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

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	CCM COTE D'IVOIRE		
Country	Republic of Côte d'Ivoire		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	Low income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a re-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Strengthening the national response to HIV in order to scale up prevention to comprehensive care, factoring in gender and key populations at high risk of HIV infection.	Yes	No
Tuberculosis[1]	Preventing multi-resistant tuberculosis by improving comprehensive care of tuberculosis	No	Yes
Malaria	N/A	N/A	N/A

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	X Yes	☐

[1] Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

		No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	x Yes	☐ No

HIV Component: Côte d'Ivoire's proposal in its HIV component is not a new submission of Round 8. This Round 9 submission was prepared as part of a largely participatory process. It included all of the actors involved in the HIV/AID strategy. To do so, it factors in gender in its AIDS-specific measures. Its purpose is to improve available prevention services to reduce new infections in the general population, women, and key populations at high risk of HIV infection; to reduce morbidity and mortality due to AIDS by providing access to care, service quality, and the care continuum, and to strengthen leadership, coordination, and Monitoring & Evaluation of the national response. The main beneficiaries of this proposal are: the general population, women, and Key Populations at high risk of HIV infection.

Tuberculosis Component
The Round 9 tuberculosis component is a new submission of Round 8. It includes the 4 targets of Round 8. However, Targets 3 and 4 have been reworded to be consistent with the Service Delivery Areas that were developed in said targets. The change is as follows:
Old wording

1. Pursue the extension of a high-quality DOTS.
2. Control co-infections of tuberculosis-HIV, multidrug resistant tuberculosis (MDR-TB) and tackle other challenges.
3. Enlist all caregivers
4. Give the ability to act to persons diagnosed with Tuberculosis and to the community.

New wording
1. Pursue the extension of a high-quality DOTS and its upgrade
2. Control TB/HIV co-infection and multi-resistant tuberculosis.
3. Strengthen the public-private partnership
4. Strengthen communication via mass media and community involvement

Currency	☐ USD	or	☒ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

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

Complete the following sections for each disease included in Round 9:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

*** Only to be included in one disease in Round 9. Refer to the Round 9 Guidelines for detailed information.*

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

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

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

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

IMPORTANT NOTE:

Applicants are strongly encouraged to read the Round 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available Here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Clarified Section

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	22,498,959	23,567,343	24,430,387	26,965,227	28,491,406	125,953,322
Tuberculosis	6 479 813. 02	3 192 443. 01	7 738 171. 39	7,672,040 .89	8,894,862. .67	33 977 331
Malaria	-	-	-	-	-	-
HSS cross-cutting interventions section 4B and 5B within *[HIV/AIDS]*	22,524,400	21,286,325	19,540,959	18,627,755	15,610,859	97,590,298
					Total Round 9 Funding Request ➔:	257,520,951

1.2. Contact details

	Primary contact	Secondary contact
Name	Prof. Auguste KADIO Dieudonné	Dr Irma AHOBA
Title	Chairperson of the CCM	Chairman of the Drafting Committee for the HIV Component
Organization	CCM COTE D'IVOIRE	Ministry of Health and Public Hygiene
Mailing address	BP V 04 Abidjan	01 BP 5420 Abidjan 01
Telephone	(+225) 20-22-17-43 / 20-22-17-44	(+225) 20 32 28 69
Fax	(+225) 20-22-17-45	(+225) 20 32 29 83
E-mail address	augustekadio@yahoo.com	irmahoba@yahoo.fr
Alternate e-mail address	ccmcotedivoire@yahoo.fr	pnpecinfo@yahoo.fr

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
3TC	Lamivudine
ABC	Abacavir
AES	Blood Exposure Incident
AGR	Revenue Generating Activities
AIBEF	Ivorian Association for Family Well-Being
AIDS	Acquired Immune Deficiency Syndrome
AIDS Ministry-MLS	AIDS Ministry
AIMAS	Ivorian Social Marketing Agency
AMD	District Maintenance Workshop
ANADER	Agence Nationale pour le Développement Rural (National Agency for Rural Development
ANRP	National Drug Regulatory Authority
ARF	Acute Respiratory Failure
ARSIP	Interfaith Alliance for AIDS and other Pandemics
ARVs	Antiretrovirals
ASAPSU	Association for Self-Promotion of Urban Health
ATG	Technical and Management Assistance
ATI	International Technical Assistance
AZT	Zidovudine
BAD	Banque Africaine de Développement (African Development Bank)
BCC	Behavior-Change Communication
BTS	Higher Technician's License
CAT	Anti-Tuberculosis Center
CBO	Community-based organization
CBO	Community-based organization
CC	Community Counselor
CCI-CI	Chamber of Commerce and Industry of Côte d'Ivoire
CCLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Services Committee)
CCM	Country Coordinating Mechanism
CD	Counseling and Testing
CD4	CD4 Lymphocytes
CDIP	Service Provider-Initiated Counseling and Testing
CDLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Committee)
CDT	Centre de Diagnostic et de Traitement (Diagnostic and Treatment Center)
CDV	Counseling and voluntary screening
CECI	Coalition of Côte d'Ivoire Businesses for HIV/AIDS Control
CeDReS	Center for AIDS Diagnostics and Research
CEROS	Think Tank on AIDS Orphans
CESAG	African Center for Advanced Management Studies

CGECI	General Federation of Côte d'Ivoire Business
CHO	Community Health Office
CHS	Specialized Hospital Center
CHS	Specialized Hospital Center
CHU	University hospital center
CHU	Urban Health Center
CHW	Community Health Worker
CIE	Ivorian Electric Company
CIMLS	Comité Interministériel de Lutte contre le SIDA (Interministerial AIDS Committee)
CIRBA	Abidjan Integrated Bioclinical Research Center
CI-TELCOM	Côte d'Ivoire Telecommunications
CM	Prise en charge (Treatment)
CMP	All-Party and Partnership Committee
CNACI	National Antituberculosis Committee of Côte d'Ivoire
CNCA	National Audiovisual Communications Council
CNLS	National AIDS Council
CNM-CI	National Trade Council of Côte d'Ivoire
CNO	Northwest Center
CNPS	Caisse Nationale de Prévoyance Sociale (National Fund for Social Welfare)
CNTS	Centre National de Transfusion Sanguine (National Centre for Blood Transfusions)
COGES	Comité de Gestion (management committee)
COLTMR	Tuberculosis and Respiratory Illness Organizational Collective
COP	Country Operational Plan
COSCI	Council of AIDS Organizations in Côte d'Ivoire
CRIEM	Regional Infrastructure, Equipment and Maintenance Center
CRLS	Comité Régional de Lutte contre le SIDA (Regional AIDS Committee)
CSE	Centre de Surveillance Epidémiologique (Epidemiological Monitoring Centre)
CSHC	City & School Health Center
CSLS	Sectorial AIDS Committee
CTAIL	Technical Support Unit for Local Initiatives
CTX	Co-trimoxazole
CVLS	Village AIDS Committee
DAF-santé	Financial Affairs Division
DBS	Dried Blood Spot
DD	Departmental Director
DDI	Didanosine
DFR	MSHP Training & Research Division
DFR	Training & Research Division
DGS	Directorate-General for Health
DHR	Human Resources Department
DIEM	Infrastructures and Medical Equipment Division

DIPE	Direction de l'Information, de la Planification et de l'Evaluation (Planning Information and Evaluation Department)
DMOSS	Mutuality and Social Agencies in the School Environment Division
DMS	Social Mobilization of MLS Division
DNT	National Treatment Guidelines
DOTS	Direct Observed Therapy strategy
DPM	Pharmacy and Drug Division
DPSE	Planning and M&E Division
DQA	Data Quality Assessment
DR	Direction Régionale (Regional Department)
DREN	National Education – Regional Division
DSRP	Poverty Reduction Strategy Document
DSRP	Poverty Reduction Strategic Document
DST	Drug Susceptibility Testing
ECD	District Management Team
EDS	Demographic Health Survey
EEQ	External Quality Evaluation
EFV	Efavirenz
EIS-CI	Survey on AIDS Indicators in Côte d'Ivoire
ESPC	Intake Health Care Facility
EST	Establishment
ESTHER	Group for In-Network Hospital Treatment Solidarity
EU	European Union
FAD	Development Aid Fund
FGM	Female Genital Mutilation
FHI	Family Health International
FILTISAC	Spinning and Weaving of Bags
FIPME	Ivorian Small and Mid-Sized Business Federation
FNLS	National AIDS Fund
FSU COM	Community-Based City Health Training
FTC	Emtricitabine
FUS	City Health Training
GAVI	Global Alliance for Vaccine Immunization
GBV	Gender-Based Violence
GDF	Global Drug Facility
GDP	Gross domestic product
GF	Global Fund to control AIDS, Tuberculosis and Malaria
GFMU	Global Fund Management Unit
GH	General Hospital
GIP	Public Interest Group
GLC	Green Light Committee
GRSE	Monitoring & Evaluation Reference Group
GSA	Scientific Support Group
GTT	Technical Working Group

GTZ	German Technical Cooperation
HD	Health district
HH	Health Center
HIPC	Highly-Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSS	Health system strengthening
ICAP	International Center for AIDS Care and Treatment Programs
ICCB	International Catholic Child Bureau
ICRC	International Committee of the Red Cross
IDE	State graduate nurses
IEC	Information-Education-Communication
IFRC	International Federation of the Red Cross
IHAA	International HIV/AIDS Alliance
INFAS	National training institute for health representatives
INS	Institut National de la Statistique (National Statistics Institute)
IO	Opportunistic Infection
IOM	International Office of Migration
IPCI	Institut Pasteur de Côte d'Ivoire (Côte d'Ivoire Pasteur Institute)
IUATLD	International Union Against Tuberculosis and Lung Disease
JHU-CCP	Johns Hopkins University- Center for Communication Programs
KAP	Knowledge, Attitudes and Practices
KFW	Kreditanstalt Fur Wiederaufbau (German Development Bank)
LFA	Local Fund Agent
LIPA	Line Probe Assay
LNME	National List of Essential Drugs
LNSP	National public health laboratory
LPV	Lopinavir
M&E	Monitoring and Evaluation
MD	Ministère de la Défense
MDG	Millennium Development Goals
MDS	Mutuelles de Santé
MEF	Ministry of Economy and Finance
MEMSP (Ministry of Health & Population)	Government Ministry: Ministry of Health and Population
MEN	Ministry of national education
MFFAS	Ministry of Women, Family, and Social Affairs
MJDH	Ministry of Justice and Human Rights
MPA	Minimum Packet of Activities
MPD	Ministry of Planning & Development
MRU	Mano River Union
MSHP	Ministry of Health and Public Hygiene
MSM	Men who have Sex with Men

National Nutrition Program (NNP)	National Nutrition Program
NGO	Non-governmental organization
NHIS	National Health Information System
NRC	National Reference Center
NSP	National Strategic Plan
NTCP	National Tuberculosis Control Program
NVP	Nevirapine
OCAL	Organisation du Corridor Abidjan – Lagos
OCHA	Office for the Coordination of Humanitarian Affairs
OHADA	Organization for Harmonization of Business Law in Africa
ONUCI	United Nations Operation in Côte d'Ivoire
OVC	Orphelins et Enfants Vulnérables (Orphans and Vulnerable Children - OVC)
PAA	Priority Action Area
PAPO	Highly Vulnerable Populations Aid Project
PDSSI	Integrated Health Services Development Project
PE	Peer Educators
PECP	Pediatric Treatment
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PF	Family Planning
PHE	Public Health Evaluation
PIAHIV	Persons Infected with/ Affected by HIV
PLWHAs	Persons Living with HIV
PMI	Protection of Mothers and Infants
PMLS	Multi-Sector AIDS Program
PMTCT	Prevention of Mother-to-Child Transmission (of AIDS)
PNC	Pre-natal consultation
PNDS	National Health Development Plan
PNLP	National Malaria Program
PN-OEV	National Treatment Program for Orphans and Children Made Vulnerable by HIV/AIDS
PNPEC	Programme national de prise en charge médicale des PVVIH (National Medical Care Program for PLWHA)
PNSR/PF	National Program for Reproductive Health and Family Planning
PPH	Pulmonary Tuberculosis
PR	Principal Recipient
PS	Sex worker
PSC	Prospective & Strategy Unit
PSI	Population Services International
PSP CI	Public Health Pharmacy of Côte d'Ivoire
PTB-	Microscopy-negative Pulmonary TB
PTB+	Microscopy-positive Pulmonary TB
PUR	Emergency/Rehabilitation Program
PVD	Lost to Follow-Up
PWC	Price Waterhouse Cooper

RAI	Annual Risk of Infection
RASS	Annual Report on Health Situation
RCI	Republic of Côte d'Ivoire
REPMASCI	Network of Media Professionals in the Arts Against AIDS and Other Pandemics in Côte d'Ivoire
RETRO-CI	Retrovirus Côte d'Ivoire
RGPH (General Census of Population & Housing)	General Census of Population and Housing
RHC	Regional Hospital Center
RHC	Rural Health Center
RHS	Human Resources – Health Care
RIP+	Ivorian PLWHA
RTV	Ritonavir
S&E	Monitoring and Evaluation
SASDE	Accelerated Strategy for the Survival and Development of Children
SCB	Banana Culture Society
SCMS	Supply Chain Management System
SDA	Service Delivery Area
SIG	Information and Management System
SIH	Hospital Information Subsystem
SISR	Routine Health Information System
SOTRA	Société de Transport Abidjanais (Abidjan Transport Company)
SR	Sub-recipient
STCO	Technical Secretariat for Operational Coordination
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB-MR	Multi-resistant Tuberculosis
TDF	Tenofovir
TMVA	Average Annual Variation Rate
TRP	Technical Review Panel
TRU	Training and Research Unit – Medical Science
UN	United Nations
UN System	United Nations System
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchasing Facility
UNODC	United Nations Office on Drugs and Crime
VAD	Home-based care
VSAT	Satellite Communications Network
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary

Sector Representation	Number of members
☑ Academic/educational sector	2
☑ Government	6
☑ Non-government organizations (NGOs)/community-based organizations	3
☑ People living with the diseases	1
☑ People representing key affected populations[2]	1
☑ Private sector	3
☑ Faith-based organizations	2
☑ Multilateral and bilateral development partners in country	5
☑ Other *(please specify): syndicates*	2
Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	25

[2] Please use the Round 9 Guidelines definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_AttachmentC_en.xls

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):		
(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

CCM Côte d'Ivoire is made up of members representing the Public and Private Sectors and Civil Society; associations of persons living with and/or affected by HIV/AIDS, tuberculosis, and/or malaria (APASTP) and development partners. CCM, to accomplish its mission appropriately, has established 4 commissions within itself: The proposal drafting commission, the monitoring & evaluation commission, the communications & resource mobilization commission, and the resource harmonization commission (Annex n° 1).

The Proposal Drafting and Monitoring & Evaluation Commissions are made up of people who are able to evaluate the impact of health system problems on projects and programs and their results for the three diseases (HIV/AIDS, Tuberculosis, and Malaria). In line with the By-laws, committees may use Technical Experts having the required capacities and experience.

For example, we can quote the Chairman of the CCM, who is an infectious disease specialist and former head of the infectious disease center at the Treichville University Hospital Center in Abidjan and former dean of the Abidjan School of Medicine). The Permanent Secretary, who is a Public Health Physician, was Director of the National Malaria Program for 13 years and a Community Health Officer, coordinating all 21 of the Ministry of Health and Public Hygiene's programs, and a representative of civil society who is an expert in comprehensive treatment and positive prevention of HIV.

The CCM includes a proposal drafting committee tasked with: (i) coordinating the consensus-building in the sectors involved in controlling the three diseases in order to develop a proposal, (ii) presenting the General Assembly, in cooperation with the harmonization and needs analysis committee, with a summary of strategic and programmatic recommendations issued by the sectors ; confronting it with identified needs and gaps to feed the debate and decision-making in regard to the priority topic(s) for the next proposal, (iii) mobilizing consultants and other technical supports necessary for developing the proposal, (iv) supervising the technical team tasked with participatory development of the proposal. This commission is made up of nine people, taken from all of the sectors. The various members are experts in cross-analysis of system-wide needs and health and planning programs. In their roles, some of the members have already participated in planning and implementing projects in health care. As such, the Permanent Secretary of the CCM and the Chairman of the Council for International AIDS Organizations have taken part in preparing the National Health Development Plan (PNDS 2009-2013) (Annex 22) and the strategy document on poverty reduction (DSRP 2009-2015) (Annex 50). This expertise of CCM members is strengthened by the support of Development Partners (WHO, UNAIDS, UNFPA, European Union, American Cooperation, World Bank, French Cooperation, and UNICEF).

Gender awareness

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

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

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

Within the CCM are a Representative from the Ministry of Women, Family, and Social Affairs, in charge of "Gender" issues at the national level, and a representative of UNFPA who currently chairs the Gender Theme Group. Representatives of the Strategic Ministries, such as Health, AIDS, and Youth, within CCM are also members of the gender theme group. In terms of representation, civil society, infected and affected persons, and the private sector are represented by 14 members within CCM, and those members also help to factor in the gender approach. In addition, in terms of parity within the CCM, eight of the 25 members are women. They are present both within the office and at the general assembly, and are active participants in decision-making regarding gender equality.

Furthermore, CCM members are stakeholders in the process of preparing the application. Some members, such as the UNFPA and MFFAS representatives, are directing programs on gender advancement on a daily basis, and, as such, have helped complete two studies on gender and three training sessions on gender mainstreaming in development programs.

As this proposal was being developed, a Consultant from the World Bank specialized in gender held several working sessions, including one training session on gender and integrating gender into the development of the Round 9 proposal, with the members of the CCM and the technical development group for this proposal (Annex 3). A National Consultant specialized in gender also participated in the Proposal Drafting Group. CCM members versed in gender issues helped incorporate those issues into the proposal.

Multi-sectoral planning

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

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

Within the CCM is, statutorily, a Proposal Development Committee, with planning and development skills for projects covering several sectors, especially health, including tuberculosis and HIV. This committee is composed of at least five (5) members of the Côte d'Ivoire CCM (in addition to the Chairman). Every sector is represented. These members include one representative from the government, two from civil society, and one from the development partners. In addition, the CCM's bylaws allow co-opting by the committee of technical experts endowed with the required capacities and experience.

Note also that, in the quest to intensify the national response to the HIV epidemic, the Ivorian government has been opting for a multi-sector, decentralized approach for several years. That is why the CNLS (National AIDS Council) was created on January 7, 2004. This Council includes members from all development sectors (health, education, hydraulics, agriculture, defense, energy, finance, etc.). Several CNLS members who have actively participated in developing the various multi-sector AIDS plans, specifically the National Strategic Plans and the Operating Plans, sit on the CCM.

Within the CCM, there are project planning and development skills covering several areas, coming from all development sectors (public, private, and civil society). For instance, from the government sector, the representative of the Ministry on AIDS, Director of the STCO of that Ministry, the representative of the WHO for bilateral and multilateral development partners; for civil society and the representatives of

persons living with or affected by HIV/AIDS, the former Executive Director of the Ivorian network of AIDS Services organizations. For the private sector, the Coordinator of the Federation of businesses against AIDS.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☉ Applied for funding in Round 7 and/or Round 8 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

2.2.2. Transparent proposal development processes

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

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

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

A wide range of actors, from Civil Society as well as the private sector, at the national, regional, and community level participated in developing the proposal. Indeed, once the call for proposals was made by the Global Fund, the CCM met to decide on the Côte d'Ivoire's candidacy and provide guidelines to guarantee the proposal's success (Annex 2). Technical management for preparing the proposal by component was entrusted to the Coordination Office of the PNPEC (National Service Program for People Living With HIV) for the HIV/AIDS component, and the Coordination Office of the National Program against Tuberculosis for the Tuberculosis component. The proposal for the HSS is being steered by the Office of Information, Planning & Evaluation.

The Joint United Nations Team on HIV provided technical and financial support to development of the application for Global Fund Round 9. This technical support was provided for the recruitment and provision of a general practitioner/consultant who coached and guided the preparation of the HIV and HSS components. Four national and three international consultant were also made use of to support the aspects of generality, gender, and budget by the World Bank, UNFPA, UNAIDS, and MSH. Technical contributions, via the personal participation of Joint Team members, specifically UNAIDS, UNICEF, UNFPA, UNDP, WFP, and the WHO have been made as needed in the different steps of the process. Joint financial support has been provided by UNAIDS, UNICEF, UNDP, and the MSH to the national development workshop and harmonization workshop, which included all stakeholders in an inclusive and highly participatory way.

To gain the involvement of all sectors, as of the beginning of the proposal development process, representatives from the different sectors were included in the groups created. With the various actors in the public (health and non-health), community, confessional, and private sectors, a workshop to finalize analysis of the situation and its gaps was organized at the WHO (enriched by the contribution of the analysis of community gaps by a national consultant at the community level, validated by three meetings). There was also participation of the partners against AIDS (Annex 8). The workshop was an opportunity to identify intervention themes and service delivery areas, and to amend the first draft of Annex A of the proposal's HIV component.

The participants' contribution during that workshop, their representation of the different sectors involved, and their areas of expertise made it possible to finalize the list of participants in the proposal drafting workshop. It lasted 12 days as a closed retreat in Bassam (Annex 8). The contribution of the financial partners, implementation partners, field actors, and recipients made it possible to draft a proposal that factored in the realities in the field and the specific needs of target populations. Both workshops were financed by the joint team of the United Nations system.

The Secretariat of the CCM launched the call for the submission of mini-proposals on the national level for the HIV and Tuberculosis components, as well as the HSS published in the national daily "Fraternité Matin" #13 300 of Thursday, 12 March 2009 (Annex 4). To receive the harmonized mini-proposals, a template was provided to the bidders (Annex 5).

After the submission deadline, the 20 mini-proposals accepted for Round 9 by the Secretariat of the CCM were summarized (Annex 6), then sent to the proposal development commissions with the summaries of the 19 mini-proposals submitted in Round 8. Note that further to the call for proposals by the Global Fund, the CCM met with the proposal drafting teams on several occasions to validate the various steps in the process and bring them up to date. Each of the meetings was an opportunity to better factor in the aspirations of all actors, in the public sector, the private sector, and Civil Society. (Annex 8).

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

In response to the call for mini-proposals (Annex 4) on HIV, tuberculosis and HSS, the CCM received 20 mini-proposals, i.e.:

- one mini-proposal from GIP ESTHER (French bilateral cooperation initiative, PIG (Public Interest Group) type;
- 15 mini proposals from 15 NGOs;
- 1 mini proposal from the Private Sector;
- 1 mini proposal from an NGO-Foundation;
- 1 mini proposal from a Foundation;
- 1 mini proposal from a United Nations System Agency.

In all, we have received 20 Mini Proposals (Annex 6). Of these, 17 were on the HIV/AIDS component, one on the Tuberculosis component, one for AIDS and HIV/TB Co-Infection, and one was on both AIDS and Tuberculosis. These mini-proposals used the following process for their potential consideration:

1. Presentation of mini-proposals by promoters before the working group created by the CCM.
2. Review of mini-proposals by the proposal development commission; the points reviewed were (i) geographic coverage (ii) the goal, targets, activities, and targets. Criteria for inclusion in the Round 9 national proposal dealt mainly with the relevance of the mini-proposal, concordance of targets with those of the national strategic plan and those resulting from the analysis of financial and program shortages.
3. Transmission of mini-proposals and comments by the CCM's proposal development commission to the working groups created for the formulation of the various national proposals.

It should be noted that the 19 mini-proposals of Round 8 supplemented the proposal.

Moreover, the actors from Civil Society and the private sector were invited to participate in the various working groups tasked with developing the national proposal (Annex 7).

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

The process used to get people other than those from CCM involved was conducted as follows:

- Identifying skills for all selected focus areas: It was conducted by the members of the proposal

development commission. Along with the definition of needs for technical support (national resource persons, national consultants, and international consultants). Then followed the development of reference terms for the formulation of the request for each component;

- An invitation was sent by the chairperson of the CCM to the national bodies (Ministries, private sector, civil society) where the resource persons matching the required profiles were identified for their availability to the national proposal development commission (Annex 7) ;
- A request was sent by the chairperson of the CCM to the development partners seeking the support of resource persons from their United Nations System institutions System des Nations Unites (UNICEF, UNHCR, WHO, WFP, UNAIDS, UNFPA), and from civil society, Rip+. Elsewhere, the proposal development committee received technical support from international and national consultants made available for the HIV component and the HSS by the United Nations System (UNAIDS, WFP, WHO) and bilateral cooperation (PEPFAR/MSH).

The mobilized resource persons and national and international consultants integrated the different working groups, in which they regularly participated in meetings and workshops held as part of the development of the national proposal.

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***Annex 8***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.

The CCM contains a commission for the monitoring & evaluation of subsidies and Principal Recipients, whose responsibility it is to supervise the program's implementation. (Annex n° 1). This committee can call on other skills inside or outside the CCM, depending on the focus and areas of supervision.

From the first proposals accepted by the Global Fund for Côte d'Ivoire, the CCM has regularly monitored the progress and quality of the programs via half-yearly reviews. Since Round 2, the first accepted HIV/AIDS proposal, of which the Principal Recipients were the UNDP for Phase I, then the NGO CARE for Phase II, the CCM has carried out its first supervision missions. These supervisions have involved the NGO CARE for Rounds 2, 3, and 5 for HIV/AIDS, and Rounds 6 and 8 for the community portion of the Malaria Services Program. Likewise, it coached the National Tuberculosis Services Program for Rounds 3 and 6, and the National Malaria Services Program for Rounds 6 and 8.

To supervise implementation of the Round 9 programs, the CCM will organize quarterly supervision missions, to be performed on the basis of terms of reference with a supervision grid prepared for Principal Recipients and Sub-Recipients, in order to improve efficacy and efficiency in implementing the proposals. This data-collection tool will be provided to the actors to be supervised and periodically revised in cooperation with them. Each supervision mission will be followed by the preparation of a supervision report, which will specify, among other things, the progress of program implementation. The supervision report will be presented to all CCM members at a plenary session, and corrective measures will be proposed with feedback to the bodies concerned for consideration of the mission's recommendations.

During these supervision missions, the CCM will review the various areas related to the working plan of the Principal Recipients and Sub-Recipients. They will also cover compliance with scheduling of approved activities in the working plan, the use of procedure manuals, the degree of completion of indicators and technical reports, disbursement procedures and financial report quality, contract awards, supply chain management, management of the partnership with the Sub-Recipients, the Sub-Sub-Recipients, and consideration of the recommendations of the CCM and the Global Fund.

Let us be clear that in 2008, the CCM held 11 general Assemblies (AG) and, as of now, 5 GM in 2009. During some of these meetings, there was a progress report on the implementation of subsidies, and solutions for improvement were adopted.

In 2008, at two workshops organized by the CCM with the support of MSH for improving its members' abilities, the CCM with all its components made two field visits in five different districts: Bonoua, Aboisso, Toumodi, Djekanou, and Yamoussoukro. Tangentially to these workshops, the CCM went on site visits

and toured community-based organizations. During these visits, CCM members and field actors discussed ways to improve methods and strategies of implementing their activities.

In these districts, the emphasis was on HIV/AIDS on a health level and on a community level, and also on malaria on the community level. In the first half of 2009, the CCM's monitoring & evaluation commission visited the Principal Recipients CARE International; Tuberculosis Program; and a Sub-Recipient of Round 6 – the Malaria Program. During the contact meetings of this CCM commission, documents such as the monitoring & evaluation plans of NTCP and CARE (Malaria and AIDS) were made use of. This commission has its 2009 action plan budgeted and currently implemented (Annex n° 12).

(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

As the CCM had learned from the difficulties encountered in supervision of the activities, recipient and sub-recipients at the implementation of the previous Rounds, it did a profound restructuring, specifically by creating an M&E commission (Annex n°1). This commission is supported by the Permanent Secretariat. The current process of supervising the implementation of programs involves other actors who are not CCM members but who have proven expertise (M&E personnel from the Ministry of Health, AIDS Services, and partners).

To this end, the M&E committee analyzes the various supervision areas and identifies the areas in which outside skills are necessary to formulate terms of reference for mobilizing national resource persons and national and international consultants.

An invitation is sent by the CCM Chairperson to the national structures (Ministries, private sector, civil society) where resource persons matching the required profiles have been identified for their availability to the CCM. A request is sent by the CCM Chairman to the development partners for the provision of resource persons or identified national/international consultants. These outside actors come into the CCM team to carry out the supervision mission. A mission report is then submitted for approval to the CCM meeting and feedback is given to the supervised bodies so that the necessary corrective measures may be taken.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*

In its restructuring begun in 2007, the CCM has clarified roles and reviewed the process of designating Principal Recipients(Annex n° 1). The CCM's structure was renewed in February 2008, in keeping with Global Fund directives. The process used to select each Principal Recipient in this proposal, in a transparent and documented manner, was as follows:

- **Stage 1**: Further to its decision to develop a national proposal as part of the submission to the Global Fund's Round 9 for the HIV/AIDS and Tuberculosis components, the Côte d'Ivoire CCM published a call for bidders for the charge of principal recipient of the Fund's grant, in the journal Fraternité Matin #13.300, 12 March 2009 (Annex n° 13).
- **Stage 2**: At its 23 March 2009 meeting, the CCM, in keeping with its bylaws, established a commission for designating the principal recipients of Round 9 (including members of the project development commission, chairpersons of the CCM's various commissions, partners in development, and resource persons) to conduct the process of designating Principal Recipients under the CCM's supervision. This evaluation commission, chaired by its second Vice President , was composed of: 1 WHO representative; 1 UNICEF representative; 1 UNAIDS representative; 1

PEPFAR representative; 2 representatives from the public sector, 2 representatives from the private sector, and 2 representatives from civil society; 1 representative from the MSH office, an office that supports CCM in its reforms and in improving members' skills. The CCM secretariat received 17 applications in response to the call for bidders, and sent them to the Recipient selection committee. (Annex° 18).

- **Stage 3**: On March 27, 2009, the evaluation questionnaire prepared on the basis of the Global Fund's evaluation criteria was sent to all 17 candidates for self-evaluation (Annex n°16). Candidates had until 1 pm on 2 April 2009 to fill out and file the self-evaluation form with the CCM secretariat.
- **Stage 4**: On Thursday, April 2, 2009, the commission, based on the evaluation questionnaire, prepared a rating grid for the self-evaluation forms. Thirteen of the 17 candidates who submitted filed their self-evaluation sheet. The commission set the date for reviewing the self-evaluation forms for Wednesday, April 8, 2009.
- **Stage 5**: On Wednesday, April 8, 2009, from 10 am to 6:30 pm, the commission reviewed the submissions and rated the candidates. This individual rating of candidates made it possible for the commission to eliminate 3 of them and preselect only 10 for an evaluation visit to their main offices. The purpose of the evaluation visit at the main offices of the 10 preselected candidates was to verify the existence of physical proof of a certain number of documents - financial, institutional, programming, monitoring & evaluation, and purchasing & inventory management (GAS), as listed on the self-evaluation form. To this end, a letter including the list of documents to be verified, as well as the date and time of the CCM evaluation team's visit was sent to the 10 preselected candidates. (Annex° 18).
- **Stage 6**: On April 14, 2009 (from 8:30 am to 6 pm) and on April 15, 2009 (from 8:30 am to 1:30 pm), the commission visited and evaluated all 10 candidates. Further to the results obtained in the field, the evaluation team completed a second rating of the candidates. The average of the two scores obtained by each of the candidates (self-evaluation score + post-visit score divided by 2) gave the final classification. (Annex° 18).

Evaluation of the principal recipient candidates was covered in a report presented to CCM at its GM of May 14, 2009 (Annex n° 19). After discussion with the commission, the General Assembly confirmed the evaluation report of said commission and remitted the list of preselected principal recipients to the harmonization workshop of the Ivorian proposal on May 18, 2009 for insertion by the various Côte d'Ivoire proposal finalization groups (Annex n° 21). The principal recipients were invited to fill out the portion of the form about themselves.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	(Annex n° 19)

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
PNPEC/MSHP	HIV	Government
CNPS	HIV	Private sector and Civil Society
NTCP	TB	Government
CARITAS	TB	Private sector and Civil Society
DIPE/MSHP	HSS	Government

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1. of Round 9 Guidelines*

2.2.6. Non-implementation of dual track financing

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

2.2.7. Managing conflicts of interest

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

2.2.8. Proposal endorsement by members

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

2.3. Sub-CCM details

2.3.1. Status of Sub-CCM	
Identify if the sub-national coordinating mechanism:	
(a) Operates under the authority of the CCM and focuses on a particular region or issue.	☐ *Answer s.2.3.2. and s.2.3.3.*
(b) Claims an independent basis to operate without oversight of the CCM	☐ *Answer s.2.3.2. and s.2.3.4.*

2.3.2. Rationale
Why does a Sub-CCM approach represent an effective approach in the circumstances of your country?
ONE PAGE MAXIMUM

2.3.3. CCM Endorsement	
(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal.	***[Insert Annex Number]***
(b) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	***[Insert Annex Number]***

2.3.4. Justification of independence of Sub-CCM
Explain how the Sub-CCM has a right to operate without guidance from the CCM.
ONE PAGE MAXIMUM

2.4. Non-CCM Applicants [delete sections 2.1. to 2.3. and only complete s.2.4 below]

2.4.1. Sector of work

(check one box only):
☐ Academic/educational sector
☐ Government
☐ Non-government organization (NGO)/community-based organizations
☐ People living with the diseases
☐ People representing key affected populations
☐ Private sector
☐ Faith-based organizations
☐ Other: *please specify:*

2.4.2. Status of Non-CCM applicant

(a)	Identify the main justification for submitting a non-CCM proposal *(check one box only)*:	
	(i) Country in conflict, facing a national disaster or in a complex emergency situation	☐ *Go to s.2.4.3.*
	(ii) Country that suppresses, or has not established partnerships, with civil society and non-governmental organizations	☐ *Complete (b) below, and then s.2.4.3.*
	(iii) State without a national government, and not being administered by a recognized interim administration	☐ *Go to s.2.4.3.*

(b) If (ii) applies:

- describe, in date order, all attempts to have activities from the non-CCM proposal included in the CCM's proposal, and the CCM's response; and
- briefly explain why you will be able to do the work and achieve the outputs/outcomes when the CCM has not supported the proposal.

TWO PAGE MAXIMUM

2.4.3. Expected benefit of proposal

Briefly explain how the work included in this proposal (HIV, tuberculosis and/or malaria as relevant) addresses gaps in the existing country efforts.
ONE PAGE MAXIMUM

2.4.4. Non-CCM knowledge and experience in cross-cutting issues

Health Systems Strengthening The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the applicant.
(a) Describe the capacity and experience of the applicant to consider how health system issues impact programs and outcomes for the three diseases.

Gender awareness The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in: • methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and • the factors that make women and girls and sexual minorities vulnerable.
(b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Multi-sectoral planning The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.
(c) Describe the capacity and experience of the applicant in multi-sectoral program design.

2.4.5. Principal Recipient(s)

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles.*

Name	Disease	Sector**

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

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

2.4.6. Non-implementation of dual track financing

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

2.4.7. Endorsement by Non-CCM Applicant

Position	Printed Full Name	Signature

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	▪ Texts and procedures of the Côte d'Ivoire CCM (Governance Manual, Bylaws)	(Annex° 1)
	▪ Report - determination and adoption of Round 9 development process	(Annex° 2)
	▪ Report - working/training session with Gender Consultant from the World Bank	(Annex° 3)
	▪ Call for mini-proposals for development of Round 9 national proposal	(Annex° 4)
	▪ Template for call for mini-proposals	(Annex° 5)
	▪ Texts and procedures of the Côte d'Ivoire CCM (Governance Manual, Bylaws)	(Annex° 1)
2.2.2(b)	▪ Summary of mini-proposals, then transmission of mini-proposals to development teams	(Annex° 6)
2.2.2(c)	▪ Invitation letter	(Annex° 7)
	▪ PV from development meetings (monitoring workshops and meetings by the CCM) for Round 9 (attendance lists).	(Annex° 8)
2.2.3(a)	▪ Reports from Grd Bassam and Yamoussokro	(Annex° 9)
	▪ Monitoring & Evaluation Commission Report	(Annex° 10)
2.2.3(b)	▪ Grd Bassam and Yamoussokro Report	(Annex° 11)
	▪ CCM Monitoring & Evaluation Commission budgeted action plan	(Annex° 12)
2.2.4(a)	▪ Call for bids for the selection of Principal Beneficiary(ies) (for) Round 9	(Annex° 13)
	▪ Establishment of a PR evaluation committee: PV AG CCM	(Annex° 14)
	▪ Briefing of commission members on evaluation methodology criteria: Report	(Annex° 15)
	▪ Letter to PR candidates + Self-Evaluation File	(Annex° 16)
	▪ Operational meeting on self-evaluation forms: Report	(Annex° 17)
	▪ Evaluation of the capacities of organizations preselected for the position of principal recipients	(Annex° 18)

Proposal checklist - Section 1 and 2

	at the 9th Round of the Global Fund: Mission report	
	▪ Report from the GA of the CCM for the designation of the Principal Beneficiary(ies)	(Annex° 19)
2.2.7	No conflict of interest between the PR, Chairperson, and Vice-Chairpersons	(Annex° 20)
2.2.8	Minutes of the proposal consolidation workshop	(Annex° 21)
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members).	**Attachment C to the Proposal Form**
Sub-CCM applicants only		
2.3.3 (***CCM Endorsement***)	Documented evidence (including minutes of the CCM meetings) that the CCM in the country reviewed and endorsed the proposal (as relevant).	
2.3.4	Documented evidence justifying the Sub-CCM's right to operate without guidance from the CCM.	
Non-CCM applicants only		
2.4.1	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
2.4.2(a)	Documentary evidence justifying the one of the three exceptional circumstances for submitting a non-CCM proposal	
2.4.2(b)	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

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

PROPOSAL FORM-ROUND 9

Component: Tuberculosis

PREVENTING MULTI-DRUG-RESISTANT TB BY IMPROVING COMPREHENSIVE CARE OF TUBERCULOSIS

Country Coordinating Mechanism (CCM) COTE D'IVOIRE

June 2009

SUMMARY

ABBREVIATION LIST

Acronym/Abbreviation	Meaning
AIDS	Acquired Immune Deficiency Syndrome
AIMAS	Ivorian Social Marketing Agency
ARI	Acute Respiratory Failure
BCC	Behavior-Change Communication
CAT	Anti-Tuberculosis Center
CCM	Country Coordinating Mechanism
CDT	Centre de Diagnostic et de Traitement (Diagnostic and Treatment Center)
CDV	Counseling and voluntary screening
CECI	Coalition of Côte d'Ivoire Businesses for HIV/AIDS Control
CeDReS	Center for AIDS Diagnostics and Research
CGECI	General Federation of Côte d'Ivoire Business
CHU	University hospital center
CHW	Community Health Worker
CIE	Ivorian Electric Company
CIRBA	Abidjan Integrated Bioclinical Research Center
CM	Prise en charge (Treatment)
CNACI	National Anti-Tuberculosis Committee of Côte d'Ivoire
CNO	Northwest Center
CNPS	Caisse Nationale de Prévoyance Sociale (National Fund for Social Welfare)
COLTMR	Tuberculosis and Respiratory Illness Organizational Collective
COP	Country Operational Plan
CSE	Epidemiological Surveillance Officer
DHR	Human Resources Department
DIEM	Infrastructures and Medical Equipment Division
DOTS	Directly Observed Short-Course Treatment

DPM	Pharmacy and Drug Department
DSRP	Poverty Reduction Strategic Document
DST	Drug Susceptibility Testing
EIS-CI	Survey on AIDS Indicators in Côte d'Ivoire
ESPC	Intake Health Care Facility
ESTHER	Group for In-Network Hospital Treatment Solidarity
FILTISAC	Spinning and Weaving of Bags
FSU Com (Community-Managed Health Facilities)	Community-Based City Health Training
GDF	Global Drug Facility
GDP	Gross domestic product
GF	The Global AIDS, Tuberculosis and Malaria Fund
GLC	Green Light Committee
GSA	Scientific Support Group
HH	Health Center
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
INFAS	National training institute for health representatives
IPCI	Institut Pasteur de Côte d'Ivoire (Côte d'Ivoire Pasteur Institute)
IUATLD	International Union Against Tuberculosis and Lung Disease
LIPA	Line Probe Assay
LNSP	National public health laboratory
MDG	Millennium Development Goals
MSHP	Ministry of Health and Public Hygiene
National Nutrition Program (NNP)	National Nutrition Program
NGO	Non-governmental organization

NHIS	National Health Information System
NRC	National Reference Center
NSP	National Strategic Plan
NTCP	National Program to Fight Tuberculosis
ONUCI	United Nations Operation in Côte d'Ivoire
PAM	World Food Program
PEPFAR	President's Emergency Plan For AIDS Relief
PIAVIH	Persons Infected with/ Affected by HIV
PLWHAs	Persons Living with HIV
PNDS	Plan National de Développement Sanitaire (national health development plan)
PNPEC	Programme national de prise en charge médicale des PVVIH (National Medical Care Program for PWHIV)
PNSR/PF	PNSR/PF National Program for Reproductive Health and Family Planning
PPH	Pulmonary Tuberculosis
PR	Principal Recipient
PSI	Population Services International
PSP CI	Public Health Pharmacy of Côte d'Ivoire
PTB-	Microscopy-negative Pulmonary TB
PTB+	Microscopy-positive Pulmonary TB
PUR	Emergency/Rehabilitation Program
RAI	Annual Risk of Infection
RASS	Annual Report on Health Situation
REPMASCI	Network of Media and Arts Professionals Against AIDS and Other Pandemics
RETRO-CI	Retrovirus Côte d'Ivoire
RGPH (General Census of Population & Housing)	Recensement Général de la Population et de l'Habitat (General Census of Population and Housing)
RHS	Human Resources
RIP+	Ivorian PLWHA

SCB	Banana Culture Society
SIG	Information and Management System
SOTRA	Société de Transport Abidjanais (Abidjan Transport Company)
TB	Tuberculosis
TB-MR	Multi-resistant Tuberculosis
TRP	Technical Review Panel
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organization

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	April 2010	March 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)* **X** 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/documents/rounds/9/CP_Pol_R9_FAQ_GrantConsolidation_en.pdf

(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? *(List the relevant grant number(s))*	

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

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

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

Côte d'Ivoire's tax cycle coincides with the calendar year; Thus it begins on January 1 and ends on December 31. Based on this, the year's four quarters are: Q1 - January 1 to March 31, Q2 – April 1 to June 30, Q3 – July 1 to September 31, and Q4 – October 1 – December 31.

The timeline for implementation and reportage of activities takes account of this schedule, to which all national plans are attuned: National Health Development Program (PNDS), Strategic Plan of the National Tuberculosis Control Plan (NTCP). Compliance with this tax cycle was factored in when developing and implementing Rounds 3 and 6 during execution by the Program.

Planning the implementation of this R9 proposal is part of the same logic, because start-up of activities is scheduled for April 1, 2010. This arrangement will facilitate the reporting of data on the availability of required funds in the same period. However, the implementation period will be different from the Ivorian tax cycle, which begins each year in January and ends in December.

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 X 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.

Preventing multi-drug-resistant TB by improving comprehensive care of tuberculosis

The National Tuberculosis Control Plan (NTCP) of Côte d'Ivoire received funding from the Global Fund in Round 3 (ended in March 2009) and Round 6. The Round 3 project "Strengthening tuberculosis control using the DOTS strategy" addressed the development and extension of the DOTS strategy throughout the country; it made it possible to strengthen tuberculosis treatment structures, to incorporate all elements of DOTS, and to provide full coverage of the territory in 2006, which went from one treatment center (CDT) per 300,000 inhabitants to one CDT per 200,000 inhabitants. In 2006, the NTCP submitted a proposal in Round 6 entitled "Intensifying tuberculosis control in Côte d'Ivoire using the DOTS strategy and the Stop TB Partnership in the post-crisis period." This project began in April 2008 and promoted a reactivation in the Center, North, and West (NWC) zones where DOTS activities had been very disrupted; its purpose is also to correct the low community and private-sector involvement, and the lack of material resources for effective supervision; it enables regular provisioning of drugs/consumables and developing integrated TB/HIV activities.

This proposal for Round 9 has three main focus areas: Decentralizing activities in Abidjan and extending them outside the NWC area; treating MDR diseases; and communicating via mass media. In addition, this request factors in the continued funding of activities when Round 6 ends.

Abidjan, the economic capital, reports more than 50% of the 24,047 tuberculosis patients in Côte d'Ivoire, although it has only 18 health care training groups for diagnostics and monitoring treatment of tuberculosis patients. The "historic" CAT of Adjamé itself reports half the cases in Abidjan, or one quarter of the entire country; it is overwhelmed. In 2007, it was in Abidjan that the worst results were posted, with 15% lost to follow-up (26% in Adjamé). To gradually make up this enormous deficit in available care for tuberculosis patients in Abidjan, it is crucial that tuberculosis services be incorporated into existing health care training, specifically the Community Urban Health Care Facility (FSUCom) and in private businesses. Multi-drug-resistant tuberculosis (MDR-TB) control is in its very earliest stage: no diseases moved into second-line treatment in 2007, and only 10 in 2008. Diagnostic possibilities must be developed and a full effective circuit created for the treatment of these patients. Preventing development of MDRs also hinges on better care of tuberculosis patients in general and, therefore, on decentralizing services in Abidjan. Many activities are carried out with communities, but the communication via mass media sector has not yet been developed by the program. Specifically, four targets have been identified:

1. Continue extension of high-quality DOTS and its upgrade by:
   - Increasing the number of CDT by 10 before 2012 in Abidjan and improving coverage in the rest of the country by creating 30 new centers.
   - increasing human resource availability in relation with the increase in CDT and providing continuing education.
   - securing first-line drug availability at the end of Round 6 and ensuring that second-line drugs are provisioned
   - having the target of attaining a 80% treatment success rate.
2. Fight TB/HIV co-infection and multi-resistant tuberculosis.
3. Strengthen the public-private partnership by involving practitioners from the liberal private sector of non-governmental businesses.
4. Strengthen communication via mass media and community involvement to destigmatize the disease and inform the community about available care.

The budget for this proposal is: **33,977,330.98** euros

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 epidemiological situation in Côte d'Ivoire is dominated by infectious and parasitic diseases, which represent 50-60% of overall morbidity. With an estimated prevalence in 2008 – according to the WHO report – of 747 cases per 100,000 inhabitants for all forms, and an incidence of 420 cases per 100,000 inhabitants for new cases, Côte d'Ivoire is deeply affected by the problem of tuberculosis. Since 2006, the International Union Against Tuberculosis and Lung Disease (IUATLD) has additionally attracted the NTCP's attention to this situation, which should be reviewed in cooperation with the WHO, and clarified by the completion of a prevalence survey, which has become imperative. As such, the NTCP reported, for 2008, an incidence of reported tuberculosis – all forms – of 113 cases per 100,000 inhabitants, and 72 cases per 100,000 inhabitants for new TPM+ cases. Based on a survey conducted in 2006, the rate of MDR-TB is 2.5% for new cases, and 8.6% for cases in retreatment. Multi-drug-resistant tuberculosis may compromise the recorded progress in tuberculosis control in Côte d'Ivoire, which makes awareness of this situation one of the National Program's priorities. The proportion of HIV in tuberculosis patients tested was 29% in 2008.

The Program has adopted the "Stop TB Strategy," which best responds to the current challenges, because it includes all aspects of the program, specifically screening, case management, monitoring & evaluation, operational research, TB/HIV co-infection control, concerted public/private involvement, advocacy, community mobilization, and resource mobilization.

The various successive plans have resulted in the following current outcomes:

- The DOTS coverage rate, which was 20% in 2001, has been 100% since 2006.
- The notification rate went from 100 cases/100,000 inhabitants in 2003, all forms, to 113 cases/100,000 inhabitants in 2008. This represents an average progress of case reporting over the last years of 3.4% for new TPM+ cases and 4.4% for cases (all forms). This increase is 9% between 2007 and 2008 concerning TPM+ (Annex V).
- The treatment's success rate went from 56% in 2001 to 75% in 2007.
- HIV treatments are in use in 92 of the 109 operational facilities for tuberculosis treatment in 2008

These results were obtained specifically because of:

- Extension of HIV services by the increase from 24 CDTs in 2005 to 92 in 2008
- The increase in regional tuberculosis reference centers (CATs), which went from 8 in 2006 to 11 in 2007, currently having at least two physicians.
- The improvement of capacities in 1,098 health staff members (physicians and nurses) from 2003 to 2007, identification of suspected cases, care and monitoring of patients under treatment
- The support provided to 12 NGOs via 19 micro-projects and the improvement of capacities in 510 community health workers trained in monitoring diseases outside of government health structures in 2008.

Still, there remain priority focus areas to strengthen these acquisitions and further improve the effectiveness of the control effort, with the necessity, in particular, of hastening the deconcentration of TB control with a specific accent to be placed on the city of Abidjan, stepping up supervision activities, and factoring in cases of resistant bacilli tuberculosis.

(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).*

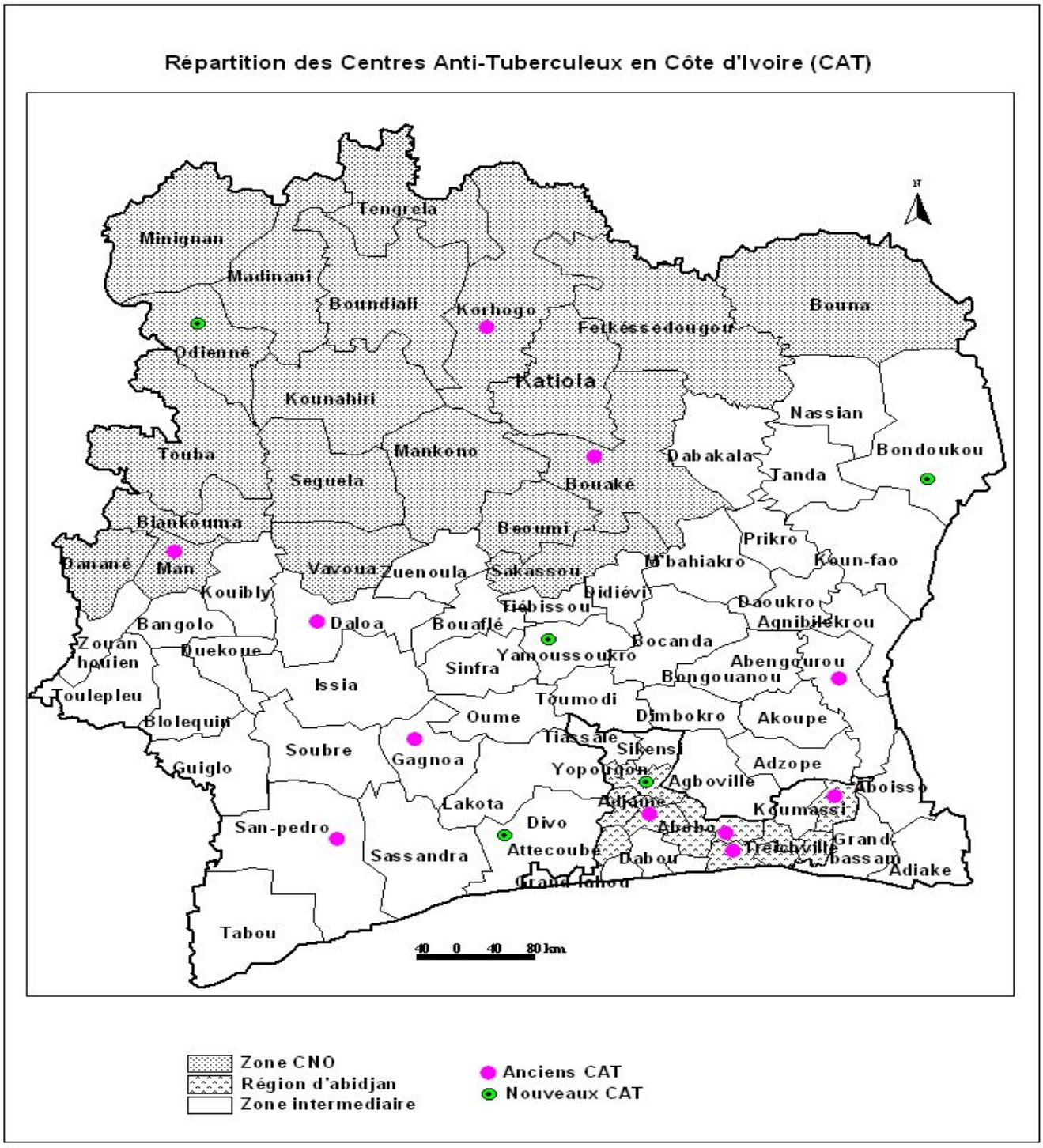
Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

ROUND 9 – Tuberculosis

	Document	Proposal Annex Number	Page References
x	National Health Sector Development/Strategic Plan	I	28
x	National Tuberculosis Control Mid Term Strategy or Plan	II	30 to 37
x	National Tuberculosis Guidelines (medical and laboratory)	III	27 to 55
x	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	IV	20 to 25
x	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	V	12 to 15
x	National Monitoring and Evaluation Plan (health sector, disease specific or other)	VI	8 to 33
Detailed description of Round 9 interventions		VII	1 to 16
NTCP 2007 Report		VIII	12 to 15
☐	National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

4.2 Epidemiological Background

4.2.1. Geographic reach of this proposal		
(a) Do the activities target:		
X 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*



Répartition des centres Anti-tuberculeux en Côte d'Ivoire (CAT)	Distribution of Tuberculosis Clinics (CAT) in Côte d'Ivoire
Zone CNO	CNO Area
Région d'Abidjan	Abidjan Region
Zone intermédiaire	Intermediate Zone

Anciens CAT	Old CAT
Nouveaux CAT	New CAT

(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)	21,260,968	INS	2008
Women > 25 years	6,885,364	INS	2008
Women 19 – 24 years	1,149,367	INS	2008
Women 15 – 18 years	1,257,799	INS	2008
Men > 25 years	6,552,842	INS	2008
Men 19 – 24 years	989,698	INS	2008
Men 15 – 18 years	968,862	INS	2008
Girls 0 – 14 years	4,478,187	INS	2008
Boys 0 – 14 years	4,594,283	INS	2008
Other **: ***Refer to the Round 9 Guidelines for other possible groups*			
Other **:			
Other **:			[*use "Tab" key to add extra rows if needed]*

4.2.2. Tuberculosis epidemiology of target population(s)

Indicators (see the footnote under this table for the references)			Number or rate or percentage	[Calculation] or (reference)
TB estimates, 2006				
A	Estimated number of new TB cases (all forms)		80,995	(1)
		Men 0 – 14 years	4,374	
		Women 0 – 14 years	5,265	
B	Estimated number of new TB cases (all forms) per 100,000 population		420	[a/population*100 000]
C	Estimated number of new smear-positive cases		33,306	(1)
D	Estimated number of new smear-positive cases per 100 000 population		173	[c/population*100 000]
E	Estimated prevalence of TB cases (all forms)		112,028	(1)
F	Estimated prevalence of TB cases (all forms) per 100,000 population		582	[e/population*100 000]

G	Estimated number of deaths due to TB (all forms)		24,722	(1)
H	Estimated number of deaths due to TB (all forms) per 100 000 population		128	[g/population*100 000]
I	Estimated number of HIV-positive new TB cases (all forms)		31,423	(1)
J	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population		163	[i/population*100 000]
K	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined)		2,427	(2)
ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant		2.8	(2)
TB notifications, 2006				
l	Number of new TB cases (all forms) notified		22,068	(3)
			Not Available	
			Not Available	
			Not Available	
			Not Available	
m	Number of new TB cases (all forms) notified per 100 000 population		115	[l/population*100 000]
n	% of estimated new TB cases (all forms) notified		27	[l/a*100]
o	Number of new smear-positive TB cases notified		14,071	(3)
		Men 0 – 14 years	182	
		Men 15 – 44 years	5,592	
		Men 45 years	1,834	
		Women 0 – 14 years	199	
		Women 15 – 44 years	4,182	
		Women 45 years and more	935	
p	Number of new smear-positive TB cases notified per 100,000 population		73	[o/population*100 000]
q	% of estimated new smear-positive TB cases notified - Case detection rate of new smear positive TB		42	[o/c*100]
s	Number of TB cases all forms (new and retreatment) that were tested for HIV		11,264	(3)
t	% of TB cases all forms (new and retreatment) that were tested for HIV		48	[s/l*100]
u	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive		4,370	(3)
v	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB		14	[u/i*100]
w	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT		1,185	(3)
x	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT		56	[w/u*100]
y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART		994	(3)
z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART		47	[y/u*100]

aa	Number of TB cases (new and retreatment) received diagnostic DST	17	(3)
ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases	Not Available	(3)
ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB	Not applicable	[ac/k*100]
Treatment outcome, 2005			
ae	Number of new smear-positive cases registered for treatment	12,868	(3)
af	% of all notified new smear-positive TB cases that were registered for treatment	100	[ae/o*100]
ag	Number of new smear-positive TB cases that were successfully treated (2005 cohort)	9,417	(3)
ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2005 cohort)	73	[ag/ae*100]
ai	Number of new smear positive TB cases that failed their treatment	214	(3)
aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2005 cohort)	2	[ai/ae*100]
ak	Number of new smear positive TB cases who died while on TB treatment	992	(3)
al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2005 cohort)	8	[ak/ae*100]
am	Number of new smear positive TB cases who defaulted	1,255	(3)
an	% of all new smear-positive TB cases registered for treatment who defaulted (2005 cohort)	10	[am/ae*100]

1. Global tuberculosis control: surveillance, planning, financing: WHO report 2008. "WHO/HTM/TB/2008.393".
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.

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[1] 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.

There are weaknesses in implementation of the current program:

1. Inadequate availability of care affecting diagnostic improvement

Data analysis shows that, in 2008, the city of Abidjan reported 12,041 people with tuberculosis, i.e. over 50% of the country's cases, and that there are only 18 health training centers where diagnosis and care of people with tuberculosis is performed. This gives an average of 688 people with tuberculosis per center, but the distribution of patients is not uniform throughout CDT, and the Adjamé CAT has itself reported more than half of the tuberculosis cases in Abidjan. It is very difficult for it to refer patients to other centers, because those centers are already full. Very populous communities (esp. Yopougon with more than one million inhabitants) have very little care available for tuberculosis, and patients must continue to go to the CAT in Adjamé. Services are stretched so thin that it is impossible to have a quality relationship between health care providers and their patients, as evidenced by the number of those Lost to Follow-Up: 26% in Adajmé and 15% for the entire city. The unequal distribution of available care affects the quality of that care, especially in the city of Abidjan. To gradually make up this enormous deficit in available care for people with tuberculosis in Abidjan, it is indispensable that hte number of centers in the city increase, and that hte network of Community-Based Urban Health Care Facilities (FSUCOM) be integrated. These trainings are financed from their own revenues. Given that the services related to TB control are free of charge, they must be supported in equipment and health care staff (nurses and lab technicians) so that they can provide this service without going bankrupt. This proposal will consider the development of anti-tuberculosis activities in private businesses

Within the country, outside of the North West Center (NWC) regions that received special support from Round 6 as part of a post-conflict redeployment of activities, the number of CDTs is still low, with 1 CDT per 200,000 inhabitants. Thirty new TC are planned, including three CAT, to achieve one TC per 150,000 inhabitants.

2. Lack of trained staff.

Since the beginning of the social and political crisis, the Training Institutes for Health Workers (INFAS) located in Bouaké and Korhogo have been closed, which has reduced the annual number of available health-care providers by an average of 200. The result has been a dearth of skilled staff for tuberculosis. The recent redeployment of staff involves a need for intensified training for new staff by the NTCP.

3. Monitoring & evaluation limitations.

The pace of supervision of care facilities scheduled in the previous proposals was two, instead of the four stipulated by the NTCP's directives. Added to this deficiency was the low level of computerization of data management, and the lack of a Data Quality Audit generated by the care facilities. These limitations impair monitoring quality and the Program's effectiveness.

4. Deficient care of MDR tuberculosis.

Lab services do not have adequate equipment nor enough consumables for culturing or sensitivity testing. The country has only three pulmonary tuberculosis (PPH) units in the University Hospital Centers (CHU) of Abidjan and Bouaké, with very low bed capacity, and does not provide the minimum biosafety conditions required for the care of MDR-TB cases. The lack of availability of second-line drugs made it

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

impossible to adequately care for MDR-TB cases in 2007. By our estimates, about fifty patients with MDR-TB must be treated each year.

5. Low health facility involvement.

We are seeing low involvement by health facilities in tuberculosis control - Public-Public and Public-Private alike.

Public-public: Certain public hospitals are reluctant to incorporate anti-tuberculosis activities due to a lack of suitable infrastructure (laboratories, consultation rooms, hospital admission room, and infection control).

Public-private: of 37 Community-Based Urban Health Care Facilities of Abidjan (FSUCOM), only 2 have incorporated TB services. As for private businesses, 2 structures (SOGB, the Sugar Complex of Borotou-Koro) are involved in TB control, out of the 20-odd private businesses that are equipped to incorporate TB services. The number of persons affected is estimated at 15,000. To date, no private clinic has been involved in tuberculosis treatment.

6. The dearth of communication, awareness-raising, and social mobilization activities,

In the R6, a few awareness-raising and social mobilization outreach activities for specific groups are planned and carried out by religious leaders, Non-Governmental Organizations (NGOs) and women's' groups. As part of this effort, two plays were created. However, the tuberculosis communication component intended for the general population via the media has not been sufficiently developed.

7. Deficiency of community sector involvement

The involvement of NGOs for community monitoring began in R3 with 12 NGOs who implemented 19 micro-projects. R6 planned to increase this support to 34 micro-projects. During the first two years of this proposal, funding of these NGOs is provided by R6. Funding for the last 3 years will have to be considered.

On R6, community support is provided by 840 Community Health Workers (CHW) in 28 TC of the North West Center from Year 1 to Year 4. The southern part of the country was not addressed by R6. Round 9 support will be extended to 86 TC in the south, not including the Abidjan TC.

8. Lack of coordination in operational research.

The operational research is performed in the context of health science topics. The lack of institutional coordination between the Ministries involved (Higher Education and Scientific Research & Health) makes it difficult to value the results and their application by the NTCP.

The combination of these weaknesses prevented reaching an optimal level for national results in 2007. With the reservations issued as to the estimate of expected incidence rates, the detection rate of TPM+ is 37%, the treatment success rate is 75%, and the death rate remains high (8%), as does the lost to follow-up rate (10%). The treatment failure rate is 2% for new cases and 7% for retreatment. This situation is conducive to the emergence of drug-resistant tuberculosis (Annex 76).

Inadequately addressed needs affect the following sectors:

- Strengthening the capacities of the NTCP laboratory network
- Availability of reagents and laboratory input
- Reinforce the infrastructures and equipment.
- Strengthening patient care and support.
- Strengthening monitoring & evaluation activities.
- Increasing numbers of trained health care staff.
- Strengthening staff capacities in pneumology units, laboratory units, and private structures.
- Increase in the bed capacity of MDR-TB care units
- Availability of second-line drugs.
- Strengthening DOTS services throughout the country in the public sector (General Hospitals,

Laboratories of Public Hospitals).

- Strengthening DOTS services throughout the country in the private sector (FSUCOM, Private Businesses, private clinics)
- Strengthening communication via the media
- Strengthening community DOTS by ASC

Strengthening operational research

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 evaluation performed in May 2008 by the Information, Planning and Evaluation Division (DIPE) revealed the following dysfunctions in the system:

Health personnel: there is a deficit of paramedical staff (Nurses, midwives, laboratory technicians) and inequality in the geographic distribution of personnel. The insufficient valuation of human resources (lack of advancement and salaries frozen for over 20 years) is a demotivating factor in service providers.

Funding: Despite the State's efforts, funding of health interventions is subject to outside help. Currently, the budget allocated to the health sector is less than 10% of the government's budget, compared to the 15% promised by Government Leaders at the Abuja 1 Summit in 2001 and Abuja 2 in 2006.

Service deliveries: There are standards & procedures documents that are poorly appropriated and distributed to actors. Côte d'Ivoire has opted for comprehensive (health services with community involvement) and integrated health care that extends progressively to all districts. Côte d'Ivoire has subscribed to universal access to AIDS, tuberculosis, and malaria programs (Abuja 2 appeal, 2006). Still, we are seeing geographic inaccessibility (40% of the population live more than 15 kilometers from a health center), financial inaccessibility (fee for service), and cultural and social barriers (85% of the population uses traditional medicine). Generally speaking, the majority of health infrastructures and equipment are obsolete and unsuitable. Furthermore, the lack of equipment standards and maintenance policy is behind the recurring breakdowns.

Medical products and purchase & inventory management: The comprehensive needs assessment is done by the national selection and quantification committee using quantification software (QUANTIMED). This evaluation factors in the needs expressed by the NTCP and is done according to the National List of Essential Drugs (LNME) and the National Treatment Directives (NTD).

The PSP (public health pharmacy) is tasked with procurement from the funding of the national portion. The PSP uses two acquisition methods per the terms set by the government procurement code. These are international open tenders in accordance with Order no. 92-08 of January 8, 1992, and the negotiated contract (if the tendering is declared a failure). For anti-tuberculosis products, the PSP buys only WHO-prequalified products, in consideration of the NTCP's requirements. The administrative procedures for the delivery of products are performed by the transit office of the PSP-CI using the documents sent by the supplier. Products received at the PSP-CI are systematically assessed to make sure they comply with the order. In addition to WHO prequalification, PSP-CI ensures the quality control of anti-tuberculosis products using systematic sampling of all drug batches received for analysis at the National Laboratory of Public Health.

Only the PSP-CI has current inventory of pharmaceutical products. The PSP-CI currently has 5 stockrooms with a total capacity of 18,846 m² and the option of expanding. A plan to increase capacities and improve storage conditions is being implemented with the support of PEPFAR. At present, the layout of stockrooms with rack assemblies for storing pallets and the establishment of a temperature monitoring system in the stockrooms with an air extraction allowance is complete. This plan provides for layouts in new stockrooms for storing products, an improved warehouse management computer system, and

reinforcements in tools and equipment for handling.

Inventory management support is computerized or manual. Management software (SAGE 1000 coupled with MACS) includes procurement, inventory, sales, and stockroom management. For each of the products, a manual inventory form is filled out. The products are submitted to random weekly rotating inventories and to a comprehensive inventory once a year.

The Global Fund - Round 2 is funding a construction project for a cold room in progress at the PSP-CI. Moreover, the PSP-CI has received handling materials. The aforementioned plans do not factor in increased storage capacities of district pharmacies.

The Public Health Pharmacy has good logistics suitable for deliveries and supervision. Twenty-seven delivery vehicles, of which 11 are 10 tons, 7 are 5 tons, and 9 are 2.8 and 1.5 tons, and 24 supervision vehicles, of which 6 are 4x4s. Distribution of Health products is done according to the district approach – in other words, the PSP-CI delivers to districts and the CAT delivers to health-care facilities.

However, we have seen a deficiency in equipment and maintenance in cold chains for drug storage and unsuitable premises at DS (health districts) and CATs.

National Health Information System: This system has difficulties related to (i) recurring breakdowns in collection media; (ii) deficient means of transmission, (iii) deficiency and irregularity of supervisions, and (iv) deficient training of health workers in data collection and processing. These deficiencies have repercussions on the quality of the national monitoring & evaluation system, which does not get real-time information for decision-making, and does not incorporate data from private sectors and University Hospital centers. Neither is there any operational drug-monitoring system.

Operational research. Its results are underutilized.

All of these weaknesses affect aspects of TB services, resulting in a deficit in health facilities and staff involved in TB control efforts.

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.

Health personnel

- Measures taken by the government of Côte d'Ivoire

A redeployment program was established by the Government to encourage all officers to step back into the jobs they left because of the crisis. As such, 3500 displaced health workers were redeployed in the country. To increase production of human health resources (HHR), specifically paramedical (nurses and midwives), both INFAS of Bouaké (Center) and Korhogo (North) were reopened for initial training. To improve the compensation of health staff, the Government signed an order to grant compensation tied to the health risks incurred by medical and paramedical staff and removed the freeze on financial effects for the promotion of workers which had been in place for 20 years. Actual implementation of these provisions is slated for 2009. A strategic RHS plan has been approved. This will make it possible to mobilize the necessary funding to effectively resolve the various issues tied to management and development of RHS. The quantitative deficiency of health staff has been partially remedied since May 2007 in regard to medical staff by the integration of 1,287 senior health officers into public service, 24 of whom have been made available to the NTCP. Additionally, the trained nurses have all been recruited into public service.

- Measures taken by the NTCP

Of the 24 senior health officers made available to the NTCP in 2007, 10 were assigned to coordination and 14 to the regional level. In addition, the NTCP initiated a process with the national authorities for the establishment of an experts' channel on tuberculosis and respiratory diseases to INFAS. This incentive will guarantee the stability of nursing staff assigned to tuberculosis treatment services. Since 2004, the NTCP has supported redeployment of TC staff to ensure continuity of services in the NWC zones.

- Measures taken by the partners

To strengthen the NTCP, five coordination workers were recruited with the support of the Global Fund: two for Round 3 and three for Round 6 (Administrative and financial support staff).

Service deliveries

A new National Health Development Plan (PNDS) covering the period of 2009-2013, developed by the

Ministry of Health, has been approved. The texts, which enact the organization and operation of the Regional Offices and the Departmental Offices of Health, have been revised to strengthen leadership of these offices in the context of the coordination, technical support, and supervision of services that are their respective duties (Annex I). Over the last few years, there has been development in non-governmental (individual, business, confessional, etc.) and public health facilities tied to the various ministerial sectors (Treasury, Customs, Taxes, Armed Forces). Since 1997, the Ivorian government has attempted to make up the deficit in health structures by creating 37 community-based health facilities in Abidjan. In addition, in the context of implementing the Emergency & Rehabilitation Program (PUR) related to the end of the crisis, notable progress has been observed in the NWC areas' health services. In fact, 62% of First-Line Health Facilities (ESPC) has been partially restored and outfitted. The restoration of some health facilities in these zones by the international community (UNICEF) is conducive to resuming anti-tuberculosis activities. The Global Fund, via Round 6, will help to restore 18 Tuberculosis Treatment Facilities (PEC) including 10 in the NWC area.

System for monitoring anti-tuberculosis activities

Since 2004, the DIPE, with financial support from PEPFAR, through Measure Evaluation/JSI, has made it possible to update the list of national health indicators and revise the tools for collecting national data. To facilitate the collection and transmission of data from health districts and regions, supplemental IT equipment was contributed to five Regional Offices and nine Departmental Offices. An effort to compile data in the field of tuberculosis is performed in the CHUs: Establishment of in/out registers, awareness-raising, and training of actors.

It should be noted that all information on tuberculosis is centralized by the National Monitoring & Evaluation System.

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	SDA 1.1: Improving diagnosis	Historical		Current		Country targets			
Indicator name	Number and % of laboratories with a quality assurance result for direct microscopy that is satisfactory, compared to those who practice quality assurance each year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		0	63 (66%)	80 (70%)	91(70%)	104 (75%)	109 (75%)	122 (80%)	127 (80%)
B: Extent of need already planned to be met under other programs		0	63 (66%)	75 (66%)	85(66%)	92 (66%)	0	0	0
C: Expected annual gap in achieving plans		0	0	5 (4%)	6 (4%)	12 (9%)	109 (75%)	122 (80%)	127 (80%)
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			6 (4%)	12 (9%)	109 (75%)	122 (80%)	127 (80%)

Priority No: 2	DPS 2-2 :Tuberculosis –MR	Historical		Current		Country targets			
Indicator name	Number and Percentage of Tuberculosis Patients (new and in retreatment) who received sensitivity testing to first-line TB drugs, compared to the number of patients eligible for that testing, according to national policy.	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		1,315	1,415	1,530	1,660	1,809	1,978	2,170	2,387
B: Extent of need already planned to be met under other programs		0	0	0	1,660	1,809	1,097	0	0
C: Expected annual gap in achieving plans		1,315	1,415	1,530	0	0	881	2,170	2,387
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	0	881	2,170	2,387

ROUND 9 – Tuberculosis

Priority No 3:	SDA 1-4: Procurement and management of supplies	Historical		Current		Country targets			
Indicator name	Number and Percentage of tuberculosis treatment units (CDT/CAT) that did not report any disruption in first-line drugs on the last day of the quarter, compared to all treatment units.	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		96 (100%)	109 (100%)	114 (100%)	130 (100%)	138 (100%)	145 (100%)	152 (100%)	159 (100%)
B: Extent of need already planned to be met under other programs		96 (100%)	109 (100%)	114 (100%)	130 (100%)	138 (100%)	0	0	0
C: Expected annual gap in achieving plans		0	0	0	0	0	145 (100%)	152 (100%)	159 (100%)
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	0	145 (100%)	152 (100%)	159 (100%)

Priority No4:	SDA-3.1: All caregivers	Historical		Current		Country targets			
Indicator name	Number of tuberculosis patients with positive smears screened in the health services of private businesses	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		25	25	25	35	50	75	95	120
B: Extent of need already planned to be met under other programs		25	25	25	25	25	0	0	0
C: Expected annual gap in achieving plans		0	0	0	10	25	50	70	95
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			10	25	50	70	95

Priority No5:	SDA 4.2: Community TB care	Historical		Current		Country targets			
Indicator name	Number of ASC mentoring meetings	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		0	52	72	340	384	476	500	524
B: Extent of need already planned to be met under other programs		0	52	72	92	112	0	0	0
C: Expected annual gap in achieving plans		0	0	0	248	272	476	500	524
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			248	272	476	500	524

ROUND 9 – Tuberculosis

➔ *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.*

The purpose of this intervention is to reduce the burden of tuberculosis by capitalizing on acquired knowledge of the control effort and guaranteeing quality care for all tuberculosis patients. The purpose of the preceding submissions to Rounds 3 and 6 was to strengthen the extension of the DOTS strategy and correct the deficiencies of that strategy in the Center, North, and West areas of Côte d'Ivoire. The primary purposes of this proposal are to increase and decentralize available care in Abidjan, manage MDR-TB cases, and use the mass media for mass communication about tuberculosis. Specifically, four targets have been identified:

- **Pursue the extension of a high-quality DOTS and its upgrade**
- **Control HIV-TB co-infection and MDR-TB.**
- **Strengthen the public-private partnership.**
- **Strengthen communication through mass media and community involvement.**

The targets, service delivery areas, and activities are related as follows: The numbering of DPS and the activities that are related to it complies with that of the Stop TB planning grid. Two Principal Recipients have been identified to manage the project. Principal Recipient 1 (PR1), from the government sector, is the NTCP (Principal Recipient of Round 6). The PR2 from the non-governmental sector is CARITAS Côte d'Ivoire. It is an NGO involved in charitable works. It will be responsible for coordinating the activities of two sub-recipients who have also been identified: The first sub-recipient is the Network of Media and Arts Professionals Against AIDS and Other Pandemics, known as REPMASCI, which will be in charge of communications via the mass media. The second sub-recipient is the Côte d'Ivoire federation of organizations controlling TB and lung disease (COLTMR-CI), it is tasked with monitoring the activities of NGOs and private facilities.
The choice of a second PR is justified by the CCM's desire to extend activities into the private sector and strengthen communications through the media.
DPS are attributed to the different principal recipients who are responsible for implementing activities.

GOAL: Reduce the burden of tuberculosis in Côte d'Ivoire.		
Objective 1: Pursue the extension of a high-quality DOTS and its upgrade		
For this objective, all the elements of the DOTS strategy are used: extension of the TC network, procurement of first-line drugs and laboratory products, program evaluation and management, and strengthening of human resources. All activities are reinforcing what currently exists, without duplicating what was already financed by Round 6, but in taking over the end of Round 6.		
SDA	**Implementation entities**	**Target populations**
SDA 1.1. Improving diagnosis	PR: NTCP, CARITAS Côte d'Ivoire Operating entities: CECI,	Target 1: Total population Target 2: Private business personnel

	CNA-CI, PSP-CI	

- **1.1.1. Improve the cover and access to diagnosis**

Priority is given to Abidjan, but the network must also be extended in the rest of the country, outside the NWC area. In this Round 9, 40 TC will be created: 4 CATs (Yopougon, Divo, Odiénné, and Bondoukou), 9 TC in Abidjan, and 27 CDT in the interior of the country. The lagoon area (Abidjan) is an area of high tuberculosis endemicity. In that area, there is one TC per 300,000 inhabitants. To provide better DOTS coverage, this proposal aims to bring this threshold to one TC per 200,000 inhabitants – i.e. 10 new centers to be created. These 10 TC will be created per the following distribution: One in public facilities (CAT in Yopougon), 4 in community facilities, and 5 in the private business sector. The NTCP will be responsible for equipping these structures. The restoration of 8 FSUCOM in Abidjan was set out in Round 6. The 27 TC to be created will be located outside the North West Center (NWC) areas. They will be in addition to the five remaining of the 15 provided by Round 6 to be opened in those areas (Appendix VII). This will bring the non-Abidjan coverage threshold up to 1 TC per 150,000 inhabitants. An x-ray unit will be installed in any CAT that does not have one. The x-ray equipment should help to increase the number of suspected cases detected in health facilities. It is especially useful in cases of tuberculosis in children and for active screening in persons living with HIV (PLWHA).

- **1.1.2. Strengthen the equipment in existing labs**

The NCTP will be tasked with replacing the aging microscopes in CDT already operating, and acquiring spare parts for microscopes that are not working properly.

- **1.1.3 Support active screening for tuberculosis in 15,000 private-sector workers.**

There is a strong human concentration around industrial, farming, and mining concerns who are living in precarious health conditions. Considering this reality, and to improve detection rates, there will be an effort made with employees from the business sector. Systematic x-ray screening, provided by the Côte d'Ivoire National TB Committee (CNA-CI), in partnership with the Côte d'Ivoire Business Coalition (CECI), should handle 15,000 people at a rate of 3,000 per year. CARITAS Côte d'Ivoire is responsible for this activity. The costs of X-ray examination will be included in this proposal. It should result in the identification of 1,500 tuberculosis cases, i.e. 10% of the people involved in these screening sessions over the five years. This screening campaign will be provided by one physician and one lab technician, who will receive additional funding from the CNA-CI. This NGO has a great deal of experience with active screening in businesses. Because of this, the NTCP will provide 4,500 microscope stages and laboratory reagents (Fuchsine base, hydrochloric acid, ethanol, methalyne blue, Auramine, and potassium permanganate).

- **1.1.4. Update technical level of the CAT in Bouaké (North West Center Zone)**

For the purpose of providing clinical units with bacteriological support and decentralizing the culturing of samples. In the short term, this proposal provides for the restoration and outfitting of the Bouaké CAT laboratory with a view to diagnosing 300 patients eligible for retreatment as of Year 3. In the long term, based on the experience of Bouaké, the regional centers of Man, Gagnoa, and Abengourou will be standardized for this activity.

See detailed description of DPS activities in Annex VII
The DPS 1.1 budget is 2,762,667.46 euros

SDA	Implementation entities	Target populations
SDA 1.2. Patient support	PR: NTCP Operating entity: Private businesses	Target: All tuberculosis patients

To improve patient adherence to treatment, the NTCP will provide them with nutrients.

- **1.2.1 Provide nutritional supplement for 24,300 vulnerable patients as of Year 3**

Nutrient intake in the form of a monthly food kit (25 kg rice, 2 L oil, 5 kg meat, 3 kg sugar) will be given to vulnerable patients (prisoners, TB/HIV co-infected patients) by the program for the intensive treatment

phase (2 months). The NTCP will purchase these additional foodstuffs. A private business bound by contract to the NTCP will be tasked with storage and distribution to the different NTCP facilities.

See detailed description of DPS activities in Annex VII
The DPS1.3 budget is 1,442,907.08 euros

SDA	Implementation entities	Target populations
SDA 1.3. Procurement and management of supplies	PR: NTCP Operating entities: PSP-CI, LNSP	Target: Tuberculosis patients

The proper care of TB patients depends on the acquisition of high-quality anti-TB drugs. These drugs, acquired by the NTCP, require appropriate storage warehouses to prevent their deterioration. Optimal management of these drugs will be facilitated by implementing an IT system.

- **1.3.1. Procure first-line drugs for CDT for Years 3, 4, and 5.**

The accepted request of Round 6 ensures funding for first-line anti-TB drugs for 2010 and 2011. The following years' needs are requested in this Round 9: provide treatment for 29,062 patients in 2012, 30,515 in 2013, and 32,045 in 2014. These drugs will be acquired by the NCTP, which will determine, as usual, the products' characteristics and the quantities required. To guarantee product quality, the NCTP will continue to seek the skills of the Global Drug Facility (GDF). Purchased products are stored at the PSP-CI, which also distributes them. Additional quality control of said drugs is carried out by Côte d'Ivoire's National Public Health Library (LNSP) based in Abidjan. The entire process is retraced in a context of cooperation established in the form of a partnership agreement between the NCTP and the PSP-CI on the one hand, and the NCTP and the LNSP on the other.

- **1.3.2. Restore the drug stockroom in the 11 CATs and at the NCTP.**

The CATs act as regional supply depot for CDT, for which they are responsible, and their restoration will make it possible to store drugs and laboratory consumables in more suitable conditions than those currently found. The NCTP pharmacy will act as a warehouse for second-line anti-TB drugs distributed in pneumology units.

- **1.3.3. Costs of drug purchase and inventory management, medical products and equipment**
- **1.3.4 Acquire 16 IT kits (computers, power supplies, printers) for inventory management of the CAT pharmacy and the NTCP.**

Computerizing the drug stockrooms and laboratory input (i.e. 16 regional pharmacies and one central pharmacy), which will have been otherwise restored, will make better inventory management possible.

See detailed description of DPS activities in Annex VII.
The DPS1.3 budget is 6,249,089.12 euros

SDA	Implementation entities	Target populations
SDA 1.4. Monitoring and evaluation	PR: NTCP Operating entities: IPCI, GSA, Study Office	Target 1: General population Target 2: Tuberculosis patients

The NTCP has a good system of quarterly monitoring of screening, results, and treatment activities, as recommended, by the DOTS strategy. Efforts will be on evaluating this system, thoroughly assessing drug resistance, and performing surveys as part of operational research.

- **1.4.1. Organize an annual audit of data recording and reporting in 10 of the program's operational facilities per year. (HSS)**

NTCP will be responsible for organizing an annual audit of data quality (DQA). Its purpose will be to review the quality of data recorded in tuberculosis control by putting the data recorded on the various media side-by-side with the data reported to the NTCP. This activity is budgeted by the HSS component

(pm)

- **1.4.2. Perform a drug-monitoring survey with new cases in Year 3**

This will be a cross-sectional study over one year. Its purposes:

- Determine the prevalence of MDR-TB in subjects never treated.
- Describe the characteristics of patients with MDR-TB.
- Characterize the mechanisms of resistance to major habitual anti-TB drugs.

- **1.4.3. Operational research**

Studies in the context of operational research will be carried out by the NTCP's Scientific Support Group (GSA). This group, created by the same order as the NTCP, is tasked with providing its support to the NTCP in the area of health research. It includes 20 people acting in different areas (clinical, biology, sociology, pharmacology, and epidemiology). They will make overall monitoring possible of the project at all operational levels of the program in terms of achievement of objectives, performance calendar, and evaluating its impact on populations. These studies will be especially oriented toward looking for factors that explain the differences in reporting rates from one region to another and the differences in Lost to Follow-Up rates, in order to identify the bottlenecks which, when resolved, will improve program performance. At the start of each year, a call for research project proposals will be launched under GSA's responsibility. Completion of five operational studies is stipulated in this proposal.

See detailed description of DPS activities in Annex VII.
The DPS1.3 budget is 148,761.02 euros

SDA	Implementation entities	Target populations
SDA 1.5. Management and supervision of program	PR: NTCP	Target: Actors involved in the control effort

The purpose of the activities developed in this DPS are to consolidate the program's acquired knowledge by strengthening coordination at all levels of the control effort (revision of existing management tools, development of new tools, acquisition of vehicles). A portion of these activities are already financed by Round 6. This proposal will ensure that the activities are sustained until the end of Round 9.

- **1.5.1. Personnel meetings at central level**

The various meetings planned in the context of monitoring MDR-TB activity are organized and steered by the NTCP. The half-yearly meetings of the Scientific Support Group (GSA) and the annual workshop for distributing the NTCP's annual report will join those meetings already included in Round 6.

- **1.5.2. Intermediate-level staff meetings: Organize 8 annual meetings on the state of anti-TB activities starting in year 3.**

These meetings are preparation for the annual assessment meeting of the central level (one physician, one nurse, and one technician per TC), the continuation of their funding is requested for Years 3, 4, and 5 of this Round.

- **1.5.3. Production and distribution of policy and strategy documents.**

For the updating of policy and strategy documents, three working groups will be established, each with 10 people. The documents will be revised according to the new national and international strategic guidelines. They will then make it possible to prepare training manuals. The actors involved in anti-TB efforts will meet in six workshops to validate these documents.

- **1.5.4. Supervisions**

To achieve the objectives of this proposal, and to maintain a high level of quality in the program activities, supervisions and coordination meetings will be organized by the study officer in charge of program monitoring & evaluation. Some of these supervisions will be specific to the drug-resistant TB care activities and oriented toward pneumology units and the National Reference Center (NRC) on tuberculosis, which are identified structures for this care. The supervision scheduled for the entire network helps bridge the gap observed in the previous proposals. And so, this proposal will support two half-yearly supervisions, from the intermediate to the peripheral level, in addition to those also conducted in Round 6.

- **1.5.5. Transport**

Five all-terrain vehicles acquired in this proposal will be allocated to the five new CATs created to ensure supervision of CDT. The liaison vehicle will be allocated to coordination. Motorcycles are used by CDT for the supervision of treatment centers and the search for undocumented patients. To increase the program's storage capacities and accelerate distribution of non-medical goods (bicycles, motorcycles, food kits), an agreement will be signed between the NTCP and a private structure. Eight all-terrain vehicles will be acquired, and allocated as follows: two to CARITAS-CI national coordination, four to four provincial coordinations, one to REPMASCI, and one to COLTMR-CI. CARITAS-CI's vehicles will be monitoring activities carried out by the sub-recipients. The sub-recipients' vehicles will be used to follow up on the activities that are assigned them. The project will provide recipients with an insurance policy for the acquired vehicles.

- **1.5.6. Facilities, equipment and supplies at the national level**

Some of the NTCP's operating expenses, and securitization of the items acquired by the NTCP, will be covered by this proposal. As such, an insurance policy and a contract with a private security firm will be taken out by the NTCP.

See detailed description of DPS activities in Annex VII
The DPS 1.1 budget is 4,457,861.95 euros

SDA	Implementation entities	Target populations
SDA 1.6. Human Resource Development	PR: NTCP Operating entities: Consultants	Target 1: Public sector health staff Target 2: Private business health staff

Implementing this DPS will be a major asset for a quality DOTS by strengthening the capacities of human resources made available to the program. There will be training and recruitment activities for medical and paramedical staff practicing at every level of the program pyramid. Technical support is necessary for the development of certain tools, program evaluation, and the shared experience of the training.

- **1.6.1. National level personnel**

This action is on the spectrum of support provided by the previous rounds.

- **1.6.2. Peripheral level personnel**

FSUCOMs are financed from their own revenues and, by definition, since anti-TB activities are free of charge, they must be supported both in equipment and in health staffing (nurse and laboratory technician) to be able to offer this service without going bankrupt.

- **1.6.3. Technical assistance**

The regular monitoring of NRC activities (organization, diagnostic tools, data management) by a consultant from the supranational laboratory will help strengthen the NRC's capacities, with an expected impact on the quality of services provided. National and international consultants will be recruited to support working groups created for the revision and drafting of policy and strategy documents for the calls for tenders. A biosafety expert consultant will come each year to certify the laboratories. To provide good project management both at the NTCP and with sub-recipients, an annual audit, sponsored by the program, will be conducted by a firm.

- **1.6.4. Training of medical and medical ancillary personnel**

In the context of strengthening capacities, 32 staff members of the CATs and eight from the NTCP, 40 people in all, will be trained in using the software acquired with the PEPFAR's contribution to ensure better inventory management. In the context of strengthening the drug-monitoring system's capacities, 184 health workers will be trained in identifying and reporting adverse reactions. The 40 microscope technicians required for the smooth operation of the new CDT will be trained in the proper use of microscopes to improve screening quality. The medical and nursing staff of the 40 TC, 22 lab technicians of the CATs, and the staff of the three pneumology units will also have their capacities strengthened. The three laboratory technicians of the Bouaké CAT laboratory will be given training in culturing. This will last

one month. This proposal provides for funding for training of the drug-monitoring staff as well as the newly-created CDT' microscopists. This proposal provides for strengthening the capacities of the 20 least effective laboratory technicians. In addition, this proposal provides for strengthening the capacities of service providers involved in the use of MDR-TB management tools. Pharmacists in service at the NTCP and in the CATs will be trained in using the inventory-management software. This will be led by the software supplier.

- **1.6.5 Managing international trainings**

On the basis of four participants per year for the International Union Against Tuberculosis and Lung Diseases (IUATLD) World Conference on TB, five for the African Zone Conference, two for the French-Speaking Pulmonologists Congress and two for the International Control Course in Cotonou, management is ensured by this proposal. For the Pulmonologists' Congress, both managements will involve only those applicants who have a poster or verbal message accepted by the scientific committee.

See detailed description of DPS activities in Annex VII

The DPS 1.1 budget is 2,451,906.32 euros

Objective 2: Control TB-HIV co-infection and MDR-TB		
SDA	**Implementation entities**	**Target populations**
SDA 2.1. TB – HIV: Cooperation in the area of TB-HIV co-infection	PR: NTCP Operating entity: PSP-CI, PNPEC, AIMAS, PARTNERS, PEPFAR	Target: all TB patients

Cooperation in the area of TB/HIV-specific partnerships has been strengthened over the last few years. Thus focal points have been identified at the NTCP and the National Care Program for PLWHA (PNPEC). A framework for collaboration has been defined – it includes both programs, the PSP-CI, the DIPE, and the partners active in the control effort. This framework defines the frequency of meetings in regard to the coordination committee (Monthly) and the enlarged committee (quarterly). In 2008, 96 tuberculosis diagnostic and treatment centers (CDT) out of the 107 operational incorporated this collaboration in routine activities. This has made it possible to quantify the co-infection rate at 29%. Counseling & screening, prescription of cotrimoxazole, and prescription of ARVs are conducted in these centers. Active tuberculosis screening is provided in HIV treatment services, based on a pulmonary X-ray before treatment with ARVs. Likewise, it is recommended to all actors tasked with monitoring PLWHA that they systematically look for tuberculosis after any morbid episode. To do this, a form mentioning the signs of tuberculosis was adopted and integrated into the client file. CDT without laboratories for integrated TB/HIV treatment will be created in the major HIV treatment centers and a reference vs. reference book will be used as a link for small units to guide suspected tuberculosis cases in the tuberculosis treatment units. As such, HIV screening tests and laboratory consumables are provided by the PNPEC and partners of the PEPFAR operating on those sites. The aforementioned activities are instrumental in preventing HIV transmission, especially in tuberculosis patients, and prophylaxis of opportunistic infections by acquisition of condoms and cotrimoxazole. The condoms provided by the Ivorian Social Marketing Agency will be distributed free of charge to screened patients in CDT as well as the cotrimoxazole provided by the PNPEC. These integrated TB/HIV activities are financed by Round 6, the PEPFAR, and the Government of Côte d'Ivoire. There are no specific needs for this Round 9. ARV are supplied and distributed free of charge by the PNPEC, and anti-TB drugs are provided to treatment centers for free by the NTCP.

The DPS 2.1 budget is 0 euro

SDA	**Implementation entities**	**Target populations**
SDA 2.2. Tuberculosis – MR	PR: NTCP Operating entity: PSP-CI (Public Health Pharmacy of Côte d'Ivoire)	Target: MDR-TB patients

In 2007, the rate of MDR tuberculosis in new cases was 2.5% and 8.6% in retreatment cases (WHO 2007). This proposal will include 230 MDR-TB patients over five years, recruited from among all suspected cases.

- **2.2.1. Strengthening diagnostic capacities for MDR-TB**

The CDC-PEPFAR finances restoration of the tuberculosis laboratories of the CeDReS (AIDS Study, Diagnostic and Research Center), the NRC, and the CAT of Adjamé in non-specific equipment (centrifuges, distillers, freezer, incubators, scales, etc.), until 2014. In addition, Côte d'Ivoire has been eligible for the UNITAID project, which will provide installation of specific equipment for the culture, antibiogram in liquid medium (MGIT 960), molecular diagnosis (Line Probe Assay), and maintenance of the installed material for three years, as well as the costs of annual laboratory certification. For the period from 2010 to 2014, a total of 19,014 patients will receive culturing and sensitivity testing. Of them, 9,010 patients with smear-negative tuberculosis (TPM-) will receive a culture of their sputum as part of this diagnostic improvement. The other 10,004 patients who are retreatment cases will receive a culture of their sputum and sensitivity testing. The support of the UNITAID project covers, on the one hand, diagnostic improvement for the 9,010 TPM- patients and, on the other hand, on the sensitivity testing in liquid medium for 2,396 patients (recurrence, recovery, failure) for all three years of the UNITAID project. Molecular sensitivity tests (1,007 tests) provided in the context of said project are allocated to patients in retreatment. Of the 10,004 patients eligible for the retreatment regimen, the culture of 7,834 will be included in this Round 9 proposal, the other 2,170 being included in R6. For these retreatment-eligible patients, the sensitivity testing of 5,438 of them is supported by this proposal, given the fact that testing of 2,170 and 2,396 patients is supported by the R6 and the UNITAID project, respectively. R9 plans to acquire molecular sensitivity tests for 1000 patients (Annex VII).
This proposal will include 230 MDR-TB patients over five years, recruited from among all the suspected cases addressed in the laboratories by the CATs capable of identifying those cases.

- **2.2.2. Ensure Outside Evaluation of NRC Quality.**

Twice a year for five years, the NRC will send sensitive and resistant strains to the supranational laboratory for an outside evaluation of the quality of sensitivity testing, necessary for guaranteeing reliable results of the measures carried out in the laboratory.

- **2.2.3. Ensure second-line drug procurement for 230 patients over five years**

Like first-line drugs, the second-line anti-TB drugs will also be acquired by the NTCP for the treatment of 230 patients over five years (10 the first year in view of the restoration work on the drop-in sites, then 40 in Year 2, 50 in Year 3, 60 in Year 4, and 70 in Year 5). These drugs will be stored at the NTCP and distributed in the care facilities.

- **2.2.4. Provide treatment of MDR-TB cases.**

In phase one, per the directives laid out by the NTCP, hospitalization is automatic to reduce contamination, manage side effects of the drugs, and guarantee DOTS-plus. The costs for additional examinations required by the directives, as well as the surgery and the attendant assessment for patients eligible for thoracic surgery, are included in this proposal. During this phase, bacteriological examinations (smears, cultures, sensitivity testing) will be monthly. The chronology of the other exams of the budget is variable and specified in the directives. In the continuation phase, bacteriological examinations will be performed every two months. After the treatment ends, these exams will be performed at months 18 and 24.

- **2.2.5. Procuring multi-resistant TB case management tool services (register, guides, patient cards and files)** (PM, under activity1.5.3.9).

MDR-TB case management is a specific activity for the pneumology units and laboratories. For the traceability of these activities, new management tools have been developed – they now need to be reproduced and put in place.

- **2.2.6. Provide 4,140 nutritional kits for 230 patients over five years.**

In support of anti-TB treatment, nutritional support will be given them when they leave the hospital. Each month, every patient will receive one food kit including a bag of 25 Kg of rice, 2 L of oil, 2 Kg of sugar, and 5 Kg of meat. The assistance given to patients will be the responsibility of the NTCP, which will delegate

a portion of its responsibilities to the pneumology units' social workers.

- **2.2.7 Help transport 230 multi-resistant TB patients over five years (nine meetings and two reviews after the end of treatment for each patient).**

For the purpose of guaranteeing the regularity of reviews that are indispensable to quality care of multi-resistant TB patients, they will be reimbursed transport costs for getting to the treatment centers.

- **2.2.8 Help to transport four social workers for home visits to 230 patients over five years.**

To ensure DOTS quality, visits will be organized by the social workers of pneumology services at the patients' homes. For each patient, one visit per week is planned for the 20 months of out-patient treatment, i.e. 80 visits made by the social worker. Costs incurred by this travel will be supported by this proposal.

- **2.2.9. Provide support to the Green Light Committee initiative.**

Support for the Green Light Committee initiative is justified to ensure regular monitoring of the implementation of this proposal.

See detailed description of DPS activities in Annex VII.
The DPS 1.1 budget is 8,297,458.56 euros

SDA	Implementation entities	Target populations
DPS 2.3.1 High-Risk Groups: Prisoners	PR: NTCP Operating entities: CAT, CDT, ESTHER	Target 1: Prisoners Target 2: Nurses

- **2.3.1.1. Extend active tuberculosis screening into 20 prisons**

In Round 6, the program initiated active tuberculosis activities in prisons, involving samples from prisoners suspected of having tuberculosis, to the district's associated CDT. This made it possible to identify 129 cases of pulmonary tuberculosis in 2008. This activity involving 10 prisons will be extended to 20 additional prisons under this proposal. To do so, the NTCP will acquire 40 coolers and 80 accumulators for 20 prisons. TC nurses and peer educators will be trained in methods of collecting sputum samples and transporting them in appropriate conditions to tuberculosis diagnostic centers. Fuel support will be given to nurses for transporting the prisoners' sputum samples. This activity also extends to prison guards and prison nursing staff.

See detailed description of DPS activities in Annex VII.
The budget for DPS 2.3.1 is 33,796.15 euros

SDA	Implementation entities	Target populations
DPS 2.3.2 Combating infection	PR: NTCP Operating entity: PSP-CI (Public Health Pharmacy of Côte d'Ivoire)	Target 1: MDR-TB patients Target 2: Staff Target3: Coaching MDR-TB patients

To limit transmission of tuberculosis in a professional setting, the NTCP plans to take measures for individual and collective protection. Technical documents about prevention of nosocomial transmission will be developed from agreements between the NTCP, general health directorate and Pneumology services of the CHUs. They will be provided to staff who will be trained and retrained in their proper use. Health care staff and service staff will be reminded of existing administrative measures. To this end, patients with MDR-TB will be hospitalized in suitable premises.

- **2.3.2.1 Combat nosocomial transmission of tuberculosis**

See detailed description of DPS activities in Annex VII.
The budget for DPS 2.3.2 is 407,236.74 euros

Objective 3: Strengthen the public-private partnership		
SDA	**Implementation entities**	**Target populations**
SDA 3.1. All caregivers	PR: NTCP, CARITAS Côte d'Ivoire Operating entities: CECI	Target: Private-sector actors

The public-private partnership, third component in the Stop TB strategy, has begun with the opening of CDT in private facilities. To date, five centers, including two in agrifood businesses and three in confessional centers, are open. The purpose of this DPS is to further integrate private sector staff operating in side rooms, processing industries, and large plantations.

- **3.1.1. Organize a semi-annual meeting between the private sector and the NTCP.**

Like the three quarterly meetings held in the NWC area and financed by Round 6, under the NTCP's responsibility, and in liaison with the collective of private-sector agents, meetings of actors from private and public sectors will be organized. These meetings will make it possible to create and maintain a framework for concerted action that is conducive to implementing combat activities in the private sector. They will be held at the county seat of the CATs, i.e. 13 meetings per six-month period, which will include private-sector and public-sector actors with staff of 20 people per meeting. At the end of Round 6 in 2012, Round 9 will support the other meetings previously set up in the NWC area

- **3.1.2. Training 500 workers from the private sector in identifying suspected tuberculosis cases and guiding them to the CDT for the first two years (300 people in Year 1 and 200 in Year 2).**

Five hundred pharmacy and private business personnel will be trained in awareness-raising and in counseling subjects presenting with respiratory symptoms who will then be guided toward care facilities. The costs for this activity are paid by the private sector.

See detailed description of DPS activities in Annex VII.
The DPS 1.1 budget is 139,666.17 euros

Objective 4: Strengthen communication through mass media and community involvement		
SDA	**Implementation entities**	**Target populations**
SDA1 4.1. Awareness-raising, communication and social mobilization	PR: NTCP, CARITAS Côte d'Ivoire Sub-recipient 1: REPMASCI Operating entity: Private practice	Target 1: Entire population Target 2: Illiterate population Target 3: Literate population Target 4: Barracks, schools

Mass communications will round out the awareness and social mobilization activities supported by Round 6. These activities will help these populations adhere more closely to the program's directives. To achieve this, a sub-recipient with significant mass communications experience has been identified.

- **4.1.1. Develop mass communications and broadcast messages**

Mass media (radio, television) are the most appropriate means of conveying information on tuberculosis to the entire population.

A private practice will be in charge of organizing the communications campaign. The objective is to use the media to spread messages destigmatizing the disease, emphasizing that there is a cure and that treatment is free of charge. These messages will also address tuberculosis prevention, screening, and treatment, TB/HIV co-infection, and MDR-TB. Proposals from media organizations will be subject to selection. Selected organizations will contract with the Sub-Recipient. Eight radio broadcasts are planned in local languages and in French, and four TV spots per month for five years. Once every quarter, short message services (SMS) on tuberculosis awareness will be broadcast via mobile phone carriers in operation. Under NTCP's responsibility, the system of communications from mobile phones between actors against tuberculosis, begun in Round 6, will be maintained and extended to 45 new structures.

- **4.1.2. Organizing awareness-raising**

Organization of World Tuberculosis Day in the 19 health regions will be covered in this proposal, unlike previous proposals, which called only for a demonstration at the national level. These days organized by the NTCP are a forum for promoting awareness throughout the population and fighting the stigma. With R6 funding, the NTCP has just acquired important awareness-raising equipment: 2 megaphones, 4 large-format baffles, 1 deck, 1 DVD player, 1 roving mike, and 1 large-format TV. For this request, the equipment will also include a large screen for projections and a podium truck for transporting the awareness-raising equipment and the leadership team beginning in Year 1. During the awareness-raising sessions under CARITAS-CI's responsibility, media (CDs, T-shirts, posters, brochures) designed in R6 and reproduced with this proposal will be distributed free of charge. Awareness-raising activities begun in R6 will be the responsibility of CARITAS-CI as of Year 3 of this proposal. In the cultural context of our country, traditional practitioners are the first recourse for patients. Their involvement against tuberculosis seems necessary. Training sessions in tuberculosis are provided for them, and case referrals to health-care centers.

- **4.1.3. KAP survey (Knowledge, Attitudes, Practice**

CARITAS Côte d'Ivoire will be responsible for a KAP survey to be conducted at the start of the project for the purpose of assessing knowledge, attitudes, practices, and difficulties of the populations in regard to tuberculosis. The results of this survey will be used to develop messages suited to the populations.

- **4.1. 4. Provide general management of awareness-raising, communications, and social mobilization activities**

Monitoring & evaluation of awareness-raising, communications, and social mobilization activities will be provided by CARITAS Côte d'Ivoire as per the activity schedule.

See detailed description of DPS activities in Annex VII.
The DPS 1.1 budget is 2,135,701.53 euros

SDA	Implementation entities	Target populations
SDA1 4.2. Community TB care	PR: NTCP, CARITAS Côte d'Ivoire Sub-recipient 2: COLTMR-CI	Target 1: NGOs Target 2: CHW

The purpose of this DPS is to strengthen the action of NGOs and ASCs involved in community support for tuberculosis patients. The 34 NGOs funded from Round 6 will receive this proposal's financial support under Caritas' responsibility as of Year 3.

For a more effective community against tuberculosis and TB/HIV, and with the aim of better coordinating, monitoring, and evaluating community activities, these NGOs came together in 2007 to form the Collective of Organizations Against TB and Respiratory Disease in Côte d'Ivoire (COLTMR-CI). This collective will be a stakeholder in the implementation of awareness-raising activities, and will participate in supervising micro projects, alongside CARITAS Côte d'Ivoire. The COLTMR-CI requests support in terms of structuring, logistics, and organization, beginning in Year 3. An annual meeting is planned among NGO members in charge of tuberculosis to exchange experiences. Since ASC activities are closely tied to health-care services, this entity will be placed under the NTCP's responsibility.

- **4.2.1. Provide assistance to the structure and organization of the COLTMR-CI:** Development support for the 5-year strategic intervention plan (national consultant and validation workshop)
- **4.2.2. Pursue logistics support (office consumables) at the Collective of Organizations Against TB and Respiratory Disease in Côte d'Ivoire (COLTMR-CI) starting in Year 3.**
- **4.2.3. Organize an annual meeting to share experiences between the members of the collective of NGOs against tuberculosis.**
- **4.2.4. Continue the funding of 34 NGOs in Years 3, 4, and 5.**

Beginning in Year 3, funding for the 34 NGOs identified from Round 6 will be provided by this request.

- **4.2.5. Organize a training workshop for tracking the evaluation of staff responsible for the micro-projects**

- **4.2.6. Organize half-yearly supervision of micro-projects**

The support provided to 12 NGOs via 19 micro-projects will be strengthened by M&E training and by half-yearly supervisions of the micro-projects, performed by the NTCP.

- **4.2.7. Strengthen ASC activities outside the NWC zone**

Community support by NGOs that began in the NWC zone as of R6 will move into the south zone in 86 CDT via this proposal, under the NTCP's responsibility. Training of 2580 ASCs and acquisition of 2580 bicycles (i.e. 30 bicycles per TC outside the NWC zone) will be supported by Round 9.

- **4.2.8. Organize a quarterly meeting between the CATs/CDT and ASCs** (248 in Year 1, 272 in Year 2, 476 in Year 3, 500 in Year 4, and 524 in Year 5)

For better coaching of ASCs, especially for collecting data on the activities conducted by the ASCs, one quarterly meeting per TC, including the TC Manager, Health District, and the 30 ASCs of its coverage area. Funding for these meetings will be extend to all 45 CDT in the NWC zones previously covered by R6 beginning in Year 3 of this project.

See detailed description of DPS activities in Annex VII.

The DPS 1.1 budget is 2,922,462.83 euros

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).

The three primary weaknesses identified by the Technical Review Panel (TRP) upon submission of Round 8 were:

1.Role of the second Principal Recipient is unclear an it is never listed in the work plan as being responsible for an activity ; the addition of this Principal Recipient may be an unnecessary complication

2. The communications component is ambitious, and the capacity for message design/testing and channel selection is not described. In addition, Round 6 grant included a BCC component (with minimal focus on mass media)

3. The start date for the round 6 tuberculosis grant was April 1, 2008, so there was no experience in implementation to feed into the development of the proposal for Round 8

The TRP's comments and recommendations regarding the role of a second PR have been taken into account in developing this proposal. In view of the important role that civil society must play to control tuberculosis in general and the reduction of MDR-TB cases in particular, a PR has been put in charge of community activities. This proposal includes four objectives. DPS for activities in the community area will be the responsibility of that PR (CARITAS Côte d'Ivoire). The same is true for the DPS of the Public-Private partnership and mass media communications.

In regard to the second weakness, it was in fact stipulated in Round 6 to carry out advocacy/ public awareness activities in the neighborhoods, with religious groups, and with women's groups. Very few communications activities through the media have been developed, and Round 9 was reformulated keeping account of the TRP's remarks.

The NTCP has just finished the first year of Round 6 and has therefore acquired a certain experience in implementing this project. This experience was particularly remarkable in terms of Purchasing and Inventory Management (GAS), financial management, program management, and monitoring of community actors.

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)?

In the Round 3 proposal "Strengthening the anti-TB effort using the DOTS strategy," the purpose of the proposal was to develop and extend the DOTS strategy throughout the country.

This project, ongoing since 2004, has gradually made it possible to strengthen tuberculosis care facilities, incorporate all elements of the DOT, and provide total coverage of the territory in 2006. Support of this fund has helped improve screening of TPM+ cases, which went from 11,388 in 2003 to 15,294 in 2008. Treatment success rates went from 72% in 2003 to 75% in 2007. With a view to decentralization, the number of CDT at the national level went from 57 CDT in 2003 to 107 CDT in 2008.

IN 2006, the NTCP submitted another proposal in Round 6 entitled "Intensifying Tuberculosis Control in Côte d'Ivoire using the DOTS strategy and the Stop TB Partnership in the post-crisis period." This project favors restarting activities in the North, West, Center zones, where DOTS activities had been considerably disrupted. Its purpose is to correct deficiencies in DOTS services in the NWC zones, low community involvement, inadequate material resources for effective supervision, and low involvement from the private sector.

These interventions have made it possible to acquire experience in creating new CDT and incorporating them into the regional CAT network. This will serve for the decentralization in Abidjan and the extension of CDT in the interior.

The previous rounds did much to improve internal communications at the NTCP, with the various meetings and supervisions of CAT/TC meetings. Since these activities have proven useful, they will be continued and strengthened in Round 9.

Round 6, but also PEPFAR, through EGPAF, supported the joint TB/HIV program. Services are increasingly available and there is no need for particular support for these activities with Round 9.

Regular procurement in first-line drugs showed itself to be much more difficult than planned in Round 3. That is why their purchases were funded by GDF on the one hand, then covered in Round 6. Round 9 will prolong this activity for the last three years.

Some activities were initiated with Round 6 to detect cases of MDR-TB. Although the establishment of a functional laboratory for these diagnostics has taken longer than planned, nothing has so far been programmed for the treatment of diagnosed cases; Round 9 addresses this concern.

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).*

Gender equality allows women and men to equally enjoy human rights, property valued by society, and resource and advantages tied to development. Côte d'Ivoire, having measured the importance of the gender dimension in the development process, took the necessary measures to integrate the gender approach in all its development projects and programs. To this end, the government has established a Central Office within the Ministry for Family, Women and Social Affairs, tasked with gender issues, which has undertaken the installation and training of gender focal points in all Ministries.

In regard to tuberculosis, access to the various health centers is free and open to men and women, rich and poor alike. However, tuberculosis most often hits low-income populations. Tuberculosis hits women at an earlier age (30) than men (40). In most countries, tuberculosis targets men aged 20-40, except in cases of TB/HIV co-infection where we see greater morbidity in young women. A study conducted in Côte d'Ivoire in 2004 (Medical Thesis 3762) entitled "The influence of gender on the evolution of baciliferous pulmonary tuberculosis" has shown that:

- the rate of cure was significantly higher in women
- there were significantly more men lost to follow-up
- Sex ratio was three men to one woman in patients with MDR-TB.

Furthermore, TB care activities in prison environments conducted under R6 will be strengthened by R9.

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.

In the country's health system, question 4.3.2 has identified significant weaknesses that have an impact on tuberculosis care. These are health staff, service delivery, medical products, and purchasing and inventory management, the National Health Information System (SNIS). This proposal has identified activities to remedy these weaknesses:

Health personnel: This proposal will recruit eight paramedical (4 technicians and 4 nurses) for the care of tuberculosis in Abidjan's health facilities, where integrating this activity is meeting with difficulties (Objective 1; DPS 1.6 Activity 1.6.2.1).

Service delivery: Strengthening geographic access to a quality diagnosis is one of the major themes retained (Objective 1; DPS 1.1 Activity 1.1.1): Increasing the number of CATs and CDT, restoring and upgrading technical equipment in existing structures, provisioning in equipment and reagents for cultures, and performing sensitivity testing.

Medical products and purchase & inventory management: The deficiency of the government's budget allocation for regular procurement of drugs and the end of GDF's support will be supported by this proposal. The supply of software by the PSP-CI for inventory management of the CAT pharmacy and 12 IT kits (computers, power supplies, printers) for inventory management of the CAT pharmacy and the NTCP (Objective 1, DPS: 1.3 ; activities 1.3.4), coupled with the corresponding user training, is likely to remedy the identified weaknesses (Objective 1, DPS : 1.6 ; Activities 1.6.4).

National Health Information System: Its deficiencies will be partially corrected by the establishment of the NTCP's data-management software. In addition to the national circuit, the NTCP's M&E system makes data transmission possible from peripheral to regional and from regional to central, every quarter. Therefore, the deficiency in data transmission at the national level will not affect the NTCP. Training of private sector staff, paired with half-yearly meetings organized between the NTCP and this sector, as well as the opening of CDT in health facilities, will help to improve the completeness and quality of the data collected. The availability of the pneumology services of the CeDReS and the NRC, in MDR-TB case management tools (register, guides, patient records), will make it possible to include these major facilities in the routine collection of data on tuberculosis.

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.

Côte d'Ivoire has received two grants from the tuberculosis component of the Global Fund. These are

Round 3 and Round 6. In regard to Round 3, no time was lost in implementing the grants: at the end of that round, the budget's absorption rate was higher than 90%. Conversely, Round 6 was late to implementation. This delay was due to the NTCP's satisfying the Global Fund's recommendations in order to assume its role as principal beneficiary. It was mainly a question of recruiting financial staff, setting up accounting software, drafting the various plans (procurement plan, M&E plan, action plan), and drafting a procedures manual. And so the project, which was slated for July 2007 did not begin until April 2008.

The activities supported by the various previous proposals, and included in this proposal, concern the following interventions:

- Extension of DOTS services: R3 made it possible to bring the number of operational CDT from 52 in 2004 to 96 in 2007. This number will go to 112 with R6 funding and to 159 at the end of R9.
- Training: 1,500 health staff, 410 NGO members, and 164 laboratory technicians were trained because of R3 – i.e. 2,074 people in all. At the end of R6, 1,474 people will have been trained: 82 health staff, 11 laboratory technicians, 541 NGO members, and 840 ASC. R9 provides for the training of 3,493 people, i.e. 359 health workers, 38 laboratory technicians, 16 pharmacists, 500 private-sector workers, and 2,580 ASC.
- Automotive equipment: R3 provided for the acquisition of 10 4x4 vehicles, 76 motorcycles, and one car. R6 provided for five 4x4s, 25 motorcycles, and 840 bicycles. R9 calls for the acquisition of five 4x4s, one rover, 40 motorcycles, and 2,580 bicycles.
- Maintenance of the equipment acquired over the two previous projects will be continued with the support of R9.
- Acquisition of reagents and consumables for culturing and sensitivity testing was provided for only in R6. It is called for in R9.
- Procure first-line anti-TB drugs. The acquisition of a safety stock of first-line anti-TB drugs was included at the beginning of R3, in anticipation of submission to the GDF. R6 provides for one year's procurement in 2011, and R9 plans to continue procurement until 2014.
- Supervision of anti-TB services: The peripheral level will be supervised quarterly with R9's funding. R3 provided annual supervision of the central level; this became quarterly supervision in R6.
- Financial support of the five workers recruited in R3 and R6 will be continued in this proposal.
- Community involvement in patient monitoring was effected using funding from 19 micro-projects in R3, and 34 in R6. R9 will maintain that funding until 2015.
- Producing awareness-raising media. R3 made it possible to prepare 6,000 posters and 10,000 brochures. R6 provides for the creation of 10,000 brochures on nutrition and 600 audiovisual media. R9 provides for the creation of 6,000 posters and 30,000 brochures over the last three years of the project.
- Fuel management, vehicle and equipment maintenance, and management tool reproduction were factored into both projects. These activities will also be included in this proposal.

While important, these interventions have not sufficiently integrated anti-MDR-TB efforts. The specific aim of this proposal is to do so by strengthening the activities of previous proposals.

4.6.2. Links to non-Global Fund sourced support

Describe <u>any</u> 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.

1. Nationally, the funding allocated to control tuberculosis comes from two main sources:

(i)Funding 1: Government Budget

Côte d'Ivoire's government has been funding the anti-TB effort since 1960. Funding for the 2009-2013 period averages 1,105,000 euros/year. This amount includes the line of 700,000 euros reserved for buying drugs. The rest is essentially for operating expenses (water, electricity, and telephone). The government also pays the workers' wages and associated expenses.

(ii) Funding 2: CNA-CI (Côte d'Ivoire National TB Committee)

The CNA-CI participates in funding the anti-TB effort. The amount provided is 25,684 euros in 2008, and will be continued in the same amount or more until 2013. This funding goes toward paying the wage costs of support staff assigned to certain CDT, support for the Program for the organization of the WTD, and the NTCP's staff training costs.

2. Internationally, funding comes from the following sources:

(i) The WHO contributes to training anti-TB actors and provides management of international consultants. It further provides financial support to the NTCP, based on the following amounts: contribution was 28,767 euros for the 2006-2007 period. This amount is 53,000 euros for the 2008-2009 period.

(ii) Global Drug Facility (GDF) provided for anti-TB drug procurement worth 113,723.21 euros in 2004. Moreover, the GDF is committed to supplying a portion of the first-line anti-TB drugs from 2007 to 2009.

(iii)PEPFAR's COP/2007 and 2008 projects came to the support of the NTCP, with 500,000 USD in 2008 and 2009. This financial support is meant for the establishment of a system to collect and transport sputum specimens to improve bacteriological diagnosis (culturing) of tuberculosis. This support should be maintained in 2009 via the COP/2009.

(iv) The UATLD provides technical support and contributes to the training of medical staff.

(v) Green Light Committee (GLC) will provide technical support to the NTCP throughout R9.

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.)*

The initial mission assigned to the private sector in the anti-TB effort is identification of suspected cases, and guiding them toward care facilities. However, two businesses, SOGB and BorotouKoro, have included a TC in their health center. These CDT handle staff members, workers' families, and coastal populations. In this proposal, the value of the private sector's contribution is estimated at 874,697 €.

(i)The business sector will be associated with the implementation of activities at three levels:

- Strengthening the anti-TB effort by opening five CDT in private businesses. The selection criteria for these centers are contingent on the existence of a laboratory, attendance rate, staff availability, and managers' desire to incorporate anti-TB services. In these facilities, premises and staff are funded by the private facilities. The NTCP will help to train staff for the application of the DOTS.
- Active screening of tuberculosis associated with awareness-raising sessions within businesses in partnership with the NTCP. Costs of active screening (pulmonary X-ray, bacteriological exams) and the cost of the anti-TB drugs will be supported by this proposal. In return, the businesses will cover the wages of the medical staff assigned to these activities.
- Training of anti-TB focal points: 300 peer educators from businesses will be trained in identifying suspected cases, guiding them toward care facilities, and monitoring screened patients in the businesses. The costs of organizing the training workshops will be co-funded by this proposal and the private sector. These peer educators will continue this activity after the end of the project.

(ii)In regard to private-sector liberal medical practice, in liaison with the Orders and professional associations, the inauguration of a framework for concerted action by the NTCP should facilitate awareness of the issue, resulting in more active involvement of practitioners in the anti-TB effort.

(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)?)* ➔	• Business staff members and their families. • Surrounding community

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**
CNPS Yopougon (National Fund for Social Welfare) Abidjan	Staff wage costs* Restorations	11,311	7,683	7,683	7,683	7,683	42,043
SCB Attinguié (Lagoons)	Staff wage costs* Restorations	11,311	7,683	7,683	7,683	7,683	42,043
FILTISAC	Staff wage costs*, Restorations	11,311	7,683	7,683	7,683	7,683	42,043
CIE	Staff wage costs*, Restorations	11,311	7,683	7,683	7,683	7,683	42,043
SOTRA Abidjan	Staff wage costs*,	11,311	7,683	7,683	7,683	7,683	42,043

	Restorations						
CNPS, SCB, FILTISAC, CIE, SOTRA	The cost per kilometer of five vehicles of the five businesses	1,183	1,183	1,183	1,183	1,183	5,915
CECI (Umbrella health programs in businesses)	Staff wage costs** for screening and awareness-raising in 100 businesses	47,564	47,564	47,564	47,564	47,564	237,820
CECI (Umbrella health programs in businesses)	Awareness-raising activities of 300 trained peer educators	43,905	43,905	43,905	43,905	43,905	219,525
CECI (Umbrella health programs in businesses)	50% contribution to operations for project coordination	54,882	36,585	36,585	36,585	36,585	201,222
TOTAL		**204,089**	**167,652**	**167,652**	**167,652**	**167,652**	**874,697**

Staff wage costs* = (1 physician, 1 nurse, 1 lab technician, 1 social assistant, 1 support staff member)

Staff wage costs** = (1 physician, 1 nurse, 1 support staff member)

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*.

Analysis of the health system has revealed weaknesses and gaps both in patient management and in the health system itself. The objectives assigned to this proposal have helped to identify interventions in different service delivery areas that are meant to fill the identified gaps. These involve health services, health professionals, medical products, the information system, management, and governance, as well as operational research. Some of these activities have an impact that goes beyond the specific framework of the anti-TB effort. Thus, the upgrade of laboratories (NRC, CeDReS, Bouaké), the strengthening of ASC capacities, and the more active involvement of social assistants in medical procedures will have a definite impact on the management of other endemics (HIV, malaria, Buruli ulcer, etc.). Private-sector involvement will also aid in this process.

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.

In Côte d'Ivoire, tuberculosis, along with malaria and HIV, is one of the primary causes of morbidity and mortality. This proposal fits into broader development frameworks as follows:

Millennium Development Goals (MDG)

In the context of achieving the MDGs adopted further to the Millennium Statement of 2000, the Ivorian government has selected the effort against HIV, tuberculosis, and malaria among the health component's goals. This proposal, which bears on improving access to quality diagnostics and incorporates the management of MDR-TB, will contribute to overall efforts to achieve the MDGs.

Global Partnership to Stop TB

This request is perfectly appropriate with the Global Partnership to Stop TB by:

- developing a broader partnership around the program: Belgian Development Cooperation, WHO, GDF, PAM, HCR, IUATLD, CICR, MSF, PEPFAR, French Development Cooperation;
- extending the DOTS strategy with the involvement of communities, opinion leaders, and NGO/Associations of persons with tuberculosis and HIV;
- taking multi-drug-resistant TB into account;
- involving all health-care providers with the public-private partnership.

Heavily Indebted Poor Countries (HIPC) programs

In the development of the Strategic Poverty Reduction Document (SPRD), the anti-TB effort was accounted for in the disease-fighting component.

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 strength of the national monitoring & evaluation system resides in its intervention at many levels:

- The peripheral level (CDT) where the primary activity is data collection; The monitoring & evaluation activities are provided semiannually by a multidisciplinary team directed by the CAT's chief physician.
- The intermediate level (Health District): The data collected are compiled at this level. Regional data quality is first controlled with the semi-annual supervisions by the NTCP's coordination. An annual review meeting of the CAT/CDT (second quality-control level) precedes the national meeting.
- The central, or coordination, level collects all national data. Validation is performed at an annual review meeting which is attended by the NTCP, the CAT's chief physicians, pneumology services, the NRC, and partners in development (third quality control level). Data analysis is supported by an annual consultant visit expedited by the UATLD.

In the anti-TB effort, the weaknesses identified at the Global Fund workshop on strengthening monitoring & evaluation in August 2007, some of which are still being resolved using funding from Global Fund Round 6 and PEPFAR, are as follows:

- Reports are not complete or prompt.
- Inadequate electronic data management system.
- Difficulties in keeping to the timetable for inspection of peripheral units since the necessary resources are not available in good time.
- Limited measurement of impact on the success rate.
- No prevalence survey.
- Unusable RAI (Annual Infection Risk).

These are the NTCP's strengths:

- Regional and central M&E units are operational.
- The information system is standardized.
- Concerted action among all players at the various levels has been developed.
- Staff numbers are being increased at central and intermediate levels.
- Building staff capacities at every level

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 M&E Plan for this proposal's activities is part of the NTCP Plan. Information for generating all the proposal's results and indicators will be sourced by means of the national information system already in place.

The screening and treatment center (CDT) is the first level for gathering data on TB-related morbidity and mortality. The management aids used by the Program at this level are: the TB declaration register, the laboratory register, the treatment forms and drug order forms, the quarterly screening reports and the treatment outcomes. These data-gathering media comply with WHO and IUATLD recommendations, and will be amended to include data on cases of MDR-TB. The data are forwarded quarterly to the CSEs (Epidemiological Surveillance Centers) of the Health District Directorates (HDD) which forward them in turn to the Regional Health Directorates (RHD) and to the regional CATs. The regional CATs compile and analyze the data, and forward them to the NTCP Co-ordination Directorate. Co-ordination draws up the quarterly national statistics and prepares the Annual TB Control Report sent in to the National Healthcare Information System (NHIS). The data management system is computerized within the CAT and the NTCP Co-ordination Directorate.

The data gathering and monitoring timetable, then, is as follows:

- Monthly gathering of data in the health center and transmission to the CSE (Epidemiological Surveillance Center).
- Quarterly gathering of data in the CDT, and transmission to the CSE (Epidemiological Surveillance Center). As in the NTCP's routine data-gathering system, the gathering of MDR-TB information will be done in the pulmonology departments, since for M&E purposes these are treated in the same way as CDTs.
- Quarterly compilation and analysis in the regional CAT of the data sent by the CSE.
- Quarterly compilation and analysis by the Coordinating Directorate of the data sent by the CAT, and annual transmission to the NHIS.

The other main sources of data are:

- The NRC's annual report on activities.
- The Annual Report on the National Healthcare Situation.
- The General Population and Residence census.

The WHO World TB Report.

4.8.3. Strengthening monitoring and evaluation systems

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

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

The improvements to the M&E system included in the proposal concern the information system, supervision/inspection and communication.

Information system

The inadequacies in the information system described above, which are liable to compromise the measurement of the program's impact, are covered by this proposal through the following means:

- the reproduction and distribution of data management aids;
- the preparation of domiciliary patient monitoring forms;
- the acquisition of computer bundles;

These activities will make it possible to improve the reporting of the data that make up the national system.

Supervision (coordinated by the DIPE – Information, Planning and Evaluation Directorate)
Supervision is a major component of the M&E system. The weaknesses here in the healthcare system will be made good by the following means:

- Organizing two supervisions by the NTCP of each of the three pulmonology departments.
- Moving from half-yearly inspections of the peripheral level by the intermediate level (in Year 1to Year 2) to quarterly inspections (Year 3 of Round 9);
- Organizing a half-yearly inspection of the intermediate level by the central level in Year 3 of Round 9.

Communication

Prompt reporting is an indicator of the M&E system's performance, and enables the data needed for efficient management of the activities to be made available in good time. The weaknesses of the system that have been observed in this area are largely due to inadequate means of communication. This concern has duly been addressed in Round 6. The present proposal aims to build on the achievements of Round 6 by covering the maintenance and insurance of vehicles and motorcycles. It is also intended that with funding from PEPFAR/COP07 the NTCP Co-ordination Directorate, all the CATs and the central laboratories involved in TB control will be equipped with fax machines

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	[National TB Program - NTCP]
Address	05 BP 1054 Abidjan 05 Tel : (225) 20 37 79 12/20 37 57 41 Fax: (225) 20 37 18 59 Mail : pnltrci@yahoo.fr

The NTCP is an organization set up to control TB. It has a Co-ordination Directorate with seven technical departments: procurement, M&E, laboratory, TB+HIV, communication & community monitoring, and treatment & capacity-building. These departments cover all aspects of TB control. The staff consists of physicians and pharmacists with full clinical, laboratory and pharmacological qualifications for TB treatment. The NTCP has been strengthened since 2008 by a Finance team composed of a Finance Officer, an accountant and an internal management auditor paid for by the Global Fund. Thus, having been a Sub-Recipient in Round 3, it became the Principal Recipient of Round 6. It has acquired considerable experience over five years in managing the financial support granted by the Global Fund. Implementation of Round 6 has made it possible for the NTCP to build its programming and financial capacity. Additionally, the project team has appropriated the Global Fund's directives and mechanisms. These acquisitions are yet another asset for efficient management of this proposal, to effectively reduce the burden of tuberculosis on the populations living in Côte d'Ivoire. Apart from the €5,555,634 granted by the Global Fund for Round 6, the NTCP manages €1,105,000 of funding from the Côte d'Ivoire government.

The NTCP's managerial capacities are also applied in the implementation of activities conducted together with national and international partners.

PR 2	CARITAS COTE D'IVOIRE (SOCIAL AND HUMAN ADVANCEMENT SERVICE OF THE CATHOLIC CHURCH OF COTE D'IVOIRE)

Address	01 BP 2590 ABIDJAN 01 - COCODY - II PLATEAUX - ANGRE 7è TRANCHE - LOT 3561 - RUE L135 / TEL (GROUP LINE) : + 225 22 42 06 84 / MANAGEMENT: (+ 225) 22 42 95 96 / Fax: (+ 225) 22 42 06 98 E-mail: caritascotedivoire@yahoo.fr / Sites: www.caritas.org / www.caritasafrica.org

CARITAS CÔTE D'IVOIRE is an Organization of the Catholic Church of Côte d'Ivoire, for coordinating social activities, development and human advancement.
It is a member of the CARITAS INTERNATIONALIS Confederation, with a Seat in Vatican City, Rome. CARITAS INTERNATIONALIS is composed of 170 Social Development Organizations of the Catholic Church, present and active in 200 countries and territories.
In Côte d'Ivoire, CARITAS was created in 1955 and registered with the Ministry of the Interior as Number 361 INT/AG of March 14, 1968. Since January 2009, it has been recognized as a Public Interest Association by the Côte d'Ivoire government, as #2009-04, January 8, 2009.
CARITAS COTE D'IVOIRE is a national network of social and development organizations of the Catholic Church that includes 15 Diocesan (Regional) Branches and 515 Basic Community (Parish) Teams throughout the national territory. This network is coordinated by the National Branch of CARITAS COTE D'IVOIRE.
CARITAS COTE D'IVOIRE has an Assistance and Emergency Branch, a Human Advancement and Development Branch, a Leadership, Communication, and Training Branch, and a Health Branch. The Health Branch coordinates the Catholic Church's Health Service Centers in partnership with the Church's other structures and organizations.

The Catholic Church of Côte d'Ivoire has a network of about 200 health facilities throughout the national territory, including 60 Reference Centers and Hospitals with varied technical support centers.
CARITAS COTE D'IVOIRE has a reassuring governance framework. Indeed, it has a reference document on administrative, financial, and accounting procedures, Financial Regulations, and a code of good conduct for member organizations. CARITAS COTE D'IVOIRE also has a Computerized Accounting Management System.

CARITAS COTE D'IVOIRE's overall resources come primarily from searches mobilized within the Christian community and the various project grants. Annually, about 700 million CFA, or €1,067,143.12, are managed by the national CARITAS-CI network. CARITAS-CI also receives funding from Secours Catholique-CARITAS-France, the PEPFAR, and the UNHCR.

CARITAS-CI produces periodic program and financial reports as part of these projects. The financial management software 'CIEL COMPTA' is in operation.

CARITAS COTE D'IVOIRE has substantial experience and expertise in managing programs and community projects. Since 1991, it has managed the multi-sector Liberian refugee aid program in partnership with the United Nations High Commission for Refugees and the Government of Côte d'Ivoire, via the Ministry of Foreign Affairs.
Since 1995, CARITAS COTE D'IVOIRE has been managing various HIV/AIDS control projects with various partnerships (NTCP, CAT, Global Fund, PEPFAR, COTE D'IVOIRE ALLIANCE, CARE COTE D'IVOIRE, PSI, EGPAF, USAID, UNICEF, CRS – CARITAS USA, SECOURS CATHOLIQUE – CARITAS France, COSCI, ARSIP, Ministry for AIDS).
CARITAS COTE D'IVOIRE's areas of intervention in HIV/AIDS control involves Prevention as well as the multi-sector care of persons affected and infected by HIV, including Orphans and Vulnerable Children.
CARITAS COTE D'IVOIRE is a leader in HIV/AIDS control on the community level. Its actions have mobilized and coached other religious communities in their commitment to the effort.
This experience and acquired knowledge will be adapted and transferred to sub-recipients as part of their grant management.
For the management of this program, CARITAS COTE D'IVOIRE has a multi-disciplinary, quality team, with in-depth, long-term experience in community health.
CARITAS COTE D'IVOIRE has a network of community health units and birthing units, mainly in the North West Center (NWC) zones. It has trained more than 5,000 Community Health Workers (CHW) and more than 2000 Matrons and provided them to the community. Due to the war, these community health facilities and the trained workers have made up for the deficiencies or closings of public health facilities.
CARITAS COTE D'IVOIRE already has certain structures and organizations in its network that ensure community monitoring of tuberculosis patients.
This acquired experience could be built on and used to help implement this project.
The proximity of the Church's health facilities with the populations is a real asset in community care of

tuberculosis patients. Likewise, CARITAS COTE D'IVOIRE is an active member of several NGO networks nationally (ARSIP, COSCI, RESOCI, CSCI, ANAFCI, GSSAN), which will make it easier to work together with those who contribute to rolling out this project.

PR 3	[Name]
Address	[street address]
[Description]	

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

4.9.2 Sub-Recipients		
(a) Will sub-recipients be involved in program implementation?	**X**	Yes
	☐	No
(b) **If no**, why not?		
(c) **If yes**, how many sub-recipients will be involved?	**X**	1 – 6
	☐	7 – 20
	☐	21 – 50
	☐	more than 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	**X**	Yes ***[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.		

In regard to the challenges to be met in the areas of TB control, the NTCP has decided to involve civil society in rolling out this proposal. To a certain extent, ignorance and lack of information are the seedbed of contagious diseases, and the media appear to be the most appropriate means for conveying information on tuberculosis to the entire population. Thus, a media professional has been selected for the rollout of the awareness communication component. It is the Network of Media Professionals in the Arts Against AIDS and other Pandemics in Côte d'Ivoire, known as REPMASCI.
Between the R3 and the R6, we are seeing a build-up of national NGOs taking action in community care of tuberculosis. Elsewhere, we observe low participation rates from the private sector in the effort against TB. For more effective community control and a build-up of the private sector's involvement in anti-TB activities, the Côte d'Ivoire federation of organizations controlling TB and lung disease was selected by the CCM.

Sub-recipient 1: The Network of Media Professionals in the Arts Against AIDS and Other Pandemics in Côte d'Ivoire, known as REPMASCI.

At the start of rollout for this project, the REPMASCI, with the support of a communications firm, will develop a media plan for the first five years of the project. For the rollout of this plan, a workshop for audiovisual media managers will be organized. During this workshop, information on tuberculosis is given to the media actors, who will be invited to propose messages and media (radio, TV, mobile phone) for awareness. These messages will be about prevention, screening, and treatment of tuberculosis; TB-HIV co-infection; and multi-drug-resistant TB. Proposals from media organizations will be subject to selection. The selected organization will contract with CARITAS-CI on the basis of the media plan.

Sub-recipient 2: President of COLTMR-CI (Collective of Organizations Against Tuberculosis and Respiratory Diseases of Côte d'Ivoire)

Except for activities involving community health workers, all other activities in the service area of "community TB care" will be entrusted to CARITAS-CI. The NGO supervision activities begun by Caritas will be conducted by a team composed of one member each of the NTCP, CARITAS-CI, and COLTMR. Active TB screening in businesses will be CARITAS-CI's responsibility.

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.

REPMASCI, that NGO of media professionals, possesses solid experience in mass awareness-raising through the media in the area of HIV. This expertise will be put to good use under this proposal, both for the creation of messages and choice of various communications channels to be used.

COLTMR-CI, by combining their respective experience, the collective of NGOs within COLTMR-CI is a definite asset for greater involvement of the community sector in the respiratory health campaign in Côte d'Ivoire. Within this collective, some NGOs have already received funding from R6 on the basis of their project's relevance. With regard to the respective outcomes and experience acquired in the field, their grouping in a structure under the CARITAS-CI's responsibility is a positive contribution for achieving the objectives assigned to this proposal.

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.

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)*.

For the rollout of Round 9 activities, two primary recipients (NTCP, CARITAS-CI) and two sub-recipients (REPMASCI, COLTMR-CI) have been designated. CARITAS-CI is responsible for both sub-recipients in charge of rolling out certain DPS from the community sector of communications, through the media and private businesses.

PNLT-CARITAS-CI

Each PR will coordinate activities under the DPS that are entrusted. However, because the project is so unique, the two PR will organize periodic quarterly meetings to measure the project's progress and identify the obstacles in the field against rollout of activities and propose corrective measures. When a single DPS will be conducted by both PR, they will come to an agreement so that the one's rollout of activities does not disrupt the rollout of the other's. Thus, the active TB screening in private businesses is an activity led in cooperation by both PRs. The NTCP will provide CARITAS-CI with the required consumables and laboratory reagents in good time, as per the mutually-approved activity schedule. This same working procedure will be applied each time it is required in the context of rolling out the activities of this proposal.

CARITAS-CI- REPMASCI

CARITAS-CI delegates a portion of the awareness, communication, and social mobilization component to the REPMASCI. There will be a partnership agreement between CARITAS-CI and this entity. CARITAS-CI will provide the REPMASCI with all the resources required for the rollout of the delegated activities. For the REPMASCI, it is a question of managing awareness-raising, communication, and social mobilization activities, and developing communication through the media, as per the specifications binding CARITAS-CI and the REPMASCI. A monthly meeting will be organized between CARITAS-CI and this sub-recipient to ensure proper monitoring of these activities. A quarterly report will be provided to CARITAS-CI by the REPMASCI. An annual audit of the REPMASCI will be organized by CARITAS-CI with the help of an auditing firm.

CARITAS-CI-COLTMR-CI

Except for activities involving community health workers, all other activities in the delivery area of "community TB care" will be entrusted to COLTMR-CI. As with the REPMASCI, a contract will be established between CARITAS-CI and the COLTMR-CI. Supervision activities by NGOs initiated by COLTMR-CI will be led by a team consisting of one member of the National Tuberculosis Program (NTP), one member from COLTMR-CI, and 1 member from CARITAS-CI. These activities will be coordinated and monitored through monthly meetings between CARITAS-CI and COLTMR-CI. COLTMR-CI will provide a quarterly report to CARITAS-CI.
CARITAS-CI will arrange an annual audit of COLTMR-CI with help from an auditing firm.

Support partners in implementing projects

As part of implementing activities, the Green Light Committee (GLC) will be involved in approving therapy protocols and negotiating reduced pricing for second-line drugs. The Global Drug Facility (GDF) will be involved in purchasing first- and second-line drugs.

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 fulfil 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.)*

Personnel involved in controlling tuberculosis have lots of general experience with case management of tuberculosis. However, certain aspects of tuberculosis control will require technical support to implement this proposal. Needs for technical assistance stem from a situational analysis (weaknesses, gaps in coverage of needs) described under Question 4.3.1.
The NTP stridently wishes to meet the performance criteria for a tuberculosis control program. It plans to bring its services up to the international standards governing performance. To get there, we request external support in the form of technical assistance for the following areas:

- technical assistance for the National Reference Center (CNR) by the supranational laboratory;
- an international consultant to evaluate the strategic plan;
- an international consultant to help draft the Strategic Plan 2011-2015;
- an annual mission to certify the culturing laboratories in Abidjan;
- a national consultant to help write the training manual and student workbook on the STOP-TB strategy;
- a national consultant to help write the training manual and student workbook on drug inventory management;
- a national consultant to help write the training manual and student workbook on direct examination of sputum samples;
- a consultant to help the NTP carry out requests for proposals;
- an auditing firm.

Consultants will be recruited in a transparent manner, based on national and international procedures for requests for proposals.
The effectiveness of this assistance will be measured through the production of quality documents and the certification of culturing laboratories in Abidjan. At the activity implementation level, the effectiveness of the assistance will be evaluated through improved program performance by following the recommendations made. Performance levels achieved by program personnel through this technical assistance will make the knowledge learned sustainable.

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.*
	X 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	Ministère de la santé et de l'hygiène publique (MSHP – Ministry of Public Hygiene and Health)	PR (NTP)	X Yes ☐ No
Intellectual property rights	MSHP through the Direction de la pharmacie et du médicament (DPM – Drug and Pharmacy Administration) and the NTP	PR (NTP)	☐ Yes X No
Quality assurance and quality control	LNSP	PERFORMING BODY	☐ Yes X No
Management and coordination *More details required in s.4.10.3.*	NTCP	PR	X Yes ☐ No
Product selection	NTCP	PR	☐ Yes X No
Management Information Systems (MIS)	NTCP	PR	X Yes ☐ No
Forecasting	NTCP	PR	X Yes ☐ No
Procurement and planning	NTP/PSP-CI	PR/PERFORMING BODY	X Yes ☐ No
Storage and inventory management	NTP/PSP-CI	PR/PERFORMING BODY	☐ Yes

More details required in s.4.10.4			X No
Distribution to other stores and end-users *More details required in s.4.10.4*	NTP/PSP-CI	PR/PERFORMING BODY	☐ Yes X No
Ensuring rational use and patient safety (pharmacovigilance)	NTP/DPM	PR/PERFORMING BODY	☐ Yes X 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)*
NTCP	PR	82,800.20 euros
Pharmacie de la santé publique de Côte d'Ivoire (PSP-CI – Public Health Pharmacy for Côte d'Ivoire)	Performing officer	27,557,904 euros
GDF	Performing officer	
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

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

The PSP-CI is the national center for procurement, storage, and distribution center for drugs and strategic incoming medical supplies. The PSP-CI uses normal purchasing procedures to procure medical products and strategic incoming medical supplies (International Request for Proposals, acceptance of products) using financing from the Nation of Côte d'Ivoire.

As for external funding, development partners procure their own medical products and strategic incoming medical supplies using their own procedures and channels. In that case, the PSP-CI only stores and distributes these products. In regards to distribution, PSP-CI provides supplies down to the health district level, using its own projected inventories. Health center managers come to the district pharmacy once a month to obtain supplies. Work is underway to set up a drug-monitoring system. A sub-administration for drug-monitoring and a national steering committee were created in order to make this system operational. This committee is responsible for taking the necessary steps to manage and report adverse reactions.

Focal Points for drug-monitoring were identified in each Health District. They will be responsible for collecting information coming from health centers. In regards to tuberculosis, the specific focal points will be positioned in the 16 Centres Antituberculeux (CAT – Tuberculosis Control Centers) and the 3 pneumology departments. The CAT focal points will be responsible for collecting records in the areas they oversee. Records collected by each focal point will be transported to the NTP's Monitoring and Evaluation department once per quarter. An emergency procedure will be put in place to handle the occurrence of unusual adverse reactions.

4.10.5. Storage and distribution systems		
(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	X	National medical stores or equivalent
	☐	Sub-contracted national organization(s) *(specify)*
	☐	Sub-contracted international organization(s) *(specify)*
	☐	Other: *(specify)*

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

At the logistics and infrastructure level, the PSP-CI has five (5) large storage warehouses and a cold room. The total storage capacity is approximately 10,000 m^2. Warehouses are equipped with pallet racks that maximize the stockpiling of products and their best vertical storage. These storage capacities are plenty large enough to accommodate expected volumes.

(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.

Following redeployment of the administration and health personnel, PSP-CI has resumed its activities to procure pharmaceutical products for the entire country. Therefore, PSP-CI once again covers all of the country's regional and departmental health administrations, or 100% of the country. All rural health facilities receive supplies from the health district to which they report. Urban local health clinics, district hospitals, regional hospitals, and university hospitals receive supplies directly from the PSP-CI. Therefore, the entire population has access to drugs via these health institutions.

This proposal anticipates the purchase and distribution of second-line anti-TB drugs for 230 patients afflicted with MDR-TB during the five years. The NPT will distribute second-line drugs to pneumology departments.

4.10.6. Pharmaceutical and health products for initial two years

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

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

The proposal includes both first- and second-line drugs. These are:

Rifampicin, Isoniazid, Ethambutol, Pyrazinamide, Streptomycin, Kanamycin,

Levofloxacin, Prothionamide and PAS.

1- first-line treatment:

- New case 2RHZE/4RH
- Old case: 2RHZES/1RHZE/5RHE

2- second-line treatment:

6ZKmLfxPtoPAS/18LfxPtoPAS

These compounds are known and used in first- and second-line treatment for tuberculosis. All these drugs appear on the essential medicines list. Prothionamide was just added through the urgent procedures channel.

4.10.7. Multi-drug-resistant tuberculosis	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	**X** 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').

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

Clarified Section:

➔ *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	6 664 358	6 618 500	7 926 440	9 511 728	10 462 901	11 509 191	12 660 110	13 926 121
Line A.1 ➔ Total need over length of Round 9 Funding Request *(combined total need over Round 9 proposal term)*								58 070 051
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	1 927 923	1 833 280	1 558 288	1 500 631	1 980 934	2 019 351	2 057 768	2 096 165
Domestic source **B3** Private Sector contributions (national)				22 867	22 867	25 154	25 154	27 669
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	1 927 923	1 833 280	1 558 288	1 523 498	2 003 801	2 044 505	2 082 922	2 123 834
External source **C 1** (*WHO*)	20 900	27 212	27 212	0	0	0	0	0
External source **C2** (*provide source name*)	0	0	762 245	381 122	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** Private Sector contributions (International)				0	**0**	0	0	0
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	20 900	27 212	789 457	381 122	0	0	0	0
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	288 199	1 011 477	1 911 929	1 032 444	1 524 862	0	0	0
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	2 237 022	2 871 969	4 259 674	2 937 064	3 528 663	2 044 505	2 082 922	2 123 834
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)	4 427 336	3 746 531	3 666 766	6 574 664	6 934 238	9 464 686	10 577 188	11 802 287
Line G = Round 9 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				6 479 814.02	3 192 443.01	7 738 171.39	7 672 040.89	8 894 862.67

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

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

(36,534,636.98 X 100/58,070,051) **= 62.9 %**

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.

The calculations account for data from the strategic plan 2006-2010 and updates to said data. The annual progression starting in 2010 is calculated based on the rate of disease progression seen in 2007, which was 5%.

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.

Every year, Côte d'Ivoire holds a budget conference, during which needs related to tuberculosis control are expressed. There is a fund systematically allocated to high-priority programs: Tuberculosis, AIDS, and the Expanded Program on Immunization to procure drugs and vaccines. This fund is held by the Pharmacie de la Santé Publique (PSP) This contribution from the government also accounts for all personnel, equipment, and supplies to control tuberculosis.

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)).

Contributions from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and WHO are reported to the Ministère de la Santé et de l'Hygiène Publique (MSHP) for Côte d'Ivoire. However, it should be stressed that the PEPFAR contribution experiences a delay due to making the funds available.

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/

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
01	Pursue the extension of a high-quality DOTS and its upgrade						
	SDA 1-1 Improving Diagnosis	1,691,867.78	394,755.45	369,160.30	168,094.34	138,789.59	2,762,667.46
	SDA 1-2: Patient support	0.00	0.00	480,969.03	480,969.03	480,969.03	1,442,907.08
	SDA 1-3: Procurement and management of supplies	427,068.72	60,849.67	1,759,821.08	1,914,861.32	2,086,488.33	6,249,089.12
	SDA1 1-4: Monitoring & evaluation	16,161.43	16,924.00	82,544.66	16,565.47	16,565.47	148,761.02
	SDA 1-5: Management and supervision of program	788,188.93	511,934.30	1,267,330.41	938,913.38	951,494.94	4,457,861.95
	SDA 1-6: Human Resource Development	567,221.57	331,582.65	489,216.63	570,975.76	492,909.71	2,451,906.32
	Subtotal Goal 1	3,490,508.43	1,316,046.07	4,449,042.10	4,090,379.29	4,167,217.06	17,513,192.95
02							
	SDA 2-1. TB – HIV: Collaboration in the area of controlling TB-HIV co-infection	0.00	0.00	0.00	0.00	0.00	0.00
	SDA 2-2: MDR-TB	710,220.80	1,327,481.75	1,813,901.40	2,094,968.15	2,350,886.46	8,297,458.56
	SDA 2-3-1: High-risk group: Prisoner	285,156.50	19,932.71	11,235.65	11,235.65	11,235.65	338,796.15
	SDA 2-3-2: Fight against infection	237,730.24	41,400.00	45,306.51	41,400.00	41,400.00	407,236.74
	S/Total Goal 2	1,233,107.54	1,388,814.46	1,870,443.55	2,147,603.80	2,403,522.10	9,043,491.45

ROUND 9 – Tuberculosis

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
03							
	SDA 3-1: All caregivers	37,552.77	30,108.68	24,001.57	24,001.57	24,001.57	139,666.17
	S/Total Goal 3	37,552.77	30,108.68	24,001.57	24,001.57	24,001.57	139,666.17
04							
	SDA 4-1: Advocacy, communication and social mobilization	909,146.05	126,815.11	107,318.28	103,802.61	888,619.49	2,135,701.53
	SDA 4-2: Community TB care	385,585.23	121,807.27	781,130.38	804,344.40	829,595.54	2,922,462.83
	Subtotal Goal 4	1,294,731.28	248,622.38	888,448.66	908,147.01	1,718,215.03	5,058,164.36
	PROGRAM TOTAL	**6,055,900.02**	**2,983,591.59**	**7,231,935.88**	**7,170,131.67**	**8,312,955.76**	**31,754,514.93**
	The principal recipient's management costs (5% of program total)	423,913.00	208,851.41	506,235.51	501,909.22	581,906.90	2,222,816.05
Round 9 tuberculosis funding request:		6,479,813.02	3,192,443.01	7,738,171.39	7,672,040.89	8,894,862.67	**33,977,330.98**

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	228,124.71	202,513.27	389,545.35	389,545.35	389,545.35	1,599,274.04
Technical and Management Assistance	32,059.37	4,344.80	4,344.80	7,774.90	7,774.90	56,298.77
Training	745,794.01	201,339.49	721,814.76	823,357.81	768,576.29	3,260,882.36
Health products and health equipment	1,473,154.36	418,593.43	686,654.16	633,001.37	634,640.13	3,846,043.44
Pharmaceutical products (medicines)	237,100.00	798,400.00	2,604,167.50	2,937,025.00	3,283,046.50	9,859,739.00
Procurement and supply management costs	85,512.72	60,849.67	164,541.08	178,501.32	195,884.33	685,289.12
Infrastructure and other equipment	1,877,061.39	547,581.80	479,622.26	192,426.02	165,084.27	3,261,775.75
Communication Materials	170,404.11	138,190.51	222,708.58	215,286.41	218,802.08	965,391.68
Monitoring & Evaluation	872,152.30	85,058.34	245,296.25	179,317.07	960,618.28	2,342,442.24
Living Support to Clients/Target Populations	168,773.01	250,756.43	962,834.02	1,021,929.10	1,084,431.14	3,488,723.69
Planning and administration	30,000.00	30,000.00	212,938.82	217,512.29	222,085.76	712,536.87
Overheads	135,764.05	245,963.85	537,468.29	374,455.04	382,466.73	1,676,117.97
Other:	0.00	0.00	0.00	0.00	0.00	0.00
PROGRAM TOTAL	**6,055,900.02**	**2,983,591.59**	**7,231,935.88**	**7,170,131.67**	**8,312,955.76**	**31,754,514.93**
The principal recipient's management costs 7%	423,913.00	208,851.41	506,235.51	501,909.22	581,906.90	2,222,816.05
Round 9 tuberculosis funding request (*Should be the same annual totals as table 5.2)*	6,479,813.02	3,192,443.01	7,738,171.39	7,672,040.89	8,894,862.67	**33,977,330.98**

5.4.1. Overall budget context
Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.
- ***Human resources*** The increase reported starting in Year 3 is because we account for personnel hired under Rounds 3 and 6 - ***Medical products and Medical Equipment*** The decrease reported is a result of x-ray devices being anticipated in Year 1. The rest of purchases relate to consumable supplies and minor laboratory equipment, protective masks. - ***Medicines*** For the first two years, drugs are essentially first-line drugs. Starting in Year 3, the plan is to acquire second-line drugs as well as first-line drugs. - ***Infrastructure and Other Equipment*** The important variance reported between Year 1 and the other years is primarily because most restoration will take place in Year 1. - ***Human support to patients and target populations*** Funding for 34 micro-projects, treatment of MDR-TB and nutritional supplementation for vulnerable patients are elements contributing to the increase noted starting in Year 3.

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*

Human resources equal 5% of total financing requested from the [Global Fund]. The staff in question consists of 4 laboratory technicians, 4 nurses to be hired in the local health clinics, an accountant, and a driver to strengthen the management team. The 4 laboratory technicians and 4 nurses strengthen the capacity to detect tuberculosis cases in the private or association sector. In these structures, it is difficult to treat tuberculosis due to a lack of motivated and available personnel.

The personnel treated under Round 3 and Round 6 will be taken into consideration starting in Year 3 of Round 9. This consists of a driver and an Assistant Manager (R3), a Finance Manager, an Internal Auditor, and an Accountant (R6). The administrative personnel and management team strengthened the Program's administrative and financial management capacity. As a reminder, the NTP is the Principle Recipient for the Round 6 proposal currently underway. It was also proposed as the Principle Recipient for Round 9.

This heading also accounts for additional compensation for 27 government officers. Compensation for government personnel constitutes a source of motivation for officers working outside normal hours, under stress, and under pressure to implement the program's projects.

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*

- **TRAINING**

The budget allocated for training equals 10% of the total budget for the term of the project. The amount for Year 1 is € 745,794.01 and for Year 2 is € 201,339.49. This funding will serve to strengthen the capacity of all players involved in tuberculosis control. Costs were calculated based on professional fees for trainers and facilitators, transportation costs, lodging during training, as well as supplies related to workshops and training sessions.

Training gives us human resources capable of acting throughout across the entire range of the tuberculosis control strategy from awareness-raising and detection to treatment of patients.

- **MEDICAL SUPPLIES AND MEDICAL EQUIPMENT**

Medical supplies and medical equipment equal 11% of the total requested from the [Global Fund]. X-ray machines help prevent and detect tuberculosis cases. Masks help combat nosocomial transmission of tuberculosis. Reagents and consumable laboratory supplies help strengthen prevention and detection of cases.

- **PHARMACEUTICAL PRODUCTS**

Second-line drugs will be purchased starting in Year 1. First-line drugs will be purchased starting in Year 3. These products equal 29% of the grant requested.

- **Infrastructure and Equipment**

The budget allocated to this budget category amounts to € 1,877,061.39 in Year 1 and € 547,581.80 in Year 2. For the term of the project, this is a total amount of € 3,261,775.75, or 10% of the program total. The costs are determined as a function of market prices considering the rate of inflation.

Funding will be used to renovate and equip new TC, Centre de diagnostic et de traitement (CDT – Diagnostic and Treatment Center), and Centre Antituberculeux (CAT – Tuberculosis Control Center).

- **HUMAN SUPPORT TO CLIENTS/TARGET POPULATIONS**

The budget allocated for target populations equals 10% of the total budget for the term of the project.

This contribution will help patients receive certain services for free in order to improve their state of health.

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.*

5.5.2. Measuring performance

How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.

5.5.3 Additionality of Global Fund request

Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism.

If the focus of the common fund is broader than the tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.

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	
4.2.1	Map if proposal targets specific region/population group	
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	
4.4	Document(s) that explain basis for coverage targets	
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).	
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	
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**	
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)	
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**List Annex Name and Number**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework*' *(or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)*** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**

Proposal checklist – Section 3 to 5
Tuberculosis

4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first two years and annual information for years 3, 4 and 5).	**Work plan**
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**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5.4.3	Information on basis of costing for 'large cost category' items	
5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	
Section 5B: HSS Cross-cutting financial information		**List Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).* Quarterly information for the first two years and annual information for years 3, 4 and 5).**	**Detailed Budget**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	
5B.4.3	Information on basis of costing for 'large cost category' items	
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**

Proposal checklist – Section 3 to 5
Tuberculosis

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Côte d'Ivoire
Disease:	Tuberculosis
Proposal ID:	Preventing multi-drug-resistant TB by improving comprehensive care of tuberculosis

Program Goal, impact and outcome indicators

	Goals
1	Reduce the national tuberculosis percentage by capitalizing on achievements in tuberculosis control efforts and by providing quality care for all tuberculosis patients.

Impact and outcome indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
Outcome	Case detection rate: New smear positive TB cases	37%	2007	WHO estimate	40%	42%	45%	47%	50%	Values estimated by the WHO in the IUATLD planning and budgeting tool
Outcome	Treatment success rate: New smear positive TB cases	73%	2007	E&R system NTCP annual report	75%	77%	78%	79%	80%	Annual report

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

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Pursue the extension of a high-quality DOTS and its upgrade	
2	Control HIV-TB co-infection and MDR-TB.	
3	Strengthen the public-private partnership	
4	Strengthen communication through mass media and community involvement	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative per year/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	Improving diagnosis	Number of tuberculosis cases detected with positive smear tests	15292	2008	E&R system NTCP quarterly report		13,212		13,918	17,514	19,517	19,368	Y	N	N - not cumulative	NTCP	Quarterly collection In the first two years, the numbers gathered did not take into account the CNW region (which are reported in R6). Beginning in the third year, the numbers pertain to the entire country.
1.2	Improving diagnosis	Number of laboratories with satisfactory direct microscopy quality assurance results compared to those that perform quality assurance each year	63	2008	E&R system NTCP quarterly report		91	91	104	109	122	127	N	N	N - not cumulative	NTCP	Annual collection
1.3	Human resource development	Number of quality assurance visits conducted for cultures and bacterial sensitivity tests by an international consultant at the National Reference Center	0	2008	E&R system NTCP annual report	1	2	3	4	6	8	10	Y	Y	Y - over program term	NTCP	Annual collection. The number of EQA assessments performed over the number to be performed
1.5	Purchase and inventory management (first line medications)	Number of tuberculosis care units that did not report first line drug inventory shortages resulting in interruptions in treatment over the course of the past year	109	2008	NTCP report	0	130		138	145	152	159	N	N	N - not cumulative	NTCP	Since the time it was founded, there have never been any drug inventory shortages at NTCP, due to support from GDF. Quarterly collection
1.6	All health care providers (PPM / ISTC)	Number of tuberculosis patients with positive smear tests in health care units at private companies	25	2008	Report on health care services in infirmaries at private companies		35		50	75	95	120	N	N	N - not cumulative	CARITAS	Quarterly collection at company infirmaries
1.7	Management and supervision of program	Number of supervisory visits conducted	218	2008	NTCP report		488		520	548	576	604	Y	Y	Y - over program term	NTCP	Quarterly supervision of peripheral structures and semi-annual supervision of regional structures
2.1	MR-Tuberculosis	Number of reported cases of MDR-TB	10	2008	NTCP report		60		70	80	90	100	N	N	N - not cumulative	NTCP	Quarterly collection
2.2	MR-Tuberculosis	Number of tuberculosis patients who received a first-line tuberculosis drug sensitivity test among the patients eligible for this test according to national policy	1415	2008	E&R system NTCP annual report		1660		1809	1978	2170	2387	N	N	N - not cumulative	NTCP	Quarterly collection
2.3	MR-Tuberculosis	Number of MDR-TB patients receiving incentive measures	0	2008	Log of MDR-TB patients	0	10	10	40	50	60	70	Y	N	N - not cumulative	NTCP	The targets take into account only newly included patients
2.4	High-risk groups	Number of prisons involved in tuberculosis screening	5	2008	NTCP report		15		20	25	30	30	N	Y	Y - over program term	NTCP	Quarterly collection at 30 prisons where there are active tuberculosis screenings
3.1	Enlist all caregivers	Number of private sector agents trained in identifying and directing suspected tuberculosis cases to the CDT treatment centers	0	2008	training reports	50	100	150	200	300	400	500	Y	N	Y - over program term	CARITAS	Quarterly collection
4.1	Community TB care	Number of ASC mentoring meetings	52	2008	NTCP report		248		272	476	500	524	Y	N	Y - over program term	NTCP	Monthly collection with quarterly reporting to the GF