ROUND 9 – Tuberculosis

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	October 2010	September 2015

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 9 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 9 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/rounds/9/faq/#5

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	Not applicable

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, for better project management and reporting, the proposed start month coincides with the start of the Round 8 TB Control Project as well as the Phase II of the ongoing Round 6 TB project.

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 9 Tuberculosis Proposal

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

Prepare after completing s.4.

Since the breakdown of the Soviet Union, the tuberculosis epidemic in the Republic of Moldova has continued to evolve and negatively impact the entire society. The low TB treatment success rate caused by high rates of treatment defaults and failures is seen as the major problem for effective TB control in the country. Despite all measures intended to optimize acceptance of and access to treatment, the value of the treatment success rate of the new smear-positive TB cases has not increased during the last years.

Therefore the CCM of the Republic of Moldova has developed a proposal for the round 9 of the Global Fund entitled ***Empowerment of People with TB and Comminities in Moldova***, as an integral element to the National TB Control Programme (NTP) and with the involvement of the Governmental (GOV) and non-governmental organizations (NGOs) the packages of services and related activities developed build on lessons learned and existing capacity to fully address the gaps in funding and service areas in order to decrease the level of epidemics in Moldova. The overall **Goal** of the project is *to control TB by accelerating community and civil society action to stop the spread of TB.* By achieving the Project objectives, Moldova will contribute to a collective and concerted campaign to Stop TB.

Despite of increasing case detection during 2002 – 2008 in Moldova, the treatment success rates for new smear positive cases is stagnant or even decreasing. This phenomenon has several likely causes, the main being confirmed as insufficient Directly Observed Therapy (DOT) during the out-patient phase of treatment. NTP estimated only **65%** of patients receive DOT during the continuation phase. It has become clear that involvement of the civil society, people with TB, people with HIV, media and community as a whole is crucial 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. However, due to continuing economic constraints, substantial financial gaps exist, especially in regard to the social programs and community mobilization. The CCM has therefore decided to solicit additional support from the Global Fund in Round 9 in bridging the gap in this field in addition to the ongoing GFATM-funded TB projects from Round 6 and 8. Because of careful planning, no duplication of activities between Round 6, 8 and Round 9 are envisioned.

The proposal targets specific interventions aimed at community mobilization, and therefore has defined the following **Key Objectives**:

- **Objective 1. Mobilize resources to support community-level partnerships**
- **Objective 2. Remove barriers to care for poor and other vulnerable communities**
- **Objective 3. Strengthen the health system and engage all available partners in TB control**
- **Objective 4. Advocacy, communication and social mobilization (ACSM)**
- **Objective 5. Operational research on TB interventions**

The **target group** are all tuberculosis patients from the country (around 26,300 TB cases, all forms, are expected to be registered in Moldova during project lifetime, or about 5,250 annually on average). Prison population is estimated to be covered in average of 10,000 persons per year. The expected impact of the project is that universal access will be provided for them to qualitative TB care and support. A specific group to be reached by the project are the most vulnerable patients who will receive comprehensive patient support (totally 13,745 TB patients will be supported 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 TB infection, thus bringing benefit for the entire population.

While the **Principal Recipient** representing governmental sector (Ministry of Health through its PCIMU) will be responsible for the implementation of strengthening health care system activities, an important role is reserved for the civil society organizations and academia; therefore, the second PR, **the Center for Health Policies and Studies (PAS Center) representing NGO sector** has been nominated for implementation of the work in the areas of community mobilization, civil society involvement, patient support and ACSM activities.

4 PROGRAM DESCRIPTION

4.1 National program and strategy

(a) Briefly summarize:

- the current tuberculosis national program or strategy;
- how the strategy responds comprehensively to current epidemiological situation in the country; and
- the improved tuberculosis outcomes expected from implementation of these programs 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[1]. 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 128 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 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).

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, the routine drug resistance surveillance system with universal coverage by drug susceptibility testing (DST) is under development with the support of the Round 8 GFATM project (oriented exclusively to the MDR-TB issues). 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. Given the low PHC DOT performance, the community based DOT activities will be developed with the anticipated support of the Round 9 GF supported project.

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

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

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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. A special follow up incentive program will be put in place with support of Round 9 project.

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. The proposal in Round 8 was focused specifically and only on DR-TB management and was built to obtain financial support for procurement of drugs and for covering other essential interventions to ensure the scale up.

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 and 2nd 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 is the high burden of drug resistance and poor DOT and adherence issues as well.

Community participation in DOT. The analysis showed (see Annex 07. Study report on risk factors associated with TB DOT treatment default and failure in Moldova) that the TB treatment success rate depends less on clinical, personal or economic factors of TB patients and are influenced mostly by the provider side, such as patient management, quality of care, continuity of care, and knowledge of the patient about TB disease and treatment. Interventions that would address the provider side of the continuum of TB care would be the most effective. It is planned that the Round 9 project activities are oriented to strengthen community participation to ensure the continuum of care, thus reducing default and failure and, ultimately improve DOT in Moldova.

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(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 7or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

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

Document	Proposal Annex Number	Page References
☑ National Health Sector Development/Strategic Plan	03, 04	
☑ National Tuberculosis Control Mid Term Strategy or Plan	05	
☐ 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	07, 08, 09, 10	
☑ National Monitoring and Evaluation Plan (health sector, disease specific or other)	06	
☐ 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		

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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

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(b) **Size of population group(s)**

(If national data is disaggregated differently then type over the categories proposed)

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	3,572,700	National Bureau of Statistics	2008
Women > 25 years	1,184,573	National Bureau of Statistics	2008
Women 19 – 24 years	209,581	National Bureau of Statistics	2008
Women 15 – 18 years	125,161	National Bureau of Statistics	2008
Men > 25 years	1,019,014	National Bureau of Statistics	2008
Men 19 – 24 years	216,052	National Bureau of Statistics	2008
Men 15 – 18 years	129,661	National Bureau of Statistics	2008
Girls 0 – 14 years	306,152	National Bureau of Statistics	2008
Boys 0 – 14 years	321,708	National Bureau of Statistics	2008

* – Breakdown by population groups does not include Tansnistria region

4.2.2. Tuberculosis epidemiology of target population(s)

	Indicators (see the footnote under this table for the references)	Number or rate or percentage	[Calculation] or (reference)
TB estimates, 2007			
a	Estimated number of new TB cases (all forms)	5,348	(1)
	Male 0-14 (5.4% of total number)	289	[a * 5.4%]
	Female 0-14 (6.5% of total number)	348	[a * 6.5%]
b	Estimated number of new TB cases (all forms) per 100 000 population	141	(1)
c	Estimated number of new smear-positive cases	2,387	(1)
d	Estimated number of new smear-positive cases per 100 000 population	63	(1)
e	Estimated prevalence of TB cases (all forms)	5,740	(1)
f	Estimated prevalence of TB cases (all forms) per 100 000 population	151	(1)
g	Estimated number of deaths due to TB (all forms)	722	(1)
h	Estimated number of deaths due to TB (all forms) per 100 000 population	19	(1)
i	Estimated number of HIV-positive new TB cases (all forms)	198	(1)
j	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population	5	(1)
k	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined)	1,077	(2)
ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant	19.4	(2)

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TB notifications, 2008				
l	Number of new TB cases (all forms) notified		3951	(3)
		Male 0-14	95	
		Male , 15 and more	2692	
		Female 0-14	65	
		Female, 15 and more	1099	
m	Number of new TB cases (all forms) notified per 100 000 population		96,3	[l/population*100 000]
n	% of estimated new TB cases (all forms) notified		78 *	[l/a*100]
o	Number of new smear-positive TB cases notified		1533	(3)
		Male 0-14	1	
		Male, 15-44	752	
		Male, 45 and more	454	
		Female 0-14	4	
		Female 15-44	223	
		Female, 45 and more	99	
p	Number of new smear-positive TB cases notified per 100 000 population		37,4	[o/population*100 000]
q	% of estimated new smear-positive TB cases notified - Case detection rate of new smear positive TB		64,4% 1533/2382	[o/c*100]
s	Number of TB cases all forms (new and retreatment) that were tested for HIV		4136/4940	(3)
t	% of TB cases all forms (new and retreatment) that were tested for HIV		83.7%	[s/l*100]
u	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive		220	(3)
v	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB		5,6	[u/i*100]
w	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT		220	(3)
x	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT		5 *	[w/u*100]
y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART		220	(3)
z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART		34 *	[y/u*100]
aa	Number of TB cases (new and retreatment) received diagnostic DST		1079	(3)
ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases		259	(3)
ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB		24.1	[ac/k*100]
Treatment outcome, 2007				
ae	Number of new smear-positive cases registered for treatment		1598	(3)
af	% of all notified new smear-positive TB cases that were registered for treatment		99,25	[ae/o*100]

ag	Number of new smear-positive TB cases that were successfully treated (2005 cohort)	989	(3)
ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2005 cohort)	61,9	[ag/ae*100]
ai	Number of new smear positive TB cases that failed their treatment	152	(3)
aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2005 cohort)	9,5	[ai/ae*100]
ak	Number of new smear positive TB cases who died while on TB treatment	165	(3)
al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2005 cohort)	10,3	[ak/ae*100]
am	Number of new smear positive TB cases who defaulted	177	(3)
an	% of all new smear-positive TB cases registered for treatment who defaulted (2005 cohort)	11,1	[am/ae*100]

* data for 2007.

1. Global tuberculosis control: epidemiology, strategy, financing: WHO report 2009. "WHO/HTM/TB/2009.411".
2. Anti-tuberculosis drug-resistant in the world. Fourth global report. WHO/HTM/TB/2008.394
3. Data from country TB routine recording and reporting system (SYMETA, www.monitoring.mednet.md)

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[2] 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.

The low TB treatment success rate caused by high rates of treatment defaults and failures is seen as the major problem for effective TB control in the country. Despite all measures intended to optimize acceptance of and access to treatment, the value of the treatment success rate of the new smear-positive TB cases has not increased during the last years. This rate stayed at the value of 62% in years 2004-2006, while the goal of the TB control programme is to cure at least 85% of the new smear-positive patients.

High burden of drug resistance contributes also to this problem. 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. The scaling-up effort to ensure universal treatment and care for MDR-TB is supported exclusively by the Round 6 and Round 8 projects.

Treatment defaults and treatment failures account for a significant share of poor treatment success rate in Moldova. Thus, from all the new smear-positive TB cases that started the TB treatment in 2005 and 2006,

[2] Please refer back to the definition in s.2 and found in the Round 9 Guidelines.

a proportion of 10.9% of them have ended with a registered treatment failure and 11% have ended with a registered treatment default (see Annex 07. Study report on risk factors associated with TB DOT treatment default and failure in Moldova). The TB treatment success rate in Moldova depends not only of clinical, personal or economic factors of TB patients, but is influenced by the provider side as well, such as patient management, quality of care, continuity of care, and knowledge of the patient about TB disease and treatment.

Therefore **the main weakness of the National TB Control Programme in Moldova today is seen as its incapacity to mobilize community, provide comprehensive approach to increase DOT of TB patients and improve treatment adherence.** 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 managerial interventions to improve patient referral from the hospital to outpatient phase. Many patients in this transition period miss their TB treatment and come to their outpatient physician with delay, including from prisons;
- Lack of effective patient management programs, such as patient support for better treatment adherence of most vulnerable people with TB;
- Insufficient infection control measures in TB settings, including infrastructure and equipment;
- Insufficient involvement of community services and civil society in TB control which prevents from ensuring proper DOT, social support and social adaptation of TB patients to motivate them to complete the therapy.

The current proposal aims to address these gaps and contribute to ensuring an increase of treatment success rate 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 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 GFATM projects, the Round 9 interventions will cover this region as well.

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 community mobilization and involvement of NGO sector in TB control at the PHC level.
- 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 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 WB 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 2nd phase of the health system reform focuses on health financing and was marked by the introduction of mandatory health insurance (MHI) since 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 (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 NTP has benefited significantly in terms of that the essential 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 #886 from 06/08/2007) and the *Strategy for Health System Development in the Republic of Moldova for the period 2008-2017* (Governmental Decree #1471 from 24/12/2007). Both documents are attached to this Proposal Form in Annexes 03 and 04, respectively.

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 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 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	*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

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.	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 clients' satisfaction.	*Resource development* The general objective is to generate and appropriately use human, infrastructural and technological resources in the health system, by: • 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 TB 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.

4.4. Round 9 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 a 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			
Indicator name	***Number of TB patients covered by patient support program (incentives and enablers) – civilian sector***	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		5799	5509	5395	5309	5167	5018	4889	4610
B: Extent of need already planned to be met under other programs		2400	2479	2428	2389	2325	2258	2200	2078
C: Expected annual gap in achieving plans		3399	3030	2967	2920	2842	2760	2689	2535
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			100%	100%	100%	100%	100%

Priority No:	2	Historical		Current		Country targets			
Indicator name	**Number of ss+ TB patients' contacts identified and investigated for TB**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		15918	15840	15994	15998	15819	15833	15772	15578
B: Extent of need already planned to be met under other programs		5034	4919	4966	4968	4912	4917	4898	4837
C: Expected annual gap in achieving plans		10885	10922	11027	11030	10907	10917	10875	10741
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			100%	100%	100%	100%	100%

ROUND 9 – Tuberculosis

Priority No:	3	Historical		Current		Country targets			
Indicator name	***Number of prison TB patients covered by educational and follow-up programs***	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		385	220	250	279	272	264	257	243
B: Extent of need already planned to be met under other programs		200	100	0	0	0	0	0	0
C: Expected annual gap in achieving plans		185	120	250	279	272	264	257	243
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			100%	100%	100%	100%	100%

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

4.5. Implementation strategy

4.5.1. Round 9 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)"), activities 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 9 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 9. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 9 Guidelines (s.4.5.1.) for information on this choice.*

GOALS, OBJECTIVES AND SERVICE DELIVERY AREAS

The overall **Goal** of the **Empowerment of People with TB and Communities in Moldova project** is *to control TB by accelerating community and civil society action to stop the spread of TB.* By achieving the Project objectives, Moldova will contribute to a collective and concerted campaign to Stop TB. 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 empower people with TB and communities as integral part of the National TB Programmes.

Despite of increasing case detection during 2002 – 2008 in Moldova, the treatment success rates for new smear positive cases from 2002 to 2006 were **62,2%, 65,2%, 61,7%, 62% and 62%** per the WHO 2009 Global TB Control report. Stagnant or even decreasing treatment success rate have several likely causes, including high level of multidrug-resistant TB (MDR-TB), TB/HIV co-infection, outmigration etc. But, there are also gaps in fulfilling management and monitoring functions of the National TB Program (NTP) as well as gaps in ensuring Directly Observed Therapy (DOT) during the out-patient phase of treatment. NTP estimated only **65%** of patients receive DOT during the continuation phase.

It has become clear that, in conditions of such high TB burden, involvement of the community as a whole (civil society, people with TB, people with HIV, media etc.) to help health workers to better control TB is crucial 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* (see Annex 03, 04. 05)

However, due to the still continuing economic constraints, substantial financial gaps exist, especially in regard to the social programs and community mobilization. The CCM has therefore decided to solicit additional support from the Global Fund in Round 9 in bridging the gap in this field in addition to the ongoing GFATM-funded TB projects from Round 6 and 8.

This additional support is sought for a number of reasons. First, the classic DOTS interventions of the National TB Control Programme are complemented **only by the Round 6 proposal**. It is heavily oriented towards health system strengthening, including first and second line drugs, laboratories, infection control and medical personnel. Even the importance of the community participation is stated in the National TB Programme, practically there are no supported community actions in the current Programme. Also, **the Round 8 proposal is entirely focused on MDR-TB** programme with the majority funds oriented to the procurement of second line drugs, laboratory and social support of only MDR-TB patients.

Second, in accordance with the recommendations of the revised Stop TB Strategy and the Global Plan, the country aims at building greater commitment to fight TB by two way communication, advocacy and

social mobilization, which are expected to be achieved with the Round 9 funding support. For this purpose, the Round 9 proposal requests support for a more comprehensive set of interventions oriented to community participation in TB care, in particular regarding capacity building, treatment adherence, addressing most vulnerable groups and patient support.

This proposal targets specifically all TB patients, most vulnerable groups (prison population, people living with HIV) and the general population of Moldova through mobilizing community-level partnerships, remove barriers to care, engaging all available partners in TB control, strengthening health care system and ACSM activities. It is first time when the National TB Control Programme will address the issue of empower people with TB and communities through such complex approach. It is foreseen to cover over **20,000 TB patients** with comprehensive support program, including penitentiary system.

The accomplishment of the project' objectives will be ensured through attracting more NGOs to be involved in TB control activities, implementing comprehensive patient support program at national scale, introducing innovative ACSM approaches, strengthening human and infrastructural capacities and establishment of a network of community TB centers. The proposal covers the needs of the civilian and penitentiary sectors and includes Transnistria region as well.

The **target group** are all tuberculosis patients from the country (around 26,300 TB cases, all forms, are expected to be registered in Moldova during project lifetime, or about 5,250 annually on average). Prison population is estimated to be covered in average of 10,000 persons per year. The expected impact of the project is that universal access will be provided for them to qualitative TB care and support. A specific group to be reached by the project are the most vulnerable patients who will receive comprehensive patient support (totally 13,745 TB patients will be supported 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 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 9 project support, full access will be provided to TB patients from Transnistria to comprehensive TB care and support program 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 9 project will be fully complementary to the support available from Round 6 and 8 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 initiating new activities to the Round 6 and 8 activities such as establishment of a network of TB community centers, a national network of peer educators in tuberculosis and comprehensive community-based support programme to most in need. Operational research will be conducted to develop evidence and inform further actions, with special emphasis on most vulnerable populations such as prison community, PLWH and extreme poor TB patients.

While the Principal Recipient representing governmental sector (Ministry of Health through its Project and Implementation Unit) through the NTP and TB service institutions and providers will be responsible for the implementation of strengthening health care system activities, an important role is reserved for the civil society organizations and academia (in particular regarding community mobilization, civil society involvement, patient support and ACSM activities); therefore, the second PR, the Center for Health Policies and Studies (PAS Center) 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 indicator: treatment success rate. In addition, specific outcome indicators are included in the Performance Framework: related to treatment adherence and DOT coverage in out-patient phase of treatment.

It is expected that, along with essential system DOTS interventions (e.g. with the support of the GFATM Round 6 and 8 TB projects), this grant will contribute to decreasing of default rate to 5%, increasing proportion of patients that receive DOT in continuation phase of treatment to 95% and increasing TB treatment success rate to 85% by the end of the project.

Other 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 empower people with TB and communities in Moldova. The proposed activities are organized in 5 objectives and 10 activities as following:

Objective 1. Mobilize resources to support community-level partnerships

Activity 1.1. Strengthen TB partnership with Local Public Authorities

Activity 1.2. Stimulate NGO' local TB initiatives: small grants program

Activity 1.3. Realize prison system partnership: follow-up on treatment, care and support

Objective 2. Remove barriers to care for poor and other vulnerable communities

Activity 2.1. Patient support: provision of incentives and enablers

Activity 2.2. Increase involvement of affected communities, including PLWH

Objective 3. Strengthen the health system and engage all available partners in TB control

Activity 3.1. Development of additional cadres of health workers based in the community

Activity 3.2. Improve health service delivery area and infection control

Activity 3.3. Involve orthodox church in reducing stigma of TB patients and their families

Activity 3.4. Use of the Patients' Charter for Tuberculosis Care: patients education

Objective 4. Advocacy, communication and social mobilization (ACSM)

Activity 4.1. Increase awareness through innovative programs: peer educators

Activity 4.2. Support to public communication campaigns for social mobilization

Activity 4.3. Enhance the role of media and advocacy

Objective 5. Operational research on TB interventions

Objective 1. Mobilize resources to support community-level partnerships

Activity 1.1. Strengthen TB partnership with the Local Public Authorities

[SDA: Community TB Care]

With the project support, it is planned to establish a network of 10 community based centers around the country. The municipalities and raions will be selected based on the status of TB burden and the willing of public authorities to support the initiative. The community centers will work in close collaboration with health specialists and local authorities to ensure complex direct observed TB treatment program, including treatment adherence and patient support to most vulnerable patients. The centers will provide a set of comprehensive social and psychological support and will create necessary prerequisites to establishing TB patients' self-support groups.

A working group comprising of representatives of the Ministry of Health, Ministry of Social Protection, Family and Child, civil society and other stakeholders will be established to elaborate the concept and terms of references for each center. The working group will oversee the progress as well. It is planned to have a light renovation of the centers in order to ensure minimum working conditions and to provide necessary furniture and equipment. The project will support procurement of a vehicle per every center in order to ensure service mobility as well as program monitoring and evaluation.

It is not intended to create a new center or facility at the local level. The community centers are seen as functional centers that can be attached to community leaders. If it is the case, the center could be attached to the family doctor office or TB specialist office in the raion. If not, it could be attached to the mayor office near to social worker. This will be decided in the frame of the working group and in close collaboration with the local authorities. It is envisioned that one center has up to 5 positions (full or part time): a manager (medical specialist), social worker, two DOT supporters and a driver. The staff terms of

references will be developed and agreed with local authorities. At the same time, a number of volunteers mobilized using NGO small grants program described below under the activity # 1.2 will be involved to work as additional DOTS supporters and assist the center to work with TB patients and their families and organize adherence activities. The team of peer educators, trained under as describe below under the activity # 4.1, will carry out community informational work.

The multidisciplinary teams of the community centers will be trained in TB control, DOT issues, community aspects, advocacy and social mobilization. Bi-annual meetings will be organized in order to bring to round table discussions the national and local stakeholders, including Local Public Authorities, TB and PHC specialists, representatives of the Ministry of Health and Ministry of Social Protection, Family and Child and civil society activists.

Activity 1.2. Stimulate NGO local initiatives: small grants program

[SDA: Community TB Care]

The project will support a small grants program in order to stimulate NGOs participation in TB control, DOT activities, case management and follow-up of TB patients at the community level. For this purpose, every year a small grants competition will be organized in order to select up to 10 local NGOs country-wide. It is intended that this program will stimulate volunteer activities as well. When possible, the Project will attract NGOs active in HIV control, thus motivating collaborative TB/HIV field activities as well.

The NGOs volunteers and community activists will work closely with other counterparts at the community level: e.g. community centers staff, TB specialist office, social worker, family doctor and others. Estimated that every volunteer will receive reimbursement for transportation costs and meal charges according to the number of days worked for the community center. It is assumed that each volunteer can work for the center 2 days per week, 32 weeks per year. The number of volunteers will vary in different centers but the average number can be 15 persons.

Initial 1day training for volunteers will be organized when the centers are opened. The volunteers will be instructed on their duties, on how to wok with TB patients and their families etc. Annually, half a day re-training will be organized when required to refresh volunteers knowledge and bring up to date newcomers.

There are very few NGOs working with TB patients and their families in Moldova. At the same time a number of NGOs are very active in prevention, care and support of PLWH and other vulnerable populations. The Project will stimulate their involvement in TB control field including their beneficiaries as well. Being trained in informational and educational work on TB they can develop their own projects and favor timely detection and treatment of TB patients.

NGOs and their members will participate in patient education and counseling sessions conducted by adherence counselors in both in-patient treatment delivery sites and later on out-patient basis described under the activity # 3.4. Also, the NGOs will favor TB contacts tracing at community level and work in close collaboration with the National Center for Prevention Medicine (former sanepid system) which is responsible for tracing and registration of infection cases described in details under the activity # 3.2.

Activity 1.3. Realize prison system partnership: social and legal support

[SDA: High risk groups]

The activities under this component will be oriented to establishment of a follow-up program for just released TB patients. It is estimated to support around 100 individuals per year. In order to maintain them adhered to the treatment it is estimated to provide financial incentives at once, at the moment of the treatment is completed after it follow-up in civilian sector. Also, some of them will need additional legal support and other enables such processing of legal papers, identification cards etc. The Project will ensure a comprehensive social and legal support to prison TB patients.

Informational and educational materials will be developed, printed and distributed among TB patients from prison system. The materials will contain info about the need to improve the treatment adherence and prevent drug resistance. Some activities will be coordinated and jointly implemented by the Ministry of Justice and the Ministry of Health. The series of patient education programs described under the activity # 2.2. will cover the prison system as well. Capacity development and training to prison staff will be supported.

At the same time, in order to reduce the pool of new infection cases in prison system and improve TB treatment success rate the prison system need to address issues on appropriate infection control

measures. In order to improve infection control, the project will renovate two departments of the penitentiary hospital, including MDR-TB. The renovation will be implemented based on WHO/CDC infection control requirements, including appropriate negative pressure ventilation system.

Some prison TB patients do not have a place to go after they are released. For this purpose, there is a temporary placement shelter in Chisinau. The Project will improve the conditions of the shelter (renovate two rooms with two beds) and provide necessary furniture. With support of the current application, two mobile X-ray machines to be used for TB active case finding among prison population will be procured. It is planned to use one machine for all prisons in Transnistria region and the second to serve another 9 prisons in Moldova.

There is an active NGO working in prison mostly in HIV prevention and control: NGO "Innovative projects in prisons". The NGO implements harm reduction activities, namely needle exchange projects, information and awareness, condoms distribution, peer education and outreach. It is intended to provide small annual grant to this NGO in order to supplement HIV with TB control and support activities in prisons.

Objective 2. Remove barriers to care for poor and other vulnerable communities

Activity 2.1. Patient support: provision of incentives and enablers

[SDA: Patient support]

Poor adherence of TB patients to treatment has been registered over the last years. This frequently leads to interruption of treatment and lack of case management standardization. The reported 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 is the high burden of drug resistance and poor DOT and treatment adherence. Poor adherence to TB treatment is partly induced by insufficient collaboration between specialized TB services and PHC. Round 9 project proposal suggests support for a more comprehensive set of interventions oriented to community mobilization in TB care, in particular regarding treatment adherence oriented to most vulnerable groups and patient support.

In order to increase the treatment adherence the project will provide incentives (food and hygienic parcels) and enablers to TB patients. According to estimations, about 55% of patients or 13,745 patients over the project life will need additional support with weekly parcels during continuation phase of the treatment. The Round 9 project will complement existing activities and fill the gap as the existing Round 8 covers only MDR-TB patients with social support programs.

Another aspect related to low treatment adherence is the long distances the patients have to pass in order to reach TB or PHC facilities. It has been estimated that about 25% of them or 6,248 patients during the project life will have to visit the health provider daily. The project proposes to cover the transportation expenses and ultimately improve patients' treatment adherence. The Project will offer additional enablers to those most vulnerable, e.g. legal support and assistance (official papers etc.).

The project will provide support in the development of informational and educational materials. The IEC materials will be printed and distributed among TB patients and family members, with special emphasis on the need to complete treatment and prevent drug resistance. This will complement the patient education program started during in-patient phase of the treatment and described in details under the activity # 3.4.

Activity 2.2. Increase involvement of affected communities, including PLWH

[SDA: TB/HIV activities]

The project will support a series of informational meetings and workshops with involvement of the National League of PLWH and its regional branches. The events aim to provide information about different aspects of TB control, with special emphasis on strengthening community involvement. It is planned to organize four meetings per year.

The project will support development of informational and educational materials on TB for PLWH and on HIV for TB patients. A series of informational and educational materials on what should PLWH know about tuberculosis: leaflets, booklets, posters etc., will be printed and disseminated among this category of population. And vice-versa, people with TB will be offered IEC materials on HIV/AIDS prevention.

Peer support groups will be organized in the frame of the Round 9 project. Monthly meetings of affected community at raion level are planned. When possible, the initiative will involve PLWH groups as well. At least 5 NGOs in high prevalence country regions will be selected to continue peer to peer work with TB patients and their families and advocate for TB control problems. There is one TB patient NGO already created in Moldova. The Project will stimulate creation of other self-support groups and TB patients associations and will support them through small grants program.

Objective 3. Strengthen the health system and engage all available partners in TB control

Activity 3.1. Development of additional cadres of health workers based in the community

[SDA: HSS - Health workers]

The project will organize trainings in DOT for medical personnel working in TB control, including PHC workers. Trainings will emphasize the importance of community involvement and measures to improve treatment adherence among TB patients. Special attention will be paid on efficient co-operation between TB specialized service, PHC, civil society and community in TB control. Four regional conferences focused on strengthening DOT for out-patient phase of TB treatment and community involvement will be organized. One day conferences will invite TB specialists, PHC workers, civil society and community activists to discuss priorities in the field.

In order to enhance health workers' capacity to carry out the informational work on TB, workshops for medical staff on methods of informational work with different groups of population will be implemented. By the end of the project such workshops should be organized each year in all raions of the country, including Transnistria region. The workshops will be held locally for PHC centers staff and nurses from rural Family Doctors Centers on the eve of World TB Day with participation of community activists.

The project will support development and printing of communication materials on how to inform people on TB as well as support multiplication of the existing documentaries on TB, PSAs on TB symptoms etc. Handbooks and video materials on DVDs about TB and other special computer programs will be distributed among PHC medical staff and TB specialists.

The project will support participation of NTP staff and M&E specialists in international trainings, meetings and conferences, as well as study tours abroad. Up to 15 persons per year during project Years 1-2 and 10 persons per year during Years 3-5 will participate to the above mentioned type of events.

Activity 3.2. Improve health service delivery area and infection control

[SDA: HSS - Service delivery]

The project will contribute to renovation of one MDR department located in Vorniceni TB hospital. The renovation will be done in accordance with WHO/CDC infection control requirements, including appropriate negative pressure ventilation system. The Vorniceni TB hospital, located about 50 km from the capital city used to be former sanatoria during the Soviet time and was decided to be built as center for excellence in TB and MDR-TB in Moldova. MDR-TB department was fully renovated with co-financing from Round 6 resources. There are two other departments that need infrastructural change and modernization. The departments already started to be renovated out of the state budget, it is proposed that Round 9 financial support will co-support these activities. The Vorniceni hospital lack of transportation means that could transfer the patients and medical workers to and from the hospital when needed. The hospital will benefit from the procurement of three mini-buses and support of vehicle maintenance during the project life.

Development and implementation of a TB health services external audit will be supported within the project. The proposed audit tool will be applied once in three years (Year 2 & 5) and aims at assessing the quality of health care services and the impact of integrated TB treatment, care and support at local level on TB control. The new audit system will be implemented by the National Center for Health Management (NCHM) that is the main responsible for the quality assurance of health services. The NCHM is also responsible for monitoring and evaluation of the national TB programme. Procurement of one vehicle has been planned in order to assure the NTP monitoring visits and evaluation of the patient support program.

The National Center for Preventive Medicine (NCPM), former sanepid service, is directly responsible for the TB contacts tracing and registration. It has a vertical system and subordinated representatives in each administrative territorial division. According to the legislation, every TB infection case contact shall be

investigated for TB infection and disease and this presume close collaboration between the NCPM and TB service. The project will support a series of field monitoring visits by the NCPM and procurement of two vehicles to be use for this purpose.

Activity 3.3. Attract orthodox church in reducing stigma of TB patients and their families

[SDA: Community TB Care]

The project will advocate for work relations with the Moldovan Metropolitan in order to obtain their commitment to be involved in TB control. The project will organize a series of workshops for priests of different levels that will further disseminate information and promote TB prevention and social involvement. It is planned to cover 45 raions and municipalities (including Transnistria) to encourage church participation in TB control and stigma reduction.

A set of informational materials on TB will be developed and disseminated by church among general population and believers. The informational materials will include poster-calendar with TB symptoms, booklets with appeal of leading Orthodox clerics to all church members. There are 4 church newspapers in different raions of Moldova which are disseminated among population, including prison inmates. The project will provide them with additional TB information as well as small support to increase the distribution of newspapers.

Currently Moldovan Metropolitan has three social centers. The project will provide small grants in order to enforce their work with the general population and decrease the stigma and discrimination of people with TB and their families.

Activity 3.4. Use of the Patients' Charter for Tuberculosis Care: patients education

[SDA: Advocacy, communication and social mobilization]

The project will support the creation and renovation of informational and educational centers within the TB hospitals, including prison system and Transnistria region. A special hospital room will be organized as informational and educational center in each hospital. The rooms will be renovated at minimum costs during the first project year. After renovation, the centers will be equipped with furniture and PCs.

The necessary video equipment will be installed in hospitals to deliver TB messages by TB video documentaries and other PSAs among TB patients. For this purpose, special TV programs to improve patients' knowledge of TB and ensure treatment adherence will be developed. The TV programs will include a set of short documentaries on TB that will give the patients the reliable and convincing information about different aspects of TB. The documentaries will be shown several times per day in TB hospitals premises.

Patient education and counseling sessions will be conducted by adherence counselors from TB hospitals with participation of volunteers from NGOs; the Patients' Charter for TB Care will be translated and distributed among all people with TB and their families.

Objective 4. Advocacy, communication and social mobilization (ACSM)

Activity 4.1. Increase awareness through innovative programs: peer educators

[SDA: Advocacy, communication and social mobilization]

The project will support creation of a peer educators' network at local level. A group of educators will be selected and trained to carry out peer informational activities and disseminate informational materials on TB among general population and disadvantaged groups while preparing public awareness campaigns at raion level. Peer educators will benefit from technical assistance. A coordinator will be appointed for each volunteer group to develop a working plan, schedule activities, and endorse the schedule with organizations/institutions when needed and to guide volunteers' activities.

The public awareness campaigns will be monitored by supervisors. Regular monitoring visits to involved raions will be organized during informational campaigns in order to monitor and evaluate volunteer activity and collect feed-back from population.

Activity 4.2. Support to public communication campaigns for social mobilization

[SDA: Advocacy, communication and social mobilization]

During the Round 9 project informational and educational materials on TB for general public will be developed and printed. Publication and dissemination of IEC materials (leaflets, booklets, posters, calendars etc.) on TB for general population was carried out during the Round 6 project and it was decided to repeat this activity during the current project: only the years not covered by Round 6 project.

The project will also support development of 2 TV and radio PSAs on TB prevention and symptoms in Romanian and Russian languages. The existing PSAs were produced in 2005 and become already old-fashioned. PSAs developed by project will be broadcasted on national and local TV and radio stations four months per year over the project life.

Activity 4.3. Enhance the role of media and advocacy

[SDA: Advocacy, communication and social mobilization]

The project will provide journalists from both print and electronic media with reliable and various information on TB. It is planed to organize eight 3 days trainings for 10 national and local journalists each. These trainings will complement and continue the activities included in the Round 6 project. Site visits for journalists to different TB hospitals and NGOs working with vulnerable groups will be organized. The journalists will visit TB hospitals in Chisinau, Balti, Vorniceni and Bender (Transnistria) to meet with TB doctors, patients and their families in order to understand better the problems they face and prepare real stories. It is planned to have 2 site visits per year by 15 journalists each.

Contests for the best publication or more active coverage of TB related problems is one of the best incentives for journalists. The project will support 4 contests during 5 years: 2 for national and 2 for local media starting from Year 2. The project will support advocacy workshops to increase and strengthen political commitment, improve coordination among local public authorities, public health offices, NGOs, and civil society. It is planned to organize workshops in all districts of the country including Transnistria.

Objective 5. Operational research on TB interventions

Activity 5.1. Operational research on treatment and adherence

[SDA: Operational research]

The operational research activities within the project will be based on priority TB problems. Research studies will target priority problems of TB treatment and treatment adherence in the country. It is planned to evaluate the very important problem of low treatment success rate. It is also intended to conduct operational surveys of risk factors and reasons for treatment failure and default per cohorts and districts. Recommendations will be developed and actions will be planned based on the studies' findings. Research activities will be conducted by national organizations.

Activity 5.2. Operational research on behavior change

[SDA: Operational research]

The operational research activities within the project will be focus on evaluation of the impact of IEC activities, the impact of the community centers at local level etc. It is planned to implement two KAP studies in Year 2 and 5 of the project including two field surveys on community impact issues. Recommendations will be developed and actions will be planned based on the studies' findings. Research activities will be conducted by national organizations.

4.5.2. Re-submission of Round 8 (or Round 7) 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 8 (or, Round 7, 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 9 (in addition to the ongoing support in Round 6 and Round 8) derives from the implementation experience which has shown that additional resources are required to establish an effective TB management programme. In particular, the following issues have been addressed when designing the interventions described above:

Programmatic issues:

- It became evident that the NTP and the Ministry of Health need to complement traditional TB control activities with support of other ministries, civil society and communities, including local public authorities and church, people living with HIV and media.
- The proposal aims at establishing a functional network of community centers to improve support to people with TB and their relatives and increase treatment adherence. Empowerment of people with TB and strengthen community involvement (which are not present in Round 6 and Round 8 applications) are addressed in this proposal.
- It has also become evident that the funds currently available in Round 6 and Round 8 projects for patient support are oriented exclusively to DR-TB patients. Therefore, a comprehensive patient support program was designed and relevant interventions included under Activity 3, with emphasis on community based support to DOT and treatment adherence.

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 9 project representing non-governmental sector (PAS Center).
- 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 and 8 projects (i.e. the start date of the Round 9 project is aligned with the beginning of the Round 6 and 8 projects).

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 overall goal of the project is to control TB by accelerating community and civil society action to stop the spread of TB. By scaling up the involvement of community and the civil society inequities will be reduced and the entire population at national level 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 PHC workers serve as gate kippers and they are the specialists who have to promptly act in the diagnosis of new TB cases as well as in their follow-up and ambulatory treatment. Unfortunately the PHC specialists do not have enough experience and knowledge in dealing with TB patients and their treatment. In this regard, the project will organize trainings DOT for medical personnel working in TB control including PHC specialists and thus improving the co-operation between the two services: the TB specialized service and The PHC system. This will increase the access to care for those in need and consequently will reduce the social inequalities.

Awareness campaigns and spreading of informational and educational materials through mass media, the Church and local authorities, as well as the development of peer educators' networks will also

contribute to better information of general public as regarding TB prevention and control issues and will enhance the social equality in general population.

Stigma associated with tuberculosis remains an important problem in Moldova, and its reduction is seen as one of the key challenges for the NTP. The project 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 2 of this proposal (provision of incentives and enablers, printing and dissemination of IEC materials) and will contribute to psycho-social adaptation of 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 prevention and control, and 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 system and patient oriented approach; involvement of TB affected communities, local authorities and church; 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 included interventions 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.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe <u>any</u> 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 or Round 8 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.

Currently the GFATM Round 6 project is being implemented in Moldova. The project started in October 2007 and has a budget of USD 6,681,421 for 5 years. The Round 8 project has been approved by GFATM and it is planned to start in October 2009.

One of the Objectives of the GFATM Round 6 TB project (Objective 4: Increase public awareness of tuberculosis, reduce stigmatization) provides support for the same activities related to informational and educational campaigns as requested in this proposal under SDR 4.2: Support to public communication campaigns for social mobilization; and SDR 4.3: Enhance the role of media and advocacy. The reasons

for applying for the additional support in Round 8 are the following:

- Informational materials for general public developed in the frame of Round 6 project and spread among population will be reprinted only in Year 4 & 5 of the project. Taking into account the low level of awareness on TB it has been decided to apply for additional support for these activities, especially for years not covered by the Round 6 project.
- The Public Service Announcements developed in 2005 with support of USAID/AIHA TB control project are already old-fashioned. The Round 9 proposal includes creation of new TV and radio PSAs and their broadcasting during 4 months of every project year.
- Trainings for journalists proposed to be organized during this Round will complement and continue the activities included in the Round 6 project by two trainings per year. In addition, visits of journalists to different TB hospitals and NGOs active in the area will be organized.

There are also links between this project proposal and the Round 8 project approved by GFATM. The objective 4 from Round 8 proposal (Patient support programme for drug-resistant tuberculosis patients) has similar activities proposed under the Objective 2 from Round 9 project. The Round 8 project is totally oriented to MDR-TB patients and intends to support treatment adherence by offering incentives to this category of patients. In turn, the current project will cover the gap of most vulnerable TB patients not being included in the social support program which are not only with MDR-TB, and will offer incentives and enablers to about 55% of patients in need. The social support will consist of food and hygienic parcels in order to increase the treatment adherence of all patients.

There is a substantial gap in the management of TB control 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 9 to bridge this gap.

The funds requested in Round 9 will be additional and complementary to the Round 6 and Round 8 grants; Activities included in this proposal will not duplicate those of the Round 6 project under Objective 4 but will complement them; The social support for TB patients proposed under the objective 2 will cover the gap that is not included in the Round 8 proposal. This complementarily activities are shown in detail in the workplan and budget files.

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 is no other external financial support in TB control in Moldova in addition to the Global Fund. The USAID/AIHA, KNCV and Caritas Luxembourg supported projects were completed in 2007 and 2008 respectively. At the same time, the GFATM projects continue to support efforts on the achievements of previous programmes, i.e. takes over further strengthening the reference laboratories, established with USAID funding, prison treatment follow-up and social support programs etc.

The proposal takes into account the current and expected commitments of the Government. In relation to the National TB 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 9 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. 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 TB facilities.

Although there are examples of private sector contributions to the health sector, it is not possible 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 9 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*.

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. 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.

It is therefore deemed that the implementation of the Round 9 project will allow consolidating 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 # 02.

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 03.

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, accelerating community and civil society action to stop the spread of TB in line with international recommendations (laid down in the revised WHO Stop TB Strategy and the Global Plan to Stop TB 2006-2015) and thus reducing social inequalities and barriers to care of the poor and vulnerable population groups. The project 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 has been appointed as Sub-Recipient of the Round 6 and Round 9 GFATM grants (HIV/AIDS and TB) and is responsible for the implementation of different activities related to the program 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 program 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 is 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 be no duplication or 'parallel reporting'. The M&E arrangements are compliant with the GFATM requirements, in particular: the Program 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 their comparison and analysis of trends. Over time, the use of standard indicators also ensures comparability of information across countries. During the process of Round 9 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 program 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 Program 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 Program 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.

One of the project activities is the design and implementation of TB health services external audit. Responsible for this activity will be the NCHM as the main responsible for the quality assurance of health services. The tool will be applied once in three years (Year 2 & 5) in order to assess the quality and impact of integrated TB treatment, care and support services at local level.

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 Program 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 Program 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 9 grant will be complementary to the ongoing support from Round 6 and the upcoming Round 8 project. 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 program. 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 Round 9 project will support the design and implementation of TB health services external audit. The external audit system has the aim to assess the quality and impact of integrated TB treatment, care and support services, including those provided by project, at local level. Collected information will be transmitted to the M&E Division of the NCHM that has the overall responsibility for M&E data collection and management of GFTAM grants.

The estimated budget allocated to M&E activities amounts to 9% of the total requested Round 9 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 and 8 projects.

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	Centre for Health Policies and Studies (PAS Center)
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 Center for Health Policies and Studies (PAS Center) was established in 1999 by the Soros Foundation - Moldova and the Institute for Public Policies. PAS Center 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 Center 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 Center took over the activities of the American International Health Alliance Inc (AIHA). Since 2003 AIHA carried out a comprehensive program 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 Center to ensure sustainability and continuation of program initiatives on TB training and communication. PAS Center is a dynamic organization with skilled and motivated professionals working in public health and social development fields.

PAS Center 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 Center 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'. The PAS Center has been appointed as Principal Recipient for the Round 8 GFATM project.

Having extensive experience of project implementation under USAID, World Bank and GFATM financing, PAS Center 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.

PR 2	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. PCIMU is also been endorsed as Principal Recipient for the Round 8 GFATM project that has to start in October 2009.

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.

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	☉ Yes
	○ No

(b) **If no**, why not?	
(c) **If yes**, how many sub-recipients will be involved?	☉ 1 – 6
	☐ 7 – 20
	☐ 21 – 50
	☐ more than 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	☉ Yes ***[Insert Annex Number for list]***
	☐ No **Answer s.4.9.4. to explain**

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

Two of the four pre-identified SRs represent the governmental sector and two of them – the non-governmental sector. The description of Sub-Recipients is given in the next sub-section (4.9.3). The non-governmental sector is expected to play an important role in the project implementation, specifically in activities aimed at supporting treatment adherence through provision of social incentives and enablers to TB patients and stimulation of the civil sector's participation in TB control by implementing of an NGO's sub-grant program.

The need to strengthen community involvement for better TB control and the need to strengthen the health service system as well has been reflected in the CCM's decision to nominate two Principal Recipients: one from the non-governmental sector (PAS Center) and another the Ministry of Health through its PCIMU.

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.

The CCM agreed to nominate four Sub-Recipients for the GFATM Round 9 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 monitoring and evaluation, external audit and operational research.
- *Institute of Phtysiopneumology* is a public organization subordinated to the Ministry of Health and the key national partner and institutional beneficiary, which bears the overall responsibility and accountability for the National TB Control Programme performance and results. It will carry out trainings for TB specialists, PHC workers and other medical personnel working on TB control. It will work in collaboration with the National Center for Preventive Medicine to improve TB contacts tracing. The Institute will also be responsible for NTP monitoring visits in the filed.
- *CarLux* is a non-governmental organization with extensive experience in implementation of TB

control interventions, in particular in the penitentiary sector. CarLux was also appointed as a SR for the Round 6 and Round 8 TB projects and took the responsibility for the patient support program for adherence to treatment of DR-TB patients. Within the Round 9 project the organization will be responsible for the social and legal support program oriented to TB patients, including those in prisons.

- *Soros Foundation-Moldova* is a non-governmental, non-for-profit and non-political organization which was established in 1992 to promote the development of an open society in Moldova by developing and implementing a range of programs and activities that address specific areas of needs including media, cultural policy, legal reform, public administration and good governance, media, civil society, public health, and European integration. The Soros Foundation-Moldova has a wide experience in implementing public health programs including harm reduction, palliative care, mental health and other. Its responsibility for the Round 9 GFATM project will be to implement a grant program to NGOs in order to stimulate their participation in TB control, DOT, monitoring and follow-up of TB patients at the community level.

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. All the nominees have substantial implementation experience (with the Global Fund projects and beyond); therefore, no major challenges to affect performance within the Round 9 project are expected from programmatic, legal or financial management perspective.

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; private 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 organizations.

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 judgment 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 organization 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 programs 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 programs 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 (PAS Center and PCIMU) 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 program 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 program 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.)*

In order to improve the quality of TB prevention, treatment, and patients' adherence in Moldova, further development of the national capacities for effective management of National TB Control Program, coordination of partners and monitoring and evaluation is essential. This project largely aims at scaling up the management capacities and improving all aspects of service delivery. Training courses for medical personnel and representatives from civil society sector have been planned and will cover a range of TB prevention, treatment and care issues such as treatment adherence and other elements of TB control.

Until now, the knowledge of service providers, especially of those from PHC, on how to meet the needs of these target groups has been deemed insufficient. The Objective 3: "Strengthen the health system and engage all available partners in TB control" addresses capacity building issues for implementing organizations and their partners in TB control. A special attention will be paid to co-operation between TB service providers and in particular to PHC personnel capacities. Development of health workers capacity to carry out the informational work on TB, and training of medical personnel in DOT and community involvement will be carried out during all project implementation years.

The community involvement approach will be sustained by technical assistance offered to peer educators involved in project activities related to informational networks on TB. The project will advocate establishing work relations with the Orthodox Church in order to obtain its support in TB informational and educational activities. Development of religion institutions capacity to carry the informational and social work on TB has been planned in this respect.

Training courses will be held throughout the regions of Moldova in order to reach the largest number of partners. In addition, the project will support trainings and technical assistance to Sub-Recipients in project management issues when needed.

The NAP is continuously involved in capacity building activities and capacity development measures have been implemented during previous and ongoing GFATM projects as well. The Round 9 project proposal includes attendance of NTP representatives and M&E specialists to international meetings / conferences abroad and study tours (activity 3.1.5).

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, MSH and others. Account will be taken of countries and institutions in the region that have advanced experience in TB control.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 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	N/A	N/A	☐ Yes ☐ No
Intellectual property rights	N/A	N/A	☐ Yes ☐ No
Quality assurance and quality control	N/A	N/A	☐ Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	N/A	N/A	☐ Yes ☐ No
Product selection	N/A	N/A	☐ Yes ☐ No
Management Information Systems (MIS)	N/A	N/A	☐ Yes ☐ No
Forecasting	N/A	N/A	☐ Yes

			☐ No
Procurement and planning	N/A	N/A	☐ Yes ☐ No
Storage and inventory management *More details required in s.4.10.4*	N/A	N/A	☐ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	N/A	N/A	☐ Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance)	N/A	N/A	☐ 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)*
N/A	N/A	N/A

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.

N/A

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.
N/A	
(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.
N/A	

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.

N/A

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 9 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 9 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 9 – 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 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	11,380,810	13,158,600	14,176,830	16,434,810	16,496,000	17,201,907	17,512,811	17,434,146
Line A.1 ➔ Total need over length of Round 9 Funding Request				*(combined total need over Round 9 proposal term)*				85,079,675
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	6,391,213	8,547,238	8,119,880	8,931,870	10,182,330	11,200,560	13,216,660	14,255,042
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:	6,391,213	8,547,238	8,119,880	8,931,870	10,182,330	11,200,560	13,216,660	14,255,042
External source **C 1** (*USAID/AIHA*)	351,596	0	0	0	0	0	0	0
External source **C2** (*KNCV/CARITAS LUX*)	145,000	117,136	0	0	0	0	0	0

ROUND 9 – 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 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C3** (WHO)	30,000	30,000	30,000	40,000	40,000	40,000	40,000	40,000
External source **C3** Private Sector contributions (International)				0	0	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	526,596	147,136	30,000	40,000	40,000	40,000	40,000	40,000
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	2,289,197	1,296,956	3,983,330	3,564,793	3,342,587	3,028,083	2,952,601	0
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	9,207,006	9,991,330	12,133,210	12,536,663	13,564,917	14,268,643	16,209,261	14,295,042
Calculation of gap in financial resources and summary of total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	2,173,804	3,167,270	2,043,620	3,898,147	2,931,083	2,933,264	1,303,550	3,139,104
Line G = Round 9 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				3,662,748	1,589,520	1,603,361	1,546,695	1,673,393

ROUND 9 – Tuberculosis

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

In Round 9, 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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2010-2014 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

26.99%

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 ensures that government, non-government and community needs were included to ensure fully implementation of country's tuberculosis program and strategy.

An analysis of financial needs was undertaken by the Ministry of Health and the NTP in 2005 during the process of development of the National Programme of Tuberculosis Control and Prevention for years 2006-2010. Latter estimations were done during the development of Round 8 proposal. Some corrections were done at that time in order to adjust the needs to the real figures.

During the process of development of the Round 9 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. The main factor for the increase of estimated needs for years 2010-2014 is the new approach proposed in Round 9 project, and mainly the community oriented approach with involvement of local authorities, civil society, and peer informational and educational programs. The emphasis on social support program for a larger group of TB patients and not only those with MDR-TB has also led to increase in estimated financial needs for the next five years. In addition, the local costs for goods and services are rising continuously and this has also been taken into account.

The financial needs presented in the table above are based on the program requirements taking into account the forecast of TB epidemic, targets of the National Program (e.g. provision of universal access to TB diagnosis and treatment), available data on drug 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 2010-2014 is estimated at equivalent to EUR 85,079,675 (or on average EUR 4.8 per capita per year). This level reflects first of all the continuation of DOTS framework expansion and provision of universal access to diagnosis, treatment and extended social support to TB patients.

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 mobilize 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: the financing of TB control increased almost 2.5 times between 2006 and 2008, and further increases are anticipated during the coming years. Although the funding gap is expected to diminish over the next years, it will be not possible to reduce it at the level of adequate financing of NTP and meet all the needs. In addition, the proposed community oriented interventions will maintain the financing deficit of the National TB Control Programme that in common with other needs justify the reason of applying for additional GFATM funding in Round 9.

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 was implemented jointly by **KNCV** and **Caritas Luxemburg** (international NGO); the commitment of the programme was 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 9 proposal is approved as requested, the GFATM's overall financial contribution to the TB control programme over the next 5 years will account to 27% of the national disease program funding needs. In case the Round 9 GFATM project is not endorsed, due to finalization of the Round 6 and Round 8 projects, the overall GFATM contribution over the next five years will decrease to 15% of the country needs, that will lead to substantial financing deficit in this area since only 68 percent of the needs are expected to be covered from national funding resources.

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/rounds/9/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 9. 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/ccm/

ROUND 9 – 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
1.1; 1.2; 3.3	Community TB care	1,033,554	459,834	473,261	506,481	468,084	**2,941,214**
2.1	Patient support	589,652	545,086	559,866	516,610	517,936	**2,729,151**
1.3	High risk groups	676,024	56,162	61,662	56,162	61,662	**911,672**
2.2	TB/HIV activities	16,100	33,100	60,100	65,100	80,100	**254,500**
3.1	HSS - Health workers	85,804	85,804	53,842	54,212	42,077	**321,739**
3.2	HSS - Service delivery	826,500	122,000	42,000	42,000	122,000	**1,154,500**
3.4; 4.1; 4.2; 4.3	ACSM	199,630	87,534	99,630	126,130	108,534	**621,458**
5.1; 5.2	Operational research	75,000	20,000	75,000	0	95,000	**265,000**
6.1; 6.2	Project management and administration	180,000	180,000	180,000	180,000	180,000	**900,000**
Round 9 tuberculosis funding request:		**3,682,264**	**1,589,520**	**1,605,361**	**1,546,695**	**1,675,393**	**10,099,234**

ROUND 9 – 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 9 Guidelines	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	336,000	339,000	342,000	345,000	348,000	**1,710,000**
Technical and Management Assistance	38,500	38,500	38,500	38,500	38,500	**192,500**
Training	239,108	191,630	181,821	228,541	160,413	**1,001,513**
Health products and health equipment	200,000	0	0	0	0	**200,000**
Pharmaceutical products (medicines)	0	0	0	0	0	**0**
Procurement and supply management costs	74,500	75,500	76,500	77,500	78,500	**382,500**
Infrastructure and other equipment	1,801,700	19,500	20,500	21,500	22,500	**1,885,700**
Communication Materials	197,892	114,262	168,907	140,839	178,147	**800,046**
Monitoring & Evaluation	171,740	197,740	173,740	99,740	275,740	**918,700**
Living Support to Clients/Target Populations	532,025	521,588	510,593	501,275	478,794	**2,544,275**
Planning and administration	90,800	91,800	92,800	93,800	94,800	**464,000**
Overheads	0	0	0	0	0	**0**
Round 9 tuberculosis funding request (*Should be the same annual totals as table 5.2)*	**3,682,264**	**1,589,520**	**1,605,361**	**1,546,695**	**1,675,393**	**10,099,234**

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 infrastructure and equipment are due to the fact that majority of equipment procurement will be done during first year. Please refer to the 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*

As one of the main weaknesses in implementing TB control strategies is the lack of management capabilities and lack of qualified staff. A large portion of the budget is devoted to developing the pool of available human resources and supporting technical expertise to train existing employees. A qualified pool of human resources is seen as a key element to ensuring improved service delivery and positive outcomes of all activities. The human resource costs are also attributed to remuneration of the Principal Recipients and sub-recipients staff. As a general rule all salaries of consultants, trainers, and technical experts are determined in accordance with local labor policies and market requirements.

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*

'Living support to clients/target population' is the largest cost category item (25.2% share of the budget over the project's lifetime). Other important categories are 'Infrastructure and other equipment' (18.7%) and 'Human resources' (16.9%) and reflect the needs to ensure proper actions oriented to most vulnerable populations (prison system with necessity of active screening and infection control measures), community mobilization and comprehensive patient support as key elements of the TB management programme.

'Training' costs (estimated at 9.9% of 5-year budget) are related to the overall capacity building and 'Monitoring and evaluation' (estimated at 9.1%) to better inform decision makers.

Other budget category items account for 1.9-7.9% of the total budget over the project's lifetime.

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 9

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 9 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions

Download '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 9 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Proposal checklist – Section 3 to 5
Tuberculosis

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	02
4.2.1	Map if proposal targets specific region/population group	n/a
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	07, 08, 09, 10
4.4	Document(s) that explain basis for coverage targets	workplan (separate worksheet)
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table.**	Attachment A
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	Work plan
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	n/a
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	n/a
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	n/a
4.9.1 *(for non-CCM applicants)*	**Document describing the organization such as: official registration papers, summary of recent history of organization, management team information**	n/a
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	included in the proposal
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**n/a**
Section 5: Financial Information		**List Annex Name and Number**
5.2	**A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)**	Detailed Budget