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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	National Coordination Council on National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes
Country	Republic of Moldova
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Lower-middle income

Applicant Type ☒ CCM ☐ Sub-CCM ☐ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☑	HIV[1]	Alleviate HIV/AIDS-related impact in PLHA	
☑	Tuberculosis[1]	Strengthening MDR-TB control and management in Moldova in the period of 2009-2014	☐
☐	Malaria		☐

Currency ☐ USD or ☒ EURO

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

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)
+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 8:
3. Proposal Summary

4. Program Description
4B. HSS cross-cutting interventions strategy **

5. Funding Request
5B. HSS cross-cutting funding details **

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

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

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

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

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

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

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

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

ROUND 8 – Tuberculosis

1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified Table 1.1:

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	4.465.735	4.140.657	2.652.385	2.777.765	2.687.274	16.723.816
Tuberculosis	2.928.726	2.352.316	2.061.178	3.028.083	2.952.601	13.322.905
Malaria						
HSS cross-cutting interventions within *[HIV/AIDS includes s.4B. and s.5B.]*						
					Total Round 8 Funding Request ➔:	**30.046.721**

1.2. Contact details

	Primary contact	Secondary contact
Name	Oleg Barba	Gabriela Ionascu
Title	TB/AIDS Consultant	Coordinator
Organization	NCC on TB/AIDS Secretariat	UNAIDS
Mailing address	3a, Cosmescu str.	27, Sfatul Tarii str.
Telephone	+373 22 280590; +373 22 727359; +373 691 52 656	+373 22 223771; +373 69123 392
Fax	+373 22 72 73 59	+ 373 22 223771
E-mail address	ccm_secretariat@mednet.md	gabriela.ionascu@unaids.md
Alternate e-mail address	obarba@mednet.md	ionascug@unaids.org

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
NCC on TB/AIDS	National Coordination Council on National HIV/AIDS/STI prophylaxis and Control and TB control and Prophylaxis Programmes
TWG	Technical working groups
	[use "Tab" key to add extra rows if needed]

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary. See Annex 17. Explanation note on NCC representativeness

	Sector Representation	Number of members
☐	Academic/educational sector	
☑	Government	9 persons: (Ministry of Health (3), Ministry of Education (1), Ministry of Finance (1),Ministry of Justice (1), Ministry of Internal Affairs (1), PCU (1), Government Chancellery (1)
☑	Non-government organizations (NGOs)/community-based organizations	5 persons: League of people Living with and affected by HIV/AIDS (1); AIDS Network (1); Soros-Moldova Foundation (1); Centre for Health Analyses and Policies (1), Red Cross Society in Moldova (1)
☑	People living with the diseases	1 person: League of People living with and affected by HIV/AIDS (1)
☑	People representing key affected populations[2]	1 person: Soros-Moldova Foundation (1)
☐	Private sector	
☐	Faith-based organizations	
☑	Multilateral and bilateral development partners in country	Multilateral: 6 persons WHO Bureau (1), UNFPA (1), UNDP (1), UNAIDS (1), UNICEF

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

(1), World Bank (1),
Bilateral: 2 persons:
USAID (1), Sida (1)

☐ Other *(please specify):*

Total Number of Members:
(Number must equal number of members in 'Attachment C'[3])

22 NCC members

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

2.1.2. Broad and inclusive membership

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

(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and ☐ No ☒ Yes

(b) Is there continuing active membership of people living with and/or affected by the diseases. ☐ No ☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

Weakness and gaps affect the Moldavian health system on the level of several of the building blocks described in World Health Report 2000 (WHO): health workforce block, service delivery block through the gaps in the infrastructure, social protection block, leadership and governance block through gaps in oversight, coordination and collaboration persisting within the system. A weakness in the **leadership and governance block** is sensed on a range of various levels.
An important gap presents the lack of coordination among the Ministries of Health and Ministry of Social Protection, Family and Child, the two ministries involved in providing services to PLHA. The social workers within the Ministry of Social protection are underpaid, overworked and have no incentive or proper HIV/AIDS knowledge to provide quality services and exclude amongst themselves the stigma and discrimination of PLHA. The component of social protection provided to PLHA is seriously lacking in coordination and planning.

Membership in the NCC is broadly representative of a variety of stakeholders, each representing an active constituency with an interest in fighting HIV/AIDS and TB. Also the members of NCC are integral parts of various governmental and non-governmental structures, bridging the gaps in coordination and collaboration among several ministers and governmental and non-governmental decision making authorities. National Coordination Council of the National HIV/AIDS/STI prophylaxis and control and TB control and prophylaxis programmes (NCC on TB/AIDS) counts 22 members (decisional level in the academic/educational sector, government, PLHA who are actively engaged in the NCC through direct interaction, NGOs, Multilateral and Bilateral Development Partners), 4 staff members within the NCC Secretariat (coordination level) and 11 technical working groups (6 on HIV/AIDS, 4 on TB and 1 mixed for M&E of TB and HIV/AIDS) as technical/operational level (See Annex 1 – NCC on TB/AIDS Bylaws). NCC members, as well as those from technical working groups (See annex 2 – List of NCC TWG members) are represented by all sectors: governmental, nongovernmental and international agencies.
The aforementioned issues, gaps and structural barriers of the health system have a serious impact on programmes and outcomes and were strongly experienced by the NCC in the process of elaboration of the following documents:

- The National HIV/AIDS/STI Prophylaxis and control and TB control and prophylaxis Programmes ((http://www.aids.md/coordination/national-aids-program -link to find it);

- Universal access towards prevention, treatment, support and care in HIV/AIDS (http://www.aids.md/coordination/national-aids-program -link to find it);

- National Law on HIV Prevention, approved by Parliament in 2007 http://www.aids.md/coordination/consultation/new-law-aids - link to find it

- Working plans of TWG for 2008 (available on www.ccm.md). **See Annex 3** (Working plans in TB field),

Annex 4 (Working plans in HIV/AIDS field)

- The specific guidelines in HIV/AIDS surveillance, palliative care, HIV/AIDS communication framework, MARA (most at risk adolescents) strategy etc. are also regarding and addressing health system issues.

The specific issues on the health and community system strengthening and fixing of the gaps and weaknesses of the system were evaluated and addressed in the application during the HIV/AIDS elaboration and reviewing proposal meetings (See Annex7 - Minutes of the meeting 28-29 March/HIV/AIDS, Annex 8 Minutes of the meeting of League of People leaving with HIV/AIDS, Annex 9 – Minutes of the HIV/AIDS review meeting 29-05, Annex 10. Minutes meeting review last 17-06).

Transparency of all NCC operations is ensured. All members receive on a timely basis the notice of meetings, the meeting agenda and copies of the documents that will be discussed at the meeting. The NCC members also receive the minutes of the meetings. All NCC members are involved in a transparent and open manner in the elaboration, implementation, monitoring and evaluation of national, as well as technical HIV/AIDS and TB strategies.

Referring to health system issues impacting TB control Programme, it is to be noticed that severe economic downturn faced by the country after independence from the USSR in 1991, has led to the breakdown of the social safety net and profound disintegration of the health system. As a result, the access of the majority of the population to essential care had become limited; there were severe shortages of essential medicines including 1st line anti-TB drugs.

Since end-1990's the country's economy began to recover thus creating conditions for rebuilding the health system. While there are notable improvements in the health system's performance over the recent years, Moldova continues to face serious challenges in this regard and there are important weaknesses and gaps in the health system that affect negatively the effectiveness of TB control:

- Despite the substantial improvement in the health sector financing, achieved during the recent years with the introduction of mandatory health insurance, domestic funding can not cover all needs of the TB control programme. It is particularly acute in regard to the management of drug-resistant TB requiring expensive drugs, laboratory equipment and consumables as well as investment measures for infection control.
- While TB control has been integrated with Primary Health Care services (which have led, inter alia, to increased case detection), the links between specialised TB service institutions and PHC are sub-optimal in many instances, especially concerning proper follow-up of patients during continuation phase of treatment.
- The link between health care services (both specialised TB service and PHC) and community establishments remains weak. In case of TB (including DR-TB) control this represents a serious obstacle to ensuring reliable adherence to treatment and appropriate social support and social adaptation of TB patients.
- Ensuring appropriate human manpower is a serious challenge for the entire health system and is very acute for TB services. Low wages, lack of social support and perspectives for career development of health care providers lead to poor motivation, high turnover of staff and the resulting shortages of medical personnel in many territories and specialties such as TB.

The TB related health system barriers, specifically targeting the present application were identified through several meetings of the members of TWG. (See Annex 11- Minutes meeting TB 24-03; Annex 12 - Minutes meeting TB 01-04). The above mentioned systemic weaknesses have direct impact on TB control and to a great extent they define and shape the 'specific' challenges for the TB control programme. It is expected that further strengthening the overall performance of the health system will contribute to improved outcomes of the 'disease-specific' interventions.

Gender awareness

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

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

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

In 2006, approximately 1 million people (30.2%) in the Republic of Moldova were living in absolute poverty, and 4.5% were living in extreme poverty. Poverty continues to affect not only traditionally vulnerable categories, such as the elderly, people with no education or professional skills, long-term unemployed and people with occasional jobs, but also the able-bodied, qualified and healthy. The level of available finance in the social sector is low and the economic burden on individuals is unfairly distributed, making access to care and social services difficult for the poor.

In 2005, the risk of poverty for the rural population was approximately 6 times higher than for the population in big cities. Despite the poverty rate being higher in rural areas compared to small towns, the poor in small towns are facing more problems in their pursuit for a better life. About 60% of the population of Moldova lives in rural areas. Due to changes in the population structure, there is a trend towards feminization of the rural population; hence, future measurements are likely to show that women are more severely affected by poverty.

Across a range of basic services in Moldova there are disturbing urban-rural inequities. The ratio of family doctors per 1,000 people is 10 times lower in rural settings with 15% of villages lacking family doctors. The difference between maternal mortality rates in urban and rural areas is almost twofold, suggesting significant differences in the quality and provision of essential services, and unequal distribution of resources. For 2007 the prices for drugs underwent the typical process of growth. During the first six months of 2007, the monthly price index varied from 0.02 to 1.56. On average, the growth rate of the retail price for drugs is 0.72% per month. Since the compulsory medical insurance assistance was introduced in 2004, a portion of drugs is included in the insurance policy and is provided free of charge. Basic medications are provided free of charge to about 77% of population benefiting from insurance policies. The situation is more difficult for those categories of population that do not have medical insurance nor sufficient resources to purchase basic drugs. In 2005, the first two poorest quintiles spent only 1.5% and 2.6% respectively on health out of total amount of expenditures.

The gender situation in Moldova varies on different dimensions. Hence:

- Men have a greater representation in management structures;
- Unemployment affected men and women equally in 2007; unemployment among women has registered a sharp increase as in 2006, 62% of the unemployed were men;
- Women are disproportionately represented in the social sector, with poorly paid positions. In average women's salaries represent 68.1% of men's salaries, and women being prone to a greater risk to lose their jobs;
- Women represent the majority of the unpaid labor force;
- Men represent the majority of students in the secondary vocational education cycle;
- Men life expectancy is lower than women's by around 8 years;
- Over 90% of violence victims are women.

Despite the lower pay of women, their incomes have a greater importance for their families, with or without children. Women are more predisposed to use their income to purchase food, to pay for education and health services, which have an impact on children welfare.

Incidence of child poverty is significantly higher than adult poverty. Children from rural area represent the most disadvantaged category: 71% of poor children live in villages, while 62.9% of all children live in rural areas. From a gender perspective, both boys and girls are almost equally subject to poverty risk. Children aged 3-10 are most vulnerable.

Youth are among most affected by the prolonged transition and manifold political, economical and social problems. Young people had to confront and are still struggling with many issues such as unemployment, illegal migration, trafficking in human beings, juvenile delinquency, and marginalization of

certain groups of young people, including MSM and PLHA. The vulnerability of young people during the transition period is shown not only through a high unemployment rate of 17,3% in 2006, but also through other blamable phenomena such as increased drug consumption, spread of sexually transmittable infections and HIV, and the culture of violence. Young people form different areas do not have equal access to economic opportunities. The youth from rural areas and small towns are more affected, but young people with disabilities are placed in worst conditions. Insufficient professional and economic opportunities drive many youth to leave the country. As a consequence, the trafficking in human beings reached alarming proportions. Victims are mostly girls and young women and the number of youth involved in criminal activities is also upsetting. Thus, according to statistical data, almost halve of the victims of trafficking are younger than 18 years, and the other half is aged between 18 and 24 years.
The interventions hereto are directly aimed at closing regional disparities and gaps in social services for most vulnerable groups and to scale up availability of such social protection and assistance services on the local level of communities addressing men and women, boys and girls for both reaching TB and HIV/AIDS services.

The capacities and experience of NCC members related to gender issues regard the issues and problems addressed by the Technical working group on social services: social assistance and education (chaired by Ministry of Social Protection, Family and Child responsible for ensuring gender equality and equity in Moldova), also involving United Nations HIV/AIDS Joint Team, TB/AIDS Monitoring and Evaluation TWG, Harm reduction/Vulnerable groups TWG, NCC Secretariat etc. The NCC members, part of the local staff of international agencies such as WHO Bureau, UNFPA , UNDP, UNAIDS, UNICEF, World Bank have experiences pertinent to the field of gender issues through a series of attended trainings and workshops.

Multi-sectoral planning

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

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

The second National HIV/AIDS Prophylaxis Programme, as well as the second National TB control Programme for the period 2001-2005, were elaborated and implemented in a participatory manner. The principle of nation wide inclusiveness was made legitimate through the Government decision N825 from August 2005 related to the institutionalization of the National Coordination Council on the National HIV/AIDS and TB Programmes. Though, the NCC Bylaws elaborated in 2005 (Annex 1), National HIV/AIDS/STI prophylaxis and control (NAPCP) and National TB Control and prophylaxis programmes (NTCPP) for the period 2006-2010 were elaborated by all interested stakeholders representing different society sectors. The draft programmes were discussed together with the NGOs during the Monitoring Resolutions of the first National NGOs Forum active in TB and HIV/AIDS from April 2005. The multi-sectoral approach was utilized for the processes like:

- establishing objectives for "Ensuring Universal access towards HIV/AIDS prevention, treatment, care and support" approved by the NCC on TB/AIDS at the NCC meeting from March, 16th, 2006.
- elaborating the proposals for the 6th round of the Global Fund to fight AIDS, TB and Malaria on two components: TB and Malaria in 2006;
- elaborating the National Law on HIV/AIDS Prophylaxis, approved by the Parliament in February 2007
- elaborating/consulting the national strategic technical documents as: guidelines, protocols

The principle is functional and finds its output at the NCC technical level – 12 technical working groups (6 on HIV/AIDS and 4 on TB, 1 common for M&E TB and HIV) are broadly representative, participation is ensured as from the governmental sector (Ministry of Health, Ministry of Education, Ministry of Justice, Ministry of Internal Affairs), NGOs, PLHA – through the participation of the League of People Living with HIV/AIDS, multilateral and bilateral development partners in country - WHO Bureau, UNFPA, UNDP, UNAIDS, UNICEF, World Bank.

The multi-sectoral approach was used for the elaboration of the 8th round for the GF, involving a broad range of authorities, stakeholders, the NCC members, TWG members and non-members in the proposal design. This approach is paramount to the proposal elaboration and future implementation, therefore a range of stakeholders with a direct interest in programmatic outcomes had the possibility to participate in the proposal's development process and all the stakeholders had a voice in determining the appropriateness of the proposal to the country's particular situation. This level of involvement ensured that the proposal's goals and objectives are "owned" by the affected and concerned stakeholders.

For HIV/AIDS component: Please, refer to Annex 7, Annex 8, Annex 9, Annex 10.

For TB component: Please, refer to Annex 11, Annex 12, Annex 14.

2.2. Eligibility

2.2.1. Application history

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

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

requirements when last applied.	➔ ***Then** also complete **sections 2.2.5 to 2.2.8 below**.*

2.2.2. Transparent proposal development processes

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

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

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

The NCC members recognized that the country's situation faces various barriers and gaps in the health system and will require timely address and additional funding to decrease the burden of the two diseases: TB and HIV/AIDS. Thus during the meeting from December 2007 it was decided to seek additional funding to address the aforementioned weaknesses and difficulties. (See Annex 13 – NCC decision N2 from December, 13th 2007). The decision to apply to the Global Fund, 8th round was taken during the meeting from March, 14th, 2008 and the working plan on its elaboration was approved (See Annex 5 - NCC Decision from March, 14th and Annex 6 – NCC Minutes of the meeting from March, 14th).

The announcement was issued through NCC members via the email message to their constituencies. The three NGOs networks (League of People living with HIV/AIDS, AIDS network, Union of NGOs working in harm reduction) announced about the invitation to participate in the application elaboration via email. Please, refer to Annex 16. Emailing lists of NGOs networks.

The announcement was also placed on the NCC web page (the link: http://www.ccm.md/?page=doc&id=40&pos=2) and UNAIDS web page www.aids.md

The announcement was published in two main Moldovan newspapers: "Moldova Suverana" (Romanian) and "Экономическое обозрение" (Russian). Please, refer to Annex 15 – Copies of press announcements.

The principles of transparency, equity, professionalism and the alignment with the national health policies were the basis for integrating the proposals into the general application. The requirements for the proposals were as follows:

1. to be in accordance with the application goal:
   a) strengthening MDR-TB control (for TB component);
   b) Health and community systems strengthening (for HIV/AIDS/STI) component;
2. to have clear objectives, activities and budgets defined;
3. to obtain the consensus of the Experts (extended review committee of the technical working groups)

All these criteria were described in the announcements (See Annex 15), web pages links.

The proposals from different members were obtained via email. The proposals were discussed during the review meetings both for TB and HIV/AIDS components (see point 2.2.2. (b))

For the development of the TB proposal an international consultant has been hired. In order to ensure transparency and participation, the consultant gathered the proposals during the extended meetings of the NCC TWG meetings from 24th of March (Please, refer to Annex 11) and the 1st of April (Please, refer to Annex 12).

For the HIV/AIDS component the elements of the proposal were established and developed during several extended meetings of the NCC TWG. The particular projects were developed by the League of People living with HIV/AIDS during their separate meetings jointly with the Ministry of Social Protection, Family and Child (non-NCC member) and the NGO "Institute for Human rights" being an active tool in the promotion and protection of human rights (non-NCC member). After the review the proposals were fully incorporated into the country application. The incorporation process was facilitated by a national consultant.

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*	
The process of reviewing the submissions has been transparent and extensively documented in a series of documents issued by NCC. A broad range of stakeholders, including NCC members and non-memebrs have been involved in the process of reviewing the submissions. Both, TB and HIV/AIDS submissions were reviewed during the review meetings of the NCC WG meetings, organized as follows: **1. TB component**: 24th of March (See Annex 11), 1st of April (See Annex 12), and 12th of June - Annex 14). The drafts of the proposals were consulted in on-line basis by NCC secretariat several times: in the period from April 8 to 11 – 1st draft; May 28th – June 6th – 2nd draft. On-line consultations represented sending the drafts to all NCC members and NGO networks (Please, refer to Annex 16). All the drafts were placed on the NCC web page: www.ccm.md at the link http://www.ccm.md/?page=docs&m=1&sm=7&pos=1. Several extended review meetings of the TWG were held dedicated to the TB component: 24th of March, 1st of April and 11th of June (Please, refer to Annex 11, Annex 12, Annex 14). All the comments were analyzed and after achieving a consensus of opinions have been integrated into the country proposal. **2. HIV/AIDS component**: Several review meetings were held during 28-29 of March, meetings of the League of People living with HIV/AIDS, meeting from May, 29th, meeting from June 17th (Please, refer to Annex 7, Annex 8, Annex 9, Annex 10). The drafts were also discussed and commented upon on-line by NCC members, including using the NGO networks emailing lists in the following periods: (May 7th-14th – 1st draft, June 3rd to 9th – 2nd draft). The process could be followed on two web sites: www.ccm.md at the link: http://www.ccm.md/?page=docs&m=2&sm=4&pos=1 and www.aids.md . The proposals gathered by NCC Secretariat (from the League of people living with HIV/AIDS and the NGO "Institute of Human Rights", NGO "Innovative ideas in penitentiaries", Local Public Authorities from Balti, Chisinau, Tiraposl and Comrat, Ministry of Social Protection, Family and Child after being reviewed and after approval, incorporated into the proposal. A common (on TB and HIV/AIDS component) updated information was sent to all NCC members, Non – NCC members (via NGOs networks emailing lists) on the 7th of May. The information contained the drafts of the proposals. The minutes of the development and review meetings, both for TB and HIV/AIDS components were placed on the NCC web page: www.ccm.md and UNAIDS web page: www.aids.md, thus feedback was provided to all the organizations that tendered a submission.	
(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*	
The whole process of application development was transparent, open and equitable. The same rules were applied for both NCC and non-NCC members (the public announcement in the newspapers (see Annex 15)), the links of NCC- www.ccm.md and UNAIDS – www.aids.md web pages. On-line consultations were shared with NCC, as well as non-NCC members via NGOs networks emailing lists and the web pages (Please, refer to Annex 16). As a result, the proposals were discussed and reviewed with the TWG members (see Annex 2) gathering a wide range of NGOs, international agencies and governmental representatives (both NCC and non-NCC members).	
(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***[[Annex 5 – NCC decision, March 14th*** ***Annex 11. Minutes meeting TB March, 24th*** ***Annex 7. Minutes of the HIV/AIDS meeting 28_29***

	of March]]

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.
NCC has put in place and maintained a transparent and well documented process to oversee project implementation. National Coordination Council on HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programmes is actually overseeing all the projects and financial resources conducted for the National programmes implementation. Accordingly to the CCM Clarifications document, NCC has developed bylaws to define and guide its oversight role and ensure the monitoring and evaluation of the implementation. The bylaws outline realistic monitoring and evaluation plans, technical assistance plans, system analysis and strategic planning reviews to ensure coordinated implementation. The processes to oversee the programme's implementation is described into the NCC Bylaws (Please, refer to Annex 1). All the projects are reporting to the NCC members during the NCC meetings, as well as events related to the mid-term review, year evaluations and during the technical working groups. All the decisions, minutes of NCC as well as TWG are available on the NCC and UNAIDS sites: www.ccm.md and www.aids.md. Moreover, in 2008, the National AIDS Programme will be subjected to reviewing. The Country Harmonization and Alignment tool (CHAT - UNAIDS) will be used to assess the process of coordination, alignment, governance and oversight, principles, within NCC. The NCC on TB/AIDS will ensure its modification accordingly to the results of the review. An NCC operational manual will be developed in fall-summer period of 2008 to ensure proper coordination and functionality of the NCC.
(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.
NCC has put in place a transparent and documented process in order to ensure the input of a broad range of stakeholders, including NCC members and non-members in the oversight process. As mainly the programmes are overseen during the NCC meetings, as well as NCC TWG meetings (according to the NCC Bylaws) all of the decisions and minutes, as well as the NCC TWG working plans are placed on the NCC web page: www.ccm.md (especially Romanian variants) and the UNAIDS web page for the HIV/AIDS processes: www.aids.md . The non-NCC members have the opportunity to participate at the programme oversight. After the NCC meetings, the decisions and minutes are shared to all NCC members, as well as the NGOs networks through their emailing lists. Yearly, the Forum of NGOs working in HIV/AIDS and TB is being organized. First Forums (from 2005 and 2006) were organized with the financial support of World Bank. The continuation of this experience was ensured through the Global Fund financial resources (round 6). The Forums have special sessions on donor programmes (content, relationship between Government, donors and NGOs discussed etc, as well as TB and HIV/AIDS National programme implementation perspectives from different constituencies and stakeholders) are discussed. The process will be strengthened through the NCC Bylaws modifications and the NCC operational manual development to address specifically these issues, which is scheduled for the second half of 2008.

2.2.4. Processes to select Principal Recipients

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

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*
NCC has established , implemented and maintained transparent process of PR selection. The process of selection laid the foundation for developing and interactive, workable and transparent relationship

between NCC and the PR. The discussions related to the **principal recipients** were raised from the first meetings on the elaboration of the grant proposal (See Annex 7 - Minutes of the meeting 28-29 March/HIV/AIDS) and Annex 11 – Minutes meeting TB 24 March). During these meetings the criteria on Principal Recipients were developed to ensure credibility and legitimacy to all parties involved. The criteria stipulate: a) the existence of the experience of work in the field of HIV/AIDS/TB no less than 3 years, b) the financial and procurement capacities in concordance with programme performance, c) technical capacities, d) to be an institution resident in Republic of Moldova e) direct responsibility for programme development and implementation, f) to be approved by consensus by the majority of NCC members.

The principal recipients for both TB and HIV/AIDS proposals were discussed and approved at several levels:

1) technical level: during the TWG review meetings for TB component on 11th, June and for HIV/AIDS component on 17th of June 17, 2008;
2) decisional level: during the NCC meeting from June, 19th 2008.

The eligibility criteria for the sub-recipients are described below relating to:
- organizations which may participate as sub-recipents
- partnerships and eligibility of partners for sub-recipients

I. Eligibility for sub-recipients: who may apply
(1) In order to be eligible for a sub-recipent, applicants must:
- be non-profit-making legal entities; and
- belong to one of the following categories:

- local communities, NGOs, community-based organizations, faith-based organizations and other non-for-profit natural and legal entities from the private sector;
- international organizations, United Nations and its agencies, as well as development banks, financial institutions, global initiatives, international public/private partnerships
- research institutes and universities;

and
- have offices, representations or headquarters in the Republic of Moldova
- be directly responsible for the preparation and management of the grant, not acting as an intermediary;

(2) Potential applicants may not participate in calls for proposals or be awarded grants if:

(a) they are bankrupt or being wound up, are having their affairs administered by the courts, have entered into an arrangement with creditors, have suspended business activities, are the subject of proceedings concerning those matters, or are in any similar situation arising from a similar procedure provided for in national legislation or regulations;
(b) they have been convicted of an offence concerning professional conduct by a judgement which has the force of res judicata (i.e., against which no appeal is possible);
(c) they are guilty of severe professional misconduct proven by any means;
(d) they have not fulfilled obligations relating to the payment of social security contributions or the payment of taxes in accordance with the legal provisions of the country;
(e) they have been the subject of a judgment which has the force of res judicata for fraud, corruption, involvement in a criminal organisation or any other illegal activity detrimental to the state' financial interests;
(f) they have been declared to be in serious breach of contract for failure to comply with their contractual obligations in connection with a procurement procedure or other grant award procedure financed by the state's budget.
Applicants will be also excluded from participation in the process of selection of sub-recipients, at the time of the call for bid, if they:
(g)are subject to a conflict of interests;
(h) are guilty of misrepresentation in supplying the information required by CCM or the Principal Recipient as a condition of participation in the process of selection of sub-recipients or fail to supply this information;
(i) have attempted to obtain confidential information or influence the evaluation committee or the CCM or Principal Recipient in any way.

(k) are closely related by blood or by marriage with key decision persons in CCM and within the office of the Principal Recipient.
In the cases referred to in points (a), (c), (d), (f), (h) and (i) above, the exclusion applies for a period of two years from the time when the infringement is established. In the cases referred to in points (b) and (e), the exclusion applies for a period of four years from the date of notification of the judgment.

Applicants must supply with their applications a statement on the honour that they do not fall into any of the above categories (a) to (f).
II. Partnerships and eligibility of partners
Applicants may act individually or in consortium with partner organisations.
Applicants' partners participate in designing and implementing the grant, and the costs they incur are eligible in the same way as those incurred by the grant beneficiary. They must therefore satisfy the same eligibility criteria as applicants. However, in addition to the categories referred to in section II, they may belong to one of the following categories:
• administrative authorities and agencies at national, regional and local levels and other decentralized organisms;
• organizations from commercial and/or profit making private sector provided they do not derive any profit from the grant;
• non-government organization and community organizations with a legal status, including associations of PLHA, networks and faith based organizations.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	Annex 10. Minutes meeting HIV/AIDS review last/17_06 Annex 14. Minutes meeting TB review last/11_06 Annex 18 – NCC Decision n2/19_06 Annex 19 – NCC minutes meeting/19_06

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Project Coordination Unit	TB	Governmental
Project Coordination Unit	HIV/AIDS	Governmental
Centre for Health Analyses and Policies “PAS”	TB	Nongovernmental
Centre for Health Analyses and Policies “PAS”	HIV/AIDS	Nongovernmental

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

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal

Recipient have not been nominated for each disease in this proposal.

ONE PAGE MAXIMUM

2.2.7. Managing conflicts of interest

(a)	Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	☉ Yes ***provide details below*** ☐ No ➔*go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☑ **Yes** ***[Annex 20 – Policy of conflicts of interests]***

2.2.8. Proposal endorsement by members

21 NCC on TB/AIDS members signed the proposal. Only,

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

3. PROPOSAL SUMMARY

3.1. Duration of Proposal

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

3.2. Consolidation of grants

(a)	Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 8 tuberculosis proposal?	☉ Yes *(go first to (b) below)* ☐ No *(go to s.3.3. below)*

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

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

(b)	If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval? *(List the relevant grant number(s))*	Round 6 TB grant No. MOL-607-G02-T

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

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

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

The current Global Fund grant approval and negotiation timeline (i.e. the Board approval in late autumn) does not allow to align the start date with the national fiscal cycle (financial year begins on 1 January).

At the same time, the proposed start date coincides with the expected start date of Phase II of the ongoing Round 6 TB project, therefore it is seen as optimal in view of the intended consolidation of TB grants from Rounds 6 and 8.

3.4. Program-based approach for Tuberculosis

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

- ☉ Yes. Answer s.3.4.2
- ○ No. ➔ *Go to s.3.5.*

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

- ○ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
- ☉ No. Do not complete s.5.5

3.5. Summary of Round 8 Tuberculosis Proposal

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

Prepare after completing s.4.

The Republic of Moldova is a country in transition in Eastern Europe with a population of 3.8 million, which gained independence from the Soviet Union in 1991. Tuberculosis re-emerged as an important public health problem after independence and its burden remains high in the country. The case notification rate is 130 per 100,000 population and is the 2nd highest among the 53 countries of the WHO European Region.

As in the other former Soviet Union republics, resistance to anti-TB drugs represents a serious obstacle to effective control of the TB epidemic. The nation-wide Drug Resistance Survey in 2006 revealed very high prevalence of MDR-TB of **19.4%** among new smear positive cases and **50.8%** - among previously treated cases.

The Government is committed to fight the disease and increasingly allocates financial, human and infrastructural resources for this purpose. However, substantial financial gaps exist, especially in regard to the complex and costly interventions in DR-TB management. To bridge the gap in this field, the CCM has decided to solicit additional support from the Global Fund in Round 8 in addition to the ongoing GFATM-funded TB project from Round 6.

The overall **Goal** of the Project is ***To reduce the burden of tuberculosis in the Republic of Moldova by scaling up the management of drug-resistant tuberculosis.*** While further strengthening essential DOTS interventions remains the key requirement for preventing resistance, it has become clear that, in conditions of very high DR-TB burden, timely diagnosis and proper treatment of DR-TB cases are necessary for the overall success in combating the epidemic and achieving TB control targets and disease-related Millennium Development Goals.

ROUND 8 – Tuberculosis

This proposal targets specifically drug-resistant TB, therefore a sole main **Objective** has been identified: ***To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis.*** Respectively, there is one **Service Delivery Area: *Management of drug-resistant tuberculosis.***

The proposal aims at scaling up the management of DR-TB in the country by enrolling a higher number of patients in second-line treatment according to the need. It is foreseen to enrol a total of **2,700** MDR-TB patients over five years from the civilian and penitentiary sectors. The project is built to support the country's application to the Green Light Committee for expansion of the treatment cohort, approved in April 2008.

The accomplishment of the project's Objective will be ensured through strengthening the human and infrastructural capacities, establishment of routine drug resistance surveillance throughout the country, upgrading the laboratory services and provision of up-to-date treatment of DR-TB cases with appropriate patient support to ensure adherence.

The proposal has a country-wide scope and covers the needs of both civilian and penitentiary sectors. It targets all TB patients in the country (about 27,500 over 5 years); a specific group to be reached by the project are DR-TB patients. Importantly, the project interventions cover the population of the separated region of Transnistria, largely excluded from the international assistance in the health sector.

The proposed Activities are organized in the following groups:

1. Strengthening national capacities for management of drug-resistant TB
2. Drug resistance surveillance and diagnosis of drug-resistant TB cases
3. Treatment of drug-resistant TB cases
4. Patient support programme for drug-resistant TB patients
5. Operational research on drug-resistant TB

The proposal aims at ensuring universal coverage with diagnosis and treatment of DR-TB: all TB patients will have access to drug susceptibility testing and all patients diagnosed with DR-TB will have access to second line treatment. It is expected that on a longer run, the project will contribute to improving the key TB outcome indicators (case detection rate and treatment success rate) and decreasing the prevalence of MDR-TB.

The Global Fund financial resources will be additional to domestic resources that will be allocated to cover substantial costs of the staff, medical interventions and facility expenses. The Round 8 project will be fully complementary to the support available from Round 6.

Two Principal Recipients for the grant have been nominated: the Project Coordination, Implementation and Monitoring Unit (PCIMU) and the Centre for Health Policies and Studies (PAS Centre), the latter representing non-governmental sector.

The duration of the project is 5 years starting 1 October 2009; the total requested budget is EUR 13,322,905 (EUR 5,281,042 for the first two years).

4. PROGRAM DESCRIPTION

4.1. National programme and strategy

(a) Briefly summarize:

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

The Republic of Moldova is a country in transition in Eastern Europe which gained independence after the breakdown of the Soviet Union in 1991. The total population is 3.8 million including the separated region of Transnistria. The Gross National Income (GNI) is USD 1,110 per capita[4]. Tuberculosis re-emerged as an important public health problem after independence and its burden remains high in Moldova. The WHO case notification rate (new cases and relapses) is 130 per 100,000 population and is the 2nd highest among the 53 countries of the WHO European Region.

DOTS is the official strategy for TB control in Moldova. Its introduction started in late 2001 and expanded it to cover the entire country by the beginning of 2004, including the penitentiary sector and Transnistria region. TB control interventions are guided by the *National Programme for Control and Prevention of Tuberculosis for years 2006-2010,* endorsed by the Government on 30 December 2005 (see Annex 5 to the Proposal Form).

The Ministry of Health has the overall responsibility for TB control in the country. It undertakes this function through the NTP Central Unit, represented by the Institute of Phthysiopneumology (IPP), and involves the Ministry of Justice and other governmental entities and collaborates with non-governmental organizations and international partners in the planning, implementation, monitoring and evaluation of activities. TB control interventions are delivered through a network of specialised TB service institutions and Primary Health Care services. Organised through the Family Medicine model, PHC providers are involved in TB control since early stages of DOTS introduction.

Passive case finding is the main method of TB detection. PHC providers are responsible for identification of TB suspects and their referral to the TB service. The diagnosis of TB is established by direct sputum smear microscopy (supported by X-ray when necessary) and confirmed by culture. Given the very high burden of drug-resistant TB, It is planned to establish the routine drug resistance surveillance system with universal coverage by drug susceptibility testing (DST) in the nearest future and with the anticipated support of the Round 8 GFATM project. The network of TB laboratories is represented by 57 microscopy centres, 3 Regional Reference Laboratories and the National Reference Laboratory.

Case classification and definition of treatment category are done in the specialized TB service institutions. Standard first-line treatment regimens are administered in line with WHO recommendations. The majority of infectious TB patients are hospitalized during intensive phase of treatment. During out-patient treatment, follow-up of patients and drug dispensing are carried out by the PHC facilities under supervision of TB specialists. Direct observation of treatment (DOT) is in place for all in-patients and for about 60% out-patients.

TB treatment delivery sites include 13 in-patient institutions with a total capacity of 1,630 beds (out of which there are 3 facilities with 310 beds in Transnistria and 2 facilities with 220 beds in the penitentiary sector). During the recent years, 490 beds in 7 facilities were re-profiled for MDR-TB treatment. In out-patient settings, there are 57 TB cabinets located in the general health service institutions.

Uninterrupted supply of quality 1st line anti-TB drugs is ensured country-wide since the start of DOTS implementation through the Global Drug Facility (GDF). The NTP has established a reliable system of drug management, which is described in detail in section 4.10.

The TB service is staffed by a total of 965 persons, including 371 TB doctors (phtysiatricians), 275 nurses, 12 laboratory doctors (bacteriologists) and 117 laboratory technicians (out of these, about 140 persons are assigned to MDR-TB in-patient treatment delivery sites). The NTP Central Unit is responsible for continuing education of TB service staff. The DOTS training programme has been extended and now

[4] Source: World Bank, 2006 (Atlas method)

covers PHC providers as well as specific topics such as TB/HIV and MDR-TB.

The NTP uses the standardized DOTS recording and reporting system, which has been upgraded to accommodate for the latest WHO recommendations and additional country needs. In 2007, individualised recording and reporting was introduced and incorporated in the country-wide electronic TB Monitoring and Evaluation System (SIME TB). Please refer to Section 4.8 for more details.

Advocacy, communication and social mobilisation are considered one of the priority areas of work for the NTP. Continuing country-wide TB informational and educational activities are implemented since 2004 (with USAID/AIHA and GFATM support) and cover different target audiences.

Systematic TB/HIV collaborative activities were initiated in 2007 by setting up a joint coordinating body, development of the national guidelines and provision of HIV counselling and testing for TB patients after relevant training of staff.

Similar to other countries in the region, TB remains a very acute problem in the penitentiary system. In 2007, the case notification rate in prisons was 2,320 per 100,000, about 18 times the country-wide level. Although DOTS implementation in the penitentiary system started even earlier than in the civilian sector, there have been substantial problems concerning follow up of released prisoners under treatment and general lack of cooperation between the two sectors. These issues are vigorously addressed during the last three years by the integration of information systems, implementation of protocols for follow-up, expanding NTP supervision and laboratory coverage for prisons and centralised procurement of drugs and other goods for both civilian and penitentiary sectors.

Main achievements in TB control. It is felt that substantial progress has been achieved in TB control in Moldova over a short period of time since DOTS introduction, in particular in terms of:

- Significantly improved TB case detection;
- Uninterrupted supply of 1st line anti-TB drugs and improved drug management;
- Strengthened and regionalised TB laboratory network;
- Reliable and comprehensive system of recording and reporting, effective programme monitoring and evaluation;
- Successful implementation of the Global Fund support (Rounds 1 and 6) and effective collaboration and coordination between the partners.

The progress in case detection has been dramatic over the recent few years. Based on WHO estimates, case detection rate for new smear positive cases increased from 39% in 2003 to 59% in 2004 and 69% during 2005-2006 thus approaching the target. It is deemed that this achievement is due to active participation of PHC in case detection, improved laboratory quality and rising public awareness.

At the same time, the country lags far behind the target in terms of treatment outcomes. For the last two years, treatment success rate in new smear positive cases was only around 62% and as low as 35% - in smear positive re-treatment cases. One of the most important reasons for this is the high burden of drug resistance.

Management of drug-resistant tuberculosis. The treatment of drug-resistant TB (DR-TB) cases according to the international standards started in December 2005 following the approval of the country's first application to the GLC for access to 2nd line drugs at concessionary prices in February 2005 (for 100 MDR-TB patients). The approval for extending the first cohort was given in September 2006 for another 600 patients. As of 19 May 2008, 497 MDR-TB patients were enrolled in second line treatment.

At the same time, the first nation-wide representative Drug Resistance Survey (DRS) was conducted during January-December 2006 and revealed extremely high MDR-TB rates of **19.4%** among new smear positive patients and **50.8%** - among previously treated cases. To scale-up DR-TB treatment, the NTP applied additionally to the GLC and received approval for another 4,150 patients on 22 April 2008, thus bringing the total GLC-approved cohort of MDR-TB patients to be treated to 4,850 people. This proposal in Round 8 focuses specifically on DR-TB management and is built to obtain financial support for procurement of drugs as well as for covering other essential interventions to ensure the scale up. More details on DR-TB situation are found in further sections of the Proposal Form as well as in Annexes 7, 8, 9, 10, 11, 13 and 14.

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

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

ROUND 8 – Tuberculosis

	Document	Proposal Annex Number	Page References
☑	National Health Sector Development/Strategic Plan	3, 4	
☑	National Tuberculosis Control Mid Term Strategy or Plan	5	
☐	National Tuberculosis Guidelines (medical and laboratory)		
☐	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*		
☑	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	10, 11, 12, 13	
☑	National Monitoring and Evaluation Plan (health sector, disease specific or other)	6	
☐	National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

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

Map of the Republic of Moldova

(b) Size of population group(s) targeted in Round 8			
Population Groups *	**Population Size**	**Source of Data**	**Year of Estimate**
Total country population (all ages)	3,793,603	United Nations' Population Division	2007
Women > 25 years	1,099,550	National Bureau of Statistics	2007
Women 19 – 24 years	203,862	National Bureau of Statistics	2007
Women 15 – 18 years	132,191	National Bureau of Statistics	2007
Men > 25 years	1,143,769	National Bureau of Statistics	2007
Men 19 – 24 years	210,827	National Bureau of Statistics	2007
Men 15 – 18 years	136,316	National Bureau of Statistics	2007
Girls 0 – 14 years	317,594	National Bureau of Statistics	2007
Boys 0 – 14 years	332,791	National Bureau of Statistics	2007

* – Breakdown by population groups does not include Tansnistria region

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated tuberculosis patients - shown as number per 100,000 population (*all ages)*	5,890 (153.7 / 100,000)	WHO Global TB Report 2008	2006
Female tuberculosis patients > 25 years	998	SIME TB (Tuberculosis Monitoring and Evaluation System)	2007
Female tuberculosis patients 19 – 24 years	250	SIME TB	2007
Female tuberculosis patients 15 – 18 years	77	SIME TB	2007
Male tuberculosis patients > 25 years	3,287	SIME TB	2007
Male tuberculosis patients 19 – 24 years	417	SIME TB	2007
Male tuberculosis patients 15 – 18 years	108	SIME TB	2007
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	5,315 (140.1 / 100,000)	SIME TB	2007
Tuberculosis patients all forms tested for HIV (rate among notified	4,270 (80.3%)	SIME TB	2007

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	2,406 (62.9 / 100,000)	WHO / Stop TB, Planning & Budgeting for TB Control tool v3	2007
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	1,592 (42.0 / 100,000)	SIME TB	2007
Case detection rate of new smear-positive cases	1,592 / 2,406 (66.2%)	SIME TB; WHO / Stop TB, Planning & Budgeting for TB Control tool v3	2007
Estimated number of multi-drug resistant cases of tuberculosis	2,035	WHO / IUATLD Global Project on Anti-tuberculosis Drug Resistance Surveillance, Report No. 4, 2008	2007
Notified number of multi-drug resistant cases bacteriologically confirmed	1,206	NTP	2006
Treatment success rate of new smear-positive cases	1,041 / 1,671 (62.3%)	NTP	2006 cohort
Defaulter and transfer rate of new smear-positive cases	195 / 1,671 (11.7%)	NTP	2006 cohort
Estimated number of girl (0 – 14 years) tuberculosis patients all forms	N / A	-	-
Notified number of girl (0 – 14 years) tuberculosis patients all forms	79	SIME TB	2007
Estimated number of boy (0-14 years) tuberculosis patients all forms	N / A	-	-
Notified number of boy (0 – 14 years) tuberculosis patients all forms	99	SIME TB	2007
MDR prevalence among new smear positive TB cases	19.4% (160 / 825)	National Drug Resistance Survey	2006
MDR prevalence among previously treated smear positive TB cases	50.8% (1,044 / 2,054)	National Drug Resistance Survey	2006

NOTE: Please refer to the Drug Resistance Survey Report (Annex 10 to the Proposal Reform) for details on resistance profile.

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[5] who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

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

High burden of drug resistance is seen as the major problem for effective TB control in the country. As in the other former Soviet Union republics, its spread was conditioned by the overall health system crisis during the 1990s and disintegration of TB control programme, which had led to critical shortages of anti-TB drugs and incomplete treatment, poor infection control in hospitals and cross-infection, poor adherence of TB patients to treatment leading to frequent interruption and lack of standardization in case management with sub-optimal treatment regimens prescribed by many providers, sometimes with unjustified addition of 2nd line drugs. It has become evident that although further strengthening essential DOTS elements is instrumental for prevention of drug resistance and therefore remains the top priority for the NTP, extremely high MDR-TB rates call for scaling up the treatment of DR-TB cases to decrease their pool and transmission of drug resistant strains.

Therefore the main weakness of the National TB Control Programme in Moldova today is seen as its incapacity to provide universal access to diagnosis and treatment of DR-TB cases as required for the countries and settings with high DR-TB burden according to the revised WHO *Stop TB Strategy* and the *Global Plan to Stop TB 2006-2015.* This may offset the achievements in TB control during the recent years and prevent the country's progress towards reaching the disease-related MDG targets. In particular, the NTP faces the following gaps:

- Lack of financial resources to ensure effective scale up of DR-TB management programme in terms of procurement of 2nd line drugs as well as other costly interventions such as laboratory investigations, infection control and patient support;
- Insufficient capacities of the NTP management and TB service providers to implement new activities and technologies;
- Insufficient involvement of community services and civil society in TB control which prevents from ensuring proper social support and social adaptation of TB patients to motivate them to complete the therapy. This is especially important for MDR-TB patients who have to undergo complex and lengthy (up to 2 years) second line treatment.

An important but insufficiently studied issue is the burden of TB, TB/HIV and DR-TB among the large group of seasonal labour migrants. This group assumingly plays a significant role in the spread of TB including drug-resistant strains, however proper evaluation of the problem is required for planning and implementing effective interventions.

The current proposal aims to address these gaps and contribute to ensuring universal access to diagnosis and treatment of DR-TB in Moldova. At the same time, solving the overall health system weaknesses and gaps (described in the next section, such as insufficient health sector financing and health manpower problems) will lead to ensuring sustainability of DR-TB management interventions in the future.

A specific problem for the country is the difficulty to ensure proper support to the population and TB patients in the separated region of Transnistria, which does not benefit from any external support in the health sector. However, building on the agreement with the local authorities and successful experience of cooperation within the ongoing Global Fund project, the Round 8 interventions will cover this region as well.

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

4.3.2. Health System

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

The description can include discussion of:

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

The severe economic downturn faced by the country after independence from the USSR in 1991, has led to the breakdown of the social safety net and profound disintegration of the health system. As a result, the access of the majority of the population to essential care had become limited; inter alia, there were severe shortages of essential medicines including 1st line anti-TB drugs.

Since end-1990's the country's economy began to recover thus creating conditions for rebuilding the health system. While there are notable improvements in the health system's performance over the recent years (please refer to the next sub-section), Moldova continues to face serious challenges in this regard and there are important weaknesses and gaps in the health system that affect negatively the effectiveness of TB control:

- Despite the substantial improvement in the health sector financing, achieved during the recent years with the introduction of mandatory health insurance, domestic funding can not cover all needs of the TB control programme. It is particularly acute in regard to the management of drug-resistant TB requiring expensive drugs, laboratory equipment and consumables as well as investment measures for infection control.
- While TB control has been integrated with Primary Health Care services (which have led, inter alia, to increased case detection), the links between specialised TB service institutions and PHC are sub-optimal in many instances, especially concerning proper follow-up of patients during continuation phase of treatment.
- The link between health care services (both specialised TB service and PHC) and community establishments remains weak. In case of TB (including DR-TB) control this represents a serious obstacle to ensuring reliable adherence to treatment and appropriate social support and social adaptation of TB patients.
- Ensuring appropriate human manpower is a serious challenge for the entire health system and is very acute for TB services. Low wages, lack of social support and perspectives for career development of health care providers lead to poor motivation, high turnover of staff and the resulting shortages of medical personnel in many territories and specialties such as TB.

The above mentioned systemic weaknesses have direct impact on TB control and to a great extent they define and shape the 'specific' challenges for the TB control programme. It is expected that further strengthening the overall performance of the health system will contribute to improved outcomes of the 'disease-specific' interventions.

4.3.3. Efforts to resolve health system weaknesses and gaps

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

Moldova started decisive reforms in the health sector in mid-1990s. The priority directions of the reform were laid down in the first reform Strategy for years 1997-2003. Priority development had been given to Primary Health Care, which was re-organised by the beginning of 2000s with the establishment of the General Practice (Family Medicine) system. PHC development has been the main component of the World Bank support to the health system reform in Moldova which started by the Health Investment Fund project in 2000. PHC is given substantial responsibilities in the control of infectious diseases and have become actively involved in the implementation of DOTS strategy for TB control since its introduction in 2001.

The second phase of the health system reform focuses on health financing and was marked by the

introduction of mandatory health insurance (MHI) since 1 January 2004. The MHI implementation has proven to be successful and is now widely accepted as one of the best practices in the region. Even over a short period of time (4.5 years), the new financing system allowed to i) substantially (over 4 times) increase the overall volume of funding for the health sector; ii) prioritise interventions for funding with emphasis on PHC services; and iii) rationalise the allocation of funds across territories, levels of care and specialties and improve provider payment mechanisms. The National TB Control Programme has benefited significantly in terms of that the essential NTP interventions are increasingly covered by the insurance funds.

The Government sees the next phase of the reform to focus on further structural changes in the health system that would result in increased efficiency and quality of the health services. This commitment was articulated by the adoption of the *National Health Policy in the Republic of Moldova 2007-2021* (Governmental Decree No. 886 from 06 August 2007) and the *Strategy for Health System Development in the Republic of Moldova for the period 2008-2017* (Governmental Decree No. 1471 from 24 December 2007).

The new Strategy bases on the previous strategic documents and the reform achievements to date; it lays down priority interventions in the health system for the next ten years and is in line with the latest international recommendations and experience. The overall goal set up in the document is to ensure high performance of the health system in Moldova that addresses the health needs of the population, operates using modern cost-effective interventions and promotes patient-centred approaches. The Strategy outlines the objectives of the health system development in accordance to the main functions of the health system, defined by WHO:

Stewardship, governance and management The general objective is to enable appropriate decision making at different levels for achieving the goals set up in the National Health Policy, through: • increasing the Ministry of Health role and responsibilities for policy development and strategic planning; • strengthening capacities of health administrations at all levels for implementation, coordination, monitoring and evaluation of health interventions; • strengthening inter-sectoral partnerships for better health system performance; • empowering civil society, communities and patients in decision making for health; • streamlining health legislation and regulations to meet the European standards.	*Financing and allocation* The general objective is to ensure financial protection of the population of the population against ill-health through: • increasing the overall level of funding in the health sector; • optimising the allocation of financial resources within the health system and mechanisms for contracting the services and payment of health care institutions and providers; • ensuring transparency, equity and accountability in the distribution of financial resources and sustainable financial protection of the population.
Service delivery The general objective is to ensure delivery of health care services that are tailored to meet priority health problems of the population and are of appropriate quality, through: • ensuring integration, continuity and coordination of health interventions at different levels of health care; • priority development of Primary Health Care and public health interventions which have strategic impact on the population's health; • improving the quality of health care interventions; • developing patient-oriented approaches in health services delivery and increasing the level of clients' satisfaction.	*Resource development* The general objective is to generate and appropriately use human, infrastructural and technological resources in the health system, through: • securing formation, professional development, diversification and retention of skilled health care manpower; • improving the technical and material base of the health care facilities; • ensuring the rational use of pharmaceuticals and medical technologies at all levels of the health system.

The Strategy further presents the Action Plan for implementation for years 2008-2017, which defines the activities and tasks to achieve the above objectives, timeframe for implementation and responsible

bodies, and indicators to monitor and evaluate the progress.

The interventions outlined in the Strategy target priority problems of the health system and are fully in line with the needs and gaps (identified in the previous section) that impact tuberculosis outcomes. Although many strategic interventions require system approaches and involve the 'macro-design' of the health system and, therefore, need time to be implemented, it is deemed that the direction and scope of the reform are correct and will contribute to effective disease control in the country in the near future.

The *National Health Policy 2007-2021* and the *Strategy for Health System Development 2008-2017* are attached to this Proposal Form in Annexes 3 and 4, respectively.

4.4. Round 8 Priorities

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

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

Priority No:	1	Historical		Current		Country targets			
Intervention	*DST investigations for DR-TB diagnosis (number of TB patients tested with rapid technique)*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		2,483	2,685	2,842	2,819	2,802	2,753	2,723	2,715
B: Extent of need already planned to be met under other programs		93	150	1,070	0	0	0	0	0
C: Expected annual gap in achieving plans		2,390	2,535	1,772	2,819	2,802	2,753	2,723	2,715
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			2,540 (90%)	2,520 (90%)	2,620 (95%)	2,590 (95%)	2,580 (95%)

Priority No:	2	Historical		Current		Country targets			
Intervention	*Treatment of MDR-TB cases (enrollment per year)*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		784	761	826	848	800	745	694	654
B: Extent of need already planned to be met under other programs		88	254	400	0	0	0	0	0
C: Expected annual gap in achieving plans		696	507	426	848	800	745	694	654
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			570 (67.2%)	540 (67.5%)	530 (71.1%)	530 (76.4%)	530 (81.0%)

ROUND 8 – Tuberculosis

Priority No:	3	Historical		Current		Country targets			
Intervention	*Patient support for MDR-TB cases on treatment (enrollment per year)*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		784	761	826	848	800	745	694	654
B: Extent of need already planned to be met under other programs		88	254	400	0	0	0	0	0
C: Expected annual gap in achieving plans		696	507	426	848	800	745	694	654
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			570 (67.2%)	540 (67.5%)	530 (71.1%)	530 (76.4%)	530 (81.0%)

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

IMPORTANT NOTE: **Figures in this table correspond to those in the Performance Framework (Attachment A to the Proposal Form) and represent the overall coverage with the GFATM support (anticipated Round 6 Phase II and expected Round 8) in view of intended consolidation of grants. Therefore, in line B support from Round 6 TB GFATM grant for years 2009-2014 is not counted (presented as '0').**

EXPLANATORY NOTE ON PROGRAMMATIC NEEDS' ASSESSMENT

Three key services have been identified for this proposal; the needs for these priority interventions were quantified and included in the tables above:

1. Drug susceptibility testing (DST) to 1st line anti-TB drugs for diagnosis of drug-resistant TB (using rapid technique for isolation of strains);
2. Second-line treatment of MDR-TB cases;
3. Patient support for MDR-TB cases to ensure adherence to treatment.

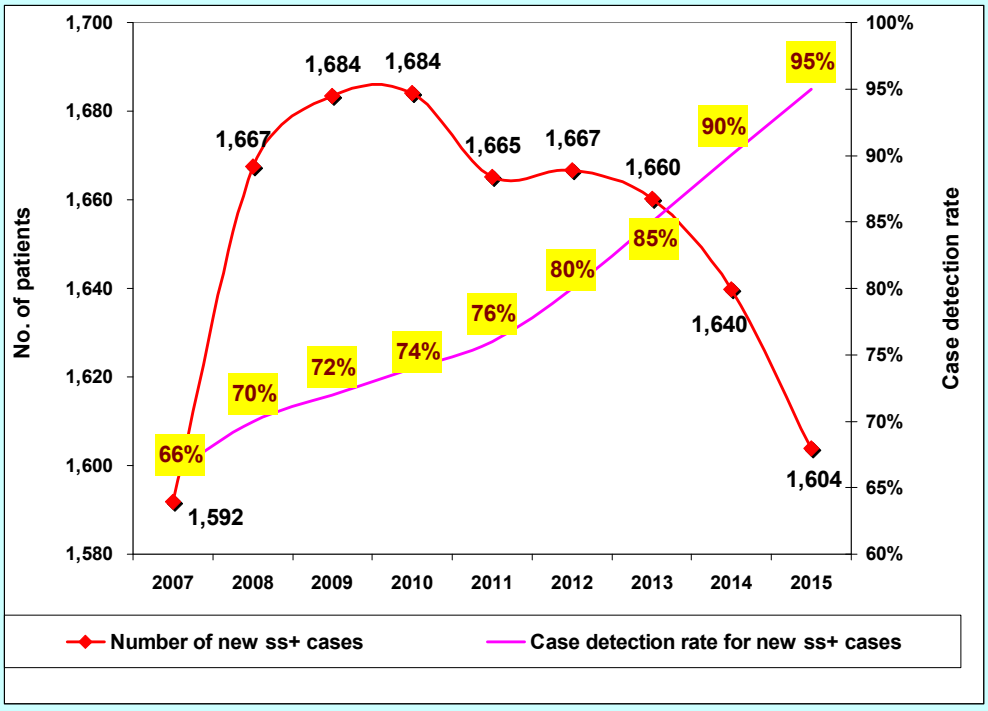
The assessment of needs in the programmatic area targeted by this proposal (management of drug-resistant TB) is based on the following:

- Country-specific projections of development of TB epidemic as presented in the *Global Plan to Stop TB 2006-2015* and supporting documents (e.g. *Planning & Budgeting for TB control* tool, WHO/StopTB, 2007; version 3 revised in February 2008);
- Goals and targets set in the National TB Control Programme;
- Results of the nation-wide Drug Resistance Survey in Moldova (January-December 2006).

The assessment included the following steps:

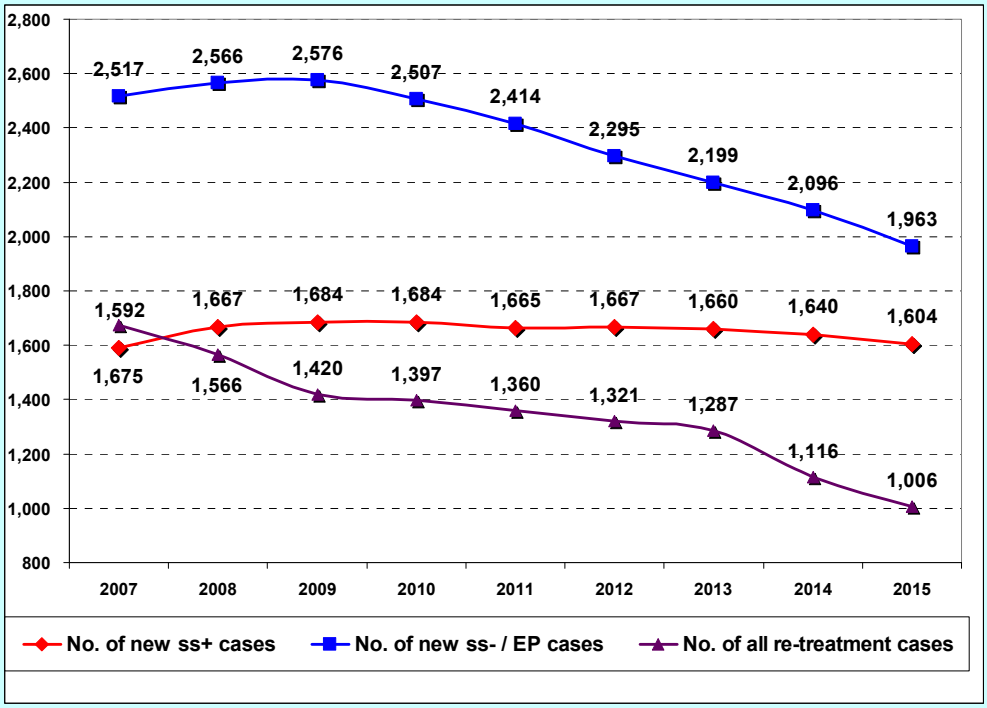
Step 1. Basing on the WHO estimates of TB burden and taking into account the target of case detection rate for new smear positive cases of 70% (to be reached for 2008, vis-à-vis estimated number of cases) and further increase it to 95% by 2015, the expected annual numbers of new smear positive pulmonary cases were estimated (see Figure below).

Figure. Projected case detection rate and number of new smear positive TB cases to be notified in Moldova, 2007-2015



Step 2. The annual numbers of TB cases to be notified by category (new smear positive, new smear negative / extra-pulmonary, previously treated cases) were estimated on the basis of the WHO projections and current trends in case notifications (see Figure below and Table at the end of this section).

Figure. Projected number of new smear positive, new smear negative / extra-pulmonary and re-treatment TB cases in Moldova, 2007-2015



Step 3. Taking into account the resistance pattern revealed by the DRS, its dynamics for the following years was projected and the number of MDR-TB cases that can be diagnosed annually was estimated. It was assumed that the resistance pattern will gradually change with time, with MDR-TB prevalence among new cases decreasing from 19% in 2008 to 14% by the end of Round 8 project and further to 10% in 2015; for previously treated cases, these figures are 50%, 40% and 32% respectively.

Step 4. The needs for key interventions were identified and, taking into consideration the service capacity, feasibility of coverage (e.g. it will not be possible to enrol all diagnosed MDR-TB patients in treatment because of medical and social reasons, therefore a maximum of 80-85% enrolment rate among diagnosed MDR-TB cases will be reached by the end of the project), the number of people in need, unmet need and the portion of unmet need to be covered with the GFATM financial support were determined:

Table. Key interventions to be covered with the GFATM support, by Years of the Round 8 project (absolute numbers and % of need to be covered)

	Key intervention	Year 1	Year 2	Year 3	Year 4	Year 5
1	Drug susceptibility testing for DR-TB diagnosis (number of TB patients with DST to 1st line drugs by rapid technique)	2,540 (90%)	2,520 (90%)	2,620 (95%)	2,590 (95%)	2,580 (95%)
2	Treatment of MDR-TB cases (enrolment per year)	570 (67%)	540 (67%)	530 (71%)	530 (76%)	530 (81%)
3	Patient support for MDR-TB cases on treatment (enrolment per year)	570 (67%)	540 (67%)	530 (71%)	530 (76%)	530 (81%)

Please refer to tables at the beginning of this section, Table on the next page and Annex 15 (calculations of DR-TB management needs in Excel format) for full details.

ROUND 8 – Tuberculosis

Table. Estimated number of patients and MDR-TB management needs for Years 2007-2015 (based on the Global Plan projections for Moldova and DRS data)

	Steps in programmatic needs assessment	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*
1	Population (projections by UN Population Division)	3,793,603	3,759,599	3,730,744	3,706,905	3,688,353	3,674,722	3,664,382	3,655,139	3,645,323
2	Estimated incidence rate new ss+ cases, per 100 000 (WHO)	63.43	63.36	62.68	61.39	59.40	56.69	53.30	49.85	46.31
3	Estimated incidence rate new ss-/EP cases, per 100 000 (WHO)	77.64	77.55	76.72	75.14	72.71	69.39	65.24	61.01	56.69
4	Estimated number of new ss+ cases (WHO)	2,406	2,382	2,338	2,276	2,191	2,083	1,953	1,822	1,688
5	Estimated number of new ss-/EP cases (WHO)	2,945	2,916	2,862	2,785	2,682	2,550	2,391	2,230	2,066
6	Case detection rate new ss+ cases, %	66.2%	70%	**72%**	**74%**	**76%**	**80%**	**85%**	90%	95.0%
7	Proportion of new ss-/EP cases detected, %	85.5%	88%	**90%**	**90%**	**90%**	**90%**	**92%**	94%	95.0%
8	Estimated number of new ss+ cases to be notified	1,592	1,667	1,684	1,684	1,665	1,667	1,660	1,640	1,604
9	Estimated number of new ss-/EP cases to be notified	2,517	2,566	2,576	2,507	2,414	2,295	2,199	2,096	1,963
10	Proportion of re-treatment cases among all TB cases, %	**29.0%**	**27%**	**25%**	**25%**	**25%**	**25%**	**25%**	**23%**	**22%**
11	Estimated number of all re-treatment cases to be notified	1,675	1,566	1,420	1,397	1,360	1,321	1,287	1,116	1,006
12	Estimated number of all TB cases to be notified	5,784	5,799	5,679	5,588	5,438	5,282	5,146	4,852	4,573
13	Proportion of ss+ cases among all re-treatment cases, %	**53.2%**	**65%**	**80%**	**80%**	**80%**	**80%**	**82%**	**84%**	**86%**
14	Estimated number of ss+ re-treatment cases to be notified	891	1,018	1,136	1,118	1,088	1,056	1,055	937	865
15	Estimated number of all ss+ cases (new and re-treatment) to be notified	2,483	2,685	2,819	2,802	2,753	2,723	2,715	2,577	2,469
16	Proportion of patients to be covered by DST for MDR-TB diagnosis (rapid technique), %	**6.0%**	**40%**	**90%**	**90%**	**95%**	**95%**	**95%**	**95%**	**95%**
17	No. of patients with DST investigations for MDR-TB diagnosis (rapid technique)	150	1,070	2,540	2,520	2,620	2,590	2,580	2,448	2,346
18	Proportion of MDR among new cases, %	**19.4%**	**19.0%**	**18.0%**	**17.0%**	**16.0%**	**15.0%**	**14.0%**	**12.0%**	**10.0%**
19	Proportion of MDR among re-treatment cases, %	**50.8%**	**50.0%**	**48.0%**	**46.0%**	**44.0%**	**42.0%**	**40.0%**	**36.0%**	**32.0%**
20	Number of MDR cases that can be diagnosed among new cases	309	317	303	286	266	250	232	197	160
21	Number of MDR cases that can be diagnosed among re-treatment cases	453	509	545	514	479	444	422	337	277
22	Total number of MDR cases that can be diagnosed (new and re-treatment)	761	826	848	800	745	694	654	534	437
23	Total number of MDR cases to be diagnosed (new and re-treatment) by DST	46	330	763	720	708	659	622	508	415
24	Proportion of diagnosed MDR cases to be enrolled in treatment, %			**75%**	**75%**	**75%**	**80%**	**85%**	**90%**	**92%**
25	Number of MDR patients to be enrolled in treatment in a given year	254	400	**570**	**540**	**530**	**530**	**530**	460	380
26	Needs' coverage with MDR-TB treatment, %	33.4%	48.4%	**67.2%**	**67.5%**	**71.1%**	**76.4%**	**81.0%**	86.1%	86.9%
	Needs in diagnostic interventions for DR-TB:									
27	No. of culture investigations (manual technique)			18,000	17,710	17,240	16,740	16,310	15,380	14,500
28	No. of culture and DST to 1st line drugs (automated MGIT) for DR-TB diagnosis			3,040	3,030	3,140	3,100	3,100	2,940	2,810
29	No. of DST to 1st line drugs (manual on solid media) for DR-TB diagnosis			3,630	3,600	3,540	3,490	3,470	3,290	3,150
30	No. of tests for identification of R/H resistance (PCR technique)			1,270	2,520	2,620	2,590	2,580	2,450	2,350

4.5. Implementation strategy

4.5.1. Round 8 interventions

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

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

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

GOALS, OBJECTIVES AND SERVICE DELIVERY AREAS

The overall **Goal** of the Project is ***To reduce the burden of tuberculosis in the Republic of Moldova by scaling up the management of drug-resistant tuberculosis.***

The Goal is set in accordance with the international recommendations (laid down in the revised *WHO Stop TB Strategy* and the *Global Plan to Stop TB 2006-2015*) to introduce and scale up DR-TB management interventions as a routine and integral part of the National TB Programmes in countries with high burden of resistance to anti-TB drugs. The results of the 2006 nation-wide Drug Resistance Survey (DRS) show that this burden is extremely high in Moldova, with multidrug-resistant TB (MDR-TB) revealed among **19.4%** new smear positive cases and among **50.8%** previously treated cases. According to the recently published *4th Global Report on Anti-TB Drug Resistance in the World* (WHO, IUATLD, February 2008), the MDR prevalence in Moldova is the second highest among the levels determined by the studies conducted in 93 settings from 81 countries between 2002-2007 and presented in this publication.

While further strengthening essential DOTS interventions remains the key requirement for preventing resistance, it has become clear that, in conditions of such high DR-TB burden, timely diagnosis and proper treatment of DR-TB cases are necessary for the overall success in combating the epidemic and achieving TB control targets and disease-related Millennium Development Goals.

The Government is committed to fight the disease and increasingly allocates financial, human and infrastructural resources for this purpose. This commitment has been further articulated in the *National Health Policy in the Republic of Moldova 2007-2021, Strategy for Health System Development in the Republic of Moldova for the period 2008-2017* and the *National Programme for Control and Prevention of Tuberculosis for years 2006-2010.*

However, due to the still continuing economic constraints, substantial financial gaps exist, especially in regard to the complex and costly interventions in DR-TB management. The CCM has therefore decided to solicit additional support from the Global Fund in Round 8 in bridging the gap in this field in addition to the ongoing GFATM-funded TB project from Round 6.

This additional support is sought for a number of reasons. First, at the time of preparation of the Round 6 proposal (spring 2006), there were no reliable drug resistance surveillance data in the country, and the burden of DR-TB was underestimated. As a sequence, insufficient number of MDR-TB treatments (1,150 over 5 years) were included in the previous application. Second, in accordance with the recommendations of the revised Stop TB Strategy and the Global Plan (both published after Round 6 proposals' submissions), the country aims at the provision of universal access to DR-TB diagnosis and treatment, which is expected to be achieved with the Round 8 funding support. For this purpose, the Round 8 proposal requests support for a more comprehensive set of interventions compared to the

Round 6 project, in particular regarding capacity building, DR-TB surveillance, laboratory diagnosis and patient support.

This proposal targets specifically drug-resistant TB, therefore a sole main **Objective** was identified: ***To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis.***

Respectively, there is one **Service Delivery Area:** ***Management of drug-resistant tuberculosis.***

The proposal aims at scaling up the management of DR-TB in the country by enrolling a higher number of patients in second-line treatment according to the need. It is foreseen to enrol a total of **2,700** MDR-TB patients over five years starting October 2009 (Year 1 of the project – 570, Year 2 – 540, Year 3 – 530, Year 4 – 530, Year 5 – 530) from the civilian and penitentiary sectors (about 10% of these patients will be from prisons).

This proposal is built to support the country's third application to the Green Light Committee (GLC). This application was approved by the GLC on 22 April 2008 for 4,150 DR-TB patients bringing the total GLC approved cohort (with two previous applications approved in February 2005 and September 2006) to 4,850 patients. The application and the GLC approval letter are attached to this proposal in Annexes 13 and 14.

The accomplishment of the project's Objective will be ensured through strengthening human and infrastructural capacities, establishment of routine drug resistance surveillance throughout the country, upgrading the laboratory services and provision of up-to-date treatment of DR-TB cases with appropriate patient support to ensure adherence. All persons diagnosed with TB will have access to drug susceptibility testing (DST); Category IV treatment will be provided to all DR-TB patients who sign an informed consent agreement and are compliant with the regimen requirements. The proposal covers the needs of the civilian and penitentiary sectors.

The **target group** are all tuberculosis patients from the country (around 27,500 TB cases, all forms, are expected to be registered in Moldova during project's 5 years' lifetime, or about 5,500 annually on average). The expected impact of the project is that universal access will be provided for them to diagnosis and, when required, treatment of drug-resistant TB. A specific group to be reached by the project are DR-TB patients who will receive Category IV treatment with the project support (totally 2,700 MDR-TB patients will be treated over five years). It should be noted that the provision of needed services to the mentioned target group will contribute to reducing the pool and transmission of drug-resistant TB infection, thus bringing benefit for the entire population.

Importantly, the project interventions cover Transnistria region. This region is politically separated and does not participate in any externally funded programmes and projects in the health sector; however, in 2003 an agreement was reached with the local authorities for joint collaboration in DOTS implementation. With the Round 8 project support, full access will be provided to TB patients from Transnistria to diagnosis and treatment of DR-TB cases according to the international standards.

The GFATM financial resources will be additional to domestic resources that will be allocated to cover substantial costs of the staff, medical interventions and facility expenses. The Round 8 project will be fully complementary to the support available from Round 6 (with intended consolidation of grants in October 2009) and will be implemented in a co-ordinated way with the support provided by other external partners in the area of TB control.

The proposal aims at both sustaining the existing interventions (expansion of drug susceptibility testing and DR-TB treatment and other activities implemented with the GFATM Round 6 project support) and initiating new activities such as establishment of routine drug resistance surveillance and comprehensive community-based patient support programme. Operational research will be conducted to develop evidence and inform further actions, with special emphasis on high risk population groups such as labour migrants and their families.

While the Principal Recipient representing governmental sector (Project Coordination, Implementation and Monitoring Unit, PCIMU) through the NTP and TB service institutions and providers will be responsible for the implementation of the majority of the planned activities, an important role is reserved for the civil society organizations and academia (in particular regarding patient support, ACSM activities); therefore, the second PR (Centre for Health Policies and Studies, PAS Centre) representing non-governmental sector has been nominated for implementation of the work in these areas.

INDICATORS AND TARGETS

Indicators for programme performance and annual targets over the proposal term are presented in the Performance Framework (Attachment A to the Proposal Form). Interventions to be supported by this project will contribute to improving the key outcome indicators (case detection rate and treatment success rate). In addition, specific outcome indicators related to DR-TB management are included in the Performance Framework in line with the WHO recommendations: interim and final treatment success rate of MDR-TB patients.

It is expected that, along with strengthened essential DOTS interventions (e.g. with the support of the GFATM Round 6 TB project), this grant will contribute to decreasing the prevalence of MDR-TB down to 14% among new smear positive TB cases and 40% among previously treated cases by the end of the project.

Routine reporting indicators represent the framework for monitoring the progress in coverage by essential interventions and correspond to the project's workplan. Please refer to the Performance Framework for details.

ACTIVITIES

The project will follow a comprehensive approach to DR-TB management. The proposed Activities are organized in five groups: strengthening capacities in DR-TB management; drug resistance surveillance and diagnosis of DR-TB cases; treatment of DR-TB cases; patient support programme for DR-TB patients; and operational research on DR-TB.

1. Strengthening national capacities for management of drug-resistant tuberculosis

Besides the support to the GLC operations according to the GFATM requirements, external technical assistance in priority issues of DR-TB management is included in the proposal.

For ensuring sufficient national human resources capacity, training of Moldovan specialists will be organized abroad – at the WHO Collaborative Centre for DR-TB in Riga, Latvia, Estonia (FILHA collaboration project) and Partners in Health project in Tomsk / Novosibirsk, Russian Federation. This will be further supported by local training in managerial, clinical and laboratory aspects of DR-TB. Expanding training activities within the Round 6 project, it is planned to train 200 TB staff from in-patient and out-patient DR-TB service delivery sites.

In addition, training in relevant aspects of DR-TB management will be provided for over 1,200 Primary Health Care providers (family doctors and nurses) as PHC is expected to play a key role in ensuring adherence to treatment, provision of psychosocial support to DR-TB patients in community and family settings.

Special attention is paid to strengthening programme monitoring and evaluation. To ensure proper monitoring of DR-TB interventions, the project will support quarterly supervision visits by the NTP Central Unit and Regional Units (Balti, Bender) to district centres and selected locations (in addition to routine NTP supervision) to oversee DR-TB surveillance and case management (laboratory specimens' transportation, drug management, DOT organisation and logistics, compliance and adherence, recording and reporting, etc.). To strengthen the operational capacities for DR-TB programme management, additional vehicles will be procured for the NTP Central and Regional Units.

The existing SIME TB (*Monitoring and Evaluation System for Tuberculosis*) electronic surveillance system will be further improved to accommodate the needs of the scaled up DR-TB management programme. This will be achieved through the establishment of a working group to revise recording and reporting documentation, develop an additional module for 2nd line drugs' management and oversee implementation. Procurement of additional IT equipment for the implementation of the electronic DR-TB management system is foreseen for the NTP, M&E Unit at the National Centre of Health Management, reference laboratories and in-patient DR-TB treatment delivery sites. Support is also included for DR-TB data quality assurance and maintenance of the national TB database.

Training will be organized for staff of the NTP Central Unit and Regional Units and TB services facilities at central and peripheral level who will be responsible for data management within the DR-TB programme,

based on the revised recording and reporting forms and upgraded software.

Limited support is requested for renovation of the MDR-TB departments in Bender and Prison Hospital No. 3 in Tiraspol (the two in-patient treatment sites for Transnistria region), specifically for installation of the ventilation systems and ensuring proper patients' separation conditions.

2. Drug resistance surveillance and diagnosis of drug-resistant tuberculosis cases

With the project support, it is planned to establish routine drug resistance surveillance in Moldova. Support is sought for ensuring weekly transportation of sputum from all peripheral microscopy laboratories to four reference laboratories (NRL in Chisinau, Vorniceni, Balti and Bender) for further culturing and DST. Implementation of routine DR-TB surveillance is of utmost importance as it provides for timely diagnosis and subsequent timely initiation of treatment of DR-TB cases. To ensure proper specimens' storage and transportation conditions, procurement of cold chain equipment (cold boxes, refrigerators and freezers) for the TB laboratory network is included in the proposal.

Given the increasing scope and load of work, the proposal aims at the strengthening the laboratory network by upgrading the reference laboratories by provision of relevant equipment and supplies. Given the high prevalence of resistance in the country, culture and DST to 1st line drugs will be performed in all smear-positive patients (both new and previously treated cases) using rapid techniques (automated MGIT method for isolation and polymerase chain reaction (PCR) method for rapid identification of R/H resistance); manual DST technique will be also used for quality control. Culturing will be also performed for verification of diagnosis in smear-negative pulmonary patients. Procurement of automated MGIT equipment, PCR equipment and necessary consumables and reagents for cultures, DST and rapid identification tests at the reference laboratories is foreseen in this proposal. The estimation of the quantities was made on the basis of forecasts of expected patients' numbers and resistance trends (described in Section 4.4 above); please also refer to the Excel file in Annex 15 for formulas used and calculation details.

Additional bio-safety cabinets for the reference laboratories will be procured to comply with the increasing workload within the scaled up DR-TB management programme.

The NRL will continue to participate in external quality assurance (EQA) by regular proficiency testing exercises with the Supranational Reference Laboratory in Borstel, Germany; in addition, strains from MDR-TB patients on treatment will be shipped quarterly to the SRL for verification and quality control of DST to 2nd line drugs.

3. Treatment of drug-resistant tuberculosis cases

The project requests funding support to Category IV treatment for DR-TB patients. The treatment in the civilian sector will start on in-patient basis in 5 sites: Institute for Phtysiopneumology, Chisinau City TB Hospital, DR-TB in-patient departments in Vorniceni, Balti and Bender (the latter for Transnistria region) and will continue on out-patient basis in specialised TB service facilities with follow-up support by the Primary Health Care institutions. For prisoners, the whole course of treatment will be administered at the TB Prison Hospital in Prunchiul and DR-TB department of the Prison Hospital No. 3 in Tiraspol (the latter for Transnistria); continuation of treatment will be ensured in the civilian TB services for persons that are released from the prison and need to complete the course. Criteria for inclusion / exclusion, treatment regimens, laboratory support, management of side effects, recording and reporting and other details are described in the attached GLC applications (Annexes 7, 8 and 13).

The number of MDR-TB patients to be enrolled in Category IV treatment was defined on the basis of forecasts of expected numbers of TB patients by category and resistance trends (described in Section 4.4 above); please also refer to the Excel file in Annex 15 for formulas used and calculation details. The schedule of enrolment is the following (by Round 8 project years): **Year 1 – 570 patients, Year 2 – 540, Year 3 – 530, Year 4 – 530, Year 5 – 530, totally 2,700 MDR-TB patients** will be enrolled during the project lifetime (among these, about 10% will be in prisons).

The Category IV treatment regimens will be applied in accordance with the WHO recommendations. After DR-TB is identified and the patient is included in the treatment cohort, he/she will start on the empiric regimen on the basis of past treatment history and DRS resistance profile; the regimen will be adjusted individually after the DST results to 2nd line drugs become available.

Given the current pattern of resistance, a range of 2nd line drugs to be used has been estimated: Capreomycin (in 100% of cases), Ofloxacin (100%), Prothionamide / Ethionamide (100%), Cycloserine (100%) and PASER (50%). In accordance to the Global Fund requirements, the project foresees procurement of these drugs through the GLC mechanism in accordance to the approved application to the GLC and its recent extension (approved in April 2008).

In addition to the GLC drugs above, other 2nd line drugs will be used in a limited number of cases (in about 10-15%) as required by the resistance profile, such as Moxifloxacin, Clarithromycin and Amoxicillin – Clavulanic Acid. First line drugs (Ethambutol and Pyrazinamide) will be added to the treatment scheme if no resistance to them is found. In detail the treatment regimens are described in the GLC application. The dosages of 2nd line agents will be applied according to the WHO recommendations (*Guidelines for the programmatic management of drug-resistance tuberculosis, WHO Geneva, 2006*).

The average cost of 2nd line drugs per full treatment course was estimated at USD 4,320 (about EUR 2,880), including delivery costs.

Support to laboratory investigations for Category IV patients on treatment is included under this Activity. Culture investigations will be performed in all MDR-TB patients on treatment (monthly during intensive phase and every 2-3 months during continuation phase of treatment). DST to 2nd line drugs will be done at the beginning of treatment and in patients during treatment with no improvement / culture conversion.

All interventions under this component are aligned with the support currently available within the Round 6 GFATM TB project. Funds available in Phase II of this project will be sufficient to procure 2nd line drugs for about 750 patients, and Round 8 grant funds will be used to procure drugs for additional treatments to reach the need (see above) as well as to ensure proper laboratory coverage and other needs such as patient support. The Government provides substantial co-financing by covering staff and facility costs and other important costs such as clinical investigations during treatment and drugs for management of side effects of 2nd line drugs.

A number of measures that need to be undertaken to strengthen infection control in TB service facilities (technical assistance and training in infection control, individual measures of protection) are an integral part of DR-TB management programme; however, most of the financial support required in this area is covered by the Round 6 GFATM grant.

4. Patient support programme for drug-resistant tuberculosis patients

Ensuring the patients' adherence to treatment and full direct observation of drug intake during a long period of time (up to 2 years) are the key requirements for effective management of DR-TB cases; therefore, a comprehensive patient support programme will be implemented with the Project support. The following measures will be undertaken:

- Technical assistance (by a local consultant) will be provided to establish, supervise and evaluate the comprehensive patient support programme to strengthen adherence to treatment of MDR-TB patients.
- Groups of 'adherence counsellors' (consisting of a psychologist, a social worker and a nurse) will be created in each district and the capital city of Chisinau; they will conduct patient education and counselling sessions and other patient support activities during intensive and continuation phase of treatment in respective areas. For this purpose, relevant training will be provided.
- Patient education and counselling sessions will be conducted by adherence counsellors in both in-patient treatment delivery sites and later on out-patient basis.
- Informational and educational materials will be developed and distributed among TB patients and family members, with special emphasis on the need to complete treatment and prevent emergence and amplification of drug resistance.
- All patients on DR-TB treatment will receive incentives (food and hygienic parcels) twice a month to ensure compliance with the prescribed regimen and adherence to treatment for the entire duration of the course.
- Daily DOT is required for DR-TB patients during the entire duration of treatment. It is expected that about 20% of DR-TB patients in the civilian sector during out-patient treatment will receive drugs at home (while the others will attend TB service institutions or PHC facilities) from DOT supporters (from

TB service, PHC, social workers and/or NGOs). Reimbursement of transportation expenses of DOT supporters is solicited in this proposal.

- Another 20% of MDR-TB patients in the civilian sector will need to cover substantial distances to come daily to a TB facility / PHC provider during out-patient phase to take medications; their transportation expenses ('enablers') will be covered to ensure better adherence to treatment.

5. Operational research on drug-resistant tuberculosis

To collect additional evidence, inform decisions and facilitate effective operational planning of the NTP interventions, the operational research component is included in the proposal. The operational research studies will target priority issues of TB and DR-TB control in the country. It is planned to evaluate the very important problem of TB among labour migrants with special emphasis on DR-TB and TB/HIV co-infection. It is also intended to conduct operational surveys of risks factors for DR-TB treatment failure and default in the civilian and penitentiary sectors. Recommendations will be developed and actions will be planned based on the studies' findings. The studies will be conducted by the national organisations, which will be selected on competitive basis.

* * *

Detailed description of the proposed project activities is given in the table below. More details are further presented in the workplan and budget files.

Table. Detailed description of the Project Activities.

Objective: To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis		
Service delivery area: Management of drug-resistant tuberculosis		
Activity No.	***Activity title***	***Description***
1	**Strengthening national capacities for management of drug-resistant tuberculosis**	
1.1	Support to the Green Light Committee operations	Technical assistance, GLC monitoring missions and operational support to the GLC in accordance to agreement between the GLC and the Global Fund.
1.2	Technical assistance in DR-TB management	Technical assistance (by external consultants) in selected aspects of the DR-TB management, such as laboratory diagnosis, clinical management of DR-TB cases, organization of treatment and follow-up during continuation phase, drug management, infection control planning, M&E (Years 1-3: 2 missions per year, Years 4-5: 1 mission per year).
1.3	Training in DR-TB management abroad	Training and study tours in priority issues of DR-TB management in Latvia (WHO Collaborative Centres), Estonia (FILHA collaboration), Tomsk, Russian Federation (Partners in Health project); 8 persons per year during Years 1-3, 4 persons per year during Years 4-5.
1.4	Local training in DR-TB management for TB service staff from in-patient treatment sites	In-depth local training in managerial, clinical and laboratory aspects of MDR-TB management (by external trainers). For in-patient staff: 16 persons per year (2 training courses) during Years 1-2, 8 persons per year (1 training course) during Years 3-5, for civilian and penitentiary sectors.
1.5	Local training in DR-TB management for TB service staff from out-patient treatment sites	Local training in DR-TB management for staff from TB service who will be involved in treatment of DR-TB patients during out-patient phase of treatment (by local trainers): 40 persons per year (4 training courses) during Years 1-2; 20 persons per year (2 training courses) during Years 3-5.
1.6	Local training in DR-TB management for Primary Health Care staff	Local training in DR-TB management for staff from PHC facilities (doctors and nurses) who will be involved in follow-up of DR-TB patients during out-patient phase of treatment (by local trainers), with special emphasis on psychosocial support to ensure adherence: 360 persons per year (24 training courses) during Years 1-2; 180 persons per year (12 training courses) during Years 3-5.
1.7	NTP vehicles	Procurement of 6 vehicles for NTP Central and Regional Units: IPP - 2, Balti - 1, Bender - 1, Prisons - 2 (including Transnistria) to strengthen supervision and coordination of DR-TB management programme.
1.8	Support to NTP supervision visits related to DR-TB management	Quarterly supervision visits by the NTP Central Unit and Regional Units (Balti, Bender) to district centres and selected locations will be conducted starting Q3 of Year 1 (in addition to routine NTP supervision) to oversee DR-TB surveillance and case management (laboratory specimens' transportation, drug management, DOT organisation and logistics, compliance and adherence, recording and reporting, etc.)
1.9	Support to the Working Group on revision of TB recording and reporting system and national TB database for DR-TB management	The existing SIME TB electronic surveillance system will be adapted and improved to accommodate the needs for scaled up DR-TB management programme. The existing DR-TB module will be improved and an additional module will be developed for 2nd line drugs' management. A Working Group will be establish to undertake this task and oversee implementation (support is requested for the first 2 years of the project).

ROUND 8 – Tuberculosis

Activity No.	Activity title	Description
1.10	DR-TB data quality assurance and maintenance of the national TB database	A local consultant will be engaged to continuously oversee information flows for different DR-TB management interventions, monitor data collection and transmission, undertake verification of data, ensure quality of data entered into the national database, produce programmatic reports and undertake other tasks related to monitoring and evaluation of DR-TB management interventions.
1.11	Training in implementation of revised recording and reporting forms for DR-TB management	Training will be provided for staff of the NTP Central Unit and TB services facilities at national and peripheral level who will be responsible for data management within the DR-TB programme, based on revised recording and reporting forms and upgraded software. 4 training courses per year will be organised during Years 1-2, followed by 2 courses per year (refresher and for newly enrolled staff) during Years 3-5 (2-day training, 10 trainees per course; totally 140 persons will be trained over 5 years).
1.12	Software upgrade and maintenance for the national TB database	Upgrade of SIME TB software (in Year 3) and regular maintenance services (in Years 1-2, 4-5) provided by the software company.
1.13	IT equipment for electronic DR-TB management system	Procurement of additional IT equipment for implementation of electronic DR-TB management system is foreseen for the M&E Division of the National Centre for Health Management (4 sets), NTP Central Unit (4 sets), Medical Department of the Ministry of Justice (2 sets), 4 reference laboratories, 7 in-patient DR-TB treatment delivery sites and 9 pharmacies. Totally 30 office equipment sets (containing 1 desktop PC, 1 laptop PC and 1 printer/copier/fax) will be procured in mid-Year 1.
1.14	Renovation of MDR-TB in-patient department Transnistria region (civilian sector)	Limited support is requested for renovation of the MDR-TB department in Bender (the only in-patient treatment site for Transnistria region in the civilian sector, 30 beds), including installation of the ventilation system and patient separation measures.
1.15	Renovation of MDR-TB in-patient department Transnistria region (penitentiary sector)	Limited support is requested for installation of the ventilation system in the MDR-TB department in the Prison Hospital No. 3 in Tiraspol (the only in-patient treatment site for Transnistria region in the penitentiary sector, 30 beds) to ensure proper infection control conditions.
1.16	Refurbishment of drug storage facilities at the DR-TB in-patient treatment sites	Procurement of refrigerators for storage of 2nd line drugs for in-patient DR-TB treatment departments (Totally 12: IPP - 3, Vorniceni - 2, Balti - 2, Bender - 2, Prisons - 2, Chisinau TB Dispensary - 1).
2	**Drug resistance surveillance and diagnosis of drug-resistant tuberculosis cases**	
2.1	Establishment of routine drug resistance surveillance: transportation of specimens from peripheral microscopy centres to the reference laboratories	Weekly transportation of sputum specimens from all peripheral TB service facilities to the reference laboratories (NRL, Vorniceni, Balti, Bender) for culturing and further DST
2.2	Cold chain equipment for TB laboratory network: freezers for reference laboratories	Procurement of 5 freezers for reference laboratories (NRL - 2, Vorniceni - 1, Balti - 1, Bender - 1) for storage of strains.
2.3	Cold chain equipment for TB laboratory network: refrigerators for microscopy centres	Procurement of refrigerators for 57 microscopy centres to ensure proper storage of sputum specimens for further transportation to the reference laboratories.
2.4	Cold chain equipment for TB laboratory network: cool boxes for specimens' transportation	Procurement of cool boxes for sputum storage for sputum specimens' transportation within routine drug resistance surveillance system. Totally 126 boxes will be procured in Year 1 (2 for each of 57 microscopy centres and 3 - for each of 4 reference laboratories).

ROUND 8 – Tuberculosis

Activity No.	Activity title	Description
2.5	Rapid test laboratory equipment for DR-TB diagnosis (isolation of strains)	Automated MGIT technology equipment for rapid isolation of strains (BD Bactec MGIT 960 System instrument). Totally 4 sets will be procured (for the NRL, Vorniceni, Balti and Bender reference laboratories).
2.6	Laboratory equipment for rapid identification of R/H resistance	Procurement of laboratory equipment for rapid identification of R/H resistance for DR-TB diagnosis (PCR machine, HAIN systems). Totally 4 instruments will be procured (for the NRL, Vorniceni, Balti and Bender reference laboratories).
2.7	Culture investigations (manual technique)	Culture investigations are performed for confirmation of diagnosis in TB patients at the beginning of treatment and in patients with no smear conversion at the end of intensive phase (2-3 months, estimated 30% of pulmonary cases), at 4-5 months (estimated 20% of pulmonary cases) and at the end of treatment (6-8 months, estimated 15% of pulmonary cases). In each instance, 2 cultures will be performed per patient. Estimated number of culture investigations (based on expected number of patients): Year 1 - 18,000; Year 2 - 17,710, Year 3 - 17,240, Year 4 - 16,750, Year 5 - 16,310.
2.8	Culture and DST to 1st line drugs for DR-TB diagnosis (automated MGIT technique)	For diagnosis of MDR-TB, culture and DST to 1st line drugs will be performed in all smear-positive patients (new and re-treatment) using automated MGIT method; manual technique on solid media will be also used for checking and quality control. Estimated number of cultures and DST to 1st line drugs by automated MGIT (based on DST coverage 90% for Years 1-2 and 95% - for Years 3-5; to the total number of isolates, 20% is added for contamination and rechecking): Year 1 - 3,040; Year 2 - 3,030, Year 3 - 3,140, Year 4 - 3,100; Year 5 - 3,100.
2.9	DST to 1st line drugs (manual technique)	DST to 1st line drugs will be performed in all culture-positive cases using manual technique on solid media, for quality assurance of automated MGIT technique. Estimated number of tests (takes into consideration all estimated smear positive cases and about 10% of smear-negative patients who are expected to be culture positive; to the total number of isolates, 20% is added for contamination and rechecking): Year 1 - 3,630; Year 2 - 3,600, Year 3 - 3,540, Year 4 - 3,490, Year 5 - 3,470 (for quality control and verification of DST results, both manual and automated MGIT method will be used).
2.10	Tests for rapid identification of R/H resistance	Starting Q3 of the project (spring 2010), identification of strains and express testing for R/H resistance will be performed using PCR technique. Estimated number of tests: Year 1 - 1,270; Year 2 - 2,520, Year 3 - 2,620, Year 4 - 2,590; Year 5 - 2,580.
2.11	Bio-safety cabinets for reference laboratories	Procurement of additional 5 class II bio-safety cabinets for reference laboratories (NRL - 2, Vorniceni - 1, Balti - 1, Bender - 1) to comply with the increasing scope of work and workload within the scaled up DR-TB management programme.
2.12	External laboratory quality assurance: shipment of strains to the Supranational Reference Laboratory	With the scope of external laboratory quality assurance of DST to 1st line and 2nd line TB drugs in support of the DR-TB management programme, strains will be shipped quarterly to the Supranational Reference Laboratory (SRL) in Borstel, Germany.
3	**Treatment of drug-resistant tuberculosis cases**	
3.1	Culture investigations for MDR-TB patients on treatment (manual technique)	By manual technique on solid media; 1 investigation per month during intensive phase, 1 investigation every 2-3 months during continuation phase; on average 14 investigations per patient per treatment course (2 cultures are used per each investigation). Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors).
3.2	DST to 2nd line drugs for DR-TB patients on treatment	DST to 2nd line drugs will be performed in all MDR-TB patients on treatment (in all patients - at the beginning of treatment and in patients during treatment with no improvement / culture conversion; on average 2 investigations per patient enrolled during treatment course). Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors).

ROUND 8 – Tuberculosis

Activity No.	Activity title	Description
3.3	2nd line anti-TB drugs	Second line anti-TB drugs for DR-TB treatment for newly enrolled patients. Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors). NOTE: Funding is included for newly enrolled patients. Drugs for patients who will start treatment before the Round 8 start date (1 October 2009), are covered by the Round 6 GFATM grant (Phase I).
3.4	Training of TB service staff in infection control	Local training will be organised for staff from DR-TB treatment delivery sites and laboratories on infection control issues: 30 persons per year (2 training courses) during Years 1-2, 15 persons per year (1 training course) during Years 3-5, for civilian and penitentiary sectors.
3.5	Individual measures for infection control: respirators	Procurement of 3M respirators for 120 TB service staff at higher risk of infection (MDR-TB in-patient departments, reference laboratories)
4	**Patient support programme for drug-resistant tuberculosis patients**	
4.1	Technical assistance for strengthening patient support activities within the DR-TB management programme	Technical assistance (by a local consultant) will be provided to establish, supervise and evaluate a comprehensive patient support programme to strengthen adherence to treatment of MDR-TB patients.
4.2	Support to treatment adherence: establishment of adherence counsellors' groups.	40 adherence counsellors' groups will be established in each district (plus 4 in the capital city of Chisinau), consisting of a psychologist, a social worker and a nurse, to perform different patient support activities for DR-TB patients during intensive and continuation phase of treatment in respective areas. 4 training courses at the central level will be organised in Year 1, supported by 1 training per year during Years 2-5 (for newly involved persons).
4.3	Support to treatment adherence: patient education and counselling sessions	Patient education and counselling sessions will be conducted by adherence counsellors in both in-patient treatment delivery sites and later on out-patient basis
4.4	Support to treatment adherence: informational and educational materials for TB patients	Informational and educational materials will be developed, printed and distributed among TB patients and family members, with special emphasis on the need to complete treatment and prevent drug resistance.
4.5	Support to treatment adherence: incentives (food and hygienic parcels) for DR-TB patients	All patients on DR-TB treatment will receive incentives (food and hygienic parcels) twice a month for better adherence to treatment: in the civilian sector - during continuation phase, in the penitentiary sector (about 10% of all cases) - during the entire duration of treatment. Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors). NOTE: during Years 1-2, funding is also requested to cover needs of patients enrolled in treatment before the Round 8 start date (1 October 2009).
4.6	Support to treatment adherence / DOT for DR-TB patients: transportation of visiting DOT supporters	Transportation expenses for DOT supporters (from TB service, PHC, social workers and/or NGOs). Daily DOT is required for DR-TB patients during continuation phase; it is expected that about 20% of DR-TB patients will receive drugs at home, while the others will come to TB service facilities or DOT spots at the general health service institutions. Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors). NOTE: during Years 1-2, funding is also requested to cover needs of patients enrolled in treatment before the Round 8 start date (1 October 2009).

ROUND 8 – Tuberculosis

Activity No.	Activity title	Description
4.7	Support to treatment adherence / DOT for DR-TB patients: transportation of patients to DOT centres	Estimated 20% of MDR-TB patients (in the civilian sector) will need to cover substantial distances to come daily to a TB facility / PHC provider during out-patient phase; transportation expenses ('enablers') will be covered to ensure better adherence to treatment. Number of MDR-TB patients to be enrolled in second-line treatment: Year 1 - 570, Year 2 - 540; Years 3-5 - 530 per year (totally 2,700 patients over 5 years will be enrolled in the civilian and penitentiary sectors). NOTE: during Years 1-2, funding is also requested to cover needs of patients enrolled in treatment before the Round 8 start date (1 October 2009).
5	**Operational research on drug-resistant tuberculosis**	
5.1	Operational research on priority problems of DR-TB	The operational research studies will target priority problems of TB control and DR-TB in the country. It is planned to evaluate the very important problem of TB among labour migrants with special emphasis on DR-TB and TB/HIV co-infection. It is also intended to conduct operational surveys of risks factors and reasons for DR-TB treatment failure and default in the civilian and penitentiary sector. Recommendations will be developed and actions will be planned based on the studies' findings. The studies will be conducted by the national organisations, which will be selected by the Principal Recipient on competitive basis.
6	**Project management**	
6.1	Management and administration costs - Principal Recipient 1 (PCIMU)	Management and administration costs of the PR 1 (Project Coordination, Implementation and Monitoring Unit, PCIMU); to be used for the project staff, procurement procedures, financial management and office operating costs arising from the additional workload in the Round 8 project.
6.2	Management and administration costs - Principal Recipient 2 (PAS Centre)	Management and administration costs of the PR 2 (Centre for Policies and Analysis in Health, PAS); to be used for the project staff, procurement procedures, financial management and office operating costs.

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

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

Not applicable

4.5.3. Lessons learned from implementation experience

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

Itself the need to apply to the Global Fund in Round 8 (in addition to the ongoing support in Round 6) derives from the implementation experience which has shown that additional resources are required to establish an effective DR-TB management programme, taking into account the latest data on DR-TB burden in the country and up-to-date international recommendations for the countries and settings with high DR-TB burden.

In particular, the following issues have been addressed when designing the interventions described above:

Programmatic issues:

- It became evident that the NTP capacities need to be strengthened specifically for DR-TB management. This is reflected in different NTP strengthening interventions under Activity 1 including technical assistance, training, supervision for DR-TB programme and upgrading of the recording and reporting system.
- The proposal aims at the establishment of routine drug resistance surveillance system in Moldova for diagnosis of DR-TB cases with their further timely enrolment in treatment. Laboratory component (insufficiently addressed in Round 6 application) is strengthened in this proposal, including rapid technologies for isolation and identification of DR-TB strains. Relevant interventions are included under Activity 2.
- It has also become evident that the funds currently available in Round 6 for patient support are insufficient to ensure proper adherence to DR-TB treatment. Therefore, a comprehensive patient support programme was designed and relevant interventions included under Activity 3, with emphasis on community based support to DOT.

Management and administration issues:

- As mentioned elsewhere in the document, it was decided that it would be beneficial to nominate the second Principal Recipient for the Round 8 project representing non-governmental sector (PAS Centre).
- Unit costs, number of units in the budget were adjusted on the basis of analysis of local and international prices of goods and services.
- The timeframe for implementation was reviewed and adjusted to be coherent with the Round 6 project and taking into account the intended consolidation of grants (i.e. the start date of the Round 8 project is aligned with the beginning of Phase II of the Round 6 project).

4.5.4. Enhancing social and gender equality

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

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

The project aims at scaling up DR-TB management interventions towards achieving universal access to diagnosis and treatment. This will directly provide for equity as not a proportion but the entire population will benefit from the GFATM support. All diagnosed patients will be given opportunity to be treated; inclusion / exclusion criteria will be applied that account only for medical factors and attitude to adherence, but not for any other factors that may undermine the principles of equity.

Although the project interventions cover the entire country and all population groups, it is known that the majority of TB patients belong to lower social classes and are therefore especially vulnerable in case of illness and often have to incur catastrophic medical expenditures or interrupt treatment because of financial reasons and, consequently, generate further risks of infecting the family members and other people, e.g. with drug-resistant forms of TB. Provision of DR-TB diagnostic and treatment services free-of-charge at the point of delivery will contribute to reducing social inequalities and increasing access to care for those in greatest need.

The proposal covers the penitentiary sector as well, so the needs of prisoners as one of the most vulnerable groups are addressed.

Stigma associated with tuberculosis remains an important problem in Moldova, and its reduction is seen as one of the key challenges for the NTP; it will allow to increase care seeking and thus improve timely detection of cases, adherence and ensure completion of treatment. Treatment adherence support is included under Activity 4 of this proposal (adherence counselling, incentives and enablers, provision of services close to the patients' place of living, informational and educational materials) and will contribute to psycho-social adaptation of DR-TB patients while on treatment and motivate them to complete the full course of therapy. Patient' and family oriented approaches bring special benefits for women, who are often much more stigmatized and discriminated then men.

4.5.5 Strategy to mitigate initial unintended consequences

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

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

The activities included in this proposal (described under 4.5.1) focus on TB (specifically, DR-TB) control, they are planned in line with the overall health system development process and therefore do not pose a risk of unintended consequences. In particular, they support the overall scope of reform of ensuring access to essential services close to the patients, families and communities; clear patterns of referral between different levels of care; priority development of PHC and patient oriented approach; and assuring appropriate quality of care through implementation of up-do-date evidence-based cost-effective interventions.

The health reform plans foresee strong Government stewardship of the process including increasing financial contributions and it is expected that the Government will be able to take over and sustain these interventions in the near future. Therefore, there is no negative impact of the 'disease-oriented' interventions expected on the overall performance of the health system. The interventions included have a country-wide coverage, and the project will not trigger regional imbalances in coverage or conditions for staff drainage from one area or another, etc. No remuneration of health care staff is solicited in the proposal.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

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

One of the Objectives of the GFATM Round 6 TB project (Objective 2: "Management of drug resistant tuberculosis by extension of implemented DOTS-Plus Project" with the budget of USD 6,681,421 for 5 years starting 1 October 2007 and USD 3,176,593 approved for Phase I) provides support for the same component as requested in this proposal. The reasons for applying for the additional support in Round 8 are the following:

- At the time of the Round 6 proposal preparation (spring 2006), there were no reliable data on anti-TB drug resistance, and the burden of DR-TB was substantially underestimated. The nation-wide Drug Resistance Survey 2006 provided representative information on very high levels of drug resistance in the country (MDR-TB was found in 19.4% of new smear positive cases and 50.8% of previously treated cases).
- The overall strategy for the management of drug-resistant forms of TB has been revised; it is recommended to include DR-TB management as a routine part of the National TB Control Programmes in countries with high resistance burden (e.g. Moldova) and ensure universal access to DR-TB diagnosis and treatment as soon as possible. These requirements are laid down in 2006 in the revised WHO *Stop TB Strategy* and the *Global Plan to Stop TB 2006-2015* by the Stop TB Partnership.
- The number of MDR-TB patients to be treated (1,150), which was included in the Round 6 application, is insufficient compared to the actual number of people in need.
- The Round 8 application requests support to a number of important DR-TB management interventions, which were not included or insufficiently included in the Round 6 project (especially in terms of capacity building, laboratory surveillance and diagnosis and patient support).

There is a substantial gap in the management of drug-resistant TB in the country, which can not be covered by domestic resources and/or other external funding within the coming several years. The CCM has therefore decided to apply to the Global Fund in Round 8 to bridge this gap.

The funds requested in Round 8 will be additional and complementary to the Round 6 grant; there is in fact one DR-TB management programme (component of the National TB Programme) to be supported by the Global Fund. Activities included in this proposal will not duplicate those of the Round 6 project under Objective 2 but will provide for scaling up and accelerating DR-TB management interventions. This complementarity is shown in detail in the workplan and budget files.

To further ensure continuity and coordination, after approval of the Round 8 proposal and jointly with the Request for Continued Funding for Phase II of the Round 6 project, the Moldovan CCM intends to submit a request to the Global Fund for consolidation of the grants

4.6.2. Links to non-Global Fund sourced support

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

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

At the moment, there are no other that the Global Fund external sources of financial support in TB control area in Moldova (USAID/AIHA and KNCV projects were completed in 2007 and limited CarLux funding is expected to end this year). At the same time, the project builds on the achievements of previous programmes, i.e. takes over further strengthening the reference laboratories, established with USAID funding).

The proposal takes into account the current and expected commitments of the Government. In relation to the DR-TB management programme, it does not request funding, for example, for procurement of drugs for management of side effects of 2nd line drugs, clinical investigations during treatment and other expenditure items that are covered by the national health insurance system.

4.6.3. Partnerships with the private sector

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

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

According to the national legislation, the responsibility for TB control (as well as for other infectious diseases and major public health problems) lies with the Government. While the private sector plays a role in a number of health care areas, its involvement in TB control has been limited so far.

The Ministry of Health, NTP and public health care services will continue to be responsible for TB control interventions, including those related to DR-TB management. At the same time, it is necessary to mention that the NTP has initiated activities with private providers of medical care in order to increase their awareness of the disease and establish proper links with the public services, in particular in terms of ensuring timely notification and referral of TB suspects to the NTP facilities.

Although there are examples of private sector contributions to the health sector, it is not possible at the moment to 'quantify' these contributions in relation to TB control.

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

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

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	Contribution Description (*in words*)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
N / A	N / A	N / A	N / A	N / A	N / A	N / A	N / A

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

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

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

DR-TB management is complex and requires strong planning and coordination of actions at different levels of the service delivery, building partnerships across different sectors and effective involvement of the communities. The provision of effective outreach and community-based services is a challenge for the country, e.g. in the health sector. This proposal is reliant predominantly on the government / public sector in terms of service delivery; it aims at strengthening the public health sector capacities through strong coordination of interventions by the NTP at central level, increasing responsibilities of the NTP regional units and optimizing the links and referrals within the specialized TB service as well as collaboration and coordination with general health services, first and foremost Primary Health Care.

At the same time, the proposal intends to strengthen the role of civil society and communities in terms of provision of care and support to TB patients close to their place of living. This intention has been reflected in the nomination of the second Principal Recipient representing the non-governmental sector and in the setting up of a comprehensive patient support programme (under Activity 4) which aims to employ community-based interventions in order to ensure the patients' adherence to lengthy and complex DR-TB treatment.

It is therefore deemed that the implementation of the Round 8 project will allow to consolidate coordination and service delivery by the public as well as by non-governmental institutions and communities.

4.7.2. Alignment with broader developmental frameworks

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

Although Moldova is classified as a low-middle income country and the Gross National Income (GNI) has nearly doubled since 1994, poverty and unemployment levels remain high. The *Economic Growth and Poverty Reduction Strategy 2004-2006* (extended until end-2007) emphasized the country's commitment to achieving the Millennium Development Goals (MDGs) and addressed health care and TB. The document aimed at improving access to the essential health services through further consolidation of the health system reform with priority development of Primary Health Care, improvement of health sector financing through mandatory health insurance and prevention and control of "socially conditioned diseases" including TB.

To further pursue the reforms initiated by the EGPRS and another important strategic planning document – the *Moldova-European Union Action Plan* (MEUAP), on 21 December 2007 the Parliament adopted the *National Development Strategy for 2008-2011* (NDS). The NDS is the main internal medium-term strategic planning paper, which defines the development objectives of the Republic of Moldova by 2011 and identifies the priority measures and actions to achieve these objectives. The key NDS objective is to ensure a better quality of people's lives by strengthening the foundation for a robust, sustainable and all-inclusive economic growth. The NDS presents a long-term vision of transformation, which includes changing the country into "a state that guarantees qualitative education, health care and social services for all citizens".

The NDS reiterates the need to progress towards achieving MDGs, including Goal 6 "Combat HIV/AIDS, tuberculosis and other diseases":

- Stabilize the spread of HIV/AIDS infection by 2015. Reduce HIV/AIDS incidence per 100,000 population from 10 cases in 2006 down to 9.6 by 2010 and 8 by 2015.
- Reduce HIV/AIDS incidence per 100,000 population from 13.3 cases in 2006 down to 11.2 by 2010 and 11 by 2015 in the 15-24-year age group.
- Have halted by 2015 and begun to reduce tuberculosis. Reduce the rate of mortality associated with tuberculosis from 16.0 (per 100,000 population) in 2002 down to 15.0 in 2010 and 10.0 in 2015.

Among the priorities for action to meet the long-term vision, the NDS identifies "Strengthening the healthy society" as one of them, by:

- Improving the quality of health services by streamlining the infrastructure and efficient use of resources, improving the management of health facilities and investing the saved resources in cost-efficient technologies, equipment and development of professional skills; including:
  - Strengthening control over communicable diseases, particularly through the programs to fight diseases outlined in the MDGs (TB, HIV/AIDS and STIs)
- Improving the access to health care services through efficient use of financial resources and by expanding coverage with mandatory health insurance.

The National Development Strategy and Action Plan (the latter approved in February 2008) are attached to this proposal in Annex 2.

On 06 August 2007, the Government endorsed the *National Health Policy in the Republic of Moldova 2007-2021* (NHP). Recognizing that population's health is of paramount importance for the state security, economic and social development, the NHP defines a set of priorities for action for the next 15 years, in order to improve health of the population and reduce the inequalities between different social groups and regions in the country. The goal of the NHP is the creation of conditions for realization of health potential of every individual throughout the life and attainment of appropriate quality standards. The general objectives set by the NHP are:

- Increase in life expectancy at birth and prolonging the healthy life;
- Ensuring life quality and reducing the differences in health between social groups;
- Strengthen inter-sectoral partnerships for better health;
- Promote individual responsibility for own health.

One of the specific objectives of the NHP is "Combating contagious diseases", which places a special emphasis to TB control. The document calls for strengthening partnerships between the central and local public authorities, health care providers and civil society to ensure high standards for TB diagnosis and care social support to TB patients and their families. Special attention is given to TB control in the penitentiary system. Importantly, the NHP stresses the need to prevent and reduce the burden of drug-resistant forms of TB.

The National Health Policy document is attached in Annex 3.

Providing essential care and having been proved as one of the most cost-effective interventions in the health sector, the DOTS-based TB control programme is compliant with the principles and priorities set in the NDS and NHP. This project proposal aims at further expanding the DOTS framework in line with the recommendations set in the WHO *Stop TB Strategy* and the *Global Plan to Stop TB 2006-2015*, focusing on scaling up DR-TB management interventions in Moldova as a country with high resistance burden. As this project will contribute to ensuring universal access to DR-TB diagnosis and treatment for the population and thus reducing social inequalities and barriers to care of the poor and vulnerable population groups, it is seen as fully aligned with the development frameworks relevant to the country context.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

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

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

The Government of Moldova, in collaboration with international partners, has developed and endorsed the concept of a comprehensive National Monitoring and Evaluation (M&E) system for health. This concept recognizes its advantages and importance over separate systems that monitor separate initiatives, programs and projects. A multi-stakeholder Technical Working Group on M&E has been established within the CCM, which acts as 'one national authority' coordinating national responses to HIV/AIDS/STI and TB epidemics.

Following the UN recommendations to implement 'The Three Ones' principle, the functions of the single M&E mechanism for the diseases concerned were delegated to the Monitoring and Evaluation Division of the National Centre for Health Management (NCHM) of the Ministry of Health. This unit is in charge of M&E of the National Programs on Prevention and Control of HIV/AIDS/STI and TB. At present, a full design of the M&E system has been conceived with a set of indicators agreed upon by all major stakeholders according to the international recommendations of Stop TB Partnership, UNAIDS and UNGASS. At the moment, the National M&E Plans for HIV/AIDS/STI and TB exist in their advanced drafts. After finalization the plans will be discussed again and submitted to the CCM for approval. The plans will include activities and strategies aimed at capacity development, advocacy and technical assistance. These activities will allow for the revision and modification of the informational flow, application of the 'One M&E Unit' concept and better use of collected information for decision making at different levels.

The NCHM acts as Sub-Recipient of the Round 6 GFATM grants (HIV/AIDS and TB) and is responsible for the implementation of different activities related to the programme monitoring and evaluation. This function is carried out by the Monitoring and Evaluation Division, established within the NCHM in 2004.

The M&E Division of the NCHM is responsible for monitoring and evaluating the national health programs and other interventions and activities aimed to improve public health. The main functions of the M&E Division are:

- Design and implementation of the M&E systems for the national health programs and other health development initiatives at country level;
- Collecting, processing, analyzing and interpreting relevant information for the M&E systems;
- Conducting operational research in priority areas relevant to M&E of the national health programs;
- Development and publication of analytical reports based on the information from the health programs' M&E systems;
- Development, implementation and maintenance of the electronic informational monitoring systems within the national health programs and initiatives, information support to the activities of the NCHM and other health institutions engaged in data collection, processing and analysis;
- Provision of technical assistance and capacity building support to the Ministry of Health and health care institutions and specialists in data collection, processing and analysis, use of new information technologies and other topics relevant to health programs' M&E;
- Development and maintenance of the web page and online applications for M&E of the health programs and other initiatives.

The collection and management of data for the GFATM grants is integrated within the overall activity of the M&E Division. The Division is in charge of elaboration and implementation of the M&E plans for the National Programmes on Prevention and Control of HIV/AIDS/STI and TB for 2006-2010. It functions as a sole monitoring and evaluation mechanism at the country level for these diseases.

The M&E Plans for the GFATM projects derive from the National M&E Plans for the above National Programmes and will mainly collect and process data through the established mechanisms. This will ensure coherency and comprehensiveness of M&E arrangements and their integration with the National M&E Plans, strengthen the in-country capacities and collaboration with partners, and contribute to

ensuring the sustainability of the robust national health M&E system in the future.

The data received from the implementing organizations are stored at the M&E Division of the NCHM and summarized and submitted to relevant bodies (including the GFATM projects' Principal Recipients) on a quarterly basis. In order to improve the routine statistics for TB, especially regarding case notifications and treatment success indicators, a special software programme was developed (SIME TB: computerized TB Monitoring and Evaluation System). The central database is located at the national level (NCHM M&E Division). Using the synchronization procedure, the local (district) levels enter data and transfer them to the central database and vice versa. The laboratories are also part of this system and are involved in the data exchange.

4.8.2. Avoiding parallel reporting

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

The impact measurement system for the Global Fund grants will be implemented in accordance with, and will be integral part of, the National Monitoring and Evaluation system for HIV/AIDS/STI and TB, therefore there will no duplication or 'parallel reporting'. The M&E arrangements are compliant with the GFATM requirements, in particular: the Programme will be an integral part of the national strategic health development plan; consistency between goals, objectives, strategies and the selected indicators will be ensured; reporting on results will build on and strengthen the existing M&E systems; indicators and targets selected for reporting are supported by the workplan and budget; and the M&E system will provide for impact / outcome measurement.

The use of standard indicators provides the National Programme with valuable measures of the same indicator in different populations, permitting analysis of trends. Over time, the use of standard indicators also ensures comparability of information across countries. During the process of Round 8 proposal development, indicators for monitoring program performance were selected in compliance with the National M&E reporting framework as well as with the Global Fund requirements, namely:

- Use of a limited set of indicators relevant for reporting including impact measurement, which are agreed by a wide range of partners and used in most countries;
- Use of a set of priority indicators and additional indicators at different levels of M&E;
- Selection of consistent indicators that are comparable over time and with clear targets;
- Selection of a number of key indicators that are comparable with other countries.

The key indicators and their definitions were selected from the internationally approved lists and sources developed by WHO and Stop TB Partnership. In particular, *Monitoring and Evaluation Toolkit for HIV/AIDS, Tuberculosis and Malaria* (Interagency guidelines, Second Edition, January 2006) was used as reference. Output and process indicators were developed in line with the Service Delivery Area and Activities included in the proposal's workplan.

Performance Framework (Attachment A to the Proposal Form) is a key document that presents a detailed description of indicators to be used to monitor the programme performance, baseline values and targets to be achieved over specific periods of time as well as methods and frequency of data collection. Besides the Performance Framework, which contains a limited set of indicators and serves as the basis for regular reporting to the Global Fund, the Principal Recipients will develop the Programme Monitoring and Evaluation Plan, consistent with the overall national M&E system. This M&E Plan will contain an extended set of indicators that will be monitored by the PRs to ensure that the activities are implemented according to the Workplan timeframe and preliminary outputs are attained. In particular, the M&E Plan will assist the PRs to monitor interventions implemented by Sub-Recipients and to undertake corrective actions as required.

The M&E Plans present detailed descriptions of sources, methods and frequency of data collection for each indicator, methods for data quality control, data processing, use and dissemination. Responsibilities of different institutions and persons in M&E, as well as formal reporting requirements, will also be outlined.

Having the overall responsibility for M&E activities for the GFATM projects, the Principal Recipients' M&E

Specialists will work in close collaboration with the NCHM M&E Division and will have the duty of finalization and clearance of all data and reports which will be deriving from the Programme implementing entities and processed by the M&E Division. They will participate in the design, implementation and oversight of M&E activities implemented by the Division including supervisory visits to the field.

Within the framework of the Program's M&E system, the data will be collected according to the indicators identified in the Components' M&E Plans using three main sources: i) routine health statistics at the national and sub-national levels; ii) operational surveys and studies; and iii) data collected by the NTP specifically for relevant interventions.

Collection of the routine statistical data and special data from service delivery sites will be performed by the M&E Division of the NCHM on a quarterly basis. Special standardized forms will be used in order to ensure the completeness and uniformity of data across different sources and possibility for further proper compilation and comparability.

The quality and consistency of data will be assured by: internal consistency checking of data collection tools; periodic site visits by the M&E Division and PRs' M&E Specialists; quarterly revision of indicators and activity reports (if applicable), submitted by Sub-Recipients and other implementing agencies; quarterly (and more frequent as necessary) meetings of the M&E Division and PRs' staff; periodic common meetings with Sub-Recipients by the PRs' and M&E Division staff; meetings with the Local Fund Agent on M&E issues and/or site visits as necessary; and technical assistance by external consultants if necessary.

The analysis of information and compilation in relevant reports will be performed by the M&E Division, coordinated with the PRs' M&E Specialists and submitted to the Ministry of Health on a quarterly basis. After the end of a Programme implementation year, annual reports will be developed by the M&E Division and submitted to the PRs and further to the Ministry of Health and CCM as relevant.

The Programme M&E information will be used for providing feedback to the implementing entities, presenting best practices and lessons learned for broad dissemination to the national and international partners, including presentation at the CCM meetings as necessary. The information collected within the Program will feed the M&E Reports of the National HIV/AIDS/STI and TB Programs, Annual Report on Drug Situation in Moldova, website of the M&E Division, country reports to WHO/EURO, European Centre for Disease Control (ECDC), WHO Global TB annual reports and other destinations.

4.8.3. Strengthening monitoring and evaluation systems

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

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

The Round 8 grant will be complementary to the ongoing support from Round 6. In the Round 6 project, support for strengthening the M&E system is included under Objective 3 (SDA 2: "Information system and operational research"). The Round 8 proposal aims at further improving the system and upgrade it to accommodate for the needs of the scaled up DR-TB management programme. For this purpose, Activities 1.8-1.13 have been designed to establish NTP supervision for DR-TB interventions, revise recording and reporting documentation for DR-TB, upgrade the existing SIME TB electronic surveillance system and provide relevant training for staff, as well as to strengthen project implementation capacities for M&E.

The estimated budget allocated to M&E activities amounts to 4.8% of the total requested Round 8 budget over the project's lifetime, which is deemed sufficient given the size of the project and taking into account support in the area available from Round 6. Please refer to Activities' description under Section 4.5.1 above and workplan and budget files for details.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

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

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

PR 1	Project Coordination, Implementation and Monitoring Unit (PCIMU)
Address	101, Sciusev Str., Chisinau MD-2012, Republic of Moldova Tel. +373 22 23 87 51 Fax +373 22 23 87 51 E-mail vvolovei@ucimp.md vburinschi@ucimp.md

The Program Coordination, Implementation and Monitoring Unit (PCIMU) is an independent legal entity which is accountable to the Government of Moldova and reports on its operations to the Ministry of Finance, Ministry of Economy and Trade and Ministry of Health. The PCIMU was established in 1999 for the implementation of the World Bank and Dutch Government grants and credits for the health system restructuring project. Its structure, functions and accountability were revised and endorsed by Decree No. 391 of the Government of the Republic of Moldova from 19 April 2000.

The PCIMU was the Principal Recipient (PR) for the GFATM Round 1 TB/AIDS grant (implementation completed in April 2008). The PCIMU was proposed by the CCM to be the Principal Recipient of the Global Fund TB and HIV/AIDS grants in Round 6 and was endorsed as the PR in the Grant Agreements signed between the GFATM and PCIMU on 18 April 2007 and 01 May 2007 respectively and acknowledged by the CCM.

The PCIMU at the country-level is legally responsible for programmatic results and financial accountability for the GFATM-financed TB and HIV/AIDS programmes. As the Principal Recipient for the Global Fund grants, the PCIMU has established systems, processes and practices in accordance to *Fiduciary Arrangements for Grant Recipients,* adopted by the 5th GFATM Board Meeting in June 2003.

As the Principal Recipient for the GFATM grants, the PCIMU role is to ensure that effective arrangements are put in place for: (i) disbursement of funds to all implementing entities (e.g. Sub-Recipients); (ii) procurement and supply management; and (iii) monitoring and evaluation, including reporting on programmatic results and financial accountability to the Global Fund and the CCM. The PCIMU functions, structure, mode of operations and other details are described in detail in the Project Operations Manual (last updated in August 2007).

PR 2	Centre for Health Policies and Studies (PAS Centre)
Address	32, Bulgara Str., Chisinau MD-2001, Republic of Moldova Tel. +373 22 22 63 43 Fax +373 22 22 63 87 E-mail viorel.soltan@pas.md

The Centre for Health Policies and Studies (PAS Centre) was established in 1999 by Soros Foundation Moldova and the Institute for Public Policies. PAS Centre is a Moldova-based, non-governmental, non-political, non-for-profit organization. Its mission is to build up a democratic society through contribution to the health and social sectors development, policy advocating, capacity building and support to reforms.

The objectives of the PAS Centre are: (1) contribute to development of democratic values; (2) promote health and social system focus on individuals; (3) analyze and develop health and social policies; (4) analyze and develop strategies and social and public health interventions; (5) support health and social reform process; (6) promote healthy life style; (7) promote public involvement in decision making processes and (8) contribute to human resources development.

Having completed its reorganization in 2007, PAS Centre took over the activities of the American International Health Alliance Inc (AIHA). Since 2003 AIHA carried out a comprehensive programme aimed at strengthening TB control in Moldova working with the Ministry of Health, the Global Fund and other key partners. Eighty per cent of AIHA staff relocated to PAS Centre to ensure sustainability and continuation of program initiatives on TB training and communication. PAS Centre is a dynamic organization with skilled and motivated professionals working in public health and social development fields.

PAS Centre has been acting as a Sub-Recipient for grant funds within the Round 6 TB GFATM, being responsible for organization of training activities for TB and PHC service providers on DOTS and DOTS-Plus, revision of curricula and guidelines, training in TB surveillance system and conducting public awareness campaigns. Other important projects implemented by PAS Centre include those on 'Strengthening ARV treatment adherence in Moldova', 'Support to orphans and vulnerable to HIV children', 'Operational research on HIV prevalence among new TB patients in Moldova'.

Having extensive experience of project implementation under USAID, World Bank and GFATM financing, PAS Centre possess necessary capacities for procurement, financial management, monitoring and evaluation. The total value of completed and ongoing projects up to date is USD 4.71 million.

4.9.2 Sub-Recipients

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

- [x] Yes
- [ ] No

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

Not applicable

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

- [x] 1 – 6
- [ ] 7 – 20
- [ ] 21 – 50
- [ ] more than 50

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

- [x] Yes
[Described under 4.9.3]
- [ ] No
Answer s.4.9.4. to explain

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

The description of Sub-Recipients is given in the next sub-section (4.9.3). One of the two pre-identified SRs represent the governmental sector and another – the non-governmental sector. The non-governmental sector is expected to play an important role in the project implementation, specifically in activities aimed at strengthening adherence to DR-TB treatment through education and different patient support activities, e.g. at the community level. The need to strengthen community involvement for better TB control has been reflected in the CCM's decision to nominate the second Principal Recipient from the non-governmental sector (PAS Centre).

4.9.3. Pre-identified sub-recipients

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

For the Round 6 TB project, the CCM identified and endorsed two Sub-Recipients: AIHA-Moldova and the National Centre for Health Management (NCHM). After the completion of USAID-funded TB project in September 2007, PAS Centre had taken over the functions of AIHA-Moldova as Sub-Recipient for the Round 6 project. For the Round 8 TB project, PAS Centre is nominated as one of the two Principal Recipients. The CCM agreed to nominate two Sub-Recipients for this project:

- *National Centre for Health Management (NCHM)* is a governmental institution accountable to the Ministry of Health. It will be responsible for the implementation of activities related to strengthening TB surveillance and information system, monitoring and evaluation and operational research.
- *CarLux* is a non-governmental organization with extensive previous experience in implementation of TB control interventions, in particular in the penitentiary sector. For the Round 8 TB project, it is expected to facilitate the patient support programme implementation for adherence to treatment of DR-TB patients with special emphasis on strengthening community involvement.

The sub-recipients were identified during the process of proposal development on the basis of demonstrated capacity and previous experience, e.g. within the GFATM financed projects. After the Objective, Service Delivery Area and Activities were agreed upon, the item of sub-recipients' nomination was included in the agenda and discussed in the CCM meeting.

Both entities have substantial implementation experience (with the Global Fund projects and beyond); therefore, no major challenges to affect performance within the Round 8 project are expected from programmatic or legal or financial management perspective.

In its capacity of the NTP Central Unit, the National Institute of Phtysiopneumology, although not nominated as Sub-Recipient, will remain the key national partner and institutional beneficiary, which bears the overall responsibility and accountability for the National TB Control Programme performance and results.

4.9.4. Sub-recipients to be identified

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

The need to identify additional Sub-Recipients may arise on the way of project implementation. In such cases, The SRs will be sub-contracted on an open bid basis. The decision on the selection of SRs will be taken by the Evaluation Committee. The selection process is the following. The potential SR(s) will be invited to submit applications in accordance with the Request for Sub-Recipient Proposals. The proposals will need to be submitted on the provided Proposal Form and will have to include complete information in accordance with the eligibility criteria. A detailed workplan and budget, M&E plan and PSM plan should be provided.

Any organization can become a SR for the GFATM grant if it is a legal entity officially represented in the Republic of Moldova, has demonstrated proper programmatic and financial management capacity and is able to enter into a legal agreement with the Principal Recipients. The SRs may represent the

government, academic / educational sector, non-governmental and community-based organizations; people living with diseases, religious / faith-based organizations and, upon justification, multi- or bilateral development partners. The SRs are directly responsible for the management of the grant funds but will not act as intermediaries. The SR may act individually or in consortium with partner organisations.

An entity can not be nominated as SR if:

- It is bankrupt or has affairs administered by the courts, has entered into an arrangement with creditors, has suspended business activities, is subject of proceedings concerning those matters, or is in any similar situation arising from a similar procedure provided for in the national legislation or regulations;
- It has been convicted of an offence concerning professional conduct by a judgement which has the force of res judicata (i.e., against which no appeal is possible);
- It has been proven of severe professional misconduct;
- It has not fulfilled obligations relating to the payment of social security contributions or the payment of taxes in accordance with the legal provisions of the Republic of Moldova;
- It has been subject of a judgment which has the force of res judicata for fraud, corruption, involvement in a criminal organisation or any other illegal activity detrimental to the state financial interests;
- It has been declared to be in serious breach of contract or failure to comply with its contractual obligations in connection with a procurement procedure or other grant award procedure.

An applicant will be also excluded from participation in the process of selection of SRs at the time of the call for bid, if:

- It is subject to a conflict of interest;
- It is guilty of misrepresentation in supplying the information required by the CCM or the PR as a condition of participation in the process of selection of SRs or fails to supply this information;
- It has attempted to obtain confidential information or influence the evaluation committee or the CCM or PR in any way;
- Its management is closely related by blood or marriage with key decision persons in the CCM and within the office of the PR.

4.9.5. Coordination between implementers

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

Comment on factors such as:

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

The Country Coordinating Mechanism (CCM) will oversee the overall implementation of the project and ensure proper coordination between different sectors, GFATM grants as well as different programmes implemented by other external partners for the three diseases. The CCM will monitor the project progress to ensure that the activities are carried out according to the workplan and indicators of programmatic and financial performance are accomplished. It will make the key financial and programmatic decisions and will have the responsibility to address the main problems and challenges related to the project.

The CCM meetings will be convened quarterly or more frequently as necessary. Technical working

groups for each component will work with the stakeholders between the CCM meetings and prepare the documentation to be endorsed by the CCM. The CCM and the Ministry of Health will carry out the role of coordination with other programmes and development initiatives. The CCM will ensure practical coordination and collaboration with all local partners involved.

On an annual basis (or more frequently as requested by the CCM), the Principal Recipients (PCIMU and PAS) will prepare summaries of the project progress for review by the CCM. These summary reports will present the current state of the epidemic, project implementation progress, financial expenditures and implementation challenges and problems. The CCM will use this information to approve the changes in the programme setup and resource allocation when necessary. The CCM will negotiate the recommended changes with the GFATM.

The Principal Recipients will execute its functions and apply procedures as laid down in the Project Operational Manuals, which will be adjusted as relevant to the needs of the new grant. The grant funds will be transferred to the special accounts of the PRs. The PRs will be responsible for all practical issues related to the project implementation including oversight of the sub-recipients. The PRs will undertake the functions of procurement (of health and non-health products, equipment, civil works and services), financial management, project-related monitoring and evaluation and reporting to the Global Fund.

The PRs will develop the work plans for the project implementation and will present the project performance reports to the CCM. Quarterly financial and activity progress reports will be forwarded to the CCM for review. On an annual basis, the CCM will review the project performance and proposed work plans for the upcoming year and will approve additional disbursements. The two nominated Principal Recipients will maintain close collaboration and coordination to ensure coherent and balanced implementation of all programme components.

The CCM Secretariat and the PRs will communicate with the GFATM on the project progress. Progress Updates and Disbursement Requests will be forwarded to the GFATM Portfolio Manager on a semi-annual basis or as otherwise agreed; other documentation will be provided as requested by the GFATM.

The National TB Programme Central Unit (Institute of Phtysiopneumology) will be the main technical partner of the project. The NTP will ensure practical coordination and collaboration with all local partners involved including non-governmental sector.

The Local Fund Agent (currently PriceWaterHouse Coopers, PWC) will act within the Terms of Reference agreed upon with the Global Fund. External audits evaluating the project performance and financial management will be an integral part of the proposed management arrangements.

4.9.6. Strengthening implementation capacity

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

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

(a) the assistance that is planned;**

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

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

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

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

Sustaining coverage, improving the quality of DOTS and expanding its framework requires further development of the national capacities for effective management of the TB control programme, coordination of partners and monitoring and evaluation. Management of drug-resistant TB is a relatively new area of work for the NTP; therefore, the national capacity and expertise are insufficient at the moment. Until now, a number of people were trained abroad and locally in different aspects of DR-TB management. To bridge the gap, training for Moldovan specialists is included in this proposal (see

description of Activities 1.3-1.6, 1.11 and 3.4 under Section 4.5.1 above and in the attached workplan). These training courses will cover a range of DR-TB management issues, including laboratory quality assurance, clinical management of cases, second-line drugs' use with side effects' monitoring and management, follow-up of patients during out-patient phase of treatment and ensuring DOT and adherence and infection control. As the treatment of DR-TB cases will scale up and an increasing number of providers (including those from out-patient facilities) will be involved, training activities are included in each year of the project, to ensure proper coverage of the staff.

Training courses abroad will be held at the WHO Collaborative Centre for MDR-TB Latvia, Estonia (FILHA collaboration) and with the support of the Partners in Health project in Tomsk / Novosibirsk, Russian Federation.

In addition, a number of training activities in project management issues (including procurement and supply management, monitoring and evaluation) will be organised for the Principal Recipient and NTP staff (budgeted under Project Management).

The NTP is in need of technical and managerial assistance to start and effectively manage a complex and demanding DR-TB management programme. External technical assistance is included in the proposal under Activities 1.2, 1.10 and 4.1; it will be provided in technical areas similar to those mentioned for capacity building / training above. The needs for technical assistance were evaluated during a number of assessment missions over the recent years, including GLC assessment missions in 2005-2007, as well as the consultations during the process of this application development. It will be complementary to technical assistance activities that are provided within the Round 6 project. Managerial assistance is also included for the Principal Recipient in priority issues of project implementation such as procurement and supply management, monitoring and evaluation.

Relevant provisions for technical and managerial assistance were included in the component budget. In addition, technical assistance by the GLC will be provided as part of the agreement between the GLC and the Global Fund (budgeted at USD 50,000 per each year of project implementation under Activity 1.1).

The services will be obtained through a transparent and competitive process; the sources of needed technical and managerial assistance will be identified in consultation with the external partner agencies such as WHO, PIH, MSH, GOPA/EPOS and others. Account will be taken of countries and institutions in the region that have advanced experience in DR-TB management. Procurement of services will be carried out in accordance with the internationally accepted practices and as laid down in the Project Operations Manual and will be described in detail in the updated PSM plan for the project.

As technical assistance is needed in selected specific areas at different points of time, it has been decided to opt for a short-term timeframe approach. Through involving local experts in the assignments, the external assistance will contribute to increasing the national capacity and expertise on a longer run.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

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

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

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

4.10.2. Table of roles and responsibilities

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	State Agency for Material Resources, Public Procurement and Humanitarian Aid Ministry of Health; PCIMU	Other Government PR	☐ Yes ☒ No
Intellectual property rights	National Agency for Intellectual Property Protection	Other Government	☐ Yes ☒ No
Quality assurance and quality control	Ministry of Health; National Drugs Agency	Other Government	☐ Yes ☒ No
Management and coordination *More details required in s.4.10.3.*	Ministry of Health; PCIMU; PAS Centre; NTP Central Unit	Other Government PR PR SR	☒ Yes ☐ No
Product selection	Ministry of Health; NTP Central Unit;	Other Government SR	☒ Yes ☐ No
Management Information Systems (MIS)	National Centre for Health Management (NCHM); PCIMU; NTP Central Unit	Other Government PR SR	☒ Yes ☐ No

Forecasting	Ministry of Health; PCIMU; PAS Centre; NTP Central Unit	Other Government PR PR SR	☉ ☐	Yes No
Procurement and planning	Ministry of Health; PCIMU; PAS Centre; NTP Central Office	Other Government PR PR SR	☉ ☐	Yes No
Storage and inventory management *More details required in s.4.10.4*	Ministry of Health; NTP Central Unit	Other Government SR	☐ ☉	Yes No
Distribution to other stores and end-users *More details required in s.4.10.4*	Ministry of Health; NTP Central Unit	Other Government SR	☐ ☉	Yes No
Ensuring rational use and patient safety (pharmacovigilance)	Ministry of Health; National Drugs Agency; NTP Central Unit	Other Government SR	☉ ☐	Yes No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
Project Coordination, Implementation and Monitoring Unit (PCIMU)	PR	EUR 3,556,441
Centre for Health Policies and Studies (PAS Centre)	PR	EUR 553,570

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

4.10.4. Alignment with existing systems

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

The proposal intends to use the existing systems for drugs' and medical technology management, established and strengthened by the Ministry of Health and relevant institutions over the recent years, including drugs quality assurance and pharmacovigilance carried out by the National Drugs Agency, which was re-organised by merging the National Institute of Pharmacy and the MOH Pharmaceuticals Department in 2006.

Processes and procedures to be used are described in more detail in the following parts of this Section.

4.10.5. Storage and distribution systems

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

- ☑ National medical stores or equivalent
- ☑ Sub-contracted national organization(s) *(specify)*
- ☐ Sub-contracted international organization(s) *(specify)*
- ☐ Other: *(specify)*

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

The Project Coordination, Implementation and Monitoring Unit (PCIMU) bears the overall responsibility for customs clearance, storage and inventory management of drugs and other health commodities and products supplied under the Global Fund financing.

The PCIMU has entered into the agreement with the semi-governmental importer / distributor San-Farm Prim JSC to handle the imports, arrange quality testing, and store the drugs at its warehouse (central medical store equivalent). San-Farm Prim has been managing the importation and storage of goods within the Round 1 and Round 6 GFATM projects. The central store will be used for storage of 2nd line TB drugs and health products procured under the Round 8 project. The store has adequate capacity (surface area 9,000 sq.m.) and conditions for the storage of drugs and medical equipment.

The first expiry / first out (FEFO) method is applied for inventory management. There is an established system of regular (monthly) stock taking and reporting that enables the programme management to effectively plan distribution, utilize the products and avoid expiry. Stock records at the central level are computerised. The software records the following data: list of stored drugs by INN and commercial name, strength and drug formulation; size of the package; quantity received; unit price and total cost; manufacturer's name and country of origin; expiry date and batch number; quantity of drugs issued; stock balance.

The health service institutions use two methods of stock records: manual and computerised. The manual record is based on the register of quantitative evidence of narcotics, toxic, psychotropic and other potent drugs (Form F-8, MOH order No. 322 from 22 November 2002). The computerized system records data on drugs name and strength, package, unit price and total cost, stock balance at the beginning and at the end of period, quantities received and released during the year. The system can generate reports on balance for any period of time.

According to the PCIMU requirements, the central medical store presents quarterly the report on the drugs balance, which includes the following information: name of drugs; strength; packaging; quantity; unit price and total cost; batch number and date of expiry; manufacturer's name and country of origin. The report is accompanied by the list of distribution sites and invoices / receipts for delivered drugs.

On a quarterly basis, the PCIMU Monitoring and Evaluation Specialist and the NTP Drug Management Team monitor the management of stock of all pharmaceuticals and health products supplied under the GFATM projects at the central, district and facility levels. Monitoring is based on both documentary examination and physical presence of goods. In relation to drugs, the main aspects that are looked into are: records practice, stock balance, drugs prescription and adherence to treatment scheme, consumption levels, reports on drug management, etc.

The in-patient treatment sites for DR-TB patients (Institute of Phtysiopneumology, Chisinau City TB Dispensary, DR-TB departments in Vorniceni, Balti, Bender as well as the prison TB hospitals in Prunchuil and Tiraspol) have sufficient capacity and storage conditions for drugs and supplies. Given an increasing number of patients enrolled, procurement of additional capacious refrigerators is included in this proposal (Activity 1.16) to ensure proper storage of 2nd line drugs (i.e. PASER). Regarding out-patient phase of treatment, all TB service and PHC facilities are equipped with refrigerators to ensure cold chain conditions as well.

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

The distribution of anti-TB drugs is based on the distribution plan, officially approved by the Deputy Minister of Health on a quarterly basis. The NTP Drug Management Team (DMT) is in charge of preparation of this plan. The process of development and approval of the distribution plan takes about 3 weeks.

The DMT uses the following tools and data for estimating the quantities for distribution: computer form for ordering, reporting and monitoring of anti-TB drugs; quarterly reports from TB service facilities that include: balance of the stock at the beginning and end of quarter, quantities received and consumed; expiry dates of drugs; report on the number of patients by treatment categories notified for the reporting quarter.

The estimated quantity for delivery comprises the needs for one quarter plus buffer stock for 3 months (100% buffer). The drugs are delivered to district / municipal pharmacies (totally 44, including Transnistria and the penitentiary system).

The district / municipal levels distribute drugs to TB service and PHC facilities once a month, basing on the report on drug consumption and available stock. Transportation of drugs to the local level is the responsibility of the administrations of the health facilities from districts and the penitentiary system.

Distribution of 2nd line anti-TB drugs

The main stock of 2nd line anti-TB drugs will be maintained at the central storehouse at San-Farm Prim. It releases drugs following the official order of the Ministry of Health and NTP Central Unit at the Institute of Phtysiopneumology. The existing general drug distribution system is used to supply the drugs and will be augmented where necessary to ensure full and complete tracking of 2nd line agents. The current DR-TB treatment programme is being implemented according to the new distribution scheme of 2nd line drugs – I Individual Patient Package (IPP). The purpose of the new scheme is to strengthen drug management within the TB control programme. The IPP provides for individualization of drug management required by each MDR-TB patient in both phases of treatment. Since the number of MDR-TB patients enrolled will increase substantially during the coming years to match the needs, the current IPP scheme will be upgraded.

At the Institute of Phthysiopneumology and other in-patient DR-TB treatment sites, drugs will be stored in line with the principles of the drug storage instruction. Separate records in the pharmacy stock register will be maintained for the GLC-sourced 2nd line drugs to document receipts, releases to the MDR wards and TB cabinets, stock levels, expiry dates, and facilitate reporting to the NTP Drug Management Team.

2nd line drugs will be released by the pharmacist only on the basis of appropriate authorization of the head of the DR-TB department (for in-patient treatment) and head of DMT (during out-patient phase of treatment). The estimated quantity for delivery is based on the number of patients in treatment, treatment regimen, distribution period and reported data on stock at the facility and ward level.

Since the scope of distribution of 2nd line drugs for DR-TB patients is relatively small compared to that of 1st line drugs, distribution of 2nd line drugs will continue to be strictly managed by the NTP, and the drugs will be delivered to all in-patient and out-patient sites using the NTP vehicles.

The NTP introduced an innovative system for the individualized management of drugs required by each MDR-TB patient for both phases of the treatment. The pharmacist, following the instructions of the Medical Committee, which determines the regimen for each case, assembles the 2nd line drugs needed for each patient for one week for in-patients and quarterly for out-patients into a patient package, labelling the package individually for each patient. The packages for patients on out-patient treatment will be transferred to the district level quarterly. Handling of drugs is minimized and accountability simplified through the implementation of the patient packages' system and the monitoring of compliance is facilitated by direct and easy review of the packages' content.

The recording of administered drug doses at both phases is based on individual principles using a specially developed form in order to ensure the tracing of each dose from port clearance to the patient.

Given a relatively small number of DR-TB patients compared to the overall number of TB cases treated, additional distribution of 2nd line drugs will contribute to a small incremental increase in the existing distribution arrangements (estimated as not exceeding 10-12%); this increase is fully manageable using the current NTP capacities at the national and sub-national levels.

4.10.6. Pharmaceutical and health products for initial two years

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

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

The project will use Category IV treatment approaches and regimens as recommended by WHO (*Guidelines for the programmatic management of drug-resistance tuberculosis, WHO Geneva, 2006*) and adopted at the national level. The treatment strategy is described in detail in the application to the GLC.

The list of pharmaceuticals and health products is presented in Attachment B to this Proposal Form.

4.10.7. Multi-drug-resistant tuberculosis

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

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

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

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

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

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

ROUND 8 – Tuberculosis

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

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

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	8,345,930	11,380,810	13,158,600	14,176,830	14,827,620	15,491,080	16,168,780	16,489,720
Line A.1 ➔ Total need over length of Round 8 Funding Request *(combined total need over Round 8 proposal term)*								**77,154,030**
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	0	0	0	0	0	0	0	0
Domestic source **B2** National funding resources	3,477,478	6,391,213	8,547,238	8,119,880	8,931,870	10,182,330	11,200,560	13,216,660
Domestic source **B3** Private Sector contributions (national)				0	0	0	0	0
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	3,477,478	6,391,213	8,547,238	8,119,880	8,931,870	10,182,330	11,200,560	13,216,660
External source **C 1** **(USAID / AIHA)**	306,458	351,596	0	0	0	0	0	0
External source **C 2** **(KNCV / CarLux)**	142,000	145,000	117,136	0	0	0	0	0

ROUND 8 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
External source **C 3** **(WHO)**	25,000	30,000	30,000	30,000	40,000	40,000	40,000	40,000
External source **C 4** Private Sector contributions (International)	[redacted]	[redacted]	[redacted]	0	0	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	473,458	526,596	147,136	30,000	40,000	40,000	40,000	40,000
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	640,848	1,348,122	2,289,197	1,296,956	1,473,490	1,393,041	1,288,242	0
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	4,591,784	8,265,931	10,983,571	9,446,836	10,445,360	11,615,371	12,528,802	13,256,660
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	3,754,146	3,114,879	2,175,029	4,729,994	4,382,260	3,875,709	3,639,978	3,233,060
Line G = Round 8 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				2,928,726	2,352,316	2,061,178	3,028,178	2,952,601

ROUND 8 – Tuberculosis

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

In Round 8, the total maximum funding request for tuberculosis in Line G is:

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

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

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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2009-2013 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

24.33%

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

Explain how the annual amounts were:

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

In 2005, an analysis of financial needs was undertaken by the Ministry of Health and the NTP during the process of development of the National Programme of Tuberculosis Control and Prevention for years 2006-2010. At that time, the estimated financial needs for 5 years were determined at eq. to USD 28.0 million (about EUR 21.5 million at the exchange rate of that time). These figures were included in the relevant section of the Global Fund Round 6 proposal.

During the process of development of the Round 8 application, a revision of financial needs' estimates was undertaken. It became evident that the previously estimated amount of funds is not valid, due to a number of factors: i) programmatic needs for some interventions were under-estimated (such as laboratory investigations and patient support measures; ii) the local costs of good and services, including those in the health sector, have risen substantially (up to 2-fold increase or more for some); iii) significant devaluation (about 30%) of US dollar vis-à-vis the national currency took place since 2005; iv) prices for goods procured internationally have also increased, in particular transportation costs (for example, the cost of 1st line drugs through GDF increased by about 30%); and iv) in the absence of reliable drug resistance data in 2005, the burden of DR-TB and, consequently, the scope and cost of required DR-TB management interventions were substantially under-estimated.

The financial needs presented in the table above are based on the programme requirements taking into account the forecast of TB epidemic, targets of the National Programme (e.g. provision of universal access to DR-TB diagnosis and treatment), available data on drug resistance burden and its expected change over years and trends in national inflation and resulting levels of costs.

The total financial needs of TB control for 5 years 2009-2013 is estimated at equivalent to EUR 77,154,030 (or on average EUR 4.1 per capita per year). This level reflects first of all the need of expansion of the DOTS framework and provision of universal access to diagnosis and treatment of drug-resistant forms of TB.

The NTP plans to conduct a more detailed costing exercise of the National TB Control Programme needs, followed by periodic updates, to inform funding decisions at the national level as well as to mobilise additional external resources for TB control.

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

Explain the processes used in country to:

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

Domestic funding of health sector has increased substantially over the last years. The total expenditures for health rose from 4.2% of GDP in 2004-2005 to 4.8% in 2006 and 5.4% in 2007. The Medium Term Expenditure Framework (MTEF) for 2008-2010 foresees further increase to 5.8% of GDP in 2008 and 6.0-6.1% in 2009-2010.

Compulsory health insurance system was introduced in Moldova in January 2004 and at present the most of public funding for TB control is provided through this mechanism (complemented by centralized procurement of several goods by the Ministry of Health and limited contributions by the local authorities). The health financing reform is considered as one of the best practices in the region;

over the four years since introduction, the budget of the National Health Insurance Company has more than doubled, and mechanisms for revenue collection and allocation of funds towards priority health needs have improved significantly.

It is reflected in the increased domestic funding of TB control: as seen from the above table, the financing of TB control increased almost 2.5 times between 2006 and 2008, and further increases are anticipated during the coming years. At the same time, it will not possible to close the funding gap during the next 5 years (although it is expected substantially diminish by 2013 – to eq. of EUR 0.5 million or less), first and foremost because of costly DR-TB management interventions, which, however, are necessary to implement taking into account the high resistance burden and its influence over the epidemic development. It is the reason for applying for additional GFATM funding in Round 8.

No other public funding such as loans or debt relief are foreseen in the near future; private contributions (domestic or foreign) in the field of TB control are not significant at the moment and difficult to predict for the future and therefore are not accounted for in this proposal.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

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

The USAID-funded TB control project (implemented by **American International Health Alliance, AIHA**) started in 2004 and was completed in September 2007. It substantially contributed to strengthening the national programme by establishment of four reference TB laboratories (NRL and three level III laboratories in Vorniceni, Balti and Bender), improvement of TB surveillance and information system, strengthening PHC capacity for TB control and increasing public awareness.

The TB project in the penitentiary system is implemented jointly by **KNCV** and **CarLux** (international NGO); the current commitment of the programme is until end-2008.

World Health Organization (WHO) provides technical assistance through its Regional Office in Copenhagen; limited support for international training and consultancy is being provided through the Biennial Collaborative Agreements (BCA).

At the moment, the Global Fund resources have become in fact the sole external source of support to TB control in Moldova. If the Round 8 proposal is approved as requested, the GFATM's overall financial contribution (Round 6 and Round 8 grants) to the TB control programme over the next 5 years will account to 24% of the national disease program funding needs.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.
   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget
2. Ensure the detailed budget is consistent with the detailed workplan of program activities.
3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)
4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)
5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

ROUND 8 – Tuberculosis

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	**Management of drug-resistant tuberculosis**	2,676,478	2,100,069	1,808,930	2,693,820	2,618,338	**11,897,635**
	Project management	252,248	252,248	252,248	334,263	334,263	**1,425,270**
Round 8 tuberculosis funding request:		**2,928,726**	**2,352,316**	**2,061,178**	**3,028,083**	**2,952,601**	**13,322,905**

IMPORTANT NOTE!

The budget figures presented in this Section refer to the funding requested in Round 8 only. However, taking into account that there is one DR-TB management programme, and in view of intended consolidation of grants, the detailed budget file attached includes the following:

A. Total costs of DR-TB management programme to be supported by the GFATM grants (Rounds 6 and 8);

B. Budget for DR-TB component of the ongoing Round 6 project;

C. Budget for the Round 8 requested (= A – B) – these figures are given in this Section and elsewhere in the document.

ROUND 8 – Tuberculosis

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

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	75,674	75,674	75,674	100,279	100,279	**427,581**
Technical and Management Assistance	56,025	58,225	58,225	53,526	40,626	**266,627**
Training	111,683	109,467	69,533	56,733	56,733	**404,150**
Health products and health equipment	537,942	264,874	278,537	427,163	424,840	**1,933,356**
Pharmaceutical products (medicines)	838,362	769,242	746,202	1,221,120	1,221,120	**4,796,046**
Procurement and supply management costs	402,467	329,006	317,715	484,238	483,980	**2,017,407**
Infrastructure and other equipment	289,200	159,400	28,800	28,800	28,800	**535,000**
Communication Materials	0	60,000	0	60,000	0	**120,000**
Monitoring & Evaluation	87,260	134,783	133,783	140,977	140,977	**637,780**
Living Support to Clients/Target Populations	472,985	333,395	294,457	374,803	374,803	**1,850,444**
Planning and administration	57,127	58,250	58,250	80,443	80,443	**334,514**
Overheads	0	0	0	0	0	**0**
Other: *(Use to meet national budget planning categories, if required)*	0	0	0	0	0	**0**
Round 8 tuberculosis funding request (*Should be the same annual totals as table 5.2*)	**2,928,726**	**2,352,316**	**2,061,178**	**3,028,083**	**2,952,601**	**13,322,905**

5.4.1. Overall budget context

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

The year-to-year variations in for several cost categories (i.e. pharmaceuticals) are due to the fact that this Round 8 grant will be complementary to the DR-TB component of the ongoing Round 6 project; the Round 8 proposal takes account of the funds available in the Round 6 and aims at scaling up DR-TB management interventions. Please refer to the explanatory note in Section 5.3 above and detailed workplan and budget files for details.

5.4.2. Human resources

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

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

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

No payment of health care personnel is requested in this proposal. The human resource costs are attributed to remuneration of the Principal Recipients' (PCIMU, PAS Centre) staff only.

5.4.3. Other large expenditure items

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

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

'Pharmaceutical products (medicines)' is the largest cost category item (36.0% share of the budget over the project's lifetime). Other important categories are 'Health products and health equipment' (14.5%) and 'Living support to clients / target populations' (13.9%) and reflect the needs to ensure proper laboratory diagnosis and comprehensive patient support as key elements of the DR-TB management programme.

'Procurement and supply management' costs (estimated at 15.1% of 5-year budget) are related to procurement of the goods above. These costs were estimated as an average of 10% of health products and equipment total cost, 20% - of 2nd line drugs and 25% - of patient incentives (food parcels and hygienic packages).

Other budget category items account for 0.9-4.8% of the total budget over the project's lifetime.

The basis for the budget calculation is explained in detail in the attached budget file (see 'Budget details' column and 'unit', 'unit cost' and 'number of units' fields for each activity.

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

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

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

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

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

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

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

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

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

Round 8 - Tuberculosis

Section	Document description	Annex Number
4.5	Tuberculosis Performance Framework	Attachment A
4.10	Preliminary list of pharmaceuticals, health products and health equipment	Attachment B
5.2	Workplan and Budget (for 5 years and for Years 1-2)	1
4.7	National Development Strategy and Action Plan for 2008-2011	2
4.3, 4.7	National Health Policy in the Republic of Moldova 2007-2021	3
4.3	National Health System Development Strategy 2008-2017	4
4.1	National Programme for Control and Prevention of Tuberculosis for years 2006-2010	5
4.8	Monitoring and Evaluation Plan for the National Programme for Control and Prevention of Tuberculosis for years 2006-2010	6
4.1, 4.5	Moldova Application to the Green Light Committee (2005)	7
4.1, 4.5	Moldova Application to the Green Light Committee for expansion (September 2006)	8
4.1, 4.5	GLC endorsement letter for expansion 13 November 2006	9
4.1, 4.2, 4.5	Moldova Drug Resistance Survey Report (2006)	10
4.1	GLC Monitoring Mission Report (September 2007)	11
4.10	GDF Monitoring Mission Report (February 2008)	12
4.1, 4.5	Moldova Application to the Green Light Committee for expansion (February 2008)	13
4.1, 4.5	GLC endorsement letter for expansion 22 April 2008	14
4.4, 4.5	Calculation of MDR-TB management needs for Round 8 TB GFATM project (Excel and PDF format)	15a, 15b

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	**Republic of Moldova**
Disease:	**Tuberculosis**
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	**To reduce the burden of tuberculosis in the Republic of Moldova by scaling up the management of drug-resistant tuberculosis**

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
outcome	Case detection rate for new smear positive TB cases (number and percentage of new smear-positive TB cases detected under DOTS to the estimated [by WHO] number of new smear-positive TB cases in a given year)	69.1% (1,679 / 2,430)	2006	WHO Global TB Report 2008	72.0% (1,684 / 2,338)	74.0% (1,684 / 2,276)	76.0% (1,665 / 2,191)	80.0% (1,667 / 2,083)	85.0% (1,660 / 1,953)	Baseline source: 'Global Tuberculosis Control: Surveillance, Planning, Financing' (WHO Report 2008). NOTE: WHO estimates are updated every year. The indicator is linked to percentage, therefore absolute numbers wil be updated annually on the basis of latest WHO estimates.
outcome	Treatment success rate: new smear positive TB cases (number and percentage of new smear-positive TB cases successfully treated [cured + treatment completed] under DOTS to the total number of new smear-positive TB cases registered in a given year)	62.3% (1,041 / 1,671)	2006 cohort	R&R TB system, yearly management report	69.0% (1,162 / 1,684)	73.0% (1,229 / 1,684)	77.0% (1,282 / 1,665)	80.0% (1,334 / 1,667)	85.0% (1,411 / 1,660)	Baseline source: NTP data for 2006 cohort of new smear positive patients. NOTE: The indicator is linked to percentage, therefore absolute numbers will be updated annually based on actual denominators.
outcome	Treatment success rate of MDR-TB patients: number of patients who were cured or completed Category IV treatment (% of the total number of patients in the same registration cohort)	64.7% (11 / 17)	2005 MDR-TB cohort	TB treatment cards, NTP R+R system	65% (for 2006 MDR-TB cohort)	66% (for 2007 MDR-TB cohort)	68% (for 2008 MDR-TB cohort)	70% (for 2009 MDR-TB cohort)	>70% (for 2010 MDR-TB cohort)	Final outcomes of MDR-TB treatment are evaluated in 36-months' cohorts (i.e. 3 years from the treatment start)
outcome	Interim treatment success rate of MDR-TB patients: number of patients who are smear and culture negative at 6 months after start of treatment (% of the total number of patients in the same registration cohort)	64.8% (55 / 88)	2006 MDR-TB cohort	TB treatment cards, NTP R+R system	67% (for 2008 MDR-TB cohort)	70% (for 2009 MDR-TB cohort)	72% (for 2010 MDR-TB cohort)	74% (for 2011 MDR-TB cohort)	77% (for 2012 MDR-TB cohort)	Interim treatment results' indicator; final outcomes of MDR-TB treatment will be evaluated in 36-months' cohorts (i.e. 3 years from the treatment start)
outcome	MDR-TB prevalence among new smear positive cases, %	160 / 825 (19.4%)	2006	Drug Resistance Survey	18.0%	17.0%	16.0%	15.0%	14.0%	Baseline source: Moldova nation-wide Drug Resistance Survey January-December 2006 (included in the WHO 4th Report on Drug Resistance Surveillance, published February 2008)
outcome	MDR-TB prevalence among previously treated smear positive cases, %	1,044 / 2,054 (50.8%)	2006	Drug Resistance Survey	48.0%	46.0%	44.0%	42.0%	40.0%	Baseline source: Moldova nation-wide Drug Resistance Survey January-December 2006 (included in the WHO 4th Report on Drug Resistance Surveillance, published February 2008)

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

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	**To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis**	

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	**Republic of Moldova**
Disease:	**Tuberculosis**
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	MDR-TB	Number of TB service staff trained in DR-TB management	77	2007	NTP training records	30	60	90	120	150	180	210	Y	N	Y - over program term	PAS	Data collection: NTP quarterly training reports. Includes civilian and penitentiary sectors. Includes training abroad and local training. Corresponding activities: 1.4-1.5.
1.2	MDR-TB	Number of Primary Health Care (PHC) staff trained in DR-TB management	0	2007	NTP training records	180	360	540	720	900	1'080	1'260	Y	N	Y - over program term	PAS	Data collection: NTP quarterly training reports. Includes civilian and penitentiary sectors. Corresponding Activity: 1.6.
1.3	MDR-TB	Number of investigations of drug susceptibility testing (DST) to 1st line drugs for DR-TB diagnosis using automated MGIT technique	133	2007	TB laboratory register, NRL activity reports	910	3'040	4'555	6'070	9'210	12'310	15'410	Y	N	Y - over program term	PCIMU	Data collection: quarterly activity reports from NRL. Includes civilian and penitentiary sectors. Corresponding Activity: 2.8
1.4	MDR-TB	Number of tests performed for rapid identification of R/H resistance using PCR technique	0	2007	TB laboratory register, NRL activity reports	0	1'270	2'530	3'790	6'410	9'000	11'580	Y	N	Y - over program term	PCIMU	Data collection: quarterly activity reports from NRL. Includes civilian and penitentiary sectors. Corresponding Activity: 2.10.
1.5	MDR-TB	Number of MDR-TB patients enrolled in second line treatment	254	2007	TB patient register, NTP activity reports	250	570	840	1'110	1'640	2'170	2'700	Y	N	Y - over program term	PCIMU	Data collection: NTP supervision reports, quarterly reports from DR-TB treatment sites. Includes civilian and penitentiary sectors. Corresponding Activities: 3.1-3.4.
1.6	MDR-TB	Number of investigations of drug susceptibility testing (DST) to 2nd line drugs performed in MDR-TB patients on treatment	868	2007	TB laboratory register, NRL activity reports	605	1'512	2'125	2'738	3'798	4'858	5'918	Y	N	Y - over program term	PCIMU	Data collection: quarterly activity reports from NRL. Includes civilian and penitentiary sectors. Corresponding Activity: 3.2.
1.7	MDR-TB	Number of MDR-TB patients on treatment receiving patient support (education, counselling, incentives and enablers) for better adherence to treatment	129	2007	TB patient register, NTP activity reports	800	1'120	1'390	1'660	2'190	2'720	3'250	Y	N	Y - over program term	PAS	Data collection: SR reports, NTP supervision reports, quarterly reports from DR-TB treatment sites. Includes civilian and penitentiary sectors. NOTE: the number of patients includes 2,700 patients newly enrolled during the project years plus 550 patients that will be on treatment by the project start date (2008 and 2009 cohorts). Corresponding Activities: 3.7-3.14.
	Please Select…				please select…								Y	N	Y - over program term		