 250 447
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	CCM Executive Secretary, facilitated the organization of CCM proposal development	Mailing address	1, Piata Marii Adunari Nationale str. Chisinau, Republic of Moldova
Member			
Agency/organization	Ministry of Health and Social Protection	Website	www.ms.md
Type	Government		
Name of representative	Boris Golovin	CCM member since	2005, the entity from 2002
Title in agency/organization	Vice Minister of Health and Social Protection	Fax	+ 373 22 73 87 81
E-mail address	bgolovin@mednet.md	Telephone	+ 373 22 72 95 90
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, facilitated the organization of CCM proposal development and provided technical input	Mailing address	2, V. Alecsandri str, MD 2009, Chisinau, Republic of Moldova
Member			
Agency/organization		Website	
Type			
Name of representative		CCM member since	
Title in agency/organization		Fax	
E-mail address		Telephone	
Main role in the Coordinating		Mailing address	

3B Proposal Endorsement

Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			
Member			
Agency/organization		Website	
Type			
Name of representative		CCM member since	
Title in agency/organization		Fax	
E-mail address		Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	

3B Proposal Endorsement

3B.1.3 National/Sub-national/Regional (C)CM endorsement of proposal

*Coordinating Mechanism members must endorse the proposal. Limited exceptions are described in the Guidelines for Proposals in section 3B.1.3. Please note that the **original** (not photocopied, scanned or faxed) signatures of the CCM members should be provided in table 3B.1.3. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal. The entire proposal, including the signature page and minutes, must be received by the Global Fund Secretariat before the deadline for submitting proposals.*

Applicant name	Country Coordination Mechanism on National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes
Country/countries	Republic of Moldova

"Each of the undersigned, hereby certify that s/he has reviewed the final proposal and supports it."

Table 3B.1.3 – National/sub-national/regional (C)CM endorsement of proposal

Agency/organization	**Name of representative**	**Title**	**Date** (yyyy/mm/dd)	**Signature**
Ion Ababii	Ministry of Health and Social Protection	Minister of Health and Social Protection	2006/07/20	
Viorelia Moldovan-Batrinac	Ministry of Education and Youth	Vice Minister of Education and Youth	2006/07/20	
Rodica Scutelnic	Government of Republic of Moldova	Senior Consultant, State Chancellory	2006/07/20	
Boris Golovin	Ministry of Health and Social Protection	Vice Minister of Health and Social Protection	2006/07/20	
Ion Chicu	Ministry of Finance	Vice Minister of Finance	2006/07/20	
Nicolae Esanu	Ministry of Justice	Vice Minister of Justice	2006/07/20	
Stefan Gheorghita	Ministry of Health and Social Protection	Prime-Vice Director, AIDS Center	2006/07/20	
Hans Lundquist	Swedish International Development Cooperation Agency / Sida	First Secretary, Embassy of Sweden, Head of Sida	2006/07/20	
Valentin Zubic	Ministry of Internal Affairs	Vice Minister of Internal	2006/07/20	

3B Proposal Endorsement

		Affairs		
Edward Brown	World Bank	Country Manager	2006/07/20	
Bruno Pouezat	UNDP	UN Resident Coordinator	2006/07/20	
Ray Virgilio Torres	UNICEF	UNICEF Representative in Moldova	2006/07/20	
Pavel Ursu	WHO	Head of WHO country office in Moldova	2006/07/20	
Gabriela Ionascu	UNAIDS	Programme Coordinator	2006/07/20	
Victor Ursu	Soros-Moldova Foundation	Executive Director	2006/07/20	
Diana Cazacu	USAID	Moldova Project Manager	2006/07/20	
Viorel Soltan	AIHA	Chief of party/Project Director	2006/07/20	
Victor Volovei	Project Coordination, Implementation and Monitoring Unit	Director Executive	2006/07/20	
Antonita Fonari	Young and Free: Training Resource Centre	Executive Director	2006/07/20	
Larisa Birca	Red Cross Society in Moldova	Chair	2006/07/20	
Igor Chilcevschii	Credinta Association	Chair	2006/07/20	
Boris Gilca	UNFPA	Programe Coordinator	2006/07/20	

For sub-national and regional Coordinating Mechanisms only, *the Chair and the Vice Chair of the national CCM of each country must also endorse the proposal. Please refer to the Guidelines for Proposals, section 3B.1.3.*

List below each of the national CCMs that have agreed to this proposal and provide documented evidence of this endorsement.

3B Proposal Endorsement

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

Country	Name of CCM	Annex number

3B Proposal Endorsement

3B.2 Regional Organization contact information and proposal endorsement:

3B.2.1 Regional Organization contact information

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

Table 3B.2.1 – Regional Organizations: contact information

	Primary contact	Secondary contact
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

3B.2.2 National CCM endorsement of Regional Organization proposal:

Please note that Regional Organizations must receive the agreement of the national CCM membership of each country in which they wish to work.

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

Table 3B.2.2 – Regional Organization proposal endorsement by national CCMs

Country	Name of CCM	Annex number

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Name/Number given to annex in application**
Section 2: Eligibility		
Coordinating Mechanisms only:		
2.2.1 b)	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	Annex 2. Discussions and decisions of the First Monitoring Workshop of the Resolution of the 1st National Forum of NGOs from the Republic of Moldova working in the field of HIV/AIDS and TB. Annex 18. Minutes of the UNTG on HIV/AIDS from 2002.
2.2.2	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism.	Annex 3. Policy of conflicts of interests in Republic of Moldova
	Documentation describing the transparent processes to:	
2.2.3 a	- solicit submissions for possible integration into the proposal.	Annex 4. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed; Annex 5. CCM decision from March 2006. Approval of TWG; Annex 6. The text of CCM information of Global Fund process in the newspapers; Annex 7. Minutes of the CCM meeting from the 11th of May 2006. Annex 8. List of CCM Technical working groups members and the institutions they represent

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
2.2.3 b	- review submissions for possible integration into the proposal.	Annex 14. Minutes on the meeting of the extended meeting of the TWG on HIV/AIDS; Annex 15. Minutes on the meeting of the extended meeting of the TWG on TB; Annex 16. Minutes on the meeting of the local technical review committees
2.2.3 c	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated).	Annex 4. CCM decision from the 11th of May 2005. The mechanism of elaboration annexed. Annex 7. Minutes of the CCM meeting from the 11th of May 2006.
2.2.3 d	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	Annex 6. The text of CCM information of Global Fund process in the newspapers Annex 8. List of CCM Technical working groups members and the institutions they represent
Section 3A: Applicant Type		
Coordinating Mechanisms:		
3A.2.1, 3A.3.1 **or** 3A.4.1	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors)	Annex 1. Nr. 825, Government decision from the 3rd of August 2005 regarding the CCM Bylaws; Annex 19. The diagram setting out the interrelationships among all key actors
Regional Organizations:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a	

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
	summary of the main sources and amounts of funding.	
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
3A.6.3 *(if from country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	
Section 3B: Proposal Endorsement		
3B.1.3 (*Coordinating Mechanisms)*	Minutes of the meeting at which the proposal was developed and endorsed. For Sub-CCMs and RCMs, documented evidence that national CCM(s) have agreed to proposal.	Annex 10. CCM Decision N3, July 20th, 2006 Annex 13. CCM minutes on the meeting from the 20th of July, 2006 www.ccm.md www.aids.md
3B.2.2 (*Regional Organization)*	Documented evidence that the national CCMs have agreed to proposal.	
Other documents relevant to sections 1-3 attached by applicant:		
2.2.1.a	Minutes of the CCM meeting from March 2006	Annex 9. Evidence of Technical working groups approval Evidence of participation of people living or affected by the disease at CCM discussions and decisions taking processes
2.2.1.a	Minutes of the CCM meeting from May 2006	Annex 7. Evidence of the decision to apply to

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Name/Number given to annex in application
		the VI round and to solicit the broad range of stakeholders participation
2.2.1.a 2.2.3.d	CCM membership list, also available on the webpages: www.ccm.md and www.aids.md List of CCM Informational Bulletin beneficiaries Samples of CCM Info Bulletin	Annex 11 Annex 17. Annex 12.

4 Component Section *Tuberculosis*

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

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

4.1 Indicate the estimated start time and duration of the component

Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval.

Table 4.1.1 – Proposal start time and duration

	From (yyyy/mm)	**To** (yyyy/mm)
Month and year:	2008/01	2012/12

4.2 Contact persons for questions regarding this component

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately six months after the submission of the proposal.

Table 4.2 – Component contact persons

	Primary contact	**Secondary contact**
Name	Dr. Liviu Vovc	Dr. Dumitru Sain
Title	Chief of General Department of MHSP	NTP Manager
Organization	Ministry of Health and Social Protection	Institute of Phthysiopneumology
Mailing address	2 Alecsandri str, MD 2009 Chisinau, Republic of Moldova	13 Virnav street, MD 2025, Chisinau, Republic of Moldova
Telephone	+ 373 22 72 93 88	+ 373 22 73 55 63
Fax	+ 373 22 72 93 88	+ 373 22 73 55 63
E-mail address	lvovc@mednet.md	ntpmd@mcc.md

4.3 Component executive summary

4.3.1 Executive summary

Describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results and associated timeframes. Specify the beneficiaries and expected benefits (including target populations and their estimated number). *(Please include quantitative information where possible. Maximum of one page.)*

The overall strategy of the tuberculosis component is to solidify the accomplishments of the DOTS expansion carried out in the previous 5 years by improving the quality of DOTS and addressing the challenges of MDR-TB, TB/HIV, and management capacity. The goal of the program is to reduce the burden of TB by fulfilling these objectives: 1) strengthening DOTS by improving detection and case management; 2) improving management of MDR-TB by expanding the DOTS-Plus project; 3)

strengthening the health system and project management for controlling TB; and 4) increasing public awareness and reducing stigma. By the end of year 5, case detection of smear-positive cases is expected to reach the global target of 70% and treatment success for these cases is expected to reach 80%, short of the global target of 85%.

During the last GFATM grant period, Moldova upgraded facilities and skills and revised policies to ensure consistency with evolving international standards. The investments made in the laboratory network, case finding, public awareness, and surveillance are critical to the tuberculosis program proposed for Round 6. Diagnosis capability will be extended to culture (30000 per annum) for all patients registered for treatment and DST (10500 per annum) for drug-resistant cases. First-line drugs will be provided to 5800 patients in year 1, decreasing to 3500 patients in year 5 as the Government funds an increasing share of these costs. Second-line drugs will be provided to 200 patients in years 1-2 and for 250 patients in years 3-5. By the end of year 5, an additional 36100 TB patients will receive treatment under DOTS and an additional 1150 TB patients will receive treatment under DOTS-Plus.

Human resources are a critical gap in TB control in Moldova. In the proposed program, training and retraining on DOTS will be conducted for 200 TB doctors, 2000 PHC practitioners, and 250 lab personnel. Training on DOTS-Plus will be conducted for 250 TB doctors and 250 PHC practitioners. Supervisory visits from the NTP are to increase from 40% of units to 100% of units by the end of year 2. DOT in the continuation phase is expected to increase from 60% currently to 85% by the end of year 5. Guidelines are to be developed for TB/HIV and training conducted for management of co-infected cases. By the end of year 5, over 80% of notified TB cases will be tested for HIV.

Training on conveying information will be provided to 65 journalists and 120 TB/HIV peer educators during years 1-4. Each year, 37000 leaflets and brochures will be provided to the general public; 6600 leaflets will be provided to TB patients and their families; and 2000 booklets will be provided to TB patients on HIV prevention. Each year, 40 informational programs and 2 PSAs on TB and 1 PSA and 4 talk shows on TB stigma will be developed and broadcast in the mass media. By the end of year 5, the percentage of the population that can identify the 3 most important symptoms of TB is expected to increase from 48.8 to 73.8; and the percentage of the population that would not try to hide tuberculosis disease is expected to increase from 62.3 to 79.8.

The proposed program is linked closely to the National Programme on Prophylaxis and Control of Tuberculosis for 2006-2010 and covers early detection, sound diagnostics, and appropriate treatment and case management. It combines critical aspects of TB control, from awareness of symptoms to laboratory and treatment capacity. It addresses management and financing gaps in current TB control and extends TB control to include MDR-TB and TB/HIV. It uses fully the investments and institutional relationships that contributed to the substantial accomplishments during the previous grant period and moves Moldova towards the path of achieving global targets for TB."

4.3.2 Synergies

If the proposal covers more than one component, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities. *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

The CCM is submitting a proposal that covers Tuberculosis and HIV/AIDS components and both components include TB/HIV collaborative activities. New national programs and budgets were approved for both diseases at the end of 2005 and the development of the programs included representation of stakeholders of the other disease. As per WHO recommendations, one CCM coordinates for both diseases in Moldova and thus has an overview that allows synergies to be realized. There is one M&E unit for both diseases, and the surveillance systems for TB and HIV/AIDS are based on the same platform and are being integrated. The revised TB reporting forms include information on testing of TB patients for HIV; and the revised HIV/AIDS reporting forms include information on testing of HIV-positive patients for TB. This will allow for cross-referencing of

cases and increase case finding among target populations for both diseases.

The proposal includes anti-retroviral treatment for coinfected TB/AIDS patients. TB and HIV-positive patients will receive services related to the other disease to reduce co-infection. TB patients are to be given VCT and HIV-positive patients are to be given prophylaxis treatment for TB.

4.4 National program context for this component

The information below helps reviewers understand the disease context, and which problems the proposal will address. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies and broader development frameworks need to be clearly documented. Please refer to the Guidelines for Proposals, section 4.4.

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

☒ National Disease Specific Strategic Plan

☒ National Disease Specific Budget or Costing

☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)

☒ Other document relevant to the national disease program context (e.g. the latest disease surveillance report)
Please specify:

Order 180, issued 21 August 2001; (English and Romanian versions)

National Programme on Prophylaxis and Control of Tuberculosis for 2006-2010; (Annex 1 TB)

New Order on TB, pending approval; (Romanian version)

Decision of MOH on NRL, issued 22 May 2003; (Romanian version)

Methodological Instructions, "Microbiologic service in TB diagnosis," approved 6 November 2004; (Romanian version)

Moldova TB Surveillance Report for 2004, verified and approved by WHO; (Annex 2 TB)

Application to the WHO GLC for Approval of a DOTS-Plus Pilot Project in the Republic of Moldova, June 2004; (English and Romanian versions) (Annex 3 TB)

GDF Monitoring Report, March 2006; (Annex 4 TB)

Economic Growth and Poverty Reduction Strategy Paper, 2004-2006. (Annex 5 TB)

4.4.2 Epidemiological and disease-specific background

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

Trends in Tuberculosis Epidemic
Moldova has undertaken a concerted effort in controlling TB in recent years, instituting international standards and strengthening diagnosis, treatment, surveillance, and public communications for TB. Case notifications have been increasing steadily, but TB mortality is also increasing and treatment outcomes are marked by high rates of default and failure and a relatively stable treatment success rate. These outcomes are due in large part to inadequate directly observed treatement (DOT) and patient support, the spread of multi-drug resistant tuberculosis (MDR-TB), and gaps in diagnosis and case management.

In late 2001, Moldova adopted the WHO-recommended DOTS strategy and rapidly expanded DOTS to

cover the entire country by January 2004. The most recent trends in TB, for the years 2004 and 2005, are presented in Table 4.4.2.a. (Annex 6) From 2004 to 2005, the total number of cases (new and relapse) increased from 5154 to 5632 and the rate per 100,000 population increased from 121.7 to 133.4. During the same period, new cases increased from 3941 to 4518 and the rate per 100,000 population increased from 93.1 to 107. Increases in the new case rate were higher, at 14.9%, than the increases in the total case rate, at 9.6%. These differential increases are an indication of enhancements in both detection and treatment in recent years. The reservoir of relapse cases is diminishing as drug supply shortages and inadequate treatment of the previous 5-10 years is being reversed. At the same time, diagnosis capabilities and surveillance are improving, resulting in higher numbers of cases notified and started on treatment.

By far the most affected population group is prisoners. In 2005, the new case rate for prisoners in Moldova (excluding Transnistrian prisons) was a staggering 1902.9 per 100,000, nearly 18 times the countrywide rate. This concentration of cases represents a significant threat to TB control because of the movement of released prisoners into the population at large and the breakdown in treatment follow-up between the penitentiary and civilian health services. To address this significant segment of the epidemic, the National Programme on Prophylaxis and Control of Tuberculosis for 2006-2010 calls for strengthening diagnosis and treatment and improving detention and maintenance conditions in penitentiaries.

There was a larger increase in new cases notified in rural areas than in urban areas and the rate per 100,000 population in rural areas is approaching the rate in urban areas. This is due to the intensification of case finding in rural areas as DOTS was expanded and new regulations concerning the national insurance system and primary health care (PHC) were put into effect under Order 180, issued in August 2001. Among new cases, the male to female ratio was 2.7 in 2005 and the increase in cases is faster for males than for females. Adults over age 18 comprised 94% of new cases in 2005, increasing from 91% in 2004. Nearly 65% of new cases in children are in the 0-14 age group.

The progress in detection of new smear-positive cases in Moldova has been enormous. According to WHO, case detection increased by nearly 50% between 2003 and 2004. In 2003, only 39% of new smear-positive cases were being detected, increasing to 59% in 2004. Although this rate is below the global target of 70%, the increase is an indication of the success of interventions in enhancing diagnostic infrastructure and skills, raising public awareness, and revamping recording and reporting systems.

TB control was integrated into PHC under Order 180. During 2004-2005, PHC practitioners were trained in diagnosis and continuation phase treatment and information campaigns for practitioners, the media, and the general public were conducted. The tandem increase in PHC patient visits and the total number of diagnostic investigations for TB indicates that increased detection is occurring at the PHC level. The more accessible PHC services are contributing to the expansion in cases notified from rural areas.

Also during 2004-2005, the TB laboratory network in Moldova was upgraded substantially. The National Reference Laboratory (NRL) and three Regional Reference Laboratories (RRLs) were renovated and reequipped with biosafety cabinets, autoclaves, Bactec/MGIT, and fluorescent microscopes. Training of laboratory personnel and revision of guidelines was undertaken in microscopy, culture, and quality control of lab results. The number of pulmonary cases confirmed by smear microscopy increased from 2227 to 2345.

Recent Trends in Tuberculosis Epidemic in Republic of Moldova are presented in the Annex 6 TB.

Treatment Regimes

The empiric treatment regime in new pulmonary and extrapulmonary TB cases (Category I) is a four-drug combination of Isoniazid (H), Rifampicin (R), Pyrazinamide (Z) and Ethambutol (E) administered on a daily basis in the intensive phase (in exceptional cases, intermittently three times per week). In cases of adverse reactions to Ethambutol, Streptomycin (S) is substituted for E. As a rule, treatment in the intensive phase is administered in hospital. Exceptions to this are allowed for patients preferring ambulatory treatment. In this case, a health worker administers DOT at a health facility close to the patient's home. This is done in coordination with the corresponding raion health center.

The intensive phase of treatment is prolonged for a third month if smear conversion has not occurred at the end of two months. The continuation phase of treatment consists of RH administered on an ambulatory basis three times per week, with a total duration of treatment of six months. S is added in the intensive phase in cases classified as retreatment (Category II) and the treatment is prolonged, with a total duration of treatment of eight months, and strengthened (Ethambutol throughout) in such cases.

The treatment regimes were revised in the New Order on TB (pending approval) and are presented in Annex 7 TB.

These treatment regimes are consistent with the International Standards for Tuberculosis Care. WHO's Green Light Committee (GLC) approved Moldova's application for a DOTS-Plus pilot project for treatment of MDR-TB in February 2005 and the project was initiated in December 2005. Thus far, 85 patients have been enrolled and by the end of 2006, Moldova expects to enroll a total of 100 patients in DOTS-Plus. An assessment conducted in May 2006 recommended an extension of the program to 1300 patients over 5 years. Moldova is planning to submit another application to the GLC in response to this recommendation and is requesting funding in this GFATM proposal to cover the requisite drugs for MDR-TB treatment. The current MDR-TB treatment protocols for Moldova, approved by the GLC, are attached to this application (Annex 3 TB).

Drug Resistance

When the Soviet Union disintegrated in the early 1990s, there was a sudden and sharp deterioration of socioeconomic conditions in Moldova, leading to an upsurge in TB from increased susceptibility of the population to TB infection and increased risk of breakdown from infection to disease. The health system failed to undertake control measures. This was due to a financial crisis which led to drug supply shortages and inadequate and interrupted treatment; non-adherence by patients; and a failure of the TB services to provide DOT, the appropriate response in such a situation. As a result, drug resistance increased step-wise with the eventual emergence and transmission of MDR strains, which are now impediments in the implementation and success of the DOTS strategy.

The prevalence of MDR-TB in Moldova has only been estimated based on laboratory and treatment outcome data for TB patients. In December 2005, a representative national survey of drug resistance was initiated, supported by WHO and StopTB. Moldova had to fulfill laboratory quality assurance protocols in order to conduct this survey. The investments in laboratories made in the previous two years are enabling Moldova to apply rigorous methods to develop the evidence base for controlling drug resistance. By 2007, a clearer picture of the drug resistance pattern in Moldova is expected to emerge. The upgraded surveillance system will begin to incorporate drug resistance data and funding for this is requested in this GFATM proposal. The historical pattern and evolution of drug resistance in Moldova is presented in Annex 8 TB.

4.4.3 Disease-control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.4.3.

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

Current Tuberculosis Control

Tuberculosis control in Moldova is managed by the NTP and based on WHO's DOTS strategy.

Under the National Programme for 2001-2005, DOTS coverage reached 100% in January 2004. The case definitions and quarterly reporting of cases, progress, and outcome are consistent with WHO standards. The Central Unit of the NTP is located in the Phthisiopulmonlogy Institute (PPI) in Chisinau. The NTP involves the Ministry of Health and Social Protection, (MHSP), the Ministry of Justice (MOJ), and the Ministry of Internal Affairs (MOIA) and collaborates with non-governmental organizations (NGOs) and international partners. The private sector does not participate in TB control.

The strong and collegial collaboration among donors in Moldova has allowed substantial progress in TB control during the previous 5 years. DOTS was implemented with funding and technical assistance from GFATM, USAID/AIHA, CarLux NGO, and WHO. Anti-TB drug supply was guaranteed with a three-year grant from the Global Drug Facility (GDF) and technical assistance from Management Sciences for Health (MSH). CarLux NGO supported DOTS implementation, including drugs, in prisons. Implementation of DOTS within the prison sector began in 2000, preceding implementation in the civil sector in 2001.

Current and planned donor programs in TB control are presented below:

GFATM - Drug supply for 2005-2008; laboratory equipment and supplies for smear, culture, DST, and x-ray; training of practitioners for DOTS; TB communications; social assistance to TB patients; monitoring and evaluation of DOTS implementation; and drugs for DOTS-Plus.

USAID/AIHA - Renovation and furnishing for laboratory network; training on quality control, revision of guidelines, and equipment and supplies for laboratory network; training for PHC practitioners; information and education campaigns; revising and computerizing surveillance system; renovation and furnishing of MDR-TB ward; training on management of MDR-TB; and revising infection control.

CarLux NGO - Implementing DOTS and DOTS-Plus in prisons.

KNCV - Treatment continuation incentives for released prisoners.

MSH - Technical assistance on drug management.

WHO/GDF/GLC - Technical assistance on DOTS and DOTS-Plus; DST surveillance; and drugs for DOTS program in 2001-2004.

A new National Programme on Prophylaxis and Control of Tuberculosis for 2006-2010 was approved by the government in December 2005. Its goals are to: 1) reduce total (new and relapse) TB incidence to 85 per 100,000; 2) reduce the TB death rate to 12 per 100,000; 3) reduce the MDR-TB rate to less than 5% of pulmonary cases; 4) increase the success rate of new smear positive cases to 85%; and 5) increase detection to 70% of estimated smear-positive cases. The National Programme covers these 12 strategies:

1. Strengthen national policy and management capacity for TB control
2. Strengthen capacity to control drug-susceptible TB treated with standardized regimens
3. Organize and implement capacity to control MDR-TB
4. Organize and implement capacity to control TB/HIV co-infection
5. Strengthen capacity to control TB in prisons
6. Conduct epidemiological surveillance and monitoring of TB infection
7. Develop human resources for TB control
8. Provide social support for TB patients and their families
9. Organize and implement communication, information, and education activities for TB
10. Implement activities for infection control

11. Reestablish the phthisiopneumology service infrastructure
12. Develop operational research on TB control

Case Finding

Persons with symptoms of TB are identified at peripheral health facilities and referred to microscopy centers and TB hospitals for confirmation of diagnosis. They may also present directly to TB services at microscopy centers or raion hospitals. The NTP (2001-2005) reoriented the TB control structure to strengthen the role of PHC in diagnosis and follow-up during the continuation phase. The Center for Preventive Medicine is responsible for conducting contact investigations, but the guidelines are outdated and inconsistent with international standards. Diagnosis and treatment services are provided free of charge, but treatment for MDR-TB is not available for every patient.

Laboratory Network

The TB laboratory network is a logical and geographically dispersed structure consisting of 57 microscopy centers (level I), 3 RRLs (level II), and one NRL (level III). The microscopy centers are attached to TB cabinets, equipped with modern microscopes, and serve a population of 50000 to 100000 (average 77000). The tasks of the microscopy centers are reception of pathological specimens containing Mycobacterium tuberculosis (MBT), smear preparation, Ziehl-Nielsen (ZN) staining, and microscopy investigation of TB symptomatics and TB patients during the continuation phase of treatment. The centers participate in quality control of microscopy investigation, both internal and external (Lot Quality Assurance System –LQAS).

The RRLs are located in TB departments and Republican TB Hospitals and serve territories with populations of about 1 million each. Their tasks are microscopy investigation, isolation of pure culture of MBT, identification of MBT species by culture investigation, DST of MBT cultures for first-line drugs; and quality control of microscopy centers. The NRL is located at the PPI and functions as the coordinating body for the microbiological service for TB diagnosis. Its tasks are microscopy investigation; isolation of pure culture of MBT; identification of MBT species by culture investigation; DST of MBT cultures for first- and second-line drugs; training of laboratory network staff; internal quality control of microscopy, culture, and DST; elaboration of legislative decrees; standardization of laboratory methods; epidemiological survey of anti-TB drug resistance; and external quality control of MBT DST.

The Ministry of Health recognized the laboratory in Chisinau as the National Reference Laboratory for Moldova in a Decision of the MOH from 22 May 2003. The roles and responsibilities of the three levels have been established with a directive entitled, Methodological Instructions “Microbiologic service in TB diagnosis”, approved by the Scientific Council of PPI on 6 November 2004. As the designated NRL, the Chisinau laboratory is the only laboratory performing DST on second-line durgs in Moldova. The RRLs in Balti, Bender, and Vorniceni perform AFB microscopy, culture, and DST on first-line drugs. In December 2005, an official relationship was established with the Reference Center for Mycobacteria, Forschungzentrum in Borstel, Germany, to serve as the Supra-National Reference Laboratory (SNRL) for Moldova. Quality control procedures have been initiated with an exchange of a panel of 20 strains between the NRL and the SNRL.

With funding and technical assistance from USAID/AIHA and GFATM, the RRLs and NRL facilities were renovated and equipped with modern bio-safety cabinets, centrifuges, incubators, refrigerators, and a BACTEC/MGIT. Training of key laboratory personnel was conducted at the WHO Centre of Excellence in Latvia in September 2004, followed by training of 35% of laboratory staff in the network. With the upgraded capacity, the laboratory network is expected to perform annually 160000 smears, 30000 cultures, 10500 DSTs, and quality control of these investigations. A new policy was instituted at the end of 2005 under which all TB patients

registered for treatment must undergo culture for DST before initiating treatment. Culture is used for all treatment cases and for differential diagnosis in TB symptomatic complicated cases without a confirmed diagnosis (smear-negative); all TB symptomatic cases under the age of 18 years; and HIV-positive cases who are TB symptomatic.

Treatment

Treatment regimes are described in section 4.4.2. The current estimate is that nearly all patients in the intensive phase receive DOT on a daily basis and 60% of patients in the continuation phase receive DOT three times per week. Patients who do not receive fully supervised therapy in the continuation phase attend a health facility once per week.

In the civil sector, there are two national TB treatment facilities: the PPI in Chisinau with 250 beds and an outpatient clinic designed for 157 visits per day; and Vorniceni TB hospital with 200 beds. The outpatient clinic in the PPI is for initial or follow-up consultations, not ambulatory DOT. There are two municipality hospitals, in Chisinau with 350 TB beds (50 for children from across Moldova) and in Balti with 150 beds (30 for children). There are small TB departments in some raion hospitals, totalling 100 TB beds in Soroca, Edinet, Cahul, and Hincesti. For continuation phase treatment, patients visit TB cabinets attached to microscopy centers or outpatient departments, as at the municipality hospital in Balti. For MDR-TB treatment, a separate ward has been established at the PPI and houses 50 of the 250 beds. Additional beds at the Chisinau municipal hospital are to be added for MDR-TB and a TB/HIV ward is to be established at Balti municipal hospital in 2007. A new MDR-TB ward is to be established at Vorniceni hospital for which partial funding is requested in this application.

In Transnistria, Bender TB hospital has 175 beds (including 30 pediatric). There is also a 60-bed TB unit in the municipal hospital in Tiraspol and a 50 bed TB department in Dubasari. For continuation phase treatment, patients visit the TB cabinet attached to the microscopy center in each raion and town in Transnistria.

In the penitentiary sector, in Moldova on average there are 10000 inmates in the system, with an annual influx of prisoners of about 25000. Pruncul hospital has 300 TB beds and another 40 beds for infectious diseases which can be used for TB if the need arises (referred to as “flexible” beds). Six prisons have TB facilities for pre-trial inmates: Chisinau prison with 100 beds; and 50 “flexible” beds in Balti, Bender, Cahul, and Rezina. There are three microscopy centers, in Pruncul, Chisinau and Bender. In the six penitentiaries in Transnistria, on average there are 3400 inmates, with an annual influx of about 10000. There are 100 TB beds plus 50 “flexible” beds.

Drug supply

A three-year GDF grant guaranteed drug supply for the DOTS program. A sound drug management system has been established. Anti-TB drugs are stored in the para-statal agency, San Farm Prim, and distributed on a quarterly basis. The private market for anti-TB drugs is virtually non-existent in Moldova. The GDF funding for drugs has ended and GDF will only continue to provide technical assistance on procurement. First- and second-line anti-TB drugs for the entire country, including Transnistria and the penitentiary system, are included in this GFATM application. The Government is expected to increasingly take over the responsibility of financing first-line drugs for the NTP.

A recent GDF monitoring report (March 2006) recommended that NTP increase the buffer stock from 50% to 100% of requirements.

Staff

In the civil sector, including Transnistria, there are 345 TB specialists, of whom 195 (64%) are over 50 years old. Of the 345 specialists, 234 are employed in hospitals and 111 are employed in TB outpatient departments. The estimated need for outpatient department TB doctors is one per 20000 inhabitants, or a total of 208. As for nurses and auxiliary nurses, there is at least one per TB cabinet, for a total of 428 in the civil system covering inpatient and outpatient departments. At the NTP, thre are 4 MDs and 2 assistants. There are no social workers employed or affiliated with the NTP.

There are 1-2 laboratory technicians per microscopy center, for a total of 69. At the NRL, there are 6 MDs and fourteen laboratory technicians. At the RRL in Balti, there are 2 MDs and 7 laboratory technicians. At the RRL in Vorniceni, there are 2 MDs and 13 laboratory technicians. At the RRL in Bender, there are 2 MDs and 8 laboratory technicians.

In the prison sector, there is a TB coordinator at the central level, a deputy chief of TB, and four departmental TB specialists. There are 21 TB doctors and four non-TB MDs working in TB facilities. There are 35 nurses and six laboratory technicians. Social workers are stationed in a special department and their function is not specific to TB and covers general health education and social support. The Transnistrian penitentiary system employs six TB doctors, 11 nurses, and two laboratory technicians.

For persons held in custody as well as for staff, a doctor stationed at the MOIA functions as TB coordinator and 17 TB nurses are stationed in police station facilities. There is a plan to increase the number of nurses to 32. TB cases from this sector are managed by MOH facilities, but the staff ensures case finding and continuity of anti-TB treatment on arrest and after release from custody. This is a new commitment, in response to a demonstrated risk of TB among MOIA staff.

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

Broader Development Frameworks

Poverty and TB

The Government's strategy for combating poverty, Economic Growth and Poverty Reduction Strategy Paper, 2004-2006, notes Moldova's commitment to the U.N. Millennium Development Goals and addresses health care and TB. The strategy calls for increased access to good quality medical services for the poor in support of sustainable development and poverty reduction. This is to be achieved by developing PHC services, improving the skills of practitioners, and preventing and treating "socially conditioned diseases," which include TB. These policies are also related to health reform efforts underway, which are reorienting health care towards more accessible PHC services and increasing resources through mandatory health insurance.

The poverty strategy links the TB mortality indicator to the Millennium Development Goals. Under medium- and long-term priorities, TB mortality is to be reduced from 15.8 per 100,000 in 2002 to 14.0 in 2006 and 12.0 in 2010. The goal for 2010 in the new National Programme reiterates the commitment to reducing TB mortality to 12 per 100,000. The National Programme, on which this application is based, contains several elements that are included in WHO's Addressing Poverty in Tuberculosis Control as a means of expanding the impact of TB control for the poor and vulnerable. Strategies proposed by WHO that are part of current strategies in Moldova are: consolidate, sustain, and advance achievement of TB control policies; strengthen health systems, especially PHC; and accelerate the response to TB/HIV. The WHO report notes that the poor and vulnerable are likely to comprise a significant portion of undetected cases which are fueling transmission, and expanding case detection is thus likely to reach disproportionately the poor.

Increased awareness of TB symptoms and treatment will help to bring in more of these cases into the TB control system.

International Initiatives
The current TB control strategy in Moldova addresses elements of the Global Plan to Stop TB, 2006-2015. It includes quality DOTS expansion, measures for early detection, and the integration of MDR-TB and HIV/TB in TB control. Early detection is promoted through enhancements in laboratory diagnostics, skills and accessibility of health care personnel, and public awareness and outreach.

The proposed program includes broadcasting of TB messages on symptoms, treatment, and stigma; improved quality of media coverage on TB; and road shows that bring the message directly to communities. Surveillance on drug resistance and HIV/TB are being integrated into routine TB control. The surveillance network is being extended with an increase in the number of reporting sites. Mechanisms are being instituted for decreasing the TB burden in PLWHA through intensified case finding, formulation of case management protocols, and improved infection control. Mechanisms are being instituted for decreasing the HIV burden in TB patients through VCT and formulation of case management protocols.

The diagnostic protocols and treatment regimes in Moldova are consistent with the International Standards of Tuberculosis Care, 2006. In the proposed program, there is a considerable amount of training to upgrade skills in diagnosis, case management, and surveillance for drug-susceptible TB, drug-resistant TB, and TB/HIV co-infection. Infection control is being improved in TB facilities and in the population at large. The guidelines on contact investigation are to be revised with expert technical assistance to bring these into line with international standards. There is provision in the current TB strategy to increase social support to TB patients.

4.4.4 National health system

a) Briefly describe the (national) health system, including both the public and private sectors, as relevant to reducing the impact and spread of the disease in question.

National Health System
The health care system in Moldova is divided into three levels: Republican institutions at the national level; raion and municipal institutions at the intermediate level; and primary health care (PHC) at the local level. Most services are governmental along with some private specialty services, clinical laboratories, and a private pharmacy sector.

Tuberculosis control is integrated in the health system, with PHC services, phthisiopneumology services, the Center for Preventive Medicine, the Center for Public Health and Management, and the Institute of Phthysiopneumology having the principal responsibility. Cases are diagnosed by family physicians and phthisiopneumologists and they have joint roles in case management and treatment. The Center for Preventive Medicine is staffed by epidemiologists, who are responsible for contact investigation and infection control. The PHC and TB services inform the Center for Preventive Medicine about infectious cases for follow-up and testing of contacts. The Center for Public Health and Management oversees the surveillance system, with all reporting sites sending data to the Center. In the past, there was a duplicate system at the NTP but there is now a unified system, the SYMETA, managed by the Center for Public Health and Management.

Beginning in the late 1990s, Moldova undertook reforms in the health care system to adapt the Soviet system to current requirements. The reforms strengthened PHC and restructured the hospital sector. In 2005, 4.7% of GDP was spent on health, a near doubling since 2001, when 2.8% of GDP was spent on health. Per capita health expenditures have tripled since 2001 and were 40.7 USD equivalent in 2005. The budget for the health sector in 2005 was 1,738.4 million Lei (equivalent to USD 144.9 million). About 70% of the population is covered by health insurance and 80% of the population has access to a family physician.

In January 2004, a system of obligatory health insurance was instituted in Moldova, with employees and employers each contributing 2% of monthly salary. The self-employed, such as farmers, contribute an annual sum to the Insurance Fund and migrants can contribute in the same manner as the self-employed. There are exempt categories, such as children, the elderly, pregnant women, invalids, police and military,

and Ministry of Justice employees. The state covers the full payments into the Insurance Fund for these categories. Those officially registered as unemployed are not insured but are covered by the state budget for certain services, such as medical emergencies, tuberculosis, and some other national programs, such as HIV. These exemptions are funded in part by external donors.

The Insurance Fund covers a "unique package" of health services. For PHC services, the Insurance Fund pays providers based on a set rate per capita. For other health care services, the Insurance Fund pays providers based on a set rate per treated case. Patients must pay for services which are not included in the unique package. The maximum length of hospital stay is 75 days under the Insurance Fund. This is sufficient for TB cases, who on average remain in hospital for 50 days. The cost per treated TB case is in the range of 6400-7100 Lei.

b) Given the above analysis, explain whether the current health system will be able to achieve and sustain scale up of HIV/AIDS, tuberculosis and/or malaria interventions. What constraints exist?

Constraints of Health System

The principal constraints posed by the health system for TB control are sustained financing for drugs and supplies, personnel at all levels, the management capacity of the NTP, and the links between the civilian and penitentiary health services.

The most significant constraint is the weak capacity of the system for sustained financing of TB control. Shortages of drugs and supplies in the early 1990s led to severe consequences in inadequate treatment, poor outcomes, and the spread of TB. An assured drug supply and diagnosis by bacteriology are integral to the DOTS program and is covered by donors and public (governmental and health inssurence) funds. During the five years of the proposed program, the local support will increase steadilly. The Government is committed to combating TB, but it requires technical assistance in devising mechanisms for sustained financial commitment to TB.

Personnel problems are endemic to the health system in Moldova and affect TB control. Turnover rates are high and skills are inadequate for improving the quality of, and expanding, DOTS and DOTS-Plus. There are insufficient personnel for monitoring diagnostic investigations and for TB case management. DOT and follow-up of cases is not being carried out according to established guidelines. The MOHSP estimates that on average in the health system, the accumulation of functions caused by vacancies leads to one person carrying out the functions of 1.2 persons.
Migration is an important contributing factor and the Government estimates that 25% of the total economically active population has left for employment in other countries.

The management capacity of the NTP needs to be improved. The structures for ensuring supervision and for planning for TB control are lacking.

Historically, the civilian and penitentiary sectors have operated separately in providing health care. This has particular consequences for TB control because of the high rates of TB among the penitentiary population and the movement of infectious or incompletely treated cases from the penitentiaries into the population at large. The extent of follow-up of released prisoners who are under treatment had been inconsistent. These constraints were addressed in the past 3 years with protocols for follow-up and combining procurement, laboratories, monitoring, and surveillance. The penitentiary health services send information to the MOHSP on the domicile of released prisoners under treatment. The local health administration verifies that the person visits the DOT facility and completes treatment. KNCV reimburses former prisoners for transport expenses to the health facility. Anti-TB drugs are purchased centrally and distributed by the NTP to the the civilian and penitentiary sectors. The NTP also monitors in penitentiaries. The reference labs serve both sectors and SYMETA includes reporting of all cases in Moldova.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

Health System Strengthening

As MDR-TB diagnosis and treatment are expanding, the need is growing for facilities with adequate infection control. The MHSP has embarked on a policy of moving all MDR-TB treatment to Vorniceni TB hospital and establishing an MDR-TB ward there. This would offer an isolated environment where

interaction between patients and the general population could be minimized. Currently, MDR-TB treatment is provided at the IPP in a central area of Chisinau where students reside. The renovation of a part of Vorniceni hospital for this purpose is included in the GFATM application. This is a critical identified need and the Government has committed four-fifths of the estimated cost in its budget and is requesting one-fifth of the estimated cost from the GFATM.

The development of the health system in Moldova is centered on PHC. In 2005, the PHC sector consisted of 48 PHC centers, 383 health centers, 554 GP offices and 329 medical units. The number of GPs in Moldova in 2005 was 6000, up from 2136 in 2001. The number of nurses is somewhat higher. The number of GPs is estimated to cover 90% of requirements and the number of nurses is estimated to cover 92% of requirements.

TB control is being integrated with PHC and this integration needs to be intensified. About 30% of current PHC practitioners have been trained in TB. The remaining practitioners and new entrants need to be trained and the senior medical staff need to be inculcated in the policy. Moreover, the university curricula for PHC needs revision in order to update the section on TB and institutionalize the TB-PHC guidelines. PHC practitioners who are engaged in TB control have reported that administrators of district health departments and the boards of clinics do not understand the TB-PHC system and question the protocols. In the proposed program, training is included for senior officials and will be conducted as part of the retraining rotation for senior medical staff. The concept of family medicine is new to Moldova and the curricula is still under development. Funding is being requested from the GFATM for elaborating the TB portion of this curricula.

The proposed program includes support for developing the planning, management, and M&E capacity of the NTP. This support is critical for improving the skills of NTP personnel in planning for TB control and increasing supervision and monitoring of peripheral units. The considerable increases in case detection have increased supervisory requirements and the NTP has to provide better oversight in order to improve treatment outcomes.

4.5 Financial and programmatic gap analysis

Interventions included in relation to this component should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Such an analysis should also recognize gaps in health systems, related to reducing the impact and spread of the disease. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described. For more information on this, see the Guidelines for Proposals, section 4.5.

Use table 4.5.1-3 to provide in summarized form all the figures used in sections 4.5.1 to 4.5.3.

4.5.1 Overall needs assessment

a) Based on an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describe the overall **programmatic** needs in terms of people in need of these key services. Please indicate the quantitative needs for the 3-5 major services that are intended to be delivered (e.g. anti-retroviral drugs, insecticide-treated bed nets, Directly Observed Treatment Short-Course for TB treatment). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table in section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.5.1.*

According to the National Programme, the most important goals are timely detection of 70% of smear-positive cases and quality treatment for 85% of these cases. The overall needs for TB control in Moldova are diagnostic investigation for the 150000-180000 TB symptomatic patients presenting annually; treatment and case management under DOTS for 7000-7800 TB patients annually for the next 3 years; and treatment and case management for a total of 1150 TB patients under DOTS-Plus during 5 years. The activities related to training, surveillance, program management, and communications are in support of these patients. The programmatic gaps for

the two principal services, DOTS and DOTS-Plus, are presented in Annex 9 TB.

b) Based on an analysis of the national goals and objectives for fighting the disease component, describe the overall **financial** needs. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., costed national strategies, medium term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [line A].)*

The financial needs as shown in Table 4.5.1-3 below are based on costs of the National Programme for the period 2006-2010. At the same time additional money are requested to cover the renovation of the Vorniceni TB Hospital ($ US 5.4 million), including MDR TB Department. The cost of renovation wasn't included during the preparation of the budget of National TB Programme for 2006-2010.

4.5.2 Current and planned sources of funding

a) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line B].)*

The first NTP (2001-2005) was planned on the basis of only domestic funds and GFATM R1 project funds. Domestic funds were from the budget of the MHSP and the Health Insurance Company. These funds were designated for maintenance of infrastructure, salaries of personnel, anti-TB drugs for ambulatory treatment, prophylactic treatment of TB contacts, and treatment of chronic cases.

Under the new National Programme (2006-2010), domestic funds are designated for treatment of new TB patients (from 1400 cases in 2006 to 3000 cases in 2010 and all such cases beginning in 2012); maintenance of infrastructure; salaries of personnel; and prophylactic treatment of TB contacts. Over the course of the 2006-2010 period, the costs of diagnostics (smear and culture investigations and radiological investigations) will be borne increasingly by domestic, public funds.

Domestic funds are being provided for the planned renovation of a MDR-TB ward at Vorniceni hospital, with four-fifths of the costs covered by the MHSP budget.

b) Describe current and planned financial contributions, anticipated from all relevant external sources (including existing grants from the Global Fund and any other external donor funding) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C].)*

During 2007-2008, the GFATM R1 funds will be used for procurement of anti-TB drugs (first- and second-line) for treatment of TB, including MDR-TB; procurement of reagents and consumables for the entire laboratory network, including the prison sector (microscopy centers and reference labs); supervisory operations of the NTP in the periphery; training of TB specialists; and social support during the ambulatory phase for MDR-TB patients under DOTS-Plus.

Other external funds were provided by USAID (external source 2) beginning in 2004 to strengthen TB control. These funds are being used to upgrade the national laboratory network, strengthen PHC practitioners' capacity to provide TB-related services; improve the TB surveillance system; and increase public awareness of TB symptoms and treatment.

External source 3 funds refer to the TB control projects in the prison sector implemented by NGO CarLux and KNCV.

The current and planned actual, planned, and estimated funds for the period 2004-2010 are presented in the table below.

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

The financial gap calculation in the table below indicates that the available resources exceed overall needs for 2004-2005 and for 2007. The reason is that the overall need figure is the original budget estimate before additional activities were added to the NTP (2001-2005) and the new National Programme (2006-2010). During 2004-2005 and 2007, these additional services are or will be funded by external sources, namely USAID, NGO CarLux, and KNCV. The additional services cover extensive renovation of reference labs, training of PHC practitioners, mass media campaigns, development of the surveillance system SYMETA, social assistance for detainees with TB, and renovation of prison TB facilities.

There is a difference in the unmet need indicated in the table below and the amount requested under GFATM R6 for 2008. This is due to additional services added to the original budget estimate for the new National Programme (2006-2010). The additional services cover renovation of the MDR-TB ward at Vorniceni hospital; mass media campaigns; training for PHC practitioners; training in drug management; and extension and maintenance of the surveillance system SYMETA.

4 Component Section *Tuberculosis*

Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

Table 4.5.1-3 - Financial contributions to national response

	Financial gap analysis (*please specify currency:* Euro / US$)						
	Actual		Planned		Estimated		
	2004	2005	2006	2007	2008	2009	2010
Overall needs costing (A)	3,302,802	3,310,434	6,500,065	5,900,860	5,711,705	5,013,605	4,880,130
Current and planned sources of funding:							
Domestic source: Loans and debt relief (*provide donor name*)	0	0	0	0	0	0	0
Domestic source: National funding resources	2,516,129	2,516,129	3,976,690	4,731,910	3,521,585	2,862,160	2,646,660
Total domestic sources of funding(B)	2,516,129	2,516,129	3,976,690	4,731,910	3,521,585	2,862,160	2,646,660
External source 1 Global Fund Grants	813,605	1,319,345	1,158,950	808,416	264,430	0	0
External source 2 (*provide donor name*)	739,580	2,540,824	459,687	527,394	0	0	0
External source 3 (*provide donor name*)	87,895	125,000	226,170	185,315	252,500	0	0
Total external sources of funding (C)	1,641,080	3,985,169	1,844,807	1,521,125	516,930	0	0
Total resources available (B+C)	4,157,209	6,501,298	5,821,497	6,253,035	4,038,515	2,862,160	2,646,660
Unmet need (A) - (B + C)	-854,407	-3,190,864	678,568	-352,175	1,673,190	2,151,445	2,233,470

4.5.4 Additionality Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this will continue to be true for the entire proposal period.
The proposed program for GFATM R6 was prepared by the CCM technical working groups and accounts for all domestic and external sources of funds. For the period 2006-2010, more than 50% of the funds for the TB control program in Moldova will come from domestic sources. The funds requested from GFATM are to cover gaps and will not be used to substitute for existing and planned resources. Implementation of the GFATM grant will be monitored by the CCM, which includes representatives of the Ministry of Finance, the Ministry of Health and Social Protection, the Ministry of Justice, and international agencies. This oversight will ensure that the GFATM funds are used only for unmet needs."

4.6 Component strategy

This section describes the strategic approach of this component of the proposal, and the activities that are intended in the course of the program. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance.

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section, all applicants must submit:

- A **Targets and Indicators Table.** This is included as **Attachment A** to the Proposal Form. *(When setting targets in this table, please refer explicitly to the programmatic need and gap analysis in section 4.5.1 a. All targets should show clearly the current baseline. For definitions of the terms used in this table, see the M&E Toolkit provided by the Global Fund. Please also refer to the Guidelines for Proposals, section 4.6.*

and

- A component **Work Plan** covering the first two years of the proposal period. The Work Plan should also be integrated with the detailed budget referred to in section 5.2.

*The **Work Plan** should meet the following criteria (Please refer to the Guidelines for Proposals, section 4.6):*

e. It should be structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.

f. It should cover the first two years of the proposal period and should:
- ***i be detailed for year 1, with information broken down by quarters;***
- ***ii be indicative for year 2.***

*g. It should be **consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

*h. It should be integrated with the first two years of the **detailed budget** (please refer to section 5.2).*

Please note that narrative information in this section 4.6 should refer to the Targets and Indicators Table (Attachment A to this Proposal Form), but should not consist merely of a description of the table.

4.6.1 Goals, objectives and service delivery areas

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

Goals, objectives and service delivery areas
The strategy of the proposed program for tuberculosis is to solidify the substantial gains made since DOTS was introduced in Moldova by improving the quality of DOTS and addressing MDR-TB, HIV/TB, and public awareness and stigma. The goal of the program is to reduce the burden of tuberculosis in Moldova over the 5-year period of the grant. The program covers four objectives and thirteen service delivery areas (SDAs), as described below.

Objective 1: Strengthening DOTS realisation to improve TB detection and case management
The purpose of this objective is to ensure that the gains made in the DOTS program can be sustained and treatment outcomes improved. It targets the quality of diagnostic investigations, diagnostic and case management skills, and treatment for drug-susceptible TB. It addresses national policies and diagnostic capability for TB/HIV co-infection. There are two SDAs under Objective 1.

SDA 1.1: TB: Timely detection and quality treatment of cases
This SDA covers the timeliness and quality of diagnosis for drug-susceptible TB. It is for improving smear, culture, and DST diagnostics and the human resources capability for diagnosis and treatment of drug-susceptible TB.

Under the SDA, equipment and supplies are provided per annum for 160000 smear investigations, 30000 culture investigations, 10500 DST investigations, and internal and external quality control for these investigations. Supplies are provided for radiological diagnoses of TB symptomatics and TB patients on treatment. First-line anti-TB drugs are provided for a decreasing number of patients per annum, from 5800 patients in year 1 to 3500 patients in year 5. The difference will be covered by government funds, increasing the number from 2000 patients in year 1 to 3000 patients in year 5.

Under the SDA, the curricula for TB is to be revised for PHC and phthisopneumology. A written guide is to be prepared and printed for the medical university, TB doctors, laboratory personnel, and PHC personnel, totaling 14700 guides. Retraining for 200 TB doctors, 2000 PHC personnel, and 250 lab personnel is to be conducted.

SDA 1.2: TB/HIV collaborative activities: Prevention of HIV in TB patients
This SDA is for developing national policies for addressing TB/HIV co-infection and improving the diagnosis of HIV in TB patients. The policies are to be formulated into guidelines for practitioners diagnosing and treating TB.

Under the SDA, national guidelines are to be developed for diagnosing and treating patients co-infected with TB/HIV and for preventing HIV in TB patients. The guidelines are to be printed and practitioners are to be trained on the new guidelines. A total of 2000 guides are to be distributed and training is to be conducted for 250 doctors on managing TB/HIV co-infection.

Under the SDA, 400 TB practitioners are to be trained on conducting VCT among TB patients.

Objective 2: Management of drug resistant tuberculosis by extension of implemented DOTS-Plus project
The purpose of this objective is to support extension of the DOTS-Plus pilot project for MDR-TB and stem the transmission of drug-resistant TB in Moldova. It targets diagnostic capability, treatment, case management, patient support, and infection control for drug-resistant TB. There are 2 SDAs under Objective 2.

SDA 2.1: TB: MDR-TB
This SDA covers diagnostic capability and treatment for MDR-TB. It allows for rapid diagnosis, appropriate treatment, enablers for patients, and infection control.

Under the SDA, equipment and supplies are provided for rapid diagnostics under safe working conditions for lab personnel. The equipment and supplies are sufficient for 4000 DST investigations

per annum. Second-line drugs are provided for 200 patients during years 1-2 and for 250 patients during years 3-5. During the continuation phase, these patients are to receive food and hygienic parcels and reimbursement of travel costs to enable them to receive treatment without interruption.

Under the SDA, 250 TB and 250 PHC practitioners are to be trained in treatment and case management of MDR-TB patients. Technical assistance is to be provided for evaluating the DOTS-Plus project and development of a follow-on application to the GLC for expanding the cohort of patients.

Under the SDA, infection control in TB facilities and contact investigation for infectious cases is to be strengthened. Technical assistance is to be provided for developing guidelines to include infection control for MDR-TB and investigation and prophylaxis for TB exposure. For infection control and contact investigation, 500 guides for each are to be distributed to personnel. Training on infection control and contact investigation is to be provided to 250 personnel of the TB services and the Center for Preventive Medicine. Supplies are provided for maintenance of biosafety cabinets and personal safety protection for laboratory personnel.

SDA 2.2: Infrastructure

This SDA is for upgrading facilities for a MDR-TB ward. It provides for in-patient treatment for the additional MDR-TB patients.

Under the SDA, one ward at the Vorniceni TB hospital is to be renovated. Technical assistance is to be provided for supervision of the renovation. The ward is to expand the hospital beds for MDR-TB patients by 80.

Objective 3: Strengthening the management and coordination of the national healthcare system for TB patients and management of project

The purpose of this objective is to improve supervision and management of TB control. It targets technical and managerial capacity of the NTP and the Project Coordination Unit (PCU), monitoring of peripheral units, drug management, adjustments and extension of the surveillance system, and monitoring and evaluation. There are 3 SDAs under Objective 3.

SDA 3.1: Human resources

This SDA is for strengthening program management at the NTP and supporting monitoring and supervision.

Under the SDA, 40 NTP staff at the central unit are to be trained in planning and management. Each year, 4 senior managers of NTP are to participate in international meetings and training courses on TB control. The communications expenses of the NTP and 5 computers are to be provided. The printing of 3000 surveillance forms per annum is to be covered. For monitoring and evaluation, 3 vehicles are to be purchased and the operating costs of the vehicles and the per diem expenses for monitoring visits and specimen collection are to be covered.

Under the SDA, a drug management consultant is to be provided to the NTP and PCU to support the expansion of second-line drugs. The standard operating procedures for mangement of second-line drugs are to be revised and 2000 guides on the new procedures are to be printed. Retraining on the management of second-line drugs is to be conducted for 60 TB coordinators. Training on the management of second-line drugs is to be conducted for 250 participants by MSH and AIHA. Training on the drug management cycle is to be conducted for NTP staff.

SDA 3.2: Information system and operational research

This SDA is for strengthening the TB surveillance system, conducting operational research, disseminating surveillance information, and upgrading the monitoring and evaluation unit.

Under the SDA, the software related to TB in SYMETA (System for Monitoring and Evaluation of TB and AIDS) is to be adjusted and modules added for surveillance of DOTS-Plus and TB/HIV cases. The software guidelines are to be developed for IT professionals and for users. Anti-virus software is to be provided for 1 year. Software maintenance services and IT consultants are to be provided for 5 years.

Under the SDA, the surveillance network is to be extended. Computers and printers are to be provided for phthisiopneumologists (60), the training hall of the M&E unit at NTP (16), and national TB institutions (5). A server and upgrades are to be provided. Equipment and installation services are to be provided for 45 units to develop a regional network. An IT consultant is to provide technical assistance for 5 years for the system extension. Training on data entry, software use, data collection, and data verification is to be provided. Training on data analysis and system maintenance is to be provided to 3 IT personnel.

Under the SDA, operational surveys are to be conducted on TB treatment default and failure rates in the civilian and prison sectors. Two KAP surveys on TB are to be conducted among the general population, PHC providers, prisoners, and military service personnel.

Under the SDA, an external evaluation of the NTP is to be conducted in year 3 of the proposed program.

Under the SDA, a web site on TB control is to be developed and an annual report produced and distributed. A minipress is to be purchased for printing reports. A vehicle, printing equipment, and computers are to be purchased for the M&E unit. Telephone communications, vehicle operations, office supplies, and technical specialists for the M&E unit are to be covered for 5 years.

SDA 3.3: Project management

This SDA is for staffing and operating the PCU, which oversees the GFATM and other donor-financed health projects in Moldova.

Under the SDA, the salaries of 6 personnel and office operating costs are to be covered for 5 years. Training events (14) and attendance at international meetings (14) are to be covered. An annual audit is to be conducted. The IT equipment of the office is to be upgraded with the purchase of 5 computers.

Objective 4: Increase public awareness of tuberculosis, reduce stigmatization

The purpose of this objective is to ensure that accurate information about TB is made available widely in Moldova and communications skills of journalists and practitioners are developed. It supports public awareness of TB and TB/HIV through the mass media and education materials

for patients on transmission, symptoms, and treatment. It addresses stigmatization of TB patients and prevention of TB/HIV co-infection. The broadcast of programs and messages is to coincide with awareness campaigns so as to maximize the effect. There are 6 SDAs under Objective 4.

SDA 4.1: Behavior change communication-mass media

This SDA is for communicating information to the the public on TB symptoms and treatment using

the mass media.

Under the SDA, per annum 20 radio informational programs and 20 TV informational programs are to be developed and made available to stations without charge. The stations are to broadcast the programs without charging for air time. On radio and TV, 2 public service announcements (PSAs) are to be broadcast 2 times per annum. These mass media transmissions are to be monitored through supervisory field visits. Technical assistance is to be provided for the conceptual design, testing, and recording of the informational programs and PSAs.

Under the SDA, 20 journalists who are active in national issues and 45 journalists who are active in district issues are to be trained on reporting of TB. An annual contest for journalists is to be held to select and award a prize for the best story on TB. Thematic meetings (8) are to be held with journalists to inform them of current trends in TB.

SDA 4.2: TB: Timely detection and quality treatment of cases

This SDA is for communicating information to the public directly on TB symptoms and treatment.

Under the SDA, information and education materials are to be developed for the general public and for TB patients and their families. For the general public, 37000 leaflets, brochures, and posters on questions related to TB, symptoms of TB, and TB in children are to be distributed per annum. For TB patients and their families, 6600 booklets and leaflets on TB cure, TB prevention, and MDR-TB are to be distributed per annum.

Under the SDA, a short documentary on TB is to be developed for presentation to a range of audiences. The documentary is to be shown in outreach meetings during public awareness campaigns. A PSA on TB symptoms is to be developed for TV broadcasting. Technical assistance is to be provided for the conceptual design, testing, and recording of the documentary and PSA.

Under the SDA, a team is to be trained in conducting road shows in which information is provided to the public through direct contact. The teams are to be trained in communications and are to conduct 30 visits per annum to different localities in Moldova. These teams will be retrained on the eve of World TB Day to synchronize themes and presentations with international events.

SDA 4.3: TB: Supportive environment-stigma reduction in all settings

This SDA is for reducing stigma associated with TB through the mass media.

Under the SDA, a PSA and 4 TV talk shows focusing on stigma are to be developed. The PSA is to be broadcast once per annum and the talk show is to be broadcast 4 times per annum, beginning in the second year of the proposed program. The talk shows are be distributed to small, private TV channels in the raions. Technical assistance is to be provided for the conceptual design and production of the PSA and talk shows.

SDA 4.4: TB/HIV collaborative activities: Prevention of TB disease in PLWHA

This SDA is for communicating information on the prevention of TB disease in PLWHA.

Under the SDA, 120 peer educators are to be trained in providing TB information directly to PLWHA. A booklet is to be developed with technical assistance for the content, design, and pre-testing. A total of 3000 booklets are to be printed and distributed through peer educators.

SDA 4.5: TB/HIV collaborative activities: Prevention of HIV in TB patients

This SDA is for communicating information on HIV prevention in TB patients.

Under the SDA, a booklet is to be developed with technical assistance on content, design, and pre-testing. These booklets are to be printed and 2000 are to be distributed to TB patients per annum.

SDA 4.6: Supportive environment: human resources

This SDA is for ensuring a cohesive TB communications strategy that covers the relevant population groups and builds on previous campaigns.

Under the SDA, the consulting services of a communications coordinator are to be provided. The coordinator's role is to ensure that activities are not disparate and repetitive; all target groups are covered turn by turn in the semi-annual awareness campaigns; and the road shows, informational programs, PSAs, and campaigns have a concentrated effect.

Under the SDA, the participation of the coordinator at meetings and conferences is to be covered.

4.6.2 Link with overall national context

Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context in section 4.4. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

The goal and objectives of the proposed program are related closely to the current situation and the National Programme for TB in Moldova. The proposed program's goal of reducing the burden of TB is consistent with the National Programme's goal of stabilizing and reducing the incidence of drug-suceptible and drug-resistant TB, reducing TB mortality, and improving case detection and treatment success. Under the proposed program, all 12 strategies in the National Programme are addressed to some extent.

Objectives 1 and 4 support the rapid expansion in case detection that is underway so that cases are diagnosed, treated, and managed in a manner that improves outcomes. This is related to the National Programme's strategies for consolidating control of drug-susceptible TB and informing the public and medical personnel about transmission and symptoms. The proposed program covers early detection, sound diagnostics, and appropriate treatment and case management. Objectives 1 and 4 also address control of TB/HIV co-infection, as indicated in the National Programme. They cover increasing awareness of co-infection and protocols for case finding and treatment.

Under Objective 2, the extension of DOTS-Plus will enable diagnosing a larger segment of these cases and treating them with adequate drug regimes. The high failure and death rates for TB cases in Moldova are linked to the insufficient diagnostic and treatment capability for MDR-TB. Under the proposed program, enablers in the form of food and hygienic packages and transport expenses are to be provided to DOTS-Plus patients. The National Programme calls for reducing the burden of MDR-TB based on the DOTS-Plus strategy and for social support to patients undergoing treatment and to their families.

The expansion of DOTS-Plus is also supported under the proposed program with the renovation of a MDR-TB ward at Vorniceni TB hospital. This addresses the National Programme's provisions for MDR-TB control and infection control. These are significant gaps in current TB control.

Under Objective 3, the NTP's oversight capability for TB control is to be improved. NTP managers will be better able to plan for, and respond to, epidemiological trends. Improved surveillance and operational surveys on the default and failture rates will enable the NTP to apply the data to design appropriate interventions for improving outcomes for TB patients. The National Programme calls for strengthening the national policy on TB control and epidemiological surveillance and monitoring. The proposed program helps to address these critical gaps that have contributed to outcomes in Moldova that are below global

targets.

Infection control is addressed in the proposed program and the National Programme. Guidelines for medical facilities, contact investigations, and TB prophylaxis are to be revised. Training is to be conducted on the revised guidelines. Training and guideline development are included in all 4 objectives of the proposed program in order to institutionalize improved TB control. The proposed program addresses the gap at the senior level of local health administrations and hospitals by including training on TB-PHC during retraining rotations of medical staff. The National Programme calls for the development of human resources, including continuing education and improving skills to support TB control consistent with international standards.

Objective 4 addresses the National Programme's strategy for communications. The National Programme calls for a communications coordinator who has the responsibility of bringing consistency to TB communications. There is much that has been accomplished in raising awareness and engaging the mass media in the past 3 years. This foundation has to be used effectively by updating messages, targeting all vulnerable populations, and using the different means of communications in concentrated campaigns.

4.6.3 Activities

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include all the activities proposed, how these will be implemented, and by whom. *(Where activities to strengthen health systems are planned, applicants are also required to provide additional information at section 4.6.6.)*

The description of the activities that will be implemented are presented in Annex 11 TB.

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

This section refers to any prior Global Fund grants for this disease component and requests information on performance to date and linkages to this application. For more information, please refer to the Guidelines for Proposals, section 4.6.4.

a) Provide an update of the current status of previous Global Fund grants for this disease component, in the table below.

Table 4.6.4. Current Global Fund grants

	Grant number	Grant amount*	Amount spent
GF Grant 1	MOL-102-G01-C-00	11,719,047	7,641,072
GF Grant 2			
GF Grant 3			
GF Grant 4			

* *For grants in Phase 1, this is the original two year grant amount. For grants that have been renewed into Phase 2, this is the total amount, inclusive of Phase 1 and Phase 2. For unsigned Round 5 grants this is the two year TRP approved maximum budget.*

b) Please identify for each current grant the key implementation challenges and how they have been resolved.

The GFATM R1 grant's TB component has been implemented according to the activity plan. As of June 30, 2006, actual disbursements were $ US 3,210,071.58 and planned disbursements for the 5-year period were $ US 4,400,641.00.

4 Component Section *Tuberculosis*

"The principal challenge has been related to MDR-TB. The DOTS-Plus application to the GLC was submitted later than planned by the NTP, delaying implementation of MDR-TB treatment and social assistance to MDR-TB patients. At present, Moldova is preparing another application to the GLC for additional patients to be treated under DOTS-Plus. This will allow for the disbursement of all R1 funds foreseen for this activity

c) Are there any linkages between the current proposal and any existing Global Fund grants for the same component? (e.g. same activities, same targeted populations and/or the same geographical areas.)	☒ Yes ➔ *complete d)* ☐ No ➔ *go to 4.6.5.*
d) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided under current Global Fund grants.	
The Application to the Round 6 of the GFATM was preapred by CCM technical working groups and has taken in consideration existing sources from all donors. At the same time GFATM R1 Grant and USAID Grant will finish at the beginning of new GFATM R6 grant. Requested resources will be used to develop, maintain, or strengthen activities started with the support of existing donors.	

4.6.5 Linkages to other donor funded programs

a) Are there any linkages between the current proposal and any other donor funded programs for the same disease	☒ Yes ➔ *complete b)* ☐ No ➔ *go to 4.6.6.*
b) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided by other donors, including in respect of health system strengthening activities.	

The proposed program is built on the foundation established with the assistance of other donors and uses earlier investments to advance TB control. The largest of the other donors for TB has been USAID and its project is ending in 2007. Under the proposed program, the laboratories renovated under the USAID project will enable culture investigations for all patients registered for TB treatment; the ongoing TB-PHC integration will be expanded to all PHC practitioners as well as higher level administrators; the electronic surveillance network will be extended to additional sites and MDR-TB and TB/HIV data; and TB communications will be refined and directed at target populations who have yet to be reached. There was close collaboration in the GFATM R1 project and the USAID project and the proposed activities make full use of the substantial progress made as a result of these past investments.

NGO CarLux and KNCV have supported TB control in prisons and will continue to have a role in technical assistance and social support. Their activities are not duplicated in the proposed program. TB control in the civilian and prison sectors in Moldova is being harmonized and unified, and NGO CarLux and KNCV will help to address the special circumstances of prisoners.

4.6.6 Activities to strengthen health systems

Certain activities to strengthen health systems may be necessary in order for the proposal to be successful and to initiate additional HIV/AIDS, tuberculosis, and/or malaria interventions. Similarly, such activities may be necessary to achieve and sustain scale-up.

Applicants should apply for funding in respect of such activities by integrating these within the specific disease component(s). Applicants who have identified in section 4.4.4 health system constraints to achieving and sustaining scale-up of HIV/AIDS, tuberculosis and/or malaria interventions, but do not presently have adequate means to fully address these constraints, are encouraged to complete this section. For more information, please refer to the Guidelines for Proposals, section 4.6.6.

a) Describe which health systems strengthening activities are included in the proposal, and how they are linked to the disease component. *(In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. See the Multi-Agency M&E Toolkit.)*

The health system strengthening activities are related to human resources, MDR-TB facilities, and the planning and management capacity of the NTP.

Under the proposed program, training is to be provided to 200 TB doctors, 2000 PHC personnel, and 250 laboratory personnel on DOTS; 250 personnel and 400 doctors on TB/HIV; 250 TB doctors and 250 PHC personnel on DOTS-Plus; 250 personnel on infection control; 40 NTP personnel on planning and management; 60 TB coordinators on management of first-lne drugs; 250 TB specialists on management of second-line drugs; 65 journalists on reporting on TB; and 120 peer educators on TB/HIV.

The renovation of the MDR-TB ward at Vorniceni hospital will increase the treatment capacity for DOTS-Plus by 80 numbers of beds.

b) Explain why the proposed health systems strengthening activities are necessary to improve coverage to reduce the impact and spread of the disease and sustain interventions. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.6.)*

These activities are necessary for improving the quality of DOTS, expanding DOTS-Plus, and initiating management of TB/HIV co-infection. The level of skills and the extent of supervision are insufficient currently and has contributed to high default and failure rates in Moldova. The proposed activities will allow for improved oversight and management of TB control.

c) Describe how activities to strengthen health systems, integrated within this component, will have positive system-wide effects and how it is designed in compliance with the surrounding context and aligned with government policies.

The National Programme calls for strengthening human resources and improving planning and management of TB and MDR-TB. Improving TB control and reducing the associated burden in human and financial costs will have a positive effect on the health system in general.

d) Are there cross-cutting health systems strengthening activities integrated within this component that will benefit any other component included in this proposal?	☒ Yes ➔ *complete e) and f)*
	☐ No ➔ *go to g)*

e) If you answered yes for d), describe these activities and the associated budgets and identify and explain how the other components will benefit. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

These activities are aimed at management of TB/HIV co-infection and cover diagnosis of TB, including among PLWHA; assuring TB treatment for co-infected cases; elaboration of guides and standards for the TB services on management of co-infected cases; and training of TB specialists in VCT. These activities will extend TB control to the PLWHA population and allow for

treatment of the most prevalent opportunistic infection in this population. The budget for these activities is included in the TB component, under Objective 1.

f) If you answered yes for d), confirm that funding for these activities has not also been requested within the other component. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

The TB component of the proposal includes the needs related to diagnosis and treatment of TB, including among PLWHA, training in VCT for TB personnel, and elaboration of guides and standards for the TB services.

"The HIV/AIDS component of the proposal includes the needs related to diagnosis of HIV in TB patients; ARV treatment for co-infected cases requiring treatment; and anti-TB drugs for prophylactic treatment in HIV-positive cases.

g) Is this component reliant on any cross-cutting health systems strengthening activities that have been included within other components of this proposal?	☐ Yes ➔ *complete h)* ☒ No ➔ *go to 4.6.7.*

h) If you answered yes for g), describe these activities and the associated budgets and identify and explain how this component will benefit. *Please refer to the Round 6 HSS Budget Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

4.6.7 Common funding mechanisms

This section seeks information on funding requested in this proposal that is intended to be contributed through a common funding mechanism (such as Sector-Wide Approaches (SWAp), or pooled funding (whether at a national, sub-national or sector level).

a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* ☒ No ➔ *go to 4.8*

b) Indicate in respect of each year for which funds are requested the amount to be funded through a common funding mechanism.

c) Describe the common funding mechanism, whether it is already operational and the way it functions. Identify development partners who are part of the common funding mechanism. Please also provide documents that describe the functioning of the mechanism as an annex. *(This may include: The agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

d) Describe the process of oversight for the common funding mechanism and how the CCM will participate in this process.

e) Provide an assessment of the incremental impact on projected targets as a consequence of the funds being requested for this component, which are to be contributed through the common funding mechanism.

f) Explain the process by which the applicant will ensure that funds requested in this application, that are contributed to a common finding mechanism, will be used specifically as proposed in this application.

4.6.8 Target groups

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

The target group is TB symptomatic and TB patients. At this time this target group is not organized in Moldova and has been reached individually. The target group will benefit directly from the proposed program in terms of reduced disease burden. Improved detection, treatment, and case management will improve treatment success and a larger percentage of TB cases will be cured. The specific emphasis is placed on groups at high risk of contracting the disease: prisoners, labour migrants, and IDPs. There are a very substantial number of labor migrants in the country who are difficult to reach by disease control interventions because of their 'dispersion' in the population and long periods of absence abroad. It is foreseen that representatives of vulnerable groups will be actively involved in the project implementation through innovative approaches such as peer education (by ex-TB patients, e.g. in prisons) and work with families of seasonal workers.

4.6.9 Social stratification

Provide estimates of how many of those expected to be reached are women, how many are youth, how many are living in rural areas and other relevant categories. The estimates must be based on a serious assessment of each objective.

Table 4.6.9 Social stratification

	Estimated number and percentage of people reached who are:			
	Women	Youth (<18)	Living in rural areas	Other*
SDA 1	30	8	49	
SDA 2	30	2	49	
SDA 3	30	8	49	
SDA 4	52	27	54	

* *"Other" to include target groups according to country setting, e.g. indigenous populations, ethnic groups, underprivileged regions, socio-economic status, etc. Targets should be defined according to country disease programs.*

4.6.10 Gender issues

Describe gender and other social inequities regarding program implementation and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities.

Gender differences in access and delivery of services for TB are not apparent in Moldova. The male to female ratio in new cases of TB is 2.7:1 and cases among males are growing at twice the rate of cases among females. There are no indications that this ratio is not representative of the underlying incidence of TB in Moldova. There are indications that females tend to visit PHC centers more frequently than men. As TB-PHC integration progresses and more cases are detected at the PHC level, the messages regarding timely detection will be addressed to both males and females.

4.6.11 Stigma and discrimination

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

Stigma towards TB patients is not a large concern in Moldova. As listed in the indicator table, 52% of people were found in a KAP survey to be afraid to be infected with TB. There are activities in the proposed program to help reduce stigma through public awareness and TV talk shows on the theme of patients needing support. The information on TB transmission and treatment will also have the effect of dispelling fears about TB. The purpose of the stigma reduction campaign is to elicit greater attentiveness towards patients.

4.6.12 Equity

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

Diagnosis and treatment for drug-susceptible TB are provided without charge in Moldova. The mandatory health insurance system covers PHC visits and TB treatment, allowing all residents to have access to services. The continuing integration of TB and PHC also supports equity principles because PHC is more accessible. Public awareness campaigns will allow the message of symptoms and free treatment to reach a wide audience in Moldova.

The treatment for drug-resistant TB is not available to all patients. The selection procedures have been outlined in the DOTS-Plus program and are based on criteria included in Aplication to the GLC.

4.6.13 Sustainability

Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the program term. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.13.)*

There is a full commitment of the Government to decrease the burden of TB in Moldova. The Government has stated its commitment to TB control in the National Programme and placed strengthening national policy as the first of twelve strategies in the National Programme. The Government intends to make TB control a priority public health concern and create policy and financing systems to fund TB at the necessary level to achieve global targets. The mechanisms for achieving this are to be developed during the period of the proposed program. It is expected that the state financing of the health sector overall and of TB control in particular will continue to increase substantially during the next five years. It is therefore anticipated that the Government will take over many interventions currently funded from external sources and support for which is requested from the Global Fund. Cost-sharing arrangements are included in this application (for example, for

renovation of the MDR-TB building in Vorniceni).

4.7 Principal Recipient information

In this section, applicants should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.

4.7.1 Principal Recipient information

Every component of your proposal can have one or several Principal Recipients. In table 4.7.1 below, you must nominate the Principal Recipient(s) proposed for this component.

Table 4.7.1: Nominated Principal Recipient(s

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

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone, fax numbers and e-mail address**
Project Coordination, Implementation and Monitoring Unit, of the Ministry of Health and Social Protection of the Republic of Moldova	PCIMU will be responsible for the project implementation, procurement, financial, management, coordination and M&E with related implemnting agencies in and outside country	Dr. Victor Volovei	Executive Director, 101 Scuisev str, MD 2012 Chisinau, Republic of Moldova, Tel/Fax: + 373 22 23 87 51 E-mail: vvolovei@ucimp.md

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements. *(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM. Maximum of half a page.)*

The CCM aims to contribute to the effective implementation of the National Program for Prevention of HIV/AIDS and the National Programme for TB Control, acting as a nexus point for coordinating and overseeing donor financing in support of the national commitment and priorities to fight HIV/AIDS/STIs and TB. The CCM on TB/AIDS has assumed oversight responsibilities for programs funded by the World Bank, the Global Fund, USAID, Swedish governments, and UN agencies ensuring a harmonized approach towards achieving the national program goals and Moldova's health-related MDGs. The CCM is an integral part of the "three ones" system in the country serving as the national HIV/AIDS and TB

coordinating body. CCM approves the national documents elaborated by technical working groups

The CCM on TB/AIDS will play a leading role in coordination and oversee the overall implementation of the project.

The CCM's structure is organized on three levels: decisional (22 representatives), coordination (CCM Secretariat), and operational: technical working groups (10). The technical working groups (5 active in HIV/AIDS field, 4 in TB field and one mixted (TB/AIDS): monitoring and evaluation are responsible to assess the needs in their specific areas, to identify solutions, to elaborate the drafts of the national documents: strategies and policies. The technical working groups are widely represented: nongovernment sector, governmental and international ones, as well as representatives from different regions of the country, including Transnistria.
The Secretariat of the CCM (supported financially by World Bank and UNAIDS) is responsible for the coordination and information activities, as well as facilitating the nation wide consultancy processes, CCM meetings: information on the CCM processes and news is mostly shared through email, via a daily online newspaper to every CCM member. CCM members are always asked to distribute the materials to their constituencies. There is also a printed quaterly newspaper "CCM Informational Bulletin" distributed to a large range of beneficiaries.

PCIMU of Ministry of Health and Social Protection will take implementaion functions. It will make contractual arrangements with sub-recipient.
PCIMU will assure the coordination of efforts with other partners that will be involved in the implementation: National TB control Programme / National TB Institute, Medical Service of Penitentiary Department Ministry of Justice, National AIDS Centre, Centre of Public Health and Sanitary Management, and technical partners of project and international agencies.

Procedures for sub-contracting, procurement and financial management, M&E, audit and oversight will be provided according with Operational Manual of the PCIMU.

Please note that if there are multiple Principal Recipients, section 4.8.2 below has to be repeated for each one.

4.8.2 Principal Recipient capacities

a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient. Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

PCIMU has been founded through the Decision nr. 391, on 19th April 2000, of the Government of the Republic of Molodva for the implementation of World Bank and Dutch Government credits for the restructuring health system of the Republic of Moldova.
After the approval of the application for the GFATM first round in 2003 the Ministry of Health and Social Protection decided to implement the grant through PCIMU, and the following additional personnel has been hired for the implementation of the TB/AIDS project: TB/AIDS coordinator, procurement officer, financial officer and M&E officer.

The PCIMU capacity has been evaluated by the Local Fund Agent during the years 2003-2004 (Institutional and Programmatic Assessment Report & Monitoring and Evaluation Assessment Report are attached: Annex 12 TB and 13 TB). During the implementation of the grant the PCIMU activity has been quarterly monitored by the Local fund Agent. The Local Fund Agent concluded that PCIMU has sufficient technical, managerial and financial capacity for adequate management of the grant.

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes ☐ No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☒ Yes ☐ No

d) If you answered yes for b) or c), provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous grants (Global Fund or other donor).

The project "Support to the National Programme for the Prevention and Control of HIV/AIDS and STIs and the National Programme for control of Tuberculosis" has been approved by GFATM in March 2002. The programme grant agreement has been signed on March 24, 2003. The total grant for five years is US$ 11,719,047.00, divided into two phases: first phase - US$ 5,257,941.00 for the first two years and second phase – US$ 6,461,106.00 for the last three years.
In 2005 the GFATM evaluated the project implementation performance and appreciated it with the Qualificativ "A" and the second phase has been approved for implementation. By July 01, 2006, PCIMU disbursed according to the approved activity plans 7,641,072.09 US$, which represent 65 % from the total grant amount.
In addition to the GFATM Grant, the PCIMU is implementing since October 2003 the IDA Grant totalling US$ 5,500,000.00 for the "AIDS Control in RM". By July 01, 2006, PCIMU disbursed 2,671,800.94 US$, which represent 49 % from the total grant amount. The activities implemented by PCIMU within this grant have been evaluated during the World Bank Mid-Term Review being satisfactorily appreciated (the Mid-Term Review Mission Aide Memoire is attached: Annex 14 TB).
The PCMIU have Operational Manual which include guidelines for the procurement and financial management according to the World Bank rules.
Annually activity plans are prepared for both grants and the budgets are revised. The M&E plan includes a list of indicators approved for both grants and a list of targets to reach.

Additionally, PCIMU (TB/AIDS staff) implemented the PHRD Grant totalling US$ 91,783.00, from December 2002 to June 2003, and the SIDA Sweden Grant totalling US$ 604,615.00, from December 2001 to September 2003, both grants aimed at supporting the Control of HIV/AIDS and TB in Republic of Moldova.

e) If you answered yes for b) or c), describe how the PR would be able to absorb the additional work and funds generated by this proposal.

The financing of activities within both grants, GFATM grant second phase and World Bank grant, will end in the second quarter of 2008. In accordance with this there are no impediments for the implementation of the activities proposed within the application for the GFATM 6th round. Available human capacity with experience in GFATM and WB grants implementation will be involved.

4.8.3 Sub-Recipient information

a) Are sub-recipients expected to play a role in the program?	☒ Yes *➔ complete the rest of 4.8.3* ☐ No *➔ go to 4.9*
b) How many sub-recipients will or are expected to be involved in the implementation?	☒ 1 – 5 ☐ 6 – 20

	☐ 21 – 50
	☐ more then 50
c) Have the sub-recipients already been identified?	☒ Yes ➔ *complete 4.8.3. d) -e) and then go to 4.9*
	☐ No ➔ *go to 4.8.3. f) – g)*

d) Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.).

The sub-recipients were selected on the basis of their demonstrated capacity for implementing the proposed activities. These entities are currently carrying out similar activities and are critical to building on the foundation established by the previous Global Fund grant and other donors in Moldova. They have systems in place for their areas of responsibility, for minimizing duplication, for financial management, and for ensuring that the accomplishments of recent years are used for advancing TB control.

AIHA-Moldova has been implementing a US-government funded TB control project since late 2003. It has been providing training for PHC-TB integration, revising guidelines and curricula, upgrading laboratories, revamping the surveillance system, and conducting public awareness campaigns. The project has been implemented in close coordination with the NTP, the medical university, and the PCU. The Global Fund supplied laboratory equipment for the renovated reference labs and computers for the surveillance network. AIHA-Moldova has extensive collaboration with mass media organizations and journalists and is knowledgeable about how to build on the awareness campaigns of the past 2 years. In the proposed program, it has responsibility for training, guidelines, and curricula and all communications activities.

The Center for Public Health and Management has been overseeing the TB surveillance system and was actively involved in revising the system. It has the knowledge base for expanding the system and conducting operational research for enhancing TB control. The Center for Public Health and Management will have responsibility for all activities related to the surveillance system and for conducting surveys.

Soros Foundation Moldova has been functioning as the NGO facilitator for Global Fund grants in Moldova. It will continue in this capacity under the proposed program and be responsible for providing incentives to MDR-TB patients and their families.

MSH has been providing technical assistance for procurement and management of anti-TB drugs. In the proposed program, it will assist the NTP in fulfilling GDF requirements and providing training on the drug supply system.

The NTP has the primary responsibility for oversight of TB control. The proposed program will provide direct support to the NTP to improve its capacity for planning, supervising, and monitoring and evaluation.

Technical services to be purchased by these sub-recipients under the proposed program will be in accordance with World Bank procedures.

e) Where sub-recipients applied to the Coordinating Mechanism, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal.

There are no instances of sub-recipients who applied to the National Country Coordinating Mechanism and were not selected.

f) Describe why sub-recipients were not selected prior to submission of the proposal.

N/A

g) Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process.

N/A

4.9 Monitoring and evaluation

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

4.9.1 Plans for monitoring and evaluation

Describe how the targets and activities indicated in the Targets and Indicator Table (attached as Attachment A to this proposal, see section 4.6) will be monitored and evaluated. Please identify any surveys to which this proposal is contributing.

The M&E system to be used by the project will be in concordance with National Informational M&E system, and most of the indicators will be in concordance with national list of indicators or will complement.

The PCIMU has an M&E Plan which describes the data what will be collected, who will collect it and how it will be collected, what the baseline is and what is the basic timeline for implementation.

According to M&E Plan, PCIMU will collect the following regular quarterly data from implementing organizations (sub-recipients and implementing partners):
- Quarterly activity reports.
- Quarterly financial reports.
- List of indicators.

The activity and financial reports received from the implementing organizations will be archived by the PCIMU and the values of M&E indicators will be inserted to the database of the PCIMU.
Subsequent to the verification of the reports and indicators from the implementing organizations PCIMU will produce reports that will be submitted to the donor.
The majority of indicators will be collected quarterly and only a few of them will be collected on an annual basis (epidemiological indicators) or once in 3 years (surveys).

PCU will be responsible for the quarterly (or annually) data collection and periodic site visits to the implementation organizations.

4.9.2 Integration with national M&E Plan

Describe how performance measurement for this program is proposed to contribute to and/or strengthen the national Monitoring and Evaluation Plan for this component. If a national Monitoring and Evaluation strategy exists, please attach it as an annex to the proposal, and provide a summary of key linkages with the national Monitoring and Evaluation Plan and data collection methods.

The Monitoring & Evaluation activities are important parts of this component. The country has established with the support of international technical agencies (WHO, Euro TB, MSH) and donors (AIHA) a functional National Informational M&E system (SYMETA) for evaluation of the progress of the implemented activities on TB and AIDS control and monitoring of both diseases.

The M&E system to be used by the project will be in concordance with National Informational M&E system, and most of the indicators will be in concordance with national list of indicators or will complement.

Relevant resources are requested under Objective 2 to assure the training of NTP staff, including in M&E activities, to support the procurement of cars and the regular supervision visits in civillian and penitentiary,

which represent an instrument for strengthening M&E activities.

In addition relevant resources are included to assure the maintenace and strenghthening of the SYMETA: development of TB/HIV and DOTS Plus modules built on, extension of the system infrastructure, support and trainings of personnel, realisation of opeartional researche and support to the M&E Unit of the Centre of Public Health and Sanitary Management.

4 Component Section *Tuberculosis*

4.10 Procurement and supply management of health products

In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.10.

4.10.1 Organizational structure for procurement and supply management

Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

The PR is conducting its activities based on a written Project Operational Manual. PCU was initially created to implement WB projects, including Moldova AIDS control project. As a result the POM was developed in accordance with the WB procurement policies, and procedures for carrying out procurement and supply management activities. These documents ensure open and transparent competition and have explicit evaluation and award criteria that guarantee efficiency and value for money.

The main methods used for procurement of goods will be: i) open international tenders; ii) request for quotations iii) procurement from UN agencies and non-profit international agencies.

To ensure quality and reliability of the orders the PCU will prefer the procurement of pharmaceuticals, condoms and standard tests (ELISA, Viral Load, CD4-CD8) from the well established international non-profit agencies such as – WHO procurement department, GDF, UNICEF, UNFPA, IDA Amsterdam

Consultants will be procured using the following methods i) Individual consultants (for individuals) ii) Consultant Qualifications iii) Quality Cost Based Selection (amounts bigger then 200 000 USD) iv) Least Cost Selection (ex. Audit services)

All the procurement principles and methods are in line with the i)Guidelines for Procurement under IBRD Loans and IDA Credits 2004 (for goods, works and services) ii) Guidelines on Selection and Employment of Consultants by World Bank Borrowers

Management capacity and coordination

NTP the coordinator. Coordinates the implementation of treatment strategy. Develops, adjusts the treatment guidelines in accordance with the WHO recommendations; epidemiological data; morbidity, resistance, categories of patients

PR – is responsible for the overall Procurement and Supply Management. For adherence to GF and national policies, for organising efficiency and transparency of the procurements.

Drug Management Team of the NTP selects and determines the items and forms of pharmaceuticals for the procurement. Monitor the distribution and use of drugs.

National Drug Agency is responsible for the drug policy. It co-participates at the development of quality assurance requirements (registration and authorisation of the drugs on the market, state control of the quality)

Coordination will be preformed at every step of the supply chain
1. Selection.
It is the responsibility of the Drug Management Team, that is under the NTP, to organise the process of selection. WHO will consult the Ministry of Health on adherence of selected pharmaceuticals to the WHO treatment protocols and practices.
Monitoring and Evaluation of the national Programme Department of the Scientific Practical Centre of Public Health and Sanitary Management provides morbidity rates, categories of patients and other statistical data. The selected products will be coordinated with the MOHSP

2. Procurement.

It is the responsibility of the PR to conduct all the procurements in line with the GF and National policies and rules.

During the quantification process the PR will advise on the unit prices, based on the big procurement experience obtained during the implementation of the WB and GF grants

PR will collect the specifications from the beneficiaries. For simple orders the PR will start the procurement process immediately. For the procurement of complex health sector goods, the specifications will be coordinated with the working group on procurements of drugs and health products of the MOHSP.

To ensure a transparent but at the same time efficient evaluation process, the evaluation committee will differ depending on the value of the contract. Contracts less then 50 000 USD will be evaluated within the PIU with the involvement of the beneficiaries of the procurement.

Contracts with between 50 000 USD and 200 000 USD will be evaluated in coordination with the MOHSP.

Contracts of 200 000 USD and higher (this refers to open tender procedures) will be evaluated by a commission the includes members from: MOHSP, UN agencies (UNAIDS), Ministry of Justice (penitentiaries), Beneficiaries.

3. Distribution.

All the import procedures for the tenders performed are the responsibility of the PR. MOHSP will issue the import authorisations based on the invoices submitted by the PCU. Customs department will issue letters for tax exemptions. Where it will be possible the health goods and pharmaceuticals will be delivered directly to the beneficiaries, thus avoiding central storage. But in some cases for drugs distribution (1st and second line TB drugs) the state company “San-FarmPrim” will be used as the central store. The drugs will be stored there and distributed in accordance with the distribution scheme prepared by the NTP and approved by the MOHSP

4. Use.

To ensure the rational use of pharmaceuticals the NTP has developed the treatment strategy of using fix dose combinations in treatment guidelines and in the selection and procurement practices. Also the packing requirements have been modified to use blisters, that improved the quality of the rendered services, inventory management and storing and distribution practices. The system for monitoring adverse drug reactions and drug resistance is implemented in the country. Measures have been taken to supervise the rational use of pharmaceuticals authorised on the territory of Moldova and namely:

- periodic review of the essential drug list
- study of the rational use of the pharmaceuticals in certain diseases (by analysing the patients cards) and further informing the practitioners by means of publications

The MOHSP has approved the regulation of data collection on the adverse reactions.

Quality Assurance

It is the responsibility of the PR to ensure that products being purchased with GF financing are of high quality and correspond to the National Drug Regulatory Authority (NDRA) and Global Fund requirements. Quality assurance of the drugs involves several levels and coordination of different institutions and namely:

- Formulation of the specifications and quality requirements of the drugs to be procured. That includes procurement only of the WHO prequalified products and adherence to GF policies on Procurement and Supply Management. The quality systems of the GDF and GLC (IDA), including pre-shipment inspections performed by international agencies (Ex. SGS)
- national system of quality assurance of the drugs before they reach and are used on the local market and includes: authorisation of drugs that includes expertise, homologation and drug registration by the Drug Commission of the Drug Agency; state control of all the batches of the imported and locally manufactured drugs
- post marketing quality surveillance. With the participation of the pharmaceuticals inspection of the National Drug Agency, Monitoring Department of the NTP.

4 Component Section *Tuberculosis*

4.10.2 Procurement capacity

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

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

From the beginning of the GFATM R 1 and IDA Grants in 2004, the PCIMU has spent $ US 5,053,562.84 for procurement of drugs and medical supplies (for Tuberculosis and HIV/AIDS components).

4.10.3 Coordination

a) For the organizations involved in section 4.10.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc

Grant of the GFATM Round 1 and IDA Grant (100%)

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

Antituberculosis I line drugs are procured using Direct Procurement mechanism through IAPSO from the Global TB Drug Facility.

Antituberculosis II line drugs are procured using GLC mechanism through IDA Amsterdam.

4.10.4 Supply management (storage and distribution)

a) Has an organization already been nominated to provide the supply management function for this grant?	☒ Yes ➔ *continue*
	☐ No ➔ *go to 4.10.5*

b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. If more than one of the boxes below is ticked, describe the relationships between these entities.	☒ National medical stores or equivalent
	☐ Sub-contracted national organization(s) *(specify which one(s))*
	☐ Sub-contracted international organization(s) *(specify which one(s))*
	☐ Other *(specify)*

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

National medical store "San Farm Prim" has sufficient capacity and territorial branches to assure the storage of antituberculosis drugs (first and second line). The drugs will be stored there and distributed in accordance with the distribution scheme prepared by the NTP and approved by the MOHSP.
This mechanisms is used and works from 2005, when has started the firs procurement of antituberculosis drugs by PCIMU. Until 2005 "San Farm Prim" has storage and distributed the first line antituberculosis drugs which Moldova had received as grant from GDF.

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

National medical store "San Farm Prim" has sufficient capacity and territorial branches to assure the storage of antituberculosis drugs (first and second line). The drugs will be stored there and distributed in accordance with the distribution scheme prepared by the NTP and approved by the MOHSP.
This mechanisms is used and works from 2005, when has started the firs procurement of antituberculosis drugs by PCIMU. Until 2005 "San Farm Prim" has storage and distributed the first line antituberculosis drugs which Moldova had received as grant from GDF.

All country, including prisons, will be covered.

[For tuberculosis and HIVAIDS components only:]

4.10.5 Multi-drug-resistant TB

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

If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.5.

4.11 Technical and Management Assistance and Capacity-Building

Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including in respect of , development of M&E or Procurement Plans, enhancing management or financial skills etc. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.11.

4.11.1 Capacity building

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

The capacity constraints are related to human resources, planning and management, and extension of TB control to include MDR-TB and TB/HIV. There are insufficient numbers of skilled personnel for strengthened TB control and they do not have sufficient means for carrying out their duties. This gap is addressed in the proposal through training, guideline development, and curriculum development to reflect the new guidelines. These activities are closely linked and are supported by provision for more supervision of TB cabinets and labs in the periphery.

The NTP's planning, management, and M&E capacity is addressed in the proposal. There is training in planning for NTP managers and direct support for the M&E unit.

Moldova is beginning to address MDR-TB and TB/HIV co-infection and needs assistance in developing guidelines and systems. These aspects have to be integrated into the PHC-TB system. The integration of PHC-TB needs to be enhanced overall in order to provide adequate diagnostic and treatment services for greater numbers of cases being detected.

4.11.2 Technical and management assistance

Describe any needs for technical assistance, including assistance to enhance management capabilities. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, section 5.6)*

Technical and management assistance is needed for developing guidelines and communications materials, quality assurance, project management, and evaluation. The budget includes funding for technical assistance on guidelines for TB/HIV and infection control in facilities and among the population. There are provisions for MDR-TB control, including external quality assurance for DST, evaluation of DOTS-Plus and an application for extending DOTS-Plus, technical assistance from the GLC, and technical supervision of the renovation of an MDR-TB ward.

The documentary and informational programs on TB are to be developed with technical assistance. The operations of the PCU are included in the budget for management of the proposed program. Planning and management assistance is provided to the NTP for field supervision. There is provision for an evaluation of the NTP.

5 Component Budget *Tuberculosis*

PLEASE NOTE THAT THIS SECTION IS TO BE COMPLETED FOR EACH COMPONENT.

In this section, applicants will need to provide summary budget information for the proposed duration of the component. Applicants are also required to provide a more detailed budget as an annex to the proposal. For more information on budget requirements, please refer to the Guidelines for Proposals, section 5.

If part or all of the funding requested for this component is to be contributed through a common funding mechanism (consistent with section 4.6.7), **applicants should provide:**

- Compile the Budget information in sections 5.1 – 5.6 on the basis of the anticipated use, attribution or allocation of the requested funds within the common funding mechanism; and
- Provide, as an annex, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request.

5 Component Budget *Tuberculosis*

5.1 Component budget summary

Insert budget information for this component broken down by year and budget category, in table 5.1 below.
(The "Total funds requested from the Global Fund" should be consistent with the amounts entered in table 1.2 relating to this component.)

The budget categories and allowable expenses within each category are defined in the Guidelines for Proposal, section 5.1. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.

Table 5.1 – Funds requested from the Global Fund

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	173,535	145,082	132,782	139,582	123,482	714,463
Infrastructure and equipment	1,169,900	374,800	43,000	0	0	1,587,700
Training	130,410	141,760	130,460	109,760	79,160	591,550
Commodities and products	846,580	767,857	718,077	681,171	626,393	3,640,078
Drugs	983,692	975,834	1,116,854	1,101,108	1,067,714	5,245,202
Planning and administration	55,720	21,720	53,400	43,400	23,400	197,640
Other (*please specify*)						0
Other (*please specify*)						0
Other (*please specify*)						0
Total funds requested from the Global Fund	3,359,837	2,427,053	2,194,573	2,075,021	1,920,149	11,976,633

5 Component Budget *Tuberculosis*

5.2 Detailed Component Budget

The Component Budget Summary (section 5.1) must be accompanied by a more detailed budget covering the proposal period, attached as an annex to the proposal. The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.2):*

*f) It should be **structured along the same lines as the Component Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities.*

g) It should cover the term of the proposal period and should:
- *i) be **detailed for year 1 and year 2** of the proposal term, with information broken down by **quarters for the first year**;*
- *ii) provide summarized information and assumptions for the balance of the proposal period (**year 3 through to conclusion of proposal term**).*

*h) It should state all key assumptions, including those relating to **units and unit costs**, and should be consistent with the assumptions and explanations included in section 5.3.*

*i) It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*

*j) It should be **consistent** with other budget analyses provided elsewhere in the proposal, including those in this section 5.*

5 Component Budget *Tuberculosis*

5.3 Key budget assumptions

Without limiting the information required under section 5.2, please indicate budget assumptions for year 1 and year 2 in relation to the following:

5.3.1 Drugs, commodities and products

Please use Attachment B (Preliminary Procurement List of Drugs and Health Products) in order to compile the budget request for years 1 and 2 in respect of drugs, commodities and health products. Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please complete table B.1 in Attachment B to the Proposal Form.)*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please complete table B.2 in Attachment B to the Proposal Form.)*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please complete table B.3 in Attachment B to the Proposal Form.)*

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

Completed Attachment B to the Proposal Form is attached.

Units cost used for drugs, products and equipment are indicated in Attachment B.

5.3.2 Human resources costs

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

Human Resources costs include fees of external consultants, local experts, local and international travel and perdiem. All these costs were bugeted using reference price levels applied currently.

PCIMU staff salaries are included under Project Management SDA.

All reference unit costs are indicated in the Attachmnet B..

5.3.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

Funds are requested for renovation of the building for the MDR TB Department in Vorniceni TB Hospital. The Government will contibute to the renovation for the second building for patients with drug-sensitive tuberculosis, and other infrastructure (purification station, canteen and laundry buildings).

5 Component Budget *Tuberculosis*

The costs for equipment to be procured are cleary indicated in Attachmnet B.

5 Component Budget *Tuberculosis*

5.4 Breakdown by service delivery area

Please provide an approximate allocation of the annual budget for each service delivery area (SDA). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). It is anticipated that this allocation of the budget across SDAs should be derived from the detailed component budget (see section 5.2).

Table 5.4: Estimated budget allocation by service delivery area and objective.

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
OBJECTIVE 1: Strengthening DOTS realisation to improve TB detection and case management	SDA 1: TB: Timely detection and quality treatment of cases	896,703	636,117	581,303	557,431	463,149
	SDA 2: TB/HIV collaborative activities: Prevention of HIV in TB patients	45,375	20,475	20,475	0	0
OBJECTIVE 2: Management of drug resistant tuberculosis by extension of implemented DOTS-Plus Project	SDA 1: MDR TB	1,181,792	1,014,837	1,189,596	1,160,731	1,151,201
	SDA 2: Infrastructure	686,600	376,600	3,300	0	0
OBJECTIVE 3: Strengthening the management and coordination of the National Healthcare System for TB patients & Management of project	SDA 1: Human resources	134,756	68,056	61,031	61,031	61,031
	SDA 2: Information system &	243,900	112,000	154,700	86,510	62,400

5 Component Budget *Tuberculosis*

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	Operational research					
	SDA 3: Project management	84,171	129,278	124,478	124,478	124,478
OBJECTIVE 4: Increase public awareness of tuberculosis, reduce stigmatization	SDA 1: Behavioural change communication - mass media	30,200	18,400	18,400	32,200	16,600
	SDA 2: TB: Timely detection and quality treatment of cases	34,940	41,040	31,040	31,040	31,040
	SDA 3: TB: Supportive environment: Stigma reduction in all settings	5,500	3,800	3,800	6,300	3,800
	SDA 4: TB/HIV collaborative activities. Prevention of TB disease in PLWHA	8,850	0	0	8,850	0
	SDA 5: TB/HIV collaborative activities. Prevention of HIV in TB patients	1,600	1,000	1,000	1,000	1,000
	SDA 6: Supportive Environment: Human resources	5,450	5,450	5,450	5,450	5,450

5 Component Budget *Tuberculosis*

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**

5 Component Budget *Tuberculosis*

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Total:		3,359,837	2,427,053	2,194,573	2,075,021	1,920,149

5 Component Budget *Tuberculosis*

5.5 Breakdown by implementing entities

Indicate in table 5.5 below how the resources requested in table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.

Table 5.5 – Allocations by implementing entities

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector					
Government	90.00%	91.00%	89.00%	88.00%	91.00%
Nongovernmental / community-based org.	10.00%	9.00%	11.00%	12.00%	9.00%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria					
Private sector					
Religious/faith-based organizations					
Multi-/bilateral development partners					
Others. *Please specify:*					
Total	100.00%	100.00%	100.00%	100.00%	100.00%

5.6 Budgeted funding for specific functional areas

The Global Fund is interested in knowing the funding being requested for the following three important functional areas—monitoring and evaluation; procurement and supply management; and technical and management assistance. Applicants are required in this section to separately identify the costs relating to these functional areas. In each case, these costs should already be included in table 5.1. Therefore, the tables below should be subsets of the budget in table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).

Table 5.6 – Budgets for specific functional areas

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and Evaluation	330,732	147,032	189,732	121,542	97,432	886,470

5 Component Budget *Tuberculosis*

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and Supply Management	159,318	157,275	177,984	173,890	165,208	833,675
Technical and Management Assistance	199,391	219,798	198,378	195,678	195,078	1,008,323

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

Procurement and Supply Management: *This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion. Do not include drug costs, as these costs should be included in section 5.3.1.*

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

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL *Tuberculosis*

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4 (Component specific): Component Strategy		
4.4.1	Documentation relevant to the national disease program context, as indicated in section 4.4.1.	Annex 1 TB
4.6	**A completed Targets and Indicators Table**	Attachment A to the Proposal Form
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	Annex 10 TB
4.6.7 c) *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	N/A
4.8.3 e) *(where SRs applied but were not selected)*	Name and type of all Sub-Recipients not selected, the proposed budget amount and the reasons for non-selection.	N/A
4.9.2	National Monitoring and Evaluation strategy (if exists)	Annex 16 TB
Section 5 (Component specific): Component Budget		
5.2	**Detailed component Budget**	Annex 15 TB
5.3.1	Preliminary Procurement List of Drugs and Health Products (tables B1 – B3)	Attachment B to the Proposal Form
5.3.2	Human resources costs.	
5.3.3	Other key expenditure items.	
5.1 - 5.6 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
Other documents relevant to sections 4-5 attached by applicant:		
4.4.1	Annual WHO data collection report 2005	Annex 2 TB
4.4.1	Application to the WHO GLC for Approval of a DOTS-Plus Pilot Project in the Republic of Moldova, June 2004	Annex 3 TB
4.4.1	The Global TB Drug Facility Direct Procurement Monitoring Mission Report, 2006	Annex 4 TB
4.4.1	Economic Growth and Poverty Reduction Strategy Paper, (2004 - 20060	Annex 5 TB

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL *Tuberculosis*

4.4.1	Monitoring and Evaluation Plan of National Programme of tuberculosis control and prevention for 2006 - 2010	Annex 16 TB
4.4.2	Recent Trends in Tuberculosis Epidemic in Republic of Moldova	Annex 6 TB
4.4.2	Chemotherapy regimes corresponding to category of patients	Annex 7 TB
4.4.2	Evolution of TB Resistance between New TB cases in Republic of Moldova	Annex 8 TB
4.5.1	Programmatic gap analysis table	Annex 9 TB
4.6	Detailed work plan for years 1-2	Annex 10 TB
4.6.3	The description of the activities that will be implemented	Annex 11 TB
4.8.2	Institutional and Programmatic Assessment Report of Principal Recipient Programme Management Unit Ministry of Health of Republic of Moldova by Local Fund Agent, PriceWaterhouseCoopers, September 2004	Annex 12 TB
4.8.2	Monitoring and Evaluation Assessment Report of Principal Recipient Programme Management Unit Ministry of Health of Republic of Moldova by Local Fund Agent, PriceWaterhouseCoopers, April 2004	Annex 13 TB
4.8.2	Aide Memoire of the Mid Term Review Mission, April 2006	Annex 14 TB

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL *Tuberculosis*